Guidelines for Documentation of Special Verbally Communicated Imaging Findings—these guidelines in no way supersede the official hospital policy (also posted in conjunction with this document) in this regard—these guidelines are meant to enhance the documentation and feedback loop in this notification process.

Please carefully read the accompanying Official Hospital Policy in this regard; this is policy all Radiologists and Radiology Residents must understand and execute.

AA Mancuso, MD

These guidelines are to be used in conjunction with the JACHO requirements for documentation of **special** verbal communications between the physicians of the diagnostic radiology service and health care providers from other services concerning the results of diagnostic imaging studies or other circumstances related to those images.

The intent of these guidelines is to provide a database of such communications that can be managed in a way that facilitates the confirmation that these important **special** verbal communications have been executed and understood. It is the responsibility of Radiology to be sure that this has been done. It is the job of the referring health care provider to use the database to confirm this has been done.

There are two types of communications that must be documented in the manner described subsequently:

1- **Critical results**- these are special communications made outside of the realm of usual verbal interactions such as those occurring in the often high acuity situations with the EMS and Trauma Service. While those interactions should be documented in the report they do not always constitute a critical result designation (**see appended policies**).

   Some discretion is required in identifying a **critical result** as such. In general, the communication so designated should convey findings that are of relatively high acuity and have to be delivered and understood in the context of acute or subacute medical decision making time frame. This is information that can neither be left to the routine reporting system nor to undocumented nor potentially misunderstood verbal interactions.

   Examples are listed in the appended policy statements. Note that these are typically the first occurrences of these conditions.

   Note that a **critical test** is a *type* of **critical result** that must be reported verbally and documented. Currently this term only applies to the studies done for first

incidence of stroke (see appended table). Please **do not** use the term critical test in the report documentation—call it a critical result and the audit system will pick it up.

2- **Unexpected findings -** these are special communications made outside of the realm of usual routine written reports. Some discretion is required in identifying an **unexpected finding** as such. These are findings, typically of relatively low acuity, but that constitute a condition that may pose some significant proximate risk to the patient that requires careful and relatively prompt follow up. These would likely be in the "orange" of the critical results hospital policy statements. This is information that cannot be left to the routine reporting systems because of potential danger to the health of the patient.

Examples:

Unexpected finding (high acuity must be verbally communicated): Non calcified, previously unidentified lung nodule on a preoperative chest x-ray; however, exercising sound clinical judgement—this would be elevated to a critical result status if the patient is scheduled for surgery within 24 hours.

Unexpected finding **(moderate acuity must be verbally communicated)**: Non calcified previously unidentified lung nodule on a routine chest x-ray or indeterminate adrenal mass on a spinal MRI.

Unexpected finding (low acuity and not needing verbal communication): Incidental thyroid nodules confined to the gland with no evidence of related cervical adenopathy or simple renal or liver cysts that can be clearly identified as simple.

These critical or unexpected findings as just defined will be reported as follows in a statement the <u>Impression</u> section or an <u>addendum</u> to the report:

1- The term (without substitutions or modifications) **Critical Result** or **Unexpected Finding** will be used as a lead off to the documentation statement.
2- The name of the person receiving the report and, asserting back to the radiologist, that the nature and implications of the communication is understood, is documented.
3- The date and time of the communication is documented.
4- There is an assertion that the communication is understood (this is a hospital JACHO requirement) and while on its surface seems unnecessary it is a part of the process that must be clearly understood by all parties involved in such important communication.

To facilitate this documentation Macros have been provided in Powerscribe. These may be used or a customized version may be used so far as all elements indicated above are included in the Impression of the report or an addendum in a single statement.

This database will be generated by a constantly updated search of our finalized (attending signed) reports and displayed on the Shands Portal under "Applications" -- "Radiology Critical Results".

This is by agreement with the Chief of Staff. The intent of this database is to broadcast these important data to all services who may be involved in the care of the patient. It does not replace the responsibility of Radiology to communicate the findings verbally as defined in the preceding text.

Any deviation from this policy should be reported immediately to a Radiologist and/or Chair of Radiology.

Memorandum Number: RM 02-32
Category: Operating Procedures

SUBJECT: Radiology Critical Test Results

PURPOSE: To improve communication systems and strategies to reduce adverse events that result from delays in communicating critical radiology results.

SPECIAL INSTRUCTIONS:

The Department of Radiology at Shands U.F. has adopted the recommendations and model of the Massachusetts Coalition for the Prevention of Medical Errors in defining the policies and procedures for communicating **CRITICAL RESULTS** to ordering physicians and services.

- The Department of Radiology has accepted the color coding recommendations of the Massachusetts Coalition and categorized results as **"red"** — immediate clinical decision required-- requires a stat call within 30 minutes or less to the Emergency Department Physician for Emergency room patients or to the Team Coordinator for all in patients and out patient studies as defined below. The need for an urgent or emergent call to the ordering physician does not necessarily apply to a finding that is considered to be known, expected, or being treated. If the Emergency Department Physician/ ordering physician have not received a call from the radiologist within 30

minutes and has reasonable suspicion of critical finding, or needs to provide other critical information, they should call the Ortho Institute Reading Room at 352-273-7158 (normal hours), or call the Radiology Body Room at 265-0680, ext. 44385 (*after hours*) and speak with the radiologist. ; **"orange"** —(to be determined at a future time) clinical decision required within hours., and **"yellow"** — results can be sent passively; clinical decision required within days. ALL ER patient results should be communicated within one hour or less no matter how urgent the result is considered to be, with the exception of critical test results as defined above.

Anatomical Area	Red Category	Orange Category	Yellow Category
CNS	Cerebral hemorrhage/ hematoma		Brain Tumor
	Herniation Syndrome		
	Acute stroke		
	Intracranial Infection/empyema		
	Complex skull fracture		
	Unstable spine fracture		
	Spinal cord compression		
NECK	Airway compromise (e.g., epiglotitis)		
	Carotid artery dissection		
	Critical carotid stenosis		
BREAST			Biopsy recommendation on mammogram
CHEST	Tension pneumothorax Aortic dissection		
	Pulmonary embolism		
	Ruptured aneurysm or impending rupture		
	Mediastinal emphysema		
ABDOMEN	Free ***air*** in abdomen (no recent surgeries)		
	Ischemic bowel (pneumotosis)		
	Appendicitis		
	Portal venous air		
	Volvulus		
	Traumatic visceral injury		
	Retroperitoneal hemorrhage		
Uro Genital	Bowel Obstruction High Grade/Complete		
	Ectopic Pregnancy		
	Placental Abruption		
	Placental Previa (near term)		
	Testicular or ovarian torsion		
	Fetal Demise		
Bone			New Finding suggestion of new fracture
General	Significant Line/ Tube Misplacement		New finding highly suggestive of malignancy

The steps in notification of results in the "red" or "orange" category are:

- First call to ordering physician.
- If no response after 15 minutes, call ordering physician again.
- If no response after 30 minutes, call the number for the ordering service.
- If the patient is an in-patient, call the nurses station and get the physician through them.
- Radiologist documents the communication with the physician in the radiology report.

The steps in notification of results in the "yellow" category are:

- Dictate that this is an urgent result in the report.

Radiologists are always encouraged to use their good judgment to determine if a result is critical and should be communicated immediately to the referring physician or service. They are not limited in any way by our initial categorization of results that should be communicated in a timely manner. The need for an urgent or emergent call to ordering physician does not necessarily apply to previously diagnosed conditions or those already under treatment. The initial categories (table 1) were taken from the Massachusetts Coalition recommendation and will be revised over time to add additional results. The list is meant to serve as a guideline and is not to be considered all inclusive or exclusive. In effect, part of the physician's training usually in his or her internship year, is to be able to triage patients and to be able to recognize a situation where immediate action must be taken to save a life or effect a treatment, to recognize a situation where treatment is urgent and should be undertaken within hours, and to recognize a situation where treatment is needed but a short delay will not effect the outcome.

APPROVED: Reviewed/Revised: July, 2009

Date: July, 2009

Melinda Chitty,
Administrative Director, Department of Radiology

Date: July, 2009

Anthony A. Mancuso, M.D.
Chairman, Department of Radiology

RM 02-32 (3)

Memorandum Number: RM 02-33
Category: Operating Procedure

SUBJECT: Critical Tests

PURPOSE: To define Critical Tests and the appropriate response to them.

POLICY:

The Department of Radiology has designated the following procedures as "Critical Tests" requiring mandatory calls to ordering physician or caregiver, regardless of the findings:

- *Head CT's for stroke protocols, first instance*

Assess the timeliness of reporting, the timeliness of receipt by the responsible licensed caregiver, of critical test results and values and if appropriate, take action to improve.

Results of the critical tests should be communicated to ordering physician within 30 minutes of the results of the procedure. Steps in notification of results are:

First call is to ordering physician

1. If no response after 15 minutes, call ordering physician again
2. If no response within 15 minutes, call the number for the ordering physician's service.
3. If patient is in-patient, call the nurses station to talk and get the physician through them.
4. Radiologist documents the communication with the physician in the radiology report.

Audits will be performed on an on-going basis.

APPROVED: Reviewed/Revised: July, 2009

_____ Date: July, 2009

Anthony A. Mancuso, M.D.
Chairman, Department of Radiology

_____ Date: July, 2009

Melinda Chitty
Administrative Director, Department of Radiology

CRITICAL TEST VS. CRITICAL RESULTS

1. CRITICAL TEST: STROKE ALERT

→ Report result *regardless of outcome* (normal, abnormal) to ordering practitioner, within 30 minutes and document time and contact name in report!

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2. CRITICAL RESULTS: Report results to care provider within 30 minutes. Document time and contact name in report!

CNS	Cerebral hemorrhage/ hematoma Herniation Syndrome Acute stroke Intracranial Infection/empyema Complex skull fracture Unstable spine fracture Spinal cord compression
NECK	Airway compromise (e.g., epiglotitis) Carotid artery dissection Critical carotid stenosis
CHEST	Tension pneumothorax Aortic dissection Pulmonary embolism Ruptured aneurysm or impending rupture Mediastinal emphysema
ABDOMEN	Free ***air*** in abdomen (no recent surgeries) Ischemic bowel (pneumotosis) Appendicitis Portal venous air Volvulus Traumatic visceral injury Retroperitoneal hemorrhage
URO-GENITAL	Bowel Obstruction High Grade/Complete Ectopic Pregnancy Placental Abruption Placental Previa (near term) Testicular or ovarian torsion Fetal Demise
GENERAL	Significant Line/ Tube Misplacement