

Tip #15: Communicating and Following-Up Critical Test Results

The Risk: The communication of test results is an important part of providing care and may involve various healthcare professionals. Test results may be over-looked, lost, scanned into the wrong record, etc. Abnormal test results requiring follow-up present an additional risk if they are not received, reviewed, or communicated to the patient. This may result in missed or delayed diagnoses, patient injuries, and subsequent claims of malpractice. If a physician orders a test, he or she is responsible for ensuring that the results have been received and reviewed. Physician practices should have policies and procedures in place for the management of test results.

Recommendations:

1. All ordered tests must be documented in the patient's medical record.
2. A process should be in place to confirm and document the receipt of test results. Many electronic health record systems allow practices to efficiently track pending laboratory/diagnostic studies.
3. All incoming laboratory reports and diagnostic tests must be reviewed and authenticated by the provider.
4. The provider must document communication of the test results to the patient. Any recommendations or interventions must also be documented.
5. Providers should have a system in place for the follow-up of pending laboratory/diagnostic test results for their patients who have been discharged from the hospital or emergency department. Receipt and review of these results should be documented in the patient's medical record. Communication of the results to the patient should also be documented.
6. It is important for physicians to clearly establish who is responsible for follow-up when tests are ordered for a patient by another specialist or consultant.
7. Patients should be advised of all test results, normal or abnormal. This communication should be documented in the medical record.