Summarising of Medical Records

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What is this?
Drivers

- Data quality!
- GP2GP
- External users
- Patient access
- Discussion and awareness
- Resources
What is a summary?

“A records summary is a coded, structured, accurately dated and attributed record of important and significant clinical information held on an electronic record system.”
What’s it for?

“The GP records summary has the primary purpose of supporting the practice in looking after that patient.”
Benefits

- accuracy
- Safety
  - Data Sharing - KIS/APCA/ Referrals
  - Decision and Prescribing Support
- Morbidity
- Quality not Quantity
- Public Health, Health Economics
Who should summarise

Demonstrate competence:

Understand medical terminology

Be appropriately trained:

In use of the clinical terminology

In data entry and information review, for example: have a clear understanding of data structure

In the practice’s guideline and process for summarising (irrespective of experience elsewhere).
Where can we get the information?

Patients’ self-reported history and registration questionnaires
Repeat medications, pharmacy information
Written paper records – A4 folders and Lloyd George cards
Document records received from the Docman to Docman Process
The patient transfer report generated by the previous practice
Any patient held records, for example, maternity and child health records, or records received from abroad
Administrative Entries

- Are these needed?
  - YES
- Why?
  - Records Started
  - Gaps in records
  - Saves time/resources
Read Terms that can help in this process and that are also used by PSD include:

9I2.. Patient paper record not available
9IJ.. Existing patient paper record available
9IK.. Patient paper record held at practice
9349. Electronic general practitioner medical record received
934Z. Computer record NOS
Read Terms that can help in this process and that are also used by PSD include:

9R8.. Date records held from
9IE.. Incomplete patient record received
93E.. Gap in patient record - two entries start and end date
915.. Patient record merged
Is the patient housebound?

Other services involved?

Is there advanced care planning/ living will, power of attorney or guardianship?

Next of kin/carer details?

Is the patient a veteran?

Social Care Information: looked after child? Vulnerable adult?
Important Medical History

- The diagnosis or symptoms that resulted in any admissions to hospital
- Any condition that has required out-patient care
- Chronic diseases
- Conditions for which the patient has taken regular medication
- All fractures
- All significant soft tissue injuries
Important Medical History

- All operations
- All hospital procedures and investigations
- Important medical diagnosis that may be made in primary care
- Important mental health diagnoses
- Obstetric events
- The presence of implantable devices
- Any notifiable infectious disease
Allergies / ADRs

- Drugs adverse reactions and allergies
- Non-drug adverse reactions and allergies
Examinations and Procedures

- PEFR – last, best, worst, usual
- FEV1
- Spirometry results
- ECGs, Exercise tests, Ambulatory Blood Pressure and ECG results.
- Angiography
- Endoscopies
General Health

- Smoking history
- Alcohol
- Height, weight, BMI
- Blood pressure readings, last, pre and post treatment if relevant
- Pulse rate and rhythm records – last recorded
- Pulse oximetry – last recorded
Immunisations

• Childhood immunisations
• Adult immunisations
• Travel immunisations
• Record manufacturer and batch number when available.
Pathology Results

- Thyroid: TSH/T4.
- Lipids: Serum Cholesterol, LDLC and HDL.
- Tumour markers such as PSA and CEA.
- Diabetes: HbA1C
- Renal function: eGFR
- Therapeutic drug levels, for example Digoxin, Lithium.
Pathology Results

- Fasting or Random Glucose results
- Urinary protein analysis: ACR/PCR
- Haemoglobin
- INRs
- Negative screening tests for infections
- Disorder codes for positive results indicating morbidity
Imaging

- X-Rays
- CT Scans
- MRI Scans
- Ultrasound Scans
- DEXA results
Women’s Health

• SCRRS and cytology data
• Breast screening attendance and outcomes
• Contraception history – implants, depo medication and intra-uterine device insertion and removal
Child Health

- Abnormal findings
- Records of completion of routine examinations
Social

• Occupation
• Relationship status and past milestones
• Employment status and occupation
• Benefits and financial status
• Housing status and with whom the patient lives
Social

- Ethnicity and languages spoken
- Dependents
- Any forensic history
- Any history of challenging behaviours
- If the patient is an armed forces veteran
Family History

- Validated or trusted family history records using the “12... Family history” of Read
Contract Data

• Data that is used for GP contract monitoring and reporting such as the Quality and Outcomes Framework.
• Check each section of data requirements depending on patient’s recorded morbidity.
• Add exclusions if appropriate and necessary.
KIS

• Check patient’s consent for ECS. This may not be recorded in the clinical but should be established through practices standard registration processes.
• Review if patient has a KIS or PCS record.
• Establish patient’s consent status with respect to these summaries.
KIS

• Record consent and decision to send as appropriate.
• Review content for KIS and PCS and ensure it is correct and current.
• Ensure resuscitation wishes accurately reflect the decision appropriate to the patient.
• Record the date of Adults with Incapacity form if appropriate.
• Record the presence of a DNACPR from if present.
Other

- Child and Adult Protection
- Obstetric
- Third Party
- Adoption
- Risk to care providers / other alerts
Minimum

- Stripped down set
- *Bare minimum for usable record*
Thank you and Questions

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