COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Non-Hospital Medical and Surgical Facilities Accreditation Program

ACCREDITATION STANDARDS

Procedural Pain Management

Non-Hospital Medical and Surgical Facilities Accreditation Program
College of Physicians and Surgeons of British Columbia
300–669 Howe Street
Vancouver BC V6C 0B4

Introduction

Procedural pain management (PPM) procedures are categorized into four tiers (basic, intermediate, advanced I and advanced II) in accordance with the BC MQI provincial privileging dictionary.[1] Basic and intermediate procedures, **with the exception of caudal and interlaminar lumbar epidural procedures**, may be performed in the physician office setting and are not subject to accreditation review by CPSBC. Caudal and interlaminar lumbar epidural procedures, advanced I, and advanced II procedures deemed appropriate for the community setting (i.e. outside of the hospital or health authority facility setting) may only be performed in an office, clinic or facility that has been accredited by the CPSBC Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP).

The PPM standards are outlined in several documents:

- procedural pain management (core) standards
- imaging modality (e.g. X-ray, ultrasound) standards
- emergency cart standards

Leadership and governance

Each PPM non-hospital facility has a leadership structure that is ultimately responsible for the quality and safety of services provided. The governance structure in a privately-owned facility may be a formal partnership group, a group of individual practitioners sharing resources, or an individual as the sole proprietor. Each non-hospital facility must have a leadership structure. Many leadership responsibilities directly affect the provision of PPM services as well as the day-to-day operations of the non-hospital facility.

No.		Description	Reference	Risk	Change
PPM1.0		**ACCOUNTABILITY AND RESPONSIBILITY**			
PPM1.1		**Accountability and responsibility are assigned for key leadership functions.**			
PPM1.1.1	**M**	A medical director is appointed responsibility for the quality and safety of the medical practice within the PPM service. *Guidance: A medical director is appointed with assigned responsibilities and accountabilities for the quality and safety of services delivered at the facility. In a solo- physician non-hospital facility, the physician is the medical director. In a multi-physician non-hospital facility, a physician who is a registrant of the CPSBC and who practises at the non-hospital facility must be appointed as the medical director.*	2, 3	H	

Medical director responsibilities

Credentialing and privileging

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 (http://bcmqi.ca/privileging-dictionaries/).

Credentialing and privileging, for physicians who hold privileges in PPM at any non-hospital facility, is performed by the medical director. There must be a formal process used for credentialing and privileging, and it is the expectation of these accreditation standards that the medical director can demonstrate these processes and provide documentation.

No.		Description	Reference	Risk	Change
PPM2.0		**MEDICAL STAFF CREDENTIALING AND PRIVILEGING**			
PPM2.1		**The medical director of a non-hospital facility ensures that PPM services are provided by qualified and competent physicians.** *Guidance: The medical director is responsible for ensuring that the credentialing and privileging of physicians takes place. In a multi-physician facility, this means ensuring that the physicians who practise in their non-hospital facility are appropriately credentialed by reviewing the credentials of the physician and ensuring that the physician has met all of the requirements for privileging. In a solo-physician facility, this means ensuring that they themselves are qualified and competent to undertake the scope of medical service provided within their non-hospital facility.*			
PPM2.1.1	**M**	The medical director grants physician privileges within the PPM service. *Guidance: An Application to Medical Director for Appointment to a Non-Hospital Medical/Surgical Facility - Physician, completed appropriate procedure list specifying the procedures the physician is requesting to perform at the facility and other required credentialing documents are submitted to the medical director by the physician applying for privileges. The medical director reviews the application form and supporting documents submitted by the applicant in accordance with the Checklist for Appointment to a Non-Hospital Medical/Surgical Facility. If the medical staff member is appointed to the facility, the medical director submits the Notification of New Medical Staff Appointment Form along with their appropriate procedures list to the NHMSFAP. Once the medical director has submitted the completed forms to the NHMSFAP, the medical staff member can begin practising at the non-hospital facility at the medical director's discretion. The medical director is responsible for granting physician privileges. Appendix A outlines the PPM procedures restricted to accredited facilities.*		H	

No.	Description		Reference	Risk	Change
PPM2.1.2	**M**	The medical director meets with the medical staff applicants to review their application, procedures requested and current experience. *Guidance: The medical director is responsible for confirming the applicant's current experience, confirming that the procedures selected are appropriate for the facility and following the BCMQI privileging dictionaries to ensure physician procedure requests meet specialty privileging and current experience requirements. The application interview is documented and filed in the individual's human resource file.*		H	New
PPM2.1.3	**M**	The medical director confirms the medical staff applicant meets the specialty privileging and current experience requirements specified in the BCMQI privileging dictionaries. *Guidance: Interview documentation makes note of the appropriate BCMQI privileging dictionary and confirms credentials and current experience.*		H	New
PPM2.1.4	**M**	The medical director meets with medical staff annually to review their re-appointment application. *Guidance: Reappointment interviews are documented and filed in the individual's human resource file.*		H	New
PPM2.1.5	**M**	The medical director confirms the reappointment applicant meets the current experience requirements specified in the BCMQI privileges dictionaries for the procedures they are requesting renewal of privileges to perform. *Guidance: Interview documentation makes note of the appropriate BCMQI privileging dictionary (not applicable for dentist applications), confirms current experience and identifies the procedures the applicant is re-privileged to perform at the facility.*		H	New
PPM2.1.6	**M**	The medical director reviews and discusses with the reappointment applicant any changes to their privileges at any facility or any regulatory restrictions on their practice during the previous year. *Guidance: Interview documentation makes note of this discussion and the outcome. Non-renewal or denial of privileges due to competence or conduct requires reporting to the medical staff member's regulatory college.*		H	New

No.		Description	Reference	Risk	Change
PPM2.1.7	**M**	Each physician with privileges at the facility holds current licensure with the College of Physicians and Surgeons of British Columbia. *Guidance: Physician licensure is confirmed through the College of Physicians and Surgeons of British Columbia website and/or by contacting CPSBC directly for relevant licence information. Confirmation of the physician's annual licensure is obtained and maintained in the individual's human resource file.*		H	
PPM2.1.8	**M**	Each physician is in good standing with the College of Physicians and Surgeons of British Columbia. *Guidance: The certificate of professional conduct from the College of Physicians and Surgeons of BC at time of initial appointment is maintained in the individual's human resource file.*		H	New
PPM2.1.9	**M**	An initial application for privileges is on file for each physician. *Guidance: A physician may apply to the medical director for a medical staff appointment to the non-hospital facility for a period of up to one year. The application states the procedures they wish to perform, their qualifications and evidence of current experience in practice relevant to the procedure(s) being requested and such applications are made on a form approved by the registrar (i.e. NHMSFAP form: Application for Medical Staff Appointment).*		M	New

No.		Description	Reference	Risk	Change
PPM2.1.10	**M**	Each physician providing PPM services have the requisite credentials for privileges as outlined in the provincial privileging dictionaries. *Guidance: To support consistent practice standards, credentialing requirements to practice PPM have been developed by the BC MQI. The BC MQI privileging dictionaries have been adopted by CPSBC. Physicians wanting to start or continue performing PPM procedures in the community setting will need to provide evidence of meeting the credentialing requirements as outlined in the BC MQI privileging dictionaries. Grandparenting will not be considered.* *PPM may not be considered a core privilege in some specialties and therefore may require further training, experience and demonstrated skills. NHMSFAP Applications for Appointment to Facility are kept on file at the PPM facility/office/clinic for each physician. Physicians may only perform those procedures which are permitted within the facility and for which the physician is privileged to perform at the non-hospital facility in accordance with the standards, rules, policies, guidelines respecting qualifications necessary for the appointment of a physician as established by the NHMSFAP Committee.*		H	Rev. Guidance
PPM2.1.11	**M**	The medical director maintains records of each physician's procedures, and these are submitted annually to CPSBC. *Guidance: In accordance with the Bylaws, the types and numbers of procedures performed by each physician in that non-hospital facility is recorded and submitted to CPSBC annually and upon request. The types and numbers of procedures performed by each physician may also be used by the medical director as one aspect of verifying physician currency as part of annual reappointment credentialing and privileging processes.*		M	

No.	Description	Reference	Risk	Change
PPM2.1.12	**M** The medical director monitors the professional performance of medical staff practising PPM through annual performance review and renewal of appointment processes. *Guidance: An Annual Reapplication for Privileges is on file for each physician. Renewal credentialing and privileging procedures include comparing the clinical privileges requested with the competency and currency requirements as outlined in the provincial privileging dictionaries (http://bcmqi.ca/privileging-dictionaries/). For solo-physician non-hospital facilities, documentation of annual reapplication for privileges of themselves (the solo physician) is reviewed at time of accreditation. For multi-physician non-hospital facilities, the medical director ensures that all physicians working in the non-hospital facility participate in annual performance review and renewal of appointment processes.*		M	

PPM3.0 DELEGATED MEDICAL ACTS

PPM3.1 **Delegated medical acts are clearly defined and performed by competent individuals.**
Note: A delegation occurs when a physician authorizes the performance of a medical act to a person who is not authorized to do so as part of a regulated health professional scope of practice. A delegation may also occur when a physician authorizes the performance of a medical act to a person who is not a regulated health professional (e.g. medical office assistant, technician). ***PPM procedures cannot be delegated*** *to another physician or person to perform. Administering medications or contrast dye and taking vital signs are examples of medical acts that may be delegated. It is not anticipated that PPM non-hospital facilities will need to delegate medical acts. However, if delegation does occur, this standard outlines the requirements for appropriate delegation. A medical act can be delegated with appropriate training and oversight so as to ensure patient safety. The medical director of the non-hospital facility must further evaluate organizational risk before approving the undertaking.*

No.		Description	Reference	Risk	Change
PPM3.1.1	**M**	Each delegated medical act is clearly defined, and the degree of medical supervision required is identified. *Guidance:* ***PPM procedures cannot be delegated to another physician or person to perform. Administering medications or contrast dye and taking vital signs are examples of medical acts that may be delegated.*** *The delegated medical act must be clearly defined in non-hospital facility policy, which includes a description of the delegated act, the competency requirements to perform the delegated medical act, and the degree of medical supervision required. Medical supervision may be direct, with the physician in attendance, or through technology (e.g. video link, telephone).*		H	
PPM3.1.2	**M**	The delegation of the medical act has been accepted by the individual(s) who will perform the delegated medical act. *Guidance:* ***PPM procedures cannot be delegated to another physician or person to perform. Administering medications or contrast dye and taking vital signs are examples of medical acts that may be delegated.*** *There shall be documentation on file confirming that the person performing the delegation has been trained in the delegated medical act and has accepted the delegation. This documentation should be dated and include the name and signature of the physician delegating the medical act, the name and signature of the person accepting the delegation, and the name and signature of the medical director.*		M	
PPM3.1.3	**M**	Agreement from the medical director has been obtained prior to the delegated medical act being carried out in the non-hospital facility. *Guidance: There is consensus in the medical community that the delegation of the medical act is appropriate.* ***PPM procedures cannot be delegated to another physician or person to perform. Administering medications or contrast dye and taking vital signs are examples of medical acts that may be delegated.*** *The medical director's agreement to the medical act being delegated is indicated by their approval of the facility's delegated medical act policy.*		H	

No.	Description	Reference	Risk	Change
PPM3.1.4	**M** Competency assessments to perform a specific delegated medical act are conducted by a physician or technical delegate initially and annually, and the competency assessments are recorded. *Guidance: The competency assessment of the technical delegate is conducted by a physician with relevant expertise in the medical act. The delegated medical act records must include all of the following: the name of the individual, date of assessment, the specific acts assessed, name of physician or delegate conducting the assessment, and signature of the physician attesting to the competence of the individual.*		H	

Human resources

The non-hospital facility must have methods in place to ensure that staff is managed as effectively as possible, since the quality of care and services provided within the PPM service will be affected by the quality of the staff working there. The human resources accreditation standard outlines the qualifications of various regulated and non-regulated health professionals that may be on staff at a PPM non-hospital facility. The types of regulated and non-regulated health professionals employed at the PPM non-hospital facility is left to the discretion of the medical director based upon the types of PPM procedures performed and the imaging modalities used.

No.	Description	Reference	Risk	Change
PPM4.0	**HUMAN RESOURCES**			
PPM4.1	**The facility has qualified and competent staff to deliver services.**			

No.	Description		Reference	Risk	Change
PPM4.1.1	**B**	Job descriptions are available for regulated health professionals or staff with positions that require entry-to-practice certification. *Guidance: The medical director is responsible for ensuring all staff are appropriately trained, qualified and competent to carry out their specific roles and responsibilities. Job descriptions should be on file for regulated health professional positions (e.g. nurses), and positions that require entry-to-practice certification (e.g. medical radiation technologist). The job description shall reflect current practice, certification or registration, and position responsibilities. Credentials should be verified upon hire and annually (e.g. British Columbia College of Nurses and Midwives practising registration).*	4	L	

No.		Description	Reference	Risk	Change
PPM4.1.2	**M**	Physicians performing PPM procedures hold current advanced cardiac life support (ACLS). *Guidance: The medical director is responsible for ensuring facility staff have the proper qualifications, training, and knowledge, and possess the competencies required for their role, which would include all specialized skill courses such as Basic Life Support (BLS) Provider, ACLS, and airway management.* ***Anesthesiologists that hold active or provisional privileges in the practice of anesthesia in the health authority or have held active or provisional privileges in the health authority within the last three years are not required to hold current ACLS.*** ***FRCP emergency medicine physicians that hold active or provisional privileges in the practice of emergency medicine in the health authority or have held active or provisional privileges in the health authority within the last three years are not required to hold ACLS.*** ***Critical care medicine physicians that hold active or provisional privileges in the practice of critical care medicine in the health authority or have held active or provisional privileges in the health authority within the last three years are not required to hold ACLS.*** *Medical directors must ensure that providers of any specialized skills training courses meet acceptable theory and in-person/hands-on components. ACLS courses may be taken directly through the Heart and Stroke Foundation of Canada (HSFC) or a third-party provider. Medical directors must ensure third-party providers instruct in accordance to the HSFC guidelines. Following initial ACLS certification, recertification is required every two years.*	5, 6, 7	M	Rev. Guidance

No.		Description	Reference	Risk	Change
PPM4.1.3	**M**	Physicians performing PPM procedures have completed an airway management course in the last three years. *Guidance: The medical director is responsible for ensuring facility staff have the proper qualifications, training, and knowledge, and possess the competencies required for their role, which would include all specialized skill courses such as BLS Provider, ACLS, and airway management. For the purpose of this standard, an airway management course is defined as a specialized skills training course that covers bag-valve-mask ventilation and supraglottic airway device insertion (i.e. rescue airway insertion).* ***Anesthesiologists that hold active or provisional privileges in the practice of anesthesia in the health authority or have held active or provisional privileges in the health authority within the last three years are not required to have an airway management course.*** ***FRCP emergency medicine physicians that hold active or provisional privileges in the practice of emergency medicine in the health authority or have held active or provisional privileges in the health authority within the last three years are not required to have an airway management course.*** ***Critical care medicine physicians that hold active or provisional privileges in the practice of critical care medicine in the health authority or have held active or provisional privileges in the health authority within the last three years are not required to have an airway management course.*** *Medical directors must ensure that providers of any specialized skills training courses meet acceptable theory and in-person/hands-on components. Airway management courses may be taken through a third party provider. Medical directors must ensure that the course content includes both theory and in-person/hands-on components, which meet necessary skills competencies for the non-hospital setting. Airway management course recertification is required every three years.*	5, 6, 7	M	Rev. Guidance

No.	Description		Reference	Risk	Change
PPM4.1.4	**M**	Nurses assisting with PPM procedures hold current practising registration with the British Columbia College of Nurses and Midwives. *Guidance: Registered nurses (RN) or licensed practical nurses (LPN) may assist physicians performing PPM procedures. For solo-physician practices, there must be a second regulated health professional immediately available to assist in the event of an emergency. The second regulated health professional may be an RN, LPN or another physician. RNs and LPNs must hold current practising registration with the British Columbia College of Nurses and Midwives.*	4	H	
PPM4.1.5	**M**	Nurses assisting with PPM procedures hold current BLS Provider certification. *Guidance: The BLS Provider course has replaced the BLS for Healthcare Providers (BLS- HCP).*	4	M	
PPM4.1.6	**M**	Technologists, if providing X-ray services, are certified by and/or are eligible to write the certification examination from the Canadian Association of Medical Radiation Technologists (CAMRT) or are Combined Laboratory X-ray Technologists (CLXT). *Guidance: Full C-Arms may only be operated by an appropriately certified medical radiation technologist; physicians may not operate full C-Arms. Mini C-Arms may be operated by physicians that have documented training in: the safe operation of the X- ray equipment and accessories used in the facility; the radiological procedure being performed; and radiation protection procedures and measures.*	4	H	
PPM4.1.7	**M**	Sonographers, if providing ultrasound services, are certified by and/or are eligible to write the certification examination with Sonography Canada or the American Registry of Diagnostic Medical Sonographers (ARDMS). *Guidance: Physicians who operate ultrasound equipment are trained on the use of the equipment and possess the training and experience in the interpretation of the ultrasound imaging. Non-physicians who operate ultrasound equipment must be certified and/or eligible to write the certification exam.*	4	H	

No.		Description	Reference	Risk	Change
PPM4.1.8	**M**	Competency assessments and performance reviews are performed annually for all regulated health professionals and staff with positions that require entry-to-practice certification. *Guidance: Regulated health professionals or certified staff includes nurses, X-ray technicians and ultrasound technicians. Competency assessments are performed to evaluate the knowledge, skills and abilities of the staff to ensure they are proficient in performing their duties. Performance appraisals are based on job responsibilities and expectations. The results of competency assessments are to be reviewed as part of their performance review. The medical director ensures documentation of the competency assessments, and performance reviews are on file for all regulated health professionals and certified staff.*	4	M	
PPM4.1.9	**M**	Orientation and training records are kept for all staff. *Guidance: Orientation: An orientation should be provided for all staff to provide them with a clear understanding of what is expected of them, how their role fits into the overall objectives of the facility, and familiarize them with the facility policies and procedures. Orientation should include emergency procedures (e.g. fire, medical emergency), infection prevention and control (e.g. hand-hygiene, proper use of personal protective equipment (PPE), occupational health and safety (e.g. WHMIS, sharps handling and disposal), and safety incident reporting. Documentation of orientation must be kept on file for all staff and should include the name of the individual, date of orientation, the specific topics covered, and the signature of the staff member and their supervisor.* *Training: Training is an organized activity aimed at imparting, maintaining, or updating skills or knowledge (e.g. hand hygiene training, basic life support training). Documentation of training must be kept on file for all staff.*	4	L	

No.		Description	Reference	Risk	Change
PPM4.1.10	**M**	Human resource records are kept for all regulated health professionals or staff with positions that require entry-to-practice certification. *Guidance: Human resource records should include a resume, date of employment, registration/certification, records of orientation, in-servicing, continuing education, and annual performance review.*	4	M	

Procedural care

No.		Description	Reference	Risk	Change
PPM5.0		**INTAKE EVALUATION AND SELECTION**			
PPM5.1		**Intake screening ensures all patients booked for a PPM procedure are appropriate for the non-hospital setting.**			
PPM5.1.1	**M**	Intake screening is conducted by regulated health professionals. *Intent: The patient's medical history/record is reviewed by a physician or nurse to ensure the patient is appropriate for the non-hospital facility setting.*	8	H	
PPM5.1.2	**M**	Intake assessment includes a physical exam related to the procedure being considered.	8	M	
PPM5.1.3	**M**	Intake assessment includes a medical history. *Guidance: A medical history includes indication(s) for the PPM procedure, comorbidities, previous surgery, medications, allergies, and sensitivities. The patient's referring physician may provide many of these elements.*	8	M	

No.		Description	Reference	Risk	Change
PPM5.1.4	**M**	Intake assessment includes a comprehensive pain assessment, including a pain management plan. *Guidance: The patient's referring physician may provide many of the elements of this assessment (e.g. consult/referral notes). The pain assessment and management plan must provide an adequate picture of the clinical information such as relevant history and physical findings (positive findings and important negative findings), conclusions (working, differential and final diagnosis), plan of action (investigations, consultations, treatment, follow-up, rationale for the plan), information given to the patient (instructions, questions asked and responses given, apparent understanding, consent, any disagreement or refusal of care).*	8	M	
PPM5.1.5	**M**	Intake assessment includes a patient self-reported check-in questionnaire. *Guidance: The self-reported questionnaire is an opportunity for the patient to provide information about their medical history, comorbidities, previous surgery, pain score, medications, allergies and sensitivities. Scientific literature suggests patient self-reported health information is a valid resource and improves the provision of healthcare. During follow-up visits, patient self-reported questionnaires should be reviewed to ensure they are updated with any new medical history.*	8	M	

No.	Description		Reference	Risk	Change
PPM5.1.6	**B**	Intake assessment includes infectious diseases and Antibiotic-Resistant Organism (ARO) screening. *Guidance: ARO screening is considered best practice, however ARO screening is not mandatory. Screening questions can be completed using the patient's self-reported questionnaire by including questions such as: Have you ever been diagnosed (infection or colonization) with an ARO, such as MRSA or VRE?; Have you received health care in a facility outside of Canada in the last 12 months?; Have you been admitted to, or spent more than 12 continuous hours as a patient, in any health-care facility in the last 12 months? The medical director and PPM physician are to be notified of any positive responses to the screening question(s). Patients with any positive responses to the screening question(s) are to remain in an "unrestricted" area of the facility (e.g. waiting room, office, consultation room) until the patient has been assessed by the physician and determined that it is appropriate to proceed with the procedure as planned. Transmission-based precautions (contact precautions) are implemented for patients known to have or considered high risk of being colonized or infected with antibiotic-resistant organisms.*	8, 9		
PPM5.1.7	**M**	Intake assessment includes consultations, as appropriate.	8	M	
PPM5.1.8	**M**	Intake assessment includes height, weight and where appropriate body mass index (BMI). *Guidance: Obese patients need to be carefully screened prior to any proposed procedure in the non-hospital setting. The decision to perform a procedure on a patient in the non-hospital setting must take into account the health risks and comorbidities associated with the planned procedure and the impact those conditions will have on the patient outcome. In addition, specialized equipment for obese patients may be needed (e.g. special seating, stretcher, procedure table, transfer mats, toilet, sinks, and monitoring equipment (e.g. BP cuffs)).*	8	M	

No.	Description		Reference	Risk	Change
PPM5.1.9	**M**	Intake assessment includes pre-procedure testing based upon the patient's clinical condition(s) (e.g. laboratory testing, ECG, other testing). *Guidance: Considerations for patients on anticoagulants and antiplatelet agents; patients with renal insufficiency or failure undergoing procedures involving the use of contrast dye.*	8	M	
PPM5.1.10	**M**	Intake assessment includes results of radiologic examination, as appropriate. *Guidance: Radiologic examination report(s), results or images are part of the patient's medical record.*	8	M	
PPM5.2	**Pre-treatment teaching contains the information necessary for patients to prepare for the procedure.**				
PPM5.2.1	**M**	Pre-admission teaching includes taking/holding of pre-procedure medications.	10	M	
PPM5.2.2	**M**	Pre-admission teaching includes review of post-procedure instructions.	10	M	

PPM6.0 CONSENT

PPM6.1	**Consent is obtained prior to and throughout the delivery of care.**				
PPM6.1.1	**M**	Consent for a PPM procedure is obtained by the physician performing the procedure. *Guidance: A valid consent process includes a consent discussion with the patient, documentation of the consent discussion in the patient's medical records, and completion of a consent form.*	11, 12, 13	H	Revised

No.		Description	Reference	Risk	Change
PPM6.1.2		The consent discussion is documented in the patient's medical record. *Guidance: The consent discussion explains the proposed treatment or course of treatment, the condition for which the health care is proposed, the nature of the proposed health care, the risks and benefits of the proposed health care that a reasonable person would expect to be told about, alternative courses of health care (and when indicated the likely consequences of no treatment). Documentation of the consent discussion includes the nature of the health care proposed, the risks, benefits and alternative(s) discussed with the patient, and any specific additional issues or concerns that arose in the discussion and how they were addressed. The anesthesiologist should include documentation of the anesthesia consent discussion with the patient on the anesthetic record.*	11, 12, 13	H	Revised
PPM6.1.3	**M**	A written consent form is completed for the procedure. *Guidance: A "rolling" consent is suitable for the same procedure performed consecutively. Confirmation that the consent remains valid must be documented at each patient visit. For "rolling" consent, a new written consent form must be completed annually.*	11, 13	H	
PPM6.1.4	**M**	Abbreviations are not used in the consent form. *Guidance: Procedure name(s) and side are written out in full.*	11	H	
PPM6.1.5	**M**	The consent form is signed by the patient (or legal guardian or authorized decision maker) and a witness. *Guidance: The patient's signature may be witnessed by the most responsible medical staff member, by another member of the health care team (e.g. nurse), by unregulated staff (e.g. office assistant) or by a family member. If signing of the consent is witnessed by another member of the health-care team, the witness will ascertain that the patient is satisfied with the information they have been given by the medical staff member and that all of their questions have been answered prior to having the patient sign the consent form. If this is not the case, the witness will notify the medical staff member.*	11, 13	H	

No.		Description	Reference	Risk	Change
PPM7.0		**PATIENT CHECK-IN – DAY OF PROCEDURE**			
PPM7.1		**Accurate patient identification precedes commencement of the procedure.**			
PPM7.1.1	**M**	Patient identification is verified at check-in. *Guidance: The practice of having the patient involved in identifying themselves and using two unique patient identifiers helps to ensure that a correct match is made between the patient and the procedure. Unique patient identifiers include legal name, date of birth, personal health number.*	14	H	Revised
PPM7.1.2	**M**	Personal and health information is confirmed and verified in a manner that maintains patient privacy and confidentiality. *Guidance: Staff demonstrate mindfulness of the surroundings when confirming, verifying and discussing patient information and when providing care.*	14	M	New
PPM7.1.3	**M**	At least two unique patient identifiers are used when verifying patient identification. *Guidance: Unique patient identifiers include legal name, date of birth, CareCard number. Gender (administrative gender and/or gender identity) is not to be used as a unique patient identifier. Check-in/arrival processes may be performed by an unregulated care provider (e.g. receptionist).*	14, 15, 16	C	Revised
PPM7.1.4	**M**	Staff confirm that information on the identification band is consistent with verbal information provided by the patient.	14	C	New
PPM7.1.5	**M**	Patient identity discrepancies are resolved before the patient is transferred to the procedure room.	14, 17	C	
PPM7.1.6	**M**	An identification band is placed on each patient. *Guidance: The identification band lists at least two unique patient identifiers.*	14	M	New
PPM7.2		**Check-in assessment confirms appropriate patient selection and patient preparation.**			

No.	Description		Reference	Risk	Change
PPM7.2.1	**M**	Check-n assessment includes allergies and sensitivities including reaction(s) description. *Guidance: Allergies and sensitivities include medication, food and latex.*	14		New
PPM7.2.2	**M**	An allergy alert wristband is placed on each patient with a sensitivity or allergy. *Guidance: Allergies and sensitivities include medication, food and latex.*	14		New
PPM7.2.3	**M**	Check-in assessment includes verifying the planned procedure, including site, side and level as appropriate.	14	H	
PPM7.2.4	**M**	Check-in assessment includes verifying consent. *Guidance: The regulated health professional confirms with the patient that the information documented on the consent (i.e. procedure, site and/or side, and name of physician performing the procedure) is accurate and that the patient has sufficient information and understanding of the procedure.*	11, 12, 13, 14	C	New
PPM7.2.5	**M**	Check-in assessment includes blood pressure and heart rate. *Guidance: Other vital signs such as respiratory rate, temperature and oxygen saturation are completed as appropriate to the procedure and/or patient condition.*	14	M	
PPM7.2.6	**M**	Check-in assessment includes a functional assessment and review of the intake assessment. *Guidance: The functional assessment reviews the patient's physical functioning (i.e. mobility, activities of daily living) and is used to evaluate therapeutic interventions. For subsequent procedures, the intake and previous check-in assessments are reviewed to determine if there have been any changes in the patient's condition and medical condition.*	14	M	
PPM7.2.7	**M**	Check-in assessment includes review of medications including last dose taken. *Guidance: Medications include prescription, over-the-counter and herbal.*	14	M	New
PPM7.2.8	**M**	Check-in procedures include review of post-procedure instructions and follow up.	14	L	

No.		Description	Reference	Risk	Change
PPM7.3		**Check-in processes ensure patient safety.**			
PPM7.3.1	**M**	Any changes in the patient's status or concerns from the check-in assessment are communicated to the physician performing the procedure.	14	M	
PPM7.3.2	**M**	The medical record of any patient with an allergy or sensitivity is labelled or flagged to communicate the allergy alert.	14	M	

PPM8.0 INTRA-PROCEDURE CARE

PPM8.1		**The procedure room provides the necessary equipment for the PPM procedures performed.**			
PPM8.1.1	**M**	The room is equipped with a procedure table or chair and positioning equipment appropriate for the intended procedure.	18	H	
PPM8.1.2	**M**	The room is equipped with patient monitoring equipment appropriate for the intended procedure(s). *Guidance: Blood pressure, heart rate, and oxygen saturation monitoring equipment must be in the procedure room. Cardiac monitoring equipment with print out capability must be available and located where it is easily accessible to the procedure room. Patients do not require continuous ECG monitoring; however, the cardiac monitoring equipment must be available in the event a patient has an unintended reaction to the procedure. Cardiac monitoring equipment is in addition to an automated external defibrillator located on the facility's emergency cart.*	18	H	
PPM8.1.3	**M**	The room is equipped with an emergency light source (e.g. flashlight).	18	M	
PPM8.2		**Procedure room staffing supports safe patient care and promotes a safe procedural environment.**			
PPM8.2.1	**M**	Only physicians perform PPM procedures.		H	

No.		Description	Reference	Risk	Change
PPM8.2.2	**M**	A second regulated health professional is immediately available when procedures are being performed. *Guidance: In practices where the procedure room is staffed with a physician and no other regulated health professional(s), there must be a second regulated health professional immediately available to assist in the event of an emergency. The second regulated health professional may be an RN, LPN or another physician. A certified medical radiation technologist is **not** considered a regulated health professional.*		H	
PPM8.3		**The procedure room environment minimizes exposure risk to potentially infectious micro-organisms.**			
PPM8.3.1	**M**	All items introduced to the sterile field are opened, dispensed and transferred by methods that maintain item sterility and integrity.	10	H	
PPM8.3.2	**M**	Only single-use items are used. *Guidance: Single-use syringes, cannulas and needles are used and discarded immediately after patient use. Reusable medical devices may be used **only** if there is no single-use option available in Canada **and** the facility has been granted a variance by the NHMSFAP Committee. Facilities granted a variance by the NHMSFAP Committee would be required to meet the BC Ministry of Health Best Practice Guidelines for the Cleaning, Disinfection and Sterilization of Critical and Semi-critical Medical Devices.*		H	
PPM8.3.3	**M**	Sterile gloves are worn when performing PPM procedures. *Guidance: PPM procedures are considered critical/sterile procedures.*		H	
PPM8.3.4	**M**	Appropriate skin preparation is performed. *Guidance: PPM procedures are considered critical/sterile procedures.*	10, 18	M	
PPM8.3.5	**M**	Single-use skin antiseptic products are used for each patient. *Guidance: Both the container of skin antiseptic and the applicator(s) must be single use. Any unused portion(s) of the skin antiseptic and/or applicators are discarded. It is not saved for use on another patient.*	10, 18	M	New
PPM8.3.6	**M**	All supplies that are opened and not used during the procedure are considered contaminated and discarded at the end of the case.	10, 18	H	

No.	Description		Reference	Risk	Change
PPM8.3.7	**M**	When a bottle of sterile solution is opened and the required amount dispensed, any remaining solution is discarded (the bottle is not recapped for later use). *Guidance: Sterile solutions may include but are not limited to dyes and local anesthetics.*		H	
PPM8.3.8	**M**	Sterile set-ups are not covered with the intent for use at a later time.	10, 18	H	
PPM8.3.9	**M**	Ultrasound probe is covered with a sterile barrier before introduction into the sterile field. *Guidance: Critical/sterile procedure ultrasound probes used for needle guidance and where there is a risk of blood or body fluid exposure require the use of a sterile probe cover during the procedure. Single-use barriers do not remove the requirement to reprocess ultrasound probes between each patient use.*	19	H	
PPM8.4	**A safety checklist facilitates team communication and improves procedure safety.**				
PPM8.4.1	**M**	The safety checklist in use at the facility has been approved by the medical director. *Guidance: The medical director is responsible for ensuring the safety checklist implemented at their facility meets the intent of the Faculty of Pain Medicine of the Royal College of Anaesthetists procedural safety checklist.*	20, 21, 22, 23	H	
PPM8.4.2	**M**	The medical director approved safety checklist is posted in each procedure room. *Guidance: A laminated copy of the approved safety checklist is posted in an area that is visible to all members of the procedure team.*	20, 21, 22	M	
PPM8.4.3	**M**	The safety checklist is consistently followed for every procedure. *Guidance: The checklist is required for all non-hospital facilities and all types of medical, surgical, dental and anesthesia procedures. Documentation of the procedure must state that the briefing (sign-in), time-out, and debriefing (sign-out) of the safety checklist were completed and staff initials must be clearly documented on the procedural record. If using an electronic record, the medical record system records the identity of the user making the entry (i.e. staff initials).*	20, 21, 22	H	Revised

No.	Description	Reference	Risk	Change
PPM8.4.4	**M** The briefing, time-out and debriefing are documented on the procedural record.	20, 21, 22	L	Revised
PPM8.4.5	**M** The full procedure team (e.g. physician, nurse) and patient are present during the safety checklist sign-in, time-out and sign-out. *Guidance: The patient participates by confirming their name, the procedure planned, and consent.*	20, 21, 22	H	
PPM8.5	**PPM procedures are performed under image guidance as appropriate.** *Guidance: Having both ultrasound and fluoroscopy imaging modalities at the facility is not necessary.*			
PPM8.5.1	**M** All spinal procedures are performed under image guidance. *Guidance: Image guidance is required for performing **all** spinal PPM procedures with the exception of caudal and interlaminar epidurals for which imaging is strongly recommended. CT and fluoroscopy are recognized as the gold standard for imaging for spinal PPM procedures. CT and fluoroscopy are also the gold standard for caudal and interlaminar epidurals for which imaging is highly recommended but not mandatory. Ultrasound may be used as imaging guidance on select patients (i.e. low or normal BMI, no previous surgery or significant deformity/degeneration) for spinal PPM procedures. However, ultrasound should not be the sole imaging modality available to a practitioner providing interventional spine procedures. Facilities with only ultrasound equipment must have procedures in place for the timely referral of patients in the event that CT and/or fluoroscopy is indicated for proper visualization.*	1	H	

PPM9.0 POST-PROCEDURE CARE AND DISCHARGE

Guidance: For procedures requiring post-anesthesia care until level of care, the NHMSFAP Post-anesthesia Care standards shall apply.

PPM9.1	**Patient assessment, monitoring, and health-care team communication supports the delivery of safe post-procedure care.**			
PPM9.1.1	**M** Patients are assessed and vital signs, as appropriate, are measured at the end of the procedure.	24, 25	M	
PPM9.1.2	**M** The most responsible physician remains at the facility until the patient(s) is discharged.	24, 25, 26	M	

No.		Description	Reference	Risk	Change
PPM9.2		**Facility processes ensure the safe and appropriate discharge of patients to their home.**			
PPM9.2.1	**M**	Readiness for discharge is individually assessed.	24, 25, 26	H	
PPM9.2.2	**M**	Discharge instructions are reviewed with the patient.	24, 25, 26	M	
PPM9.2.3	**M**	Written discharge instructions are provided to the patient. *Guidance: Discharge instructions should include general instructions (e.g. pain, fever, driving restriction), medication instructions (e.g. resuming medications), follow up care (e.g. appointments, telephone calls), accessing emergency care (e.g. interventionist, facility, other) and notifying the facility of any reportable incidents as per the CPSBC Bylaws.*	24, 25, 26	H	

General safety

The general safety accreditation standards include those most common to a PPM non-hospital facility; however, they do not encompass all of the requirements under the *Workers Compensation Act* of British Columbia. Physicians and staff are encouraged to review section 115 of the 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.

No.		Description	Reference	Risk	Change
PPM10.0		**OCCUPATIONAL HEALTH AND SAFETY**			
PPM10.1		**Blood and body fluid precautions are in place and followed.**			
PPM10.1.1	**M**	There is a blood and body fluid (BBF) exposure procedure in place (e.g. needle stick injury). *Guidance: The BBF exposure procedure includes who to notify at the facility (e.g. supervisor, medical director) and the required follow up.*	27, 28	M	
PPM10.2		**Safe and effective practices are followed for the use and disposal of sharps.**			

No.		Description	Reference	Risk	Change
PPM10.2.1	**M**	Safety-engineered needles and medical sharps are used whenever possible. *Guidance: Needleless devices or safety-engineered hollow bore needles are used for any procedure involving the potential for an exposure to accidental parenteral contact for which a needleless system or safety-engineered hollow bore needle system is available.*	27, 28	M	
PPM10.3		**Chemicals are used, stored and disposed of safely.**			
PPM10.3.1	**M**	Hazardous products such as chemicals are properly labelled. *Guidance: Hazardous products or the container of a hazardous product is attached or printed with a supplier label. Supplier labels are not to be removed, defaced, modified or altered as long as any amount of a hazardous product remains in the workplace in the container in which it was received from the supplier. If the supplier label becomes illegible or is accidentally removed from the hazardous product or container, it is replaced with either a supplier label or a workplace label. If a hazardous product is decanted into a container other than the container in which it was received from the supplier, it is appropriately labeled with a workplace label. A workplace label must include the name of the hazardous product as it is named on the hazardous product's safety data sheet, information on the safe handling of the hazardous product, and the availability of a safety data sheet.*	27, 28	C	Revised

No.		Description	Reference	Risk	Change
PPM10.3.2	**M**	Safety data sheets (SDS) are available for all controlled substances subject to Workplace Hazardous Materials Information System (WHMIS) and are current. *Guidance: WHMIS provides information on hazardous products as defined and described in the federal* Hazardous Products Act *and Hazardous Products Regulations (https://www.worksafebc.com/en/health-safety/hazards-exposures/whmis). SDS must have been published or revised within the last three years. There is a supplier SDS for each hazardous product in use, handled or stored at the workplace. Hazardous products include but are not limited to chemicals, gases, dyes and coolants used in equipment (e.g. lasers). The SDS must be readily available to the workers who may be exposed to the hazardous product. SDSs must be up to date. When the supplier SDS for a hazardous product is three years old, the employer must obtain from the supplier an up-to-date SDS.*	27, 28	M	
PPM10.3.3	**M**	Hazardous substance containers are in good condition to securely contain the substance. *Guidance: Any material used to contain, transfer or convey a hazardous substance must be reasonably resistant to the substance. If an open container of a hazardous substance could pose a hazard, the container must be kept sealed or covered when not in use. 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 SDS. Hazardous substances such as chemicals include but are not limited to skin prep solutions, cleaning and disinfection products.*	27, 28	H	Revised
PPM10.3.4	**M**	Spill kits are clearly labelled and kept where chemicals are used and stored. *Guidance: Whether a spill kit is needed depends on the chemicals at the facility.* The type and number of spill kits required will depend on the variety of chemicals in the facility as well as the quantities that are typically in use. *The chemical's SDS provides information on what to do and what equipment (e.g. spill kit) is needed in the event of a chemical spill.*	27, 28	H	

No.		Description	Reference	Risk	Change
PPM11.0		**EMERGENCY PREPAREDNESS**			
PPM11.1		**The facility is prepared for disasters and emergencies.**			
PPM11.1.1	**M**	Facility access and entry points are clearly marked.	29	H	New
PPM11.1.2	**M**	Emergency exit routes are marked and provide an unimpeded exit.	29	H	
PPM11.1.3	**M**	Fire and smoke detectors are unobstructed and located throughout the facility.	29	H	New
PPM11.1.4	**M**	Fire and smoke detectors are inspected annually at a minimum.	29	H	Revised
PPM11.1.5	**M**	Fire alarms are unobstructed and located throughout the facility.	29	H	New
PPM11.1.6	**M**	Fire alarms are inspected annually at a minimum	29	H	Revised
PPM11.1.7	**M**	Fire extinguishers are unobstructed and located throughout the facility. *Guidance: Section 6.2 of the BC Fire Code requires that fire extinguishers be checked monthly to confirm that they are located in their designated place, there is no obstruction to access or visibility, there is no obvious physical damage, corrosion or leakage, safety seals and tamper indicators are not broken or missing.*	29	H	Revised
PPM11.1.8	**M**	Fire extinguishers are inspected annually at a minimum. *Guidance: Documentation of fire extinguisher inspection is on file and each fire extinguisher has a tag confirming that it has been inspected and tested by an authorized fire protection professional.*	29	H	Revised
PPM11.1.9	**M**	Emergency instructions are posted in the office for easy reference.	29	M	
PPM11.1.10	**M**	Emergency telephone numbers and the facility address are posted near every telephone near patient care areas and wherever there is a telephone available.	29	L	
PPM11.1.11	**M**	There is a process/system to alert staff members when a medical emergency occurs. *Guidance: In the event of a medical emergency, there needs to be a process/system in place to alert other staff members that help is needed (e.g. overhead page for assistance, call for assistance).*	29	H	
PPM11.2		**Emergency medications and equipment supports the early treatment of medical emergencies.**			

No.	Description		Reference	Risk	Change
PPM11.2.1	**M**	The emergency cart is portable. *Guidance: The rolling/mobile care transports the emergency cart medication and equipment to the location of the medical emergency.*	29	H	Revised
PPM11.2.2	**M**	The emergency care is located in a common patient care area that allows for a target collapse-to-shock interval of less than three minutes. *Guidance: The emergency cart is located near the procedure room and recovery areas. The emergency cart is **not located** in the procedure room.*	29	H	Revised
PPM11.2.3	**M**	The emergency cart is checked weekly. *Intent: The equipment is checked to ensure proper working order and the contents are visually reviewed to ensure the cart is appropriately stocked. The emergency cart should be checked before the start of the first case of the day. The emergency cart is stocked in accordance with the PPM – Emergency Cart standard. The emergency cart checks are recorded in a log.*	29	M	
PPM11.2.4	**M**	The emergency cart is checked by a regulated health professional. *Guidance: If the PPM procedures team is comprised of more than one regulated health professional (i.e. PPM physician and a nurse or two PPM physicians) then duty of checking the emergency cart is rotated among the regulated health professional as this practice will familiarize all clinical staff with the contents of the cart and how to operate the equipment so that in the event of an emergency, locating items in the cart and operating the equipment becomes second nature.*	29	C	New
PPM11.2.5	**M**	Emergency medications are within their labeled expiration date.	29	H	Revised
PPM11.2.6	**M**	The emergency medications are accessible and organized. *Guidance: The equipment and medications in the emergency cart should be organized to facilitate easy identification and retrieval in the event of a medical emergency.*	29	H	
PPM11.2.7	**M**	The emergency equipment is within its labeled expiration date.	29	H	Revised

No.		Description	Reference	Risk	Change
PPM11.2.8	**M**	The emergency equipment is accessible and organized. *Guidance: The equipment and medications in the emergency cart should be organized to facilitate easy identification and retrieval in the event of a medical emergency.*	29	H	
PPM11.2.9	**M**	Emergency cart checks are documented.	29	L	New
PPM11.3		**Periodic emergency drills ensure that the facility is physically prepared and staff are ready to act in the event of an emergency.**			
PPM11.3.1	**M**	All personnel receive education and training on what to do in the event of an emergency. *Guidance: Personnel include but are not limited to physicians, nurses, support staff, etc. Education and training occurs upon hire and anytime there is a change in the protocols, medications or equipment.*	29	M	
PPM11.3.2	**M**	Periodic simulated emergency drills are performed annually. *Guidance: Documentation of emergency drills includes personnel attendance/participation, date of drill and type of drill. At minimum, mock drills for the following scenarios are completed annually: anaphylaxis, cardiac arrest, respiratory distress and fire. It is strongly recommended that mock drills be performed more frequently (i.e. semi-annually, quarterly) depending on the needs of the facility.*	29	L	Revised
PPM11.3.3	**M**	All personnel participation in simulated emergency drills is documented.	29	L	

PPM12.0 INCIDENT ANALYSIS

PPM12.1		**Adverse events and critical incidents are managed appropriately.**			
PPM12.1.1	**M**	All patient safety incidents are documented in the patient's medical record and reported to the NHMSFAP. *Guidance: Patient safety incidents (e.g. adverse events or complications) are documented and investigated. The NHMSFAP Patient Safety Incidents Reporting Policy lists the patient safety incidents requiring mandatory reporting. The organization's policy and procedures for patient safety incident and near miss management include reference to PSI requiring mandatory reporting and the required reporting form.*	2	M	Rev. Guidance

No.		Description	Reference	Risk	Change
PPM13.0		**PHYSICAL DESIGN**			
PPM13.1		**The design and layout of the physical environment ensures patient safety and privacy.**			
PPM13.1.1	**M**	There is adequate clearance around all four sides of the procedure table/chair. *Guidance: Access to the patient in the event of an emergency is an important patient safety consideration. In accordance with CSA standard Z8000 Canadian Healthcare Facilities (design), there should be at least 800 mm (2 feet 7.5 inches) clearance on all sides of an examination/procedure/treatment room.*	30	M	
PPM13.1.2	**M**	The procedure room is the appropriate square footage (wall to wall). *Guidance: **This applies only to PPM facilities that existed when PPM accreditation came into effect and were granted provisional accreditation.** All new and/or renovated facilities are required to meet the minimum procedure room size requirements that have been adopted from the Facilities Guideline Institute (FGI) Radiography room, net area m^2 16.72 (180 square feet) for procedure rooms that utilize fluoroscopy equipment. All new and/or renovated facilities are required to meet the minimum procedure room size requirements that have been adopted from the Facilities Guideline Institute (FGI) Ultrasound room, net area m^2 11.15 (120 square feet) for procedure rooms that utilize ultrasound equipment. Procedure rooms that utilize both fluoroscopy and ultrasound equipment are required to meet the minimum procedure room size requirements for a Radiography room net area m^2 16.72 (180 square feet). **Existing facilities** may be granted a variance by the NHMSFAP Committee until the variance term specified by the committee has expired.*	30	M	

No.		Description	Reference	Risk	Change
PPM13.1.3	**M**	Procedural pain management procedure rooms that do not utilize any imaging modalities are at minimum 14 m^2 (150 ft^2). *Guidance: This applies to new PPM facilities and existing PPM facilities that undergo major renovation or new construction in accordance with the NHMSFAP Renovations and New Construction to a Facility policy.* *Procedural pain management procedure rooms meet CSA Z8000 standards. Access to the patient in the event of an emergency is an important patient safety consideration. There must be at least 800 mm (2 feet 7.5 inches) clearance on all sides of an examination/procedure/treatment room. When procedure rooms are used for multiple medical-surgical services or utilize different imaging modalities, the room shall meet the more stringent requirements for that space.* *Note: The majority of PPM procedures require the use of imaging (ultrasound, CT or fluoroscopy). Image guidance is required when performing all spinal PPM procedures with the exception of caudal and inter-laminar lumbar epidurals, for which imaging is strongly recommended. In future should imaging become mandatory for all PPM procedures, this procedure room size would no longer meet the standard.*	30	M	
PPM13.1.4	**M**	Procedural pain management procedure rooms that utilize ultrasound are at minimum 17 m^2 (183 ft^2). *Guidance: This applies to new PPM facilities and existing PPM facilities that undergo major renovation or new construction in accordance with the NHMSFAP Renovations and New Construction to a Facility policy.* *Procedural pain management procedure rooms meet CSA Z8000 standards. Access to the patient in the event of an emergency is an important patient safety consideration. There must be at least 800 mm (2 feet 7.5 inches) clearance on all sides of an examination/procedure/treatment room. When procedure rooms are used for multiple medical-surgical services or utilize different imaging modalities, the room shall meet the more stringent requirements for that space.*	30	M	

No.		Description	Reference	Risk	Change
PPM13.1.5	**M**	Procedural pain management procedure rooms that utilize mobile X-ray equipment are at minimum 29 m^2 (312 ft^2). *Guidance: This applies to new PPM facilities and existing PPM facilities that undergo major renovation or new construction in accordance with the NHMSFAP Renovations and New Construction to a Facility policy.* *A C-arm is an example of a mobile X-ray system. Procedural pain management procedure rooms meet CSA Z8000 standards. Access to the patient in the event of an emergency is an important patient safety consideration. There must be at least 800 mm (2 feet 7.5 inches) clearance on all sides of an examination/procedure/treatment room. When procedure rooms are used for multiple medical-surgical services or utilize different imaging modalities, the room shall meet the more stringent requirements for that space.*	30	M	
PPM13.1.6	**M**	Procedural pain management procedure rooms that utilize fluoroscopy are at minimum 46.5 m^2 (500.5 ft^2). *Guidance: This applies to new PPM facilities and existing PPM facilities that undergo major renovation or new construction in accordance with the NHMSFAP Renovations and New Construction to a Facility policy.* *Procedural pain management procedure rooms meet CSA Z8000 standards. The fluoroscopy procedure room requires a radiology room (39 m^2) plus a control room (7.5 m^2). A washroom is not required within the fluoroscopy procedure room.* *Access to the patient in the event of an emergency is an important patient safety consideration. There must be at least 800 mm (2 feet 7.5 inches) clearance on all sides of an examination/procedure/treatment room. When procedure rooms are used for multiple medical- surgical services or utilize different imaging modalities, the room shall meet the more stringent requirements for that space.*	30	M	

No.		Description	Reference	Risk	Change
PPM13.1.7	**M**	Procedural pain management procedure rooms where minimal to moderate procedural sedation is used are at minimum 38 m^2 (408 ft^2). *Intent: This applies to new PPM facilities and existing PPM facilities that undergo major renovation or new construction in accordance with the NHMSFAP Renovations and New Construction to a Facility policy.* *Guidance: Procedural pain management procedure rooms meet CSA Z8000 standards. Access to the patient in the event of an emergency is an important patient safety consideration. There must be at least 800 mm (2 feet 7.5 inches) clearance on all sides of an examination/procedure/treatment room. When procedure rooms are used for multiple medical-surgical services or utilize different imaging modalities, the room shall meet the more stringent requirements for that space.*	30	M	
PPM13.1.8	**M**	Heating, ventilation and air-conditioning system air-changes are at least 9 total air- changes and 3 outside air-changes. *Guidance: All new and/or renovated facilities are required to meet the HVAC requirements as specified in the CSA Z317.2-15 Special requirements for heating, ventilation and air-conditioning (HVAC) systems in health care facilities for a Diagnostic Imaging Suite: minimum total air-changes nine; minimum outside air- changes three.* ***Existing facilities*** *that have been granted a variance by the NHMSFAP Committee are not required to meet the HVAC requirements until the variance term specified by the committee has expired. Air-change rates should be assessed annually by an HVAC technician and documented in the HVAC service records on file at the facility.*	31	M	
PPM13.1.9	**M**	Patient areas are safe and visibly clean, and washrooms are conveniently located and accessible.	30	M	
PPM13.1.10	**M**	Patient privacy is maintained. *Guidance: Physicians and staff take every precaution to ensure that conversations regarding patient information are not inadvertently overheard by others. Extra sensitivity is required when discussing patient matters, either on the telephone or in person within hearing distance of others (e.g. conversation is taking place close to a reception area).*		M	

No.		Description	Reference	Risk	Change
PPM14.0		**MEDICAL GAS SAFETY**			
PPM14.1		**Oxygen is safely stored and secured.**			
PPM14.1.1	**M**	Oxygen cylinders are clearly labeled with the cylinder's contents.	32	H	Revised
PPM14.1.2	**M**	Oxygen cylinders are clearly marked as full, in use or empty.	32	H	Revised
PPM14.1.3	**M**	Oxygen cylinders are appropriately stored and secured. *Guidance: Cylinders are protected from sparks, flames, excessing heat, physical damage, electrical contact or corrosion and are secured by a holder or stand designed to prevent the cylinder from falling or rolling during storage, transportation and use.*	32	H	
PPM15.0		**ELECTRICAL SAFETY**			
PPM15.1		**Electrical systems ensure effective and safe patient care.**			
PPM15.1.1	**M**	Electrical cords, plugs and footswitch cords are in good working order.	33	H	
PPM15.1.2	**M**	Cords lying on the floor in walking areas are secured (e.g. taped, covered).	33	M	

Patient safety

Patient safety is fundamental to the delivery of quality PPM services and optimal patient outcomes. A priority for all PPM non-hospital facilities is to ensure that procedures are safe and that a continuous effort is made to improve patient safety.

No.		Description	Reference	Risk	Change
PPM16.0		**MEDICATION MANAGEMENT AND ADMINISTRATION**			
PPM16.1		**The facility has methods in place to ensure that medication is managed and administered to patients safely and effectively.**			
PPM16.1.1	**M**	Medications are stored appropriately and in an area not accessible to patients and non-authorized personnel.	34	H	

No.	Description		Reference	Risk	Change
PPM16.1.2	**M**	Expired and non-usable medications are stored away from the medication inventory until returned to a pharmacy for disposal.	34	L	
PPM16.1.3	**M**	Only authorized staff can obtain and administer medication.	34	H	
PPM16.1.4	**M**	Medication orders are patient-specific. *Guidance: Medications administered to a patient by an authorized staff, other than a physician, require a pre-existing medication order. Medication orders are to be written on a physician order form such as a pre-printed order set. The medication order must contain the patient name, date and time the medication order was written, medication name, dosage, route of administration, frequency of dosing, prescriber signature and printed name. If using an electronic record, the medical record system records the identity of the user making the entry (i.e. staff initials).*	34	M	
PPM16.1.5	**M**	Medications are never prepared in advance by pre-dispensing, prefilling syringes or leaving syringes ready on the counter. *Guidance: Medications are to be administered immediately after drawing them up/preparing them. The physician must personally prepare any medications used for the PPM procedures.*	34	H	
PPM16.1.6	**M**	All medications and solutions are labeled with the medication name and strength. *Guidance: All medications and solutions transferred from their original packaging to another container (e.g. drawn up into a syringe) are appropriately labeled. The only exception to requiring a label is if the physician prepares only one syringe of medication that is then immediately administered to the patient without any break in the process (i.e. the syringe may not be placed down on a countertop, or on the sterile field, or prepared in an area outside the procedure room and then carried to the procedure room with the intent to administer it immediately). Each syringe is immediately labeled, one at a time, before preparing the next. Empty syringes are not pre-labeled. Medications or solutions found unlabeled are immediately discarded. Although some physicians may use a colour-coding system in their practice, the identification of a medication must be verified by reading the label.*	34	H	

No.	Description		Reference	Risk	Change
PPM16.1.7	**M**	Medication administration is documented in the patient's medical record and includes the medication name, dose, route and site.	34	H	
PPM16.2	**Controlled drugs and substances (CDS) are safely stored and appropriately managed.**				
PPM16.2.1	**M**	Controlled drugs and substances are stored in a metal safe that is securely anchored to the building. *Guidance: Narcotics must be securely stored at all times to protect against loss or theft. Controlled drugs and substances located in the refrigerator or emergency cart must be stored in a locked compartment or drawer of the refrigerator or emergency cart and counted as part of the start and end of day counts. Targeted substances (e.g. benzodiazepines) must be stored in a secure environment and reasonable steps must be taken to protect any targeted substance from loss and theft. However, the regulations do not specifically require that benzodiazepines and other targeted substances be stored in a metal safe or that physical inventory counts be performed. To ensure targeted substances are protected, a non-hospital facility may wish to implement these additional controls to ensure reasonable steps are taken to protect any targeted substance in their possession from loss and theft.*	34	H	Revised
PPM16.2.2	**M**	Access to CDS is restricted to regulated health professionals only. *Guidance: Keys or code to the controlled drugs and substances safe are carried by/provided to regulated health professionals only (e.g. nurse, physician). When there is no regulated health professional on site, the keys are stored in a locked compartment that is accessible only to authorized regulated health professionals. When a combination lock is used, only regulated health professionals are provided with the code. The code should be changed every six months, when it is suspected the code may be in the possession of unauthorized personnel, and following any loss or theft of controlled drugs and substances.*	34	M	Rev. Guidance

No.	Description		Reference	Risk	Change
PPM16.2.3	**M**	Controlled drugs and substances administered, dispensed or wasted are recorded in a log. *Guidance: The controlled drugs and substances log header includes the name of the facility, page number, medication name(s) and strength and unit of issue (e.g. tablet, ampoule). The controlled drugs and substances log main body includes the date, time, patient's name, the name of the practitioner who ordered the medication, the medication quantity retrieved, amount given, (if applicable) amount wasted and signature/initials of the regulated health professional. Wastage is witnessed and signed/initialed by a second person.*	34	M	Revised
PPM16.2.4	**M**	Controlled drug inventory is counted at the beginning and end of each business day and recorded in the CDS log. *Guidance: Count discrepancies are immediately investigated and if unresolved are reported to the medical director. Any loss or theft of controlled drugs and substances must be reported to the federal minister within 10 days of discovery.*	34	M	New Guidance
PPM16.2.5	**M**	Controlled drug inventory counts are performed by a regulated health professional and witnessed by another staff member concurrently. *Guidance: Controlled drugs and substances counts and reconciliation are documented and signed by a regulated health professional. The second person witnesses the count, records the count and co-signs the log. In facilities where there is only one regulated health professional (physician) the count is witnessed, recorded and co-signed by a second unregulated staff member.*	34	M	Revised

Infection prevention and control

Infection prevention and control activities and precautions 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 non-hospital facility, the resources available, the services provided and the patients served.

No.		Description	Reference	Risk	Change
PPM17.0		**INFECTION PREVENTION AND CONTROL ACTIVITIES**			
PPM17.1		**Single-use devices and multi-dose vials.**			
PPM17.1.1	**M**	All needles are single-patient use only.	35	H	
PPM17.1.2	**M**	All cannulas are single-patient use only.	35	H	
PPM17.1.3	**M**	All syringes are single-patient use only.	35	H	
PPM17.1.4	**M**	Single-use vials are discarded when the appropriate dose has been drawn up. *Guidance: Leftover contents of single-dose vials are never combined or pooled.*	35, 36	H	
PPM17.1.5	**M**	Multi-dose vials dedicated to a single patient are labeled with the patient's identifiers, dated when initially accessed and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) beyond-use date after which the opened multi-use vial should not be used. *Guidance: The use of multi-dose vials is **strongly discouraged**. If multi-dose vials are used, the access diaphragm is scrubbed using friction and 70% alcohol and allowed to dry before inserting a new needle and new syringe into the vial. Multi-dose vials dedicated to a single patient are discarded immediately if sterility is questioned or compromised, if the vial is not marked with the date it was initially accessed, if the vial is not marked with the patient's identifiers and it has been more than 28 days since it was initially accessed or if it has been greater than the beyond-use date (i.e. discard date) specified by the manufacturer which is usually 28 days but may be shorter or longer.*	35, 36	M	

No.		Description	Reference	Risk	Change
PPM17.1.6	**M**	Multi-dose vials used for more than one patient are dated when initially accessed and discarded within seven days of opening. *Guidance: The use of multi-dose vials is **strongly discouraged**. If multi-dose vials are used, they should be **dedicated to a single patient** (i.e. multiple doses for one patient). If multi-dose vials are used, the access diaphragm is scrubbed using friction and 70% alcohol and allowed to dry before inserting a new needle and new syringe into the vial. Multi-dose vials used for more than one patient are discarded immediately if sterility is questioned or compromised, if the vial is not marked with the date it was initially accessed, or if it has been greater than seven days since the vial was initially accessed. Most multi-dose vials have a manufacturer recommended discard date of 28 days after opening; however, the antimicrobial preservative in these vials has no effect on blood-borne viruses. Therefore, in the interest of patient safety, multi-dose vials used for more than one patient are to be discarded within seven days of opening to limit the time frame for risk of contamination.*	35, 36	M	
PPM17.1.7	**M**	Single-use medical devices (e.g. needles, cannulas, syringes) are not reused or reprocessed.	35	H	
PPM17.1.8	**M**	Needles, cannulas and syringes are discarded immediately following single use.	35	H	

PPM18.0 GLUCOMETER TESTING

PPM18.1 The glucometer is safely used.

No.		Description	Reference	Risk	Change
PPM18.1.1	**M**	Single-use, auto-disabling finger-stick devices are used. *Intent: Hepatitis B virus (HBV) infection associated with blood glucose monitoring has been identified. Protection from blood borne viruses and other infections is a basic requirement and expectation anywhere healthcare is provided.* *Guidance: There are two main types of finger-stick devices, also called lancing devices; those that are designed for reuse on a single person, and those that are disposable and for single-use. Reusable finger-stick devices often resemble a pen and have the means to remove and replace the lancet after each use, allowing the device to be used more than once. Reusable finger-stick devices are not to be used in non-hospital facilities.*	37, 38, 39	H	
PPM18.1.2	**M**	Glucose meters are cleaned and disinfected after every use in accordance with the manufacturer's instructions for use. *Guidance: Glucose meters are to be low-level disinfected after each patient use. Examples of low-level disinfectants include 3% hydrogen peroxide, 0.5% accelerated hydrogen peroxide (e.g. Cavicide wipes).*	37, 38, 39	M	
PPM18.1.3	**M**	Quality control testing and/or calibration of the glucose meter is performed in accordance with the manufacturer's instructions for use. *Guidance: The manufacturer's instructions for use should specify the recommended frequency for performing quality control testing and/or calibration.*	37, 38, 39	M	
PPM18.1.4	**M**	Testing reagents and testing strips for the glucose meter are within their labeled expiry date.	37, 38, 39	M	

PPM19.0 ROUTINE PRACTICES

PPM19.1		**Routine practices are used for every patient, every time, regardless of their location or diagnosis of infection/colonization status.** *Intent: Routine practices and transmission-based precautions (additional precautions) are the core principles of infection prevention and control strategies. Routine practices are based on the assumption that all patients are potentially infectious, even when asymptomatic, and that the same standards of practice should be used routinely with all patients.*			
PPM19.1.1	**M**	Personal protective equipment (PPE) is appropriate and accessible to staff.	40, 41	H	

No.		Description	Reference	Risk	Change
PPM19.1.2	**M**	PPE is put on, taken off and disposed of appropriately.	40, 41	M	
PPM19.1.3	**M**	Gloves are worn when there is potential for contact with blood, body fluids, secretions, mucous membranes and non-intact skin of patients.	40, 41	H	
PPM19.1.4	**M**	Gloves are worn when handling dirty or potentially contaminated items/equipment and environmental surfaces.	40,41	H	
PPM19.1.5	**M**	Gloves are put on immediately before the activity for which they are indicated.	40,41	M	
PPM19.1.6	**M**	Gloves are changed between patients.	40,41	H	

PPM20.0 HAND HYGIENE

PPM20.1		**A hand hygiene program has been implemented at the facility.** *Intent: Hand hygiene is the single most important activity for preventing the transmission of infections. In British Columbia, hand hygiene is one of the priority areas of the Ministry of Health's clinical care management initiative.*			
PPM20.1.1	**M**	Clinical staff complete hand hygiene training at time of orientation and every three years thereafter. *Guidance: Staff complete education on the indications for hand hygiene, factors that influence hand hygiene, hand hygiene agents, hand hygiene techniques, and hand care to promote skin integrity. There are records of hand hygiene training on file for each staff member (for staff that also work in the health authority, having copies/evidence of their health authority hand hygiene training on file at the non-hospital facility would satisfy this requirement). Facility policy specifies the frequency of periodic training which may be no longer than every three years. Records of hand hygiene periodic (refresher) training is on file. If the hand hygiene compliance audit results are less than 80%, all personnel are required to repeat the provincial hand hygiene education module (i.e. PICNet Hand Hygiene online education module) before the next hand hygiene compliance audit*	42, 43	M	Revised
PPM20.1.2	**M**	A sink for hand washing is available. *Guidance: A dedicated hand washing sink in close proximity to the procedure room shall be available.*	42, 43	M	

No.	Description	Reference	Risk	Change
PPM20.1.3	**M** Liquid hand hygiene products (i.e. soap or alcohol-based hand rub) are dispensed in disposable pumps/cartridges that are discarded when empty. *Guidance: Hand-washing soaps (liquid and/or foam) are located at each hand hygiene sink. The hand-washing soap is within its labeled expiry date. Dispensers are not to be "topped up" or refilled, and bar soap is not used.*	42, 43	M	
PPM20.1.4	**M** Single-use paper towels are provided. *Guidance: Cloth drying towels are not used.*	42, 43	H	Revised
PPM20.1.5	**M** Paper towels are dispensed singly. *Guidance: The paper towel dispenser design is either hands-free or such that only the towel is touched during removal of the towel for use. Paper towel rolls are not appropriate.*	42, 43	M	New
PPM20.1.6	**M** Paper towel dispensers are mounted at each hand hygiene sink.	42, 43	M	Revised
PPM20.2	**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.*			
PPM20.2.1	**M** Hand hygiene is performed at essential moments. *Guidance: Examples of hand hygiene indications are before initial contact with a patient or items in their environment; before putting on gloves; before performing an invasive/aseptic procedure; before preparing or handling medications; after care involving risk of exposure to or contact with blood, body fluids, secretions and excretions of a patient even if gloves are worn; immediately after removing gloves and before moving to another activity; when moving from a contaminated body site to a clean body site during health care; after contact with a patient or items in their immediate surroundings when leaving even if the patient has not been touched; and whenever in doubt.*	42, 43	M	

No.		Description	Reference	Risk	Change
PPM20.2.2	**M**	Hand hygiene is performed with liquid soap and running water or alcohol-based hand rubs (ABHR). *Guidance: Hand-washing soaps (liquid and/or foam) are located at each hand hygiene sink. The hand-washing soap is within its labeled expiry date. At least 15 seconds of lathering with soap is required before rinsing. Bar soap shall not be used for hand hygiene. ABHR with antimicrobial agents (i.e. surgical hand rub) is not recommended for use at point of care. Non-alcohol-based waterless antiseptic agents shall not be used for hand hygiene.*	42, 43	M	
PPM20.2.3	**M**	70 to 90% alcohol-based hand rub (ABHR) is used throughout the facility. *Guidance: While alcohol-based hand rub available for health-care settings range in concentration from 60 to 90% alcohol, a minimum concentration of 70% is required.*	42, 43		Revised
PPM20.2.4	**M**	Alcohol-based hand rub (ABHR) has a drug identification (DIN) from Health Canada. *Guidance: Non-alcoholic, waterless antiseptic agents are not acceptable.*	42, 43	M	Revised
PPM20.2.5	**M**	Alcohol-based hand rub is within its labeled expiry date.	42, 43		Revised
PPM20.2.6	**M**	Alcohol-based hand rub dispensers are located at all entrances to and exits from the facility.	42, 43		New
PPM20.2.7	**M**	Alcohol-based hand rub dispensers are located at point-of-care areas throughout the facility.	42, 43		New

PPM21.0 ENVIRONMENTAL CLEANING

PPM21.1		**The physical environment of the facility is clean.**			
PPM21.1.1	**M**	All areas, rooms, surfaces and furnishings of the facility are visibly clean. *Guidance: All areas, rooms, surfaces and furnishings are free of gross dust, gross soil, stains, spills and streaks.*	44, 45, 46	M	
PPM21.2		**Environmental cleaning of the procedure room minimizes the risk of infection.**			

No.		Description	Reference	Risk	Change
PPM21.2.1	**M**	Patient care items (e.g. stethoscope, blood pressure cuff) and surfaces in direct contact with a patient (e.g. procedure table) are low-level disinfected before use on another patient. *Guidance: Patient care items and surfaces in direct contact with a patient are to be low-level disinfected after each patient use. Examples of low-level disinfectants include 3% hydrogen peroxide, 0.5% accelerated hydrogen peroxide (e.g. Cavicide wipes).*	44, 45, 46	M	
PPM21.2.2	**M**	Cleaning and disinfection products are hospital-grade and used in accordance with the manufacturer's recommendations for dilution, contact time and use.	44, 45, 46	M	

PPM22.0 MEDICAL DEVICE REPROCESSING

This applies to special equipment that is not single-use and is identified as reusable by the manufacturer. Also see the NHMSFAP Procedural Pain Management – Ultrasound Modality standard, as appropriate.

PPM22.1		**Medical device reprocessing is performed in an area that is clean and appropriately equipped.**			
PPM22.1.1	**M**	Medical device reprocessing occurs in a physical space solely dedicated for that purpose. *Guidance: There should be a centralized area for reprocessing of medical devices. The area should be segregated away from patients and clean areas. If reprocessing occurs in a dual-purpose space (e.g. exam room), patients are never present when reprocessing activities are being performed.*	47	M	
PPM22.1.2	**M**	There is sufficient cleanable, non-porous counter space to handle the volume of reprocessing work. *Guidance: The work surface must be able to withstand environmental cleaning with hospital-grade disinfectants.*	47	M	
PPM22.1.3	**M**	There is one-way workflow from dirty to clean to prevent cross-contamination.	47	H	
PPM22.1.4	**M**	There is a sink sufficient in size and depth for cleaning medical equipment/devices/instruments in the reprocessing area.	47	M	

No.		Description	Reference	Risk	Change
PPM22.1.5	**M**	A sink that is used for both medical device reprocessing and hand hygiene is cleaned and disinfected prior to using it for hand washing. *Guidance: If the facility only has a single sink that is used for both medical device reprocessing and hand hygiene, the sink is considered dirty and must be cleaned and disinfected prior to using it for hand washing.*	47	M	

PPM23.0 WASTE MANAGEMENT

PPM23.1		Waste is safely and appropriately contained.			
PPM23.1.1	**M**	Waste is appropriately segregated at point of generation. *Guidance: Waste containers are colour-coded and/or labeled according to the type of waste for which they are intended (e.g. biomedical, general, sharps).*	48	M	
PPM23.1.2	**M**	Sharps are placed in a rigid, puncture-resistant and leak-proof container. *Guidance: Sharps include glass, metal or similar rigid, sharp-edged waste.*	27, 28, 48	H	
PPM23.1.3	**M**	Sharps containers are close to the point of use and maintained in an upright position.	27, 28, 48	H	

Information management

Depending on the PPM non-hospital facility, 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 accessible.

No.		Description	Reference	Risk	Change
PPM24.0		**MEDICAL RECORD** *Guidance: The patient's medical record functions not only as a historical record of a patient's PPM procedure but also as a method of communication between physicians and staff. The patient's medical record contains all the clinical data and information related to the patient's medical history and PPM procedures. These records facilitate the continuity of care and aid in clinical decision-making.*			
PPM24.1		**The facility maintains complete and accurate medical records.**			
PPM24.1.1	**M**	The medical record is a single, comprehensive file containing all information and documentation related to the patient's care. *Guidance: Demographic information includes age, gender, date of birth, personal health number (PHN), address and next of kin.*	49, 50	M	Revised
PPM24.1.2	**M**	The patient's medical record includes patient identification and demographic information. *Guidance: Patient identification and demographic information includes the patient's legal name (e.g. name on government identification or CareCard), name used (i.e. the name specified by the patient that should be used in the context of health care; this may be different from their legal name, sex assigned at birth, date of birth, personal health number (PHN), and contact information (i.e. address and telephone number). Documentation of the patient's emergency or next of kin contact information is recommended. Medical or claim record numbers (e.g. health authority, WorkSafeBC, ICBC) should also be documented as necessary. This information should be contained on a "face sheet" at the front of the medical record. If a face sheet is utilized, it is recommended that the face sheet also contain the name of the surgeon, patient diagnosis, planned surgery, and date of surgery. Under PIPA, implied consent (i.e. the patient provided information for the purposes of care and treatment) is sufficient for the collection, use and disclosure of personal information for direct health-care purposes and may extend to parties who provide care to the patient as part of the patient's care team (i.e. referring physicians, lab technicians, nurses).*	49, 50	M	Revised

No.		Description	Reference	Risk	Change
PPM24.1.3	**M**	The medical record is organized in a standardized and chronological order. *Guidance: The medical record is organized in sections, and the information in each section is organized in chronological order. Sections include but are not limited to patient identification and demographic information, consent, history, physical, progress notes, forms/records (e.g. intraoperative (nursing), anesthesia record, post-anesthesia recovery), consultations, orders, diagnostic testing, radiologist examination results. Each section of the medical record (paper or electronic) should be tabbed for ease of review. The order of the medical record is at the discretion of the facility, as per facility policy.*	49, 50	M	New
PPM24.1.4	**M**	Each form in the medical record clearly identifies the patient. *Guidance: At minimum, there are two unique patient identifiers (i.e. full name and date of birth) on each form. In circumstances where a multi-page document is separated into individual sheets (i.e. scanning to an electronic medical record system), each page clearly identifies the patient with two unique patient identifiers.*	49, 50	C	Revised
PPM24.1.5	**M**	Intake documentation is complete. *Guidance: The documentation includes a medical history, physical exam related to the procedure being considered, comprehensive pain assessment including a pain management plan, patient self-reported check-in questionnaire, height, weight and where appropriate BMI, consultations as appropriate, pre-procedure testing based upon the patient's clinical conditions, radiological exam results as appropriate and pre-admission teaching (i.e. taking/holding of medications, post-procedure instructions).*	49, 50		New
PPM24.1.6	**M**	Check-in documentation is complete. *Guidance: The documentation includes blood pressure and heart rate, medications, allergies, functional assessment, review of post-procedure instructions and any changes in the patient's status from the check-in assessment.*	49, 50		New

No.		Description	Reference	Risk	Change
PPM24.1.7	**M**	The consent discussion is documented in the patients' medical record. *Guidance: The consent discussion explains the proposed treatment or course of treatment, the condition for which the health care is proposed, the nature of the proposed health care, the risks and benefits of the proposed health care that a reasonable person would expect to be told about, alternative courses of health care (and when indicated, the likely consequences of no treatment). Documentation of the consent discussion includes the nature of the health care proposed, the risks, benefits and alternative(s) discussed with the patient, and any specific additional issues or concerns that arose through the discussion and how they were addressed.*	49, 50	L	Revised
PPM24.1.8	**M**	Procedure record documentation is complete. *Guidance: The documentation includes the name and role of each person involved in the care provided in the procedure room and any visitors, safety checklist briefing, time-out and debriefing, patient positioning, skin preparation, electrosurgery devices as appropriate (placement of dispersive electrode pad, device serial number), medications and/or solutions administered, use of imaging, and any unusual occurrences.* ***When the procedure room is staffed with a nurse, there must be both a procedure room record and a physician's procedure note.***	49, 50		New
PPM24.1.9	**M**	The physician's procedure note is complete. *Guidance: The physician's procedure note includes the pre- and post-procedure diagnoses, date of the procedure, the exact procedure(s) performed, detailed account of the procedure and findings (i.e. patient positioning, procedure details/technique, relevant medications, use of imaging), any complications, and the physician's signature.* ***When the only regulated health professional in the procedure room is the physician performing the procedure, only the physician's procedure note is required, a procedure room record is not required,***	49, 50		New

No.		Description	Reference	Risk	Change
PPM24.1.10	**M**	Post-procedure care and discharge documentation is complete. *Guidance: The documentation includes vital signs, as appropriate, readiness for discharge assessment findings and discharge instruction review.*	49, 50		New

PPM25.0 DOCUMENTATION RETENTION AND CONTROL

PPM25.1		The facility retains documents and records in a manner that protects patient confidentiality and privacy.			
PPM25.1.1	**M**	Medical records are retained for a minimum period of 16 years from the date of last entry. *Guidance: Medical records are stored according to British Columbia's* Limitation Act. *Where the patient is a minor, records are kept for at least 16 years from the age of majority.*	49, 50	M	Rev. Guidance
PPM25.1.2	**M**	Electronic medical records are backed up and the backup is securely located in a separate physical location. *Guidance: Electronic records database backup is performed to prevent deletion or loss of information. Backup should be performed regularly. Although CPSBC does not specify the frequency of backup, it is recommended that electronic records database backup be performed each day PPM procedures are performed.*	49, 50	L	
PPM25.1.3	**M**	Data is protected from unauthorized access and safeguarded against harm (e.g. water, fire, etc.). *Guidance: Written records are located in a secure area where there is no public access and where only authorized personnel are allowed. Computer-based systems are password protected, and generic login accounts are not used.*	49, 50	M	

Equipment

Patient care relies on the safe and optimal performance of the equipment. It is the expectation that the equipment performance meets the manufacturer's specifications and complies with regulations.

No.		Description	Reference	Risk	Change
PPM26.0		**EQUIPMENT**			
PPM26.1		**Equipment is safely operated, maintained and monitored in a manner that ensures performance specifications are met.**			
PPM26.1.1	**M**	Scheduled preventative maintenance and safety checks of the equipment are conducted as per the manufacturer's recommendations. *Guidance: Records of safety checks and preventative maintenance are retained for the lifetime of the equipment.*	33	M	
PPM26.1.2	**M**	All equipment used for patient care is tested by a biomedical engineer prior to being put into clinical use. *Guidance: Testing is performed when the equipment is new or has been upgraded or repaired. Documentation of the equipment testing is on file at the facility.*	33	M	
PPM26.1.3	**M**	Only equipment bearing a Canadian Standards Association (CSA) mark/label recognized by the CSA is used. *Guidance: The CSA mark indicates that a sample of the product/equipment has been certified to applicable standards. The CSA mark or label indicates that the product has been independently tested and has met the required standards for safety and performance. You will find CSA marks and labels on a range of products, including electrical products, personal protective equipment and mechanical products.* *Examples of CSA marks and labels can be found on the CSA website (http://www.csagroup.org/about-csa-group/certification-marks-labels/csa-marks/).*	33	M	

Policies and procedures

No.		Description	Reference	Risk	Change
PPM27.0		**POLICIES AND PROCEDURES**			
PPM27.1		**Policies and procedures contain all the information necessary for the safety of patients, staff and visitors.** *Intent: Policies and procedures ensure that examinations are performed consistently and accurately by all personnel within the non- hospital facility.*			
PPM27.1.1	**M**	Policies and procedures are readily available to all staff.		M	
PPM27.1.2	**M**	Policies and procedures are reviewed annually by the medical director.		L	
PPM27.1.3	**M**	There are policies and procedures for medical emergencies. *Guidance: Medical emergencies include but are not limited to anaphylaxis, cardiac arrest and respiratory distress.*		M	
PPM27.1.4	**M**	There are policies and procedures for building emergencies. *Guidance: Building emergencies include but are not limited to fire, earthquake, gas leak.*		M	
PPM27.1.5	**M**	There are policies and procedures for environmental cleaning.		M	
PPM27.1.6	**M**	There are policies and procedures for patient transfer to hospital. *Guidance: All facilities are required to have policies and procedures for patient transfer to hospital. When patient transfer to hospital is indicated, the patient must be transferred via emergency health services (EHS). The most responsible physician (MRP) determines whether a regulated health professional needs to accompany the patient during transfer. If not accompanying the patient, the MRP must contact the receiving physician immediately by phone or in person to ensure continuity of care. Patient transfer to hospital is a patient safety incident requiring mandatory reporting to CPSBC.*		M	

Appendix A: Procedural pain management – procedures restricted to accredited facilities

The BC MQI privileging dictionary, which has been adopted by CPSBC, categorizes procedural pain management procedures using a tiered approach (basic, intermediate, advanced I and advanced II) reflective of underlying complexity and required training. The following procedural pain management procedures are **not** considered appropriate for the community setting (i.e. physician office, clinic, facility) and may only be performed in an accredited facility.

Intermediate	Advanced I	Advanced II
Caudal and interlaminar lumbar epidural	Epidural injections: • Lumbar transforaminal/nerve root block • Thoracic interlaminar • Thoracic transforaminal/nerve root block Medial branch blocks and facet joint injections: • Lumbar • Thoracic Sympathetic nerve blocks: • Lumbar sympathetic nerve block • Celiac plexus and splanchnic nerve block • Stellate ganglion block • Ganglion impar block Other: • Intercostal nerve blocks	Chemical neurolytic procedures: • Peripheral non-neuraxial blocks, intercostal nerves, autonomic nerves or plexus Epidural injections (Class 1 General Anesthesia facilities only): • Cervical interlaminar • Cervical transforaminal/nerve root block • Epiduroscopy and/or epidural adhesiolysis Medial branch blocks and facet joint injections: • Cervical Thermal neurolysis: • Use of radiofrequency technology • Cryoablation Other:

Intermediate	Advanced I	Advanced II
	• Paravertebral block of the lumbosacral plexus	• Deep cranial nerve blocks (trigeminal branches, sphenopalatine, etc.) (Class 1 General Anesthesia facilities only) • Intradiscal injections

Note: "Basic" and "intermediate" tier procedures, with the exception of **caudal and interlaminar lumbar epidural procedures**, (i.e. trigger point/bursal injections, intra-articular injections, and mid-sized peripheral nerve blocks) may be performed in an office setting and are not restricted to an accredited facility.

References

1. BC Medical Quality Initiative (BC MQI). The procedural pain management (PPM) privileging standard [Internet]. Vancouver: BC Medical Quality Initiative; 2019 Oct 11 [cited 2025 Feb 6]. 10 p.
2. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: governance and leadership [Internet]. Version 2.1 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 27 p. Document No.: 11923.
3. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: medical director [Internet]. Version 2.1 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 10 p. Document No.: 11925.
4. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: human resources [Internet]. Version 6.1 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 27 [cited 2025 Feb 6]. 56 p. Document No.: 10820.
5. BC Medical Quality Initiative (BC MQI). The anesthesiology dictionary [Internet]. Vancouver: BC Medical Quality Initiative; 2015 Oct [revised 2019 Jul 11; cited 2025 Feb 6]. 23 p.
6. BC Medical Quality Initiative (BC MQI). The emergency medicine dictionary [Internet]. Vancouver: BC Medical Quality Initiative; 2018 Apr [revised 2023 Jun 22; cited 2025 Feb 6]. 10 p.
7. BC Medical Quality Initiative (BC MQI). The critical care medicine dictionary [Internet]. Vancouver: BC Medical Quality Initiative; 2019 Jul [revised 2024 Apr 25; cited 2025 Feb 6]. 12 p.
8. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: pre-admission evaluation and selection [Internet]. Version 4.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2025 Jan 10 [cited 2025 Feb 6]. 14 p. Document No.: 10846.
9. Ontario Agency for Health Protection and Promotion (Public Health Ontario) Provincial Infectious Diseases Advisory Committee. Infection prevention and control for clinical office practice [Internet]. Toronto (ON): Queen's Printer for Ontario; 2013 [1st revision 2015 Apr; cited 2025 Feb 6]. 116 p.
10. Operating Room Nurses Association of Canada (ORNAC). The ORNAC standards, guidelines, and position statements for perioperative registered nurses. 16th ed. Toronto: CSA Group; 2023. 562 p.
11. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: consent [Internet]. Version 3.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2025 Jan 9 [cited 2025 Feb 3]. 11 p. Document No.: 10796.

12. College of Physicians and Surgeons of British Columbia. Practice standard: consent to treatment [Internet]. Version 1.1 Vancouver: College of Physicians and Surgeons of British Columbia; 2023 Apr 19 [cited 2025 Feb 6]. 6 p.
13. British Columbia Ministry of Health. Healthcare providers guide to consent to healthcare [Internet]. Victoria: British Columbia Ministry of Health; 2011 Jul [cited 2025 Feb 6]. 44 p.
14. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: admission and pre-procedure care [Internet]. Version 5.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Apr 16 [cited 2025 Feb 6]. 15 p. Document No.: 10782.
15. World Health Organization (WHO). Patient identification. Geneva: WHO Press; 2007. [cited 2025 Feb 3]. 4 p.
16. ECRI Institute, Patient Safety Organization (PSO). Deep dive: patient identification executive summary [Internet]. Plymouth Meeting (PA): ECRI Institute; 2016 Aug [cited 2025 Feb 3]. 20 p.
17. Healthcare Insurance Reciprocal of Canada (HIROC). Wrong client, site and/or procedure: risk reference sheets [Internet]. Toronto (ON): HIROC; 2023 Jul [cited 2025 Feb 3]. 6 p.
18. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: intraoperative [Internet]. Version 3.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2025 Jan 9 [cited 2025 Feb 6]. 33 p. Document No.: 10827.
19. Provincial Health Services Authority, Provincial Infection Control Network of British Columbia (PICNet). Revised ultrasound cleaning and disinfection recommendations for all health care settings [Internet]. Vancouver: Provincial Health Services Authority; 2018 Jun 22 [cited 2025 Feb 11]. 4 p.
20. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: surgical safety checklist [Internet]. Version 3.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2025 Jan 9 [cited 2025 Feb 6]. 10 p. Document No.: 10856.
21. Canadian Patient Safety Institute. Surgical safety checklist – why: information, rationale, and FAQ. Edmonton: Canadian Patient Safety Institute; 2009. 9 p.
22. World Health Organization (WHO). Patient safety. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO Press; 2009. 133 p.
23. Royal College of Anaesthetists, Faculty of Pain Medicine. Faculty of Pain Medicine safety checklist for: interventional pain procedures under local anaesthesia or sedation (adapted from the WHO surgical safety checklist) [Internet]. London, UK: Royal College of Anaesthetists; 2025 [cited 2025 Feb 6]. 2 p.

24. National Association of PeriAnesthesia Nurses of Canada. Standards for practice. 5th ed. Ottawa, ON: National Association of PeriAnesthesia Nurses of Canada; 2023. 190 p.

25. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: post-anesthesia care [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 11 p. Document No.: 10844.

26. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: discharge [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 27 [cited 2025 Feb 6]. 11 p. Document No.: 10803.

27. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: occupational health and safety [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 13 p. Document No.: 10838.

28. WorkSafeBC. OHS regulation & related materials. [Internet]. Richmond, BC: WorkSafeBC; 2025 [cited 2025 Feb 11]; [about 1 screen].

29. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: emergency preparedness [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 21 [cited 2025 Feb 6]. 10 p. Document No.: 10802.

30. Canadian Standards Association. Canadian health care facilities. Toronto: Canadian Standards Association; 2024. 712 p. CSA Standard:Z8000-24.

31. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: heating, ventilation and air-conditioning (HVAC) [Internet]. Version 1.4 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 11 [cited 2025 Feb 6]. 12 p. Document No.: 10824.

32. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: medical gas – free standing tank system [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 5 p. Document No.: 10831.

33. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: electrical systems and safety [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 21 [cited 2025 Feb 6]. 9 p. Document No.: 10807.

34. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: medication management [Internet]. Version 3.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 10 p. Document No.: 10835.

35. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: single use vials [Internet]. Version 2.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 6 p. Document No.: 10849.

36. Centers for Disease Control and Prevention. Injection safety checklist [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; 2024 [cited 2025 Feb 11]. 1 p.

37. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: point-of-care [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 7 p. Document No.: 10841.

38. Centers for Disease Control and Prevention. Considerations for blood glucose monitoring and insulin administration [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; 2024 Aug [cited 2025 Feb 11].

39. U.S. Department of Health and Human Services, Food and Drug Administration. Guidance for industry and food and drug administration staff blood lancet labeling [Internet]. Silver Spring (MD): U.S. Food and Drug Administration; 2010 Nov [cited 2025 Feb 11]; 6 p.

40. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: routine practices [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 10 p. Document No.: 10854.

41. Ontario Agency for Health Protection and Promotion (Public Health Ontario) Provincial Infectious Diseases Advisory Committee. Routine practices and additional precautions in all healthcare settings [Internet] 3rd ed. Toronto (ON): Queen's Printer for Ontario; 2009. [3rd revision 2012 Nov; cited 2025 Feb 6]. 113 p.

42. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: hand hygiene [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 10 p. Document No.: 10814.

43. British Columbia Ministry of Health. Best practices for hand hygiene in all healthcare settings and programs [Internet]. Victoria: Ministry of Health; 2012 [cited 2025 Feb 6]. 71 p.

44. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: environmental cleaning program and non-clinical areas [Internet]. Version 2.1 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 21 [cited 2025 Feb 6]. 28 p. Document No.: 12191.

45. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: environmental cleaning of pre- and post-anesthesia care areas [Internet]. Version 2.1

Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 21 [cited 2025 Feb 6]. 28 p. Document No.: 12190.

46. Ontario Agency for Health Protection and Promotion (Public Health Ontario) Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings [Internet]. 3rd ed. Toronto (ON): Queen's Printer for Ontario; 2018 [cited 2025 Feb 6]. 250 p.
47. British Columbia Ministry of Health. Best practice guidelines for cleaning, disinfection and sterilization of critical and semi-critical medical devices in BC health authorities [Internet]. Victoria: Ministry of Health, 2007 [revised 2011 Dec; cited 2025 Feb 6]. 136 p.
48. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: waste management [Internet]. Version 1.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2024 Nov 22 [cited 2025 Feb 6]. 12 p. Document No.: 10855.
49. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: medical records and documentation [Internet]. Version 7.0 Vancouver: College of Physicians and Surgeons of British Columbia; 2025 Jan 9 [cited 2025 Feb 6]. 48 p. Document No.: 10829.
50. College of Physicians and Surgeons of British Columbia. Practice standard – medical records documentation [Internet]. Version 4.3 Vancouver: College of Physicians and Surgeons of British Columbia; 2022 May 6 [cited 2025 Feb 6]. 4 p.

Revision history

Date	Revisions
June 1, 2020 Version 1.0	• Original publication
June 3, 2021 Version 2.0	• New room size requirements (Section 13.0 Physical Design) • Published March 2022
September 8, 2022 Version 3.0	• Section 4.0 Human Resources – anesthesiologist qualifications: o PPM4.1.2 guidance revised from: "…Anesthesiologists who hold active hospital privileges in the practice of anesthesia or have held active hospital privileges within the last three years are not required to hold current ACLS…" to "… Anesthesiologists **that hold active or provisional privileges in the practice of anesthesia in the health authority or have held active or provisional privileges in the health authority** within the last three years are not required to hold current ACLS…" o PPM4.1.3 guidance revised from "…Anesthesiologists who hold active hospital privileges in the practice of anesthesia or have held active hospital privileges within the last three years are not required to have an airway management course…." to "Anesthesiologists that **hold active or provisional privileges in the practice of anesthesia in the health authority** or **have held active or provisional privileges in the health authority** within the last three years are not required to have an airway management course…"
March 24, 2023 Version 3.1	New CPSBC logo (no content changes) (version 3.1) (published March 24, 2023)
June 30, 2025 Version 4.0	Substantial revisions to the following sections (version 4.0) (effective within 30 days of notification) • Section 2.0 Medical Staff Credentialing and Privileging • Section 4.0 Human Resources – FCRP Emergency Medicine and Critical Care Medicine Physicians • Section 6.0 Consent

	• Section 7.0 Patient Check-In Day of Procedure • Section 8.0 Intra-Procedure Care (single use antiseptic products, safety checklist documentation) • Section 10.0 Occupational Health and Safety • Section 11.0 Emergency Preparedness • Section 16.0 Medication Management (controlled drugs and substances) • Section 20.0 Hand Hygiene • Section 24.0 Medical Record • Reference list updated