| Policy | Worcestershire NHS Acute Hospitals NHS Trust |
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# Policy for the Management of Clinical Diagnostic Tests

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| **Department / Service:** | Trust-wide |
| **Originator:** | Heather Warner |
| **Accountable Director:** | MD for Patient Safety |
| **Approved by:** | Trust Management Committee |
| **Date of Approval:** | 26TH April 2017 |
| **Review Date:**<br>**This is the most current document and is to be used until a revised version is in place** | 26th July 2019 |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments:** | Divisions & Clinical Directorates |
| **Target staff categories:** | Medical, nursing, Allied Health Professionals, Administrative |

| **Policy Overview:** |
|---|
| The purpose of this policy is to provide a framework for the development of detailed local Standard Operating Procedures, guidelines or protocols to support robust verification and communication of all diagnostic test results. The main objectives are to minimise the risk of misdiagnosis or failure/delay in diagnosis, to improve patient outcomes and quality of care. |

**Key amendments to this Document:**

| Date | Amendment | By: |
|---|---|---|
| Sep 11 | Policy drafted | H. Warner |
| Aug 12 | Policy revised following NHSLA / DNV briefing | C. Rawlings |
| Mar 15 | Revision following clinical audit – generic process now described to move on from providing a template for local SOPs | C. Rawlings<br>C. Catchpole |
| Jan 2017 | Review and updates and to incorporate standards for the communication of patient diagnostic test results on discharge from hospital | S. Graystone |
| April 2017 | Document approved at the Key Document Approval Group | KDAG |
| March 2019 | Document extended for 3 months whilst review is carried out and approved | Suneil Kapadia |

**Contents page:**

## 1. Introduction

1.1 There are screening and diagnostic tests performed in healthcare every day on both inpatients and outpatients. As healthcare providers we must ensure that these tests are required for patient management, and the results are accessed, reviewed and acted upon in a timely way for optimal patient care.

1.2 Criterion 5.7 in the NHSLA Risk Management Standards for Acute Trusts (2012) included this rationale:

*"The failure to access, acknowledge and act upon the results of diagnostic tests may result in an inappropriate delay and lack of timely treatment resulting in harm to patients. Organisations should have in place clear clinical risk management systems that identify guidance to reduce this risk.*

*These should include the ability to record timely and accurate data; ensure that staff are trained in the use of software systems that support diagnostic functions; enable communication channels that are consistent across the organisation; provide known pathways that assist in the tracking of patients; and advise patients on how their test results will be communicated to them."*

*Analysis of claims on the NHSLA database shows that a failure or delay in interpreting or acting on test results is one of the most common factors in relation to claims."*

1.3 The purpose of this policy is to provide a standard framework that describes responsibilities and the requesting process as well as setting standards for review and action regarding results. This will minimize the risks associated with failure/delay in accessing, reviewing and acting upon test results

1.4 For the purpose of this policy 'timely' is defined as:

- For inpatients no longer than 24 hours after the result is available
- For patients transferred to other providers or the care of their general practitioner a list of outstanding investigation results must be included in the transfer/discharge summary
- For outpatients, before the patients next planned outpatient/inpatient episode.

## 2. Scope of this document

2.1 This policy applies to all diagnostic testing processes undertaken within the Trust. Appendix 1 provides a list of some of the principal diagnostic tests, investigations and procedures available to clinicians to support diagnosis and clinical care

2.2 Any local policies, guidelines or SOPs should reference and follow the principles set out in this policy

## 3. Definitions

3.1 **Verification** - for the purpose of this policy, the term verification refers to acquisition, interpretation, communication and action.

3.2 **Skilled** – for the purpose of this policy, the term interpretation refers to trained or experienced practitioners/professionals.

3.3 **Interpretation** – for the purpose of this policy, the term interpretation refers to the explanation provided by the performer of the test and the understanding of the individual reviewing a test result.

3.4 **Diagnostic Tests** – These are performed on patients with specific complaints or signs or symptoms of a disease/condition – these include procedures such as laboratory tests and other pathology investigations, endoscopy, physiological measurements, and imaging procedures (a list of diagnostic tests will be developed refer to Appendix 1)

3.5 Standard Operating Procedure (**SOP)** – For the purpose of this policy all local documents will be described as SOPs e.g. a policy, guideline, protocol or Standard Operating Procedure

3.6 **ICE** – The 'ICE Order Communications' system. This system is used to electronically request and report all pathology (except blood transfusions and histopathology) and radiology diagnostic tests

3.7 **CRIS** – Clinical Radiology Information System

3.8 **Suitably trained health care professional** – Health care professionals, including medical practitioners and other staff groups who are competent to undertake the required actions (e.g. requesting investigations or receiving and taking appropriate action).

## 4. Responsibility and Duties

4.1 **Divisional Management Teams:**
Must ensure that all relevant staff are aware of and adhere to this policy. They are also responsible for ensuring that monitoring of diagnostic tests requested by their clinical teams takes place and provide assurance that results are viewed by suitable trained health care professional and acted upon appropriately: and where there is a shortfall in compliance action is taken to improve.

4.2 **All Staff employed by Worcestershire Acute Hospitals NHS Trust**

- All staff are responsible for:
  - carrying out the designated duties as outlined in this policy and within their local guidelines or equivalent protocols/Standard Operating Procedures (SOPs) where present.
  - requesting a clinical diagnostic test, investigation or screening procedure only when the result is likely to influence diagnosis or patient management.
- All clinical diagnostic tests must be undertaken by authorised healthcare staff following appropriate training where necessary.
- When diagnostic tests are requested healthcare staff must ensure that information provided includes:
  - The correct patient/service user details.
  - The appropriate clinical diagnostic test, investigation or screening procedure required.
  - The details of the appropriate healthcare worker for return of the clinical diagnostic test or screening result for viewing and subsequent action.

- The requesting of the diagnostic test must be clearly documented in the medical record
- Timely viewing and recording the receipt of the clinical diagnostic test, investigation or screening result is required; the interpretation and the consequent management plan must also be recorded in the clinical record;
- If appropriate, information regarding any urgent requests with pending results should be formally handed over to the relevant clinical team looking after the patient if there is a transfer of care e.g. out of hours or in-patient transfer between teams.
- The process for how results are communicated to the patient/service user and other appropriate healthcare staff as appropriate is also required.
- Ensure that appropriate actions on results are taken and documented, and that the method of communication is recorded, i.e. face to face contact, phone call, letter, email, fax, etc.
- Where electronic requesting is available e.g. ICE, this must be used as the primary requesting method.

4.3 **Administrative Staff**
The role of administration staff may include acquiring or the recording of the receipt of clinical diagnostic test or screening results.

4.4 Locum staff requesting investigations
Where locum staff request investigations that will not be reported before the end of their period of employment specialities/divisions must have a robust system for handing over the responsibility for care of patients managed by the locum to a named clinician, together with any outstanding investigations for that patient. The responsibility for ensuring investigation results are reviewed will then pass to that named individual.

4.5 Divisional Governance Groups
Divisional governance processes must ensure that monitoring of the timely review of investigation results is happening and where necessary improvement action is occurring to ensure practice is in line with the standards outlined within this policy. Divisions will report performance to the Clinical Governance Group with a frequency determined by that group but no less than every 6 months..

4.6 **Clinical Governance Group (CGG)**
Chaired by the Chief Medical Officer, the CGG will review the effectiveness of this policy and request for improvement actions if appropriate.

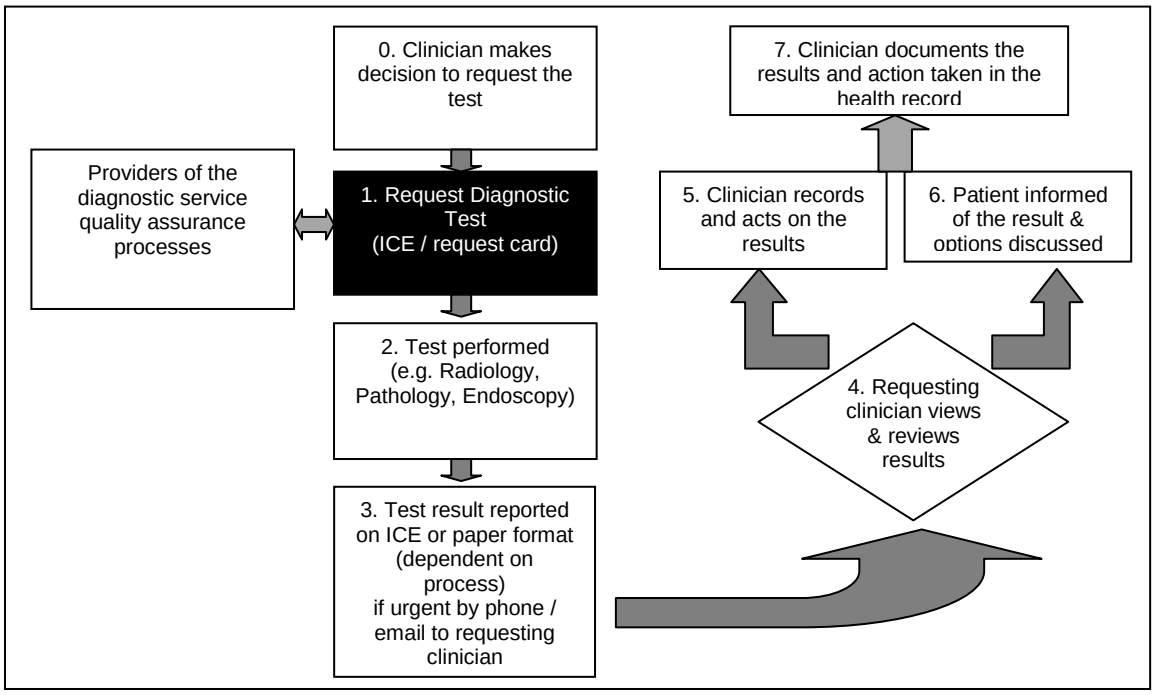
## 5. The Diagnostic Test Process - overview

5.1 **General Principles**: The elements of the diagnostic test process include the following: the decision to test, making a request, the processing/undertaking of the investigation, reporting of the results, acting upon the results, and communicating the outcome and implications of the test results to patients are set out below.

5.2 **Accessing ICE requires a password**. It is the responsibility of individual directorates/ divisions to ensure that all clinicians have a log in /access to the system including short term locums. Where appropriate an understanding of the alternative method of requesting a test, investigation or procedure may also be required.

5.3 It is the responsibility of the clinician or the clinical team requesting the diagnostic test to view and act upon the findings of the results and communicate the impact or resulting treatment options to the patient, with advice where necessary

**Diagram 1 – The Diagnostic Test Process:**



| Element | Guidance |
|---|---|
| 0. Decision made by clinician to request the diagnostic test | • Following national/local best practice guidance relevant to the patient's clinical need |
| 1. Request the test | • The request must provide full details of the requesting clinician and the patient demographic details along with the relevant clinical details.<br>• Include who requests the test and their authority to do so (see below).<br>• The request will be made electronically through ICE when it is possible to do so, or via a paper using the request form appropriate to the test required.<br>• A decision may be made by the diagnostic service not to perform the test/investigation (e.g. inappropriate test, lack of clinical information, test contraindicated)– this will be communicated back to the referring clinician. |
| 2. Test performed by the diagnostic service | The departments undertaking (or outsourcing) the diagnostic test are responsible for:<br>• The quality control and quality assurance of those tests.<br>• Performance of the test within agreed timescales |
| 3. Test result reported | The departments undertaking (or outsourcing) the diagnostic test are responsible for:<br>• Issuing the results (and providing interpretation when required) within agreed timescales on ICE or other agreed means<br>• Contacting the requesting clinician via phone, email or in person if the results need to be urgently communicated |
| 4. Requesting clinician (or clinical team) views and reviews the results | The clinical team that initiated the original investigation is responsible and accountable for:<br>• Reviewing the investigation result in a time frame that fits with the patients' clinical condition and does not compromise their safety.<br>• Validating the result with respect to the clinical context (and requesting further investigation where necessary)<br>• Documenting that the results have been reviewed and the impact on patient care in the clinical record,<br>• Acting upon the result<br>• Giving sufficient, clear and timely information to all patients (and where appropriate their families, carers, care coordinators and key-workers) about diagnostic tests and test results at discharge. This should include details of any follow-up arrangements and contact details for assistance if there are any concerns or delays.<br>• Tracing / retrieving / following up non-receipt of results<br>• Filing the results on ICE or other agreed systems<br><br>• When a patient is discharged, hospital clinical teams should have a process in place to ensure that test results are seen, acted on and communicated to general practitioners and patients in a timely and responsive manner. Responsible consultants leading clinical teams |

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| | must ensure their team members understand and comply with this local process.<br><br>• When a patient is discharged there should be a mutually agreed standardised system between primary care and secondary care to support the safe and effective hand-over of diagnostic tests and test results, including any outstanding actions where appropriate. Essential information about diagnostic tests and test results should be clearly identifiable and highlighted to avoid important information being overlooked.<br><br>• Any diagnostic tests that are processed by the Worcestershire Acute Trust Pathology or Radiology Services regardless of whether ICE was used to request the test will be viewable using the ICE system.<br><br>• Other diagnostic test results not processed by the Worcestershire Acute Trust Pathology or Radiology Services will be reported to the requesting clinician via the agreed method for that test, usually in writing / paper report. It is the responsibility of the clinician to ensure the test result is entered into the patients' medical record. |
| 5. Requesting clinician acts upon the test results | • The clinician documents the impact of the results in the patient's health record, determines the actions required and informs the relevant health care professionals responsible for on-going care. |
| 6. The clinician informs the patient of the results | • The patients will be informed of the results within an appropriate timescale and their management plan and options will be discussed. |
| 7. Recording the test results | • Documentation of the results and logging the actions taken in the patient's record, is undertaken by a member of the clinical team reviewing the results – this will normally be the requesting clinician but may be a delegated function. |

## 6. Implementation

### 6.1 Plan for implementation

Following approval the policy will be implemented through the following actions:

- Publication on the Trust's intranet
- Dissemination of information regarding the policy through the Trust Communications department
- Provision of the policy to Divisions for local implementation

### 6.2 Dissemination

This policy will be disseminated to all staff through publication on the Trust's intranet and to the Divisional Management Teams

### 6.3 Training and awareness

The training required for requesting, validation and communication of results to clinical teams will be covered in the ICE training programme (new staff receive this at

induction). There must be staff training about the verification of results process so that each staff member understands how his or her role contributes to the overall process. Training must also include locum staff having access to ICE who will receive training in requesting and accessing results in ICE using a personalised temporary account.

Any policy update will be re-launched with appropriate Trust-wide publicity

## 7. Monitoring and compliance

A range of methods will be used to monitor the effectiveness of this policy:

- ICE viewing Audit with feedback to Divisional management teams
- Diagnostic services monitoring of turnaround times against agreed standards.
- Clinical audit of paper results – to be included in clinical service audit forward plans.
- Clinical Audit of results and appropriateness of actions taken
- Audit of discharge communication to ensure test results and outstanding investigations are include in documentation and that this information has been communicated to patients and/or carers.
- Report on policy compliance by divisions every 6 months to CGG with actions to improve when standards are not met.

## 8. Policy Review

This policy will be reviewed no later than two years from its approval date.

## 9. References

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| Early identification of failure to act on radiological imaging reports, NPSA Safer Practice Notice 16, February 2007 |
| CRIS – Radiology Information System |
| ICE Order Communications – Results reporting (Trust) guide |
| WAHT-CG-564 - Early Identification of failure to act on Radiological Imaging Reports |
| ICE Requesting Handout – Web Access – Quick Guide V2 |
| ICE Requesting – Inpatient Phlebotomists Ward Round - Handout |
| ICE Requesting – Inpatient requesting Radiology and Pathology Tests - handout |
| Pathology Handbook |
| NHSLA Risk Management Standards for NHS Trusts providing Acute, Community or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care (2011/12) |
| Policy for the development, management and approval of key documents – WAHT-CG-001 |
| Policy to identify all patients – WAHT-CG-019 |
| Standards for the communication of patients' diagnostic test results on discharge from hospital. NHSE Patient Safety Domain. March 2016 |

## 10. Background

### 10.1 Consultation

The following have been consulted in the development of this policy:

Task & Finish Group
Divisional Management Teams
Pathology Directorate
Radiology Directorate

Endoscopy Directorate
ICE Project Manager
MD for Patient Safety
Heads of Nursing / Midwifery
Matrons

### 10.2 Approval process

This policy will be approved by the Key Documents Approval Group following the consultation process described above.

### 10.3 Equality requirements

This policy does not have equality impacts.

### 10.4 Financial risk assessment

There is no specific financial risk associated with the implementation of this policy. The systems for requesting and reporting the results of diagnostic tests are in place.

The implementation of this policy should lead to improved reliability, reduce delays, reduce the harm caused to patients and over time reduce claims related to missed or delayed diagnosis.

**APPENDIX 1**

**List of Clinical Diagnostic Tests Procedures**
Examples to be considered can be seen below (NB this list is not exhaustive):

**Cardiac Investigations**
ECG
Exercise testing/stress testing
Ultrasound
Angiography

**Near Patient Testing**
Blood glucose
Blood pressure
Body mass index
Urinalysis
Blood gas analysis

**Pathology**
Biochemistry
Haematology
Non-gynae Cytology
Histology
Microbiology
Andrology
Immunology

**Radiology**
Ultrasonography
X-Ray
CT
MRI
Dexa scan
Nuclear medicine
Fluoroscopy
Mammography

**Respiratory Tests**
Lung function
Sleep investigations

**Other**
Urodynamics
Vascular ultrasound
Endoscopy
Colposcopy
Maternity ultrasound
Maternal Cardiotocography (CTG)
Neurophysiology

## Supporting Document 1 – Checklist for review and approval of key document

This checklist is designed to be completed whilst a key document is being developed / reviewed.

A completed checklist will need to be returned with the document before it can be published on the intranet.

For documents that are being reviewed and reissued without change, this checklist will still need to be completed, to ensure that the document is in the correct format, has any new documentation included.

| | | |
|---|---|---|
| 1 | Type of document | Policy |
| 2 | Title of document | Policy for the management of clinical diagnostic tests |
| 3 | Is this a new document? | Yes ☐ No ☒<br>If no, what is the reference number<br>**WAHT-CG-746** |
| 4 | For existing documents, have you included and completed the key amendments box? | Yes ☒ No ☐ |
| 5 | Owning department | Corporate Clinical Governance |
| 6 | Clinical lead/s | AMD Patient Safety & Clinical Effectiveness |
| 7 | Pharmacist name (required if medication is involved) | n/a |
| 8 | Has all mandatory content been included (see relevant document template) | Yes ☒ No ☐ |
| 9 | For policies and strategies, does the document have a completed Equality Impact Assessment included? | Yes ☒ No ☐ |
| 10 | For patient information, have you piloted the leaflet? If yes, please give details. | Yes ☐ No ☐<br>N/A ☒ |
| 11 | Please describe the consultation that has been carried out for this document | Review with the Divisional Management Teams and diagnostic test providers. |
| Once the document has been developed and is ready for approval, send to the Systems and Standards department, along with this partially completed checklist, for them to check format, mandatory content etc. Once checked, the document and checklist will be returned to yourself, to submit to relevant committee for approval. | | |
| 12 | **Step 12 To be completed by Systems and Standards Department**<br>Is the document in the correct format?<br><br>Has all mandatory content been included?<br><br>Date form returned _____/_____/_____ | <br>Yes ☐ No ☐<br><br>Yes ☐ No ☐ |
| 13 | Please state the name of the approving body (person or committee/s) | |

| | | |
|---|---|---|
| 14 | Approval date | _____/_____/_____ |
| 15 | Please state how you want the title of this document to appear on the intranet, for search purposes and which specialty this should be saved under | |

**Implementation**
Briefly describe the steps that will be taken to ensure that this key document is implemented

| Action | Person responsible | Timescale |
|---|---|---|
| Implementation plan devised with DMT's to include monitoring of compliance | AMD Pt Safety | April 2017 |
| | | |
| | | |
| | | |

**Plan for dissemination**

| Disseminated to | Date |
|---|---|
| All staff via the Trust's intranet | |
| Divisional Management Teams | |
| Medical staff via clinical forums | |
| | |

**Please return an electronic version of the approved document and completed checklist to the Clinical Governance and Patient Safety Department**

**Please sign below**

**Name** _____

**Designation** _____

**Date** _____

| Office use only | Reference Number | Date form received | Date document published | Version No. |
|---|---|---|---|---|
| | | | | |

**Supporting Document 2 - Equality Impact Assessment Tool**
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the policy/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | N/A | |
| **4.** | **Is the impact of the policy/guidance likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | N/A | |
| **6.** | **What alternatives are there to achieving the policy/guidance without the impact?** | N/A | |
| **7.** | **Can we reduce the impact by taking different action?** | N/A | |

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

## Supporting Document 3 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval