Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Telephoned Pathology Results

This procedural document supersedes: PAT/T 61 v.3 – Telephoned Pathology Results

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Executive Sponsor(s):	Abigail Trainer
Author/reviewer: (this version)	Andrew Wood Pathology Quality Manager
Date written/revised:	15 September 2021
Approved by:	Policy Approval and Compliance Group
Date of approval:	29 September 2021
Date issued:	21 October 2021
Next review date:	29 September 2024
Target audience:	Clinical and Pathology staff, Trust-wide and in Primary Care

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 4		-Updated Pathology Policy reference number -Updated formatting for SBAR script for easier viewing -Updated SBAR script to include requesting the name of the information is being given. -Formatting changes throughout -Further clarification throughout, changes highlighted in blue -Addition of Data protection section added -Appendix 1 flowchart updated to merge information about doctor receiving results.	A Wood
Version 3	26 October 2018	Updated to reflect Care Group structure & references updated & added Designated Bleep holder as an alternative to Clinical Site Manager	F Dunn
Version 2	19 October 2015	Updated to reflect Care Group structure	J Wardell
Version 1	24 June 2013	This is a new procedural document, please read in full	S Bayliss

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1. INTRODUCTION

This policy has been developed to ensure that all staff

- Understand the significance of telephoned pathology results
- Are clear about the actions they need to take
- Know the timescale within which they must act

This policy does not replace the essential requirement for each clinician to be responsible for promptly accessing and acting on the result of every investigation they request, but is designed to provide a safety net for the highlighting of 'highly significant' findings i.e. those that fall outside the critical limits as defined by the laboratory. These limits have been developed following guidance issued by the Royal College of Pathologists (document number G158, Oct 2017). The limits are based on the first abnormal set of results or on repeat results that have shown a markedly significant change for an individual patient. It is anticipated that immediate medical evaluation is required for patients with such results. The laboratory does NOT telephone all abnormal results, only those outside the critical limits.

The electronic requesting and reporting system (also known as Order Comms or ICE) provides a reliable electronic means of accessing pathology results that have been released. ICE includes a 'flag' for highlighting reports that include an abnormal result, but it remains incumbent on requestors to actively search for the results of all pathology investigations they have requested, including ones that have not yet been reported and are therefore not visible on ICE. It is also the responsibility of the requesting clinical team to have proper handover arrangements in place to review and act on abnormal results 'out of hours' or when a particular clinician is away. A 'green tick' against a result in ICE indicates that someone has viewed the result, but NOT necessarily that they have acted upon it OR even that they were clinical staff rather than admin (e.g. Clinical Coders). Therefore, the Trust recommends that clinicians should electronically 'file' reports once they have reviewed them AND taken the required action.

2. PURPOSE

Results outside the laboratory critical limits require urgent clinical evaluation and appropriate action. This policy is designed to introduce designated pathways between Pathology and requesting clinicians and their teams, and to minimise the risk of serious harm to patients resulting from significant pathology results being overlooked, even though they have been correctly reported. It defines timescales within which staff are expected to act.

3. DUTIES AND RESPONSIBILITIES

This policy covers the communication of critically abnormal pathology results to Trust and Primary Care staff. This includes:-

- Trust employees
- Agency/Locum/Bank Staff
- Primary Care staff

It is the responsibility of each member of staff involved in the requesting, reporting and review of pathology tests:-

- To comply with the standards set out in this guidance.
- To work within their own competence.
- To report all issues regarding the communication of urgent pathology results (including near miss events) using the Trust's Incident Reporting procedures.
- Where possible to ensure that location and responsible consultant information on request forms and ICE are clear, relevant to the time the request will be actioned and if necessary a clear alternative escalation path for critical results is stated.

Any such issues should be discussed at relevant Clinical Governance Groups and any identified actions that result from the incidents should be implemented.

It is the responsibility of each member of staff and individual clinical departments to ensure they adhere to the training and audit requirements set out in Sections 5 and 6 of this guidance.

Trust Board: The Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manage the risks associated with critically abnormal pathology results

Medical Director: Is responsible for implementing patient management strategies throughout the Trust that include appropriate and timely requesting and review of pathology tests

Divisional Directors, Clinical Directors and Specialty Leads: Are responsible for implementing patient management strategies throughout the Trust that include appropriate and timely requesting and review of pathology tests, and have proper handover arrangements in place to review and act on abnormal results when a particular clinician is not available/away.

Consultant Medical Staff: Are responsible for ensuring that their team, including junior staff, read and understand this policy, and adhere to the principles contained in it at all times.

Ward and Department Managers: Are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.

Clinical Site Managers or Designated Bleep Holder (1393 DRI, 3235 BDGH): are responsible for identifying an appropriate clinician to evaluate a patient with a critically abnormal result, when the responsible consultant cannot be contacted and the escalation process has been implemented.

Primary Care Clinical Commissioning Groups: are responsible for implementing patient management strategies throughout Primary Care that include appropriate and timely requesting and review of pathology tests, and have proper handover arrangements in place to review and act on abnormal results when a particular clinician is not available/away.

4. PROCEDURE

Pathology staff

Pathology staff will urgently telephone results that fall outside the laboratory critical limits as follows:

In-patients: Will phone to the patient location i.e. ward, and will ask to speak to a doctor or nurse. They may give the results to another member of ward staff if a doctor or nurse is unavailable.

Out-patients: Will phone the DBTH based secretary of the named consultant (or t*h*e patient location if they are likely to still be present on a hospital site).

Primary Care patients: Will phone the GP practice (or out-of hours GP service if practice is closed)

Pathology staff will attempt to telephone the results, using all the available numbers on ICE or the request form and/or those listed for the consultant/GP or patient location, on at least three occasions, a few minutes apart. If this is unsuccessful **within 30 minutes** they will follow the Pathology Escalation Procedure. They will log successful calls as per Pathology procedure - PATH-SOP-19 (Telephone Answering and Results Service)

Pathology staff will use the **SBAR Communication Script** for communicating results that fall outside the laboratory critical limits as follows:
(Establish and record the name and position of the person taking the call)

Situation:	Hello, this is (name). I'm calling from Pathology with a critical result that needs urgent action for patient (name/number) Do you have this patient on your ward/clinic/surgery? **If yes**: the result is (value), the abnormal result is (name), and the normal reference range for this patient is (range). Ask for receiver to repeat back information to ensure understanding. **If no**: review request details and CaMIS and phone to correct location/doctor
Background:	The results should be accessible electronically via ICE/ your practice system
Assessment:	covered in 'situation'
Recommendation:	These results need urgent review and action. If the doctor is not available within one hour you must follow the Trust policy for escalating telephoned pathology results.

Pathology staff will ask receiver to repeat key information to ensure understanding, take their name and log all details as per Pathology local policy PATH-SOP-19 (Telephone Answering and Results Service).

Pathology Escalation Procedure

Pathology staff must follow this escalation procedure if they have been unable to contact the consultant/GP or patient location **within 30 minutes**.

In-patients and Out-patients:

1. First level escalation to Specialist Registrar of the clinical service, department from which the request originated (Bleep via switchboard), any stated escalation procedure given on the request form or, for visiting consultants, the relevant specialist registrar at their source hospital.
2. Second level escalation to Consultant on-call for the relevant division (Bleep via switchboard)
3. Third level escalation to Clinical Site Manager (Bleep via switchboard) or Designated Bleep holder (1393 DRI, 3235 BDGH),

Pathology staff will ask receiver to repeat key information to ensure understanding, take their name and log all details in the Telephone Module of the Pathology IT system as per Pathology local policy PATH-SOP-19 (Telephone Answering and Results Service).

Primary care patients (GP Practice closed or cannot be contacted):

Pathology staff will phone results to the deputising service (typically this is the out of hours service located in the respective A&E departments and the GP contact lines will redirect calls to the appropriate one). When telephoning results in these circumstances, staff will use the SBAR script and will provide the following additional information:

- The date and time of the request if available
- The name of the requesting physician and/or the practice number
- As much clinical history as is available
- Contact address for the patient, and telephone number if known

Staff will record all information as per Pathology local policy PATH-SOP-19 (Telephone Answering and Results Service).

In line with Pathology standard operating procedures, Pathology staff will inform the requesting GP of the information provided to the 'Out of hours GP service' as soon as possible after the event.

Clinical staff receiving telephoned pathology results

Staff must record information from the phone call (in patient notes or on locally agreed documentation) , detailing the patient ID, the result that falls outside the laboratory critical limits, the reference range, the time the call was received, the name of the Pathology member of staff, their own name and any other relevant information. They must communicate the information to a doctor as soon as possible, but no longer than **one hour** after the phone call**,** using the SBAR tool as follows:

Situation:	*Hello, this is (name). I have received a telephone call from Pathology with a critical result that needs urgent review/action for patient (name/number) and location (name). The abnormal result is xxx, value yyy and reference range zzz*
Background:	*I have the following additional information about the patient…….*
Assessment:	*covered in 'situation'*
Recommendation:	*I need you to urgently review the electronic results on ICE, with reference to the clinical condition of the patient, and take immediate appropriate action*

Actions should be recorded in writing in the patient notes, and/or using the electronic 'notepad' function on ICE.

Consultants/Doctors should electronically 'file' reports on ICE once they have reviewed them AND taken the required action.

If the doctor/clinician is not available **within one hour**, you must follow this escalation procedure:

In-patients and Out-patients:

1. First level escalation to duty doctor/Specialist Registrar
   1.1. Bleep the appropriate duty doctor according to the site and clinical service involved

Use the SBAR Communication Script for communicating the results that fall outside the laboratory critical limits:

Situation:	*Hello, this is (name). I have received a telephone call from Pathology with a critical result that needs urgent review/action for patient (name/number) and location (name). Consultant/doctor (name) or location (name) have failed to respond to my attempts to contact them with the urgent result. The abnormal result is xxx, value yyy and reference range zzz.*
Background:	I have the following additional information about the patient….
Assessment:	*covered in 'situation'*
Recommendation:	*I need you to urgently review the electronic results on ICE, with reference to the clinical condition of the patient, and take immediate appropriate action.*

2. Second level escalation to Consultant on-call
   2.1. In the event that the first level escalation is unsuccessful, staff should pass the result to the Consultant on-call for action and investigation (Bleep via switchboard)
3. Third level escalation to Clinical Site Manager or Designated Bleep holder.
   3.1. In the event that the second level escalation is unsuccessful, staff should pass the result to the Clinical Site Manager or Designated Bleep holder (1393 DRI, 3235 BDGH), who will identify an appropriate clinician to provide action and investigation (Bleep via switchboard)

Consultant / Doctor Actions

On receipt of a telephoned pathology result, the Consultant/Doctor should urgently review all available results electronically on ICE, along with patient notes (if available), and determine if urgent treatment is required. Actions should be recorded in writing in the patient notes, and/or using the electronic 'notepad' function on ICE.

If the patient has left the hospital, and the Consultant/Doctor determines that urgent treatment is required, the Consultant/Doctor should:

- Attempt to telephone the patient, using all known contact details, to arrange for them to attend for urgent treatment
- If this is unsuccessful, they should telephone the next of kin, as listed on CaMIS

- If this is unsuccessful:
  - In normal working hours, they should telephone the GP to request their assistance in contacting the patient.
  - Out of hours, they should contact Police to request their assistance in contacting the patient.

Actions should be recorded in writing in the patient notes, and/or using the electronic 'notepad' function on ICE.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5. TRAINING/SUPPORT

Each staff member is accountable for his or her practice and should always act in such a way as to promote and safeguard the wellbeing and interest of patients. Staff will receive instructions and direction regarding the requesting, review and communication of critically abnormal pathology results from a number of sources:-

- Trust Policies and Procedures available on the intranet
- Ward/departmental/line managers

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

The Pathology Services Management Team will review this policy in the following circumstances:-

- When new national or international guidance is received.
- When newly published evidence demonstrates need for change to current practice.
- Every three years routinely.

Responsibility for implementation of this policy lies with the Divisional Directors.

Incidents where non-compliance with this policy is noted, and are considered an actual or potential risk, should be documented on DATIX.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Did Pathology staff phone the urgent result within 30 minutes?	Pathology CSU	Ongoing via DATIX	Pathology Services Management Team
Did Clinical staff receiving the urgent result record the information and communicate it to a relevant doctor within one hour	Clinical CSUs	Quarterly	Clinical Service Management Team or Clinical Governance Group

7. DEFINITIONS

CaMIS : Patient administration system (PAS)
Critical limits: Specific action limits for pathology tests or analytes. Results falling outside these for the first time, or repeat results that have shown a markedly significant change for an individual patient, may require immediate medical intervention, including admission to hospital or change in the patient's treatment
DBTH: Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Highly significant findings: results that fall outside the critical limits as defined by the laboratory (follow guidance issued by the Royal College of Pathologists)
IBMS: Institute of Biomedical Science
ICE: "Integrated Clinical Environment" web-based applications for electronic requesting and reporting. Available for Pathology and Medical Imaging at DBTH
NHS: National Health Service
SBAR: Situation, Background, Assessment, Recommendation communication tool, as recommended by the NHS Institute for Innovation and Improvement
SOP: Standard Operating Procedure

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 2.

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Standard Operating Procedure, Pathology procedure - PATH-SOP-19 Telephone Answering and Results Service
- Standard Operating Procedure, Pathology procedure - PATH-SOP-20 Communication of critical pathology results
- Trust Policy CORP/COMM 1 - Approved Procedural Documents (APDs), Development and Management Policy
- Trust Policy CORP/EMP 04 - Fair Treatment For All
- Trust Policy CORP/EMP 27 – Equality Analysis Policy
- Trust Policy PAT/PA 19 - Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- Trust Policy PAT/PA 28 - Privacy and Dignity Policy
- Trust Policy PAT/PA 31 - Handover Policy

10. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

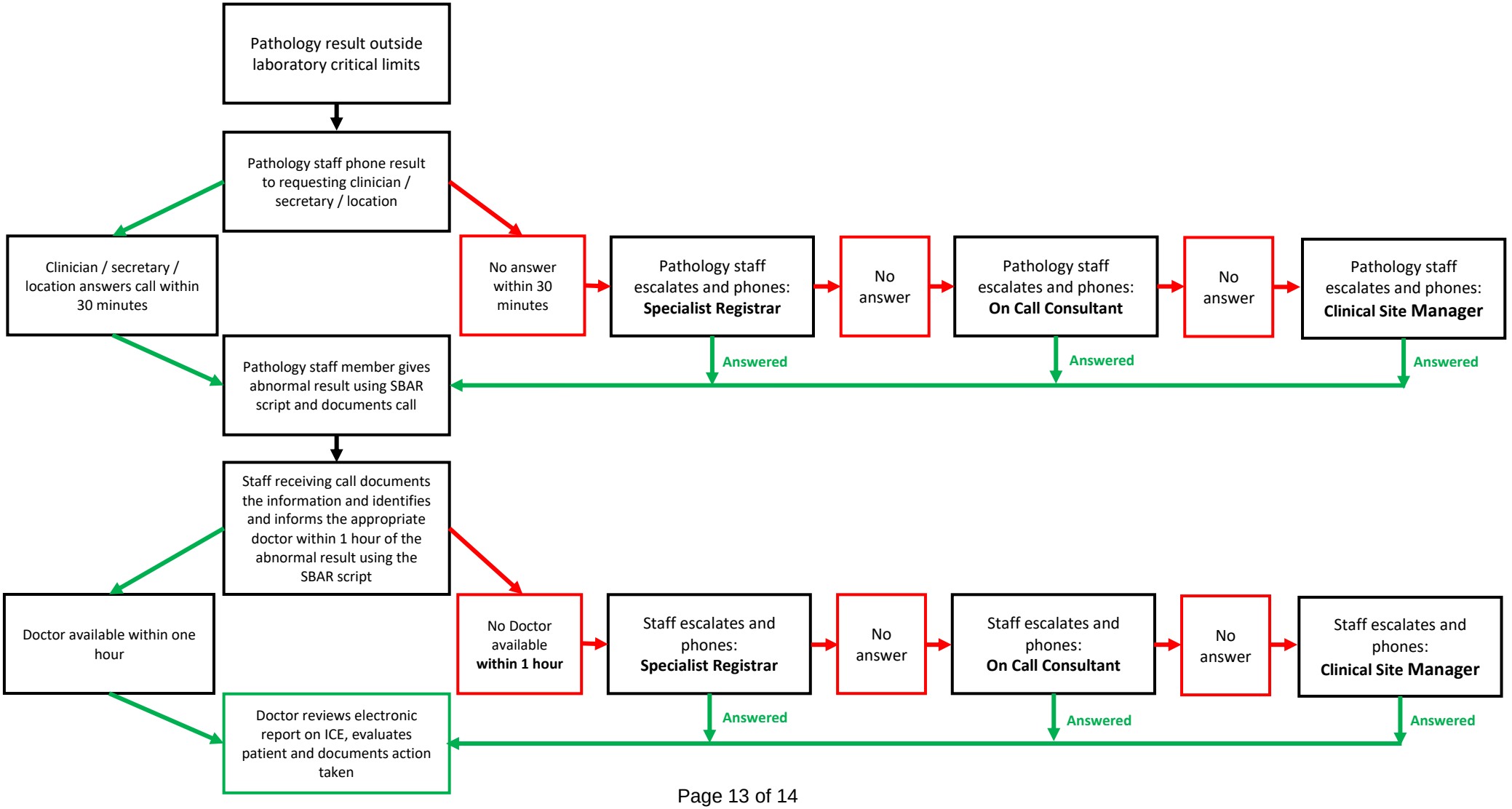
For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11. REFERENCES

- IBMS (2018) Communication of Pathology Results
- NHS Institute for Innovation and Improvement (2008) *SBAR: Situation, Background, Assessment, Recommendation*
- Royal College of Pathologists (document G158, Oct 2017) *The communication of critical and unexpected pathology results*
- Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 www.dca.gov.uk

APPENDIX 1 - FLOWCHART FOR TELEPHONED PATHOLOGY RESULTS

Appendix 1: flowchart for telephoned Pathology results PAT/ T61



APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Telephoned Results Policy	Clinical Specialties Division	Andrew Wood	Revised Existing Policy	12/10/2021

1) Who is responsible for this policy? Clinical Specialties Division

2) Describe the purpose of the service / function / policy / project/ strategy? Trust wide policy

3) Are there any associated objectives? This policy has been developed to ensure that all staff:

i. understand the significance of telephoned pathology results
ii. are clear about the actions they need to take
iii. know the timescale within which they must act

4) What factors contribute or detract from achieving intended outcomes? – compliance to policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? no -

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? no

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: 29/09/2024

Checked by: Dr. Richard Stott Date: 29/09/2021