

# WAYS TO KEEP OUR PATIENTS SAFE

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## ACT IN THEIR BEST INTEREST



Ensure 2 patient identifiers are verified

Adhere to ALARA principles

- > ↓ time
- > ↑ distance
- > ↑ shielding



Conduct regular QA/QC checks

Prior to contrast administration, check for:

- > history of allergies
- > kidney function



Carry out infection control practices appropriately



## CARE & COMMUNICATE COMPASSIONATELY



Is there anything you need me to know before we get started?

Remember the last time you had your vision / hearing / speech impaired; how did you feel?

**Frustrated? Anxious?**



If removing an aid (i.e. spectacles, hearing aids, speech cue cards), ensure they are returned back to patients ASAP.  
**Impaired senses can be very stressful.**

## ACT WITHIN OUR KNOWLEDGE, SKILL & EXPERIENCES



**If you see something, say something!**

Some of the **Serious medical emergencies**

- hip fracture
- pneumothorax
- testicular torsion
- brain haemorrhage
- cervical spine fractures
- abdominal aneurysm
- pneumomediastinum

Learn to identify these on imaging + alert the care team so that further intervention can happen promptly

## ENGAGE IN PROFESSIONAL DEVELOPMENT

Following latest research = using current evidence-based practice = safer patient management!



Gain knowledge/research inspiration by attending conferences (local, regional or international)

Great chance to network with like-minded individuals too!



Access latest research publications by peer-reviewed journals



Follow peer-reviewed journals on their social media accounts - some regularly post links to the newest articles published



You're doing great, just a few more steps and you'll be on the bed!



Do you need help with changing into a gown?

Hello, my name is →, I will be doing your hand x-ray today!



1. Introduce yourself and your role

2. Tell me:
  - > What you're going to do & why
  - > How you're going to do it
  - > What sensations to expect
  - > When I'll get results & who from

3. Ask sincerely & patiently if I have any questions



**Ann-Marie O.**  
Patient Advocate

# 4 WAYS TO KEEP OUR RADIOLOGY PATIENTS SAFE

BY AMANDA ER TW



## Amanda Er TW

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The requesting doctor walked away after glancing at my portable machine's screen, concluding with, "the chest x-ray looks fine." Then, staring wide-eyed at the same screen, I blurted, "Doctor, I see a large left-sided pneumothorax. Loss of lung markings. Would you like to have a look again?" The kind-eyed patient in front of me was breathing heavily while trying to calm their haggard breathing. They had been in an accident the previous day with multiple left rib fractures yet no sign of a collapsed lung; their oxygen saturation level had suddenly plummeted in the ward.

As radiographers, we have a duty of care to our patients - to keep them safe. Being cognisant that the word 'safe' can encompass several aspects, I have taken inspiration from the Allied Health Professions Council (AHPC)'s Code of Professional Conduct [1] to share ways we can keep our patients safe.

### Act in the best interest of our patients

To ensure our patient's safety, we owe it to them to provide imaging services per the principles of medical ethics, especially encompassing beneficence, non-maleficence, and being fair and just in our work.

The fundamentals of a radiographer's role require that we:

- verify our patients appropriately
- adhere to the ALARA principle
- conduct frequent quality assurance and control checks: patient safety relies heavily on crucial checks to ensure machines are administering accurately calibrated doses
- check for allergies and kidney function prior to contrast administration

### Communicate effectively with our patients, caregivers and other professionals

Using my international links with several patient advocates on Twitter, I gained insights (view here: <https://bit.ly/PatientSafetySSR>) as to what safety meant to our patients. I recommend reading these as it gives a perspective toward an environment that is foreign and daunting to our patients yet familiar to us.

I am of the belief that when we can show genuine care for our patient's well-being [2, 3], it allows enhanced cooperation and rapport building. Some compassionate and assuring phrases I was taught as an undergraduate and still serve me well are:

- "You're doing really well, just hold that position for a little longer and we'll be done soon."
- "Please stay still. It's really important that we can get high-quality pictures which can help your doctor find out why you're in pain."

At times, certain actions we carry out require more thought to them. I had a family member undergo a day procedure recently. Before the procedure began, she had the urge to go to the toilet. However, her spectacles and belongings were in a locker situated in another part of the hospital. With a high degree of myopia, manoeuvring to the toilet without her glasses left her immensely stressed out, resulting in a terrible patient experience.

On another occasion, a non-speaking patient was presented in a trolley bed to my department; she was clutching a laminated card featuring the alphabet. The card was for her to point out the different alphabets as a way of spelling out words to communicate. To prevent obscuring the region of interest during imaging, I took the card out of their hands. However, after the examination, my patient desperately wanted the out-of-reach card back in their hands so that they could communicate.

From my family member's experience and the encounter with the non-speaking patient, it made me realize how stressful it could be to have objects which aid with patients' important senses to be taken away. I implore all to consider this whenever you have to remove a patient's aid for imaging.

**Act within the limits of our knowledge, skill and experience, and if necessary, refer the matter to another professional**

In my hospital, the radiographer abnormality detection system (RADS) has become crucial for patients in the Emergency Department (ED). Through RADS, ED clinicians have the added benefit of a radiographer's eye in aiding their treatment planning [4], especially during the absence of an immediate radiologist's report (i.e., after office hours).

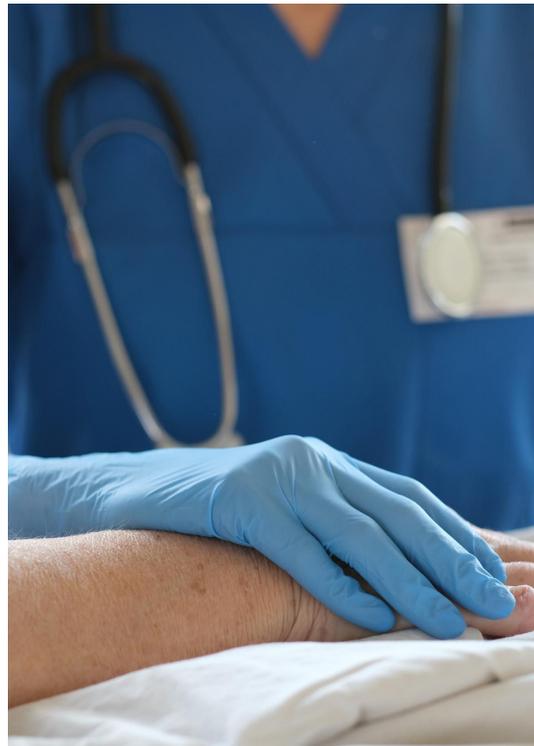
This sentiment and its benefits were also echoed during my undergraduate years in Australia, where the "see something, say something" campaign [5] by the Medical Radiation Practice Board of Australia (MRPBA) was heavily emphasised.

Considering that we are often the first pair of eyes to view these images, I firmly believe that we owe it to our patients to flag when their images do not look right, ensuring that any serious medical emergencies are effectively communicated to their primary care team and/or doctor-in-charge. I have had the privilege of "saying something" where needed, which allowed patients to receive (sometimes life-saving) treatment much more quicker. By escalating such abnormalities, we inevitably provide a safer environment for our patients.

**Engage in professional development and keep our professional skills and knowledge up-to-date**

Engaging in CPD includes attending local, regional and international conferences, reading relevant journal articles, and browsing social media profiles of journal sites for the newest article. Occasionally, you may connect with like-minded individuals worldwide, leading to novel research ideas. By investing in our own professional development, we can improve our own competencies and abilities, which ultimately leads to better patient safety.

I hope my sharing helps you to take a step back, reflect on your practice, and see if there are gaps you can bridge. A reflective radiographer will always be safer and more useful in a healthcare team than one who is not.



The requesting doctor marched back to my machine to find what I had seen in the image. A senior doctor nearby had overheard our exchange and strode over, immediately declaring, "There's a large pneumothorax. Let's get a chest tube in" before walking off.

"Where? I still don't see it!" exclaimed the doctor. I carefully outlined the lung margins to the doctor and received continuous 'thank yous' after. What a moment it was, and I continue to have such moments till this day. We are, after all, healthcare professionals striving to keep our patients safe.

**References**

1. Allied Health Professions Council. Code of professional conduct. <https://www.healthprofessionals.gov.sg/ahpc/information-for-registered-allied-health-professionals/code-of-professional-conduct> (Accessed 1 December 2022)
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4. Petts A, Neep M & Thakkaipalli M. Reducing diagnostic errors in the emergency department at the time of patient treatment. *Emergency Medicine Australasia*. 2022. <https://doi.org/10.1111/1742-6723.14146>
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# Promontory

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