RESEARCH ARTICLE

An evaluation of referral tickets for acute psychiatric admissions

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ABSTRACT

Background

Tickets of referral assist in clerking and the enforcement of the Mental Health Act. Initial reviewers of the patient who may be more aware of his/her background may provide this information when transferring a patient to Mount Carmel Hospital, Malta's psychiatric hospital.

Objectives

The aims of this study were to assess whether key information on referral tickets was lacking as well as to justify the importance of such information when referring a new case and raise awareness on appropriate referral.

Methods

Permission to review the tickets of referral for new admissions from the community to Mount Carmel Hospital during the month of June 2015 was obtained from the Chairman of Psychiatry. The files of new admissions were assessed to see if the following were present: official referral ticket; drug history; next of kin details; handover to staff at Mount Carmel Hospital. The place of initial assessment was also noted. All data was anonymised and data input was done using a prepared proforma. Patients referred from the civil prison and by the caring consultant's firm were not included.

Results

Seventy admissions were assessed. Eighty-nine per cent ($n=62$) of these admissions included an official ticket of referral. Most referrals came from health centres: 31% ($n=22$). Seventy-four per cent ($n=51$) had a drug history present. Seventy-six per cent ($n=53$) were lacking next of kin details. Forty per cent ($n=28$) of the cases had documentation of a handover to a senior on call.

Conclusions

Poor quality referral tickets with missing information are often present which makes it difficult for the on-call staff at Mount Carmel Hospital to clerk the patient and come up with a provisional treatment plan.

Key words

Referral and consultation, mental health, patient admission, psychiatry, hospitals

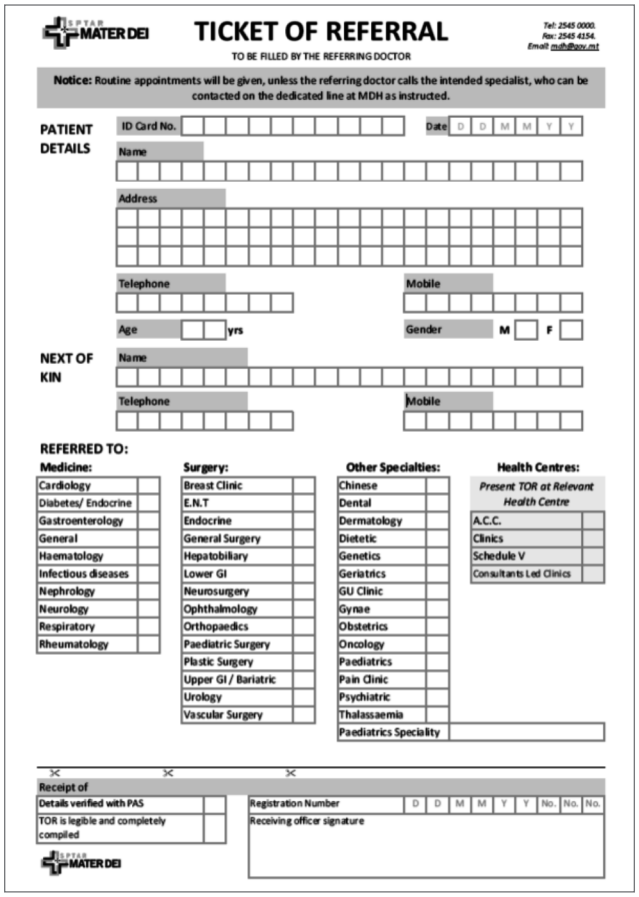
INTRODUCTION

The aim of this study is to emphasize the importance of appropriate referral practices in the acute psychiatric setting to Mount Carmel Hospital (MCH), Malta's psychiatric hospital. Referrals are mainly done from the GP (general practitioner) clinic, psychiatric outpatient department or even an elderly home. Referral tickets should accompany all new admissions. These are written on site and should contain information on symptom presentation, contact details of next of kin and current treatment.

The standard referral ticket supplied by the Department of Health which is used for all the specialties provided by the national health service is made up of 4 main sections to be filled in by doctor doing the referral. The first page (Figure 1) is comprised of a section for: patient's details (ID Card No., Date, Name, Address, Patient Telephone number, Patient Mobile number, Age), next of kin's details (Name, Telephone, Mobile) and 3 tables to tick the specialty where the referral is being made. On the second page (Figure 2) the patient's history is written and, in order to do so, it is split into 5 subsections: reason for referral, past history, current treatment & any allergies, clinical examination findings and investigations done by referring doctor. On the second page the referring doctor should also write his details: full name, registration number, signature and rubber stamp. On this page the referring doctor can write in a specifically dedicated box if the case was discussed with a consultant.

Ideally, the case is discussed with the psychiatrist trainee / psychiatrist at MCH prior to transfer to confirm

Figure 1: Ticket of Referral - first page



TICKET OF REFERRAL

TO BE FILLED BY THE REFERRING DOCTOR

Notice: Routine appointments will be given, unless the referring doctor calls the intended specialist, who can be contacted on the dedicated line at MDH as instructed.

PATIENT DETAILS

ID Card No. | Date D D M M Y Y

Name

Address

Telephone | Mobile

Age yrs | Gender M F

NEXT OF KIN

Name

Telephone | Mobile

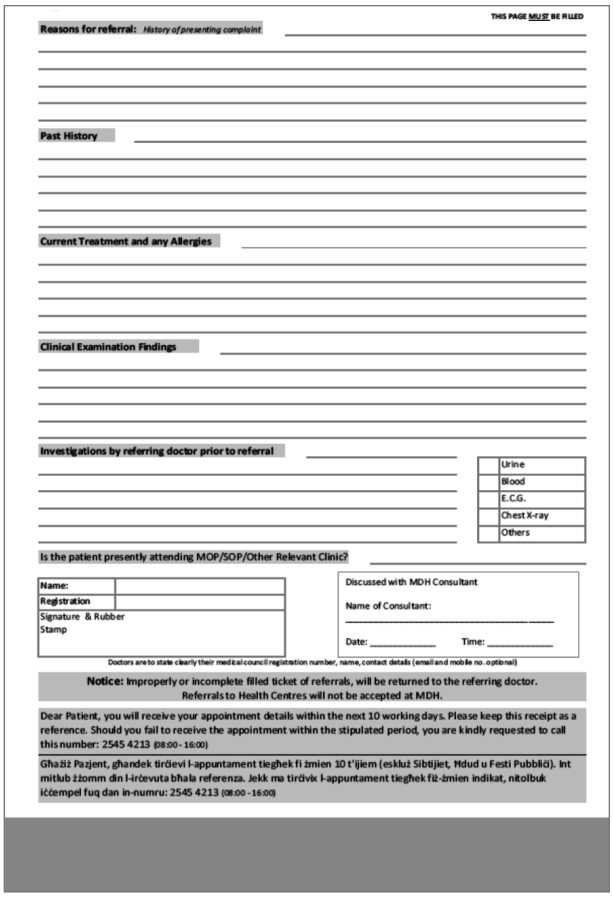
REFERRED TO:

Medicine:	Surgery:	Other Specialties:	Health Centres:
Cardiology	Breast Clinic	Chinese	*Present TOR at Relevant Health Centre*
Diabetes/ Endocrine	E.N.T	Dental	A.C.C.
Gastroenterology	Endocrine	Dermatology	Clinics
General	General Surgery	Dietetic	Schedule V
Haematology	Hepatobiliary	Genetics	Consultants Led Clinics
Infectious diseases	Lower GI	Geriatrics	
Nephrology	Neurosurgery	GU Clinic	
Neurology	Ophthalmology	Gynae	
Respiratory	Orthopaedics	Obstetrics	
Rheumatology	Paediatric Surgery	Oncology	
	Plastic Surgery	Paediatrics	
	Upper GI / Bariatric	Pain Clinic	
	Urology	Psychiatric	
	Vascular Surgery	Thalassaemia	
		Paediatrics Speciality	

Receipt of

Details verified with PAS		Registration Number	D D M M Y Y	No. No. No.
TOR is legible and completely compiled		Receiving officer signature		

Figure 2: Ticket of Referral - second page



THIS PAGE MUST BE FILLED

Reasons for referral: *History of presenting complaint*

Past History

Current Treatment and any Allergies

Clinical Examination Findings

Investigations by referring doctor prior to referral

	Urine
	Blood
	E.C.G.
	Chest X-ray
	Others

Is the patient presently attending MOP/SOP/Other Relevant Clinic?

Name:	
Registration	
Signature & Rubber Stamp	

Discussed with MDH Consultant

Name of Consultant:

Date: Time:

Doctors are to state clearly their medical council registration number, name, contact details (email and mobile no.-optional)

Notice: Improperly or incomplete filled ticket of referrals, will be returned to the referring doctor. Referrals to Health Centres will not be accepted at MDH.

Dear Patient, you will receive your appointment details within the next 10 working days. Please keep this receipt as a reference. Should you fail to receive the appointment within the stipulated period, you are kindly requested to call this number: 2545 4213 (08:00 - 16:00)

Ghażiż Pazjent, għandek tirċievi l-appuntament tiegħek fi żmien 10 t'ijiem (eskluż Sibtijiet, Hdud u Festi Pubbliċi). Int mitlub żżomm din l-irċevuta bħala referenza. Jekk ma tirċivix l-appuntament tiegħek fiż-żmien indikat, nitolbuk iċċempel fuq dan in-numru: 2545 4213 (08:00 - 16:00)

the details of the admission and whether it is warranted. The patient is then transferred to MCH where the on call doctor decides, according to the facts of the referral, the location where to admit a patient and under what level of supervision. Apart from this information, doctors may also speak with the firm caring for the patient and hand over the case details to them.

This study has 3 main aims: to assess whether key parts of the referral tickets are lacking information during referral, to raise awareness on the areas that are lacking on referral, and to justify their importance when referring a new case.

METHODOLOGY

This prospective study prospectively reviewed patient referral tickets of cases that were newly-admitted during the month of June 2015. All data that was kept was anonymised. Permission to review patient files was obtained from the Chairman of Psychiatry before the study began.

Table 1: Details documented in referral tickets

	Percentage of details present or not (n=70)	
	Present	Not Present
Is a referral ticket present?	89%	11%
Are next of kin details written?	24%	76%
Is a drug history present?	74%	26%
Was verbal handover with senior staff documented in the referral?	40%	60%

Referral tickets in files of new admissions were assessed individually for: the presence of a referral ticket, location of assessment, drug history, next of kin details, reason for referral and documented handover to staff at MCH. Data input was done using a prepared template.

Cases where files were not available were not included in the study. Patients referred from the Corradino Correctional Facility (Malta's civil prison) and by the same caring consultant's firm of the forensic branch of MCH were not included in the study.

RESULTS

Seventy cases fitted criteria for inclusion in this study. Eleven per cent (n=8) of admissions were referred to MCH without an official referral ticket (Table 1).

Seventy-four per cent (n=52) of the admissions sent with a referral ticket had a drug history written (Table 1). With regards to next of kin details these were written in only 24 % (n=17) of the admissions sent with a formal referral ticket. Apart from filling in the formal referral ticket we also looked into whether verbal handover was done with the senior staff at MCH. With regards to those patients referred with a formal referral ticket, verbal handover was documented in 40% (n=28).

The majority of the admissions had the location of the assessment clearly written (Figure 3). Health centres were the prime location of assessment - 31% (n=22). Only 6% (n=4) had the location of assessment unknown. The majority of the referral forms had the reason for referral clearly written but in 3% (n=2) the reason for referral was unknown (Figure 4).

DISCUSSION

Not much information is available on the epidemiology leading to acute psychiatric referrals to psychiatric hospitals. In a study conducted in the United States (Larkin *et al*., 2005) the prevailing reasons for psychiatric emergency department visits were substance-misuse and related disorders (30%), mood disorders (23%), anxiety disorders (21%), psychoses (10%) and suicide attempts (7%).

Research undertaken in England (Foot, Naylor and Imison, 2010) shows the importance of high quality referral. Elements worth focusing on for a good referral include:

- The necessity of referring patients when appropriate and without delay;
- The identification of the destination at the end of the referral: the emergency department; the outpatient setting; the acute psychiatric hospital;
- The practice of the referral: what investigations are ordered; the referral ticket details; the awareness about the condition between the GP and patient.

Figure 3: Site of referral as percentage of cases

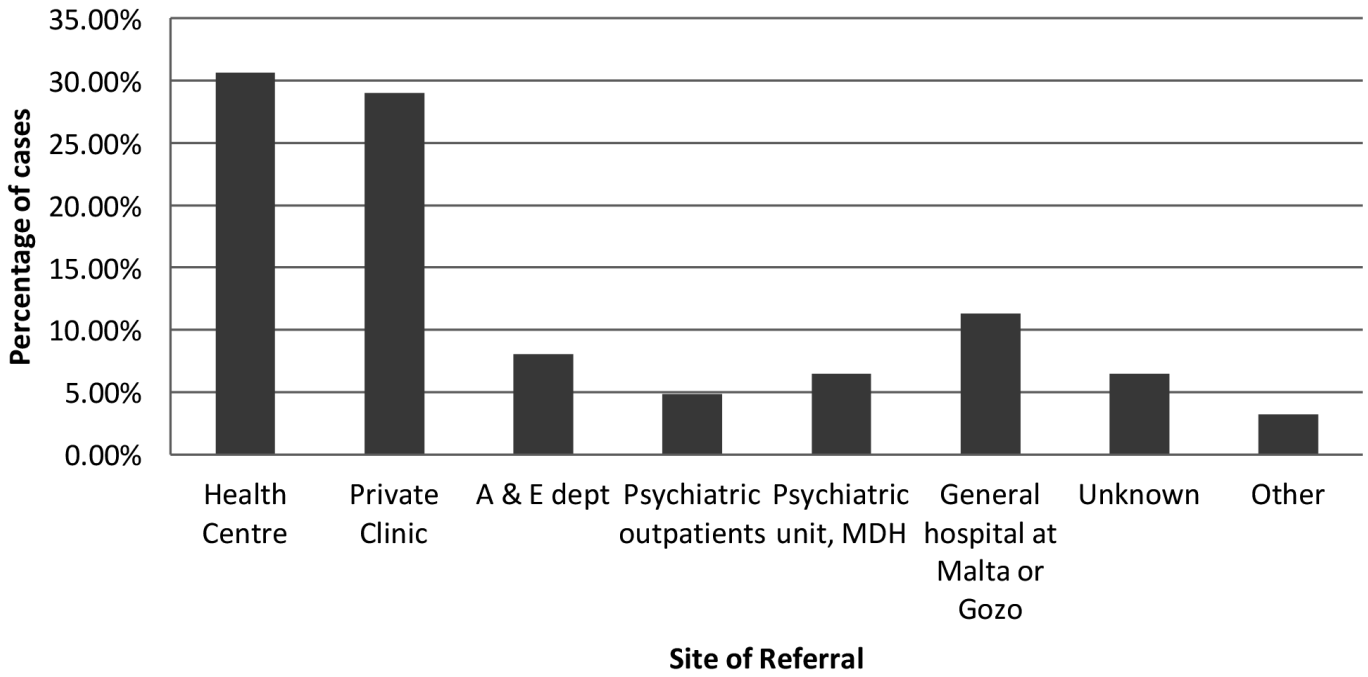
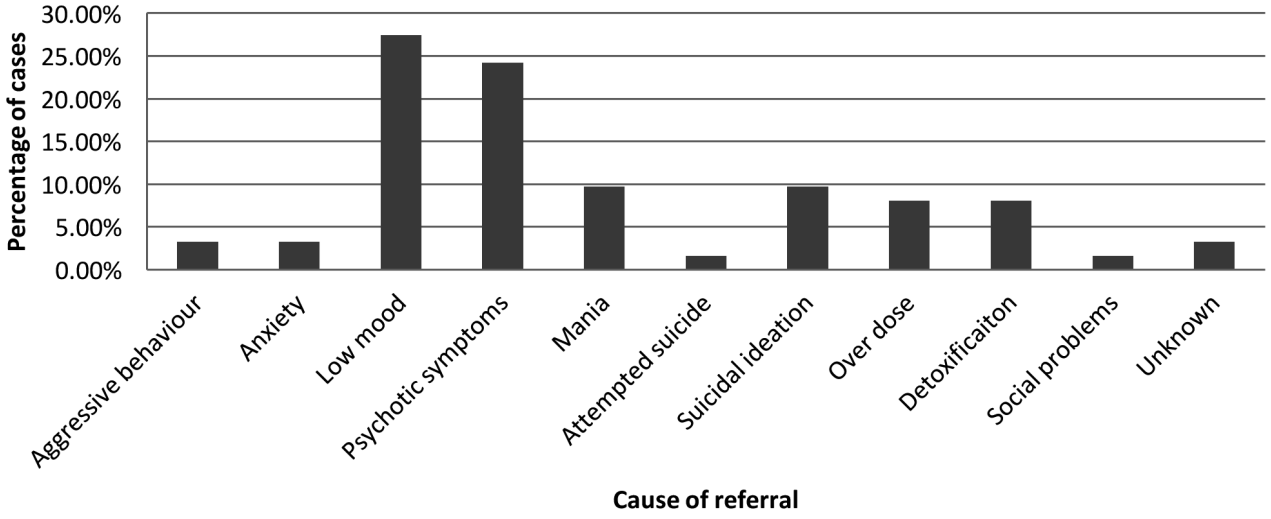


Figure 4: Reason for referral as percentage of cases



Taking the above into consideration, one cannot appropriately refer without the correct patient details, understanding the pathophysiology, the patient's background, the system of psychiatric care in Malta, appropriate documentation and referral. The latter is highly researched as Bodek *et al*. (2006) found that it can make the difference in appropriate triage and prioritisation as well as the destination for the referral and assist the psychiatrist in determining whether to enforce the Mental Health Act.

Doctors and other health care workers face the challenge of transferring a patient suffering from acute mental illness to a safe place where he can receive better care. The more developed the general practitioners' role is the easier it is for them to serve as gatekeepers (Deraas *et al*. cited in Uden *et al*., 2003). Whether such admissions were indicated was not the aim of this study; however the input of trainees and specialists prior to referral should see to them being made appropriately. Public health centres and private physician clinics together accounted for more than half of referrals in this study, showing that first point of contact mainly occurred in the community (Figure 3). Half of admissions were in view of low mood or psychosis (Figure 4).

Almost 1 out of 10 admissions was without a referral ticket (11.43%) (Table 1). Such cases were either referred with a simple note from a physician, or had an accompanying emergency order only, or no note at all. Regrettably there are also individuals who present themselves under extraordinary circumstances to the hospital, for example complaining of suicidal intent, and these cannot be taken lightly.

The environment and pressures under which these referrals were made could not be assessed. Admissions involving aggressive persons, self-harming individuals and people actively under the influence of a substance already pose a struggle to the referring doctor and psychiatric team at MCH. In fact Hunt, Marsden and O'Connor (2011, p. 316) go on to state that it is in fact more troublesome and time consuming to interact with patients and that most information could be on prior medical records. Unfortunately Chetcuti, Farrugia and Cassar (2009, p. 28) pointed out that missing referral information is not just limited to psychiatry but also other specialities.

Verbal handover with the caring team or on-call doctor was not documented in the referral in 60% of cases (Table 1). Perhaps doctors were confident that the patient would be accepted without documentation of this after handover over the phone. Twenty-six per cent of referrals regrettably did not have a treatment list written down, and next of kin details which could be used to trace back treatment were absent in 76% of cases (Table 1).

Substance misusers being followed up at the substance-misuse out-patients unit at St. Luke's Hospital could have their treatment confirmed during first medical contact with the latter only during limited opening hours. Substance misuse related admissions are surely underrepresented in this study since they themselves carry a higher tendency of psychiatric co-morbidity

as well as an aptitude for earlier discharge against medical advice. Norwegian studies demonstrated that substance-misuse related co-morbidities accounted for 54% of admissions (Helseth *et al.* cited in Deraas *et al.*, 2006) compared to 16% of combined detoxification and overdose scenarios during this review.

LIMITATIONS

Files of patients that were discharged early on were not available and information was manually collected. Cases brought under police custody were not documented as such in this study.

The referral tickets drawn up by public GPs were not compared with those of private GPs to see whether they were statistically different regarding details on referral ticket.

The referral tickets drawn up by GPs were not confronted with those drawn up by psychiatry specialists (for patients from Corradino) to see whether they were statistically different.

CONCLUSION

This small study shows that the majority of acute psychiatry referrals are done in the community by GPs. Despite contacting the psychiatric trainee at the hospital prior to transfer, details on the referral form are still left missing, including documentation of verbal handover. Sources of information such as next of kin details are not written down in the majority of referrals.

It is proposed that, in the case of drug misusers, the detoxification centre should be contacted early to confirm current treatment. Also, a plan could start to be considered at prima facie in discussion with the psychiatric team, such as at which ward the patient should be admitted to and under what level of supervision. Considering that the referral ticket is used for admission, such details could be documented in the referral: this would save time and be safer for both the reviewing doctor and patient.

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ACKNOWLEDGMENTS

Dr Ethel Felice and Dr Edward Zammit for assisting in the publication of this material.

References

Bodek, S., Ghori, K., Edelstein, M., Reed, A. and MacFadyen, R.J., 2006. Contemporary referral of patients from community care to cardiology lack diagnostic and clinical detail. *Int J Clin Pract*, 60(5), pp. 595–601.

Chetcuti, C., Farrugia, R., and Cassar, K., 2009. GP referral letters: time for a template? *MMJ*, 21(2), pp. 26-9.

Foot C., Naylor C., and Imison C., 2010. *The Quality of GP Diagnosis and Referral*. The King's Fund, London.

Helseth, V., Lykke-Enger, T., Aamo, T.O. and Johnsen, J., 2005. Drug screening among patients aged 17-40 admitted with psychosis. *Tidsskr Nor Laegeforen*, 125(9), pp. 1178–1180.

Hunt, G.E., Marsden, R., and O'Connor N., 2011. Clinical handover in acute psychiatric community mental health settings. *J Psychiatr Ment Health Nurs*, 19(4), pp. 310-8.

Larkin, G.L., Claassen, C.A., Emond, J.A., Pelletier, A.J. and Camargo, C.A., 2005. Trends in U.S. emergency department visits for mental health conditions, 1992 to 2001. *Psychiatr Serv*, 56(6), pp. 671-677.

Uden, C.J., Winkens, R.A., Wesseling, G.J., Crebolder, H.F. and Schayck, C.P., 2003. Use of out of hours services: a comparison between two organisations. *Emerg Med J*, 20(2), pp. 184-7.