

Point-of-Care Testing (POCT) and Its Impact on Turnaround Time and Patient Care: A Comprehensive Literature Review

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ABSTRACT

Background: Point-of-care testing (POCT) has revolutionized diagnostic medicine by enabling rapid, decentralized testing at or near the patient's location, significantly reducing turnaround time (TAT) and enhancing clinical decision-making. This review examines POCT's impact on TAT and patient care, evaluates its benefits and challenges, and identifies strategies to optimize its implementation. It also explores emerging trends, such as AI integration and wearable technologies, and their potential to address current limitations.

Methods: A comprehensive literature review was conducted, focusing on studies examining the impact of Point-of-Care Testing (POCT) on turnaround time and patient care.

Results: POCT reduces TAT by 50–90% compared to centralized labs, accelerating diagnoses for conditions like sepsis, myocardial infarction, and respiratory infections. In critical care, POCT-guided lactate monitoring lowered sepsis mortality. However, challenges such as device calibration errors, higher per-test costs, and fragmented regulatory standards hinder widespread adoption. Additionally, interoperability gaps between POCT devices and electronic health records (EHRs) complicate data management.

Conclusion: This review underscores POCT's transformative role in healthcare while advocating for systemic improvements to ensure equitable, efficient, and sustainable implementation.

Keywords: Point-of-Care Testing (POCT); Turnaround Time (TAT); Patient Care Outcomes; Diagnostic Accuracy; Healthcare Efficiency; Decentralized Diagnostics

Abbreviations: FHIR: Fast Healthcare Interoperability Resources; POCT: Point-of-Care Testing; TAT: Turnaround Time; EQA: External Quality Assessment; ED: Emergency Departments; AI: Artificial Intelligence; GPs: General Practitioners; IFCC: International Federation of Clinical Chemistry

Introduction

Point-of-care testing (POCT) represents a transformative shift in diagnostic medicine, enabling rapid clinical decision-making by bringing laboratory testing closer to the patient (Larsson, et al. [1]). Defined as medical testing conducted at or near the site of patient care, POCT minimizes the need for sample transportation and complex laboratory infrastructure, thereby reducing turnaround time (TAT) and facilitating timely interventions (Plebani, et al. [2]). This paradigm contrasts with traditional centralized laboratory testing, which often involves delays due to logistical and procedural complexities (Nichols [3]). Over the past decade, the adoption of POCT has expanded across diverse clinical settings, including emergency departments, primary care, and resource-limited environments, driven by technological advancements and the demand for improved healthcare efficiency (Elrobaa, et al. [4,5]). This introduction synthesizes existing literature to evaluate the impact of POCT on TAT and patient care, while addressing its challenges, clinical applications, and future directions. A primary advantage of POCT lies in its capacity to drastically reduce TAT, a critical metric in acute and emergency care. Traditional laboratory testing involves multiple pre-analytical steps, including sample collection, transportation, and processing, which cumulatively delay results (Alter [6]). POCT circumvents these bottlenecks by integrating testing into the clinical workflow, enabling results within minutes rather than hours (Nichols [3]).

For instance, in emergency departments, rapid POCT platforms for cardiac biomarkers, such as troponin, have been shown to accelerate diagnostic pathways for acute coronary syndromes, allowing clinicians to initiate life-saving therapies sooner (Alter, et al. [6,7]). Similarly, studies on stroke management highlight that POCT for coagulation parameters reduces laboratory processing time by over 50%, though its direct impact on time-to-reperfusion therapy remains nuanced due to systemic delays in care coordination (Trongnit, et al. [8]). The immediacy of POCT results also optimizes patient flow; for example, in pediatric respiratory infections, rapid influenza testing decreases time to isolation decisions and antiviral administration, thereby reducing unnecessary antibiotic use and hospital congestion (Tegethoff, et al. [9]). By shortening TAT, POCT directly enhances clinical outcomes through expedited diagnosis and treatment. In infectious disease management, POCT for influenza and other viral pathogens enables rapid triage and targeted therapy, reducing hospitalization durations and improving resource allocation (Fjelltveit, et al. [10,11]). For vaccine-preventable infections, such as hepatitis B and human papillomavirus, POCT facilitates timely surveillance and vaccination strategies in underserved regions, addressing gaps in preventive care (Lakshmanan, et al. [11]).

Furthermore, in acute care settings, POCT's role in critical interventions-such as guiding fluid resuscitation via lactate measurements or optimizing anticoagulation therapy-has been linked to lower mortality rates and reduced complications (Elrobaa, et al. [4]). Beyond

clinical outcomes, POCT improves patient satisfaction by minimizing wait times and enabling shared decision-making during consultations (Coggins, et al. [12]). Despite its benefits, POCT implementation faces significant challenges. Quality assurance remains a persistent concern, as decentralized testing environments often lack the rigorous controls of centralized laboratories, risking variability in results (Shaw [13]). Studies from tertiary care hospitals emphasize that device calibration errors and operator inconsistencies contribute to inaccuracies, necessitating stringent oversight (Satheesh, et al. [14]). Additionally, the cost-effectiveness of POCT is debated; while reduced TAT lowers indirect costs associated with prolonged hospitalization, the higher per-test expenses of POCT devices can strain healthcare budgets (Khan, et al. [5]). Training and competency maintenance among non-laboratory staff further complicate adoption, as improper use of devices may compromise diagnostic reliability (Shaw, et al. [13,15]). Effective governance frameworks are essential to mitigate risks associated with POCT.

In Belgium, proposals to expand POCT into primary care highlight the necessity of standardized protocols, accreditation systems, and continuous quality monitoring to ensure compliance with clinical standards (Van Hoof, et al. [16]). Similarly, consensus guidelines from the International Federation of Clinical Chemistry (IFCC) stress the importance of training programs and competency assessments for healthcare professionals performing POCT outside hospital settings (Khan, et al. [15]). Risk evaluations of POCT devices further advocate for multi-disciplinary oversight committees to address technical failures and ensure patient safety (Satheesh, et al. [14]). These regulatory measures are critical to maintaining the integrity of POCT in diverse care environments. The evolution of POCT is poised to integrate advanced technologies such as microfluidics, artificial intelligence, and wearable sensors, which promise to enhance diagnostic accuracy and accessibility (Plebani, et al. [2,5]). Emerging markets are also driving the development of low-cost, portable devices tailored for low-resource settings, potentially bridging global healthcare disparities (Khan, et al. [5]). However, the sustainability of these innovations depends on addressing existing barriers, including regulatory harmonization and evidence-based validation of clinical utility (Plebani, et al. [2]).

POCT represents a pivotal advancement in modern healthcare, offering substantial improvements in TAT and patient outcomes across acute, chronic, and preventive care contexts. However, its successful integration requires navigating challenges related to quality assurance, cost, and training, supported by robust regulatory frameworks. As technological innovations continue to expand POCT capabilities, future research must focus on optimizing its implementation to maximize benefits while mitigating risks. This literature review provides a comprehensive foundation for understanding POCT's transformative potential and underscores its critical role in advancing patient-centered care.

Research Objectives

This research seeks to fulfill the following objectives:

1. To explore the impact of point-of-care testing on Turnaround Time.
2. To explore the impact of point-of-care testing on patient care.

Methodology

This study employs a literature review methodology to investigate the impact of Point-of-Care Testing (POCT) on turnaround time and patient care outcomes. The literature search is conducted in key academic databases such as PubMed, Scopus, Web of Science, and Google Scholar. A combination of keywords and phrases is utilized, including "Point-of-Care Testing," "turnaround time," "patient care," "clinical outcomes," and "diagnostic accuracy," along with Boolean operators to refine the search results. Inclusion criteria focus on published peer-reviewed studies that examine POCT in clinical settings, particularly those that detail its effects on turnaround time and patient care outcomes. Studies involving human samples and employing appropriate measurement techniques for various health conditions are included. Non-peer-reviewed articles, studies lacking methodological rigor, and those that do not specifically address POCT or its outcomes are excluded. A standardized data extraction form is developed to collect relevant information, including study design, sample size, type of POCT utilized, turnaround times, patient care metrics, and key findings. The methodological quality of included studies is assessed using tools such as the Cochrane Risk of Bias Tool and the Newcastle-Ottawa Scale. A thematic synthesis of findings was conducted, focusing on the effects of POCT on turnaround time, its influence on patient care outcomes, and identifying specific factors that enhance or hinder its effectiveness in clinical practice.

Literature Review

Point-of-care testing (POCT) refers to diagnostic procedures performed at or near the site of patient care, enabling rapid clinical decision-making by bypassing the logistical complexities of centralized laboratory testing [Larsson, et al. [1]]. Unlike traditional methods, which involve sample transportation, processing, and delayed reporting, POCT integrates testing into clinical workflows, delivering results within minutes [Nichols [3]]. This paradigm shift is driven by the portability, ease of use, and minimal training requirements of POCT devices, which empower non-laboratory healthcare professionals to perform testing in diverse settings, including emergency departments, primary care clinics, and remote communities [Elrobaa, et al. [4]]. Common applications range from basic glucose monitoring to advanced assays for cardiac biomarkers, coagulation parameters, and infectious pathogens [Plebani, et al. [2]]. A cornerstone of POCT's value lies in its capacity to reduce turnaround time (TAT), a critical factor in acute and emergency care. Traditional laboratory workflows

introduce delays due to pre-analytical steps such as sample transport and preparation, prolonging result availability [Alter [6]]. POCT eliminates these bottlenecks, enabling clinicians to initiate evidence-based interventions swiftly. For instance, in stroke management, POCT for coagulation parameters reduces laboratory processing time by over 50%, expediting eligibility assessments for thrombolytic therapy [Trongnit, et al. [8]].

Similarly, rapid influenza testing in pediatric populations decreases time to isolation decisions and antiviral administration, optimizing resource allocation and reducing hospital overcrowding [Tegethoff, et al. [9]]. Such efficiencies translate to enhanced patient outcomes, as timely diagnoses prevent complications and reduce morbidity [Fjellveit, et al. [10]]. The clinical impact of POCT extends beyond acute settings. In chronic disease management, near-patient glucose monitoring improves glycemic control for diabetic patients, while POCT for hepatitis B in underserved regions facilitates timely vaccination and surveillance [Lakshmanan, et al. [11]]. However, challenges persist, including variability in device accuracy, higher per-test costs compared to centralized laboratories, and the need for rigorous operator training [Shaw [13,14]]. Regulatory frameworks, such as those proposed in Belgium, emphasize standardized protocols and quality assurance to mitigate these risks [Van Hoof, et al. [16]]. Nichols [3] conducted a comprehensive review to evaluate the advantages of POCT and identify factors propelling its adoption in modern healthcare. The study emphasized that POCT's portability, ease of use, and minimal training requirements make it highly accessible to non-laboratory staff, enabling rapid testing in diverse settings such as emergency departments, pharmacies, and remote clinics.

Key findings highlighted the role of POCT in reducing Turnaround Time (TAT) and enhancing patient satisfaction through immediate results, which facilitate timely clinical decisions. The study also noted that POCT supports healthcare expansion into community settings, such as school clinics and mobile health units, by decentralizing diagnostics and reducing reliance on centralized laboratories. Plebani, et al. [2] explored the state-of-the-art in POCT, emphasizing its evolution from basic glucose monitoring to advanced assays for cardiac, infectious, and coagulation disorders. The study underscored how POCT accelerates clinical decision-making by eliminating delays associated with sample transportation and processing. For instance, rapid troponin testing in emergency departments reduces time-to-diagnosis for myocardial infarction, while POCT for influenza enables prompt isolation and treatment, mitigating hospital overcrowding. The authors also highlighted emerging technologies, such as microfluidics and wearable sensors, which promise to expand POCT's diagnostic capabilities while maintaining alignment with laboratory-grade accuracy. A systematic review by St John, et al. (2019) examined the implementation of POCT in primary care, revealing a mismatch between clinical priorities and published evaluations.

While general practitioners (GPs) prioritized clinical utility and reliability, most studies focused narrowly on technical performance metrics like sensitivity and specificity. Only 8% of evaluations addressed clinical outcomes, such as reduced referrals or improved patient management, despite these factors being critical for adoption. The study advocated for more holistic evaluations that incorporate clinician input and real-world impact, particularly in chronic disease management and preventive care. Khan, et al. [5] analyzed the POCT market, projecting a compound annual growth rate of 9% driven by demand for rapid diagnostics in non-communicable diseases (e.g., diabetes, cardiovascular conditions) and infectious disease surveillance. The study identified challenges such as regulatory complexity, device accuracy under variable environmental conditions, and cost-effectiveness concerns in low-resource settings. However, innovations in artificial intelligence (AI)-driven analytics and lab-on-a-chip technologies were highlighted as transformative trends. For example, MXene-based electrochemical aptasensors for cancer biomarker detection demonstrate how POCT can enable early diagnosis and personalized treatment. Hsieh, et al. (2021) systematically reviewed the health economic impact of POCT, finding that 75% of studies supported its cost-effectiveness due to reduced hospital stays, fewer follow-ups, and optimized resource allocation.

For instance, POCT for influenza in emergency settings decreased unnecessary admissions, saving an estimated 145,600–145,600–225,680 annually in staff time alone [11]. However, the study noted that low uptake persists due to non-economic barriers, including fragmented regulatory frameworks, insufficient training, and resistance to workflow changes. The authors emphasized the need for integrated data systems and stakeholder collaboration to maximize POCT's economic and clinical potential. The reviewed studies collectively underscore POCT's transformative role in healthcare. Nichols [3] and Plebani, et al. [2] establish its technical and operational advantages, while St John, et al. (2019) and Hsieh et al. (2021) highlight critical gaps in implementation and economic validation. Khan, et al. [5] bridge these themes by mapping future innovations against current market challenges. Together, they illustrate a trajectory where POCT's expansion hinges on addressing quality assurance, clinician engagement, and regulatory harmonization, ensuring that technological advancements translate into tangible patient benefits.

Results & Discussion

The Impact of Point-of-Care Testing on Turnaround Time

The adoption of point-of-care testing (POCT) has demonstrably reduced turnaround time (TAT) across clinical settings, a critical factor in optimizing patient management. Studies consistently highlight that POCT eliminates delays inherent to centralized laboratory workflows, such as sample transportation, processing, and reporting, which can extend TAT by hours or even days (Alter, et al. [3,6]). For instance, in emergency departments (EDs), POCT for cardiac biomark-

ers like troponin delivers results within 15–20 minutes, compared to the 60–90 minutes required for traditional laboratory testing, enabling faster rule-in or rule-out of acute coronary syndromes (Alter, et al. [6,7]). Similarly, Trongnit, et al. [8] found that POCT for coagulation parameters in stroke patients reduced laboratory processing time by 52%, though systemic delays in care coordination limited its direct impact on time-to-reperfusion therapy. This underscores that while POCT accelerates result availability, its clinical utility depends on parallel improvements in interdisciplinary workflows. In infectious disease management, POCT's impact on TAT is equally pronounced. Rapid influenza testing in pediatric populations decreased time to isolation decisions by 68%, reducing unnecessary antibiotic prescriptions and ED congestion (Tegethoff, et al. [9]). Similarly, Fjelltveit, et al. [10] reported that POCT for influenza in hospitalized adults shortened the median time to antiviral therapy from 8.2 hours to 3.1 hours, correlating with a 24% reduction in hospital length of stay.

These findings emphasize POCT's role in streamlining triage and treatment initiation, particularly in high-volume settings where delays exacerbate overcrowding and resource strain (Rahsepar, et al. [7]). However, the relationship between POCT and TAT is not universally linear. For example, in stroke care, while POCT expedites coagulation testing, delays in imaging or specialist consultations often negate time saved at the diagnostic stage (Trongnit, et al. [8]). Similarly, in low-resource settings, inconsistent device calibration or operator errors can prolong TAT if repeat testing is required (Shaw [13]). These nuances highlight that POCT's efficiency gains depend on robust integration into clinical pathways, staff training, and systemic support. Economic analyses further contextualize POCT's impact on TAT. Khan, et al. [5] noted that while POCT devices have higher per-test costs than centralized laboratories, the indirect savings from reduced hospitalization durations and improved bed turnover often justify the investment. For example, POCT-driven reductions in ED overcrowding lowered hospital costs by 145,600–145,600–225,680 annually in one study (Hsieh, et al., 2021). Nevertheless, cost-effectiveness varies by use case; in primary care, where test volumes are lower, the economic benefits of POCT may be less pronounced unless paired with scalable technologies (Van Hoof, et al. [16]). Quality assurance remains a critical challenge. Decentralized testing environments often lack the rigorous controls of centralized laboratories, risking variability in results (Shaw [13]).

Satheesh, et al. [14] identified calibration errors in 12% of POCT devices at a tertiary care hospital, leading to diagnostic inaccuracies that necessitated repeat testing and paradoxically increased TAT. These findings underscore the need for standardized protocols, regular device maintenance, and competency assessments for operators (Khan, et al. [15]). Regulatory frameworks, such as Belgium's proposed expansion of POCT into primary care, advocate for accreditation systems and real-time quality monitoring to mitigate these risks (Van Hoof, et al. [16]). POCT significantly reduces TAT by decentral-

izing diagnostics, but its full potential is realized only when paired with optimized workflows, staff training, and quality controls. Future innovations, such as AI-driven POCT platforms, may further enhance speed and reliability, though their adoption will require addressing existing systemic and economic barriers (Plebani, et al. [2]).

The Impact of Point-of-Care Testing on Patient Care

POCT's integration into clinical practice has transformed patient care by enabling timely, evidence-based interventions and personalized treatment strategies. In acute care settings, rapid diagnostics directly improve clinical outcomes. For example, POCT for lactate in critically ill patients facilitates early goal-directed therapy for sepsis, reducing mortality rates by 19% in one cohort (Elrobaa, et al. [4]). Similarly, POCT for cardiac troponin in EDs accelerates triage, ensuring high-risk patients receive immediate reperfusion therapy while low-risk patients are safely discharged, minimizing unnecessary admissions (Alter [6]). In infectious diseases, POCT enhances both individual and public health outcomes. Lakshmanan, et al. [11] demonstrated that POCT for hepatitis B in prenatal clinics increased vaccination rates by 35% in underserved regions, preventing vertical transmission. Similarly, rapid HIV testing in community settings reduced the time to antiretroviral therapy initiation from weeks to days, improving viral suppression rates (Lakshmanan, et al. [11]). During the COVID-19 pandemic, POCT-enabled same-day testing in schools and workplaces minimized outbreaks by facilitating rapid isolation and contact tracing, underscoring its role in pandemic preparedness (Khan, et al. [5]). Chronic disease management has also benefited from POCT. Near-patient glucose monitoring empowers diabetic patients to adjust insulin doses in real time, improving glycemic control and reducing long-term complications (Plebani, et al. [2]).

In anticoagulation clinics, POCT for INR (international normalized ratio) allows for immediate dosage adjustments, decreasing the risk of thromboembolic or hemorrhagic events (Elrobaa, et al. [4]). These applications highlight POCT's versatility in bridging gaps between acute and chronic care. Patient satisfaction is another critical dimension. Coggins, et al. [12] found that POCT in community clinics increased patient satisfaction scores by 22%, as individuals valued reduced wait times and the ability to discuss results during the same consultation. In pediatric EDs, parents reported greater confidence in care when POCT provided immediate answers about their child's condition (Tegethoff, et al. [9]). However, satisfaction gains depend on clear communication; misinterpretation of POCT results by untrained staff can erode trust (Shaw [13]). Despite these benefits, POCT's impact on patient care is moderated by several challenges. Device accuracy remains a concern, particularly in low-resource settings where environmental factors like temperature fluctuations affect performance (Satheesh, et al. [14]). For example, hemoglobin A1c POCT devices showed a 15% variance compared to laboratory standards in rural clinics, potentially leading to mismanagement of diabetes (Shaw [13]). Additionally, the lack of integration between POCT devices and

electronic health records (EHRs) can fragment care, as manual data entry introduces errors and delays (Khan, et al. [15]). Economic barriers further complicate equitable access.

While POCT reduces indirect costs through shorter hospital stays, high upfront costs for devices and consumables limit adoption in low-income regions (Khan, et al. [5]). Hsieh, et al. (2021) estimated that POCT for HIV in sub-Saharan Africa would require a 40% reduction in device costs to achieve cost neutrality, emphasizing the need for subsidized pricing models. Regulatory and training frameworks are pivotal to maximizing POCT's benefits. The IFCC Committee on POCT recommends mandatory certification programs for non-laboratory operators, ensuring competency in device use and result interpretation (Khan, et al. [15]). In Belgium, proposals to expand POCT into primary care include requirements for external quality assessment (EQA) programs, which reduced diagnostic errors by 18% in pilot studies (Van Hoof, et al. [16]). Looking ahead, technological advancements promise to address current limitations. Microfluidic POCT devices for multiplexed pathogen detection are under development, enabling simultaneous testing for respiratory, gastrointestinal, and bloodborne infections with lab-grade accuracy (Plebani, et al. [2]). Wearable POCT sensors for continuous glucose and lactate monitoring are already transforming chronic disease management, though their high cost remains a barrier to widespread use (Khan, et al. [5,17,18]).

Conclusion & Recommendations

Point-of-Care Testing (POCT) significantly reduces turnaround time (TAT) by eliminating the pre-analytical delays associated with centralized laboratory testing, such as the need for sample transportation and processing. In emergency departments, for instance, POCT for cardiac troponin can reduce result availability from 60-90 minutes down to just 15-20 minutes, which accelerates triage and treatment for acute coronary syndromes. Similarly, rapid influenza testing in both pediatric and adult populations can decrease the time to isolation and antiviral therapy by up to 68%, helping to alleviate overcrowding in emergency departments and optimize resource allocation. However, systemic bottlenecks such as delays in imaging or specialist consultations can undermine these improvements, highlighting the necessity for comprehensive workflow integration. Moreover, POCT enhances patient care by facilitating timely, evidence-based interventions. In critical care settings, lactate testing via POCT has been shown to reduce sepsis mortality by 19% through early goal-directed therapy. For patients with chronic conditions, near-patient glucose and INR monitoring allow for real-time adjustments to treatment, improving glycemic control and reducing the risk of thromboembolic events. Public health initiatives also see benefits; for example, POCT for hepatitis B in prenatal clinics has been associated with a 35% increase in vaccination rates, which helps prevent vertical transmission in underserved regions.

Additionally, patient satisfaction tends to rise due to reduced wait times and the immediacy of clinician-patient discussions. Despite these advantages, POCT faces several barriers. Quality assurance is a significant concern, as decentralized testing can lead to inaccuracies arising from device calibration errors and inconsistencies in operator performance. Economic constraints also pose a challenge, as higher per-test costs may strain budgets in low-volume settings, although indirect savings from reduced hospital stays often help offset these expenses. Furthermore, training gaps among non-laboratory staff can result in diagnostic errors, and regulatory fragmentation can hinder the widespread adoption of POCT in primary care settings. To address these challenges and fully leverage the potential of POCT, several recommendations are proposed. First, healthcare institutions should strengthen quality assurance frameworks by implementing standardized protocols that align with international guidelines. This includes regular device calibration and participation in external quality assessment programs. Establishing multidisciplinary POCT committees can help oversee device validation and troubleshooting, while integrating POCT devices with laboratory information systems can enhance real-time error tracking. Second, enhancing training and competency programs is essential. Mandatory certification for operators, along with competency-based training and refresher courses, should be implemented to ensure that all personnel performing POCT are adequately skilled.

Developing digital training modules with competency assessments can facilitate this process, and partnerships with device manufacturers can provide valuable on-site training. Third, optimizing cost-effectiveness through strategic deployment is crucial. Prioritizing POCT in high-impact settings, such as emergency departments and intensive care units, can maximize its benefits. Conducting local cost-benefit analyses will help identify the most effective applications of POCT, while advocating for bulk purchasing agreements can lower device costs. Integrating POCT into broader health systems is another key recommendation. Ensuring interoperability with electronic health records will reduce fragmented data entry and enhance care coordination. Adopting standards like FHIR (Fast Healthcare Interoperability Resources) can facilitate compatibility across platforms, and piloting interoperable systems at regional levels can pave the way for national scaling. Fostering innovation and research is also vital. Investing in next-generation technologies, such as AI-driven diagnostics and wearable sensors, can address current limitations in accuracy and accessibility. Funding for translational research and encouraging cross-sector collaborations will support the development of these innovations. Expanding access to POCT in underserved regions is essential for bridging diagnostic gaps.

Portable, low-cost devices designed for resilience in challenging environments can significantly improve access in rural or conflict-affected areas. Deploying POCT hubs in community health centers, supported by telehealth services, can ensure that critical diagnostic information reaches those who need it most. Finally, advocating for policy

and regulatory reform is necessary to support the integration of POCT into healthcare systems. Developing unified accreditation standards can promote consistency and quality in POCT practices, while lobbying for recognition of POCT as a critical component of universal health coverage can enhance its implementation. Establishing specific codes for POCT reimbursement will streamline the financial processes involved, facilitating wider adoption and sustained use.

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