APPENDIX C

Audit Title: Communication of Urgent Reports
Descriptor: The policies that are in place for the communication of urgent or unexpected findings to the referrer.
Background:
The NHS National Patient Safety Agency have published Safer Practice Notice 16 following the receipt of 22 reports where the failure to follow up radiological imaging reports led to patient safety incidents, most of which involved fatalities or significant long term harm. Every department should provide a means for the communication of urgent reports as outlined by Safety Practice Notice 16. (Refs 1 and 3) The processes involved should be transparent and form clear available trust policy agreed between the radiology department and requesting clinicians. The processes involved should be subjected to regular audit.

The cycle:
THE STANDARD
The communication of the report of all cases of suspected malignancy should follow a defined 'safety net' procedure agreed locally for example, copy reports to the GP, cancer services multidisciplinary team or other identified health professional in consultation with the referring health professional.

☐ National ☐ Local

Target
100%

LOCAL PRACTICE WAS ASSESSED AS FOLLOWS

- The indicator(s)
- Data items collected
- Number of patients / cases / episodes ____________________

SUGGESTIONS FOR CHANGE IF TARGET NOT MET

The Resources Used …
THE DATA was collected by ...

☐ Computer records
☐ Review of images
☐ Review of reports
☐ Review of requests
☐ Ongoing data recording
☐ Questionnaire
☐ Other (specify) ____________________ ____________________

ASSISTANCE

☐ None
☐ Secretarial
☐ Audit office
☐ Medical records
☐ Data analysis
☐ Software (off shelf)
☐ Software (customised)
☐ Clinical professionals
☐ Other (specify) ____________________ ____________________ ____________________

TIME to help complete stages 1–3 of the first cycle

RADIOLOGIST	RADIOGRAPHER	OTHER (specify)
Approx _____ hrs per week	Approx _____ hrs per week	Approx _____ hrs per week
for _____ weeks	for _____ weeks	for _____ weeks
= total _____ hours	= total _____ hours	= total _____ hours

COSTS (stages 1–3 of the cycle) apart from radiologists' / radiographers' time

□ None/minimal

□ Temporary staff

□ Information technology

□ Other (specify) ____________________ ____________________

Stages 1–3 of the first cycle

£ ________________

Results of the Completed Cycle…

- Local practice was re-assessed ____________ months after the changes were introduced
- Date of re-assessment ________________
- Data items collected
- Assistance obtained from
- Costs (stages 5–6) of the re-audit (not including the cost of the changes)

£ ________________

Comparison of findings …
(a) with the standard, shows that ...

(b) with the previous audit findings, shows that ...

(c) indicates that an improvement on the previous audit findings has occurred □ Yes □ No

A Further Audit will Occur …
in ______________ months to start (date) ________________

Useful References …

1.Early identification of failure to act on radiological imaging reports: National Patient Safety Agency Notice 16 2007
2. Communicating radiology results. L Berlin. The Lancet (2006), 367; 373-375.
3. Royal College of Radiologists. Guidelines for the Communication of Urgent Reports 2008

The Audit was carried out by …
Stages 1–4 ______________________________ Stages 5–6 ______________________________

Hospital ______________________________

Address ______________________________ Telephone No: ______________________________

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______________________________ Fax No: ______________________________

A Copy of this form has been …

- ☐ placed in the Department's Audit File
- ☐ sent to the Hospital's Audit Office
- ☐ sent to the Clinical Audit Unit at the RCR

Appendix …
Further information (audit design / questionnaire / analysis of results / introduction of change) is included as follows ...

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