# Follow up alert following abnormal chest x-ray- Is it acted on by the requesting clinician?

**Descriptor:**

A "Follow up" alert is issued in any abnormal chest x-ray (CXR) report that requires repeat imaging after a certain time interval. This audit is to assess if these alerts are acted on by the requesting clinician.

**Editors' note**: The audit could be adapted to different types of management advice given in the report.

**Background:**

CXR “follow up” alerts are generated by the radiologist if there is any abnormality found on the CXR which needs further imaging after an appropriate time interval. This alert is sent to the requesting clinician and should include advice on the type of modality as well as suggested timeframe for the repeat imaging. Radiology alerts are developed following numerous patient safety incidents which occurred as a result of failure to acknowledge and act on abnormal radiological reports. The 2007 NPSA Safer Practice Notice 161 and subsequent RCR publications on standards of communication of significant radiological findings2, 3 both emphasised on the importance of communication of radiological reports especially in abnormal or unexpected results to the requesting clinician and that appropriate action is taken. Several studies to date have specifically highlighted the importance of such an electronic communication system for CXR reports4, 5.

This audit looks at CXR “follow up” alert specifically and assesses whether this alert is acted on by the requesting clinician.

## The Cycle

**The standard:**

CXR “follow up” alert should be appropriately acted on by the requesting clinician in the appropriate timeframe.

**Target:**

100% of the CXR “follow up” alert should be acted on

100% of reports with an alert should indicate time interval and modality

## Assess local practice

**Indicators:**

1. Assess if further imaging has been performed as suggested by the alert

2. Assess if the repeat imaging is of the same modality suggested by the alert

3. Assess the timeframe suggested for the repeat imaging if indicated in the report.

4. Compare the actual timeframe of the repeat imaging to the timeframe suggested by the alert

**Data items to be collected:**

1. The modality suggested by the “follow up” alert (repeat CXR, CT chest or others)

2. The timeframe suggested for the repeat imaging (i.e. 4 weeks, 6 weeks, etc)

3. Has the advice of repeat imaging been followed?

4. The actual timeframe in which repeat imaging is done

**Suggested number:**

50 CXR with “follow up” alerts from 4 different sources i.e. GP, Outpatients, Inpatients, A&E

In total 200 CXR with “follow up” alerts

**Suggestions for change if target not met:**

• Setting up a read/receipt system in PACS / RIS / OrderComms for requesting clinicians to acknowledge the receipt of this alert

• Radiology secretaries to send the alert directly to the requesting clinician’s secretary/medical practice (if GP) via secure email

• Disseminating the information on the importance to act on this alert in grand rounds and A&E meetings so that junior members of the team are aware of such an alert

• Add a comment to all reports stating that it is the responsibility of the referring clinician to review and act upon radiology reports accordingly.

• Repeat audit cycle in 6 months following recommendations

**Resources:**

• Use CRIS system to identify 50 CXR with “follow up” alerts from GP, outpatients, inpatients and A&E sources

• Use PACS to collect data on the “follow up” alert advice – what modality is suggested, suggested timeframe

• Use PACS to check if subsequent imaging is done as per alert advice

• Use PACS to check the date of the repeat imaging

• Radiology secretary to obtain list of patients with “follow up” alert via CRIS system

• Radiologist/doctors to check on PACS for above information

• Time recommended: 2.5 hours for every source of referral -GP/Outpatients/Inpatients/A&E

• 10 hours in total for all 4 sources

[**radiology\_audit\_performa\_sample.pdf**](https://www.rcr.ac.uk/sites/default/files/audit_template/radiology_audit_performa_sample_0.pdf)PDF - 102.96 KB

**References:**

1. National Patient Safety Agency. Safer practice notice 16. Early identification of failure to act on radiological imaging reports. <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59817>
2. The Royal College of Radiologists. Recommendations on alerts and notification of imaging reports, 2022. https://www.rcr.ac.uk/our-services/all-our-publications/clinical-radiology-publications/recommendations-on-alerts-and-notification-of-imaging-reports/
3. Bhaludin BN, Shelmerdine SC, Arora S, Senbanjo T, Parthipun A. Delays and errors in abnormal chest radiograph follow-up: a systems approach to promoting patient safety in radiology. *J Eval Clin Pract*. 2014;20:453–459. <http://onlinelibrary.wiley.com/doi/10.1111/jep.12178/full>
4. Hayes SA, Breen M, D McLaughlin et al. Communication of unexpected and significant fndings on chest radiographs with an automated PACS alert system. *J Am Coll Radiol*. 2014:11(8):791-5

**Submitted by:**

Dr Peng-Kwan Ng Updated by J Parikh, J Mak 2024

**Co-authors:**

Dr Akash Ganguly

Dr Chinedum Anosike

**Published Date:**

28 January 2016

**Last Reviewed:**

20 May 2024