GIG CYMRU NHS WALES

Pwyllgor Ymgynghorol Gwyddonol Cymru
Welsh Scientific Advisory Committee

Standards for reporting critical, untoward, urgent or unexpected radiological findings

Guidance from the Welsh Scientific Advisory Committee

Produced by the Medical Imaging Subcommittee on behalf of WSAC

This document highlights the importance of timely reporting of radiological examinations and actions that need to be taken in line with good medical practice especially when the report concerns critical, emergency, urgent or significant unexpected findings.

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Introduction

It is important that all radiological examinations should be reported in a timely manner and that reports be read and acted on in line with Good Medical Practice [1,2]. It is particularly important that critical, emergency, urgent or significant unexpected findings be reported straight away and the findings acted on immediately in order to minimize harm to the patient and to optimise the patient's outcome. It is the radiologist/radiographer/qualified reporter's role to communicate those findings in a timely manner. It is then the referring clinician's responsibility to acknowledge receipt and to take the appropriate action.

The Royal College of Radiologists has published guidance for the communication of critical, urgent and unexpected significant findings [3]. The guidance recommends the introduction of 'additional steps' to supplement the normal systems of communication between reporters and referrers. This builds on earlier advice from the National Patient Safety Agency to establish 'safety nets' to ensure effective communication [4]. We are now setting Welsh standards for the reporting of critical, untoward, urgent or unexpected findings in radiological examinations which endorse the ethos of Good Medical Practice, with a service delivered in a timely, appropriate and safe manner to patients. Our own evidence from previous audits and incidents indicates that additional guidance and direction is needed to supplement the existing guidance. These new Welsh standards are based on the three categories outlined in the RCR document [3] plus a fourth, specifying the need for audit.

The standards need to be implemented without delay in order to increase patient safety. However, it is recognised that an IT-based acknowledgement system that flags reports of high priority, logs when reports have been read by the referrers and documents actions, would add further strength to the process and should be a goal for future development.

Standards for radiology departmental policy

Standard 1: Critical and/or Emergency

Findings requiring immediate emergency action (e.g. tension pneumothorax, extra-dural haematoma with compressive features, leaking aortic aneurysm, placenta praevia/abrupto)

Actions

- The reporter will communicate the findings immediately by telephoning the referrer (or responsible clinician)
- The reporter will document the date and time and the name of the clinician receiving the message
- The reporter will report and authorise immediately straight onto the Radiology Information System (RIS)

Standard 2: Urgent

Findings requiring medical or surgical evaluation within 24 hours of receiving the radiology report (e.g. pulmonary embolism, cerebral tumour)

Actions - In inpatients

- The examination will be reported and authorised within 24 hours

Actions - In outpatients

- The report will be authorised within 24 hours
- The reporter will fax or email the report to the requesting clinician and send a copy report to the relevant MDT
- The referring clinician should immediately acknowledge receipt of the report
- If no acknowledgement has been received within 24 hours of sending the report, the radiology department will telephone the referrer (or responsible clinician)

Standard 3 Red Star Report

Significant unexpected findings – a finding which is unexpected and the radiologist thinks may be significant for the patient (e.g. apical lung cancer on a shoulder radiograph, renal-cell carcinoma on an ultrasound scan looking for gallstones, large aortic aneurysm on an MRI lumbar spine)

Actions

- The reporter will fax or email the report to the requesting clinician and copy to the MDT if appropriate
- The referring clinician should acknowledge receipt of the report
- Monthly audits will be used to ensure that red star findings have been acted upon

Standard 4 Audit of compliance

Actions

- There should be regular “spot” audits with annual formalised audits of compliance with the above 3 Standards.

References and Bibliography

1. Good Medical Practice, General Medical Council, 2013, http://www.gmc-uk.org/static/documents/content/GMP_2013.pdf_51447599.pdf

2. Welsh Reporting Standards for Radiology Services, Welsh Scientific Advisory Committee, 2011, http://new.wales.gov.uk/topics/health/cmo/committees/scientific/reports/111001miscreportingstandards/?lang=en

3. Standards for the communication of critical, urgent and unexpected significant radiological findings, 2nd ed., Royal College of Radiologists, 2012, http://www.rcr.ac.uk/docs/radiology/pdf/BFCR(12)11_urgent.pdf