POLICY ON:

Reporting Critical Imaging Findings

Introduction:
The intention of this policy is to provide a framework for the communication of imaging findings. This policy should be construed as a guide; exceptions and more stringent criteria may apply on a case-by-case basis. If there are questions, please page Dr. Valerie Jewells (919-216-0668). In her absence, please page Dr. Keith Smith (919-347-1786) or Fidaa Abualhawa (919-347-1431, phone 984-974-7780).

Multiple sources have been used to formulate this guideline, with particular emphasis on the American College of Radiology Practice guideline for communication of diagnostic imaging findings.

Policy:
Non-routine communications essentially describe circumstances that fall into three major categories: (1) diseases of an acute nature, which have the potential to greatly affect patient outcome within a 24-hour period, (2) diseases of a subacute nature, where the observation of unanticipated findings has the potential to affect patient health and health care management in a subacute time frame, from weeks to months, and (3) circumstances of a change of original (preliminary or final) interpretation that may impact clinical care.

Entities that fall into Category (1): suggest a need for immediate or urgent intervention and should have information relayed to a “responsible health care worker,” if not clinically suspected within one hour. The definition of a “responsible health care worker” is the physician or that physician’s representative, whose name appears on the ordering requisition or that physician’s representative. Generally, these cases may occur in the emergency and surgical departments or critical care units, and may include pneumothorax, pneumoperitoneum, or a significantly misplaced line or tube.

For entities in Category (2): An expedited report (preliminary or final) should be generated by the radiologist (resident or attending) in a manner that reasonably ensures timely receipt of the findings. An EPIC note also may be indicated, particularly if there is any difficulty reaching the physician and changes in patient management are likely.

Examples of clinical situations that may be included in Category (2):
- unsuspected malignancy
- unsuspected infectious disease process
- unsuspected disease that has a progressive nature and potential for patient debilitation (example: inflammatory condition)

The most updated version of this policy will appear on the UNC Radiology web site.

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Mechanisms for Reporting Category (1) and (2) Critical Imaging Results:

1. Critical findings found during initial review of images:
   a. The ordering physician or a representative/designee should be contacted to report any critical results or findings that require immediate medical attention, if not already known. Documentation should be made in the report describing which physician was contacted, the date, and time.
   b. If the ordering physician cannot be reached, the physician’s representative or designated contact should be notified. Designated contact may include: physician practice partner, physician member of the ordering physician’s inpatient team, designated emergent contact in a department, or a nurse practitioner partner. “Search For On-Call Schedule” in WebExchange may be utilized. Documentation should be made in the report of the contacted individual, the date, and time (at the time of dictation is not acceptable).
   c. Findings for patients in Category (1) should be reported within one hour of the study being available on the PACS system.
   d. Findings on Head CT and Chest x-ray on newly diagnosed stroke patients in the ED must be reported within 45 minutes.

The following two mechanisms of reporting apply to modified image interpretation results, Category (3):

2. Critical findings identified after Resident report sign-off (during image review by an attending):
   a. The text of a report will not be modified. The preliminary results may have been viewed by clinicians and they may have already acted on the results.
   b. A new paragraph will be added to the report that will be prefaced by “Attending Addendum:” and “Upon further review, [data] was noted and [Dr. X] was notified (include date and time).”
   c. The ordering clinician will be made aware of the change from the original report.
   d. If the ordering physician cannot be reached, the designated contact will be notified.

3. Critical findings after faculty approves reports:
   a. The original report will not be altered and an addendum will be created (as above).
   b. The ordering clinician will be made aware of the change from the original report. This will be documented in the report, with the physician name, date and time of notification.
   c. If the ordering physician cannot be reached, the designated contact will be contacted using the “Search For On-Call Schedule” on WebExchange. Documentation within the report of the designated contact, the date and time.

Disclaimer:
The intention of this policy is not to form the basis of medico-legal practice either here at UNC or at other institutions. This policy should serve as a guideline to achieve optimal health care delivery to the patients of the UNC Health Care System. The policy will be updated to reflect the dynamic evolution of health care.

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