

**WAC 246-226-060 CT events.** (1) The purpose of this section is to improve patient safety by supporting health care providers and facilities in their efforts to reduce the incidence of medical errors that contribute to deterministic injurious health effects. This rule does not relieve the department of its statutory obligation to enforce this and other radiation protection laws.

(2) The registrant shall initiate an investigation within twenty-four hours and complete the investigation within ten business days when:

(a) The cumulative  $CTDI_{vol}$  over the course of an individual study at a particular anatomical location exceeds 600 mGy for a pediatric CT procedure or 1500 mGy for an adult CT procedure; or

(b) Any ionizing radiation exposure from a CT procedure results in unanticipated hair loss, erythema, or functional damage to an organ or physiological system.

(3) For each event, the registrant shall conduct a root cause analysis in consultation with a medical physicist, the lead interpreting CT physician, lead CT technologist, and the operator who performed the CT procedure. The root cause analysis must:

(a) Follow the procedures and methods of:

(i) The joint commission;

(ii) The department of veterans affairs national center for patient safety; or

(iii) A department-approved nationally recognized root cause analysis methodology.

(b) Include the following information:

(i) The findings regarding the root cause of the event;

(ii) The number and types of health professionals present at the time the reported event occurred;

(iii) A corrective action plan consistent with the findings of the root cause analysis and including:

(A) How each finding will be addressed and corrected;

(B) When each correction will be completed;

(C) Who is responsible to implement the corrections;

(D) What action will be taken to prevent the event from recurring; and

(iv) A monitoring schedule to assess the effectiveness of the corrective action plan, including who is responsible for the monitoring schedule.

(c) If the registrant determines there is no need to create a corrective action plan for a particular event, include a written explanation for the determination.

(4) The root cause analysis must not include any identifying information for any health care professional, facility employee, or patient involved.

(5) The registrant shall make appropriate modifications consistent with the corrective action plan to prevent future events.

(6) This rule does not remove a registrant's responsibility to report a licensed practitioner's unprofessional conduct to the department, as defined under RCW 18.130.180.

(7) A registrant is exempt from the requirements of this section when the registrant is subject to other coordinated quality improvement requirements under RCW 70.41.200 or 70.230.080, and includes CT events as part of the required coordinated quality improvement program.

(8) A registrant is exempt from the requirements of this section when the registrant includes CT events as part of a department-approved coordinated quality improvement program under RCW 43.70.510.

[Statutory Authority: RCW 70.98.050 and 70.98.080. WSR 16-23-030, § 246-226-060, filed 11/8/16, effective 1/1/17.]