Follow-up of test results

Issues related to the follow-up of test results are a feature of a number of complaints to HDC in both the primary and secondary care settings.

Doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results. The primary responsibility for following up on abnormal results rests with the doctor who ordered the tests. However, if a doctor knows that they will not be personally following up a test that they have ordered, that doctor needs to be confident that the appropriate person has been alerted that the test has been ordered and of the need for follow-up. In order to support doctors in fulfilling the requirements around follow-up of test results, practices and hospitals must have robust laboratory tracking systems and protocols for test result checking and filing, including identifying who will be responsible for review and follow-up.

Another precaution doctors can take to ensure that appropriate action is taken in response to abnormal test results, is to involve patients in the test ordering process. Doctors should tell the patient why the test is being ordered and when and how the patient will learn the result, as well as the steps the patient should take if they have not received the result as expected. Providing patients with this "safety net" advice provides an additional check in the system to correct errors and ensure that the patient receives the information they require.

These principles are highlighted in the following HDC cases concerning inadequate follow-up of patient test results:

1. A woman with duplicate cervixes presented to her GP with inter-menstrual bleeding and the GP performed a smear test on each cervix. Previously, when conducting smears for the woman, the GP had sent two samples for testing but only one form, and had only ever received one result from the laboratory. On this occasion, the GP sent two samples and two forms. The GP received a normal smear result. The laboratory did not indicate which cervix the result related to or that this was result one of two. The medical centre later received the second smear test result, which was abnormal. Again, there was nothing to indicate the specific specimen site or that this was result two of two. The abnormal result was mistakenly filed as a duplicate. The Commissioner found that the GP failed to ascertain whether there should have been two results after sending two specimens with two forms and, as a consequence, she failed to follow up a material test result. The Commissioner was also critical of the medical centre for not having an adequate laboratory tracking system to ensure that incoming test results or other investigations were being sighted and actioned by the team member who requested them or by a designated deputy. (C13HDC00903)
2. A man with flu-like symptoms was referred for blood tests by his GP. The GP did not document any safety net advice, and there was disagreement between the GP and the man as to the adequacy of the advice given. The GP reviewed the blood test results and noted that they were abnormal and that, in particular, the man's C-reactive protein was markedly elevated. The GP intended to ask a practice nurse to advise the man of the results, but forgot to do so. Two days later, the man went to a hospital which lead to him being diagnosed with a post-infectious inflammatory disease. The Commissioner considered that it was not adequate for the GP to rely on his memory alone to ensure the results were actioned, and that the GP should have had in place a more robust system. The Commissioner found that the GP failed to fully inform the man of his abnormal blood test results and failed to ensure that the abnormal results were followed up in a clinically appropriate manner. (C14HDC00368)
3. A woman attended a pre-anaesthetic assessment for dental surgery. The dental surgeon who requested the assessment understood that any abnormal test results would be reported to, and acted on, by the anaesthetic team, whereas the anaesthetist understood that abnormal results

would be brought to the attention of the dental unit. The anaesthetist requested a chest X-ray, and the radiologist's report noted an abnormal opacity on the lung and recommended follow-up investigations. The report was not copied to the surgeon, anaesthetist, or GP and, although the dental unit received the report, no specific surgeon was listed as the referrer on the report, and the report was not sighted by unit staff or placed on the woman's health record. A year later the woman was diagnosed with lung cancer. The Commissioner found the DHB in breach of the Code as there was no one clinician charged with taking clinical responsibility for viewing the chest X-ray result and ensuring that the result was followed up. (C12HDC00112)

In the vast majority of cases the key principles outlined above are adhered to and doctors follow up test results in an effective and timely manner. However, as evidenced by the cases above, when there is a failure to follow-up on an abnormal test result this can lead to a missed opportunity to provide a patient with a timely diagnosis or referral for specialist care. In some circumstances, such delay can have a profound impact on the patient and their prognosis.

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