Worcestershire Acute Hospitals NHS Trust

Breast Imaging Department

Ionising Radiation (Medical Exposure) Regulations 2017
Regulation 6 Schedule 2 Employer's Procedures

(l) Procedure to ensure that the referrer, practitioner and the individual exposed or their representative are informed of the occurrence of any relevant clinically significant unintended or accidental exposure and the outcome of the analysis of this exposure	
Responsibilities relating to IR(ME)R procedures:	
Ensuring the required IR(ME)R procedures are in place	Worcestershire Acute Hospitals NHS Trust (WAHT)
Authorisation of Breast Imaging IR(ME)R procedures	Clinical Director of Breast Imaging
Development, review and amendment to this document	Superintendent Radiographer
Assisting in development, review and amendment to this document	Radiation Protection Supervisors
Governance pathway:	
Medical Physics Expert review (IRS)	12.7.2024
Submission to Breast Directorate for approval	11.1.2023
Circulation to Women and Children Division for information	1.3.2023
Circulation to Radiation Protection Committee for information	28.4.2023
Authorised by Clinical Director of Breast Imaging	1.3.2023

Version No	Reviewed	Action	Next Review Date
1	9.12.22 IRS	Revision of format and IRMER audit	1.3.2026
2	12.7.2024 IRS JB	No changes	12.7.2025

Objective

To describe the steps to be followed to ensure that relevant persons are informed following accidental or unintended exposures.

Scope

This procedure applies to any accidental or unintended exposures categorised as clinically significant within Breast Imaging.

Responsibility

Once it has been established that an unintended or accidental exposure is categorised as clinically significant the radiology manager shall:

- Notify the practitioner and/or referrer (if applicable)
- Ensure that the incident is recorded in a manner consistent with the hospital procedure for recording such incidents. All incidents will be raised via the DATIX system
- In the case of incorrect referral and exposure it is the responsibility of the referrer to ensure that the patient or their representative are informed of the occurrence and the outcome of the analysis of this exposure including root causes and corrective actions implemented that are designed to minimise the risk of a recurrence.
- Ensure that the outcome of the analysis of this exposure including root causes and corrective actions implemented that are designed to minimise the risk of a recurrence, are shared so that wider learning is made.

Procedure

If an accidental or unintended exposure is suspected, the Superintendent shall request that the Medical Physics Expert (MPE) carries out an assessment of the dose and risk associated with the exposure according to the relevant employer's procedure.
If the MPE's assessment and advice concludes that the accidental or unintended exposure is clinically significant then the Superintendent shall initiate an investigation to determine the root causes of the incident and implement corrective or preventative actions to minimise the risk of a recurrence.

The Superintendent/RPS has a responsibility to:

- Ensure that the incident is recorded in a manner consistent with the hospital procedure for recording such incidents. All incidents will be raised via the DATIX system.
- Provide a written notification to the Referrer and Practitioner of the occurrence of the incident, the analysis of and the outcomes.
- Notify Care Quality Commission (CQC) if the incident is reportable.
- Notify the Medicines and Healthcare Regulation Authority (MHRA) if the exposure is the result of equipment failure.

Unintended dose or over-exposure, including accidental exposure, incorrect patient, equipment failure, vetting error or incorrect timing etc