Advancing safety with closed-loop communication of test results

This Quick Safety includes information and a patient story provided by the Society to Improve Diagnosis in Medicine (SIDM). The Joint Commission appreciates the sharing of this important information to improve medical diagnosis in our accredited and certified organizations.

Issue:

A 47-year-old
medical record (EMR) as the imaging center and, because of front office changes, missed the
to follow up. The patient was told that the radiologist would contact her if the results were
otherwise, it was safe to assume that things were normal. Since the patient never received a
all, she thought she was okay. The radiologist responsible for making follow-up calls worked from
st and had received only Page 1 of the month's list; Page 2, which included the patient's name,