Diagnostic Services – Department of Radiology – Diagnostic Division

SUBJECT/TITLE: **MANAGEMENT OF ADVERSE PATIENT EVENTS OR OUTCOMES IN THE RADIOLOGY DEPARTMENT**

PURPOSE: Describe procedure for staff to follow should a serious adverse event occur in the Department of Radiology

DEFINITION:

Serious Adverse Event: an Incident that necessitates special intervention because the potential for serious injury is high. Serious Adverse Events will be evaluated to see whether they meet criteria for the definition of Sentinel Event.

POLICY:

A radiology staff physician must examine the patient who experiences an adverse event in Radiology, make appropriate notes in the patient's chart, notify the referring physician, make appropriate care orders, and file an incident report.

PROCEDURE:

Procedure:

1. All patients having an adverse event in the Radiology Department must be seen by a Radiology physician.

2. If the Radiology physician is a resident, the staff Radiology physician responsible must be promptly notified.
    a. On nights, weekends, and evenings this would be staff Radiology physician on-call.
    b. During regular hours this would be staff Radiology physician in charge of that service.

3. A notation involving the adverse event must be made in the patient electronic medical record (EMR) by a Radiology physician.

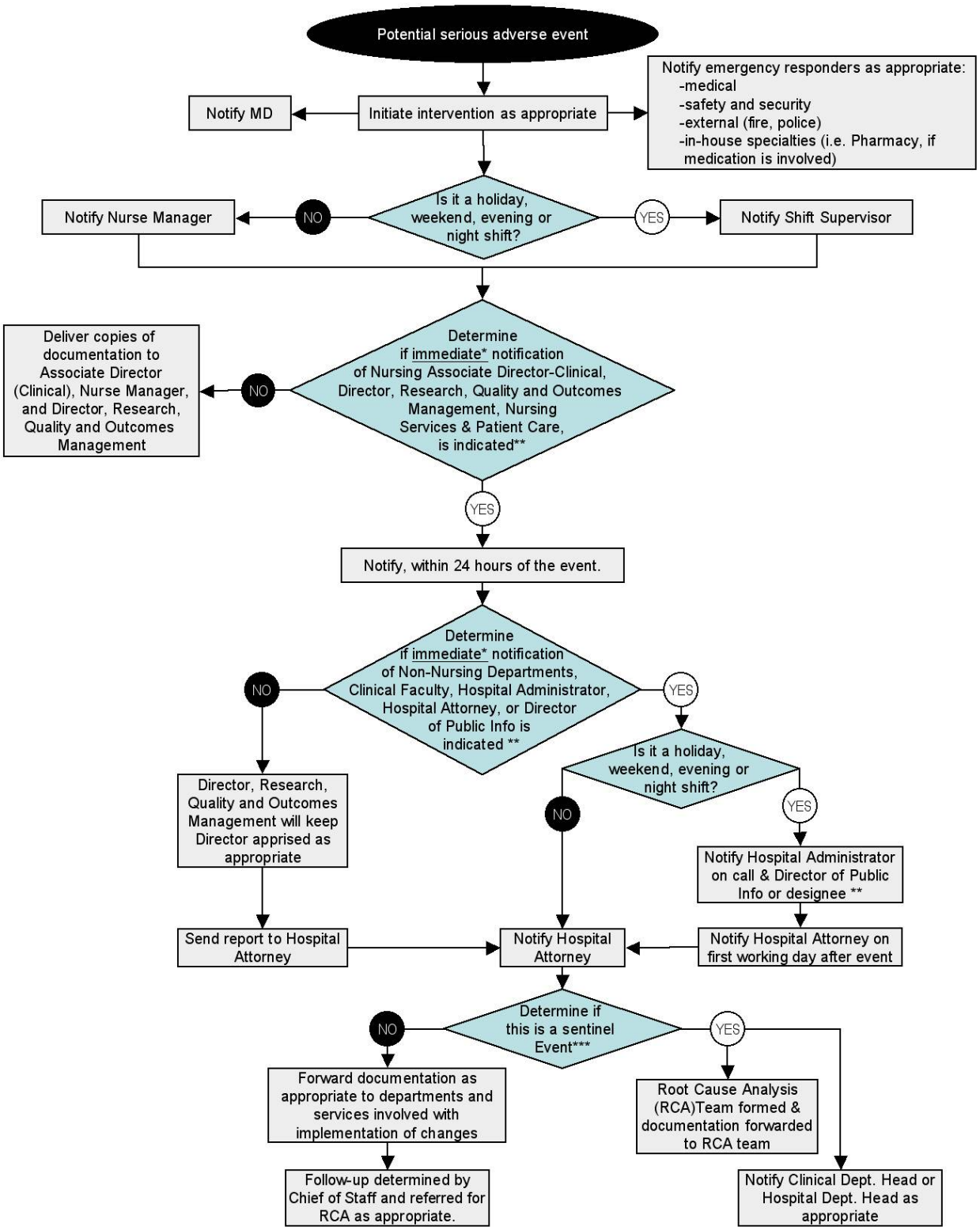
4. The clinical physician responsible for the patient must be promptly notified and this notification must be documented in the EMR.

5. If patient care orders relative to the event are necessary, these should be written by the radiologist. In the event of a complex adverse event where care is assumed by another physician (i.e., cardiac arrest with care assumed the Medical Intensive Care Unit), the radiologist is relieved of the direct patient care responsibility.

6. If adverse event involves contrast a Contrast Media Reaction Report Form must be promptly completed and forwarded to the Contrast Committee Chairperson.

7. Any staff member who believes a Serious Adverse Event has occurred should notify their immediate supervisor for determination of the severity of the event, preservation of the evidence, and initiation of the reporting process described below. Events in the Department of Radiology should included notification of the appropriate technical director and clinical chief or supervisor.

FLOWCHART FOR REPORTING PROCESS WHEN SERIOUS ADVERSE EVENTS OCCUR



* Consideration of immediate notification is based upon seriousness of event.

** The individual responsible for notification of the next tier in the reporting process is determined by these individuals

FLOW0065-0901 *** Determination by Chief of Staff, Director, Research, Quality and Outcomes Management, and Hospital Attorney