The Problem: Failure to Inform of Abnormal Tests

Background:
- Diagnostic errors are most frequent cause of claims
- Failure to inform/document are legally indefensible

Study showed:
- Failure to inform/document informing was 7.1%
- Use of partial EMR & paper progress notes had highest failure rates

Conclusion
- A common problem
- Use a simple process for managing results

The Problem (con’t)

Findings:

- Ranges 6.8% to 62% for laboratory tests
- 1.0 - 35.7% for radiology
- Test management practices varied with multiple staff involvement
- Few guidelines of responsibility for patient notification and follow up

Impact:

- Missed cancer diagnosis

The Problem: Orders on Day of Discharge

• Affects 20% - 61% of in-patients tests
• Tests ordered earlier in stay have a better chance of review
• Tests ordered on day of discharge = opportunity!
  – Have a shorter time window for review
  – Accounted for 65.5% of all abnormal results that were un-reviewed
  – Contributes to: 1 in 5 patients experiencing an adverse event transitioning from hospital to home with 62% preventable

When Physicians Were Asked…

If they thought they had missed a lab in the last year:

- 21% thought they had
- 47% thought a colleague had
Case Study

1. Missed diagnosis
2. Communication and patient instruction
3. Test management
   a. Process of test ordering, reporting, reviewing and follow-up
4. Team leadership and support
5. Organizational Safety Culture
   a. Name and blame
   b. Punitive Culture
   c. Organizational Ethics
A Safety Strategy - Involve the Patient

When your doctor orders tests for you...

1. Make a note of which tests they are so that you can check that the correct test is being performed
2. If you don't hear back from the office about the results, give them a call to follow up.
3. Make sure that the right tests were done and that you know the results and what they mean for you and your health
What Learning Will You Take Home?

1. Review test management process and test for vulnerabilities
2. IT (abnormal test result flags) and communications technologies (alerts) should be integrated
3. Consider the multidisciplinary nature of the process and include stakeholders in the design of the process
4. Include the role of the patient as a possible safety net against error
5. Don’t forget the continuum of care communication!
Thank You for Sharing!