

Standard Operating Procedures for Radiology Examinations

General guidance applicable to all examinations

Examinations should only be carried out by Radiology staff trained or training in diagnostic imaging.

Business Rules

- The radiology request form is legal documentation and should only be completed by a valid IR(ME)R referrer. If you are unsure as to the validity of the request please see a Radiologist or Team Lead before proceeding.
- All patients must have an RUH hospital number before putting the request on CRIS
- Any patient without an RUH hospital number must be registered on Millennium (babies must be registered by the CRS team). Millennium populates CRIS with patient demographics.
- Patient demographics must be checked at every point of the patient journey and changed in Millennium if necessary
- All radiology requests must be entered onto CRIS
- All handwritten requests must be signed by the referrer
- The correct ICE order, waiting list entry, request list entry or appointment must be selected in CRIS
- Check that the patient has not already been scanned or has an appointment already booked.
- The patient alarm must be checked in CRIS prior to appointing or attendance.
- Ensure orders in ICE are cancelled if no longer required or duplicates.
- If the referrer or referring location cannot be identified in CRIS please use the code *NOT ON CRIS* for the referring location and referrer and take a copy of the request and pass to the PACS Team. ICE request referrer details should not be changed unless CRIS does not recognize the referrer.
- For plain film radiography, the Radiographer acts as a Practitioner under the IR(ME)R regulations and must check that the examination is justified and that the clinical details match the request. The request form must be signed and dated to confirm this
- The patient should be positively identified with the three point ID check – the request form must be signed and dated to confirm this. The 3 point check is carried out confirming the patients Name, Address, DOB.
- Further questions/checks should also be undertaken as appropriate and documented accordingly i.e. is the Patient Pregnant or Breast Feeding?
- Check the Patient has followed the preparation instructions if appropriate.
- Radiographers take ownership of x-raying their patients and post-processing their images.

Prior to attendance

- All patients must have an RUH hospital number before putting the request on CRIS
- Any patient without an RUH hospital number must be registered on Millennium (babies must be registered by the CRS team). Millennium populates CRIS with patient demographics.
- Patient demographics must be checked at every point of the patient journey and changed in Millennium if necessary
- All radiology requests must be entered onto CRIS
- Booking teams are responsible for their own modality and must book according to modality booking rules. Appropriate preparation/documentation to be posted or verbally communicated where necessary. The appropriate vetting pathway must be followed prior to booking/attendance
- All request cards and supporting documentation must be scanned and put on the Waiting list or Request List in CRIS as soon as it is received in department (as current process).
- The correct hospital site code must always be used when dealing with community requests.
- If written request referring location and referrer must be completed.
- The correct ICE order, waiting list entry, request list entry or appointment must be selected in CRIS
- Check that the patient has not already been scanned or has an appointment already booked.
- The patient alarm must be checked in CRIS prior to appointing or attendance.
- Ensure orders in ICE are cancelled if no longer required or duplicates.
- If the referrer or referring location cannot be identified in CRIS please use the code *NOT ON CRIS* for the referring location and referrer and take a copy of the request and pass to the PACS Team. ICE request referrer details should not be changed unless CRIS does not recognize the referrer.
- All requests must be assigned the correct urgency codes (if stated from vetting)
- For appointments, the practitioner must check that the examination is justified under IR(ME)R regulations and that the clinical details match the request
- All paper requests must be filed in the correct modality or community sections
- Appointment lists must be printed off the day before and sorted by modality. Request forms must be attached to the modality appointment lists for the day's appointments.
- All modality appointment lists and request forms must be distributed to each modality area and put in an agreed confidential area ready for appointment
- If there is no request on CRIS the GP/Clinic must be contacted before the examination can be undertaken
- The patient must only be 'Attended' on CRIS if they are present. (If the request is not completed, at midnight the appointment will automatically change to DNA)
- If the request cannot be found check ICE to see if the request has been cancelled before reprinting.
- All inpatient, outpatient and GP requests should come through ICE (at present some requests are still handwritten)
- Out of hours inpatient requests are on ICE and the Radiographer is bleeped
- Urgent inpatient requests must be discussed with the appropriate modality lead

Cancellations

- All demographics must be checked
- All cancellations must be cancelled in CRIS with the cancellation reason clearly stated as a comment
- The patient must be contacted as soon as the cancellation is known if hospital reason for cancellation
- Reschedule appointment at time of cancellation where possible, or send further appointment by post.
- Reschedule with the first appropriate/available appointment for the specific modality

Upon Attendance

- For plain film radiography, the Radiographer acts as a Practitioner under the IR(ME)R regulations and must check that the examination is justified and that the clinical details match the request. The request form must be signed and dated to confirm this
- For other examinations, this will have been undertaken by the relevant Practitioner
- The radiographer acts as an Operator under IR(ME)R when undertaking checks with the patient
- All demographics must be checked against request form and updated in Millennium where necessary
- The patient should be positively identified with the three point ID check – the request form must be signed and dated to confirm this. The 3 point check is carried out confirming the patients
 - Name,
 - Address
 - Date of Birth
- Further questions/checks should also be undertaken as appropriate and documented accordingly i.e. is the Patient Pregnant or Breast Feeding?
- Check the Patient has followed the preparation instructions if appropriate.
- The reason why the test is being carried out should be explained to the patient.
- A description of what to expect should be given.
- A brief clinical history should be obtained if appropriate to examination.
- The patient should be verbally consented for the procedure.
- Any patient handling problems should be identified and managed in accordance with local Manual Handling guidelines and protocols.
- Infection risks should be identified and managed in accordance with Infection Control Policies.
- Radiographers must check the correct patient details are on the imaging device before starting the examination
- Radiographers must check examination/order details are correct and correspond with the order line currently being dealt with (there may be occasions where there is more than one order placed, generating multiple lines)

During the examination

- Radiographers take ownership of x-raying their patients and post-processing their images.
- The radiographer acts as an Operator under IR(ME)R when taking the image (s), although for plain film radiography it is likely to be the same radiographer who justified the examination
- The appropriate equipment for the examination should be selected.
- Items of clothing should be removed from the area of interest for all examinations whilst maintaining the patient's modesty.
- The patient should be positioned appropriately for the examination
- The Radiology equipment should be optimised for the examination and controls continually adjusted to ensure image optimisation.
- Images must be viewed on the appropriate monitors to ensure that the images are of diagnostic quality before the patient leaves the department.

Following the examination (patient information & post-processing)

- The patient should be given an explanation of the results if appropriate.
- The patient should be informed who will receive the results and what they should do next.
- Complete Operators notes on request form ensuring that all relevant sections are filled in
- Radiographers need to accept the image/ close patient episode on the imaging device to be able to post process on CRIS
- Requests must be modified by Radiographers on CRIS if a different examination is undertaken.
- Any modifications must be carried out in CRIS (modifications don't pull through from ICE)
- Post process patients on CRIS and ensure that all information from request form is transcribed onto CRIS i.e.
 - Examination
 - Room
 - Operator plus Patient ID and pregnancy checks
 - Exposure factors
 - Contrast media, etc
- Scan form onto CRIS to complete post processing

Following the examination (reporting)

- Images must be reported on a PACS monitor to ensure high resolution, apart from on the wards where web PACS is to be used to view images
- Radiographer must check correct PACS image is with correct patient being reported
- Report should be dictated, then verified or sent for review as appropriate
- Relevant reports are batch printed where appropriate
- Urgent information should be verbally communicated to referrer or referring team
- Any inconclusive results should be discussed with the referring clinician

Did Not Attend

- The status of patients who do not show up to their appointment automatically changes to DNA's in CRIS overnight by the system
- Patient DNA's must be checked and marked as DNA in CRIS manually (to cross check against DNA's automatically placed on CRIS by the system)
- A DNA letter must be sent with a copy of the original request form to the Referrer
- A DNA letter must be sent to the patient
- Patient is allowed 3 appointments (DNA or cancellations) or 3 months to be seen from referral before they are returned to the referrer