INDEPENDENT HEALTH FACILITIES PROGRAM

Pre-Assessment Questionnaire

PULMONARY FUNCTION

NOTE: This document must be prepared/completed by the most responsible person involved in the day-to-day activities within the facility

The information contained in this document is accurate to the best of my knowledge.

Signature of Quality Advisor/Medical Director	Date
Signature of Owner/Operator	Date
Signature of Most Responsible Person	Date

THE FACILITY

Please include a copy of your facility's organizational chart **Attachment included:** ☐

GENERAL			
Name of Facility			
Billing Number			
Mailing Address			
Telephone		Fax	
Hours of operation			

Name and mailing address of owner/operator of this facility, if different from above:

Name(s) and billing number(s) of other facilities owned or operated by the licensee of this facility:

Name of Manager/Technical Director of facility (if applicable)			
Telephone		Fax	
Email			

What category of procedures are you **licensed** to perform in this facility?
What procedures are you **currently** performing in this facility?

Does your facility have separate areas for each of the following functions:			
Patient waiting area	☐ Yes	☐ No	☐ N/A
Patient washrooms	☐ Yes	☐ No	☐ N/A
Patient prep area	☐ Yes	☐ No	☐ N/A
Record Storage	☐ Yes	☐ No	☐ N/A
Facility storage supply	☐ Yes	☐ No	☐ N/A

Is the facility wheelchair accessible?	☐ Yes	☐ No	☐ N/A
Where is your IHF License posted?			

GENERAL

Are any procedures performed/reported by physicians without specialist qualifications?	
What is the percentage (%) of examinations performed by pulmonary function technologists?	
What percentage (%) of studies are performed by physicians?	
If the physicians are not on site, describe the method in which technologists consult with him/her on a case by case basis.	
Which staff are trained in Basic Cardiopulmonary Resuscitation? **List staff members with this training:**	
Please provide a copy of your staff's current certificates.	**Attachment included:** ☐

QUALITY CONTROL

Name the person responsible for conducting and documenting quality control activities:
Based on the tests conducted at the facility, briefly explain the QC procedures and frequency in which this is performed:

QUALITY ADVISOR

Please ensure that your curriculum vitae, Continuing Professional Development activities and the written agreement between the owner/operator and yourself are available for review **on the day of the assessment.**

Surname (as given on CPSO register)			
Given name(s) (as given on CPSO register)			
CPSO #		Date of Birth dd/mm/yyyy	
Sex	M F		
University from which you obtained your Medical Degree			
Year obtained			
Royal College of Physicians and Surgeons of Canada Fellowship	☐ Yes	☐ No	
Specialty			

CONTACT INFORMATION			
Facility Name and Billing #			
Facility Address:			
Email		Office phone	
Direct phone		Fax	
Other facilities for which you are Quality Advisor (please indicate facility name and billing #):			
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Please attach a list of the facilities for which you provide interpreting services but are not the quality advisor, if applicable. **Attachment included:** ☐			

Services (e.g. interpreting, consultation) you currently provide within the IHF:	
How often do you visit the facility and how is this documented?	
When was your last visit?	
Do you have regular contact and interaction with peers?	☐ Yes ☐ No (pick one)
Do you have regular contact and interaction with referring clinicians and specialists?	☐ Yes ☐ No (pick one)
Do you have regular contact and interaction with the owner/operator/licensee?	☐ Yes ☐ No (pick one)

Continuing Professional Development/Continuing Medical Education	
Please provide information about the type of professional development activities in which you participated in the past three years and the amount of time spent within each activity:	
Regardless of your certification or membership with the RCPSC do you voluntarily fulfil their professional development requirements?	☐ Yes ☐ No (pick one)

Please estimate number of hours you spent in the following formal CME activities in the past 12 months:

	0-10 hrs	11-20hrs	21-30hrs	31-40hrs	41+hrs
RCPSC accredited courses, conferences and workshops	☐	☐	☐	☐	☐
Internet based CME activities (e.g. online journals, guidelines etc.)	☐	☐	☐	☐	☐
Practice-based small group learning sessions	☐	☐	☐	☐	☐
Self-directed learning programs	☐	☐	☐	☐	☐
Hospital Committees	☐	☐	☐	☐	☐

Hospital Educational Rounds	☐	☐	☐	☐	☐
Reading Journals	☐	☐	☐	☐	☐
Other courses, conferences and workshops	☐	☐	☐	☐	☐
Radiology rounds	☐	☐	☐	☐	☐
Other (please describe):					
	☐	☐	☐	☐	☐

Describe your activities in relation to interaction with the facility staff:			
How do you contribute to the process of continuous quality improvement?			
How are you involved in updating and maintaining the quality control activities?			
As Quality Advisor you are required to advise the licensee on the quality aspects of the facility. Briefly explain how you accomplish this role:			
Do these activities include, the following:			
Quality control results (i.e. HARP testing) are reviewed and signed off	☐ Yes	☐ No	(pick one)
Corrective actions documented and signed off	☐ Yes	☐ No	(pick one)
Quality control activities reviewed annually	☐ Yes	☐ No	(pick one)

INTERPRETING PHYSICIAN OTHER THAN QUALITY ADVISOR

Please ensure that your curriculum vitae and Continuing Professional Development activities are available for review **on the day of the assessment**.

Surname (as given on CPSO register)			
Given name(s) (as given on CPSO register)			
CPSO #		Date of Birth dd/mm/yyyy	
Sex	☐ M ☐ F		
University in which you obtained your Medical Degree			
Year obtained			
Royal College of Physicians and Surgeons of Canada Fellowship	☐ Yes ☐ No		
Specialty			

CONTACT INFORMATION			
Facility Name and Billing #			
Facility Address:			
Email		Office phone	
Direct phone		Fax	
Other facilities for which you are Quality Advisor (please indicate facility name and billing #):			
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Please attach a list of the facilities for which you provide interpreting services but are not the quality advisor, if applicable. **Attachment included:** ☐			

Services (e.g. interpreting, consultation) you currently provide within the IHF:	
How often do you visit the facility and how is this documented?	
When was your last visit?	
Do you have regular contact and interaction with peers?	☐ Yes ☐ No (pick one)
Do you have regular contact and interaction with referring clinicians and specialists?	☐ Yes ☐ No (pick one)
Do you have regular contact and interaction with the owner/operator/licensee?	☐ Yes ☐ No (pick one)

Continuing Professional Development/Continuing Medical Education	
Please provide information about the type of professional development activities in which you participated in the past three years and the amount of time spent within each activity:	
Regardless of your certification or membership with the RCPSC do you voluntarily fulfil their professional development requirements?	☐ Yes ☐ No (pick one)

Please estimate number of hours you spent in the following formal CME activities in the past 12 months:

	0-10 hrs	11-20hrs	21-30hrs	31-40hrs	41+hrs
RCPSC accredited courses, conferences and workshops	☐	☐	☐	☐	☐
Internet based CME activities (e.g. online journals, guidelines etc.)	☐	☐	☐	☐	☐
Practice-based small group learning sessions	☐	☐	☐	☐	☐
Self-directed learning programs	☐	☐	☐	☐	☐
Hospital Committees	☐	☐	☐	☐	☐

Hospital Educational Rounds	☐	☐	☐	☐	☐
Reading Journals	☐	☐	☐	☐	☐
Other courses, conferences and workshops	☐	☐	☐	☐	☐
Radiology rounds	☐	☐	☐	☐	☐
Other (please describe):					
	☐	☐	☐	☐	☐

TECHNOLOGISTS

Please complete for each Technologist currently working in the facility.

Full Name	
Position/Title	
How many hours per week do you work at this IHF?	
Are you a:	
☐ Registered Cadiopulmonary Technologist (RCPT)?	☐ Registered respiratory care practitioner (RRCP)?
Where and when did this occur?	
Are you a health care professional with relevant training in pulmonary function testing?	
☐ Yes ☐ No	
Please describe your training in pulmonary function testing including location and dates:	

Training	Location	Dates

Do you provide training to non-registered technologists?	☐ Yes ☐ No
If yes, give details of the training program you provide:	
How much time do you spend in the facility?	
Do you provide testing for other facilities?	
If so, please identify those facilities/locations:	

Please indicate tests which you are currently performing in the facility:	
☐ Oximetry	☐ Non-specific bronchoprpvocative testing
☐ Carbon monoxide diffusing capacity (DLCO)	☐ MIPs & MEPs
☐ Functional residual capacity (FRC)	☐ Stage 1 exercise testing
☐ Exercise challenge testing for asthma	

Please list your continuing education for past two years using the Professional Activity Log on next page.

PROFESSIONAL ACTIVITY LOG

Name			
Activity			
Summary of Activity			
Impact on Practice			
Evaluation of Activity	☐ Excellent	☐ Good	☐ Poor
Hours of Participation		Completion Date	

Name			
Activity			
Summary of Activity			
Impact on Practice			
Evaluation of Activity	☐ Excellent	☐ Good	☐ Poor
Hours of Participation		Completion Date	

Name			
Activity			
Summary of Activity			
Impact on Practice			
Evaluation of Activity	☐ Excellent	☐ Good	☐ Poor
Hours of Participation		Completion Date	

POLICIES & PROCEDURES

Please provide a copy of the manual to the technologist assessor.

Does your facility have a policies and procedures manual as described in the Clinical Practice Parameters and Facility Standards for Pulmonary Function?	☐ Yes ☐ No
Is the manual site specific?	
Where is the policies and procedures manual kept?	
Is a printed copy accessible to all staff?	☐ Yes ☐ No
How frequently is the policies and procedures manual reviewed by staff?	
Who reviews and updates the policies/procedures manual? (i.e. Quality Advisor, Technologists, Managers, etc.)	
What is the process to advise staff of changes to the policies/procedures manual?	
Are all changes initialled and dated by staff?	☐ Yes ☐ No
Do all staff sign and date the policies/procedures manual?	☐ Yes ☐ No

PROVIDING QUALITY CARE

Who are the members of your Quality Advisory Committee? **Please provide a list of names and their title** **Attachment included:** ☐
How often does the Quality Advisory Committee meet?
Are these meeting documented and minutes taken?
How is information communicated to staff?
How often are staff meetings held and are they documented?

What steps are taken to ensure patient privacy?
Does staff contribute to continuously improve the services provided? How is this done?

EQUIPMENT & SUPPLIES

Where are the fire extinguishers located?	
Has all staff received WHMIS training?	
Where are the material safety data sheets posted?	
Is the following equipment available for managing emergencies related to the types of services provided?	
☐ First Aid Kit	☐ Sphygmomanometer & Stethoscope
☐ Airway Management Equipment	☐ Appropriate Drugs
☐ Resuscitation Equipment	☐ Fire Extinguishers
☐ Other (specify)	

EQUIPMENT

List ALL the equipment currently in use in this facility:

Type of equipment	Year manufactured	Equipment manufacturer	Serial number	Date acquired yy/mm/dd	Modifications and upgrades	Calibration record available (please attach copy)
						Copy attached ☐
						Copy attached ☐
						Copy attached ☐
						Copy attached ☐
						Copy attached ☐
						Copy attached ☐
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						Copy attached ☐
						Copy attached ☐

REQUESTING & REPORTING

Please enclose a sample requisition, tech worksheets and a Sample (John Doe) report.

Attachment included: ☐

When/how are previous studies from another IHF/Hospital facilities obtained for the interpreting physician?
How does the facility obtain necessary information for requisitions that are incomplete?
What is your standard practice for report turnaround time to the referring physician?
In point form, describe the process from the time a test is performed and the final report is completed and sent to the referring physician?
Do you have a process for handling stat requests? ☐ Yes ☐ No
If so, please describe the process:
Where are your patient records stored?
What is your method of filing each record/storage media?
How do you flag your unusual and interesting examinations?
How long are your records retained and how are they identified for purging?

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