Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

76 incidents in 2020

65 incidents occured 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

Source | www.hiqa.ie