NHS Education for Scotland

Driving Improvements in Healthcare: Implementation Evidence

7 Learning Brief 7:
Safe Systems for Test Results Management

Introduction

- The management of laboratory test ordering and results handling in primary care is currently variable and is a known patient safety risk.
- Such risks may impact negatively on patients (e.g. delayed/poor care), general practitioners (e.g. potential medico-legal implications), and primary care organisations (e.g. increased administration duties) (1).

Views and Experiences of Patients

- In one study, patients highlighted a range of views and experiences around the results handling process (2):
  - Lack of awareness of the process, and potential concerns around breaches of confidentiality.
  - Little follow up contact with the practice, and only incentivised when feeling ill.
  - Requests for communicating with dedicated results-handling staff.
  - Requests for 'alerting technology' for the availability of results.

Views and Experiences of Administrators

- Within the UK primary care setting, administrators process repeat prescriptions, handle laboratory test results, and engage in a variety of other tasks which are considered to be safety-critical.
- Perceptions and experiences of administrators include (3):
  - Concerns about system variations and weaknesses in results tracking.
  - Ambiguous doctor-administrator test communications, causing feelings of anxiety.
  - Privacy issues and dealing with patient reactions to test results.
  - Failure of patient contact and follow up of test results.

Good Practice Statements in Test Results Handling

- Early consensus (at UK and European levels) on safe practice standards has been achieved (4).
- Ten safety domains and 77 related 'good practice' statements were developed. Checklist examples include:
  - **A Commitment to a System Approach and Improving Safety Culture:** *The practice is fully committed to regular safety audits of the system to establish ongoing reconciliation performance with regard to tests ordered, results actioned and results communicated to the patient.*
  - **Managing Results Returned to the Practice:** *Assign responsibility to an individual staff member to conduct small-scale 4-weekly tracking audits of random samples to reconcile tests ordered with results returned and appropriately actioned.*
  - **Patient Monitored through Follow-Up:** *Create a tracking system to avoid patients being lost in the system who require clinical follow up.*

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Summary

- Laboratory test ordering and results handling processes are known sources of error in primary care (5,6).
- In supporting ongoing improvement, there are opportunities for primary care teams to use or adapt elements of the 'good practice guidelines' to develop new results handling systems, or augment existing ones.
- Opportunities for practices to further publicise results handling processes also exist.
- Finally, further research studies to support improvement within this area is advocated (7,8)

Use the Good Practice Statements in Test Results Handling

- Driving Improvements in Healthcare: Implementation Evidence. Learning Briefing 7: Safe Systems for Test Results Management. NHS Education for Scotland, 2017.
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