THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000 – 1661 PORTAGE AVENUE, WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750

MEDICAL ACT

Bylaw 3D

Accreditation of Non-Hospital Medical/Surgical Facilities

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on December 15, 2017, repealing and replacing Bylaw 3D originally enacted on October 20, 2000.)

Contents

ARTICLE 1 - DEFINITIONS 3
ARTICLE 2 - FACILITY ACCREDITATION 4
ARTICLE 3 - HOSPITAL AGREEMENT 6
ARTICLE 4 - APPROVED PROCEDURES 6
ARTICLE 5 – PRIVILEGES 6
ARTICLE 6 - PATIENT CARE 8
ARTICLE 7 - FACILITY DIRECTOR 9
ARTICLE 8 - AUDIT AND QUALITY CONTROL 10
ARTICLE 9 - INFECTION CONTROL 10
ARTICLE 10 - APPEAL 10
ARTICLE 11 - INSPECTIONS AND AUDITS 11
ARTICLE 12 - FEES 11
ARTICLE 13 – REPEAL 11

THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

BYLAW
Under Subsection 40(2) of The Medical Act
NON-HOSPITAL MEDICAL/SURGICAL FACILITIES

ARTICLE 1 - DEFINITIONS

1 (1) General

In this Bylaw:

“accreditation” means the approval granted by the college to a non-hospital medical/ surgical facility to carry out certain diagnostic and/or treatment procedures.

"certificate of accreditation" means a certificate issued to a non-hospital medical/surgical facility by the committee of the college certifying that it has received accreditation.

“procedural sedation” means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

i. includes, but is not limited to, the use of any IV agent for this purpose; and
ii. requires the monitoring of vital signs,

but does not include the use of oral pre-medication alone or in combination with local anaesthesia.
No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

"committee" means the Central Standards Committee of the college responsible for the administration of this Bylaw.

“direct or indirect financial interest” means any interest owned by a member, by individuals connected by blood relationship, marriage or adoption to a member, by any corporation, proprietorship, partnership, society, business, association, joint venture, group or syndicate in which a member or any individual connected by blood relationship, marriage or adoption to a member have any interest.

"director" means a physician who is appointed the director of a non-hospital medical/surgical facility.

"facility" means a non-hospital medical/surgical facility.

“general anaesthesia” means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently, or to respond purposefully to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic methods, alone or in combination.

” hospital” means a hospital under *The Hospitals Act* with an operational Emergency Department.

"privileges" means the authority to admit and treat patients at a facility.

"procedure" means the diagnostic and treatment procedures, both medical and surgical, as approved by the committee to be carried out in a facility.

1(2) Subject to subsection (3), this Bylaw applies to the following procedures:

A. Any procedure that is carried out with the concurrent use of:
   a. procedural sedation, or
   b. local, regional or general anesthesia,
   c. provided that the standard of care requires monitoring of vital signs as a result of the administration of the drug to induce sedation or anesthesia;
B. Any procedure that the committee directs must be performed in an approved non-hospital surgical/medical facility in order to meet the minimum acceptable standard of care for that procedure.

1(3) This Bylaw does not apply to any facility which is wholly owned and operated by a Regional Health Authority.

1(4) In this Bylaw, words and phrases defined in *The Medical Act* have the same meaning as in *The Regulated Health Professions Act.*

ARTICLE 2 - FACILITY ACCREDITATION

2(1) A facility seeking accreditation must:
   a. apply on the form prescribed by the committee, specifying the procedures for which accreditation is sought;
   b. provide full and complete details of the facility’s ownership, the facility’s administration and a list of all members who wish to have privileges to carry out procedures at the facility, including but not limited to: the names of the director(s) and owner(s) of the facility, including any members who have direct or indirect financial interest in the facility, and a medical corporation has an direct or indirect financial interest, the names of the medical corporation’s officers and directors;
   c. provide the name of the facility director, a written outline of his or her duties and responsibilities, an outline of the facility’s administration, and an organization chart;

d. submit the application form, signed by the director, and supporting documents to the committee with the prescribed fee for the application and inspection processes.

2(2) The accreditation process will include:
a. completion of a pre-visit questionnaire;
b. an on-site inspection by one or more members, with expertise in the appropriate area of medical practice, designated by the committee; and
c. review of the facility's compliance with the college's standards.

2(3) In circumstances which the committee deems appropriate, provisional approval may be granted for the operation of a facility pending the completion of the accreditation process.

2(4) On completion of the accreditation process, the committee may:
a. grant full accreditation and issue a certificate of accreditation to a facility if the committee is satisfied that the facility has met all of the requirements of this Bylaw and there are no identified deficiencies.
b. grant conditional accreditation to a facility with identified deficiencies, and issue a conditional certificate of accreditation specifying the date it will expire if the identified deficiencies are not corrected.
c. deny accreditation pending correction of identified deficiencies.

2(5) Where conditional accreditation is granted, the director must provide a written response to each deficiency within the time specified by the committee, and a follow-up inspection may occur, if the committee so directs. Full accreditation will only be granted when identified deficiencies have been corrected to the satisfaction of the committee.

2(6) A certificate of accreditation will be issued by the committee for a period not to exceed five (5) years.

2(7) Each certificate of accreditation must append a schedule of procedures approved for the facility.

2(8) Where a facility is no longer being used for the procedures set out in ss. 1.2, the committee may revoke the facility's certificate of accreditation.

2(9) If the committee is of the opinion that a facility is not meeting the requirements of this Bylaw or is unsafe, the committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the committee deems appropriate in the circumstances. Where the committee is of the opinion that a facility does not meet the required standards, the committee must report the matter pursuant to ss. 40(3) of *The Medical Act.*

2(10) In order to renew a certificate of accreditation, the facility must apply for renewal of accreditation at least six (6) months prior to the date the certificate of accreditation is to expire. The re-accreditation process will follow the same procedure as required for

accreditation. Where an application to renew is pending, the facility's accreditation continues until a decision is made on the renewal application.

2(11) The facility must inform the committee of any changes in the information provided in its application for accreditation within 15 days of the date of the change.

ARTICLE 3 - HOSPITAL AGREEMENT

3 Every facility must have a written agreement with a hospital or a Regional Health Authority pursuant to which the hospital or the Regional Health Authority agrees to provide emergency treatment if a patient has to be transferred from the facility.

ARTICLE 4 - APPROVED PROCEDURES

4(1) Each certificate of accreditation must include a schedule listing the procedures which have been approved for the facility, and the names of the members who have been given privileges to perform the procedures at the facility.

4(2) The schedule of procedures may be amended from time to time upon the application of the facility and the approval of the committee.

4(3) Only those procedures which are approved by the committee and set out in schedule to the facility's certificate of accreditation may be performed in the facility

ARTICLE 5 – PRIVILEGES

5(1) A facility must not grant privileges to a member unless:
- a. the member qualifies for privileges in accordance with this bylaw, or
- b. the member's application for privileges is expressly approved by the college.

5(2) An applicant seeking privileges at a facility must:
- a. apply in writing to the director,
- b. provide to the director:
  - i. a description of any privileges currently held in a hospital or a Regional Health Authority in the city or the municipality where the facility is located; and
  - ii. a letter from the hospital or Regional Health Authority confirming the privileges held and the good standing of the applicant.

5(3) Provided that:
- a. the applicant complies with the requirements of clause 5(2)(b),
- b. the privileges sought by the applicant are no greater than those the applicant holds at a hospital or the Regional Health Authority in the municipality or the city where

the facility is located, and

c. the director is satisfied that the applicant is a suitable candidate for the privileges requested,

the director may grant privileges to the applicant.

5(4) Within 15 days of granting privileges pursuant to Article 5(3), the director must provide to the College particulars of the privileges granted in the facility and, upon request by the College, a copy of the correspondence from the hospital or the Regional Health Authority referred to in clause 5(2)(b)(ii).

5(5) A member seeking privileges who does not hold the same or similar privileges in a hospital or a Regional Health Authority in the municipality or the city where the facility is located must provide to the director:

a. details of the same or similar privileges, if any, currently held in other facilities;
b. numbers of procedures performed during the past year similar to those for which he/she is seeking privileges and the name(s) of the facilities in which they were performed;
c. any other relevant past experience; and
d. the names of two (2) referees who can be consulted as to the skill and judgment of the member to perform such procedures.

5(6) For any application made pursuant to Article 5(5), the director must forward to the College:

a. a copy of the application,
b. the director's assessment of the suitability of the applicant for the privileges requested,
c. a letter from the Regional Health Authority or an appropriate hospital located in the municipality or city in which the facility is located confirming that patients treated by the applicant at the facility shall be treated and admitted to a hospital, as necessary, under the care of members who have appropriate credentials and privileges.

5(7) In considering an application made pursuant to Article 5(5), the committee may request such further or other information as it deems necessary to assess the application.

5(8) The committee may grant privileges to a member who does not have the same or similar privileges at a hospital or a Regional Health Authority in the municipality or the city in which the facility is located only on the following conditions:

a. the member shall be subject to a periodic review conducted by the director and/or any other person(s) deemed appropriate by the committee, to ensure maintenance of competence of the procedures he or she performs; and
b. where applicable, a process for reviewing pathology reports shall be established and followed by the facility.

5(9) Any member who performs procedures without obtaining privileges in the facility and any director who permits a member to perform procedures without obtaining privileges in the facility may be found guilty of professional misconduct.

ARTICLE 6 - PATIENT CARE

6(1) In a facility:

a. All patients proposed to undergo anaesthesia in a facility must be assigned an American Society of Anaesthesia risk score.
b. Only patients with ASA I, II and III Risk scores may have a procedure performed.
c. General anaesthesia must not be given to infants under the age of twenty-four (24) months.
d. A patient who receives general anaesthetic or procedural sedation should only leave the facility in the care of an adult.
e. Procedural sedation must be administered by or under the direct supervision of a member approved by the college to provide procedural sedation.
f. A patient who receives procedural sedation must be attended by a registered nurse or a member who is not assisting in the surgical procedure and who is trained to monitor patients under procedural sedation.
g. All personnel who administer anaesthesia, major regional block or procedural sedation or who monitor the recovery of patients who receive anaesthesia, major regional block or procedural sedation must maintain a current certificate of proficiency in basic cardiopulmonary resuscitation.
h. There must be at least two (2) personnel who are certified in basic cardiopulmonary resuscitation within the facility while patients are receiving care.
i. All equipment for the administration of anaesthetics must be readily available, clean and properly maintained.

6(2) A member must:

a. be in the room at all material times during the performance of a procedure in the facility.
b. ensure that following any procedure patients receive an adequate recovery period under supervision before leaving the facility.
c. be responsible for the post-operative care of the patient within the facility.
d. ensure qualified support staff are be on duty during and after a procedure in the facility.
e. maintain accurate information concerning the medical condition of patients in a clinical record which meets the expected standards of medical record-keeping, including documentation related to the informed consent of the patient for the procedure(s) performed in a facility.
f. perform procedures in a facility only if the facility has adequately equipped and maintained operating and post-operative rooms and all equipment is safe, well maintained and compliant with applicable federal, provincial, and municipal legislation.

6(2) A procedure within the cranium, the thorax, or the abdomen and major joint surgery may be performed, assisted or provided in a facility only where the committee has given its written authorization to the facility to perform the procedure, which authorization may include conditions or restrictions specified by the committee.

ARTICLE 7 - FACILITY DIRECTOR

7(1) The facility shall appoint a director, who is a member acceptable to the committee, to be responsible for:

A. the administration of the facility;
B. the standards of care in the facility, which include:
    a. the safe and effective care of patients in the facility;
    b. the development of appropriate and up-to-date policy and procedure manuals, including acceptable staff health policies;
    c. ensuring that the duties and responsibilities of all personnel are written and understood;
    d. ensuring that the requirements for granting privileges are met and the necessary approvals are obtained;
    e. ensuring that sufficient numbers of appropriately trained personnel are present during procedures;
    f. ensuring that procedures and equipment are appropriate and safe;
    g. ensuring that agreements are in place for the emergency transfer and admission of patients as required herein;
    h. ensuring that complete and accurate confidential patient records and documentation relating to the operation of the facility and procedures performed are kept;
    i. ensuring that adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place;
    j. ensuring that only those eligible procedures which are approved by the committee as set out in the certificate of accreditation are performed at the facility by members; and
    k. ensuring that complete records are kept of all members who obtain privileges at the facility, including their applications and to make such records available to the committee or its designates on request. (AM. 03/07)
C. Ensuring that documentation, fees and a full be complete reporting of all required information to the college is submitted.

ARTICLE 8 - AUDIT AND QUALITY CONTROL

8 All certificates of accreditation are subject to the following conditions:

a. All procedures and all clinical records must comply with the requirements of standards of care set by the college.
b. Quality assurance and improvement programs are in place sufficient to demonstrate that standards of patient care set by the college are met in the facility.
c. At least annually the director must review the facility's quality assurance and improvement programs.
d. Within 30 days of each calendar year end, the facility must forward an annual report to the college outlining:
    i. the number and types of procedures performed in the facility;
    ii. the number and type of adverse outcomes, including infections and complications, arising from procedures done in the facility;
    iii. quality improvement program initiatives in the facility; and
    iv. the number of transfers to hospital from the facility.

ARTICLE 9 - INFECTION CONTROL

9(1) A facility must:

a. use sterilization techniques,
b. store medical and dental supplies, and
c. use waste handling and disposal procedures

consistent with the standards applicable to infection control and waste handling and disposal in a hospital.

9(2) A facility must comply with all guidelines the college may require the facility to comply with to meet best practices on the subject of infection control practices in a facility setting.

ARTICLE 10 - APPEAL

10 The facility or a member may appeal any decision of the committee to the Executive Committee by filing a Notice of Appeal with the Registrar within thirty (30) days of being informed of the decision.

ARTICLE 11 - INSPECTIONS AND AUDITS

11(1) At any time and at the cost of the facility, a facility is subject to on-site inspection by members designated by the committee to conduct inspections.

11(2) If access to the facility for any inspection is refused, the committee may take such action it deems necessary including, suspending, revoking or amending the facility's certificate of accreditation.

ARTICLE 12 - FEES

12 The facility shall pay all expenses, charges and fees including any licence fees imposed by the committee, in respect of the administration of this Bylaw.

ARTICLE 13 – REPEAL

13 Bylaw 3D of the College enacted on October 20, 2000 with all amendments thereto, is repealed effective December 15, 2017, and the foregoing Bylaw is substituted therefor. This Bylaw shall be in force as of December 15, 2017.