THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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BYLAW 3

(Under Section 40(2) of The Medical Act)

ACCREDITED FACILITIES

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on 17 June 2011, repealing and replacing By-laws #3A, 3B, 3C)

Effective Date 1 September 2011 with Amendments to 04 June 2014.

BY-LAW #3
ACCREDITED FACILITIES

Preamble

This by-law applies as follows:

1. Pursuant to *The Medical Act*, ss.40(1)[1], to all diagnostic facilities in Manitoba in which services are performed by members of the College, other than those under the jurisdiction of the provincial or municipal governments and those approved as hospitals under *The Hospitals Act*.
2. Pursuant to ss.40(6)[2] of *The Medical Act* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the government of Manitoba as specified in the Service Purchase Agreement.

PART 1 - DEFINITIONS

1(1) In this By-Law:

(a) "**accreditation**" means a review process conducted by the College to determine whether the facility being reviewed meets or exceeds the standards specified by the College.

(b) **"anatomic pathology facility"** means a place where human surgical tissue biopsies and specimens, cytologic specimens and autopsies are examined for diagnostic purposes.

(c) **"certificate of accreditation"** means a certificate issued under this by-law.

(d) **"clinical pathology laboratory"** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, blood banking, cytology, immunology, microbiology, virology, histology or pathology.

(e) **"Committee"** means the Program Review Committee of the College.

(f) **"diagnostic imaging facility"** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy or mammography but does not include a physician's office where ultrasound is done by a physician or under a physician's supervision for the diagnostic of the physicians own patients.

(g) **"facility"** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology facility, a clinical pathology laboratory, a diagnostic imaging facility, a nuclear medicine facility, or a short list laboratory. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

(h) **"facility director"** means a physician appointed as director of a facility in accordance with this by-law.

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[1] Subsection 40(1) states:
40(1) The council may appoint a committee to be known as the "program review committee" which may investigate and inspect on behalf of the council all diagnostic and treatment facilities in which services are performed by members in Manitoba other than those which are under the jurisdiction of provincial or municipal governments and those facilities that are approved hospitals under *The Manitoba Hospitals Act*.

[2] Subsection 40(6) states:
40(6) The program review committee may enter into agreements with the federal, provincial or municipal governments to apply the provisions of subsections (1), (2) and (5) of this section to any facilities or any portion of a facility falling within the jurisdiction of that government and such agreements shall specify the procedures not inconsistent with any Act to be followed when the program review committee believes that the facility does not appear to meet the required standards.

(i) **"nuclear medicine facility"** means a place where patients are imaged using radiopharmaceuticals or where patients are treated through the use of radiopharmaceuticals, or where radioimmunoassays are performed.

(j) **"patient service centre"** means a location operated by a clinical pathology laboratory for the collection of specimens of blood and of body fluids for the purpose of testing in a registered and licensed Manitoba laboratory.

(k) **"physician office laboratory"** means a physician's office where specimens are collected by the physician or an employee under the physician's supervision for the diagnosis of the physician's own patients.

(l) **"short list laboratory"** means a laboratory which limits its services to those tests listed in the Manitoba Health Physician's Manual as short list procedures.

(m) **"standards"** means the standards established by Council for facilities.

(n) **"vehicle"** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

(i) used primarily for the purpose of offering diagnostic services; and
(ii) has the approval of the Standing Committee on Diagnostic Services to offer diagnostic services in Manitoba, but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1(2) In this by-law, words and phrases defined in *The Medical Act* have the same meaning as in *The Medical Act*.

PART 2 - FACILITY ACCREDITATION

2.1 A facility is required to obtain accreditation before it offers any services to the public.

2.2 Accreditation of a facility must be:

(a) except in the case of a vehicle, for a specific address or addresses.
(b) for the fixed period of time determined by the Committee, to a maximum of 5 years.
(c) for the procedures specified in the certificate of accreditation.

2.2.1 Accreditation of a clinical pathology laboratory may be for its primary location and for some or all of its patient service centres. Accreditation may be granted to or withdrawn from any one or more of the primary location and its patient service centres.

2.2.2 In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

2.3 Prerequisites to full accreditation of a facility pursuant to this By-law are:

(a) compliance with the relevant standards; and
(b) appointment of a facility director acceptable to the Committee.

2.4 The Committee must establish and make available on request:

(a) standards for each type of facility.
(b) the accreditation process for each type of facility, which may include but is not limited to:
    (i) completion of a pre-inspection questionnaire in a manner satisfactory to the Committee.
    (ii) an on-site inspection by one or more health care professionals who have expertise in the appropriate area of practice and who are designated by the Committee to conduct the inspection.

(iii) review of the facility's compliance with the relevant standards.

(c) the Committee's policies governing the accreditation process for each type of facility.

2.5 Applications for accreditation of a facility must be made to the Committee by the facility director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

2.6 Where an inspection is conducted as part of the accreditation process, the Committee must issue a report of the inspection, and must provide a copy of the report to the applicant.

Full Accreditation

2.7 Where a facility fully complies with the relevant standards, the Committee will grant full accreditation, and will specify in the certificate of accreditation the procedures for which the facility has received accreditation.

Accreditation Not Granted

2.8 Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to Executive Committee.

Conditional Accreditation

2.9 Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

2.10 Where conditional accreditation is granted, the Committee must:
(a) provide written notice of its decision and the reasons therefor and information on the right of appeal to Executive Committee.
(b) state in its decision a fixed deadline for the facility to comply with all relevant standards and for the facility director to provide written confirmation of compliance to the Committee.
(c) state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

2.11 The Committee may extend the deadline for compliance with standards fixed pursuant to Article 2.10 if, in its sole discretion, the Committee deems it appropriate to do so.

2.12 Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:
(a) direct an inspection.
(b) withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.
(c) if the Committee is of the opinion that it is unsafe for the facility to provide services, direct the Registrar to notify the public of the deficiencies and to require that physicians not use the diagnostic facility.

Accreditation Status Review

2.13 Accreditation status will be reviewed if the facility ownership changes or the facility director changes.

Temporary Accreditation

2.14 Temporary approval may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

PART 3 - MAINTENANCE OF ACCREDITATION

3.1 In order to maintain accreditation, a facility must:

a) comply with the relevant standards.
b) perform only the procedures permitted pursuant to the facility's certificate of accreditation.
c) at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.
d) cooperate with and participate in the inspection process approved by the Committee for its type of facility.

3.2 If during the currency of a full or conditional accreditation, the Committee is of the opinion that a facility may not meet the relevant standards of practice or is not in compliance with the requirements of the Act, the regulations, this by-law or relevant standards of practice, the Committee may direct an inspection for the purpose of monitoring compliance.

PART 4 – VARIANCE OF ACCREDITATION

4.1 A facility may apply at any time to vary its accreditation.

4.2 The accreditation process on a request to vary is the same as the process for initial accreditation.

PART 5 – RENEWAL OF ACCREDITATION

5.1 In order to renew accreditation, a facility must re-apply for accreditation at least six (6) months prior to the expiration date of the existing accreditation.

5.2 The accreditation process for a renewal is the same as the process for initial accreditation.

PART 6 – CANCELLATION OF ACCREDITATION

6.1 Where a facility is no longer providing patient services, the Committee may cancel the facility's accreditation.

6.2 Council may cancel accreditation in accordance with The Medical Act.

PART 7 – FACILITY DIRECTOR

7.1 A facility must have a facility director.

7.2 A facility director must be a physician whose credentials are acceptable to the Committee.

7.3 The Committee must establish and make available on request the qualifications for facility directors in each type of facility.

7.4 The facility director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a facility director must:

(a) define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.
(b) obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.

(c) obtain full particulars of the applicant's education, training, competencies and experience.
(d) take reasonable steps to ensure that the applicant has the education, training, competencies and experience required and that the applicant is otherwise a suitable candidate for privileges.

7.5 Within one year of first granting privileges to a physician, the facility director must review that physician's privileges. Thereafter, privileges must be reviewed by the facility director at least every two years.

7.6 Before granting renewal of privileges or extending the existing privileges of any physician, the facility director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7 The facility director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical and administrative activities of the facility, and for compliance with this by-law and with the relevant standards established by the Committee.

7.8 Without limiting the generality of the foregoing, the facility director must: (AM06/14)
(a) have access to all records and documents relating to the operation of the facility and the procedures performed therein.
(b) communicate with any facility under his/her direction a minimum of once per year.
(c) ensure that quality management system requirements and improvement programs are in place.
(d) ensure that the facility has current manuals as required by the Standards for that facility.
(e) ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are retained.
(f) ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.
(g) ensure that persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited.
(h) ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.
(i) promptly notify the Committee of any change in the ownership or directorship of the facility.
(j) promptly notify the Committee if the facility is no longer providing patient services.
(k) where applicable, be available for consultation with referring physicians.
(l) promptly notify the Committee if there is a major change in the following:
    (i) equipment.
    (ii) the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.

7.9 The facility director must submit to the College such annual report forms as required by the Committee from time to time.

PART 8 - APPEAL

8.1 The facility or a physician who has been adversely affected by a decision of the Committee may appeal the decision of the Committee by filing a Notice of Appeal in writing with the Registrar within thirty days of the decision, and the appeal process shall be in accordance with policies established by Council.

PART 9 - FEES

9.1 A privately owned facility must pay all expenses, charges and fees incurred by the College in relation to the accreditation or inspection of that facility.

9.2 Each facility must pay any licence fees fixed by resolution of the Council of the College as payable by facilities for the purpose of recovering the cost of administering this By-Law.

PART 10 – PHYSICIAN OFFICE LABORATORY

10.1 Physicians must not operate a physician office laboratory without first obtaining the written approval of the College.

10.2 A physician who operates a physician office laboratory with the approval of the College does not require accreditation of the facility where physician office laboratory procedures are performed.

10.3 The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

PART 11 – STANDING

11.1 Upon the request of a facility, the Committee may issue a letter confirming the facility's standing.

PART 12 - TRANSITION

12.1 A facility that holds accreditation at the time this by-law comes into force continues to hold that accreditation status under this by-law in accordance with the terms of that accreditation.

12.2 A facility which has not undergone the accreditation process will be notified in writing by the College that it is exempt from the requirement of accreditation set forth in this by-law until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with the College for the timely completion of its accreditation process in accordance with this by-law.

12.3 A physician who holds a facility directorship at the time this by-law comes into force continues to hold that status under this by-law.

12.4 A physician who holds privileges in a facility at the time this by-law comes into force continues to hold those privileges until January 1, 2013 or the date on which the facility director has met the requirements of Article 7 of this by-law for privileging within the facility, whichever is earlier.