Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: Diagnostic Results Management Policy

Document Type:	**CLINICAL POLICY**

Keywords:	Tests; ordering; requesting; receiving; standards; process; communication; received; read; verifying; communicate; critical; urgent; unexpected

Version:	Published Date:	Review Date:
1.0	28th February 2018	December 2021 (ext3)

Supersedes:	Not Applicable – NEW		
Approved by (committee/group):	Diagnostics and Outpatients Divisional Governance Patient Safety & Quality Board	**Date Approved:**	18-01-2018 07-02-2018

Scope: (delete as applicable)	**Trustwide/ Corporate** (for the majority)

Evidence Base/ References:	• NPSA (Feb 2007) *Early identification of failure to act on radiological imaging reports*. Safer Practice Notice. National Patient Safety Agency • RCR (2012) *Standards for the communication of critical, urgent and unexpected significant radiological findings*. Second Edition. The Royal College of Radiologists. London. • Good practice agreed within the trust

Lead Division:	Diagnostics & Outpatients
Lead Specialty:	Divisional responsibility
Author:	Donna Staples; Clinical Governance Co-ordinator – D&O
Sponsor:	Shafiq Gill; Divisional Clinical Director

	Name the documents here or record not applicable
Associated Clinical Guideline(s)	Not Applicable
Associated Clinical Procedure(s)	Not Applicable
Associated Clinical Pathway(s)	Not Applicable
Associated Standard Operating Procedure(s)	• Individual Specialty SOPs as applicable
Other associated documents e.g. documentation/ forms	Not Applicable

Consultation Undertaken:	• All divisional governance groups

Template control:	v1.2 August 2017 (Appendix to Clinical Documents Procedure)

CONTENTS

1 Introduction / Background

This policy sets out Sherwood Forest Hospitals NHS Trust's (SFHT) intentions in relation to the minimum standards and procedures for the process of communicating the results of diagnostic tests.

The National Patient Safety Agency (NPSA) has highlighted a significant number of serious incidents where patients were harmed by delays in appropriate management due to clinical teams not having received or read the reports of diagnostic testing they had requested.

There is a wide range of screening and diagnostic tests performed each day at SFHT (see Page 6 Definitions) and we need to be assured that standards are in place to support the process of requesting, undertaking, verifying and for the purposes of this policy – communicating the results; both amongst the appropriate clinical colleagues and to the patients.

2 Aims / Objectives / Purpose

Diagnostic tests can be used to determine what conditions, diseases or syndromes a patient has or is likely to develop. These tests are integral to the management of patients and their associated conditions. Because of the variety of tests employed, the range of professional reviews and the subsequent actions that may occur, there is an absolute need for clear pathways that identify how, when and whom the tests should be communicated to and what action they should take upon receipt.

This policy aims to enable all staff to ensure that all diagnostic tests undertaken within the Trust are managed to minimise the risk to patients and improve the patient outcome and quality of care.

The purpose of this policy is to provide a framework for the Trust to ensure robust systems are in place for the communication of diagnostic testing. This includes ensuring that all specialties have in place a suitable Standard Operating Procedure (SOP) which outlines the process for the communication (both dissemination and receipt) of diagnostic results, in particular urgent or unexpected findings.

For the definitions of what diagnostic tests are covered within this policy please see Section 6.

Related Trust Documents:

- Policy for the Release of Histopathology Results
- Telephoned Pathology Results Policy
- Radiology UUUU New or Unsuspected Imaging
- Radiology XXXX Policy Critical and Urgent Findings
- Cardiology Echo XXXX Protocol

3 Roles and Responsibilities

The Requesting Clinician

The clinician who requests a test is responsible for reviewing, acting and communicating the result and taking appropriate action, even if the patient has been discharged from hospital. This includes General Practitioners.

(Every test result received by a GP practice for a patient should be reviewed and acted upon by a responsible clinician in the practice even if it is not the clinician who ordered the test).

As a minimum the requesting clinician should:

- acknowledge the results;
- read and act upon and document the results in the patients' record.
- have a clear process as to how to access reports for tests/examinations that have been requested;
- keep a log of all requests that have been made and when they were reviewed and acted upon;
- have a robust system in place for handover to ensure that in their absence the diagnostic tests they have requested are followed up. Additionally, a robust handover should be in place whereby tests requested that have not have not yet been reported on are identified as outstanding at the point of handover.

In addition to the above, each Specialty in the Trust that requests diagnostic testing should have in place a procedure/SOP documenting their internal mechanisms and process to ensure that all tests are managed. This procedure/SOP will be the responsibility of the Clinical Governance Lead within each Specialty. (Details of what should be included within the SOP are included in Section 6).

The Reporter

The reporter has the responsibility to:

- ensure the test is timely, clear and precise and that any urgency is documented as per Trust policy;
- to clearly document any advice or further management or action required; based on the clinical information available at the time of reporting
- to contact the referring clinician or another appropriate member of the clinical team if they consider the results to be of an urgent / unexpected nature;
- to document who they have contacted, date and time and means of communication.

Each Specialty that undertakes diagnostic testing at the request of clinicians within the hospital and outside should have in place a suitable procedure/SOP which clearly outlines their responsibilities for communicating those findings, highlighting enhanced practice for the dissemination of urgent / unexpected findings.

Head of Service / Clinical Governance Lead

The Head of Service / Clinical Governance Lead for each Specialty should ensure that there is a robust procedure/SOP in place that supports all of the principles within this policy including undertaking of audits of compliance in relation to this SOP.

4 Policy Details (including Flowcharts)

Process for the receipt of diagnostic test results

Diagnostic test results will be distributed in the first instance electronically via the ICE and Orion internal Trust systems. These results are accessible to all users of the system. Those individuals who have made the request will be expected to view them in a timely manner. All results should be acknowledged within 15 days with a best practice target of 5 days.

In some diagnostic testing Specialties, the results are additionally communicated on paper. Once the results have been reviewed and action taken then the paper copies should be placed in the patient notes. If paper results and images are to be used then these can be acknowledged by signing and dating the paper copy.

It is recognised that not all results that have been requested will have been requested internally via SFHT staff and may have been requested via other teams such as Primary Care. Acknowledgement of these results is the responsibility of the requesting clinician. However, it would also be appropriate for an internal clinician to take responsibility for those results especially if they have taken over the on-going responsibility of care, e.g. if the patient has been admitted and if they form part of the impact or reason for the admission.

Patient Groups

Emergency Cases and Inpatients

Communication of these test results usually focuses on results that may need action immediately or within hours. It is the responsibility of the referring clinician and/or their team to read, acknowledge and take action on these reports as soon as they are received. The Trust provides these referring clinicians a mechanism for clinicians to view their recently requested results – ICE and Orion. At present this is at the clinicians discretion as to which system they use and how they do this, however it must be done.

Outpatient and Primary Care

In this group of patients it is possible that there can be significant findings such as cancer. These results are just as important as for in-patients however often the patient has left the Trust's care. Where electronic alerts are not in place to GPs and Primary Care, then the

Trust should have in place a mechanism where a more laborious method is required such as telephoning, faxing, emailing, etc. It is every clinician's responsibility to ensure that patients' results who are no longer in our care are passed on to the appropriate Primary Care provider and, once passed on, documented to whom the results have been given.

The Diagnostic Test

The diagnostic Specialty undertaking the test should have a procedure/SOP in place which covers the following:

- Ensure that critical, urgent or unexpected findings are clearly articulated and it is obvious as to the degree of urgency required by the requesting clinician.
- If appropriate, a policy should be developed which highlights coding which would be assigned to urgent or unexpected findings, for example XXXX (critical or urgent findings) or UUUU (new or unexpected findings).
- UUUU copies will be sent to the relevant MDT Leads / Cancer Nurse Specialist. They are required to have a process in place to record this information and ensure appropriate follow up which offers a further safety net. Notwithstanding, that the responsibility lies with the original requester to refer to the MDT if appropriate.
- Safety net measures should be identified in addition to the 'ordinary' defined communication, such that if a result is urgent, what alternative actions will be taken to ensure the result is communicated should the first option not work.
- Explicit target timeframes for reporting of results should be identified.
- Diagnostic testing Specialties will reject diagnostic testing requests that have not been properly completed or contain the correct patient identifiable information or required clinical history.
- Evidence that there is an audit mechanism in place to provide assurance that ALL results will be reported.

Communication is essential, especially in cases where the results or findings are either critical, urgent or unexpected.

> *Critical findings:* those where emergency action is required as soon as possible e.g. a pneumothorax or free gas on a chest x-ray; an intracranial bleed on a CT scan; large volume pulmonary embolism disease (expected or unexpected).
> *Urgent findings:* where medical evaluation is required within 24 hours
> *Significant unexpected findings*: cases where the reporting radiologist is concerned of the findings that is significant to the patient and will be unexpected
> e.g. pulmonary embolism on a staging CT scan; evidence of new metastatic disease in a follow-up routine staging scan that previously showed no secondary spread.

The above category results should be communicated by the person who has identified the urgency of the results (or an assigned individual); they should ensure that this information is immediately communicated to the requesting clinician. If the requesting clinician cannot be contacted, then the on-call Registrar for that Specialty should be bleeped. The time of this communication and details of the person contacted should be documented in the history of

the reporting system. *It remains necessary for the requesting clinician to review the report - a phone call does not replace the need to review the report.*

It may also be necessary (for example in cases of malignancy) to be referred to a Multidisciplinary Team (MDT) in accordance with SFHT practices. In cases of suspected cancer, the information should be forwarded to the Cancer Pathway Co-ordinator /Specialty MDT for discussion. For histology that shows cancer it will be added to the MDT for discussion and treatment options. These patients will also be added to the Patient Tracking Lists so that the Cancer Pathway Co-ordinators can start tracking. A report is also sent to the referring consultant.

The Requesting Clinician

The requesting clinician should take full responsibility for reviewing and acting upon the findings of diagnostic test results which they have requested. If the result arrives outside of normal working hours or the requesting clinician knows that they may not be available to receive the result there must be adequate arrangements in place in the Specialty for handover of this responsibility to a suitable alternative qualified clinician to act on the report. This process should be documented in the Specialty procedure/SOP. If non-clinical administrative staff are to play a large part in the acceptance of diagnostic results then it must be made clear what action is to be taken and how this is to be documented.

If the individual who accesses the result cannot take the appropriate action, e.g. Patient Pathway Co-ordinator / medical secretary, it is the responsibility of that individual to bring it to the attention of someone who can. Actions taken should be recorded and the method of the communication indicated, e.g. face-to-face, phone call, email, letter. It is always best practice to use the electronic method of communicating test results wherever possible, whilst maintaining patient confidentiality and information governance protocols.

If tests are requested by a SFHT clinician but are copied to the GP for information, it remains the responsibility of the requester to ensure the report is reviewed and acted upon.

The Trust has in place a mechanism for clinicians to view all diagnostic tests they request through the ICE and Orion systems. This enables clinicians not only to see what diagnostic tests have been requested in their name but whether or not these have been viewed. If they have been viewed, it also states the last person to view them. It also offers functionality to alert you to 'you have some results'. These also appear in the work list. A quick reference guide showing how this works is attached in Appendix A.

In case of radiological imaging, requesting clinicians are encouraged to review the image when reviewing interim reports.

Procedure / SOP

Each Division or Specialty that is in receipt of diagnostic tests should have in place a clear procedure/SOP which details how to request tests and access the systems to do so. There is flexibility within each SOP for services to define what procedure works best for them; however they should in all cases outline their standards as detailed below. It is best practice for the SOP to include the following information as a minimum and should highlight any risks with the agreed process.

a) The requesting of diagnostic tests
b) The receiving and reviewing of diagnostic tests
c) Missing test results
d) Delayed test results
e) Interpreting of diagnostic test results
f) Actioning diagnostic test results
g) Recording actions taken, in particular urgent or unexpected findings
h) MDTs
i) Informing the patient of the results
j) Incorrect results or misdiagnosis
k) Filing, storing and retention of diagnostic test results

Auditing / monitoring all of the above.

For a 'best practice' version of a completed SOP please follow the link to view the one from Integrated Sexual Health Service:
http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?ContentId=52720

5 Education and Training

It is the responsibility of each Clinical Specialty, once they have a procedure/SOP in place which meets the standards of this policy, to ensure that all staff are trained in how to accept diagnostic testing results. This includes all clinical staff, all administrative staff and any new staff such as Registrars.

6 Definitions

Below gives details of the Specialties within SFHT and what tests would be deemed inclusive to this policy. This list is not exhaustive.

Radiology	Plain film imaging CT Ultrasound MRI Radio nuclide imaging Fluoroscopy procedures Interventional procedures
Endoscopy	
Pathology	Microbiology Haematology Histopathology Immunology Cytology (external) Molecular Biology (external) Genetics (external)
Cardiology	ECGs Lung function Oesophageal function Ambulatory blood pressure

ICE:	Electronic system for placing Pathology and Radiology requests. ICE also receives reports from Pathology and Radiology and displays them.
Orion:	Electronic system to view reports from Pathology and Radiology.
PACS:	Picture archive and communication system – currently GE PACS electronic system to store Radiology imaging and view images.
CRIS:	Radiology information system (RIS) provides functionality similar to PAS but specifically for Radiology, e.g. bookings and appointments. Distributes Radiology reports to other systems.
ERAD Cockpit:	Reporting system for radiologists and radiographers to report on. Reports are sent back to CRIS which then sends the reports to relevant systems.
Winpath:	Laboratory information management system used by all of the areas in Pathology.

A **standard operating procedure** (SOP) is specifically designed to describe a set of step-by-step instructions compiled by the Trust to help staff carry out routine activity. It clearly states how to do something. Unlike a standard procedure (outlined above), it concentrates on capturing more than just the process; it additionally captures the element of the doing and details the functional responsibilities.

SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply with Trust approved process. It is a set of written instructions staff can refer to when performing the steps of the process which ensures everything is done correctly. It is particularly useful for when new employees are trained; standard operating procedures help keep their training fresh and serve as an important reference tool for all staff.

7 Monitoring

The Diagnostics and Outpatients Division remain responsible for this policy. However, the focus of this policy aims to steer Specialties in the right direction to take ownership of their own diagnostic test results, therefore the compliance for this policy will be measured through the Specialty procedures/SOPs.

Compliance with this policy within local Specialty teams will be the responsibility of the Clinical Governance Lead within that Specialty. It will also be his or her responsibility to ensure there is an appropriate procedure/SOP aligned with this policy for their Specialty.

Following the implementation of all SOPs, there will be in place a trust-wide clinical audit which all Specialties will be required to participate in on a monthly basis to monitor their compliance against their own SOP.

Within the Specialties any issues arising from this policy should be dealt with by the Clinical Governance Lead and discussed with the Clinical Director for that Division.

8 Equality, Diversity and Inclusivity and Impact Assessments

Equality Impact Assessment (EqIA) Form (please complete all sections)

- Guidance on how to complete an EIA
- Sample completed form

Name of service/policy/procedure being reviewed:			
New or existing service/policy/procedure:			
Date of Assessment:			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality

	consider?		
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	No	None
Gender:	None	No	None
Age:	None	No	None
Religion:	None	No	None
Disability:	None	No	None
Sexuality:	None	No	None
Pregnancy and Maternity:	None	No	None
Gender Reassignment:	None	No	None
Marriage and Civil Partnership:	None	No	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	No	None

What consultation with protected characteristic groups including patient groups have you carried out? Consulted with a range of staff across divisional governance forums and clinical effectiveness group
What data or information did you use in support of this EqIA?
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? Yes

Level of impact
From the information provided above and following EqIA guidance document, please indicate the perceived level of impact:
Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Donna Staples
Signature: Donna Staples
Date: 18th February 2018

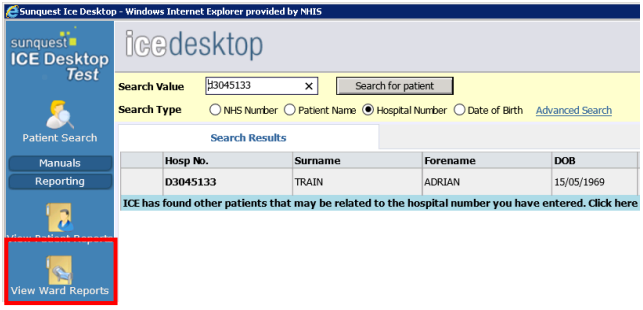
9 Appendices

Appendix A – Quick Reference Guide

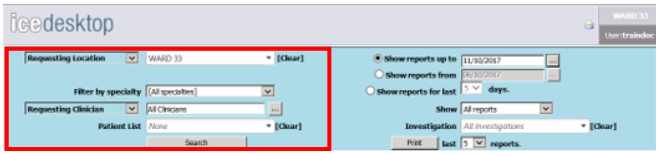
Appendix A – Quick Reference Guide

View Clinician Reports

Click **View Ward Reports**

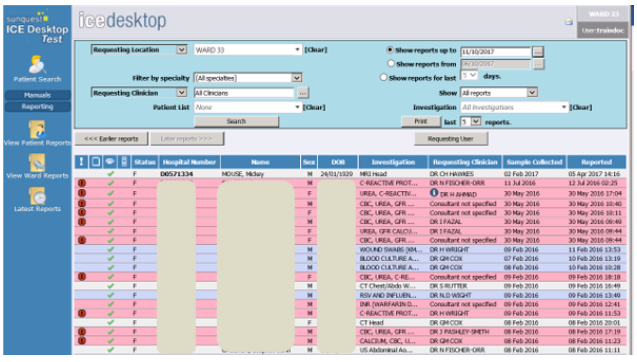


Ward / Specialty / Requesting Clinician can be filtered using the filter options at the top of the page

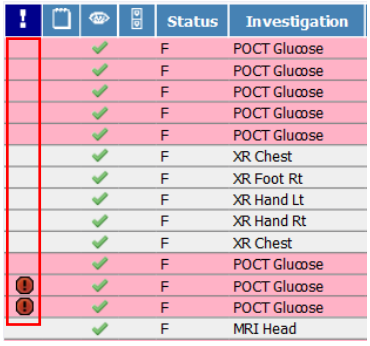


- Select **[Clear]** to remove reference to a specific Requesting Location.
- To set the Requesting Clinician, select the ... button.
- Enter your name into the search box, press Search and then select your name from the search results.
- Finally press **Search**

A list of patient reports will be displayed that have been requested in your name. Click on a Patient to view their results.



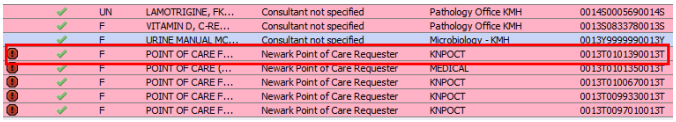
Abnormal reports are displayed with an exclamation mark.



The viewed status show:

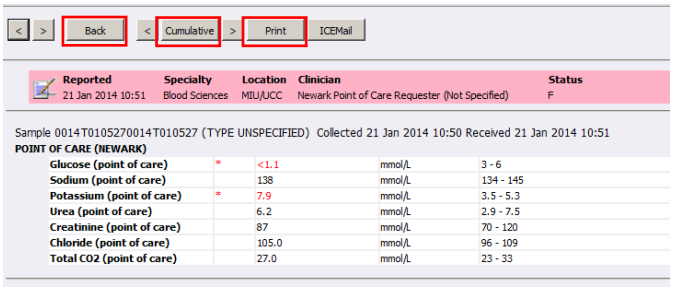
	Indicates the report has been read. Hovering the mouse over the green tick will display who last viewed the report.
	Indicates the report has not been read.
	Indicates the report has been updated since last viewed

Click a report to view



Abnormal results are shown in **red** text within the report.

Navigation buttons appear at the top of the patient report.



CONTACT

SERVICE DESK 01623 410310 or Ext 4040

IT TRAINING 01623 622515 Ext 611