Half Of Radiology Dept. Employees Don’t Report All Safety Concerns

Radiology department employees are expected to report safety concerns, ensuring that their patients are cared for in the safest environment possible. However, according to a new study published in Radiology, employees don’t always report such issues.

The article publishers surveyed more than 600 employees of a tertiary care institution’s radiology department, receiving more than 350 completed surveys. The participants were asked to describe their own reporting habits and various human factors that keep them from reporting all safety concerns.

Half of all respondents said they always speak up about safety concerns, meaning the other half do not report safety concerns 100% of the time.

In addition, 37% said they speak up “most of the time,” 10% said they speak up “sometimes” and two percent said they “rarely” speak up. 1% of respondents never speak up about such issues. So why don’t employees speak up 100% of the time? Looking specifically at answers of respondents who said they do not always speak up, more than 69% identified a high reporting threshold as a barrier.

“This was the most common reason among attending staff and nursing, administration, and transport personnel and refers to staff members not reporting an event unless they are absolutely sure that they were correct, realizing only after the fact that they should have said something, or staff members not being sure to whom to report,” said Bettina Siewert, MD, with the department of radiology at Beth Israel Deaconess Medical Center in Boston, and colleagues.

“Voicing a concern about an uncertain observation may be especially difficult in medicine because of an unspoken societal expectation that the physician or principal health care provider is all-knowing in his or her work area.”

More than 67% of respondents who do not always speak up identified the presence of an authority figure as a human factor that keeps employees from reporting safety concerns, making it the second most common answer.

“Hierarchy within the health care team is traditionally established on the basis of level of training and clinical expertise to help guide team members in providing appropriate patient care,” the authors stated. “In an ideal scenario, authority gradients in medicine are used to minimize medical error. However, authority gradients can compromise patient care when they undermine the willingness of team members to speak up about safety concerns and thereby become a barrier to achieving 100% safety reporting.”

Respondents identified other human factors as well that act as barriers to reporting safety concerns, including a fear of disrespect, a lack of listening and fear of retribution.

Are You Dense?

Coding and Compliance Tips by Lori Shore, CPC, RCC

34 states now require some sort of reporting on a woman’s breast density. In fact, breast density now has BI-RAD categories:

A — Fatty
B — Scattered fibroglandular tissue
C — Heterogeneously dense
D — Extremely dense

About 10% of women fall into both BI-RAD categories A and D. 40% of women fall into both categories B and C. This means that 50% of women are considered to have “dense breasts”, having BI-RAD categories C or D. Why is this important? Dense breasts can make breast cancer much more difficult to detect. Women with very dense breasts are 4 to 6 times more likely to develop breast cancer. Studies show that dense breast tissue was found to increase the risk of breast cancer more than other risk factors, such as family history, or late childbearing.

The Breast Density and Mammography Reporting Act of 2017 was introduced to both houses of Congress. The Act seeks to have mammography reports include information regarding breast density and the impact of breast density on the detection of breast cancer. To learn more about this subject please visit www.densebreast-info.org or areyoudense.org.
Structured report templates, while not new to radiology, have been growing in popularity in recent years. These templates provide a standardized format and layout—differing based on exam type—that guide the radiologist through the read and generate clear, consistent reports for referring providers. Some organizations are now taking structured reports even further, developing disease-specific reporting templates. These templates enhance the quality benefits of structured reports by reminding radiologists what aspects of the image they need to examine for the suspected condition and providing a straightforward, consistent organization of findings that match directly to the reason for exam.

While structured reports are not without detractors, as some radiologists feel that the structure limits personal preferences during the read-and-report process, we here at the Imaging Performance Partnership feel that structured reports—and disease-specific templates in particular—are an effective way to improve quality in radiology.

**The benefits of a disease-specific template**

To assess the efficacy of disease-specific templates, a [new study](http://example.com) in the *Journal of the American College of Radiology* examined the quality impact of switching from a general structured report for chest CT to a disease-specific template for CT angiography for suspected pulmonary embolism. Specifically, researchers measured the percentage of complete reports—reports that included all desired information on the suspected pulmonary embolism—before and after implementing the disease-specific reporting template. According to the study, switching to the disease-specific template increased the report-completeness rate from 69.4% to 94.4%.

The study authors attributed this huge jump in report quality in part to how the disease-specific templates were created and implemented. In designing the templates, the researchers created a picklist for each subsection of the read—an approach that standardized language in the report, reducing the amount of free text radiologists needed to enter. And to ensure usage of the new template, the researchers made it automatically load when a radiologist pulled up a CT angiography for suspected pulmonary embolism.

Creating these new report templates with standardized language not only ensured radiologists covered every necessary subsection, but it also provided a new data source for the researchers. After looking closely at the data, researchers found that there were a larger-than-expected number of cases being described as "indeterminate" due to image quality. In response, the researchers created a standard document describing how to properly perform a CT for suspected pulmonary embolism and distributed the document among technologists for additional training. According to the researchers, data collected for three months after these new trainings demonstrated a significant drop in "indeterminate" exams.

Ultimately, these disease-specific structured reporting templates improved both radiologist and technologist quality. In today's competitive imaging landscape, such quality gains can provide a leg-up for programs willing to adopt more advanced structured-reporting templates, both disease-specific and otherwise.

**How to incorporate structured-reporting templates at your organization**

Interested in implementing these disease-specific templates or more general structured-reporting templates? Here are some key steps you can take to ensure radiologists utilize these new tools:

1. Include radiologists in the development process;
2. Leverage existing reporting templates that radiologists already use;
3. Utilize technology or artificial intelligence software to improve the accessibility and utility of reporting templates;
4. Conduct an initial rollout of templates with a subset of radiologists.
5. Track adherence across radiologists and subspecialties; and
6. Increase utilization via scorecards and tie utilization of templates to radiologist bonus compensation. [Read more here](http://example.com)