THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in **Interventional Pain Premises**

Approved by the Premises Inspection Committee
July 7, 2011

This document has been updated to correspond with the revisions made to the core OHPIP Standards 2016

College of Physicians and Surgeons of Ontario Mandate

Build and maintain an effective system of self-governance.

The profession, through and with the College, has a duty to serve and protect the public interest by regulating the practice of the profession and governing in accordance with the Regulated Health Professions Act.

Our Vision – Quality Professionals, Healthy System, Public Trust

Our new vision is the framework by which we organize ourselves. It guides our thinking and actions into the future. It defines not only who we are, but what we stand for, the role we see for ourselves, our critical relationships, in what system we work, and the outcomes we seek. Each component of our vision is defined below:

Quality Professionals – as a profession and as professionals, we recognize and acknowledge our role and responsibility in attaining at a personal, professional, and at a system-level, the best possible patient outcomes.
We are committed to developing and maintaining professional competencies, taking a leadership position on critical issues that impact the performance of the system, and actively partner to provide tools, resources, measurement, to ensure the optimal performance at all levels of the system.

Healthy System – the trust and confidence of the public and our effectiveness as professionals is influenced by the system within which we operate. Therefore, we as caring professionals are actively involved in the design and function of an effective system including:

- accessibility
- the interdependence of all involved
- measurements and outcomes
- continued sustainability.

Public Trust – as individual doctors garner the trust of their patients, as a profession we must aim to have the trust of the public by:

- building positive relationships with individuals
- acting in the interests of patients and communities
- advocating for our patients and a quality system.

Our Guiding Principles – Integrity, accountability, leadership and cooperation

The public, through legislation, has empowered the profession to regulate itself through the College. Central to the practice of medicine is the physician-patient relationship and the support of healthy communities. As the physician has responsibility to the patient, the profession has the responsibility to serve the public through the health-care system. To fulfill our vision of quality professionals, healthy system, public trust we will work to enhance the health of the public guided by professional competence and the following principles:

Integrity – in what we do and how we go about fulfilling our core mandate:

- Coherent alignment of goals, behaviours and outcomes
- Steadfast adherence to a high ethical standard.

Accountability to the public and profession – we will achieve this through:

- An attitude of service
- Accepting responsibility
- Transparency of process
- Dedicated to improvement.

Leadership – leading by proactively regulating our profession, managing risk and serving the public.

Cooperation – seeking out and working with our partners – other health-care institutions, associations and medical schools, etc. – to ensure collaborative commitment, focus and shared resources for the common good of the profession and public.

Guiding Policies

It is expected that physicians will manage medical and surgical conditions within the scope of their certification and experience. For all CPSO members this means practicing with the appropriate qualifications or equivalency subject to requirements set out by the RCPSC, or CPSO "Specialist Recognition Criteria in Ontario" and "Changing Scope of Practice" policies.

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Background:

The **Out-of-Hospital Premises Inspection Program** (OHPIP) supports continuous quality improvement through developing and maintaining standards for the provision of medical care/procedures in Ontario out-of-hospital premises (OHPs), and inspecting and assessing for safety and quality of care. This is mandated by the amendment to Regulation 114/94 under the *Medicine Act* adding **Part XI, Inspection of Premises where Certain Procedures are Performed,** which was enacted on April 9th, 2010.

The Regulation is appended in the OHP Standards and can also be found on the College website www.cpso.on.ca **.** For interventional pain OHPs specifically, the Regulation states the following definition of 'procedure':

> *(b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to, (iv) a nerve block solely for the treatment or management of chronic pain.*

In November 2009, Council adopted the core Out-of-Hospital Premises Standards which are the basis of inspection-assessments for the variety of procedures performed in OHPs. An external review of the core OHP Standards identified opportunities to provide more practice specific information about the Standards and how they will be applied for the purpose of an inspection-assessment. To meet this opportunity, in 2010 the College engaged a working group consisting of a cross-section of interventional pain practitioners (including academic and community-based physicians) to provide guidance about the application of the core OHP Standards in this specialty setting.

It is expected that physicians will manage medical and surgical conditions within the scope of their certification and experience. For members of the College of Physicians and Surgeons of Ontario (CPSO), this means practicing with the appropriate qualifications or equivalency subject to requirements set by the Royal College of Physicians and Surgeons of Canada (RCPSC), or CPSO "Specialist Recognition Criteria in Ontario" and "Changing Scope of Practice" policies.

The Purpose of this Document:

This document was developed to help interventional pain practitioners plan for and participate in their inspection-assessments. It in no way replaces the core OHP 2013 Standards; rather, it helps the practitioner understand how the OHP Standards will be applied in their interventional pain practice. This Guide should be considered a required companion document to the OHP Standards for interventional pain practitioners as only those Standards requiring guidance are included. The core OHP Standards are available at www.cpso.on.ca>cpso members>out of hospital premises inspection program.

Please note, the use of sedation as defined in the OHP Standards for interventional pain procedures in OHPs is not considered the standard of practice by the Interventional Pain Working Group. Therefore the guidance in applying the OHP Standards in these premises is based on this safer patient practice. Any interventional pain procedure using/requiring sedation regardless of the procedure will fall under a Level 2 OHP and all of the associated, relevant OHP Standards must be applied.

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Dr. Kevin Rod
Dr. Eddie Wasser

Acronyms:

Note: Procedure/OR = Procedure room and/or operating room

ACLS	-Advanced Cardiac Life Support
AED	-automated external defibrillator
ASA	-American Society of Anesthesiologists
BLS	-Basic Life Support
CFPC	-College of Family Physicians of Canada
CNS	-central nervous system
CPSO	-College of Physicians and Surgeons of Ontario
CSA	-Canadian Standards Association
ECG	-electrocardiogram
MHAUS	-Malignant Hyperthermia Association of the United States
MRP	-Most Responsible Physician
OHP	-Out-of-Hospital Premises
OHPIP	-Out-of-Hospital Premises Inspection Program
OR	-Operating Room
PALS	-Paediatric Advanced Life Support
QA	-Quality Assurance
RCPSC	-Royal College of Physicians and Surgeons of Canada
RHP	-Regulated Health Professional
RHPA	-Regulated Health Professions Act
RN	-Registered Nurse
RPN	-Registered Practical Nurse
SVT	-supraventricular tachycardia

Index of Standards to Guide the Application of Out-of-Hospital Standards in Interventional Pain Premises

3.1 OHP Levels, Page 12

Guidance to the Standard The following procedures are suitable to be safely performed in a level 1 OHP include:

- Auriculotemporal nerve block
- Ilioinguinal/ iliohypogastric/ genitofemoral nerve blocks
- Infraorbital nerve block
- Median nerve blocks
- Mental nerve blocks
- Occipital nerve blocks
- Sacroiliac joint injection
- Spinal accessory nerve block
- Supraorbital nerve block
- Suprascapular nerve blocks
- Transcapular nerve block
- Zygomatic temporal nerve block

The following procedures are suitable to be safely performed in a level 2 OHP include:

- Brachial plexus blocks
- Caudal blocks
- Epidural blocks
- Femoral nerve block
- Intercostal nerve blocks
- Ketamine infusions
- Lidocaine infusions
- Lumbar sympathetic block
- Maxillary and Mandibular nerve blocks
- Paravertebral nerve blocks
- Pudendal blocks
- Sciatic nerve block
- Stellate ganglion block

3.1 OHP Levels

The OHP level has two determinants: anesthesia and procedure — the level is decided by the higher ranking of the two, e.g., if the patient is receiving a minor nerve block (level 1) for limited invasive procedure (level 2), the OHP is considered level 2.

Table 02: OHP Levels

OHP Level	Anesthesia	Procedure
OHP Level 1	• Local infiltration • Minor nerve block (e.g. digital) • Tumescent anesthesia < 500cc of infiltrate solution	Minimally Invasive: • No surgical wound is created **and** • Procedure does not interfere with target organ function or general physiological function.
OHP Level 2	• IV Sedation • Regional anesthesia (e.g., major nerve blocks, spinal, epidural, or caudal) • Tumescent anesthesia > 500cc of infiltrate solution	Limited Invasiveness: • Surgical wound is created, but not for the purpose of penetration of a body cavity or viscus (e.g., rhinoplasty, facelift) **and** • Procedure has minimal impact on target organ or general physiological response **and/or** • Liposuction 1 to 1000cc of aspirate **and/or** • A small subcutaneous implant is inserted (e.g. lip, chin)
OHP Level 3	• General anesthesia	Significantly Invasive: • Surgical wound allows access to a body cavity or viscus (e.g., laparoscopic banding surgery, arthroscopy), **OR** • A significant amount of liposuction aspirate is removed (1000 - 5000 cc.) **OR** • A large prosthesis is inserted (e.g., augmentation mammoplasty).

Notes:

- It is expected that any one procedure incorporating multiple blocks on any one patient will be performed within the accepted standard of practice.
- For nerve block definitions, please refer to the CPSO document "Expectations of Physicians who have changed, or plan to change their scope of practice to include IPM", which has been updated (May 12, 2016).

4.2 Procedure Room/Operating Room Physical Standards, Pages 15-16

Guidance to the Standard

Physical Requirement, Standard 4.2.1.3 is applicable to those interventional pain procedures where the standard of care requires they are performed in a sterile field.

4.2 Procedure Room/Operating Room Physical Standards

Note: Depending on the procedure performed, not all standards may apply.

Table 04: Procedure Room/Operating Room Physical Standards

	Level 1	Level 2	Level 3
1 Physical Requirements	1. All OHP levels provide: a) lighting as required for the specific procedure b) floors, walls and ceilings that can be cleaned to meet infection control requirements 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.		

Guidance to the Standard

Ventilation, Standard 4.2.2.2. – Standard 4.2.2.3 does not apply to interventional pain OHPs unless it is used.

	Level 1	Level 2	Level 3
2 Ventilation	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.		

Guidance to the Standard

Equipment, Standards 4.2.3.3 – items e) and f)are not applicable.

d) If packs are used they must be sterile.

g) Suction equipment must be available on the premises.

	Level 1	Level 2	Level 3
3 Equipment	1. Medical equipment must be maintained and inspected yearly by a qualified biomedical technician. 2. Related documentation for all equipment is available: a) equipment operating manuals b) equipment maintenance contracts with an independent and certified biomedical technician c) log for maintenance of all medical devices 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: a) cleaning equipment as required for the specific procedure b) accessible anesthetic 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.		

Guidance to the Standard

Anesthetic and Ancillary equipment**,** Standard 4.2.4.1 and 4.2.4.2 – Medical gases used in interventional pain OHPs can be made available in tank form, in which case a back-up tank must be available. Tanks must be appropriately maintained, and maintenance documented as per the OHP Standards.

	Level	Level 2	Level 3
4 Anesthetic and Ancillary Equipment	Level 1 NA	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 1 NA	Level 2 NA	3. Level 3 OHP provides: a) anesthetic machine b) anesthetic equipment/drug cart.

4.3 Recovery-Area Physical Standards, Page 16

Guidance to the Standard

Recovery-Area Physical Standards, Size and Layout: Standard 4.3.2 – does not apply. A specific room for patient recovery is not required for interventional pain OHPs.

4.3 Recovery-Area Physical Standards

Table 05: Recovery-Area Physical Standards

	Level 1	Level 2	Level 3
1 Physical Requirements	1. A sink for hand washing is accessible.		
2 Size and Layout	Level 1 NA	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.	
3 Equipment	Level 1 NA	Monitoring, suction, oxygen, and bag-valve mask devices, intravenous and other medical supplies are immediately available.	

4.7 Monitoring and Resuscitation Requirements, Page 19

Guidance to the Standard

Monitoring and Resuscitation Requirements, Standard 4.7:

Level 1 premises require:

- AED
- IV Setup
- Adequate equipment to manage local anesthetic toxicity
- Appropriately sized equipment for infants and children, if required

Level 2 requires everything outlined in Table 4.7 with the exception of quantitative means to verify end-tidal CO_2

4.7 Monitoring and Resuscitation Requirements

Level 1		
• AED		
Level 1	**Level 2**	**Level 3**
• IV setup • Adequate equipment to manage local anesthetic toxicity • Appropriately sized equipment for infants and children, if required.		
Level 1	**Level 2**	**Level 3**
Level 1 NA	-Assortment of disposable syringes, needles, and alcohol wipes -Cardiopulmonary resuscitation equipment with current ACLS/PALS-device) compatible defibrillator -ECG monitor -Intubation tray with a variety of appropriately sized blades, endotracheal tubes, and oral airways	-Laryngeal mask airways -Means of giving manual positive pressure ventilation (e.g., manual self-inflating resuscitation -Qualitative and quantitative means to verify end-tidal CO_2 -Oxygen source -Pulse oximeter - Suction with rigid suction catheter -Torso backboard

6.2 Pre-Procedure Requirements, Page 25-27

Guidance to the Standard

In a level 1 or 2 interventional pain OHP where sedation is not performed, the following Pre- Procedure Standards are applied:

- 6.2.1
- 6.2.4 – documentation should be pertinent to the patient and the procedure as per the standard care.

Table 06: Pre-Procedure Requirements: OHP Level 1

Pre-Procedure Requirements: OHP Level 1	Responsibility
BEFORE day of procedure:	
1. Provide fasting instructions as required.	
2. Advise patient that a responsible adult should be accessible during the duration of the OHP stay.	
BEFORE or ON day of procedure:	
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 procedure b) blood pressure and pulse c) allergies.	Physician performing procedure
4. The physician is responsible for obtaining informed consent and a procedure consent form signed by the patient or substitute decision maker and witnessed.	

Table 08: Pre-Procedure Requirements: OHP Levels 2 and 3

Pre-Procedure Requirements: OHP Levels 2 and 3	Responsibility
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).	Physician performing procedure
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.	
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).	Physician performing procedure

6.4 Verification Process, Pages 28

Guidance to the Standard

Verification Process, Standards 6.4/6.5/6.6/6.7- Minimal verification is required in interventional pain OHPs and should only include verifying the patient, the procedure, and ensuring the patient chart corresponds to the patient.

1. Procedures Included

Procedures with any of the following components require a verification process; a) intravenous sedation; b) surgical incision (of any size); c) removal of tissue; d) primary procedure is itself an injection of any kind. This requires verification of the correct patient, procedure, and correct site at two different times and locations, as follows:

	When	Where
First Verification	Before entering the procedure room/operating room	The pre-procedure area
Second Verification	During the time-out	In the procedure room/operating room

Note: Procedures exempted from site marking still require a verification process.

6.8 Intra-Procedure Patient Care for Sedation, Regional Anesthesia or General Anesthesia, Page 30-31

Guidance to the Standard

Standard 6.8.1– Interventional pain OHPs require physicians administering the anesthetic to have a current ACLS certificate. A second person is required on the premises that is a Regulated Health Professional (as per the Standard) who has a current BLS certificate. It is not necessary for the second person to be involved in the procedure but should be available for patient safety and emergency response.

Standard 6.8.2– The patient should be appropriately attended by the physician, or second individual that is a Regulated Health Professional as defined above, from the beginning until the time they leave the premises.

Standard 6.8.3– If clinically indicated, patient monitoring should include (i) O_2 saturation, (ii) blood pressure and (iii) pulse.

Standard 6.8.4– This Standard does not apply to interventional pain OHPs.

6.8 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

Requirements for managing patients undergoing sedation, regional anesthesia, or general anesthesia, are as follows. Note: See physician qualification as well.

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, respiratory therapist, RN or anesthesia assistant) 1) who is NOT assisting in the procedure and 2) who is trained to monitor patients undergoing sedation or regional anesthesia.
1.1 The second physician, respiratory therapist, RN or anesthesia assistant shall hold ACLS (and PALS if pediatric patients are being treated) certification and the following skills:
    1) assessing and maintaining patient airway
    2) monitoring vital signs
    3) venipuncture
    4) administering medications as required
    5) assisting in emergency procedures including the use of a bag-valve-mask device
    6) documenting in the Anesthesia/Sedation Record
2. Note: 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. Capnography must be available at the premises for use, where appropriate, on patients receiving deep sedation. Capnography is always required for patients receiving general anesthesia as defined in section 3.2.
    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 must not be indefinitely disabled. The variable pitch pulse tone and the low-threshold alarm of the pulse oximeter and the capnograph alarm must give an audible and visual alarm. Variable pitch tone pulse oximeter must be clearly audible at all times.
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:
        - O_2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA [5] is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals
        - 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

Note: IV access should be established where clinically indicated, e.g., central neuraxial procedures, sympathetic blocks such as lumbar or stellate, and major plexus blockades.

6.9 Post-Procedure Patient Care, Page 32

Guidance to the Standard:

This section does not apply to interventional pain OHPs.

6.9 Post-procedure Patient Care

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. This must ensure the safe recovery and discharge of the patients.

Table 09: Recovery area Focus and Staff Requirements [6]

	OHP Level 1	OHP Level 2	OHP Level 3
Recovery Phase I (most acute) **Focus:** monitoring recovery of the patient to a state requiring less acute nursing interventions.	NA	**Staff required:** • One RN in the same room at all times with the patient • A second RN or RPN available on site	
Recovery Phase II **Focus:** Preparing the patient for self/family care in the home or for care in Phase III.	NA	**Staff required:** • Minimum of 2 nurses of which one must be an RN, competent in post- procedure care.	
Recovery Phase III **Focus:** ongoing care for the patient requiring or requesting extended observation and intervention prior to discharge.			

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:
   a) name and age of patient
   b) procedure performed
   c) pertinent history including allergies, medical/physical limitations
   d) type of anesthesia/sedation used
   e) other medications given
   f) any unusual or adverse events pertaining to patient
   g) estimated fluid or blood loss
   h) 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, $Sp0_2$, 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.
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.

6.10 Patient Discharge, Page 33

Guidance to the Standard:

Standards 6.10.1 and 2 – do not apply in interventional pain OHPs.

Note: Level 2 interventional pain OHPs always require discharge instructions as per Standard 6.10.3.

6.10 Patient Discharge

For OHP levels 2 and 3:

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.

8. Quality Assurance (QA), Page 35-36

Guidance to the Standard:

A quality assurance program should be developed and monitored regardless of whether the OHP is a solo or group practice.

8 Quality Assurance (QA)

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. The Medical Director is also individually responsible for OHP compliance with all internal CPSO policies, guidelines and directives within their Policy and Procedure Manual.

The Medical Director is responsible for 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.

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.

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

8.1 Monitoring Quality of Care

The purpose of monitoring activity is to identify problems and frequency, assess severity, and develop remedial action as required to prevent or mitigate harm from adverse events.

Monitoring OHP Activity

The OHP must have a documented process in place to regularly monitor the quality of care provided to patients. These activities include, but are not limited to, the following:

1) Review of 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)

The suggested protocol is, annually, random selection of 5-10 patient records to review:

i) record completion and documentation of informed consent
ii) percentage and type of procedures
iii) appropriate patient selection
iv) appropriate patient procedure
v) where required, reporting results in a timely fashion
vi) evaluation of complications (see 8.2)
vii) assessment of transfer to hospital, where required
viii) follow up of abnormal pathology and laboratory results

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).

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[1] RHPA, Medicine Act, etc.