TELEPHONED PATHOLOGY RESULTS POLICY

POLICY

Reference	CPG-TW-TPRP
Approving Body	Pathology Governance Committee
Date Approved	10th January 2019
Issue Date	14th January 2019
Version	2.0
Summary of Changes from Previous Version	Update to the references in the Evidence Base section to the most up to date guidance
Supersedes	v1.0, issued 22nd December 2015 to Review Date November 2018
Document Category	• Clinical
Consultation Undertaken	Pathology Clinical Teams
Date of Completion of Equality Impact Assessment	07/01/2019
Date of Environmental Impact Assessment (if applicable)	N/A
Legal and/or Accreditation Implications	United Kingdom Accreditation Service for all pathology disciplines
Target Audience	Requestors and designated individuals responsible for pathology requests
Review Date	May 2022 (ext[2])
Sponsor (Position)	Medical Director
Author (Position & Name)	Patrick McCormack, Pathology Quality Manager
Lead Division/ Directorate	Diagnostics & Outpatients
Lead Specialty/ Service/ Department	Pathology
Position of Person able to provide Further Guidance/Information	Pathology Laboratory Management Team

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
N/A	N/A

CONTENTS

1.0 INTRODUCTION

Markedly abnormal laboratory test results require urgent clinical evaluation and appropriate action. This policy is designed to introduce designated pathways between Pathology and requesting clinicians and their teams, and to minimise the risk of serious harm to patients resulting from significant pathology results being overlooked, even though they have been correctly reported. It defines timescales within which staff are expected to act.

2.0 POLICY STATEMENT

This policy does not replace the essential requirement for each clinician to be responsible for promptly accessing and acting on the result of every investigation they request, but is designed to provide a safety net for the highlighting of markedly abnormal test results as defined by the laboratory. The criteria for identifying results that fall into the 'markedly abnormal test result' category have been developed in Pathology following guidance issued by the Royal College of Pathologists (document number G158 Oct 2017). Pathology staff will alert the requesting clinician and their team of the first abnormal set of results or repeat results that have shown a markedly significant change for an individual patient. It is anticipated that immediate medical evaluation is required for patients with such results. The laboratory does NOT telephone all abnormal results, only those satisfying the criteria for markedly abnormal test results.

The electronic requesting and reporting system, also known as Orion or ICE (Order Comms) provides a reliable electronic means of accessing pathology results. ICE includes a 'flag' for highlighting reports that include abnormal (numerical) results issued by Haematology and Clinical Chemistry, but it remains incumbent on requestors to actively search for the results of all Pathology investigations they have requested. It is also the responsibility of the requesting clinical team to have proper handover arrangements in place to review and act on abnormal results 'out of hours' or when a particular clinician is away. A 'green tick' against a result in ICE indicates that someone has viewed the result, but NOT necessarily that they have acted upon it.

This clinical document applies to:

Staff groups

- Clinicians and Registered Nurses
- Agency/Locum/Bank Staff
- Primary Care Staff

Clinical areas

- All areas of the Trust across all sites – King's Mill Hospital, Newark Hospital and Mansfield Community Hospital
- All areas of Primary Care

Patient groups

- All patient groups – adult, maternity and paediatric

Exclusions

- No patient groups are excluded

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
Pathology Staff:	All Pathology staff including the scientific and technical staff and Medical Consultant staff
BMS:	Biomedical Scientist
Abnormal Test Results:	Results falling outside the accepted normal reference range for a particular analyte that may require immediate medical intervention, including admission to hospital or change in the patient's treatment
SFH:	Sherwood Forest Hospitals NHS Foundation Trust
IBMS:	Institute of Biomedical Science
ICE:	"Integrated Clinical Environment" web-based applications for electronic requesting and reporting. Available for Pathology and Medical Imaging at SFH

4.0 ROLES AND RESPONSIBILITIES

It is the responsibility of each member of staff involved in the requesting, reporting and review of pathology tests:-

- to comply with the standards set out in this guidance
- to work within their own competence
- to report all issues regarding the communication of markedly abnormal test results (including near miss events) using the Trust's Incident Reporting procedures. Any such issues should be discussed at relevant Clinical Governance Groups and any identified actions that result from the incidents should be implemented.

It is the responsibility of each member of staff and individual clinical departments to ensure they adhere to the training and audit requirements set out in Sections 7 and 8 of this Policy.

Trust Board: The Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place to effectively manage the risks associated with markedly abnormal test results.

Medical Director: is responsible for implementing patient management strategies throughout the Trust that include appropriate and timely requesting and review of pathology test results.

Clinical Directors: are responsible for implementing patient management strategies throughout the Trust that include appropriate and timely requesting and review of pathology test results, and have proper handover arrangements in place to review and act on abnormal test results when a particular clinician is not available/away.

Consultant Medical Staff: are responsible for ensuring that their team, including junior staff, read and understand this policy, and adhere to the principles contained in it at all times.

Ward and Department Managers: are responsible for ensuring implementation of this policy within their area, and for ensuring all staff working within the area adhere to the principles at all times.

Duty Nurse Managers: are responsible for identifying an appropriate clinician to evaluate a patient with markedly abnormal test results, when the patient's Consultant cannot be contacted and the escalation process has been implemented.

Primary Care Clinical Commissioning Groups: are responsible for implementing patient management strategies throughout Primary Care that include appropriate and timely requesting and review of pathology test results, and have proper handover arrangements in place to review and act on abnormal test results when a particular clinician is not available/away.

5.0 APPROVAL

This document was approved by the Pathology Clinical Governance Team

6.0 DOCUMENT REQUIREMENTS

See Appendix 1 – Flowchart for telephoned pathology results

6.1 Pathology staff

Pathology staff will urgently telephone results that meet the criteria of markedly abnormal test results as follows:

In-patients: will phone to the patient location i.e. ward, and will ask to speak to a doctor or qualified nurse. They may give the results to another member of ward/department based support staff if a doctor or nurse is unavailable.

Out-patients: will phone the secretary of the named consultant or the patient location if they are likely to still be present on the hospital site.

Primary Care patients: will phone the GP practice or out-of hours GP service if the practice is closed.

Pathology staff will attempt to telephone the results, using all the available numbers on WinPath, switchboard, the request form or those listed for the consultant/GP or patient location, on at least three occasions, a few minutes apart. If this is unsuccessful **within 30 minutes** they will follow the Pathology Escalation Procedure.

Pathology staff will ask the receiver of the call to repeat key information to ensure understanding, take their name and log all call details in the patient record on the Laboratory Computer System.

6.2 Pathology Escalation Procedure

Pathology staff must follow this escalation procedure if they have been unable to contact the Consultant/GP or patient location **within 30 minutes**.

In-patients and Out-patients:

1. First level escalation to Specialist Registrar of the department from which the test request originated (Bleep via switchboard)

2. Second level escalation to the appropriate Consultant on-call for the department from which the test request originated (Bleep via switchboard)

3. Third level escalation to the Duty Nurse Manager to identify an appropriate clinician to receive the results and evaluate the patient (Bleep via switchboard)

Pathology staff will ask the receiver of the call to repeat key information to ensure understanding, take their name and log all details in the patient record on the Laboratory Computer System.

Primary care patients (GP Practice closed or cannot be contacted):

Pathology staff will phone results to the deputising service (typically this is the out of hours service and the GP contact lines will redirect calls).

When telephoning results in these circumstances, Pathology staff will provide the following additional information:

- The date and time of the request if available
- The name of the requesting physician and/or the practice number
- As much clinical history as is available
- Contact address for the patient

Pathology staff will record all call information in the patient record on the Laboratory Computer System.

6.3 Ward/department staff receiving telephoned Pathology results

The Clinician, registered Nurse or Midwife must record the information in the patient's clinical notes, detailing the results that are markedly abnormal, the time the call was received, the name of the Pathology member of staff, their own name and any other relevant information.

6.4 Ward/department escalation procedure

The following escalation procedure must be followed if the doctor/clinician is not available **within 30 minutes**:

In-patients and Out-patients:

1. First level escalation to the Duty Doctor/Specialist Registrar according to the ward/department involved (Bleep via switchboard)

2. Second level escalation to the Consultant on-call
   In the event that the first level escalation is unsuccessful, staff should pass the result to the appropriate Consultant on-call according to the ward or department involved for action (Bleep via switchboard)

3. Third level escalation to the Duty Nurse Manager
   In the event that the second level escalation is unsuccessful, staff should pass the result to the Duty Nurse Manager to identify an appropriate clinician to receive the results and evaluate the patient (Bleep via switchboard)

Maternity /Gynaecology and Children's services.

These services ARE NOT supported by the Hospital at Night team.

The same escalation applies 24/7 for these services.

1. First level escalation to duty doctor/Specialist Registrar according to the ward/department involved (Bleep via switchboard)

2. Second level escalation to the Consultant on-call
   In the event that the first level escalation is unsuccessful, staff should pass the result to the appropriate Consultant on-call according to the ward/department involved for action and investigation (Bleep via switchboard)

6.5 Consultant/Doctor actions

On receipt of a telephoned pathology result, the Consultant/Doctor should urgently review the results electronically on ICE, along with patient notes (if available), and determine if urgent treatment is required. Actions should be recorded in writing in the patient notes, and/or using the electronic 'notepad' function on ICE.

If the patient has left the hospital, and the Consultant/Doctor determines that urgent treatment is required, the Consultant/Doctor should:

- Attempt to telephone the patient, using all known contact details and arrange for the patient to attend for urgent treatment
- If this is unsuccessful, then an attempt should be made to telephone the next of kin, as listed on PAS

- If this is unsuccessful:
  In normal working hours, the patient's GP should be telephoned to request their assistance in contacting the patient.
  Out of hours, the Police may be contacted to request their assistance in contacting the patient.

Actions should be recorded in writing in the patient notes, and/or using the electronic 'notepad' function on ICE.

To Note: For Cellular Pathology results, enquiries can be made direct to the Cellular Pathology Department. The department only phones parathyroid frozen section results and this is based on a pre arrangement with the Clinician.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Did Pathology staff phone the urgent result within 30 minutes regardless of whether or not the call was successful?	Pathology Management Team	Audit	Every six months	Pathology Management Team/Clinical Governance Groups
Did Clinical staff receiving the urgent result record the information and communicate it to a relevant doctor within 30 minutes?	Pathology Management Team	Audit	Every six months	Pathology Management Team/Clinical Governance Groups

The Pathology Management Team will review this policy in the following circumstances:-

- When new national or international guidance is received.
- When newly published evidence demonstrates need for change to current practice.
- Every three years routinely.

Responsibility for implementation of this policy lies with the Medical Director.

Incidents where non-compliance with this policy is noted, and are considered an actual or potential risk, should be reported to Datix.

8.0 TRAINING AND IMPLEMENTATION

Update on existing policy where training has already rolled out. Document to be distributed via the Intranet and available for all users of pathology services to access.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 2
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- IBMS (2018) IBMS Policy on the Communication of Pathology Results
- NHS Institute for Innovation and Improvement (2008) *SBAR: Situation, Background, Assessment, Recommendation*
- Royal College of Pathologists (document G158, Oct 2017) *The Communication of critical and unexpected pathology results*

Related SFHFT Documents:

- Incident Reporting Policy

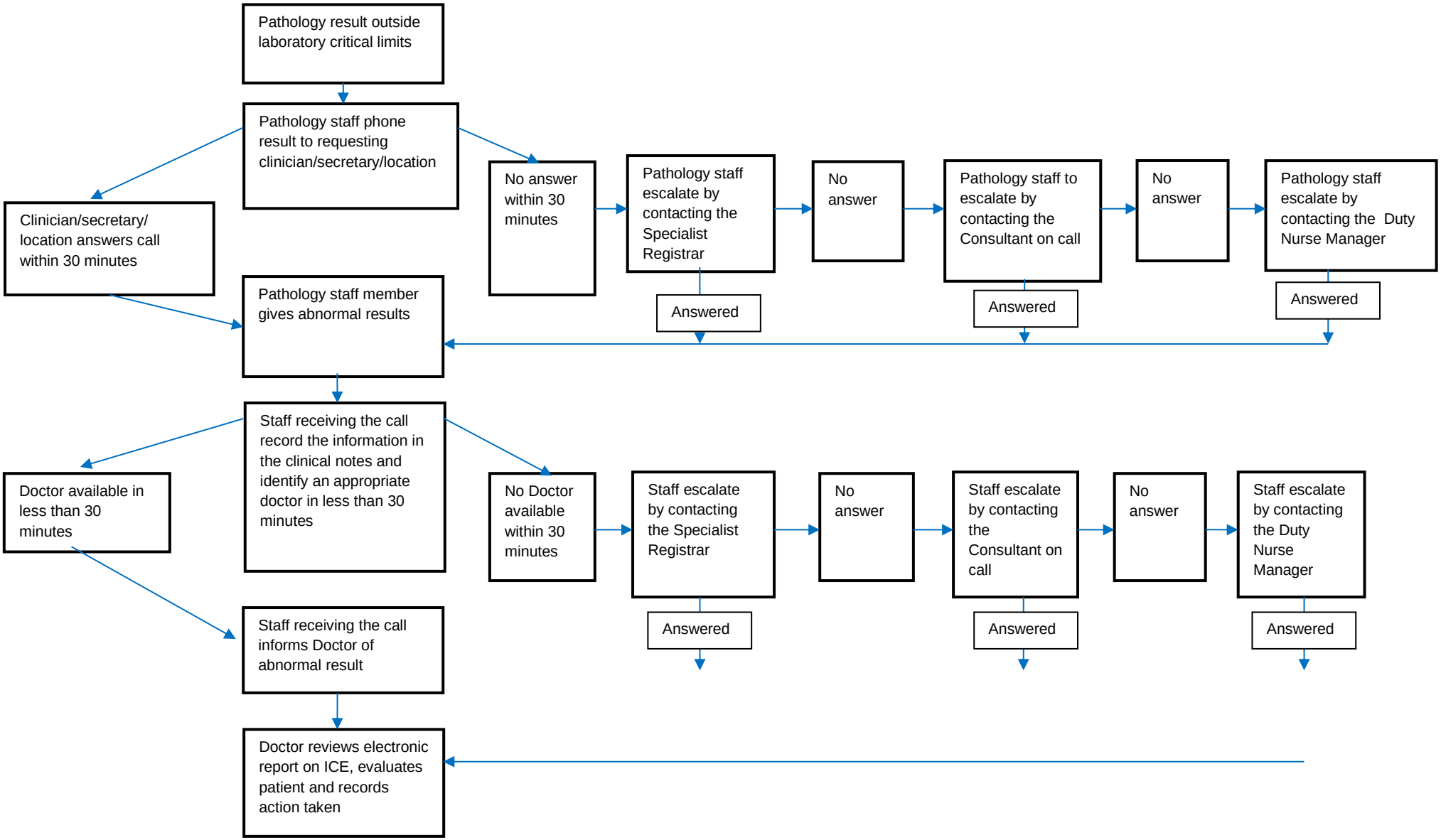
11.0 KEYWORDS

- path lab, urgent, urgently, review, critical, abnormal, phone, phoned, telephone, ring, call, markedly abnormal laboratory test results, treatment, evaluate,

11.0 APPENDICES

Appendix 1 – Flowchart for telephoned pathology results
Appendix 2 – Equality Impact Assessment Form

Appendix 1: Flowchart for telephoned pathology results



APPENDIX 2 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Telephoned Pathology Results Policy			
New or existing service/policy/procedure:			
Date of Assessment: 07/01/2019			
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 consider?**	**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**
The area of policy or its implementation being assessed:			
Race and Ethnicity	N/A		
Gender	N/A		
Age	N/A		
Religion	N/A		
Disability	N/A		
Sexuality	N/A		
Pregnancy and Maternity	N/A		
Gender Reassignment	N/A		
Marriage and Civil Partnership	N/A		

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	N/A		

What consultation with protected characteristic groups including patient groups have you carried out?

N/A

What data or information did you use in support of this EqIA?

N/A

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?

N/A

Level of impact

Low Level of Impact

Name of Responsible Person undertaking this assessment:

Signature:

Patrick McCormack

Date: 07/01/2019