NHS
University Hospitals Birmingham
NHS Foundation Trust

Clinical Alert

For Immediate Action

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Re: Incorrect patient referrals for imaging / radiology tests

For action by:
All clinical and medical staff requesting radiology tests
Objective: To comply with Ionising Radiation (Medical Exposure) Regulations – IR (ME)R

Immediate action required

Situation
The Trust has experienced an increase in the number of radiation incidents. A number of these have been reportable to the Care Quality Commission.

Background
Radiation is potentially harmful. CT scanning involves the use of higher doses of radiation (a CT abdomen/pelvis is equivalent to 500 chest X-rays). As a result of the incorrect patient details being inputted into the electronic radiology requesting system patients have received unnecessary doses of radiation. This can result in significant delays in performing the correct test for the intended patient. There is a risk of exposing the incorrect patient to a dose of ionising radiation.

Assessment
All staff requesting an imaging / radiology tests to be made aware of this danger.

Recommendation
All medical and senior nursing staff who are involved in requesting radiology tests must ensure the **correct identity** of the patient is inputted into the electronic radiology requesting system.

- **Take care and check the correct identity before submitting the electronic referral.**
- **Cross reference the clinical history to ensure the correct test is requested.**
- Do not refer to single pieces of identifying information to make a request e.g. a PID number only
- Do not delegate the requesting task to another person who cannot confirm the correct identity and the correct test for the patient.
- Wherever possible the patient should be present to confirm their identity
- Avoid delaying the request until the end of the clinic or ward round.
- Avoid multiple requests where patients and clinical histories can get muddled.
- Avoid having multiple computer windows open with multiple patients when requesting.

All incidents of incorrect referral should be reported immediately to imaging (ED X-ray out of hours) for cancellation as an electronic request cannot be recalled when submitted and an IR1 form completed.
Where a patient receives an unnecessary dose due to incorrect referral a full investigation will be instigated and the incident may be reportable to the Care Quality Commission (CQC).

For further information please contact:
Imaging: Ext 43279

Supervising medical staff must cascade this information to all radiology referrers in their team