

### **CL3 – The service implements and monitors systems to ensure the clinical and technical quality of reports.**

- a. For effective diagnosis and management of patients, all images should be reported as accurately and as quickly as possible. Methodologies and formats used to support reporting should be grounded in current best practice and reflect professional guidance and statutory requirements.
- b. The structure and content of reports should be agreed locally in consultation with referrers. Reporting staff, including those external to the service, should be aware of local guidelines and be able to access them. Changes in guidelines should be communicated to all reporting staff.
- c. Effective reports might include the following:
  - A summary of information received from the referrer, including: relevant clinical information; age of the patient; any previous or contemporaneous imaging; and the name and position of the referring clinician;
  - Technical information, including: the precise imaging examination and date and time; and details of any drugs or contrast media used;
  - A brief description of the relevant findings/observations;
  - An assessment of the presence of an active pathological process after inspection of inherent characteristics such as: size; shape; density; signal intensity; echogenicity; or contrast enhancement pattern;
  - A diagnosis or appropriately ranked differential diagnosis, taking into account factors such as: age; sex; ethnicity; and previous imaging investigations. Staging information should be offered if cancer is present or likely.
  - Identification of how definite or likely the diagnosis is and advice on further appropriate imaging or diagnostic tests that may be necessary;
  - A concluding impression or summary stating the significant diagnostic probabilities and addressing any question posed on the request form;
  - The name of the reporting practitioner and their position; if reporting is carried out remotely, contact details for the reporter should also be provided.
- d. There should be clear local agreements about who will report different types of examination. If certain examinations are not reported within the service then a procedure for transferring responsibility must be in place. There should be regular audits of reports by the Service to ensure that transferred responsibility provides the same standard, level and timeliness of the service.
- e. Reporting staff should have access to optimised and appropriate display units in an environment which facilitates viewing. Radiology information systems (RIS) and picture archiving and communication systems (PACS) should be integrated to facilitate patient identification and the recording and storage of results. This should include teleradiology services where contracted out.

- f. Previous imaging investigations should be available for review by staff undertaking the reporting of current investigations. Where further information may substantially influence the radiological opinion, this should be sought from the referring clinician or via laboratory or histology reports.
- g. Alterations or amendments to reports should be carried out in accordance with a documented procedure, and should be recorded. Reports should be checked for clinical and grammatical accuracy before authorisation and release.
- h. Processes should be in place and monitored to ensure that reports, particularly those with critical, urgent or unexpected findings, are received by the referrer. Communication of reports should be documented either at the end of a formal report or in the patient's case notes. All emergency reports should be communicated as soon as possible after the examination is concluded. This is facilitated by integrated PACS and RIS with electronic priority labelling of reports. In the absence of this, reporting individuals should be responsible for contacting the clinical team and ensuring that urgent reports are received by the referring consultant. Rapid referral of patients with suspected malignancy should be supported by sending copies of reports to cancer multidisciplinary team co-ordinators. Robust systems should be in place to ensure reports are seamlessly transferred between organisations.
- i. Cases should be reviewed at regular multidisciplinary team meetings. Double reporting of a group of selected cases should occur routinely. Routine double reporting of all skeletal surveys for non-accidental injury and symptomatic mammography is recommended.
- j. Discrepancy reporting meetings are essential to ensure that lessons are learnt and action taken to improve the service. Discrepancy meetings should: follow current guidance; occur at least bimonthly; focus on learning; and avoid a blame culture. Consideration should be given to various forms of bias that may affect ability to meet outcomes. There should be a formal protocol for the identification of 'missed diagnoses' including anonymous case reviews. Audits should be carried out regularly to ensure maintenance of the standard and quality of the reporting service.
- k. Processes should be in place to ensure that reporting staff have ready access to a second opinion. Non-medically qualified healthcare professionals who are reporting images should have ready access to a fully qualified radiologist for advice.
- l. There should be evidence that the same standard is applied whether the service is in-house or outsourced.
- m. Audits of radiological diagnoses should occur regularly and the incidence of disease should be compared with national rates where available or any rates published in the medical literature. Information from audits and multidisciplinary meetings should be disseminated to reporting staff to promote continuing improvement.

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