



PATIENT SAFETY

Bulletin No.7

Critical Test Results: Communication

Slow comms on a low K

A young woman with anorexia nervosa was admitted into a local community psychiatric inpatient unit. Bloods were taken on Friday evening and test results authorised on Saturday afternoon, with a markedly low potassium result of 2.0 mmol/L. Multiple attempts were made to communicate the result, until 8pm, when the result was phoned through to the GP out-of-hours service. It was not escalated to the on-call consultant. Fortunately, the out-of-hours GP contacted the inpatient unit (the laboratory had the incorrect telephone number) and the patient was treated with intravenous fluids and potassium and came to no harm. The GP alerted the lab manager to the problem on the following Monday.

Lots of learning....wrong contact numbers, an 'out of the ordinary' community setting, wrong contact route, lack of timeliness, failure to report as a problem internally, and a broader theme around knowledge and clinical harm. So a complex problem that needs a think around how the department is working. Useful thoughts on support below!

Moving tale

A potassium of 6.9 mmol/L was reported on admission in a patient with sepsis in an acute medical unit (AMU) during a busy Saturday morning shift. Two attempts to ring AMU over a three-hour period by biomedical scientist staff reached lines that were engaged. The result was finally communicated four hours later to an AMU staff nurse, but the patient had been moved to a ward. The result was not handed over to the clinical team. The high potassium was spotted by a junior doctor and the patient was treated and came to no harm but it was a near miss.

Critical result communication should include clear escalation steps to appropriate responders, explicit time frames and emphasise responsibility for handover of results.



Potential misunderstanding of a key telephone conversation

A renal biopsy report on an urgent case was phoned through to the (very busy) on-call nephrology senior trainee. The message was written down as 'no evidence of rejection' when the report was actually 'worrisome but not meeting the formal criteria for rejection'. The histopathologist asked the senior trainee to read back what they had written, and the mistake was picked up and corrected. Moral of the story, don't assume that what you say is what is heard! Check back...

What can you do to help?

Tools such as [Failure Modes and Effect Analysis](#) can be employed to identify high-risk steps in processes to inform policies and priorities for change. [The Model of Improvement](#) (Plan/Do/Study/Act) can be used to identify, test and enhance additional improvement ideas. See more information on quality improvement on the College website, and on the [eCPD app](#).