2023 Quality Improvement Data – Order Entry Errors

January

February

March

1st Quarter (January – March) average # of errors per month = 14 errors

April

May

# of Order Entry Errors has risen over the past month – Began email reminders to slow down when placing orders and also when receiving orders.

5/1 Email discussion Dr. name similarity ex. Suri vs Siva – MUST check first and last name for Dr.’s

Email regarding DAT testing MUST be ordered from the OE Keypad – do NOT key in test codes

Discussion topic on Support Services 2nd Quarter Check ins with Leads

June

2nd Quarter (April – June) average # of errors per month = 15 errors

July

August

September

3rd Quarter (July – September) average # of errors per month = 15 errors

Discussion topics on Support Services 3rd Quarter Check ins with Leads – LIS Order Entry policy, OE & Receiving Training, CBC without Diff examples, PSA screening vs. Diagnostic diagnosis code examples, and DAT testing MUST be ordered from the OE Keypad – do NOT key in test codes

October

November

December

4th Quarter Average # of errors per month = 10 errors

# of Order Entry Errors has dropped over the past 2 months – Continue to implement order entry and receiving tips

Discussion topics on Support Services 4th Quarter Check ins with Leads – Releasing orders correctly to allow for correct Dr to be requesting Dr., PSA screening vs. Diagnostic diagnosis code examples

Going forward from here…

Please use the OE and Receiving tips that you were trained on to help eliminate unnecessary Order Entry errors.

Order Entry – **MUSTs**

1. Review REGISTRATION LABEL and ORDER **match** for: Patient Last and First name

Patient DOB

Drs. Last and First Name

Ward

1. Order all tests and double check none missed

**Tricks:**

Count # of tests total

Circle tests and then check mark once ordered

Highlight tests (YELLOW only acceptable) and then check mark once ordered

Receiving – **MUSTs**

1. Review REGISTRATION LABEL and ORDER **match** for: Patient Last and First name

Patient DOB

Drs. Last and First Name

Ward

Additional items to consider: Courier specimens – **Date of Service MUST be date specimen collected**

Time it takes to FIX error – at least 1 hr (calls, conversations, LIS, etc.)

Time it takes to be on a REPORT – at least 1 week (so usually specimens thrown away)

Please continue to document Specimens / Orders w Issues and Lab Occurrences when necessary. These are not intended to be punitive but rather to educate staff.

In 2024 we have broken the Order Entry, Labeling/Processing, and Specimen Rejection errors in to some categories.

Megan has added the following categories:

Order Entry Specimen Rejection Labeling/Processing

Missed test QNS Unlabeled

Wrong test Hemolyzed Incorrect Label

Wrong Dr Clotted

Wrong Ward Wrong supplies given

Wrong Date of Service Wrong tube drawn

I will be working with the Lead phlebotomists to help me input the information in to the spreadsheet and evaluate the errors in a more real time view. We will be using this information to obtain a better picture of where we are falling short or where we need to train and educate staff.

Michele