ACR Accreditation
Facility Tool Kit

The ACR will be performing site surveys as part of the accreditation process. This toolkit is designed to assist you in gathering and maintaining the documentation that is required for accreditation and will be reviewed during the survey. It is recommended you create a binder to keep this information in one place. Representatives of the ACR (a radiation oncologist and medical physicist) will survey facilities with scheduled visits.

Table of Contents:

American College of Radiology

APPLICATION CHECKLIST

❒ **1. Completed Application**
Complete Part I for each site physical location and Part II for the entire practice.

❒ **2. Uploaded (physics documentation)**

a. Most recent ADCL calibration report for primary standard ion chamber and electrometer well counter (if applicable). Application Technical Standard question no. 1, Part II - Page 9
b. RPC/TLD Comparison Reports for the last year for each energy for all linear accelerators. Application Technical Standard Part I - Page 5
c. Annual calibration report for each accelerator including SRS treatment unit (include MLC and Imaging QA). Application Technical Standard Part I - Page 5
(If Applicable):
d. A copy of HDR QC testing performed prior to initial use. Application Technical Standard question no. 11, Part II - Page 10
e. IROC Houston end-to-end QA phantom reports for the past 5 years. Application Practice Parameter Part I - Page 5
f. A copy of the most recent IROC Houston onsite dosimetry review visit report performed during the last 5 years. Application Practice Parameter Part I - Page 5
g. Any additional physics QA documents Application Practice Parameter Part I – Page 5

❒ **3. Survey Agreement** ***including consent form from each radiation oncologist in the practice (after page 5 of Part I).***

❒ **4. Survey Fee**

Single Facility	**$9,500.00**	_____
Additional Sites @	**$3,000.00 each**	_____
Total Survey Fee:		_____

❒ **5. Organizational Chart for the Radiation Oncology Department.**

❒ **6. Available Dates for Survey** from 30 to 90 days from submission of the application. Specific dates must be supplied (i.e., July 30 or 31). For single sites, a Monday or Friday is preferable. For Multi-sites, Monday-Tuesday or Thursday-Friday is preferable.

****** PLEASE NOTE: It may take months for your survey to be scheduled so please make sure that the dates you submit will not have to be changed once we confirm your survey. If an emergency arises and you need to re-schedule, your facility may experience a 3-6 month wait for your next confirmed date. Any requested change in the survey date by the facility or cancellation of a scheduled survey after ACR has invested funds in the survey (such as travel funds) must be reimbursed by the facility in addition to the survey fee. Fees are not refundable.***

Mail check to:
American College of Radiology
Radiation Oncology Practice Accreditation Program
1891 Preston White Drive
Reston, Virginia 20191-4397

Site Information

Country:

Facility Name:

Street Address:

City : State: Zip:

Facility Website Address:

Mailing Address If different from above

☐ Check if Mailing Address is same as above

Facility Name :

Street Address:

City : State: Zip:

Work Phone:

Fax :

Contact Person:

Contact Phone:

Contact Email:

Chief of Radiation Oncology:

Contact Email for Chief of Radiation Oncology:

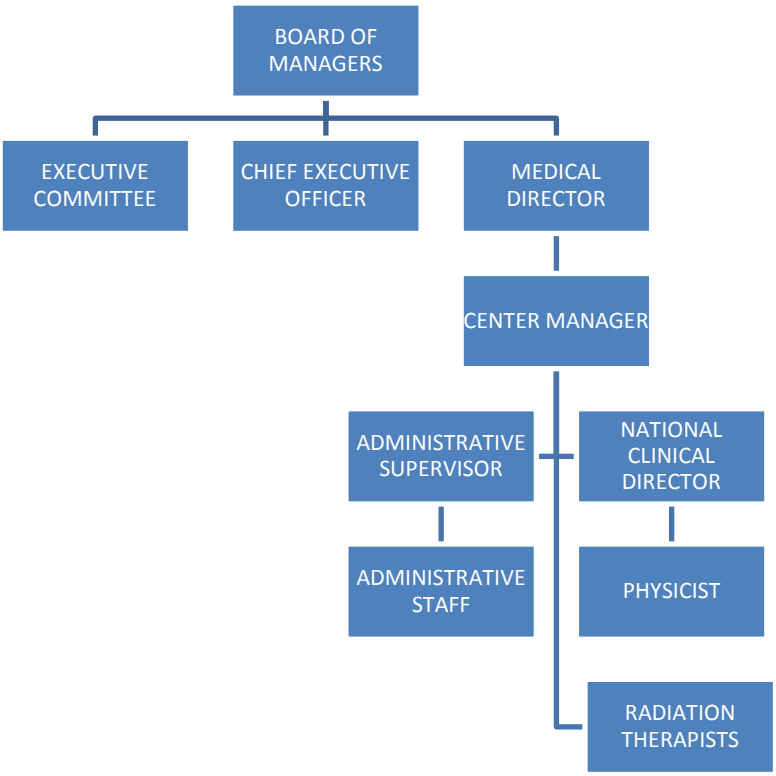
Personnel Qualifications Sheet

Please submit this form listing the names of the radiation oncologists, physicists, dosimetrists, therapists and nurses and the number of hours that each staff member actually works at the facility per week. If a therapist also works as a dosimetrist or manager, please indicate how many hours he/she works in each discipline.

Certifications: ABR, ABMP, ARRT(R), ARRT (T), CMD, LPN, OCN, RN, Board Eligible, Other

First Name	Last Name	Position	Participation of R-O PEER	Hours Worked Per Week	FTE *	Certification	Edit	Delete

*Copy of Certification(s)


BOARD OF MANAGERS
EXECUTIVE COMMITTEE
CHIEF EXECUTIVE OFFICER
MEDICAL DIRECTOR
CENTER MANAGER
ADMINISTRATIVE SUPERVISOR
NATIONAL CLINICAL DIRECTOR
ADMINISTRATIVE STAFF
PHYSICIST
RADIATION THERAPISTS

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_____to _____
			Disease_____Stage_____
			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**	
			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.)* _____
			Dose and fraction size appropriate
			Planned total dose: _____
			Total number of fractions:_____*(large field)* _____(*conedown if applicable)*
			Dose per fraction:_____cGy _____ cGy (*conedown if applicable)*
			Mode and energy: _____
			Patient position Supine ❑ Prone ❑
			Immobilization device for reproducible set-up: Describe _____
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 *(circle only one)* *Best*
1 2 3 4 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 *(circle only one)* *Best*
1 2 3 4 5

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

Comments:

I. ISODOSE DISTRIBUTION PLAN

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

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

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:**

A.	Chart Rounds	Yes	No	Does not apply	Comments:

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

Completing My Patient Census Forms

Cases for On-Site Review

Completion to be directed by Radiation Oncologist.

Note:

- Once your survey date is confirmed, please log back into your application and under the tabs 'Data- Collection-Census Sheets-Page 2' submit cases of definitively treated patients who have recently completed treatment at your facility and have had at least one follow up visit.

Cases should include:

- Breast
- Prostate
- Head and Neck
- Lung
- "Generic" cases, such as seminoma, esophagus, cervix, colo-rectal, etc.

- Submit five cases of each disease site for the main site and only 2-3 cases from each disease site for each satellite. We also want to review cases that represent all of the modalities that you provide, such as IMRT, HDR, SRS, seed implant, and so forth. A minimum of two cases per physician will need to be reviewed. We will ***not*** review cases from any physician no longer in the practice.

- We will select patients from this list whose records will be reviewed during the on-site survey. For these cases, patient records, simulation/port films/DRRs, and planning CT scans must be available for the surveyor(s). ***If recent conversion to paperless medical records and cases we are reviewing were in the transition, please retrieve paper charts from offsite storage if any of them contain items not available in EMR.***

- If you do not have enough cases in a particular disease site (for example, head and neck), simply include additional generic cases.

ATTENTION: Use a unique patient identifier (ID number) that is not associated with the patient's medical record number (MRN). Do **not** include the patients' names, social security number, or date of birth. Your unique number will be the only number tied to the MRN during the time of the survey. You will need to provide the list of unique ID numbers with the corresponding MRNs to the surveyors (see Fig. A below).

List the cases by a numbering system of your choice. For example, if Mr. John Doe is a patient with prostate cancer, and has the MRN of 1234567, you can assign that case with a random number (i.e. 0000-99, 9999, 001, 1).

Figure A: Facility Visit Medical Records

Please use the tracking chart below for your records. This worksheet contains protected patient health information (PHI). DO NOT submit this worksheet to ACR.

Facility Patient Identifier	Patient First Name	Patient Last Name	MRN

Patient Census Data

Please indicate the following treatment code next to the appropriate unique ID numbers if applicable:

TX Code:

S =	**Seed Implant**	**SR =**	**Stereotactic**
H =	**HDR**	**C =**	**Conformal**
L =	**LDR**	**T =**	**TBI**
I =	**IMRT**	**IG =**	**IGRT**
P =	**Protons**	**A =**	**APBI**
E =	**ELS**		

Breast

*Facility can add, edit, and delete cases before ACR approves. Once cases have been approved, facility cannot update or change cases

Breast | Prostate | HeadNeck | Lung | Generic

Patient ID	Final Treatment Date	Treatment Code	Site Name	R-O PEER Staff	MD	Disease Site	Edit	Delete
9999	05/15/2013	SI	ACR Test Site	No	monzon	test	Edit	Delete
9999-0	05/22/2013	HD	ACR Test Site	N/A	monzon	test	Edit	Delete
		Seed Implant Stereotactic HDR Conformal LDR TBI IMRT IGRT Protons APBI ELS	ACR Test Site	Yes Select			Save Cancel	
							Edit	Delete

Add New Patient

Prostate

Breast | Prostate | HeadNeck | Lung | Generic

Patient ID	Final Treatment Date	Treatment Code	Site Name	R-O PEER Staff	MD	Disease Site	Edit	Delete
1111-0	05/31/2013	Stereotactic	ACR Test Site	N/A	monzon	test	Edit	Delete
1111-2	05/18/2012	Seed Implant	ACR Test Site	N/A	monzon	test	Edit	Delete

Add New Patient

Head & Neck

Breast | Prostate | HeadNeck | Lung | Generic

Patient ID	Final Treatment Date	Treatment Code	Site Name	R-O PEER Staff	MD	Disease Site	Edit	Delete
2222-1	05/25/2010	IMRT	ACR Test Site	N/A	monzon	brain	Edit	Delete
2222-0	05/16/2013	IGRT	ACR Test Site	N/A	monzon	trachea	Edit	Delete

Add New Patient

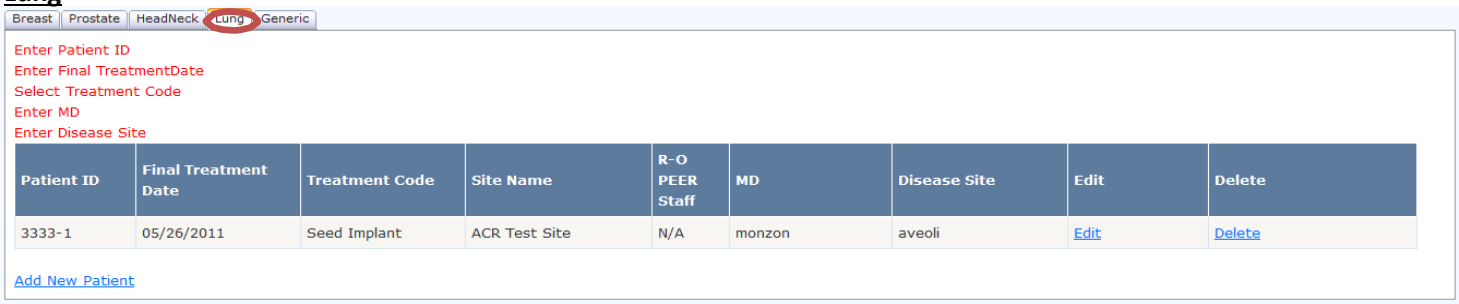
Patient Census Data—Continued

Please indicate the following treatment code next to the appropriate unique ID numbers if applicable:

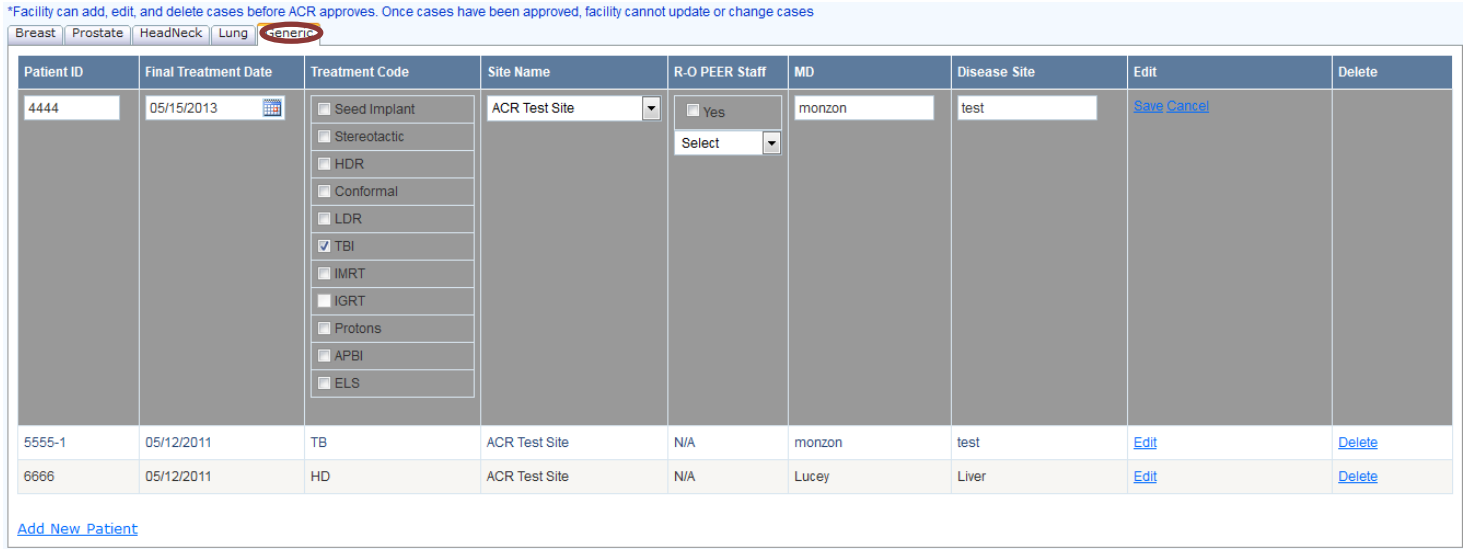
TX Code:

S =	**Seed Implant**	**SR =**	**Stereotactic**
H =	**HDR**	**C =**	**Conformal**
L =	**LDR**	**T =**	**TBI**
I =	**IMRT**	**IG =**	**IGRT**
P =	**Protons**	**A =**	**APBI**
E =	**ELS**		

Lung



Generic



Questions for the practice: Please submit to the ACR after your site visit has been confirmed.

1. Where do the surveyors need to park?

2. Who is the onsite point of contact and their mobile number?

3. Where do they need to meet you?

4. Will the appropriate staff be available? (The Chief/Medical Director of Radiation Oncology, the chief physicist, department administrator/chief therapist, dosimetrist, nurse and other key personnel.)

5. Will your IT department provide at least ***one computer per surveyor***, each with dual monitors and ***wired*** internet access? (The two monitors will be connected to each computer to view your EMR(s) and for data entry to our website simultaneously). If you are paper charts, we will need two computers with single monitors only.

6. If you are EMR, are all cases accessible from both your main facility and satellite location(s)? If not, then we will need workstations setup as described in question five for each satellite location that does not employ centralized EMR. ***(for multi-site practices only)***

7. What is the best route for our surveyors to take to get to the other site(s) and can you provide an escort to take them to the other location(s) if needed? ***(for multi-site practices only)***

8. Will your IT department provide at least ***one*** of the following web browsers on the computers supplied?

Google Chrome (version 22+)
Firefox (version 27+)
Safari (version 5+)
Internet Explorer (version 10+)

Resources

The following list of references is by no means complete, but it may be used as a starting point to assist you with your application and survey process:

Radiation Oncology Practice Accreditation (ROPA):
http://www.acraccreditation.org/Modalities/Radiation-Oncology-Practice

ACR ROPA Program Requirements:
http://www.acraccreditation.org/~/media/ACRAccreditation/Documents/ROPA/Requirements.pdf?la=en

ACR RO Practice Parameters:
https://www.acr.org/Quality-Safety/Standards-Guidelines/Practice-Guidelines-by-Modality/Radiation-Oncology

ACR Medical Physics Technical Standards (RO and Diagnostic):
https://www.acr.org/Quality-Safety/Standards-Guidelines/Practice-Guidelines-by-Modality/Radiation-Oncology