IONISING RADIATION
Incident investigations should focus on:

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

WHAT happened?

Consider:

- incident details
- complete review of patient's journey by investigation team
- additional dose and patient risk

HOW did it happen?

Consider:

- impact of existing systems and processes
- contribution of organisational decisions, cultural or environmental factors
- any previous similar incidents and or effective actions

WHY did it happen?

Consider:

- adherence to and strength of systems and processes
- appropriate and current knowledge, skills and training for radiation protection

Rather than focusing on the actions of staff

Source | www.hiqa.ie