2024 Quality Improvement Data – Order Entry Errors

October 2024

**Total # of errors = 11**

We continued this month to show an upward trend in the number of OE errors but several factors; Health fair workload high, staff busy and not documenting errors, 2 new staff members working on their own, staffing strains due to coverage issues, etc. continue to contribute to the increase. Education with NEW staff are happening in real time when possible. Will continue to monitor and encourage staff to completed Lab Occurrences and Specimens with Issues log sheets.

See above the corresponding categories:

**Ordering Error – outlier – incorrect comment attached to a test by not placing the comment in the Internal Notes section**

**Wrong Test – 1 error was a continuation of the Vitamin D25 ordered as Vitamin D1,25. 2 of the errors involved PTH instead of PT/INR. “PT” and “INR” both added as synonyms by LIS for “Prothrombin Time”**

**Wrong Doctor – Be careful when placing orders on hold in Allscripts that you do Not order as “Myself” Must pick a Doctor. Also make sure that you are changing the “Requesting Dr.” to the doctor that has written the order.**

**Wrong Billing Number – Be careful to Not use X billing numbers.**

**Missed Test – 2 – Be careful when releasing results from Allscripts and also when reading a paper order. If you opt not to release some tests, make sure to document in the LIS.**

*Please continue to document OE errors even when the errors are found at receiving to evaluate our progress (remember – these are NONE punitive – we are NOT tracking to “get co-workers in trouble”).*

Megan Billerman and I will evaluate our Lab Occurrence form, etc. at the end of the year for ease of documentation, etc.