BrisDoc Patient care by people who care

NHS

Summarising Patient Records

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Summarising Patient Records

Paper records - Going through these:

When they arrive, the paper notes will *not* usually be in the right order. Furthermore, they will often also contain duplicates of various documents. These documents will therefore need to be sorted out and 'culled'.

i) There is a long list of what can be discarded, and there are several examples below, for reference:

GP-related Admin:

- Previous GMS1 forms
- Previous New Patient Questionnaires (NPQs) – (once any relevant family history has been recorded)

Old Letters:

- Hospital *and* previous GP Letters already scanned into system (via *GPtoGP* transfer)
- Duplicate copies of any letters
- Routine invite letters for screening, immunisation etc., from previous practice

Investigation results:

- Blood test result slips, Microbiology result slips (unless highly significant and not already recorded, in which case; record it and discard the slip)
- Investigation result slips: ECGs (check if result recorded, then discard), X-ray results (any >5 yrs old that are normal)

Other/ Misc:

- Hospital did not attend (DNA) letters; once the information has been recorded
- Old invoices, payment slips & other financial admin letters from Previous Practice
- Copies of Insurance medical reports from previous GP
- Old hospital pharmacy slips for medication (if medication recorded in a letter)
- Blank Lloyd George (LG) cards, or ones with only name and details on

ii) Organising the documents into the correct order;

- The principle is: 'Most recent document on top'. Sort into reverse date order, down to the oldest at the bottom. (For all the Summaries, Letters, and Investigations). In separate piles.
- Each pile to have a hole punched in top left hand corner, and a short treasury tag to attach them
- Also ensure the written cards are attached together in this way (if not already done)

Old or Excess Envelopes: Any old Lloyd George envelopes that are not required can have the old address label section cut out (and placed back in the records), and the rest discarded***.*** Excess duplicate envelopes that are not required (because the notes are now smaller) can be discarded for shredding.

Computer Records- Working on these:

Problem titles; on Problems screen

These should only be used for ***Clinical Diagnoses and Procedures***, rather than for administrative titles (such as 'telephone encounter', or 'had a chat to patient' – which should appear in the 'Care history' screen only). This is in order for the front screen to be clear, de-cluttered and more useful in a clinical way.

Firstly:

Tidy up the Problem screen *prior* to adding new information:

- On the details that are already on this screen, check to see if any of the 'Active' problems can be changed to 'Past', and edit these accordingly
- Also edit any wrongly-assigned 'significant / minor' entries, as appropriate
- (See below; under '*Categorisation*' for guidelines on the above)
- This applies even when the notes are *gp2gp*
- Grouping of Problems together: If several of the same problem titles are on the screen, then they should be *grouped* together. (See below also, under 'Date order and Grouping' on P.4)

Next:

Going through the previous paper Summaries, paper Letters and Investigations -

Enter the Snomed codes for relevant aspects, as follows:

i) What Clinical headings to enter, or not to enter onto Clinical Problems Screen?

Context is important – So, what to add depends on various factors:

- **Significant childhood infections**
  E.g Chicken Pox, Measles, Mumps; should be entered into *Minor Past* category, whatever age they are.

- **How long ago the diagnosis was made:**

No need to enter uncomplicated 'minor past' problems if >5 years ago.

E.g: uncomplicated Otitis Media in childhood, when the patient is now 40, would usually be unnecessary to enter, but would probably be worth entering if it was <5 years ago (and would certainly be, if complicated or required procedures etc – but then only in *minor past*).

E.g. 'Chest infection' 8 years ago, in a 30 year old

E.g. 'Boil of thigh' 7 years ago, in a 28 year old

- **How much there is in a patient's history overall**.
  I.e. we are less likely to add all minor ailments from years back if there are many other more recent minor, and/or more significant diagnoses to be added.

However, common minor diagnoses which *in general* **do not** need to be entered at all, would be for example:

- Verrucae
- Hand warts
- Molluscum contagiosum
- Skin tags
- Ringworm
- URTIs
- Hay fever
- Sprained ankle
- Simple diarrhoea & vomiting
- Headache (if single episode, uncomplicated etc)

There *could* be exceptions to these, as discussed above, although this would be uncommon.

Investigations:

> That *do* need to be entered:

- Mamogram results
- Cervical smear results (see below, P.6)
- Other *significant* abnormal or normal results, where relevant (ask if uncertain)

> That *don't* need to be entered as a code:

- *Normal X-ray & Ultrasound results >5 yrs old (**however**, if problem still active or relevant, then result **does** does need to be entered)*
- *Normal ECGs >5 years old*
- *Normal Audiogram results*
- *Normal blood test and Microbiology results*

Although *could* be added as free-text under relevant clinical diagnosis where relevant, significant or important.

ii) Correct Categorisation of 'Problem titles':

- **Active / Past**
- **Significant / Minor**
- **Health Admin**

Active category For the following:

> Recent minor conditions (in the past month)

> Ongoing major conditions (e.g Asthma, Hypertension, Hypercholesterolaemia -*Unless resolved*)

> NB Check if 'Indefinite' is ticked; this may *not* be correct for previous or resolved conditions, even if they are significant or major. In which case, alter to e.g. 3m or 6m accordingly.

Past:

> For minor conditions entered, or ones that patient has been seen for; > 1 month ago

> Significant conditions that have resolved and/ or they have not been treated for in past 6 months (e.g. Myocardial Infarct (MI), Deep vein thrombosis (DVT), Pulmonary Embolus (PE))

Significant or Minor category?

There are no simple, or absolute rules to categorisation of problems or procedures. However, the following guidelines should help:

'Significant' (in either Past or Active) category should only be reserved for major, or longstanding medical problems or procedures.

However, whether to enter a diagnosis or procedure as significant will also depend on:

- the context, and/or complexity of it
- the length of time since it occurred

So, something maybe significant if diagnosed (or done) in the past 5-10 years, but not if diagnosed or done 15 or 20 years ago:

E.g.

1. Fractured Radius, or #metacarpal bone, could both go on 'Significant' if in last 5 years. But '*Minor*' if >5 yrs ago.
   These entries should therefore be changed to 'minor past' where they have already been entered into 'significant' >5 years ago.
2. 'Standard circumcision' may default to 'significant', but this should be changed to, or added as '*Minor*', since although it might seem relatively significant, it is a simple day-case procedure and not normally of long-standing medical significance

NB Depression is often (or usually) 'Minor'. But if it was very longstanding, severe, and / or they've been under the psychiatric clinic for it, then it would be categorised as 'Significant'.

Not all **Operations** are necessarily 'significant past': E.g. Tonsillectomy, adenoidectomy, insertion of grommets, appendicectomy (*if uncomplicated*) would all be **'Minor past'**.

iii) Free-texting a few details (next to code on problem screen):
Where useful or important. This will help to explain the problem without the clinician necessarily having to refer to old letters and / or consultations.

Duration, related clinic appointments or procedures, and outcome are useful to know for significant conditions.

iv) Date order and Grouping of problem headings

If there is a major diagnosis, such as 'Asthma' that they've had many years ago, then it should be added under the date and/or year of *original diagnosis* where possible. If it is then a long term problem, the same code should be added under the most recent date they have been seen for it as well.

These two (or more) codes should then be Grouped together, as follows:

- Significant (past or active): Original/ earliest date of diagnosis *on top* (with any more recent ones grouped below this)
- Minor (past or active): *Most recent* code date on top (and any earlier ones grouped below this). i.e. The opposite of grouping significant problems.

v) Some examples of Codes to be placed in 'Health Admin' section, rather than in 'Problem' sections:

- New patient medical check
- Depot contraceptive started/ given *(but only if ongoing. If not, then it can just be put in 'Care history' screen)*
- MRI scan result *(<5 yrs, otherwise only add in as free text under relevant diagnosis)*
- ECG result *(If significant, and <5 yrs. Otherwise, can either be added in free-text under the relevant problem title, and/or enter as a code in 'Care history')*
- Drug Allergies. *(NB Enter as code 'Adverse reaction to…' [TJ…] where possible. Otherwise use; 'Adverse drug reaction NOS')*
- Case conference: *E.g. child protection with social services*

vi) Other codes which should only be added to 'Care history' screen, and are *not necessary* to be entered in any category onto the Problems screen:

- Pregnancies or Normal Births (not a medical 'problem', unless complicated in some way – then alternative code anyway)
- Has a carer
- *(See separate sheet also, for more examples)*

vii) Examples of Codes to avoid in general:

- h/o: depression (misleading / historical reference)
- h/o: asthma (" ")
- 'depressed' (= a *symptomatic* code, not diagnostic)

Instead, use only these clinical codes for these two conditions:

- [X]Depression (or “Anxiety with Depression”, as appropriate).
- Simply the “Asthma” code.

Immunisations:

For Childhood, Travel and other Health Protection vaccinations:

Enter some, or all of these where recorded onto the Immunisations screen, as follows:

- Childhood imms:
  Where patient is <16 y.o: Add all the ‘primary’ (DTP, polio, HIB), and any other imms not already recorded onto the system.
  For patients >16 y.o: Add the 3rd (DTP + polio), and the 4th (pre-school booster only)
- All other Travel, BCG, Booster, and HPV (female only) vaccs. to be added for any age group
- Influenza vaccs – put the last 2 they’ve had (and free-text in if they have had them all annually for previous years etc)

(NB there is no need for the template to be used for adding these).

Cervical Smears:

- Enter into the ‘care history’ screen only
- Add the *last 2 smear results* if normal, and *all* abnormal smears.
- If any abnormal smears, record all subsequent smears
- Code for normal is: ‘Cervical smear:negative’ (4K22). (This comes up when just ‘cerv..’ is typed in)
- No need for template to be used
- Recall: Normal recall is Age 25-60; once every 3 years
- N.B. May be more frequent if they’ve had previous abnormal smears
- Diary Entry, for their next follow-up *smear due date*:
  To be entered when in ‘Diary’ screen only.
  Code for this is: ‘Cervical neoplasia screen’ (6859). (This also comes up on the picking list when ‘cerv…’ is typed in).
  For the relevant recall; enter the due date as e.g. 3 years from the last recorded

smear result. (N.B. This may be a *past date* if they have missed their last smear, and entering it will then automatically confirm the smear overdue reminder).

Finishing off each set of notes:

(ii) 'Notes summary on computer' [9344. code]

- Add this onto Care History screen
- Free-text your initials into space

(iii) Summarising Log

- Enter date the summary was done, your initials, and whether gp2gp transfer

(iv) Find their new GMS1 form

- Add this into the paper records at the end.

Other tasks and codes to be added, where relevant:

(i) [Degrade] codes on GPtoGP transfers:

- Where seen, delete these and replace them with the same/ correct clinical code and date

- Done in order to eliminate the red 'Degrade' code that is sometimes shown on gp2gp transfers.

(ii) Where patient's notes are incomplete (e.g. for those people arriving from abroad):

- Enter the code; 'Date records received' into the Care History screen

- Dated as per date of first consultation (i.e. registration info)

- If **Immunisations** are not recorded; add 'Immunisations' code into Immunisations screen and free-text in; 'None recorded'. Also make sure that this goes into 'Health admin' section on problems page, by checking relevant box (so as to draw attention to it, for the nurses).

GP2GP

See link below

gp2gp_key_activities_2017_v0_4.pdf

Finally; if in doubt about anything above, or whilst summarising records, please check with an experienced member of the team.

Change Register

Date	Version	Author	Change Details
July 14	001	P Mansfield	Full revision of previous policy
July 19	002		Addition of GP2GP information
June 23	003		Reviewed and ‘Read code’ changed to ‘Snomed code’