WASHINGTON ADVENTIST HOSPITAL
PATIENT CARE POLICY MANUAL

REPORTING OF CRITICAL RESULTS OF TESTS AND DIAGNOSTIC PROCEDURES

Effective Date: 12/6/93 **Policy No.** 5204
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SCOPE:
This policy has hospital-wide application.

PURPOSE:

To provide guidelines for the immediate reporting and documentation of critical results of tests and diagnostic procedures to the responsible Licensed Independent Practitioner (LIP) within the established time frame set forth by the organization.

DEFINITIONS:

Critical Results of Tests / Diagnostic Procedures: Results, values, or interpretations of tests/diagnostic procedures that have fallen significantly outside the normal range, indicate a life threatening situation, and or any other results that are determined by the laboratorian, radiologist, or any other diagnostician to be critical to the patient's subsequent treatment decisions.

Read-back and confirmation process: The process in which the receiver of the information documents the complete test/diagnostic procedure result in the progress notes in the medical record, reads the test result back, and receives confirmation from the individual who reported the test result.

Procedure:

Reporting of Critical Results of Tests / Diagnostic Procedures:

A call will immediately be initiated to the responsible LIP as soon as a critical result/diagnostic procedure is received. When reporting critical results, the read-back and confirmation process will be used to verify accuracy. The allowable time frame for reporting the critical result of a test and/or diagnostic procedure to the LIP from the time the result is available will not exceed **60 minutes for inpatients** and **two hours for outpatients**. If unable to notify the responsible LIP within 60 minutes, the chain of command for medical management will be followed (Policy WAH.5911 Patient Care Management Issue Resolution). Critical results are not to be left on a recording device or with an answering service or secretary.

I. Critical Result Reporting

A. **Critical Lab Values (including ABG lab)**

1. Laboratory personnel will immediately call the result to licensed nursing staff responsible for the patient upon identification of any critical results as defined by the Laboratory portion of the Critical Results Policy (please refer to attachment A.) If the patient's assigned nurse is unavailable to receive the result, the supervisor (e.g. charge nurse), or another licensed nurse on that patient care unit will receive and document the critical result in accordance with this policy. In some departments (e.g., ABGs in ED and ICUs), the physician responsible for the patient may be notified of the result directly.
2. Results will be documented on the Critical Results Reporting sticker. To document results, place the Critical Results Reporting sticker in the progress notes and enter results into the progress notes on the sticker. Results not received by telephone (e.g., I-Stat results) will also be documented in the progress notes using the Critical Results Reporting sticker, along with any action taken. No need to notify the LIP if protocol/ordered parameters already exist however, it should be documented. [Exception: Results reported directly to the responsible LIP.]

3. The read-back and confirmation process will be used to verify accuracy.
4. Upon receipt of the critical result, the nurse will (a) immediately notify the responsible LIP, or (b) take action based on existing protocols/orders, (e.g. heparin protocol). Communication of the result will include the read-back and confirmation process to verify accuracy. If after 30 minutes, the responsible LIP has failed to return the call, the nurse will place a second call to the physician, and simultaneously call another physician/LIP on the case, if no response from either LIP, initiate chain of command (COC).
5. Discharged Patient Results or Outpatients: Results will be telephoned directly to the physician who ordered the test/physician's designee, and will include the read-back and confirmation process to verify accuracy.

B. **Critical Radiology Results**

1. The interpreting physician will immediately notify the responsible LIP of the critical test results as defined in the radiology portion of attachment A.
2. The interpreting physician will also document the critical diagnostic findings, which includes the name of physician who received the results and the date and time of notification in the radiology department critical reports log.
3. The read-back and confirmation process will be used to verify accuracy.
4. Discharged patient results or outpatient results: Results will be called and reported to the physician in a manner consistent with this policy.

C. **Critical Cardio-Diagnostics**

1. EKG: Upon completion of any EKG, the technician will provide a copy of the EKG with the preliminary interpretation to the nurse responsible for the patient or the charge nurse. Upon receipt of a critical result (per policy WAH.5602), the nurse will take action based on existing protocols/orders or immediately notify the responsible LIP. If after 30 minutes, the responsible LIP has failed to return the call, the nurse will place a second call to the physician, and simultaneously call another physician/LIP on the case, if no response from either LIP, initiate chain of command (COC).
2. Echocardiogram (ECHO): The interpreting physician will immediately call the critical results as defined by the Cardio-diagnostic portion of this policy (Attachment A) to the responsible LIP.
3. The read-back and confirmation process will be used to verify accuracy.
4. Discharged patient results or outpatients: Results will be called and reported to the physician in a manner consistent with this policy.

Attachment A

RADIOLOGY

New diagnosis of, or unsuspected acute:

- Acute cerebral hemorrhage and/or significant mass effect, hydrocephalus
- Aortic rupture, aortic dissection
- Pneumoperitoneum, pneumothorax, tension pneumothorax
- Finding suggesting ischemic or infarcted bowel
- Ectopic pregnancy
- Fetal anomaly
- DVT (outpatients)
- Torsion of testicle or ovary
- Pulmonary embolism

CARDIODIAGNOSTICS

Echos/TEE with the following findings:

- Cardiac tamponade
- Significant pericardial effusion
- Significant or marked increase Pulmonary artery pressure
- Myocardial rupture
- Aortic root dissection
- Bacterial endocarditis
- Acute valvular insufficiency
- LA or LV Thrombus

EKG (Per policy WAH.5602 Physician Notification of Change in Patient Status)

- Acute changes in ST elevation or interpretation of acute MI
- Ventricular tachycardia
- Atrial fibrillation or flutter (new onset)
- Junctional rhythms
- Second and third degree heart block

LABORATORY – BLOOD GASES

- pH less than or equal to 7.3
- pH greater than or equal to 7.6
- pCO_2 greater than or equal to 60
- pO_2 less than or equal to 55

LABORATORY

Microbiology:

CULTURE	RESULT
Blood Culture	Any organism
Cerebral Spinal Fluid	Any organism
Fluids (sterile body fluids other than urine)	Any organism
Malaria	Any organism

Blood Bank:

- Blood Bank calls positive antibody screens on pre-operative patients
- Any delay in the following: Before surgery
    - Inability to crossmatch
    - Inability to procure blood

Chemistry, Hematology Toxicology, Immunology:

TEST NAME	AGE	CRITICAL LOW	CRITICAL HIGH	REF UNIT
Acetaminophen			≥ 50	µg/mL
Alcohol			≥400	mg/dl
Amikacin, Peak			>35	µg/mL
Amikacin, Trough			>10	µg/mL
Ammonia			≥200	mmol/L
Bleeding Time			≥15	mins
Calcium		≤ 6	≥13	mg/dl
Carbamazepine			≥15	µg/mL
Chloride		≤ 75	≥125	mmol/L
CO_2		≤ 10	≥40	mmol/L
DADS CSF			POS	
Digoxin			≥2	ng/mL
Fibrinogen		≤ 100	≥800	mg/dL
FSP			Pos >5)	µg/mL
Gentamicin, Peak			≥10	µg/mL
Gentamicin, Random			≥10	µg/mL
Gentamicin, Trough			≥2	µg/mL
Glucose	0 – 31 Days	≤ 30	≥300	mg/dl
Glucose	32 Days +	≤ 40	≥500	mg/dl
Hgb		≤ 6	≥20	g/dl
K		≤ 2.9	≥6	mmol/L
Lithium			≥2	mmol/L
Magnesium		≤1	≥3	mg/dL
Na		≤120	≥160	mmol/L
NAPA			≥10	µg/mL
Total Bilirubin			>18	mg/mL
Phenobarbital			≥50	µg/mL
Phenytoin			≥30	µg/mL
Phosphorous		≤1		Mg/dL
Platelet Count		≤ 30	≥900	K/uL
Procainamide			≥16	µg/mL
PTT			≥63	Secs
Quinidine			≥8	µg/mL
Salicylate			≥30	mg/mL
Theophylline			≥21	µg/mL
Tobramycin, Peak			≥10	µg/mL
Tobramycin, Random			≥10	µg/mL
Tobramycin, Trough			≥2	µg/mL
Troponin-I* (see note)			≥0.6	Ng/mL
Valproic Acid			≥175	µg/mL
Vancomycin, Peak			≥40	µg/mL
Vancomycin, Random			≥40	µg/mL
Vancomycin, Trough			≥10	µg/mL
WBC		≤ 2	≥30	K/uL
WBC	<16Y	≤ 2	≥20	K/uL
INR			≥4	None

***NOTE: Subsequent critical results for troponin that are trending downward from the previously reported value will not be treated as a critical result. However, if a subsequent troponin result is greater than the previously reported value, the result will be treated as a critical result.**

Preop Values

PREOP	AGE	ABNORMAL LOW PREOP	ABNORMAL HIGH PREOP	REF UNIT	NORMAL LOW	NORMAL HIGH
BUN	20Y+		>40	mg/dl	7	20
Creatinine	19Y+		>2.5	mg/dl	0.6	1.3
Glucose	19Y+	< 50	>170	mg/dl	74	105
HCG			POS			
Hgb	19Y+	< 10	>20	g/dl	F 11.5 M 13.5	F 16 M 18
K		< 2.9	>6	mmol/L	3.5	5.1
Platelet Count		< 150	>600	K/uL	150	450
PTT			>37	Secs	23	37
Uric Acid			>12	mg/dl	2.6	7.2
WBC	19Y+	< 3	12	L/uL	4.5	11
LOCATIONS INCLUDE: WPAT, WSDS WSS5, WITRC WIOBS						