BACKGROUND TO THE AUDIT

• National Patient Safety Agency (NPSA) notice 16: ‘Patient safety incidents are being caused by a failure to acknowledge and act on radiological imaging reports’.1

• The RCR also sets out standards for the communication of critical, urgent and unexpected significant radiological findings to registered referring health professionals (RRP).2

• Failed radiology communications are an increasing cause of malpractice litigation and harm to patients.3

AUDIT STANDARD

Recommendation: All radiological reports marked as urgent and/or with unexpected significant findings should be duly acknowledged by the RRP.2

Indicator: Response from the RRP that the report and its findings have been acknowledged.

Target: 100% compliance after the reminder to the RRP.

METHODOLOGY

• All radiology reports with significant or unexpected findings are labelled as ‘imaging alerts’ and emailed to the RRP.

• RRP are then required to acknowledge receipt within 2 weeks.

• If no acknowledgement is received within this time, a paper reminder is sent by a department secretary who keeps a record of all imaging alerts issued and their responses.

RESULTS OF 1ST AUDIT ROUND

• Total number of imaging alerts sent was 460.

• The overall number of acknowledgements received after the reminder were 266 (58% compliance), 60% received in 2011 (Fig. 1) and 53% in 2012 (Fig. 2).

RESULTS OF SECOND AUDIT ROUND

• A re-audit was conducted from January to April 2013. This demonstrated a much improved acknowledgement compliance rate of 90% (Fig. 3).

SECOND ROUND ACTION PLAN

• A repeat audit will be carried out in 6 months time to assess the maintenance of standards.

• Radiology Department will look at ways to optimise the reporting times4 and continue to make the RRP aware of their responsibilities for acknowledgement of radiology imaging alerts in different forums.

REFERENCES


