The College of Physicians and Surgeons of Ontario

INDEPENDENT HEALTH FACILITIES PROGRAM

Pre-Assessment Questionnaire

DIAGNOSTIC IMAGING - FACILITY

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 (IHF) #			
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 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
Procedure rooms	◯ Yes	◯ No	◯ N/A
Image storage	◯ Yes	◯ No	◯ N/A
Processing areas	◯ 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 services are you <u>licensed</u> to perform in this Facility (i.e radiography, BMD)? (only list those that pertain to this particular billing number)	
Are you performing all the services listed on your license?	◯ Yes ◯ No
If no, please identify which services are not being performed.	

Are you accredited for mammography?	◯ Yes ◯ No
Are you accredited for BMD?	◯ Yes ◯ No

* FOR MOBILE DIAGNOSTIC IMAGING FACILITIES *

Please use separate page for each site for those facilities providing mobile services

Site Information	
Location #:	
Facility Name:	
Site Code:	
Site Location:	
Location Type	
◯ Doctors Office ◯ LTC Facility ◯ Hospital ◯ Correctional ◯ Other	

How often is the site visited?	◯ Weekly ◯ Monthly:
Average hrs/visit?	
Where are images interpreted?	

ULTRASOUND	
Number of **abdominal** examinations per week:	
Number of **obstetrical/gynaecological** examinations per week:	
Number of **vascular** examinations per week:	
Number of **Nuchal translucencies** per week**:**	
GENERAL RADIOGRAPHY	
Number of **chest** examinations per week:	
Number of **extremity** examinations per week:	
Number of other types of examinations **not listed** per week:	

Copy pages as necessary

STAFF

GENERAL	
Name of Radiation Protection Officer:	
(Please attached signed agreement)	Attachment included ☐
Name of Quality Advisor:	
For facilities providing Ultrasound Services, which of the following physicians perform/interprets ultrasound in your facility.	
If imaging physicians are not on-site, describe the method in which technologists consult with him/her on a case-by-case basis?	
If technologists are performing fluoroscopic procedures, is there a radiologist on-site on a case-by-case basis?	◯ Yes ◯ No
How do you ensure that there is a radiologist on site?	

For facilities providing Ultrasound Services, which of the following physicians performs/interprets ultrasound in your facility:				
				% of studies interpreted by each specialist?
Radiologists	◯ Yes	◯ No	◯ N/A	
Obstetricians/Gynecologists	◯ Yes	◯ No	◯ N/A	
Vascular Surgeons	◯ Yes	◯ No	◯ N/A	
Urologists	◯ Yes	◯ No	◯ N/A	
Ophthalmologists	◯ Yes	◯ No	◯ N/A	
Cardiologists	◯ Yes	◯ No	◯ N/A	
General Surgeons	◯ Yes	◯ No	◯ N/A	
Other:	◯ Yes	◯ No	◯ N/A	

TECHNOLOGISTS - Radiography

Please complete for EACH Technologist currently working in the facility (part time and full time).

Name:		
CMRTO #		Copy of your online registration status sheet attached ☐
Please check procedures which you are performing at this Facility: (X)		
☐ General Radiography ☐ Mammography	☐ Fluoroscopy ☐ Bone Mineral Densitometry	
☐ Other:		
If performing mammography: Please describe in detail your extra training, with dates. List extra certification.		
If performing Bone Mineral Density: Please provide evidence of your Society for Clinical Densitometry or any equivalent competency training in BMD.		
If performing fluoroscopic procedures: Please provide evidence of your successful completion of a recognized training program.		
Have you taken any formal or refresher courses?	○ Yes ○ No	
Please provide a list of the other facilities you provide services for:		

Please provide A DETAILED LIST your continuing education for past two years using the Professional Activity Log provided on page 8.

TECHNOLOGISTS Ultrasound

Please complete for EACH Technologist currently working in the facility (part time and full time).

Name			
ARDMS/CARDUP #		Attach a copy of your current reg. card.	Attached ☐
Please check procedures which you are performing at this Facility: (X)			
☐ General Ultrasound	☐ Vascular Ultrasound	☐ OBS/GYN	
☐ Other			
Please list procedures for which you have been **certified** and the organization(s).			
Do you perform Nuchal Translucency ultrasound?	◯ Yes	◯ No	
If yes, please provide evidence that you completed the Fetal Medicine Foundation Certification Program.			
Please list the procedures in which you **currently scan**?			
Have you taken any formal or refresher courses?	◯ Yes	◯ No	
Please provide a list of the other facilities you provide services for:			

Please provide A DETAILED LIST your continuing education for past two years using the Professional Activity Log provided on page 8.

PROFESSIONAL ACTIVITY LOG

Name		Attachment ☐	

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	

QUALITY CONTROL

For facilities providing ultrasound services: Please provide the name of the person/ company responsible for calibration/preventive maintenance (including probes).	
Attach copies of the last three preventive maintenance reports.	Attached ☐
Name the person responsible for conducting and documenting quality control activities?	
For facilities providing general x-ray/fluoroscopy services:	
Attach copies of the last three HARP inspection reports along with summary sheets.	Attached ☐
For facilities providing bone density services:	
Please attach copies of the acceptance testing	Attached. ☐
For facilities providing mammography services:	
Attach copies of the last three HARP inspection reports along with summary sheets.	Attached ☐
For facilities providing mammography services:	
Attach copies of the last three physicist inspection reports along with summary sheets	Attached ☐
How and where are the lead protective devices stored?	
Are the lead protective devises screened on at least an annual basis for cracks, wear and tear?	
◯ Yes ◯ No	
Is this activity documented?	◯ Yes ◯ No

POLICIES & PROCEDURES

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

Does your facility have a policies and procedures manual as described in the Clinical Practice Parameters and Facility Standards for Diagnostic Imaging?	◯ Yes	◯ No
Is the manual site specific?	◯ Yes	◯ No
Where is the policies and procedures manual kept?		
Is it easily 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 at least annually?	◯ Yes	◯ No

PROCESSOR MAINTENANCE

If you are using PACS, please complete the PACS questionnaire.

Repeat/Reject Analysis (this needs to be documented on the PACS Questionnaire as well)		
How often do you clean your processor?		
Is the following equipment on site?		
Densitometer	◯ Yes	◯ No
Sensitometer	◯ Yes	◯ No
Processor thermometer	◯ Yes	◯ No
Splash glasses, protective apron & gloves	◯ Yes	◯ No
Name of the person/company who conducts the processor maintenance?		

Name of the person who is responsible for recording daily sensitometry?	
State whether the following activities are performed and how frequently: (Please have supporting documentation on site the day of the assessment.)	
Cleaning of crossover rollers	
Cleaning of processor tanks	
Checking of replenishment rates	
Recording of temperature	
Screen/Contact testing	
Screen cleaning	
Darkroom light leak testing	

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
Please provide copies of the last three meetings	Attached ☐
What steps are taken by the staff in order to carry out Diagnostic Imaging procedures in a manner that respects patient privacy?	
How do staff contribute to continuously improve the services provided?	

How is information communicated to your staff?

How often are **staff meetings** held?	
Please provide copies of the last three meetings	Attached ☐
Are these meeting documented and minutes taken?	
Describe your performance appraisal system:	
How frequently is this carried out?	
What is your mechanism for assessing the accuracy of interpretations and the appropriateness of procedures?	

FACILTIIES, EQUIPMENT & SUPPLIES

Please describe the general layout of the facility	
Are radiation warning signs posted at the boundary and every access point to rooms where radiation is used?	◯ Yes ◯ No
Where are the fire extinguishers located?	
Has all staff received WHMIS training?	◯ Yes ◯ No
Where are the material safety data sheets posted?	
What are your infection control procedures for ultrasound transrectal/transvaginal probes? (if applicable)	
What are your infection control procedure for ultrasound gel bottles? (if applicable)	

Is the following equipment available for managing emergencies related to the types of services provided?	
First Aid Kit	◯ Yes ◯ No
Is there an emergency eyewash station available for the employees as per WHMIS requirements?	◯ Yes ◯ No
Is at least one staff member onsite at all times who is certified and current in Basic Cardiopulmonary Resuscitation (BCLS)?	
Please list names	
**For mobile services – Is the facility affiliated with a nearby hospital imaging facility or IHF for interpretation of images or consultation as necessary?	◯ Yes ◯ No
**Please provide name of IHF/Hospital:	

EQUIPMENT

List ALL the equipment currently in use in this facility:

Type of equipment	Year manufactured	Equipment manufacturer	Serial number	Date acquired yy/mm/dd	Modifications and upgrades	Calibration record available (please attach copy)
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

REQUESTING & REPORTING

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

Attachments included ☐

If a patient arrives with a requisition containing incomplete information, how does the facility obtain the necessary information prior to conducting the procedure?	
When/how are previous films from other IHF/Hospital facilities obtained for the interpreting physician?	
What is your standard practice for report turnaround time to the referring physician?	
In point form describe the process from time an exam is performed and the final report is completed and sent to the referring physician?	
For examinations interpreted by the referring physicians for immediate treatment, does the referring physician write the preliminary findings on the patient record or record in PACS?	
What is your process for handling STAT requests?	
How are unusual, unexpected or urgent findings communicated to the referring physician by the interpreting physician?	
How is this documented?	
Where are your films stored?	
What is your method of filing each image/storage media?	
What do you use as your hard copy/permanent record? (e.g. film/video/digital)	
○ X-ray ○ Ultrasound ○ BMD ○ Mammograph ○ Other	
How are they stored and protected?	
How do you view these stored images? (e.g. viewbox/internet/mammo viewer etc.)	
How do you flag your unusual and interesting examinations?	
How long are your records retained and how are they identified for purging?	

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