Out-of-Hospital Premises Inspection Program

Appendix A: Inspection-Assessment Preparedness Document

Please ensure the following are available for the Nurse Inspector's review and upload to the provided link:

1. Up-to-date certifications for all affiliated staff at the premises. a) *Valid ACLS for Anaesthesiologists* b) *Valid ACLS for Proceduralists, if performing sedation or if there is no Anaesthesiologist on-site* c) *Valid ACLS for RN involved in administration of sedation, monitoring, and recovery.* d) *Valid BLS for any other Registered Health Practitioner involved in patient care* *Note: All ACLS, BLS and PALS courses must contain both hands-on and theory components and align with Heart and Stroke Foundation Ontario.* e) *For all reprocessing staff, please see the attached document "Out-of-Hospital Premises Inspection Program Update: Sterilization and Reprocessing Courses" for reference regarding the accepted reprocessing certificates. All sterilization and reprocessing certificates must be valid within five years.*
2. CPSO Change of Scope approval for physicians who have been approved to perform the intended procedures at the Premises, if applicable.
3. Contract with third party reprocessing company, if applicable.
4. Contract with biomedical waste management/removal, if applicable.
5. **For Pain Premises** – if a pharmacy is preparing the prefilled syringes for the Premises, please provide a letter ensuring that they are prepared in a sterile manner
6. Evidence that the space meets building and fire codes
7. Evidence of annual maintenance and/or calibration for all refurbished equipment or equipment purchased >1 year ago. I.e. biomedical inspection report, endoscope maintenance records, AER maintenance records.
8. Evidence of approval for use in Canada*, i.e.* Health Canada license numbers printout and/or photo evidence of CSA labels for all equipment • Canadian Medical Device Active License search
9. If applicable, copy of written medical directives. Please ensure the directives encompass the required elements as set out in the CPSO policy on Delegation of Controlled Acts
10. Evidence of HVAC maintenance in the last 6 months, and that the HVAC system meets CSA requirements

11. Fluoroscopy/radiation information (if applicable) a) Unit details: • Make, model, serial number, manufacturer date • Description of unit's functionalities b) Ministry of Health *Approval of Installation Plan* letter(s) c) Report for most recent tests per HARP Act, Lead PPE Tests, dosimeter badge testing d) Signed Radiation Worker Forms for all staff currently involved in/that will be involved in Fluoroscopy Procedures
12. Copy of most recent Quality Assurance meeting minutes and documentation of activities to monitor quality of care
13. Evidence that staff have reviewed the policies and procedures manual
14. Logs/checklists for reprocessing, emergency equipment audits, controlled substances, etc.

The above items are derived from the PHO Guidelines on Infection Prevention and Control and the CPSO Out of Hospital Premises Standards

CPSO

Appendix B: Policy and Procedure Guide

For reference, the OHPIP Program Standards and other inspection documents can be found in the College's website here: https://www.cpso.on.ca/Physicians/Your-Practice/Quality-Management/Clinic-Inspections-Special-Programs/Out-of-Hospital-Premises-Inspection-Program#OHPIP-Standards

The Premises' Policies and Procedures Manual must encompass all that is set out in the Program Standards. Please see the following chart summary of the Standards for ease of review:

Administrative	a. Responsibility for developing and maintaining the PPM b. Organizational chart c. Scope and limitations of OHP services provided
Job Descriptions	a. OHP staff job descriptions that define scope and limitations of functions b. Responsibilities for patient care c. Who is supervising staff
Procedures:	a. Adverse events: monitoring, reporting, and reviewing b. Adverse events: response to an adverse event c. Combustible and volatile materials i. Comb/Volatile – O2 storage (keep away from heat sources, chained or in tank holder), well ventilated area ii. Safety Data Sheets (renewed Q 3 years), labels with DIN & expiry dates on cleaning products. d. Delegating controlled acts e. Emergency evacuation f. Equipment: routine maintenance and calibration i. HVAC ii. Biomedical inspection for all equipment g. Infection control i. IPAC policies and procedures that are based on the most current best practices ii. Containment, cleaning, and disinfection of spills of blood and body fluids iii. Prevention and management of injuries from sharp objects iv. Prevention of transmission of blood-borne pathogens (i.e. hepatitis B, hepatitis C and HIV) that includes an immunization policy v. blood-borne pathogen post-exposure management policy or procedure that incorporates worker education and facilitation of timely access to a medical assessment for appropriate post-exposure

	prophylaxis PEP if indicated, and reporting of sharps injuries to WSIB and MOL, as appropriate vi. Procedures for cleaning each area of the setting vii. Reprocessing procedures viii. Written process/policy for when the staff is away on vacation or ill, if there is only one reprocessing staff. h. Medications handling and inventory i. Medical directives j. Patient booking system k. Patient consent (written/verbal/rolling/etc) l. Patient preparation for OHP procedures m. Response to latex allergies n. Safety precautions regarding electrical, mechanical, fire, and internal disaster i. Fire - do they use a fire safety acronym (i.e., RACE or REACT) ii. Electrical - Back up power that is appropriate for medical equipment/UPS. Equipment is CSA or approved by Health Canada. o. Urgent transfer of patients p. Waste garbage disposal q. OHSA - PPE, SEMDs, MSDS, Worker Education
Quality Assurance	a. Proposed Quality Assurance Meeting Agenda b. Proposed activities to monitor quality of care; I.e. staff performance reviews, review of medical care (peer review, patient and procedure are appropriate?), chart reviews, Documentation of the numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment) c. Staff Training and Education - Orientation and continuing education - Competency testing of personnel reprocessing endoscopes
Forms	a. Consent form b. Discharge instruction sheet c. Medication logs d. Controlled substances logs e. Reprocessing logs f. Other
Ketamine Infusion policy (if applicable)	a. Scope and Limitations of the services provided b. Staffing policy, i.e. for monitoring and recovery c. Most responsible physician for all aspects of care – MRP must have appropriate training and experience in providing psychiatry care (if indicated for mood disorders)

	d. Accepting physician-referrals and self referrals e. Consent. *NOTE: consent form should comply with CPSO Policy on Complementary And Alternative Medicine regarding off-label use of Ketamine*. f. Pre-procedure anaesthetic assessment protocol (and psychiatric assessment for mood disorders) g. Ketamine Administration protocol h. Equipment - infusions are being administered using a dedicated line, only using an infusion control device/syringe pump with a locked control panel; and by continuous infusion only, (i.e. not by patient-controlled devices or bolus dosing) i. Intra-procedure monitoring protocol j. Protocols for management of behavioural crisis and adverse events k. Post-procedure evaluation protocol (and psychiatry evaluation if indicated for mood disorders) l. Discharge, crisis management and adverse event instructions m. Post-discharge follow-up protocols n. Continuation of care, follow up evaluations, and return visits, o. Discharge Instruction p. QA protocols q. Medical Directives – – Note: Deep sedation cannot be delegated to RNs in OHP
Fluoroscopy (if applicable)	a. Equipment maintenance: Description and logs. • For example: HARP testing q6 mos, maintenance per manufacturer's guidelines, preventative maintenance, calibration, daily testing, etc. b. Lead apron testing and image retention c. PPE program d. ALARA principles and guidelines e. Equipment use and training f. QA agenda to include review of: • Recommendations from Assessment/Accreditation Visit/Ministry of Health X-Ray; Inspection Services and HARP (if applicable); over exposures (if applicable); HARP testing that is to be completed every 6 months; dosimetry badge logs including control badge & relevant staff badges; PPE Checklist for X-ray / Fluoroscopy; g. Medical Records • Must include: Exposure time in seconds; Pregnancy declaration if applicable; Operator signature documentation; etc. • How images are transferred to patient chart, backup, etc.

	h. Staff and patient access to examination room, and signage use i. Cleaning of equipment procedures j. Overexposure management protocol k. Employee pregnancy and exposure l. Dosimeter use and documentation m. Education/Training n. Any other Occupational Health and Safety requirements
Inventories/lists of equipment and medications to be maintained	
External (non-OHP) policies	

Please note, this is not an exhaustive list. The Premises may have additional policies and procedures as appropriate for the setting. The above items are derived from the PHO Guidelines on Infection Prevention and Control, the CPSO Out of Hospital Premises Standards, and MOL Guidelines on Radiation Hazards and Protection.