

MEDICAL PHYSICS BRIEF

Practical guidance for safer, survey-ready imaging

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CT SAFETY • OCTOBER FIELD NOTES

CT Dose Check: Is Your Safety Net Switched On?

A scanner can have Dose Check capability without the team knowing how it is configured or what to do when it activates. This month: verify the setting, practice the response, and keep the evidence.

Notification or alert? Know the difference.

Notifications flag projected dose indices for an individual scan. **Alerts** address projected cumulative dose indices at an anatomic location during an examination and call for a more stringent review before proceeding.

AAPM endorses the FDA-suggested **1,000 mGy CTDIvol alert value**. This is a safety checkpoint—not a routine dose target, patient-specific dose estimate, or acceptable upper limit. Protocol notifications are separate settings; do not set them all to 1,000 mGy. Pediatric patients need separate consideration; review appropriate notification and alert values with your medical physicist.

Leadership takeaway

Assign a CT lead to confirm scanner capability, locally approved settings,

and staff response. Use manufacturer guidance; do not assume every scanner behaves identically.

REQUIREMENT CHECK

Recommendations and Requirements Are Different

Accreditation criteria and a department's safety responsibilities are different questions. ACR explains that its Practice Parameters and Technical Standards are separate from accreditation requirements; either may be more restrictive. For local decisions, verify applicable accreditation criteria and state requirements, consult professional and manufacturer guidance, and follow approved site policies.

[ACR requirements and professional guidance: how they differ.](#)

WEEKLY READINESS ACTION

One Record to Audit This Week

Choose one CT scanner. Record its identifier, Dose Check status, alert value and units, review date, and responsible reviewer. Have a technologist explain the response and escalation process using a manufacturer-approved training example—not a patient exposure. Resolve discrepancies with physics and your CT leadership team.

PRACTICAL IMAGING INSIGHT

Back to BASICS: A Practical Image-Review Tool

Image Gently's one-page BASICS poster gives technologists a structured way to review pediatric digital radiographs. It prompts a check of beam alignment, artifacts, patient support, exposure/deviation indicators, collimation, and the anatomy shown. Review the indicator alongside image noise and technique—not as a stand-alone assessment.

Use it in your next team huddle: Print the poster and walk through a de-identified pediatric image together. Identify one positioning, communication, or technique improvement to carry into the next similar examination. Department leaders can use the same tool to support staff coaching and consistent image review.

[Download the BASICS Image Analysis Poster \(1-page PDF\)](#) — developed by Image Gently for pediatric imaging.

LESSONS FROM NRC REPORTS

NRC Event: Check the Worksheet, Not Just the Number

A Utah Y-90 event reported August 28, 2026 (NRC event 58428) described preliminary confusion over entering two treatment targets on one planning worksheet rather than separate worksheets. The licensee's review identified a dose discrepancy; investigation was ongoing in the posted report.

Our takeaway: For Y-90 teams, independently reconcile each target, prescribed dose, worksheet, and supplier handoff before treatment. Across imaging, ask: could another qualified reviewer reconstruct the intended procedure from the written record and handoff, without verbal assumptions? The worksheet arrangement was specific to this case—not a universal instruction. A reported medical event does not necessarily mean patient harm. [Read the NRC report](#).

PRACTICAL PHYSICIST'S TOOLKIT

Three Resources to Keep

01 / CT Dose Check guidance

[AAPM's notification and alert recommendations](#) explain the distinction and provide starting points for local review. Established guidance—not a newly issued rule.

02 / Patient gonadal/fetal shielding: explaining the change

[AAPM's patient gonadal and fetal shielding guidance](#) explains the limited benefit and potential for obscured anatomy or interference with automatic exposure control. Use it for staff education and patient conversations. This is **not** advice to stop staff protective apparel; follow approved policies and applicable state requirements.

03 / 2026 ACR MR Safety Manual

[Download the manual and summary of changes](#). Ask your MR safety team to identify which updates affect local policies, screening, and staff education.

ASK A PHYSICIST

What should we explain next?

What dose, QC, shielding, or accreditation question keeps coming up? [Send a question for a future Brief](#). We will keep your identity private unless you give permission. Please do not include patient-identifying information.

COMING NEXT

Practical checks for safer technology adoption and stronger imaging workflows.

Educational guidance, reviewed September 25, 2026. Follow current site policies, manufacturer instructions, applicable requirements, and your qualified medical physicist's guidance. Event reports may be updated as investigations proceed.

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