# Audit of Communication of Fail-safe Alerts [QSI Ref: XR-510]

**Descriptor:**

National Patient Safety Alert, Patient Notice 16, states that for critical and significant unexpected results, safety nets should be established with additional steps for communication, commonly referred to as fail-safe alerts [1].  It is a matter of professional judgement on the part of the reporting radiologist when additional steps need to be taken to supplement the normal systems of communication to referrers [2]. This audit provides evidence on clinical effectiveness.

**Background:**

Accurate reporting of imaging studies and timely effective communication of reports to those who treat the patient is essential. The issue of communication of reports has been highlighted as a problem for UK radiology departments, starting with the publication of the Early identification of failure to act on radiological imaging reports, NPSA Safety Alert 16 in 2007 [2]. Duncan et al (2015) found that only 34% of radiology departments in UK have an automated alert system in place and even fewer (17%) have the facility for enterprise-wide tracking of radiology reports for referring doctors [3].

O’Connor et al (2016) in their study conducted at a large academic centre in the Massachusetts, USA reported that integrating Alert Notification of Critical Results and EHR provides an additional workflow for acknowledging non-urgent, clinically significant results without significant change in rates of closed-loop communication or follow-up of alerts [4].

## The Cycle

**The standard:**

• Every department should have a defined process for the communication of fail-safe alerts as outlined by Safer Practice Notice 16 [1]

• The processes involved should be transparent and form clear and available trust policy, agreed between the radiology department and requesting clinicians

• The processes involved should be subjected to regular audit

• There should be defined fail-safe alert procedures for significant unexpected findings – such as unexpected cancer on imaging. Processes involved may include copy reports to the GP, cancer services, multidisciplinary team or other identified healthcare professional in consultation with the referring healthcare professional

**Target:**

• Flagging of imaging findings that need a fail-safe alert in a report: target 100%

• Electronic communication of fail-safe alerts to PACS, EPR and GP systems: target 100%

• Manual process for communication of fail-safe alert (if used): target 100%

• Record is kept of delivery of all reports delivered (if manual process used), by secretary making a call or faxing : target 100%

## Assess local practice

**Indicators:**

As stated in targets.

**Data items to be collected:**

• Choose a site-specific cancer (for example, lung) or other agreed pathology and determine whether alerts were appropriately used and issued

   - For example, for lung cancer, ask for a list of all new cases of newly diagnosed lung cancer from the lung MDT for the past three months, including the date of diagnosis

• Review all the radiology reports prior to the diagnosis to assess whether the reports have been flagged with a fail-safe alert within the radiology report text

• Review all reports on EPR or PACS to see if the fail-safe alert has been transmitted electronically by phone, fax

• Review the report information and RIS or radiology reporting application information to look for manual fail-safe processes documentation – for example, that a copy of the report was sent to the MDT co-ordinator, the report was telephoned etc

**Suggested number:**

For example, all newly diagnosed lung cancer for the past 3 months.

**Suggestions for change if target not met:**

1. Present Audit results at the local clinical governance meeting

2. Re-iterate that radiology reports should ensure that critical findings are emphasized and obvious that the degree of urgency for action by the referring health professional is clear

3. Local practice guidelines – define and develop a policy for radiological imaging reports which require particularly timely and reliable communication. For example, abnormal, unexpected and / or critical ranges

4. Define and document local ‘safety net’ procedures. For example copy reports to the GP, cancer services, multidisciplinary team or other defined health professional in consultation with the referring health professional

5. Recommend Trust Management to provide Imaging departments and referring doctors with robust IT systems for electronic tracking, reading and acknowledgement of radiology reports in the full clinical context

6. Re-audit in 6 months post local education and changes

**Resources:**

• Personnel: IT facilities and clerical time to pull the necessary lists

• Time: allow eight hours for scrutinising records and preparing formal report

**References:**

1. NPSA/2007/16.  Type Alert.  Early identification of failure to act on radiological imaging reports.  NPSA Safety Alert 16. <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59817>
2. The Royal College of Radiologists. Standards for the communication of radiological reports and fail-safe alert notification.  London: The Royal College of Radiologists, 2016. Ref No. BFCR(16)4 <https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr164_failsafe.pdf>
3. Duncan, K.A., Drinkwater, K.J., Dugar, N., Howlett, D.C., of Radiologists' Clinical, T.R.C. and Radiology Audit Committee, 2016. Audit of radiology communication systems for critical, urgent, and unexpected significant findings. Clinical radiology, 71(3), pp.265-270. <https://www.ncbi.nlm.nih.gov/pubmed/26738965>
4. O'Connor, S.D., Dalal, A.K., Sahni, V.A., Lacson, R. and Khorasani, R., 2016. Does integrating nonurgent, clinically significant radiology alerts within the electronic health record impact closed-loop communication and follow-up?. Journal of the American Medical Informatics Association: JAMIA, 23(2), pp.333-338. <https://www.ncbi.nlm.nih.gov/labs/articles/26335982/>

**Editor's comments:**

Organising this audit, delivering the report and carrying out the action plan is the responsibility of the clinical director and radiology services manager.

**Submitted by:**

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