

New Patient Information Posters published by the Clinical Imaging Board

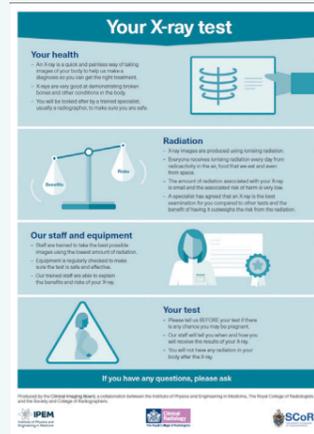
With the introduction of IR(ME)R 2017 came the requirement for benefit and risk information to be provided to patients undergoing procedures involving ionising radiation prior to the exposure taking place. The Clinical Imaging Board has produced a number of posters to fulfil this requirement which can be displayed in patient waiting rooms and changing areas.

The posters provide information to patients and their carers about the radiation exposure from common imaging procedures. There are six posters in total covering CT, general X-ray, dental X-ray, fluoroscopy, symptomatic mammography and nuclear medicine imaging.

The posters have been designed to be printed locally and displayed in the relevant modality.

They can be freely downloaded **HERE**
<https://www.rcr.ac.uk/clinical-radiology/service-delivery/clinical-imaging-board/clinical-imaging-board-projects>

Readers should consult RPC's IR(ME)R 2017 Employer's Procedure template on Relating Benefits and Risk to Patients for full details of the process for ensuring that this requirement is met by radiology services.



RPC launches new online radiation protection training course

We are pleased to announce the launch of our fourth online radiation protection course. The latest course is designed to provide around two hours of certificated radiation protection update training and focuses mainly on recently published guidance relating to IR(ME)R 2017.

The course comprises three modules:

1. Patient contact shielding guidance from the British Institute of Radiology
2. Radiation incidents update from the Care Quality Commission
3. Key IR(ME)R 2017 updates

The course aims to be engaging and informative and includes quizzes between each module (in which delegates must score at least 80% to gain certification). The training is suitable for radiographers, radiologists and any other person involved in diagnostic radiology.

Any person wishing to take the training should contact RPC to enrol (info@sghrpc.co.uk), making sure to put 'Moodle training' in the subject field and provide a full name and email address. A username, password and access instructions will then be provided. Sites with several staff who wish to enrol are kindly asked to request access for all persons in a single email message. The training is provided free of charge to RPC's customers. Usernames and passwords used for our previous online training modules will not be valid for the latest course.

Please note, this course is not suitable for staff who have not had previous radiation protection training.



Latest Care Quality Commission IR(ME)R 2017 Report Published

The latest IR(ME)R 2017 report from the CQC has recently been published (November 2021) and is available via their website. The report provides an analysis of notifications of Significant Accidental or Unintended Exposures ("SAUE") between April 2020 and March 2021. Direct comparisons of notifications cannot be made to the previous year due to the effects of the COVID-19 pandemic on levels of activity and a change to the reporting requirements for notifications from June 2019, which meant that data for 2019/20 was for a 10-month period only.

During the reporting period, the CQC received 499 SAUE notifications across all modalities. The largest proportion of notifications (66%) came from diagnostic imaging, 88% of which were from NHS trusts. The highest proportion of notifications were from CT with 236 (72%). The next highest was plain X-ray with 57 notifications (17%).

The most common type of error has continued to be where a patient received an examination meant for another patient (36%). 85 patients had been wrongly referred for diagnostic imaging examinations and there were 33 cases where the operator failed to correctly identify the patient. Referral errors overall accounted for the highest origin of incidents notified to CQC (36%).

The most common operator errors involved patient identification errors, patient set-up

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Welcome to the latest edition of RPC News

Dear Colleague

We are pleased to bring you this latest edition of RPC News.

After the last couple of years of disruption we look forward to getting back to 'business as usual'.

We hope that you find the information in this newsletter of interest. If you want further information on any of the articles, or if you would like us to include a specific topic in a future publication, please don't hesitate to get in touch. Please feel free to share this newsletter with your colleagues and teams.

Best wishes from

All at RPC

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errors, failure to check imaging history and failure to upload images to PACS.

In nuclear medicine, which accounted for 7% of all notifications, the highest number was from PET-CT. In a change from previous years, referral errors were not the most common cause of nuclear medicine incidents. Instead, operator errors were the most prevalent, including incorrect preparation or administration of radiopharmaceuticals to patients.

Based on the analysis of the notifications received during this reporting period, the CQC has provided some recommendations and advice:

- In 2020, the Clinical Imaging Board published guidance on implementing the definitions for clinically significant accidental and unintended exposures (CSAUEs). The CQC have found several cases where notifications have been categorised incorrectly as CSAUE due to a misunderstanding of the definition. Along with the guidance from professional bodies, it is important for a multidisciplinary team to determine whether the exposure is clinically significant. It is also important to ensure that any information provided to the patient in the case of a CSAUE uses clear language and terms.
- There were several instances of the CQC being notified of the same incident by multiple parties. Where multiple care providers are involved in an IR(ME)R pathway, there should be an agreement about who notifies the CQC of incidents. The CQC recommends that the radiation employer who carried out the exposure should make the notification.



- The CQC have received a number of enquires about whether to notify a group of incidents as a 'theme' since this new category was introduced. The CQC relies on employers using their professional judgements when deciding to make a notification. Examples of when and when not to make a notification in this category are given in the full report.

This report highlights the importance of honest and open discussion surrounding errors in radiation exposures within and between Trusts in order to better instil a culture of radiation protection and to share good practice in order to prevent future incidents. RPC's customers should continue to report radiation incidents to us and we will advise when notification to the CQC is necessary, as well as give advice on the reporting process.

this forum for the majority of our 2022 training programme. However, our newfound experience of online teaching has also demonstrated the opportunities of using an online format in terms of convenience and accessibility for delegates. As such, this year we will be offering our IR(ME)R 2017 theory courses using an online platform.

We would be grateful to get feedback from our customers as to their preferred method for accessing radiation protection and laser safety training. Your opinions will help us shape our course strategy for the coming years. We would appreciate if feedback could provide specific ideas about the perceived advantages and disadvantages of the various course delivery methods, which we will take into account when deciding whether to increase the number of our scheduled courses that are offered online. Please provide feedback via email to info@sghrpc.co.uk. Please note that ad hoc training courses can be provided online or face-to-face, depending on the preference of the customer. We look forward to receiving your feedback.

New COMARE report on radiation doses in interventional radiology published: issues for patients and staff in the UK

The Committee on Medical Aspects of Radiation in the Environment (COMARE) has recently published its 19th report, which focuses on current issues in interventional radiology. The development of interventional radiology techniques has revolutionised therapeutic interventions, superseding conventional some surgical techniques; patient recovery is quicker and the technique is minimally invasive. Despite its clear benefits, workforce evaluations suggest that the UK has a relatively low number of interventional radiology specialists, making it difficult to maintain out-of-hours services.

The Department of Health and Social Care (DHSC) independent expert advisory body COMARE has published several recommendations regarding the radiological protection issues in interventional radiology:

- Formal training should include radiation protection for staff and patients for all healthcare staff undertaking interventional radiology procedures.
- There should be a suitable out-of-hours staffing arrangement for interventional procedures, as recommended by the DHSC.
- Real-time electronic personal dosimeters should be available for all relevant staff, wherever possible.
- Rapid establishment and reinforcement of national DRLs in interventional procedures, particularly for paediatric patients, with the UK collaborating with the ICRP and international partners to develop and agreed methodology. Resources should be made available for NHS England and the equivalents in the devolved administrations to include interventional procedures in UK dose surveys, supporting regular updates of national DRLs.
- Healthcare providers (NHS and the independent sector) should submit interventional procedure numbers and summarised patient and staff dose data on an annual basis.

- The UK should be actively involved in further research into the radiosensitivity of high-risk groups in procedures using ionising radiation. Professional bodies and medical and scientific societies should continue to provide educational opportunities to increase the understanding of clinical staff regarding all potential risks to patients from radiological procedures. This is particularly relevant for children and groups with genetic disorders associated with an increased susceptibility to ionising radiation.
- Further research into paediatric interventional procedures and associated radiation doses is supported by appropriate grant-funding bodies, particularly for those associated with the treatment of congenital heart disease.
- In conjunction with the production of new regulations for medical exposures, the DHSC provides supporting guidance on optimisation, to which interventional procedure providers should refer, including a requirement for radiology services to consider appointing a team of radiation protection champions, including a radiologist, a radiographer and Medical Physics Expert.
- The overall safety regime for interventional radiology when introducing new technology (and in training for staff) should include a role for equipment manufacturers in all procurement and on-going maintenance contract to maximise the benefits of new technology.

RPC seeks customer feedback on training courses

Readers may be aware that we have resumed our full programme of training courses following the disruption caused by the pandemic.

The schedule of courses for the first part of 2022 is available via our website (www.sghrpc.co.uk/Courses.htm). Despite offering some online training during 2020 and 2021, we decided to resume classroom-based teaching as soon as it was practical to do so. Our experience of face-to-face teaching is that it is interactive, engaging, enjoyable (for delegates and teaching staff) and ultimately a better learning experience for attendees. Feedback from recent courses has been outstanding and we partly attribute this to the sense of appreciation experienced by delegates when attending face-to-face training after a lack of recent opportunity. As such, we believe that classroom-based teaching should be offered wherever possible and our intention is to continue using