Out-of-Hospital Premises Inspection Program Standard Updates

Shandelle Johnson, Manager

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Section 2.2.3

Appointment of Acting Medical Director (Page 8)

In the event the Medical Director is unable or unavailable to perform all of his or her duties due to illness, leave, or other circumstance, then an Acting Medical Director who is acceptable to the CPSO must be appointed. An agreement must be signed by the Acting OHP Medical Director that articulates all responsibilities, with emphasis on the need to respond to CPSO requests for documentation in the form and timeframe required, as follows:

- Within 24 hours for adverse events submissions (as indicated in College By-law No. 77)
- Within 14 days for regular CPSO requests, or otherwise specified timeframe as identified by the CPSO for other CPSO requests

Section 2.2.3
Appointment of Acting Medical Director

- The CPSO encourages Medical Directors to make prior arrangements that identify Acting Medical Director(s) at each of their premises to ensure systematic coverage during absences. The Acting Medical Director is deemed to be the Medical Director of the premises if he or she is in the role for more than three months - unless otherwise directed by the CPSO.
- Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee, which means that the premises can no longer provide the services under the OHPIP regulation.
- All staff working at the OHP must be notified in the event an Acting Medical Director is appointed.

Section 2.2.3

Appointment of Acting Medical Director

- **Any** change to the Medical Director must be reported to the CPSO (see 2.2.4 “Notification of OHP Changes to CPSO”) within 48 hours of the change.
- All of the above applies with such modifications as are necessary in the event that the Acting Medical Director is unable or unavailable to perform his or her duties due to illness, leave, or other circumstance.
- Medical Director/Acting Medical Director is accountable for fulfilling all obligations and duties to the OHP and the CPSO.
- If it is determined that the Medical Director or Acting Medical Director is not performing his or her duties in accordance with the legislation, regulations, and policies, the CPSO can require the OHP Medical Director to appoint an Acting Medical Director acceptable to the CPSO and/or take such other steps as deemed necessary.

Section 2.2.5

Annual Declaration of Responsibilities (Page 9)

The Medical Director must review, and sign an annual declaration of his/her responsibilities, which will include agreement to:

- perform his or her duties with due diligence and in good faith;
- ensure that the OHP meets its responsibilities;
- attend and chair QA Committee meetings at the OHP at a minimum of twice per year;
- ensure staff qualifications are current;
- ensure policies and procedures are reviewed and updated when necessary, and in accordance with relevant standards and guidelines including, but not limited to, the CPSO OHPIP Standards, updates to the Provincial Infectious Diseases Advisory Committee's (PIDAC) Infection Prevention and Control for Clinical Office Practice, Malignant Hyperthermia Association of the United States (MHAUS), etc.

Section 2.2.6
OHP Policies and Procedures (Page 9)

1. The Medical Director is responsible for the regular review, update, and implementation of OHP policies and procedures, which must address the following areas:

2.2.6.1.1 Administrative:

e) ensuring that records kept for each RHP working in the OHP are current and include qualifications, relevant experience, and relevant hospital privileges as appropriate to the RHP.

f) ensuring all physicians performing OHP procedures at the premises have provided online notification to satisfy the regulation requirements (see section 2.2.1), and documentation verifying approval (emails from College staff) is on file.

Section 2.2.6.1.3

Urgent Transfers of Patients (Page 10)

a) The patient must be transferred by appropriate transportation service; in most situations this would mandate transfer by ambulance. It is expected that the most-responsible physician (MRP) will exercise clinical judgment on a case-by-case basis to determine 1) whether transfer by ambulance is required, and 2) whether a regulated health professional or another staff member should accompany the patient during the transfer.

Section 2.2.6.1.5

Procedures (Page 10)

f) Infection control, including staff responsibilities in relation to the Occupational Health and Safety Act

j) Detailed and clear patient selection/admission/ exclusion criteria for services provided at the OHP

3. The Medical Director is responsible for ensuring that OHP staff who are members of regulated health professions have professional liability protection required by their regulatory body. Physicians need to have professional liability protection in accordance with CPSO bylaws.

Section 2.2.7

CPSO Policies/Procedures & Regulations (Page 11)

The Medical Director is responsible for ensuring all CPSO policies and procedures, as well as applicable laws including Ontario Regulations enacted pursuant to Statute, are adhered to in the operation of the premises.

Section 5.0

OHP Staff Qualifications (Page 20)

2. All staff who: 1) administer sedation, regional anesthesia, or general anesthesia; or 2) monitor or recover such patients, must maintain a current ACLS certification.

Note: Basic (BLS), advanced (ACLS) or paediatric (PALS) life-saving training, as referenced in these standards, includes certification in both theory and hands-on components3.

5. Qualifications of all regulated health professionals (RHPs) must meet requirements of their respective regulatory college, and they must practice within their scope of practice.

Section 5.1

OHP Medical Director Qualifications (Page 20)

- A physician who is applying to become a Medical Director must hold a valid CPSO certificate of registration and must not be the subject of any disciplinary or incapacity proceeding in any jurisdiction.
- If, during the course of serving as a Medical Director, the Medical Director becomes the subject of a disciplinary or incapacity proceeding, the Medical Director must inform the Out-of-Hospital Premises program staff at the CPSO, and may be required to appoint a substitute Medical Director at the discretion of the CPSO. The Medical Director may only resume the role upon CPSO approval.
- The OHP must have a Medical Director appointed at all times. Failure to have an appointed Medical Director will result in an outcome of Fail.

Section 5.7

Other Staff Qualifications (Page 23)

- Staff from other regulated health professions must be adequately trained and registered with their regulatory body.
- Staff responsible for the sterilization and reprocessing of medical equipment must be adequately educated and trained. Please contact the College for an approved list of courses specific to reprocessing and sterilization in an OHP.

Section 7

Infection Control (Page 34)

The CPSO, in partnership with Public Health Ontario (PHO), have developed accepted standards of practice for OHPs and physician offices for infection control. The document can be found at the following link:
www.publichealthontario.ca/ClinicalPractice

The Medical Director is responsible for:

- compliance with the requirements set out in the Provincial Infectious Diseases Advisory Committee (PIDAC) document
- ensuring periodic reviews of the CPSO and PHO website documents by the Medical Director, staff and physicians working in the OHP
- ensuring implementation and compliance by all physicians and staff of the OHP with the PHO requirements.

All OHP staff, including the Medical Director must stay current with standards for infection prevention and control.

Section 8.0

Quality Assurance (Page 35)

The Medical Director is responsible for:

- OHP compliance with external regulatory requirements including all Acts relevant to the practise of Medicine[1], including the CPSO OHP Standards, Companion documents to the Standards, and other guidelines, such as, the Provincial Infectious Diseases Advisory Committee's (PIDAC) Infection Prevention and Control for Clinical Office Practice, Malignant Hyperthermia Association of the United States (MHAUS), etc.
- individually responsible for OHP compliance with all internal CPSO policies, guidelines and directives within their Policy and Procedure Manual.
- appointing other individuals as necessary to assist with OHP staff compliance with policies and procedures set out by the Medical Director, especially as it relates to monitoring and reporting on the quality of anesthetic and surgical procedures.

Section 8.0

Quality Assurance

OHP Quality Assurance Committee

- Each OHP must have a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance so that the care provided will satisfy requirements as appropriate to the volume and scope of service provided.
- The Medical Director must attend and chair, at a minimum, two QA Committee meetings at each OHP site, per year. Meetings must include representation from all staff providing patient care for every type of anesthetic or surgical procedure. All meetings must be documented. The documentation of the QA Committee meetings must be available upon request by the Premises Inspection Committee and be available for OHP assessors to review.

Section 8.0

Quality Assurance

At minimum, every QA Committee meeting must address the following topics:

1) Reports on Quality of Care for each service (8.1)

2) Infection Control– duties as set out in Section 7

3) Adverse Events

4) Staffing credentials

Program Updates

1. Program Tools
2. Website Updates
3. Online Portal
4. Program Process Change

Out-of-Hospital
Premises Inspection Program Tools

- Premises Standards
- IPAC Tools
  - IPAC CORE Elements
  - Reprocessing of Medical Equipment/Devices
  - Endoscopy

Website

- PIC meeting dates and deadlines now on our website
- What additional information could we add to the website to further assist premises?

Online Portal

All forms are available within the Member's Portal effective 2014. This is the CPSO portal which you renew your licenses to practice:

- Staff Affiliation
- Status Change Request
- Adverse Events
- Annual Reporting of Tier 2 Adverse Events (September each year)

Process Change for Premises Changing Locations

- There are now two process options available to premises intending on changing locations
  - Routine Process
  - Expedited Process

Routine Process VS Expedited Process

Routine Process to Move	Expedited Process to Move
Once the premises changes location they must cease performing procedures until the Premises Inspection Committee has granted approval	Premises must currently have a Pass to be eligible for this process
	Inspection of Current Location for conditional approval for Change in Location
Inspection of New location only	Once the conditional approval is granted, the premises may change locations and commence performing procedures
	Inspection of New Location for Final Approval
The premises is non-operational for 4-5 weeks	The premises does not stop performing procedures

Status Change Process

Routine Process to Move	Expedited Process to Move
Medical Director completes Status Change Request form, provides initial materials for Change in location, provides dates for change in location and specifies process type (Process Time will be dependent on premises to provide CPSO completed materials)	
Premises moves following an Inspection of new location (with equipment already set up)	Inspection of Current location scheduled and completed
OHP staff receives NAC report (1 week)	
Premises addresses any outstanding recommendations outlined in the Assessment Summary (1-2 weeks)*	PIC Preliminary Review for conditional approval to move and become operational at the new location
Premises response and Assessment Summary will be reviewed by Committee *The Committee meets every 2 weeks	Inspection of New Location within one week of premises moving to new location
Decision Report is written and approved by Committee Chair within 1 business day of the Meeting	OHP staff receive NAC Report and sends to Premises
	Premises provide response to NAC Report
	Reviewed at next available PIC Meeting for Final approval
	Decision Report is written and approved by Committee Chair within 1 business day of the Meeting
Process Time for Final Approval from the time of Inspection: 5-7 Weeks	Able to move within a week if OHP maintains a Pass status Process Time for Final Approval from the time of inspection at current location: 2-3 Weeks
The premises is not operational for OHP procedures during this time	The premises does not stop performing procedures

QUESTIONS…