

Lab, Diagnostic Test Results and Change in Resident's Condition – Clinical Protocol

Assessment and Recognition

1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs.
2. The staff will process test requisitions and arrange for tests.
3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility.
4. Physician will be notified of resident's change in condition

Review by Nursing Staff

1. A nurse will review all results.
 - a. If the staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (Supervisor, Charge Nurse, etc.) should follow or coordinate the procedure.
2. The person who is to communicate results to a physician will review and be prepared to discuss the following (to the extent that such information is available):
 - a. The individual's current condition and any recent changes in status, including vital signs and mental status.
 - b. Major diagnoses, allergies, pertinent current medications, other recent pertinent lab work, actions already taken to address results and treat the resident, and pertinent aspects of advance directives (for example, limitations on testing and treatment).
 - c. Why the tests were obtained.
 - d. How test results might relate to the individual's current status, treatments, or medications.
 - e. Any concerns or issues the physician will be expected to address upon receiving the results.
3. Before contacting the physician, the nurse will gather and organize the information listed above and coordinate any telephone communications with others who may also need to speak with the physician.

Attending Physician Responsibilities

1. The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls or emergencies. In addition, the physician is responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate.

Prompt Notification for Acute Problems

1. Nurses should promptly notify the physician of any significant abnormal laboratory results. Such situations require direct communication with physician and may not be faxed. Prompt call must be made after office hours or when physician offices are closed. The following symptoms, signs and laboratory values should prompt the nurse to notify the physician as soon as possible. If you do not obtain a response from a physician, call the designated alternate physician. If you still do not receive the response, notify the Director of Nursing or designee for further instructions.

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**Notification for
Acute Problems
Continued**

** Situations requiring immediate action (life threatening) warrant calling 911 first and physician notification second.

A. Laboratory Results Warranting Prompt Notification:

1. Any laboratory result, normal or abnormal which the physician requests on a "stat" or "same day" basis.
2. All "panic" or critical values.
3. Any of the following abnormal reports:
 - Glucose < 60 > 200 in a diabetic or oral hypoglycemic or insulin; or <60 in anyone (diabetic or non-diabetic), unless otherwise directed by the physician
 - BUN > 40 without history of chronic evaluation or altered mental status
 - Positive urine culture >100,000 colonies/ml of a pathogen
** only if 1) resident has symptoms and is not on treatment; or
2) the pathogen is not sensitive to antibiotic which has been prescribed
4. Hemoglobin <9 if not pre-existing and without treatment.
5. WBC >12 if not pre-existing.
6. Potassium <3 >5.6.
7. Calcium >11.
8. Calcium >12 (resident being treated with dialysis).
9. Abnormal reports when there are signs and symptoms of related illness assessed or outside of physician-ordered parameters, such as Hemoglobin, Hematocrit, WBC, electrolytes, dilantin levels, prothrombin time, INR and other lab values.

B. Normal test results should be faxed to the physician.

The following laboratory results should be reported to the physician verbally or by fax. The physician should be informed of the problem or event during normal business hours. If in your judgment this is not soon enough, do not delay and notify the physician immediately.

1. All normal laboratory results are to be forwarded/communicated within 72 hrs.
2. Observations in the course of routine nursing procedures that might require action, for example:
 - a. Poorly controlled blood pressure in a resident on anti-hypertensive therapy
 - b. Changes in urine or blood sugar values in diabetics (i.e. high determinations in a resident who is normally well controlled).
3. Poorly controlled blood sugars while on daily injections or sliding scale coverage.

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**Non-Immediate
Notification for
Subacute Problems**

Documentation

The following should be documented:

1. Any calls to and from physician will be documented in the nurses notes, or on the 'Physician Notification Form' indicating information conveyed or received.
2. All orders taken from the physician or his/her office nurse, Physician's Assistant or Nurse Practitioner.
3. The nurse receiving telephone verbal orders should write it on the 24 Hour report.
4. Acute and subacute laboratory values are to be communicated shift-to-shift by verbal report and highlighting or discussing the problems listed on the 24 Hour Shift Report to facilitate communication and Quality Assessment follow-up.
5. The nurse should indicate in the nurses notes ongoing conversations with the physician regarding response to notification(s) (faxes, phone calls and verbal conversations) of changes in condition and/or laboratory.