Innovating follow up: telephone follow up for epididymo-orchitis and pelvic inflammatory disease

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BACKGROUND

- BASHH guidelines suggest 2 week follow up for individuals diagnosed with either pelvic inflammatory disease (PID) or epididymo-orchitis (EO)1,2. This follow up consists of determining that partners have been notified, symptoms have resolved and that patients have abstained from sex.
- We audited attendance and documentation of outcomes over a 3 month period.
- Following the results, our innovation was to provide follow up by booked telephone consultation using a proforma to collect relevant information. Here we present the audit of telephone clinic outcomes against the baseline audit.

Methods

- An audit form was designed based on the information suggested by BASHH guidelines, with an additional score to assess convenience of telephone clinic. We were particularly interested in the follow up of patients, and although there are no strict standards in the current BASHH guidelines for PID and EO, there are a number of recommendations and suggestions. The results informed us that it might be feasible to provide telephone follow up.
- A proforma for information gathering was created and a full telephone clinic established. Patients with a CSA diagnosis (PID or EO) were offered a choice of telephone or face-to-face follow up. Exclusion criteria were severe CSA diagnosis and inability to communicate in English. After three months the telephone clinic was audited to establish any change and the need for embedding.

Baseline audit

110 case notes identified, 92 (84%) were correctly coded and retrievable for the interval being audited.

Demographics:

- Mean age 24.5 years
- Gender split 35 (38%) male/ 57 (62%) female

Number of non-attendances: 25 (27%) of which 22 (24%) did not receive follow up at all, and 3 (3%) were later available by telephone for health advisor follow up.

Follow up outcomes:

- Attendance at baseline
  - Attended: 102 (75%)
  - Did not attend: 27 (25%)

Post innovation audit: 135 case notes identified, of which 102 (75%) cases notes were retrieved and coded correctly for the interval being examined. Of these 102 cases, 69 (68%) had face to face follow up, and 33 (32%) had telephone follow up.

RESULTS

Telephone clinic follow up outcomes:

<table>
<thead>
<tr>
<th>Number of non-attendances</th>
<th>Overall (60/62)</th>
<th>Face to face (47/52)</th>
<th>Telephone (13/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of non-attendances</td>
<td>5/6 (83%)</td>
<td>4/5 (80%)</td>
<td>1/4 (25%)</td>
</tr>
<tr>
<td>Unable to contact patient</td>
<td>7/7 (100%)</td>
<td>5/5 (100%)</td>
<td>2/2 (100%)</td>
</tr>
<tr>
<td>Unable to contact patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No outcome recorded</td>
<td>13/13 (100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No outcome recorded</td>
<td>13/13 (100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No outcome recorded</td>
<td>13/13 (100%)</td>
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</tbody>
</table>

Assessment of innovation: To assess whether the innovation was to be permanently implemented, we compared the results of the baseline audit to the results of the telephone component of the repeat audit.

Comparison outcomes of baseline audit vs telephone audit

- The DNA rate was 3% lower in the telephone follow up and the documentation of outcomes was much improved with the proforma in the telephone clinic.
- We were also able to contact a higher proportion of patients who did not attend their telephone appointment than for other appointments, and were therefore able to complete follow up.
- Other parameters that were improved with telephone follow up when compared to baseline were: those documented as abstaining from sex (by 18%), the record of whether a partner had been notified (by 16%) and recording whether symptoms had resolved (by 8%).
- For the telephone clinic we also looked at the convenience score (out of 10) and the number of patients who had to be recalled due to their responses:
  - 25 patients (76%) patients gave a convenience score out of 10, the mean was 9.3.
  - 9 patients (27%) had to be recalled to clinic following the telephone appointment for further treatment and/ or examination.

Conclusion

- The telephone follow up is feasible, effective, has improved documentation and is convenient for patients.
- The DNA rate was reduced in the telephone clinic.
- A standardised form for all CSA follow up appointments is likely to improve documentation regardless of whether this is by telephone or face to face.
- The limitations of the audit are that this is still a relatively small sample size, and so we plan to re audit all follow up for patients with a CSA coding over a six month period. In addition, audits are limited by correct coding, retrieval of documents and accurate documentation of what was covered during the consultation.

References: