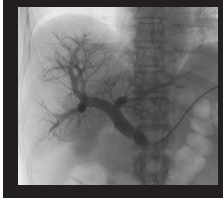


Radical Views...

from the Department of Radiology

Volume 8, Number 7

JANUARY 2016

Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Bettina Siewert, MD
Executive Vice Chair &
Vice Chair of Quality

Dear all,

The next few months will be all about Joint Commission preparedness. We are now in the official time window for the visit, i.e., the Joint Commission could arrive any day unannounced, but are expecting the visit sometime in March/April.

Our last TJC visit 3 years ago was the first one that I participated in, in my then new role as Vice Chair for Quality and Safety. I must admit that I was quite nervous when we started on our first "walkthrough" with the TJC surveyor, feeling that I did not know the answers to many of the questions they could ask. However, I quickly I learned that my worries were completely unnecessary: Along our way, we ran into many of you who had all the right answers and were able to show just how excellent the patient care in our department truly is. Thanks to all of your contributions, the visit was a huge success for radiology and you made me feel so proud to be a part of it.

SAVE THE DATE:
Friday, Feb 26, 2016
12-1 pm
Sherman Auditorium

This year Suzanne Swedeen, Donna Hallett and all our managers are leading the effort to get all of us ready for the visit and I thank all of them for their efforts. In previous years, our preparation included a didactic grand round lecture focused on "all you need to know about the Joint Commission visit". This year, we wanted the preparation to be more interactive and fun and have published the needed information here in Radical Views (see pgs 8-11, including a crossword puzzle to test your knowledge) and we will hold a team jeopardy event on Friday, February 26 (12-1PM) in the Sherman auditorium (with fantastic prizes awaiting the winning team). Teams will consist of 5 staff members from 3-5 different staff groups (technologists, nursing, PACS/Image archive, transporters, administration, schedulers, radiology residents and fellows, attending radiologists). Start building your team and send an email to Suzanne Swedeen with the names of your team by Friday February 5, 2016. If you need help forming your team, please contact Suzanne or me and we will be happy to assist you.

Thanks for helping us again to show the Joint Commission what excellent care patients at BIDMC receive in radiology. Please feel free to contact me with any questions or suggestions you may have. – *Bettina*

** Thanks to Ammar Sarwar for the trans-splenic portal venogram prior to portal vein embolization which is our new icon for Radical Views 2016 issues.*

QUALITY UPDATE: TJC *The Joint Commission)* Update

Suzanne Swedeen, RN
MSN CNIV
Quality Improvement Specialist

Hi Everyone,
We are well within our window for an unannounced Joint Commission survey. While the window runs from November 2015 through May 2016, we are anticipating they will likely arrive between January and April. In preparation for this upcoming survey I began sending out weekly Joint Commission emails in December and offer them in Radical Views as well (*Please see pgs 8-11*). Each week a new topic will focus on the important elements you need to know. Please take a moment to review. So far, we have sent out Tips on the essentials of equipment and supply management and emergencies. Stay tuned for more!

Thanks,
– Suzanne

For example:

This week's Joint Commission focus is on emergencies

After reading this you should be able to state:

- the number you would call in the event of an emergency
- the information you would need to give the page operator when calling a code ***(Don't forget it's now the Rosenberg building not the Clinical Center)***
- what to do in the event of a fire
- how to use a fire extinguisher
- what your responsibilities are related to medical gas shut off valves in your area
- who can shut off medical gases

(Please see pgs 8-11)

Radiology Calendar JANUARY 2016

Check for the most up-to-date schedule at: **https://apps.bidmc.org/departments/radiology/residency/conferences/displayMonth.asp**

Mon	Tues	Wed	Thurs	Fri
Weekly Mon Section Meetings: 3:00-4:00 ED section meeting [ED annex, WCC]		Weekly Wed Section Meetings: 11:00-12:00 MSK clinical conference 12:00-1:00 CardioThoracic, GI/GU Oncology 3:00-4:00 Mammo [TCC-484]	Weekly Thurs Section Meetings: 12:00 - 1:30 Abd [WCC-354] 12:00-1:00 MSK	Friday Grand Rounds: 12 noon Sherman Auditorium, East Campus (unless stated otherwise)
				1 New Year's Day
4 7:30 - 8:15 Pre Transplant Imaging (Leo Tsai) 8:15 - 9:00 Malignant liver lesions on CT and MRI (Jesse Wei)	5 7:30 - 8:15 Postoperative Complications (Bettina Siewert) 8:15 - 9:00 Vascular Ultrasound (Robert Sheiman)	6 7:30 - 8:15 Brain Tumor and Tumor Like Conditions (Rafael Rojas) 8:15 - 9:00 Cases (neuro fellow) EVENT: Interview Day - Residents	7 7:30 - 8:15 Gallbladder/Biliary (Robert Kane) 8:15 - 9:00 Gyn malignancies (Olga Brook)	8 7:30 - 8:15 Understanding Contracts (Annamarie Monks) EVENT: Interview Day - Residents 12:00-1:00 Chief Rounds Drs. Drew Colucci, Quang Nguyen, Jeff Dines, Suma Kannabiran
11 7:30 - 9:00 MSK (TBD) 12:00-1:00 MRI Meeting [Ansin 2]	12 7:30 - 9:00 Root Cause Analysis (Justin Kung) 10:30-11:30 NMMI meeting [GZ-103]	13 7:30 - 9:00 MSK (TBD) 7:15-8:00 US meeting [WCC-304A]	14 7:30 - 9:00 MRI Pulse Sequences (Georgeta Mihai)	15 EVENT: Interview Day - Residents 12:00-1:00 Grand Rounds: Intravenous Contrast Media: AKI and Other Matters (Matthew Davenport)
18 Martin Luther King Day	19 7:30 - 9:00 Fellow's talk + cases (Dominique DaBreo) 8:00-9:00 IR Meeting [West Recovery]	20 7:30 - 9:00 Neuro (TBD)	21 7:30 - 8:15 Pericardial Diseases (Diana Litmanovich) 8:15 - 9:00 Radiation Dose in Cardiothoracic CT (Diana Litmanovich)	22 7:30 - 8:15 QA Tools (Olga Brook) 12:00-1:00 Grand Rounds: Future Directions in X-ray Computed Tomography (Rajiv Gupta)
25 7:30 - 9:00 Nucs Week (TBD)	26 10:30-11:30 NMMI meeting [GZ-103]	27	28	29 7:30 - 8:15 Resident Case Conference (Chiefs) 12:00 PM - 1:00 PM NERRS/No Grand Rounds

The Gallery presents Local Boston Art Photos by

at WCC-304B

Peter Gross, MD

Breast Imager & Photographer Extraordinaire

Peter's photos of artist Janet Echelman's aerial sculpture show ***"As If It Were Already Here"*** are being featured in the Gallery December and January. This aerial sculpture commorates the removal of the elevated highway through Boston echoing the location's history far above the Kennedy Greenway and Peter's night photo (right) was featured by the Boston Globe!

As always, please contact Donna Wolfe if you, too would like to share your photos, paintings or sculptures: dwolfe@bidmc.harvard.edu or 4-2515

JANUARY 2016 GRAND ROUNDS

Friday, January 15, 2016
12 noon - 1:00 PM • Sherman Auditorium

Intravenous Contrast Media: AKI and Other Matters

Matthew S. Davenport, MD - Assistant Professor of Radiology, University of Michigan Medical School, Ann Arbor, MI

Following his Bachelor's degrees in both biological sciences and psychology, Dr. Davenport earned his MD from the University of Cincinnati College of Medicine and completed radiology residency training at the University of Michigan Health System, Ann Arbor and a fellowship in diagnostic radiology at Duke University Medical Center, Durham, NC. His research has focused on Genitourinary imaging, radiographic contrast media, contrast reactions, extravasation of contrast media, prostate cancer, quality assurance, pelvic MRI, and cross-sectional interventional procedures.

Most recently, Dr. Davenport published the following in Radiology: McDonald RJ, McDonald JS, Newhouse JH, **Davenport MS**. Controversies in Contrast Material-induced Acute Kidney Injury: Closing in on the Truth? Radiology. 2015Dec;277(3):627-32. doi: 10.1148/radiol.2015151486. PMID: 26599922. [Abstract: *In the risk-benefit analysis that should precede all medical tests, consideration must be given to both sides of the equation, with decision-making guided by fact instead of fear and misinformation.*]

Friday, January 22, 2016
12 noon - 1:00 PM • Sherman Auditorium

Future Directions in X-ray Computed Tomography

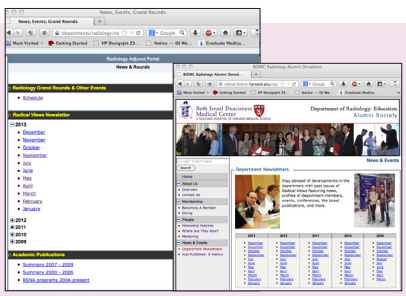
Rajiv (Raj) Gupta, MD, PhD - Associate Radiologist, MGH; Director, Advanced X-ray Imaging Sciences (AXIS) Center • Assistant Professor, Harvard Medical School

Dr. Gupta earned his MD from Weill Cornell College of Medicine in New York and completed his residency and fellowship training at Massachusetts General Hospital. His research and clinical interests are in neuro- and cardiac radiology, particularly in the development and clinical applications of ultra-high resolution CT. Currently, he is developing a prototype CT system based on flat-panel X-ray detectors with a resolution of 150 microns. When fully developed, this system will enable, in a single scanner, dynamic imaging of temporally evolving processes, image-guided interventions, and high-resolution computed tomography. For dynamic CT imaging, he has developed a new technique and demonstrated its feasibility in an animal model of aneurysms. Algorithms for efficient and accurate reconstruction of dynamic data are under development. The paradigm of volumetric CT using a large area detector also enables image-guided interventions in the same scanner. To this end, he is developing a new genre of low-cost, X-ray transparent, disposable robots that can operate inside the bore of the scanner.

In case you missed an issue of Radical Views!

All back issues are available on the BIDMC portal under "News and Events":
https://portal.bidmc.org/Intranets/Clinical/Radiology/news.aspx

and ***we also have an outside link on the alumni site:***
http://radnet.bidmc.harvard.edu/education/newsletters.asp



The portal will always have the most current/revised versions so please keep checking as needed.

Congratulations & Farewell to Breast Imager Peter Gross -

December was full of numerous celebrations and congratulatory events in honor of Dr. Peter Gross' retirement. Joining BIDMC in 1998, Peter started out as a community radiologist, practicing all aspects of imaging, doing everything from barium enemas, to abdominal ultrasounds, to mammography. A few years later, due to the needs of the department and fortunately for the breast team, he transitioned to being a dedicated breast imager. When asked to describe Peter, he is described as "compassionate", "caring", "dedicated", "loyal", "a true gentleman", "connected to his patients", and "available for the referring clinicians". Reflecting on his career, Peter stated how lucky he was in life, but that his one regret was that he did not join the BIDMC faculty sooner. Peter is a fantastic radiologist with "a sharp eye", and more importantly, he is an amazing person, a devoted friend, and a supportive colleague. Thank you Peter for many wonderful years of service, and for bringing laughter and fun to the workplace!

- Tejas Mehta, BIDMC Chief of Breast Imaging

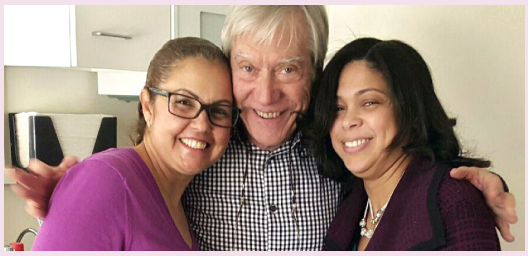
(Below) Peter's retirement celebration at Davio's restaurant on 12/8/15 included BIDMC radiologists, other BreastCare physicians and members of the breast imaging team, as well as his daughter Melissa and son-in-law Jonas.

Did you know that Peter and Bob Kane were in the same class at Tufts University School of Medicine?

Note while Peter's last day was Dec. 31st, his wonderful photo show in the West Campus Gallery will be up through the month of January and we look forward to the possibility of Peter presenting more of his photos in the coming year as he leaves BIDMC to travel!

The Lexington and Chelsea radiology departments also celebrated Peter Gross[1]'s retirement, this time at Chopps restaurant in Burlington. It was an evening of laughter and tears along with best wishes for his next adventure. Peter held the role of lead physician of breast imaging for many years. During this time he built close relationships with all the staff at both locations, not just professionally but also on a personal level. He leaves behind a legacy of encouragement, achievement and a work ethic that will always be part of our staff. He will be sincerely missed by all.

– Judy Farina RTRM, Radiology Manager
Beth Israel Deaconess HealthCare-Lexington/Chelsea



Josefina Valera with Peter and Audris Ruizat at his luncheon celebration at 1101 Beacon St.

Team Building in Breast Imaging

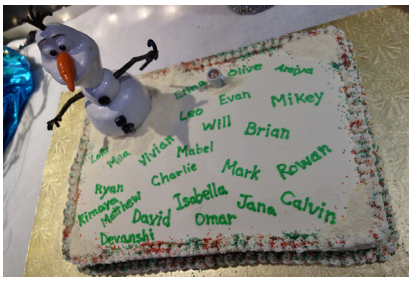
On Wed., Dec. 9, the breast imaging group participated in "The Marshmallow Challenge" (Moderated by Tejas Mehta). We discussed what lessons we learned during this short exercise and how these lessons translate into our daily work:

- We are most successful when we work together, and everyone participates.
- Every member of the team has something to contribute, regardless of title or rank.
- Teams found they were not successful when there was not a unified vision of what needed to be accomplished.
- Having 2-3 different visions of an end product resulted in failure.
- The best 'self-declared' team leader encouraged his/her group and was receptive to input from other members of the team.
- Planning is important but at some point one must commit and start.
- Don't be afraid to make mistakes.
- If things are not going well, it's ok to modify or deviate from the original plan.
- Don't be overzealous in your vision as this could result in complete failure. One can succeed even with limited resources.

Team Building in Abdominal Imaging/Body MRI -

In December, staff, fellows, and physician extenders had a great night of excellent food and camaraderie at the Dali restaurant in Somerville as a way to say "thank you" for all of their hard work during the past year!

The Abdominal Imaging/ Body MRI section also held their annual holiday children's party which was again very joyful. Santa got to surprise 26(!) abdominal imaging/Body MRI kids this year! *(see page 7)*



Many thanks to Lois Gilden and her "Santa" Jim Gilden for his annual appearance at BIDMC!

Suzanne Swedeen,
RN MSN CNIV
Quality Improvement
Specialist, Radiology

Radiology's Preparation for The Joint Commission (TJC) Survey at BIDMC:

BIDMC is now within the timeframe for which The Joint Commission (TJC) will be conducting its unannounced triennial survey of BIDMC's Quality and Safety (2015-2016). The following is the first in a series of Tips for helping BIDMC maintain its Joint Commission Accreditation.

TIP #1: This week I had the pleasure of interviewing Gary Schweon, Director of Environmental Health and Safety. I asked Gary to tell me the top 5 things he would like all staff to know regarding **Equipment and Supply Management**. I know we will all benefit in keeping these points in mind and practice.

Gary Schweon RN MS, HEM
Director, Environmental
Health and Safety, BIDMC

1. **All equipment and supplies should be stored no higher than 20 inches from the ceiling.**
   - Rationale: to allow for proper functioning of sprinkler systems

2. **No supplies are stored directly on floor.**
   - Rationale: Infection control: allows for proper cleaning

3. **Supplies are not stored in original shipping boxes**
   - Rationale: Infection control: Potential for rodents

   Exception: Original boxes where the expiration date of the supply is located only on the shipping box

4. **All supplies are within expiration date**
   - Rationale: Integrity of supplies

5. **Equipment will not be stored in hallway:** "stored" is defined as : the placement of objects, left unattended, in a location for more than the time necessary in normal routine of work practices. It does not apply to the equipment left unattended momentarily in the course of normal work procedures, eg., stretcher left unattended in hallway while patient is scanned.
   - Rationale: Allows for emergency egress

   Exception: Emergency equipment

For more detailed information, go to BIDMC's Joint Commission: The Right Way Every Day and Organizational Policies, Procedures, Guidelines, and Directives (PPGD)

If you have any questions, comments or suggestions on how we can get this type of information out to the whole department, please contact me at: sswedeen@bidmc.harvard.edu

Radiology's Preparation for (TJC) Survey at BIDMC:

BIDMC is now within the timeframe for which The Joint Commission (TJC) will be conducting its unannounced triennial survey of BIDMC's Quality and Safety (2015-2016). The following is the 2nd in a series of Tips for helping BIDMC maintain its Joint Commission Accreditation.

TIP #2: EMERGENCIES

What do I do in the event of a fire?: RA²C²E²

Rescue anyone in immediate danger

Alarms: PULL the nearest fire alarm and CALL 2-1212

Contain the fire by closing doors/windows; Clear corridors

Evacuate per area plan: Extinguish if trained

What number should I call in an emergency?: 2-1212 for emergencies and first aid response and state **correct code** or team, as well as your location and call back number.

What are the various types of "codes"?

Code Red – Fire/Smoke

Code Blue – Cardiac/Respiratory Arrest

Code Blue Pedi – Pediatric Emergency

Code Silver – Threat with Weapon

Code Purple – Psychiatric Emergency

Code Pink – Infant Abduction

Code STEMI – Acute MI

Code Grey – Security Emergency

Code Orange – Hazardous Material Spill

Code OB Emergency

Code TRIAGE – Disaster (requires AOC activation)

Code Malignant Hypothermia

Emgergent Surgical Airway

First Aid/Medical Emergency

Remember 2-1212

How do I use a fire extinguisher?: PASS

Pull the safety pin at the top of the extinguisher

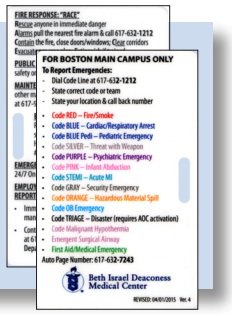
Aim the nozzle, horn or hose towards the base of the flame

Squeeze Stand approximately 8 feet away from the fire and squeeze the handle to discharge the extinguisher. If you release the handle, the discharge will stop.

Sweep the nozzle back and forth AT THE BASE OF THE FIRE. After the fire appears to be out, watch it carefully since it may re-ignite.

How do I remember all of this?

Be sure you have the most up-to-date badge card which lists all of this information. The most current badge card has a revision date of 4-1-15.


FIRE RESPONSE: "RACE"
Rescue anyone in immediate danger
Alarms pull the nearest fire alarm & call 617-632-1212
Contain the fire, close doors/windows; Clear corridors
Evacuate per area plan; Extinguish if trained

PUBLIC
safety or

MAINTE
other em
at 617-6

EMERGE
24/7 On

EMPLOY
REPORT

FOR BOSTON MAIN CAMPUS ONLY
To Report Emergencies:
- Dial Code Line at 617-632-1212
- State correct code or team
- State your location & call back number

- Code RED – Fire/Smoke
- Code BLUE – Cardiac/Respiratory Arrest
- Code BLUE Pedi – Pediatric Emergency
- Code SILVER – Threat with Weapon
- Code PURPLE – Psychiatric Emergency
- Code PINK – Infant Abduction
- Code STEMI – Acute MI
- Code GRAY – Security Emergency
- Code ORANGE – Hazardous Material Spill
- Code OB Emergency
- Code TRIAGE – Disaster (requires AOC activation)
- Code Malignant Hypothermia
- Emergent Surgical Airway
- First Aid/Medical Emergency

Auto Page Number: 617-632-7243

Beth Israel Deaconess Medical Center

REVISED: 04/01/2015 Rev. 4

What should I know about emergency gas shut off valves?

- All clinical personnel are responsible for knowing what areas of the floor are served by the control / "zone" valves for medical gases.
- A clinician with a thorough knowledge of the medical gas requirements of all patients on a floor or unit may shut off the control valves for the affected area.
- Never block an emergency shut off valve

Now that I know all this, what should I do next?

Walk around your area and locate the nearest –

- Fire alarm pull station
- Fire extinguisher
- Gas shut off valve and the area the valve serves

Radiology's Preparation for (TJC) Survey at BIDMC:

BIDMC is now within the timeframe for which The Joint Commission (TJC) will be conducting its unannounced triennial survey of BIDMC's Quality and Safety (2015-2016). The following is Tip #3 for helping BIDMC maintain its Joint Commission Accreditation.

The following is a quick reference guide to help you remember or answer the following:

- How do I know if something is cleaned or dirty? How does a particular piece of equipment need to be cleaned?
- Which wipe should I use for cleaning this equipment? How do I use the wipes? What is "wet time"?
- Low level disinfection is done on equipment shared between patients that does not come in contact with broken skin our mucous membranes.
- High-level Disinfection (HLD) – the process of complete elimination of all microorganisms in or on a device, except for small numbers of bacterial spores. Used on equipment that comes in contact with mucous membranes or non-intact skin.
- Sterilization monitor expiration dates: **sharpies** should not be used on sterile packages in an area that could impact the contents' sterility if the marker were to bleed through.

Medical Equipment cleaning and disinfection/identification of clean equipment

How do I know if equipment is clean?

If a piece of equipment is not taken from a designated Clean Area, it should always be cleaned before and after use. In some cases there is a special process in place to identify equipment that is clean vs unclean. You should understand the cleaning process related to the equipment you are using.

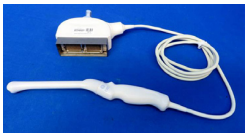
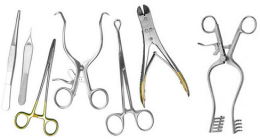
We have 2 different types of wipes. How do I know which one to use?

The Red top - Steris wipes is for general disinfection of equipment and surfaces (contains alcohol).

The Grey top is PDI-AF3- alcohol free disinfectant wipes for disinfecting where manufacturers state not to use alcohol, i.e., non-invasive ultrasound probes.

How do I clean the equipment?

The Spaulding Classification defines the minimum levels of disinfection or sterilization required for the three different categories of medical devices based on intended use. Always defer to manufacturer's instructions for use for cleaning, disinfection, and sterilization recommendations.

Patient Contact	Examples	Device Classification	Disinfection Level	What you need to know
Intact Skin	Contrast injectors, blood pressure cuffs, Pulse oximeters, Thermometer, EKG machines, X-ray plates, Glucometers, Portable Dopplers, Slide boards, Exam tables 	Non-Critical	Low level or Intermediate level Disinfection 	Use as many wipes as needed to keep surface wet for required disinfection time as directed on bottle. AKA: "wet time"
			OR 	Air dry
Mucous membranes or non-intact skin		Semi-Critical	High level Disinfection (e.g., Trophon)	Per manufacturer's instructions
Sterile areas of the body, vascular system		Critical	Sterilization	Per manufacturer's instructions

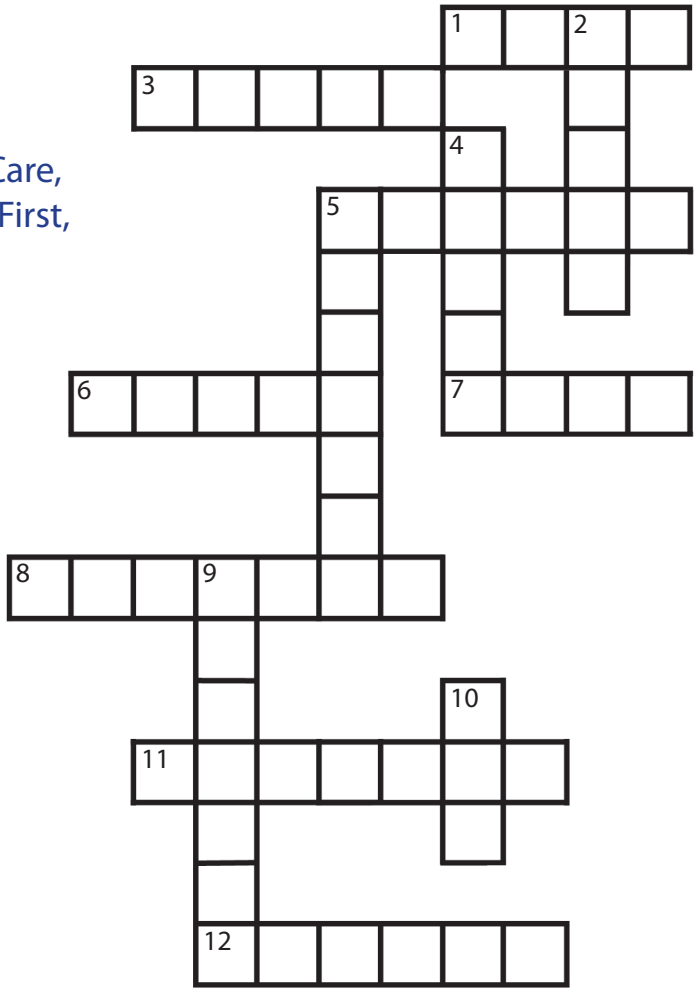
Isopropyl alcohol is used only to clean Hologic 3D Mammography equipment.

Hydrogen peroxide is not an approved cleaning agent.

Remember: Gloves should be worn for cleaning and disinfection of equipment if there is any risk for blood or body fluid exposure.

Now that you have read the last three pages of Tips, Suzanne invites you to complete the TJC Quiz to help us all prepare for The Joint Commission Survey!

BIDMC Mission:
To Provide Extraordinary Care, Where the Patient Comes First, Supported by World Class Education and Research.



ACROSS

1 How to use a fire extnguisher

3 The number you called in the event of a fire

5 Code ____ is for a threat with a weapon

6 Supplies should never be stored directly on the ____

7 What to do in the event of a fire

8 Emergency equipment including gas shut off valves should never be ____

11 Should always be done to equipment before and after use

12 Should be worn for cleaning equipment if there is a risk of blood or body fluid exposure

DOWN

2 Using a fire extnguisher, I do this at the base of the fire

4 The "C" in "RACE" is for Contain and _____

5 Should not be used on sterile packages in an area that impacts the contents' sterility if it were to bleed through

9 Supplies should be stored no higher than 20 inches from this

10 Slide boards are cleaned between patient use using ___ top wipes

QUALITY UPDATE: OUR RADIOLOGY SAFETY TEAM's PROGRESS

In December, our safety workgroup met to review the opportunities for safety improvements called out in our cockpit gradient survey. The group looked at these opportunities to better understand their prevalence and possible solutions. Transporting ICU precaution patients is an example of an opportunity for improving the safety of our patients and transporters. In this case, transporters were receiving mixed messages regarding the use of PPE while transporting precaution patients from the ICU. A multi-disciplinary group worked with Infection Control and changes to the policy have been made to ensure the safety of all. ***If you have a safety concern in your work area, please feel free to contact a safety workgroup representative.***

SUZANNE SWEDEEN DONS HER OTHER HAT AS KIP COACH IN RADIOLOGY:

KIP Coach TIPS

Accessing a Medical Record?

Less is Best

When going into a medical record for work, keep in mind **minimum necessary**:

- Double-check to ensure you are going intot he right record
- Look only at the information you need to do your task
- Share only the information another clinician or co-worker needs

Remember, access only the information you "need to know for TPO" – Treatment, Payment or Operations.

Questions? Call or email Suzanne Swedeen
at 617-754-2768 or sswedeen@bidmc.harvard.edu

KIP Keep Information Private

Beth Israel Deaconess Medical Center

KUDOS - Each month, we share the positive feedback we receive about staff members and ask you to join us in congratulating them; as always, we are especially proud to acknowledge an unprecedented constellation of staff for providing outstanding care and service!

Diagnostic Radiology

Tech Assistant **David Manyok** goes above and beyond for coverage of open ED shifts. He was also recently recognized by one of his peers who said "David is such a hard worker, never complains, skips his break if we are too busy, stays late when he can, works doubles, often works alone lately, helps me when I'm too busy...and to top it all off, he does it all with a great attitude and is absolutely a joy to be around."

Thank you Clinical Instructor **Ana Cordero** for your Imaging month activity preparations. Ana goes above and beyond to support imaging month celebrations. This year she even supported BID-Needham and Milton in getting a radiation protection CEU.

Technologist **Sara Ross** was recognized by a patient for excellent customer service. Here is part of what the patient said about Sara: "Sara Ross, who obviously loves her job, that she does so well, should be held up as an example of a staff member who personifies the image of caring, empathy, vitality and professionalism that BIDMC tries so hard to project. She would be great at training new employees!"

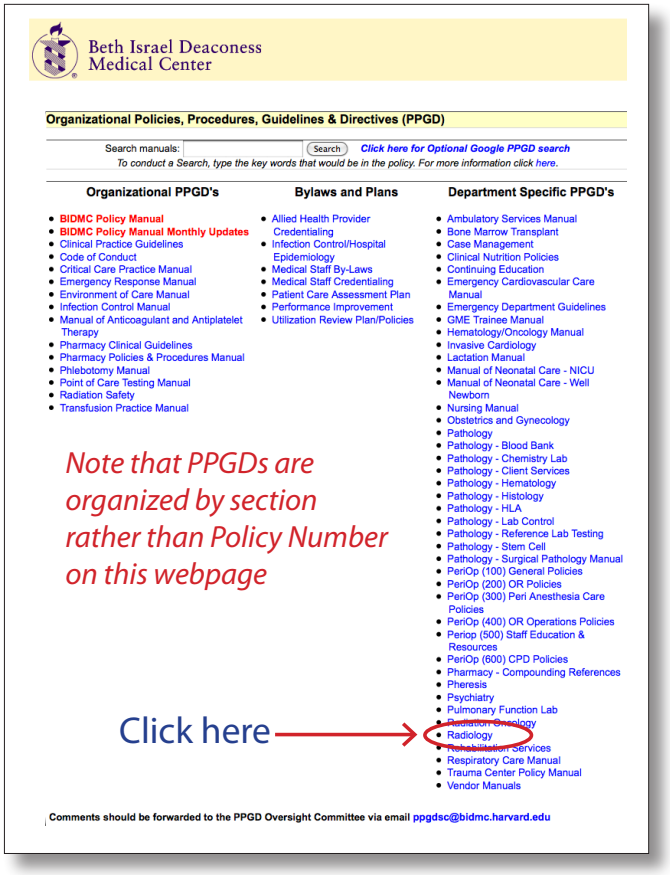
PACS/RIS Informatics

Thanks to Sr. Programmer/Analyst **Larry Barbaras** for providing programming for Imaging Month, License and Registration expirations, and Holiday scheduling. Larry is innovative and partners with the modalities in improving efficiency.

Updated Policy Notifications*

Donna Hallett, BSc
Director of Operations

As we announced in July, 2014 the following departmental policies, procedures, guidelines and directives (PPGD) have been added, edited or reviewed with no change. To ensure that you are up to date on the newest, most current information, please click on the link below to view the specific PPGD:



https://apps.bidmc.org/cms/dispManuals.asp

**Please see page 14 for important updates to RAD-13 Communication of Critical Imaging test Results*

New / Updated Policies

RAD-98 MRI Device and Object Screening
– New policy as recommended by ACR

RAD-85 Personnel Response during and after a controlled or uncontrolled MRI magnet quench
– Made changes in the policy statement to reflect cryogen leak and quench
– Updated information for emergency situations in MR as recommended by ACR
– Combined magnet quench and cryogen leakage policy versus having two separate policies

RAD-58 Use of IV contrast for CT and MR imaging
– Policy Statement reworded to add information on a physician response to any adverse event post contrast administration as recommended by ACR

RAD-77 Submission Content for the Radiology Online QA system and the Patient Safety Reporting System - minor revisions

Several additional events have been added to the sample list of what should be reported in the PSRS

In the QA database system an "unsure" button has been added so staff can forward cases to Dr. Siewert for review if they are unsure what system the event should be reported in. (This button is now up and operating). This is now reflected in the guideline.

RAD-99 Job Shadow Observations in the Radiology Setting
– NEW Guidelines for Job Shadow observations in Radiology

RAD-25 MRI exams done under anesthesia policy
RAD-25 MRI exams done under anesthesia policy
Minor grammatical changes made. Policy reviewed by MR and Anesthesia team. Two attachments:
– IP MRI with anesthesia flow chart- no changes
– MRI how to book in-patient anesthesia- no change

RAD-59 Cardiac Stent Policy - changes made are
– Question # 5, and # 6 changed MR compatibility to MR safe or MR conditional.
– Question #8--added the SAR's scanning limitation.

RAD-70 Off shift staff transportation between the East and West campuses phone number for service response changes only.

PUBLICATION CALL OUT: Historically, we have used this column to feature outstanding published papers but this month, we call out a very important revised updated policy at BIDMC for your convenience!

Beth Israel Deaconess Medical Center	
Title:	***Communication of Critical Imaging Test Results***
Policy #:	*RAD-13*
Purpose:	To provide radiologists with guidelines for the communication and documentation of critical imaging test results to ordering physicians

***Policy Statements*:**

The attending physician interpreting a radiological study is responsible for directly communicating and documenting this communication of critical findings to the ordering physician.

Guideline(s) for Implementation:

A list of critical test results requiring direct communication has been established and provided to all radiologists. These are listed below.
When identified on any imaging study, these findings must be directly and immediately communicated to the ordering (or responsible covering) physician and this communication should be documented in the final radiology report.

In accordance with Joint Commission requirements, the following five (5) parameters must be included in the documentation:
1. Name of person to whom results were communicated
2. Method of communication (e.g. phone)
3. and 4. Time and date of communication of critical result
5. Time from discovery of finding to communication of finding (in minutes)

*To facilitate this documentation, all structured reports contained within the BIDMC Radiology Voice Recognition Reporting System (Fluency for Imaging FFI) include a macro listed as "**critical results**".*

Principles of Communication of Critical Test Results in Radiology

Communication of patient information must be done in accordance with federal and state privacy requirements. Direct communication should always be documented in the official radiology report. In those situations in which the interpreting physician feels that immediate patient treatment is indicated the interpreting physician should communicate in person or by telephone directly with the referring or responsible covering physician, other health care provider, or an appropriate representative. All of the standards for communication used in the Department of Radiology at Beth Israel Deaconess Medical Center are in accordance with the American College of Radiology Standard for Communication in Diagnostic Radiology, as revised in 2014.

Critical Test Results

A list of critical radiological findings has been established in our Department. These results are divided into two groups: those requiring immediate notification to the ordering physician, where urgent treatment may be necessary (**red group**), and those non-urgent findings requiring direct notification within 3 days (yellow group). These findings are based on a Learning Collaborative on Safe Practice Recommendations, held by the Massachusetts Coalition for the Prevention of Medical Errors in 2003.

1. Urgent or life threatening finding (Red group) that require immediate and documented notification include the following:

1. Pneumothorax, if unexpected, including tension pneumothorax
2. Leaking or ruptured aortic aneurysm, or signs of impending rupture of an aortic aneurysm
3. Unsuspected acute aortic dissection.
4. Ischemic bowel, or findings concerning for ischemic bowel
5. New or enlarging pneumoperitoneum (non post-op)
6. Unsuspected or enlarging hemoperitoneum on CT or US
7. Acute extra-axial brain collection, including acute subdural and epidural hematoma
8. New brain metastases or lesions concerning for brain metastases with mass effect
9. Unknown or unstable spinal fracture
10. Malpositioned tubes, lines or catheters requiring repositioning

New Critical Result

<u>Additional results requiring urgent communication by the Department of Radiology at BIDMC:</u>

1. **Ectopic pregnancy** (even if suspected by ordering physicians)
2. **Procedural complication** (such as hemorrhage or pneumothorax that may or may not require hospital admission)
3. **Appendicitis** or imaging findings concerning for appendicitis
4. New or unexpected **DVT or pulmonary embolus**
5. **Pneumonia on pre-op CXR**
6. Any finding suggestive of a **new or unsuspected malignancy**, even if examination is ordered to evaluate for a possible malignancy
7. Any result not necessarily in the preceding list which the reporting radiologist feels will require immediate medical attention
8. **Potentially impactful change in a previously rendered interpretation** including changing reports from positive finding to no abnormalities, downgrading the extent of an abnormality or making a new finding

This item is easily overlooked:

Please note that this refers to reporting a new abnormality in the final read as well as changing a previously "abnormal result" to a normal study. For example a study where initially a pulmonary embolus was reported and the final read is changed to "no pulmonary embolus". This change needs to be communicated directly and documented in the final report, as the patient has likely been placed on anticoagulation which now needs to be discontinued.

- Bettina Siewert, MD, Executive Vice Chair & Vice Chair of Quality

2. Abnormal results that requires clinical communication within 3 days (Yellow group). Any new fracture even if suspected by ordering physician

1. Biopsy recommendation on a mammogram
2. Change in a previously rendered interpretation that relates to a finding of current or potential clinical importance, but not one requiring immediate intervention.

Abnormal Findings in the Emergency Room
All CT and ultrasound studies on ED patients have a provisional or "wet" reading typed into the Fluency/CCC system by the ED Radiology resident. This result populates the ED dashboard. For positive findings that need to be communicated to ED staff urgently, the ordering ED physician is paged for direct documented communication of the result, and the result is also placed on the ED dashboard using the 'ED urgent" macro.

Recommended Actions if Ordering Physician Cannot be Contacted:

1. If the referring physician, other health care provider, or an appropriate representative cannot be reached despite reasonable repeated attempts at telephone calls and beeping, and the interpreting physician feels that immediate patient treatment is indicated, the interpreting physician should directly communicate the need for emergent care to the patient or responsible guardian, if possible. In addition, an e-mail message should be sent to the ordering physician, making note of the nature and time of this communication.

2. If both the ordering physician and patient cannot be contacted, and the interpreting attending radiologists believes that the results require urgent medical attention, then the local EMT Service must be contacted.

3. In those situations in which the interpreting physician feels that the findings do not warrant immediate treatment but constitutes significant, unexpected findings, the interpreting physician or his or her designee should communicate these findings to the referring physician, other health care provider, or an appropriate individual in a manner that reasonably ensures receipt of these findings, such as by entry into the departmental Online Notification System.

One goal of this policy is to foster greater direct communication between interpreting radiologists and ordering physicians.

Vice President Sponsor: Robert Cherry, SVP, Support Services

Approved By:

☒ **Operations Director, Radiology 11/1/2015 Donna T.Hallett, Operations Director**

☒ **Radiology Clinical Operations : J. Kruskal, MD, Chair**

APPROVED BY CCSC 1/25/05 Last Reviewed:

Requestor Name: Donna Hallett

Original Date Approved: 1/25/05
Next Review Date: 11/1/2018
Revised: 2/2007,12/15/2015

2016 BIDMC Radiology Publications - *A PubMed search for new BIDMC publications is made each month; however, if we miss your paper, please send the reference to dwolfe@bidmc.harvard.edu. Note that 1) Epub dates are included only in publications where the Epub and paper publication dates occur in different years, i.e., Epub in 2015 and paper publication in 2016; and 2) doi addresses are only included until citations are updated with hard copy page citations.*

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2015 BIDMC Radiology Publications - BIDMC Radiology published 167 papers in 2015*

Citations in blue denote publications that appeared in PubMed between the Dec 2015 and Jan 2016 issues of Radical Views. Note also that the 2015 citations have been updated to reflect paper publication information.

***This total includes "Epubs ahead of print" which will be credited to 2016 as they are published**

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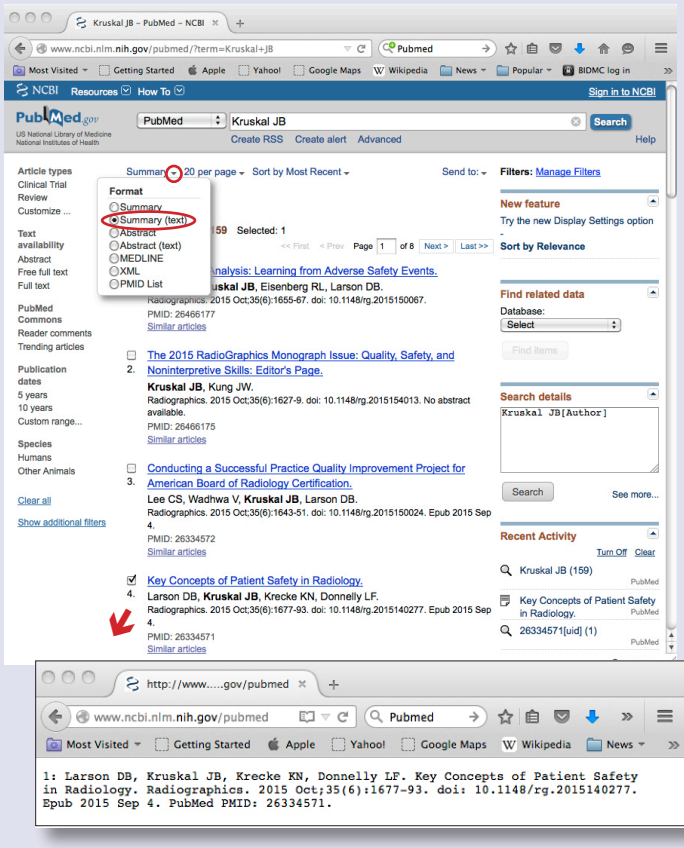

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