Critical Communication: A Proactive Laboratory Approach To Improving Patient Safety and Clinical Outcomes

Failure to report critical lab values in a timely and reliable manner is an ongoing threat to patient safety and healthcare quality. Thus, effective communication between the laboratory and healthcare professionals remains at the forefront of patient safety and clinical outcomes improvement initiatives. So much so, that out of the three required 2015 Joint Commission (JC) Laboratory National Patient Safety Goals, and the seven Hospital JC National Patient Safety Goals, the second-most-important goal for both focuses on improving the effectiveness of communication among caregivers with the sole intent to get important test results to the right person on time.1,2 The key role of the laboratory in communicating the result as quickly as possible cannot be stressed enough, as delays in reporting may result in failure of the clinical team to recognize and respond quickly to a possibly imminent life-threatening condition.

An overview of critical value reporting published by Medscape Pathology reviewed articles that compared the time to notification of the laboratory critical value with other steps in diagnosing an important change in clinical therapeutic status.3 While the time between testing being completed to the laboratory contacting the caregiver represented 6 percent to 7 percent of the total time interval to correction of the patient problem, the longer interval more likely to affect patient outcomes is the time it takes the caregiver to initiate therapy to correct the abnormality.4-6 This clearly implies that once the laboratory has discovered a critical value, any delays in...
reporting to the caregiver would lead to a longer time interval for initiation of patient therapy, which could lead to adverse consequences. Hence, those laboratories that strive to achieve effective communication practices can have a positive direct impact on the patient’s clinical outcome.

**Information in the Right Hands**

Effective communication involves providing the information to the right person. While JC indicates that the right person, specifically the licensed caregiver, be notified of the result, a standardized approach for reporting has not been adopted by all laboratories. Wagar et al, in a College of American Pathologists (CAP) Q-Probe study found that 27 percent of laboratories allowed reporting to clerical staff for inpatients and 48 percent allowed reporting to clerical staff for outpatients.  

This reporting practice is likely more prone to miscommunication and delayed communication of results, which can result in poor patient outcomes.

Even more detrimental is communicating the result to the wrong caregiver or an intermediary who may not hand off the communication to the correct caregiver. Unfortunately, and beyond the scope of discussion for this article, the fact is that it is not uncommon to find that the ordering provider may not actually be the provider caring for the patient. Thus, the key in communicating effectively is taking the extra step to check the patient record or check with the nurse caring for...
the patient to ensure that the individual taking the information is currently caring for the patient.

Several institutions have implemented automated notification systems for critical value reporting to improve the speed of communication and to allow for complete electronic documentation of the elements of reporting required by regulatory agencies. The automated notification systems may also allow for more efficient tracking and ease of monitoring quality of data. However, as with telephone calls, electronic systems are not foolproof and escalation policies need to be in place to allow for communication of results when providers do not acknowledge receipt of the critical result.

Once the hurdles of reaching the correct provider are overcome, accurate communication of patient information is paramount and represents a critical element of patient care and safety. Communication failures have been found to be a leading cause of preventable medical errors in studies of closed malpractice claims. Thus, a key element of documentation required by regulatory agencies is “readback,” to ensure that the receiver understood the information being communicated.

Facilities that are inspected and accredited by agencies such as JC, CAP and/or AABB are more likely to have higher standards when it comes to critical value notification. In addition, these accredited facilities have likely implemented quality monitoring of the critical value notification process and can improve patient outcomes by identifying areas for improvement. Metrics for monitoring may include measurement of the turnaround time for reporting of critical results, monitoring documentation of read-back information and tracking of staff compliance with critical call policies. Although not a common practice, facilities with patient safety committees seeking further improvements in critical value notification might consider a multidisciplinary approach to critical laboratory reporting monitoring that includes tracking of healthcare provider documentation to try to deduce the time interval for patient intervention and impact on patient outcomes. Multidisciplinary monitoring may also dispel the misconception that the laboratory is the sole owner of the critical laboratory reporting process, and fosters an holistic approach that focuses on patient outcomes rather than a data set. Monitoring of the entire process encourages shared responsibility, instills a culture of accountability, and improves teamwork across and between clinical disciplines.

Ongoing dilemmas in communication of critical laboratory values implies a global lack of understanding among the healthcare team of the importance of these results in respect to patient morbidity and mortality. It requires a proactive approach to educate all healthcare providers regarding the importance of communication with each other and with the ancillary services. Laboratories can enlist the help of the facility risk managers to ensure compliance with the timeliness of critical laboratory value reporting. Risk managers are heavily invested in patient safety, and are usually more adept at providing education on key risk management principles, including the use of a back-up strategy, such as access to alternate healthcare providers to receive critical results, and how to access the chain of command if designated caregivers are unavailable or unresponsive.

Last but not least, since the laboratory director is ultimately responsible for defining critical results in consultation with the clinicians served, usually in the setting of a medical executive committee, this forum can be used to encourage education of clinical staff on the facility critical laboratory tests and values and facility policies. By acknowledging and educating clinical staff on communication with ancillary services, medical directors can potentially remove the barriers to effective communication through top-down modeling for quality improvement.

References


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