FACTSHEET

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Best Practice in Managing Test Results

Doctors have to order tests of various sorts (e.g. x-rays, scans, bloods, swabs, urine samples, etc.) on a daily basis.

This factsheet assumes that, where appropriate there is safe and secure transport of these tests to a hospital/laboratory.

Ideally each clinic / practice should have a robust protocol to ensure the following:

1. The correct test is ordered and carried out;
2. These tests get to the correct laboratory;
3. Results are received in a timely manner and followed up within a specified timeframe;
4. Investigations performed and their results are recorded in correct patient's file;
5. There is appropriate follow-up of tests results, particularly that there is a doctor in charge of test results where there may be handovers or a doctor going off duty;
6. Tests are repeated when necessary.

These steps may involve different members of staff, but the overall responsibility for carrying out these steps lies with the ordering clinician. A rigorous system should be in place to minimise errors and potential harm to the patient. The staff involved in these steps should receive adequate training and be aware of their roles and responsibilities.

It is also helpful for clinics / practices to educate patients on the importance of the patient also following up their test results, however as above, it is the responsibility of the ordering clinician to ensure results are followed up and acted upon when necessary.

Step 1: The correct test & correct patient

The doctor must be clear on what investigations are needed – itemise each individual test, e.g. FBC, CRP, LFTs etc. This should be documented clearly in the patient's file (i.e. not documented as "routine bloods" ordered) to ensure that the person undertaking the test has clear explicit instructions as to the test required.

If the doctor has serious concerns about the expected test results, they should consider scheduling an appointment with the patient before they leave. The clinic / practice should have a good system to follow up on patients who do not attend scheduled appointments and schedule immediately if there is a cancellation.

Doctors may wish to consider providing the patient with a list of the samples that they have had taken using a pre-printed sheet. Use the patient as a safety net - inform them how to obtain results of their tests, e.g. to call the clinic / practice, to make another appointment etc. Doctors should never rely on a policy of 'No news is good news', and should ensure every patient receives their results according to the clinician's individual arrangements.

Ideally a log of all tests sent from the clinic / practice should be recorded each day. Most software systems will facilitate accurate recording of this, however a paper based or spreadsheet record will suffice. This will enable the clinic / practice to review the logging of patient samples sent to the laboratory to ensure that all results are returned.

Step 2: Tests arrive to correct lab / hospital

The clinic / practice may have a HSE courier or engage a local courier compliant with regulations regarding specimen transportation. Consider having confidentiality agreements in place with courier companies.

Step 3: Results are received in a timely manner

Currently most hospitals communicate results to clinics / practices via "HealthLink". This is a very efficient and timely process. Other hospitals may still send results by post but usually call the clinic / practice if there is a critically abnormal result. The clinic / practice should have a robust process in place for dealing with any emergency test results communicated by the laboratory, including out of hours.

Where the patient is in the hospital the doctor in charge should ensure that results are received, acted upon and communicated to the patient as appropriate.

Step 4: Tests are recorded in correct patient files

All results received should be entered into the correct patient file. Close attention should be paid to any abnormal results, and action taken or planned as appropriate.

Step 5: Appropriate follow-up of test

Ideally results should be reviewed by the clinician who has ordered the test. If he/she is absent from the clinic / practice then a 'buddy 'system should be in place so that no results are missed when staff are absent from the clinic / practice, e.g., when a clinician is not available, another doctor checks the results, thus making sure no urgent abnormal results are overlooked, or the necessary immediate response delayed. This is particularly relevant in a hospital setting also, when one doctor might go off duty and be replaced by another. An appropriate handover should always be performed, including communication of the fact that tests were ordered and results are awaited.

There should be a protocol in place to follow up all abnormal tests. This will assume the clinic / practice has relayed to the patient in advance how they will contact them – phone, email, letter or follow up visit.

There equally needs to be a protocol in place to ensure that tests that do not arrive in a timely manner are noted and followed up.

It may help to have a dedicated phone-in time for patients to call for their results. The clinic / practice needs to decide who can provide test results if a patient telephones, e.g. a nurse or doctor.

Significant results should always be conveyed by the doctor. Consider developing a traffic light system:

- Green results are those that can be conveyed by the adminsitrator, nurse or doctor
- Amber results are those that can be conveyed by either the nurse or doctor
- Red results are those that can be conveyed by the doctor only.

Any communication about test results should only be transmitted to the patient and not to relatives or others without the patient's consent.

HSE Guidance on Communication of Critical Test Results

The HSE publication "Communication of Critical Results for Patients in the Community" was published in October 2019 which provides key recommendations for clinicians as follows:

- Clinicians are responsible for developing a system whereby test results returned from medical testing laboratories are examined and appropriate action taken in a timely manner.
- It is recognised that occasionally, unexpected critically abnormal results are found on analysis, such that laboratory staff become aware of a potential emergency before the treating clinician. In these circumstances, laboratory staff should follow this guidance to contact the requesting clinician to relay the result.
- Clinicians should have a system in place whereby appropriately trained staff receive results, and communicate same within the timeframe indicated. As most labs operate a normal service at least between 8am and 8pm (and often later), with community tests which arrive late in the day frequently analysed between the time of arrival and midnight, such systems should be operational at all times. Clinicians should update this contact information with their local laboratories in the event of any changes.
- Information provided to the laboratory must be accurate, including patient demographics, contact details and date and time of phlebotomy. Ex vivo changes may cause spurious critical results, and incorrect specimen information may result in action which causes unnecessary stress and inconvenience to patients.

Step 6: Repeat testing

A system should be put in place that alerts the clinician regarding repeating a test at the appropriate time where that is clinically indicated.

Failure to follow up test results

Unfortunately even where clinic and practices have good protocols in place, abnormal results get “missed” and patients can suffer harm as a result. For example, marginally elevated PSA level may ultimately be of no significance, but nevertheless must be followed up according to national protocols to avoid missing a significant prostate cancer.

While clinics / practices should have a robust and effective result management system and all staff should be fully trained in the procedure, it should be recognised that no system is ever fool proof. If an adverse event or ‘near-miss’ does occur, the protocol should be reviewed and lessons learnt to prevent a repeat occurrence.

Medisec strongly advocates for open disclosure of any adverse incidents. The patient should be informed as soon as possible and the doctor should offer to meet with them and answer any questions they may have. Please see our factsheet on Open Disclosure available on our website, for further information.

The advisory team at Medisec is happy to assist you if you have any specific queries regarding the above.

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