

Critical results reporting – a medico-legal view

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What we will cover

- Concepts of responsibility and liability
- Practical considerations
- Massachusetts Coalition guidelines



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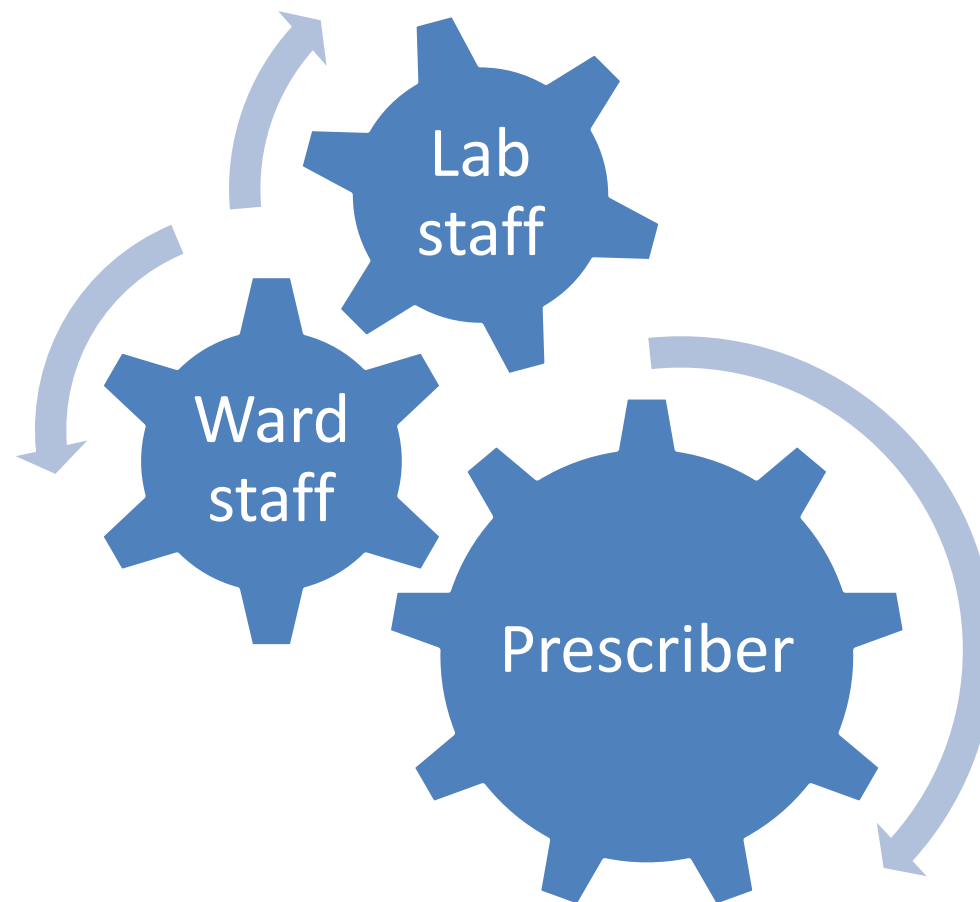
Responsibility and liability

- Terms can be confusing
- A professional is responsible for his or her actions or decisions
- In civil claims within the NHS, the employing trust is vicariously liable for its staff
- Where there is a criminal allegation there is usually individual liability
- There is individual liability to professional regulators
- Employees will be individually liable under trust disciplinary proceedings



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Communicating results



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Potential for error

- More stages/intermediaries may increase the risk of error
- Transcription error may creep in when telephone results taken
- Failure to categorise importance/urgency
- Failure to identify who can take definitive action on result
- Wrong decision despite prompt, accurate receipt of information



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In the lab setting

- Professional responsibility
 - What do local guidelines and protocols say
 - What professional standards does your professional regulator require
 - Do focus on the patient: safety is paramount
 - Avoid collusion of anonymity
 - Design processes with input from all those likely to be affected by it



Massachusetts Coalition – the “what”

Red

- Immediate danger of mortality or morbidity
- Direct notification to someone who can intervene

Amber

- Highly significant, not immediately threatening
- Notification by a high priority process within several hours

Yellow

- May be significant if treatment not initiated in a timely manner
- Notification within three days



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Massachusetts Coalition for the Prevention of Medical Errors (2005) *Communicating critical test results – safe practice recommendations* Jt Comm J Qual Patient Saf 31(2) 68- 80

Massachusetts Coalition – the “how”

Safe practice recommendations cover the following areas:

- Who should receive the results
- Who should receive results when ordering clinician is not available
- What results require timely and reliable communication
- When the results should be actively reported to the clinician within defined timescales
- How to notify the clinician
- How to design, support and maintain the systems involved

Massachusetts Coalition safeguards can be accessed free on their website at:
<http://www.macoalition.org/communicating-critical-test-results.shtml>



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Summary points

- Errors will occur – a good system will reduce their occurrence to a minimal level
- Too many intermediaries risks error
- Define what is critical (e.g. red/amber/yellow)
- Are you speaking to the decision maker?
- Consider routinely noting name and getting read-back where telephone is used
- Constantly audit and improve – use patient safety incidents as catalysts for change



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