# Communicating Critical Test Results

The Critical Test Results Collaborative
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# Communicating Critical Test Results: Scope

- Promoting timely and reliable communication of critical test results to the clinician who can take action
- Inpatient, outpatient, and emergency settings
- Laboratory, cardiology, radiology and other diagnostic tests

# Collaboratives

- 40 Massachusetts hospitals

**Aim Statement**

- 100% of our patients with critical test results will have the results communicated and acknowledged within our target goals (e.g. 1 hour, 6-8 hours, 3 days) within 1 year

# Consensus Group Recommendations

- Represent our best understanding of what will work
- Written from the patient's perspective, but they must work for clinicians
- Integrate proven safety and performance improvement concepts
  - Simplify
  - Minimize handoffs
  - Provide access to information
- Link with JCAHO safety goal of improving teamwork and communication among caregivers
- Assimilated a lot of knowledge about what requires communication
  - Degree of agreement varies substantially but represents major contribution as a starting point

# Best Practice Recommendations

1. Define what test results require timely and reliable communication
2. Identify when test results should be actively reported to the ordering provider with explicit time frames for this process

# Best Practice Recommendations (cont.)

3. Identify who the results should go to
4. Identify who the results should go to when the ordering provider is not available

# Best Practice Recommendations (cont.)

5. Identify how to notify the responsible provider 100% of the time
6. Establish a shared policy for uniform communication of all types of test results

# Communicating Critical Test Results

- **What are critical tests?**
- **Communicating results (who)**
  - Identifying the responsible provider
  - Commit to direct communication to MD
  - Reaching a provider who can take action
- **Building reliable systems (how)**

# What are critical tests?

- **Key issues**
  - Defining critical values/interpretations for all diagnostic areas
  - Setting time frames
- **Common pitfalls or failure modes**
  - Lack of perceived need in current system
  - Some specialty groups reluctant to create a list; fear of setting a standard
  - Hard to revise a list that developed over time from critical incidents
  - Clarifying terminology between providers
  - Individual MD preferences

# What are critical tests?

- **What have we learned?**
  - Short lists are best;  eliminate nuisance calls
  - Some values/interpretations are easier than others
  - Changes can be made incrementally, testing to ensure safety and build confidence
  - Need to identify time targets for when results should be received by provider
    - Set target time frames (1 hours, 8 hours, 3 days)

# What are critical tests?

- **What have we learned? (cont.)**
  - Build lists by using language that makes sense to all stakeholders
    - List includes, but is not limited to…
    - New diagnosis of…
    - If represents a change of….
  - "Red", "Orange", "Yellow" time targets differ
    - All require acknowledgment

# Communicating Results: Identifying the responsible provider

- **Key issues**
  - Identifying the provider **who can take action**
- **Common pitfalls or failure modes**
  - Major difficulties exist in our ability to have the entire clinical team be able to identify and locate the responsible provider at any given time
  - Staff must agree on the care model; do we call the attending or the HO? decision will vary by site; once this decision is made, then deal with the coverage issues
  - All clinical team members do not have equal access to information about the responsible provider

# Communicating Results: Identifying the responsible provider

- **What have we learned?**
  - There is value in creating a forcing function at the point of test entry for the name of the ordering provider
  - Centralized call systems can work; provide uniform access to information; web-based or one phone number (call center) makes it easy for all
  - Create a patient-centered system linking the patient to the coverage team

# Communicating Results: Direct to MD Communication

- **Key issues**
  - Making the commitment to call the MD directly for "red" alerts
- **Common pitfalls or failure modes**
  - Diagnostic centers are unable to identify the responsible provider
  - Failure to get MD buy-in for communication from the lab
  - How to keep nursing in the process; what is the role of the RN in a "red" situation?
  - MD convenience; easier for RN to call MD vs. MD to call RN
  - Possible exceptions: situations covered by protocols (e.g. hypoglycemia, heparin dosing)

# Communicating Results: Direct MD Communication

- **What have we learned?**
  - The importance of leadership commitment to direct communication to MD
  - Make it easy for diagnostic center to identify and reach the responsible MD to facilitate buy-in
  - Direct to MD phone confirmation safest for "red"
  - If the list is short and indisputable, then MD resistance drops
  - Calling the results also to the RN builds support for the patient and adds reliability to the system (redundancy)

# Communicating Results: Reaching the responsible provider

- **Key issues**
  - Reaching a provider who can take action
- **Common pitfalls or failure modes**
  - We are meeting time frames for most, but delays continue to exist
  - New communication technology constantly changing; one solution does not fit all clinical settings

# Communicating Results: Reaching the responsible provider

- **What have we learned?**
  - Alpha pages and cell phones can enhance communication
  - Alternative communication techniques might be appropriate for orange and yellow categories, provided we have a reliable system of acknowledgment
  - Working collaboratively with IS teams can build systems to enhance identification
  - Lists of back office numbers can help
  - Negotiate win/win solutions
    - Alpha page stat requests, but phone all <u>red</u> criticals
  - Using fail-safe can build pressure for compliance

# Building reliable systems

- **Key issues**
  - Acknowledgement [“you know that they know”, “the pass is complete”]
  - Building the “Fail-Safe” process
- **Common pitfalls**
  - Lack of real-time tracking of acknowledgement and documentation
  - Lack of system for identifying when the time limit is reached for activating the fail-safe process
  - Non-standard terminology for notifying about critical test results, particularly in radiology

# Building reliable systems

- **What have we learned?**
  - Real-time log books and tracking tools can build reliability
  - Assign "owner" for tracking system; monitor at regular intervals
  - Use standardized communication tools
    - "I have a critical result" flag (with "read-back" for verbals only)
    - Simple documentation tools can make it "easy to do the right thing"; there is value in only writing once (forms, sticky notes)
  - Reciprocal responsibilities
    - Sender responsible for tracking and activating fail-safe
    - Receiver responsible for responding in a timely fashion

# Key Recommendations

1, 2. What & When - Agree on which tests require communication and set the time frames

3. Who - Get the result directly to someone who can take action with acknowledged receipt

4. Who – coverage,  have a fail-safe backup system with clear delineation of when to escalate

5. How - Use central call systems

6. Use the same policy across domains

# Questions?

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