RADIOLOGY CONSULTANTS OF IOWA, PLC

RCI Report Communication Protocol
Routine, Urgent, STAT/Medical Emergency Radiology Test Orders
Unexpected, and/or Critical Findings

PURPOSE:

The purpose of this protocol is to define types of imaging orders, to describe the process of communicating the findings of imaging exams, and to state the requirements for documenting certain communications.

Effective communication begins with an accurate characterization of the clinical urgency of imaging studies by ordering providers. For example, while it is appropriate to order an imaging study as STAT for an unstable patient, it is not appropriate to order all ER or Urgent Care studies as STAT, as the word STAT has no usefulness for radiologist interpretation triage if it is overutilized. Accurate performance of the exam by hospital technologists with prompt preparation of the images and supporting documentation is critical to allow timely reading. The communication of results is completed with a radiology report signed by the radiologist.

DEFINITIONS:

ROUTINE ORDER: Unless otherwise indicated, all requests for medical imaging studies are considered "routine." Routine requests for imaging exams are handled in a routine manner, with reports generally issued on the same day, often within a few hours of exam completion. However, during high volume periods and depending on specialty coverage, these could take up to three business days.

URGENT ORDER: The ordering provider will designate an exam as "urgent" or "ASAP" when an expedited report is required based on patient condition. This term should not be used for routine exams nor should the term be attached to a request for imaging services merely to expedite reporting or for the convenience of nursing or staff. Urgent exams are handled on a priority basis and will be moved ahead of any routine exams, and are generally reported within about 90 minutes of exam completion. Most ER and Urgent Care imaging exams on stable patients should be ordered as "urgent". Although the radiologist's read will not be available for ER and Urgent Care exams 100% of the time before the patient is discharged, a radiology report will often be available within 60-90 minutes of exam completion.

STAT ORDER (medical emergency): The ordering physician will designate an exam as "medical emergency" (STAT) when the patient is unstable and in a potentially life-threatening or permanent disability situation. Exams on unstable patients will be handled promptly and before all routine and urgent exams, with reports issued as soon as possible and usually within 30 minutes after exam completion. The ordering provider or his/her designee should call the radiologist for a preliminary verbal report if the situation is immediately life-threatening.

UNEXPECTED FINDINGS: Conditions not expected on the basis of the patient's clinical history or presenting symptoms are classified as unexpected findings. Some unexpected findings produce an immediate risk of serious harm to the patient and therefore may represent critical findings. Other unexpected findings present no immediate risk of harm, but represent conditions that may become life threatening or require further clinical or imaging follow-up to exclude the possibility of serious underlying pathology. Unexpected findings should be reported and documented as described under Non-Routine Communication Methods (below).

CRITICAL FINDINGS: Critical findings are potentially acutely life threatening and include conditions that create a substantial risk of serious immediate harm. Once observed, these findings create an obligation for timely and accurate reporting to reduce the likelihood of delayed diagnosis and treatment. If a technologist notices a critical finding on a radiology exam, the radiologist should be notified immediately.

The following conditions are considered critical findings when first identified, and the radiologist will verbally notify the provider or his/her designee of the critical finding. Follow-up exams showing the same finding will not necessarily be verbally notified unless the condition has worsened.

RADIOLOGY CRITICAL FINDINGS

New diagnosis of any of the following:

1. Tension pneumothorax or new pneumothorax
2. Pneumomediastinum (unexplained)
3. Pneumoperitoneum (unexplained)
4. Acute pulmonary embolism
5. Acute DVT
6. Aortic dissection
7. Aortic rupture or leaking aortic aneurysm
8. Acute intra-abdominal or retroperitoneal hemorrhage
9. Acute Intracranial hemorrhage
10. Significant intracranial mass effect with or without mass lesion
11. Epiglottitis
12. Ectopic pregnancy
13. Fetal Demise
14. Placental abruption
15. Unstable spine fracture where there is significant risk of neurologic injury
16. Acute spinal cord compression
17. Suspected non-accidental trauma (child abuse)
18. Acute arterial occlusion
19. Unexpected postoperative foreign body
20. Life threatening line/tube placement
21. Other conditions the radiologist feels likely warrant immediate intervention

GENERAL PROTOCOL FOR COMMUNICATING RADIOLOGY FINDINGS:

1. REPORT CREATION AND DISTRIBUTION: Radiologists will primarily use speech recognition technology to create reports with the majority self-edited and electronically signed when dictation is complete. Correctionists will be used to review and edit reports when requested by the radiologist. Reports are available on-line in PACS and EMR/RIS. Reports are also auto-faxed and/or printed to nursing units or physician offices as requested. Distribution of reports is accomplished by the hospital EMR/RIS system if the process is automated or by the radiology department if manual distribution is required.

2. ROUTINE COMMUNICATION METHODS: Routine exams are read throughout the day with reports available on-line and faxed or printed to requested locations shortly after they are dictated and signed.

Routine exams are prioritized behind urgent and STAT medical emergency exams, and many are reported on the day the exam is performed. However, during high volume periods, depending on specialty coverage, these may take up to three business days. Screening exams (e.g. mammograms, DEXA) and nonurgent subspecialty radiology exams will usually be reported within 1-3 business days. This protocol does not preclude a radiologist from handling a routine or screening exam in an expedited manner. Selected communication methods will be consistent with the urgency of the findings detected on any given study.

3. NON-ROUTINE COMMUNICATION METHODS: The method of communicating non-routine findings must be tailored to the clinical urgency of findings regardless of how the exam was initially characterized. Non-routine communications should be documented as part of the written radiology report. Documentation includes the person to whom the report was given and the time and date of the communication. The radiology report should state if there were specific recommendations for additional imaging or follow-up. When critical findings are relayed to persons other than the ordering or covering provider, the person receiving the oral report MUST read back the entire report verbatim to ensure accuracy of the communication, and this conversation should be documented in the radiology report.

4. CRITICAL FINDINGS: The preferred method for reporting critical findings is for the interpreting radiologist to immediately contact the ordering or covering provider and directly relay the findings verbally to the provider. Direct radiologist-to-provider communication does not require reading back the report, but does require documentation of the communication in the radiology report including the name of the provider receiving the report and the time and date of the communication. While there may be specific circumstances allowing or requiring other methods to communicate critical findings, no alternative method represents a best-practices standard. Communicating through individuals other than the interpreting radiologist and the ordering/covering provider increases the theoretical risk of delayed reporting or miscommunication. To assist in timely notification of the provider, the cell phone number, pager number, or back office number should be provided. Hospital department staff will assist the radiologist in making contact with the ordering provider as requested.

5. CODING CRITICAL FINDINGS: In addition to documenting the critical finding communication as noted in #4 above, the radiologist will dictate a QA code at the end of the report so compliance with critical finding reporting can be monitored through an audit. When critical findings are communicated to the provider, the radiologist will insert the autotext “QA CODE: Code 99” at the end of the report. Radiology department administrative staff can run a report at any time for a specified date range to pull all reports dictated with that QA code. The code does not appear on the final printed or displayed report.

6. CODING FOLLOW-UP RECOMMENDATIONS: When the radiologist dictates a recommendation for follow-up, he/she will also insert the autotext “QA CODE: Code F” at the end of the report. The radiology department staff is responsible for periodically running a list of all Code F reports and taking the necessary steps as directed by hospital policy.

7. VARIATIONS FROM PROTOCOL: This communication protocol is not absolute. Varying from this protocol may be fully consistent with the goals of accurate and timely communication of radiology findings. However, any such deviation from this protocol should be reasonable under the clinical circumstances and should generally be documented to explain the reasons for using other methods or means to communicate.