Trust Policy

NHS Worcestershire Acute Hospitals NHS Trust

Diagnostic Tests – Including the Requesting Process, Review and Filing of Results

Department / Service:	ICT
Originator:	Head of ICT
Accountable Director:	Chief Medical Officer
Approved by:	Chief Medical Officer, Clinical Governance Group
Date of Approval:	1st February 2022
Review Date: **This is the most current document and should be used until a revised version is in place**	1st February 2025
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Clinical Divisions
Target staff categories	Clinicians & Nurses

Policy Overview:
The intention of this document is to ensure that all clinical Trust staff requesting all diagnostic tests undertaken within the organisation are appropriate and managed to minimise the risk to patients and to improve patient outcome and quality of care. In particular to ensure that the requesting staff are aware of their responsibility to view results of all diagnostic tests that they or their clinical team make and take the appropriate actions.

Latest Amendments to this policy:
December 2018 – Policy approved at Clinical Governance Group 18th January 2021 - Document extended until June whilst thoroughly reviewed and updated – Mike Hallissey 12th May 2021 – Document extended for 6 months whilst thoroughly reviewed and updated by Mike Hallissey February 2022 – Addition to the audit & ICT Department sections – approved by CGG

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Appendices

1. Introduction

This Strategic Policy has been developed in response to the introduction of full paperless Requesting & Reviewing of Pathology & Radiology tests through the Trust Wide Sunquest ICE system. It sets out clearly the responsibility of clinicians with regard to requesting and acting on the results of diagnostic tests, in line with GMC good medical practice guidance.

All the statements in this Policy assume that individuals are acting within the guiding principles of the Data Protection Act, the Trust Access to Medical Records Policy and the Trust Code of Conduct in respect of Confidentiality.

2. Purpose

Diagnostic tests can be used to determine what conditions, diseases or syndromes a patient may currently have or is likely to develop. These tests can be used in a variety of ways including screening, monitoring chronic conditions, suggesting diagnoses, ruling out or confirming suspected diagnoses, monitoring patients following treatment for side effects or recurrence, and predicting future events. Because of the variety of tests employed and the range of professional review and subsequent actions that may occur as a result of testing, there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated.

3. Definitions

Diagnostic Testing Procedures:

This Policy includes the management of test procedures and results relating to all diagnostic tests including:

Imaging: Plain Film X-rays, CT Scanning, MRI, US, nuclear medicine, and other radiological procedures within and outside the radiology department.
Pathology tests for all disciplines including Microbiology, Haematology, Biochemistry, Histopathology, Cytology, Immunology, Molecular Biology and Genetics. Blood Transfusion (BT) is not yet available to request on ICE but is a planned development.

Standing Operating Procedures (SOPs):

A clear, step-by-step instruction of how to carry out agreed actions that promote uniformity to help clarify and augment processes. SOPs document the way activities are to be performed to facilitate consistent conformance to requirements and to support data quality. SOPs provide individuals with the information needed to perform a job properly and consistently.

4. Responsibility and Duties

Chief Executive
The Chief Executive Officer for the Trust takes final responsibility for adherence to, and the implementation of all Policy Documents issued and approved by the appropriate Trust Committee(s).

Trust Board
The Trust Board receives regular reports concerning clinical governance issues within the Trust, and this should include a report every year concerning the matters related to this policy, particularly

relating to the acknowledgment of receipt of tests, clinical incidents arising from the failure to act on a report and the overall safety of the diagnostic process to include the incorrect attribution of specimens or reports to individual patients.

Reporting Committee
The reporting Committee will be the Clinical Governance Committee (CGC). Any exceptions will be reported to the Quality Governance Committee by CMO/CNO if serious problems are brought to their attention.

In practice, any serious incident concerning patient safety, patient confidentiality or data protection should initiate a review well before the issue is raised at the CGC.
Adherence to the target of 95% of reports to be viewed & filed within 28 days is monitored through the integrated performance report.

ICT Department
Supports the investigation of issues relating to the Sunquest ICE system which might be related to requesting, reporting, filing and correct attribution of patient or responsible clinician.

Works with the clinical teams to utilise system functionality effectively.

Clinical Directorates and Clinical Leads
Ensures the development and adherence to local SOPs relating to diagnostic testing procedures and the management of associated risks. Monitor adherence to good Medical Practice with regard to Diagnostic tests and review thereof.

Clinical, Nursing and Administrative Staff
All clinical, nursing and administrative staff involved in the requesting, reviewing, acknowledging and acting on diagnostic tests should be aware of their responsibilities in this role. They will be expected to undertake training and pass the required competencies before access is granted to the system.
Formal class room based or e-learning training can be provided if required, with regard to using the electronic processes for Diagnostic tests. Individual clinical departments may need to develop protocols or standing operating procedures (SOPs) to ensure safe and confidential practice.

Policy Detail

a. Duties of Clinicians, Nurses or administrative Staff

- In line with Good Medical Practice (GMC), when diagnostic tests are requested details should be noted in the patients' event notes and clinicians should ensure that diagnostic tests comply with appropriate protocols for patient assessment
- All Radiology & Pathology tests set out in Section 3 will be requested electronically on the Sunquest ICE system. The exceptions to this are where investigations need to be undertaken outside WAHT and may require a separate requesting process.
- The **Requester of the test** is the individual who has the responsibility for checking and acting on the test result. This responsibility may be delegated to a colleague with their consent, providing the requester is satisfied that the delegate has the qualifications, experience, knowledge and skills to act on the result. It is not acceptable to delegate responsibility for checking test results to untrained administrative staff.
- All radiology referrals for tests involving ionising radiation must be requested in line with IR(ME)R 2017 requirements. They must be a registered health care professional who is entitled in accordance with the Trust to refer individuals for exposure to a practitioner. http://www.legislation.gov.uk/uksi/2017/1322/pdfs/uksi_20171322_en.pdf

- When viewing the results on ICE the clinician should document acknowledgment of results by **'**Filing' electronically. By 'Filing' the result a Clinician is indicating that they have noted the result, and have taken appropriate action on the patients' behalf.
- Clinicians will need 'fail-safe' mechanisms to ensure that results are reviewed in a timely manner, and that these results are acted upon, particularly when the care of the patient is handed over to another provider or to primary care.
- Clinicians as part of a clinical team will need to ensure that there is a nominated consultant colleague who will take responsibility to review urgent results for consultants during their periods of leave e.g. sickness, annual leave, study leave.
- Where a test has been requested for an inpatient but the result is not available by the time the patient is discharged, the requester remains responsible for checking the result of the test and communicating the result to the patient or GP as appropriate.
- Pathology results will be displayed as abnormal if numeric values fall outside the normal range, these will be highlighted with a red exclamation mark.
- Radiology have a defined processes in place for the communication of urgent Radiology results, please see Appendix B for further details on how these will be communicated.
- Requesters are expected to ensure that 95% of pathology & radiology reports (abnormal and normal) are viewed and filed within 28 working days.
- If an individual without authority to take clinical decisions notes a seriously abnormal result, they must bring this to the attention of someone within the clinical team who can make the decision in a timely manner.
- It is the responsibility of the reporting doctor/practitioner to validate and authorise the result in a timely fashion. It is the responsibility of the Trust to have systems in place to ensure results are received by the referring staff. Ensuring correct patient identification and referrer attribution is a key requirement of the system to ensure prompt and appropriate patient management.
- It is the responsibility of all participating staff to be familiar with relevant processes, policies, protocols and software to ensure that errors are kept to a minimum.
- It is the responsibility of the Trust and relevant clinical team to investigate and act upon adverse events associated with inappropriate action or lack of action on test results.
- For examinations involving Radiation and as per IR(ME)R 2017 regulations, a clinical evaluation of the outcome of each patient exposure must be recorded. This is a legal requirement. This is normally the formal Radiological clinical report sent to ICE.
- Some Radiology examinations will, by agreement with Radiology and the referring Directorates, not receive a formal radiological clinical report. The clinical evaluation therefore of these images must have documentation within the patient's notes or records by the clinical teams, made by their own staff who have the skills and training to do this. Typical examples are Follow-up Fracture clinic images, ERCP and cardiac angiography.
- If a formal report is not being issued by radiology then in these instances Radiology will mark the study on its RIS system as being completed using the following phrase. "*The referring clinician should record their clinical evaluation of the examination to comply with IR(ME)R regulations. These images are not clinically evaluated (reported) by Radiology, however further advice may be sought from the Radiology directorate on a case by case basis if necessary."*
  These reports are automatically filed in the ICE system

b. Process for Requesting Diagnostic Tests

Having ensured the correct patient attribution, the requester should select tests through a tick box menu on the diagnostic areas. This will ensure that only appropriate members of the clinical staff can request certain tests, such as certain MRI and CT investigations. Vetting procedures will be embedded within the Radiology requesting process.

Having completed the selection, a request will be generated electronically and a paper request will be printed for all pathology requests to go along with the sample. Paper requests may occasionally be printed by default for some Radiology tests.
The patient can then be instructed about the next steps, which might be immediate or delayed.
Some tests will still be requested on paper, but this is by exception only.
For Pathology tests that are requested on ICE but are deferred to be collected later – it is then the responsibility of the ICE User collecting the Samples to update the 'Sample Collection' Tab in ICE to "Mark as Collected" updating the status of the Request to "Specimen Collected" If this is not completed properly these Requests are effectively 'Manual Requests' and will not be received into the pathology labs as electronic requests.

c. Process for Receipt of Diagnostic Test Results

Diagnostic test results will be available to view in Sunquest ICE. These results will be accessible to all users of the system. Those individuals or teams who have made requests will be expected to view those results in a timely manner.
The ICE Requester is responsible for viewing and acting on the Test result.
It is recognised that many patients will have test results available that have been requested by other teams, or in Primary Care. Acknowledgement of such results is the responsibility of the clinician who made the request, although there will be circumstances within the Trust where it would be more appropriate for the clinician with ongoing responsibility to acknowledge those results.

d. Communication of Critical, Urgent and Unexpected findings on Radiological Imaging Reports to Hospital Clinicians

Responsibility of the Radiology department:

- Critical reports – the reporting clinician must speak with the Clinical Team directly to ensure immediate communication of findings.
- Be aware of the Radiology policy and key points – Policy for Communication of Critical or Urgent Radiology reports. Please see Appendix B.
- Ensure processes are in place to provide assurance that all results are formally reported except those documented under the Plain Film Reporting Policy. Please see Appendix A.

e. Taking Action on Diagnostic Test Results

It is the responsibility of the clinician or other individual accessing a result to act on that information in an appropriate and professional manner. If the individual who accesses the result cannot take appropriate action (such as a Medical Secretary), it is important that they bring this to the attention of someone who can.
Actions taken should be recorded and the method of communication indicated (face to face contact, phone call, letter, e-mail and so on).
Pathology & Radiology tests requested by hospital clinicians are all viewable on the ICE system by GP practices. Where a copy of the pathology test has been requested by the GP, they will receive the result in via GP links into EMIS.
It remains the responsibility of the requester to ensure that the result is reviewed and acted upon.

f. Documenting Diagnostic Test Results

Retaining test results electronically means there is no need for paper copies to be filed in the notes.

g. Process for Communication of Diagnostic Test Results

a) It should be made clear to patients as to how and when they should expect to receive the results of a Diagnostic test.

b) The nature of the communication of the result will depend on the test itself and the implications of the result. Clinical teams may develop local policies or guidance around communication of results

6. Training and awareness

All staff engaged by the Trust who are expected to access the diagnostic test system Sunquest ICE will be expected to undergo a period of training to familiarise themselves with the electronic systems. All staff involved in diagnostic testing procedures, particularly junior and senior doctors, nursing and allied health professionals and clinical secretaries should be aware of the competencies needed and the training requirements expected by the organisation.

Any new starters with effect from 1st December 2018 will be required to complete an e-learning module on ICE requesting and reviewing when they attend their Induction to clinical systems training and achieve 100% competency in order to receive their password to use the system.
If any of the software functionality changes as a result of a software upgrade or the introduction of new functionality, ICT will assess the impact of the change and develop e-learning material that staff will use to ensure they are fully aware of the changes.

All staff will be expected to be aware of their responsibilities in relation to this policy.
This Policy will be disseminated to all staff through the Chief Medical Officer and Divisional Medical Directors. All Clinical Leads will be expected to be aware of, and understand their responsibilities in terms of implementing this policy.

7. Monitoring and compliance

Audit
Monitoring of unviewed and not 'filed' results will be undertaken on a regular basis by the Clinical Divisions as part of their local clinical governance arrangements.
Requesters are expected to ensure that 95% of pathology & radiology reports (abnormal and normal) are viewed and filed within 28 working days.
Where it is deemed clinically appropriate; auto filing rules / batch filing of historical results will be applied. These will be agreed by the Divisional Director and Chief Medical Officer (or deputy).

8. Policy Review

This policy will be reviewed annually, with the exception of where a significant change has occurred.

9. References

	Code:
Diagnostic Tests – Including the requesting process and review with Acknowledgement – Salisbury NHS Foundation Trust	
National Patient Safety Agency (NPSA) alert No.16, Issued February 2007: **Early identification of failure to act on radiological imaging reports**.	
The Royal College of Radiologists, Approved 29th February 2008 **Standards for the communication of critical, urgent and unexpected significant radiological findings**	

SHA Document, South West, Issued 9th March 2009. **Radiology Review, Section 8**	
BMA Document, October 2010 **Acting upon test results in an Electronic world**	
Reporting of unexpected Radiological findings, May 2012 **Communication to SHA Medical Directors from Professor Sir Bruce Keogh, NHS Medical Director**	
Radiology Department, Salisbury District Hospital, June 2012 **Communication of Critical, Urgent and Unexpected findings on Radiological Imaging Reports to Hospital Clinicians**	

10. Background

a. Equality requirements

b. Financial risk assessment

c. Consultation

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Dr Suneil Kapadia, Chief Medical Officer
Dr Jasper Trevelyan, Divisional Medical Director, Speciality Medicine
Dr Julian Berlett, Divisional Medical Director, SCSD
Dr Andrew Short, Divisional Medical Director, Women's & Children's
Mr Paul Rajjayabun, Divisional Medical Director, Surgery
Dr Jules Walton, Divisional Medical Director, Urgent Care
David Hill, Chief Radiographer
John Auld, Pathology Directorate Manager
Dr Jenny Braid, Consultant Radiologist
Dr Robert Johnson, Consultant Radiologist & Clinical Director for Radiology
Dr Ed Mitchell, Clinical Lead for Intensive Care Medicine
Mr Richard Lovegrove, Consultant
Mr John Hughes, Consultant Obstetrics & Gynaecology
Dr Danny Cheung, Consultant Gastroenterologist
Dr Baylon Kamalarajan, Paediatric Consultant
Sonia Lloyd, Clinical Risk and Governance Lead

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Clinical Governance Committee

d. Approval Process

This policy will be approved by Chief Medical Officers Office.

Appendix A – Plain Film Reporting Policy

plain film reporting policy.pdf

Appendix B – Communication of Urgent Results

Communication of critical and urgent rac

Appendix C – Standards and Key Performance Indicators

AUDIT MEASUREMENT	DATA SOURCE
Proportions of Radiology & Pathology results not viewed	Sunquest ICE
Proportion of Radiology & Pathology results not filed	Sunquest ICE
Numbers of patient duplications	Sunquest ICE
Numbers of Serious Incidents arising from Electronic Requesting	Trust Incident monitoring
Numbers of Serious Incidents arising from the use of Diagnostic tests	Trust Incident monitoring
Incidents arising from inappropriate actions or inaction taken on receipt of result	Trust Incident monitoring

Appendix D – Access levels for different groups of employees working in the trust

Employee Category	Patient Details and Results Viewing	Pathology Test Requesting	Radiology Test Requesting	Training Required	Results Sign Off
Doctors*	Automatic	Automatic	Automatic	At Induction or Pre induction	**Yes**
Trained Nurses, including Bank and Agency Nurses	Automatic for those with long term SFT contracts (but not Agency staff unless supported by their line manager)	Only when supported by their Line Manager	Only when approved by Radiology	At Induction or Pre induction	Only when approved by their Line Manager (eg CNS)
Allied Health Professionals**	Only when supported by their Line Manager	Only when supported by their Line Manager	Only when approved by Radiology	At Induction or Pre induction	Only when approved by their Line Manager
HCSW including Phlebotomists	Patient Results not normally made available unless access requested by their Line Manager. Limited to patient 'look-up' and 'Sampler'.	Only when supported by their Line Manager	**Not** to be made available	At Induction or Pre induction	**No**
Non Medical Staff***	Only when supported by their Line Manager	Only when supported by their Line Manager	Only when approved by Radiology	At Induction or Pre induction if approved by line manager	Only when approved by their Line Manager
Locum Doctors	Automatic, but those with contracts <5 days to use a Generic Locum accounts	Automatic, but those with contracts <5 days to use a Generic Locum accounts	Automatic, but those with contracts <5 days to use a Generic Locum accounts	Pre Induction	**Yes**
Medical Students	Only if supported by their Clinical Supervisor The exception to this will be the pre Foundation shadowing students in July who should have full access to all modalities and full Training	**No**	**No**	At Induction if approved by clinical supervisor	**No**
Other Students	**No**	**No**	**No**	**N/A**	**No**

*** This includes all Senior Doctors, all Doctors in Training and all other Grades excluding Locums**
**** This includes Pharmacists, Physiotherapists, Occupational Health Workers and Dieticians**
***** This includes Medical Secretaries, Ward Clerks, Clinical Coders and some Managers**

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the Policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	No	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**	No	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval