THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

INDEPENDENT HEALTH FACILITIES

FACILITY PRE-ASSESSMENT QUESTIONNAIRE

HAEMODIALYSIS

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.

Name of Quality Advisor	Date
Name of Licensee	Date
Name of Most Responsible Person/Title	Date

THE FACILITY

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

GENERAL			
Name of Facility:			
Billing (IHF) #			
Mailing Address:			
Telephone:		**Fax:**	
Hours of operation:			

Name and mailing address of Licensee for 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 Unit Manager of Facility:			
Telephone:		**Fax:**	
Email:			
Valid cNEPH or equivalent Certificate:	Attachment included ☐		

Provide a list of all acute care hospitals that refer patients to the facility.

Can the facility accommodate transient patient?	Yes ◯ No ◯
Is there a formal referral mechanism?	Yes ◯ No ◯

Describe your patient record. (i.e. Paper, EMR, Hybrid) **EMR system:**	
Does the Facility utilize Telemedicine for Physicians or Allied Health Team?	Yes ◯ No ◯
If yes, please describe. (i.e. Secure Network, appropriate privacy in place)	

STAFF

GENERAL	
Name of: Medical Director	
(Please attach signed agreement)	Attachment included ☐
Name of Quality Advisor and Specialty:	
(Please attach signed agreement)	Attachment included ☐

Is there a Joint Health and Safety Committee (based on number of workers)? Refer to the Guide for Health and Safety Committees and Representatives **Attach the last 3 meeting minutes.**	Yes ◯ No ◯ N/A ◯ Attachments included ☐

TRAINING & CERTIFICATION

The following table is to be completed for all staff employed at the Facility (including regulatory license # - casual, part time and full time; administrative staff) (RPN, RN, Hemodialysis technologist, Hemodialysis Aide, Dietician, Pharmacist, Social Worker, etc.)

Name	Role	Certificate of Registration Number or N/A	Online Regulatory Status Attached	D'Souza Certification[1] Attached	WHMIS[2] Date Completed dd/mm/yyyy	Health and Safety Awareness[2] Date Completed dd/mm/yyyy	Workplace Violence and Sexual Harassment[2] Date Completed dd/mm/yyyy	AODA[2] Date Completed dd/mm/yyyy	BLS[3] Attached Or N/A (Att) (n/a)	IPAC Core[4] Attached (6 modules)	IPAC Reprocessing[5] Attached (9 modules)
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1) D'Souza Certification for each staff member (include copies of course registration if close to expiry)

2) Workplace Hazardous Materials Information System 2015 (WHMIS 2015); Health and safety awareness; Workplace violence and sexual harassment, and Accessibility for Ontarians with Disabilities: The Clinical Practice Parameters and Facility Standards stipulate under "Staffing a Facility" that staff obtains education/training (which is documented and maintained on site) in areas mandated by the Ontario Government

3) BLS: Attach a copy of *valid* cards for each staff member (include copies of course registration if close to expiry)

4) IPAC: ALL STAFF: Public Health Ontario's Infection Prevention and Control online training courses: IPAC Core Competencies Course

5) IPAC: STAFF RESPONSIBLE FOR CLEANING, DISINFECTING, STERILIZING, AND/OR REPROCESSING OF MEDICAL EQUIPMENT MUST COMPLETE ADEQUATE EDUCATION AND TRAINING, INCLUDING MANUFACTURER'S TRAINING. Public Health Ontario's Infection Prevention and Control online training courses: Reprocessing in Community Health Care Settings Course.

POLICIES & PROCEDURES

Please provide a complete COPY of the manual to IHF Program at the CPSO. ☐

Where is the policies and procedures manual kept?	
Is the manual easily accessible to all staff?	Yes ◯ No ◯
How frequently is the policies and procedures manual reviewed by staff?	
When was the policies and procedures manual last updated?	(dd/mm/yyyy)
Who reviews and updates the policies/procedures manual? (i.e. Quality Advisor, Unit Managers, etc.)	
What is the process to advise staff of changes to the policies and procedures manual?	
Are all changes initialled and dated by staff?	Yes ◯ No ◯
Do all staff sign and date the policies/procedures manual at least annually?	Yes ◯ No ◯

INFECTION CONTROL

Attach written policy with a detailed description of infection control procedures for *disinfection* of equipment and training, and process of compliance and annual review.	Attachment included ☐

FACILITIES, EQUIPMENT & SUPPLIES

Please describe the location of the facility. (e.g. location in community (e.g. medical building, free standing building)
Describe the parking at the facility (free or paid).
Provide a diagram of the facility layout including the dimensions of the hemodialysis treatment area, description of the nursing station and storage areas, and the location of all sinks and drains, # of washrooms. Attachment included ☐

Where is your IHF License posted?	
Is the facility wheelchair accessible?	Yes ◯ No ◯
Can the facility accommodate for bariatric patients with: • **Chairs?** • **Scales?**	Yes ◯ No ◯ Yes ◯ No ◯
Where are the fire extinguisher(s) located?	
Where are the safety data sheets posted?	

Does your facility have separate areas for each of the following functions?			
Patient waiting area	Yes ◯	No ◯	N/A ◯
Change rooms	Yes ◯	No ◯	N/A ◯
Patient washrooms	Yes ◯	No ◯	N/A ◯
Hemodialysis Treatment Area	Yes ◯	No ◯	N/A ◯

Nursing Station	Yes ◯	No ◯	N/A ◯
Facility storage supply	Yes ◯	No ◯	N/A ◯
Medication Storage Area	Yes ◯	No ◯	N/A ◯

Describe the method used to track patient/staff incidents and include a copy of the incident report used. Attachment included ☐

Is the following equipment available for managing emergencies related to the types of services provided?	
First Aid Kit **Where?**	Yes ◯ No ◯ _____
Is there an emergency eyewash station (plumbed)? **Where?**	Yes ◯ No ◯ _____
Is there an emergency/resuscitation cart (if applicable)? **Where?**	Yes ◯ No ◯ _____

If contracted services are used, are these written contracts/agreements outlining responsibilities of all parties.	
Nursing:	Yes ◯ No ◯
Clerical:	Yes ◯ No ◯
Housekeeping:	Yes ◯ No ◯
Equipment/technical:	Yes ◯ No ◯

Provide a list of all routine diagnostic testing conducted and the frequency. Is the testing conducted at the facility, an outside laboratory or at the referring hospital?
Describe the water treatment facility and the waste quality monitoring procedures.
Describe the type of dialysate concentrate used and the manufacture.

EQUIPMENT

List ALL the equipment currently in use in this facility (water treatment equipment, dialysis machine and ultrasound and access flow monitor):

Type of equipment (Modality)	Year of manufacture	Equipment manufacturer (Make, Model, & Maintenance Schedule)	Serial number	Date acquired DD/MON/YY i.e. 01/Jan/18	Modifications and upgrades (including dates)	Quality Control records (provide last annual maintenance report)
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QUALITY MANAGEMENT

Who are the members of your Quality Advisory Committee? Please list their names and roles	
Name:	**Role:**
Please provide copies of agendas and minutes for the last three meetings.	Attachments included ☐

What steps are taken by the staff in order to carry out procedures in a manner that respects patient privacy?	
How is information communicated to staff?	
How often are staff meetings held?	
Please provide copies of the agendas and minutes for the last three meetings	Attachments included ☐
Describe your performance appraisal system including how frequently it is carried out:	

PATIENT ACCESS & OUTCOMES

Do patients have access to an allied care team?	Yes ◯ No ◯
Provide an explanation of how patients receive the services of the allied care team?	
Provide a sample of the dialysis treatment record.	Attachment included ☐
How is the adequacy of dialysis assessed and include the frequency?	

Describe the facility's systems of quality control and monitoring of patient outcomes.

Based on the number of patients on treatment in your facility on the last day of the month prior to your assessment, please provide the data requested for each of the following:	
Anaemia	
For all facility patients	
• Mean haemoglobin	
• Percent of patients with a haemoglobin less than 90 gm/l	
• Number of patients transfused in the last year	
• Percent of patients on intravenous iron	
• Percent of patients on oral iron	
Infection	
• Number of patients treated with IV antibiotics for sepsis annually	
Blood Pressure	
• Percent of patients with a post-dialysis systolic BP > 160 mmHg or diastolic >100 mmHg	
Nutrition	
• Percent of patients with an albumin < 35 gm/l	
• Percent of patients with a predialysis K.> 6.0 mmol/l	
• Mean serum albumin for all patients	
Adequacy	
• Percent of patients with a URR < 60%	
• Percent of patients with a Kt/V < 1.2	
Osteodystrophy	
• Percent of patients with a serum calcium < 2 pmol/L	
• Percent of patients with a serum phosphate > 2 pmol/L	
• Percent of patients with an alkaline phosphatase greater than 150% of normal	
• Percent of patients with a serum PTH more than 4 times normal	
Transplantation	
• Percent of patients on a transplant waiting list	
General	
• Number of patients transferred acutely to an acute care hospital by month	
• Number of deaths	
• Number of cardiac arrests	

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