CPSO

INDEPENDENT HEALTH FACILITIES

FACILITY PRE-ASSESSMENT QUESTIONNAIRE

COMPUTED TOMOGRAPHY / MAGNETIC RESONANCE 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. CT, MRI)? (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.	

STAFF

GENERAL	
Name of Radiation Protection Officer:	
(Please attach signed agreement)	Attachment included
Name of Medical Physicist:	
Name of Charge Technologist:	
If imaging physicians are not on-site, describe the method in which technologists consult with him/her on a case-by-case basis?	

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

All Physicians providing interpretative services for the facility must submit the Interpreting Physician form.			
NAME:	**CPSO#**	**Still providing Services**	**Form Submitted**
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	

All Physicians providing interpretative services for the facility must submit the Interpreting Physician form.			
NAME:	**CPSO#**	**Still providing Services**	**Form Submitted**
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		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 and MRTs)

Name	Role	Certificate of Registration Number or N/A	Online Regulatory Status Attached	Injection Certification[1] Attached	WHMIS[2] Date Completed dd/mm/yyyy	Health and Safety Awareness[2] Date Completed dd/mm/yyyy	Workplace Violence and Sexual Harassment[2] Date Completed dd/mm/yyyy	AODA[2] Date Completed dd/mm/yyyy	BLS[3] Attached Or N/A (Att) (n/a)	IPAC Core[4] Attached	IPAC Reprocessing[5] Attached

1) Injection Certification for each MRT performing CT and MRI.

2) 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

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

4) IPAC: ALL STAFF: Public Health Ontario’s Infection Prevention and Control online training courses: IPAC Core Competencies Course

5) 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.

QUALITY ADVISOR

Ministry of Health – Quality Advisor Acknowledgement Form **(Please attach signed agreement)**	Attachment included
The written & signed agreement between the Licensee and yourself stating your responsibilities (job description) as the QA of the IHF.	Attachment included

Surname (as given on CPSO register):		
Given name(s) (as given on CPSO register):		
CPSO #		
Year Speciality obtained (dd/mm/yyyy):		
Royal College of Physicians and Surgeons of Canada Fellowship:	Yes	No
Speciality:	Yes No	Please list:

CONTACT INFORMATION			
Facility Name and IHF Billing Number			
Facility Address:			
Email:		**Office Phone:**	
Direct Phone:		**Fax:**	

What services (e.g. interpreting, consultation) do you currently provide within the IHF?

How often do you visit the facility? Is this documented?

When was your last visit (dd/mm/yyyy)?	
Do you have regular contact and interaction with peers?	Yes No *(pick one)*
Have you chosen to focus, subspecialize or restrict your practice?	Yes No *(pick one)*
If yes, please specify	
Do you have regular contact and interaction with referring clinicians and specialists?	Yes No *(pick one)*
Do you have regular contact and interaction with the Licensee?	Yes No *(pick one)*

Where do you report?	Onsite Offsite	If offsite, where, (e.g. Home, Hospital)	
If offsite, describe your interpreting workstation(s) setup. (# of monitors (colour vs BW), resolution (e.g. 3 MP/5MP).			

Please indicate the types of examinations that you perform/interpret in a typical work-week at this facility.	
Examination Categories	**# of examinations read or procedures performed**
Computed Tomography	
Magnetic Resonance Imaging	

Describe your activities in relation to interaction with the facility staff:

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

How are you involved in updating and maintaining the quality control activities?

As Quality Advisor you are required to advise the Licensee on the quality aspects of the facility. Briefly explain how you accomplish this role:

For CT imaging, do the quality activities include the following:			
Are all quality control results reviewed and signed off (e.g. HARP testing for CT)?	Yes	No	*(pick one)*
Are all corrective actions documented and signed off?	Yes	No	*(pick one)*
Are quality control activities reviewed bi annually?	Yes	No	*(pick one)*

Storage of Imaging Studies for CT and MRI			
Please indicate how you store your imaging examinations:			
Conventional Films	Yes	No	*(pick one)*
PACS	Yes	No	*(pick one)*
Combination of the Above	Yes	No	*(pick one)*

Please identify other facilities for which you are Quality Advisor:			
Facility Name:		Billing #	
Facility Name:		Billing #	
Facility Name:		Billing #	

Please identify other facilities for which you provide interpreting services but are NOT the Quality Advisor (if applicable).			
Facility Name:		Billing #	
Facility Name:		Billing #	
Facility Name:		Billing #	

INTERPRETING PHYSICIAN

(This section must be completed by ALL affiliated physicians *other than* the Quality Advisor)

Surname (as given on CPSO register):			
Given name(s) (as given on CPSO register):			
CPSO #			
Year Speciality obtained (dd/mm/yyyy):			
Royal College of Physicians and Surgeons of Canada Fellowship:		Yes	No
Speciality:	Yes	No	Please List:

CONTACT INFORMATION			
Facility Name and IHF Billing #			
Facility Address:			
Email:		**Office Phone:**	
Direct Phone:		**Fax:**	

What services (e.g. interpreting consultation) do you currently provide within the IHF?			
Do you have regular contact and interaction with peers?	Yes	No	*(pick one)*
Have you chosen to focus, subspecialize or restrict your practice?	Yes	No	*(pick one)*
If yes, please specify			

Do you have regular contact and interaction with referring clinicians and specialists?	Yes No *(pick one)*
Do you have regular contact and interaction with the Licensee?	Yes No *(pick one)*

Where do you report?	Onsite Offsite	If offsite, where, (e.g. Home, Hospital)	
If offsite, describe your interpreting workstation(s) setup. (# of monitors (colour vs BW), resolution (e.g. 3 MP/5MP).			

Please indicate the types of examinations that you perform/interpret in a typical work-week at this facility:	
Examination Categories	# of examinations read or procedures performed
Computed Tomography	
Magnetic Resonance Imaging	

Please identify other facilities for which you provide interpreting services but are NOT the Quality Advisor (if applicable).			
Facility Name:		Billing #	
Facility Name:		Billing #	
Facility Name:		Billing #	

MEDICAL RADIATION TECHNOLOGIST

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

<table>
<tr><td>Name (as given on CMRITO register):</td><td colspan="2"></td></tr>
<tr><td>CMRITO #</td><td></td><td>Copy of your online registration status sheet
Attached</td></tr>
<tr><td colspan="3">Please check procedures which you are performing at this Facility:</td></tr>
<tr><td colspan="3">Computed Tomography Magnetic Resonance Imaging</td></tr>
<tr><td colspan="3">Please provide a list of the other facilities you provide services for:</td></tr>
<tr><td colspan="3">Facility Name(s) and IHF Billing #:</td></tr>
<tr><td colspan="3"></td></tr>
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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 Computed Tomography and/or Magnetic Resonance 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/yy)?		
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

REQUESTING & REPORTING

Please enclose a sample requisition, and a Sample (John Doe) report for CT and/or MRI.

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
Are Restricted Access signs posted in all areas within the 5 guass magnetic field line of the MRI magnet?	Yes No
Where are the pregnancy warning signs posted?	
Where are the fire extinguisher(s) located?	
Are all fire extinguishers MRI compatible?	Yes No
Where are the safety data sheets posted?	

Is the following Major and Minor emergency equipment available related to the types of services provided?			
ECG Monitor	Yes	No	N/A
Defibrillator	Yes	No	N/A
Oxygen source with mask	Yes	No	N/A
Oxygen and suction	Yes	No	N/A
Oxygen Saturation Monitor (compatible for MRI)	Yes	No	N/A
Resuscitation drugs as per ACLS protocols	Yes	No	N/A
Stethoscope	Yes	No	N/A
Sphygmomanometer	Yes	No	N/A
IV pole (non magnetic for MRI)	Yes	No	N/A
Wheelchair (non magnetic for MRI)	Yes	No	N/A
Stretcher (non magnetic for MRI)	Yes	No	N/A

Laryngoscope and endotracheal tubes (adult /paediatric sizes)	Yes No N/A
Oropharyngeal airways (adult /paediatric sizes)	Yes No N/A
Ambu Bag or equivalent (adult /paediatric sizes)	Yes No N/A
Appropriate medications essential for contract reaction	Yes No N/A

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 ______________________________

INFECTION CONTROL

Attach written policy with a detailed description of infection control procedures for *disinfection* of surfaces and immobilization devices and process of compliance and annual review. (if applicable)	Attachment included N/A
Attach policies for use of ear protection including disposable and /or disinfection of non-disposable ear protection.	Attachment included N/A

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 Computed Tomography:	
Name of the Physicist/company	
Attach the last Physicist Inspection Reports along with summary sheets.	Attachments included
Name of the person/company responsible for calibration/preventative maintenance.	
Attach copies of the initial acceptance testing of equipment and related systems/components performed by the Medical Physicist.	Attachments included
Attach copies of the last three preventive maintenance reports.	Attachments included
Name the person responsible for conducting and documenting quality control activities?	
Attach copies of the last three Quality Control reports. (3x daily, 3x monthly and 1 annual)	Attachments included

For facilities providing Magnetic Resonance Imaging:	
Name of the Physicist/company	
Attach the last Physicist Inspection Reports along with summary sheets.	Attachments included
Name of the person/company responsible for calibration/preventative maintenance.	
Attach copies of the initial acceptance testing of equipment and related systems/components performed by the Medical Physicist.	Attachments included
Attach copies of the last three preventive maintenance reports.	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) or Please check Not applicable if this does not apply to your facility.

Not Applicable

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. *(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 interpreting physicians.	Attachments included
Please submit Peer Review program findings for two physicians.	Attachments included