ASHRM PATIENT SAFETY TIP SHEET

Laboratory and Diagnostic Test Result Communication

AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

SITUATION: Laboratory and diagnostic test result communication has a high potential for patient harm when the reporting process is not well established. In particular, when critical or abnormal test results are not communicated in a timely manner across the care continuum, it can cause delayed or missed treatments and/or diagnoses with serious and sometimes life-threatening consequences. A standardized workflow that utilizes an interoperable electronic health record and testing site interface provides the basis for an effective test result communication process.

BACKGROUND: In 2003, The Joint Commission implemented National Patient Safety Goals to improve the effectiveness of communication among caregivers. In 2005, the timely reporting of critical tests and diagnostic procedures became a goal (NPSG.02.03.01). Effective practices for the timely and accurate reporting of laboratory testing are also required by the Clinical Laboratory Improvement Amendments (CLIA) regulations of 1988, are featured in the World Health Organization's World Alliance for Patient Safety of 2004, and are codified in the ISO's standards for medical laboratories (ISO 15189).

ASSESSMENT: Of 424 patient safety risk assessments performed by The Doctors Company, 14 percent showed problematic test tracking. Communication of test results to the patient was the most common finding. Passively waiting for results rather than actively reconciling outstanding reports for patient communication and revised plan of care and follow-up had the highest risk of and actual suboptimal patient outcomes and patient harm.

Automated healthcare technology including the EHR, patient portals and testing site applications among other interfaces meant to enhance communication have shown not to be the entire solution. Without the human factor consideration, the problem persists.

RECOMMENDATIONS

To reduce test result communication failures, organizations must analyze existing processes and commit to a change management endeavor. Self-assessment tools can help identify vulnerabilities in the communication process as well as actionable change management steps. Several are listed below.

For example, IHI's *National Action Plan to Advance Patient Safety* outlines the perspective of "total systems safety." The plan emphasizes anticipating risks and establishing safety processes across the entire care continuum. Utilizing this approach, laboratory and diagnostic test management can become a priority among many competing process improvement activities.

AHRQ » Improving Your Office Testing Process
https://www.ahrq.gov/sites/default/files/publications/files/officetesting-toolkit.pdf

HealthIT.gov » SAFER Guide for Test Results Reporting and Follow-Up
https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf

IHI » Safer Together: A National Action Plan to Advance Patient Safety
http://www.ihi.org/Engage/Initiatives/National-Steering-Committee-Patient-Safety/Pages/National-Action-Plan-to-Advance-Patient-Safety.aspx

The Doctors Company » Medical Office Assessments Uncover Hidden Liability Risks
https://www.thedoctors.com/the-doctors-advocate/third-quarter-2018/medical-office-assessments-uncover-hidden-liability-risks/