

# *Critical Test Results*

## **Troubleshooter**

Practical Strategies and Tools for JCAHO Compliance

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# CONTENTS

List of figures .....	v
Index of questions .....	vii
About the author .....	.xi
Foreword .....	.xiii
Introduction .....	.xv
<b>Chapter 1: Room for improvement .....</b>	<b>1</b>
“Why do we need to do better?” .....	3
Physician support .....	7
Take the long view .....	9
<b>Chapter 2: Elements of a workable policy .....</b>	<b>11</b>
“Why does it take so long to get a critical result?” .....	13
Define your most critical test results .....	14
Refine your critical value policy .....	18
Collect data .....	21
Put your data into action .....	23
Fewer hand-offs, faster communication .....	26
Nurses are a “critical” component .....	34
Smallest is best .....	36
<b>Chapter 3: What is critical? .....</b>	<b>39</b>
<b>Chapter 4: What is timely reporting? .....</b>	<b>59</b>
<b>Chapter 5: How should we handle read-back? .....</b>	<b>87</b>
“When is a read-back required?” .....	89

## CONTENTS

---

<b>Chapter 6: Who gets the call?</b> .....	103
<b>Case Study: Read-back</b> .....	113
Sleepy Eye Medical Center .....	116
CoxHealth .....	116
Inland Surgery Center .....	117
<b>Appendix</b> .....	121
Sample read-back policy .....	123
Mount Auburn Hospital cardiology data collection tool .....	126
Mount Auburn Hospital training tools .....	127
Sample educational tool for communicating critical test results .....	130
Troubleshoot your CTR reporting policy .....	133

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## LIST OF FIGURES

Figure 2.1 Mount Auburn Hospital laboratory critical value list . . . . .	16
Figure 2.2 Mount Auburn’s critical test result reporting policy in action . . . . .	20
Figure 2.3 Sample data: Reporting times for laboratory vs. radiology . . . . .	24
Figure 2.4 Example of a measurable performance improvement . . . . .	26
Figure 2.5 Mount Auburn Hospital sample lab results . . . . .	30
Figure 2.6 Mount Auburn Hospital critical result policy—radiology . . . . .	32
Figure 2.7 Mount Auburn Hospital critical result policy—cardiology . . . . .	33
Figure 3.1 Positive results—radiology . . . . .	49
Figure 3.2 Positive results—cardiology . . . . .	50
Figure 3.3 Mount Auburn Hospital Critical Value Policy . . . . .	52
Figure 3.4 First time critical results, subsequent results . . . . .	56
Figure 4.1 Reporting results to ED and ICU physicians . . . . .	66
Figure 5.1 Read-back compliance . . . . .	93
Figure 6.1 Inpatient vs. outpatient policies . . . . .	109
Case Study Inland Surgery Center read-back policy highlights . . . . .	119
Figure A.1 Sample read-back policy . . . . .	123
Figure A.2 Mount Auburn Hospital data collection tool . . . . .	126

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# Room for improvement

*“Why do we need to do better?”*

Practitioners at every facility—even at hospitals with a strong track record for communicating critical test results—need to have a compelling answer for this question.

To keep your policy on the reporting of critical test results running well and to help your staff constantly strive for improvement, executive-level support is as essential as buy-in from physicians and other caregivers.

Probably the best way to get and keep that support is to remind everyone about the consequences of delays and miscommunications—and how these consequences can affect your entire organization.

You don’t have to look far to uncover some compelling facts and figures that can help you make your case. Throughout much of the literature about critical test

results, it is very easy to find evidence that shows effective communication can improve patient safety and does reduce errors and complications.

Unfortunately, delays in communicating these results still happen far too frequently. National Patient Safety Goal (NPSG) 2, “Improve the effectiveness of communication among caregivers,” has been part of the Joint Commission’s NPSG list since 2004.

However, ineffective communication is described as “the most frequently cited category of root causes of sentinel events” in the JCAHO’s NPSG Implementation Expectations.

There is plenty of data to support the JCAHO’s statement. In one study of adverse events among inpatients, for example, it was found that faster and more appropriate responses to critical laboratory results might have prevented 4.1 percent of adverse events, and another 5.5 percent of adverse events might have been prevented by the improved communication of lab results.<sup>1</sup>

In addition, other hospital studies have shown that there are often substantial delays in responding to critically abnormal test results. In one study, for example, there was found to be “a delay of more than five hours before beginning treatment related to a critical result, in 27% of patients.”

The same study indicated that longer delays in treatment could increase mortality rates—by as much as 13%.<sup>2</sup>

With these stark findings in front of us, it is easy to understand why communicating critical test results effectively should be a major concern at every level in every hospital. However, nationally, I have heard from many facilities that getting high-level support remains a challenge.

At Mount Auburn, we enlisted some of our top staff for our hospital-based Critical Test Results Task Force Committee from the very beginning, and made sure to keep administrators as well as RNs and MDs in the loop as to what we were trying to do, why it was important, and the progress we made.



#### QUICK TIP

Information is one of your most effective tools: Keep your leaders informed about new developments, problems, and changes in your critical test result policy.

Our Critical Test Results Task Force Committee included the following:

- Chief Operating Officer
- Director of radiology
- Director of cardiology
- Laboratory director
- Doctors representing all testing areas
- IT staff
- QA and patient safety officers
- Nurses

We met monthly to chart our progress and used our annual Education Day (which everyone in the hospital must attend) to stress the importance of our plans to improve the communication of critical test results and keep all staff apprised of policy changes and what these changes might mean for them.



### **QUICK TIP**

Getting high-level attention to your critical test result reporting policies might not be easy, but be persistent, and be prepared to show administrators how this issue will affect them directly.

## Physician support

*“We know we need to do a better job of quickly reporting critical test results, but how do we get doctors on board?”*

I have heard this question quite frequently. People often assume that implementing new processes or changing established practices for communication of critical test results will be too bothersome to physicians.

My response is this: If you have a really focused, concise critical value list, the calls made to the physicians should be infrequent and therefore will not be considered bothersome. The shortness of the list determines the number of calls you’ll be making to the physician.



**QUICK TIP**

Short list = fewer calls = less “bother.”

Our doctors believe the less-is-more approach is very positive and helpful—and all of our practitioners understand that an effective critical test result reporting system can save lives when minutes count.

Mount Auburn Hospital’s decision to go to a direct-to-physician notification system many years ago was based on the result of a critical incident and, in its aftermath, a hospitalwide understanding that we had to improve our critical test result communication processes.

Our mission to improve began in our laboratory, but these first steps also included physicians and staff from other departments, and we couldn’t have succeeded without everyone’s input.

## Take the long view

*“Where should we start?”*

No matter where your hospital’s quest for better critical test results communication begins, realistic, workable policies and standards must be put in place and then reevaluated regularly.

Only this type of long-term strategy will improve an institution’s overall ability to consistently communicate critical test results in a timely, reliable way.

Our laboratory had close to 20 years’ experience communicating critical test results to the ordering physician, but we found that when we took the lessons we learned from the lab and extended them to radiology, cardiology, and our other diagnostic testing areas, there was—and might still be—room for improvement in our system.

In order to prevent as many communication lapses as possible, every institution needs to continually make the same evaluation.

Rethinking and refining your facility’s communication policy for critical test results might seem like an overwhelming project, but it is vital in today’s healthcare environment of increased regulatory scrutiny and rising demands for accountability.

Even if your institution has already implemented a workable policy for communicating critical test results, you must understand that the reevaluation process is equally important, because critical values, caregiver needs, and patient populations change.

However, there are also rewards for having an effective CTR reporting policy in place. Probably the greatest benefit we have seen is the expectation of effective communication—timely critical test result reporting is a given now. All practitioners know we're trying to do this as quickly and safely as we can, and they understand the need for it.

That expectation is part of the reason Mount Auburn received a 2006 Excellence in Patient Safety Award for communication of critical test results from the Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Hospital Association.

### **Footnotes:**

1. G.J. Kuperman, MD, and others, "Improving Response to Critical Laboratory Results with Automation: Results of a Randomized Controlled Trial," *Journal of the American Medical Informatics Association* 6, no. 6 (Nov./Dec. 1999): 513.
2. G.J. Kuperman, MD, and others, "How promptly are inpatients treated for critical laboratory results?" *Journal of the American Medical Informatics Association* 5 (Jan./Feb. 1998): 112–119.

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