NHS Borders
Planning & Performance

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Freedom of Information request 89-20

Request

The information being requested relates to the risk controls/systems in place to mitigate the risks of significant abnormal finding in radiology reports not being actioned.

1. Please confirm if a computer based system/paper based system is in place to provide reports on abnormal radiology findings.
2. Please provide a detailed description of any systems in place to report abnormal radiology results.
3. Please also advise me if any system has an audit trail of when results are read and acted upon by the referring clinician or viewed by any other clinician involved in the patient's care.
4. Please define the principals upon which the abnormal findings are reported i.e. significant abnormal, critical, urgent etc or whatever principals are currently in use by yourselves
5. Is there a defined list of conditions for which an alert is always triggered? If so what are the conditions? e.g. suspected cancers, aortic aneurysm, bowel blockage etc
6. Is there a monitored and audited acknowledgement system in place to ensure that clinicians act on alerted radiological findings? If no system is in place please provide and explanation why this has not been implemented.
7. What is the method/methods used of advising clinicians of abnormal findings which require further action and for which an audit trail is provided i.e, email, telephone etc
8. Is the patient advised of any abnormal findings? If so how is it communicated to them. If no why not? If the result is given to the patient where is this recorded/confirmed that it has been explained to them? Is it followed up in writing to them by the clinician?
9. Are the results of any abnormal findings routinely sent to the patient's GP? If so how are they communicated to them? If not why not?
10. What fail safe checks are in place to ensure that the requesting clinician takes the appropriate action when a report identifies an abnormality which requires that further investigations should take place?
11. Does the radiologist routinely recommend the extent of further investigations that should be undertaken or is that the responsibility of the clinician? i.e. CT or MRI scans
12. What is the job title of the employee responsible for the monitoring and reporting on any radiology reporting systems you have in place. On what frequency are these systems monitored and audited. i.e. weekly, monthly etc
13. With regard to the clinical history given to the radiologist, to what extent does the referring clinician detail this on their referral request? e.g. are detailed results of previous investigations/operations/biopsies/ blood tests given? for example colonoscopies, family history of diseases etc and if these indicate the probability of specific diseases/conditions, is the radiologist alerted to look for these specific diseases/conditions along with any other abnormalities?

Response

1. All reports are dictated via voice recognition software. These reports are created in dedicated reporting software and inserted directly into the Radiology Information System (RIS) which then inserts them into the Hospital Information System (HIS) and Patient Archive Communication System (PACS).

2. Expected or non urgent abnormalities will be detailed in the report.
   If there are findings requiring action by the referrer, expected or unexpected then these will be actively flagged by text at the end of the report '****ACTION REQUIRED BY REFERRER****'. These reports will be actively flagged to the referrer by telephone and/or email if they require urgent action.
   A text line 'Administrative Action' will be inserted at the end of a report, with details of the action required to instruct the radiology office staff to email the report to the referrer if required.

3. TRAK has an audit trail of results being “signed off”. This only applies to secondary care activity.

4. Expected or non urgent abnormalities will be detailed in the report.
   Findings requiring action by the referrer, expected or unexpected will be flagged to the referrer by including the text ‘****ACTION REQUIRED BY REFERRER****’ or ‘****URGENT ACTION REQUIRED BY REFERRER****’. Reports requiring urgent action will be actively communicated to the referrer by emailing the report directly to the referrer and/or telephoning the referrer. The reporter will instruct the office staff to email the report if necessary by inserting the phrase ‘Administrative Action. Email report to referrer’ at the end of the report.

5. No defined list.

6. No system in place. There is no practical way of auditing this on our current IT systems. Upcoming change to a new RIS system in the next few months may provide an opportunity for this to be put in place however.

7. As above ACTION REQUIRED BY REFERRER and Administrative Action. The text may request that referrer make contact when the action has been undertaken.

8. The responsibility to discuss radiology reports with patient lies with the referrer. Image acquisition is totally divorced from Image interpretation therefore the report of abnormal finding usually follows after the patient has left the department. On rare occasions a significant abnormality is identified by Radiographers at imaging and is highlighted to Radiologists at that time. If an immediate action is required, the radiologist speaks to the patient, explains the abnormality briefly and refers the patient to a secondary care clinician for immediate management.

9. Abnormalities identified via secondary care referrals are identified to the referrer. The secondary care clinician is responsible for contacting the GP with the findings and information on any further investigation required and management plan.

10. No definitive fail safe checks as the clinician and patient may discuss the findings and agree that no further investigation will be initiated if the patient does not consent to this. The further investigation is a recommendation only.

11. Usually the recommendation is specific.

12. Clerical Officer monitors Administrative Action daily.

13. Highly variable. There will be sufficient information to justify the imaging test to being booked and performed. However the comprehensiveness of the information supplied from a reporting radiologist’s perspective is very variable.

If you are not satisfied with the way your request has been handled or the decision given, you may ask NHS Borders to review its actions and the decision. If you would like to request a review please apply in writing to, Freedom of Information Review, NHS Borders, Room 2EC3, Education Centre, Borders General Hospital, Melrose, TD6 9BS or foi.enquiries@borders.scot.nhs.uk.

The request for a review should include your name and address for correspondence, the request for information to which the request relates and the issue which you wish to be reviewed. Please state the reference number **89-20** on this request. Your request should be made within 40 working days from receipt of this letter.

If following this review, you remain dissatisfied with the outcome, you may appeal to the Scottish Information Commissioner and request an investigation of your complaint. Your request to the Scottish Information Commissioner should be in writing (or other permanent form), stating your name and an address for correspondence. You should provide the details of the request and your reasons for dissatisfaction with both the original response by NHS Borders and your reasons for dissatisfaction with the outcome of the internal review. Your application for an investigation by the Scottish Information Commissioner must be made within six months of your receipt of the response with which you are dissatisfied. The address for the Office of the Scottish Information Commissioner is, Office of the Scottish Information Commissioner, Kinburn Castle, Doubledykes Road, St Andrews, Fife.