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MLMIC Risk Management Tips

Tip #9: Reliably Communicating and Acting on Critical Test Results

The Risk: According to a study in the June 22, 2009 issue of Archives of Internal Medicine, 7%, or about 1 out of 14, clinically significant abnormal test results were not reported to the patient or documented as disclosed to the patient by their primary care physician. Abnormal test results requiring follow-up that are not reviewed or communicated to the patient can result in missed/delayed diagnoses, patient injuries, and subsequent malpractice claims. If a physician ordered a test, he or she is responsible to act upon the results of that test. Both the physician's office and the hospital must have appropriate policies and procedures in place to confirm that test results are reviewed, communicated, and acted upon.

Recommendations:

1. Tests which are ordered must always be documented in the patient's medical record. In the office setting, a stamp or check-off sheet may be used to document orders for routine or recurrent laboratory and other tests, such as PSAs, mammograms, INRs, etc.
2. A log book must be maintained to confirm and document receipt of the test results, including: the date, the patient's name, and the test ordered. The staff must review the log at least weekly, and highlight and date receipt of those results. If the office practice has an electronic health record system, a number of software programs are available that can track the status of diagnostic and laboratory test results. A plan for follow-up of outstanding results must be developed and made part of the office's procedures.
3. The physician must date and initial all incoming laboratory reports and diagnostic tests to confirm review of the results.
4. The physician must also document communication of the test results to the patient or referring physician in the medical record. The note must state that the patient and/or the physician have been advised of the results. The recommended action(s) to be taken, if appropriate, must also be documented. The results of tests and actions to be taken must also be discussed during subsequent visits and those discussions documented in the patient's medical record.

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5. Laboratory or other diagnostic tests ordered for a hospital in-patient also require follow up, particularly when the results are received after the patient's discharge. A mechanism must be in place at the facility to communicate and confirm that the test results have been sent to the patient's primary care provider or other responsible provider, if the patient is no longer an in-patient. It is important for physicians to clearly establish who is responsible for follow-up, when tests are ordered for a patient by another specialist or consultant.
6. In the ED, there must be a system in place to confirm that test results are reviewed prior to the patient's discharge. It is very important to document that the results received after discharge, together with recommended action (e.g. to return to the ED) are communicated to the patient and their primary care or responsible provider. The individual who is responsible for communicating with the patient after discharge must be determined prior to discharge.
7. In the hospital, the progress notes must contain documentation that the laboratory or other test result has been reviewed and what action has been taken due to the result.
8. The American College of Radiology advises that a radiologist must communicate "non-routine findings" in a manner most likely to reach the attention of the treating or referring physician. This must be done in sufficient time to provide the most benefit to the patient. Communication by telephone or in person to the treating or referring physician or his/her representative is appropriate. However, receipt of the findings by the ordering physician must be documented in a log or in the EMR. Results may be communicated directly by the radiologist or, when judged appropriate, by the radiologist's designee.
9. The patient and family (when permitted by the patient) must be included as partners in care. By doing so, the patient is much less likely to forget that he/she is awaiting a test result. Patients must be advised not to assume that no communication means a normal test result. There should be a fail-safe mechanism for patients to obtain all test results.
10. Policies and procedures, as well as patient records, must be retrospectively reviewed on a regular basis to confirm that patients are being informed of test results and that this type of communication is being documented. An ongoing system for such retrospective review should be developed and corrective action implemented to further reduce errors in the future.