NF211* V1.0	**Health Information and Quality Authority** Accidental or unintended exposure to ionising radiation	Health Information and Quality Authority An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Section 1. Undertaking and medical radiological installation details		**For official use**
Undertaking **name**		
Undertaking **address** (include **Eircode**)		
Undertaking **email address**		
Undertaking **contact number**		
Medical radiological installation name where incident **occurred**		
Address incident **occurred** (include Eircode)		
Designated manager **name**		
Designated manager **email address**		
Designated manager **contact number**		

Section 2. Significant event details				**For official use**
Exact location incident **occurred** (area **or** department **or** room **or** unit)				
Date incident **occurred**				
Time incident **occurred** (HH:MM)				
Date incident **discovered**				
Multiple patients affected	**Yes**	**No**	**Number**	
	☐	☐		
Patient **Details**	**Gender**		**Age**	
	Male ☐	Female ☐		

Type of procedure **or** treatment involved in the **incident**				
Computed Tomography (CT)	☐	Mammography	☐	
Dental	☐	Nuclear medicine	☐	
Dual-energy X-ray absorptiometry (DXA)	☐	Positron Emission Tomography/CT	☐	
Fluoroscopy	☐	Radiology - general	☐	
Interventional cardiology	☐	Radiotherapy	☐	
Interventional radiology	☐	Other, **please specify:**		

* Please complete this form with HIQA's statutory notification guidance. You can download the guidance at www.hiqa.ie.

Significant event category			
1	Administration of a Reference Point Air Kerma ($K_{a,r}$) of 15 Gray (Gy) or greater as a result of a single interventional radiological procedure (including interventional cardiology) or a cumulative $K_{a,r}$ dose of 15 Gy arising from a series of interventional radiological procedures carried out over a six month period	☐	
2	Tissue reactions (deterministic effects) as a result of interventional radiology/cardiology	☐	
3	Diagnostic overexposure of an adult of more than twice the exposure intended that leads to a dose that is greater than 10 millisievert (mSv) or 20 times the dose intended	☐	
4	Diagnostic overexposure of a child of more than twice the exposure intended that leads to a dose that is greater than 3 millisievert (mSv) or 15 times the dose intended	☐	
5	Dose given to comforters and carers greater than 3 millisievert (mSv) for adults under 60 years of age and 15 millisievert (mSv) for those over 60 years of age	☐	
6	Dose to a breastfed child greater than 1 millisievert (mSv)	☐	
7	Inadvertent dose to a foetus greater than 1 milligray (mGy)	☐	
8	Incorrect anatomy greater than 1 millisievert (mSv)	☐	
9	Incorrect procedure greater than 1 millisievert (mSv)	☐	
10	Incorrect radiopharmaceutical	☐	
11	Therapeutic dose given instead of diagnostic dose, for example, in the use of radioiodine	☐	
12	Administered activity variation of 20% from intended dose during use of therapeutic nuclear medicine	☐	
13	No dose intended/incorrect patient exposed to greater than 1 millisievert (mSv)	☐	
14	Radiotherapy dose or volume variation of 10% or greater from the total prescribed	☐	
15	Radiotherapy dose or volume variation of 20% or greater from the fraction prescribed	☐	
16	Unexpected tissue reactions (deterministic effects) as a result of radiotherapy treatment	☐	
17	Any other radiation exposure incident considered to have serious patient safety implications, for example, multiple non-notifiable incidents of a similar nature	☐	

Please provide **brief details** of the incident					
Have **appropriate actions** been taken to **mitigate** against immediate **recurrence** of this incident?	**Yes**	☐	**No**	☐	

Please provide **brief details** of the **initial actions** taken to **mitigate against immediate recurrence** of this incident		

Section 3. Dental / Radiology / Nuclear Medicine incident details			**For official use**
Radiology, diagnostic nuclear medicine and interventional procedures Please provide an **initial estimated effective dose** in millisievert (mSv)	1 to 5 mSv	☐	
	Over 5 to 10 mSv	☐	
	Over 10 to 15 mSv	☐	
	Over 15 to 20 mSv	☐	
	Greater than 20 mSv	☐	
Therapeutic nuclear medicine procedures Please provide an **initial estimated radiation dose variation**	Greater than 20% total dose, **please specify**:		
Type of incident	Hardware/software – Ancillary equipment	☐	
	Hardware/software – Medical radiological equipment	☐	
	Inappropriate or incorrect justification	☐	
	Inappropriate or incorrect referral	☐	
	Incorrect protocol selection	☐	
	Optimisation error (practical aspects)	☐	
	Patient movement	☐	
	Patient related circumstance	☐	
	Quality assurance error	☐	
	Scheduling error	☐	
	Wrong patient	☐	
	Wrong anatomical site	☐	
	Wrong side (laterality)	☐	
	Wrong patient setup	☐	
	Other, **please specify**:		

Section 4. Radiotherapy incident details			**For official use**
Process step where the incident **occurred**	Patient assessment/consultation	☐	
	Imaging for radiotherapy planning	☐	
	Treatment planning	☐	
	Pre-treatment review and verification	☐	

	Treatment delivery external beam radiotherapy				☐	
	Treatment delivery brachytherapy				☐	
	On-treatment quality management				☐	
	Post-treatment completion				☐	
	Other, **please specify:**					
Treatment **intent**	Radical	☐	Palliative	☐		
Radiotherapy treatment delivery Please provide an **initial estimated radiation dose variation**	Greater than 10% variation total dose, **please specify**:					
	Greater than 20% variation in a fractionated dose, **please specify:**					
Other radiotherapy incidents	Please provide an **initial estimated effective dose** in millisievert (mSv)					
Type of incident	**Dose** error	Calculation error			☐	
		Calibration error			☐	
		Excess imaging dose			☐	
		Treatment plan not physically deliverable			☐	
		Wrong plan dose			☐	
		Wrong prescription dose			☐	
	Hardware/software error	Medical radiological equipment			☐	
		Ancillary equipment			☐	
	Volume error	Patient movement			☐	
		Wrong anatomical site			☐	
		Wrong patient			☐	
		Wrong patient setup			☐	
		Wrong shift from setup point			☐	
		Wrong side (laterality)			☐	
		Wrong target or organs at risk contours, or planning margins			☐	
		Wrong treatment accessories			☐	
	Other errors	Inappropriate or poorly informed decision to treat or plan			☐	
		Patient related circumstance			☐	
		Scheduling error			☐	
	Other, **please specify**:					

Section 5. Open Disclosure				For official use
Was the incident that occurred considered to be a **clinically significant** unintended or accidental exposure?		Yes ☐	No ☐	
Did you **inform** the following individuals of this incident?	Patient/patient representative	Yes ☐	No ☐	
	Referrer	Yes ☐	No ☐	
	Practitioner	Yes ☐	No ☐	

Section 6. Notification of stakeholders				For official use
Please indicate, **where applicable**, if the following **stakeholders** have been **notified** of the incident:				
Medical Physics Expert	☐	Radiation Safety Officer	☐	
Referrer	☐	Radiography Services Manager	☐	
Practitioner	☐	Radiation Therapy Services Manager	☐	
Radiation Safety Committee or equivalent	☐	Risk Manager	☐	
		Undertaking	☐	
Other regulatory agencies where necessary, **please list if applicable**:				

Section 7. Follow-up documentation
Please **submit** to HIQA a copy of the undertaking's **internal investigation results and corrective measures to avoid such events** ensuring to remove any personal identifiable information in line with General Data Protection Regulation within **120 calendar days** of discovery of this incident.

Section 8. Declaration		For official use
I, the undersigned, **declare** that the information I have provided in this notification form is true to the best of my knowledge and belief. The undertaking is aware that I am making this submission on its behalf.		
Name (**print**)		
Job Title		
Contact number		
Signed (**type signature if electronic submission**)	If completing the PDF version of the notification form, **type** your name in the signature field	
Date		

- **Email** form to: radiationprotection@hiqa.ie
- **Telephone**: 01 8286750