

SUNDERLAND HEALTH COMMUNITY

NOTES SUMMARISING PROTOCOL

Janet Turner  
IM & T Dept  
Sunderland Health Authority  
Durham Road  
Sunderland  
SR3 4AF

Tel:0191 565 6256  
Ext 45216

Produced January 2002

As part of the project the team, you should always be aware of the following golden rules:

## 1. CONFIDENTIALITY

Remember your signed confidentiality agreement:

NEVER DISCUSS ANYTHING YOU SEE OR HEAR IN THE COURSE OF YOUR WORK OUTSIDE THE SURGERY.

RESPECT EVERY PATIENT'S RIGHT TO PRIVACY AND DIGNITY

## 2. BEHAVIOUR

Remember you are guests in someone else's surgery. Although you are there doing a job which will bring great benefit to the practice.....

ALWAYS BE POLITE AND COURTEOUS TO PRACTICE MEMBERS OF STAFF.

RESPECT THE RULES OF THE PRACTICE.

TRY NOT TO OVERWHELM THEM WITH YOUR PRESENCE.

## 3. QUALITY OF WORK

All your hard work and effort will be in vain if you do not take care to ensure that all your work is accurate:

NEVER ASSUME ANYTHING – ALWAYS CHECK IF YOU ARE UNSURE ABOUT ANY INFORMATION.

BE AS ACCURATE AS YOU CAN ABOUT THE ORIGINAL DATE OF A DIAGNOSIS OR EVENT.

ALWAYS MAKE SURE THAT YOU SPECIFY THE CORRECT PATIENT WHEN ENTERING DETAILS ON THE COMPUTER.

## AIM OF THE PROJECT

The project will be used to establish a database of information which can be used to provide an overview of disease in the Sunderland area and form a foundation and methodology which practices can continue to build upon. The first phase of this project is to summarise medical notes in GP practices and enter Read Codes from the summaries onto the practice computer system. This information can later be used to improve patient care locally and may be used to feed into national health plans.

This protocol aims to guide staff through summarising notes in order to provide morbidity data. Please ensure that you read and understand everything in the protocol

## THE AIM OF A NOTEBUSTER IS TO:

- ◆ SUMMARISE ALL MAJOR DIAGNOSIS AND EVENTS THAT HAPPEN IN A PATIENT'S LIFE TO A PRE-SPECIFIED LIST OF CODES.
- ◆ RECORD THESE SUMMARY EVENTS AGAINST THE PATIENT'S COMPUTER MEDICAL RECORD.
- ◆ ENSURE THAT THE ALL PIECES OF INFORMATION ARE RETURNED TO THE MEDICAL RECORD WALLET IN CHRONOLOGICAL ORDER AND IN EXACTLY THE SAME FORMAT AS YOU FOUND THEM.

## HANDLING PATIENT NOTES

- ◆ NEVER WORK WITH MORE THAN ONE SET OF NOTES AT A TIME!
- ◆ Please ensure that details from one set of notes do not get mixed-up with another set being worked on by someone else. Try and give yourselves enough room to work comfortably without overlapping different sets of notes.
- ◆ It is not your job to cull notes; please ensure that you throw nothing away.
- ◆ It is not your job to tidy the notes: please ensure that all details are returned to the wallets exactly as you found them, unless, the details are not filed chronologically in which case anything out of date by more than 6 months should be removed and filed in the correct place (oldest to the bottom).
- ◆ If the patient is known to you then please pass the notes to another member of the team.
- ◆ Ignore any major summary entries already made on the pink or blue summary card at the front of the patient's medical record (if one is available), until you have completed summarising yourself. You may use the card at the end to ensure that nothing appears on there that you might have missed. Be aware that information could have been put on the wrong patient's card or that information relating to old events might have been recorded on the card and then destroyed (i.e sex of new born babies).
- ◆ Always make sure that you have all the wallets relating to that person and that they are the same person.
- ◆ Be aware that medical records can become split, mixed-up, wrongly filed or wrongly labelled over a period of time.
- ◆ If you find any information relating to another patient in the set of notes you are working on then you should remove it and put it in the pre-arranged place or give it to the pre-arranged person.

## GUIDE TO SUMMARISING MEDICAL RECORDS

- ◆ You should familiarise yourself with the coded list of conditions so that you are aware of the type of information you are looking for.
- ◆ On entering the practice, obtain two printed alphabetical lists of all patients registered with the practice.
- ◆ One printed list should be left in the reception area for practice staff to identify which notes are currently being used by the summarising team. The second list should be used by the team to record which notes have been summarised and returned.
- ◆ Working progressively from the top of the list, fill your project box with the notes of patients from the list. Highlight the names of the patients whose notes you have taken on the reception lists.
- ◆ Make sure that you have all the volumes of notes relating to each patient.
- ◆ There are several parts to a patient's clinical record – read everything that might be helpful – especially hospital letters, discharge summaries, referrals, casualty reports and continuation (consultation) cards.
- ◆ For every piece of correspondence that you read, check the patient name and D.O.B.
- ◆ Read from the oldest documents to the latest to ensure that you get the correct date of an original diagnosis / event .
- ◆ Patient notes do not always contain a clear diagnosis, if in any doubt leave the queried file to one side until it is convenient to ask a doctor of the practice.
- ◆ Underline in red pen the major summary item as you discover it, identify the appropriate read code from the table and write the read code in the margin.
- ◆ When you have completely actioned a patient's medical records, take the them to the computer and prepare to enter all the highlighted / coded summaries on to the practice medical computer system.

- ◆ Before recording your summaries on the practice computer system, check the the "Medical Records" screen to see if any of the entries have already been recorded.
  - ◆ If the information that is there is accurate you need not replace it – just leave it as it is.
  - ◆ If you find an entry which, on checking the notes you find is incorrect in anyway you should amend it.
  - ◆ If you find an entry on the computer which you can find no evidence to support in the notes then you should discuss with someone from the practice.
  
- ◆ Remember to use the "free text field" where appropriate to record further details or to clarify any uncertainties in the collection of the data
  
- ◆ Remember, we only code confirmed diagnosis/events, not suspected.
  
- ◆ Only summarise one set of patient's medical records at a time.
  
- ◆ The medical history must be recorded chronologically, the most recent diagnosis at the top.
  
- ◆ Always enter the exact date of a diagnosis or event if known. If the exact date is not clear for any of the following:
  - ◆ No day of the month - use the 1<sup>st</sup> .
  - ◆ No day or month - use 1.1.
  - ◆ Day, month and year unclear - use the nearest date you can and specify the problem in free text.
  
- ◆ When the set of notes has been completely summarised the very last entry of Read Code 9344 (Notes Summary on Computer) should be entered onto the computer system. The practice will then be able to recognise that any new entry made after that point has been done by the practice.
  
- ◆ When all pieces of correspondance have been placed back into the patient's wallets you should write T.A.C. (Tagged And Computerised) on the front of the notes and highlight it.
  
- ◆ Highlight the patient on the team's list in the colour of the day and record the date the notes were returned to reception at the side and your initials.
  
- ◆ Add the completed set of notes to your total list for the day.
  
- ◆ When you return the notes to the reception area, cross through the highlighted names to indicate that they have been returned.

- ◆ A doctor from the practice should randomly select 10 sets of notes a week from those summarised and check them against the computer entries for accuracy. Feedback from this exercise should be given to the Notebusting Team Co-ordinator.

## READ CODES

“Read Codes” is a term used to describe a method of applying computer coding to medical diagnosis. It is a nationally approved system developed by a GP (Dr Read) and almost all GP computer systems use them for recording clinical information.

The list of Read Codes that accompany this protocol are not exhaustive but have been selected from the vast range of available Read Codes to be used to standardise the recording of clinical information across Sunderland.

If you come across any condition which is rare to the patient you are summarising and you feel is significant enough to warrant coding then you should inform the Team Co-Ordinator who will arrange for it to be considered by the Team Doctors for appropriate coding.

If the diagnosis is not on the table then do not read code it. However you should be aware that certain conditions are referred to by different names in clinical correspondence so check in your medical dictionaries or seek advice if you are unsure of the correct medical phrase used on the Read Code Table.

Read Codes go to more complicated levels than the some of the codes used on the table but you should not use these lower levels of coding, even if you think it details the condition better. (eg. Read Code 792 will give a description of coronary artery operations which is fine for the level of detail we need but the list could bring up all the specific operations such as CABG, angioplasty; do not enter these specific codes – even if the specific diagnosis is on the hospital summary).

## ENTERING FREE TEXT

The table provided shows the diagnoses which are to be Read Coded. There are a few diagnoses which need text description (known as 'free Text') to explain the nature of, or give more specific details of the condition. Some examples are:-

Old MI's      dated 1998 which states "known or evidence of MI 3 years ago" should be recorded with the 1998 date and a free text entry of "history of MI (3 years ago)"

CVA            There may be a more specific description of the type of CVA, this should be recorded in free text if known.

Drug dependence      State the drug

Depression      State the nature if known ( i.e. post natal, single episode, reactive eg bereavement).

Note depression is only to be Read Coded if it is treated with medication or is referred.

Arthritis      If the type is unknown record as osteoarthritis. If known specify the part of the body eg hips, knees, hands.

Some free text prompts are given on the read code table and should be used as appropriate.

## USING EMISS COMPUTER SYSTEM

The practice will assign you a log in code which should be used everytime you use the computer. Always enter information under your own log in and ensure that you log out when you are finished. Never let anyone else enter any information under you log in.

- ◆ From EMISS main menu select function key F5 (swap patients)
- ◆ Enter patient name
- ◆ Check carefully to make sure that the patient details presented on the screen match the one you are working on.
- ◆ Enter MR (Medical Records screen).
- ◆ Check to see whether the entry you want to make already exists and proceed as stated earlier in the protocol.
- ◆ Enter A (Add)
- ◆ Enter the appropriate read code and check that the description applied to that code matches the one you want.
- ◆ Keep on Adding the read codes until all summary items recorded.
- ◆ All summary items should be added as a PROBLEM, as SIGNIFICANT and as ACTIVE (this data will be edited by medical staff at a later stage). Note: "PAST" may be entered automaically, if so change to ACTIVE.

If any entry already exists but needs to be amended:

### HANDY NOTES

- F1 Takes you back to previous page
- F4 Find
- F5 Change patients

If a mistake is entered:

Return to main page for patient

Choose "P" for problems

Highlight problem (space bar marks an entry if multiple deletes are necessary)

Choose "edit" and make alteration or choose "D" for delete