

LABORATORY COLLECTION MANUAL	LABORATORY REPORTING OF RESULTS
Effective Date: 6/96	Page 1 of 3

**THE LABORATORY INFORMATION SYSTEM PROVIDES A PRINTED REPORT FORM THAT CONTAINS ALL THE FOLLOWING INFORMATION:**

- ☆ The name of the patient and Date of Birth
- ☆ The patient billing identification number and Medical Record number.
- ☆ The name of the ordering physician or primary physician. (The name of the primary physician is the name on the patient report form, if the name of the ordering physician is different, this information could be found by a review in the Order/Entry module or on the patient chart.
- ☆ The date and time the specimen is collected.
- ☆ The date and time the report is printed.
- ☆ The date and time verified or resulted
- ☆ The reference values of each test ordered, when appropriate.
- ☆ The name and address of the laboratory performing the test, including if performed at a reference lab. Some reference lab testing is the printed report from the reference lab. If the test is interfaced into the system, the name and address of the testing laboratory is included in the report.
- ☆ The report form contains comments that are necessary to complete the patient report such as: (but not limited to.)
  - ◆ Documentation of notification of critical results that includes:
    - Date and time of notification.
    - Laboratory individual making the call.
    - Person notified.
    - Tests results that were called. ⇒**ALL QUANTITATIVE CRITICAL VALUES, WHEN ENTERED, ARE PROMPTED WITH A POP-UP SCREEN REMINDING THE TECH TO CALL THE RESULTS.**
    - Read-back of the results must be performed by the person accepting the results and technologist making the call must document in the computer system that read-back was performed. Documentation of this can be found by viewing the individual patients' information in the system. This does not print on the patient report.
  - ◆ Documentation of notification of problems or delays in testing.
  - ◆ Documentation that floor is called when blood is ready to be transfused.
  - ◆ Documentation that specimens that are run with the notification to the physician about hemolysis or other specimen limitations, etc.
  - ◆ Documentation of any specific problems with specimens and the documentation of the physician or appropriate person being notified.
- ☆ Qualified testing personnel review all test results before final reporting. Results that are interfaced must be reviewed and verified before reporting.
- ☆ If outside the reportable range, it is resulted with a greater than or less than sign. If the result is greater than the analytical range and a dilution is needed, specimens are run on diluted specimens. It is noted in the computer system that the specimen was diluted. If the lower reportable limit is zero, and the instrument flags below detectable limits, a zero is entered as a result. Comments can be attached.
- ☆ When appropriate, the report identifies the specimen by source (for example micro specimens) and time and date of collection. When using specimens that are hemolyzed or very lipemic, there is a comment added to the report. Any specimen that might be contaminated in any way is also noted on the report.
- ☆ Interpretative data is attached to many tests giving the physician additional information about the testing results.

LABORATORY COLLECTION MANUAL	<b>LABORATORY REPORTING OF RESULTS</b>
Effective Date: 6/96	Page 2 of 3

- ☆ The reports are maintained in the system for at the very least 2 years for look-up and then are maintained archived on electronic tape. Inpatient/Outpatients reports can also be found in the patient medical records file in Health Information Management. Industrial reports are kept electronically, only.
- ☆ Test results that are extremely high or low, or do not seem clinically appropriate are repeated before reporting.
- ☆ When errors are detected in patient test reports, we promptly notify the responsible clinician and issue a corrected report. This is documented as a corrected report, with previously reported results attached.
- ☆ Certain analytes have “Delta checks” built into the computer system that helps detect possible errors in reporting of results. The computer system has several reminders for different test results such as these delta checks and critical ranges.
- ☆ Different technical procedures include possible situations or interfering substances that might cause analytical inaccuracy. All abnormal results should be reviewed by clinical staff before reporting. All critical tests or values should be reviewed and reported within 30 minutes. Any incongruent result on a patient would be reviewed and repeated and/or redrawn.
- ☆ The Laboratory Medical Director reviews and approves the content and the format of Laboratory Reports initially or with revisions and annually thereafter.
- ☆ All reports requiring specific interpretation such as surgical pathology and cytology, are authenticated by the pathologist performing the interpretation.
- ☆ **REPORTING OF MICROBIOLOGY RESULTS:**
  - ◆ Source of specimen is noted
  - ◆ Results are clearly indicated as either “preliminary” or “final” on patient reports.
  - ◆ Some preliminary reports of growth are issued as soon as detected.
  - ◆ Preliminary reports of “no growth” are issued for blood cultures, CSF, and cultures of normally sterile body fluids.
  - ◆ Smear reports are issued as soon as test is performed.
  - ◆ Any test with a defined critical limit requires initiation of immediate physician notification. Read-back of the results must be performed and also documented in the computer system.
- ☆ **REPORTING OF SENSITIVE TEST RESULTS:**
  - When reporting sensitive test results such as positive test results for HIV, these reports are hand delivered to the appropriate nursing unit for them to be placed on the patient’s chart. The Infection Control/Employee Health Nurse receives a copy. If the patient is an outpatient or has already been discharged, these are taken to the HIM department. Reports of this nature are sent to the physician in a sealed envelope.

LABORATORY COLLECTION MANUAL	LABORATORY REPORTING OF RESULTS
Effective Date: 6/96	Page 3 of 3

☆ RELEASE OF PATIENT INFORMATION

- ◆ No patient medical or demographic information will be released to the patient or any unauthorized person, without written consent of the patient. Patients must go to HIM to receive their report and a HIPAA release form must be completed.
- ◆ Any patient medical or demographic information is treated with strict confidentiality, and is not given over the phone or via fax without knowing that the person receiving the information is an authorized person.
- ◆ In order to prove the person is authorized when not known, a letter head from the facility or some other means of proof will be requested to be faxed to our laboratory for verification.
- ◆ Examples of an authorized person means the physician, the physician's office staff, Nursing home staff, inpatient nursing floor, Home Health staff (verified), other authorized Health Care personnel.

WRITTEN BY:     **Kay Shaw, MT(ASCP)SBB**          DATE:     **6-96**    

APPROVED BY:     **Martin F. Belli, M.D.**          DATE:     **6-96**    

REVISED BY:     **Kay Shaw, MT(ASCP)SBB**          DATE:     **3-98, 5-99, 5-2000, 9-2000, 6-2002, 12-2002, 8-2003, 6-2004, 2-2006, 4-2006, 6-2006, 10-2006, 12-2007, 3-2008, 6-2008, 4-2010**    

APPROVED BY:     **Martin F. Belli, M.D.**          DATE:     **3-98, 5-99, 5-2000, 9-2000, 6-2002, 12-2002, 8-2003, 6-2004, 2-2006, 4-2006, 6-2006, 10-2006, 12-2007, 3-2008, 6-2008, 4-2010**    

***See original policy in the Laboratory for all documented annual reviews.***

Reference:

1. CAP General Checklist, College of American Pathologists, Laboratory Accreditation Program, 1996.1 edition, 1996, pp.12-13.
2. Medical Laboratory Management and Supervision, Lionel A. Varnadoe, F. A. Davis and Company, 1996. p. 273
3. JCAHO Perspectives on Patient Safety, September, 2003 (See Goal #2 about communication)

Laboratory Standard Operating Procedures Manual, Laboratory Collection Manual