Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Lessons learned from medical exposure to ionising radiation incidents in 2021

## 86 incidents in 2021

**66** incidents occurred in diagnostic imaging, mainly in CTservices.

**20** incidents occurred in radiotherapy services.

## What we found

### Increased reporting

26% increase in notifications submitted in 2021 when compared with that of 2019 when HIQA began receiving notifications

### Our Portal

Increased use of HIQA's portal system for submission of notifications

### The wrong person

26% of incidents involved the wrong person

## What needs to improve ?

### Corrective Actions

Consider system-focused measures rather than people-focused measures for increased effectiveness.

### Low Reporting Rates

Review practices in place to ensure all incidents are being identified and reported, as required.

### Timely Reporting of Incidents to HIQA

HIQA must be informed within three working days of discovery of an incident.

### Use of Quality, Risk and Safety Resources

Use quality, risk and safety resources where available to enhance oversight, mitgate risk and increase learning.

Source | www.hiqa.ie