Penus C, 2026, Reducing Referral Errors Through Training. International Journal of Integrated Care 26(S2):510 DOI: doi.org/10.5334/ijic.ICIC26510

POSTER ABSTRACT

Reducing Referral Errors Through Training

International Conference on Integrated Care (ICIC26), Birmingham, 13-15 April 2026

Cris Anthony Penus[1]

1: National Orthopaedic Hospital Cappagh, Ireland

Background:Radiology referral errors pose significant risks to patient safety and service efficiency. In April 2023, an audit at the National Orthopaedic Hospital Cappagh revealed urgent need to evaluate referral practices and implement targeted interventions.

Approach: A quantitative audit tool was developed to capture and categorise referral errors under three primary types: Incorrect Procedure/Body Part, Incorrect or Insufficient Clinical Information, and Incorrect Side. Referrals were anonymized using a coding system (A-Z) and reviewed by radiographers using a standardized hard-copy template. Error frequency and patterns were analysed, particularly focusing on the contribution by different referrer groups.

Results: There was a substantial reduction in overall referral errors from April 2023 to August 2024, showing that previous 9.4% referral error was reduced to 1% error. The most significant decrease was seen in 'Incorrect Procedure' errors, which had been the most common issue initially. By 2024, 'Incorrect Side' errors were almost eliminated.

These improvements coincided directly with the rollout of medical intern training and dissemination of referral guidelines booklet, indicating the effectiveness of these interventions which encourage medical interns ordering correct protocols for radiology examinations. Impact on patients, staff or service workflow. The reduction in referral errors led to enhanced patient safety, minimized unnecessary imaging, and improved clinical workflows. Radiology staff reported smoother processing of referrals, and patients experienced shorter waiting times. Furthermore, the initiative fostered a culture of accountability and learning among junior doctors, ultimately contributing to improved service quality.

Implications: Audit results highlighted that medical interns were the most frequent contributors to referral errors. As a result, a structured training initiative was launched, mandating dedicated radiology referral training for all incoming interns which was approved by the Radiation Safety Committee of the hospital. Additionally, a referral guidelines booklet, aligned with the Royal College of Radiologists' iRefer standards, was developed and electronically distributed to each new cohort. These interventions aimed to promote adherence to proper referral protocols from the outset of clinical duties. Measurement Referral error rates were measured during the initial

audit in April 2023 and then compared to August 2024. Tables tracking the frequency and type of referral errors across these periods were used to evaluate changes. Quantitative metrics were supported by categorical analysis of error types to assess the impact of targeted training.