

Identifying and Measuring Radiography Ordering Errors Using a Web-Based Event Reporting Tool and RIS to Analyze Errors and Identify Opportunities for Improvement



Stacy R. Schultz, BA, Karl N. Krecke, MD, Michelle R. Nordland, RT(R)(M), Toni R. Fabian, RT(R), Deborah A. Ritten, RT(R), Tamara J. Schmidt, RT(R)

Department of Radiology

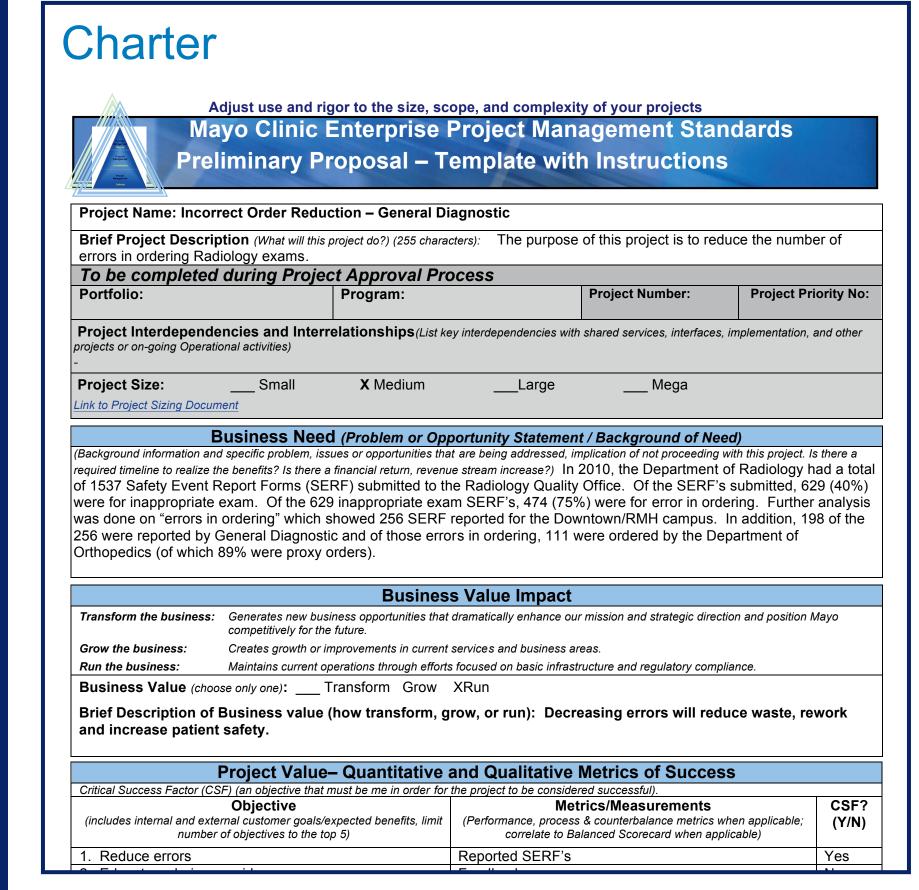
Mayo Clinic, Rochester, MN

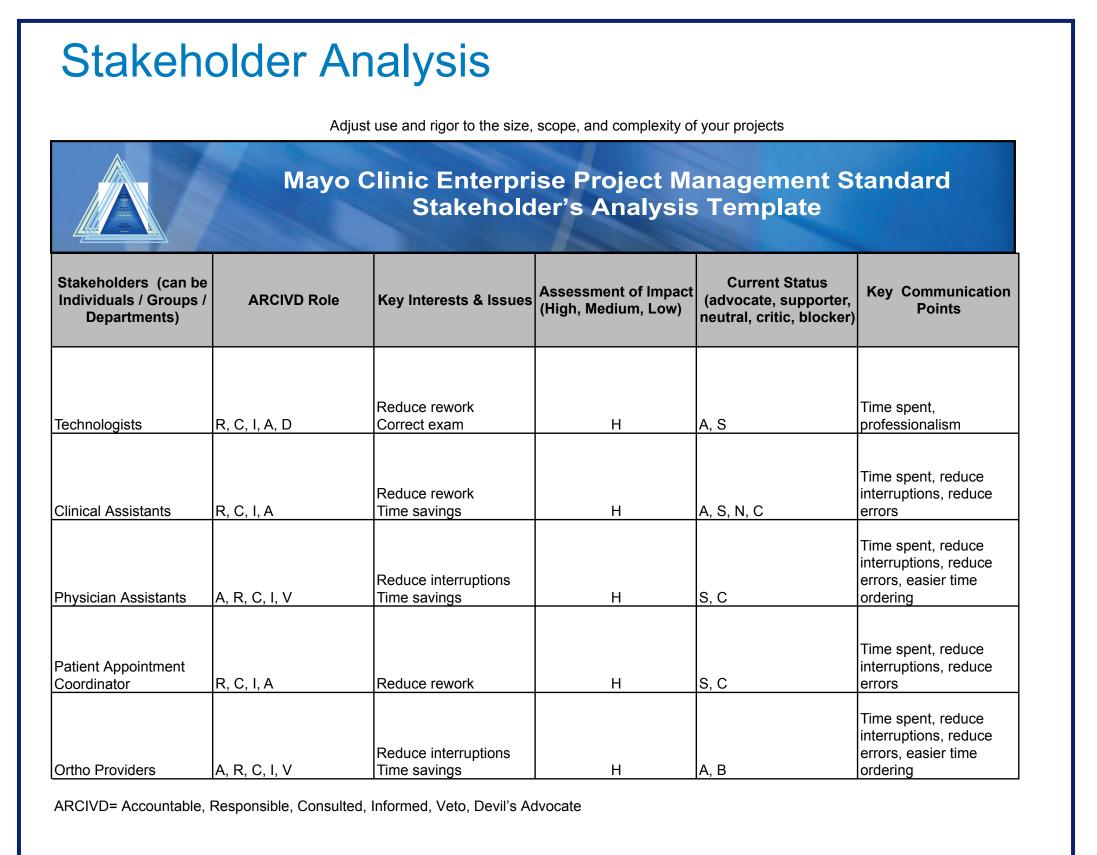
Purpose

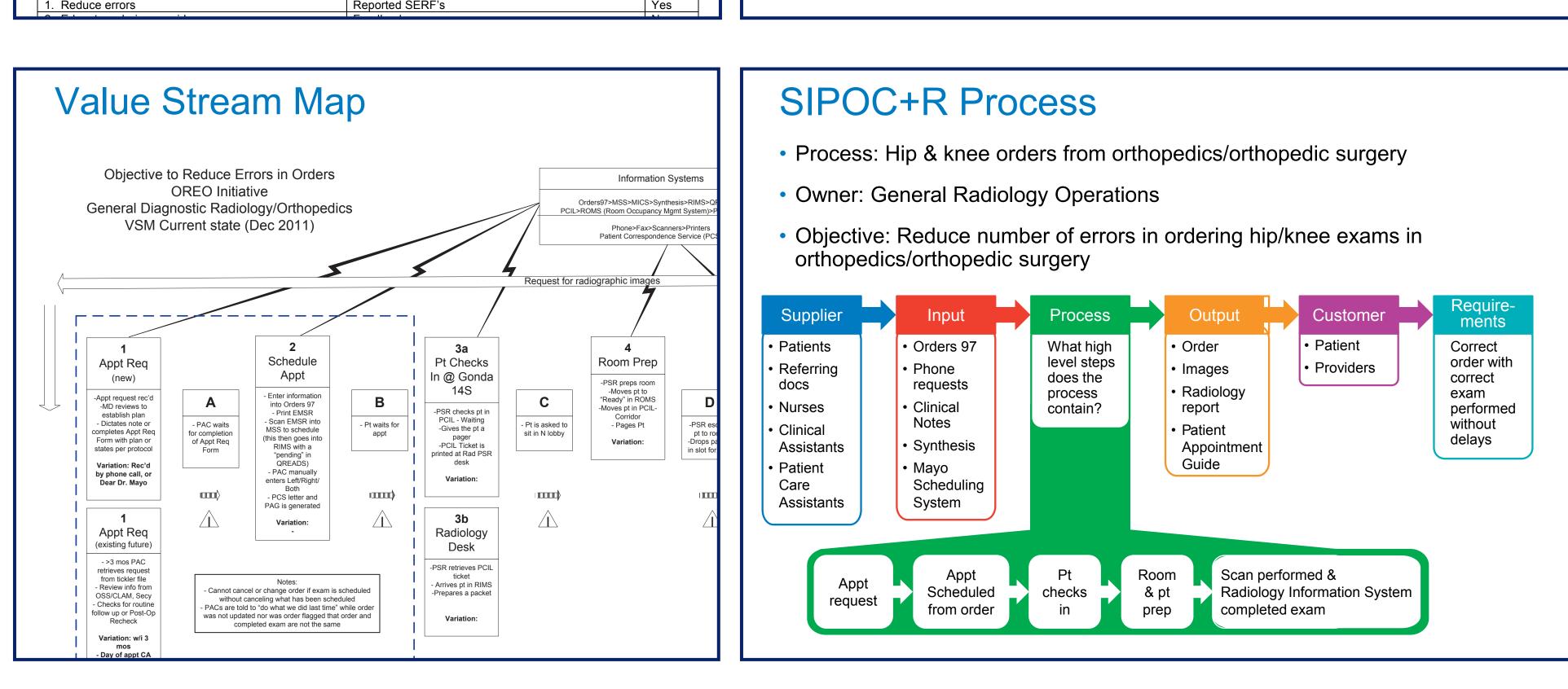
Performing the correct examination is a fundamental goal in good patient care. Our internal voluntary Safety Event Reporting Form (SERF) indicated an opportunity for improvement in accurate ordering of radiographic exams.

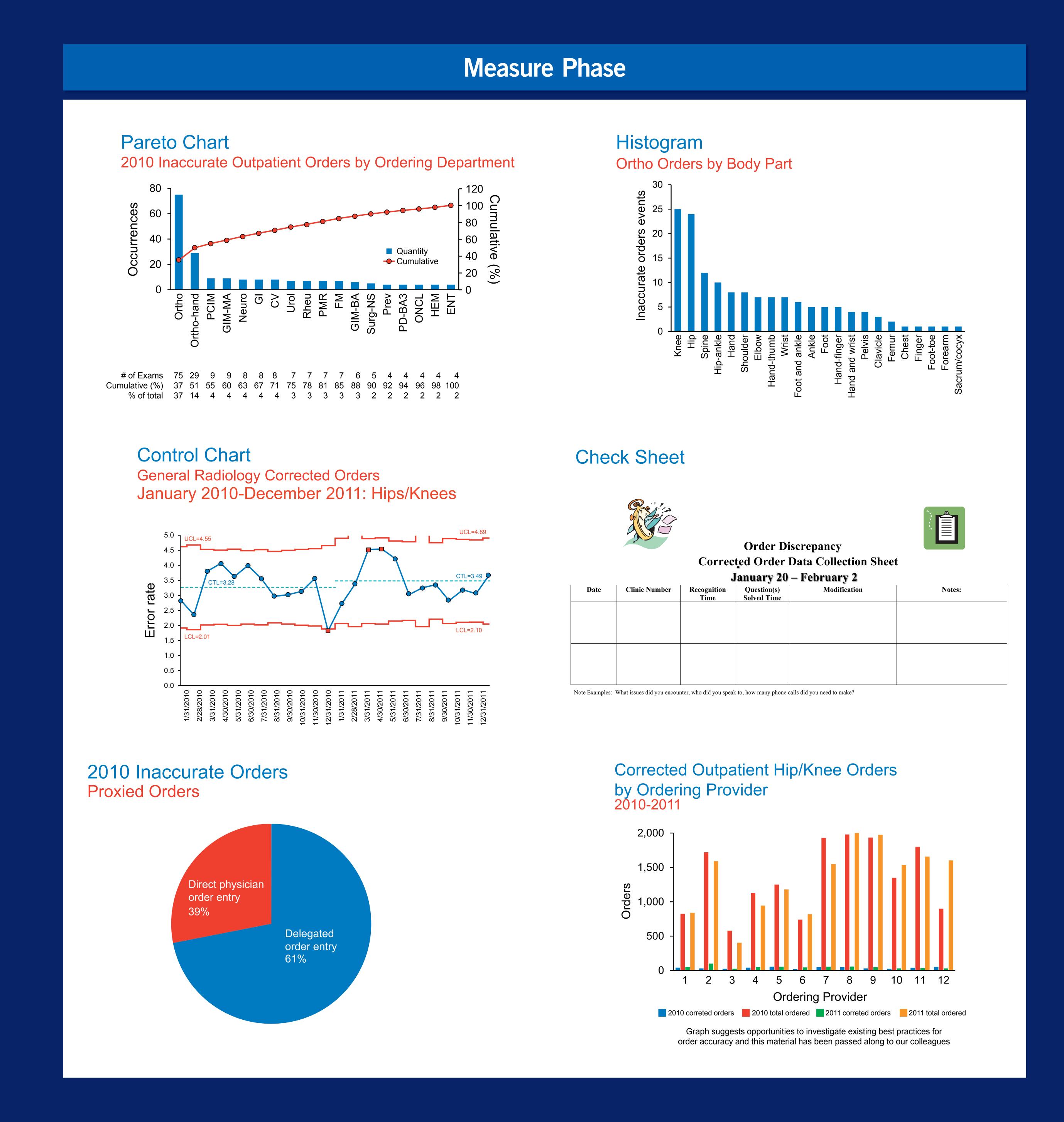
We sought to understand the nature and severity of this problem, assess opportunities for change, and implement change where appropriate.

Define Phase (partial snapshots)









Technologist Time

- Corrected exams 2010 2011
- 1,948 corrected cases
- 5 avg minutes to investigate and correct discrepancy
- \$0.67 avg tech compensation per minute
- \$3,250 assuring correct exam per year

2010 Sigma Level

- 37,888 Ortho exams ordered
- 264 corrected orders
- 10 actual wrong radiographs (4.8 sigma)

Conclusion & Lessons Learned

- 1. Stable order error rate of 3.5%
- 2. Radiology work flow "time out" process reduces actual rate to 0.04%
- 3. Cost of in-process error correction is low at a mean \$3,250 per year
- 4. Providers with a high volume of orders appear to have better accuracy

Future Opportunities

- 1. Delegated ordering appears to increase order errors
- 2. Ordering providers statistics suggest opportunity to find "best practice"