## Recording of x-ray interpretation in patients' notes: clinical evaluation of urgent and emergency cases

## Descriptor

Hospital compliance with Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER) regarding x-ray exposure and appropriately timed written evaluations.

## Background

IRMER states

‘The employer must take steps to ensure that a clinical evaluation of the outcome of each exposure, other than where the person subject to the exposure is a carer or a comforter, is recorded in accordance with the employer’s procedures including, where appropriate, factors relevant to patient dose.[1]'.

Therefore, each individual examination requires a written evaluation (report) in the patient’s record at a time when the evaluation will influence the management of the patient. For many examinations, especially out of hours, this interpretation will be performed by the clinician because the management decision will be made before the definitive report from the radiology department is available. This audit focuses on those areas where the final radiology report is unlikely to be available when the management decision is made. The audit should be targeted at areas of work where this is likely to be the case e.g. A&E and Emergency Admissions Unit and should consider in-hours examinations separately from out-of-hours where it may be appropriate to wait for the radiology report for a non-urgent in-patient x-ray in-hours, but if the patient requires an urgent out-of-hours x-ray this implies the need for an urgent management decision. Also there may be less clinical support for trainee grade doctors out-of-hours. The Care Quality Commission wrote to all Acute Trust Chief Executives in July 2011 requiring them to audit the recording of radiological reports and to develop an improvement plan. The RCR 2016 publication of standards for the reporting of imaging investigations by non-radiologist medically qualified practitioners states that compliance with the standards outlined in the document should be audited as experience shows that if there is no record of the imaging interpretation, it may appear that the imaging investigation has not been viewed [2].

## The Cycle

### The Standard

100% of urgent and emergency plain x-ray examinations will have a written evaluation (report) recorded in the notes by the clinician at a time when the evaluation will influence the management of the patient.

### Target

100%

## Assess local practice

### Indicators

Percentage of x-ray exposures with a written evaluation recorded in the patient notes at a time which will influence patient management.

### Data items to be collected

• Patient x-ray exposures over a selected time period

• Correlation with patient records for the selected exposures

### Suggested number

Look at 5 examinations per day for a week (25 cases) in a number of different clinical settings.

## Suggestions for change if target not met

1. Present audit findings to the relevant departments

2. Impress on the clinicians the need to record an x-ray interpretation in the notes when it is not timely to await the formal report

3. Emphasise to trainee doctors they are not expected to be expert reporters and offer help in recognising common imaging findings in their practice.

4. Repeat audit in 3-6 months to confirm compliance

## Resources

• Access to PACS and HISS/RIS system

• Access to patient notes

• Radiologist (4-6 hours)

## References

1. The Ionising Radiation (Medical Exposure) Regulations 2017. <https://www.legislation.gov.uk/uksi/2017/1322/pdfs/uksi_20171322_en.pdf>
2. Standards for the reporting of imaging investigations by non-radiologist medically qualified practitioners. BFCR (16) 5. https://www.rcr.ac.uk/system/files/publication/field\_publication\_files/bfcr165\_non-radiologist\_reporting.pdf [accessed 22 09 16]

## Editors Comments

## Submitted by

Dr MAF McNeill and Dr L Cope. Updated by A-L Chang and D Remedios 2023

## Co Authors

## Published Date

Monday 10 October 2011

## Last reviewed

14 April 2023