College of Physicians and Surgeons of Ontario

POLICY STATEMENT #1-11

Test Results Management

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Test Results Management

INTRODUCTION

Managing test results effectively is vital to quality patient care; failure to follow up on test results can lead to patient harm. It is recognized that test results are managed within a complex health care system and physicians cannot control every variable in the test results process. This policy establishes expectations for the variables that are in a physician's control and outlines the steps physicians are expected take to help prevent failures in follow-up on test results. The policy outlines expectations for physicians involving:

- Developing and maintaining an effective system for managing test results;
- Following up on test results appropriately.

PURPOSE

To outline expectations for physicians regarding the management of all types of test results in all of their places of work.

LEGAL CONTEXT

This policy establishes professional expectations. It does not constitute legal advice for physicians. In Canada, case law related to failures in follow-up on test results is continuing to evolve and physicians are encouraged to seek independent legal counsel or refer to current materials from the CMPA regarding legal expectations related to the management of test results.

PRINCIPLES

1. Good communication is a fundamental component of an effective doctor-patient relationship.
2. Physicians should ensure that patients are appropriately informed about their medical care.
3. When communicating with patients, physicians should recognize their patient's autonomy.

DEFINITIONS

For the purposes of this policy, the following definitions apply:

Follow-up: clinically appropriate action taken following receipt of a patient's test results.

Abnormal Test Result: is a term used by medical laboratories and other diagnostic centres to refer to a result that falls outside of a pre-determined normal range.[1] Abnormal test results are not necessarily clinically significant or critical results.

Critical Test Result: is a term used by medical laboratories to identify abnormal test results that are significantly out of the normal range and which need to be communicated to the physician and/or the patient urgently in the interest of patient safety.

Clinically Significant Test Result: is a result determined by a physician based on his or her clinical judgment to be one which requires follow-up with appropriate urgency. A physician will determine clinical significance based on his or her knowledge of the patient's symptoms, previous test results, and/or diagnosis.

POLICY

Physicians must ensure that they maintain an effective test results management system in order to ensure that appropriate follow-up on test results occurs in all of their work environments.[2] The details of these requirements are outlined below.

1. System Requirements

Any electronic or paper-based system used to manage test results must enable physicians to:

- Record all tests they order;[3]
- Record that all test results they receive have been reviewed;
- Identify high risk patients and clinically significant test results;[4]
- Record that a patient has been informed of any clinically significant result and that appropriate follow-up has occurred.

In certain health care environments, the physician who orders a test may not be the same physician who receives the test result (for example in the emergency room or a walk-in clinic). In these environments, practitioners should take extra care to ensure the system in place will ensure that the physician who receives the result can follow up on the result appropriately.[5]

1 Casalino, L.P. et al. "Frequency of Failure to Inform Patients of Clinically Significant Outpatient Test Results" *Arch Intern Med.* 2009; 169(12):1123-1129.

2 Physicians should think critically about the environment they work in and make sure that the test results management system that is in place meets the criteria laid out in this policy.

3 To record tests ordered, physicians could include a copy of the requisition form in the file, make a note on file, maintain a spreadsheet of tests ordered, maintain an electronic record, etc.

4 See guidelines section for further information about identifying high risk patients.

5 See guidance section regarding handovers of care.

Physicians are encouraged to capitalize on advances in Electronic Medical Records (EMRs) for the purpose of test results management; EMRs may make it easier to record and track tests ordered and their results and follow-up.

2. Appropriate Follow-up

Physicians have responsibility for ensuring appropriate follow-up on test results they receive for tests they order. The four key components of appropriate follow-up are outlined below:

Effective communication

When ordering a test, physicians are expected to explain the significance of the test to their patients. When in receipt of a normal result, physicians should communicate the result to their patient at their next visit. If a patient has voiced specific anxiety about a test, it may be helpful to encourage them to phone in for their results.[6] When in receipt of a clinically significant result, physicians are expected to communicate that result to their patient in a timely fashion, urgently if necessary. Physicians should ensure that the communication method they employ respects the patient's privacy and maintains their duty of confidentiality.[7, 8]

When in receipt of a clinically significant result, physicians should also use their clinical judgment to determine if it is necessary to contact other health professionals who are involved in their patient's circle of care.[9] In some situations it may be necessary to contact the patient's other health-care providers in a more urgent manner than usual (for example, by phone or fax when in receipt of a clinically significant result) or, alternatively, to encourage the patient (if appropriate) to communicate the result to their other care providers in a timely fashion.

Managing high risk patients

In all circumstances, physicians have responsibility for ensuring appropriate follow-up on test results they receive for tests they order. In some circumstances, when dealing with high-risk patients, physicians have an additional duty to follow up on tests they order and ensure the timely receipt of test results for patients who the physician has identified as being at a high risk of receiving a clinically significant result.[10] When ordering a test for a patient who has a high risk of receiving a clinically significant result and in addition to the expectations for managing all test results in this policy, physicians must:

- Communicate to the patient the added significance of taking the test; and
- Ensure results are received when expected, and tracked if not received.

Providing current contact details to laboratories

To ensure laboratories can communicate critical test results to physicians, physicians must provide the laboratory with their current contact details so that critical results can be communicated to them both during and after office hours.[11]

As it may not be possible for physicians to be available to the laboratory at all times, physicians should participate in an after hours call group, such as a telephone triage, or a specific on-call arrangement with other doctors or the local emergency department to ensure that results can be communicated.

Taking action when in receipt of a clinically significant result

When a physician receives a clinically significant result for a test that he or she has ordered, the physician is expected to take appropriate action and follow-up with the patient with appropriate urgency.

Sometimes physicians receive or become aware of a clinically significant result for a test they have not ordered. The result may pertain to their patient, a patient previously in their care, or the patient of another physician. In these situations, the physician may have a duty to inform the patient or the patient's physician of the result.[12] The more serious the result and possible consequences of the result, the more urgent it is for the physician in possession of the result to take steps to inform the patient or the patient's physician[13] of the result. If the result was sent in error, the receiving physician is encouraged to contact the diagnostic centre to notify them of the error in a timely fashion so that the information can be forwarded to the correct practitioner.

6 See guidelines section for further information about involving patients in the test results cycle.

7 See the CPSO Medical Records and the Confidentiality of Personal Health Information policies for more information.

8 See CMPA Information Letter June 2009 for more information on the risks of using e-mail.

9 The Information and Privacy Commissioner of Ontario *Circle of Care, Sharing Personal Health Information for Health-Care Purposes*, 2009.

10 See guidelines section for further information about identifying high risk patients.

11 On occasion, a laboratory may need to communicate critical test results to a physician after hours.

12 As outlined in the CMPA's Information Letter, June 2008.

13 There may be some occasions when the test result is urgent enough to warrant a phone call to the patient's physician to ensure that the information is communicated quickly.

GUIDELINES

The following guidelines may help physicians manage test results effectively:

1. How to identify high-risk patients prior to ordering tests

To identify patients who are at a higher risk of receiving a clinically significant result for a test they order, physicians may wish to consider patients who have, for example:

- Presented with serious clinical symptoms;
- Been diagnosed with a life-threatening illness.

These are just examples and the list is not comprehensive; physicians should use their clinical judgment to identify other situations in which the management of a patient's test results should be prioritized.

2. The practice of 'no news is good news' policies

Regarding test results, some physicians practice a 'no news is good news' policy. This practice may not adequately protect their patients from the harm that can be caused by failures in follow-up on clinically significant test results. Physicians should only practice 'no news is good news' policies if they are confident that the test management system in place is sufficiently robust (meeting the criteria outlined above) to ensure that patients who receive clinically significant results will be informed, and that no news really means good news.

3. Involving patients

It is often beneficial to involve patients in the management of their own test results and to encourage them to be active participants in their own care. While not appropriate for every patient, some patients may welcome the opportunity to phone in for their results after an appropriate interval. Encouraging patients to get involved in the follow-up process does not relieve the physician of their duty to follow up, but it may add a layer of protection to the test results management system and may be empowering for patients.

4. Additional measures to prevent failures to follow-up

Physicians should try to identify other obstacles in their own practices to timely follow-up and take action to ensure appropriate follow-up occurs. For example:

- Physicians who are going on vacation should ensure that follow-up on test results is handed over to another health professional in the interim who can handle patients who require urgent care.
- Physicians who interpret and report results of tests to other physicians can help to prevent failures in follow-up by contacting the ordering physician (by phone if necessary) when a potentially significant result is discovered to ensure this information is communicated quickly and that it does not go astray.[14]
- Handovers of care can present added challenges and risks for the safe management of test results. In particular, when handovers occur in environments like hospitals, emergency rooms, and walk-in clinics it is particularly important for physicians to consider the system that is in place to manage results and ensure they are confident the system will prevent pending results from slipping through the cracks during handovers of care from one physician to another.

14 For example, a physician interpreting a prenatal ultrasound where there is a risk to the fetus would phone the referring physician in addition to generating a written report.