Sleep Health FOUNDATION

Raising awareness of sleep health

Code of Practice for Suppliers of CPAP Sleep Therapies

Renewal

Purpose of this Application:

The Code of Practice for Suppliers of CPAP Sleep Therapies is an initiative of the Sleep Health Foundation to recognise organisations who demonstrate excellence in the delivery of services to patients. The purpose of this application is to demonstrate compliance with the Code of Practice.

Instructions:

Please complete all sections of this form. Applicants should provide sufficient information in each section to demonstrate compliance with the Code. Incomplete applications will be returned. Payment by Cheque or Credit Card must accompany this application.

Section 1: Organisation Details and Staffing

Organisation Details

Organisation name _____

Postal Address _____

_____

Please specify ALL of the sites (business name, address, telephone, email) to be covered by this agreement.

_____

_____

_____

_____

_____

_____

_____

Contact Person for this Application

Name _____

Position Title in Organisation _____

Telephone Number _____

Email _____

Staffing of Organisation

Persons directly involved in provision of clinical services to patients.

Name	Role/Duties	FTE*	Years of experience in sleep therapy
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	
		%	

(*percent of full time work spent in supply of sleep therapy)

Section 2: Description of Services and Compliance with Code of Practice

To comply with the Code of Practice, suppliers must:

1 **Place the patient's health and well-being at the forefront of their approach by ensuring their needs are adequately assessed and all treatment options are adequately considered.**

2 **Provide the opportunity for home product trial of equipment prior to sale. Supply facilities should offer patient's privacy and provide a setting (bed/recliner/chair) suitable for fitting of/adjustment of/acclimatisation to therapy.**

i. Please describe the availability of therapy trials in the home through your organisation. Please describe the facilities used in the provision of clinical services to patients.

ii. Enclose/attach a photo of the clinic facilities.

★ *If you require more space, please include your response as a separate attachment.*

3 **Have capacity to provide patient support services at short notice, including a point of contact for after-hours needs and mobile services where possible.**

Please describe the availability of services for patients, including ability to access services at short notice, after-hours and provision of mobile services.

★ *If you require more space, please include your response as a separate attachment.*

4 **Have available a range of masks and CPAP devices for pre-purchase trial and for loan/rental when repairs are required. All trial/loan masks and devices must be maintained in accordance with the manufacturer's recommendations for multi patient use.**

Please outline the range of equipment available, services for equipment trial and protocols for cleaning and maintenance of masks and devices.

★ *If you require more space, please include your response as a separate attachment.*

5 **Ensure patients can access the face-to-face consultation to discuss purchasing equipment, therapy initiation and follow-up as needed. Furthermore, if the patient experiences problems with product use or side-effects the supplier must offer appropriate advice and resolution, with the option of a face-to-face consultation.**

Please describe the availability of face to face consultations both pre-purchase and ongoing follow-up.

★ *If you require more space, please include your response as a separate attachment.*

6 **Maintain accurate records of patient interactions and equipment sales which can be easily accessed for the purpose of regulatory matters or medical needs. Suppliers must preserve the confidentiality of patient information restricting access to those directly involved in the patient's care or processes arising from it.**

Please outline how clinical interactions and equipment sales are recorded and stored. Please describe how the confidentiality of these records is maintained.

★ *If you require more space, please include your response as a separate attachment.*

7 **Demonstrate a scheduled and recorded patient follow-up service including the provision of a patient CPAP data download service.**

Please outline how patients are routinely followed up by the organisation, including the ability to provide a device data download service.

★ *If you require more space, please include your response as a separate attachment.*

8 **Encourage the patient's to actively participate in the treatment and the entire decision-making process.**

Please describe how patients are encouraged to be active participants in the services provided by your organisation.

★ *If you require more space, please include your response as a separate attachment.*

9 **Avoid or minimise conflict of interest that may limit patient choices and impact negatively on patient outcomes. Before the provision of equipment, the patient should be independently assessed by an appropriately trained medical practitioner. This practitioner should order and interpret diagnostic sleep test reports and provide treatment prescription separate from any financial or other inducement by the equipment supplier. These diagnostic services should be separated from the sale of treatment such that the patient is informed of and can consider options for treatment, including alternatives to CPAP, by providers independent of the diagnostic facility.**

Please outline any real/perceived/potential conflicts of interest that may exist within your organisation related to diagnostic services and the sales of equipment. Please describe how these conflicts of interest are managed where the organisation has any pecuniary or other interest in diagnostic services. Please include how patients are informed of real/perceived/potential conflicts of interest and what treatment options are routinely provided.

★ *If you require more space, please include your response as a separate attachment.*

10 **Maintain an adequate level of knowledge and a commitment to continue learning and professional development. Staff should be encouraged to attend at least one externally provided sleep education session annually (for example ASA, ASTA, Sleep Health Foundation, manufacturer training).**

Please outline all professional development activities attended by each staff member who has direct clinical interaction with patients.

★ *If you require more space, please include your response as a separate attachment.*

11 **Provide care in a professional manner with objectivity and integrity. Exercise and professional judgement, manage complex and provide qualified and ongoing service and support.**

Please describe any policies, processes or procedures utilised by your organisation to monitor the quality of the services provided. Please outline how your organisation obtains feedback from patients and referring clinicians and the processes used by your organisation for management of negative feedback or complaints.

★ *If you require more space, please include your response as a separate attachment.*

12 **Ensure changes to recommended therapy are made in consultation with the referring medical practitioner responsible for the patient.**

Please describe the nature of communication with the referring medical practitioner and processes by which changes to recommended therapy are made.

★ *If you require more space, please include your response as a separate attachment.*

13 **Work collaboratively and professionally with other healthcare professionals to optimise the health outcomes of the patient. Always act in a professional manner and never in a way which may bring disrepute to the Sleep Health Foundation.**

Please describe any professional relationships with other healthcare professionals relevant to this application. If you require more space, please include your response as a separate attachment.

★ *If you require more space, please include your response as a separate attachment.*

Section 3: Terms and Regulation of Agreement

Self regulation is the first line. The Audit System is as follows:

- ☐ The code must be prominently displayed in the showroom.
- ☐ Code standards are auditable but this is a reserve function.
- ☐ Complaints are directed to the company concerned in the first instance.
- ☐ Failure to resolve the complaint or a clear transgression of the code are referred to the Foundation.
- ☐ Corrective actions may be recommended.
- ☐ Failure to implement these may result in withdrawal of certification.
- ☐ Fees are non-refundable.
- ☐ Any dispute regarding these matters will be resolved by the Board.

The disputing party(ies) have the right to formally put their case(s) to the Board in writing. A primary consideration of the Board in resolving disputes will be to determine the appropriateness of ongoing Sleep Health Foundation recognition of the business(es) concerned under the code. The Board's decision will be final.

Section 4: Certification

The foundation will provide a letter of approval and a copy of the Code of Practice for display.

Approved businesses will have their details displayed on the Sleep Health Foundation website and be entitled to use the Sleep Health Foundation Code of Practice Logo in their advertising. Their approved status will be made known and promoted to members of the Australasian Sleep Association.

Section 5: Fees and Payment Options

Annual fees are based on the number of sites to be covered by the agreement and are as follows:
☐ Tier 1: $350+GST ≤ 2 sites ☐ Tier 2: $1,000+GST ≥ 3-9 sites ☐ Tier 3: $2,500+GST ≥ 10 sites
Please note discounts apply for Foundation corporate partners.

Total $ _____ **+ GST =** **Payment $** INCL. GST

Payment Method

☐ **Cheque** (payable to Sleep Health Foundation) enclosed

☐ **Credit Card** ☐ Visa ☐ Mastercard (American Express & Diners Club not accepted)

Name on Credit Card _____

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry date ☐☐/☐☐

Signature _____

☐ **EFT** using the following details:

Account Name: Sleep Health Foundation
Bank: NAB
BSB: 082 330 Account: 15976 4715

Please ensure you include your name when depositing with EFT.

Section 6: Declaration

I agree to the Terms and Regulations of the Sleep Health Foundation Code of Practice for Suppliers of CPAP Sleep Therapies as outlined in this application and certify that the information provided in this application is accurate.

Signature _____

Date _____

Print Name _____

PLEASE RETURN THIS COMPLETED FORM TO:

Sleep Health Foundation
Suite 114, 30 Campbell Street, Blacktown NSW 2148
© admin@sleephealthfoundation.org.au