Title: Assessment and improvement of the history and examination of conjunctivitis diagnoses in primary care

Problem: Ocular health is an important part of the NHS, with 10% of healthcare use being by ophthalmology. In primary care, over half of all ocular presentations are for red-eye/conjunctivitis. Notoriously, medical professionals have low confidence towards ocular problems, and commonly do not know what to look for. Combining these with poor documentation exposes patients to unsafe care and makes caregivers vulnerable. This project has only been performed once before, in a different area in the UK - it did not, however, look at trauma history.

Aims: 1) Evaluate the documentation of conjunctivitis diagnoses in the past 24 months
2) Propose recommendations to bring documentation to target standards (conditional to the results of the former aim)

Approach: This was a retrospective audit project. All patient notes coded for a diagnosis of conjunctivitis between 13th August 2017 and 13th August 2019 were pulled, and assessed against NICE criteria. Surveys were also completed for a) availability of eye examination equipment to GPs, b) GP attitudes and confidences towards ocular health and conjunctivitis. SystemOne (the electronic health record system used in the group) templates were also assessed for completeness.

All the data would help understand the problem, and contextualise it to find potential reasons.

Findings: Red flags were documented at the following rates: unilateral/bilateral (74.8%), pain (41.2%), visual acuity (19.1%) photophobia (14.5%), trauma history (13.0%). There were 2 cases of misdiagnosis without key red flag symptoms documented in the notes. GPs in general agree with NICE CKS guidelines on red flags. Fluorescein was not readily available at the practice. GPs do not use the SystemOne template, which is poorly designed anyway. No targets were met.

Conclusions: Documentation of conjunctivitis consultations is poor. The surveys suggest this is mainly due to a) availability of equipment, and b) recall of red-flags. Recommendations to improve the documentation include recall flashcards, sourcing fluorescein strips for the practices and to implement a SystemOne pop up to ensure full documentation of eye consultations. Re-audits are suggested for the implementations, over a 12-18 month period to have a comparable data set.

Mini Re-audit: A re-audit was performed after 5 weeks of flashcard implementation. Red flags were documented 100% of the time, except for photophobia, documented at 80% (4 out of 5). Flashcards were effective at improving documentation for conjunctivitis patients but a longer audit should be performed to ensure this is not due to the chronological proximity to the original audit.

Implications: The findings show that documentation needs to be improved, and can be with simple interventions. There is currently an 18-month re-audit occurring that will have a more comparable data set. This would not only make things safer for patients, but generally make GPs more aware of red flag symptoms in the eye.

Author: Ali Abdall-Razak

Authors Institution: Imperial College London

Presented by: Ali Abdall-Razak