Quality Improvement Assessment Questions
Nuclear: Equilibrium Radionuclide Angiography

Answer the questions below by reviewing the images and final report for a given case study. It is recommended that any discrepancies noted in the assessment be reviewed and shared with medical and technical staff members. The assessment is provided to assist the facility in furthering its ongoing Quality Improvement (QI) process.

For the purposes of Quality Improvement (QI), annual case study self-assessment must be sufficient to ensure the achievement of continuous actions that lead to measurable improvement in the imaging examinations performed in the facility. To attain maximum benefit to the facility, a minimum of 30 case assessments is strongly recommended. However, for facilities with lower procedure volumes, 5% of the facility's testing volume is encouraged.

Note: Although the case may be in compliance with the IAC Standards based on your assessment, there may be opportunity for improvement.

### I. Test appropriateness

Based on clinical judgement, was the clinical indication for the test appropriate?  

- Appropriate/usually appropriate
- May be appropriate
- Rarely appropriate/usually not appropriate

Comments:

### II. Technical quality review

1. Is the study free of artifact? (e.g. motion, attenuation, subdiaphragmatic activity, metal, flickering, contamination, brown fat, free pertechnetate, poor labeling)  
   
   - Yes  
   - No

2. Does the study demonstrate adequate count density?  
   
   - Yes  
   - No

3. Was the study processed/displayed/labeled correctly?  
   
   - Yes  
   - No

Could the technical quality of this case have been improved?  

- Yes  
- No

Comments:

### III. Interpretive quality review

1. Is ventricular size reported?  
   
   - Yes  
   - No

2. Is ventricular wall motion, regional or global, and quantitative data (EF) reported?  
   
   - Yes  
   - No

3. Does the report include a succinct impression (e.g., normal, abnormal, equivocal, stable finding)?  
   
   - Yes  
   - No

Could the interpretive quality of this case have been improved?  

- Yes  
- No

Comments:

### IV. Report completeness and timeliness
1. Does the report contain all of the required demographic data elements including facility name, facility address, facility phone number, patient gender, patient age or birthdate, requesting health care provider’s name, name of the procedure [type of examination(s)]? Part A, 3.4.1A–3.4.4A
   ○ Yes ○ No

2. Does the report state the clinical indication and pertinent history leading to the performance of the examination? Part A, 3.4.7A
   ○ Yes ○ No

3. Does the report include an adequate and/or accurate description of the procedure performed? Part A, 3.4.8A
   ○ Yes ○ No

4. Was the radiopharmaceutical and pharmaceutical identity, exact dose (i.e., XXX mCi or XX. X mg) and route of administration (e.g., intravenous, oral, inhaled, subdermal) reported? Part A, 3.4.8.3A
   ○ Yes ○ No

5. Is the radiopharmaceutical dose within the range published in current professional society guidelines? Part B, 2.2.3.1B
   ○ Yes ○ No

6. Does the report contain the date the procedure was performed? Part A, 3.4.6A
   ○ Yes ○ No

7. Is the report signed by the interpreting physician and is the date the report was finalized included in the report? Part A, 3.4.11.1A and 3.4.11.2A
   ○ Yes ○ No

8. Was the report finalized within two working days? Part A, 3.2.5A
   ○ Yes ○ No

Could the report completeness and timeliness of this case have been improved?

Comments: