ACR AMERICAN COLLEGE OF RADIOLOGY — RADIATION ONCOLOGY PRACTICE ACCREDITATION

Facility Name ______________________

Address ______________________

City, State ______________________, ______

Patient ID ______________

M.D. Initials_______**(Treating)**

M.D. Initials_______**(Reviewing)**

Rating Scale

A five-point rating scale has been established for the 12 categories on the data collection forms.
It is essential that only one numerical score be checked for each category. A score of 4 is given for good performance in a particular category. A score of 5 signifies excellent or outstanding performance.

Preliminary Self-Assessment

*A radiation oncologist who did not provide the patient's care should complete this form. Please Check **Yes, No or NA** for categories A through L and comment as needed.*

Category — **Overall Score**

		Worst	*(circle only one)*			*Best*
A.	**HISTORY AND PHYSICAL / CONSULTATION**	**1**	**2**	**3**	**4**	**5**

Yes	No	N/A	
\			Dates of Treatment 2/14/2019 to 3/8/2019
—			Disease DCIS Stage X
\			Pathology report
\			Current history of present illness/past medical history
\			Review of systems
\			Family and social history
	\		Risk factors
\			Informed consent (risks, complications, benefits, alternatives, questions answered)
\			Pre-treatment numerical functional performance stated
\			Physical exam
		\	Chemotherapy: Prior ❑ Post RT ❑ Concurrent ❑ Agents used ______
If **Breast** patient, were the following items documented:			
Yes	**No**	**N/A**	
\			Pathologic size of primary tumor
	\		Final margin status of resected primary tumor
\			Hormone Receptor status
\			Use of hormone replacement therapy
\			Hormonal therapy/chemotherapy planned/given
Yes	**No**	**N/A**	
		\	Electron Boost
If **Prostate** patient, were the following items documented:			
Yes	**No**	**N/A** (circled)	
			Recent pre-treatment PSA :________ Gleason's Score: _
			Patient's potency history prior to and after treatment documented

Comments:

B. PRESCRIPTION/DOSE/IMMOBILIZATON

Worst (*circle only one*) *Best*
1 2 3 4 5

Yes	No	N/A	
/			Signed (prior to treatment)
/			Dated (prior to treatment)
/			Site or volume in prescription
		/	Treatment volume is appropriate
/			Describe treatment fields *(AP/PA, 7 field IMRT etc.)* Tangents - FiF
/			Dose and fraction size appropriate
/			Planned total dose: 4240 cGy
/			Total number of fractions: 16 *(large field)* ________ *(conedown if applicable)*
/			Dose per fraction: 265 cGy - cGy (*conedown if applicable)*
/			Mode and energy: Photon, per plan
/			Patient position Supine ☒ Prone ☐
/			Immobilization device for reproducible set-up: Describe Wingboard

Comments:

C. PATIENT EVALUATION DURING TREATMENT

Worst (*circle only one*) *Best*
1 2 3 4 5

Yes	No	N/A	
/			Weekly examinations of the patient during treatment by radiation oncologist
			Progress notes include:
/			Progress/tolerance
/			Accumulated dose
		/	Treatment plan change
		/	Treatment break
		/	Other clinical issues

Comments:

D. TREATMENT SUMMARY (COMPLETION)

Worst *(circle only one)* *Best*
1 2 3 4 5

Yes	No	N/A	
\			Chart Includes Treatment Summary (if yes, answer the following)
			Treatment summary includes:
\			Area treated, dose (includes all treatment to volume) and energy
\			Treatment dates
\			Number of fractions/number of days
\			Treatment status (*completed, discontinued, etc.*)
			Narrative includes:
\			Treatment tolerance
		\	Tumor response
\			Follow-up plan
\			cc's to referring physicians
Comments:			

E. FOLLOW-UP

Worst *(circle only one)* *Best*
1 2 3 4 5

Yes	No	N/A	
	\		First follow-up within 4-6 weeks of treatment completion
		\	Evidence of on-going follow-up by radiation oncologist
	\		Evidence of on-going follow-up by referring physician and/or correspondence regarding patient status
			Other: *Specify*
Comments:			

F. TREATMENT FLOW SHEET / TREATMENT RECORD

Worst *(circle only one)* *Best*
1 2 3 4 5

Yes	No	N/A	
Daily treatment record is:			
			Satisfactory
			Unsatisfactory *(Specify)*
			Missing items: (*Describe)*
			Other:
Comments:			

G. PORT FILMS / ELECTRONIC IMAGES

Worst 1 *(circle only one)* 2 3 4 *Best* 5

Yes	No	N/A	
✓			At least every 5-10 treatments
		✓	When field changes were made or No field changes were made
		✓	Weekly verification of IMRT- If yes, how?
✓			Signed/initialed/dated by radiation oncologist
			Other: *Specify*

Comments:

H. TREATMENT PLANNING SIMULATION

Worst 1 *(circle only one)* 2 3 4 *Best* 5

Yes	No	N/A	
		✓	None
		✓	Conventional simulation
✓			CT simulation
		✓	Diagnostic CT planning

Comments:

I. ISODOSE DISTRIBUTION PLAN

Worst 1 *(circle only one)* 2 3 4 *Best* 5

Yes	No	N/A	
	✓		Present in chart
✓			Signed and dated by both the physician and physicist (within one week of initiation of treatment)
		✓	Documentation of heterogeneity corrections
			Used correctly for dose calculation

Comments:

J. IMRT DOSIMETRY

Worst *(circle only one)* *Best*
1 2 3 4 5

Yes	No	N/A	
			Documentation includes: delivered doses to volumes of target and non-target tissues, in the form of dose volume histograms and representative cross sectional isodose treatment
			Inverse planning performed
			Accuracy of dose delivery documented by irradiating a phantom containing either calibrated film to sample the dose distribution or an equivalent measurement system to verify that the dose delivered is the dose planned. In addition, the dose to a small region should be verified using an ionization chamber or other appropriately calibrated measurement device.
Comments:			

K. BRACHYTHERAPY

Worst *(circle only one)* *Best*
1 2 3 4 5

Yes	No	N/A	
			Written directive
			Documentation of radiation safety survey
			Post Implant dosimetry (seed implant)
			If **Cervix** case, did patient receive an implant (LDR or HDR)
			Other:
Comments:			

L. CHART and PHYSICS DOCUMENTATION

Worst *(circle only one)* *Best*
1 2 3 4 5

Yes	No	N/A	
/			Diagrams and/or photos of fields documented in the chart
//			Diagrams and/or photographs of fields labeled (name, date, field #)
///			Weekly physics check documented
/			Evidence that the physicist examined the chart at the completion of treatment (within 1 week)
			Other:
Comments:			

Additional Comments: ____

Checklist

1. **Policy and Procedures documents including:**

					Comments:
A.	Time Out Policy	(●) Yes	( ) No	( ) Does not apply	
B.	Contrast Policy	(●) Yes	( ) No	( ) Does not apply	
C.	Imaging Portal and IGRT	( ) Yes	(●) No	( ) Does not apply	
D.	Disaster Plan	( ) Yes	(●) No	( ) Does not apply	
E.	Infection Control	( ) Yes	(●) No	( ) Does not apply	

Rating Scale

A four-point rating scale has been established for each category on the data collection forms. It is essential that only one numerical score be checked for each category. A score of 3 is given if compliant in a particular category. A score of 4 signifies excellent or outstanding performance. Scores that are 1, 2, or 4 will require a comment. Scores of 3, comments are optional.

Non-Compliant=1 Minor Deviation=2 Compliant=3 Compliant Plus=4

( ) 1 ( ) 2 ( ) 3 ( ) 4

2. **QA and CQI Documents including:**

					Comments:
A.	Chart Rounds	(●) Yes	( ) No	( ) Does not apply	

B. M&M	(•) Yes	( ) No	( ) Does not apply	Comments:
C. Focus Studies	(•) Yes	( ) No	( ) Does not apply	Comments:
D. Internal Outcome	(•) Yes	( ) No	( ) Does not apply	Comments:
E. Physician Peer Review Documentation	(•) Yes	( ) No	( ) Does not apply	Comments: Prior last site visit, ret
F. Physicist Peer Review Documentation	( ) Yes	(•) No	( ) Does not apply	Comments: I w ill defer to the phy:

Rating Scale

A four-point rating scale has been established for each category on the data collection forms. It is essential that only one numerical score be checked for each category. A score of 3 is given if compliant in a particular category. A score of 4 signifies excellent or outstanding performance. Scores that are 1, 2, or 4 will require a comment. Scores of 3, comments are optional.

Non-Compliant=1 Minor Deviation=2 Compliant=3 Compliant Plus=4

( ) 1 ( ) 2 ( ) 3 ( ) 4