



Report results; avoid risk

Q What is the correct way to deal with results for incorrect tests ordered on a patient? In our hospital system, some labs delete the test, removing the result from the computer patient report and the next printed cumulative report. Some labs leave the result in and issue a credit to the patient. What if the error is discovered after the patient is discharged? Two examples: A vancomycin trough was ordered and resulted on a patient; the correct testing should have been tobramycin. Once, a B-type natriuretic peptide result was entered — completely inconsistent with previous/subsequent testing. An instrument-log review did not show any testing on that sample or any other testing with the particular result reported.

A The correct response depends on the definition of “incorrect test.” Your examples outline two different situations with very different risk-management implications. In any case of testing error, it is incumbent upon the lab to correct the mistake, report the proper results to the chart, and directly notify the physician in case the error has an effect on patient care. Depending on the situation, there can be several additional and appropriate risk-management responses.

If an incorrect test has been properly performed (reporting a perfectly valid vancomycin level when a tobramycin level was ordered), first collect the specimen for running the correct test, especially if (as in the case with peak and trough measurements) the value is time-sensitive. If the wrong test has a correctly reported value, there is no pressing need to remove the value from the medical record; however, a notation to that effect should be made, and the patient should not be charged. A good risk-management argument is

that the results should be left in the medical record because once seen, they may be relied on by the physician if they have unexpected relevance to the patient’s care. Culling the result from the record here might cause confusion later, especially if a lawsuit arises and lawyers go through the chart with a fine-toothed comb.

When the test is ordered properly but the result is invalid (e.g., performed on the wrong sample, operator error, or simple unexplained testing glitch), it is still imperative to get the right test results into the record as soon as possible, identifying the new results as corrected values and confirming that the patient is not charged twice.

Reporting invalid results raises a far more serious risk-management question, especially when it involves clinically sensitive tests on which patient management will be based. Purging the invalid result from the record may confuse a review of the case later, if — again — a lawsuit arises and lawyers question why certain treatment decisions were made on the basis of values no longer in the chart. In some states, if chart alterations are not done clearly and appropriately, the lab might be open to charges of fraudulent medical-record alteration. If the value is left in the record without clear notification of error — even if a new result is posted — an unwary physician might mistake the old, invalid results for the correct ones.

Most institutions have policies — which need regular review — for correcting such errors. Legal consultation comparing such a policy to state record-keeping requirements is a good idea. My preference? Remove the offending incorrect report, issue a clearly marked replacement with the correct value, and issue an incident narrative to the medical record’s progress notes, indicating the date/time of the initial

incorrect report/initial incorrect reported value, and the date/time of the corrected report/corrected value.

An excellent idea is to notify by telephone the hospital and outpatient-testing personnel, and the attending physician when the error is discovered and again when the correction is made, including those notification(s) in the narrative correction. If the error is discovered after the patient is discharged, it is particularly important to notify the physician directly, rather than just correcting the record.

This assures that the erroneous result and its value are still in the record, but makes it less likely that a casual reading will result in treatment decisions based on the original report left in the “lab results” section. Here, because the physician may have relied on the incorrect value between the time of initial reporting and correction, it is crucial not to cull the incorrect value without leaving a trace. Imagine initially reporting a pregnancy test as negative — clearing the way for the use of medicine or radiological procedures that should be avoided on a pregnant woman — only to find out later that the test was actually positive. For medical-legal purposes, having some record of the initial, if erroneous, result would be important for the physician’s defense in a subsequent lawsuit — even though it points a finger directly at the lab.

No matter what the genesis of the error, once found, the lab should investigate, to determine how the mistake was made, and correcting any policy, procedure, or system flaws that led to it. If it happened once, it can happen again! □

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