University Hospitals of Leicester NHS
NHS Trust

# Diagnostic Testing Procedures UHL Policy

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| **Author / Originator(s):** | **Review:** Dr Dan Barnes, Deputy Medical Director |
| **Name of Responsible Committee/Individual:** | Medical Director |
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## CONTENTS



### Changes made at review

1. 6.4.1 (i) This states that requesters must always follow the locally agreed pathways for requesting a diagnostic test particularly if there is a different process for in and out of core working hours.

2. 6.4.2 This provides a high level process for the rejection of diagnostic imaging requests.
3. 6.4.3 (g) This now highlights that CRIS/ eCRIS is the primary source for all radiology reports including both primary reports and addendums.
4. 6.4.3 (h) If a clinically significant addendum is added to a primary report then this should be directly communicated to the referrer.

## KEY WORDS

NHSLA Standards, Diagnostic tests

## 1 INTRODUCTION

1.1 This policy sets out University Hospitals of Leicester NHS Trust guidance for how clinicians (doctors, physician assistants, nurses, midwives, allied health care professionals) request diagnostic tests, acknowledge, act on and inform patients of results.

1.2 It is important the hospital teams are clear on where responsibility lies relating to both the review of diagnostic tests and any subsequent action needed. The General Medical Council (GMC) states that traditionally a clinician who orders a test is responsible for receiving and acting upon the results once available. This may require direct action by the clinician or a transfer of responsibility to another clinician.

1.3 Delegation of responsibility is a vital part of how the Trust functions and therefore it is imperative that such delegation must be clear, appropriate and flexible to manage planned and unplanned absences of various clinical team members including the responsible consultant.

1.4 The guidance in this policy must be viewed as an interim solution whilst awaiting a fully integrated electronic patient records system.

## 2 POLICY AIMS

2.1 This policy aims to provide a set of Trust-wide principles and processes for managing diagnostic testing in the following:

a) Requesting diagnostic tests

b) Acknowledging diagnostic test results

c) Acting on results (including timescales)

d) Informing patients of results (including timescales)

e) Monitoring and auditing arrangements to ensure compliance with the above

## 3 POLICY SCOPE

3.1 This policy applies to the management of diagnostic tests carried out on patients within UHL and in Community Hospital out-patient or pre-assessment clinics staffed by UHL clinicians.

3.2 This policy is intended to complement existing local /national guidelines policies and regulations such as (this list is not exhaustive):

a) Laboratory Manuals for pathology staff

b) The Ionising Radiation (Medical Exposure) Regulations, Dept of Health 2000.

c) Written policy for Rapid Notification of an unsuspected diagnosis of cancer including local contact information.

d) UHL Point of Care Testing (POCT) Equipment strategy

3.3 This policy applies to all medical staff, nursing staff and health care professionals who request diagnostic tests on in-patients, out-patients and Emergency Department attendees.

3.4 This policy relates to tests performed on in-patients, out-patients and Emergency Department attendees.

3.5 It applies to patients who have diagnostic tests performed as in-patients, outpatients or whilst in the Emergency Department but who go home before the result is available.

3.6 It applies to patients who have diagnostic tests requested whilst they are an in-patient, outpatient or whilst in the Emergency Department but who go home before that test is performed.

3.7 This policy relates to tests performed remotely and also to Point of Care Testing carried out within the Trust. The UHL Point of Care Testing (POCT) Equipment Strategy must be referred to for such procedures.

### 3.8 Exclusions

This policy does not comment upon how diagnostic results are managed by clinicians once results have been communicated outside of the Trust e.g. into Primary Care.

## 4 DEFINITIONS

### 4.1 Diagnostic Test

A test, investigation or measurement performed on patients within the Trust to determine what conditions, diseases or syndromes a patient may currently have or is likely to develop, to monitor patients during treatments, and to inform future treatment options. See Appendix A.

### 4.2 Acknowledgement of result

A recorded acknowledgement of receipt of a result by a clinician, (either electronically, documentation in the hospital records, or as a signature and date for paper copy results), implying acceptance of responsibility for the result.

### 4.3 Management of diagnostic procedures

For purposes of this policy, this refers to:

a) How a diagnostic test is requested

b) How the clinician treating the patient is informed of the result, taking into account timescales for return of test results where these have been agreed (See Appendix B).

c) How the patient is informed of the result, including timescales

d) Actions to be taken by the clinician, including timescales

e) How the above are recorded

f) How the Trust monitors compliance with all of the above

## 5 ROLES AND RESPONSIBILITIES

### 5.1 Chief Executive

Accountable for the quality of care provided to patients undergoing diagnostic tests within the Trust, and retains overall responsibility for implementation of this policy.

### 5.2 Medical Director

Provides Board assurance for quality and safety in respect of diagnostic testing.

### 5.3 Deputy Medical Director (Acting on Results)

Responsible for ensuring a Trust-wide policy for the Management of Diagnostic Testing Procedures is developed, and for providing Board assurance that the policy is implemented.

### 5.4 Clinical Management Group (CMG) Clinical Director

Responsible for ensuring that all Specialties and clinical areas within their CMG have developed a policy for the management of diagnostic testing procedures and that this is risk assessed and highlighted on the CMG risk register (if the central policy could not be delivered), regularly monitored and audited and annually reviewed.

*Specialty Leads*

Responsible for ensuring that

a) Departmental policies for 'acknowledging and Acting on Results' are developed and made widely available to all requesting clinicians and are regularly reviewed to ensure that they are appropriate to ensure safe high-quality patient care.

b) Copies of these departmental policies should be available on SharePoint.

c) Each Consultant in their specialty is required to complete a Consultant Statement within the annual job planning review process, agreeing to the Specialty process for management of diagnostic testing procedures. Where applicable, the Specialty Lead should facilitate the consultant to take steps to reduce risk in their working practice.

### 5.5 Consultants

Responsible for ensuring that diagnostic test requests and results for their patients are appropriately managed, as per this policy. They must describe how they (and their team) manage diagnostic test results, and inform patients of results (Specialty Policy and Consultant Statement, Appendix C& D and E &F).

A discharging consultant and/or their delegated team members are responsible for ensuring that all results are acted upon and communicated to the patient and GP appropriately.

### 5.6 Junior Doctors

Responsible for ensuring that diagnostic test requests and results for their patients are well managed, as per this policy. They must be able to describe how they (and their team) manage diagnostic test results, and inform patients of results (Specialty Policy and Consultant Statement, Appendix C& D and E &F), and take part in related monitoring within the annual appraisal system.

### 5.7 Physician Assistants

Physician Assistants must confirm agreement with CMG or specialty policies for the management of diagnostic testing procedures and take part in related monitoring within their annual appraisal system.

### 5.8 CMG Head of Nursing (or Matrons where delegated) and Therapy Heads of Dept

Responsible for ensuring any Specialist Nurses/Advanced Practitioners or other AHPs, who request diagnostic tests, prepare a Statement within their annual appraisal process, agreeing to Specialty process for management of diagnostic testing procedures.

### 5.9 Advanced Nurse Practitioners and Allied Health Professionals (who request diagnostic tests)

Responsible for ensuring that diagnostic test requests and results for their patients are well managed, as per this policy. They must describe how they (and their team) manage diagnostic test results, and inform patients of results (Specialty Policy and Consultant Statement, Appendix C& D and E &F), and take part in related monitoring within the annual appraisal system

### 5.10 Departments Responsible for generating diagnostic results

Responsible for ensuring that diagnostic results are communicated reliably to an appropriate clinician by agreed mechanisms and in an agreed time period, as per departmental guidelines/ policies (Appendix B).

### 5.11 All Clinical and administrative staff

Have a responsibility to:

a) adhere to Trust and local policies and guidelines

b) be able to demonstrate competency, and undertake training as necessary

c) always use their allocated log-on and passwords when required

## 6 POLICY STATEMENTS, PROCESSES AND PROCEDURES

This section sets out the Trust-wide principles and processes for managing diagnostic procedures, the requirement for Specialty and Consultant statements on managing diagnostic results, and how they will be risk assessed and monitored.

### 6.1 Specialty statements

a) All CMGs/Specialities need to review and agree a CMG/Speciality policy, as per this policy, for all investigations, describing how their Consultants and their multi-professional teams manage diagnostic tests, including timescales, taking into account national guidelines where available (Appendix C)

b) All Specialties and teams should decide how they as a team of Consultants, trainee doctors, nurses, midwives and Allied Health Professionals are going to order, acknowledge and action results for both in-patient and out-patients under their care.

c) Currently, the methods for this will vary by location of the patient and by the individual test.

d) The complexity of this means that Specialties must be explicit in how this will be achieved and in what timescales. It must be clearly stated for each Specialty and agreed at CMG level. It will then be the responsibility of each clinician to abide by the Speciality policy.

e) A document outlining how a specific Specialty of Consultants and their team manage and risk assess diagnostic test results must be produced and reviewed annually by the CMG and held at CMG Clinical Director level and be available on Share Point (Appendix C and D).

### 6.2 "Consultant" Statement on managing diagnostic procedures

a) All Consultants, Nurses, Midwives and AHPs involved in managing diagnostic testing procedures must complete a statement in their annual job planning review (medical staff) or appraisal detailing agreement with the agreed Specialty process (See Appendices E and F).

b) Consultants, nurses and allied health professionals not involved in managing diagnostic procedures are exempt.

### 6.3 Risk Assessment of CMG / Consultant Statements

Specialty and "Consultant" Statements must be risk assessed by the Specialty (Appendix D & F) and then by the CMG Quality/Safety Board. The CMG Quality /Safety Boards must produce an assurance report annually to Executive Quality Board.

### 6.4 Trust-wide principles and processes for managing diagnostic tests

#### 6.4.1 How diagnostic tests are requested

a) A clinician must request a test only if it is expected to impact upon the management of the patient and if they have the appropriate authority.

b) Requests are made using established electronic formats ('paper only' in cases where it is currently not possible).

c) Requests must contain sufficient accurate patient identifier details (including NHS number, up-to-date demographic information).

d) Relevant requester's contact information should be clearly stated to enable the request to be discussed where appropriate, and results to be communicated to the appropriate clinician and location.

e) All requests must have sufficient clinical information to allow justification and performance of the test.

f) If the request is urgent or time critical this should be identified on the form or electronic request, or the relevant department should be contacted by telephone

g) Staff must obtain their own unique log-in to request tests and this unique log-in must be used on all occasions.

h) For planned tests the requesting clinician should indicate a time frame and confirm patient availability for the test.

i) Requesters must conform to any variations in the way requests are made and/ or discussed if there is variance in and out of core working hours particularly for those specialities still working an on-call system at any grade.

### 6.4.2 Process for rejection of requests

a) As per local guidelines if a diagnostic test is rejected this should be recorded and communicated to the referrer including the reason why the test has been rejected.

b) Any rejection communication should include a point of contact (person or department) with whom the referrer can discuss the case.

c) Specifically for radiology the reason for a rejected inpatient request should be recorded on CRIS which can be viewed by the referrer on iCRIS. Imaging have formal guidelines for rejection of referrals which can be obtained from the department if required.

### 6.4.3 How the clinician treating a patient is informed of a result

a) As a default position, a clinician or clinical team requesting a test are responsible for receiving and taking action on the results once available. Any delegation or transfer of this responsibility, within, or between clinicians and teams, must be clear and where appropriate documented, and be flexible enough to manage planned and unplanned absences of various team members including the responsible consultant.

b) The exception to the above (a) is if a patient moves between clinical teams during admission, then it is the responsibility of the clinical team under whose care the patient has been placed, to acknowledge and act on any results that become available whilst the patient is under their care.

c) When a patient is discharged, hospital clinical teams should have a process in place to ensure the test results are seen, acted on and communicated to GP and patients in a timely and responsible manner.

d) The discharging consultant is responsible for ensuring that all results are acted upon and communicated to the GP, if the patient is discharged before any result becomes available.

e) Diagnostic test results are communicated to the responsible clinician via established systems, i.e. electronic. As the Trust moves to paper light results may not be available on paper format.

f) The laboratory currently ensures that results that fail critical limits are alerted by phone to the concerned ward or clinician. It is the responsibility of the CMG/Specialty to inform labs of appropriate contact numbers/email addresses where this information should be relayed. The list and value of results that are alerted by phone are as per established protocol in the laboratory. This service is considered to be a back-up service. The primary responsibility for reviewing results remains with the requesting clinician.

g) CRIS (radiology access) or eCRIS (clinician access) remains the Radiology information systems and are the reference point for accurate final radiology reports. Reports on PACS and ICE are secondary feeds from CRIS and may not be the most up-to date version. This includes both the primary report and any addendums added at a later date.

h) An additional direct response should be made in the following circumstances.

- Clinically significant discrepancies from the original communicated report after an internal review including the addition of a clinically significant addendum.
- Unexpected clinically significant results.

Clinical radiologists are trained to recognise clinically critical or urgent conditions and can recognise when direct communication is important.

In the acute scenario the radiologist should alert the clinical team of critical results where emergency action is required as soon as possible. In the absence of visible interval appropriate treatment or knowledge of on-going review of reports by the referrer, the radiologist should contact the referrer or the available on-call team directly.

The current GE PACS system now has an embedded function (CONSERUS) to allow the reporting radiologist to electronically alert the requesting named consultant to the result as appropriate. Where the finding is clinically acute and may alter patient management it should not replace direct communication with the patient team. See Guidelines: Imaging and Medical Physics Acting on Results – Imaging Local Guidelines, agreed by the CMG Deputy Director, CSI on INsite.

g) If a planned diagnostic test is cancelled (as opposed to postponed) due to patient factors (including non-attendance, medically unfit, deceased) the referral will be returned to the test requestor with information as to reason for this as per policy.

h) In the absence of test results the clinician should contact the appropriate laboratory to follow up the result. If there is no record of the test sample being received, the clinician needs to contact the patient and GP to determine whether the test has been performed.

i) Timescales for reporting: UHL has varying standards for reporting pathological and radiological investigations depending on their nature and their place of referral.

These are set out in Appendix B.

**j) Suspected malignancy**

The Lead Clinician for cancer imaging has agreed that there is a requirement for rapid notification of an unsuspected diagnosis of cancer to the referrer and also directly to the relevant Multidisciplinary Team. A specific code for the MDT must be used by the Radiologist and reporting radiographers. A report of all patients coded for a specific MDT is sent to the MDT coordinator. A copy of the report is sent to the Consultant identified on the request as looking after the patient this includes GPs and external referrers.

The clinician needs to communicate the unsuspected results to the patient and the GP and inform them of the process of MDT.

See Policy: Written Policy for Rapid Notification on an unsuspected diagnosis of cancer including local contact information, agreed by the lead clinician for cancer imaging. (Trust reference C113/2005)

k) Images and results must be available to all clinicians electronically on a central system (preferably a single system for ordering and accessing test results).

### 6.4.4 Actions to be taken by the clinician when results are available

a) All diagnostic tests must be clinically evaluated. Where no report is generated, e.g. fracture clinic x-rays, documentation of clinical assessment in the notes effectively indicates receipt and endorsement of the result.

b) Clinicians must review, and act upon diagnostic test results, within a timescale that is not expected to adversely affect patient care.

c) In respect of tests requested in Outpatients, clinicians must review and act on all results within 15 working days of receipt.

d) When a clinician requests a test, they accept responsibility to ensure it is interpreted and acted on appropriately (this may include seeking senior opinion, or delegation of responsibility).

e) Actions on receipt of diagnostic tests must be documented in the patient's notes with a letter to the patient and their GP. If the patient attended ED, is an out-patient or has been discharged after an in-patient admission, it is not acceptable to expect that GPs should be responsible for chasing up the results of diagnostic tests performed whilst patients are in-patients, even if the patient has subsequently gone home. It is the responsibility of the requesting clinician, unless communication with the GP is clear in regards further management based on test results.(see 6.4.4d)

### 6.4.5 How the patient is informed of the result

a) How a patient is informed of results must take into consideration the sensitivity of the test/result, the clinical picture and setting, and any specific communication needs of the patient.

b) Health care Professionals must share with patients, in a way they can understand, the information they want or need to know about their results, in a sufficient, clear and timely fashion. This should include details of any follow up arrangements and contact details for assistance if there are any concerns or delays

c) Systems must be in place to allow patients to be informed of test results (or their implications) within timeframes that are predictable, and that are not expected to compromise patient care (Also see Specialty and Consultant Statement, Appendix C& E).

d) 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 results, including any outstanding actions where appropriate.

### 6.4.6 How 6.4.1 to 6.4.4 are recorded

Patient notes must contain a record of the following:

a) Diagnostic tests requested (irrespective of whether test was ordered electronically or via paper format)

b) Diagnostic test results received

c) Actions following review of results

d) Patients being informed of results.

e) Whilst it would be impractical to document every communication on test results held with each patient, communications must be documented when implications are serious, complex, or sensitive, including when patients go against medical advice.

f) When "routine" results have been reviewed in the presence of the patient, e.g. on a ward round or during a clinic appointment, unless there is reason to believe otherwise, it maybe implied from documented decisions that the patient has been informed of results verbally.

## 7 EDUCATION AND TRAINING REQUIREMENTS

7.1 All staff working with in-patients must be familiar and kept up to date with the ICE ordering system and have a smart card and password to use this system.

7.2 Smart Cards and passwords must not be shared. This is a disciplinary offence.

7.3 Consultants and their teams must be made aware of the agreed processes for their specialty during local induction and on an annual basis.

7.4 Involvement of patients and where appropriate, their families/carers and key workers in the follow up of pending diagnostic tests should be encouraged by educating them about the tests, its importance, how to obtain the results and what to do after. This leads to patient empowerment and adds a layer of protection to test results.

## 8 PROCESS FOR MONITORING COMPLIANCE

### 8.1 Monitoring compliance

"Consultant" Statements must be monitored annually during annual job planning review or appraisal process (Appendix E & F) alongside supporting data from UHL.

8.2

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements | Lead(s) for acting on recommendations | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|
| Speciality Processes for managing diagnostic testing procedures | CMG Clinical Director | Specialty Policy and "Consultant " Statement as part of Job Planning or Appraisal (non-medics) | Annual | Annual report to Executive Quality Board in May each year | CMG Clinical Director | Trustwide – through the Learning from Experience Group (LEG)<br><br>CMG through relevant Boards |
| Failure to Act on Results | CMG Clinical Director | Datix for serious untoward incidents, complaints, inquests and claims | Quarterly | Quarterly to Learning from Experience Group<br><br>Annually to Executive Quality Board | CMG Clinical Director | Trustwide – through the Learning from Experience Group (LEG)<br><br>CMG through relevant Boards |

8.3 As part of routine quality assurance, each speciality should monitor compliance with the policy in regards to requesting tests, acknowledging, acting on, and communicating results, as well as follow-up after discharge .Results should be shared with health professionals to facilitate learning and drive care quality improvement.

## 9 EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

## 10 LEGAL LIABILITY

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their CBU to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies. For further advice contact: Head of Legal Services on 0116 258 8960.

## 11 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES


British Medical Association. (2010). Acting upon test results in an electronic world. BMA. Available at: www.bma.org.uk

Department of Health, 2000. The Ionising Radiation (Medical Exposure) Regulations 2000 http://www.legislation.gov.uk/uksi/2017/1322/contents/made

General Medical Council (GMC) 2009: Good Medical Practice

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

General Medical Council (GMC) 2008: Consent: patients and doctors making decisions together

http://www.gmc-uk.org/static/documents/content/Consent_0510.pdf

Mitchell R et al. The safety implications of missed test results for hospitalised patients: a systematic review. BMJ QualSaf 2011;20:194-199.

National Patient Safety Notice (February 2007) Patient Safety Notice 16 Early identification of failure to act on radiological imaging reports. www.npsa.nhs.uk

UHL Point of Care Testing (POCT) Equipment strategy

Standards for the Communication of Patient Diagnostic test results on discharge from hospital, NHS England March 2016


## 12 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

12.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

12.2 Review will take place on a three yearly cycle by the appropriate member of the Medical Directors team.

**APPENDIX A**

## Summary :List / Examples of Diagnostic Tests Available for Trust Patients

### 1. Haematology

a) Routine haematology, including FBC and differential, blood film, reticulocytes, malarial parasite screening, plasma viscosity, Paul Burnell, bone marrow examination

b) Coagulation services

c) Transfusion laboratory services

d) A range of haematological molecular genetic and flow cytometry tests

### 2. Biochemistry

a) General chemistry, including liver function tests, kidney function, bone profile, electrolytes, glucose, protein disorders, troponin and lipid profiles

b) Investigation of endocrine disorders, including diabetes, thyroid, adrenal, pituitary fertility function

c) Screening tests for drug abuse and drug levels

d) Limited serology and haematinics testing.

### 3. Microbiology

a) The growth, isolation and identification of relevant bacteria, fungi, protozoa

b) Antimicrobial susceptibility testing of bacterial isolates

c) Typing of organisms

d) Serology testing

e) Virology testing

### 4. Histopathology

a) Surgical pathology (histology, bone marrow biopsy, STOP [Surgical termination of pregnancy])

b) Post Mortem examinations (hospital and coroners post mortems)

c) Gynaecological cytology (gynae cytology and rejected cytology)

d) Non-Gynaecological cytology

e) Immunofluorescence for autoantibodies (Autoimmune Serology)

f) Andrology including semen analysis and infertility assessment

### 5. Radiology

a) Ultrasound (including obstetric & vascular ultrasound)

b) Xray (Soft tissues examinations using x-rays [including barium studies and Intravenous Urogram or IVU])

c) Positive Emission Tomography (PET) scan
d) Nuclear medicine
e) Magnetic Resonance Imaging (MRI) scan
f) Computerised Tomography (CT) scan
g) Mammography
h) Bone densitometry
i) Interventional radiology (e.g. femoral angiogram)

## 6. Cardiorespiratory

a) ECG
b) 24 hour ECG
c) 7 day event recorder
d) Cardio-memo recorder
e) 24 hour ambulatory blood pressure recorder
f) Tilt test
g) Exercise tolerance test
h) Pacemaker checks
i) Transthoracic echocardiogram (+/- contrast)
j) Transoesophageal echocardiogram (TOE)
k) Stress echocardiogram
l) Angiography (cardiac)
m) Full lung studies
n) Spirometry (+/- bronchodilation)
o) Cardiopulmonary exercise testing (CPET)
p) Oximetry
q) Bronchial challenge
r) Sleep studies

## 7. Electrophysiological

a) EEG
b) EMG/Nerve Conduction Studies
c) Audiology

## 1. Automated Biochemistry/Haematology tests:

**(Turn around times for individual tests available through UHL Insite - type 'Pathology handbook' in search box)**

Generic turnaround times for automated Chemistry and Haematology are in 95% of instances;

Emergency specimens including ED and other priority wards: 1 hour All in-patients: 3 hours

All out-patient and Primary Care specimens: 24 hours Primary Care urgent samples: 8 hours

Some specimens including those which are sent to other laboratories: 4-6 weeks

## 2. Microbiology

Refer to the **Clinical Microbiology Laboratory Services – Incorporating the 'User Handbook** on InSite for specific tests.

The turnaround time quoted for the most commonly requested tests is from receipt of specimen in the laboratory (registered with iLab) to the production of the final report. The times quoted are those that are normally expected for the majority ***(95%)*** of our specimen workload processed during normal working days.

| **Test - Bacteriology** | **Turnaround Time (Working Days)** |
|---|---|
| Blood cultures | 2-7 days |
| Clostridium difficile toxin | 1 day |
| CSF Microscopy | 1 day |
| Swabs | 2-4 days |
| Faeces culture | 2-3 days |
| Fluids and tissues (Special Cultures) | 5 days |
| Fungal microscopy | 1-7 days |
| Fungal culture if microscopy positive (GP specimens) | 14-21 days |
| Fungal culture (dermatology specimens) | 14-21 days |
| MRSA screen | 2 days |
| Parasitology | 2-3 days |
| Sputum | 2-4 days |
| TB microscopy | 1 day |
| TB culture | 7-10 weeks |
| Urine culture | 1-4 days |
| Urine Microscopy | 1 day |

## 3. Histopathology and Clinical Cytology

Specific turnaround times guidance available on Insite – type "availability of results" in search box.

Expected turnaround times are:

| Specimen Type | Earliest Time Report Available |
|---|---|
| Urgent Specimens | Lunchtime of next working day |
| Small Biopsies | No earlier than 48hrs after receipt |
| Large Specimens | No earlier than 72hrs after receipt |

### 4. Radiology

There are no national standards for turn-around times for Radiology

The National Diagnostic Imaging Board published Radiology Reporting Times: Best Practice Guidance in July 2008. However, there was a general acceptance that these were not achievable and were aspirational only.

Within UHL, the Imaging services aim to provide reporting turnaround times as follows:

a) Emergency Department patients: all modalities 2 days (1 hour for CT)

b) GP patients 24 hours for plain film and ultrasound

c) GP patients 3 weeks routine CT and MR

d) In-patients all modalities 1 week (IPS for admission units 4 hours CT, 24 hrs US)

e) Out patients all modalities 3 weeks

### 5. Cardio-respiratory

Results are available for clinical review within 24 hours of the procedure, with the following exceptions:

- ECG: hard copy immediately available
- 24 hour ECG and 7 day event recorder results available within 2 weeks
- Cardio-memo recorder and 24 hour ambulatory blood pressure recorder results available within 1 week of return of equipment

## To be agreed and completed by Specialty (annual review)

***Example:*** *The responses below give an indication of the depth and type of information required, but are only intended to be illustrative. They are not intended to represent best practice.*

**Specialty: [insert name here]**

### 1. Acting on results (review and endorsement).

To enable optimal clinical management of patients, test results must be reviewed and endorsed in a systematic and timely way (endorsement is taken to indicate that responsibility for clinical management has been accepted).

**11 Outline how your team ensures diagnostic results are reviewed and endorsed, for:**

**a) Inpatient (or acute care) results** (include timeframes):

Team members involved: Example

| Role | Responsibility |
|---|---|
| *Junior Doctors* | *Requests and chases blood tests, imaging and special tests as directed by senior or as part of everyday management, communicates urgent results to senior and/or patient within 1 hour. Handover responsibility of test management safely at end of shift-written/electronically or with endorsed clinical handover systems. Order outpatient investigations and ensure follow-up/mechanism for chasing result by consultant* |
| *Ward staff* | *Communicate abnormal results received to team within 1hour.* |
| *Consultant* | *Inpatients are informed at the bedside of implications of new results during the consultant/senior ward round. Urgent results requiring intervention in the interim are communicated as needed.* |
| *Administrative and clerical staff* | *Ensure any paper copies of results are given to clinician before filing in notes, book follow-up as requested by clinician (communicate any difficulties to appropriate staff)* |

**b) In-patient results once patient has been discharged**

| Role | Responsibility |
|---|---|
| *Junior Doctors* | |
| *Ward staff* | |
| *Consultant* | |

**c) Out-patients (including time frames)**

Team members involved: Example

| Role | Responsibility |
|---|---|
| *Consultant* | *Complete outcome form for each patient at clinic detailing tests ordered and time for follow-up. Order tests. Results reviewed within appropriate time frame as suggested in Appendix B. Patient and GP* |
| | *informed, either by letter or follow appointment. Lists of patients not for follow-up are maintained by admin staff and results chased as described below. Ensure appropriate contact numbers/ email address available for urgent results to be communicated.* |
| Junior Doctors | *Complete outcome form, order test, review results as part of team approach to managing results after discussion with consultant/team* |
| *Administrative and clerical staff* | *Clinic co-ordinators keep track of test requested and chase these on a weekly basis till result available. Clinic co-ordinator collates paper results and presents to clinician for endorsement. Ensure all paper copies of results are given to clinician with recent clinic letter or notes before filing in notes, book follow-up as requested by clinician (communicate any difficulties to appropriate staff). Secretary keeps track of any patient queries and communicates with clinician.* |

**1.2 Outline arrangements for reviewing and acting on results when Consultant is on planned leave and in the event of unplanned absence.**

*Example: If Consultant is on annual leave for a week or more, an alternative Consultant is asked to review and act on results or await Consultant return. If absent for longer than 2 weeks, specialty to organise alternative arrangements.*

**1.3 Outline any problems Specialty team has encountered over the last 12 months in relation to acting on results, and any subsequent changes to working practice.**

*Example: A patient had 'missed cancer' due to a long delay in reviewing results (due to a combination of annual leave and a lack of clarity re whose responsibility it was to review results in my absence). After a review of the incident, the processes described above came about and they appear to be working well.*

## 2. Informing patients of results

Patients should be informed of test results (or implications of results) in an appropriate way, and within predictable timeframes.

**2.1 Outline how patients under care of Specialty can expect to be informed of results (or implications of results):**

**a) Inpatients (or acute care patients including those where test results available after discharge)** (include timeframes)

*Example: Inpatients are informed at the bedside of implications of new results during the consultant/ senior ward round daily. Urgent results requiring intervention in the interim are communicated as needed.*

**b) Outpatients** (include timeframe)

*Example: Patients are informed of outstanding results at their follow-up out-patient appointment (although timeframe for this will vary). If, for any reason, the patient needs to be informed earlier than the planned appointment, or if no follow up is planned, the patient is contacted by phone and follow up letter to patient and GP.*

**22 Outline any problems your Specialty has encountered over the last 12 months in relation to informing patients of results, and any subsequent changes to working practice.**

*Example: No problems encountered.*

**Signature of Specialty Lead:**

**Date:**

**Managing Diagnostic Results:**
**Specialty Risk Assessment Form.**

University Hospitals of Leicester NHS
NHS Trust

**APPENDIX D**

**To be completed by the Specialty**

## 1. Acting on results (review and endorsement).

**1.1 Based on the Specialty Policy and supporting data, rate the risk of results not being managed safely:**

Insignificant / minor / moderate / major / catastrophic (UHL Risk Management Policy).

**1.2 Action plan to reduce moderate/major/catastrophic risk areas (if applicable):**

| Issue | Action | Who | When |
|---|---|---|---|
| | | | |

## 2. Informing patients of results.

**2.1 Based on the Specialty Policy rate the risk that patients will not be informed of results appropriately:**

Low/ Moderate/ High (delete as appropriate)

**2.2 Action plan to reduce moderate/major/catastrophic risk areas (if applicable):**

| Issue | Action | Who | When |
|---|---|---|---|
| | | | |

**Lead Clinician signature:**

**Date for review:**

**To be completed and agreed by all healthcare professionals. (Annual review)**

***Example:*** *The responses below give an indication of the depth and type of information required, but are only intended to be illustrative. They are not intended to represent best practice.*

**Name and Designation:**

**GMC number/Professional number:**

## 1. Acting on results (review and endorsement)

To enable optimal clinical management of patients, test results must be reviewed and endorsed in a systematic and timely way (endorsement is taken to indicate that responsibility for clinical management has been accepted).

### 1.1 Outline how your team ensures diagnostic results are reviewed and endorsed, for:

**a) Inpatient (or acute care patients including those where test results available after discharge) results** (include timeframes):

| |
|---|
| *Example: Junior doctors in the team follow up, endorse, and act upon any outstanding results for inpatients, prioritising urgent results, as part of their daily role (Monday to Friday) with senior support as needed.*<br><br>*Or: I comply with Specialty statement* |

**b) Outpatient results** (include timeframes):

| |
|---|
| *Example: Results are reviewed by myself or the trainee doctor who requested the test in clinic. I would expect results to be reviewed within 2 weeks of the result being available. Any additional results are endorsed by me within 2 weeks of receipt, and either acted on by myself or delegated as appropriate within the team.*<br><br>*Or: I comply with Specialty statement* |

### 1.2 Outline arrangements for reviewing and endorsing results in your message centre when you are on planned leave and in the event of unplanned absence.

| |
|---|
| *Example: If I am on annual leave for a week or more, I ask Dr X to review and act on result. Likewise if I am absent for other reasons, e.g. sick leave. Management will be informed of the person who I have delegated responsibility to.*<br><br>*Or: I comply with Specialty statement* |

### 1.3 Outline any problems you/ your team have encountered over the last 12 months in relation to acting on results, and any subsequent changes to working practice.

*Example: A patient had 'missed cancer' due to a long delay in reviewing results (due to a combination of annual leave and a lack of clarity re whose responsibility it was to review results in my absence). After a review of the incident, the processes described above came about and they appear to be working well.*

## 2. Informing patients of results

Patients should be informed of test results (or implications of results) in an appropriate way, and within predictable timeframes.

### 2.1 Outline how patients under your care can expect to be informed of results (or implications of results):

**a) Inpatients (or acute care patients including those where test results available after discharge)** (include timeframes)

*Example: Inpatients are informed at the bedside of implications of new results during the consultant/senior ward round daily. Urgent results requiring intervention in the interim are communicated as needed.*

*Or: I comply with Specialty statement*

**b) Outpatients** (include timeframe)

*Example: Patients are informed of outstanding results at their follow-up out-patient appointment (although timeframe for this will vary). If, for any reason, the patient needs to be informed earlier than the planned appointment, or if no follow up is planned, the patient is contacted by phone or letter, copy to GP depending on the clinical scenario.*

*Or: I comply with Specialty statement*

### 2.2 Outline any problems you / your team have encountered over the last 12 months in relation to informing patients of results, and any subsequent changes to working practice.

*No problems encountered*

**Consultant signature:**

**Date:**

| Managing Diagnostic Results: Risk Assessment Form | University Hospitals of Leicester NHS NHS Trust<br>**APPENDIX F** |
|---|---|

**To be completed by the health care professional in job planning (annual review)**

## 1. Acting on results (review and endorsement).

**1.1 Based on the AOR Statement and supporting data, rate the risk of results not being managed safely:**

Insignificant / minor / moderate / major / catastrophic (UHL Risk Management Policy).

**1.2 Action plan to reduce moderate/major/catastrophic risk areas (if applicable):**

| |
|---|
| |

## 2. Informing patients of results.

**2.1 Based on the AOR Statement rate the risk that patients will not be informed of results appropriately:**

Insignificant / minor / moderate / major / catastrophic (UHL Risk Management Policy).

**2.2 Action plan to reduce moderate/major/catastrophic risk areas (if applicable):**

| |
|---|
| |

**Healthcare professional signature**

**Date for review:**