MRAD 223:

MRT Program
Edenbrook College

Administrative Procedures

- Charting/Record Keeping
- Requisition
- Types of Consents
- Patient Identification
- Oral Reporting
- Incident Reports

Written records such as "charting"

- *Any written record must be*:

1. Accurate (sequence, time, date etc.)
2. Pertinent (how is this info useful/purpose)
3. Legible
4. Objective (no emotion, only observations)
5. Complete (details, specifics)
6. Consistent (use correct terminology)

Purpose of Patient Charts

- To provide accurate records of the care given to meet the patient's needs during their hospitalization.
- A means of communication for all members of the health team. Systematic approach
- Aid in the treatment and care of the patient. Example- reduce risk of performing duplicating x-rays
- Resource for research.
- To some extent educate/involve the patient.

Patient Charts

What should be documented in a patient's chart if having an invasive x-ray procedure?

- *Most charting is done by the DI nurse. The information recorded includes*:
  - The patient's condition upon arrival in radiography.
  - Track regular monitoring during the patient's stay in radiography. The more seriously ill the patient is, the more frequently their condition will be documented, including vital signs.
  - The patient's condition upon discharge from the radiography department.
- Often, radiologists record a preliminary report.

E-charting vs paper charting

Institutions can use either paper or e-charting but in most cases both.

Advantages of e-charting are:

1. More legible than hand writing
2. More easily stored
3. Accessible from multiple locations within the site and off site.

Patient Charts in Emergencies

There are two primary situations where quick access to the important information found in a patient's chart is necessary.

1. Allergies – Does the patient have any allergies to medications? An emergency situation in the x-ray dept. may require the administration of drugs.
2. A "do not resuscitate" (DNR) order – The patient has previously decided and made legal their wishes to the level of treatment they wish to receive.

Accountability

- It's crucial for medical records to be objective. If you're not willing to repeat it in court than it shouldn't be documented.

- All info in patient's records are considered confidential and permanent.

- Be sure to log off the computer workstations when you finish using it to prevent unauthorized access to confidential medical records. The employer does random checks of your computer activity and you'll be expected to explain your activity.

Patient Charts (cont'd)

Which of the following examples is a better way to record information in a patient's chart?

1. "Too drunk to climb onto x-ray table."
2. "Patient unable to move unassisted onto x-ray table"

Purpose of Requisition

- To provide a work order that provides legal protection and proves the reason for a radiographic procedure.
- Includes patient's history (i.e., why are they having this x-ray done?).
- Gives the technologist information about whether modifications to the procedure need to made and why.
- *The requisition is a part of a patient's medical record.*

Key Info found on Requisition for Technologists

1. Is the patient on isolation? If so, what type.
2. Is the patient on oxygen? If so, What is the flow rate?
3. Does the reason for the exam (clinical history) align with the x-ray ordered
4. Location of the patient. Are they in the ER dept. or are they an In-pt.?
5. Has patient had previous x-rays similar to the ones ordered before? WHY is this important?

Note- *refer to instructor handout regarding list of general information found on a requisition*

Consent

In radiology, there are three types of consents that a patient can give:

- Implied consent
- Expressed consent
- Informed consent
- CAMRT Consent Guidelines: Instructor Handout.

https://camrt-bpg.ca/patient-management/patient-care/communication-of-critical-findings/

Consent (cont'd)

According to CAMRT, in order to be valid, consent must be:

- Voluntarily given
- Informed
- Given specifically for the act performed
  - **Note:** Minor modifications and extensions are **implied**, as long as they are well within the scope of the procedure or of the condition to be remedied.

Implied Consent

- Occurs in emergency situations when it is not possible to obtain consent from the patient, guardian or legal representative.

- The healthcare provider operates under the belief that the patient would give permission.
  - Example: an unconscious patient brought into emergency after a motor vehicle accident.

Expressed Consent

- Occurs when the patient does not stop the procedure from taking place.
- By allowing the procedure to occur, the patient has given his or her express consent to the technologist.
  - Example: walking in to an x-ray clinic.
- However, **legally**, silence is not an agreement to having the procedure/exam performed.

Informed Consent

Informed consent is required:

- *For any invasive procedures.*
- *For procedures that involve substantial risk.*
- *When IV contrast media is required.*
- *In the case of minor children by their parents or legal guardian.*

Informed Consent (cont'd)

- The legal age to give consent is 18 years old.
- This consent requires the patient to sign a special consent form. There are two primary examples:
  - An "IV Injection of Iodinated Contrast and Screening" form
  - A "Consent to Treatment Plan or Procedure" form.

Legal Implications of Consent

- Patients must receive a full explanation of procedure, risks and benefits and sign the consent form **before** any sedative or anesthesia is given.
- Patient must be competent to sign an informed consent.
- Only parents or legal guardians may sign an informed consent for a child.
- Only a legal guardian may sign for a mentally incompetent patient.

Legal Implications (cont'd)

- Consent forms must be completed before being signed. Patients should never be asked to sign a blank form or a form with blank spaces "to be filled in later."
- Only the physician named on the consent form may perform the procedure. **Consent is not transferrable** from one physician to another.
- Any condition stated on the form must be met.
  - Example: having a family member present during procedure.

Legal Implications (cont'd)

- Informed consent can be revoked by the patient **at any time** after signing.
- It is not the technologist's responsibility to determine whether a procedure should be terminated. The radiologist and/or ordering physician must decide this.
- It is your responsibility to bring the patient's concern(s) to the radiologist/physician in charge for resolution.

Consent Forms

- Provides the patient with information about the procedure and its risks and benefits.
- Hope is to establish a positive rapport with the patient through effective communication, leading to a successful exam/procedure.
- The legal implications of informed consent cannot be overemphasized.

Obtaining Informed Consent

When it is your duty to obtain informed consent:

- Be sure, as a technologist, you fully understand the procedure so that you can answer any questions within your **scope of practice** and refer to the radiologist when necessary.
- If the patient asks a question you cannot answer, seek the correct answer **before continuing**, because an improper response may **invalidate** consent.
- Read the CAMRT Informed Consent Document

Patient Identification

- Each patient who comes to the DI department **must** have a requisition (medical emergencies are exceptions).
- The **safest** method of patient identification is to compare the information on the requisition with the patient's identification band.
- For outpatients or in clinics, call the person's name and then use another question to verify it is the correct patient (e.g., DOB, purpose/body part to be x-rayed, name of doctor).

Patient Identification (cont'd)

- Use open-ended or feedback questions to properly identify your patients whenever possible (i.e., questions that can't be answered using yes or no).

- Double identify (e.g., spelling of last name and DOB).

- It is a legal responsibility to ensure that the correct patient receives the correct procedure.

Oral Reporting

Advantages:

- Quick
- Good in an emergency
- Easy

Disadvantages:

- Can easily be misunderstood
- Easy to make mistakes
- Can be paraphrased

Oral Reporting (cont'd)

Examples in the DI department:

- Patient history given to the radiologist by the technologist, before contrast injection.
  - *Example: maybe the amount of contrast given will be changed as per radiologist. Document changes on the patient's requisition.*
  - Nursing staff on unit may receive an oral report from a technologist
- as to the status of the patient following a procedure.
  - Example: patient tolerated procedure/exam well.

Incident Report

Incident reports may be needed when there is:

- *Accident or injury to any patient, staff or visitor.*
- *Loss of, or damage to, property of patient, staff, visitor or hospital.*
- *Incorrect drug or procedure administration.*
  - *Example: x-rayed the incorrect hand*
- *Incorrect events that occurred during the procedure.*
  - Example: incorrect type of injection given

Incident Report (cont'd)

- Care for yourself and/or the patient and provide first aid as required.
- Notify the physician and assist with any medical intervention.
- Complete the "Incident Form."
  - Use factual information and eyewitness accounts
- Evaluate the situation. *Review what occurred and see if there are any precautions to take next time.*

Incident Report (cont'd)

- Forms are then forwarded to administration and will be placed in the patient's chart, in medical records and with department heads.

- If a staff member is injured then follow site protocol.