THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

INDEPENDENT HEALTH FACILITIES PROGRAM

Pre-Assessment Questionnaire

SLEEP MEDICINE

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			

Does the facility provide/perform:		
Polysomongraphy/evaluation of drowsiness and daytime sleepliness (MSLT and MWT)	Yes	No
Pediatric polysomnography	Yes	No
If yes, what are the age groups		
Clinical diagnostic and treatment services (patient examination, assessment and evaluation by the consulting physician with management recommendations, and follow-up planning)	Yes	No

If no, please identify other IHF/Hospital to which you refer these patients for these services:

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
Where is your IHF License posted?		
What time does the facility open in the evening and what time are patients requested to attend for their study?		
Number of beds in the facility		
What collection system and software version is currently used in the facility? (i.e. Sandman 8.0)		

For Facilities Providing Overnight Polysomnography:	
Level 1 Polysomnography (approximate # of patients per month)	
For Facilities Providing Day Time Nap Studies:	
Multiple Sleep Latency Test (MSLT) (approximate # of patients per month)	
Maintenance of Wakefulness Test (MWT) (approximate # of patients per month)	
What percentage of MSLT studies have an overnight polysomnogram the preceding night?	
What percentage of MWT studies have an overnight polysomnogram the preceding night?	

Does the sleep disorder facility perform overnight CPAP titrations or ventilator studies?	Yes	No	N/A

Is the Sleep Disorder Facility registered with ADP for the provision of PAP devices?	Yes	No	N/A
ADP Clinic Number			
What percentage of referrals to the sleep disorder facility are from:			
MD Referral (OHIP)			
Non-MD Referrals			
Procedure		# per month	
CPAP Titration	Yes	No	N/A
Bi-Level S Titration	Yes	No	N/A
Invasive or non-invasive ventilation (Bi-Level ST or volume cycled ventilation)	Yes	No	N/A

STAFF

How many technologists work in the facility per night?			
What is the maximum number of CPAP or Bi-Level Titrations performed per tech, per night?			
What is the maximum technologist/patient ratio for overnight polysomnography?			
Does the facility use an external company for scoring records?	Yes	No	
Provide company name here:			
Are all staff trained in Basic Cardiopulmonary Resuscitation? *(provide a copy of your staff's current certificates)*	Yes	No	N/A

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 in which you obtained your Medical Degree	

Year obtained		

Royal College of Physicians and Surgeons of Canada Fellowship	Yes No

Specialty	

Please outline your Sleep Medicine qualifications and experience:

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 provide a list of the facilities for which you provide interpreting services but are not the quality advisor (if applicable).	
Facility name	
Facility name	
Facility name	

Please provide a list of the facilities for which you provide consulting services but are not the quality advisor (if applicable).			
What services (e.g. interpreting, consultation) do 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)*
Have you chosen to focus, subspecialise or restrict your practice?	Yes	No	(*pick one)*
If yes, please specify			
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)*

Please indicate the types of examinations that you perform/interpret in a typical work-week at this facility.	
Examination Categories	**# of examinations read or procedures performed**
Polysomnography	
CPAP Titration Studies (1)	
Bi-PAP Studies (1)	
MSLT	
MWT	

CONTINUING PROFESSIONAL DEVELOPMENT/CONTINUING MEDICAL EDUCATION

Please provide information about the professional development activities in which you participated in the past 12 months 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 Unsure *(pick one)*

Please estimate how many hours you spent in the following formal CME activities in the past 12 months:

	0-10 hrs	11-20hrs	21-30 hrs	31-40 hrs	41+hrs
RCPSC accredited courses, conferences and workshops					
Internet based CME activities (e.g. on-line 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?:

Are all quality control results reviewed and signed off?	Yes	No	*(pick one)*
Are all corrective actions documented and signed off?	Yes	No	*(pick one)*
Are quality control activities reviewed annually?	Yes	No	*(pick one)*

INTERPRETING PHYSICIAN

(Other than the Quality Advisor)

Please ensure that a copy of your CPSO approval letter, 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						
Please outline your sleep medicine qualifications and experience:						

CONTACT INFORMATION			
Facility Name and Billing #			
Facility Address			
Email		Office Phone	
Direct Phone #		Fax	

Other facilities for which you provide interpreting services but are not the Quality Advisor (if applicable):			
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
Please provide a list of the facilities for which you provide consulting services but are not the Quality Advisor (if applicable)			
Facility name		Billing #	
Facility name		Billing #	
Facility name		Billing #	
What services (e.g. interpreting consultation) do 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)*
Have you chosen to focus, subspecialise or restrict your practice?	Yes	No	*(pick one)*
If yes, please specify:			

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)*

Please indicate the types of examinations that you perform/interpret in a typical work-week at this facility:	
Examination Categories	**# of examinations read or procedures performed**
Polysomnography	
CPAP Titration Studies (1)	
Bi-PAP Studies (1)	
MSLT	
MWT	

CONTINUING PROFESSIONAL DEVELOPMENT/CONTINUING MEDICAL EDUCATION

Please provide information about the professional development activities in which you participated in the past 12 months 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 Unsure *(pick one)*

Please estimate how many hours you spent in the following formal CME activities in the past 12 months:

	0-10 hrs	11-20 hrs	21-30 hrs	31-40 hrs	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):					

Storage of Studies			
Please indicate how you store your sleep studies examinations:			
Paper	Yes	No	*(pick one)*
CDs/Hard Drive	Yes	No	*(pick one)*
Combination of the Above	Yes	No	*(pick one)*

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 polysomnographic technologist (RPSGT)?	
Where and when did this occur?	
For **non-registered technologists**, have you received relevant training in polysomnography?	

Please describe your training in polysomnography including location and dates:

What specific studies do you perform?	
Do you provide training to non-registered technologists?	Yes No
If yes, give details of the training program you provide:	

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	

PAEDIATRIC PATIENTS

Are children studied in this facility?	Yes No	
If no	If yes, what age?	

What are the Quality Advisor's/Interpreting Physicians qualifications in paediatric sleep/wake disorders and paediatric polysomnography? **Please attach a detailed description of the training and qualifications. Attachment included:**
What are the technologists' qualifications in paediatric polysomnography? **Please attach a detailed description of the training and qualifications. Attachment included:**
Are technologists certified in paediatric basic cardiopulmonary resuscitation (BCLS)? **If yes, please attach copies of the certification. Attachment included:**
List the names of specialists (paediatric or with paediatric expertise) in Respirology, Otolaryngology, Surgery, Neurology, Psychiatry and Psychology, as well as Urology, Paediatrics, Neonatology, and others, if any that may provide care to children in the sleep facility:

POLICIES & PROCEDURES

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

Question	Answer
Does your facility have a policies and procedures manual as described in the Clinical Practice Parameters and Facility Standards for Sleep Medicine?	Yes No
Is the manual site specific?	Yes No
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

QUALITY CONTROL ACTIVITIES

Are all AC amplifiers calibrated monthly?	Yes	No
Transcutaneous and End-Tidal CO2 monitors		
Is a two point calibration performed prior to use?	Yes	No
If the monitors are used overnight are they checked for drift in the morning?	Yes	No
Oximeters		
Calibration performed according to the manufacturer's recommendations?	Yes	No
CPAP/Bi-Level Pressures		
Are they calibrated at least every three months over the entire range?	Yes	No
Any other DC channels where numeric values are reported? (e.g. esophageal pressure or pH)		
Are they calibrated prior to use?	Yes	No

PROVIDING QUALITY CARE

Who are the members of your Quality Advisory Committee? **Please list their names and title:**		
How often does the Quality Advisory Committee meet?		
Are these meeting documented and minutes taken?	Yes	No

EQUIPMENT & SUPPLIES

Where are the fire extinguishers located?		
Has all staff received WHMIS training?	Yes	No
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	Fire Extinguishers	
Other (specify)		

EQUIPMENT

List ALL the equipment currently in use in this facility:

Type of equipment	Year manufactured	Name of manufacturer	Serial number	Date acquired yy/mm/dd	CSA Sticker			Modifications and upgrades	Calibration record available (please attach copy)
					Yes	No	N/A		

REQUESTING & REPORTING

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

When/how are previous studies from another IHF/Hospital facilities obtained for the interpreting physician?	
Where are your polysomnograms 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?	

CLINICAL ACTIVITY IN THE FACILITY

Are patients seen in the facility? i.e., are consultations or physician visits performed within the facility	Yes	No
If yes, please answer the following questions:		
What are the hours for the clinical assessment and management of patients with sleep/wake disorders?		
How many new patients are assessed in the clinic monthly?		
How many follow-up visits are carried our monthly?		
What proportion of new patients are only seen clinically and not assessed in the sleep laboratory?		
What proportion of new patients are only seen in the laboratory and not assessed clinically?		
Are the clinical records available on site at the facility?	Yes	No
If no, please ensure that they are available for assessor review on the day of the assessment.		
Briefly describe specialized clinical programs or services for the diagnosis and management of patients with sleep/wake disorders:		