The Reporting of Laboratory Medicine Results

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Target audience: This policy applies to all those who request and need to act on the results of Laboratory Medicine tests and to those who process these tests.

Relevant Regulations and Standards
- ISO 15189: 2012, clause 5.9.1
- ISO15189:2012, clause 5.9.3

Links to Organisational/Service Objectives, business plans or strategies
- Improve Quality & Safety

Executive Summary
This policy describes the pathways that identifies how, when and to whom results should be communicated and acted upon.

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.
**Version History Log**
This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Approved</th>
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<th>Details of significant changes</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Number</td>
<td>Heading</td>
<td>Page</td>
<td></td>
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<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Contents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Process flowchart</strong></td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td><strong>Introduction &amp; Scope</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Definitions / Terms used in policy</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Policy Statement</strong></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1 How the diagnostic test is requested</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2. The reporting of Laboratory Medicine test results</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.2 Hard copy reports</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.3 Electronic reports</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.4 Results by telephone</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.5 Alert/Critical results</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.6 Amended Reports</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.7 Business Continuity Plans</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Actions to be taken by the test requestor/ responsible HCP</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.4 How the patient is informed of test results</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Impact Upon Individuals with Protected Characteristics</strong></td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Accountability</strong></td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Appendices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Appendix 1 - Laboratory Medicine LIMS - Telepath Reporting Explained</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic copy Type 1: PMEP reports</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic Report Type 2: HL7/HISS Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic Report Type 3: DAWN INR Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic Report Type 4: Renal Patient Copy Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Appendix 2 – Procedure for Telephoned Laboratory Medicine Results</strong></td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Appendix 3 – Policy Management</strong></td>
<td>17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step 1
Request for Laboratory Medicine Examination Requested by Requester/ Responsible Health Care Professional

Step 2
Examination Completed
Technical & Clinical Validation

Step 3
Result Released to Responsible HCP

Path A
Electronic Report

Path B
Hard Copy Report

Path C
Telephone Report

Electronic Report Type 1: PMEP Report
See Appendix 1

Electronic Report Type 2: HL7/HISS Report
See Appendix 1

Electronic Report Type 3: DAWN INR Report
See Appendix 1

Electronic Report Type 4: Renal Patient Copy Report
See Appendix 1
1 Introduction & Scope

The diagnostic pathway begins when a test is indicated and a request is generated, progresses via the diagnostic process and ends when a report is acted upon by the requester / responsible HCP (Health Care Professional). Failures at any point in this pathway may lead to delays in the care of the patient and impact on the York Teaching Hospital NHS Foundation Trust's Key Performance Indicators (KPI's); harm events, readmission rates, and average length of stay, patient satisfaction and confidence and Emergency Department 4 hour rule. There will be clinical and business consequences to these failures.

There is an absolute need for clear pathways that identify how, when, what and to whom results will be communicated including both the primary and secondary care setting.

There are clearly situations whereby a more rapid communication or raised awareness of a critical or unexpected laboratory test result can significantly alter the time taken for appropriate medical care to be initiated that would otherwise have been delayed and in turn would likely to be detrimental to patient care and outcome.

Laboratory Medicine will communicate the results of tests considered clinically and business critical to patient care to the responsible HCP in a timely and reliable manner according to established guidelines. This policy aims to provide the framework for achieving this:

- To prevent delays in taking actions in responding to critical results that may have potential for serious harm to the patient.
- To define critical results.
- To establish a communication process with the responsible HCP.
- To develop a system for measuring and assessing the timeliness of reporting critical tests and critical results with the goal of ensuring timely reporting.

This policy applies to all those who request, process and need to act on the results of Laboratory Medicine tests. Having an appropriate system in place to cover such communication of results is an explicit requirement of ISO 15189:2012, clause 5.9.1 and clause 5.9.3.

2 Definitions / Terms used in policy

Requester – Generic term for any individual requesting a test.
Responsible HCP – The named Health Care Professional responsible for the order and therefore the result.
Critical test result - Defined as a result indicating an immediate risk to the patient of injury or death (ISO 15189: 2012), indicating the requirement for rapid communication of results to the responsible HCP. A delay in taking action to respond to the result may result in a serious adverse outcome for the patient. The definition is also extended to business critical results linked to national KPI's.
3.0 Policy Statement

3.1 How the diagnostic test is requested

It is the responsibility of the requester to complete the request form accurately, clearly indicating the responsible HCP and location of the patient as detailed in the Trust Policy for Completing Request Forms and Labelling Samples. This document is available from Staff Room:

Home › Policies and Procedures › Clinical Documents › Laboratory Medicine.

It is also available on the Trust Website:

https://www.yorkhospitals.nhs.uk/our-services/a-z-of-services/lab-med/general-information/information-for-health-care-professionals1/

The laboratory must be informed of urgent requests by telephone to alert the laboratory staff of their arrival. The request form must be clearly marked URGENT. Results will not be telephoned unless specifically requested or are deemed critical (section 3.2.5) but will be fast tracked through the laboratory to ensure prompt accessibility to the results by the requestor or responsible HCP.

3.2. The reporting of Laboratory Medicine test results

3.2.1 The majority of results do not require a clinical decision to be made immediately and as such are reported passively to the responsible HCP. Laboratory Medicine will issue a report which shall include the information necessary for the interpretation of the examination results. These reports may be issued either as a hard copy or electronically. An overview of the Laboratory Medicine reporting mechanisms using the Telepath LIMS can be found in Appendix 1. Any changes to the mechanism of the reporting of Laboratory Medicine results should be discussed with the Laboratory Medicine IT Systems Manager to ensure the information of how results are transmitted to each clinical area is maintained and adequate change control is applied. This information is maintained on the Laboratory Medicine Quality Management System (QMS) Q-Pulse (Q-Pulse Filename: LM-INF-TP-CODES LOC)

3.2.2 Hard copy reports

Hard copy reports are currently issued only to out-patient clinic locations, external hospitals or on specific request.
3.2.3 Electronic reports

Electronic reporting is the method of choice, maximizing accessibility and audit trail and reducing the potential for transcription errors. Test results are issued electronically to both Trust clinicians (via CPD and ICE), GPs (via GP link and ICE), and to the other Laboratories via the National Pathology Exchange (NPEx). Electronic reports are issued on the hour and every 15 minutes thereafter throughout the day, every day.

3.2.4 Results by telephone

Specific laboratory test results may require more rapid communication. While this policy is concerned mainly with such test results that may be life threatening or of immediate clinical significance and that require urgent action, it should also be acknowledged that rapid communication of results may also be required to meet or maintain patient flow targets within the wider organisation or to enable a more efficient use of healthcare resource.

Results are available by telephone, however, it is not Laboratory Medicine policy to routinely telephone results. Result pads are available from the Laboratory Medicine Ground Floor reception on request to facilitate the correct transmission of telephoned results using the SBARR script (Q-Pulse Filename: LM-TEM-RESULTS).

The HCP transcribing results issued from the laboratory is responsible for keeping up to date with information on the tests (e.g. reference ranges, units). For more information please access Laboratory Medicine pages of the Trust Website as detailed in section 3.1 or contact the respective department directly.

3.2.5 Alert/Critical results

3.2.5.1 The acceptable length of time between the completion of the test (identifying the critical result) and receipt by the responsible HCP will be within 30 minutes unless:
   a) The provider documents specific diagnostic notification range values in the medical record,
   b) The critical value is improved from a previous value and the provider is aware of the previous value.
   c) The critical value is consistent with previous results and / or a known clinical condition and the provider is aware of the previous value.

3.2.5.2 The responsible HCP will be notified by telephone of abnormal/critical results as detailed in Appendix 2. It is acceptable for critical results to be communicated to authorized staff members who would then be accountable for communication to the responsible clinician. Results will never be left with an answering machine.
3.2.5.3 Laboratory Medicine will maintain a prioritized list of alert/critical intervals (based on the guidance issued by the Royal College of Pathologists) to eliminate unnecessary telephone interruptions in clinical areas.

3.2.5.3 The Directorate will review and verify the list to ensure priorities focus limited resources on clinical risk what really matters to the users from user feedback. Users are encouraged to contact Laboratory Medicine to discuss and formalize their individual requirements for their area of work.

3.2.5.4 The laboratory will follow the following explicit steps to notify the test requestor/responsible HCP:

- First call to responsible HCP or patient location
- 2 further attempts may be made to accelerate follow up
- After 15 minutes escalate to clinician supervising the designated area as identified through Trust switchboard this may be the medical or surgical registrar on call.
- After 30 minutes, the ‘fail-safe’ provider should be notified
- An example of the ‘fail-safe’ provider would be
  - ED clinician or Duty Bed Manager

3.2.5.5 The laboratory will maintain an audit of all telephone calls

3.2.6 Amended reports

3.2.6.1 An amended report is a report that is changed in any way after the initial report has been sent out.

3.2.6.2 It is of utmost importance that all electronic records are corrected and hardcopy records are corrected or destroyed. Laboratory Medicine procedures are in place to ensure this occurs to comply with ISO15189:2012, clause 5.9.3.

3.2.6.3 Where amendments are potentially clinically significant (i.e. could impact on patient care) they MUST be communicated to the requestor within an appropriate timescale. Laboratory Medicine staff will notify the clinical area of clinically significant amendments as directed by their procedures as described in section 3.2.5 and section 3.3.

3.2.7 Business Continuity Plans

As with all electronic and computer systems unplanned failures will cause disruption. The Laboratory Medicine IT Team and Systems & Network Services (SNS) monitor CPD, ICE and Keystone to ensure the systems are functioning and reports are being released electronically. Any faults with these systems should be reported to either:

- Laboratory Medicine IT Team:
  - E-Mail: yhs-tr.pathologyit@nhs.net
  - Telephone: 01904 72 4878 / 6766
- Systems & Network Services:
  - E-Mail: Service.Desk@york.nhs.uk
  - Telephone: 01904 72 5000.
Issues with the LIMS can also cause disruption if the fault is not rectified promptly.

Laboratory Medicine has Business Continuity plans accessible within each department in the event of planned or unexpected failure in issuing reports. Maintenance and upgrade, where possible, is planned to cause minimum disruption.

When this occurs

- All acute users are notified by messages on ICE and the Intranet.
- Key departments and wards (A&E, APU, CCU and ICU) are phoned.
- GP surgeries are alerted by e-mail from the Laboratory Medicine IT Team.
- Similar messages are sent out once the fault is rectified.

At all times, urgent, abnormal and critical results will be phoned to the clinical area.

Single System failure

When there is an issue within a single discipline, e.g. analyser failure, the senior Management in that department will ensure the effect of this failure is conveyed to the user if there is to be significant delay in the issue of results. Significant delays may require the tests to be sent to the alternative laboratory site until the failure is rectified.

3.3 Actions to be taken by the test requestor/ responsible HCP

3.3.1 “Fail-safe” procedures must be established within each Specialty to ensure all results are acted upon in a timely manner and high risk diagnoses and results are not inadvertently missed. The procedure must take account of patients moving from area to area within a hospital and being discharged before results are received. A patient must be linked at all times with a provider (or practice) who is responsible for his/her care.

3.3.2. Alert/Critical Laboratory Medicine results telephoned to the clinical area often require escalation for medical team attention following Trust procedure and the SBARR script – A copy of the results should be placed in the patients notes.

3.3.3. The Responsible HCP will take responsibility for ALL investigations requested by them or in their name but the responsibility for acknowledging a result can be appropriately delegated.

3.3.4. The requester is responsible for reviewing any urgent results requested during their shift and passing that responsibility on if they finish their shift. For those tests requested where the patient has moved to another area before the
result is available, responsibility for the results passes to the clinician responsible for the patient in that area.

3.3.5. It is incumbent on the Responsible HCP to ensure that he or she personally checks the reporting systems on a regular basis for investigation results and then acts on the information with the necessary degree of urgency. If they are unable to do this they must delegate the responsibility to a colleague. Failure to do this will put patients at risk.

3.4 How the patient is informed of test results

3.4.1 It is the responsibility of the responsible HCP to consider how, when and what to tell the patient.

4 Impact upon Individuals with Protected Characteristics

The document author has reviewed this document in conjunction with the Trust’s Equality and Diversity Facilitator and has judged that there will be no negative impact on any of the groups of individuals with protected characteristics.

5 Accountability

- Operational implementation, delivery and monitoring of the policy reside with:
  - All healthcare staff involved in the diagnostic pathway – including Doctors, Nurses, Healthcare Assistants/Support workers and Laboratory Staff (BMS, Clinical Scientists etc.) are responsible for:
    - Being aware of this policy and any documents referred to within it
    - Adhering to any requirements described in this policy pertaining to their role in the diagnostic pathway.
    - Attend the required IT training to fulfil their role.
  - Line managers are responsible for:
    - Ensuring their staff follow those processes and procedures relevant to the part they play in the diagnostic pathway.
    - Conducting stringent recruitment checks to ensure that only appropriately qualified and registered members of staff request, undertake or authorise tests and act on results.
    - Ongoing checks of professional registration, training and competence.
    - Ensuring their staff have the required level of IT permissions and training to fulfil their role
• It is the responsibility of the Specialty Directors to ensure that ‘fail-safe’ providers are in place within their specialties so that every Laboratory Medicine result requested from within Trust is acted upon.

• The Patient Safety Group is responsible for the approval of this policy.

• Monitoring of the policy will be conducted by Laboratory Medicine. Deviations from the policy are recorded as DATIX which are reviewed at departmental governance and management meetings.

However there are a number of key responsibilities placed on individuals within the organisation to ensure the effective implementation of this policy:

• Switchboard
• SNS to improve communications and advancing technologies e.g. automatic notifications
Appendix 1: Laboratory Medicine LIMS - Telepath Reporting Explained

When a result is authorised it is immediately available for reporting by hard copy and by electronic copy. There are four types of electronic copy:

1. **Electronic copy Type 1: PMEP reports**
   
   These reports are issued to the majority of GP practices and to York Trust wards and departments.

   Some location codes on Telepath are not set as PMEP reportable. It is possible to see that this type of report has been issued by looking at the report status in the SENQ specimen enquiry program in Telepath (see later). Electronic reports are issued on the hour and every 15 minutes thereafter throughout the day, every day.

   All PMEP reports from all links on all three Telepaths send to York ICE and reports are viewed in the hospital either by direct access to ICE, or more usually by using the PATHVIEW module on CPD (which is in fact a front end to ICE written by the CPD team in order to avoid issuing ICE accounts to all CPD users).

   PATHVIEW is set up to look directly at the ICE database — although it will only reveal results for patient records present on CPD that match records on ICE.

   All PMEP reports from all links on all three Telepaths send to Scarborough ICE but these reports are only visible to those with an account on Scarborough ICE. They are not addressable using PATHVIEW.

   Laboratory Medicine results for all specialisms, whether produced at York or Scarborough (including Microbiology, Histology and Blood Transfusion) can now be found on CPD in PATHVIEW.

   **Note:**

   - Records on ICE without a matching casenote number or NHS number will not be visible on CPD – even though they will be visible on ICE.
   - In order for a PMEP report to be sent to ICE the location code on Telepath needs to be set within the PMEP programme on Telepath as PMEP reportable.
   - The setting in PMEP to add a Location code is 7. “Enter/amend GP location code table”. Adding a code is a manual process.
   - Once added to the above “GP location code table” paper for a location can be switched off using option 9 “Discard hardcopy format for this practice (Y/N)” and setting to “Y”.

2. **Electronic copy Type 2: HL7 reports (aka “HISS” reports)**

   This report is issued as soon as the report is authorised and it is not easily possible to see if a report has been issued, other than by searching the ARES audit queue. The CPD Inpatient Care Record and the National Pathology Exchange (NPEx) inter-Laboratory communications system both receive HISS format reports.
NOTE: Whether a given result is “HISS reportable” is set in its Set Definition (Telepath mnemonic “SETM”) under the HISS menu (option 1: “Report required (Y/N)”).

These reports are issued on the majority of Biochemistry, Haematology and Immunology results for all* wards and GP sites (*all where the CHM location code on Telepath has its “Hiss report” flag set to Y anyway). Where the “Hiss report” flag for a location code is set to N or is blank in CODES (within CHM) no HL7 report will be sent from the CHM database on Telepath.

The Telepath mechanism for HL7 reporting is different in other Lab departments (i.e. MIC, HIS and BBS) – and indeed the Location CODES “Hiss Report” option is not visible or relevant in these other specialisms.

- HISS reports are sent from MIC for all specimens using a local RBPST rule.
- HISS reports are sent from HIS for all specimens using a local RBPST rule.
- HISS reports are not sent from BBS as this functionality is not yet present in Telepath.

These reports (except BBS) are viewable in CPD under ORDVIEW and CHECKRES. BBS reports can only be viewed in PATHVIEW.

If all of the following data is supplied in the HISS report message, there must be a combination of at least 4 successful matches in order for the patient details to be valid – if not they will be marked as errors and not filed to CPD. CPD do not try to match on address or sex.

- NHS No
- PER_ID [a unique identifier generated by and hidden in CPD, but added to order messages]
- Forename1
- Surname
- DOB
- Bag No (as held in the middle of TP Sample No)

Per_Id appears on Telepath in the field “PER ID” and is viewable on the Biochemistry booking in screen – “Registered patient/Specimen screen”- prompt 4 as shown below.

<table>
<thead>
<tr>
<th>York &amp; Scarborough Blood Sciences</th>
<th>Clinical Chemistry request entry - Registered patient/Specimen</th>
</tr>
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<tbody>
<tr>
<td>NHS No. 9999999468........</td>
<td>1) Surname EDITESTPATIENT......  2) Forename ONE..................</td>
</tr>
<tr>
<td>3) Check NHS No 9999999468 4) PER ID 6640333... 5) DOB 27.01.25  6) Sex M</td>
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If a Per_id is received by CPD in a result it still requires the four matches above. This is probably because if there has been a case note merge on CPD then the Telepath entry could have a different per_id from the CPD entry.
Any results that do not match on these strict criteria are discarded by CPD (although they may show on ICE / PATHVIEW).

[The CPD development team send a daily email listing these non-filing results to the Pathology IT Team who work with the Data Quality Team to fix any that can or should be filed.]

HL7 results are displayed in real time for admitted patients on the wards using the WARDLIST screen, in Accident & Emergency using the AE_LIST screen, and can be found directly by those with access to the ORDVIEW and CHECKRES screens showing respectively ordered tests and results. Hospital Consultants have access to another screen called “Consultant Worklist [NOTIFY]. This however only shows results for patient contacts deemed Inpatient or Accident & Emergency. Results from Outpatient contacts are not flagged to users - although the results can be sought by them using ORDVIEW & CHECKRES.

The HL7 record shown on CPD via the above routes are not a complete record of all results for a patient, for example we are unable to report DFT results using HISS. Users are directed to use PATHVIEW for the greatest range of reports. PATHVIEW is essential for viewing Microbiology, Histology and Blood Transfusion reports as these are not visible at all on CPD.

NOTE: Paper-only reports including details of any “Send-Away” Reference Laboratory reports that are not transcribed into Telepath will not show in either the PMEP or HISS electronic systems.

3. **Electronic copy Type 3: DAWN INR reports**

   These are transferred via a devoted HL7 link to the DAWN system as and when an INR is released.

4. **Electronic copy Type 4: Renal Patient Copy Reports (via PMEP to RR8J9)**

   Electronic reports are transferred to the VitalPulse VitalCare system at Leeds using the same PMEP reporting that handles electronic reports to external partners such as GPs. VitalPulse is managed by the Informatics Department at Leeds Teaching Hospitals NHS Trust. This system then populates the BHLY (Bridlington Hull Leeds and York) Renal System (aka “Billy”) used by staff treating Renal failure patients in the listed areas and by patients themselves via a nationally managed https://www.patientview.org/ website. Our results there join with those submitted by other hospitals in the region including Harrogate.

   These results are issued on a patient specific basis on lists of patients supplied to Telepath by the various Renal Clinics. It is continually being updated as more patients require dialysis. It is possible to see if this report has been sent using Specimen Enquiry under reports. Reports go to location RR8J9. The sending of these is accomplished by an Automatic Copy Report rule in Telepath Rule Based Processing. It looks for patient records flagged with “REN” in the special Interest field. Separate copy rules are in place in Blood Sciences (CHM) and Microbiology(MIC) but not in the other specialisms.
5. **Hardcopy reports (paper-only vs paperless)**

These are queued up throughout the day, but only for those Location codes that are not PMEP reportable (hence termed “paper-only”), and for PMEP reportable locations that have their “Discard hardcopy format for this practice (Y/N)” setting either blank or set to “N”. PMEP locations that are so set produce both a PMEP report and a hardcopy report.

Where this setting in the PMEP location is set to Y the location will be “paperless”.

Most Trust ward locations are now paperless although Outpatient locations still require paper.

**Diagram (Reports from Telepath)**

![Diagram showing the flow of reports from Telepath to various systems, includingCombined Telepath, DAWN, YTH ICE, and CPD, with connections to NPEX and messaging exchange for social care and health (MESH).]
Appendix 2: Procedure for Telephoned Laboratory Medicine Results

Results will only be given by telephone in the following circumstances:

- Those which contain abnormal results, which exceed specific laboratory set limits, or are judged by a competent member of staff to warrant telephoning.

- Those where telephoning has been specifically requested for clinical reasons (urgent results)

- To a registered Healthcare Professional, or other staff designated by the HCP to take results, e.g. ward clerk, medical secretary.

- Only one patient’s results will be reported by telephone at one time to avoid mix up

Procedure for the person giving out the results (laboratory staff)

Confirm the patient is currently based on that ward / in that department (or obtain details of their current location to report the results there)

Correctly identify the patient the results relate to (three points of identity required - name; NHS or hospital number; date of birth)

Confirm the reason why the result is being telephoned

Give the results identifying the abnormal result requiring attention

Record the identity of the registered Healthcare Professional receiving the results on the Laboratory Computer System (TPATH)

Receive assurance the results have been written accurately in the patient’s clinical records by ensuring the registered practitioner receiving the results repeats them back
Appendix 3: Policy Management

1 Consultation, Quality Assurance and Approval Process

Consultation Process
The Trust will involve stakeholders and service users in the development of its policies.

Consultation has taken place with the following stakeholders:
- Patient Safety Group

Quality Assurance Process
The author has consulted with the following to ensure that the document is robust and accurate:
- Laboratory Medicine Clinical Governance Committee and Directorate Management Team

The policy has also been proof read and the review checklist completed by the Policy Manager prior to being submitted for approval.

Approval Process
The approval process for this policy complies with that detailed in section 6.3 of the Policy Guidance.

The approving body is the Laboratory Medicine Clinical Governance Committee.

2 Review and Revision Arrangements
The Laboratory Medicine Quality Manager will be responsible for review of this policy in line with the timeline detailed on the cover sheet.

Subsequent reviews of this policy will continue to require the approval of the Laboratory Medicine Clinical Governance Committee.

3 Dissemination and Implementation
Within laboratory Medicine this policy will be kept in documentary control on the directorate’s Q-Pulse.

This policy will also be stored on Staffroom, in the policies and procedures section and will be stored both in an alphabetical list as well as being accessible through the portal’s search facility and by group. The register of policies will be maintained by the Healthcare Governance Directorate.

This policy will also be stored on the Trust Website, A – Z of Services, Laboratory Medicine. The Laboratory Medicine area of the Website will be maintained by the Quality Manager, Laboratory Medicine.

If members of staff want to print off a copy of a policy they should always do this using the version obtainable from Staffroom but must be aware that these are only valid on the day of printing and they must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

4  Register/Library of Policies/Archiving Arrangements/ Retrieval of Archived Policies

On review of this policy, archived copies of previous versions will be automatically held on the version history section of each policy document on Q-Pulse. The Healthcare Governance Directorate will retain archived copies of previous versions made available to them. Policy Authors are requested to ensure that the Policy Manager has copies of all previous versions of the document.

To retrieve a former version of this policy from Q-Pulse, the Healthcare Governance Directorate should be contacted.

5  Standards/Key Performance Indicators

The number of DATIX should not increase beyond the standard background rate.

6  Training

Training on, and the practice of, obtaining Laboratory Medicine Results is delivered and supported organisationally through a range
of methods/processes linked to clinical interventions, both medical and non-medical.

7  Trust Associated Documentation
   • Trust/Laboratory Medicine: Completing Request Forms and Labelling Samples Policy

8  External References
   • Medical Laboratories- Requirements for quality and competence (ISO 15189:2012)
   • RCPATH: The communication of critical and unexpected pathology results Click Here
9 Process for Monitoring Compliance and Effectiveness
In order to fully monitor compliance with this policy and ensure effective review, the policy will be monitored as follows:

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Process for monitoring</th>
<th>Responsible Individual/ committee/group</th>
<th>Frequency of monitoring</th>
<th>Responsible individual/ committee/group for review of results</th>
<th>Responsible individual/ committee/group for developing an action plan</th>
<th>Responsible individual/ committee/group for monitoring of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Correct results are available to the responsible HCP within the timeframe designated by laboratory procedures and KPIs.</td>
<td>DATIX</td>
<td>Quality Manager</td>
<td>Monthly</td>
<td>Quality Manager Directorate Management Team Clinical Governance Group</td>
<td>Quality Manager Directorate Management Team Clinical Governance Group</td>
<td>Quality Manager Directorate Management Team Clinical Governance Group</td>
</tr>
</tbody>
</table>
10 Dissemination and Implementation Plan

<table>
<thead>
<tr>
<th>Title of document:</th>
<th>The Reporting of Laboratory Medicine Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date finalised:</td>
<td>October 2016</td>
</tr>
<tr>
<td>Previous document in use?</td>
<td>No</td>
</tr>
<tr>
<td>Dissemination lead</td>
<td>Elizabeth Fox</td>
</tr>
<tr>
<td>Implementation lead</td>
<td>Elizabeth Fox</td>
</tr>
<tr>
<td>Which Strategy does it relate to?</td>
<td>Quality &amp; Safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dissemination Plan</th>
<th>Publish on Staff Room and Trust Website, A-Z of services, Laboratory Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method(s) of dissemination</td>
<td>Publish on Staff Room and Trust Website, A-Z of services, Laboratory Medicine</td>
</tr>
<tr>
<td>Who will do this</td>
<td>Policy Manager</td>
</tr>
<tr>
<td>Date of dissemination</td>
<td>On approval of document</td>
</tr>
<tr>
<td>Format (i.e. paper or electronic)</td>
<td>Electronic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation Plan</th>
<th>Quality Manager – Laboratory Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual with responsibility for operational implementation, monitoring etc</td>
<td>Quality Manager – Laboratory Medicine</td>
</tr>
<tr>
<td>Brief description of evidence to be collated to demonstrate compliance</td>
<td>The number of DATIX should not increase beyond the standard background rate.</td>
</tr>
</tbody>
</table>