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Serving the people of Ontario through effective regulation of medical doctors

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OUT OF HOSPITAL PREMISES INSPECTION PROGRAM

INSPECTION ASSESSMENT SUMMARY

Name

Address

Address

City **Postal Code**

Assessment Date

Date Report Submitted to CPSO

Type of Assessment

Level of Premises

Assessment Team Representing CPSO:

Staff Members Present at the Premises:

List of physicians who were assessed:

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Out-of-Hospital Premises Inspection Program Assessment Protocol

Procedures:

Background Information:

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Section 2: OHP Background

OHPIP STANDARD 2.2 Medical Director Responsibilities				
Indicator	**C**	**NC**	**N/A**	**Notes**
The Medical Director is responsible for all duties outlined in the OHP Standards.				
OHPIP STANDARD 2.2.1 Notification to Operate a New OHP				
a) Notification has been made by the Medical Director planning to operate a new OHP shall be made to the CPSO.				
b) All physicians planning to work in an OHP has completed the online Staff Affiliation form by logging in to their membership account on the College Website.				
OHPIP STANDARD 2.2.2 Inspection-Assessment Process				
a) The Medical Director must inform patient(s) prior to the scheduled inspection-assessment that an observation of the procedure may be a component of the inspection-assessment process.				
b) The Medical Director must ensure that complete records are onsite on the date of the inspection-assessment.				
OHPIP STANDARD 2.2.3 Appointment of Acting Medical Director				
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 is appointed.				
OHPIP STANDARD 2.2.4 Notification of OHP Changes to the CPSO				
a) The Medical Director must notify the CPSO immediately in writing of any OHP changes.				

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OHPIP STANDARD 2.2.2 Inspection-Assessment Process				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. The premises' policy and procedure manual is current, complete and available for personnel signed by Medical Director/Acting Medical Director: • Administrative (Section 2.2.6.1.1) • General Response to Emergencies (Section 2.2.6.1.2) • Urgent Transfer of Patients (Section 2.2.6.1.3) • Job Descriptions (Section 2.2.6.1.4) • Procedures (Section 2.2.6.1.5) • Forms Used (Section 2.2.6.1.6) • Inventories/Lists of equipment to be maintained (Section 2.2.6.1.7) • External (non-OHP) policies (Section 2.2.6.1.8)				
2. The Medical Director /Acting Medical Director shall ensure that all staff: a. Read P&P manual upon being hired and confirm action with signature and date. b. Review P&P manual annually, and confirm action with signature and date. c. Read their individual job descriptions of duties and responsibilities, and sign and date, indicating they have been read and understood.				
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.				
OHPIP STANDARD 2.2.7 CPSO Policies/Procedures & Regulation				
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.				

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Section 4: OHP Physical Standards

OHPIP STANDARD 4.1 GENERAL PHYSICAL STANDARDS *The premises is neat, comfortable and clean and facilities patient care and safety*				
Indicator	**C**	**NC**	**N/A**	**Notes**
OHPIP STANDARD 4.1.1 Building Codes				
The site complies with all applicable building codes, including fire safety requirements.				
OHPIP STANDARD 4.1.2 Electrical				
1. All electrical devices are certified by CSA or licensed for use in Canada.				
2. Emergency power supply can provide for safely completing the procedure and recovering the patient.				
OHPIP STANDARD 4.1.3 Access				
1. Access for disabled persons complies with provincial legislation (Ontarians with Disabilities Act) and/or municipal by-law.				
2. Doors and corridors can safely accommodate stretchers and wheelchairs.				
OHPIP STANDARD 4.1.4 Size				
OHP size is adequate for all procedures to be performed.				
OHPIP STANDARD 4.1.5 Layout				
1. The following areas are functionally separate, where appropriate, allowing adequate space to ensure patient safety, privacy, confidentiality, emergency protocols and infection control standards: *administration and patient-waiting area; procedure room and/or operating room; recovery area; clean utility area; dirty-utility room; reprocessing room; endoscope cabinet and staff change room and staff room.*				
OHPIP STANDARD 4.1.6 Physical Emergency Measures				
a. Hallways, stairways and elevators are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.				
b. Provisions are in place to ensure the safe evacuation of patients and staff in case of an emergency, i.e., stretchers, wheelchairs, or other adequate methods of transport are available.				
c. Provisions are in place to ensure there is appropriate access to the patient for an ambulance to transfer the patient to a hospital.				

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OHPIP STANDARD 4.2.1 Physical Requirements ****All levels				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. All OHPs provide the following physical requirements: a. adequate lighting for the procedures performed b. floors and walls can be cleaned to meet infection control requirements (e.g. surfaces are smooth and washable) c. immediate access to hand-washing facilities and proper towel disposal d. openings to the outside effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current or other effective means.				
2. Space can accommodate equipment and staff required for the procedure.				
3. Space allows the physician and assisting staff, when sterile, to move around the OR/procedure table with access to both sides of the patient, without contamination.				
OHPIP STANDARD 4.2.2 Ventilation ****All levels				
1. Ventilation must ensure patient and staff comfort; and fulfill occupational health and safety requirements.				
2. Where applicable, ventilation and air circulation should be augmented to meet manufacturer's standards and address procedure-related air-quality issues; e.g., cautery smoke, endoscopy, disinfecting agents (e.g., Glutacide venting is separate from the other internal ventilation).				
3. Where gas sterilization is used, a positive pressure outbound system is used, vented directly to the outside.				

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OHPIP STANDARD 4.2.3 Equipment ****All levels				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. Medical equipment must be maintained and inspected yearly by a qualified biomedical technician.				
2. The following documentation for equipment is available: a) equipment operating manuals b) equipment maintenance contracts c) log for maintenance of all medical devices (e.g. suction machines) d) equipment necessary for emergency situations (i.e. Defibrillators, oxygen supply, suction) should be inspected on a weekly basis and documented.				
3. The following equipment is provided in all OHPs: a) cleaning equipment as required for the specific procedures b) accessible material and equipment c) blood pressure and oxygen saturation monitoring equipment d) sterile supplies and instruments e) table/chair that permits patient restraints and Trendelenberg positioning (level 2 & 3) f) table/chair/stretcher that accommodates procedures performed and provides for adequate range of movement for anesthetic procedures g) suction equipment and backup suction, for anesthesia provider's exclusive use.				
OHPIP STANDARD 4.2.4 Anesthetic and Ancillary Equipment ****Levels 2 & 3 only				
1. Both a) anesthetic and ancillary equipment (selection, installation, maintenance) and b) medical compressed gases and pipelines must comply with: • Canadian Standards Association (CSA) or licensed for use in Canada, and • Specific applicable recommendations arising from provincial legislation or as identified in other CPSO requirements.				
2. A second supply of (full cylinder) oxygen capable of delivering a regulated flow must be present.				
****Level 3 only**				
a. anesthetic machine				
b. anesthetic equipment/drug cart				

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OHPIP STANDARD 4.3 Physical Standards for Recovery-Area				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. A sink for hand washing is accessible.				
OHPIP STANDARD 4.3.2 Size and Layout ****Levels 2 & 3 only				
1. The size of the recovery area depends on planned use: it must accommodate the volume of patients expected for a minimum of two hours operating room time, i.e (1 hour procedure = 2 patients; 0.5 hour procedure = 4 patients.).				
2. The recovery area allows for transfer of patients to/from a stretcher and performance of emergency procedures.				
OHPIP STANDARD 4.3.3 Equipment ****Levels 2 & 3 only				
Monitoring, suction, oxygen, and bag-valve mask devices, intravenous and other medical supplies are immediately available.				
OHPIP STANDARD 4.4 General Medical Standards ****All levels				
1a) Maintain a general medication inventory record.				
1b) Periodically inspect all medications for viability.				
1c) Date multidose vials of medication on opening and dispose according to manufacturer's guidelines.				
1d) Medications are labeled in accordance with the Food and Drug Act (FDA) and the Controlled Drugs and Substances Act (CDSA) and its regulations (Drug name, Drug dosage, Expiration date and D.I.N).				
1e) Medications are stored according to the manufacturer's recommendations (e.g., refrigeration if required) and in a manner suitable for security and restocking.				
1f) Store emergency drugs in a common location. In facilities where procedures are done in multiple procedure rooms, a crash cart is advisable.				
1g) Document administration of medications in the patient record.				
1h) Dispense medications at discharge accompanied by verbal and written instructions that are given to the patient and/or accompanying adult.				
1i) Make available resources to determine appropriate drug dosages and usage.				
2. If services are provided to infants and children, the required drugs must be available and appropriate for that population.				

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OHPIP STANDARD 4.5 Controlled Substances Standards				
Indicator	**C**	**NC**	**N/A**	**Notes**
1) Controlled substances are handled and administered in accordance with Food and Drug Act (FDA) and the Controlled Drugs and Substances Act (CDSA) and its regulations.				
2a) There is one qualified designated staff (e.g. RN, RPN with medication skills, physician) assigned to managing controlled substances.				
2b) Controlled substances are stored in a designated fixed, locked cabinet.				
2c) Controlled substances are accounted for in a "Log of Controlled Substances" that specifies: i) for each controlled substance: name; quantity; date received; expiry date; loss (damaged, expired, spilled); date and quantity. ii) for patient administration: patient name; drug name and amount removed from inventory; date and time; name of staff administering the medication.				
2d) An end-of-day balance of the inventory of controlled substances is calculated by physical count and verified by the signatures of qualified (regulated) staff.				

OHPIP STANDARD 4.6 Drugs for Resuscitation ****All levels*				
Indicator	**C**	**NC**	**N/A**	**Notes**
a) Diphenhydramine				
b) Epinephrine for injection				
c) Salbutomol				
d) Intralipid if Bupivicaine/Ropivicaine is used				
e) Oxygen				

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OHPIP STANDARD 4.6 Drugs for Resuscitation ****Level 2 and 3 only				
Indicator	**C**	**NC**	**N/A**	**Notes**
a) Amiodarone IV				
b) Antihypertensive IV (at least **one** of the following: Labetalol or Hydralize)				
c) ASA 81 mg po				
d) Atropine IV				
e) Benzodiazepine IV (at least one of the following: Midazolam, Diazepam, or Lorazepam)				
f) BETA Blocker IV (at least **one** of the following: Metoprolol, Propranolol or Esmolol)				
g) Calcium IV (chloride or gluconate)				
h) Dextrose 50% IV				
i) Diphenhydramine IV				
j) Flumazenil IV				
k) Hydrocortisone IV 100mg or 500mg				
l) IV agent for SVT (at least **one** of the following: Adenosine, Esmolol, or Verapamil)				
m) MHAUS treatments if triggering agents present, following MHAUS guidelines				
n) Naloxone IV (if narcotics are stocked)				
o) Neuromuscular blocking agents, *if qualified staff available*				
p) Nitroglycerine spray				
q) Pressor IV (at least **two** of the following: Epinephrine, Ephedrine, Vasopressin, or Phenylephrine)				
r) Sodium bicarbonate IV				

OHPIP STANDARD 4.6 Drugs for Resuscitation ****Level 3 only				
Indicator	**C**	**NC**	**N/A**	**Notes**
a) Antihypertensive IV (at least **two** of the following: Labetalol, Hydralazine or Nitroglycerine)				
b) IV agent for SVT (at least **three** of the following: Adenosine, Esmolol, Verapamil, or Metoprolol)				
c) Lasix IV				
d) Lidocaine 2% (pre-filled syringe)				
e) Magnesium Sulfate IV				

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OHPIP STANDARD 4.7 Monitoring and Resuscitation Requirements				
Indicator	**C**	**NC**	**N/A**	**Notes**
******Level 1 Only**				
a) AED				
******All levels**				
b) IV setup				
c) Adequate equipment to manage local anesthetic toxicity.				
d) Appropriate sized equipment for infants and children, if required.				
******Levels 2 and 3 only**				
e) Assortment of disposable syringes, needles, and alcohol wipes				
f) Cardiopulmonary resuscitation equipment with current ACLS/ PALS-compatible defibrillator				
g) ECG monitor				
h) Intubation tray with a variety of appropriately sized blades, endotracheal tubes, and oral airways				
i) Laryngeal mask airways				
j) Means of giving manual positive pressure ventilation (e.g., manual self-inflating resuscitation device)				
k) Qualitative and quantitative means to verify end-tidal CO2				
l) Oxygen source				
m) Pulse oximeter				
n) Suction with rigid suction catheter				
o) Torso backboard				

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Section 5: Staff Qualifications

OHPIP STANDARD 5 STAFF QUALIFICATIONS				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. It is expected that physicians will manage medical and surgical conditions within the scope of their specialty training, certification and experience.				
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.				
3. If services are provided to infants and children, staff must be trained to handle paediatric emergencies and maintain a current PALS certification.				
4. Physicians who do not meet OHP physician qualification standards must successfully complete a Change in Scope of Practice application process.				
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.				
5.1 OHP Medical Director Qualifications				
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, 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.				
5.6 Nurse Qualifications				
1. Registered nurses (RNs) and registered practical nurses (RPNs) working within their scope of practice in OHPs must hold: a) current registration with the College of Nurses of Ontario b) additional training and appropriate experience as required for procedure performed c) current BLS certification d) must have current ACLS if administering sedation to, monitoring or recovering patients (RNs only).				
5.7 Other Staff Qualifications				
a. Staff from other regulated health professions must be adequately trained and registered with their regulatory body. b. Staff responsible for the sterilization and reprocessing of medical equipment must be adequately educated and trained.				

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Section 8: Quality Assurance

OHPIP STANDARD 8 Quality Assurance ****All levels				
Indicator	**C**	**NC**	**N/A**	**Notes**
a) The Medical Director must attend and chair, at a minimum, two QA Committee meetings at each OHP site, per year. All meetings must be documented.				
b) Quality Assurance meetings must be comprised with representation of all staff providing patient care for every type of anesthetic and surgical procedure.				
c) Quality Assurance Meetings must address the following topics: 1)Reports on Quality of Care for each service; 2)Infection Control; 3)Adverse Events; 4)Staffing Credentials.				
OHPIP STANDARD 8.1 Monitoring Quality of Care				
a) The OHP has a documented process in place to regularly monitor the quality of care provided to patients. These activities include, but are not limited to a review of: 1. Non-medical staff performance.				
2. Review of individual physician care to assess: a) patient and procedure selection are appropriate; b) patient outcomes are appropriate; c) adverse events (see 8.2).				
3. Review a selection of individual patient records to assess completeness and accuracy of entries by all staff.				
4. Review of activity related to cleaning, sterilization, maintenance, and storage of equipment.				
5. Documentation of the numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment).				
OHPIP STANDARD 8.2 Monitoring and Reporting Adverse Events				
a. All OHP staff must monitor adverse events. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure.				
b. Every member who performs a procedure in an OHP shall report Tier 1 Events to the College within 24 hours of learning of the event. These events are termed `to denote the potential serious nature of the event and the need to prevent a recurrence.				
c. Members performing procedures in an OHP are required to document other quality assurance incidents (Tier 2) which are deemed less critical for immediate action. The premises' QA Committee and the Medical Director/Acting Medical Director will submit Tier 2 events to the College after review (on an annual basis).				

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OHPIP STANDARD 8.2 Monitoring and Reporting Adverse Events-continued				
Indicator	**C**	**NC**	**N/A**	**Notes**
d. All OHP staff should report adverse events as follows: i) The member must report Tier 1 adverse events (see above) to the Medical Director/Acting Medical Director and to the College in writing within 24 hours of learning of the event using the form provided on the College website. ii) Death occurring within the OHP should also be reported to the coroner. iii) The member should report in writing any Tier 2 adverse event (see above) to the Medical Director/Acting Medical Director within 24 hours of the event. The written report should include the following: a) name, age, and sex of the person(s) involved in the incident; includes staff and patients; b) name of witness(es) to the event (if applicable); c) time, date, and location of event; d) description of the incident and treatment rendered; e) date and type of procedure (if applicable); f) analysis of reasons for the incident; g) outcome.				
OHPIP STANDARD 8.3 Review of Adverse Events and other QA Monitoring Activities				
a. The Medical Director/Acting Medical Director should: 1) Review all adverse events reports and QA monitoring findings occurring over a 12-month period. 2) Document the review and any relevant corrective actions and quality improvement initiatives taken. 3) Provide feedback to all staff regarding identified adverse events.				

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Section 6: Procedural Standards

OHPIP STANDARD 6 PROCEDURAL STANDARDS				
Indicator	**C**	**NC**	**N/A**	**Notes**
OHPIP STANDARD 6.1 Pre-Procedure Patient- Care Standards *****All levels*				
1. The physician must: i. assess the risks inherent in each procedure or combination of procedures to determine if the OHP setting is safe; and ii. appraise each patient's medical risk factors and capacity to undergo anesthesia.				
2. Documentation: All actions taken for pre-procedure patient care are entered in the patient record; separate forms, e.g., consent form, are placed in the patient record.				
OHPIP STANDARD 6.2 Pre-Procedure Requiments: OHP Level 1 Only				
Where appropriate, the responsibility for the actions listed in the chart below may be performed by appropriately qualified providers under the direction of the Most Responsible Physician (MRP). 1. Provide fasting instructions as required. 2. Advise patient that a responsible adult should be accessible during the duration of the OHP stay. 3. Conduct pre-procedure assessment, which includes, but is not limited to: a) Focused history and physical examination that includes findings indicating the rationale for the proposed procedures; b) Blood pressure and pulse; c) Allergies. 4. The physician is responsible for obtaining informed consent and a procedure consent form signed by the patient or substitute decision maker and witnessed. 5. Complete admission assessment: Confirm baseline history and physical as in point 3 above.				
OHPIP STANDARD 6.3 Pre-Procedure Requirements (Level 2 and Level 3 only)				
Before day of procedure: 1.Provide fasting instructions as required for the procedure, specific conditions (e.g. diabetes), and for medications the patient routinely takes (e.g. diabetic medications, antihypertensives, antiplatelets). 2.Advise patients if they will require adult accompaniment on leaving OHP after the procedure. 3.Advise patient that a responsible adult must be accessible during the duration of the OHP stay.				

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OHPIP STANDARD 6.3 Pre-Procedure Requirements (Level 2 and 3 Level Only) - *Continued*				
Indicator	**C**	**NC**	**N/A**	**Notes**
Before or On day of Procedure: 4. Conduct pre-procedure assessment that includes, but is not limited to: a) History and physical examination that includes findings indicating the rationale for the proposed procedure b)All current medications (prescribed and non-traditional, e.g herbal remedies) c) Weight, height, body mass index (BMI), blood pressure and pulse d) Allergies e) ECG, laboratory tests, x-rays, pre-procedure consultation, and investigations (all as indicated).				
5. For patients with significant co-morbidities (including sleep apnea), arrange a consultation with an anesthesiologist, and other medical specialists as required, prior to procedure acceptance. 5.1 If classified as ASA3, patients may be accepted only if the disease entity could not reasonably be expected to be affected adversely by the anesthetic or procedure. 5.2 The physician and anesthesiologist should discuss all Class ASA3 cases well in advance of the scheduled procedure, with regard to the: a) pre-procedure assessment and care required, b) intra-procedure and post-procedure requirements, and c) appropriateness of OHP setting for the safe performance of the procedure.				
6. Obtain informed consent and a procedural consent form signed by the patient. A rolling patient consent (which requires specific information to be documented) is suitable for the same procedure performed consecutively and should be documented in the patient's chart.				
7. Provide adequate explanation to the patient about the proposed anesthesia including anticipated outcome, significant risks, and alternatives available. This may be included in the procedure consent form.				
On day of procedure: 8. Complete admission assessment: Confirm pre-procedure anesthetic/sedation assessment (may be unnecessary if anesthesiologist conducts pre-procedure anesthetic/sedation assessment on same day as procedure).				
9. Complete admission assessment: Confirm baseline history and physical as in point 4 above; update if >14 days. Take vital signs (BP, pulse, respiration, oxygen saturation, temperature), and glucometer reading for diabetic patients where appropriate.				

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OHPIP STANDARD 6.5 First Verification				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. The first verification takes place in the pre-procedure area. 2. The patient is awake and aware. 3. The nurse preparing the patient for the procedure: a) Confirms the patient identity, procedure, site and/or side with the patient/substitute decision-maker/legal guardian; b) Documents the first verification on the “Surgical Safety Checklist".				
OHPIP STANDARD 6.6 Second Verification				
1. The second verification must be conducted during the time-out in the location where the procedure takes place, immediately before starting the procedure. 2. The patient is not required to be awake. 3. The entire procedure team confirms the patient identity, procedure, site and/or side and acknowledges their agreement: nurse(s), attending physician, attending anesthesiologist [if applicable], and physician-assistant [if applicable].				
OHPIP STANDARD 6.7 Site Marking				
1. Marking must take place with the patient awake and aware, if possible. 2. The physician performing the procedure marks at or near the incision/insertion site. Site- sensitive areas must be marked above or lateral to the procedure site (e.g., scrotal surgery sites are marked on the groin area on the appropriate side of the body; breast sites are marked on the breast or above the breast on the upper chest area).				
3. Procedures involving right/left distinction or multiple structures (fingers, toes) must be marked.				
4. The mark must be: a) placed using a permanent marker; b) visible at the time of patient preparation and visible at time of incision; c) explicit (e.g., initials) to indicate the intended site of incision or insertion or actual incision.				
5. Site marking is exempted in the following situations: a) The procedure requires a surgical measurement to the operative part when applied on an awake and oriented patient. b) Patient refuses to allow site marking. In this situation, a risk report is completed and placed in the patient's record.				
OHPIP STANDARD 6.8 Intra-operative Patient Care				
1. If the physician administering the sedation or regional anesthesia is also performing the procedure, the patient must be attended by a second individual (physician, RT, RN or AA) 1) who is NOT assisting in the procedure and 2) who is trained to monitor patients undergoing sedation or regional anesthesia.				

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OHPIP STANDARD 6.8 Intra-operative Patient Care-Continued				
Indicator	**C**	**NC**	**N/A**	**Notes**
2. If assistance is required during the procedure, a third HCP must be available. The person monitoring the anesthetic shall remain with the patient at all times throughout the duration of anesthetic care until the patient is transferred to the care of a recovery-area staff in the recovery area.				
3. Patients shall be attended for the duration of the anesthetic care as follows: 3.1 O2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals. Continuous monitoring of end-tidal carbon dioxide (waveform capnography) is mandatory during general anesthesia and for moderate or deep procedural sedation.				
3.2 Pulse, blood pressure and electrocardiography must be in continuous use during the duration of anesthetic care. Heart rate and blood pressure shall be documented at least every 5 minutes. During sedation (see section 3.2) in healthy patients without cardiac disease and for whom no cardiovascular disturbance is anticipated, it may be acceptable to waive ECG monitoring as long as pulse oximetry is in continuous use and ECG monitoring is immediately available.				
3.3 Audible and visual alarms are activated.				
4. The Anesthesia/Sedation Record is completed; it includes the following: 1. pre-procedure anesthetic/sedation assessment; 2. all drugs administered including dose, time, and route of administration; 3. type and volume of fluids administered, and time of administration; 4. fluids lost (e.g., blood, urine) where it can be measured or estimated; 5. measurements made by the required monitors: i. O2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals. ii. Pulse, blood pressure documented at least every 5 minutes until patient is recovered from sedation. 6. complications and incidents (if applicable); 7. name of the physician responsible (and the name of the person monitoring the patient, if applicable); 8. start and stop time for anesthesia/sedation care.				

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OHPIP STANDARD 6.9 Post-Procedure Care ****Level 2 and Level 3 Only				
Indicator	**C**	**NC**	**N/A**	**Notes**
1. Recovery area focus and staff requirements are as shown in Table 09. Depending on the invasiveness of the procedure and the level of anesthesia, the staffing requirements may be increased at the discretion of the most responsible physician as appropriate. • One RN in the same room at all times with the patient and a second RN or RPN available on site during Recovery Phase I • Minimum of 2 nurses of which one must be an RN, competent in post- procedure care during Recovery Phase II and Recovery Phase III				
2. Following sedation/regional anesthesia/general anesthesia, the anesthesiologist/physician must accompany the patient to the recovery area and communicate the appropriate information to the appropriate recovery-area staff. This verbal report includes, but is not limited to: *name and age of patient; procedure performed; pertinent history including allergies, medical/physical limitations; type of anesthesia/sedation used, other medications given; any unusual or adverse events pertaining to patient; estimated fluid or blood loss and anesthetic progression.*				
3. The anesthesiologist/physician should stay with the patient until the appropriate recovery-area staff accepts responsibility for the patient.				
4. Recovery-area staff caring for patients in phase I, II, or III recovery provide care and document it in the patient record; this includes but is not limited to: a) patient identification, date and time of transfer to recovery area, initial and routine monitoring of: blood pressure, pulse, respirations, Sp02 , temperature, level of consciousness, pain score, procedure site and general status; b) continuous monitoring of vital signs until the patient has met requirements of discharge criteria using an objective scoring system from time of transfer to recovery area until discharge from Phase II recovery; c) medication administered: time, dose, route, reason, and effect; d) treatments given and effects of such treatment; e) status of drains, dressings, and catheters including amount and description of drainage; f) summary of fluid balance.				

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OHPIP STANDARD 6.9 Post-Procedure Care ****Level 2 and Level 3 Only *Continued*				
Indicator	**C**	**NC**	**N/A**	**Notes**
5. An anesthesiologist/physician must remain on site until the patient has met Phase 1 discharge criteria. Where there is an overnight stay at an OHP, all of the following conditions must be met: a) The physician or designate physician, appropriately qualified in accordance with Section 5 of the OHP core standards, shall be immediately available by telephone and shall be available onsite at the premises within thirty minutes for urgent medical matters; and, b) The minimum staffing requirements at the premises for overnight stays will be: a minimum of two nurses, one must be a RN with ACLS certification. The second nurse can be a RN or a RPN. The second individual cannot be a Personal Support Worker.				
OHPIP STANDARD 6.10 Post-Procedure Care ****Level 2 and Level 3 Only				
1. An anesthesiologist or physician is responsible for writing the discharge order. However, the actual decision for discharge from the recovery area must be based on discharge criteria using an objective scoring system; the decision can be delegated to recovery-area staff.				
2. All patients should be accompanied by an adult when leaving the OHP. Patients having received sedation or general anesthesia must be accompanied by a responsible adult.				
3. Appropriate verbal and written post-discharge instructions are given to the patient and the accompanying adult.				
4. The patient and accompanying adult are instructed to notify the OHP of any unexpected admission to a hospital within 10 days of the procedure.				

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Out-of-Hospital Premises Inspection Program
Exit Interview

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Out-of-Hospital Premises Inspection Program
Summary of Observations

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Recommendations to be addressed by the Premises