

Summarising Practice Notes

A guide to help practices decide on their own policies

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kind permission**

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1 Purpose

The purpose of this document is to give some guidance to B&NES practices on some basic principles to follow in the process of setting up a process for summarising practice notes.

2 Background

This document has been largely based on a similar document that was created by Dr Chris Ree, a GP based in Bristol South and West PCT. This updated version has been reviewed by Dr Ree and is produced with Dr Ree's agreement. The only area of debate has been whether to include Mental Health 'Eu' codes as being appropriate to be used instead of 'E' codes. B&NES PCT recommend that 'Eu' codes are appropriate in preference to 'E' codes as they link in with secondary care and ICD10 codes.

2.1 Relationship with PMS Quality Information Preparation guidance

There is PMS quality information preparation guidance on notes summarising in 'Sustaining Innovation Through the New PMS Arrangements' from 23/12/03 (pages 40-41) (<http://www.doh.gov.uk/pmsdevelopment/pmsarrangementsdec03.pdf>)

This guidance states that the quality information preparation payment should provide a contribution to providers cost's in summarising medical records that have not already been summarised, and continuing to summarise those that have. It is a plan agreed by the PCT and provider that must contain a protocol for how the summarising is to be done, and contain arrangements for ongoing maintenance. It states that non-medical personnel must:

- (a) be fully trained;
- (b) not take medical records away from the practice premises;
- (c) have appropriate access to GP performers when they have queries;
- (d) sign a confidentiality agreement; and
- (e) be appropriately supervised

Guidance for the GMS quality information preparation scheme is very similar.

3 Recommendations for practices

Information must be coded as this renders it searchable whereas free text is generally not searchable.

3.1 Suggested scheme of Read coding

The following suggestions are aimed at ensuring the most important information is recorded on the patient record, but each practice should discuss their own priorities:

Most important:

- Diseases: These codes begin with a capital letter
- Operations: These codes begin with a 7

Less important but useful:

- Important biochemical parameters: HbA1c, creatinine or urea, cholesterol, HDL
- Important Values: Last BP, Last PEF
- Key Personal data if known: esp. Smoking Status, Alcohol
- Key Family history data especially Family History (FH) IHD < 60, FH CVA

NB: if the coding schedules start to fall behind then these should be dropped in order to preserve the coding of disease and operations.

3.2 Suggested practical approach

- Check the notes have not been already summarised by a previous practice who might have left a computer printout of their summary.
- Check there is no handwritten summary: update any part of the record not covered by this summary.
- Then summarise hospital letters provided there is administration and medical time to do so.
- Then look at the GP notes and scan them looking for important diseases which may not appear in the hospital letters.
- Ignore trivia. A reasonable rule would be to code anything which:
 - Involves regular review e.g. Hypertension.
 - Involved a significant period of time off work, anything say more than a month or two.
 - Anything for which the patient receives on going treatment.
 - Resulted in an admission to hospital.
 - Resulted in surgery.
- Then put the patients telephone number into the computer.
- Then enter the code for 'notes summary on computer' (9344.) or 'computer summary updated' (9348.) as appropriate. This is so you can search for records that you have not summarised yet because at the time the notes were pulled off the shelf for summarising certain notes were elsewhere.

Practices need to decide whether to record this data on paper first for subsequent transfer to the computer or to record directly onto the computer. The former suggestion may be preferable if 2 different people are doing the summarising and then the data entry but the latter is probably more efficient. It is suggested that because it is impossible to maintain 2 disease and operation registers that the computer summary should replace the paper one as the definitive practice summary and the one which will be constantly updated in the future. Keeping the morbidity register on paper does little to move the practice forward, as it is not searchable.

Please refer to Appendix A for an example of a notes summarising protocol for completion.

3.3 Updating and daily data entry of important new diseases and operations

Practices need to devise a system by which the computer summary is constantly updated with new diseases and operations. This will involve doctors entering important diagnoses themselves or delegating this function to others. The important issue is that someone does it. It is vastly preferable if the doctor does this as the coding will be more precise because of the greater medical knowledge. Important new problems from hospital correspondence need to be coded and entered. This is not as big a task as mercifully the number of new disease and operations contained in the daily post is not large as most letters refer to reviews of existing problems. **The practice scheme for daily updating of important diseases and operations must start on day one of the summarising process** otherwise the record becomes out of date as soon as it is summarised. Important data from visits and DDS activity must be coded.

4. The Read code system

Effective coding requires an understanding of the Read Code System. Many will be very familiar with this but for those who find it akin to a black box the following is an attempt to demystify it. It is based on a summary of a 130-page document on Health Data Collection in General Practice with a few personal views thrown in.

Virtually all medical items have a Read Code. The coding system is hierarchical i.e. it branches like a tree so that the higher level codes give rise to subsets of codes and these subsets give rise to further subsets. The parentage of the code is identifiable by its structure e.g. G33 (Angina pectoris) is a subset of G3 (Ischaemic Heart Disease) that is a subset of chapter G (Cardiovascular diseases). There are 2 versions in current use: 4 character codes and the more modern Version 2 that use up to 5 characters. All GP system suppliers are moving to 5 character Read Codes, if they haven't already.

Example of 5 byte Read code hierarchy:

	Chapter
Cardiovascular diseases	G
Ischaemic heart Disease	G3
Angina pectoris	G33
Angina pectoris NOS	G33z
Stable angina	G33z7

4.1 Process of care codes

Chapter	Read 4-byte	Read 5-byte
History / symptoms	1	1
Examination / signs	2	2
Diagnostic procedures	3	3
Laboratory procedures	4	4
Radiology / physics	5	5
Preventive procedures	6	6
Surgical procedures	7	7
Other therapies	8	8
Administration	9	9

Thus all operation codes begin with a 7, all symptom codes begin with a 1 etc. The converse of this is that if you see a code beginning with a 7 e.g. 7KIP4 then it must be an operation code, similarly a code beginning with a 9 must be an administrative code regardless of whether the text sounds as if it should be somewhere else. The importance of this is that the code determines which part of the computer medical record it goes into and also whether it appears under diseases and operations or referrals or whatever. In addition, proper coding in the correct category is needed for subsequent effective searching.

4.2 Illness and disease codes

Chapter	Read 4-byte	Read 5-byte
Infectious / parasitic diseases	A	A
Neoplasms	B	B
Endocrine / nutrition / metabolic diseases	C	C
Blood diseases	D	D
Mental disorders	E	E
Nervous system / sense organ diseases	F	F
Circulatory system diseases	G	G
Respiratory system diseases	H	H
Digestive system diseases	I	J
Genitourinary system diseases	J	K
Pregnancy / childbirth / puerperium	K	L
Skin / subcutaneous tissue diseases	L	M
Musculoskeletal / connective tissue diseases	M	N
Congenital abnormalities	N	P
Perinatal conditions	O	Q
Symptoms / signs / ill-defined conditions	R	R
Injury and poisoning	P	S
Causes of injury and poisoning	Q	T
[X] External causes of morbidity & mortality	-	U
Diseases NOS (unspecified conditions)	Z	Z

So all illness and disease codes begin with a capital letter, and are subdivided into disease areas. Some disease areas start with a different capital letter between 4 and 5 byte.

An understanding of the Read Code structure is essential for those recording, extracting or analysing data, as similar terms may have different meanings depending on where they are located in the structure. For example, to record a patient with asthma, there may be a choice of (among other codes):

- Asthma – cardiac (G581. [synonym for LVF] – circulatory diseases chapter)
- Asthma (H33.. – respiratory diseases chapter)
- Exercise-induced asthma (173A. – history/symptoms chapter)

- Moderate asthma (663V2 – preventive procedures chapter)

So when summarising notes the disease codes which are needed are those beginning with a capital letter and the operations beginning with a 7

4.3 Entering Read codes

Do this by one of three methods:

- Entering the first few letters in the diagnosis or synonym (key term searching).

Adding more letters to the key will shorten the picking list, but it is possible to be too specific, and the term you are looking for may be missing altogether from the picking list.

When looking for several terms together (e.g. chronic duodenal ulcer), search on the site term first. I.e. search for duodenal as this is the most specific term, and this will narrow down the picking list.

You can also enter a synonym e.g. DM for Diabetes Mellitus. Some systems allow practices to define their own synonyms and this can be hugely helpful for getting quickly to the codes you want. For instance in one practice the most important operative codes have synonyms beginning with an X.

- Searching through the hierarchy. This method generally relies on a good knowledge of how the Read code hierarchy is structured, so is not suitable for everyone.
- Entering the code if you can remember it, or if you have a formulary of commonly used codes to refer to: e.g. C10.. for Diabetes Mellitus.

Read code formularies such as the 'Core data set & Read codes for CHD NSF', and 'Using Read Codes not Climbing Mountains!' can help to locate the correct high level code. It is advisable for practices to use such formularies to standardise the use of codes within the practice. By entering in the high level parent code, the hierarchy can then be browsed to find the more detailed child code you need.

5. General tips

- Remember to code both the disease and operation. E.g. for Nasal Polypectomy the medical record should show an entry for nasal polyps diagnosis (capital letter code) and nasal polypectomy (7 code).
- Level of coding: You need to code to a reasonable level to make the code you are using sufficiently accurate to describe the condition. As a general rule all disease codes should have at least 3 letters or numbers i.e. code to level 3. 4 levels are often needed for many diseases. Operation codes as a general rule need to be coded to 4 levels. Further detail by going to 5 levels is getting too picky for many disease codes and often it's not worth it. E.g. GPs don't need to know that the patient had closed fracture of the neck of the proximal phalanx of the finger, just closed fracture of phalanx will do.
- Use of OS (Otherwise Specified) and NOS (Not Otherwise Specified) codes: At the end of nearly all subsets of Read codes are OS codes (end in y) and NOS codes (end in z). **These codes should not be used unless there are no other existing codes that are appropriate.** These are useful codes when the item you are trying to code can't be matched easily to a Read code but you know you are in

about the right place to find the code if it existed. You can then use these codes and then use free text to specify more exactly the problem. I personally prefer to use the NOS codes (end in z). They are particularly useful in coding some of the more unusual operations. It is better to use one of these codes and clarify it with free text than to falsely use a more specific Read Code because at least you are keeping the medical record true. These codes are best avoided at the higher levels of the Read Codes e.g. Gz...for Cardiovascular disease NOS doesn't really tell you a lot.

- Use of free text with the code: This is important as it conveys the nuances and details of a problem in a way that no coding system can cope with and this is necessary medico-legally. The free text is not searchable and so it should be used merely to refine the description of the code. Importantly, it is not currently possible to specify the side of the body affected by coding though this is crucially important and so this should appear in any free text. Keep it reasonably brief.
- Use of "R" Codes (working diagnoses): This group of codes begin with a capital letter and so are classified under diseases but which describe symptoms. They are best used when a patient has a persistent symptom which impacts or has impacted significantly on their life but which has never had a proper diagnostic disease label, yet are important enough to appear under diseases and operations. An example might be when someone has had a first fit that precipitated hospital admission with negative investigation and no diagnosis of epilepsy made. Use of "[D] fit" which is a code beginning with an R would usefully express this. Another example is persistent chest pain "[D] chest pain" for which significant cardio-respiratory disease had been excluded. These are extremely useful but only use them when you can't satisfactorily use another Read code.
- Coding of cancers: don't use morphology codes that have descriptions that begin with [M] and have codes that begin with BB... to describe cancers. Use the correct regional cancer code, starting with B... You can use a morphology code in addition if you wish but never in place of a regional cancer code.
- Psychiatric coding: this is a difficult area and no one seems to have the answer. Major psychosis is usually easily coded. The problem arises with the milder forms of particularly affective disorder. A useful code is Single Major Depression – Mild that keeps the condition within the affective disorders whereas Neurotic Depression Reactive Type places it in Neuroses.
- Codes which appear in 2 different places: No coding system can cope with the fact that diseases cross classification systems and so for example TB Meningitis can be coded as a neurology code F004 or an Infection code A130. There is no rule about what to do here and it probably doesn't matter which code you choose as long as you don't put both in.
- Diagnosis codes: **Don't enter diagnosis codes unless there is reasonable diagnostic certainty.**
- Familiarisation with the coding structure: Explore the Read coding system by travelling up and down the tree (looking at what is happening to the codes rather than the description of the code) and familiarize yourself with the way it works.
- Proprietary codes: Some systems use proprietary codes e.g. the EGTON codes of EMIS. These are generally best avoided unless there is no other alternative.
- Synonyms: there can be several different terms that mean the same thing and have the same Read code. For example, Myocardial Infarction, heart attack, coronary thrombosis, MI are all synonyms of the preferred term Acute Myocardial Infarction, and they all have the same code (G30..). **However, some clinical**

systems use their own proprietary synonyms with a dash ‘-’ (e.g. foot pain 245-3). These are best avoided if there is an alternative as their meaning can be misleading and they do not always show up in searches (including MIQUEST searches).

- “History of codes”: **Do not use H/O codes (starting with 1....) as these are symptom codes not disease codes.** For example if a patient has a past history of tuberculosis and the diagnosis of tuberculosis has not been recorded on the patients record, it is better to record the diagnosis code (with a date - at least a year) rather than to record the symptom of H/O tuberculosis.
- [X] codes: Avoid if possible code descriptions with [X] in their description starting with ‘U’. These codes appear in 5 byte Read codes and are an attempt to map the common hospital coding system (ICD10) to Read. However, ‘Eu’ codes also have an [X] in their text and can be used. These ‘Eu’ codes are the B&NES PCT recommended codes for Mental Illness diagnoses in 5 byte (they link in with secondary care codes used by ICD10).

However, you can still use ‘E’ mental health codes if you prefer. PCT searches will continue to search on both ‘E’ and ‘Eu’ codes, so which ever you use, the searches should find them.

- [V] codes: Similarly under the umbrella of Health Service Contact Factors come codes which begin with Z and which have descriptions beginning with [V]. These are best not used unless you are desperate.
- FH codes: Do not record the fact that a patient has a family history (FH) of a disease as a disease diagnosis or as a history of (HO) code. You must use a specific FH code that is a subset of 1 (history).
- **Mother and baby codes: Do not record neonatal (baby) problems in the mothers record. Do not record obstetric problems in the baby’s record.**
- **Chronic illness: Do not record several episodes of a single chronic illness as separate diagnosis codes, code it once only.**
- **Acute illness: However, serious acute events like Myocardial Infarction (MI) should be recorded as a diagnosis each time they occur.**

5.1 What not to code (in a notes summarising context)

Different practices will have different views on what not to code in the notes summarising process. **Please get agreement from your practice clinicians about what they feel does not need to be transferred from the paper notes to the computerised summary.**

Hence it is difficult to encapsulate what to avoid coding, but the following are some ideas for agreement within your practice:

- Minor Childhood illnesses e.g. Chickenpox, Rubella, Mumps
- Acute Cystitis or UTI but code if problem is very recurrent
- Minor short lived menstrual problems
- All short lived minor infections e.g. gastroenteritis, conjunctivitis

- Minor ENT problems e.g. earaches , sore throat pharyngitis, Otitis Media, Otitis Externa nose bleeds (but if recurrent then use single code for recurrent disease)
- Minor Sprains and Strains and Tendinitis, Phlebitis
- Minor infestations Lice etc
- Gastroenteritis
- Epistaxis
- Minor Head Injury i.e. not admitted
- Influenza
- Vaginal infections unless unusually severe
- Minor Varicose Veins
- URTI

The list could go on. In general don't code anything that was very short-lived or had minimal impact on the persons medical history. Code if referred, admitted or operated on. Code if treated with drugs for a significant period of time.

5.2 Active problems

Some systems ask you to categorise codes as you enter them into active or inactive (with active problems appearing on the active problem list). The important point here is that active problems are easily accessible to the user and should contain the summary of important medical data that you would always want to be reminded about.

As a general rule:

- Any disease that is subject to regular review should be active.
- Any cancer except possibly minor and fully cured skin cancers should be active.
- Any very major operation should be active e.g. lung removal or major brain procedure.
- If in doubt always make the code active, as it is easier to deactivate active codes than to reactivate inactive ones. Some systems further request classifications of episode types.

See Appendix A for further for further clarification of active problems.

6. Concise summary of Read coding principles for notes summarising

- Play around in the Read Code classification system and get familiar with it. Ensure you know how to move down the branching structure and also how to move back up.
- Disease codes begin with a CAPITAL letter and operation codes with a number 7. THESE ARE THE PRIORITY CODES.
- Enter data by typing a few letters and choosing options, by using synonyms or by using the Read code if you can remember it. Browse the full classification if you are stuck or have a look at section 4 of this document. A few hours spent devising

a good synonym system can reap huge rewards (for those systems which allow customisation of synonyms).

- Remember to enter both disease and operation codes where appropriate.
- **Generally code to at least 3 characters and often you will need 4, sometimes 5 characters. Always code to the level of detail that is available.**
- Use OS or NOS codes when other members of the subsection do not adequately describe the condition or operation; supplement with free text if this will clarify the condition.
- Use codes beginning with R or [D] only when the condition is important enough to code under diseases but is really a symptom with no specific disease diagnosis has been made e.g. [D] chest pain (R065.) may become the diagnosis if angina is not confirmed. Always use another disease code if possible but sometimes it isn't.
- Use free text to convey important but non-codeable information after the code, provided it is relevant and non-codeable in its own right. Free text can be useful in refining/amplifying the meaning of a code e.g. Fracture of neck of femur qualified with free text '*left*'. Free text can also be bad e.g. Hysterectomy qualified with free text '*not performed*' or faint qualified with the text '*bp 140/60*'. In the latter case the bp should be coded as a separate entry.
- Don't code illnesses which were short lived with little impact on persons life
- Code most things where the person was admitted, referred, operated on or for which he receives long term medication. Code any illness subject to regular review.
- Don't repeat codes at each review or admission i.e. for chronic diseases code once only.
- Avoid if possible codes which start with:
 - [M] or BB
 - H/O codes
 - [V]
 - [SO]
 - [X] codes except those mental health codes starting with 'Eu...' that are preferred to 'E' codes in B&NES PCT.

7. Future recommendations

It is recommended that practices become aware of the content of this guide and decide on a practical way of implementing the suggestions it makes about coding as soon as possible. Reference should be made to the appropriate PMS quality information preparation guidance (see section 2.1).

Refer to up to date Read code formularies that have been cross-referenced with the Quality and Outcomes Framework codelists in order to choose appropriate codes. Contact one of the PCT Facilitators on 01225 831478 for up to date formularies of codes to use.

It may be appropriate to produce a local practice guide/policy or protocol along the lines of the one in Appendix A to support local notes summarising implementation.

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Appendix A: A medical record summary on computer – protocol for completion

Aims and objectives

1. To maintain an accurate, up-to-date medical summary on computer
2. To maintain a comprehensive practice disease register
3. To facilitate the process of clinical audit

Implementation

1. Existing Patient Records: the existing paper-based records will need to be systematically worked through and summarised onto the computer;
2. New Patient Records: the new patient paper-based records will need to be summarised onto the computer as they are received into the practice;
3. Clinical Correspondence: to maintain the patient's computer-based records, a system will need to be established whereby all relevant data is extracted from all clinical correspondence received and entered onto the computer;

Method

1. Check clinical history already recorded on the computer;
2. Going through the paper notes!
 - the Lloyd George / A4 folder can be quickly and efficiently reviewed if done in the following systematic order:
 - summary printouts
 - summary card
 - letters and discharge summaries
 - consultation records
3. The following information should be recorded for each patient:
 - childhood illnesses
 - chronic diseases (e.g. diabetes, asthma, hypertension)
 - significant illnesses (e.g. rheumatic fever, malaria, TB)
 - ALL operations (including site and pathology)
 - ALL fractures and trauma (including side e.g. L or R)
 - ALL preventative procedures (e.g. flu immunisations)
 - health promotion data recorded within past 5 years
 - known family history for first degree relatives only
 - for WOMEN only:

- miscarriages (incl. timing/procedure e.g. “12/40; ERPC”)
- terminations (incl. medical reason e.g. “fetal abnormality”)
- type of delivery (incl. sex/birth weight e.g. “Male/3250g”)
- cervical cytology reports and follow-up required
- IUCD (Coil) insertions, removals and follow-up
- Rubella immunity status (most recent only)

- for ASTHMATIC patients:
 - all hospital admissions
 - annual reviews with other practice/hospital within past 12 months only

- for DIABETIC patients:
 - annual reviews with other practice/hospital within past 12 months only
 - annual fundoscopy and visual acuity (e.g. from optician reports)
 - annual reviews in order to set-up computer-based recall system

- for CHD patients:
 - cholesterol levels, BP, smoking status and lifestyle advice where recorded
 - advice about or on salicylate prophylaxis?
 - diagnostic investigations (e.g. ECG; echocardiogram) with result

4. What is an ‘Active’ or ‘Current’ Problem?

the following definition can be used:

- chronic
- life threatening
- impacts on quality of life
- consulting doctor/nurse should be aware of

4. The computer and Lloyd George records should be marked to confirm summary has been completed (e.g. Read code 9344. – notes summary on computer **or** 9348. - computer summary updated 9348.)

Progress

Monthly reports can be generated through the reporting package to monitor current level of records summarised.

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