

# Patient Safety ALERT – Right patient, correct x-ray

There have been **7** incidents in the last 12 months that have resulted in harm to patients. Staff groups involved in these incidents include doctors, nurses, radiology staff and portering staff.

Incidents include

- patients receiving unnecessary (sometimes very high) doses of radiation due to the errors described,
- unnecessary x-rays being performed because the wrong patient has been identified on the ward and taken to radiology,
- additional x-rays being required because the detail on the xray request form is incorrect or unclear, leading to the wrong body part being x-rayed.

Incidents like result in

- Very poor patient experience – including increased anxiety,
- Delays in the treatment of other patients who should have been x-rayed,
- A waste of patient and staff time.

**Required Actions** - Please ensure ALL staff are aware of the following:

- adhere to the **Patient Identification Policy** – registered staff are ACCOUNTABLE for ensuring the right patient is identified at each stage of the patient's journey – from completion of the referral form, to transfer to Radiology, to the x-ray being performed,
- **Ensure the details on the x-ray request form are correct and legible** – is this the right patient, being referred for the correct investigation, for the correct body part? Ambiguous or incomplete request cards will be rejected.

Any incidents that are contrary to the regulations relating to Radiology (known as IRMER), such as those describe above are reportable to the Care Quality Commission (CQC)