1.0 Policy

Policy and Procedure for the Communication of Critical and Urgent Results in Laboratory Medicine within Mayo University Hospital (MUH).

2.0 Purpose

2.1 The purpose of this policy and procedure (P&P) is to define the process for communication of Critical and Urgent Laboratory Medicine Results to clinicians/ appropriate personnel responsible for the patient's medical care.

2.2 The purposes of this policy are to:

- Define what is meant by urgent, critical and clinically significant laboratory test findings.
- Describe how urgent, critical and clinically significant findings are communicated.
- Minimise the risk of serious harm to patients.

3.0 Scope

3.1 This policy and procedure relates to

- All Consultant Medical Staff, Registrars, Senior House Officers, Interns, NCHD's, Staff Nurses, Staff Midwives and General Practitioners (GPs).

- Reporting Consultants in Laboratory Departments /Laboratory Clinical Directors/ Medical Scientists in Mayo University Hospital.

4.0 Definitions

4.1 According to the ISO standard to which a Laboratory may be accredited, ISO EN 15189:2012 Standard for Medical Laboratories - Requirements for Quality and Competence, a **critical test value** is defined as:

An interval of examination results for an alert (critical) test that indicates an immediate risk to the patient of injury or death.

NOTE 1 The interval may be open ended, where only a threshold is defined.

NOTE 2 The laboratory determines the appropriate list of alert tests for its patients and users.

From a reference paper on "Harmonisation of critical result management in laboratory medicine" (Clinica Chimica Acta 432 (2014) 135-147), the following definitions were proposed:

Critical result: A test result which may signify a pathophysiological state that is possibly life threatening or that could result in significant patient morbidity or irreversible harm or mortality and therefore requires urgent medical attention and action.

Significantly abnormal result: A test result that is not life-threatening but that requires a timely medical attention and follow-up action within a medically justified timescale.

Critical test: A test that requires rapid communication of the result irrespective whether it is normal, significantly abnormal or critical.

Alert thresholds: The upper and/or lower threshold of a test result or the magnitude of change in a test result within a critical or clinically significant timescale beyond which the finding is considered to be a medical priority warranting urgent or timely action.

Alert list: A list of laboratory tests, including critical tests and non-critical tests with alert thresholds for critical and/or significantly abnormal results that reflect an agreed policy between laboratory and clinical staff for rapid communication within a pre-specified timeframe and according to procedure.

5.0 Legislation / Related Policies

Irish Standard ISO 15189:2012: Medical laboratories - Requirements for Quality and Competence

6.0 Roles & Responsibilities

6.1 This policy applies to:

- Consultant Medical Staff
- Registrars, Senior House Officers, Interns (NCHDs), Staff Nurses, Staff Midwives.
- General Practitioners (GPs)
- Reporting Laboratory Medical Consultants
- Laboratory Medical Scientists
- Biochemists
- Designated clerical officers

Responsibility for complying with policy:

Consultant Medical Staff

- **To ensure that they have a system in place to provide assurance that requested tests are carried out and results are viewed, acknowledged and acted upon accordingly and recorded.**
- To ensure that they are ready at all times to receive critical, urgent and significant communications by the mechanisms outlined in this policy.
- To ensure that phone contact details are made available at Switchboard for communication of critical, urgent and clinically significant findings.
- To act appropriately upon relevant reports.

Non-Consultant Medical Staff

- **To ensure that they are ready at all times to receive critical, urgent and significant communications by the mechanisms outlined in this policy.**
- To ensure that phone contact details are made available at Switchboard for communication of critical, urgent and clinically significant laboratory test findings.
- To act appropriately upon relevant reports.

Staff Midwives and Staff Nurses

- **To ensure that they are ready at all times to receive critical, urgent and significant communications by the mechanisms outlined in this policy.**
- To act appropriately upon relevant reports.
- It is anticipated that Staff Midwives and Staff Nurses would be informed of critical findings when the relevant medical staff cannot be contacted.

General Practitioners

- All GP services i.e. those with existing SLAs or who are currently registered and those who apply to develop an SLA or register with the Laboratory, should provide contact details for reporting of critical results outside normal practice hours. The emergency contact telephone number should be submitted to the Laboratory for the communication of critical results, outside normal Practice hours i.e. Weekends, Evenings and Bank Holidays.
- Where a proxy agency e.g. Westdoc, is used by a GP service, arrangements must be made between the relevant parties to ensure that markedly abnormal results can be telephoned directly to the agency, without complication. This is a critical clinical risk management issue for all parties concerned.

Reporting Laboratory Medical Consultant / Medical Scientist

- To ensure that critical, urgent and clinically significant laboratory tests findings are reported and communicated to the referring clinical team/ GP, designated staff member or the on-call team or on call GP service in a timely manner.

Responsibility for ensuring compliance to policy:

Associate Clinical Director, Laboratory Directorate MUH

- To ensure that all relevant Laboratory Medical Consultants and Medical Scientists are aware and have access to, this policy.
- To ensure implementation and compliance with the policy.
- To identify any problems with compliance with the policy and bring these to the attention of the appropriate MUH Patient Quality and Safety Manager, Laboratory Directorate, Executive Management Board & Laboratory Clinical Director.
- To ensure regular Audit of the policy is carried out.

Responsibilities of the MUH Clinical Governance Committee

- To review periodic reports from the Laboratory Directorate on quality, risk and safety issues relating to this policy.
- To take or recommend action as needed.

Responsibilities of the Clinical Lead / Clinical Directors / Hospital Management Team of Mayo University Hospital

- Ensure health professionals are adequately trained in the use of the organisation's systems (software, Q-Pulse, PAS, LIS, paper-based) in order to comply with the policy.
- Ensure appropriate resources are in place to achieve compliance with the policy.
- Ensure appropriate resources are in place to ensure audit of the policy.
- Ensure governance structures are in place to allow development and review of the policy.

Consultant Clinical Staff

- To ensure that all staff within their area of responsibility are aware and have access to the policy.
- To ensure implementation and compliance with the policy.
- To identify any problems in compliance with the policy and bring these to the attention of the MUH Patient Quality and Safety manager, the MUH Associate Clinical Director, Laboratory Directorate and the Hospital Management Team.

7.0 Identification of a Critical Alert Value

Within Mayo University Hospital, the Department of Laboratory Medicine (Pathology Laboratory), has documented critical alert values (adult and paediatric) which are then approved by the relevant Laboratory Medical Consultant /Laboratory Clinical Director in each discipline; these may also be presented for agreement with the clinicians, as appropriate. A timeframe in which these alerts must be communicated must also be defined.

This information is communicated to the service users within Mayo University Hospital and external practitioners via the Mayo University Hospital Laboratory User Manual (PATH/PD/001), at a minimum.

This information may also be made available to the Hospital Transfusion Committee (HTC) and Hospital Management Team (HMT) for review and feedback to the Laboratory Manager on an annual basis or as required.

8.0 Procedure

8.1 The following process shall be adhered to in the event of reporting a critical, urgent or clinically significant finding.

The reporting Consultant /Medical Scientist should contact the referring clinician or documented responsible person (for example, on-call consultant for that specialty, clinical team or on call GP service) by a preferred method depending on the urgency of the communication. It should be noted on the validated report or on the LIS system (or authorised alternative hardcopy system) that communication has occurred and should state the method of communication (phone call or HSE email), to whom the communication was given (named person & job title) and when the communication occurred (date and time). If email is used, it is essential that the email is acknowledged and that an addendum is issued to the report to indicate that the communication loop has been closed. If the initial email is not acknowledged then alternate communication is necessary. Please note that the Data Protection Commissioner does not recommend the use of Text messaging (SMS) or Fax to convey patient information.

If not facilitated by the LIS, sample statements might read as follows:

1. "These findings were verbally communicated by Dr. [Full name] or Medical Scientist [Full name] to Dr. [Full name] by telephone at 15:15 hours on Monday, February 2, 2015".
2. Case discussed with Dr. [Full name] at 15:15 hours on Monday, February 2, 2015".
3. "I have emailed Dr. [Full name] the details of this clinically significant laboratory findings at 15:15 hours on Tuesday, July 2, 2015".
4. Addendum to report: Dr [Full name] has confirmed by email that he is aware of the findings of the report above. Dr [Laboratory Medical Consultant Full Name] 15.20 hours Wednesday, July 3 2015".

9.0 Audit & Evaluation

9.1 The Line Managers/Heads of Department shall ensure that all policies, procedures and guidelines comply with this policy and are maintained as correct.

9.2 This policy will be reviewed every 2 years or sooner if there is a change in best practice. The responsibility for revision and audit of this policy rests with the Laboratory Clinical Director, Consultants and Laboratory Manager/ Laboratory Director.

10.0 Implementation Plan

- All Staff of Mayo University Hospital and referring GPs will be informed of this policy and procedure.
- The policy and procedure will be disseminated through local hospital procedures and/or through Q-Pulse.

11.0 References

- Out-of-hours reporting of laboratory results requiring urgent clinical action to primary care:
  Advice to pathologists and those that work in laboratory medicine (Royal College of Pathologists, November 2010)

- Harmonisation of critical result management in laboratory medicine (Clinica Chimica Acta 432 (2014) 135-147)

12.0 Appendices

Appendix 1 : Signature Sheet
Appendix 2 : Peer Review Sheet
Appendix 3 : Memo from Dr Pat Nash

Appendix 1 : Signature Sheet

The following staff have read and understood the above Policy/ Procedure/Protocol/Standard.

Name (BLOCK CAPITALS)	Signature	Date

Appendix 2

Peer Review of Mayo University Hospital Policy and Procedure for the Communication of Critical and Urgent Results in Laboratory Medicine

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy and Procedure for the Communication of Critical and Urgent Results in Laboratory Medicine that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Mayo University Hospital Policy and Procedure for the Communication of Critical and Urgent Results in Laboratory Medicine

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I acknowledge the following:

- I have been provided with a copy of the Policy, Procedure, Protocol or Guideline described above.
- I have read the Policy, Procedure, Protocol or Guideline document.
- I agree with the Policy, Procedure, Protocol or Guideline and recommend its approval by the committee developing the PPPG.

_____ _____ _____

Name *Signature* *Date*

Please return this completed form to:

Appendix 3: Memo from Dr Pat Nash

Memorandum

To: Clinical Directors, Galway Roscommon University Hospitals Group (GRUHG).

From: Dr. Pat Nash, Group Clinical Director, GRUHG.

Re: Responsibility for follow up of blood tests.

Date: 1st August 2013.

Dear Colleague,

With regards to the responsibility for the follow up of blood tests, I would like to emphasise that the person who orders a blood test for a patient is the person who is responsible for ensuring that the result of the test is received, reviewed and acted upon.

It is important that staff have clarity around this issue and I would appreciate if you could bring this to the immediate attention of all Consultants and NCHDs in your Directorate.

Regards,

Dr. Pat Nash,
Group Clinical Director,
Galway Roscommon University Hospital Group.