Summarising of Medical Records

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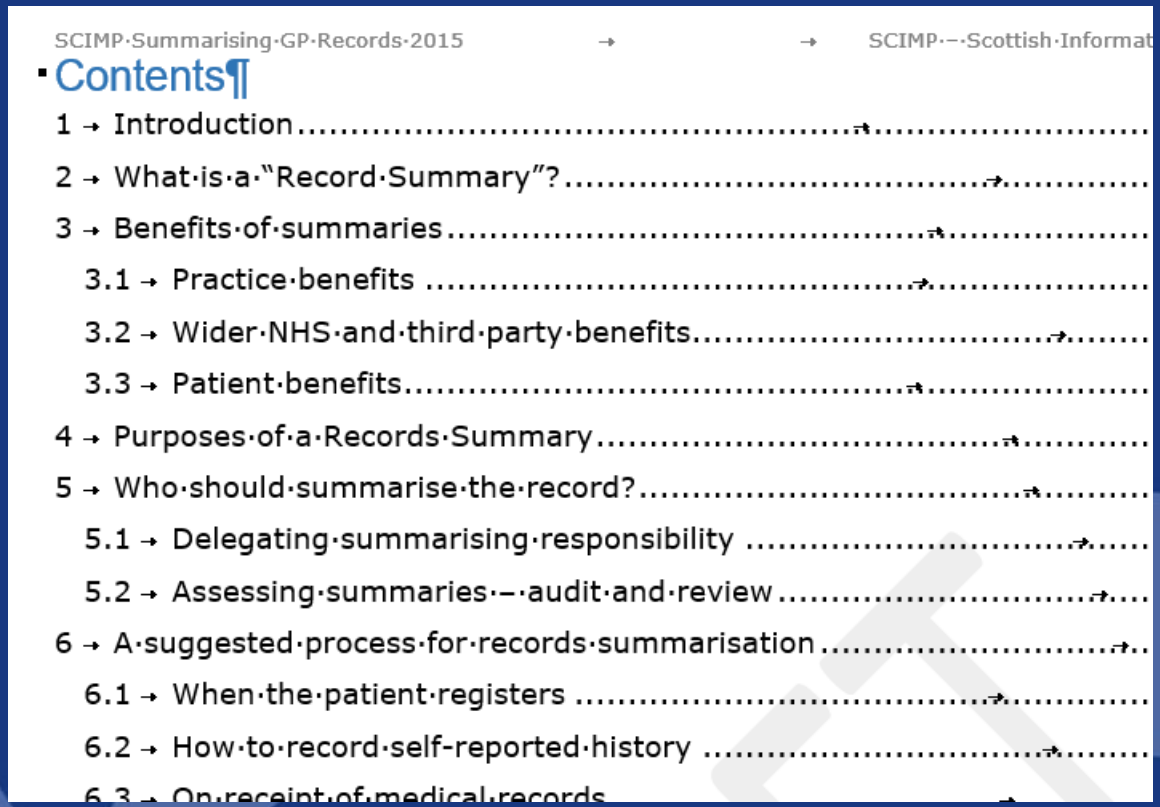
Scottish Clinical Information Management In Practice

NHS SCOTLAND

What is this?



SCIMP·Summarising·GP·Records·2015 → → SCIMP·–·Scottish·Informat

Contents¶

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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."

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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

GP

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 summarisng (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

Standard Administrative Entries

Read Terms that can help in this process and that are also used by PSD include:

9l2.. Patient paper record not available

9lJ.. Existing patient paper record available

9lK.. Patient paper record held at practice

9349. Electronic general practitioner medical record received

934Z. Computer record NOS

Additional Administrative Entries

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

9I5.. Patient record merged

Important Data Items

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?

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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

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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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