Failure to Perform/Communicate Critical Test Results

Sector: Family Health Teams

Critical test results (CTRs) are clinically significant diagnostic test results which if not addressed could result in significant patient harm. Factors associated with failure to follow-up in ambulatory settings such as Family Health Teams (FHTs) are complex and multi-faceted (e.g. systems, people, organizational factors, work practices). Missed or delayed diagnoses and treatment may expose organizations and their team members to professional liability and malpractice claims. As such, healthcare providers must ensure CTRs are relayed to the most responsible practitioner in a timely way. It is essential solutions are integrated into the work of ambulatory care delivery.

**COMMON CLAIM THEMES**

- Failures/mix-ups or delays in:
  - Ordering tests;
  - Conducting tests in a timely way;
  - Ensuring the patient has undergone testing;
  - Reviewing test results;
  - Pursuing results;
  - Informing the patient or most responsible practitioner and family physician of test results;
  - Acting upon abnormal test results.
- Non-standardized and inconsistent test reporting practices.
- Lack of or unclear standards or policies with respect to discrepant reports/interpretations of CTRs.
- Unclear accountabilities related to reporting abnormal results to the most responsible practitioner.
- Inadequate call back processes (relying on voicemail without direct/personal contact).
- Not having the mechanism to follow up on tests once patient is discharged.
- Consequences related to failure to communicate CTR include:
  - Misdiagnosis;
  - Missed cancer diagnosis;
  - Delayed treatment;
  - Inappropriate treatment;
  - Loss of trust in healthcare practitioner(s) and/or facility and/or healthcare system.

**CASE STUDY 1**

A patient was referred to and seen by a dermatologist for a skin lesion. Shortly thereafter, a positive biopsy report became available which necessitated a second referral by the family health team to the dermatologist for an abnormal result. The patient was informed of the need for the second referral and awaited the notification of the booking by the clinic. In the interim, there was a mix-up in scheduling by the clinic and the second referral appointment was never made. A diagnosis of melanoma was eventually made several months later.

**CASE STUDY 2**

A pathologist’s report confirming invasive high grade bladder carcinoma was not acted upon for several months following a cystoscopy and biopsy by a patient’s urologist. By the time this test result was acted upon, the cancer had advanced throughout the patient’s body and they died one year later. A review showed the biopsy report was neither reviewed nor followed up by the urologist. Healthcare organizational protocols/procedures that would have ensured the report was emailed or delivered in paper copy to the urologist were not followed. Review of the case indicated the urologist should have been alerted to the patient’s results and looked for the biopsy report sooner and the healthcare organization failed to email/send the pertinent reports.

**Canadian Case Examples**
REFERENCES

• HIROC claims files.


RISK REFERENCE SHEET

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MITIGATION STRATEGIES

Note: The Mitigation Strategies are general risk management strategies, not a mandatory checklist.

Reliable Care Processes

- Ensure orientation, education, policies and procedures & algorithms reflect reporting of CTRs expectations including:
  - A ‘read back’ practice to ensure accurate CTRs communication;
  - Document and record (date and time) CTRs received and by whom;
  - Document (date and time) verbal or electronic communication of CTRs to most responsible physician (MRP) and/or NP;
  - CTRs are not to be left on answering machines and/or voice mail messages.
- Ensure reporting of CTRs policies and procedures incorporate timeframes for follow-up and direct person-to-person communication with the following:
  - The MRP and/or NP (who can take action immediately not an intermediary);
  - The ordering practitioner;
  - The primary care provider;
  - The patient.
- Ensure the laboratory and diagnostic imaging services have up-to-date contact information for all healthcare practitioners.
- Ensure patient handoffs and transitions include a review of pending CTRs.
- Work with the lab to establish protocols to address instances when lab cannot reach the physician with CTR. (e.g. When not able to reach physician, call patient and communicate results).
- Ensure reporting of CTRs policies and procedures align with acute care, primary care, and local/regional laboratory services.
- Adopt a carefully defined list of critical, unexpected or significantly abnormal CTRs which require timely and reliable verbal communication. This list should be reviewed annually and be accessible to all staff.

Patient and Family-Centred Care

- Develop strategies to engage patient and families as partners in the communication of the CTRs process; as well ensure the patient understands the call back notification process.
- Educate patients and families to follow-up with practitioners when diagnostic test have not been reported.

Documentation

- Ensure complete, consistent and timely documentation (including date/time/practitioner):
  - Whenever blood is drawn;
  - Upon delivery and receipt of TDM levels;
  - When communicating results to the most responsible practitioner;
  - Of education/training provided to patients/clients (e.g. the need for strict adherence/compliance with administration/testing/monitoring schedule, possibility of repeat testing, signs/symptoms of toxicology, the need to report changes or disturbing symptoms immediately to the most responsible practitioner.

Monitoring and Measurement

- Implement formal strategies to help ensure consistent adherence to CTRs policies/practices (i.e. periodic chart/e-record audits, analysis of reported incidents/event and learning from medico-legal matters).
- Participate in quality of care reviews with healthcare system stakeholders involving occurrences when there has been a delay and/or failure to communicate CTRs.