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Procedure for Follow-up of Results

Purpose

- Ensure timely, reliable, documented follow-up of all clinical test results to support patient safety and meet RACGP standards.

Scope

- Applies to all clinical and administrative staff involved in ordering, receiving, reviewing, communicating and documenting test results (pathology, imaging, specialist reports, diagnostic tests, telehealth results).

Definitions

- Result: any diagnostic, pathology, imaging or specialist report, and clinical test outcome.
- Actionable result: any result requiring follow-up, treatment change, further investigation, referral or urgent action.
- Acknowledgement: initial receipt/triage entry into tracking system.

Procedure

1. Ordering tests

- Clinician documents clinical indication, relevant history, test ordered, and expected timeframe for result in the medical record.
- Patient is informed who will receive results, how they will be notified, and expected timeframe. Obtain and record patient communication preferences and consent for electronic communication.

2. Receipt and acknowledgement

- All incoming results are received into the practice’s electronic health record (EHR) or designated results inbox.
- Administrative/clinical staff acknowledge receipt in the EHR within 1 business day and mark the result as “to be reviewed” or route to the ordering clinician per practice workflow.

3. Triage and prioritisation

- Results are triaged by a clinician or trained clinician delegate:
    - Urgent/critical: immediate clinician review and patient contact within 24 hours (or sooner if clinically indicated).
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- Actionable/non-urgent: clinician review and patient contact within clinically appropriate timeframe (commonly within 2 business days — local timeframe to be defined in practice).

- Normal/non-actionable: documented, and patient notified per agreed method within defined timeframe (commonly within 5 business days).

Clinician Review and Documentation

- The reviewing clinician documents review date/time, interpretation, clinical significance, and planned action in the medical record.

- If no further action is required, document rationale and safety-netting advice where appropriate.

- If follow-up tests, referrals, or changes to management are required, document explicit plan, timeframe, and responsible clinician.

Patient notification

- Results are communicated following the patient's consented preference (phone, SMS for non-sensitive notification, letter or in-person).

- For urgent/critical results, contact by phone and document time, person contacted, content, and any advice given. If patient unreachable, follow escalation steps (voicemail with appropriate wording, second call, registered letter, and/or notification to nominated contact or GP).

- Provide clear advice about what to do if symptoms worsen and where to seek urgent care.

Escalation when patient not contactable

- Document all contact attempts in the record.

- If high-risk/urgent and patient cannot be contacted after reasonable attempts (e.g., 24–48 hours depending on urgency), escalate to clinician lead and consider:
    - Contacting emergency services or next-of-kin (if consent recorded),
    - Notifying the patient's preferred GP (with consent),
    - Sending a registered letter requesting urgent contact.

Safety-netting and recall

- Provide written or verbal safety-netting instructions for borderline or uncertain results.

- Schedule follow-up appointments or repeat tests in the EHR with reminders/recall.

- Use recall registers for results requiring medium- or long-term review (e.g., abnormal screens, chronic disease monitoring).

Delegation and responsibilities

- Define roles: who receives results, who triages, who reviews, who contacts patients, and who documents. Ensure clinicians delegate only to appropriately trained staff and remain responsible for clinical decisions.

- Maintain consultant contact for complex/uncertain results.

Tracking and fail-safe system

- Use an electronic results tracking system or register to ensure no unreviewed results remain outstanding.

- Implement automatic alerts for overdue results and regular reconciliation (daily or as defined by practice risk profile).

Critical result management

- Maintain a critical results list with agreed thresholds and actions.

- Ensure staff are trained to identify critical results and follow immediate escalation procedures.

Confidentiality and privacy

- Communicate results securely and in accordance with privacy policy; avoid sending sensitive clinical details by unencrypted email/SMS unless patient consent and secure systems are in place.

Documentation retention

- Record all steps: receipt, review, interpretation, communication attempts, patient contact details used, advice given, and follow-up actions. Retain records according to legal and practice retention policies.

Training and competency

- Staff receive induction and regular training on result management, triage, confidentiality, and escalation procedures. Maintain competency records.

Audit, monitoring and continuous improvement

- Regularly audit result management processes (e.g., overdue results, missed follow-ups, timeliness of notifications).

- Review incidents, complaints and audit findings, and implement corrective actions. Review this procedure at least every 24 months or after a significant incident or change in legislation/practice systems.

Version and authorisation

- Approved by: Dr Tian Zhuang
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