LETTERS

Referral of patients to an anticoagulant clinic

We previously reported an audit of the referral of 80 patients to an anticoagulant clinic.¹ Referral letters were never received in the anticoagulant clinic for five of 72 (7%) patients referred from within the study hospital, and in the 67 letters received important administrative and clinical information was missing.

In response to these problems the referral form was redesigned and incorporated into the hospital computer system so that the referral could be printed out within the haematology department. Three entry procedures were incorporated into the computerised referral form: firstly, administrative details were transferred by default from the patient administrative system; secondly, five items of clinical data were prompted on the screen; and thirdly, all other clinical information was optional entry. To guide doctors on the optional information required, summarised guidelines were shown on a screen which appeared when the referral form was accessed.

After establishing the option of computer referral we reaudited 62 referrals from within the hospital to clinic. Six (10%) referral letters were never received, nine (15%) were received in written form, and 47 (76%) were received through the computer system. Among the 47 computer referrals, there was an improvement

Internal hospital referrals

Computer entry procedure	Details on referral forms	No (%) of referrals with complete documentation	
		First audit written referrals (n = 67)	Second audit computer referrals (n = 47)
Default entry:	Age of patient	58 (87)	47*
	Name of referring doctor	62 (93)	47
	Date of referral	22 (33)	47**
Prompted entry:	Indication	67	47
	Anticipated duration	55 (82)	39 (83)
	Who to stop anticoagulation	33 (49)	42 (89)**
	Other concurrent medical problems	28 (42)	29 (62)
	Drug interactions	4 (6)	15 (32)**
Optional entry:	Date of last international normalised ratio	7 (10)	1 (2)
	Result of last international normalised ratio	12 (18)	3 (6)
	Objective investigation	13 (19)	5 (11)
	Start date of treatment	1 (1)	1 (2)
	Current warfarin dose	24 (36)	4 (9)**

*p < 0.05.

**p < 0.001.

in documentation of administrative data entered by default and in some, but not all, of those items of clinical data promoted by the system (table). For the optional clinical data, however, documentation continued to be poorly completed. We also noted that case notes were less likely to be retrieved for patients whose referral had been made by computer generated referral letters rather than by a standard written letter (21% (10/47) v 89% (8/9), p < 0.001).

We conclude that incorporating referral into a computerised system can improve completeness of documentation provided that data are transferred by default or are specifically prompted. Optional data entry through a computer did not improve the quality of referral. Clinicians should be actively involved in the design of software to ensure that systems are flexible enough

to facilitate complete documentation and to produce the maximum benefit to patient care. Computerised systems that allow referral directly to a clinic from distant input may need to include a written reminder at ward level to ensure that parallel systems, such as those for retrieving notes, are also activated.

F TAYLOR

M RAMSAY

A RENTON

Academic Department of Public Health,
St Mary's Hospital Medical School,
London

H COHEN

Department of Haematology,
Central Middlesex Hospital,
London

- 1 Tan G, Cohen H, Taylor F, Gabbay J. Referral of patients to an anticoagulant clinic: implications for better care. *Quality in Health Care* 1993;2:96-9.

DIARY

27-29 September

Leeds: Nuffield Institute for Health. Qualitative and quantitative analysis in health and social care. A course comprising overview of data analysis; qualitative analysis of data; quantitative analysis of data; presenting results of data analysis; interpreting test results; and practical applications of statistical and non-statistical data analysis. (£360 excluding accommodation.) Further details (and of other courses) from Vivienne Sercombe, Information and Admissions Officer, Nuffield Institute for Health, University of Leeds, 71-75 Clarendon Road, Leeds LS2 9PL (tel 0532 336941; fax 0532 460899).

12 October

London: Royal Society of Medicine. Forum on quality in health care conference. Consumers, users, and patients. (£35, including materials, lunch, and refreshments (£25, fellows/members)). Further details from Miss Lisa Spicer, RSM, 1 Wimpole Street, London W1M 8AE (tel 071 290 2986; fax 071 290 2989).

18-20 October

Leeds: Nuffield Institute for Health. Change management in health and social care. Course contents include organisational culture; assessing organisations; change theory; internal marketing; developing organisations, with special reference to the NHS; attitude change. (£360 excluding accommodation.) Further details from Vivienne Sercombe (see above).

7 December

London: Royal Society of Medicine. Trying issues: dissecting the medical mishap. Joint meeting of Forum on Quality in Health Care and British Association of Medical Managers. Including a case study of a medical negligence trial and lessons in clinical risk management. (£30, RSM fellows and members; £45 NHS employees; £80 others.) Further details from Miss Lisa Spicer (see above).

THE CONSCIENTIOUS OBJECTOR

If I audit I improve the quality of care...

If I improve the quality of care the number of mistakes are reduced...

Every mistake is an opportunity to teach...

I will not sacrifice the education of junior staff!

SCRIV

Amusing or erudite items relating to quality - including examples of "qualityspeak", cartoons, etc - are welcomed for publication and should be addressed to the editor