Audit of Suffolk Optometric Referrals

A good quality referral is an essential part of the clinical care of our patients (1). A referral that is clear and precise will help build trust with our local ophthalmology team and GPs.

Clinical audit is defined as a quality improvement process that seeks to improve patient care and outcomes. (2) It is accepted that it can be very difficult for community optometrists to audit their own referrals as the feedback from secondary care is generally poor, with only 13% referrals receiving a reply. (3) An audit of optometric referrals has been designed to assess local care provision against current good practice. The results of the audit will be reported to each optometrist in Suffolk. Anonymised results will be published in the Suffolk Local Optometric Committee (LOC) Newsletter distributed to all optometrists in the county to further improve standards. Anonymised results may also be shared with national optometry journals.

An electronic literature search was conducted in respect of previous audits of optometric referrals (Table 1). The references found from this search were used to influence the proposed audit in Suffolk.

Table 1. Details of online literature searches conducted in respect of audits of optometric referrals.

<table>
<thead>
<tr>
<th>Website searched</th>
<th>Date of search</th>
<th>Search terms</th>
<th>Matches</th>
<th>Relevant papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometry Today <a href="http://www.optometry.co.uk/clinical/">http://www.optometry.co.uk/clinical/</a></td>
<td>7 January 2014</td>
<td>referral, audit</td>
<td>54</td>
<td>4 Refs(4-7)</td>
</tr>
<tr>
<td>College website <a href="http://www.college-optometrists.org/">http://www.college-optometrists.org/</a></td>
<td>7 January 2014</td>
<td>referral, audit</td>
<td>1</td>
<td>1 Ref(2)</td>
</tr>
</tbody>
</table>

There are a number of logical steps to implementing a clinical audit. They include:
- Decide on the topic
- Find the standards for that area of clinical practice
- Collect the data
- Analyse the data and review the findings
- Implement any changes to improve the practice/service
- re-audit to see if we have achieved the desired improvement (6)

Background and Previous Referral Audits

An audit by Khan et al. (8) examined referral letter information from community optometrists and compared to 2009 guidelines published jointly by the College of Optometrists and Royal College of Ophthalmologists on referring glaucoma suspect patients. UK optometrists are well equipped to screen for chronic open angle glaucoma, although there is a lack of standardisation with respect to equipment used (9).

Many studies to date have investigated agreement between optometrists and a ‘gold-standard’ specialist ophthalmologist. (10, 11) In order to clearly establish whether the referral is appropriate the patient under consideration would need to be re-examined by an experienced optometrist or an
ophthalmologist. This would be expensive and time consuming for practitioners and patients. In this case the referral quality will be judged by fellow optometrists against an agreed ‘good practice’ standard ascertained from the guidelines and consideration given to completing the audit process with change and completion of the audit loop. (12, 13)

Sheen & Macken (5) looked at the effectiveness of an optometric scheme but not specifically the quality of referrals. They did however record the number of referrals where vision and prescription details were not recorded or were recorded inadequately.

The College of Optometrists Clinical Audit Framework (14) includes guidance on conducting many types of audit including accuracy and feedback of referrals. This however is mainly concerned with tracking feedback from referrals rather than the quality of the referrals. It suggests the initial data to be collected for each patient referred should include date of examination, reason for eye examination, date of referral, reason for referral and referral method (GOS18/ letter/ telephone/ other).

**Standards in respect of Optometric referrals**

The topic for the audit is quality of optometric referrals. The College of Optometrists website has been a good tool to facilitate the establishment of audit processes and define standards from available frameworks. There is indeed a need for clear establishment of good practice to allow the audit process to be effective.(2)

Rules relating to referral changed from the year 2000, whereby an optometrist is not now obliged to refer all patients with any disorder. The optometrist has a statutory duty to refer a patient suffering from injury or disease unless, in his/her professional judgment, there is ‘no justification to do so’. (15, 16) Parker looked at referral letter quality and the potential to reduce referrals. (7) An optometrist referral was considered necessary if there was no primary care alternative and College Guidance would have suggested referral, or if diagnosis, treatment or further investigations were indicated by secondary care. A referral was considered to be on the correct route if the referral pathway and stated urgency followed College Guidance and local referral protocols, making use of primary care enhanced services or GP referral when necessary.

The specific College of Optometrists competencies (17) covered by this audit are:

1. Makes an appropriate judgement regarding referral and understands referral pathways (Section 2.2.6),
2. Is able to work within a multi-disciplinary team (Section 2.2.2),
3. Is able to work within the law and within the codes and guidelines set by the regulator and the profession (Section 2.2.3), and
4. Communicates effectively with any other appropriate person involved in the care of the patient (Section 1.2.5).

**Methods**

Prior to commencing the audit Suffolk optometrists were given access to this document via the LOC website which informed of what content is required in a referral according to the Guidance and Regulations following an NHS (General Ophthalmic Services) or private eye examination, especially for the common referral conditions such as suspect open-angle glaucoma. This information is included in
Appendix 1- 4. Appendix 5 shows the check-list form to be used by the audit team to assess referral quality. It is recommended that community optometrists use the tools in the Quality in Optometry website (18) to start auditing their own record keeping. This is a good place to start the audit process.(2)

Suffolk optometrists were informed in the January 2014 Newsletter that the audit is to take place. Details of the audit herewith, including background information on standards and the referral quality audit check-list form were added to the Suffolk LOC website prior to commencing and optometrists informed of how to access this information.

The audit will be performed by the author and other optometrists from the LOC during the months of July, August and September 2014 on a selection of optometrist referrals. It is intended to audit 10% of the referrals from each individual optometrist, with a minimum of 2 referrals audited per practitioner or the number of referrals, whichever is higher. This is likely to involve a minimum of 400 referrals. The highest standards of information governance will be adhered to (2, 14, 18), including secure electronic transfer.

The audit is considering the quality of the referral itself and its apparent appropriateness given the information it contains. It is not a review of outcomes and whether the referral was correct. Results for each practitioner will be entered on an Excel spreadsheet. This can show whether each specific aspect of a referral has been included adequately and graded as ‘green’, ‘amber’ or ‘red’. Constructive comments will be provided where the referral does not meet the required quality in any specific area, based on the Standards and Guidelines. For the purposes of this audit the classification is as follows:

- Green = the relevant information is present and legible.
- Amber = some relevant information is missing or partly illegible.
- Red = important information is absent or illegible.

Statistical analyses will then enable comparison and highlight outlying optometrists. As used by Davey et al. (19) results can also be displayed in a table with numbers and percentages referred for each condition/diagnosis.

Referral forms specifically designed for these commonly referred conditions are likely to improve referral quality.(19) The Evolutio online referral system available to Suffolk optometrists does include fields specifically for visual acuity, spectacle prescription and intra-ocular pressure. Suffolk LOC has received permission from Accipter (who manage the referrals and Evolutio software) to view the referrals in order to carry out the audit.

Feedback to optometrists

Feedback regarding the quality of referrals will be sent confidentially to each optometrist whose referral has been audited. Additionally, where possible every optometrist will be informed of the percentage of their referrals that were subsequently sent to an Enhanced Service Provider (ESP), or Optometrist with Special Interest, and the percentage of these that were discharged by the ESP, rather than sent to the eye clinic. Information gained will be discussed with local ophthalmologists and used to target training but the names of optometrists involved will not be divulged. Anonymised data from the audit and conclusions will be shared with all optometrists in the county and may be published.
This audit has been agreed with the East Anglia Area Team of NHS England with whom anonymised results will be shared. The Area Team is keen to take the learning from the audit and share it amongst optometrists to enhance the quality of patient care. In the unlikely event that poor clinical performance becomes apparent from the referrals then the audit team from the LOC will offer support and suggestions for training as part of their feedback, whilst still keeping the practitioners names confidential. The LOC is appreciative of advice and support from the Association of Optometrists, Local Optical Committee Support Unit (LOCSU) and local Clinical Commissioning Groups (CCGs) in respect of this project.

If you have any questions regarding this audit please contact Derek Dunstone (derek@dunstoneinsight.com) or any other committee member. Participation is voluntary and so please let us know if you do not want your referrals to be included in the audit. The LOC hopes you agree that this is a great opportunity to gain useful feedback regarding referral quality.

Derek Dunstone
May 2014

References


Appendices

Appendix 1. Relevant points from Guidance regarding Examining patients at risk from glaucoma (20):

- Where pressures are high or borderline, arrangements should be made for the test to be repeated, noting the time of day of each test *
- Assessment of the anterior eye and angle (e.g. by slit lamp van Herick technique) is advisable for all patients suspected of having glaucoma
- Assessment of the optic nerve head would include assessing the size of the disc, cup/disc ratio,
presence of any asymmetry between the two eyes, colour and width of the neuro-retinal rims especially superiorly and inferiorly, and unusual features such as notching, disc haemorrhage etc.

- Whilst visual field examination may sometimes produce anomalous results in the absence of pathology, the usefulness of baseline measures and ongoing comparisons should not be underestimated.

* Unless the optometrist participates in a funded repeat tonometry service, they would not be expected to bring the patient back for further tonometry on a different day. It would be reasonable to expect a non-contact tonometry repeat at the time of the test. (LOCSU, unpublished email communication 10 April 2014)

Appendix 2. Joint guidance from The College of Optometrists and the Royal College of Ophthalmologists on the referral of glaucoma suspects by community optometrists. (21)

This guidance includes the following points regarding glaucoma referrals:

- When practitioners consider it necessary to refer the patient, they should provide as much factual information derived from the eye examination as possible to the ophthalmologist. For optic disc assessment, practitioners should state whether the disc appears normal or abnormal, and if it appears abnormal, why this is so. Where practitioners have determined that it is clinically necessary to perform a visual field assessment as part of particular eye examination, a copy of the visual field assessment should also be provided.

- When referring a patient on IOP grounds alone, Goldmann applanation tonometry (or Perkins tonometry) is regarded as offering greater accuracy.

- Practitioners may consider not referring patients at low risk of significant visual field loss in their lifetime -
  a. Patients aged 80 years and over with measured IOPs <26mmHg with otherwise normal ocular examinations (normal discs, fields and van Herick).
  b. Patients aged 65 and over with IOPs of <25mmHg and with otherwise normal ocular examinations (normal discs, fields and van Herick).

  These groups do not qualify for treatment under current NICE guidance. Such patients may be advised that they should be reviewed by a community optometrist every 12 months.

- Procedure for using Non-contact Tonometers:
  Practitioners should ensure the patient is prepared for the procedure. For example, they should instruct patients to loosen neck ties and not to hold their breath. Before considering referral, practitioners should take four readings per eye and use the mean as the result. Only when the mean result is > 21 mmHg should the practitioner consider referring the patient for further assessment if this is the only abnormality found.
Appendix 3. The College of Optometrists guidance as to which specific conditions require emergency or urgent referral.\(^{(22, 23)}\)

This information is for guidance only, and if local protocols are in place optometrists should refer according to the local protocol. These are the standards to be used to judge urgency of optometric referrals.
Guidance D9.03:

(a) **Emergency referral**
- Chemical injuries;
- CRAO < 12 hours old;
- Acute dacrocystitis, if severe or in children;
- Acute glaucoma;
- Hyphaema;
- Hypopyon;
- IOP ≥ 45 mmHg (independent of cause);
- Sight threatening keratitis;
- Orbital cellulitis;
- Papilloedema;
- Penetrating injuries;
- Unexplained pre-retinal haemorrhage (in a diabetic patient with known proliferative retinopathy who is already being actively treated in the HES this would not need an emergency referral);
- Symptomatic retinal breaks and tears;
- Retinal detachment unless this is longstanding and asymptomatic;
- Scleritis;
- Sudden severe ocular pain;
- Suspected temporal arteritis;
- Unexplained sudden loss of vision;
- Uveitis;
- Vitreous detachment symptoms with pigment in the vitreous.

(b) **Urgent referral (within one week)**
- Symptoms or signs suggesting:
  - Acute dacroadenitis;
  - CMV and Candida retinitis;
  - Commotio retinae;
  - CRVO with elevated IOP;
  - Sudden onset diplopia;
  - IOP > 35 mm Hg (and < 45 mm Hg);
  - Retinal detachment if not an emergency (see above);
  - Retrobulbar/optic neuritis;
  - Rubeosis;
  - Squamous cell carcinoma;
  - “Wet” macular degeneration/choroidal neovascular membrane, according to local fast-track protocol.
Appendix 4. Details to be included in a referral.

According to the Framework for Optometric referrals (23)(section 8.2) a good referral should contain the following:

- Date;
- Full name of referring optometrist and practice address;
- Full details of patient including name, address, telephone number, date of birth,
- reason for referral, supporting signs and symptoms;
- reports of relevant tests / investigations,
- copies of any supplementary data;
- Provisional diagnosis;
- Indication of urgency, and
- Referral correspondence should be legible and preferably typed.

According to Newsom (1) an effective referral should contain the following:

- Visual acuities,
- History and symptoms,
- Past ocular history,
- Why you are referring the patient, including a provisional diagnosis,
- Relevant signs, and
- IOP, disc appearance, visual fields and Van Herick for suspected glaucoma.
- It is also advised that the patient be given a copy of the referral, and
- handwriting is to be avoided.
Appendix 5. Check-list form to be used to assess the quality of referrals.

<table>
<thead>
<tr>
<th>Referral aspect</th>
<th>Grading</th>
<th>Comments</th>
</tr>
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<tbody>
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<td>Date of examination</td>
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</tr>
<tr>
<td>Optometrist name &amp; address</td>
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</tr>
<tr>
<td>Patient details including name, address, telephone number &amp; date of birth</td>
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<tr>
<td>(Are details accurate?)</td>
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<tr>
<td>Name and address of GP (Are details accurate?)</td>
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<tr>
<td>Signs and symptoms, including severity and onset</td>
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<td>Reason for referral</td>
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<tr>
<td>Reports of relevant tests / investigations</td>
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<td>Copies of any supplementary data (when applicable)</td>
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<tr>
<td><strong>Glaucoma referral:</strong></td>
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<td><em>Adequate disc description (incl. normal or abnormal)</em></td>
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<td><em>IOP and/or visual fields repeated</em></td>
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<tr>
<td><em>Repeated readings for NCT (average)</em></td>
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<td><strong>Assessment of anterior eye and chamber angle</strong></td>
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<tr>
<td>Provisional diagnosis</td>
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<td>Indication of urgency</td>
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<td>Referral quality</td>
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<td>Action to be taken by optometrist</td>
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