COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Non-Hospital Medical/Surgical Facility

Accreditation Report

Pacific Centre for Reproductive Medicine

Originating Committee: Non-Hospital Medical/Surgical Facilities Committee

These accreditation materials have been adapted with permission from documents developed by the College of Physicians & Surgeons of Alberta.

ACCREDITATION SUMMARY

Inspection Date: March 09, 2022

Response Required: 90 days from receipt of this report.

Accreditation Expiry Date: March 09, 2023

INTRODUCTION

The on-site accreditation assessment was conducted on March 09, 2022.

Following is a summary of the inspections.

GENERAL INFORMATION

Facility Name:	Pacific Centre for Reproductive Medicine
Address:	500 - 4601 Canada Way, Burnaby, B.C. V5G 4X7
Telephone:	604-422-7276
Fax Number:	604-434-5522
Facility Type:	Class 1
Level of Anesthesia:	1
Committee Reviewed:	TBD

MEDICAL DIRECTOR

Name:	Dr. Kenneth Seethram
Qualifications:	MD

PREAMBLE

Pacific Centre for Reproductive Medicine has been in operation since 2006 as a Class II facility. In 2008 the facility was re-classified as a Class I (General Anesthesia) facility offering fertility treatments.

The following nonconformances are the result of findings from the accreditation assessment conducted March 09, 2022 and from documentation provided by the facility.

The term of accreditation will be awarded by the NHMSFAP Committee

NONCONFORMANCES (NC) SUMMARY

	Outstanding Critical and Semi-Critical NC	Outstanding NC	Accepted Critical and Semi-Critical NC	Accepted NC	Recommendations
Emergency Preparedness	0	0	1	0	0
Intraoperative Care	0	0	2	0	0
Human resources: Non-hospital facility services are provided by qualified and competent physicians	0	0	0	1	0
Intraoperative Care: Preoperative preparation of the patient's skin reduces the risk of post-operative surgical site infection	0	0	0	1	0
Specimen Handling: Specimen collection procedures ensure correct patient identification and protect specimen quality	0	0	0	1	0
Medical Device Reprocessing: General	0	0	0	1	0
Hand Hygiene: Hand hygiene is performed at essential moments	0	0	0	1	0
Waste Management: Non-anatomical biomedical waste is safely and appropriately contained	0	0	0	1	0

Occupational Health and Safety: An occupational first aid program is in place	0	0	0	1	0
Medical Gas - Pipeline System: Medical gases are safely and effectively managed	0	0	0	1	0
Documentation: Pre-admission documentation provides an accurate account of the patient's preoperative status and supports appropriate patient selection	0	0	0	1	0
Documentation: Admission documentation provides an accurate account of the patient's preoperative status and supports appropriate patient selection	0	0	0	1	0
Documentation: Sedation documentation provides an accurate account of the patient's status and outcome	0	0	0	1	0
Documentation: Intraoperative documentation provides an accurate account of the patient's status, the actions of the perioperative team, and the patient's outcome	0	0	0	2	0
Documentation: Post-anesthesia care unit (PACU) documentation provides an accurate account of the patient's status, the actions of the perianesthesia team, and the patient's outcome	0	0	0	1	0
2.00 Environmental requirements for the	0	0	0	0	1

reprocessing area: Environmental Requirements					
4.00 Education and training: Education and Training	0	0	0	1	0
11.00 Storage and use of reprocessed medical devices: Storage and Use of Reprocessing Medical Devices	0	0	0	1	0
TOTAL	**0**	**0**	**3**	**16**	**1**

SEMI-CRITICAL NONCONFORMANCES

Emergency cart

EMGP1.4.5 The emergency cart equipment is checked every surgical/procedural day to ensure proper working order.

Background **Observed and Discussed:**

A powered intraosseous (I/O) driver and two laryngoscope handles are located on facility's emergency cart.

Facility staff provided the information that the I/O driver and laryngoscope handles are not tested each day that procedures are scheduled.

Action:

The medical director shall confirm that:

1. The powered I/O driver is tested at the beginning of each procedural day, before the first procedure.
   Guidance: The powered I/O driver is replaced if the LED blinks red when the trigger is activated indicating that only 10% battery life remains.

2. Both laryngoscope handles are tested (i.e. with a laryngoscope blade) at the beginning of each procedural day, before the first procedure.

3. The above requirements are reflected in facility policy and staff have read and followed the policy.

4. The policy and proof of staff review are submitted to the College within 90 days of receiving final accreditation assessment report.

Reference Emergency preparedness
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Emergency-Preparedness.pdf

Facility Response:
March 18, 2022
PCRM confirms that the I/O driver and the Laryngoscope handle (with blade) are tested at the start of each procedural day, prior to the first procedure. These items have been relocated and photographic evidence will be submitted. We also confirm that the policy regarding emergency crash cart will be amended, and that staff acknowledgement evidence will be obtained and duly submitted.

College Response:
March 25, 2022
1. Accepted.
2. Accepted.
3. Accepted.
4. Pending submission.

Facility Response:
The policy has been amended as well as the nursing checklist. Attached are the following:
1. updated SOP-OPR-001-BUR
2. updated checklist for morning checks of the emergency cart FRM-OPR-053-BUR
3. As Medical Director, I and our Nursing manager attest that these policy changes have been reviewed by our medical and nursing staff.

College Response:
July 6, 2022
4. Accepted.
A policy reflecting the above requirements was submitted to the College.

Intraoperative Care

IOC1.7.2 All items are assessed for sterility prior to opening

Background **Observed and Discussed:**

A sterile set-up for a hysteroscopy was observed during the accreditation assessment.

One of the sterilized peel-pouch containing a uterine sound instrument had a puncture on the seal of the package (i.e. caused by the tip of the uterine sound instrument penetrating the seal). Facility procedure room nurse did not assess this peel-pouch for sterility prior to opening.

A sterilized enclosed container that had a hysteroscope was observed placed on the sterile field for later use. Facility procedure room nurse did not assess the internal chemical indicator located inside this enclosed container.

Action:

The medical director shall confirm that:

1. All items (e.g. peel-pouches) are assessed for sterility prior to opening.

2. Internal chemical indicator located inside the hysteroscope container is assessed for sterility during sterile set-up.

3. Sterility is assessed by observing for:
    - Signs/presence of moisture
    - Confirming wrapper integrity
    - Verifying external locks, latch filters, valves and tamper-evident devices of rigid containers
    - Verifying the presence and appropriate changes of external and internal indicators
    - Confirming expiry date, as applicable

3. Any items/packages assessed that have concerns of sterility are considered contaminated and unsterile.

4. The above requirements are reflected in facility policy and staff have read and followed the policy.

5. The policy and proof of staff review are submitted to the College within 90 days of receiving final accreditation assessment report.

Facility Response:
March 18, 2022
PCRM confirms that all reprocessed items are assessed for sterility by examining packaging for moisture, integrity of wrapping, verifications of rigid containers, assessing external and internal indicators, and confirming any relevant expiry dates. Any packaging with concerns will be pulled from circulation and reprocessed. We also confirm that the sterile indicator inside the hysteroscope cartidge is examined by the set-up nurse after opening (i.e. the lid is uncovered and the chemical strip assessed). Lastly we confirm that we will be making the suitable policy/procedure changes and obtaining verification of staff awareness and training - these will be duly submitted.

College Response:

March 25, 2022

1. Accepted.
2. Accepted.
3. Accepted.
4. Accepted.
5. Pending submission.

Facility Response:
Please find attached:
1. SOP-NUR-015 reflects the modified policy.
2. As Medical Director, I attest that I have reviewed this inspection and count process with our nursing manager and nursing teams, including the MDRD staff.

College Response:
July 6, 2022

5. Accepted.
   A policy reflecting the above requirements was submitted to the College.

IOC1.8.4 The surgical count process is a primary patient injury prevention strategy.

Background **Observed and Discussed:**

A standardized count sheet is used at the facility.

An initial count was performed audibly and viewed concurrently by two regulated health professionals however, this initial count was not documented on the standardized count sheet.
Note: Facility staff documents the closing surgical count (i.e. count out) however the initial count is not documented.

A count of syringes, injection needles and camera adapters is not performed.

Action:

The medical director shall confirm that:

1. The initial surgical count is documented on the standardized count sheet after each type of item is counted.

2. An audible count of syringes, injection needles, camera adapters and other miscellaneous items (i.e. any item that has the potential for being retained) is performed and the count is documented.

3. The above requirements are reflected in facility policy and staff have read and followed the policy.

4. The policy and proof of staff review are submitted to the College within 90 days of receiving final accreditation assessment report.

Reference Intraoperative Care
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Intraoperative-Care.pdf

Facility Response:
March 18, 2022
We acknowledge that the count documentation was not done correctly and deviates from our current policy and procedure. For further clarity, audible counts will be done and documented prior to procedure and the process for this will be reviewed by the appropriate staff and documented. We will submit any policy/procedure changes in the proscribed timeframe.

March 21, 2022
The medical director provided the following response by email:
I do confirm that an audible count will be performed of syringes, injection needles, camera adapters and other miscellaneous items (like light cord adapters, reducers, or any retainable item) is performed and the count is documented.

We have modified our count sheets already to provide a more keen visual alert, and meet with our nursing teams to reiterate this. The suitable policies and read-and-signs will be forwarded within the 90 day period.

College Response:
March 25, 2022
1. Accepted.
2. Accepted.
3. Accepted.
4. Pending submission.

Facility Response:
Please find attached:
1. SOP-OPR-016 reflecting the policy change
2. I do confirm as Medical Director that the counting process has been reviewed by Nurse manager, Nursir staff, MDRD staff and OR equipment manager

College Response:
July 6, 2022
4. Accepted.
A policy reflecting the above requirements was submitted to the College.

Semi-critical Nonconformances Summary

As of July 6, 2022, all semi-critical nonconformances have been remediated.

NONCONFORMANCES

Human resources

Non-hospital facility services are provided by qualified and competent physicians

HR1.2.5 That each physician and nurse holds current basic life support certification

Background **Observed and discussed:**

- Current Basic Life Support (BLS) certification was not on file for a facility physician.
  Note: Dr. has a First Aid CPR AED certificate, BLS certification must be obtained for health-care professionals (health-care provider or equivalent, i.e. BLS-Provider).

- Current BLS certification was not observed for a facility nurse
  Note: Nurse's BLS Pre-requisite Challenge certificate was submitted to the College, however a BLS certification must be obtained for health-care professionals.

- An expired advanced cardiovascular life support (ACLS) certificate (i.e. expired December 2021) for an IV procedural sedation nurse was submitted to the College.

- Record of completion of procedural sedation management course for registered a nurse was not observed.

- Evidence of IV procedural sedation and analgesia (IV-PSA) refresher training was not on file for a number of IV procedural sedation nurses:

  Note: In accordance with NHMSFAP standard for IV procedural sedation and analgesia, registered nurses and physicians currently administering and/or monitoring patients under IV-PSA that completed an IV procedural sedation management course more than 5 years ago may be grand-parented until June 2021, after which time evidence of IV procedural sedation refresher training must be on file.

Action:

The medical director shall confirm that:

1. Current BLS certificates for Physician and facility nurse are submitted to the College.

2. Any physicians and nurses without current BLS certification by **June 11, 2022** are not permitted to provide patient care at the facility until current BLS certificate is obtained.

3. All active physicians and nurses hold current BLS certification (within 2 years) and a copy is on file at the facility.

4. Current ACLS certificate for IV procedural sedation nurse is submitted to the College.

5. Record of completion of procedural sedation management course for registered nurse is submitted to the College.

6. Any nurses without current ACLS and completion of procedural sedation management course by **June 11, 2022** are not permitted to provide IV-PSA patient care at the facility until current ACLS certificate and completion of procedural sedation management course is obtained.

7. All active physicians and registered nurses that administer IV procedural sedation and analgesia (IV-PSA) or monitor a patient under IV-PSA at the facility hold current ACLS certification (within 2 years) and have completed a procedural sedation management course and the copies are on file at the facility.

8. IV procedural sedation refresher training is completed, and evidence of training is on file for the IV procedural sedation nurses.

9. An IV procedural sedation refresher training is completed every 5 years for all registered nurses and physicians who have completed an IV-PSA course and evidence of training is on file at the facility.

10. Actions three (3), seven (7), and nine (9) are reflected in facility policy and staff have reviewed and follow the policy.

11. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Human Resources
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Human-Resources.pdf

Facility Response:
1. BLS for staff are submitted to the program via email for confirmation
2. Staff is on maternity leave and documentation will be confirmed prior to return to work
3. Staff's BLS was submitted
4. find attached the IV PSA on the 7 RN's in point 8 above
5. POL-OPR-003 reflects the noted BLS, ACLS, and IV PSA standards - attached
6. I attest as Medical Director that the HR policies have been reiterated to clinical and administrative staff

As part of a revamping of our HR systems, these regulatory items will be brought under the UKG Human resource management software in July 2022.

College Response:
July 6, 2022
1. Accepted.
   BLS certifications for staff were submitted to the College.
2. Accepted.
3. Accepted.
4. Response acknowledged.
5. Accepted.
   Record of completion of a procedural sedation management course for Sherry Dacuyan was submitted to the College.
6. Accepted.
7. Accepted.
8. Accepted.
9. Accepted.
10. Accepted.
11. Accepted.
    A policy reflecting actions three (3), seven (7), and nine (9) was submitted to the College.

Intraoperative Care

Preoperative preparation of the patient's skin reduces the risk of post-operative surgical site infection

Ultrasound gel are dated when opened and discarded within 28 days of opening

Background **Observed:**

An open, undated bottle of ultrasound transmission gel was observed in the procedure room.

Action:

The medical director shall confirm that:

1. Ultrasound transmission gel bottles are dated when opened and discarded within 28 days of opening.

2. All opened ultrasound transmission gel bottles that are not dated when opened are considered contaminated/expired and are discarded.

3. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

4. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Reprocessing Requirements for Ultrasound Probes
https://www.cpsbc.ca/files/pdf/Reprocessing-Requirements-Ultrasound-Probes.pdf

Facility Response:
Current policy reflects that we do not refill ultrasound gel bottles. When ordered from suppliers, US gel bottles do not come sealed, but just capped. To conform, all gel bottles when removed from packaging will be labeled with a sticker stating the expected date of discard (+28d). Attached is the modified policy SOP-INF-007.

As Medical Director I attest that I have reviewed this policy update with all clinical and administrative staff..

College Response:
July 6, 2022

1. Accepted.
2. Not accepted.
   A response to this requirement has not been provided.
3. Accepted.
4. Not accepted.
   Action #2 is not reflected in facility policy.

Facility Response:

July 7th, 2022
US gel bottles will be labeled upon opening with a discard date of 28d. If any unlabeled US gel bottles are seen, they will be assumed to be expired and immediately discarded. The policy modification language appears as noted below.

1. Sterile gels must be used for transvaginal procedures involving vaginal puncture.
2. Gel bottles cannot be "topped up" and are single use only.
3. Ultrasound bottles are to be discarded within 28 days of opening and a label with the discard date shall be applied to the bottle. For greater clarify, the label will say "DISCARD BY DD-MMM-YYYY"
4. Any unlabeled ultrasound gel bottles shall be assumed to be expired and immediately discarded.

The medical director provided the following information via email:

The SOP has been modified – it goes through an approval process on LabQMS, but the wording of modification reads as below.

College Response:
Response accepted.

Specimen Handling

Specimen collection procedures ensure correct patient identification and protect specimen quality

SPEC1.1.7 That the specimen collection is documented on the intraoperative record

Background **Observed and discussed:**

Intraoperative nursing record does not include an area for specimen documentation.

Action:

The medical director shall confirm that:

1. Intraoperative nursing record documentation includes specimen.

2. Specimen documentation includes:
    - Name of specimen
    - Date and time
    - Type of specimen

3. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

4. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Specimen Handling
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Specimen-Handling.pdf

Facility Response:
The revised intraoperative record FRM-OPR-006*** has now included an area for the name/type of the specimen(s), and date and time. SOP-OPR-014 reflects this policy change also. I have reviewed these policy changes with all staff to ensure specimen handling is updated.

College Response:
July 6, 2022

1. Accepted.
2. Accepted.
3. Accepted.
4. Accepted.
   A policy reflecting the above requirements was submitted to the College.

Hand Hygiene

Hand hygiene is performed at essential moments

HH1.2.5 That hand hygiene is performed before donning gloves

Background **Observed and discussed:**
Repeat Nonconformance

Facility embryologist was observed performing an embryo transfer.

This embryologist did not perform hand hygiene at the following moments:

- Before donning gloves to perform the embryo transfer
- After doffing gloves and before proceeding to perform other activities

Action:

The medical director shall confirm that:

1. Hand hygiene is performed at the following moments:
   - Before donning gloves
   - After care involving risk of exposure to, or contact with, body fluids
   - After doffing gloves
2. Hand hygiene compliance is monitored, and results are reported to staff.

3. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

4. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Hand Hygiene
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Hand-Hygiene.pdf

Facility Response:
Hand hygiene policy (SOP-INF-009) reflects the need to complete hand hygiene before and and after gloves. This policy will be reviewed by all staff. In Particular, I have reviewed this importance with our Laboratory director and all embryology staff.

College Response:
July 6, 2022
1. Accepted.
2. Accepted.
3. Accepted.
4. Accepted.
A policy reflecting the above requirements was submitted to the College.

Waste Management

Non-anatomical biomedical waste is safely and appropriately contained

WMGT1.3.2 That the non-anatomical biomedical waste container is lined with a yellow waste-holding plastic bag

Background **Observed:**

Non-anatomical biomedical waste (i.e. follicular fluid and cultured tissue and cells) was discarded into a yellow biohazard waste container in the laboratory. This yellow waste container was not lined with a yellow waste-holding plastic bag.

Action:

The medical director shall confirm that:

1. Non-anatomical biomedical waste containers are lined with a yellow waste-holding plastic bag.

2. The above requirement is reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Waste Management

https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Waste-Management.pdf

Facility Response:
The yellow biohazard bins in the laboratory are single use - they are sealed after filling, and brought to the biohazard waste remove for removal from a third party service. If we additionally use liners, holding pipettes and other glass instruments will puncture the liner. This is why these have a fluid resistant lid and are NOT re-used.

College Response:
July 6, 2022
Response acknowledged.

Occupational Health and Safety

An occupational first aid program is in place

OHS1.2.3 That the first aid attendant holds a current first aid certificate at the required level, as appropriate

Background **Observed and discussed:**

The facility does not currently have a first aid attendant.

Action:

The medical director shall confirm that:

1. A first aid attendant that holds a current first aid certificate at the required level is assigned at the facility.
   Guidance: The Occupational Health and Safety Regulation – Schedule 3-A – Minimum Levels of First Aid outlines the minimum certificate level of first aid held by the first aid attendant. In accordance with WorkSafeBC, facilities need to conduct a risk assessment to determine the workplace's specific first aid requirements to determine which level of first aid attendant a facility will need. Some facilities will need a first aid attendant with a current level 1 certificate.

2. The above requirement is reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Occupational Health and Safety
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Occupational-Health-Safety.pdf

Facility Response:

According to Worksafe BC, we require a level II first aide attendant.
1. the POL-SAF-013 is found revised
2. a PCRM RN will be sent for training and documentation will be forwarded upon completion.

College Response:
July 6, 2022
1. Accepted.
2. Accepted.
3. Accepted.
   A policy reflecting the above requirement was submitted to the College.

Medical Gas - Pipeline System

Medical gases are safely and effectively managed

MEDGP1.1.4 That cylinders not in use or empty are shut off and capped

Background **Observed and discussed:**

The laboratory medical gas supply room was assessed by the laboratory accreditor and the following were observed:

- The temperature in the lab medical gas supply room is not monitored.
- A medical gas cylinder (i.e. carbon dioxide cylinder) marked as "empty" was observed connected to the pipeline in the lab medical gas supply room. This empty gas cylinder was not shut off and capped.
- A procedure for changing medical gas cylinders was posted in the medical gas supply room however, the procedure did not include the following:
  - Checking hose and tubing integrity
  - Checking cylinder valve damage before attachment to pipeline
  - Checking for leaks after attachment to pipeline

Action:

The medical director shall confirm that:

1. The temperature in the medical gas supply room(s) is not to exceed 40 degrees Celsius for any gas and never below 15 degrees Celsius for nitrous oxide and carbon dioxide.
2. The temperature in the medical gas supply room(s) is monitored and documented in a log each procedural day.
3. Medical gas cylinders not in use or empty are shut off and capped.

4. Procedures for changing the medical gas supply cylinders include but are not limited to:
    - Checking hose and tubing integrity
    - Checking cylinder valve damage before attachment to pipeline
    - Checking for leaks after attachment to pipeline

5. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

6. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Medical Gas - Pipeline System
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Gas-Pipeline-System.pdf

Facility Response:
1. temperature in the lab gas room is now being monitored and will not exceed 40 or be less than 15 degrees C
2. We do log temperature in the Medical gas room (see log attached)
3. Empty cylinders will now be capped (see amended policy)
4. Regarding hose integrity and leak inspection, please see the modified
5.6. - attached are the policies and read & signs on those policies

College Response:
July 6, 2022
1. Accepted.
2. Accepted.
3. Accepted.
4. Accepted.
5. Accepted.
6. Accepted.

A policy reflecting the above requirements was submitted to the College.

Documentation

Pre-admission documentation provides an accurate account of the patient's preoperative status and supports appropriate patient selection

MRDOC1.6.8 That the pre-admission documentation includes a patient self-reported questionnaire

Background **Observed:**

A medical record review was completed by the accreditation team.

Pre-admission documentation of a patient self-reported questionnaire was not observed in several local anesthesia and IV procedural sedation medical records.

Action:

The medical director shall confirm that:

1. All pre-admission documentation (e.g. for local anesthesia and IV procedural sedation patients) includes a patient self-reported questionnaire.

2. The above requirement is reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Medical Records and Documentation
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Records-Documentation.pdf

Facility Response:
Upon receipt of a referral, all patients must complete a patient portal questionairre. The patient portal of our EMR is a secure two-way facility that allows patients to confidentially enter this information. A sample report is provided in the evidence.

College Response:
July 6, 2022
Response accepted.

Admission documentation provides an accurate account of the patient's preoperative status and supports appropriate patient selection

MRDOC1.8.7 That the admission documentation includes current medication(s), including last dose taken

Background **Observed:**

Admission documentation includes current list of medication(s) however, last dose taken was not observed.

Admission documentation of blood glucose levels was not observed in IV procedural sedation medical records.

Action:

The medical director shall confirm that:

1. Admission documentation includes:
    - Current medication(s), including last dose taken

- Blood glucose level (e.g. for IV procedural sedation patients), as indicated

2. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Medical Records and Documentation
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Records-Documentation.pdf

Facility Response:
Our pre-procedure check list does include medications and serum glucose if indicated. It has now been modified to include the time of last dose take. See updated FRM-OPR-006 and 007. As Medical Director, I attest that I have reviewed this with the Nursing Manager and all nursing staff.

College Response:
July 6, 2022
Response accepted.

Sedation documentation provides an accurate account of the patient's status and outcome

MRDOC1.10.2 That the sedation record documentation includes height, weight and BMI

Background **Observed:**

Sedation record documentation did not include the following:

- Patient's height
- Name and role of each person involved in the IV procedural sedation care (i.e. procedural nurse, procedure physician)
- Confirmation of IV procedural sedation safety checks
- Procedure performed

Action:

The medical director shall confirm that:

1. Sedation record documentation includes:
    - Patient's height
    - Name and role of each person involved in the IV procedural sedation care (e.g. procedural nurse, procedure physician)
    - Confirmation of IV procedural sedation safety checks (e.g. monitoring equipment, suction and oxygen equipment, emergency cart medication and equipment, and availability of medication reversal agents)

- Procedure performed

2. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Medical Records and Documentation
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Records-Documentation.pdf

Facility Response:
The procedure performed has been added to the operating room as well as the roles of the various personnel involved in the procedure and the confirmation of the safety checks. Attached are:
1. the modified form FRM-OPR-006
2. I attest that I and the nurse manager have reviewed this with all nursing staff conducting preadmission and OR nurse work.

College Response:
July 6, 2022
Response accepted.
An amended procedural sedation record that reflects the above requirements was submitted to the College.

Intraoperative documentation provides an accurate account of the patient's status, the actions of the perioperative team, and the patient's outcome

MRDOC1.11.1 That the intraoperative (nursing) record documentation includes perioperative event times

Background **Observed and discussed:**

Intraoperative nursing record documentation did not include:
- Time patient entry and exit from the procedure room
- Name and role of each person involved in the patient care provided in the procedure room, and any visitors
- Skin assessments (i.e. preoperative and postoperative)
- Patient positioning
- Exact procedure(s) performed

Action:

The medical director shall confirm that:

1. Intraoperative nursing record documentation includes:
    - Time patient entry and exit from the procedure room

- Name and role of each person involved in the patient care provided in the operating room, and any visitors as indicated
- Skin assessments (i.e. preoperative and postoperative)
- Patient positioning
- Exact procedure(s) performed

2. The above requirements is reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Medical Records and Documentation
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Records-Documentation.pdf

Facility Response:
The OR Nursing record has now been modified to include:
1. entry and exit times
2. skin assessments (pre and post) have been added to the GA operative record
3. attached is the OR records for PSA and GA (modified)
4. As Medical Director, I have worked with the Nurse manager and attendant nursing staff to ensure understanding and adherence to this policy and form change.

College Response:
July 6, 2022
Response accepted.
An amended operative report that reflects the above requirements was submitted to the College.

MRDOC1.11.1(That the intraoperative (nursing) record documentation includes all medications, solutions and irrigation solutions administered intraoperatively by the surgeon and/or nursing staff

Background **Observed:**

Intraoperative record documentation during the patient tracer did not include the following:

- Skin preparation agent (i.e. Betadine) used
- The amount of 1% lidocaine administered
- Normal Saline irrigation solution used

Action:

The medical director shall confirm that:

1. Intraoperative record documentation includes:
    - Name and concentration of skin preparation agent(s) used

- All medications, solutions and irrigation solutions administered intraoperatively including:
    - Name
    - Dose/concentration
    - Volume
    - Location
    - Method of administration
    - Name of person who administered it

2. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

3. The policy and proof of staff review are submitted to the College.

Reference NHMSFAP Standard: Medical Records and Documentation
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Records-Documentation.pdf

Facility Response:
The operative nursing record have been modified to include solutions, routes, concentrations, methods of administration, and person.
Attached is the form and as Medical Director, I attest that I have reviewed this with our nursing manager and nursing staff who are involved in intraoperative care.

College Response:
July 6, 2022
Response accepted.
An amended operative report that reflects the above requirements was submitted to the College.

Post-anesthesia care unit (PACU) documentation provides an accurate account of the patient's status, the actions of the perianesthesia team, and the patient's outcome

MRDOC1.13.9 That the patient's medical record includes an orders form

Background **Observed and discussed:**

Documentation of pre-operative and intraoperative medication orders were not observed in several local anesthesia and IV procedural sedation medical records.

Action:

The medical director shall confirm that:

1. All medication orders (e.g. pre-operative, intraoperative) are written on a physician order form such as a pre-printed order set and must contain the following:
    - Patient's name
    - Date and time the medication order was written

- Medication name
- Dosage
- Route of administration
- Frequency of dosing
- Prescriber's signature (wet signature) and printed name.

2. The above requirements are reflected in facility policy and staff have read and follow the policy.

3. The policy and proof of staff review are submitted to the College within 90 days of receiving final accreditation assessment report.

Reference NHMSFAP Standard: Medical Records and Documentation
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Medical-Records-Documentation.pdf

Facility Response:
1. All documentation on our EMR is via electronic verified signature.
2. This point for physician orders was a defiency that we had not recognized previously. As such have created a new "Preanaethetic Physicians Orders" form which the Physician will electronically sign pre-operatively. This form provides guidance to the Peri-operative nursing team with regards to medication administrations.
3. The form is attached as evidence and this has been reviewed with Nursing manager and Nursing staff.

College Response:
July 6, 2022
Response accepted.

Medical Device Reprocessing (MDR)

All Medical Device Reprocessing (MDR) requirements may be referenced to the following Ministry of Health document: http://www.health.gov.bc.ca/library/publications/year/2011/Best-practice-guidelines-cleaning.pdf

General

QFA17.1.4 That the Ministry of Health MDR Audit Checklist is completed annually by qualified MDR staff and copies are kept on file

Background **Observed:**
Repeat Nonconformance

Completed Ministry of Health 'audit checklists' prior to 2021 were not available for review.

Action:

The medical director shall confirm that:

1. The Ministry of Health 'audit checklist' is completed annually by qualified MDR staff and is kept on file at the facility.

2. Deficiencies arising from the annual checklist audit are followed-up and documented.

3. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

4. The policy and staff review are submitted to the College.

Reference: BC Ministry of Health – Best Practice Guidelines for Cleaning, Disinfection and Sterilization of Critical and Semi-Critical Medical Devices in BC Health Authorities
http://www.health.gov.bc.ca/library/publications/year/2011/Best-practice-guidelines-cleaning.pdf

Facility Response:
Audit checklists will now be completed annually with suitable outcomes and process change as identified. These are reflected in policy (see evidence index) and I attest that I have reviewed this in the OR equipment coordinator, MDRD and Nursing Manager/IPC Nurse and Nursing staff.

College Response:
July 6, 2022
1. Accepted.
2. Accepted.
3. Accepted.
4. Accepted.
   A policy reflecting the above requirements was submitted to the College.

4.00 Education and training

Education and Training

4.3.3b Once hired, the competencies of reprocessing staff are checked regularly as outlined in department policy.

Background **Observed:**
Repeat Nonconformance

Annual competency assessments for facility MDRD staff were not observed.

Action:

The medical director shall confirm that:

1. A competency assessment for all MDR staff is performed within 30 days of receiving the final report.

2. Annual competency assessment for MDR staff is completed and in accordance with facility policy.

3. MDR staff receive ongoing education and/or training when there are gaps identified by the competency assessments.

4. Results of the competency assessments for MDR staff are documented and kept in HR files.

5. The above requirements are reflected in facility policy and staff have reviewed the policy.

6. The policy and proof of staff review are submitted to the College.

Facility Response:
Competency assessments were all completed prior to the accreditation date. A new member of our MDRD staff has now completed her 3 month probationary period and will need to complete a competency assessment. Please find attached the assessments. KS****AMIN - please amend policy to reflects items 2-6 above.

College Response:
July 6, 2022

1. Accepted.
2. Accepted.
3. Accepted.
4. Accepted.
5. Accepted.
6. Accepted.

A policy reflecting the above requirements was submitted to the college.

11.00 Storage and use of reprocessed medical devices

Storage and Use of Reprocessing Medical Devices

11.02 That temperature and humidity are maintained and monitored (18-23 deg C and 30-60% relative humidity)

Background **Observed and discussed:**

There are three sterile storage rooms located at the facility. Facility sterile storage rooms' temperature and relative humidity are monitored daily and recorded in a log.

The relative humidity in the sterile storage rooms was observed documented outside of normal range (i.e. below 30%) on several procedural days.

Examples:

- Storage room #1 - 23% on March 9th, 2022
- Storage room #2 - 25% on March 9th, 2022
- Storage room #3 - 28% on March 6th and 7th, 2022 and 22% on March 9th, 2022

Action:

The medical director shall confirm that:

1. Relative humidity in sterile storage rooms is maintained between 30-60%.

2. Relative humidity that is consistently outside of normal range is investigated.

3. The above requirements are reflected in facility policy and staff have reviewed and follow the policy.

4. The policy and proof of staff review are submitted to the College.

Facility Response:
The relative humidity is controlled with our HVAC systems. When we see ongoing trends (particulary high humidity) the base building and our engineers work to find solutions. In the cases noted above, we were aware of the humidity alterations due to our continuous environmental monitoring and controls. As these were on-off events, not action was taken as no trend was seen. As well, the base building confirmed that environmental conditions during those times resulted in low humidity in several buildings in Vancouver.

College Response:
July 6, 2022
Response acknowledged.

Nonconformances Summary

As of July 7th, 2022, all nonconformances have been remediated.

RECOMMENDATION

2.01c That all reprocessing areas, including the decontamination area, have adequate space for area tasks as well as equipment and supply storage

Background **Observed:**

Several biohazard waste containers were observed stored in the decontamination MDRD.

Recommendation:

Due to space limitation in the MDRD, it is recommended that empty biohazard waste containers currently stored in the decontamination MDRD are relocated outside of the MDRD, and storage in the MDRD is kept to a minimum.

Facility Response:
Our storage space is limited. We have now re-tooled our biohazard room to allow a minimum quantity of biohazards in the MDRD Decontamination room.
College Response:
July 6, 2022
Response acknowledged.