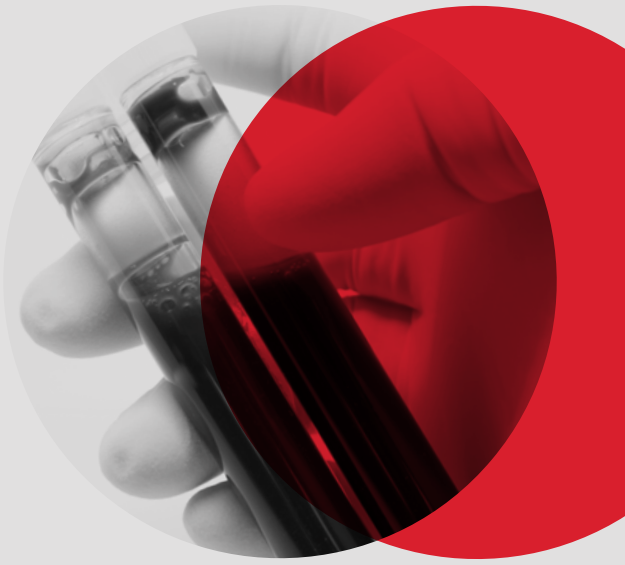
A KIMMS survey on high risk results handover



Stephanie Gay[1], Tony Badrick[1], Ken Sikaris[2]

[1]Royal College of Pathologists of Australasia Quality Assurance Programs – KIMMS program, Sydney, Australia;
[2]Chair KIMMS advisory committee, c/o Melbourne Pathology, Victoria, Australia;

Clinical handover is an area of high patient risk that is recognized by ACSQHC[1]. The RCPAQAP KIMMS group ran a survey to investigate the current state of play with regards to finding, communicating and recording High Risk (HR) results in Australian pathology laboratories. A survey was distributed to 71 Australian laboratories. All of these representative laboratories participate in RCPAQAP programs – Clinical Pathology, Haematology or Microbiology.

The survey asked about the demographics of the laboratory, what their critical results process is, how this is monitored and finally, the actual number and type of critical results obtained on a typical day.

Definition: A HR result is one deemed to be of high enough risk to patient health that is should be immediately notified by phone. They are also known as critical results[2].

Responses

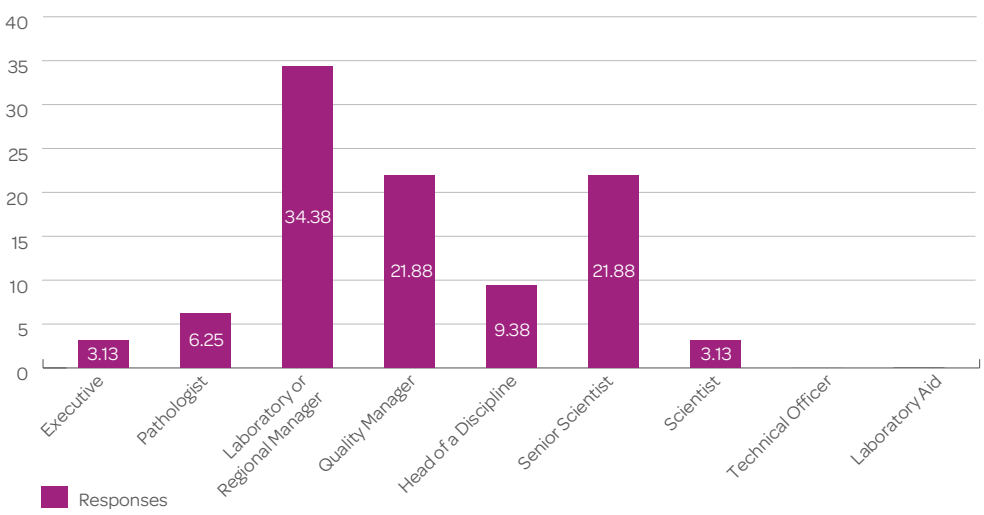
These were received from a variety of different staff and a range of disciplines as seen in the graphs below.

34% of respondents said communication of HR results were a problem.

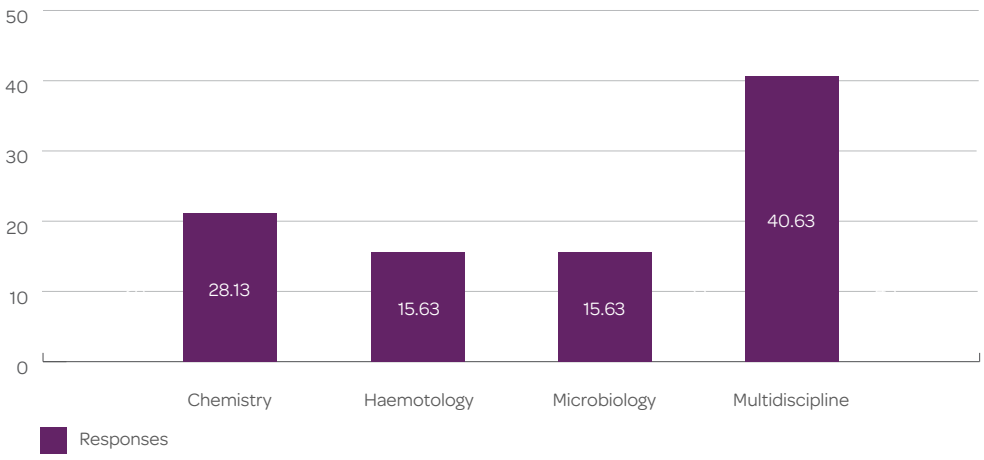
92% of laboratories have reviewed their HR results policy in the last 3 years.

15% of respondents said they did not have an escalation policy for when it was not possible to communicate a HR result. Of 25 respondents who indicated an escalation policy, 20% did not involve a pathologist from their organisation.

This survey asked participants to: Please choose from the drop down options the role you, the responder, hold in your organisation.



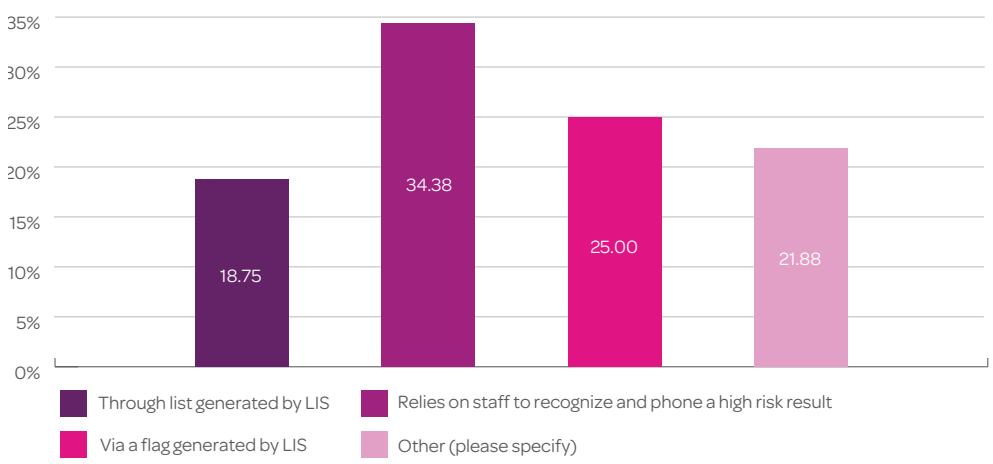
This survey has been sent to participants in Chemistry, Haematology and Microbiology. Which discipline do you represent? If you work in a small, multidiscipline laboratory, you may answer for all 3 disciplines.



Monitoring

Over a third of responding laboratories rely on staff to recognise HR results. Where a list is produced by the LIS (19% of the time), two thirds of these are monitored by scientists and pathologists the other 30% are monitored by results staff. Most responders (70%) stated that the person who authorises/validates the results is responsible for phoning the result

This survey asked participants: How does your department/laboratory monitor high risk results?



High Risk Results

Reports were received on 333 episodes from 39 laboratories that resulted in 345 HR results (see table below). 43% of collections were from inpatients, followed by 30% from community collections (GP's, nursing homes etc), 14% from emergency departments and 13% from outpatients. Anywhere from 3 to 120 HR results were found on any single day.

Category	Amount	As % of total
Potassium	39	11.3%
Haemoglobin	38	11.0%
Blood culture	33	9.6%
Troponin	31	9.0%
Neonatal Micro	12	3.5%
WCC	16	4.6%
INR	5	1.4%
CSF	1	0.3%
Other Chemistry	104	30.1%
Other Haem	25	7.2%
Other micro	13	3.8%
Test not recorded	5	1.4%

Notification Time

Only 119 of the 333 results had the time taken to notify the referrer recorded. As this is likely to be the major KPI for notification of HR results, this is a poor outcome. It is unknown whether this information is not kept or is too difficult to extract from laboratory's LIS.

Discussion

As expected, most HR results are from inpatients and emergency departments, however a significant number come from non-hospital situations (43%). A third of respondents still find communication of HR results a problem, and a third do not see this issue as a "a clinical transfer". There is no common practice of when a pathologist should be called into an escalation procedure, and in many cases they are not involved. More than a quarter of laboratories rely on staff to recognize a HR results i.e. with no input from the LIS system.

Conclusion

There are many different practices in the management of HR results in Australia. Best practice has been outlined in the document Consensus Statement for the Management of Laboratory Results that Pose High Risk to Patients and Require Timely Communication.[2] The results of this survey will be discussed in conjunction with the above statement at the next KIMMS workshop.

References
1. https://www.safetyandquality.gov.au/publications/nsqhs-standards-fact-sheet-standard-6-clinical-handover/
2. https://www.aacb.asn.au/documents/item/2324

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