## Interdepartmental Communication in Emergency Radiology - Documentation of Referrer Opinion on A&E Radiographs

## Descriptor

An Audit of documentation of the referring clinician's opinion on A&E radiographs.

## Background

Emergency department radiographs are commonly reported in retrospect. It is important that any discrepancy between the A&E opinion and the reporting radiologist be highlighted. This requires A&E staff to supply documentation of their opinion of the radiograph, so that at the time of reporting the radiologist can highlight important findings to the clinician.

The following method described is for departments using Fujifilm Synapse or Sectra PACS software. Alternatively if A&E opinions are documented by other methods, either electronically or manually, the principles of this audit can still be applied.

In our hospital, the documentation of the referrer opinion can be performed at the same time as reviewing the image in the emergency department via the use of a ‘canned note’ within the PACS viewing software. Each referrer while logged in to a Trust computer, then opens the PACS viewing software 'Synapse'. Once in Synapse and viewing a radiograph, there is the option to write a free text note which is then linked to the radiograph. This canned note is then available to the radiologist at the time of reporting.

If the clinician leaves a canned note, the reporting radiologist can write their report and be satisfied that the patient is being appropriately treated.

If there is no A&E opinion on the radiograph, a positive finding, such as fracture, will be flagged in the report but also placed into an A&E Discrepancies folder (urgent findings will also be phoned through to the clinical team). A&E will then routinely review this folder and then review the case to ensure the radiograph was not misinterpreted by the referring clinician.

Conversely if there is an incorrect opinion noted on the canned note system, then the reporting radiologist can highlight this in the A&E Discrepancy folder and ensure appropriate action is taken.

This process seeks to ensure that patients are not mistakenly diagnosed and seeks to promote safe practice in A&E. However, in order for this system to work it requires a high level of compliance from both A&E staff and radiology staff.

## The Cycle

### The Standard

All radiographs undertaken from the emergency department should have an opinion documented by the referrer of the findings shown in the imaging study, which should be available to the radiologist at the time of reporting.

There are a number of standards available for this audit, from both radiology and emergency medicine, which are listed below;

Radiology Standards

- 100% recording of referrer opinion on A&E radiograph [1]

- Referrers should “ensure. requested images are performed ...viewed and acted upon accordingly and recorded” [2]

Emergency Medicine Standards

- “All... radiological investigations must be reviewed by a clinician. The process of review, and the actions taken as a result of the review must be recorded.” [3]

### Target

100% documentation of referrer opinion on A&E radiographs.

## Assess local practice

### Indicators

Percentage of radiographs from A&E that have an accompanying opinion from the A&E referrer available at the time of formal radiology reporting.

### Data items to be collected

Sample

A random sample of A&E radiographs to be taken over a 4week period . A mix of patients from different areas of A&E (Minors, Majors, Resus), as well as a mix of radiographs (Chest, MSK, Abdominal) should be analysed. A number of different days and times are selected including out of hours (5pm- 9am) to ensure a range of A&E referrers are sampled and the data collated is a comprehensive representation of practice.

Data to be collected

The type of radiograph, the area of A&E the patient was seen, the presence or absence of referrer opinion (and if present, the referrer's opinion), pathology present or absent, and agreement with the final report are to be collected from CRIS/RIS as per local trust IT system. It is also important to record the job title of the referrer so that appropriate interventions can be planned.

### Suggested number

A random sample of a minimum of 120 radiographs to be collected over a 3 week period.

## Suggestions for change if target not met

Presentation of the audit results to the Radiology department and the emergency department at their Clinical Governance meetings. The benefits to compliance with this system of work should be highlighted. The most important benefit relates to patient safety, ensuring important findings are identified and acted upon in a timely manner. The additional gain is a reduction in additional work for the emergency department staff due to radiographs placed in the discrepancy folder for review due to a lack of documentation by the referring clinician.

Attempts to improve will include education on the importance of documentation and posters within the emergency department. Efforts can be focused on those referrer groups that are underperforming, for example; information on this documentation can be included in the induction packs for incoming doctors. Awareness can also be focused on those areas of A&E that are underperforming, through the use of posters in these areas, in Majors for example.

When renewing PACS, consideration should be given to acquiring systems that enable electronic documentation of opinion and archiving of cases to relevant folders such as discrepancy category.

Following these interventions above, a re-audit can take place.

## Resources

Data collection will take approximately 6 hours. All data can be collected into a spreadsheet. Analysis and graph production will take a further 2 hours approximately.

## References

1. The Royal College of Radiologists. Audit Live.

https://www.rcr.ac.uk/audit/documentation-referrer-opinion-ae-radiographs

1. The Royal College of Radiologists. Standards For The Communication Of Critical, Urgent And Unexpected Significant Radiological Findings.

https://www.rcr.ac.uk/sites/default/files/docs/radiology/pdf/BFCR%2812%2911\_urgent.pdf

1. The Royal College of Emergency Medicine. Best Practice Guideline: Management of Radiology Results in the Emergency Department.

https://www.rcem.ac.uk/docs/College%20Guidelines/5q.%20Management%20of%20Radiology%20Results%20 in%20the%20Emergency%20Department%20(February%202016).pdf

## Editors Comments

## Submitted by

Robert Foley

## Co Authors

Adrain Pollentine

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