Diagnostic Imaging Facility Standards Assessor Checklist

Facility Name:	
Billing Number:	
Date of Assessment:	

HOW TO USE: The purpose of the assessor checklist is to verify that the information that the facility has provided in the pre-visit questionnaire has been reviewed by you (the assessors).

STAFFING	Meets	Meets with Rec's	Does not meet	N/A	Comments
1. Are the physicians providing interpreting services licensed to practice by the CPSO and					
• Certified by the RCPC in Diagnostic Imaging?					
• Certified by the RCPC or RCSC to conduct ultrasound services within the scope of their practice and demonstrate knowledge skills and competency to perform these studies?					
• Or approved by the Registration Committee of the CPSO with an independent practice licence?					
2. If the interpreting physician is not on site, is he/she available for consultation by telephone on a case-by-case basis?					
3. Are the ultrasound technologists registered with either the ARDMS or CARDUP?					
4a. Are the ultrasound technologists (ARDMS certified) registered in the specific modalities performed in the IHF? (see PVQ)					
4b. Do the CARDUP registered technologists have the appropriate designation (CRGS/GRCS/CRVS)?					
5. Do the medical radiation technologists meet the requirements for certificate of registration by the CMRTO?					
6. Have the technologists performing bone densitometry obtained certification by the International Society for Clinical Densitometry or have documented any equivalent competency training in BMD?					

7. Have the technologists performing mammography obtained further training in either their training curriculum or through special courses and are performing these services on a regular basis?					
8. Have the technologists performing fluoroscopy procedures completed a recognized training program in fluoroscopy procedures?					
9. Do the physicians maintain continuing professional development activities relevant to the types of modalities provided and as mandated by their respective College?					
10. Do the technologists maintain continuing professional development activities as mandated by their respective Colleges/Organizations?					
11. Is at least one staff member with current BCLS certification on site at all times during hours of operation?					
12. Have staff have obtained education in WHMIS training which is documented and maintained on site?					
QUALITY ADVISOR	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Is there a designated Quality Advisor?					
2. Is there a formal written agreement for the Quality Advisor to advise the facility owner/operator with respect to the quality of the services provided?					
3. Does the Quality Advisor personally attend the facility at least twice year or more frequently, where required, in the opinion of the Quality Advisor based on the volume and types of services provided in the facility?					
a) Are these visits documented in relation to the Quality Advisor's role?					
4. Does the Quality Advisor seek advice from other health professionals where necessary to ensure that all aspects of the services provided through the IHF are provided in accordance with generally accepted professional standards?					
5. Does the Quality Advisor obtain copies of assessment reports from the licensee/owner/operator?					

6. Does the Quality Advisor advise the licensee on the implementation of an ongoing Quality Management Program?					
7. Does the Quality Advisor advise the licensee and document the provision of such advice in connection with the following:					
b) Health professional staff hiring decisions in order to ensure that potential candidates have the appropriate knowledge, skill and competency required to provide the types of services provided in the facility					
c) Continuing Education for all health professional staff members employed as may be required by their respective regulatory Colleges or Associations					
d) Appropriate certification for all health professional staff with their respective regulatory Colleges or Associations					
e) Leadership as may be required to address and resolve any care-related disputes that may arise between patients and health professional staff					
f) Appropriate resources for health professional staff members employed in the facility					
g) Technology used in the facility, in order to ensure it meets the current standard(s) and is maintained through a service program to deliver optimal performance					
h) Equipment and other purchases as may be related to patient care					
i) Issues or concerns identified by any staff member, if related to conditions within the facility that may affect the quality of any aspect of patient care					
j) Establishing and/or updating system(s) for monitoring the results of the service(s) provided in the facility.					
8. Has the Quality Advisor met the expectations of a Quality Advisor as outlined above, if not please specify?					
POLICIES & PROCEDURES	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Is the policies and procedures manual available for consultation by all facility staff?					

2. Are there written policies and procedures for the following:					
Facility					
• Scope and limitation of diagnostic imaging services provided by the facility					
• Patient-booking systems					
• Documentation of and method for receiving written and telephone referrals for consultation					
Facility Staff					
• Delegated acts/medical directives					
• Safety training for medical and non-medical staff					
Records and Communication/Reporting & Privacy Principles					
• Methods for preliminary interpretations (e.g. verbal reports) and/or telephone calls of reports, and for the subsequent written interpretation of images by qualified diagnostic imaging physicians					
• Patient consent, written or verbal based on the scope of practice in the facility and in accordance with the Health Care Consent Act.					
• Maintenance of requisitions, imaging media and interpretation reports as per the IHF Regulations					
• Confidentiality					
Diagnostic Services					
• Instructions regarding routine preparation of patients.					
• Appropriate technique charts for all diagnostic imaging services performed in the facility					
• Use of protective devices including procedures on proper collimation and shielding					
• Timing and permission of additional family/friend presence during the performance of any examination.					
Equipment Maintenance					
• Routine maintenance and calibration of equipment.					
Quality Management					

• Are the goals, procedures and protocols for the quality management program written and included in the policy and procedure manual?					
Emergency Procedures and Safety Policies					
• Specific first aid measures to be followed in an adverse health event, including a description of the arrangements for transferring patients to an acute care facility when required					
• Latex anaphylaxis					
• Material Safety Data Sheets for all chemicals maintained in the facility					
• Infection Control- resources available through the Provincial Infectious Disease Advisory Committee of Public Health Ontario					
• Radiation Safety and Dose Reduction (ALARA)					
3. Is the manual reviewed annually, revised as necessary and dated to indicate the time of the last review or revision?					
4. Is there evidence that the policies and procedures are implemented by the staff?					
INFECTION CONTROL	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Does the facility have available the basic supplies for infection, prevention and control on site and used appropriately as per the currently provincial guidelines/policies (PIDAC)?					
Imaging Equipment					
2. Is the patient table, stands, x-ray tubes and accessory equipment cleaned regularly according to the infection control protocols?					
Ultrasound Probe Care					
3. Are all vaginal and transrectal probes or any other probes coming into contact with bodily fluids covered by a disposable sheath for examination?					
4. Is the disinfectant solution checked daily for potency?					
5. Following an examination, are the probes manually cleaned, then soaked in a high level anti-microbial disinfectant solution according to manufacturer and infectious disease recommendations?					

6. Are there a sufficient amount of probes available in order to ensure sufficient reprocessing times as per manufacturer's directions in order to properly clean and disinfect the transducers between uses?					
7. Is appropriate hand hygiene performed before handling the disinfected transducer to dry the unit and replace back into holder?					
8. Are the disinfectant solutions changed and disposed of as per manufacturer's instructions?					
• Is this activity documented?					
9. When changing, is the container cleaned appropriately prior to the container being refilled with the new disinfectant solution?					
10. Are ultrasound gels used in accordance to Health Canada recommended practices?					
11. Are there appropriate gloves, masks, gowns and eye-protection equipment available and used when necessary to protect both patient and personnel?					
12. Is there a written protocol to manage all patients with potentially infectious respiratory conditions?					
REQUESTING & REPORTING MECHANISMS	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Are copies of the reports and written requests maintained as per the IHF Act regulations 57/92?					
2. Is the imaging media and reports filed using an accepted coding system which allows films and reports to be retrieved by patient identification information.					
3. Is there a mechanism in place to identify urgent requests and communicate critical information on a timely basis?					
4. Is there a mechanism in place to ensure technologists are not providing preliminary findings to patients/referring physicians without consulting the radiologist?					
5. Are unusual and interesting examinations maintained for educational purposes?					

6. Are previous stored diagnostic images available for the interpreting physician?					
7. Does the IHF have the ability to retrieve and/or produce a copy of the image(s) stored within one working day of the request as required?					
8. Are the final interpretive reports transmitted to the referring physician within 24-48 hours?					
9. If the reports are transmitted by paper, fax or secure e-mail is there a "read receipt" mechanism in place to identify any report that has been sent but not viewed by the ordering physician/healthcare provider?					
10. Is there a mechanism in place to ensure that when requested, films from another IHF for comparison purposes are provided to the facility within 3 – 5 working days of the IHF receiving the original request?					
11. When requested, are films/reports provided to patients at no cost for their ongoing care/treatment within 3 working days of receiving the request?					
FACILITIES, EQUIPMENT & SUPPLIES	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Does the facility have adequate equipment and supplies for the safe and efficient performance of diagnostic imaging services?					
2. Is the facility neat, clean and free from waste material?					
3. Is there appropriate emergency/facilities equipment for the types of services provided including:					
• Fire extinguisher?					
• MSDS information sheets?					
• First Aid Kit?					
4. Is there sufficient space to meet the workload requirements to ensure the effect care and privacy of patients available?					
5. Are TLD monitoring devices (with the exception of mammography services) worn by the technologist staff?					

6. Are the TLD monitoring reports posted within the facility and available for staff review?					
7. Does the facility have alternate materials available for patients with known or suspected latex allergies?					
8. Are pregnancy warning signs posted in the following areas? (if applicable)					
• waiting area					
• change rooms					
• examination rooms					
9. Does the diagnostic radiography and fluoroscopy equipment meet the recommended guidelines for age (20 years)?					
• If beyond the recommended age does the equipment continue to meet HARP requirements and/or has been upgraded to meeting current specifications?					
10. Does the mammography equipment meet the CAR Accreditation Standards requirements?					
11. Does the BMD equipment meet the requirements of the Canadian BMD Accreditation Program (CMBD)?					
12. Does the ultrasound equipment meet the recommended guidelines for age (7 years)?					
• If beyond the recommended age, does the equipment continue to undergo preventive maintenance/calibration and /or has been upgraded to meet current specifications?					
QUALITY CONTROL	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
Radiography					
1. Is there appropriate lead equipment available in each radiation examination room?					
2. Are doors leading to all radiation examination rooms self-closing?					
Mammography					

3. Does the mammography equipment and quality control activities meet CAR Accreditation?					
BMD					
4. Do the BMD equipment and quality control activities meet Canadian BMD Accreditation Program requirements?					
Ultrasound					
5. Do all ultrasound units and probes have a regular program of preventive maintenance to ensure optimal operation as per the manufacturer's recommendations?					
• Are these activities documented?					
PROCESSING	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Does the processor undergo regular maintenance? Does the facility maintain records of this activity?					
2. Does the facility conduct the following processor activities: regular processor cleaning, maintenance and monitoring (if applicable), screen contact testing, screen cleaning, lead protective devices check on at least an annual basis, repeat/reject analysis, darkroom light leak test.					
3. Is this a PACS Facility?					
4. Is there a designated PACS Administrator?					
PROVIDING QUALITY CARE	**Meets**	**Meets with Rec's**	**Does not meet**	**N/A**	**Comments**
1. Has a Quality Advisory Committee being established as outlined in the IHF Act?					
2. Is the Quality Advisor been appointed Chair of the Quality Advisory Committee?					
3. Does the QA Committee consist of health professionals who provide health services in or in connection with the IHF?					
4. Does the QA Committee meet at least once a year and/or at least twice a year if the facility employs more than six full time staff equivalents including the Quality Advisor?					

5. Are there regular agenda items including but not limited to the following:					
• Review of cases					
• Policies and procedures					
• QC matters on equipment					
• Incidents					
• Staffing issues					
6. Does the Committee supervise the creation and maintenance of a quality management program adequate to reach the quality management program goals?					
7. Do the goals of the program include but are not limited to ensuring that:					
• Services planned and provided are consistent with the patient's needs and assure diagnostic reliability and patient safety					
• Services conducted in the facility are safe					
• Services conducted are appropriate to the problem(s) being investigated					
• Performance of diagnostic radiological examinations comply with the CAR standards and/or generally accepted medical standards of practice?					
8. Does the facility's quality management activities include but are not limited to:					
a) Review quality management goals and objectives annually					
b) Supervise and document a systematic ongoing review of the facility policy and procedures manual					
c) Review safety data on any equipment new to the facility since the last meeting, and ensure that all equipment in the facility meets safety standards					
d) Review any incident or accident report since the last meeting and document any such actions to prevent similar incidents or accidents. Provide a report of all such proceedings to the Quality Advisor					
e) Recommendations from other assessing bodies such as the MOHLTC X-ray Inspection Services and HARP					

f) Supervise and document a program of annual performance reviews for all staff who have patient contact, including documentation of action taken to correct any significant deficiencies in performance					
g) Ensure registration certificates, BCLS certificates, etc. are current					
h) Review the CPD activities of the technical and medical staff					
i) Promote the discussion of interesting/challenging cases seen at the facility and disseminate any teaching points to the staff for educational purpose					
j) Review results of regular surveys of patient, referring physician and staff satisfaction documenting actions to address any suggestions, problems or issues raised.					
k) Scope of practice: services provided including staff qualifications and CPD plans					
l) Compliance with quality assurance protocols as appropriate (such as nuchal translucency (NT) qualification)					
m) Assessing the accuracy of interpretations and the appropriateness of procedures process. The IHF must provide a description of the process of how this is done.					
n) Review any deficiencies identified from previous assessment reports with the Quality Advisor approving and signing any written plan of actions to correct deficiencies to the CPSO?					
9. Does the staff participate in planning strategies to overcome any deficiencies and to continually improve the services provided to patients?					
10. Are <u>all</u> these activities documented?					
11. Based on the information reviewed has the facility established and documented a quality management program appropriate for its volume and types of services provided?					

Comments: