

Reflection on serious untoward incidents (SUIs): a tool for clinical oncologists and clinical radiologists

Tools for improving professional practice in
clinical oncology and clinical radiology

This tool is designed by The Royal College of Radiologists (RCR) to help clinical oncologists and clinical radiologists to collect the supporting information required for revalidation.

The RCR would also recommend using these methods to help improve professional practice, irrespective of when the first round of revalidation is implemented.

A series of further tools and pro formas is currently in development and will be added in the future.

As the revalidation process develops and changes with implementation, the RCR will review its tools and would expect the portfolio to evolve. Any feedback to assist with this process would be most welcome.

List of generic tools published

- *Reflection on complaints: a tool for clinical oncologists and clinical radiologists*
- *Reflection on compliments: a tool for clinical oncologists and clinical radiologists*
- *Revalidation audit tool*
- *Revalidation continuing professional development (CPD) summary tool*
- *Reflection on 'near miss' incidents: a tool for clinical oncologists and clinical radiologists*
- *Attendance at mandatory training: a tool for clinical oncologists and clinical radiologists*
- *Supporting information for health for use in appraisal and revalidation*
- *Supporting information for probity for use in appraisal and revalidation*

List of radiology-specific tools published

- *Multisource feedback: recommended specialty-specific questions, generic questions related to performance and guidance for use*
- *Peer review: guidance on the use of double reporting*
- *Personal reflection on discrepancies and adverse events*
- *Self-review of practice for diagnostic radiologists*
- *Self-review of practice for clinical radiologists undertaking interventional procedures*
- *Recording attendance at radiology discrepancy meetings*
- *Case-based discussion for diagnostic radiologists*

Introduction

The Royal College of Radiologists (RCR) considers it important to provide tools to help Fellows and members produce the supporting information that they will require to achieve revalidation, and to support them in improving their professional practice.

The RCR has published its specialist standards framework¹ which details the types of supporting information clinical oncologists and clinical radiologists will need to produce to enable them to revalidate.

As revalidation processes develop and change with implementation, the RCR will review its revalidation tools and would expect them to evolve over time. We would welcome any feedback from those who use the template to assist with this process.

The RCR has developed this tool to allow clinical oncologists and clinical radiologists to reflect in a structured fashion on the outcome of a serious untoward incident (SUI) investigation and record any resulting changes to practice. This could be used as a form of supporting information for revalidation.

An SUI is an incident which caused or had the potential to cause serious harm. Investigations are designed to discover the root causes or contributory factors so that an explanation can be given to the patient/relatives and appropriate action may be taken to reduce the risk of a similar event happening in future. Although their purpose is a positive one, recognising that most failures are system and multifactorial rather than individual-related, such investigations may be a difficult experience for the staff involved. Nevertheless, they usually provide useful lessons, and as part of an individual's reflection on their practice, consideration of the investigation and what emerged in the report is recommended.

Please anonymise any patient information/data entered in the pro forma.

Approved by the Board of the Faculty of Clinical Oncology: 2 July 2010

Approved by the Board of the Faculty of Clinical Radiology: 25 June 2010

Reflection on serious untoward incidents (SUIs) pro forma

Date of incident

Brief description of the background to the incident. Please attach an anonymised copy of the final report on the SUI.

What was the outcome of the investigation?

What have you learnt from being involved in the SUI investigation?

How has your practice/service changed as a result?

--

Have any departmental changes been agreed as a result?

Reference

1. The Royal College of Radiologists. *Specialty standards and supporting information for revalidation*. London: The Royal College of Radiologists, 2010.

Citation details:

The Royal College of Radiologists. *Reflection on serious untoward incidents (SUIs): a tool for clinical oncologists and clinical radiologists*. London: The Royal College of Radiologists, 2010.

Ref No. RCR(10)6 © The Royal College of Radiologists, July 2010

For permission to reproduce any of the content contained herein, please email: permissions@rcr.ac.uk

This material has been produced by The Royal College of Radiologists (RCR) for use internally within the National Health Service in the United Kingdom. It is provided for use by appropriately qualified professionals, and the making of any decision regarding the applicability and suitability of the material in any particular circumstance is subject to the user's professional judgement.

While every reasonable care has been taken to ensure the accuracy of the material, RCR cannot accept any responsibility for any action taken, or not taken, on the basis of it. As publisher, RCR shall not be liable to any person for any loss or damage, which may arise from the use of any of the material. The RCR does not exclude or limit liability for death or personal injury to the extent only that the same arises as a result of the negligence of RCR, its employees, Officers, members and Fellows, or any other person contributing to the formulation of the material.