RISK REFERENCE SHEET

HIROC

Failure to Communicate and/or Respond to Critical Test Results

Critical test results (CTRs) are abnormal values that arise from diagnostic tests and studies which represent possible life-threatening situations. The ensuing consequences of missed or delayed diagnoses and treatments expose healthcare organizations and their team members to professional liability and malpractice claims. Communication errors are frequently cited causes of such adverse outcomes, and contribute to consequences such as misdiagnosis and delayed and inappropriate treatment.

COMMON CLAIM THEMES

System

- Cumbersome and/or ineffective discrepant critical test results protocols and practice.
- Lack of or unclear standards or policies with respect to discrepant and CTRs:
  - Non-standardized and inconsistent management discrepant and CTR practices across units, programs and sites;
  - At transport points.
- Unclear accountabilities and/or inadequate processes related to the:
  - Review and communication of abnormal or critical results to the most responsible practitioner;
  - Follow up on outstanding, delayed and missing test results (e.g., Most Responsible Practitioner (MRP) not following up on biopsy results as assumed the hospital or patient would call if results not received);
  - Follow up on test results ordered, including (but not limited to) results received post-discharge and/or in the non-hospital setting;
  - Patient call-back (e.g., who is to call the patient and under what circumstances; actions to be taken when patient is not responding).
- Failures, mix-ups and delays in:
  - Ordering tests;
  - Conducting tests in a timely way;
  - Ensuring the patient has undergone testing;
  - Pursuing results;
  - Reviewing test results;
  - Acting upon abnormal test results;
  - Informing the patient and/or the most responsible practitioner and family physician of test results.

Knowledge and Judgement

- Lack of team and practitioner awareness and/or lack of compliance with local or regional discrepant and CT protocol and policies (including but not limited to):
  - Discrepant and CTR results communicated to unregulated staff and unit clerks versus the ordering practitioner or designate;
  - MRPs not following up on ordered tests.
- Results sent to the wrong practitioner due to look-alike and sound-alike names.

Communication and documentation

- Disagreement between ordering practitioners and laboratories, nurses and clerks as to when and whether the communication of the CTR took place.
- Inconsistent documentation:
  - Documentation or records to demonstrate that the CTR was communicated to the ordering practitioner and/or patient (e.g., audit trail).

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MITIGATION STRATEGIES

Critical Tests and Values

- Adopt a standardized evidence-based CTR and 'discrepant test' (i.e., discrepancies in test interpretations) protocol/process/algorithm that includes (but is not limited to):
  - Clear definitions of key terms (e.g., what is deemed 'critical' versus 'significantly abnormal');
  - A carefully defined, limited list of critical tests and values which require timely and reliable verbal communication directly to the ordering practitioner and/or their on call substitute;
  - Who should receive the results;
  - Who should receive the results when the ordering practitioner is not available;
  - A standardized escalation process with clearly defined steps for CTR communication and time thresholds for next steps if the appropriate professional cannot be reached;
  - Communication and management of CTR in ambulatory and community clinics, after patient discharge, after-hours, weekends and holidays;
  - A chain of responsibility and explicit time frames for communication of CTRs for all patients in all care settings overseen by the healthcare organization;
  - How the communication is to take place (e.g., laboratory and diagnostic imaging staff are to state the emergency nature or level of urgency of the call, provide the name of the patient and the test, and test results;
  - The need to communicate CTR and discrepant test results verbally in addition to electronic notifications.
- Ensure the list of critical test results requiring reporting directly to the MRP include the following:
  - Reports of malignant or possibly malignant tissue;
  - Significant variance between frozen section and final reports;
  - Amended reports based on special stains or testing;
  - New or substantively changed diagnoses by an outside consultant;
  - Recommendations for follow-up or repeat tests such as when test results do not correlate with the clinical presentation.

Reliable Communication Processes

- Adopt best practice to support and enhance the effectiveness and reliability of the CTR protocol/process, including (but not limited to):
  - Establishing rules such as ensuring CTRs are not left on voice mail or with unregulated care providers or unit clerks;
  - Implementation of patient call back notification processes requires direct or personal contact with the patient (or substitute decision maker where indicated);
  - Handoff communications include a review of critical and pending test results;
  - Implementation of pre-discharge processes include a review and a formal plan for the follow-up and management of pending and outstanding test results.

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- Implement strategies to reinforce documentation of CTR and discrepant test result delivery and receipt including (but not limited to):
  - Upon delivery and receipt of CTRs;
  - When communicating with the ordering practitioner or designate.
- Implement strategies to ensure the internal, external and regional laboratory, diagnostic imaging, cardiology and radiology programs:
  - Have access to up-to-date most responsible practitioner contact information;
  - Are oriented to the organization's and/or program's CTR and discrepant test result protocol and process.
- Incorporate the local organization's and/or program's CTR and discrepant test result expectations into contracts and agreements with external or third party laboratory, diagnostic imaging, cardiology and radiology service providers.

Strategies for nurse practitioners, midwives, and physicians:

- Be familiar with the organization's CTR protocols and processes.
- Adopt formal follow-up practices for ordered tests that ensure outstanding and abnormal test results are received in a timely manner and acted upon as necessary, including pending test results post discharge or transfer to another practitioner, program or facility.

Patient and Family-Centred Care

- Implement strategies to engage patient and families as partners in the communication of the CTRs process.

Education

- Implement formal multifaceted strategies to support and enhance the ongoing timely and consistent management and communication of CTR and discrepant test results by programs and practitioners (e.g., interdisciplinary workshops, in-situ simulations, sharing of learnings and trends from periodic chart audits and extracts, analysis of reported incidents, and medical-legal matters).

Monitoring and Measuring

- Implement formal strategies to monitor and measure the effectiveness and efficiency of, and interdisciplinary adherence to CTR and discrepant test result protocol and process, including (but not limited to):
  - Adoption of formal process, outcome and balancing indicators surrounding CTR and discrepant test results (e.g., percent of CTRs meeting time targets; percentage of CTR with documented communication to and from the ordering practitioner);
  - Review of learnings from CTR and discrepant test result near miss and harm incidents (e.g., chart audits, trigger tools, incident reports, team debriefs, critical incident and quality of care and quality improvement committee reviews, medical legal claims).

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Date last reviewed: September 2020