

## **QUDI Project QS09**

### **Radiology events register (RaER)**

#### **RANZCR response**

#### **Introduction**

The aim of the Radiology Events Register (RaER) is to develop a means of systematic data collection and analysis of incidents in radiology, in order to obtain reliable data to assist quality improvement and increase patient safety. It is based on an established, validated data collection system called the Advanced Incident Management System (AIMS). All data collected is protected by qualified privilege.

#### **What the report tells us**

The database needs more incident reports in order to be more effective and realise its enormous potential to provide analysis on incidents and recommend quality improvement strategies. This needs to be an ongoing process with no end point.

There are cultural factors apparent within the radiology profession that do not encourage reporting incidents, including near misses.

#### **Implications for Australia's health sector**

The recently convened National Health and Hospitals Reform Commission has identified in its governance principle on safety and quality "an emphasis on open, transparent reporting. There must be a just and positive culture in dealing with adverse events, mistakes and near misses"<sup>1</sup>. RaER is uniquely placed to make a significant and ongoing contribution to this area of health care provision.

The RaER database supplements generic critical incident reporting processes by analysing 'near misses' as well as adverse events, in a way that is relevant and meaningful for radiology.

#### **Implications for RANZCR**

This project has the potential to influence the College's standards of practice as well as the curriculum for trainees. Any future need to define competencies to be applied in credentialing processes may also be informed by the outcomes of the analysis of incident data.

If successfully implemented by the ongoing, reliable reporting of all incidents, this project has enormous potential to be a world class source of data about the real risks of tests and procedures. It has the potential to be an 'early warning system' if used appropriately by the profession.

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<sup>1</sup> <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/content/principles-lp>

The College proposes to assist a culture change toward incident data sharing in radiology and in radiology training by:

- Encouraging promotion of clinically relevant RaER outputs to the profession through publication of findings and conference/ASM presentations;
- Encouraging the use of RaER incidents, or sets of RaER incidents, for teaching purposes;
- Promoting to Fellows the use of RaER as a tool for quality improvement and incident monitoring;
- Linking reporting of incidents through RaER to the RANZCR Continuing Professional Development points system.

Reinforcing the privileged status of the data and the non-judgemental analysis in RaER is critical if radiologists are to be successfully encouraged to contribute. Demonstrating the power of data to improve practice is critical in this task, such as using the data to inform the fellowship of emerging safety issues.

Educating radiologists as to what constitutes a 'near miss' and why it is critical to report them is also important.

### **College recommendations**

The College recommends that the RaER project should continue for the collection and analysis of radiology incidents. It should be considered as a high priority in the proposed QUDI II work program.

The College recommends that CPD points are awarded for every incident entered into the RaER database.

The College also commends the database to practices and hospitals for use as part of their incident monitoring and quality improvement frameworks.