QUALITY ASSURANCE

Practice Assessment Questionnaire

Dear member:

As part of your practice assessment, please complete the attached Practice Assessment Questionnaire. The purpose of the Questionnaire is twofold. First, it assists the Assessor in the interpretation of your records as well as giving the Assessor and the Quality Assurance Committee a snapshot of your practice in order to determine if you are meeting regulatory and professional standards.

In order to assist the Assessor and Committee in clearly understanding your answers to the questionnaire, when indicated, please provide type written answers to questions separately.

Please include this completed questionnaire in the package with your clinical records. If you have any questions about the questionnaire, please do not hesitate to contact me.

Thank you for your time and cooperation.

Sincerely,

Manager, Quality Programs

PRACTICE REVIEW QUESTIONNAIRE

1. SERVICES PROVIDED

Please indicate which of the following therapeutic/treatment services you provide:

Oculovisual Assessment ☐
Refractive surgery co-management ☐
Glaucoma co-management ☐
Cataract surgery co-management ☐
Spectacle Therapy ☐
Contact Lens Therapy ☐
Binocular vision therapy / orthoptics ☐
Low Vision therapy ☐

Do you provide any additional services not listed above? Yes ☐ No ☐
If so, please describe:

_____

_____

_____

Do you limit your practice to a particular patient population? Yes ☐ No ☐
If so, please describe:

_____

_____

_____

2. ACRONYMS / ABBREVIATIONS

Please provide a type written response to this question by attaching a separate form clearly indicating the acronyms and abbreviations you commonly use in your clinical records.

In order to allow our assessors to properly interpret your notes, review the records you are submitting to ensure all acronyms and abbreviations that you have used appear on the list.

In addition, please provide a copy of your template/blank patient record for reference.

List attached: ☐
Blank patient record attached: ☐

3. REFERRALS

Please provide a type written response to this question. Describe your protocol for referral to and from other healthcare professionals.

4. REQUIRED CLINICAL EQUIPMENT

Please provide a type written response to this question

OPR 4.1 indicates that optometrists have access to certain instrumentation, pharmaceuticals and supplies. Please indicate what specific instrumentation, pharmaceuticals and supplies you use in your practice to:

- Measure distance visual acuity
- Measure near visual acuity
- Objectively determine refractive status of the eyes
- Subjectively determine refractive status of the eyes
- Measure corneal curvature
- Assess ocular motility and binocular function
- Examine external structures of the eye
- Examine internal structures of the eye
- Measure intraocular pressure
- Perform pupil dilation
- Perform cycloplegia
- Anesthetize the cornea
- Diagnostically stain external structures of the eye
- Measure parameters of spectacle lenses
- Measure parameters of contact lenses
- Assess the eye and ocular adnexa
- Treat common primary ocular emergencies
- Provide in-office infection control

5. PUPIL DILATION

Please provide a type written response to this question.

Describe your protocol for pupil dilation and how you determine which patients require fundus internal ocular structure examination through a dilated pupil.

6. CYCLOPLEGIA

Please provide a type written response to this question.
Describe your protocol for cycloplegia and how you determine which patients require assessment using cycloplegia.

7. DELEGATION AND ASSIGNMENT

Please provide a type written response to this question.
Review the College policy on Delegation and Assignment (OPR 4.3). Describe the tasks in your office that are delegated or assigned to staff. Describe your process for delegation and assignment or attach your office policy that includes:

- Education, ensuring the currency of the delegate's knowledge and skills
- Ensuring that the delegate maintains competence in the performance of the delegated act
- Documentation of procedures
- Supervision
- Ongoing quality assurance

8. IDENTIFICATION OF RECORDS

Is there more than one optometrist at your practice location? Yes ☐ No ☐
If yes, a type written response is required for the following.
What method is used to identify the individual that makes entries in a patient record?

9. OCULAR URGENCIES AND EMERGENCIES

Do you have staff guidelines for identifying patients who require urgent care?

Yes ☐ No ☐

Please describe these guidelines or attach your office policy. If providing a description, a **type written** response is required.

10. ELECTRONIC RECORDS

Do you use electronic records in your office? Yes ☐ No ☐
If yes, a type written response is required for the following:

Describe how your computer system manages:

- Recording date and time of each entry of information for each patient.
- Indicates changes in the recorded information.
- Preserves the original content of the recorded information when changed or updated.
- Protection against unauthorized access.
- Backup and recovery of electronic data.

11. WELCOME SHEET

Do you use a "welcome" sheet for patients? Yes ☐ No ☐

If yes, do you use the "welcome sheet" for each visit of every patient? Yes ☐ No ☐

In addition, please provide a copy of your template "welcome sheet" for reference.