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.

The manager of accreditations provides leadership for the delivery of the accreditation of non-hospital facilities including leadership to accreditation assessment officers and

Table 1: Examples of accreditation report documentation

Rating	Mandatory Criterion	Critical- or High-risk Criterion	Assessment Report	Facility Action
“Yes”	M (Yes)	Yes	DBE	

Facility self-assessment indicates “Yes” outcome

organization. The agreement is to be completed and signed by the medical director. [illegible] 0 g

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 the24 anesthesia level, the size and complexity of the facility.

Site Confirmation Letter

- 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.

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.

- 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.
  - 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

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.

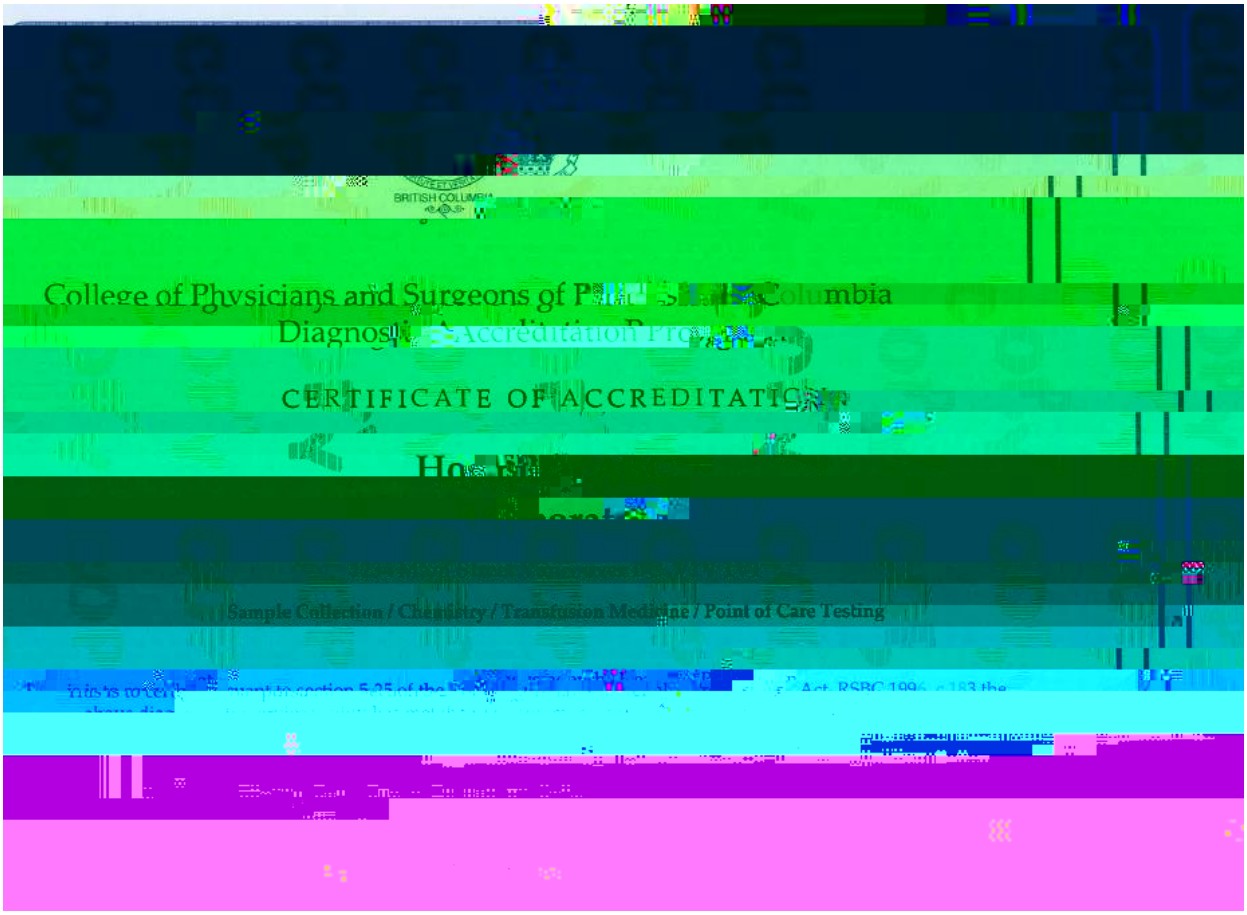
Reference:

College of Physicians and Surgeons of

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 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

Appendix A: Certific ation of Accreditatio n