Policy

Communicating safely – if urgent or unexpected findings are identified

8 November 2019

Medical Radiation Practice Board Ahpra

Who this policy applies to?

This policy has been developed by the Medical Radiation Practice Board of Australia (the Board) to help medical radiation practitioners meet their obligations if urgent or unexpected findings are identified.

The policy also informs other registered health practitioners, employers, health services, education providers, patients and the public of the Board's expectations of medical radiation practitioners and the role that they play in patient safety.

Obligation

If a medical radiation practitioner identifies urgent or unexpected findings, they must ensure this information is shared with, and understood by, the appropriate persons who may include the reporting medical specialist, the requesting health practitioner and/or other health practitioners, for the immediate and appropriate management of the patient/client.

The patient/client and their family and/or carers should be informed if further medical advice is needed before leaving the hospital/clinic or other healthcare setting.

Documenting critical information in the patient's healthcare record is essential for patient safety and supports subsequent communications and decisions about care. Medical radiation practitioners should record information shared with other health practitioners and/or members of the multidisciplinary team in accordance with relevant procedures.

This minimum expectation of medical radiation practitioners reflects outcomes of coronial findings and must be read in conjunction with the requirements of *Standard 6 – Communicating for safety* in the National Safety and Quality Health Service (NSQHS) Standards.

What's expected?

Formal reports are the gold standard

Formal reporting of medical images is usually conducted by a reporting medical specialist. It is recognised that the formal report is the gold standard and the most appropriate way to communicate findings in medical images.

If you see something, say something

If a medical radiation practitioner identifies something urgent or unexpected in a medical image, they must communicate this in a timely way to another health practitioner involved in the care or the patient/client.

In most cases the appropriate health practitioner to communicate urgent or unexpected findings to is the reporting medical specialist. This allows the report writer to prioritise the production and communication of a formal report.

Timely communication to the point of care is essential

Medical radiation practitioners are expected to exercise professional judgement.

If critical information emerges or there is a risk to patient care, timely communication of this information to clinicians involved in the care of the patient/client is essential.

Clinicians directly involved in the care of the patient/client are best placed to make decisions about care requirements, and this includes making decisions about acting on an alert or seeking further specialist advice or a formal report.

The focus of the capability is on communicating safely

Medical radiation practitioners must ensure that they deliver safe care for the patient. This includes communicating safely when urgent or unexpected findings are identified.

The Professional capabilities for medical radiation practice (the professional capabilities) do not impose an obligation on medical radiation practitioners to make specific diagnoses or to issue formal reports. The responsibility for making a definitive diagnosis sits with the formal report writer.

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Professional capabilities for medical radiation practice

Domain 1, Key Capability 7

1. Apply quality criteria to assure image quality, evaluate medical images and identify any urgent and/or unexpected findings.
2. If the practitioner identifies any urgent or unexpected findings, take appropriate and timely action to ensure the immediate management of the patient/client.

Taking appropriate and timely action is a key responsibility if a medical radiation practitioner identifies medically significant findings on an image and must be interpreted in the context of Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service Standards (NSQHS) Standard 6 Communicating for Safety.

Information must be conveyed verbally or in writing, in line with relevant guidelines. Medical radiation practitioners must ensure information is conveyed to, and understood by, the appropriate persons who may include the reporting medical specialist, the requesting practitioner or other practitioners, for the immediate and appropriate management of the patient/client.

The patient/client and their family and/or carers should also be informed if further medical advice is required prior to them leaving the hospital/clinic. Communication between health practitioners about the clinical status of a patient/client should be recorded in accordance with relevant procedures.

Identifying urgent and unexpected findings includes recognising and applying knowledge of normal from abnormal imaging appearances and relating appearances to the patient/client's clinical history.

Reporting medical specialist may include, but is not limited to a radiologist, radiation oncologist, nuclear medicine specialist, cardiologist, gastroenterologist, obstetrician/gynaecologist or vascular surgeon.

Review

This policy was approved by the Board on 21 October 2019 and will be reviewed as required. This will generally be every three years.