

CHANGE IN INTERPRETATION

General Principles

Changes in interpretation are unavoidable. We require a system which ensures that these changes are communicated in a timely fashion to the necessary providers and, when appropriate, the patient.

1. Notification: Radiology takes ownership of the process even if the Radiologist does not ultimately contact the patient or provider.
2. Documentation: It is absolutely necessary that any communication is documented accurately.

Guidelines for resolving how patients or physicians are contacted after change in interpretation

Cases with clinically significant finding or change that requires input from ED

1. Direct communication between ED and Radiology to discuss the case and appropriate management. Direct contact at a staff to staff level is strongly recommended.
2. Based on those discussions a decision is made regarding patient management including who will contact the patient.
 - a) This decision should be based on the specific circumstances of the given situation.
 - b) Guiding principles which should help inform this decision include:

ED contacts:

1. Concern for acute clinical deterioration
2. Clinically complex (e.g. any need for reassessment at time of phone contact).
3. Patient needs to be reassessed clinically in the ED 2.

Radiology Contacts

1. Patient's condition is clinically stable
2. Clinical scenario straightforward
3. Patient needs to be referred to another (not ED) clinical service for evaluation e.g. Orthopedics clinic, Neurosurgery

Examples:

While it is impossible to provide an appropriate resolution for every potential situation, several examples of how the general principles listed above might be applied to individual cases are listed below.

1. Abnormality requiring further clinical and possibly imaging evaluation.
 - a. E.g. Fracture of the lateral process of the talus missed on ankle x-ray.
 - b. Resolution: referral to Ortho Clinic by Radiology
2. Equivocal finding requiring clinical reevaluation, possibly only requiring a telephone conversation with the patient.
 - a. E.g. CT of the abdomen for patient with generalized abdominal pain. No abnormality reported at the time of initial review. The final report notes the presence of ill-defined increased attenuation of the fat in the RLQ raising the possibility of early findings associated with appendicitis.
 - b. Resolution: phone contact by ED staff.
3. Change in interpretation requiring return visit to ED and assessment by subspecialty service.
 - a. E.G. Hemorrhage on head CT

- b. Resolution: ED contacts patient. Radiology discusses case with Neurosurgery.

Short term patient contact information

In response to concerns regarding the occasional lack of accurate patient contact information the following steps have been taken:

At the time of the ED visit the PASS intake staff will acquire and record the patient's self-identified regular health care provider (RCP) and 72 hour phone contact information. This information is available on the patient summary page of CIS. 72 hour phone contact will be listed as home phone or alternate phone e.g. cell, and best provider contact listed under RCP. RCP includes provider extenders such as nurse practitioners and physician assistants.

Cases which do not require input from the ED

1. Admitted patients

Radiology discusses the change in interpretation directly with admitting service

2. "unexpected findings" which are not time sensitive (e.g. pulmonary nodule on CXR whether identified on a wet reading or not)

Radiology contacts the PCP (not the ordering physician in the ED in this instance) and documents the change in interpretation through use of the "Unexpected Finding" pathway.

Cases from outreach sites

The radiologists (attending or resident) will directly contact the ordering provider to discuss the case and appropriate management. This communication will be documented in the report.

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