PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Hospital reports critical results within one hour

Facility earns Excellence in Patient Safety award

Marlborough (MA) Hospital has not only achieved its initial goal of reporting critical test results in less than one hour, but its new critical test results program also has enabled its staff to perform interventions within that same time frame. These accomplishments have earned the hospital the Excellence in Patient Safety award from The Massachusetts Hospital Association and the Massachusetts Coalition for the Prevention of Medical Errors.

For the reporting of critical test results and taking action in respiratory care, the improvement from December 2004 to December 2005 went from 60 minutes to 32 minutes, a 47% improvement. Reporting and taking clinical action were under one hour in the laboratory and diagnostic imaging as well.

The two statewide organizations began initiatives in critical test results and medication reconciliation in May 2003, recalls **David Polanik**, MHA, director of risk management. "The significance was very apparent," he recalls, "and our staff readily understood this."

"Actually, [reporting critical results] has been a standard of practice here for a long time," says **Candra Szymanski**, MS, RN, chief operating officer. "What we did was formalize the process." While people were being called with results, she explains, there was not an effective process for documenting that fact. "We put one in place to make sure the loop was closed," she declares.

Two major aspects

The program has two major aspects — critical values, which pertains to lab values, X-ray results, and other diagnostic testing, and patient education. "The first step was to agree on what those values would be, and then communicate the tracking process," says Polanik.

Laboratory staff and medical staff worked together to home in on those values that were in fact considered critical, and radiology and medical staff did the same, he recalls. "The idea was to keep the critical values to as short a list as possible, so when we called a nurse in the wee hours of the morning, it would be based on a very narrow focus," Polanik explains.

"We started working on how to approach the program that summer [2003]," he says. "The task forces were up and running by the end of the summer, and the staff bought into the program by the fall." Marlborough has about 15-20 critical lab values and about 10 radiology values, he says.

The program works like this: With regard to the lab, once a specimen is obtained and processed, the results are electronically posted within the hospital's information system. "But we are not relying on that," says Polanik. "When the lab tech recognizes a critical value based on our criteria, he or she will call and ask for the patient's nurse."

Safety nets

This is a change from the old process, where the unit clerk might have been called. "The nurse will understand what the values mean and will be in a position to act upon that information," Polanik explains. The nurse also is required to read back the information to the tech. "That's a cornerstone of patient safety

initiatives," he asserts.

The program also has "safety nets," Polanik continues. "If they can't reach the primary nurse within five minutes, the lab is instructed to ask for the resources nurse," he says. "For outpatients, there are different processes; for example, they may call the doctor's office."

There also is a protocol set up for critical results in diagnostic imaging, says **Paul Riggieri**, BS, CNMT, director of diagnostic imaging.

"If there is a life-threatening situation, or if you need some sort of intervention within an hour's time, the radiology staff member reading the image will contact the clinician [doctor or nurse] taking care of the patient and will verbally give them the results. Then, it will be documented into the report that the results were communicated at such and such a time." In this process, says Polanik, the name of the individual who receives the information is included in the report as well.

In the case of an outpatient, if the radiologist sees something on an exam he or she feels may be suspicious, those results are faxed over to the referring physician's office. "Then we follow that up with verification, ensuring the fax has been received, and then we log that into the communication book," says Riggieri.

"When the coalition was describing their vision for a program, one of the things they mentioned were color categories — such as red [dangerous], orange, and yellow [results that would not need to be acted upon within an hour]," notes Polanik. "It's pretty easy to understand how that would work in radiology — for example, an aortic aneurism would be critical to respond to, so it would be category red."

For results that fall within the yellow category, such as a nodule showing up on a mammogram, certified letters are sent to the patient's home. "As part of our patient education program, the patient should be expecting to receive those results," Polanik says.

Education integrated

Patient education, including follow-through with the patient, is integrated into the care process, says Polanik. "We have a patient education committee, but this was not something that was necessarily handled by a formal task force," he explains. "We paralleled the Joint Commission's education program and included important specific items, such as how long a patient should wait for their radiology reports, who they should speak to in order to find out what the results mean, and so forth, to help the patient better understand what is going on."

"We want to empower them to be involved in decisions about their treatment and care," Szymanski explains. "For a long time, patients have felt the provider's word was final; this is our hospital's way to involve them in their own care."

While patients do receive educational packets about the importance of being involved in their care, "We hope the nursing staff and the physicians have developed an ongoing relationship with their patients [that includes education]," says Polanik. "It's not a case where they walk in with a piece of paper and just tell the patient to read it; it's more of an ongoing process."

A pleasant surprise

Even Polanik did not expect the results of the program to be as impressive as they were. "We were really pleased when we started to measure," he says. "Our expectation was that critical results would be made available to the clinician within an hour. Since the data are captured in our computer system, that type of performance is easy to trace. But not only were the results being communicated with an hour, but we were seeing interventions within an hour. In our opinion, we raised the bar."

Polanik says there's really no reason why other hospitals couldn't duplicate what he and his staff have achieved.

"The medical staff needs to be in agreement as to what the critical values are," he notes. "And the reporting mechanisms may vary from facility to facility, for example, if you have residents and interns, the results may be communicated to them. But this is something that is easily replicated."

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