

Medico-legal examination of a radiography incident



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Patients' safety is of huge paramount when undergoing diagnostic treatment. It is the participating staff's fiduciary duty to ensure patients do not sustain any injury during this process. But however, sometimes mistakes happen and when injuries occur, there could be repercussions. These mistakes could be as a result of negligence, no up to date training and incompetence. According to the Management of Health and Safety at Work... (date), all employees are required to perform their job safely without causing any harm to patients and also, it is the employers obligation and duty to give adequate training, clear information and instructions to employees, in order for them to carry out their roles diligently.

In reference to the court scenario, the incident that occurred between the patient, student radiographer and the supervising radiographer shall be discussed and related to the medico-legal aspects, scopes of practice and ethics and other principles related to the health and social care environment. So also, the actions of the radiology manager and the manual handling expert would be discussed.

Student Radiographer

From the court room video, it is obvious that the student radiographer and the radiographer did not have good communication. Mr Lung, the patient, was transferred from the Porter to the student radiographer but the supervising radiographer was not there to make sure the student did the right checks. The student inspected the wheelchair, in which Mr Lung was brought to the department and confirmed it was safe. The student also went ahead to do the identity checks and risk assessment and during this period,

the radiographer still was not there to supervise. The student radiographer, as a result of the risk assessment done on the patient, decided to do an AP (Anterior Posterior) view chest x-ray. The radiographer came along after the student had just finished the risk assessment on Mr Lung and was about to take an AP view of the chest. The radiographer never asked the student to update him on what she had done so far. He went ahead to ask the Mr Lung to stand for PA (Posterior Anterior) view of the chest x-ray, without carrying out a proper risk assessment and ascertaining Mr Lung had the capability of standing for the x-ray. Ehrlich and Daly (2009) states a radiographer should assess situations, exercise care, discretion and judgement. He should assume responsibilities, professional decisions and act in the best interest of the patient. Although he decided to do PA view on the patient in order to get the best image of the patient's chest, he compromised Mr Lung's safety by asking him to stand, without doing a proper risk assessment on him. " The Society's Code of Professional Conduct states: You must communicate effectively and appropriately with patients, introducing yourself and giving relevant information during their examination or treatment" (sor. org). " The importance of interacting effectively with the patient is critical to the radiographer as well as to the patient. Those techniques greatly improve the quality of the radiology image, as well as the patient's care" (Adler and Carlton, 2003)

Although the radiographer is known to have good years of experience in his field, the student should not have hesitated to query his judgement of asking the patient to stand, despite the patient's condition or told him that she had

done a risk assessment of the patient standing and the patient would not be able to stand.

While the patient was standing, the radiographer moved the wheelchair behind the patient and told him to sit when he felt the need. The patient sat down when he needed to sit down but unfortunately, the wheelchair rolled back and turned around, causing the patient to land on his hip and suffered from NOF (Neck of Femur) fracture. The A and E consultant also confirmed this but however the NOF fracture could have been made easier as a result of bone degeneration, associated with old age (Gunn, 2007). But, this accident should not have occurred if proper risk assessment and precautions were undertaken. As one of Dutton et al, (2013) ethical principles; non-maleficence: the radiographer is obligated to practice in a safe manner at all times. To further disapprove of the radiographer's action, which affected the patient, (Dutton et al, 2013) gave another principle; paternalism. This simply means a radiographer is justified to take action in instances in which not acting would do more harm than the lack of patient input into the decision. This however was not the case, as the potential outcome (good view of the chest) did not justify compromising the patient's health

The patient suffered pain as a result of negligence on the part of either the student radiographer not being able to assess the wheelchair's safety or the supervising radiographer forgetting to apply the brake. The radiographer claimed the accident was not his fault, as he applied the brake when he placed the wheelchair behind the patient. This could mean the wheelchair tyres had low pressure. If this were true, he could have realised the low pressure in the tyre when he did the safety checks on the wheelchair. And if

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indeed the wheelchair were unsafe when transferred to the student radiographer and she did not do the right assessment, the supervising radiographer will still be held responsible because the job was delegated to the student radiographer. According to NLIAH (2010), “delegation is the process by which you (delegator) allocate clinical or non-clinical treatment or care to a competent person (delegate). However the delegator remains responsible for the overall management of the service and accountable for the decisions and actions of the delegate”.

After the accident occurred, the supervising radiographer told the student to agree to the fact that the brake to the wheelchair was applied before placing it behind the patient, otherwise, they both would be in trouble. The student radiographer felt coerced into supporting his false intention, as she believed the brake was not applied. Dutton et al (2009), in one of their ethical principles; autonomy- states “the right of all persons to make rational decisions free from external pressure”. Coercing the student radiographer made her feel bullied and harassed. According to *Bullying and Harassment at Work* (2014), it is the employer’s duty to prevent bullying. It is an “offensive, intimidating, malicious or insulting behaviour; an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient. Bullying could lead to retaliation, anxiety, humiliation, or demotivation. All these could lead to stress, loss of self-confidence and self-esteem”.

The next day after the incident, the student radiographer followed one of the guidelines of dealing with bullying and harassment at work, by confiding in someone and expressing her emotions of her feeling bullied (Dignity at Work <https://assignbuster.com/medico-legal-examination-of-a-radiography-incident/>

Policy, 2012). This person was her practice educator and she listened without judgment. She transferred the case to the radiology manager for investigation.

When accidents occur at work, these are meant to be reported in the accident report form. In the NHS, Datix reporting is used, where incidents are reported on a web-based system that can be used by anyone with access to the NHS net. Some of the information required includes details of the incidence and people involved.

Reporting Incidents, Disease and Dangerous Occurrences Regulation (RIDDOR, 2013) is a law that requires employers and other people who are in control of work premises to report certain incidents. This is a legal requirement and it informs the enforcing authorities (Health and Safety, and Local Authorities) about deaths, injuries, occupational disease and dangerous occurrences, so they can identify where and how risks arise and whether they need to be investigated.

Moreover, when the radiographer reported this incident in the datix system, it was reported that the wheelchair had its brake on, which was a false. He did this consciously just because he did not want to be in trouble or disciplined.