**Critical Results Reporting**

Establish safe and reliable processes for reporting results of tests and diagnostic procedures.

### Domain

**Processes to Support Care:**
Processes that are essential to support and maintain the delivery of care to all types of patients, across all units and settings in the hospital.

### Aims

- **Timely:**
  Care delivery that is prompt and provided without delay to mitigate any harm to a patient.

- **Safe:**
  Delivery of care in a manner that minimizes any risk of harm to a patient.

### Process Attributes

<table>
<thead>
<tr>
<th>$</th>
<th>Cost to Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The monetary resources required to implement this process</td>
<td></td>
</tr>
<tr>
<td><strong>Moderate:</strong> In addition to the improvement effort, relies on additional personnel and/or technology</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>🕒</th>
<th>Time to Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The amount of time, from months to years, it will take on average to establish this process</td>
<td></td>
</tr>
<tr>
<td>1 to 2 years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>👇</th>
<th>Difficulty to Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The challenges of implementing this process</td>
<td></td>
</tr>
<tr>
<td><strong>Most Challenging:</strong> Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>📄</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale</td>
<td></td>
</tr>
<tr>
<td><strong>Some Evidence:</strong> Level III — Studies published with some control included</td>
<td></td>
</tr>
</tbody>
</table>
Details

Elements

- Identify who should receive the results
  This is particularly important when the ordering provider is not available.

- Define which test results require timely and reliable communication

- Identify when any test or diagnostic results should be actively reported to the ordering provider and establish explicit time frames for this process.

- Identify the most direct way to notify the responsible provider(s)

- Establish a shared policy for uniform communication of all types of test results to all recipients
  This includes laboratory, cardiology, radiology, and other diagnostic tests.

- Design reliability into the system: standards, redundancies, review of failures

- Develop infrastructure to support and maintain systems

Outcomes

- Harm: Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)

- Readmissions within 30 Days: Decreased readmissions within 30 days

Service Lines and Critical Functions

- Applies in All Patient Settings

Key Measures

- Average Time to Acknowledgement by the Provider Who Is Responsible for Clinical
  - Numerator: Time from when a critical test value is available to time of receipt of that result by someone who can take action (acknowledged) for all critical test results in the sample
  - Denominator: Total number of critical test results in the sample

- Percent of Critical Tests Meeting Time Targets
  - Numerator: Number of tests that are communicated and acknowledged within the target time period (e.g., 1 hour for “red” zone critical tests, 6-8 hours for “orange,” 3 days for “yellow”)
  - Denominator: Total number of tests that meet the defined criteria as critical (target set that should be communicated and acknowledged within the specified time period)

Reasons and Implications

Importance for Patients and Families
When the results of tests and diagnostic procedures are reported and caregivers act upon them promptly, the patient receives the right care at the right time.

Requirement, Standards, Policies, and Guidelines

- Centers for Medicare & Medicaid Services (CMS)

- College of American Pathologists (CAP)
  CAP has identified reporting of critical results as a National Laboratory Patient Safety Goal. Commission on Laboratory Accreditation. Laboratory general accreditation checklist. Northfield, IL: College of American Pathologists; 2007

- National Quality Forum (NQF)
  Safe Practice for Better Healthcare—2009 Update
  Safe Practice 13: Order Read-Back and Abbreviations

http://app.ihi.org/imap/tool/#process=f7eb9f4c-360e-4a54-b3ea-a2d38e94a32a
Copyright © 2009 Institute for Healthcare Improvement All rights reserved. Individuals may photocopy these materials for educational, not-for-profit uses, provided that the contents are not altered in any way and that proper attribution is given to IHI as the source of the content. These materials may not be reproduced for commercial, for-profit use in any form or by any means, or republished under any circumstances, without the written permission of the Institute for Healthcare Improvement.
The Joint Commission (TJC)
Up to the Minute: Ensuring Timely Reporting of Critical Test Results
TJC Perspectives on Patient Safety, December 2011, Volume 11, Issue 12

Financial Implications

- Expense reduction can occur due to reduction in duplicate testing.
- Expense increase can occur due to a system to ensure appropriate communication.

Prerequisites

Establish timeframes for reporting

Resources

Additional Resources

- Massachusetts Coalition for the Prevention of Medical Errors
  Communication Critical Test Results, Safe Practice Recommendations
- The Joint Commission (TJC)
  Critical tests, results, and values

Information Compiled By

IHI