

# TELEPHONE APPOINTMENT – MAKING A REFERRAL

## MODULE: MAKING A REFERRAL

## TARGET: ST1/2 GP TRAINEES STARTING GP PLACEMENTS

### BACKGROUND

Making acute referrals to secondary care was identified as key areas of worry for trainees entering GP placements for the first time. Trainees have often been the doctor taking referrals but not had as much exposure to making referrals. An area of concern highlighted was worrying about what to do if a referral is refused.

### MRCGP COMPETENCIES

1	Communication and consultation skills - communication with patients, and the use of recognised consultation techniques
5	Clinical management - recognition and management of common medical conditions in primary care
8	Working with colleagues and in teams - working effectively with other professionals to ensure good patient care, including sharing information with colleagues

### MRCGP CURRICULUM

1.	Being a General Practitioner
2.01	The GP Consultation in Practice
2.02	Patient safety and quality of care
2.03	The GP in the wider professional environment
3.03	Care of acutely ill people

### LEARNING OBJECTIVES

To be able to confidently and competently make acute referrals to secondary care

Specifically:

- To be able to describe the components of SBAR
- To be able to use SBAR when communicating with other professionals
- To be able to outline what options are available if a referral is refused

### SCENE SETTING

Location:	GP surgery – telephone appointments.
Personal in scenario	GP trainee, Gynaecology SHO, Surgical SHO
Expected duration of scenario:	15 mins
Expected duration of debriefing:	15 mins

**PATIENT BACKGROUND (DO NOT GIVE TO PARTICIPANT – SEE DEBRIEFING NOTES)**

Start by giving the instruction: You are a GP trainee in a GP practice placement. You have just assessed a patient with acute abdominal pain and want to refer her to on call at the hospital.

Facilitated group discussion – **What information do you want to have before you refer?**

<b>Situation</b>	<ul style="list-style-type: none"> <li>• Chloe Holmes</li> <li>• Age 22, DOB 1/2/1991</li> <li>• Hospital number 3498265</li> </ul>
<b>Background</b>	<ul style="list-style-type: none"> <li>• Sudden onset right iliac fossa pain</li> <li>• Started about 4 hours ago</li> <li>• Sharp, no radiation</li> <li>• Increasing in severity now 8/10</li> <li>• Has had paracetamol and ibuprofen no relief.</li> <li>• Associated with nausea</li> <li>• Bowels opened normally yesterday</li> <li>• No urinary symptoms</li> <li>• LMP 1/52 ago, normal for her, now on day 2 of pill pack microgynon, no missed pills, takes correctly, no IMB</li> <li>• Long term partner, regular SI</li> <li>• No unusual PV discharge</li> <li>• Not had pain in the RIF before</li> <li>• PMH – no abdominal surgery, no pregnancies, 2 years ago L sided ovarian cyst – watch and wait, self-resolved over 4 months, never required admission or had severe pain like this.</li> <li>• Medications – microgynon</li> </ul>
<b>Assessment</b>	<ul style="list-style-type: none"> <li>• Temp 37.6, HR100, RR18, BP110/70</li> <li>• In obvious pain, very tender RIF with guarding and rebound tenderness, bs normal, R adnexal tenderness on PV</li> <li>• Urine dipstick 1+ leucocytes</li> <li>• Impression – acute abdomen with RIF, ddx – ruptured ovarian cyst or ovarian torsion vs. acute appendicitis</li> </ul>
<b>Recommendation</b>	I would like to refer this patient for further assessment and management

## SURGICAL SHO BRIEFING

### On call surgical SHO

- One of your colleagues called in sick, you've been asked to cover the on call again; this is making you frustrated....
- There's already 4 people waiting in the surgical assessment unit for clerking and your bleep has just gone off again as you took this call.
- Last time you were on call with the same registrar he left you to do all the work and sat in the mess all day.

- A GP registrar is calling you to refer a patient with RIF pain
- Answer the call with 'Surgical SHO on call'
- Then let the GP do the talking before you ask any questions

Questions to ask if answers not already given by GP:

- About the pain – SOCRATES
- Any urinary symptoms?
- Any diarrhoea/constipation?
- LMP / PV discharge?
- PMH and medications?
- Observations
- Abdominal examination findings? What about PV?
- Urine dipstick? Pregnancy test?
- What is the GP trainees impression?

This could be appendicitis or it could be a gynaecological cause. It would be much easier for you if the patient was accepted by the gynaecology team first, it's a trainee so you should be able to persuade them. Things to say:

- If no pregnancy test mentioned: Have you done a pregnancy test? Why not? I think you should do a pregnancy test.
- 'From what you've said I think this sounds more like an ovarian cyst rupture or torsion, particularly given the past medical history, I think you should refer to the gynaecologists'

If the GP trainee gives a good referral including all the salient points, then listens to your opinion about gynaecology referral, remains calm and gives a reasoned argument about why you should accept the patient you will. Otherwise you will become more insistent that they refer to gynaecology.

## GYNAECOLOGY SHO ON CALL

### On call Gynaecology SHO

- You're fairly new to the hospital, this is your second on call shift as an SHO, you want to make a good impression with your team
- Last time the consultant had a go at you for accepting a patient with a suspected ovarian torsion who later turned out to have appendicitis

- A GP registrar is calling you to refer a patient with RIF pain
- Answer the call with 'Gynaecology SHO on call'
- Then let the GP do the talking before you ask any questions

Questions to ask if answers not already given by GP:

- About the pain – SOCRATES
- Any urinary symptoms?
- Any diarrhoea/constipation?
- LMP / PV discharge?
- PMH and medications?
- Observations
- Abdominal examination findings? What about PV?
- Urine dipstick? Pregnancy test?
- What is the GP trainees impression?

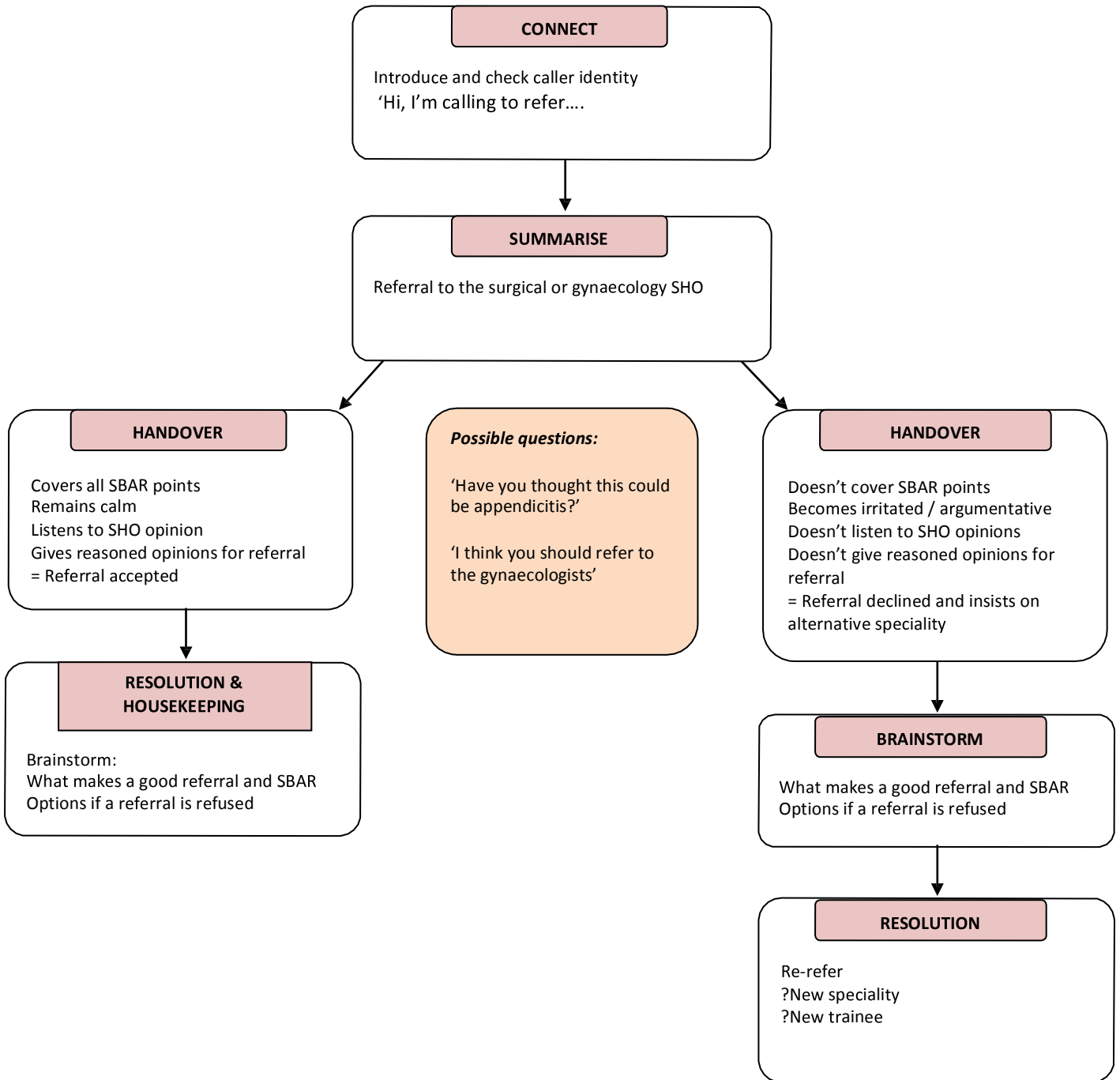
This could be a gynaecological cause or it could be appendicitis. You're worried about how your consultant will react if you accept another RIF pain that turns out to be appendicitis. It would be easier if the GP trainee referred the patient to the surgical team.

Things to say:

- 'Had you thought that this could be appendicitis?'
- 'I think it might make more sense to refer to the surgical team in the first instance and they can ask us to review later if needed'

If the GP trainee gives a good referral including all the salient points, then listens to your opinion about surgical referral, remains calm and gives a reasoned argument about why you should accept the patient you will. Otherwise you will become more insistent that they refer to the surgical team.

**CONDUCT OF SCENARIO 7**



**DEBRIEFING – POINTS FOR FURTHER DISCUSSION**
**MODULE FORMAT**

This scenario is about making referral to on call teams.

Start by giving the instruction: You are a GP trainee in a GP practice placement. You have just assessed a patient with acute abdominal pain and want to refer her to on call at the hospital.

Facilitated group discussion – **What information do you want to have before you refer?**

Answer the questions with the information in the patient background and fill in any other details needed.

Once the trainees are happy they have all the information they need run the scenario with one trainee as the doctor and one as either the gynaecology or surgical SHO depending on which speciality the doctor wishes to refer to.

Facilitated group discussions:

**Referring - What information should you give and how should you give it?** Introduce the SBAR tool.

**What can you do if a referral is not being accepted? Why might a referral not be accepted?**

If the initial referral did not cover the information that SBAR would repeat the scenario with another trainee using SBAR

If the initial referral was not accepted or led to unnecessary conflict run again with another trainee trying ideas from the group or referring to the other speciality

**When referring, what information should you give and how should you give it?**

The SBAR tool<sup>1</sup> can be used in communications between healthcare professionals to ensure that concise and focused information is given. The aim is that the doctor accepting the referral has adequate information about the clinical need.

**Situation:**

- This is Dr X, I'm calling from X GP surgery
- Confirm the name/grade speciality of the doctor you are speaking to – important to record this in the notes
- I am ringing to... refer a patient / seek advice
- The patients name is X, their DOB is X, their hospital number is X

**Background**

- The reason for the referral
- Significant PMH

**Assessment**

- Observations and examination findings
- Investigations / treatment so far
- Clinical impression / concerns – making sure they know why you think referral is needed

**Recommendation**

- What do you want to happen at the end of the conversation – Referring for further investigation/management, Requesting advice
- Where should you tell the patient to go?
- Anything else they want you to do first e.g. give a nebuliser, get the patient to drink lots so they have a full bladder

**What can you do if a referral is not being accepted?**

- Ensure you have given clear and adequate information using the SBAR technique
- Remain calm and professional

- Take the time to listen to the other doctors opinions
  - What are their reasons?
  - What are their recommendations?
  - Put yourself in their shoes – they could: be right the patient doesn't need referral, not have been given enough information to understand the need for the referral, not had the clinical need explained clearly, be stressed, under pressure not to accept more referrals, have a lack of beds, have been shouted at for accepting an inappropriate referral, already have 10 people waiting to be clerked, have personal problems.
- Are their recommendations safe and do you feel they are good practice / best for your patient?
  - Yes
    - Follow the advice given
  - No
    - Explain your impression of the patients problem, that you think they should accept the referral and why it is needed.
    - Say if you've discussed this with another GP already
    - Show empathy with their position but explain why you don't think their recommendation is appropriate /safe/best for your patient
    - Remember at this stage you are the person who has assessed the patient so as well as the findings you also have your professional judgement of the problem which is important and difficult for someone who has not assessed the patient to argue with.  
E.g. 'I realise that with further tests this could go either way (surgical or gynaecological), but these aren't available at the moment and I've assessed the patient and my instinct is that this is most likely to be a surgical(gynaecological) problem which is why I think the patient should be referred to your team.'
- Refer to an alternative speciality / alternative route e.g. hot clinic – if on discussion this seems more appropriate
- Talk to your trainer / another GP – what do they think of your assessment / the advice given?
- Sometimes the diagnosis will not be clear before a patient is referred – this is ok, some patients need to have further tests or a specialist opinion. With an acute admission this can sometimes mean it is debatable which should be the admitting speciality. If it can be argued either way, the speciality you called should accept the patient unless they have good reasons that another course of action provides better care for the patient.
- Can you agree to disagree and they accept the referral and assess the patient then you'd be happy to talk to them again later to learn from the case?
- Refer the problem higher – agree should you or they talk to their registrar/consultant?
- After the issue is resolved, consider discussion with your trainer or if the case was more serious significant event analysis

Remember:

Patient safety and providing good quality care for your patient are your main concern. If you are not happy that the advice given would fulfil these it is your responsibility to pursue the issue further.

'You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times.'

Conduct and performance of colleagues, Working with colleagues: - GMC Good Medical Practice<sup>2</sup>

## RESOURCES

1. SBAR:

<http://www.ihl.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx>

[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/sbar\\_-\\_situation\\_-\\_background\\_-\\_assessment\\_-\\_recommendation.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html)

Referral of Patients from Emergency Department (ED) to Inpatient Teams (Salisbury District Hospital, 2012)

<http://www.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/Local%20Guidelines/default.asp>

2. GMC Good Medical Practice - Working with colleagues. [http://www.gmc-uk.org/guidance/good\\_medical\\_practice/working\\_with\\_colleagues.asp](http://www.gmc-uk.org/guidance/good_medical_practice/working_with_colleagues.asp)

3. Acute abdominal pain in a young woman: gynaecology or general surgery? Yap R and Daniels B. O&G magazine Vol 13 No 1 Autumn 2011 31

4. Report on a recommended referral document. SIGN publication No. 31. <http://www.sign.ac.uk/guidelines/fulltext/31/index.html>



**GENERAL PRACTICE – SCENARIO 7 - HANDOUT**
**LEARNING OUTCOMES**

To be able to confidently and competently make acute referrals to secondary care Specifically:

- To be able to describe the components of SBAR
- To be able to use SBAR when communicating with other professionals
- To be able to outline what options are available if a referral is refused

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## KEY POINTS COVERED

### MODULE FORMAT

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**GENERAL PRACTICE – SCENARIO 7 – PRE-TEACHING QUESTIONNAIRE**

Please ring the score that reflects your views:

	1 Agree strongly	2	3	4 Neither agree nor disagree	5	6	7 Disagree strongly
1. I can safely assess a cough over the telephone	1	2	3	4	5	6	7
2. I know what questions to ask a patient with a cough in order to decide whether they need further review	1	2	3	4	5	6	7
3. I can confidently discuss with patients why antibiotics don't help viral URTIs	1	2	3	4	5	6	7
4. I can give clear safety netting advice over the telephone to a patient with a cough							

**GENERAL PRACTICE – SCENARIO 7 – POST-TEACHING QUESTIONNAIRE**

Please ring the score that reflects your views:

	1 Agree strongly	2	3	4 Neither agree nor disagree	5	6	7 Disagree strongly
1. I can safely assess a cough over the telephone	1	2	3	4	5	6	7
2. I know what questions to ask a patient with a cough in order to decide whether they need further review	1	2	3	4	5	6	7
3. I can confidently discuss with patients why antibiotics don't help viral URTIs	1	2	3	4	5	6	7
4. I can give clear safety netting advice over the telephone to a patient with a cough	1	2	3	4	5	6	7

**GENERAL PRACTICE – SCENARIO 7 – TRAINEE FEEDBACK**

**Overall score out of 5:**

The scenario covered material that was useful and relevant to me (1 = strongly disagree, 5 = strongly agree)

Will you use the information / ideas from this scenario? If yes how will you use them?

How could this scenario be improved for future participants?

Other comments?

**GENERAL PRACTICE – SCENARIO 7 – FACILITATOR FEEDBACK**

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn't it go well?

How could the scenario be improved for future participants?