FACTSHEET

MEDISEC

We look after you

Safer Management of Test Results

GPs order laboratory tests on a daily basis, for the purpose of diagnosing, monitoring, and screening patients, e.g., bloods, swabs, urine samples, smears tests, etc.

There are many steps in the process of managing test results such as tracking and reconciling tests ordered, reviewing results, and communicating findings to the patient, with numerous staff members being involved. Owing to the complexity of managing test results, there is great potential for human and system error throughout the whole process.

Failure to follow up on results may contribute to poor clinical outcomes for patients, avoidable patient harm, patient complaints, and potential medico legal difficulties for clinicians.

The Medical Council's Guide to Professional Conducts and Ethics, 9th edition, 2024 has clearly outlined the professional responsibilities of a doctor concerning test results. Paragraph 33.8 states:

"When discharging care to the patient's GP, the doctor who orders diagnostic tests or investigations must follow up on the results to ensure these investigations have taken place, results are followed up and appropriate action taken, including communication to the GP."

It is, therefore, essential that practices develop a robust system to ensure the safer management of results.

Systems and protocol

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

1. The correct test is ordered for the correct patient and carried out.
2. These tests get to the correct laboratory, within the appropriate timeframe.
3. Results are received, and brought to the attention of the ordering clinician, in a timely manner and followed up, where appropriate, within a specified timeframe.
4. Investigations requested and their results are recorded in the correct patient's file and communicated to the patient.
5. There is an appropriate system in place following up of test results and a system for receiving out-of-hours urgent results in accordance with the HSE guidance for communicating critical results[1].
6. Tests are repeated when necessary.

These steps may involve different members of staff, but it is important to remember that the overall clinical governance of test results lies with the ordering clinician. A rigorous system should be in place to minimise the risk of errors and potential harm to the patient. The staff members involved in these steps should receive adequate training and be clearly aware of their individual roles and responsibilities.

It is also helpful for practices to communicate to patients the importance of their involvement in the test result process.

We recommend that GPs consult the HSE document: *Communication of Critical Results for Patients in the Community National Laboratory Handbook (2019*), available on the HSE website.

Step 1: The correct test and correct patient

The doctor should be clear on what investigations are required, and why they are needed, and 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, e.g., nurse, undertaking the test has clear instructions as to the exact test required. It is also important to record the reasons for the investigations.

If the doctor has serious concerns about the expected test results, they should consider scheduling an appointment with the patient before they leave. The practice should have a good system to follow up on patients who do not attend scheduled appointments for follow up.

As part of your safety-netting process, inform the patient how and when to obtain results of their tests, e.g., to call the practice, to make another appointment, etc.

Practices should never rely on a policy of '*no news is good news*'. The patient's records should reflect the advice given to the patient on how to follow up their results.

It is important to have a system in place to confirm that results of all investigations ordered are received. Some software systems can facilitate this by running a report to identify any outstanding results. It is important to remember that the doctor who orders the test assumes overall responsibility for reviewing and acting on the test result, even if they were asked by a third party (e.g., secondary care clinician), to order the test.

Step 2: Transport of samples to the correct lab / hospital

Practices need to ensure they are compliant with all the necessary guidelines concerning the packaging and transport of samples. Many practices may use a local HSE courier, compliant with these regulations. It is important to have a formal arrangement in place with any private courier companies used, ensuring compliance with current guidelines.

Step 3: Results are received in a timely manner

Currently, most laboratories communicate results via "HealthLink". This is a very efficient and timely process. Results should be downloaded from "HealthLink" regularly. The practice should consider delegating the task to a specified member of staff. This important step should be included on the practice protocol.

Some laboratories may still send results by post. These results should be directed to the referring clinician, in a timely manner.

If the laboratory telephones the practice with a critically abnormal result, these calls should be directed **immediately** to the referring clinician or their deputy.

Step 4: Clinical review of results and appropriate follow-up

Ideally test results should be reviewed by the clinician who ordered the investigation. If they are absent from the practice then a "'buddy system" should be in place to ensure no urgent abnormal results are overlooked, or the necessary immediate response/follow-up delayed. If a locum is employed for a single-handed GP or to provide long-term cover, it is important to ensure the locum is fully briefed in the practice's test result protocol.

The Medical Council's Ethical Guide states at paragraph 33.8:

"When discharging care to the patient's GP, the doctor who orders diagnostic tests or investigations must follow up on the results to ensure these investigations have taken place, results are followed up and

appropriate action taken, including communication to the GP."

It is important to remember that "normal results" may require an action as well as abnormal results.

It may help to have a dedicated telephone-in time for patients to call for their results. The patient's identity should be confirmed, if possible, using three identification markers, such as name, address, and date of birth before giving out a result. Patients should be encouraged to keep their contact details up-to-date; ideally, the doctor/nurse should check this prior to taking the test.

The practice needs to decide who can provide test results if a patient telephones the practice, e.g., a nurse or doctor.

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

Step 5: 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.

Adverse event

While the practice should have a robust and effective test result management system in place and all staff should be fully trained in the procedure, it should be recognised that no system is ever foolproof. If an adverse event or "near miss" incident 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.

January 2024