Results management

A mishandled test result is a frequent contributor to a delayed or missed diagnosis, which is the primary cause of medical negligence claims and a frequent cause of complaints in primary care. Carefully considered and robust processes are required to minimise the chances of such an incident occurring, with all the potential ramifications for both patient and doctor.

Basic considerations

There are many steps to the results management process and each point in the process carries the risk of a required action not being taken – sometimes with serious consequences for the patient. Throughout the process, there should be clear documentation and effective communication with the patient.

General

- There should be a written practice policy or protocol for managing tests and their results.
- All team members should be aware of their responsibilities in dealing with tests and results, including locums, receptionists and other non-clinical staff.
- The right balance needs to be found between patients taking responsibility for undergoing and following up on tests with practices ensuring these are done and followed up on in the interests of patient safety and good clinical care.

The decision to test

- Clearly explain to the patient why the test is being recommended. This helps them to understand the potential implications of not following through and having the test undertaken.
- Specify the urgency or otherwise of the test to the patient, including the timeframe in which it should be undertaken. Record this in the notes.
- If the decision to test is made remote from the patient (for example, based on another result or advice from a colleague), confirm that this has been communicated to the patient and that they have given their consent. This avoids the risk that a patient may have changed their address or phone number without notifying the practice. There should be an audit trail of these actions. The patient should be able to speak to a clinician if necessary
- The reason for the test should be clearly recorded to aid subsequent interpretation of the result. For example, a result slightly outside the normal range may be interpreted as requiring no action if there are no specific symptoms noted. But if some symptoms are present, that could indicate the slightly abnormal result is relevant and requires action.

- Diarise any tests required to be undertaken or repeated at a later date, and ensure that these are acted on. This should be done at an organisational level rather than just individually.
- Also consider diarising urgent tests, or ones with a high level of clinical significance, to ensure that the test has been undertaken and the result received and reviewed - for example, a PSA test in someone with urinary symptoms. Again this would best be achieved at organisational level.
- Explain to the patient how results will be communicated and what action they may need or want to take.

Undertaking and processing the test

- Check the identity of the patient and ensure that all the tests being requested are completed.
- Ensure the correct type and number of specimen containers are used and that they are labelled accurately. Confirm the patient's name and date of birth are correct.
- Record in the notes that the tests are being carried out.
- Check again that the patient understands how results will be communicated, and what actions they may need or want to take. This can be supplemented by information in leaflets, on posters, or on the practice website.
- Ensure all samples are stored correctly prior to being transported, and that a log is kept of samples stored and then sent to the laboratory.
- Have a system in place for identifying and checking expected results that have not been received.
- These systems should apply equally to tests undertaken remotely.
- If a patient cancels an appointment for a test and doesn't rebook, or doesn't turn up for a test, this should be recorded and consideration given as to whether to contact the patient and/or notify a clinician for advice.

Actioning test results internally

- Results received should be date-stamped, whether received in writing or electronically.
- No results should be filed automatically without review.
- Any results received should be managed by a recognised protocol. This should include a system for determining who reviews results (taking into account absence due to leave), standards for how quickly results are reviewed, and how urgent results received by phone, email or fax are managed.
- Any delegation of results management (such as of cervical screening results or normal mammograms) should be to someone with the knowledge, skills and experience to undertake the task, and the person should be adequately supervised.
- There should be a clear record of who has reviewed a filed result, including for locums, and when.
- There should be an identified and understood method for clinicians to indicate which action may be required for each result received, for example through an ink or electronic date stamp with a free text option. Any free text should be clear and unambiguous. The urgency of the action should be specified. It should be remembered that the result may be communicated by a non-clinician.

- It is helpful to include in free text why a particular decision has been taken in respect of an abnormal result, particularly when this is a decision not to take action.
- Systems for internally communicating actions needed on a result should be robust and auditable, with the ability to raise queries when there are uncertainties.
- All actions should be completed within an appropriate time frame, with urgent actions flagged and prioritised.
- Care should be taken to identify outstanding results that may need to be chased.

Communicating results to patients

- Patients have the right to see their investigation results. They also have the right to have them explained to them in a way that they can understand.
- Have a policy to determine which results are communicated, when and how. For example, are patients contacted about all results, even if normal? Do they receive text messages, phone calls or letters? Who is responsible for communicating results in which circumstances? For example should a clinician communicate all urgent results? How quickly should results be communicated? Results requiring urgent action should be prioritised.
- When a result requires further action, such as a repeat test or appointment, try to arrange this at the time of communication. Have a policy for determining which results may need clinician review if an appointment cannot be made, or is later cancelled, as these may need further action. Some may need follow-up to confirm that a review or repeat test has been arranged and is completed.
- The identity of the patient should be confirmed, as should consent/other justification for sharing results with another individual. For example, if the patient is a minor or someone lacking capacity.
- Be clear when communicating to patients the results and any further required actions. This includes informing them of any outstanding results, recommendations for follow-up tests, requirement for review, and the urgency or otherwise.
- Non-clinical staff should have a low threshold for referring queries about results to a clinician. A protocol should be in place to facilitate this, taking into account the nature and urgency of the query.

Common pitfalls

- A doctor reviewing test results for an unfamiliar patient missing an opportunity for action due to lack of knowledge and continuity.
- A clinician or admin team member not viewing and acting on results in a timely way.
- The need for follow-up of a patient by the practice not being adequately or correctly diarised in the system for future recall.
- Required actions by patient not being followed up – particularly where the practice have information available to indicate this risk (e.g. an uncollected acute prescription or the patient not attending an appointment).

Key points

- Ensure that you have a robust results management process in place which is followed by all members of the practice team.
- Ensure that you understand each stage of the results handling chain, and where things could go wrong.
- Report any adverse events or near misses involving test results and consider subjecting these to further analysis perhaps via a SEA.

MDDUS Resources:

GP risk toolbox