

# Diagnostic Accreditation Program

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## Continuous Improvement of the Laboratory Medicine Accreditation Program



**BCSLS Telehealth Video Broadcast**

**March 17, 2011**



# Presentors

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Executive Director (outgoing)

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Accreditation & Research Development Officer



# Presentation Outline

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- Historical Overview
- Changes to Accreditation Assessment Methodology and Processes
  - Why, what, and how
- New Accreditation Standards for Laboratory Medicine
  - Highlights and implementation
- Accreditation of the DAP – “accrediting the accreditors”



# 40<sup>th</sup> Year of Service

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- 1971 DAP operated as a joint program of the BCMA and CPSBC.
- Currently, DAP a program of the CPSBC
- Mandate to accredit diagnostic services in the province of BC
- Authority derives from the *Health Professions Act, Bylaws of the CPSBC*.
- > 500 facilities accredited by the DAP
  - 140 DAP accredited laboratories in BC



## 2002 - 2007

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- DAP practice of reviewing itself through external reviews every 5-7 years.
- 2002 Dr. Don Carlow conducted external review:
  - Implement “Modern Accreditation Methodologies”
  - Accreditation Standards
  - Accreditation Processes
  - Internal operations to support new processes
  - Sustainable funding model
  - Governance
  - Accreditation by ISQua



- 2007 edition Accreditation Standards for Laboratory Medicine
  - Standards focusing on systems and processes
- 3 year accreditation cycle
  - On-site surveys – medical, technical, management “peer” surveyors using “tracers” and “protocols”
  - Self assessments
  - Mid-cycle assessments
  - Proficiency testing



# 2002 - 2007

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- 2006 on-site surveys recommenced using medical, technical and management peer surveyors
- DAP Staff conducting initial/focused visits

Year	# On-site Survey	# Initial Assessment / Focused Visit	Total assessments
2006	19	11	30
2007	53	27	80
Total	72	38	110

Data for Diagnostic Imaging and Laboratory Medicine Accreditation Programs



2006-2008

## What did we learn about *Facility Performance?*

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- 51 Laboratory facilities, 191 disciplines assessed
- Management and quality systems were still developing
- Quality Improvement lowest scoring standards area
- Safety issues most frequently cited in laboratories
  - “Clean” sinks for hand washing
  - Safety audits/inspections
  - Chemical and biological spill kit availability



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

- Proficiency Testing/QC:

- When mandated PT is not available, alternative PT is used to validate performance

- QC policies and procedures are documented and maintained

- Document Control:

- All procedures are documented, communicated to and available to staff performing the analysis

- Invalid or obsolete documents are promptly removed from all points of use

- Instrumentation and Equipment:

- Process for correction action when temperatures deviate from the acceptable ranges



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

Sample collection, transport, accessioning

- Two identifiers used by collector to identify patient

- Unaltered gloves are worn during phlebotomy

- Current comprehensive sample collection manual

- Sample rejection criteria established

- Acceptable time limits between collection and processing of samples are established and monitored

- Policies and procedures to deal with unlabeled, mislabeled, lost or compromised samples



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

### Point of Care Testing:

Unaltered gloves are worn during testing

Critical values are established as appropriate

Collection sites are properly decontaminated

Contingency plans are available if the appropriate action cannot be followed for a critical result

Patient identification is confirmed using a minimum of two identifiers



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

### Hematology:

There is a process for validating results and following up on samples with unexplained prolonged coagulation results

The ISI and geometric mean to determine the INR are validated

The INR is re-established when instrument or reagent changes are made

There are criteria for pathologist review of abnormal results



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

### Chemistry:

Documents are reviewed and approved by the medical leader prior to issue

QC policies and procedures are documented and maintained

Methods are validated using documented policies, procedures and processes

Invalid or obsolete documents are promptly removed from all points of use

Corrected results: notification of clinical staff is recorded

QC results are reviewed and verified at regular intervals to detect trends and outliers

Corrected results: both the original and corrected result are reported



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

### Transfusion Medicine:

There are processes to notify all recipients of blood components

There are processes for the evaluation of inventory in critical shortage situations

There are procedures for monitoring and documenting temperature data

There are processes to remove unsafe products from the blood supply

Temperature monitoring data is regularly reviewed by the technical supervisor



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

### Microbiology:

The laboratory participates in the appropriate mandatory PT programs

All documents are uniquely identified

Invalid or obsolete documents are removed from all points of use

Appropriate controls are run with appropriate frequency

Procedures are available for handling special requests

Individual sample work up is based on defined criteria



2006-2008

# What did we learn about *Facility Performance?*

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## Most frequently cited mandatory requirements:

### Anatomic Pathology:

Gross dictation of all samples begins with positive patient identification by accession number and patient name

Work lists include the number of tissue pieces per cassette

Turn around times for pathology reports are established and monitored

Written intraoperative consultations always include positive patient identification and are documented on the patient chart within the perioperative time frame



2008-2010

# What did we learn about *Facility Performance?*

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## Top 10

1. Safety - PPE and other safety equipment/ supplies are available and used
2. SCTA – sample rejection criteria are established
3. Safety – emergency showers
4. SCTA – P&P to deal with requests containing errors of lack information



2008-2010

# What did we learn about *Facility Performance?*

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## Top 10

5. SCTA – P&P to deal with unlabeled, mislabeled, lost, compromised samples
6. Hematology – corrective action when temperature deviates from acceptable range
7. POCT – POCT sites participate in PT as defined by the lab medical leader



2008-2010

# What did we learn about *Facility Performance?*

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## Top 10

8. Transfusion Med – procedure for notifying recipients of blood components.
9. Transfusion Med – terms of reference for Transfusion Committees
10. POCT – documentation of adequate and specific training

Performance appears to be improving



# What did we learn *From You?*

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- 2009 DAP internal review
  - Laboratory Standards - formal review process commenced
  - Accreditation Processes
- Feedback from DAP surveyors and Advisory Committee members, facilities
- Meetings with Health Authority senior leaders
- Comparison to current practices of other leading accreditation organizations



# *Improvements to the Accreditation Programs*

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## Targeted Key Areas for Improvement:

1. On-site assessment process
2. Monitoring facility performance mid-cycle
3. Improving efficiency and cost effectiveness
4. Standards content



# ***Improvements to the Accreditation Process***

## ***Client organizations' perspectives:***

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- 3 year cycle too frequent - too costly
- Size of survey teams too large – overwhelms smaller facilities, too costly
- Surveyors drawn from facilities causing burden to operations – cost of backfilling, unavailable staff to backfill, impacts care
- Concerns with peer surveyors:
  - Inconsistent interpretation of standards and surveying
  - Confidentiality concerns
  - Unreliable DAP peer surveyors, changes to schedules
  - “Have you considered using DAP *staff* surveyors?”



# *Improvements to the Accreditation Process*

## *DAP's perspectives:*

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- 3 year cycle - heavy workload with current FTEs; difficulty finding surveyors
- Very committed surveyors, but challenges exist:
  - Accuracy and consistency of surveyors difficult to measure
  - Surveyor bias
  - Surveyor management – time and cost intensive – 250+ surveyors
  - Lack of medical surveyor involvement
  - Conflict of interest – Lower Mainland consolidation; private to private; HA to private not same experience
  - Confidentiality concerns
  - Incorrect/inaccurate knowledge sharing by surveyors
- Expensive model – for facilities and for DAP: surveyor \$, travel, orientation and training
- Assessment methodology requires refining; incorporate practices from leading accreditation organizations



# ***Changes to Accreditation Assessment Strategy Summary***

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## **Accreditation cycle over 4 years**

### **Use of enhanced “Desk Top Audit”**

#### Improvement:

- Provides DAP with better, focused data used to monitor facility performance continuously
- Removes requirement to review some documentation during on-site assessment
- Provides DAP with data that will enable targeted patient and system tracers to be selected for use during the on-site assessment

## **Scheduled on-site assessment at each facility once every 4 years**

#### Improvement:

- Cost savings
- Less potential impact to patient care and operations
- More efficient using targeted tracers



# ***Changes to Accreditation Assessment Strategy***

## ***Desk Top Audit***

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- 1. Internal audit submissions to DAP once per year**
  - Internal audits focus on patient safety and clinical quality processes:
    - High risk practices
    - Patient safety tracer
    - Infection control tracer
    - Clinical informatics tracer
  - DAP will provide education to facilities of how to conduct these audits for improvement purposes using tracers; provide templates for documenting the audit and reporting, etc.



# ***Changes to Accreditation Assessment Strategy***

## ***Desk Top Audit***

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### **2. Performance indicators**

- Key performance indicators related to quality and safety to monitor:
  - Clinical outcomes
  - Patient and client focused outcomes
  - Utilization and resource use outcomes
  - Safety effectiveness outcomes
- DAP will work with existing management groups to develop the indicator sets
  - Build upon indicators already in use
  - Discuss and resolve challenges in data collection and reporting



# ***Changes to Accreditation Assessment Strategy***

## ***Desk Top Audit***

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### **3. Pre-survey information form**

### **4. Self assessment**

- Submissions to DAP prior to scheduled on-site assessment
- Data and information from these submissions focuses activities of the on-site assessment

### **5. Proficiency Testing**

- Continuous submissions throughout the 4 years

### **6. WorkSafe BC Report**

- Annual check for significant safety concerns



# ***Changes to Accreditation Assessment Strategy***

## ***Desk Top Audit***

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### **7. Evidence Submission for On-site Assessment**

- Many DAP accreditation standards can be effectively assessed through desk top audit
- Prior to scheduled on-site assessment, facility will submit specified documentation and evidence



# ***Changes to Accreditation Assessment Strategy***

## ***Desk Top Audit***

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### **8. Distance Medical Review (DMR)**

- Medical assessment essential component of ensuring high quality, safe diagnostic care
- Medical surveyors assess protocols/methods; critical values and reference ranges; patient requisitions, final reports, etc.

#### Improvements:

- Improved efficiency – 1 medical surveyor can assess more than 1 facility in a DMR session
- Less intrusive to physician's schedules
- More cost effective – reduces travel costs



# ***Changes to Accreditation Assessment Strategy*** ***On-site Assessment***

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## **Scheduled on-site assessment – once every 4 years**

### **Assessment team composition:**

- DAP staff assessor(s) – targeted tracers focusing on those standards that can only be assessed on-site
  - Additional peer surveyors may be utilized for complex facilities and/or specialized testing
- Medical assessment:
  - distance medical review by DAP medical reviewer
  - selected facilities/disciplines may have on-site medical surveyor



# DAP Accreditation Assessment Officer

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## Cathy Sheppard, RT

- Joined DAP in January 2008
- Previous experience as a Laboratory Manager and Quality Specialist
- Has worked in remote laboratories, high-volume, and specialized research labs
- General RT
- Clinical Laboratory Management Certificate, Michener Institute



# DAP Accreditation Assessment Officer

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## **Gail McNabb, BSc, ART**

- Joined DAP in January 2008
- Previous experience as a Laboratory Manager and Technical Supervisor
- Has worked in the development and implementation of several quality initiatives
- BSc (hon) Bacteriology and Immunology, General RT and ART in Virology
- Laboratory Quality Management Certificate, UBC



# *Changes to Accreditation Assessment Strategy*

## *On-site Assessment*

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### Improvements:

- On-site assessment focuses on critical aspects of service delivery that can only be assessed through direct observation
- Fewer surveyors – less overwhelming; more cost effective
- Challenges previously identified by facilities and DAP with peer surveyor model are addressed
- Accreditation report turn around time will be improved significantly

Formative and summative evaluation of this accreditation assessment strategy will be conducted over the next 2 years.



# *Improvements to the Accreditation Programs*

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## Targeted Key Areas for Improvement:

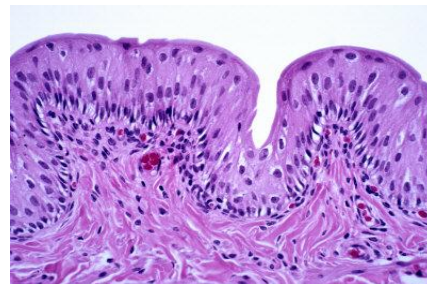
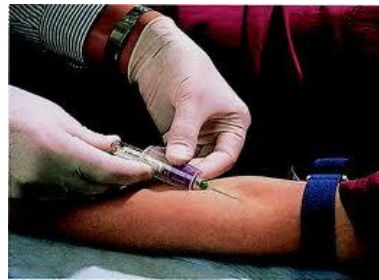
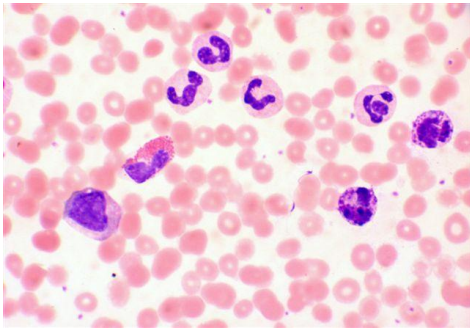
1. On-site assessment process
2. Monitoring facility performance mid-cycle
3. Improving efficiency and cost effectiveness
4. **Standards content**

Improvement goal to reduce ambiguity, increase specificity, remove redundancy, provide more clarity through “guidance” statements.



# Laboratory Medicine Accreditation Standards 2010

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# Organization of Accreditation Standards

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## Quality Categories Defining Performance Excellence



# Discipline Specific Accreditation Standards for Laboratory Medicine

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Global Laboratory Medicine

Sample Collection, Transport & Accessioning

Hematology

Chemistry

Transfusion Medicine

Microbiology

Anatomic Pathology

Cytology

Cytogenetics

Point of Care Testing



# What Are Standards?

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- Standards are documents developed and adopted by a consensus process that contain criteria, best practices and/or processes that if followed, produce an intended result
- A standard might simply be defined as '*a set of rules for ensuring quality*'



# How Are Standards Created?

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- Existing standards & source documents reviewed
  - ISO
  - CSA
  - CLSI
  - ASTM
  - Other accreditation bodies: e.g. CAP, AABB
  - Other resources: e.g. Westgard



# How are Standards Created?

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- Standards cannot be written in isolation
  - High level of consultation with pathologists and technologists
- Advisory Committees
  - One per discipline
  - Composed of medical and technical staff
  - All health authorities, public and private sectors
  - Appointed by the DAP committee
  - Creation and review, advise on content



# How are Standards Created?

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- After review and edits the advisory committee recommends acceptance to the DAP committee
- DAP committee reviews standards, makes revisions if necessary, and approves standards
- Any changes to the standards must go through the DAP committee



# Why Produce Standards?

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- 2007 standards documented activities to evaluate quality, quality improvement and risk
- Create consistency among surveyors
- Ensure all areas are assessed
- Focus on continuous quality improvement and goal oriented standards of quality
- Assess from a systems perspective
- Provide quality guidelines for facilities



# What do DAP Standards Look Like?

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- List of rules and suggestions
- Written in affirmative statements
- Don't use the terms “shall” and “should”
- Define actions as mandatory (**M**) or best practice
- Provide a unique identifier



# What do DAP Standards Look Like?

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DAP1.0	Standard (10,000 feet)
DAP1.1	Criteria (1,000 feet)
DAP1.1.1	Descriptor (ground level)
DAP1.1.2	Descriptor (ground level)
DAP1.1.3	Descriptor (ground level)
DAP1.1.4	Descriptor (ground level)

Rating:    NA    1    2    3    4    5



**SCT 3.0** Sample receipt, accessioning and processing systems ensure that samples are acceptable for testing, that viability is maintained and that positive patient identification is maintained throughout all processes.



# Criteria

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- SCT3.1** Sample receipt processes in the laboratory encourage sample integrity and ensures that the appropriate information accompanies the sample.
- SCT 3.2** Sample processing and aliquoting ensures that positive patient identification and sample integrity is maintained.
- SCT 3.3** Records are retained and tracking mechanisms are maintained for samples referred to regional or reference laboratories for further testing



# Descriptors

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**SCT 3.2** Sample processing and aliquoting ensures that positive patient identification and sample integrity is maintained.

SCT3.2.1 **M** A unique identifier is used that ensures a primary sample can be traced back to the patient.

SCT3.2.2 **M** Slides, aliquots and other portions are traceable to the original primary sample.

SCT3.2.3 **M** There are written procedures for those samples requiring preparation prior to analysis (e.g. centrifugation).

SCT3.2.4 **M** Blood samples are allowed to clot for an appropriate length of time prior to centrifugation.



# Accreditation Standards 2007 for Laboratory Medicine (Disciplines)

- Sample Collection, Transportation, Accessioning
- Hematology
- Chemistry
- Transfusion Medicine
- Microbiology
- Anatomic Pathology
- Point of Care - 2008
- Cytology - 2008



# Accreditation Standards 2007 for Laboratory Medicine (Disciplines)

For every discipline:

1. Method selection, evaluation and validation
2. Document control
3. Quality Control
4. Instruments and Equipment
5. Reagents and supplies
6. Reports
7. Sample storage and discard
8. Discipline specific items



# Why Develop a New Set of Standards?

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- Things change (e.g. Human Pathogens and Toxins Act, legislation on safety-engineered sharps, Commissions of Inquiry (NF, NB) recommendations, changing proficiency testing requirements)
- There was redundant redundancy
- Some items were confusing for some groups (e.g. Reports indicate when a non-diagnostic method has been used for diagnostic purposes)



# Why Develop a New Set of Standards?

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- There was a high proportion of non-mandatory to mandatory items
- There were areas where the standards were too general (e.g. Appropriate controls are run with appropriate frequency, in accordance with manufacturer's guidelines\*)
- Some quality requirements were omitted (e.g. capillary samples, mixing samples, changing gloves between patients)



# Why Develop a New Set of Standards?

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- Some mandatory requirements were very difficult to achieve (because of the way the standard was written or system inflexibility)
- Concern about the utility of general items in discipline specific standards (“The transfusion medicine standards seem like chemistry standards!”)
- DAP has always maintained the standards are dynamic and will be reviewed regularly



# 2010 Laboratory Medicine Standards

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## Global Standards

Hematology

Transfusion Medicine

Anatomic Pathology

Point of Care Testing

## Equipment & Supplies

Chemistry

Microbiology

Cytology

Cytogenetics

Gynaecological Cytology

ECG and Holter Monitor

Informatics

Molecular Testing



# How are 2010 Standards Different?

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- Creation of “Global Laboratory Standards”
  - Requests (previously in sample collection)
  - Method selection, evaluation and validation
  - Procedures and documentation
  - Quality Control
  - Consultations and reviews (new)
  - Reports



# How are 2010 Standards Different?

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- Creation of Equipment and Supplies Standards
  - General
    - Maintenance and monitoring
    - Operating
    - Resolving problems
    - Verification of Compatibility
  - Specific
    - Thermal equipment, glassware, pipettes, balances
  - Calibration
  - Reagents, Chemicals and Supplies



# How are 2010 Standards Different?

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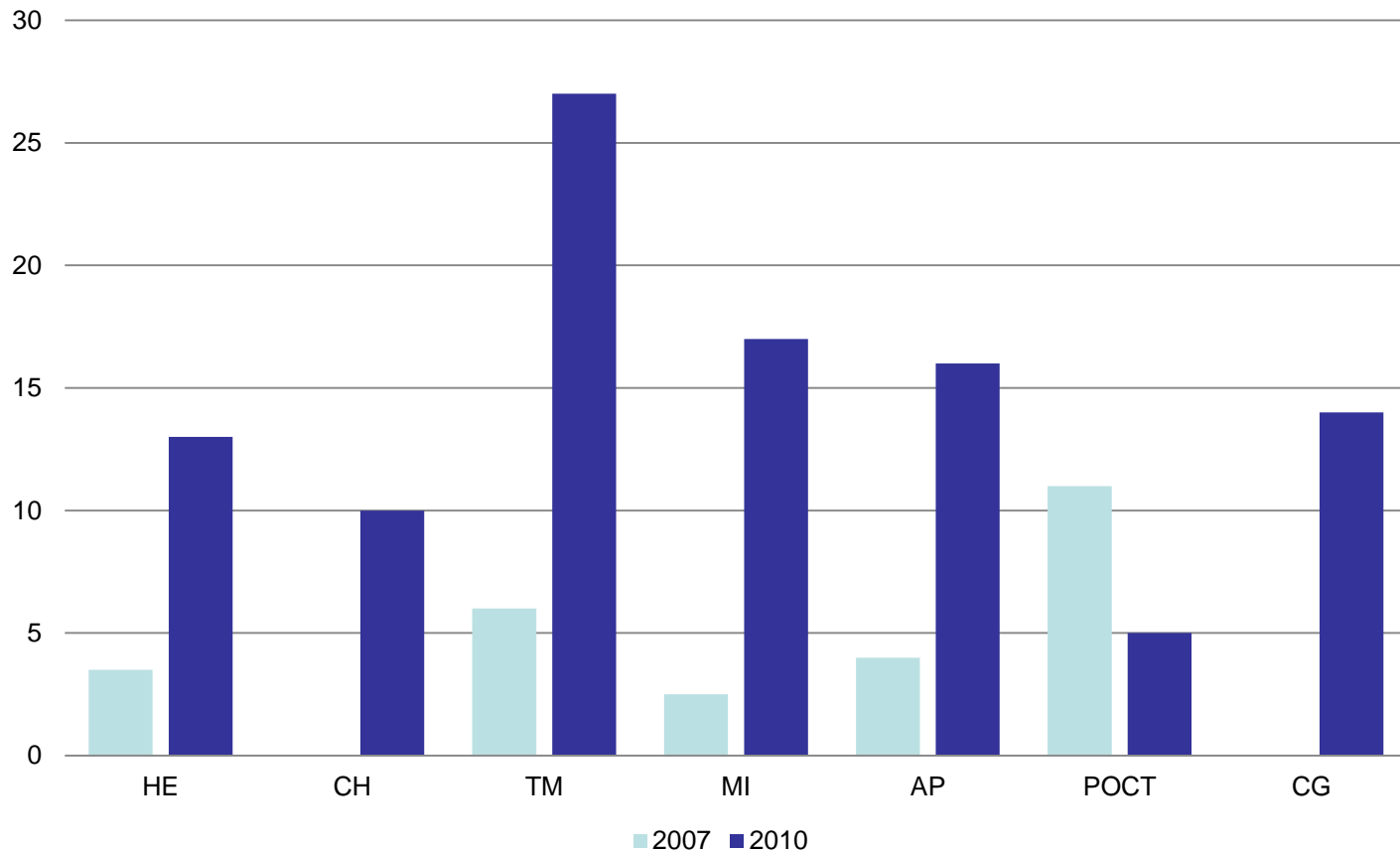
- In the General documents, the language and content used for Diagnostic Imaging and Laboratory Medicine has been harmonized (e.g. sample labeling requirements)
- 2010 Standards recognize the need and desire to have more discipline-specific material



# How are 2010 Standards Different?

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Discipline-Specific Standards (in pages)



# How are 2010 Standards Different?

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- But number of pages is somewhat misleading!
  - Content is laid out differently
    - Lines as spacers
    - One item per line
  - Guidance is provided



# “Checklist” Layout 2007

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- 58.1.6 An International Normalized Ratio (INR) is reported for Prothrombin Time testing.
- 58.1.7 **The INR is re-established when instrument or reagent changes are made.**
- 58.1.8 The International Sensitivity Index (ISI) and geometric mean to determine the INR are validated.



# Different Layout-2010

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...ISI and geometric mean.

(line as spacer)

The calculation of the INR is checked: → non descriptor

HE1.5.5 when the instrument is serviced.

HE1.5.6 when there is a software upgrade

HE1.5.7 when there is a laboratory information system (LIS) upgrade and the INR is calculated by the LIS.

separate  
lines

(line as spacer)

Validation of the ISI occurs when...



# 2007-No Guidance

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A minimum of two different stabilized control samples are run during each 24 hours of analysis



# 2010-Guidance

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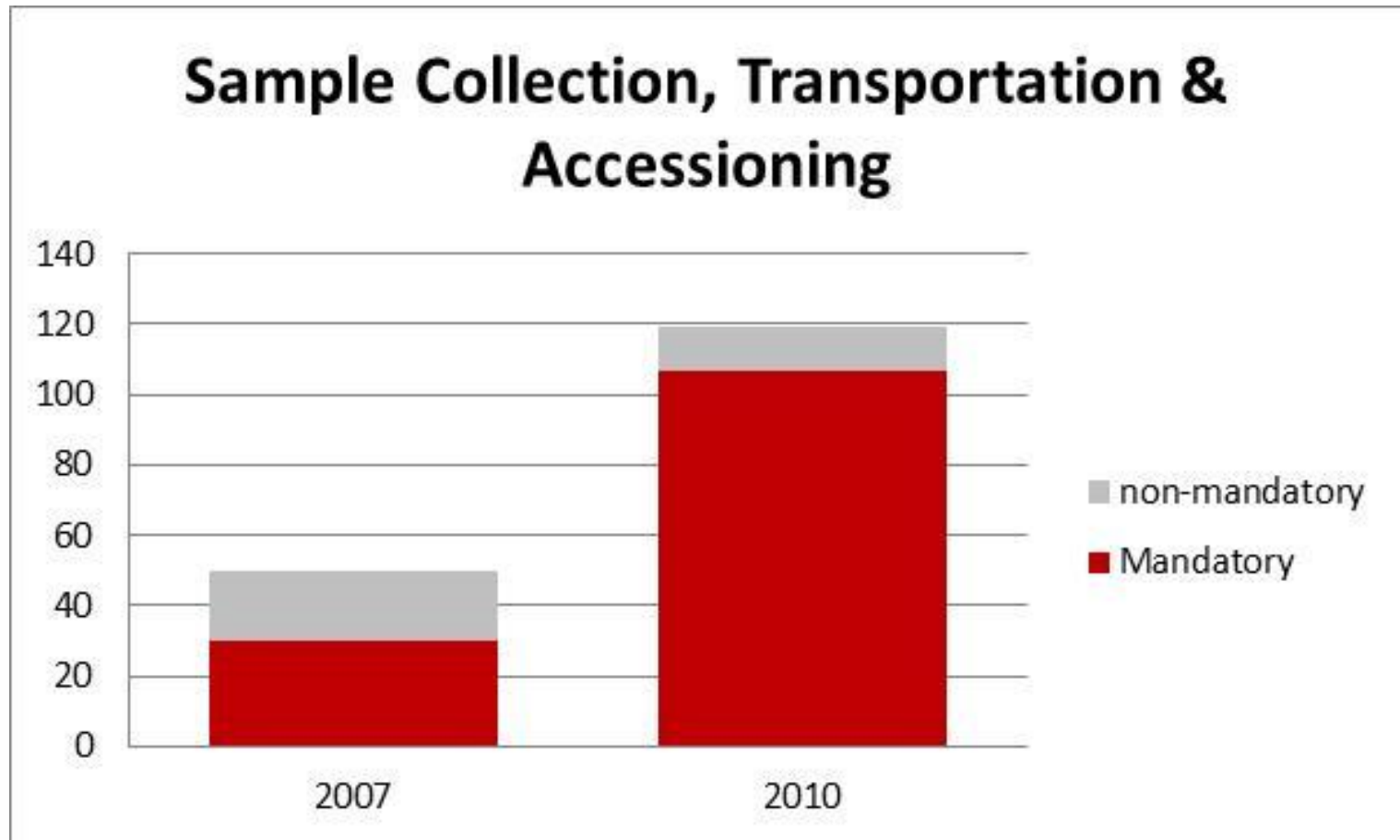
A minimum of two different stabilized control samples are run during each 24 hours of analysis

*Guidance: Stabilized control materials must be at 2 different analytic levels (i.e. “normal” and “high”). Three levels of control is a conceptual carryover from clinical chemistry, and does not apply to hematology particle counting. Dilute, “low level oncology controls” (e.g. leukopenic and thrombocytopenic) are less informative indicators of calibration status, and are neither required nor recommended. The laboratory should also define how many patient assays are used to separate controls on the basis of workload and experience with the drift characteristics of the analyzer.*



# How are 2010 Standards Different?

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# Why are SCTA Standards Bigger?

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- Blood Cultures (11)
- Capillary Samples (17)
- Labeling (8)
- Gloves
- Mixing
- Clotting
- Tourniquet pressure
- Fist pumping
- Bruises (4)



# Why Are There More Mandatories?

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- Reduced the number of non-mandatory items
- Items previously not mandatory are now **M**
  - There are written procedures for samples requiring preparation prior to analysis
  - Requests and samples are systematically reviewed for acceptability
- High risk area
  - More potential for error



# 2007 General Language

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Appropriate\* controls are run with appropriate frequency, in accordance with manufacturer's guidelines

\*as determined by the medical leader



# 2010 Specific Language

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2010:

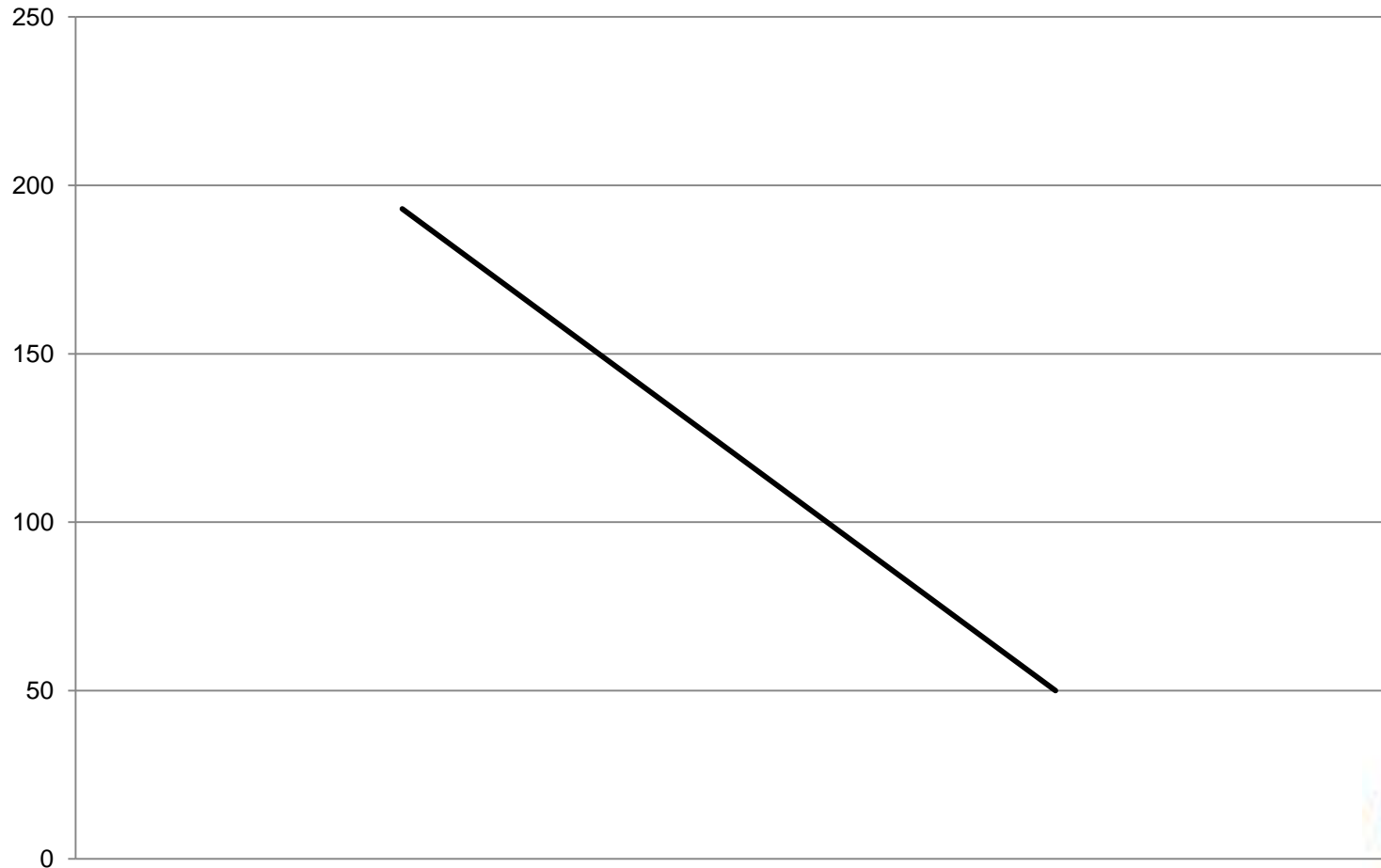
**QC procedures are documented and contain the specific activities needed to assess the quality of each analysis including the:**

- frequency of controls.
- order of controls.
- number of levels of controls.
- process for analysis of controls.
- type of control material used.
- acceptable ranges and/or tolerance for controls.
- actions to be followed when controls fall outside acceptable ranges.
- criteria for acceptance, review and rejection.
- supplementation of electronic QC with traditional QC, where appropriate.



# POCT Descriptors 2008-2010

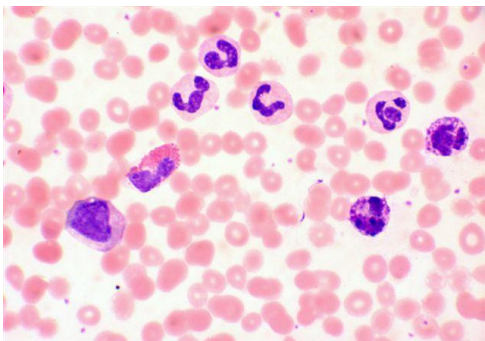
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# Hematology

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- Detecting drift or shift in analyzer calibration
- Automated differential counters
- More detailed coagulation testing standards
- More guidance in coagulation testing



# Chemistry

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- Results outside linearity or reportable range
- Urinalysis
- Radioimmunoassay
- Thin Layer Chromatography
- Gas Chromatography
- Mass Spectrometry



# Chemistry

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- Electrophoresis
- Blood Gas Analysis
- Sweat Chloride Testing
- Alpha-Fetoprotein Testing



# Transfusion Medicine

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- Extensive glossary
- All descriptors linked to CSTM & CSA standards
- More extensive standards on storage
- Thawing
- Quarantine and segregation
- Recording of results
- Testing and transfusion of neonates
- Selection, Modification, Labeling



# Transfusion Medicine

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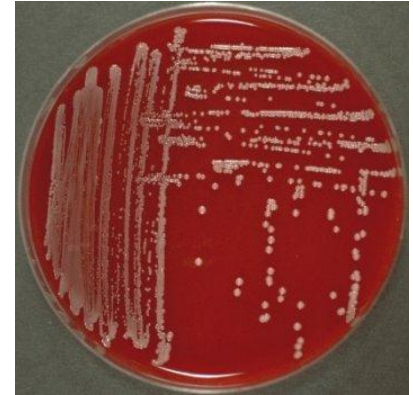
- Sterile connection devices
- Compatibility labeling
- Issue records
- More extensive standards on administration, adverse events
- Transfusion related bacterial sepsis
- More to come on use of processing and administration equipment.
- Extensive cross referencing



# Microbiology

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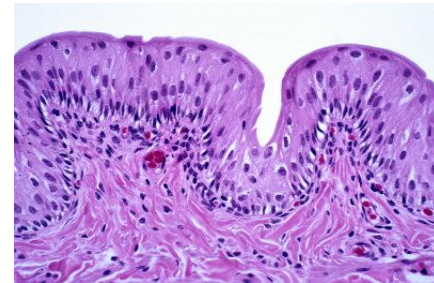
- Regulatory requirements
- Quality control
  - Staining
  - Media
  - Antimicrobial Testing
- Antimicrobial susceptibility testing
- Workup and interpretation of cultures by site
- Molecular testing



# Anatomic Pathology

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- Supervision of grossing by non-pathologists
- More extensive standards on IHC
- More extensive standards on intraoperative consultation
- More extensive standards on autopsy services
- Electron microscopy
- Reports
  - Synoptic reporting



# General Sections

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## The content of the DAP Accreditation Standards are derived from:

- ISQua Accreditation Requirements for Standards
- other accreditation program standards
- other quality, patient safety, and standards setting organizations
- safety codes and other relevant legislation
- provincial directives and guidelines
- expert opinion from DAP Advisory Committees
- feedback received from DAP surveyors, accredited facilities, and other stakeholders



# “Highlights” from the Standards

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## Medical Staff

- Improved clarity regarding medical leader responsibilities
- Delegation of medical acts

## Human Resources

- Technical staff - Mandatory requirements for CSMLS certification
- Scientific staff and Pathologists’ Assistants -Mandatory requirements for education



# “Highlights” from the Standards

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## Human Resources

- It is NOT the intention of DAP that current staff that do not meet the mandatory requirements are displaced.
- Facilities with current staff that do not meet the mandatory requirements should contact the DAP to discuss available options to ensure staff are “safe to practice”.



# “Highlights” from the Standards

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## Patient Safety

- Use of the “universal protocol” for all invasive procedures

## Quality Improvement

- More comprehensive
- More direction on how to establish quality improvement programs and initiatives
- Detailed requirements for medical peer review
- Internal auditing and performance indicators



# Implementation and Timelines

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- 2010 edition of the standards is in effect
- New services/laboratories will be assessed to the 2010 standards for initial assessments
- On-site Assessments of currently accredited laboratories will use the 2010 standards starting September 2011.
- DAP will be planning education sessions

Please let us know the content areas where you wish education to be focused.



# Where do I find the Standards?

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[www.dap.org](http://www.dap.org)



# Accrediting the Accreditors

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Laboratory Medicine  
Accreditation Standards

Accredited by the  
International Society for  
Quality in Healthcare  
(ISQua) in October  
2010



# Accrediting the Accreditors

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## “Standards” for ISQua Standards Accreditation

- Content of the standards addresses:
  - Quality Improvement Programs
  - Patient/service User Focus
  - Organizational Planning and Performance
  - Safety
- Standards Development Process
- Standards Measurement



# Accrediting the Accreditors

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## Organizational Accreditation by ISQua

Eight standards areas:

1. Governance
2. Strategic, Operational and Financial Management
3. Risk Management and Performance Improvement
4. Human Resources Management



# Accrediting the Accreditors

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## Organizational Accreditation by ISQua

Eight standards areas:

5. Information Management
6. Assessor Management
7. Assessment Management
8. Accreditation Award Processes



# ISQua Survey Team

November 1-5, 2010

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- Elma Heidemann
  - Former CEO  
Accreditation Canada
- Dr. Paul Chang
  - Joint Commission  
International  
(Singapore)
- Nancy Morelli
  - Aged Care Standards  
and Accreditation  
(Australia)



# Summary

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- New accreditation processes and standards have resulted from CQI initiatives.
- The implementation will be monitored and assessed. Feedback is essential.
- Questions?
  - Helen Healey, Interim Executive Director, DAP
  - Colin Semple, DAP
  - Dr. Robbert Vroom, CPSBC

