**Assessing if radiology reports are read [QSI Ref: XR-508]**

**Descriptor:**

• An audit to assess whether radiology reports are read within an institute

• To identify specific clinical areas which do not meet the required standard

**Background:**

The National Awareness and Early Diagnosis Initiative identified many cases of late diagnoses of cancer related to system failures and that despite the Radiologist raising the suspicion of disease, no further action was taken.

This audit was designed to assess whether reports in any institution are read as per standard 6 of ​Standard for communication of radiologist reports and fail-safe notification [2].

## The Cycle

**The standard:**

Every radiology report should be read.

**Target:**

100% of radiology reports should be read.

## Assess local practice

**Indicators:**

• Identify where acknowledgement of radiology report is not documented

**Data items to be collected:**

• Acknowledgement in case notes / medical record that the radiology report has been read

• Identify different clinical areas for assessment e.g. acute care settings (A&E, Medical assessment unit (MAU), Surgical assessment unit (SAU)), Outpatients, In-patients

For a set number of patients who have undergone a radiology examination in a set time period - interrogate notes to obtain:

    o Patient demographics

    o Type of radiological procedure

    o Date reported

    o Date of report / comment on report in notes

**Suggested number:**

5-10 cases per clinical area, obviously this will depend on the number of different clinical areas in the institution, but suggest division into different directorates:

1. Acute care i.e. A&E / SAU / MAU

2. Out-patients i.e. Surgical, Medical

3.  In-patients - again different specialities; Medicine, Surgery, etc.

Aim for a total of 50 patients.

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

1. Clear documentation of radiological imaging in patient notes

2. Clear indication that a radiology study was requested and who will take responsibility for reviewing report E.g. ‘stickers’ for patient notes; "CT scan performed [date]. Report to be reviewed by Dr X”

3. Built-in acknowledgement of a report being read

4. Implement a changeable status within the PACS system to verify that reports have been read. Record details of accessing physician(s) creating a traceable chain on PACS; "Reported by Dr X at 12.15pm on 3/3/16, Report accessed by Dr Y at 12.30pm on 3/3/16."

5. In-built system whereby reports which have not been read within set time period (14 days) are automatically ‘flagged,’ with an email to the referring consultant

6. Labour intensive for the Radiologist, but bleep/email/fax significant reports to referring physician at time of reporting +/- organising further investigations

7.  Re-audit

**Resources:**

o Access to patient notes on ward/clinic

o Access to PACS and RIS

o Data extractor e.g. Radiologist / Clinician time: 10 hours

**References:**

1. National Awareness and Early Diagnosis Initiative - <http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/awareness_early_diagnosis>
2. C Garvey, S Connolly. Radiology reporting – where does the radiologist’s duty end? Lancet (viewpoint) 2006;367:443-45
3. 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/publication/standards-communication-radiological-reports-and-fail-safe-alert-notification>

1. National Patient Safety Association. Safer Practice Notice 16: Early identification of failure to act on radiological imaging reports.  London: National Patient Safety Association, 2007.

**Editor's comments:**

The audit can be adapted to compare different services/directorates/modalities of radiological study. A similar audit template is present for the Standards document ‘results acknowledgement system’.

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**Published Date:**

Thursday 13 October 2011

**Last Reviewed:**

Wednesday 1 January 2020