PENROSE-ST. FRANCIS HEALTH SERVICES

INTERDISCIPLINARY PRACTICES

SUBJECT: **Critical Value Notification**

PREVIOUS DATE: 12/97, 11/02, 11/03, 4/06, 7/07, 9/07, 3/08, 4/08 9/08, 8/09 EFFECTIVE DATE:12/11

RECOMMENDED BY: Interdisciplinary Practice Committee

ADMINISTRATION APPROVAL: Jeff Oram Smith, MD, CMO, Katherine D McCord, RN, CNO

DEFINITION:

**Critical Tests**—Those tests which always require rapid communication of the results, even if normal.

* **Critical Results**—Those findings (even if from routine tests) which always require rapid communication of the results as determined by a physician, the Laboratory, Imaging Department, Cardiology or other areas to be critical to the patients subsequent treatment decisions. When the patient has a chronic condition and the lab values are “critical” by the hospital’s definition but are actually within the “normal” range for that patient or are trending toward the normal value, it is not necessary to call the physician these results unless specifically ordered to do so. It is not necessary to notify the LIP (licensed independent practitioner) or document in the CIS the “expected value” in the following situations
* When a protocol is ordered and in use
* When the patient has a chronic condition and the values are “critical” by the hospital’s definition but are within “normal’ range for that patient.
* When values are trending toward normal or there are repetitive abnormal values.
* When it is in the nurse’s clinical judgment that calling the LIP with the results is not warranted based on the patient’s condition and plan of care.

**STAT—**used for the highest priority and often used by the ordering practitioner when a critical test or result is requested. A test/study may be ordered STAT but the results may not be available on a STAT basis (e.g. blood cultures) or ordered STAT with STAT results (e.g. fingerstick glucose).

**Read Back** – When receiving critical values/results via the phone, the associate will verify the results by writing it down first then reading what is written back to the caller.

**Repeated Back** – The only time values would be “repeated” back versus read back would be in an emergency situation when the individual who has the values is physically present and relays the value to a caregiver, i.e. in a code blue situation.

GUIDELINES FOR CARE: Critical tests/results will be communicated to the practitioner in a timely manner in order to facilitate the patient treatment decisions.

PRACTICES

A. The organization defines critical tests and critical results.

1. **Critical Tests (Outpatients/Inpatients)**
	* PSF has defined the following as critical tests for the departments of Imaging, Cardiology and the Laboratory

 ***Imaging***

* CT of head for Stroke Alert

 ***Cardiology***

* Stat EKG for chest pain in patients with history of CAD, vital sign changes and other accompanying signs and symptoms such as diaphoresis, nausea, pain radiating to jaw, arm etc.

 ***Emergency Department***

* STAT EKG for patients presenting with a possible ST Elevation Acute Myocardial Infarction (STEMI) as part of the American College of Cardiology’s Door to Balloon Initiative.

 ***Laboratory***

* ABGs in the code blue patient
1. **Critical Results/Values**

***Imaging***

* Aneurysm of Aorta >5cm and expanding or with evidence of leak or tear
* Pulmonary embolism
* Acute intracranial abnormalities—evidence of, including but not limited to, intracranial bleed, mass, edema, and/or shift
* High grade symptomatic carotid stenosis
* Unsuspected abdominal abscess, appendicitis, bowel/organ perforation/free air
* Spinal fracture (acute)
* Cord compression (acute or impending)
* Pneumothorax (new or increasing)-this entry is fine, no change
* Pericardial effusion (new or significantly larger)
* Ectopic pregnancy (suspected)
* Major vessel dissection
* Multiple injuries leading to suspicion of child abuse
* Acute testicular or ovarian torsion
* Dangerous malposition of central line ETT or NG tube
* Tuberculosis (suspected active), anthrax or other public health risks such as SARS
* Foreign body (unsuspected)
* Migration of aortic stent graft

   ***Cardiology***

* Chest pain
* Heart rate below 40 bpm
* Heart rate above 120 bpm
* Frequent pauses or arrest greater than 3 seconds
* PSVT
* VT
* Frequent multifocal PVC’s
* PVC greater than 15 per minute
* ST elevation or depression
* EKG’s that look different than their previous EKG reading
* Any other EKG readings that appear questionable to the tech

***Laboratory – See attachment A (SFMC) and B (PH)***

1. **Imaging Reporting**
* Imaging services personnel will notify the ordering physician of the results of critical tests and critical results discovered upon interpretation. Alternatively, for IP/ED patients only, the results may be given to the nurse caring for the patient or the charge nurse. The results, the name of the individual notified, and the date and time of notification will be documented by Imaging Services
1. **Laboratory Reporting**
	* + Critical tests/results have been defined by the Laboratory Director, in consultation with clinicians served, which are life threatening and require rapid clinical attention to avert significant patient morbidity or mortality.

 *LAB TESTING PERSONNEL* will follow the PSF Laboratory Critical Values Notification policy. Critical values may only be given to the physician or an RN. Lab Personnel will inform the Physician/Nurse that the lab result is a Critical result.

1. Medical/Surgical unit: Notify the Charge Nurse/Primary Care Nurse.
2. Critical Care units (ICU, Birth Center, Pediatrics, NICU): Notify the nurse providing care to the patient or the charge nurse. .
3. In the PSF Emergency Departments:
4. St Francis Medical Center (SFMC): The SFMC Laboratory will notify the ED physician and the charge nurse.
5. Penrose Emergency Department: PH Laboratory will notify the ED charge nurse. For point of care testing, the Lab PCA is responsible for reporting the critical value directly to the ED physician and to the ED charge nurse. If a critical value is obtained, and it is felt that the specimen needs to be re-run to confirm the value, the laboratory will first report the preliminary critical/’red alert’ value as “critical high or low” to the nurse and then inform the charge nurse that the test will be repeated to confirm the value.
6. When the lab personnel report a critical lab value; the person they are giving the result to must read the result back. Lab personnel must document in the lab computer or, when applicable, on the Lab worksheet.
7. The name of the patient care provider taking the report.
8. The time the report was communicated.
9. “RRB” (results read back) to confirm that the critical result was read back.

EXCEPTIONS:

* The first Troponin I level (0.78 or greater) performed in the main laboratory will be called, subsequent critical Troponins will be noted as “Previous Critical”
* The first critical Magnesium levels performed on labor and delivery patients will be called, subsequent critical Magnesium levels will be noted as “Previous Critical”.
* The first critical Creatinine and BUN levels will be called. Document “Previous Critical” on subsequent criticals.
* The first critical results for WBCs and Platelets on 11th floor oncology patients will be called subsequent critical WBCs and Platelets will be noted as “Previous Critical”.
* Point of Care Glucose testing which falls within the parameters of the glycemic control protocol (sliding scale, carbohydrate counts, insulin drip, etc). Documentation of results will be found under Special Panels/Endocrine/Diabetic in the CIS.
1. Documentation/Reporting

 *Patient Care Personnel* shall initiate the following protocol:

* The ED Laboratory PCA, **charge nurse or the nurse providing care for the patient** receiving the critical value shall read back the report to laboratory personnel**.** Patient care personnel receiving the critical value must read the result back to lab personnel and then document notification of LIP in CIS.
* When Critical results are called to the floor/unit of patients for which the physician has already prescribed treatment (Protocols, Dept. order sets, written orders, etc), the physician should only be called if the treatment protocol is not working to correct the critical value OR if the patient's clinical picture is deteriorating. If either of these events occur, the physician MUST be notified STAT, with documentation as to date/time/physician notified & lab/clinical information provided
* If the patient has frequent repetitive critical laboratory values reported on one shift, instead of recording each value in the CIS, the caregiver may make one summary entry in the computer stating the frequency of the value, the LIP communication when appropriate and action taken.
* The notifying nurse shall report the patient’s condition in relationship to the critical’ result/ value. At the nurse’s discretion, the physician may be asked specifically to come in to evaluate the patient.
* The notified physician shall provide orders or come in to evaluate the patient.
* All communication with the physician concerning the patient’s critical lab value shall be documented in the patient record, such as; date, time critical result/ value, signs, symptoms, and the physician’s orders.
* Documentation in the CIS will include the following :
* Document all critical values communication in the LIP intervention section of the CIS.
* The LIP intervention has two groups: the first is LIP Notification Value Critical Test Results—this is where the nurse documents receipt of critical result/value to include which department called, type of test results, **reading back of the results,** confirmation that the LIP is called.
* The second is LIP Notification Value / LIP communication—this is where the nurse documents the call to the LIP to include name of the LIP, time the nurse called the LIP, method of communication when the LIP responded, and the SBARQ template if appropriate.
* Documentation in ORM: critical values, when the LIP was notified and the interventions, these are to be documented in the OR/PACU notes.
1. Reporting Time Frame
	* Critical Tests--the acceptable length of time between the *ordering* of critical tests and the *reporting* of the test results/ values is ONE HOUR
	* Critical Results—as soon as the result is known to be in a critical range, the result/value should be reported to the patient care area within 15 minutes. The acceptable length of time between the reporting to nursing of the critical result/value and receipt by the responsible licensed care giver is 45 minutes.
	* Certain lab values are obtained at the bedside per POC (point of care) testing by the nursing staff. Example: finger stick glucose. These values are sent from the nursing units to the EMR (Electronic Medical Record). Glucose levels < 35 or >350 do not require a laboratory collection or testing in the central laboratory. When there are critical results, they will NOT be called to the nursing unit by the laboratory since the nurse is already aware of the results he/she obtained.
2. Data is collected on the timeliness of reporting critical results/values. The data is assessed and opportunities for improvement are brought to the Patient Safety Committee for discussion and the development of an action plan.
3. All action plans and the results are shared at the Clinical Effectiveness Committee and the Medical Executive Committee on a quarterly basis. .

Last review facilitated by Renee Ward, Director of Imaging

**ATTACHMENT A (St. Francis Medical Center)**



 CONTINUED ON NEXT TWO PAGES





**ATTACHMENT B (Penrose)**