Richmond and Twickenham **NHS**
Primary Care Trust

Richmond & Twickenham PCT
Protocol for Summarising Electronic Patient Records
May 2004

This protocol is based upon a workshop attended by GPs and staff from twenty one practices, using documents from other PCTs and national guidance.

The aim is to improve the quality of the information held on practices' clinical systems and thus contributes to better management and care of patients. Practices should also find that this would help in achieving the indicators in the new GP contract on notes summarising. Good quality data will support record transfer between practices, in whatever form this is made available.

The protocol discusses the issues around notes summarising and lists the information that should be included in the summary of information taken from the paper record and added to the electronic clinical system.

ISSUES

The issues are considered under these headings: organisational, maintenance, skills required, data quality and challenges.

Organisational

- There should be a **GP responsible** for the overall management of summarising who is available to summariser for answering queries.
- This does not have to be a formal process, but should fit with the way the practice works.

- The summariser should be able to **take breaks**, so that they do not lose concentration; in particular if they are carrying out data input.

- A **log** of difficult coding issues may prove helpful.

- **Prioritise** the notes as follows:
  a. Patients with **chronic diseases**. These can be identified by searches and will ensure that disease registers are kept up to date and patient management is supported.
  b. **New notes** - in date order
  c. **Newly registered patients**
  d. **Frequent attenders**
  The summariser may wish to "mix and match" thick and thin notes in order to pace the work. The A to Z approach is used, but not recommended, as it does not target the notes of most use to the practice.

- **Organise the paper record first**. This is worthwhile doing, to speed up the process of transferring data to the computer. Training practices will have completed this task already.
  a. **Sort** the paper notes first into chronological order and pick up any misfiling, eg of the wrong patient's records in the notes. Letters can be kept in one section and results in another.
  b. Agree how paper notes should be **culled** or weeded.
  b. **Summarise to paper** first or highlight the points on the paper for inclusion.
  c. **Delegate** tasks to other members of staff in the practice, if possible or appropriate.
  d. Don't assume that **previous summaries** are accurate and up to date.
  e. **Medical reports** for insurance purposes are useful but should not be used in isolation.

- **Organise the electronic record**
  Consider using problem headings or priorities. The choice will depend on the clinical system and whether the practice has been using priorities for some years already.

Maintenance

Once a paper record is summarised onto the electronic record, it is crucial that the electronic record is kept up to date and becomes the main patient record. Subsequent incoming paper information must be transferred to the computer, or else that patient will have two incomplete and parallel records. Similarly, consultations will also need to be recorded electronically.

- Consider **all data sources** (see separate list attached).
- **Consultations** for all the primary care team are key; consider district nurses, health visitors, home visits, telephone calls.
- **Paper** information from the range of sources.

- Have a consistent **system** of dealing with information
- Consider how information, which is not summarised, is **archived**.
- Encourage GPs and staff to **edit and tidy** electronic notes for inaccuracies, as they go along.

Skills

The core skills are:

- An understanding of clinical terminology; an appropriate person may be a nurse, medical student, medical secretary or other health care professional, but do not exclude other suitable people who can be trained.
- An analytical mind.
- Attention to detail and a methodical approach.
- Self-motivation, as this work is often carried out in isolation.
- An understanding of the Read Code hierarchy and content so that the correct terms can be found.
- A sufficient knowledge of the clinical system for data entry.
- An understanding of the importance of the task.

Data Quality

Data should be as consistent and complete as possible.

- Use **all data sources** available.
- Include **confidential or sensitive** data.
- Consider the **level of detail** for entries (see list for examples).
- Decide which **diagnostic investigations'** normal and abnormal results should be added.
- Agree what **information may be omitted** - eg past normal results (apart from agreed exceptions), past contraception except coils, past therapy.
- Agree which **Read codes** should be used in the practice, to ensure consistency and accuracy.
- Use **templates** where possible (eg new patient checks) to make the task of data entry and choice of Read codes easier and more consistent.
- If past codes require **editing** because the code used was incorrect or the diagnosis recorded needs changing, record the reason for doing this and date it, when the old code is deleted and the new code added.
- Decide as a practice whether and which **old letters** should be scanned.
- Keep a record if paper records are **shredded**.
- Use a Read code and date to record that a set of notes have been summarised (see list for detail).
- Mark the Lloyd George envelope to show that it has been summarised.
- Consider auditing the process - eg take a random set of summarised notes and check the paper and electronic record. Someone other than the summariser, eg the GP responsible, should carry this out.

Challenges

Not to be underestimated!

- The size of the backlog
  Ensure that the summariser can demonstrate progress and the numbers and quality of notes summarised over a period of time. Estimate the time it will take; take into account list turnover.
- The state of some of the notes. There is not much to be done about this, but preparation of the paper record, as described above, can be delegated.
- Space and storage - this is a problem for many practices.
- Clinicians' handwriting: say no more.

Useful documents:

Good Practice Guidelines for General Practice Electronic Patient Records Oct 2003
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4069764&chk=cajlh1

Direct Enhanced Service Specification for quality information preparation

Accreditation for working paper light RTPCT June 2003 (on intranet: -> information for clinicians -> working paperlight)

Read coding - a reference note for users in practices - Susan Wilson, RTPCT October 2000 (on intranet: -> information for clinicians -> working paperlight)

DATA SOURCES

- Acute and repeat prescribing
- GP surgery consultations
- Nurse surgery consultations
- Other clinician's consultations (eg psychologists, counsellors etc)
- Community staff surgery consultations (eg. midwife, health visitor, district nurse, CPN, physio's etc)
- Other contacts - home visits; telephone advice; nursing homes)
- Out of hours services
- New patient checks
- Incoming medical records from other practices, whether summarised or not
- Patients' faxes, phone calls, emails, letters.
- Referrals
- Appointments
- Investigations carried out in the surgery
- Requests for tests
- Test results (including those in discharge letters)
- Discharge letters and notifications
- Outpatient letters
- A&E letters
- Correspondence with social services
- Other correspondence
- Social services staff contacts
- Cytology
- immunisations

DATA FLOWS

Consider all means of communication: paper (forms, letters, notes, advice sheets), electronic (email, NHSNet for registration, IoS & pathology results), telephone calls, face to face contact (in the surgery, at home).

Individuals involved: patient, relative, member of team (GP, assistant, registrar, locum, practice nurse, practice manager, clerical and secretarial staff, district nurse, health visitor, physio, OT, midwife, CPN, counsellor, social worker)

Organisations: hospital or community services, private and NHS, hospice, nursing home, residential home, social services, pharmacy, health authority, screening service, DSS, lawyers, insurance companies.

Electronic Patient Record Summaries: Standard Summary Information: What to include

All dates should be date of diagnosis, operations, significant events, investigations etc, not "today's date"

Major diagnoses:	**Read Code chapter/s**
Chronic or recurrent disease requiring attention; important conditions requiring investigation or treatment in primary or secondary care.	
e.g CHD, Hypertension, CVA/TIA, Diabetes Mellitus, Asthma, COPD, Epilepsy, Thyroid Disorders, Malignant Disease, Mental Illness, Osteoarthritis & Rheumatoid Arthritis, Glaucoma	A - Z (note that I,O & Y not used,
Surgical operations	
All significant surgical procedures and the reasons for them	
e.g CABG, Angioplasty, Joint replacements, Hysterectomy, sterilisation, Limb amputation, All "oscopies"	7
Significant events	
Accidents and injuries, trauma and torture, overdose, other attempted suicide, major fracture, visceral or extensive soft tissue injury, recurrent minor injury suggestive of abuse - particularly in children and the elderly	S, T & U
Obstetric and Gynaecology	
Miscarriage, terminations and complications of pregnancy, serious gynaecological conditions requiring referral to secondary care.	L, 7, 8 & 9
Cytology and mammography results, latest, and others where relevant	4, 5 & 6
Relevant follow up and/or recall dates	

Investigations, Diagnostic Procedures & Monitoring	**Read Code chapter/s**
Specific investigations and their results from the Lloyd George records. Important positive and negative investigations associated with condition.	
e.g Echocardiogram for heart failure, CT or MRI scan for strokes, biopsies for malignancy, retinal screening for retinopathy,spirometry for COPD and Asthma, ECGs, EEGS. Blood results positive and negative, normal and abnormal where relevant to condition, event or occupation. Anti-coagulation monitoring	3, 4 & 5
Hospital Admissions	
All significant admissions, with relevant details.	
e.g name of hospital, patient's hospital number and consultant where known	1, 6, 8 & 9
Outpatient or A&E Attendance	
Significant and recurrent attendances, reference the name of the hospital and number of attendances over period of time.	8 & 9
Maternal and Paternal Details	
Current contraception, relevant past problems, infertility, children and birth history	1, 3, 4, 6, 7, L & Z

Therapy	Read Code chapter/s
Current, reference to past therapy where there is a long history	a - s
Non - tolerance & maximum tolerated therapy	8
OTC medication (eg. aspirin)	8
Personal Data	
Height	229
Weight	22A
BP - most recent	246
Urinalysis - most recent	4
Smoking - most recent	137
Alcohol	136
Exercise, if current	138
Ethnicity	9i
Family history	12
Immunisations, latest booster or where in course	65
Vaccinations	65
Is a Carer	918G
Has a Carer	918F
Adopted	1337
Registration data checked for accuracy and completeness	
e.g spelling of names, telephone numbers, address and post code	9
Next of kin	

Allergies and Alerts	Read Code chapter/s
Contra - indications and adverse reaction to therapy	8, T, U & Z
Adverse reactions to plasters, foods and plants	
Declined or refused	
Diagnostic investigations and procedures, reason where known.	8 & Z
Immunisations and vaccinations, reasons where known.	6
Therapy, recent and number of times.	8
Social History	
Definite history of drug or alcohol abuse	1, 6, E, S, Z
History of sexual, physical and emotional abuse	1
Homeless (relate to DES or enhanced service)	1
Confidential / Sensitive Data	
Violence (relates to DES or enhanced service)	1 or R
Child Protection, Violence or Abuse	13IM or 64c
HIV/AIDS	1, 4 or A788
Past Abortions	L
Summarising	
Lloyd George record received	9314
Lloyd George + problem summary	9311
Lloyd George - culled + tagged	9312
Lloyd George culled + summarised	9313
Notes summary on computer	9344
Extensive notes on computer	9345
Total notes on computer	9346