Practical experiences of risk management in Nuclear Medicine

B. McCoubrey, Dublin (IE)

The second presentation will focus on practical experiences of risk management in Nuclear Medicine. An overview of the most common incidents presenting in Nuclear Medicine Departments will be provided. All incidents should initially be reported, reviewed, and where necessary, further investigated by an organisation’s local risk management structures. The role of other organisational methods to enhance risk management including clinical audit, quality assurance programmes, ongoing training and education of staff, reviewing and updating of procedures in line with good practice will be reviewed.

An effective Risk Management programme involves 5 key steps:

1. Identifying the hazard
2. Putting control measures in place
3. Evaluating the risks
4. Formulating an action plan
5. Review of the process

Through a series of practical examples taken from the RNI and PET/CT departments of a large teaching hospital, this process will be explored and the effectiveness of each step evaluated against a national risk assessment matrix.

The local process of incident reporting will be discussed, the structure for delineated responsibility for the Risk Management process and the necessity of incorporating a vigorous review and learning mechanism into the management of both incidents and near-misses.