DIAGNOSTICS RESULTS MANAGEMENT POLICY

POLICY

Reference	CPG-TW-DRMP		
Approving Body	Diagnostic & Outpatient Division Governance Committee		
Date Approved	March 2022		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	4th April 2022		
Version	2.0		
Summary of Changes from Previous Version	A full re-write of this policy has been undertaken which has had a thorough consultation as indicated below		
Supersedes	v1.0, Issued 28th Feb 2018 to Review Date May March 2022 (ext4)		
Document Category	• Clinical		
Consultation Undertaken	All Divisional Governance Groups		
Date of Completion of Equality Impact Assessment	12th October 2021		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	N/A		
Target Audience	Trust wide		
Review Date	March 2025		
Sponsor (Position)	Dr Shafiq Gill, D&O Divisional Clinical Chair		
Author (Position & Name)	Dr Alia Elkadiki, D&O Divisional Clinical Governance Lead		
Lead Division/ Directorate	Diagnostics and Outpatients Division		
Lead Specialty/ Service/ Department	D&O Divisional responsibility		
Position of Person able to provide Further Guidance/Information	D&O Divisional Clinical Governance Lead		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Individual specialty/ divisional SOPs	As per issue dates of individual specialty/ divisional SOPs
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

This policy sets out Sherwood Forest Hospitals NHS Foundation Trust's (SFHFT) intentions in relation to the minimum standards and procedures for the process of communicating and acting on 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 diagnostic tests performed each day at SFHFT. Currently there is no comprehensive electronic system of requesting, reporting and tracking investigations and we need to be assured that standards are in place to communicate and act on the results of the diagnostic tests.

2.0 POLICY STATEMENT

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

Examples of Diagnostic Tests

Radiology	Plain film imaging CT Ultrasound MRI Radio nuclide imaging Fluoroscopy procedures Interventional procedures
Endoscopy	Gastroscopy, Colonoscopy, flexible sigmoidoscopy, Bronchoscopy, Cystoscopy, Oesophageal function.
Pathology	Clinical Chemistry Microbiology Haematology Histopathology Immunology Cytology (external) Molecular Diagnostic(external) Genetics (external) Point of Care Testing (POCT)
Medicine	ECGs Echocardiography Lung function Ambulatory monitoring

3.0 DEFINITIONS/ ABBREVIATIONS

SFHFT/The Trust	Sherwood Forest Hospitals NHS Foundation Trust
POCT	Point of Care Testing
SOP	Standard Operating Procedure
AMaT	Audit Management and Tracking
D&O	Diagnostics and Outpatients

4.0 ROLES AND RESPONSIBILITIES

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 standard operating 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.

The requesting clinician should:

- Provide accurate details of the identity and location of the patient.
- Clearly articulating the urgency of the request
- Provide accurate clinical information including the working diagnosis
- Acknowledge the results;
- Have a clear process as to how to access reports for tests/examinations that have been requested;
- 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 yet been reported on are identified as outstanding at the point of handover.
- Each Specialty in the Trust that requests diagnostic testing should have in place a SOP documenting their internal mechanisms and process to ensure that all tests are managed. This SOP will be the responsibility of the Head of Service within each Specialty.

POCT generated results that are abnormal are the responsibility of the operator to communicate to the requesting responsible clinician. As these tests are performed in real time communication and action are required when the result is generated on the instrument. Unexpected point of care test (POCT) results that don't fit with the clinical presentation should be confirmed by laboratory testing/alternative method/repeat testing where appropriate.

The Trust has in place a mechanism for clinicians to view diagnostic tests they request through the ICE system. Not all diagnostic tests are yet requested or reported through ICE. A quick reference guide showing how this works is attached in Appendix B.

The Department providing the diagnostic test

The department providing the diagnostic test has the responsibility to:

- Ensure the test is timely and accurate;
- Document clearly any advice or further management or action required, based on the clinical information available at the time of reporting;
- Contact the referring clinician or another appropriate member of the clinical team about urgent / unexpected results when appropriate, and document whom they have contacted, when and how.
- Depending on the clinical information provided and results obtained on initial tests, additional testing to support the initial investigation may be added at the discretion of the laboratory clinical team. If critically abnormal these will be telephoned as per the laboratory telephone policy, otherwise it remains the responsibility of the requesting clinician to review and act on the results.
- Each department that undertakes diagnostic testing must have in place a suitable SOP describing the communication of urgent or unexpected findings.

Head of Service

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

5.0 APPROVAL

Following consultation this policy (v2.0) has been approved by the Diagnostics & Outpatients Divisional Clinical Governance Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

Each Specialty that is in receipt of diagnostic tests should have in place a clear 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) Acting on diagnostic test results
d) Recording actions taken, in particular urgent or unexpected findings
e) Incorrect results or misdiagnosis
f) Filing, storing and retention of diagnostic test results
g) Auditing / monitoring all of the above.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

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 SOPs.

Compliance with this policy within local specialty teams will be the responsibility of the Head of Services within that specialty. It will also be their responsibility to ensure there is an appropriate SOP aligned with this policy for their Specialty.

Within the specialties any issues arising from this policy should be dealt with by the Specialty Clinical Governance Leads and discussed with the Clinical Chair for that Division.

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)**
Standards outlined within the trustwide audit registered on AMaT	Specialty Head of Service	Audit via AMaT using minimum of 20 sets of patient notes	Minimum of every 6 months	Specialty Clinical Governance Meetings with highlights/ exceptions/ improvement plans being reported through respective Divisions.

8.0 TRAINING AND IMPLEMENTATION

It is the responsibility of each Clinical Specialty, once they have a 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 rotational medical staff.

9.0 IMPACT ASSESSMENTS

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

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

Evidence Base:

- 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.

Related SFHFT 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 UUUU Significant or unexpected results
- Cardiology XXXX Urgent findings that require urgent interventions
- Point of Care Testing (POCT) Policy

11.0 KEYWORDS

Tests; ordering; requesting; receiving; standards; process; communication; received; read; verifying; communicate; critical; urgent; unexpected, diagnostic

12.0 APPENDICES

Appendix A – Equality Impact Assessment Form
Appendix B – ICE Quick Reference Guide

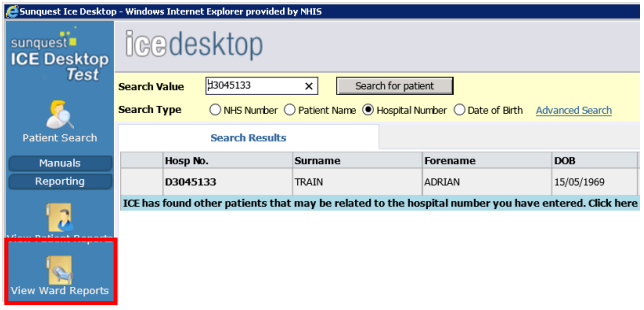
Appendix A – Equality Impact Assessment Form

Name of service/policy/procedure being reviewed: Diagnostics Results Management Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 12/10/21			
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:	None	N/A	None
Gender:	None	N/A	None
Age:	None	N/A	None
Religion:	None	N/A	None
Disability:	None	N/A	None
Sexuality:	None	N/A	None
Pregnancy and Maternity:	None	N/A	None
Gender Reassignment:	None	N/A	None
Marriage and Civil Partnership:	None	N/A	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	None
What consultation with protected characteristic groups including patient groups have you carried out? •			
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? • No			
<u>Level of impact</u> From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), 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: Dr Alia Elkadiki			
Signature:			
Date: 12/10/2021			

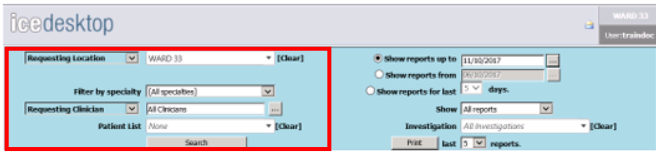
Appendix B – ICE Quick Reference Guide

View Clinician Reports

Click **View Ward Reports**

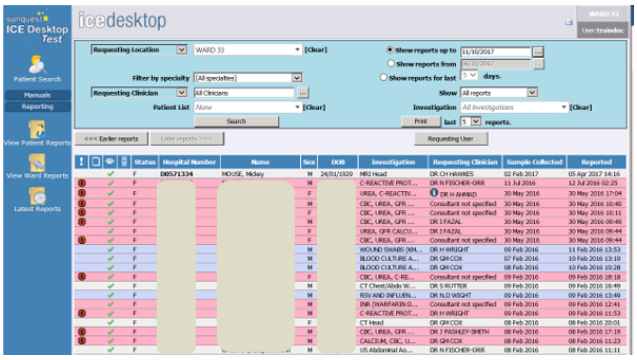


Ward / Specialty / Requesting Clinician can be filtered using the filter options at the top of the page

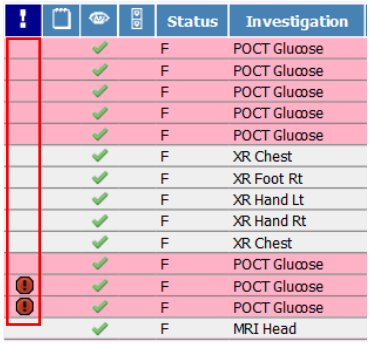


- Select **[Clear]** to remove reference to a specific Requesting Location.
- To set the Requesting Clinician, select the ... button.
- Enter your name into the search box, press Search and then select your name from the search results.
- Finally press **Search**

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.

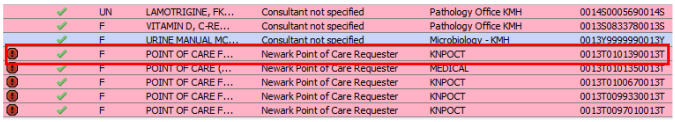


!				Status	Investigation
		✓		F	POCT Glucose
		✓		F	POCT Glucose
		✓		F	POCT Glucose
		✓		F	POCT Glucose
		✓		F	POCT Glucose
		✓		F	XR Chest
		✓		F	XR Foot Rt
		✓		F	XR Hand Lt
		✓		F	XR Hand Rt
		✓		F	XR Chest
		✓		F	POCT Glucose
!		✓		F	POCT Glucose
!		✓		F	POCT Glucose
		✓		F	MRI Head

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

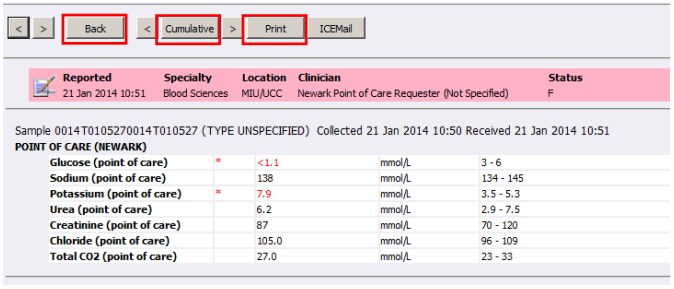
Click a report to view



✓	UN	LAMOTRIGINE, FK...	Consultant not specified	Pathology Office KMH	001450005690014S
✓	F	VITAMIN D, C-RE...	Consultant not specified	Pathology Office KMH	001350833780013S
✓	F	URINE MANUAL MC...	Consultant not specified	Microbiology - KMH	0013Y9999990013Y
✓	F	POINT OF CARE F...	Newark Point of Care Requester	KNPOCT	0013T0101390013T
✓	F	POINT OF CARE (...	Newark Point of Care Requester	MEDICAL	0013T0101350013T
✓	F	POINT OF CARE F...	Newark Point of Care Requester	KNPOCT	0013T0100670013T
✓	F	POINT OF CARE F...	Newark Point of Care Requester	KNPOCT	0013T0099330013T
✓	F	POINT OF CARE F...	Newark Point of Care Requester	KNPOCT	0013T0097010013T

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

Navigation buttons appear at the top of the patient report.



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