Pre-Assessment Questionnaire for Pulmonary Function Studies

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

GENERAL - Please provide a list of all staff currently working in the facility.

1. Name of Facility: ________________________________________________
   Mailing Address: ________________________________________________
   Telephone Number: __________________ Fax Number: ______________

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

3. Name(s) and mailing address(s) of other facilities owned or operated by the
   licensee of this facility: _______________________________________
   ______________________________________________________________
   ______________________________________________________________
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   ______________________________________________________________
   ______________________________________________________________

4. Name of Manager/Supervisor of facility (if applicable): ________________
   Mailing Address: ________________________________________________
   Telephone Number: __________________ Fax Number: ______________

5. What category of procedures are you licensed to perform in this facility?
   ______________________________________________________________
   ______________________________________________________________

6. What studies is the facility currently performing?
   ______________________________________________________________
   ______________________________________________________________

7. Are staff trained in Basic Cardiopulmonary Resuscitation (BCLS)?
   Yes ☐ No ☐ Please provide a copy of your staff’s current certificates
8. Does your facility have separate areas for each of the following functions:

<table>
<thead>
<tr>
<th>Function</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Patient waiting area</td>
<td>☐</td>
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<td>N/A</td>
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<tr>
<td>Change Rooms</td>
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<tr>
<td>Patient washrooms</td>
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<tr>
<td>Procedures rooms</td>
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<td>N/A</td>
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<tr>
<td>Facility storage supply</td>
<td>☐</td>
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<td>N/A</td>
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</table>

9. Is the facility wheelchair accessible? Yes ☐ No ☐

10. Is your IHF license posted in the patient waiting area? Yes ☐ No ☐

If no, where is the IHF licence posted? ________________________________

11. Are any procedures performed or reported by physicians without specialist qualifications? Yes ☐ No ☐

12. Percentage of examinations performed by pulmonary function technologists. _____________%

13. Percentage of pulmonary function studies performed by physicians. _____________%

14. If the physicians are not on site, describe the method in which technologists consult with him/her on a case by case basis?

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15. What improvements/recommendations were you asked to address from the previous assessment?

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16. Have you hired any new staff since your last assessment? Yes ☐ No ☐ If yes, list start date: ________________________________
Please ensure that a copy of your curriculum vitae and the written agreement between the owner/operator and yourself are available to be reviewed on the day of the assessment.

1. Name: _______________________________________ CPSO#______________
   Office address: ______________________________________________________
   ____________________________________ _______________________________
   Telephone Number: ___________________ Fax Number: ___________________
   Cell Phone: __________________________ E-mail Address: ___________________
   Royal College Certification in: _________________________________________
   Year completed: ___________________________________________________

2. List procedures in which you provide interpreting services: _________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

3. List CME within the last three years relevant to the patterns of practice; Please complete the professional log on Page 6

   *Note: Be sure to attach a copy of your Maintenance of Certification Credit Summary and Royal College of Physicians and Surgeons of Canada Activity Summary.*

4. How often do you visit the facility and how do you document this?  
   ___________________________________________________________________

5. When was the last visit? ___________________________________________

6. Describe your activities in relation to interaction with the facility staff?  
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

7. How do you contribute to the process of continuous quality improvement?  
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

8. How are you involved in updating and maintaining the quality control activities?  
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
Do these activities include, but are not limited to the following:

- All corrective actions documented and signed off? Yes ☐ No ☐
- All quality control results reviewed and signed off? Yes ☐ No ☐
- Quality control activities reviewed annually? Yes ☐ No ☐

9. Please provide a list of the facilities you are quality advisor for?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

10. Please provide a list of facilities that you provide interpreting services for but are not the Quality Advisor (if applicable)

_________________________________________________________________
_________________________________________________________________
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11. As Quality Advisor you are required to fulfill the roles and responsibilities of the QA, briefly explain how you accomplish this role

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<tr>
<th>Activity</th>
<th>Summary of Activity</th>
<th>Impact on Practice</th>
<th>Evaluation of Activity</th>
<th>Hours of Participation</th>
<th>Completion Date</th>
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</table>
Please complete for each interpreting physician. Please ensure that your curriculum vitae and continuing professional activities are available for review on the day of the assessment.

1. Name: _______________________________________ CPSO#__________________
   Office Address: ____________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   Telephone Number: ___________________ Fax Number:____________________
   Cell Phone:____________________ Email Address________________________
   Royal College Certification in: _________________________________________
   Year Completed: ___________________________________________________

2. List procedures you provide interpreting services: _________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. List CME within the last 3 years relevant to the patterns of practice. Please complete the Professional Activity Log on Page 6.

   Note: Be sure to attach a copy of your Maintenance of Certification Credit Summary and Royal College of Physicians and Surgeons of Canada Activity Summary.

4. How often do you visit the facility and how do you document this?
   ________________________________________________________________

4. When was the last visit? ________________________________________

5. Describe your activities in relation to interaction with the facility staff?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
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   ________________________________________________________________

6. How do you contribute to the process of continuous quality improvement?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
7. Please provide a list of the other facilities you provide interpreting services for? How many other facilities do you provide interpreting services for?

__________________________________ _______________________________
1. Name: ______________________________________________________

2. Are you a:
   Registered Cardiopulmonary Technologist (RCPT)   Yes □ No □
   Registered respiratory care practitioner (RRCP)? Yes □ No □

3. Are you a health care professional with relevant training in pulmonary function studies? Yes □ No □

4. Please describe your training in pulmonary function studies including location and dates: __________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

5. Please explain how you keep current with the technical trends in the cardiopulmonary field?
   G attend conferences
   G meetings or other forms of continuing educations
   G review of literature

   Please complete the Professional Activity Log on Page 6.

6. Please check tests which you are currently performing in the facility
   G oximetry
   G non-specific bronchoprovocative testing
   G carbon monoxide diffusing capacity (DLCO)
   G MIPs & MEPs
   G functional residual capacity (FRC)
   G stage 1 exercise testing
   G exercise challenge testing for asthma

7. What percentage of time do you spend in the facility? ______________

8. Please list other facilities you provide testing for (if applicable)?
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
List the pulmonary function equipment currently in use in this facility:

<table>
<thead>
<tr>
<th>TYPE OF EQUIPMENT AND YEAR MANUFACTURED</th>
<th>EQUIPMENT MANUFACTURER</th>
<th>SERIAL NUMBER</th>
<th>DATE ACQUIRED YY/MM/DD</th>
<th>MODIFICATIONS &amp; UPGRADES</th>
<th>CALIBRATION RECORD AVAILABLE (please attach copy)</th>
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</tbody>
</table>
1. Where are the fire extinguishers located?

2. Is the following equipment available for managing emergencies related to the types of services provided?

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sphygmomanometer and stethoscope</td>
<td>G</td>
<td>G</td>
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<tr>
<td>Wheelchair</td>
<td>G</td>
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<tr>
<td>Airway Management Equipment</td>
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<tr>
<td>Appropriate Drugs</td>
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<tr>
<td>Resuscitation Equipment</td>
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</table>

3. Is staff trained in Basic Cardiopulmonary Resuscitation (BCLS)? G Yes G No
   Please provide a copy of your staff’s current certificates

4. Has all staff received WHMIS training? G Yes G No

5. Where are the Material Safety Data Sheets (MSDS) posted?

6. Name the person responsible for conducting and documenting quality control activities?

7. Based on the tests conducted at the facility, briefly explain the QC procedures and frequency in which this is performed?

   ———————————————————————————————————————————————————————————
   ———————————————————————————————————————————————————————————
1. Does your facility have a policies and procedures manual as described in the Clinical Practice Parameters and Facility Standards for Pulmonary Function Studies? G Yes G No

Is the manual site specific? G Yes G No

*Please provide a copy of the manual to the technologist assessor along with the completed pre-visit questionnaire*

2. Where is the policies and procedures manual kept? ____________________________________________________________

3. How frequently is the policies and procedures manual reviewed by staff? ____________________________________________________________

4. Who is responsible for reviewing and updating the policies and procedures manual? (example Quality Advisor, Manager, Technologist) ____________________________________________________________

5. What is the process to advise staff of changes to the policies and procedures manual? ____________________________________________________________

6. Are all changes initialled and dated by staff? G Yes G No

7. Do all staff sign and date the policies and procedures manual? G Yes G No
Please enclose a sample requisition, technologist worksheets and a sample (John Doe) interpretation report.

1. If a patient arrives with a requisition containing incomplete information, how does the facility obtain the necessary information prior to conducting the procedure?

   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________

2. What is your standard practice for report turnaround time to the referring physician?

   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________

3. 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?

   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________
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4. Do you have a process for handling stat requests? If so, please describe the process.

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5. Where is your patient records stored?
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6. What is your method of filing each patient record?
___________________________________________________________________
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7. How do you flag your unusual and interesting examinations for educational purposes?
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___________________________________________________________________
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8. How long are your records retained and how are they identified for purging?
___________________________________________________________________
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___________________________________________________________________
1. Who are the members of your Quality Advisory Committee? Please provide a list of their name and title within the organization.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2. How often does the Quality Advisory Committee meet?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Are these meetings documented and minutes taken? G Yes G No

Does your quality management program include the following components?:

- Establishing a mechanism for periodic review of selected original data for all types of tests performed by the facility to establish that tests are properly performed and reliable [GYes GNo]
- Regular review of calibration and validation data on equipment, noting any deviations from accepted norms and recording corrective action taken, if required. [GYes GNo]
- Reporting and reviewing all incidents, adverse drug reactions, complications [GYes GNo]
- Review of goals and objectives for the facility [GYes GNo]
- Review of policies and procedures [GYes GNo]
- Review of clinical data, e.g. assessing accuracy of interpretation, appropriateness of examinations [GYes GNo]
- Referring physician surveys [GYes GNo]
- Patient Surveys [GYes GNo]

3. What steps are taken by the staff in order to carry out PFT testing in a manner that respects patient privacy?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
4. Does staff contribute to continuously improve the services provided? How is this achieved?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

5. How is information communicated to your staff?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

6. How often are staff meetings held? ________________________________

➢ Are these meetings documented  GYes  G No