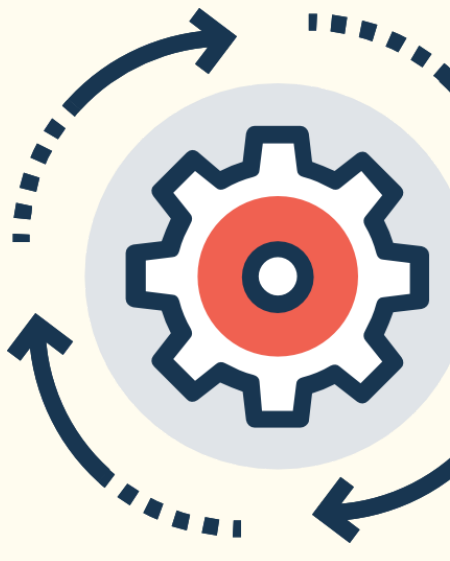
# HIQA'S 2019 OVERVIEW REPORT ON ACCIDENTAL OR UNINTENDED MEDICAL EXPOSURES TO IONISING RADIATION

## In 2019, we received 68 notifications

But zero notifications from some relatively high dose services from Interventional Radiology and Cardiology.

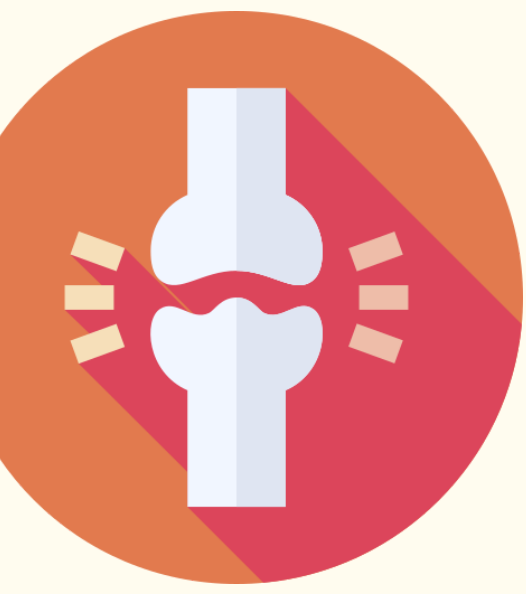
## Patient safety culture

To prevent errors, you need to implement robust and efficient measures. These measures should review systems and process as a whole, human error being only one part of a system.



## Why should I report near-misses locally?

- To be compliant
- To improve patient safety
- To minimise the probability of preventable events



## Diagnostic Imaging

In 2019, the majority of the notifications came from CT and related to the incorrect service user being imaged.

The key learnings were to have strong patient identification systems in place to correctly establish the right patient at all stages of the patient journey for X-ray.

## Radiotherapy

HIQA received 13 notifications from radiotherapy services in 2019.

Overall, there was a positive culture of reporting across radiation oncology services.

READ OUR FULL REPORT AT WWW.HIQA.IE