Title: Aligning Critical Test Result Policy with National Patient Safety Goal (02.03.01)

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Purpose and Rationale: Through standardization and improved patient processes, our aim is to further enhance patient safety by establishing a process, metrics, and monitoring system to assure critical test results (CTR) are accurately communicated and available to the physician, APRN, or designee in a minimum time frame for identification of clinical relevance in the immediate care of the patient.

Research Question: What is the best practice to improve workflow communication patterns related to timely and accurate reporting of CTR?

Synthesis of Review of the Literature: A CTR is a test result that suggests a serious medical condition may require immediate attention for the safety of the patient. The Joint Commission's National Patient Safety Goal (NPSG 02.03.01) states, "for verbal or telephone order or for telephone reporting of CTR, verify the complete order or test result by having the persons receiving the order or test result read back the complete order or test result." In order to achieve this important patient safety measure, a multidisciplinary clinical team is essential to the success as the NPSG 02.03.01 crosses many clinical lines, including physicians, laboratory and nursing. Education of all clinical areas, along with auditing the process to ensure the documentation is correct is essential. However, the nursing staff's participation in the auditing process, timely feedback to them, and being able to speak about their metrics is crucial to the sustainability of the success of the project.

Methods/Procedures: From 2007 through 2008, reporting and communication of critical test results was documented in a hand written log. Two years of data identified the paper process as a barrier to nursing work flow. At the request of those at the bedside, CTR documentation was moved to an electronic process in Sunrise Clinical Manager (SCM). A medical unit was designated at the pilot unit for the electronic documentation of CTR. The pilot demonstrated much improved compliance of both timely reporting and accurate documentation. Therefore, the process was disseminated throughout all nursing units in early 2009. An education component was added in the fall of 2009 along with closer communication with the staff about their audit results.

Results: Throughout 2007 and 2008 the paper process demonstrated laboratory compliance between 85 to 100 % and nursing unit compliance significantly lower at 20 % or less. In 2009 the SCM process began with a less than 20 % compliance rate for the nursing units. With improved feedback of the performance metric to the nurses and further education, compliance was above 80 % by October, 2009.

Discussion/Application to Practice: A seamless system requires notification of a physician or their designee directly with CTR will greatly improve patient safety and ultimately the patient's outcome. Unifying all the patient's results into the electronic medical record and analyzing patient systems will lead to less fragmented care and also close the loop of performance improvement metrics. In addition to continuous education and learning, it is crucial to the success that all members involved are able to speak to their metrics, thus achieving greater compliance at the unit level. This will lead to the success and sustainability of any project.