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Royal Cornwall Hospitals NHS Trust

Diagnostic Testing Procedures in Neurophysiology Policy

V3.0

September 2022

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. This policy describes the testing procedures undertaken by the Department of Neurophysiology and sets out the procedures governing their procurement, performance, and reporting.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of this policy is to prevent avoidable harm to patients who need neurophysiology tests, arising

- Directly from the tests performed, or
- From delays in tests being undertaken, or
- From delays in reporting the results of tests, or
- From delays in acting upon the results

3. Scope

This policy applies to all those who request neurophysiology diagnostic tests, those who perform them and those who receive, process, or need to act on the results.

4. Definitions / Glossary

- GP: General Practitioner
- PAS: Patient Administration System
- RCHT: Royal Cornwall Hospitals NHS Trust

5. Ownership and Responsibilities

The strategic and operational roles responsible for the development, management and implementation of the policy are shown below.

5.1. ***Role of the Managers***

Line managers are responsible for:

- Conducting stringent recruitment checks to ensure that only appropriately qualified and registered staff undertake tests and authorise test results
- Checking professional registration in line with renewal requirements
- Checking staff training and competence to perform tests
- Ensuring that staff follow established processes and procedures, as described below

5.2. *Role of the Medicine & ED Divisional Governance Management Board*

The Medicine & ED Divisional Governance Management Board is responsible for the development, approval and communication of this policy and monitoring compliance with it.

5.3. *Role of Individual Staff*

The diagnostic pathway begins when a request is generated; it progresses via the diagnostic testing process and ends when a report is received by the requestor and acted upon. Various healthcare staff are involved in this pathway including Doctors, Nurses, Healthcare Assistants/Support workers and Professions Allied to Medicine.

- Ward based administrative staff have an important role in ensuring that, for paper-based reporting systems, all results are communicated to the clinical staff in charge of the patient.

- Neurophysiology Department staff must ensure that any paper reports are despatched in a timely manner.

5.4. *All staff members are responsible for:*

- Being aware of this policy and any documents referred to within it pertaining to their part in the diagnostic pathway.

- Adhering to any requirements described within this policy and documents described in the standards and practice section pertaining to their role in the diagnostic pathway.

5.5. *Role of Governance Leads*

It is the responsibility of Governance Leads to ensure that processes are in place within specialties which ensure that every neurophysiology test result is acted upon.

6. Standards and Practice

6.1. *Diagnostic tests provided by the service*

A list of tests provided by the Neurophysiology Service may be found at Appendix 1.

6.2. *Risk assessment of diagnostic tests*

6.2.1. Diagnostic tests are evaluated prior to introduction (e.g., to check that they are ‘fit for purpose’, that they are within the competence of the staff who will perform them, etc.).

6.2.2. As new guidelines are developed or equipment introduced, the level of risk is reassessed.

6.2.3. Responsibility for ensuring that these tasks are undertaken by suitably qualified personnel rests with the Specialty Lead for Neurophysiology at the time.

6.3. *Requesting diagnostic tests*

Test requests are made for both inpatients and outpatients and fall into 3 categories:

- Those ordered by Trust clinicians
- Those ordered directly by General Practitioners to inform their decisions in primary care
- Those ordered by clinicians working for other healthcare providers

6.4. *Patient preparation*

Where any specific measure is required (e.g., fasting, cessation of medication), it will be indicated in user guides/requesting information or specific information provided for patients.

6.5. *Informed consent*

6.5.1. Patient consent is required for all neurophysiology testing procedures, but it need only be oral consent.

6.5.2. In all cases, the person obtaining consent must be satisfied that the patient is giving informed consent, i.e., that the patient has been given and understood all relevant information about the proposed procedure.

6.5.3. Informed consent for a diagnostic test must either be obtained or checked by the person performing the test.

6.5.4. Further information may be found in the RCHT consent policy.

6.6. *How the diagnostic test is requested*

6.6.1. Format

Tests may be requested by completion of a referral process on maxims or by email. Until order communication for neurophysiology is in place, referring clinicians are responsible for taking all necessary steps to ensure that urgent requests are placed without delay.

6.6.2. Process

6.6.2.1. Referrals may be sent to the Neurophysiology Department by maxims or e-mail. A daily check of all sources is made from Monday to Friday.

6.6.2.2. Referrals are sorted by test category and the number of referrals recorded on a monthly basis.

6.6.2.3. For straightforward tests, outpatient appointments are sent, or arrangements made with the wards if the patient is an inpatient.

6.6.2.4. Some referrals are measured against set criteria, following which they are either returned to referrers or appointed as for straightforward tests.

6.6.2.5. Some referrals are passed to a consultant neurologist for expert vetting. In these cases, a record is made of the onward referral and subsequent return to ensure that no referral is lost in the process.

6.7. How the person requesting the test is informed of test results

6.7.1. All reports are sent to referring clinicians – to their offices or the wards where their patients are located - in paper format. A documentary record of the sending of every result is uploaded onto Maxims.

6.7.2. Copies of all reports are kept electronically on the hospital server under Neurophysiology, accessible from the department.

6.8. How the patient is informed of test results

6.8.1. Patients must be made aware of the reason for tests being requested and the approximate timescale and communication method for availability of the results so that they may request an update on results, as necessary. Results which have significant implications for the patient must be discussed with them in the appropriate timescale.

6.8.2. There is an expectation that patients are informed of results by the requesting clinician in a timely fashion. It is the responsibility of the requestor to consider how, when and what to tell the patient.

6.8.3. The mechanisms and timescales for informing patients of results are the responsibility of the requesting clinician but may include, according to the nature of the test, availability of result and the significance of the result:

- telling patients (face to face or, with the consent of the patient, by telephone)
- writing to patients
- discussing with patients at outpatient or pre-operative assessment clinics
- writing to the patient's GP
- adding to a discharge summary letter

6.9. Actions to be taken by a person receiving test results

6.9.1. The person receiving the results should ensure the results are brought to the attention (urgently if necessary) of the clinical team currently caring for the patient. Results should be reviewed by a person with clinical

responsibility for the patient who is able to interpret the results and ensure a management plan is recorded as required.

6.9.2. A requesting consultant will take responsibility for ALL investigations requested personally or in her/his name, but responsibility for signing off a result can be appropriately delegated.

6.9.3. Requesting clinicians are responsible for reviewing urgent results requested during their shift and passing the responsibility on if they finish their shift. For those tests that are requested but the patient has moved on to another area when the test is done or the result is available, responsibility for the results passes to the clinician responsible for the patient in that area.

6.9.4. It is incumbent on the responsible clinician to ensure that he or she personally checks the reporting systems on a regular basis for the investigation results and then acts on the information within the report with the necessary degree of urgency. If they are unable to do this they must hand the responsibility over to a colleague. Failure to do this may put patients at risk.

6.9.5. 'Safety net' procedures must be established by requestors, to ensure high risk diagnoses and results are not inadvertently missed. The procedure must take account of patients moving from area to area within a hospital and being discharged before results are received.

6.10. How the minimum requirements are recorded

6.10.1. Requesting

6.10.1.1. Requests received by Neurophysiology from maxims are recorded on PAS

6.10.1.2. Outpatient tests are recorded as outpatient appointments on the PAS system

6.10.1.3. Inpatient tests are recorded on Maxims

6.10.2. Informing the clinician

6.10.2.1. A documentary record of the sending of every result is kept in the department on a shared drive.

6.10.2.2. Communication of test results between clinical staff who have received results and other healthcare staff, or patients must be recorded in the notes.

6.10.3. Informing the patient

Records are kept of any discussion or correspondence with patients or their GP in the case notes.

6.10.4. Actions taken

6.10.4.1. Actions taken are documented in the case notes. When recording results within the patient's case notes, the minimum information which must be included is:

- Forename and surname
- NHS/Hospital number
- For unknown patients, a coded identifier may be used
- Test or procedure
- Date and time test was performed

6.10.4.2. Interpretive comments made or conclusion reached may also be recorded.

6.10.4.3. The method of communication of the actions must be recorded, i.e., face to face contact, phone call, letter, email.

6.10.4.4. Hospital discharge summaries should record confirmed diagnosis and any outstanding investigations.

6.11. How the organisation monitors compliance

The lack of an integrated neurophysiology information system is not compatible with effective, sustainable compliance monitoring. It is acknowledged that consideration must be given to the development of suitable technologies and processes to address this requirement.

7. Dissemination and Implementation

This document will be placed on the Royal Cornwall Hospital Intranet Documents Library with notification to all users via email.

8. Monitoring compliance and effectiveness

Information Category	**Detail of process and methodology for monitoring compliance**
Element to be monitored	Patients progressing through RTT pathways
Lead	Service Lead
Tool	Booking Tool to be used to monitor diagnostic and Phase 2 patients
Frequency	Booking Tool is reviewed on a weekly basis to ensure diagnostics booked within required booking window and Phase

Information Category	Detail of process and methodology for monitoring compliance
	2 patients are monitored on a weekly basis to ensure pathways progressing
Reporting arrangements	Reported through local Performance Meeting and RTT Meeting
Acting on recommendations and Lead(s)	RTT Committee
Change in practice and lessons to be shared	Through local Performance Meeting and Neurology Specialty/Governance Meeting

9. Updating and Review

This policy will be reviewed every three years or sooner if circumstances suggest this may be necessary.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Diagnostic Testing Procedures in Neurophysiology Policy V3.0
This document replaces (exact title of previous version):	Diagnostic Testing Procedures in Neurophysiology Policy V2.0
Date Issued/Approved:	5 September 2022
Date Valid From:	September 2022
Date Valid To:	September 2025
Directorate / Department responsible (author/owner):	Anne Clarke, Clinical Physiologist
Contact details:	01872 252430
Brief summary of contents:	This policy sets out an approved documented process whereby the risks associated with diagnostic testing procedures in Neurophysiology are managed.
Suggested Keywords:	Diagnostic results, diagnostic reporting, management of results
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Neurology Governance Group
General Manager confirming approval processes:	Rachel Pearce, General Manager
Name and Post Title of additional signatories	Jonathan Stewart, Consultant Neurologist
Name of Governance Lead confirming approval by specialty and care group management meetings:	Siobhan Hunter
Links to key external standards:	NHSLA Standard 5 – Criterion 7: Diagnostic Testing Procedures

Information Category	Detailed Information
Related Documents:	Safer Practice Notice 16, February 2007 An Organisation-wide Policy for the Diagnostic Testing Procedures in Neurophysiology Page 11 of 13 Management of Diagnostic Testing Procedures
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Neurology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
10 Sept 2012	V1.0	Initial Issue	Paul Eddy Service Lead, Medicine
8 April 2019	V2.0	Full review. Removal of reference to fax machines and electronic referral information added at 6.6.2 and 6.7.1 and 6.7.2.	Anne Clarke, Clinical Physiologist
12 June 2022	V3.0	Amended the details on admin PAS/ Maxims pathway	Anne Clarke, Clinical Physiologist

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Diagnostic Testing Procedures in Neurophysiology Policy V3.0
Directorate and service area:	Specialist Medicine, Neurology and Neurophysiology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Helen Williams, Service Lead
Contact details:	01872 252218

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Sets out an approved documented process whereby the risks associated with diagnostic testing procedures are managed through the provision of local policies which are implemented and monitored.
2. Policy Objectives	The risks associated with diagnostic testing procedures are minimised; compliance with Diagnostic Testing Procedures is achieved.
3. Policy Intended Outcomes	To ensure that the diagnostic process contributes the maximum benefit to the treatment of patients.
4. How will you measure each outcome?	As described in Section in the 'Monitoring Compliance' section of this policy.
5. Who is intended to benefit from the policy?	All patients

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Neurology Governance Group
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** Guidelines from the BSCN (British Society for Clinical Neurophysiology)

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g., gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:
Helen Williams, Service Lead

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Diagnostic tests undertaken by the Neurophysiology Department

TEST	TYPE OF CONSENT
Electroencephalography (EEG) - departmental - ambulatory	 Oral Oral
Evoked Potentials (EP)	Oral
Electromyography (EMG)	Oral
Nerve Conduction Velocity Studies (NCV)	Oral
Adult and Paediatric Video Telemetry	Oral