INDEPENDENT HEALTH FACILITIES

FACILITY PRE-ASSESSMENT QUESTIONNAIRE
DIAGNOSTIC IMAGING

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.

Quality Advisor	Date
Licensee	Date
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 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 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 licensed to perform in this Facility (e.g. 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 currently not being performed.	

Name of the Mammography Facility Lead (Physician):	
Is the facility accredited by CAR-MAP to read Mammography?	◯ Yes ◯ No
What is the CAR-MAP ID#?	
When does your accreditation expire?	Date: dd/mm/yyyy

Are you accredited for BMD?	◯ Yes ◯ No
If so, when does your accreditation expire?	Date: dd/mm/yyyy

* 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?	Daily: ◯ Weekly: ◯ Monthly: ◯
Average hrs/visit?	
Where are images stored?	
Where are images interpreted?	

ULTRASOUND	
Number of abdominal examinations per visit:	
Number of obstetrical/gynaecological examinations per visit:	
Number of TVS examinations per visit?	
Number of vascular examinations per visit:	
Number of Nuchal translucencies per week:	

GENERAL RADIOGRAPHY	
Number of chest examinations per visit:	
Number of extremity examinations per visit:	
Number of other types of examinations not listed per visit:	

Copy pages as necessary

STAFF

GENERAL	
Name of Quality Advisor:	
(Please attach signed agreement)	Attachment included ☐
Name of Radiation Protection Officer:	
(Please attach signed agreement)	Attachment included ☐
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 fluoroscopic examinations?	

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

Is there at least one staff member, who is certified and current in Basic Life Support (BLS) on site at all times?	Yes ◯ No ◯

For facilities providing Ultrasound Services, list the physicians who perform/interprets ultrasound in your facility.	

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	
Obstetricians/Gynecologists	◯ Yes ◯ No	
Vascular Surgeons	◯ Yes ◯ No	
Urologists	◯ Yes ◯ No	

Ophthalmologists	◯ Yes ◯ No	
Cardiologists	◯ Yes ◯ No	
General Surgeons	◯ Yes ◯ No	
Other: _____	◯ Yes ◯ No	

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, Support Staff, MRT(R), DMS, etc.) For the attachments listed in the table below (BLS & IPAC), please append the documents to the end of this questionnaire in the order that the MRT(R) and DMS staff are listed.

Name	Role	Certificate of Registration # or N/A	Online Regulatory Status Attached	WHMIS[1] Date Completed dd/mm/yyyy	Health and Safety Awareness[1] Date Completed dd/mm/yyyy	Workplace Violence and Sexual Harassment[1] Date Completed dd/mm/yyyy	AODA[1] Date Completed dd/mm/yyyy	BLS[2] Attached Or N/A (Att) (N/A)	IPAC Core[3] *Attached	IPAC Reprocessing[4] Attached
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[1] **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

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

[3]**IPAC: ALL STAFF:** Public Health Ontario's Infection Prevention and Control online training courses: IPAC Core Competencies Course

[4]**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.

MEDICAL RADIATION TECHNOLOGIST

Please complete for EACH Technologist currently working in the facility (casual, part time and full time). One MRT can list information below. Each additional MRT can enter info into the standalone "Facility Pre-Questionnaire – Additional Technologists".

Name (as given on CMRITO register):		
CMRITO #		**Copy of your online registration status sheet Attached** ☐
Please check procedures which you are performing at this Facility: (X)		
☐ General Radiography	☐ Fluoroscopy	
☐ Mammography	☐ Bone Mineral Densitometry	
Other:		
If performing mammography: **Please describe in detail your extra training, with dates. List additional certification.**		
Are you a CAR-MAP registered member, if so list the CAR-MAP ID(s)?		
If performing fluoroscopic procedures: **Please provide evidence of your successful completion of a recognized training program.**		
Please provide a list of the other facilities you provide services for:		
Facility Name(s) and IHF Billing #:		

DIAGNOSTIC MEDICAL SONOGRAPHER - Ultrasound

Please complete for EACH Sonographer currently working in the facility (casual, part time and full time). One DMS can list information below. Each additional DMS can enter info into the standalone "Facility Pre-Questionnaire – Additional Sonographers".

Name (as given on CMRITO register):		
CMRITO#		**Copy of your online registration status sheet** **Attached** ☐
Please check procedures which you are performing at this Facility: (X)		
☐ General Ultrasound ☐ Vascular Ultrasound		
Other:		
Do you perform Nuchal Translucency ultrasound?		◯ Yes ◯ No
If yes, please provide evidence that you completed the Fetal Medicine Foundation Certification Program:		FMF ID #:_____
Please list the procedures in which you currently scan for this facility?		
Please provide a list of the other facilities you provide services for:		
Facility Name and IHF Billing #:		

POLICIES & PROCEDURES

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

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?	
When was the policies and procedures manual last updated?	dd/mm/yyyy
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 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 ultrasound transrectal/transvaginal probes which would include probe reprocessing, solution change, training, and process of compliance and annual review. (if applicable)	Attachment included ☐ N/A ☐
Attach written policy with a detailed description of infection control procedures for *sterilization* of equipment maintenance, process, training, and process of compliance and annual review. (if applicable)	Attachment included ☐ N/A ☐
Attach your written policy with a detailed description of your infection control procedures for *ultrasound gel* use (both external & internal)? Attach your written policy for your gel bottle use and storage? (if applicable)	Attachment included ☐ N/A ☐

REQUESTING & REPORTING

Please enclose a sample requisition, tech worksheets and a Sample (John Doe) report for x-ray, BMD and vascular US. **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 the time an exam is performed to the final report is completed and sent to the referring physician?	
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?	
How do you flag your unusual and interesting examinations?	
How long are your records retained? If applicable, How are they identified for purging?	

FACILITIES, EQUIPMENT & SUPPLIES

Please describe the general layout of the facility. (e.g. square footage, # of exam rooms by modality, # of washrooms, location in community (e.g. medical building), parking (free or paid).)

Are radiation warning signs posted at the boundary and every access point to rooms where radiation is used?	◯ Yes ◯ No
Where are the pregnancy warning signs posted?	
Where are the fire extinguisher(s) located?	
Where are the safety data sheets posted?	

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 _____

**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 (Modality)	Year of manufacture	Equipment manufacturer (Make, Model)	Serial number	Date acquired DD/MON/YY ie. 01/Jan/18	Modifications and upgrades

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.	Attachments included ☐
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.	Attachments included ☐

For facilities providing Bone Mineral Density services:	
Attach copies of the acceptance testing	Attachments included ☐
Attach copies of Physicist approved reports for any X-Ray, Fluoroscopy and BMD equipment past CAR Equipment Life Expectancy Guidelines (CPP 2.6).	Attachments included ☐

For facilities providing Mammography services:	
Attach copies of the last three HARP inspection reports along with summary sheets.	Attachments included ☐
Attach copies of the last three physicist inspection reports along with summary sheets.	Attachments included ☐

How and where are the lead protective devices stored?		
Are the lead protective devices screened on at least an annual basis for cracks, wear and tear?	Yes ◯	No ◯
Attach copies of the last three lead check reports.	Attachments included ☐	

PROCESSOR MAINTENANCE (Film/Screen and/or CR Readers)

Repeat/Reject Analysis (provide last 3 months for x-ray and mammography)	Attachments included ☐
CR Readers: How often are PMs done?	
Attach the last 3 PMs.	Attachments included ☐
How often do you clean your processor?	
Attach the last 3 PMs	Attachments included ☐
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	
Recording of temperature	
Screen/Contact testing	
Screen cleaning	
Cassette cleaning (Film/screen & CR)	
Darkroom light leak testing	

PROVIDING QUALITY CARE

Who are the members of your Quality Advisory Committee? Please list their names and roles	
Name:	**Role:**
How often does the Quality Advisory Committee meet?	
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 do staff contribute to continuously improve the services provided?	
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:	
How frequently is this carried out?	

What is your mechanism for assessing the accuracy of interpretations and the appropriateness of procedures? Peer Review for radiologists, medical radiation technologists and diagnostic medical sonographers. *(This would require a written policy outlining what is reviewed, how often, how many cases, by whom and what actions are taken in the event of a discrepancy of findings during the Peer Review Process).*

Attach copies of your written peer review program protocols for both the medical radiation technologists, diagnostic medical sonographers and interpreting physicians.	Attachments included ☐
Please submit Peer Review program findings for two physicians.	Attachments included ☐
Please submit Peer Review program findings for two technologists (ie. If US/Xray IHF – Submit 1 MRT & 1 DMS).	Attachments included ☐

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