QUALITY IN HEALTH CARE

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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 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), $p < 0.001$).

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)**

*$p < 0.05$.
**$p < 0.001$.

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.

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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).

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

Instructions for authors

Papers should be sent in triplicate to the editor, *Quality in Health Care*, BMA House, Tavistock Square, London WC1H 9JR (tel 071 383 6204). They should be prepared according to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (Vancouver agreement) (*BMJ* 1991;**302**:338–41).

General

- All material submitted for publication is assumed to be submitted exclusively to the journal unless the contrary is stated.
- All authors must give signed consent to publication. (Guidelines on authorship are given in *BMJ* 1991;**302**:338–41.)
- The editor retains the customary right to style and if necessary to shorten material accepted for publication.
- Authors should submit questionnaires not established and well known.
- If requested, authors shall produce the data on which the manuscript is based for examination by the editor.
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- Number the pages.
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ARTICLES

Articles report research and studies relevant to quality of health care. They may cover any aspect, from clinical or therapeutic intervention, to promotion, to prevention. They should usually present evidence indicating that problems of quality of practice may exist, or suggest indications for changes in practice, or contribute towards defining standards or developing measures of outcome. Alternatively, they should contribute to developing approaches to measuring quality of care in routine practice. The journal is interprofessional and welcomes articles from anyone whose work is relevant, including health professionals, managers, practitioners, researchers, policy makers, or information technologists. Papers are usually up to 2000 words long with up to six tables or illustrations. Shorter practice reports, which may not be original in concept but must contain information sufficiently novel to be of importance to other units, are also invited. Articles of a discursive or debating nature, which do not conform to the criteria for original papers given above, will be considered.

- Give the authors' names, initials, and appointment at the time of the study.
- Articles should generally conform to the conventional format of structured abstract (maximum 250 words; see *BMJ* 1988;**297**:156), introduction, patients/materials and methods, results, discussion, and references.
- Whenever possible give numbers of patients/subjects studied (not percentages alone).
- Any article may be submitted to outside peer review and assessment by the editorial board as well as statistical assessment; this may take up to ten weeks.
- Manuscripts rejected for publication will not be returned.

LETTERS

- Should normally be a maximum of 400 words and 10 references.
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- Authors do not receive proofs.

Tables

- Should be on separate sheets from the text.
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Figures

- Should be used only when data cannot be expressed clearly in any other form.
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- Should be accompanied by the numerical data in the case of graphs, scattergrams, and histograms (which may be converted into tables).
- Should include numbers of patients/subjects (not percentages alone) whenever possible and relevant.
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LINE DRAWINGS

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References

- Should be numbered sequentially in the text.
- Should be typed in double spacing.
- Should give the names and initials of all the authors (unless there are more than six, when the first six should be given followed by *et al*); the title of the article or chapter, *and* the title of the journal (abbreviated according to the style of Index Medicus), year of publication, volume number, and first and last page numbers *or* the names of any editors of the book, title of the book, place of publication, publisher, and year of publication, and first and last pages of the article.
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