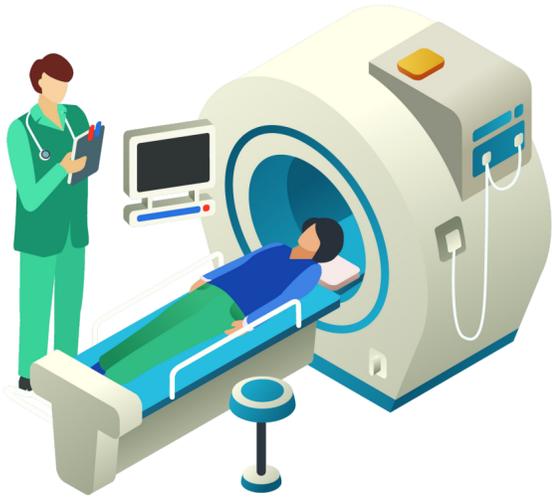


# Lessons learned from notifications of medical exposure to ionising radiation in 2020



**76 incidents in 2020**

**65** incidents occurred in diagnostic imaging, mainly in CT services.

**11** incidents occurred in radiotherapy services.

## What we found



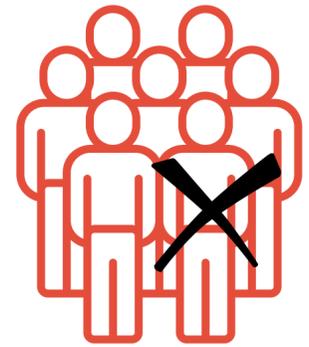
### Increased reporting

**11%** increase since 2019 in number of incidents reported **but** reports received from only 20% of hospitals



### 1st time

We received reports from fluoroscopy, mammography, interventional cardiology



### The wrong person

**34%** of incidents involved the wrong person

## What needs to improve ?

### Empowerment

Empower staff to report

Empower patients to be involved in the identification process

Empower staff and patients to share relevant information

### Justification

Justify procedures at every step

Seek previous imaging

### Communication

Communicate within the service and with patients

Communication with other service providers and to HIQA

### Correction

Review all incidents

Look for trends in similar incidents

Take corrective actions appropriate for the incidents