Despite the importance of diagnostic testing in provision of care, this complexity renders the process vulnerable in the face of increasing demand, stretched resources and a lack of supporting guidance" Litchfield et al (2015).

Abstract:

Background: The testing and result communication process in primary care is complex. Its successful completion relies on the coordinated efforts of a range of staff in primary care and external settings working together with patients. Despite the importance of diagnostic testing in provision of care, this complexity renders the process vulnerable in the face of increasing demand, stretched resources and a lack of supporting guidance.

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Methods: We conducted a series of focus groups with patients and staff across four primary care practices using process-improvement strategies to identify and understand areas where either unnecessary delay is introduced, or the process may fail entirely. We then worked with both patients and staff to arrive at practical strategies to improve the current system.

Results: A total of six areas across the process were identified where improvements could be introduced. These were: (1) delay in phlebotomy, (2) lack of a fail-safe to ensure blood tests are returned to practices and patients, (3) difficulties in accessing results by telephone, (4) role of non-clinical staff in communicating results, (5) routine communication of normal results and (6) lack of a protocol for result communication.

Conclusions: A number of potential failures in testing and communicating results to patients were identified, and some specific ideas for improving existing systems emerged. These included same-day phlebotomy sessions, use of modern technology methods to proactively communicate routine results and targeted training for receptionists handling sensitive data. There remains an urgent need for further work to test these and other potential solutions.

Full Text

Reference:

Litchfield, I., Bentham, L., Hill, A., McManus, R.J., Lilford, R. and Greenfield, S. (2015) Routine failures in the process for blood testing and the communication of results to patients in primary care in the UK: a qualitative exploration of patient and provider perspectives. BMJ Safety & Quality. 24, p.681-690.

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