



NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES
ACCREDITATION PROGRAM

Accreditation Manual

Accreditation Manual

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Introduction to the Accreditation Process

The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) Accreditation Manual is designed to help facilities understand the processes, forms, and requirements of the NHMSFAP accreditation cycle. The accreditation process is expected to be a collaborative process, so please contact us if you have any questions. This manual will be revised and improved using stakeholder feedback.

Background

As a program of the College of Physicians and Surgeons of British Columbia (the College), the mandate and authority of the NHMSFAP is derived from section 5 of the College Bylaws under the *Health Professions Act*, RSBC 1996, c.183. The NHMSFAP's mandate is to assess the quality of medical, surgical, dental and anesthesia services in private medical and surgical facilities in the province of British Columbia through accreditation activities.

Specifically, the College Bylaws state:

- 5-2 (1) Every facility must be accredited and maintain accreditation by the committee before it can provide medical, surgical, dental or anesthesia procedures.

What is Accreditation?

Accreditation is the evaluation of processes to ensure the quality of safe patient care and staff safety, through competence and conformance to the NHMSFAP Accreditation Standards and guidelines. Patients accessing non-hospital medical and surgical services always expect safe care. Accreditation elevates the confidence of patients, registrants, nursing and support staff, facility administration, government and any others working in the accredited facility. Accreditation provides formal recognition that the organization meets industry best practices.

Accreditation Application

Many procedures are only permitted to be performed in an accredited NHMSFAP facility. Please refer to the [appropriate procedures list](#) on the NHMSFAP website.

Facilities wishing to perform these procedures must apply for accreditation using the [new facility application](#), which is located on the NHMSFAP website under "Forms for facility accreditation".

Accreditation Cycle and Award Expiry

NHMSFAP accreditation involves a formal assessment against all appropriate NHMSFAP accreditation standards once every 46 to 48 months. The outcome of the assessment is reviewed with the NHMSFAP Committee ("the committee"), who then decides on the accreditation award including:

- Provisional accreditation:
 - Once a facility is ready to open, an assessment is conducted to assess if the facility meets requirements such as applicable CSA Z8000 standards, facility management, patient experience, building services, emergency preparedness, infection prevention

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and control, and safety and risk standards. A facility must remediate any nonconformances before they can open and provide patient care.

- After being granted permission to open, an assessment is conducted within the first year, using the patient tracer methodology. The facility is assessed for conformance to the standards related to the patient experience.
- After successful completion of the patient tracer, the committee may grant the facility full accreditation (a four-year term of accreditation with a five-year certificate), with or without a requirement for a further on-site assessment during the term of accreditation.
- The four-year term of accreditation and the five-year certificate are dated for the first day of the provisional accreditation.
- Full accreditation:
 - A facility must demonstrate conformance with all mandatory criteria from the applicable core standards.
 - Depending upon the medical, surgical, dental or anesthesia services provided, a non-hospital facility may also be required to be in conformance with all mandatory criterion from procedure-specific accreditation standards to be awarded full accreditation. Examples of procedure-specific accreditation standards include immediately sequential bilateral cataract surgery and laparoscopic adjustable gastric banding.
 - If any criterion is rated “No” it must be remediated to the satisfaction of the committee to be awarded full accreditation.
 - A facility does not need to demonstrate conformance with a best practice criterion to achieve full accreditation.
 - The committee may grant the facility full accreditation not to exceed five years with or without a requirement for a further on-site assessment during the term of accreditation.
- Accreditation with conditions:
 - The committee may direct the NHMSFAP to conduct a further assessment during the accreditation cycle to ensure the facility nonconformances are met.

The NHMSFAP committee may revoke, suspend, or change the terms of accreditation at any time during the period specified on the certificate of accreditation if, in the opinion of the committee, revocation, suspension or change is warranted by:

- a failure of the facility to comply with the Bylaws; or
- a failure of the facility to comply with the NHMSFAP standards; or
- one or more unacceptable patient outcomes at a facility.

NHMSFAP Team

The team is comprised of a manager of accreditations, manager of standards and facilities, quality improvement lead, accreditation assessment officer, and accreditation assistants.

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The **manager of accreditations** provides leadership for the delivery of the accreditation of non-hospital facilities including leadership to accreditation assessment officers and contracted assessors to ensure planned accreditation activities are conducted by qualified, trained personnel.

The **manager of standards and facilities** is responsible for the development of accreditation standards and evaluation of processes and practices in private non-hospital medical/surgical facilities within the province of BC.

The **quality improvement lead** is responsible for conducting reviews of patient safety incidents occurring within the non-hospital sector and credentialing and privileging activities for review of registrant applications for appointment to non-hospital facilities. and may participate in patient safety incident investigations.

The **accreditation assessment officer** is responsible for assessing the performance of facilities for awarding accreditation and managing assessment teams during facility accreditations.

The **accreditation assistants** will work collaboratively with program staff and other College departments to uphold its mandate to establish, monitor and ensure standards of practice in private medical and surgical facilities in British Columbia.

Credentialing and privileging

All medical staff in accredited non-hospital facilities in British Columbia must undergo an appointment process. Privileges at a non-hospital facility are requested through the medical director of the facility.

The NHMSFAP reviews and verifies the privileges granted by the facility medical director. The NHMSFAP Committee has adopted the BCMQI dictionaries as objective criteria within each specialty. This includes the following requirements:

- privileges that are core and non-core for each specialty
- training and current experience requirements

Please refer to the college website for more information on credentialing and privileging.

NHMSFAP Accreditation Standards

The NHMSFAP accreditation standards are available on the College [website](#).

NHMSFAP accreditation standards detail the level of performance expected of all non-hospital medical/surgical facilities that perform procedures restricted to accredited facilities and are used to evaluate the safety and quality of care delivered in these facilities. Standards, guidelines and policies focus on important patient care practices and organizational functions that represent the minimum level of performance required to achieve accreditation and are essential to safe and quality care. This includes but is not limited to: clinical care processes, medication safety, infection prevention and control and medical device reprocessing processes.

NHMSFAP accreditation standards are developed using a defined and rigorous process. This process reflects best practice guidelines established by national and international evaluation organizations that assess accreditation programs and standards.

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NHMSFAP accreditation standards are developed through a collaborative, consultative and consensus building process that may involve health professionals, organizations, academics, experts, health authorities, and other colleges. The process for standards development and review includes input from the medical and surgical facilities that will be using the standards. The NHMSFAP Committee is responsible for final approval in its capacity to establish performance standards to ensure the delivery of high quality and safe services in British Columbia.

The research and development of the accreditation standards may involve an expert advisor/advisory committee if subject matter expertise required exceeds the scope of program staff and/or the NHMSFAP committee. If convened, an advisory committee has specific terms of reference that outline the role, membership, term of appointment and frequency of meetings. Terms of reference guide the activities of each advisory committee.

The NHMSFAP accreditation standards are a group of over 50 standards that cover the following areas:

- facilities management
- patient experience
- procedure-specific management
- emergency preparedness
- building services
- infection, prevention and control
- safety and risk

NHMSFAP accreditation standards that assess the common systems and processes that every non-hospital facility must have in place, are referred to as the core standards. Examples of core standards include:

- Pre-admission evaluation and selection (patient experience);
- Governance and leadership (facilities management);
- Electrical systems and safety (building services);
- Emergency cart (emergency preparedness);
- Hand hygiene (infection, prevention and control); and
- Surgical safety checklist (safety and risk).

Structure of NHMSFAP Accreditation Standards

NHMSFAP accreditation standards have the following structure:

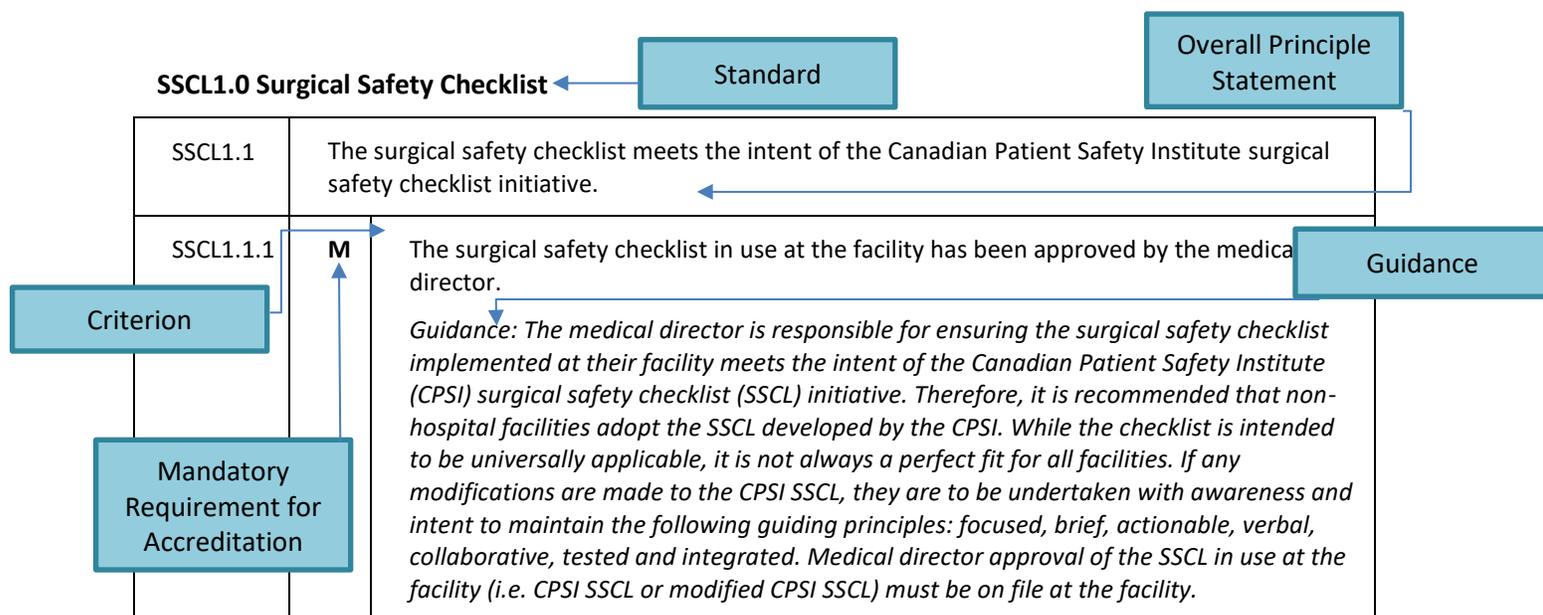
1. **Standard** – the title of the standard is the subject matter, topic or function assessed by the standard.
2. **Overall principle statements** – these describe the high-level outcomes within each standard. Each principle statement within a standard is identified by two digits (e.g. 1.1).

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3. **Criteria** – these describe the practices, actions or documentation that collectively demonstrate conformance with the overall principle statement. Criteria are identified by three digits (e.g. 1.1.1). A criterion is either a mandatory requirement for accreditation, or a best practice.
 - a. Mandatory (compulsory) criteria are indicated by a bold type face **M**.
 - b. Best practice (non-compulsory) criteria are indicated by a bold type face **B**.
4. **Guidance** – this explains and expands on the concepts contained within the criterion when the criterion is not obvious or self-explanatory. The guidance is shaped and driven by the College’s four values:
 - a. Transparent – information is easy to understand, clear, accessible and applied consistently.
 - b. Objective – regulatory decisions are evidence-based and rationale is clearly explained and defensible.
 - c. Impartial – regulatory processes and decisions are unprejudiced and free of bias.
 - d. Fair – regulatory processes and proceedings are conducted according to established rules of order and the law.

The guidance takes the “guess-work” out of what practices, actions or documentation is expected, assists facilities in assessing their own performance against the standards and improves inter-assessor reliability. While compliance with the criterion may be demonstrated in ways other than those outlined, the guidance outlines the preferred practices, actions or documentation for demonstrating conformance with the criterion.

Example of an Accreditation Standard



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Rating Scale Methodology

A binary rating system of “Yes” or “No” is used for measuring the overall achievement of each criterion along with a “Not Applicable” option. **A facility must achieve “Yes” on all mandatory criteria to be awarded full accreditation.**

NHMSFAP standards are written to avoid more than one element in a criterion. However, in the rare occasion where a criterion may have more than one element, the facility must demonstrate conformance with all the elements within the criterion to achieve a “Yes” outcome. Each mandatory criterion has a risk rating: **critical, high, and moderate/low-risk**. Each mandatory criterion has the same weight regardless of its risk rating.

- Critical:** A nonconformance that presents immediate hazardous or unsafe conditions for patients or facility personnel or pervasive deficiency in the facility, that represents systemic failure leading to unsafe conditions for patients or facility personnel.
- High:** A nonconformance that will result in hazardous or unsafe conditions for patients or facility personnel.
- Moderate/low:** A nonconformance that could result in hazardous or unsafe conditions for patients or facility personnel, or a nonconformance that undermines safety/quality but is very unlikely to contribute to harm.

A mandatory criterion with more than one element does not have more weight than a mandatory criterion with only one element. A “No” outcome on a critical or high-risk mandatory criterion, however, requires the facility to quickly resolve the non-conformance within the timelines specified in the *Accreditation Program Nonconformance Definitions and Management* policy.

The “NA” option can be used when the criterion guidance specifies that it is not applicable to a type of facility or situation. For example, NHMSFAP *Pre-admission Evaluation and Selection* standard PAE1.1.6 states Class 3 (local anesthesia only) facilities are not required to screen patients for venous thromboembolism (VTE).

The “NA” option is also be used when based upon the medical, surgical, dental and anesthesia procedures performed at the facility, the core standard or a section of the core standard does apply.

For example, the NHMSFAP *Anesthesia* standard and section MRDOC1.9 anesthesia documentation of the NHMSFAP *Medical Records and Documentation* standard would not apply to a facility with no anesthesiologists on staff. The self-assessment should state the reason the core standard, section of the core standard or specific criterion is not applicable. If the assessment team determines that the core standard, section of the core standard or specific criterion is applicable, this is documented in the report as a requirement.

NHMSFAP accreditation assessment reports use the documentation by exception (DBE) method. Conformance with a criterion is recorded in the e-accreditation software as a “Yes” rating but all “Yes” ratings are filtered out by the software and do not appear in the accreditation report. Non-conformance with a criterion is recorded in the e-accreditation software as a “No” rating and appears in the accreditation report as a requirement (i.e. citation).

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Table 1: Examples of accreditation report documentation

| Rating | Mandatory Criterion | Critical- or High-risk Criterion | Assessment Report | Facility Action |
|---|------------------------------|----------------------------------|---|--|
| "Yes" | M (Yes) | Yes | DBE | |
| <p>Facility self-assessment indicates "Yes" outcome</p> <p>Facility assessment demonstrates conformance with the criterion and there is evidence to support the above (i.e. practice observed, awareness by relevant staff, processes to ensure intended outcomes are achieved, documented evidence)</p> | | | | |
| "Yes" | B (No, Best Practice) | NA | DBE | |
| <p>Facility self-assessment indicates "Yes" outcome</p> <p>Facility assessment demonstrates conformance with the criterion and there is evidence to support the above (i.e. practice observed, awareness by relevant staff, processes to ensure intended outcomes are achieved, documented evidence)</p> | | | | |
| "No" | M (Yes) | Yes | Non-conformance(s) cited | All critical-and high-risk non-conformances must be resolved within the timelines specified in the <i>Accreditation Program Nonconformance Definitions and Management policy</i> |
| <p>Facility self-assessment indicates "No" outcome</p> <p>Facility does not demonstrate conformance with the standard, criterion or element and/or there is no evidence to support the above (i.e. practice not demonstrated, staff are not aware of required practices and procedures, written policies to support practice are not in place).</p> | | | | |
| "No" | M (Yes) | No | Non-conformance(s) cited | All mandatory criterion non-conformances must be resolved to be awarded full accreditation |
| <p>Facility self-assessment indicates "No" outcome</p> <p>Facility does not demonstrate conformance with the standard, criterion or element and/or there is no evidence to support the above (i.e. practice not demonstrated, staff are not aware of required practices and procedures, written policies to support practice are not in place).</p> | | | | |
| "No" | B (No, Best Practice) | NA | Opportunity for Improvement (OFI) noted | All OFIs should be acknowledged |
| <p>Facility self-assessment indicates "No" outcome</p> <p>Facility does not demonstrate conformance with the standard, criterion or element and/or there is no evidence to support the above (i.e. practice not demonstrated, staff are not aware of required practices and procedures, written policies to support practice are not in place).</p> | | | | |
| "Yes" | M (Yes) | DBE | --- | |

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| Rating | Mandatory Criterion | Critical- or High-risk Criterion | Assessment Report | Facility Action |
|---|------------------------------|---|--|-----------------|
| <p>Facility self-assessment indicates “Yes” outcome</p> <p>Facility assessment demonstrates conformance with the criterion and there is evidence to support the above (i.e. practice observed, awareness by relevant staff, processes to ensure intended outcomes are achieved, documented evidence)</p> | | | | |
| “Yes” | B (No, Best Practice) | DBE | --- | |
| <p>Facility self-assessment indicates “Yes” outcome</p> <p>Facility assessment demonstrates conformance with the criterion and there is evidence to support the above (i.e. practice observed, awareness by relevant staff, processes to ensure intended outcomes are achieved, documented evidence)</p> | | | | |
| “No” | M (Yes) | Non-conformance(s) cited | <p>All critical-and high-risk non-conformances must be resolved within the timelines specified in the <i>Accreditation Program Nonconformance Definitions and Management</i> policy</p> <p>All moderate- and low-risk mandatory criterion non-conformances must be resolved to be awarded full accreditation</p> | |
| <p>Facility self-assessment indicates “No” outcome</p> <p>Facility does not demonstrate conformance with the standard, criterion or element and/or there is no evidence to support the above (i.e. practice not demonstrated, staff are not aware of required practices and procedures, written policies to support practice are not in place).</p> | | | | |
| “No” | B (No, Best Practice) | Opportunity for Improvement (OFI) noted | All OFIs should be acknowledged | |
| <p>Facility self-assessment indicates “No” outcome</p> <p>Facility does not demonstrate conformance with the standard, criterion or element and/or there is no evidence to support the above (i.e. practice not demonstrated, staff are not aware of required practices and procedures, written policies to support practice are not in place).</p> | | | | |

Assessment Process

Pre-Assessment

Assessment Notification Letter

Facilities that have been awarded a four-year accreditation, will be sent a “Notice of Upcoming Accreditation Assessment” letter approximately nine months before the expiry date of the accreditation award. The letter informs the facility of their current accreditation award expiry date and to anticipate

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receipt of a pre-accreditation documentation package in preparation for their upcoming on-site assessment.

Pre-Accreditation Documentation Package

This package is sent by email to the medical director and administrative leader approximately six months before the expiry date of the accreditation award.

The pre-accreditation documentation package includes:

- A pre-accreditation letter outlining the accreditation process including a submission deadline;
- A pre-accreditation documentation checklist;
- A pre-accreditation questionnaire (appropriate to the facility's level of accreditation and which mirrors the standard(s);
 - Facilities are required to use this tool to self-assess their conformance with all criterion, both mandatory and best practice, using the same binary rating system (Yes/No or not applicable) to measuring achievement.
- BC Ministry of Health Best Practice Medical Device Reprocessing Audit Questionnaire; and
- An Accreditation Agreement Form;
 - provides a formal understanding that the facility will comply with requirements of the program and abide by the defined responsibilities of an accredited organization. The agreement is to be completed and signed by the medical director.

Next, a courtesy phone call with the appropriate facility staff (e.g. medical director, accreditation lead) is completed to inform them of their upcoming accreditation assessment.

The facility is asked to provide the NHMSFAP with potential assessment dates in the month(s) outlined in the pre-accreditation email. Once the assessment date is confirmed the assessment team is scheduled. The assessment team members are selected based on the anesthesia level, the size and complexity of the facility.

Site Confirmation Letter

Once the assessment date is established, the medical director and administrative leader are provided with a site confirmation letter.

The assessment date stated on the letter marks the **commencement** of the assessment. Please note, the assessment may be conducted over the course of one to two days (six to eight hours per day) depending on the complexity of services. Where possible, the assessment length is confirmed in advance.

The facility is required to inform the accreditation team of the following:

- The names of staff who will work with the assessors during the assessment. Staff with specific knowledge (e.g. intraoperative staff, PACU, anesthetist, MDR, nursing manager, laser safety officer, medical radiation technologist) can also be included to address specific standards in a modality/discipline;

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- The name(s) of the facility team who will work with the accreditation assessment officer/manager accreditations throughout the assessment;
- Surgical Attire and PPE for the accreditation assessment team, as appropriate; and
- Any pertinent information which may assist the assessment team in locating the facility (e.g. parking, directions to the department, etc.)

Assessor Biographies

The biography of each assessor (staff and peer) is also provided with the site confirmation letter to help the facility identify conflicts of interest.

Please inform the NHMSFAP accreditation assistant immediately if there is a suspected conflict of interest, such as the assessor:

- is currently employed by the facility being assessed (staff member or consultant);
- is currently employed with a parent organization being assessed (staff member or consultant);
- was previously employed by the facility being assessed (staff member or consultant less than two years ago);
- has a family connection with employee/owner/shareholder of the facility being assessed;
- has a financial interest in the facility being assessed;
- is actively soliciting consulting business;
- has other industry affiliation (e.g. assessor affiliated with laboratory specimen transport); or
- is an industry competitor.

All peer (non-staff) assessors for the NHMSFAP are required to sign an agreement with the College which includes code of conduct, conflict of interest and confidentiality commitments as part of their employment agreement. For this reason, assessors are not required to sign a facility confidentiality agreement.

Rescheduling

Accreditation assessments must be completed on or before the accreditation award expiry unless there are unforeseen extenuating circumstances. A request for an assessment date after the accreditation award expiry must be approved by the deputy registrar and/or the Committee.

If the facility has unforeseen extenuating circumstances that prevent the assessment from occurring on the scheduled date(s), the facility must immediately contact the NHMSFAP (by email) to request a date change and include the rationale for such change.

If the grounds for rescheduling are not considered reasonable, the original date(s) will be maintained.

Cancellation of a confirmed accreditation assessment date less than six weeks prior to the confirmed date may result in a rescheduling fee of \$500. The facility may also incur the cost of the accreditation teams' honorarium and/or expenses.

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Pre-assessment teleconference

A pre-assessment teleconference will be scheduled with the facility's medical director and administrative leader one to two weeks before the accreditation assessment date.

The teleconference is an opportunity for the accreditation assessment officer/manager accreditations to review the site confirmation letter including:

- scheduled dates;
- assessment schedule;
- accreditation team arrival time;
- required preparations;
- anticipated time for completion of the assessment;
- accreditation team members; and
- an overview of the day of accreditation site assessment.

Assessment

The Assessment Process

The assessment team (NHMSFAP staff and peer assessors) focus on the management and clinical service delivery using the patient tracer methodology and review of documents provided by the facility.

A patient tracer methodology is used to determine whether there is consistent provision of appropriate and safe access to care, treatment, and services. By viewing care across the organization, it allows the assessors to observe and assess the full scope of service that occurs at the facility.

For example, assessors will observe a patient journey including admission, pre-procedure care, intraoperative care, surgical procedure, post-anesthesia care, discharge practices, imaging modalities (if used), and medical device reprocessing.

The assessment team follows specific assessment protocols applicable to the facility and based on the NHMSFAP Accreditation Standards. The protocols direct the assessment activities and outline what questions to ask, and what activities to observe. The use of protocols increases the objectivity and consistency amongst assessors.

The facility is required to provide the assessment team the following documents:

- personnel files of all staff (e.g. MDRD, registrants, nursing) for review by the accreditation team during the assessment
- patient medical records
- facility policies and procedures manual
- maintenance records (e.g. HVAC, equipment, fire, generator, medical gas pipeline system, electrical system and generator)

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- other documentation as required by the assessment team (e.g. quality assurance manual/documentation, emergency drill records)

Assessor Work Room

During the assessment, the assessor(s) will require a room or office to leave their personal items and complete their protocol(s). On occasion, the room may also be necessary for undisturbed discussions with the staff.

Assessment Schedule

The following arrangements are recommended for the assessment day(s):

- Patient surgical procedures are booked for the various accredited services offered at the facility;
- Fewer scheduled patients are booked to ensure staff has sufficient time to discuss processes with the assessor when patients are not present, or a mock patient tracer may be requested; and
- If your facility's scope of service includes any of the below, please attempt to book these procedures on the assessment day to ensure the assessor can observe the full scope of service:
 - Procedures requiring general anesthesia;
 - Cataract procedures/immediately sequential bilateral cataract surgery (ISBCS); and
 - Pediatric dental.

Assessment End

A verbal summary of the assessment findings is provided at the end of the assessment, including critical and high-risk nonconformance(s). Please note:

- The facility will be required to remediate the critical nonconformance(s) prior to being allowed to provide further patient care, i.e. the facility may be required to suspend patient care immediately or may only be allowed to complete cases booked for the assessment day(s).

The facility will receive a short survey to evaluate the college's accreditation process, standards and assessors. The survey link should be forwarded to other accreditation participants.

Post-assessment Process

Assessment Reports

Critical/High-risk nonconformance report:

After the assessment, the NHMSFAP prepares report(s) outlining any critical and high-risk nonconformances (NC). See Nonconformances (NC) below.

- Critical nonconformance(s) are provided to the facility within **two** business days.

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- Commencement of patient care procedures or examinations will not be permitted until the facility has provided a response to the report, including required evidence submission. Facilities are not permitted to provide further patient care until such time that they receive written notice from the College.
- High-risk nonconformance(s) are provided to the facility within **seven** calendar days.
 - The facility will be required to provide a response to each nonconformance and required evidence submission within **seven** days of receipt of the report.

Final Report:

An accreditation assessment report containing all remaining non-conformances (moderate/low risk) will be provided to the facility within 45 calendar days after the final day of the assessment. The facility will be required to provide a response to each non-conformance and required evidence submission within 90 days of receipt of the report. The Medical Director is required to sign a letter to acknowledge the receipt of the report. **Note:** If the primary contact will be unavailable to receive and respond to any of the reports provided, the NHMSFAP should be notified of an alternate contact.

After all the NC have been remediated and facility's responses and evidence submission have been accepted, an updated report is sent to the facility requesting the correction of factual inaccuracies (e.g. staff names and roles) only. **Note:** All feedback regarding factual inaccuracies will be reviewed and may or may not result in changes to the report. If feedback is not received within seven calendar days of receipt of the report, the report will be finalized.

Once all NCs have been remediated, the NHMSFAP will submit the report to the NHMSFAP Committee for decision. Once approved by the committee, the facility's **final** report, letters and certificate will be sent to the facility.

Nonconformances (NC)

A NC is a requirement that was not met at the time of the assessment. To be granted a new accreditation award, all NCs must be remediated within the timelines specified in the *Accreditation Program Nonconformance Definitions and Management* policy. Facilities are required to submit evidence to the NHMSFAP, demonstrating that the criterion, within the standard, have been implemented and the standard met within defined timelines. The timelines are based on risk to patient and staff safety.

Facilities are encouraged to contact the NHMSFAP with any questions about the NCs.

Preparing evidence for NCs

The draft report includes a text box for each NC which is used by the medical director to add a written response to the NC.

To demonstrate fulfillment of a NC, appropriate evidence submission is required to illustrate remediation of a NC and implementation of an action item. Evidence may be provided in many forms (e.g. policies, procedures, staff signatures, photographs, records, etc.). Draft documents are not accepted as evidence.

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Contact the NHMSFAP if there are questions as to what constitutes evidence of completion of a nonconformance.

Submitting evidence in response to NCs

All documentation (report with responses and evidence) is to be submitted electronically to NHMSFAP at: nhmsfap@cpsbc.ca.

Review and outcome of NC submission

The NHMSFAP will review the responses and evidence to determine whether the requirements are met. The College's subsequent response is provided in the report (i.e. approved, not approved or response acknowledged). If further clarification is required from the facility, the report is sent back to the facility. Further evidence may need to be provided if the submission is not approved.

Extension requests for NCs

If a NC is unable to be implemented within the required timeframe, the facility may request an extension with the reason, including a detailed plan of implementation. Any extension requests must be approved by the deputy registrar and/or the committee. NHMSFAP staff will communicate the decision to the facility.

Variance requests for NCs

If a facility believes that an NC is not relevant to their facility, the facility may request a variance. The facility must request a "Variance Request Form" from the NHMSFAP. Variance requests are reviewed and decided by the NHMSFAP Committee.

Approved variance requests will result in an update to the final accreditation report. Please note, the variance may only be valid for the duration of the accreditation cycle and may be re-evaluated during the next accreditation cycle.

Overdue responses

If the draft report is not returned to the NHMSFAP on time, program staff will contact the medical director by email. Failure to respond to the email within 1 week may result in a letter sent to the medical director and administrative leader from the deputy registrar.

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Accreditation Award

The NHMSFAP is the only regulatory body in British Columbia that can grant an accreditation award on behalf of its governing authority. Accreditation is granted by the NHMSFAP Committee when a facility has met all the mandatory requirements. Once accreditation is granted, the NHMSFAP will issue letters and the accreditation certificate.

Accreditation Certificate

Facilities that receive full accreditation or accreditation with conditions, will receive a four-year term of accreditation with a five-year certificate (see Appendix A).

The certificate states the services that the facility provides, the effective date of accreditation as granted by the NHMSFAP Committee and a five-year expiry date. The certificate is printed on paper that cannot be duplicated. The new certificate is expected to be displayed in a place viewable by patients using your services.

A re-accreditation assessment will be conducted on or before the end of the four-year term of accreditation which will be four years from the facility's last accreditation assessment.

The purpose of the additional year (i.e. five-year certificate) is to facilitate the following:

- Time to conduct accreditation business processes;
- Time for the facility to remediate all nonconformances; and
- Accreditation decisions to be conducted at NHMSFAP committee meetings.

Review of Accreditation Decision

Accreditation decisions may be reviewed upon request and according to the College Bylaws (5-5), as stated below:

- 5-5 (1) A medical director may request that the committee review any decision denying accreditation to the facility or changing the terms of accreditation, by filing a written request for review with the registrar within 30 days after the date of the committee's decision but the decision of the committee will remain in force pending the outcome of the review by the committee.
- (2) A medical director may request a review on the record by the board of a final decision of the committee, by filing a written request for review with the registrar within 30 days after the date of the committee's final decision but the decision of the committee will remain in force pending the outcome of the review by the board.

Reference:

College of Physicians and Surgeons of British Columbia. Bylaws: health professions act RSBC 1996, c.183 dated June 1, 2009 (revised August 31, 2020). Vancouver: College of Physicians and Surgeons of British Columbia; 2020. Part 5-5 page 70.

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Maintenance of Accreditation

Reporting Significant Changes

Existing accredited facilities embarking on significant changes must notify the NHMSFAP.

1. Level of anesthesia: Facilities considering upgrading or downgrading the class of anesthesia procedures being provided must contact the NHMSFAP before making any changes. Facilities planning to upgrade their class of anesthesia may require an on-site assessment before proceeding.
2. Medical Director change: Every facility must appoint a medical director who is a registrant of the College. A facility is not permitted to operate without a medical director. The NHMSFAP must be informed of any change in medical director
3. Ownership changes: Facilities planning on making any changes in its ownership rights or interests should contact the NHMSFAP early in the process. A signed letter from the medical director must also be provided before any change in ownership of the facility.
4. Facility closure: Facilities planning to discontinue procedures which require an accredited facility or close completely, must provide the NHMSFAP a signed letter from the medical director. The signed letter must confirm the procedure cessation or facility closure and the effective date. This notification must be made no later than 30 days prior to discontinuation or closure.
5. Renovation: Facilities considering renovations for any reason must contact the NHMSFAP before they start work. The medical director must provide a signed letter at least 90 days before the start of any work.

Directions regarding the above may be found on the NHMSFAP webpage. Upon receipt of any of the above significant changes, the NHMSFAP will review and provide a written response regarding the outcome.

Patient Safety Incidents

The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) Patient Safety Incident Review Panel recognizes that patient safety incident (PSI) reviews can assist medical directors and the surgical team in understanding what happened and what improvements can be made to reduce the risk of similar harm to other patients in the future.

A medical director must notify the program after the discovery of a reportable incident at their facility. All patient safety incidents shall be reviewed by the medical director and reported on the approved form (see the College's website) and must include the details of investigations, outcomes and recommendations. The form and patient clinical chart must be made available to the NHMSFAP PSI Review Panel within 30 days of notification of the incident.

All PSI reports submitted to the NHMSFAP by facility medical directors will be reviewed by the panel for recommendations, preventative steps and process improvements. Where recurrent incidents are reported, or where quality improvement actions do not meet the requirements of the panel, an assessment by the NHMSFAP PSI Panel may be directed. In this case, an assessment is scheduled, and a

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report prepared for the panel that focuses on the area of patient safety concern identified by the panel. The review of patient safety incidents is designed as a patient safety and continual improvement process and is not designed to be punitive in nature. Should the NHMSFAP identify an area of concern, the facility may be subject to a focused visit by a NHMSFAP accreditation team.

Complaints

Information required to file a complaint is available on the College website (<https://www.cpsbc.ca/accredited-facilities/nhmsfap/complaints>).

Client Information Protection

The names of facilities that have current accreditation status are disclosed by the NHMSFAP on the College website (<https://www.cpsbc.ca/programs/NHMSFAP>).

The NHMSFAP and its assessors will treat with confidence any information acquired during the accreditation assessment or during the ongoing monitoring process. Please be aware that some records obtained during the accreditation process may be disclosed in response to freedom of information requests. For further details, please request a copy of the NHMSFAP *Client Information Protection* policy.

Reproduction of the Accreditation Report

The facility and its leadership may publish or otherwise release the final accreditation report at their discretion, but if they choose to do so, the report must be disclosed in its entirety.

How to Contact the NHMSFAP

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

Email: nhmsfap@cpsbc.ca

Office Hours: 8 a.m. to 4:30 p.m. Monday to Friday

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Appendix A: Certificate of Accreditation

