NEWS RELEASE

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Joint Commission Alert: Use diagnostic radiation carefully
Action urged to prevent harm from radiation

(OAKBROOK TERRACE, Ill. – August 24, 2011) While diagnostic radiation tests can help save lives, a new Joint Commission Sentinel Event Alert warns that health care organizations must seek new ways to reduce exposure to repeated doses of harmful radiation from these diagnostic procedures. The Alert urges greater attention to the risk of long-term damage and cumulative harm that can occur if a patient is given repeated doses of diagnostic radiation.

Over the past two decades, the U.S. population’s total exposure to ionizing radiation has nearly doubled with the increased use of diagnostic imaging in hospitals, imaging centers, physician and dental offices. Any physician can order radiologic tests at any frequency with no knowledge of when the patient was last irradiated or how much radiation the patient received. Several recent studies have raised concerns about the risk of cancer from diagnostic imaging, especially in vulnerable populations such as children, young adults and pregnant women.

“Diagnostic imaging is a necessary medical tool, but it must be used with great care,” says Mark R. Chassin, M.D., FACP, M.P.P., M.P.H., president, The Joint Commission. “Although there is still debate about how much is too much radiation, and the timeframe within which radiation can be safely administered, the recommendations in this Alert give health care organizations practical strategies to make sure that patients get the right diagnostic imaging tests with the lowest dose of radiation needed to make a diagnosis. In addition, The Joint Commission’s standards support the use of safe and effective diagnostic radiation and promote a safety culture, which is necessary for the safe use of diagnostic radiation.”

The Joint Commission’s Sentinel Event Alert suggests that health care organizations can reduce risks due to avoidable diagnostic radiation by raising awareness among staff and patients of the increased risks associated with cumulative doses and by providing the right test
and the right dose through effective processes, safe technology and a culture of safety. The specific actions suggested by The Joint Commission include:

- Use of imaging techniques other than CT, such as ultrasound or magnetic resonance imaging (MRI), and collaboration between radiologists and referring physicians about the appropriate use of diagnostic imaging.
- Adherence to the Nuclear Regulatory Commission’s ALARA (“as low as reasonably achievable”) guidelines, as well as guidelines from the Society for Pediatric Radiology, American College of Radiology and the Radiological Society of North America for imaging for children and adults, respectively.
- Assurance by radiologists that the proper dosing protocol is in place for the patient being treated and review of all dosing protocols against the latest evidence either annually or every two years.
- Expansion of the radiation safety officer’s role to explicitly include patient safety as it relates to radiation and dosing, as well as education on proper dosing and equipment usage for all physicians and technologists who prescribe diagnostic radiation or use diagnostic radiation equipment.
- Implementation of centralized quality and safety performance monitoring of all diagnostic imaging equipment that may emit high amounts of radiation cumulatively.

In addition to the recommendations contained in the Alert, The Joint Commission urges health care organization to use accreditation standards to guide the use of diagnostic imaging. These standards are related to the accreditation manual chapters addressing Leadership, Human Resources and the Environment of Care.

The warning about diagnostic imaging risks is part of a series of Alerts issued by The Joint Commission. Much of the information and guidance provided in these Alerts is drawn from The Joint Commission’s Sentinel Event Database, a voluntary reporting system for serious adverse events in health care. The database includes detailed information about both adverse events and their underlying causes. Previous Alerts have addressed violence in health care facilities, maternal death, health care technology, anticoagulants, wrong-site surgery, medication mix-ups, health care-associated infections, and patient suicides, among others. The complete list and text of past issues of Sentinel Event Alert can be found on The Joint Commission website.

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