# TORONTO JOINT DEPARTMENT OF MEDICAL IMAGING

# **Background & Objectives**

### **Problem Statement:**

- Variable quality of general radiography x-rays produced
- Differences in knowledge base and experience of technologists
- Possibility for additional radiation exposure from repeated imaging

### **Accepted Solution:**

- Establishment of peer review program over 8 months in a multisite department with 80+ rotating general radiography technologists
- Non-punitive education based peer to peer program to monitor image quality
- Coral Review<sup>®</sup> software enabled
  - Random assignment of images
  - Anonymity of performing technologists and reviewer comments

#### **Program Design:**

- Standard quality improvement project principles were applied to establish governance, roles and workflow, education, policy development, training and communication
- Collaborative interprofessional governance structure was set up to guide Key stakeholders included departmental committees with focus on academic decision making practice, Quality and Safety committee and modality leadership

#### **Program Roles and Workflows (Figure 2):** Technologists

- Perform one peer review per working day with a workload of less than 5 Formal training session held for Quality Leads to orientate them to software minutes and understand core responsibilities
- Acknowledgement of part time, after hours and extended shift workers

#### Technologist Quality Leads

- Serve as administrators in the peer review process for their respective sites
- Point of escalation for cases requiring immediate follow up
- Identify cases for review at quality rounds
- Report to departmental Quality and Safety Committee

#### **Education and Quality Rounds:**

- Pivotal to success of program allowing for peer to peer knowledge dissemination
- Quarterly meeting of technologists to present identified educational themes
- Recorded to provide access to after hours and casual/part time staff
- Student technologists encouraged to participate to share in learning



# Implementing A Technologist Peer Review Program: Methods and Lessons Learned

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### **Objectives:**

- To reduce variability in image quality
- Create a formalized quality assurance program for technologists
- Promote a culture of reflective practice reinforced through Quality Rounds



## Materials & Methods

#### **Policy Development:**

- A departmental policy was scripted to establish expectations for practice
- Duties and accountabilities for all participants and leadership clearly outlined

#### **Training and Communications for Launch:**

- Town hall meetings served as info sessions on the program and training to use software were held just prior to the launch with executive support
- Quality Leads supported the post launch monitoring serving as mechanism for staff to report issues impacting workflow and quality of care

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### **Key Lessons Learned From Implementation:**

- Importance of enthusiastic clinical champions
- Significance of senior leadership support
- Importance of communication and post launch follow up **Sustainability Challenges:**
- Sustaining engagement amongst staff
- High staff turnover in General Radiography resulting in lower participation
  - Need to embed training on Peer Review tool within onboarding process identified
  - Maintenance of rules for large group of staff proved time consuming for Quality Leads

# Conclusions

- Technologist peer review program established to address variable quality of general radiography x-rays produced in multisite department
- Quality rounds allows for ongoing learning, culture of quality improvement, transparency and accountability
- Sustainability of program requires continued clinical champion support and ongoing engagement of staff
- Planned next steps for the peer review program:
  - Sharing lessons learned from the general radiography pilot program with other sites
  - Expansion to other imaging modalities
  - Creating set of image critique parameters