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Royal Cornwall Hospitals NHS Trust

Diagnostic Testing Procedures in Respiratory Policy

V3.0

March 2022

1. Introduction

1.1. Diagnostic testing information supports many clinical decisions both in the identification of new conditions and the monitoring and treatment of existing ones. As such it sits within the overall patient clinical pathway. The diagnostic pathway begins when a test is indicated such that a request is generated, progresses via the diagnostic process and ends when a report is received by the requester and acted upon. Failures at any point in this pathway may lead to delays in the care of the patient, sometimes with serious clinical consequences.

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

2. Purpose of this Policy/Procedure

This policy sets out an approved documented process whereby the risks associated with diagnostic testing procedures within Respiratory are managed through the provision of local policies and procedures which are implemented and monitored. It has been developed to ensure these risks are minimised and give assurance to external bodies, specifically the NHS Resolution 2017. No patient's treatment should be delayed because of delays in the availability of Diagnostic information and the objective of this document is to ensure that this does not happen, recognising that communication problems are often the root of such delays; there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated. **This policy is aimed at those who provide and those who use the Respiratory services.**

3. Scope

This policy applies to all those who request Respiratory diagnostic tests and those who receive, process or need to act on the results of these. (Bronchoscopies will be covered under Endoscopy policy and Chest x-rays will be covered under Clinical Imaging policy.)

4. Definitions / Glossary

- CITS: Cornwall IT Services
- CRIS: Clinical Radiology Information System
- DBMS: Database Management section within CITS
- GP: General Practitioner
- MAXIMS: Electronic clinical record system designed by IMS (Irish Medical Systems)
- PACS: Picture Archive Communication System
- RCHT: Royal Cornwall Hospitals NHS Trust

5. Ownership and Responsibilities

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

5.2. *Role of the Managers*

Line managers are responsible for:

- Conducting stringent recruitment checks to ensure that only appropriately qualified and registered staff undertake and authorise test results and ongoing checks of professional registration
- Ongoing checks of Training & competence to perform those tests within the scope of activity of individual staff
- Ensuring that staff follow those processes and procedures described in the Standards and Practice section relevant to the part they play in the diagnostic pathway.

5.3. *Role of the Diagnostics and Therapeutics Divisional Governance Management Board*

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

5.4. *Role of Individual Staff*

- The diagnostic pathway begins when a request is generated and any samples required are taken; it progresses via the diagnostic testing process and ends when a report is received by the requester and acted upon. Various healthcare staff are involved in this pathway including Doctors, Nurses, Healthcare Assistants/Support workers and Professions Allied to Medicine (Biomedical Scientists, Radiographers etc.).
- 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.
- Administrative staff also have a role to play in ensuring appointments are booked and appropriate preparation instigated in accordance with agreed operating policies.
- Laboratory based Administrative staff ensure that any paper reports are despatched in a timely manner.

5.5. *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.

5.6. *Role of Governance Leads*

It is the responsibility of governance Leads to ensure that processes are in place within specialties which ensure that every respiratory investigation result requested from within RCHT is electronically acknowledged and is acted upon.

6. Standards and Practice

6.1. *Content*

The content of this section takes account of the information provided in the overarching Trust-wide policy and is used to provide details and information describing the practices, systems, and processes staff are expected to follow in order to comply with this document.

6.2. *Diagnostic tests provided by the service*

A list of tests provided by the Respiratory Department is available from the Respiratory Nurse Specialists.

6.3. *How diagnostic testing procedures are risk assessed*

6.3.1. Departments need to focus on the degree of intervention required, the consequence of missed diagnosis and the impact for the trust. Information sources include a trawl of the complaints, claims and incidents data to see if there are common themes as this would also indicate an area of increased risk for the organisation.

6.3.2. Diagnostic testing procedures are evaluated at the time of introduction (e.g. to check that the procedure is ‘fit for purpose’). Risk assessment tends to be reactive to changes such as the introduction of new guidelines or equipment or changes to existing equipment (e.g. with age) which require that the current level of risk is reassessed.

6.3.3. All respiratory investigations are vetted by a practitioner and a decision made to proceed on the risk versus clinical benefit.

6.4. *Measures that need to be in place for the diagnostic test to enable any preparation of the patient required*

Where these are required this will be indicated in User guides/requesting information or specific information provided for patients.

6.5. *Identifying the process for ensuring that informed consent is obtained prior to a diagnostic test*

Consent for investigations is obtained by the test requester. The reader is referred to their Organisation's consent policy.

6.6. *How the diagnostic test is requested*

6.6.1. It is important that requests are generated, received and processed correctly in order for the diagnostic process to be initiated in the first place.

6.6.2. Requesting respiratory investigations is currently done verbally, completing paper request forms, electronic request forms, email, letter or experienced clinical judgement.

6.6.3. The professional expectation is that anyone requesting a test should have the training, experience and authority to explain the result to the patient. The Respiratory Department has a duty to carry out reasonable tests on the assumption that they have been legitimately requested. [chest x-rays require a doctor's authorisation – clinical imaging policy]

6.6.4. Medical practitioners are deemed qualified to be referrers as a result of their overall training; non-medical referrers have to provide evidence of specific training. The protocol states who can refer patients for imaging procedures and any authorisation requirements e.g. of non - medical referrers (e.g. Physiotherapists, Emergency Nurse Practitioners). This document is available on the Document Library. All referrals are 'justified' by a suitably qualified Practitioner as laid out in IR(ME)R.

6.7. Systems in place to ensure that the sample(s) are correctly identified and labelled, prepared and transported

Pathology has a sample (blood, sputum, mid-line tips) acceptance policy which describes sample and request form labelling and considerations regarding the integrity of samples. Sample transport arrangements are described in the Pathology User guide. Both documents are on the Documents Library (refer to endoscopy policy for bronchoscopy samples).

6.8. Identifying where it is appropriate to request an acknowledgement from the receiving laboratory for specific samples

Where results are required within an accelerated timescale or samples are of an irretrievable or labile nature or analysis is only carried out on a scheduled basis, requesters may wish to contact labs to ensure that samples have been received.

6.9. How the clinician treating the patient is informed of the result, including timescales

6.9.1. For in-patients and out-patients the results are available electronically via Maxims or paper copies are sent to referring clinicians and copied to GP's. [blood, sputum, mid-line tips]. Paper copies are signed by clinician before being filed in medical notes. In the future, results will be scanned and uploaded to Maxims.

6.9.2. Full lung function test results will be scanned and up-loaded to Maxims plus a paper copy will be sent to referring clinician.

6.9.3. Spirometry paper copy results are sent to referring clinician via internal post or via medical notes and are now scanned directly onto Maxims.

6.9.4. If a range of respiratory investigations has been carried out, the nurse will write to the GP with the results, interpretation and advice / treatment.

6.9.5. The clinician chases up receipt of results.

6.9.6. Every result will have to be finally marked off as checked off.

6.9.7. The Ward Telephoned Results policy describes the process and actions to be followed by both the Laboratory and Ward when results are telephoned from the lab to Wards.

6.10. How the patient is informed of the result, including timescales

6.10.1. 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. [annual review investigations for cystic fibrosis within 3 months as some bloods are sent to another hospital for analysis. Sputum sample results within 2 weeks]

6.10.2. There is an expectation that patients are informed of results by the requesting clinician in a timely fashion; this includes any tests added on by the laboratory in order to achieve a definitive diagnosis. It is the responsibility of the requester to consider how, when and what to tell the patient.

6.10.3. 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

- Writing to patients
- Discussing with patients at Outpatient clinics
- Writing to their GP
- Telephone call
- Adding to discharge summary

6.10.4. Every opportunity should be taken to check for/flag outstanding results including at hospital discharge, Outpatient and GP appointments.

*6.11. **Actions to be taken by the clinician, including timescales***

6.11.1. Actions to be taken on receipt of telephoned results are described in the Trust's Ward Telephoned Results procedure.

6.11.2. 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. Processes must be in place for notification of results to patients.

6.11.3. The requesting Consultant will take responsibility for ALL investigations requested by them or in their name, but the responsibility for signing off a result can be appropriately delegated. In MAXIMS results default to going back to the Consultant who is in charge of the patient, under whose name the tests are requested. However the person who actually requested the test can also search under their name and find the result.

6.11.4. The requesting Clinician is responsible for reviewing any 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.

6.11.5. 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.

6.11.6. By and large inpatient results will be signed off by the team who is currently looking after the patient, independent of where the request was made. If this doesn't happen it will still fall to the Consultant under whose name the tests were originally requested to sign-off the results. Outpatient results will usually be signed off by the

Consultant under whose name the test was requested or a designated member of their team.

6.11.7. 'Safety net' procedures must be established by requesters, to ensure high risk diagnoses and results (e.g. cancer) 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.

6.12. How the minimum requirements for NHSLA are recorded

6.12.1. **Requesting**

Not all requests are recorded, but sending samples to laboratories is documented.

6.12.2. **Informing the clinician**

6.12.2.1. At present there is no record of clinicians being informed of the result other than the printing of reports and those which are telephoned. Practices vary as to what is recorded by the requester and where. When results are available on MAXIMS, every result has to be finally marked off as checked.

6.12.2.2. Communication of test results between the results provider and clinical staff involved with the care of the patient must be recorded in Pathology or Clinical Imaging Information Management systems including the name of any individual staff results are given to (e.g. by telephone).

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

6.12.3. **Informing the patient**

Records are kept of any written correspondence with the patient or their Doctor in the notes or on Maxims. Records are kept of discussions (in person or over the telephone) in the notes.

6.12.4. **Actions taken**

6.12.4.1. Actions taken are documented in the notes. In the future, results will be scanned and up-loaded to Maxims.

6.12.4.2. When recording results within the patient's record the minimum information which must be included is:

- Forename and surname
- NHS/Hospital number
- Test or procedure

- Date and time investigation was performed or sample taken.

- Interpretive comments made/conclusion reached may be recorded

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

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

6.13. How the organisation monitors compliance

6.13.1. **How the clinician treating the patient is informed of the result, including timescales**

6.13.1.1. For hospital laboratory electronic reports, the Trusts Integration Engine has automatic monitoring which emails the Database Management Section team in CITS day or night if any delays are detected.

6.13.1.2. The Maxims system is also monitored throughout the day by a separate team in CITS. The Maxims software application has an inbuilt interface that monitors incoming messages from various other applications such as PAS, Winpath (pathology results only at the moment) CRIS (request status updates and results). The only outgoing HL7 messages from Maxims currently are Radiology order requests which feed through to CRIS and the Pathology order forms feed into Pathology.

6.13.1.3. Transmission of electronic laboratory reports to GP's is checked (report has successfully arrived at the GP practice, with no errors in the transmission, and is available in their system) as a minimum twice daily by the Database Management Section team in CITS. Unacknowledged reports are automatically retransmitted but this is quite rare now.

6.13.1.4. It is difficult to audit how many results have been looked at with the current systems of informing clinicians of results. Since the move to using Maxims for acknowledgement we would expect everybody to look at their results on the system and not use any of the other systems. A comprehensive report will be carried out monthly to ensure that all results are looked at.

6.13.1.5. Reporting timescales are monitored on a weekly or monthly basis for selected tests/procedures. A quarterly diagnostic census checks for any Pathology tests which have not been reported within 6 weeks.

6.13.1.6. For patients with Sleep Apnoea there is a care pathway which can be audited.

6.13.1.7. For patients with cystic fibrosis results are stored on a National Database (providing patients have consented to this).

6.13.1.8. For patients with lung cancer there is a care pathway which can be audited (see lung cancer policies).

6.14. How the patient is informed of the result, including timescales

6.14.1. Requesters should check that they have received all reports back (allowing for diagnostic turnaround times) and that results have been correctly documented and acted upon (including telephoned reports/results) and patients informed as appropriate on an ongoing basis as part of their safety net procedures.

6.14.2. Requests will be monitored regularly for data omissions (paper), errors (e.g. wrong patient requested) or incorrect transfer to Radiology or Pathology Information Systems. Imaging monitoring arrangements include a weekly check report for orders from MAXIMS going onto the appointment list in CRIS; assigning to clinical imaging reporting areas is checked weekly. Pathology requests are audited annually with ongoing review of DATIX incidents.

6.14.3. When patients “DNA” [Did not attend] an appointment for a respiratory investigation, an outcome form is completed stating either “DNA, discharge and inform GP” or “re-book”. Clinical decision may be made to “re-book” according to clinical need and patients may be contacted by phone asking if they’d like to be re-booked. Sleep patients may be written to asking them to contact the respiratory department to discuss their treatment.

7. Dissemination and Implementation (including education and training)

The document will be placed on the Cornwall & Isles of Scilly Health Community Documents Library with notification of all users via email. It will also appear on the Respiratory A-Z of Services Intranet pages.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. Informing the clinician treating the patient of the result; ensuring they are looked at/acknowledged – choose those tests assessed as highest risk 2. Reporting timescales 3. Acting on, documenting & Informing the patient of the result – choose those tests assessed as highest risk
Lead	1.Respiratory
Tool	1.MAXIMS
Frequency	1. Monthly (from when universal acknowledgement via MAXIMS starts)
Reporting arrangements	Reports will be reviewed by Governance and Management Committees within Respiratory. Each report should contain a summary and action points to enable these to be readily identified; these should be discussed and recorded in meeting minutes. The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.
Acting on recommendations and Lead(s)	The Committee which reviews the report will delegate recommendations and action planning, for any or all deficiencies and recommendations within reasonable timeframes, to the appropriate committee, department or lead. Required actions will be identified and completed in a specified timeframe.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within the minimum achievable timescale. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

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 Respiratory Policy V3.0
This document replaces (exact title of previous version):	Diagnostic Testing Procedures in Respiratory Policy V2.0
Date Issued/Approved:	7 March 2022
Date Valid From:	March 2022
Date Valid To:	March 2025
Directorate / Department responsible (author/owner):	Julie Jephson, Respiratory Clinical Nurse Specialist
Contact details:	01872 252640
Brief summary of contents:	This policy sets out an approved documented process whereby the risks associated with diagnostic testing procedures in Respiratory are managed.
Suggested Keywords:	Diagnostic Test, Respiratory
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Respiratory Governance Meeting
General Manager confirming approval processes:	Rachael Pearce
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 Management of Diagnostic Testing Procedures Ward Telephoned Results procedure.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Respiratory

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
20 Jun 12	V1.0	Initial Issue	Ruth Holding, Respiratory Clinical Nurse Specialist
31.01.19	V2.0	Full review. In the future more requests will be electronically requested and reported on Maxims.	Ruth Holding Respiratory Clinical Nurse Specialist
03.03.22	V3.0	Full review with minor amendments: 6.6.2. No longer accept verbal referrals and changed to electronic via Maxims or ESR. 6.9.3. Spirometry traces are electronically recorded on Maxims . Paper copies are no longer sent.	Julie Jephson, Respiratory Clinical Nurse Specialist

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 Respiratory Policy V3.0
Directorate and service area:	Respiratory, Specialist Medicine
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):	Julie Jephson, Respiratory Clinical Nurse Specialist
Contact details:	01872 252640

Information Category	Detailed Information
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.
Policy Objectives	The risks associated with diagnostic testing procedures are minimised; compliance with NHSLA Standard 5 – Criterion 7: Diagnostic Testing Procedures is achieved.
Policy Intended Outcomes	To ensure that the diagnostic process contributes the maximum benefit to the treatment of patients.
How will you measure each outcome?	As described in Sections 6.59 - 6.75 & 8.
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.	**Please record specific names of individuals/ groups:** Respiratory 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:** No

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	Any written information provided to the patient needs to be in an accessible format for their needs. An alternative to phone contact needs to be agreed for patients with hearing loss.
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: Julie Jephson, Respiratory Clinical Nurse Specialist

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