PEER-REVIEWED

An audit of the quality of referral letters received by the Department of Oral and Maxillofacial Surgery, Dublin Dental School and Hospital

Abstract

One hundred consecutive referral letters, sent by dental practitioners to the Department of Oral and Maxillofacial Surgery, Dublin Dental School and Hospital, were audited in terms of quality. The audit was based on the Scottish Intercollegiate Guidelines Network (SIGN) recommendations of 1998. The audit demonstrated that in general referral letters required modification and did not give the clinician the required information. This paper sets out the results of the audit and suggests a template that should be used for future referrals.

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Background

Referral letters of high quality are an essential part of good clinical care as they act as the interface between healthcare professionals in the primary and secondary environments. They are a flexible means of transferring information and can be adapted in form and content to cover both straightforward and complex clinical cases. The referral letter provides demographic as well as clinical information and is used by clinical staff and medical records appointments staff. Adequate information is essential to allow the secondary care professional to assess clinical need and urgency, and for administrative staff to arrange appointments. All referrals are reviewed by the clinician responsible for their care and given a priority.

In 1998 the Scottish Intercollegiate Guidelines Network (SIGN) established a multidisciplinary working group to review the literature and to assess examples of good practice. Their aim was to make recommendations on a minimum essential dataset for communication from primary to secondary care. A detailed review of the literature yielded 60 articles that were deemed relevant. No evidence existed from randomised controlled studies to show that better communications improved patient outcomes. Evidence came from non-experimental descriptive studies that used consensus methods to judge referral letters and score them. The information was extracted and synthesised, and presented to a national consensus forum of healthcare professionals. Delegates were asked to complete a questionnaire before and after the conference. This information was added to the literature review to help the working group to make recommendations on essential information to be included in a proposed pro forma referral letter. The group did not grade the information in terms of importance. All data included was considered equally important and completeness of the referral letter was paramount.

Their recommendations were presented in the form of a referral letter template.[1] Several recent dental articles have addressed the issue of referral quality.[2,3,4]

Aims of the audit

The Department of Oral and Maxillofacial Surgery receives referrals from many healthcare professionals and wished to assess whether these can be improved. The aim of the current audit was to assess the quality of referrals and to establish a referral pro forma that practitioners may wish to use. By using this pro forma, the gold standard in referrals can be attained.

Method

The study population consisted of 100 consecutively received referral letters. They were analysed using the following categories:

1. Patient details.
2. Referring practitioner details.
3. General medical practitioner details.

4. Clinical information provided.
5. Social issues.
6. Legible and comprehensible.

Data was captured on a pro forma and simple totals were obtained.

The data are presented in the following tables:

Patient details	
Full name	100
Complete address	99
Telephone number	78
Date of birth	55
Gender	78
Hospital number	0
Medical card number	13
Previous names	0

Referring practitioner details	
Name of referring practitioner	99
Address	100
Telephone number	98
Fax number	29
Email address	10

GP details	
GP details	0

Clinical information provided	
Presenting complaint	57
History of presenting complaint	22
Clinical findings mentioned	51
Investigation results	20
Specific treatment requested	86
Urgency of referral	14
Past medical history	34
Past or current medications	9
Medical alerts, e.g., allergy	2

Social issues	
Patient issues	12
Social circumstances	2
Special needs	0
Ambulance required	0

Other relevant information	
Legible	100
Comprehensible	100

Discussion

Patient details were satisfactory in terms of name, address and date of birth. Gender was mentioned in 55% of letters. Society is now multinational and names often do not give clear indication of whether the patient is female or male. This is important because of childbearing age, radiographs, chaperoning and childcare. One in five letters gave no telephone number for the patient. This made it difficult to contact the patient to confirm an appointment. Name, address and telephone number for the referring practitioner were almost universally provided; however, only one in three letters gave a fax number. One in ten gave an email address. In an electronic age, email is becoming a more efficient and cheaper form of correspondence.

No general medical practitioner (GMP) details were given in any letter. This element was considered essential by the SIGN and it implied that many GDPs do not possess this information. Contact with the GMP is required for those patients with a complicated medical history and treatment outcomes may be copied to them by letter.

The category of "clinical information provided" demonstrated that key information was frequently omitted. A presenting complaint was absent in 43% of letters and a history of presenting complaint was absent in 78%. Half of the letters only included clinical findings. One in five contained results of investigations. It is impossible to prioritise without the presenting complaint and many patients may be disadvantaged if the history of the presenting complaint is not given, e.g., pain, ulcer, possible cancer. One in three letters mentioned medical history and one in ten stated medications. Medical alert warnings were given in only two out of 100 letters. In the absence of a warning such as an allergy or a blood-borne virus, good practice warrants stating the negative, i.e., "there are no special warnings for this patient", or simply striking out the relevant area of the pro forma. On social issues, for example phobia, social difficulty and special needs such as wheelchair use, scant information was provided. Again, it should be stated in the negative that there are no special issues pertaining to the patient if this the case.

Conclusions

It is clear that the information required in referrals to the Department of Oral and Maxillofacial Surgery is not being received and this warrants improvement. Not one referral letter fulfilled all criteria for referral as highlighted by the SIGN. Key clinical information was too often missing. This may be contributing to the long waiting list for assessment clinics, as lack of information makes prioritisation and organisation of these lists more difficult. Suspicion of malignancy constitutes an urgent referral. Conditions such as recurrent aphthous ulceration or burning mouth syndrome do not. These latter patients are seen on an 'as soon as possible' basis. The use of the non-specific term 'lesion', without any further descriptive element, is impossible to assess, e.g., "the patient has a lesion on his tongue". Size, shape, consistency, colour, ulceration and induration should be mentioned. If the patient has an ulcer or other lesion related to sharp dentures or teeth, this trauma should be eliminated and the patient reviewed. If there is no improvement at that stage then a referral to secondary care is warranted. If the patient is under the care of another consultant, the request that the referral is for a second opinion must be made clear.

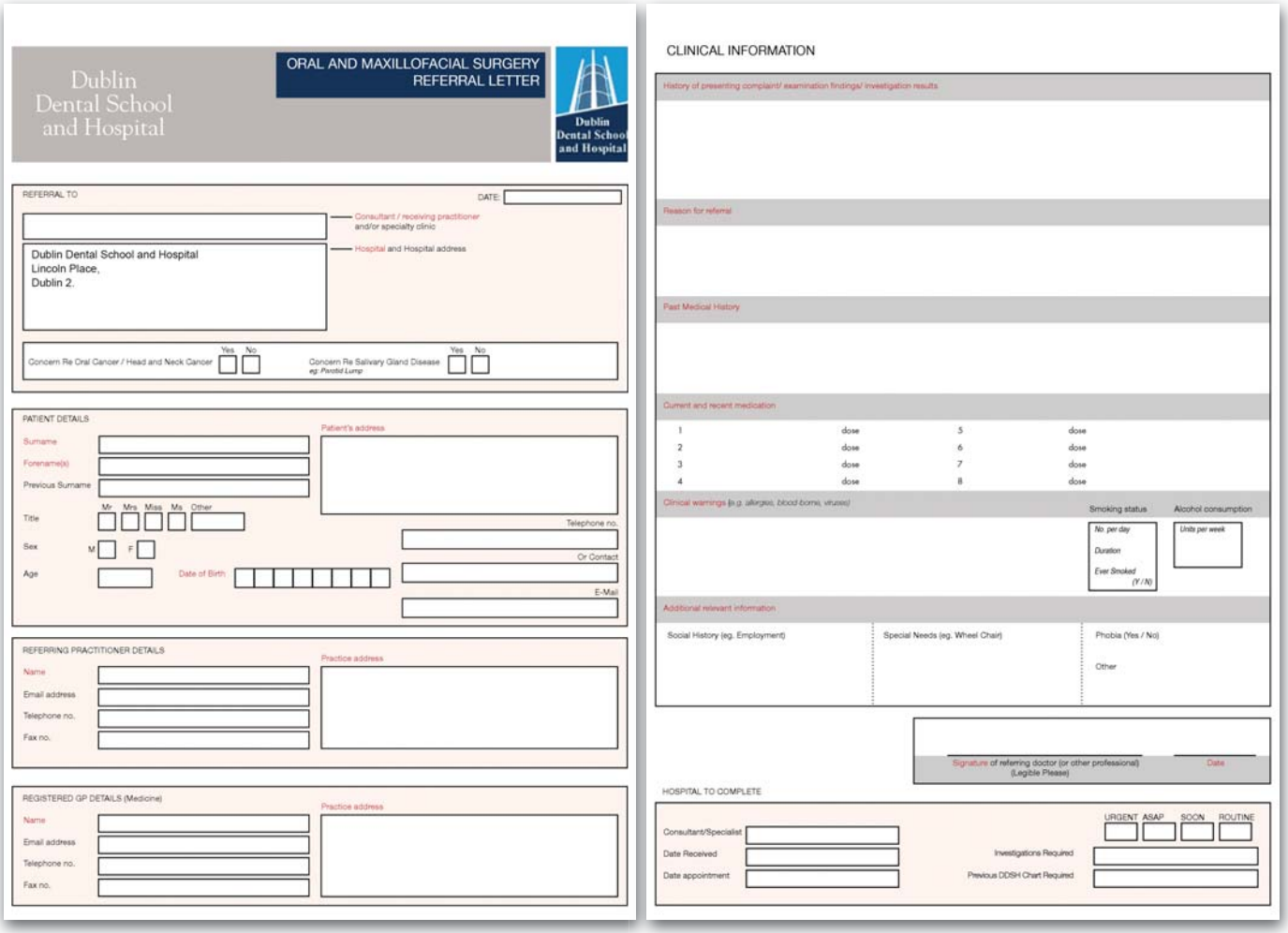

FIGURE 1: Pro forma referral letter.

High quality referral in theory may make it possible to book patients for assessment and treatment in the same session for certain simple procedures. This is one concrete way of reducing waiting times and improving patient outcomes.

Recommendations

The results of this audit have been used as an educational tool for students and clinicians, and it is planned to implement a referral pro forma for referring practitioners. One strategy that has been tried in another department in the Hospital, is to return poor referral letters with the request that they be resubmitted with the rquired information. However, this action is not supported by senior clinicians in oral and maxillofacial surgery and oral medicine in case an important referral is missed. The important issue is two-way feedback eliciting an improvement in referral letters. It is planned to re-audit in one year. Finally, the use of a custom-designed pro forma, such as ours (**Figure 1**), is recommended. It may be possible to roll out this pro forma as a universal Dublin Dental School and Hospital referral document. It is planned that the pro forma be downloadable from the DDSH and IDA websites.

References

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