A look at The Joint commission

Organizations struggle with critical test reporting

Are you frustrated with the amount of time it takes your hospital's laboratory, radiology, or pathology department to report critical test results? For instance, during an intraoperative procedure, surgeons don't want to wait unnecessarily long for frozen section results on a biopsy—they need results quickly. Likewise, in the emergency department, a surgeon needs to know quickly if a patient's chest pain is a medical problem or a surgical problem; promptly reported test results contribute to the accuracy of the diagnosis.

When every moment counts, delayed diagnostic results can affect the workflow of the surgical team and potentially harm the patient, but what can surgeons do about this?

Surgeons should request to learn their hospital's compliance success with The Joint Commission's National Patient Safety Goal Requirement 2C that addresses the timeliness of reporting critical test results. Requirement 2C states: "Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test and critical results and values."

Requirement 2C was introduced in 2005; however, organizations still face significant compliance challenges. The requirement was among the top 10 areas cited for noncompliance during routine surveys conducted in 2007, and hospital and laboratory programs aren't alone in their struggles. This requirement also appeared on the lists of top compliance areas for 2007 for the critical access hospital, ambulatory, and home care accreditation programs.

Organizations are expected to do the following:

- Define the terms "critical tests" and "critical results and values"
- Define the acceptable length of time between the ordering of critical tests and reporting the critical tests and critical results and values
- Define the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed caregiver
- Collect data on the timeliness of reporting critical tests and critical results and values
- Take appropriate action to improve and measure the effectiveness of those actions

The term "critical test result" refers to both the results of a critical test and test results with critical values and applies to all diagnostic tests including imaging studies, electrocardiograms, and laboratory tests and other diagnostic tests defined by an organization as "critical." Organizations need to make a distinction between "critical tests" and "critical results." Critical tests will always require rapid communication of the results, even if normal. Critical results, also known as critical values, refer to test results that fall significantly outside the normal range and may represent life-threatening values even if from routine tests.

Surgeons should address what their organization's expected turnaround time is for reporting. The turnaround time must be established by policy, and it should include measurement of the timeliness of reporting the results of critical tests. The measurement in this situation is from the time the test is ordered to the time the result is reported to the responsible licensed caregiver.

The ultimate objective, however, is for critical test results to be reported to the responsible licensed caregiver and for any unnecessary delays in the treatment or care of patients to be avoided.