# UW Medicine - Pathology

100-02-01-01

Test Results Requiring Urgent Physician Notification

| |
|---|
| Adopted Date: 6/13/2013 |
| Revision Date: 8/6/2013 |

## PURPOSE

To insure that unusually significant surgical pathology, neuropathology, or cytology diagnoses are communicated in a prompt and documented manner. It is intended only to help expedite patient care and does not relieve the submitting provider from the obligation to check the written pathology reports for all specimens they submit to Pathology. The written pathology report for the patient record remains the primary mode of communication of results.

## SCOPE

This procedure is to be followed by all attending pathologists.

## DEFINITIONS

**Licensed Independent Practitioner**:
The licensed care provider who is directly responsible for the care of the patient.

**Licensed Care Provider**:
Provider classes allowed to receive test results requiring urgent physician notification are: MD, ARNP, PA, RN, RPh and RCP (Respiratory Care Practitioner).

*Note: This policy assumes that any UW Medicine Licensed Care Provider who has either submitted a tissue sample to Anatomic Pathology for analysis or is identified as the provider who is primarily responsible for the care of the patient when that sample is submitted will have read and will be familiar with the content of all pathology reports distributed to him/her within 24 hours of receipt of that report.*

## POLICY

Certain specimen types in Pathology require that the licensed independent practitioner (LIP) be notified of the result immediately, even if the result does not have emergent implications for patient management. These tests and instances include (and for the purposes of policy, are limited to):

a. Intra-operative consultation.
b. Rush biopsies.

i. *Note*: A biopsy or other surgical sample may be designated 'rush' by the physician obtaining the sample or by the treating/requesting physician based on the urgency of the clinical situation that has prompted the biopsy procedure. However, the Pathologist-of-record or Chief of Service (Director, Anatomic Pathology) may re-designate the specimen as 'routine' (and not subject to this policy) after conferring with the ordering or treating physician.

c. Receipt by Pathology of a specimen container that is empty (contains no identifiable tissue).

If one of the following findings becomes apparent, the Pathologist-of-record is encouraged to notify the LIP and document notification in the report or in the laboratory information system. See § Procedure, *infra*.

Abnormal infectious/inflammatory findings:

- Acute or chronic transplant rejection requiring treatment
- Leukocytoclastic vasculitis
- Pathogenic bacteria/fungi/viral in tissue, fluid, or FNA specimens from critical anatomic sites such as fungi in CNS; PCP, fungi, or viral changes in bronchial specimens; invasive fungi in sinus tissue; etc.
- Pathogenic bacteria/fungi/viral in tissue, fluid, or FNA specimens from any anatomic site in immunocompromised host
- Acid fast bacteria in any specimen or host
- Bacteria in valve/bone marrow tissue
- Herpes in vaginal specimens near term

Unexpected malignancy:

- In the absence of prior pathology records of malignancy and in the absence of clinical suspicion of malignancy
- In uncommon anatomic sites and in the absence of clinical suspicion of malignancy for which the pathology report may be overlooked (femoral head, hernia sac, heart valve, tonsil, intervertebral disk material)
- Choriocarcinoma in uterine contents
- In clot from superior vena cava syndrome
- In a site of threatening organ constriction (anaplastic thyroid carcinoma, carcinoma adjacent to spinal cord, etc.)

Other abnormalities:

- Crescents in >50% of glomeruli
- Evidence of organ perforation (small bowel or fat in endometrial biopsy, mesothelial cells in cardiac biopsy)

Absence of expected findings:

- Uterine contents lacking villi/trophoblast

Disagreements between pathology messages:

- Clinically significant change in a frozen section or immediate cytologic interpretation after review of permanent sections.
- Significant differences between primary diagnosis and second opinion (regardless of whether the difference occurs in-house within UW Medicine; after review of outside materials within UW Medicine; or after outside review of materials previously diagnosed at UW Medicine).
- Addenda or amendments to reports that materially change the original diagnosis, including those based on additional study, special stains or techniques, internal review or outside consultation.
- Significant discrepancy between preoperative and postoperative pathologic diagnosis. A "significant" discrepancy would lead to either treatment or prognostic change.

## PROCEDURE

### PHYSICIAN NOTIFICATION

1. In addition to the issuance of a written pathology report for the medical record, results requiring urgent physician notification are communicated by phone to the submitting **Licensed Independent Practitioner (LIP)** within **60 minutes** of when the result becomes apparent. A report by phone is subject to existing requirements for read back verification. A pathologist-of-record or designee must verbally notify the appropriate LIP. If attempts at direct notification of the LIP are unsuccessful, then another appropriate Clinical Attending Physician, Chief Resident, or other Licensed Care Provider covering the patient must be notified of the diagnosis.

2. The notification must be documented in the pathology report, in the initial report, or as an addendum. The pathologist-of-record or designee selects "Treating Physician Notification" from the synoptic report drop-down menu. *See* Fig. 1. Under the "Treating Physician Notification" header, the information below should be included (*see* Fig. 2):

    a. The notifying Pathologist's name (if not the signing-out Pathologist);
    b. The name of the notified physician;
    c. The date and time of the notification; and
    d. Content of notification.

*Fig. 1*

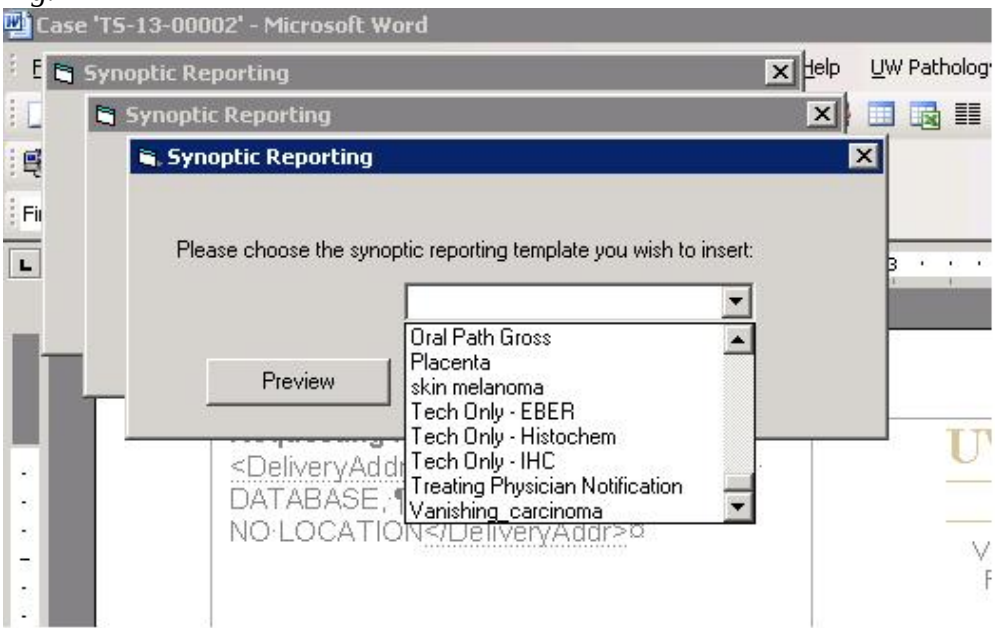
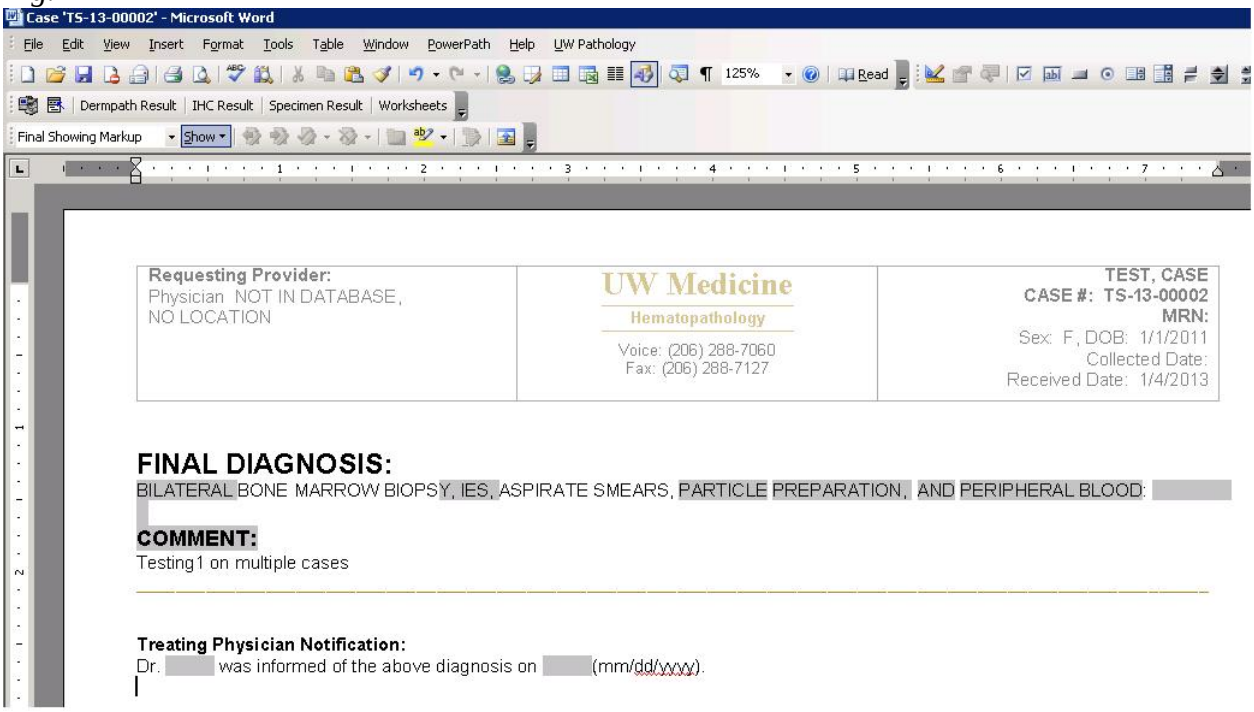



*Fig. 2*




3. If the attending pathologist is unable to verbally notify the LIP or other Licensed Care Provider after complying with the procedure specified above, the Pathologist-of-Record is also encouraged to directly contact the responsible Clinical Chief of Service for assistance with contacting an appropriate Licensed Care Provider.

4. Should the attending pathologist remain unable to verbally notify the LIP or other Licensed Care Provider after complying with the procedure specified above, the case must be reported in the Patient Safety Net (PSN) system (in accordance with UWMC policy).

## QUALITY MEASURES

The Pathology Chief of Service will audit Pathology reports on a regular basis to ensure that:

1. Tests requiring urgent physician notification are reported to the LIP or other appropriate Licensed Care Provider.
2. Communication of test results requiring urgent physician notification is documented appropriately in the Pathology report (or that PSN notification of a failure to transmit results has occurred).

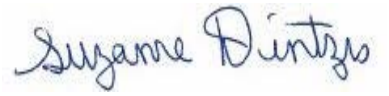
Disagreements between pathology messages, pre- vs. post-operative discrepancies, and discrepancies found during slide review assigned a quality concern score (QCS) of 3 or higher will be reported to the appropriate hospital quality improvement committee. Quality concern scores are defined as follows:

| QCS Score | Definition |
|---|---|
| 0 | No quality of care concerns evident (No variation from a generally agreed-upon standard of care, no delayed diagnosis, and/or no medical error) |
| 1 | Reached patient or near-miss with low risk to patient (Variation in practice, delayed diagnosis or medical error did not affect hospital course or well-being AND was not associated with clinically significant risk to the patient) |
| 2 | Near miss with high risk to patient (Variation in practice, delayed diagnosis or medical error did not affect hospital course or well-being BUT was associated with a clinically significant increased risk to patient) |
| 3 | Event reached patient and required additional care (Variation in practice, delayed diagnosis or medical error reached the patient and resulted in escalation of care, e.g., additional monitoring, new drugs, ventilator, specialty consult, new or prolonged ICU/recovery room or hospital stay) |
| 4 | Event reached patient and was potentially life-threatening or caused disability (Variation in practice, delayed diagnosis or medical error resulted in extended or permanent disability or was potentially life-threatening) |
| 5 | Event reached patient and was life-threatening or caused death (Variation in practice, delayed diagnosis or medical error resulted in death or was life-threatening) |

## REFERENCE

- WAC 246-330-155.
- CAP Checklist COM.30100 (Critical Result Read-Back) (Sep. 2012).
- The Joint Commission Standard PI.01.01.01.
- The Joint Commission National Patient Safety Goal NPSG.02.03.01 (Jan. 2013)
- Clinical Laboratory Improvement Amendments of 1988: Final Rule 42 CFR 405

Director Approval:
(Signature and Date)



8/6/2013

UWMC, Suzanne Dintzis
Date

Director Approval:
(Signature and Date)

8/6/2013

HMC, Stephen Schmechel Date