**Accuracy of scanning the entire request information onto the Radiology information system (RIS) [QSI Ref: XR-501]**

**Descriptor:**

Audit to assess errors in scanning request documentation onto the Radiology Information System.

**Background:**

The requirement to manually scan investigation request documentation onto the Radiology Information System (RIS) is a source of human error. Instances of wrong patients’ request documentation being scanned have been reported and scanned documentation may have missing, obscured clinical or patient information. This hampers the reporting radiologists’ productivity and may potentially result in adverse clinical incidents. The aim of this audit was to look at the frequency of these and other errors to determine whether current practice is robust or whether changes are necessary to ensure patient safety and facilitate smooth departmental running.

## The Cycle

**The standard:**

All appropriate documentation should be scanned onto the system for the correct patient - this may necessitate more than one sheet of paper / card and possibly two sides depending on the type of documentation used

**Target:**

100% of scanned request documentation should meet the designated criteria.

## Assess local practice

**Indicators:**

Percentage of scanned documentation on the RIS meeting the criteria.

**Data items to be collected:**

For each set of request documentation, check:

• Whether the documentation is for the correct patient

• Whether all sheets that may include front and back depending on the documentation type used have been scanned in

• Whether any part of the documentation is missing or obscured due to technical problems

• Whether additional, unnecessary documentation has been scanned onto RIS

• Whether documentation has been scanned in the correct order

**Suggested number:**

The request documentation for all patients undergoing radiographic, CT, MR or ultrasound examinations on two separate days. Alternatively concentrate on an area which receives a lot of paper requests eg from GPs if they do not yet have electronic access.

**Suggestions for change if target not met:**

- Moving to electronic requesting would eliminate this issue but until this is achieved:

   • Raise the matter in meetings with staff involved in the scanning of request documentation

   • Use posters to raise awareness of the required standards for request documentation scanning

   • Offer further training in scanning technique where appropriate.

- Identify date for re-audit (2-3 months)

**Resources:**

- Departmental computer with RIS

- Any radiological or clerical staff member with access to RIS

- Approximately 3 hours per 200 sets of requests documentation scrutinised

- Number of auditors dependent on departmental throughput

**Editor's comments:**

As departments move to a more paperless working practice, the RIS can be used to store documentation such as completed LMP forms, MRI safety questionnaires and consent forms. Local policy will dictate the details of this, but the completeness and accuracy of the scanning of agreed additional documentation can be added into this audit to expand its scope.

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