Summarising GP Records

SCIMP

Scottish Clinical Information
Management In Practice

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Authors	Paul Miller paulmiller@nhs.net Roslynne O'Connor roslynne.oconnor@nhs.net

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1 About

This document provides guidance for general practices in NHS Scotland on best practice for summarising medical records onto electronic record systems. This process of record reconciliation can be complex and requires a methodical and planned approach to do well. We have addressed the background; why this process is required, and outlined some of the benefits. We provide a description of ideal content and advice on how this should be identified and captured to the primary care electronic health record on currently used systems in NHS Scotland general practice. Appendices provide a checklist for summarisation; a list of our recommended minimum data set for the process and a copy of our simple guide to using Read Version 2 Clinical Terms in general practice.

This guidance will be used to support the migration to GP2GP in NHS Scotland with many of the processes of receipt and incorporation of the electronic record similar in process and intent.

2 Introduction

A patient's paper record was the vehicle for recording patient consultations, compiling problems lists, holding third party information, filing correspondence, results and any other clinical and administrative records.

In NHS Scotland A4 paper colour coded sheets were provided for filing medical notes. This aided in the management of the information - everything had a place and a standard structure could be maintained. The paper record also had disadvantages: illegible handwriting, variability in use of recommended ordering, identifying provenance, and no easy way to sort or filter the information.

These records moved between practices as the patient changed surgeries and each subsequent clinician involved in the patients care added content to the record. Commonly the receiving practice amalgamated the medical records into their system - reorganising the record structure to their preference, whilst still retaining the integrity of the paper record.

In May 1999 the Scottish Executive changed GPs' terms of service to allow part or all of patient medical records to be held on a computer system. This supported the introduction of the GMS contract in 2004. The business requirements of the Quality and Outcomes Framework (QOF) emphasised the need to be able to record, compile and provide data to support patient care and as evidence for payment claims. Clinical systems developed to support this. A new requirement of the GMS contract was that medical records should be summarised by the new practice within eight weeks of receipt.

In December 2006 NHS National Services Scotland (NSS) Practitioner Services Division (PSD), developed the Docman transfer process and the subsequent rollout of a national document scanning platform supported by a national folder structure. When introduced practices were able to store all paper correspondence electronically. When a patient left a practice this information transferred electronically to the next practice or to a central repository. This was a catalyst for many practices to stop writing in the paper notes, and to record consultations within the electronic clinical system.

This created a situation where information relating to patients was being held in two different systems. Historical information was stored in the paper record and new information was being added to the electronic record.

Summarising the paper record into the electronic system was an obvious solution. Although defined as a contractual requirement in 2004, there has been no single definition of what

constitutes an adequate summary for this or other purposes. Nationally the development of the Emergency Care Summary (ECS), Key Information Summary (KIS), Electronic Palliative Care Summary (ePCS) and ePrescribing Services accelerated the move to electronic patient records.

The fundamental issue of which information to include in a summary has never been fully resolved. Many practices still re-summarise new patient records to ensure the data meets their own standards. This is in part because there is no agreed quality assurance marker.

Increasing users and uses of GP records provide drivers for a more formalised summary process. To form the basis for national guidance for this, this document uses information from:

- The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004
- Practitioner Services Division, Payment Verification Team
- The Good Practice Guidelines for GP electronic patient records v4 (2011), Department of Health
- PRIMIS [www.nottingham.ac.uk/primis]

3 What is a "Records 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.

4 Benefits of summaries

4.1 Practice benefits

- Better data quality improves the usability of the records by providing better information. This improves patient care by:
  - Making it easier for practice staff to obtain accurate and useful patient information to support their work.
  - Reducing duplication of data entry and procedures.
  - Creating accurate disease registers.
  - Supporting automated and curated shared summaries such as ePCS and KIS.
  - Improving medication management and reconciliation processes.
  - Enabling computerised decision support.
  - Assist in the implementation of call and recall systems.
  - Aid joint decision making.
  - Reduce or eliminate the need to reference historical paper records.

4.2 Wider NHS and third party benefits

- Good data can be made available for public health and research purposes such as SPIRE[1]
- Accurate data is a requirement for better governance.
- High quality electronic records have resilience and persistence even when transferred to new records systems.
- Supports the automated inclusion of relevant data in referral letters and reports to third parties.
- Required to support the sharing of GP records system clinical data to other direct patient care services.

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[1] http://www.spire.scot.nhs.uk/

- Aids in the delivery of the five new strategic NHS Scotland e-health aims, developed as part of the eHealth strategy 2014-2017[2].

4.3   Patient benefits

- Can improve encounters with the practice as previous history clearly documented.
- Will support patient access and sharing of their records.
- Improves the transfer of records when changing practice.
- Facilitates accurate call and recall for any monitored conditions.
- Improves medicine safety.

5 Purposes of a Records Summary

The GP records summary has the primary purpose of supporting the practice in looking after that patient. This influences the information captured and how it is structured.

Secondary purposes are the realisation of the benefits outlined above.

6 Who should summarise the record?

In ideal circumstances the best person to summarise a patient's record is a clinician directly involved in that patient's care. This is not always possible because of other demands on clinical time, as well as competency with respect to maintaining aspects of the electronic record with which a clinician may be unfamiliar. It is therefore entirely reasonable for suitably trained staff to carry out all or part of the tasks required.

Practices may engage different members of their team to undertake different aspects of the process. There is value in improving quality and consistency by identifying a member of the team to act as the data quality lead, providing others a named person to ask when querying data entry issues. It is important that the practice team are aware that they all have a responsibility to maintain good medical records.

People recording summary data must have a good understanding of the record system in use, must know where in the record system to store information, and have a working knowledge of the underlying terminology i.e. Read Codes or SNOMEDCT.

Without a practice wide agreement different users will record different things in different ways. An agreement on information capture and data recording may be a formal document, but informal agreements through discussion are also helpful.

The practice should agree which items are to be captured from previous records; how and when they are to be identified and subsequently recorded, and by whom.

Examples of practices delegating tasks include engaging a practice nurse to review the previous records and write down important events, passing this to an administrative staff member to enter the items to the patient's electronic record. The practice manager may review the patient's important contract data such as chronic diseases, the GP could enter the medication and allergy history. Summarising the record is a team based task and does not all need to be undertaken by a single individual.

6.1   Delegating summarising responsibility

A summariser's roles and responsibilities should be agreed and documented and reviewed regularly, at least annually. All summarisers should have a 'confidentiality' clause in their contract of employment in common with other practice staff.

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[2] http://www.gov.scot/Publications/2015/03/5705

Summarisers must:

- **Demonstrate competence**
  - Understand medical terminology and good clinical record keeping practice.
- **Be appropriately trained:**
  - In use of the clinical terminology as used in the clinical system for this purpose.
  - In data entry and information review using the practice's clinical system.
  - In the practice's guideline and processes for summarising.

6.2   Assessing summaries – audit and review

Practices should periodically review their summarisation quality. This can be achieved by:

6.2.1 Sampling audits

Another reviewer can check the original reviewer's summary on a sample of records. One record in 10 to 50 is typically acceptable for this purpose, but exact numbers depend on competencies and experience of summarisers and reviewers. Errors, mismatches and omissions should be discussed and corrections agreed with the original reviewer. A record of the sampling audit should be kept.

6.2.2 Multiple reviewers

A process whereby two or more people review every record for summary information is probably beyond the resource of most practices. In some instances delegating specific summary tasks to different reviewers, perhaps with some crossover checking, can be effective.

6.2.3 Review with patients

A process whereby the records summary is discussed and agreed with the patient has benefits or providing clarity for both clinician and patient, and may also identify errors.

6.2.4 Searches and analysis

Data quality searches can be authored to look for common errors and mismatches in coded records.

6.2.5 Ad Hoc audits and searches

As part of general work of managing the work of the practice users may identify gaps or errors in historical data in patient records. A process for having these corrected should be outlined.

6.2.6 Commercial review

External companies may be able to offer review of clinical data for specific condition management or contractual improvement. Commercial arrangements must of course be subject to suitable governance and ethical requirements.

7 A suggested process for records summarisation

It is essential for summarisation that the practice receives and understands the information sources that can be used for finding relevant information to add to the new electronic record. These are:

- Patient's self-reported history obtained at interview
- Patient's self-reported history obtained from registration questionnaires
- Patient's record of repeat medications, including 're-order' slips
- Written paper records – A4 folders and Lloyd George cards
- Paper correspondence and reports records not yet scanned to Docman
- Document records received from the Docman to Docman Process

- The patient transfer report generated by the previous practice
- Any patient held records, such as maternity records, or records received from abroad
- Any available pharmacy records

The administration staff within a practice are involved with medical records even before summarising takes place. They have registered the patient, received any Docman transfer images and await the paper medical record (if there is one).

PSD has a process in place that advises new practices in what format to expect medical records. The sending Practice, during the removal process has to advise the next practice:

- via Docman export process if paper records do or do not exist for the patient
- via a form attached to the paper record if Docman images should have been received.

These counter checks advise the new practice what they should expect to receive. The start date of the eight weeks summarising window is from when all expected medical records have been received.

7.1   When the patient registers

Practices can use standard proforma for patients to gather some initial information about the patient's history. The accuracy of self-reported history does vary and clinical judgement is required to assess its validity and significance.

In general self-reported history should be validated when the formal medical record is received and added or amended at that time.

Although no standard questionnaire exists for new patient registrations, and practices need to adapt such forms for their own circumstances, we would recommend the following is asked:

7.1.1 "Do you have any allergies or any record of bad side effects from any medicines?"

Self-reported adverse drug reactions are always helpful in guiding prescribing decisions before the formal record is received. The patient's reporting of the adverse reaction should always be validated later on as in some instances it may be incorrect or misleading.

7.1.2 "Have you ever been admitted to hospital and, if so, what for?"

This may help to identify any significant acute illness, chronic conditions, procedures and operations.

7.1.3 "Have you ever had any serious injuries, such as broken bones or bad sprains?"

Important injuries that may not have required admission.

7.1.4 "What medication do you currently take, if any?"

A medication list is helpful in identifying current conditions. Medication lists can be more accurately reconciled using a repeat prescription order form from the previous practice. If the patient has a pharmacist that helps to manage their medicines then contacting them can be helpful.

7.1.5 "Do you currently attend any hospital as an out-patient and, if so, what for?"

Ongoing treatment and care is important to identify, and may also reveal additional significant clinical conditions.

7.1.6 "Are you a carer or does someone care for you?"

Recording the carer status is useful for a number of services and future clinical tasks such as influenza immunisations.

For women:

7.1.7 "Have you ever been pregnant?"

An obstetric history can be useful to have available to cross check later with the formal record.

7.1.8 "Do you have any children?"

Although this can help to clarify obstetric history for a woman, it is also useful to have this information for a man with respect to dependents. In addition, patients may have step or adoptive children for which they may have some parental responsibility and this should be recorded.

7.1.9 "Have you had a cervical smear?"

For woman in the screening age range it is helpful to obtain a verbal report of their smear history.

7.2 How to record self-reported history

7.2.10 Scan to Docman

At this stage the practice may simply wish to scan a record of the questionnaire and attach this to the patient's document record. This scanned document can be used by the records summariser at a later date to help validate their analysis.

7.2.11 Adverse drug reactions

If a severe adverse drug reaction has been self-reported it is good practice to add this to the electronic record at this stage as it will inform clinical decision support at prescribing events. Such records must be added as 'Allergies' using the interface on your clinical system that is provided for this. A free text comment could be added to indicate this is self-reported information or other attributes used to qualify the accuracy and severity of the reported reaction. If the date of onset is unclear then it would be reasonable to use the current date, this can be corrected later. We recommend that a prescriber enters (or at least checks) the adverse reaction record to reduce the risk of incorrect data entry.

7.2.12 Self-reported past history

Self-reported past medical history can be entered if desired using Read codes from the chapter "14...   Past medical history". This chapter is under the Chapter 1 – History / Symptoms section of Read so does not indicate the presence of the condition, just the reported history of it. As such the date to use for these records should be the date the history was taken, not the suspected date of the event itself.

Simply using the code and term '14... Past medical history' and using free text to record the patients reported past history can be a useful workaround until conditions are properly entered when validated on receipt of the records. For example:

> *"14...Past medical history*
>
> *Dementia, IHD, CVA, Hiatus hernia"*

7.3 On receipt of medical records

In NHS Scotland PSD will arrange for the new practice to receive any paper records held by previous practices, the Docman document record and a complete record from the last practice's GP electronic record as a document, normally received into the patient's Docman record via the Docman to Docman (D2D) process.

On occasion this may fail and the practice will receive a paper printout of the previous electronic record (or occasionally no record). This document is sometimes referred to as the

'Data Protection Summary' or 'Full Patient Summary' and in this document is called the 'Patient Transfer Report'.

The official process for transfer of records to NHS Scotland from NHS England is for all electronic records to be printed and sent to PSD.

As practices increasingly make use of 'back-scanning' of old paper records the received Docman record may contain the only copy of previous paper records.

Practices should have in place processes to allow them to track receipt of historical records of various types. They may wish to use Read codes in the GP record to do this, or have a log book or spreadsheet kept to do so. Read Terms that can help in this process and that are also used by PSD include:

- 9I2..   Patient paper record not available
- 9I6..   Previous general practitioner clinical record requested
- 9IJ..   Existing patient paper record available
- 9IK..   Patient paper record held at practice
- 9349.   Electronic general practitioner medical record received
- 934Z.   Computer record NOS

When received the practice needs to undertake a process of review of these records to identify information from the historical record that should be added to the new record on their system. This is, in essence, the creation of a summary. A recommended approach is described below.

7.3.13   On receipt of the Docman records

The D2D process can provide quick access to the patient's document record.

Check:

7.3.13.1   *The date of the earliest document filed in Docman.*

Where a patient has not changed practices multiple times, it can generally be assumed that the document record in Docman will be complete from this date and practices will not need to review paper copies of correspondence from this date onwards.

7.3.13.2   *Is the patient's electronic record report in Docman?*

If the previous practice has followed recommended procedures then the previous electronic record will have been exported to a document now filed into the patient's Docman record. If this is not present then practices should inquire from PSD whether a paper copy of this record will be received in due course.

7.3.13.3   *Does the patient transfer report contain a summarised version of the patient's record?*

Because of the QOF requirement the majority of GP electronic records will have been previously summarised. The records will probably contain a Read Term indicating this, typically one of:

- 9344.   Notes summary on computer
- 9346.   Total notes on computer
- 9345.   Extensive notes on computer

Identifying this term will allow the summariser to determine when the last summarisation exercise was completed. This can help direct the new review of records to reduce the need for duplication. "9344." was the recommended code to use as part of the GP Contract.

7.3.13.4   *Does the Docman record contain back-scanned paper notes?*

If this is the case the practice should not expect to receive a paper record as well and will be able to complete the summarisation process and review using only the Docman records.

7.3.14   On receipt of the paper records

Paper records may be received in A4 or Lloyd George folders but commonly a combination of both. A4 Folders were introduced in NHS Scotland in 1984 using a standard set of colour coded pages for filing specific types of information. Patients born and living in Scotland after this date are likely to only have an A4 record file. Patients from other parts of the UK will have additional paper records in Lloyd George or A4 printouts.

As many practices have now moved to paperless records there will be instances where the patient has no paper record, but there is no single date that this can be determined from due to different rates of migration and change. In general such 'electronic only' records will apply to younger patients.

7.3.14.5   Review the paper record

The paper records received should be examined for completeness. Gaps in the records can arise for a number of reasons and any gap can be recorded as described 8.1.3 below.

7.3.14.6   Does the paper record contain a written summary?

The grey coloured A4 record sheets were used by practices to record summary information. These sheets, when present, can provide a useful resource for practices undertaking a summary review. No standard process has been applied to the information contained on the grey sheet, however, and the information they contain will be subject to variability in information accuracy, completeness and context in a similar way to any summary content in the electronic record.

7.3.15   Content review process

Once all information sources have been received and reviewed the practice can undertake a summarisation exercise. Using the various records available we recommend the content in section below is identified and coded. This should be approached systematically with each information section being marked as completed in turn.

7.4   Chronological Review of Paper Records

7.4.16   Clinical Notes (Pink A4 sheets and Lloyd George)

Summarisers should begin with the earliest held paper clinical notes and briefly review these, noting any important items. Important diagnoses commonly made in general practice may be identified at this stage as well as narrative discussing other clinically relevant events which may be more completely recorded in the document record. Where the details of the disorder are precise enough with respect to the date of the event and the specific condition the clinical code can be recorded in the electronic record at this stage. If there is doubt or ambiguity about the clinical note summarisers should make a note of the possible condition on their worksheet and validate it later during review of correspondence and other records.

This brief review will also indicate the quality and completeness of the paper record.

7.4.17   Correspondence Records

Summarisers should next review all correspondence, letters to and from practices about the patient, which are normally filed in the last section of the paper notes. These are commonly (but not universally) filed in chronological order by practices, but there may be some inaccuracies in this as well as other variability in this filing methodology. Summarisers need to be aware of this when analysing records to determine the most precise diagnosis date for a condition.

Summarisers should aim to identify relevant content from the correspondence record content items and enter these at the time into the GP clinical system record.

7.4.18   Immunisation Records

The yellow A4 sheet was used to record any immunisations. Where these pages are present and contain content these immunisations should be added to the GP system record.

7.4.19   Results, pathology and radiology

Green A4 sheets were used to file results. The organisation of these varied between different practices. Summarisers should review these sheets to identify any relevant content and add it as appropriate.

7.4.20   Grey 'summary' sheets

These were used by practices for noting important medical history items. Summarisers should identify items on these sheets and verify the record is accurate with an appropriate date, noting each one as this is completed. The clinical codes can be entered into the GP system during this process.

7.5   Review of Docman Records

Docman has been used in NHS Scotland as the Document Management System since 2004. Not all practices progressed to scanning and paperlight working at the same time, however, so the Docman record may not be contiguous or complete, with some correspondence still present in the paper files. A quick review of the paper and Docman records can be undertaken to establish this.

7.5.21   Docman Folders

NHS Scotland recommends a filing structure for practices to use for different sources and types of documentation stored in Docman. This structure can help guide summarisation processes by letting the summariser filter views to particular types of clinical information. Review of correspondence and results will follow a similar process to the paper records in this instance. The same summariser should review the paper and Docman records to limit the risk of duplication of work and data where identical documents exist in both record sources.

7.5.22   Back scanned records

The Docman record may contain a scanned copy of the paper record. Normally the paper record will have been destroyed if this is the case. Summarisers should review the copy of the paper record on Docman using the same processes as outlined above for the original record.

7.5.23   Patient transfer reports

When a patient leaves a practice, the practices should generate a report that prints all the patient's electronic records held in the GP clinical information system to an image file that is then stored in and transferred with the patient's Docman records to the new practice. EMIS PCS and INPS Vision provide standard reports for this purpose.

7.6   Correcting previous summary information

Part of the summariser's work is to review summary data added by previous practices and validate it for accuracy. Is it:

- Correctly coded – does it use the correct Read Code for the condition? Refer to the SCIMP guide to Read Codes[3], included as an appendix to this document.
- Correctly dated – the event date for a record should be the date the event occurred, not the date it was entered on the system. See section on 9.4 below9.4 on dates.

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[3] http://www.scimp.scot.nhs.uk/wp-content/uploads/SCIMP-Guide-to-Read-Codes-1-6.pdf

- Correctly stored – allergies, for example, must be recorded using the correct form on Vision and EMIS PCS for them to trigger decision support functions.
- Relevant – is the summary data really important? Sometimes routine care records are promoted to 'significant' by users either through error or to support a local requirement.

Information so identified should be corrected when coded and added to the receiving practice's records.

Note this type of correction is different from correcting medical history that is wrong (the patient never had the condition) or has evolved or changed over time (the patient was thought to have condition A, but after some time it became clear it was condition B.) See section 9.5 below.

8 Recommended content for the summary?

8.1 Administrative coding of records

These are Read codes that can be used to record the administrative tasks of receipt, summarising and merging records. These are in addition to the standard process used when acknowledging receipt of records from PSD. From a clinical perspective administrative coding may seem unimportant but identifying gaps, start and end dates at this stage will significantly improve your understanding of the completeness and currency of the record.

8.1.1 Date records held from

9R8.. Date records held from

This should be the first entry added to the electronic medical record before any other entry is made. It is useful to record this especially if the patient has come from abroad. Insurance companies often require this piece of data for reports.

8.1.2 Incomplete patient record

9lE.. Incomplete patient record received

Use this code and term if significant parts of the record are missing.

8.1.3 Breaks in the medical record

93E.. Gap in patient record

Use this term with a free text comment of "start of gap in patient record" and a second entry when the break ends with free text comment of "end of gap in patient record".

8.1.4 Record merged

9l5.. Patient record merged

Use this code and term when the notes have been fully summarised and merged into the clinical system. This should not be confused with "9344. Notes summary on computer", which is used by each practice to identify when the information has been fully transferred into their system and is recognised by QOF.

8.2 Significant and Important Medical History

Key information to code is:

- Any diagnosis or symptoms that resulted in any admissions to hospital.
- Any morbidity that has required out-patient care.
- Any chronic diseases, past or present.
- Any conditions for which the patient takes or has taken regular medication, roughly defined as more than one prescription for the same episode of a condition.
- All fractures.

- All significant soft tissue injuries – defined as those that required treatment from hospital or physiotherapy, or resulted in significant impairment of function, time off work or curtailing of usual activities.
- All operations including minor excisions, incisions and curettage.
- All hospital procedures and investigations, as well as the diagnoses made from such procedures e.g. outcomes of a colonoscopy
- Primary care procedures such as minor operations and contraceptive devices.
- Important medical diagnosis that may be made in primary care such as back pain, urine infections, community acquired pneumonia, migraine, hypertension, asthma and acne.
- Important mental health diagnoses that may be managed solely in primary care including depression, anxiety and panic disorder.
- All obstetric events of deliveries, miscarriages and terminations.
- The presence of implantable devices such as pacemakers and stents.
- Any infectious diseases that are notifiable.

8.3   Chronic Disease Registers

Practices have found it helpful to be able to identify patients who currently have a specific morbidity such as Asthma or Hypertension. Clinical systems sometimes have specific data structures for managing disease registers. Disease registers for morbidities that are included in the QOF are determined by specific logical business rules that use the presence of dated terminology codes and other values, making the use of explicit records of 'on' or 'removed' from a register redundant.

For conditions not covered by contract business rules practices will need to identify terminology codes to use to identify the required cohort of patients, and consider how to manage instances where the condition resolves.

8.4   Allergies and Adverse Reactions

All drug and non-drug allergies and adverse reactions should be recorded.

8.4.5 Adverse Drug Reactions and Allergies

These should be recorded using the appropriate form on the clinical system. This will ensure that the record can be used by prescribing decision support systems and also ensures records can be viewed and understood by users.

We recommend that a prescriber reviews or records all adverse drug reaction and allergy records as both Vision and EMIS link adverse reaction records to actual drugs, ingredients or classes of drugs and use this value for decision support. It is therefore essential that the correct drug or ingredient is selected after "14L.. H/O: drug allergy" is selected.

When recording an allergy to Penicillins for example: if a Read Term is required by the clinical system then a high level term such as "14L.. H/O: drug allergy" is recommended. There is no clinical requirement to record a more specific Read Term, such as "14L1. H/O: penicillin allergy" as this is not used for decision support.

It is not incorrect to add or use a more specific term if the data recorder wishes to do so, and it does not cause any problems with decision support, but it will not always be possible to find a specific term and can be time consuming trying to do so.

If the reaction is an 'intolerance' or significant side effect (rather than an 'allergy') then if a Read Term is required it is better practice to use a Read Term such as "TJz.. Adverse reaction to drug NOS" to distinguish between immune reactions (allergies) and adverse reactions (side effects).

Always use the correct form or interface for recording adverse reactions on Vision or EMIS. This will allow the recording of a drug name or ingredient. The clinical system decision

support functions will then handle identifying what class or group of drugs the specified drug or ingredient belongs to. For example, recording an adverse reaction to 'Amoxicillin' will trigger a decision support alert if a future user tries to prescribe 'Phenoxymethylpenicillin' as the software can identify all drugs of the type 'penicillins'.

There is no requirement to add the adverse reaction record as an EMIS 'Problem'.

When available, users should also record values for the reaction either as free text or as a Read Term depending on the system (e.g. 'causes a rash' or '1D14. - C/O: a rash'), likelihood and severity. If these values cannot be established, then we would recommend no entry against them.

Vision requires a value is selected for these attributes and in cases where the details are not known we recommend completing the form using the values:

Type of Reaction: "TJz..   Adverse reaction to drug NOS"

Likelihood: Possible

Severity: Moderate

And we would recommend adding a free text comment: "specific reaction, severity and certainty is not known.'

If the patient has an adrenaline pen for anaphylaxis treatment this should also be documented along with the date it was last reviewed if part of the prescribing record. Use the code "66G8. Carries adrenaline preloaded injection pen" to capture this data in the record. If the device is still part of the patient's current medication then a prescribing record should also be made.

Adverse reaction records should be dated using the date that the reaction first occurred, if possible. The date it was first diagnosed could also be acceptable. If neither are known we would recommend using the date of recording and appending a comment to the effect that the date of onset is unknown.

8.4.6 Non Drug Allergy

Non-drug allergies should be recorded using the appropriate form on the clinical system if one is available. They should also be recorded using the most specific Read Term available. This may require an additional entry.

Prescribing decision support for non-drug allergies does make use of the Read Terms in the patient's record (in contrast to Drug allergy and adverse reactions above). For example, adding the Read Term "SN582   Peanut allergy" to a patient's record can trigger a decision support alert when prescribing Arachis Oil Enema.

The implementation of decision support based on Read terms for non-drug allergy is different in different clinical systems. Recording non-drug allergies using a Read Term will allow them to be shared more reliably outside of the practice.

8.5   Examinations and procedures

It is not possible here to provide a comprehensive list of examinations and procedures that practices should record. The test to apply is how useful the record of the investigation and its result will be to the clinical team in the practice. Examples include:

- Respiratory measurements such as Peak Flow, FEV1, and spirometry. Multiple values showing trends can be helpful, but recording best, worst and usual values are of most clinical significance.
- Cardiovascular tests, typically ECGs, are helpful to record even when normal as the record of a normal result can be important. Similarly exercise tolerance tests and ambulatory

ECG and Blood Pressure results as well as invasive investigations such as cardiac catheterisation and angiography should be recorded.

- Any invasive test such as an endoscopy is helpful to record, even if normal. This would include colonoscopies, upper GI endoscopies, cystoscopies and hysteroscopies.

8.6   General health Status

Include the most recent:

- Smoking status and stop smoking advice.
- Height, weight and body mass index (this latter is often calculated rather than separately entered). If BMI is or was over 30 add a separate Read term for Obesity (From C380. Obesity subchapter).
- Alcohol consumption and alcohol advice
- Last three blood pressures, or more if considered clinically relevant e.g. pre-treatment levels in people with hypertension

8.7   Medications

When a patient registers it is essential that any medications they are currently receiving as a Repeat Prescription are added to the electronic record.

We recommend that a prescriber, normally a GP, adds this data to the record. This process of medication reconciliation can be facilitated by:

- Using the patient's repeat prescription order slip
- Reviewing the patient transfer report for medication information
- Discussing directly with the patient at a consultation
- Discussion with the community pharmacist who dispenses for the patient.
- For patients in care homes, discussing the medicines list with the nurse in charge, or obtaining a copy of the patient's medication administration record ('MAR' sheets).
- Reviewing the immediate discharge letter if the patient has been discharged from hospital.

The prescriber should add the medications to the patient's medication records on the computer system using values that meet their local requirements. We recommend using a standard medication description from the Dictionary of Medicines and Devices (dm+d[4]) whenever possible. Aim to provide quantities that can be met using standard pack sizes. Directions such as how much to use, or how often to take, should always be present for medicines and should not contain abbreviations or non-English words. Wherever possible directions should be specific and not use terms such as 'As directed'.

Clinicians should record that at least a Level 2 Medication Review has been completed after undertaking this work.

If the practice and patient are enabled for the Chronic Medication Service then the prescriber should decide which medicines, if any, are appropriate for using this prescribing model and add them accordingly.

All repeat medication must have a clear indication in the patient's record. This can be managed in a number of ways. Some practices may wish to use a 'Problem' record in the patient's record and link the medication to this. Adding some additional text after the direction text can also be useful, and this can help inform the patient also. For example: "Take one tablet every morning [For Blood Pressure]".

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[4] http://dmd.medicines.org.uk/

Use of Read Terms from the subchapter "8BG..   Drug indicated" is also appropriate, and practices can add free text comments to indicate which drugs are for which conditions.

Simply recording the indication in narrative text, not necessarily linked to any Read Term, is not recommended as this can make it harder to identify the indication on brief review of the records.

Recurrent medication that may be prescribed as 'Acute' may also be apparent from review of the patient's medication. There is no specific way to add these prior to them being actually issued. A clinician may comment as part of a medication review record that the patient is also currently receiving this additional medication or a Read Term could be used to record this such as those in sub-chapter "8B2..   Therapeutic prescription".

From a summarisation perspective the most important process is to add the patient's current repeat medication.

8.7.7 Recording Past Medication

There is no requirement to manually re-enter all previous medication records, and indeed this could be potentially risky and misleading. Practices may choose to enter some selected past records, for example if a patient had a period on long term immunosuppressive therapy, but this should be to meet local clinical contexts.

8.7.8 Recording non-practice medication

There is no absolute requirement to do this and it can introduce risks. A decision should be made on a case by case basis. Refer to SCIMP's guidance on this topic[5].

8.8   Vaccinations and Immunisations

All childhood and adult vaccinations should be included using the dates in the received record and including the manufacturer, batch number and expiry dates when available. If the patient receives the influenza vaccination then at least the last vaccination needs to be recorded on the new records system.

Immunisations should always be recorded using the correct form or functions on the GP system to ensure they can be identified as immunisation records in the future. The record should be added with an event date of the date the immunisation was administered, where this is known. If attributes are available for recording additional elements such as Manufacturer, Batch Number and Expiry Date then these should be entered into the electronic record in the appropriate fields.

Children's immunisations when entirely administered in NHS Scotland will be on the SIRS system also. The essential task is to ensure the child is registered with SIRS and that their record is up to date.

8.9   Pathology results

It is not possible to provide definitive guidance on what should be recorded as part of the patient's record as it depends on clinical need and thus the patient and care context. For example: a patient with ongoing Chronic Kidney Disease (CKD) may require to have multiple eGFR results entered to allow the clinician to understand the trend.

In general the last test result should be sufficient for:

- Thyroid: TSH/T4.
- Lipids: Serum Cholesterol, LDLC and HDL.

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[5] http://www.scimp.scot.nhs.uk/wp-content/uploads/Microsoft-Word-SCIMP-Non-Practice-Medication-Recording-Guidance-v2-Jan-2014.pdf

- Tumour markers such as PSA and CEA.
- Diabetes: HbA1C
- Renal function: eGFR
- Therapeutic drug levels, for example Digoxin, Lithium.
- Fasting or Random Glucose results
- Urinary protein analysis: ACR/PCR
- Haemoglobin

For anticoagulant monitoring aim to capture at least six previous INR values if the practice is responsible for monitoring this. Doses and testing periods should be entered to give a trend, such information may need to be captured as free text. Other trends of importance include cholesterol and tumour markers such as PSA and CEA.

Bacteriology and virology results may also be of importance even when negative where they represent a screening test, such as for Hepatitis viruses or HIV. Similarly negative results for sexually transmitted diseases and for Helicobacter are significant for future management.

Positive results are not as important to capture as a result where the associated diagnosis is coded and added separately. For example, a positive Hepatitis B viral test should result in the record having the code "A703. Viral (serum) hepatitis B" added to the record – the method of diagnosis is not as significant though practices may wish to record this for completeness.

Test results required for managing the GP contract should always be captured and entered.

8.10 Imaging procedures and results

X-rays and other imaging reports may well contain relevant information such as positive findings, but the imaging event itself may be relevant even where the outcome is normal. It is good practice to record in the GP system imaging procedures as this information can be helpful for future management, preventing unnecessary duplication of investigations and limiting radiation exposure. As a minimum any imaging results with abnormal findings should be added.

DEXA test results should also be captured, ideally recording at least one value outcome, although use of terms specifying normal, osteopenic or osteoporotic without a specific value is acceptable. A diagnosis code should also be added if osteopenia or osteoporosis was demonstrated.

8.11 Screening results

The outcome of screening services encounters should be recorded when available. For example bowel and breast screening records. The only requirement is to record the final outcome from each screening event, including non-participation.

The presence of an aortic aneurysm should be recorded as a significant history item in the record and the patient should have a Key Information Summary created and ensure this data is included[6].

8.12 Women's Health

In Scotland, if a woman is registered on the Scottish Cervical Cytology Recall System (SCCRS), then historical smear data is provided electronically after the patient registers with a practice. It can be helpful if the summariser checks that this has happened and enters the data if not present. Patients transferring from other parts of the UK will not have such data so it will require to be manually entered.

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[6] http://www.healthscotland.com/uploads/documents/20207-AAAScreeningResultsBriefingSheet.pdf

Other useful data to record includes:

- Result of previous mammograms. If all normal the last result will suffice, but all abnormal historical results and normal results from investigations at clinics should be added to the record.
- Contraceptive history, in particular if an IUD or contraceptive implant is currently being used or has been used in the past.

8.13 Child Health Records

There is no requirement to record all information from routine child health examinations, but summarisers should record a significant finding or outcome. Practices may wish to record the event dates of routine child health examinations for completeness.

8.14 Other social data

Where known it is helpful to record data relating to:

- Occupation
- Relationship status and past milestones
- Employment status and occupation
- Benefits and financial status
- Housing status and with whom the patient lives
- Ethnicity and languages spoken
- Dependents
- Any forensic history
- Any history of challenging behaviours
- If the patient is an armed forces veteran
- If the patient is a carer or has a carer

8.15 Family History

Family history of important conditions is helpful to record where the information can be reasonably judged to be accurate. Family history of illnesses that may have a hereditary component are those with most value. Examples include a family history of ischaemic heart disease under the age of 60 years; family history of some types of cancer such as bowel or breast; a family history of atopy. Ensure family history is coded using the codes in sub-chapter "12...   Family history" of Read. Do not use a disease or condition code qualified as referring to family history in free text.

Family history items should be dated using the date the information was obtained if possible, but the date of recording is also acceptable.

8.16 Contractual data requirements

As records are summarised codes that relate to QOF, typically those that place the patient on a disease register, may also trigger specific data entry requirements often around the method of diagnosis. When a coder enters a QOF relevant morbidity term they should check for any additional data that should be captured from the previous record for the contract reporting.

It is useful to have a template that will ensure that the practice captures the information in the medical recorded related to the QOF domains for the current year, including exclusions. Vision and EMIS both provide templates to assist with this data entry.

8.17 Key Information Summary / Palliative Care Summary Data

When a new patient registers practices should review the records to determine if they have in place a Key Information Summary. The presence of a 'Decision to Send' or a 'Consent to KIS' record in the patient's record could indicate this. If the patient has a palliative condition they

may also have records indicating a PCS is in place. The patient's consent for this summary will need to be reviewed and added on the new system.

Data for eKIS should be reviewed and completed on the GP system using the system provided forms or interface for this. This may require a consultation with the patient. Important data items include:

- Is the patient housebound?
- Are there other services in primary and community care involved, such as district nursing or social work?
- Is there advanced care planning in place?
- Is there a living will, power of attorney or guardianship?
- Is the patient a carer or do they have a carer?
- Next of kin details.
- The patient's resuscitation wishes or decision, including the presence of a DNACPR form.

8.18 Social and Child Care records

Is the patient:

- Currently on a looked after child register or subject to child protection or emergency protection notification
- Currently on a Person of Concern Notification from the Police or Social Work or identified as a vulnerable adult
- Are there any social agencies currently involved with the patient

This information should be included in the summary. Historical information of this nature: should be at the discretion of the agreed Practice policy. Further advice on the coding of child protection issues can be found http://www.scimp.scot.nhs.uk/better-information/clinical-coding/child-protection-codes-v1-0-june-2012/

8.19 Obstetric History

Care should be taken to record delivery data using codes that apply to the mother, not the child. For example, a mother who has a premature delivery could have a record coded using "L1431   Premature labour with premature delivery" or "L1421   Early onset of delivery – delivered". The child's record, however, would be coded with "635.. Premature   baby". Birth history codes are also available under "14Y..   Birth history".

8.20 Third party information

Care must be taken when recording references to third parties in the record, if any. For example, narrative records in a patient's record discussing illness in a relative. In general such records may not be considered significant for the summary but where they are a number of Read terms exist to allow recording of these issues. For example, terms under "13L.. Family illness" and "9f0.. History obtained from third party" are useful in this regard.

8.21 Other Information:

On a case by case basis; practices must take into account any safety notices regarding a patient; e.g. "only seen by male GP" and agree how to add this information so that it is available when needed.

Adoption information is also sensitive; and could be noted through a change of name.

9 How to record significant data items

We recommend that practices aim to maintain a convention when storing clinical codes in the patient record for the purposes of the 'GP summary'. Local functions in GP systems can be

used to make it easier to filter data that the summarisers have identified as significant and many records sharing services use this property to share the GP summary for other uses. For example: the Key Information Summary and SCI Gateway referrals.

Practices can also use problem orientation functions to manage significant conditions, this functionality allowing linking of related elements in the record and generally an indication of whether the condition is active or resolved.

It is essential that data entered onto the system uses the correct Read Code and Term for the condition being recorded.

Consideration needs to be given at a practice level about how this information should be recorded. Vision and EMIS PCS use different ways of marking an item as significant and therefore part of the GP Summary.

9.1   INPS Vision

Vision provides two main methods of marking items as important – Priorities and Problems.

9.1.1 Vision Priorities

Priority in Vision is a number from 0 to 9 that is stored as part of a Medical History entry. This is the default form in Vision for entering Read Codes. Priority numbers are not available to other types of clinical data in Vision, such as examination findings with values (e.g. Blood Pressures, FEV1, PEFR) or pathology results. As recommended above, the data stored by summarisers should always be entered into the most appropriate form on the clinical system – a blood pressure reading value should always be added using the blood pressure form (or 'SDA'). For recording important medical history (generally from Chapters A to U in Read) most of the time this will be added to the Medical History form by default.

Although it is not possible to mandate use of a particular priority number for specific purposes, we recommend that all items identified as important are allocated a priority value of '1'. This convention was used in NHS Tayside and is the most commonly applied use of this priority value.

We also recommend that practices use an agreed value ('3' is preferred) for all other routine medical history records. This has some value in supporting filtering of data by the practice. Other priority numbers can be allocated to meet local requirements. Some practices use another value for identifying items that are of 'medium' importance (commonly '2') but this has no value outside of the practice.

We would recommend that practices use the Priority attribute in Vision for creating data summaries even if they also maintain Problems, as below, for local use.

9.1.2 Vision Problems

Vision has functions to create 'Problems' associated with data items. This allows users to group all associated data with the Problem, allowing a quick filtering of condition related information for clinical care. Problems can be Active or Inactive. An Active problem is used for conditions that are currently affecting the patient's health and wellbeing; an Inactive problem is one that is either completed or in remission.

Careful management of Problems is needed in practices to maintain the quality of the Problem Orientated Record. Practices should agree which items are considered important enough to be managed as Problems and ensure that as conditions evolve Problem records are maintained and made Inactive as appropriate.

Correct use of Problems in Vision can be used to create a GP Summary for local use, and data sharing services could also use Problem data.

Using Problem functionality does not prevent users also using the Priority values as described above – both methods can be used to provide views of the data in the patient's record. Practices do not need to maintain problem orientated records in Vision.

9.1.3 Episode Types and End Dates

Practices can find it helpful to make use of Episode Types and End Dates to further define if a condition is first, new or continuing. End Date values can be entered using the date a condition or episode ended.

Sharing services could make use of these values either to filter or display data but at present in NHS Scotland we are not aware of any services that do. Data extracts for contracts, specifically QOF, do sometimes make use of the Episode Type value and practices should refer to the system supplier's guidance in this regard.

Users can create filters in Vision to display data for medical history items with specific Episode Types, or with end dates.

9.2 EMIS PCS

9.2.4 EMIS Problems

EMIS has functions to create 'Problems' associated with Read Terms, this can be done either as part of the consulting process or when adding a code to the record. This allows users to group all associated data with the Problem, allowing a quick filtering of condition related information for clinical care. The use of Problems in Consultation Mode in EMIS will automatically filter the past medical history based on this problem revealing past consultations of the same problem. Problems can be Active or Past, Significant or Minor.

	Active	Past
Significant	Significant Active	Significant Past
Minor	Minor Active	Minor Past

An Active problem is used for conditions that are currently affecting the patient's health and wellbeing; a Past problem is one that is either completed or in remission.

Careful management of Problems is needed in practices to maintain the quality of the Problem Orientated Record. Practices should agree which items are considered important enough to be managed as Problems and ensure that as conditions evolve Problem records are maintained and move into Past Problems as appropriate.

Correct use of Problems in EMIS can be used to create a GP Summary for local use, and data sharing services could also use Problem data.

9.2.5 EMIS Episode Types and End Dates

Practices can find it helpful to make use of Episode Types and End Dates to further define if a condition is first, new or continuing. End Date values can be entered using the date a condition or episode ended. By default from consultation manager minor problems have a duration of 28 days, though this can be adjusted when saving the consultation. Significant problems default to being permanent and have to be active made past problems in the problem management screen or when reviewing the problems in a consultations.

Sharing services could make use of these values either to filter or display data but at present in NHS Scotland we are not aware of any services that do. Data extracts for contracts, specifically QOF, do sometimes make use of the Episode Type value and practices should refer to the system supplier's guidance in this regard.

9.3   Event or Episode Types

The Clinical systems have similar 'event types' and to ensure consistency it is recommended for summarising the correct event types are used. An event type or episode type is an attribute of the data that describes its currency. Events may be, for example, new or first, continuing, past or ended.

For each entry the first instance that is recorded, should be recorded as a "First" event type.

Subsequent events for the same condition should be recorded as continuing because if recorded again as "First" event, there is a danger of misrepresenting the morbidity of a condition in a population.

A difficulty arises with certain conditions from which the patient gets better and then relapses, Depression for example. It is not the first time that the patient has had the condition however there has been a break in management of the condition. It should be recorded as a "new" episode type. For some areas of QOF it is essential to use this attribute correctly for reporting.

9.4   Dates

In general when recording data items users should use the most precise 'event date' that can be identified. That is: the date that the condition, disorder or procedure occurred. The date the item was recorded is normally captured elsewhere in the clinical system (typically stored in the audit trail) and should not need to be recorded specifically or separately by the clinical coder.

For dates of events that may have occurred during an illness episode in hospital, coders can use the admission date if it is not otherwise specified in the discharge document.

For test results and reports we would recommend using the date the investigation occurred rather than the date it was reported.

The date a correspondence item has been received by a practice is generally not relevant to the clinical data it contains – data should not be recorded using the received date. Received date may have value in other processes, but it is not useful for summarising in most cases.

Where a precise date is hard to identify systems may allow coded data to be entered using an approximate date value, such as year only, or month and year, or with no date in some cases. Nevertheless, we recommend that users always try to enter a complete date of Day-Month-Year as described below. Partial or imprecise dates can lead to difficulties in reporting and this can effect GP Contract business rules.

9.4.6   Day of month unknown

Use the value '01' i.e. the first day of the month.

9.4.7   Day and month unknown

Use the value '01-January' i.e. the first day of the first month.

9.4.8   Date unknown

Where possible simply estimate a likely year and use the 1st January for the day and month. If it is impossible to estimate use the patient's Date of Birth.

In all such instances it is good practice to qualify in the free text that a precise date is unknown.

9.5   Corrections and Deletions

9.5.9 Incorrect data

If a historical coded entry is found to be incorrect then the practice should change it or delete it. The amended entry should be qualified in the free text to indicate when it was changed, why and by whom. If an entry is deleted this action should be coded using the term "9R9.. Error entry deleted" and free text used to describe the original entry including its date, why it has been deleted and by whom.

9.5.10   Changed data

This may occur where a condition has changed over time. As above, where a diagnosis is found to be wrong it must be corrected in the record. This can be managed by amending the original entry to another term. Use of a Chapter 1, symptom term may be appropriate (for example '182..   Chest pain') or using the 'Suspected Condition' terms is sometimes an effective fix, found in the 1J… subchapter of Read '1J...   Suspected condition'.

As for deletions, a record of the amendment should be made in the free text.

9.5.11   Patient disagreement

If the patient disagrees with an entry in the record and there is evidence to support the correction then the same process as above for incorrect data can be used.

If no evidence to support the correction then do not delete the entry. Use code "9b02. Administration note" note and enter the information given by the patient at the same date as the entry is recorded.

Appendix A.   Data summarisation checklist

A.i Information Sources:

- Patient's self-reported history obtained at interview
- Patient's self-reported history obtained from registration questionnaires
- Patient's record of repeat medications, including 're-order' slips
- Written paper records – A4 folders and Lloyd George cards
- Paper correspondence and reports records not yet scanned to Docman
- Document records received from the Docman to Docman Process
- The patient transfer report generated by the previous practice
- Any patient held records
- Any available pharmacy records

A.ii Administration Codes

9l2..	Patient paper record not available
9l6..	Previous general practitioner clinical record requested
9lJ..	Existing patient paper record available
9lK..	Patient paper record held at practice
9349	Electronic general practitioner medical record received
934Z.	Computer record NOS
9R8..	Date records held from
9lE..	Incomplete patient record received
93E..	Gap in patient record
9l5..	Patient record merged
9344.	Notes summary on computer
9346.	Total notes on computer
9345.	Extensive notes on computer

A.iii Significant and 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
- 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

A.iv   Allergies and Adverse Reactions

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

A.v Examinations and Procedures

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

- Endoscopies

A.vi   General health status

- 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

A.vii   Immunisations

- Childhood immunisations
- Adult immunisations
- Travel immunisations
- Record manufacturer and batch number when available.

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

A.ix   Imaging Results

- X-Rays
- CT Scans
- MRI Scans
- Ultrasound Scans
- DEXA results

A.x Women's Health

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

A.xi   Child Health Records

- Abnormal findings
- Records of completion of routine examinations

A.xii   Social Data

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

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

A.xiii   Family History

- Validated or trusted family history records using the "12...   Family history" of Read

A.xiv   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.

A.xv   Key Information Summary / Palliative Care Summary / Emergency Care Summary

- 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.
- 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.

A.xvi   Child Protection Data

- Ensure any records are coded, especially if current. Refer to child protection codes guidance.

A.xvii   Adult Protection Data

- Currently on a Person of Concern Notification from the Police or Social Work or identified as a vulnerable adult
- Are there any social agencies currently involved with the patient

A.xviii   Obstetric Data

- Pregnancies and outcomes. Ensure term applies to mother, not baby.

A.xix   Third Party Data

- If recording this as important, be aware of sensitivities and use appropriate Read Terms.

A.xx   Other Information

- Patient alerts e.g. history of aggressive behaviour, not to be seen alone
- Adoption data.

Appendix B.   Minimum data set recommendations

Here we provide recommendations on the minimally acceptable content for a GP records summary based on the guidance above.

B.i Administration Codes

Use this code when the summary is completed:

- 9344.   Notes summary on computer

B.ii Significant and Important Medical History

- The diagnosis or symptoms that resulted in any admissions to hospital.
- Any morbidity that has required out-patient care.
- Any chronic diseases, past or present.
- Any conditions for which the patient takes or has taken regular medication,
- Important fractures (all *except* uncomplicated phalangeal fractures)
- All significant soft tissue injuries
- All major operations (thus *excluding* minor excisions, incisions and curettage)
- Diagnoses made from diagnostic procedures e.g. outcomes of a colonoscopy
- Important medical diagnosis that may be made in primary care
- Important mental health diagnoses that may be managed solely in primary care
- All obstetric events of deliveries, miscarriages and terminations.
- The presence of implantable devices such as pacemakers and stents.

B.iii Allergies and adverse reactions

- All drug and non-drug allergies and adverse reactions.

B.iv   General health Status

The most recent record of:

- Smoking status
- Height, weight and body mass index
- Alcohol consumption

B.v Pathology Results

- Those within the time frame and required for contract management.

B.vi   Imaging Results

- Diagnoses and abnormal findings from imaging investigations.

B.vii   Screening Results

- The presence of an aortic aneurysm must be added as a significant item and recorded in the KIS.

B.viii   Women's Health

- Date and result of last cervical smear.
- Presence of an IUD or contraceptive implant.

B.ix   Social Data

- Ethnicity and Language spoken.
- Risks to care workers.
- If a carer or has a carer.

B.x Medications

- Repeat medications the patient is currently prescribed.

B.xi   Key Information Summary or Palliative Care Summary

If patient has a shared summary then data must be correctly provided to populate it and consents must be entered.

Appendix C.   SCIMP Guide to Read Codes

This document is for GP practice staff and clinicians and is intended as a brief guide to understanding and using Read Terms in practice. We only refer to Read Version 2, 5 byte as this is the version in use in GP systems in NHS Scotland.

C.i What are Read Terms?

Read terms are a set of clinical descriptions that practices can use to manage the data in patients' records. They are named after Dr James Read, the initial author of the terms.

The 'Read terms' refers to the words – the descriptions such as 'Asthma'. Each term is associated also with a 'Read Code' – this is the letter and number code that uniquely identifies the clinical term. This can be up to five characters long, including full stops. For example, the Read Code 'H33..' is associated with the Read Term 'Asthma'.

Read Codes can be used by computer systems for searching, reporting and decision support and allow data to be shared reliably between different computer systems.

C.ii How Read Terms are organised

C.ii.i   Chapters

Read terms are organised by Chapters starting at Chapter 0 (zero), which contains terms for occupations, through to Chapter 9, and then chapters A to Z. The image below is from INPS Vision and shows this arrangement:


```
0.... Occupations
1.... History / symptoms
2.... Examination / Signs
3.... Diagnostic procedures
4.... Laboratory procedures
5.... Radiology/physics in medicine
6.... Preventive procedures
7.... Operations, procedures, sites
8.... Other therapeutic procedures
9.... Administration
A.... Infectious and parasitic diseases
B.... Neoplasms
C.... Endocrine, nutritional, metabolic and immunity disorders
D.... Diseases of blood and blood-forming organs
E.... Mental disorders
F.... Nervous system and sense organ diseases
G.... Circulatory system diseases
H.... Respiratory system diseases
J.... Digestive system diseases
K.... Genitourinary system diseases
L.... Complications of pregnancy, childbirth and the puerperium
M.... Skin and subcutaneous tissue diseases
N.... Musculoskeletal and connective tissue diseases
P.... Congenital anomalies
Q.... Perinatal conditions
R.... [D]Symptoms, signs and ill-defined conditions
S.... Injury and poisoning
T.... Causes of injury and poisoning
U.... [X]External causes of morbidity and mortality
Z.... Unspecified conditions
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C.ii.i.i Chapter 0 – Occupations

The '0' (zero) chapter contains terms used to describe occupations.

C.ii.i.ii Chapters 1 to 9 – History, Examination, Procedures and Administration.

Chapter 1 contains terms useful in recording the patient's history – symptoms, presenting complaints and past history. Chapter 2 has terms for recording examinations. Chapters 3, 4 & 5 allow the recording of investigations and tests. Chapter 6 contains preventative procedures such as screening and chronic disease monitoring. Chapter 7 provides terms for recording operations. Chapter 8 has terms for recording other therapeutic procedures such as physiotherapy, counselling and referrals. Chapter 9 contains terms useful for recording administrative procedures such as recording reports and certificates.

In general for most day to day activities of general practice Chapters 1 to 9 are the most useful – they contain terms that allows the practice to record the things it is doing every day and to manage its work and business.

C.ii.i.iii *Chapters A to U – Conditions, diagnoses, injuries*

From Chapter A onwards the Read Terms are for recording disorders – diseases, conditions, injuries. These are sorted into chapters based on system (e.g. Respiratory) or cause (e.g. Congenital).

C.ii.i.iv *Chapter Z – Unspecified conditions*

This chapter is for completeness and links to ICD-10 – the coding system used mostly in secondary care. It contains terms to record "Supplementary factors influencing health status or contact with the Health services other than for illness". In general its usefulness in general practice is limited.

C.ii.ii   Hierarchical

Within the chapters terms are organised hierarchically, that is moving from more general terms to more specific terms as you move down the hierarchy.

Generally the Read Code is incrementally increased as you move down the hierarchy. For example:

1....	History / symptoms
17...	Respiratory symptoms
171..	Cough
1714.	Productive cough -green sputum

Organising the Read Terms like this makes it easier to find an appropriate term – users can drill down into Read Hierarchy to find the most specific term they can for any given clinical concept. It also makes it easier to search and report on stored data. For example, a computer can find all patients with respiratory conditions by looking for records that contain any codes beginning with 'H', or all patients with a record of cough by looking for records that contain codes beginning with '171'.
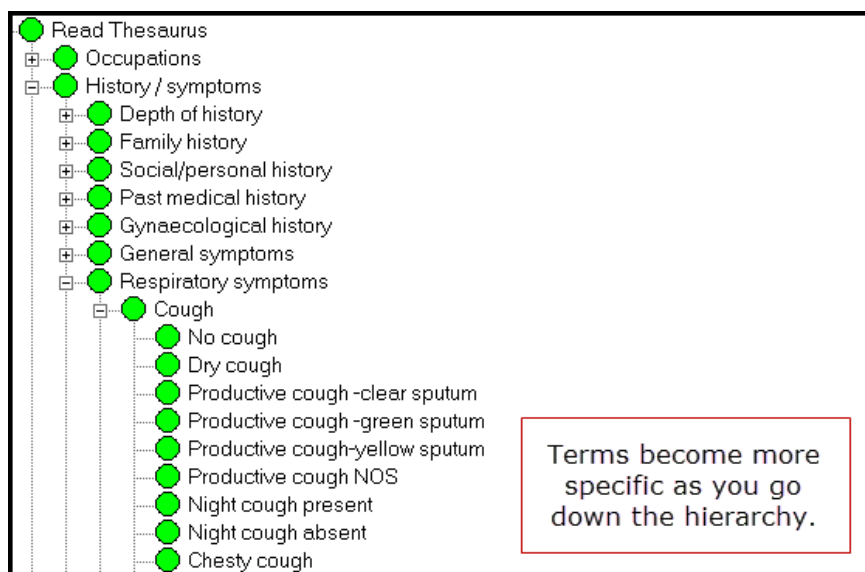
C.ii.ii.v *Absence or 'Negation' – aim to be specific*

The Read terms do not always manage to make it easy to say that a particular condition or event is not present or did not happen. This is because often the first Read Term in a

hierarchy may be the Term stating that the condition is not present. As above, the first term after 'Cough' is 'No Cough'.

This has the effect of complicating searches. Users of Read Terms can reduce this complexity by trying to use the most specific and appropriate Term for any condition by selecting a term lower down the hierarchy whenever possible.

C.ii.iii   Abbreviations

Read Terms often have abbreviations or prefix letters associated with them. These have different meanings and it is helpful to have some understanding of them.

C.ii.iii.vi   *'NOS' – Not Otherwise Specified*

This is a common abbreviation in many parts of Read. It should be used when no other clinical term is available that is more specific or accurate for describing the concept you are trying to record.

By way of illustration: for cough with sputum, as shown above, there are specific terms for 'Clear', 'Green' and 'Yellow' but if your patient was complaining of 'Grey' sputum, or 'Frothy' sputum then the term 'Productive Cough NOS' would be appropriate.

C.ii.iii.vii   *'NEC' – Not Elsewhere Classified*

This refers to Read Terms which appear only in one place – that is the same clinical concept is not available to be recorded in a better way in a different part of Read. This can occur where a condition may have different classifications – such as neurological conditions that are caused by infections – and so could be represented in different ways in different chapters. In practice this does not matter significantly, and unless you think there may be a better chapter in which to find an appropriate code it is often reasonable to use the 'NEC' term.

C.ii.iii.viii   *Chapter R – '[D]' Terms*

The terms in Chapter R are defined in the Read Thesaurus as 'Symptoms, signs and ill-defined conditions.'

In general practices should avoid using these terms as they are often vague and non-specific. Normally when trying to find the best Read Term for a disease or disorder the other disorder chapters are more appropriate. Better and more comprehensive symptoms and signs terms are available in Chapters 1 and 2.

There are occasions, however, where a symptom or sign is considered significant enough to record as a disorder, or where it is the only presentation of the disorder. For example, where a patient complains of chest pain but, after investigation, no cause is found it may be appropriate to use the term "R065. [D]Chest pain" to record it as a disorder. For recording the symptom of chest pain chapter 1 terms of '182..00   Chest pain' or below would be more appropriate.

C.ii.iii.ix   *7N...Subsidiary classification of laterality and operation sites – '[SO]' – 'Site of'*

Chapter 7 describes terms for Operations, Procedures and Sites. The section under 7N contains terms for describing the site of an operation (e.g. Appendix) – this does not describe the actual operation or procedure itself (i.e. Appendectomy). In general practices should avoid using the terms prefixed with '[SO]'.

C.ii.iii.x   *BB...   '[M]' - Morphology of neoplasms*

Chapter B contains terms for recording the diagnosis of Neoplasms. Chapter BB contains terms that describe the neoplasm's morphology not the actual diagnosis. Unless specifically recording the morphology of a neoplasm, practices should avoid using terms prefixed with '[M]'.

C.ii.iii.xi   *14… Past Medical History 'H/O' Terms – 'History Of'*

These terms are prefixed with 'H/O' and can be used to record the patient's reported past medical history, or where noting that a clinician is aware of the past condition. For example: if during a consultation the patient states they have 'Diabetes', the user may wish to note this and code it as '1434. H/O: diabetes mellitus', but the record of the condition would still need to be added separately using the actual date of onset and a code from the section 'C10.. Diabetes mellitus'.

'H/O' terms *do not* code disorders and the actual condition needs to be recorded using a term from Chapter A or later. Do not use '14… H/O' codes for recording important summary items.

C.ii.iii.xii   *12...00 Family history – 'FH'*

Terms prefixed 'FH' in chapter '12…' refer to the patient's reported or known family history and do not indicate the patient themselves has the disorder.

C.ii.iii.xiii   *'[X]' Prefix*

These terms, such as those under 'Eu...00 [X]Mental and behavioural disorders', have an '[X]' prefix. This simply means that the term has an equivalent code in ICD-10, the hospital coding system. The terms themselves are reasonable to use for recording disorders in primary care, the '[X]' prefix is irrelevant for our purposes.

C.ii.iv   Synonyms or 'Term Codes'

Sometimes there is more than one way of describing the same clinical concept. For example, a 'Myocardial Infarction' may be referred to as a 'Heart Attack'. In Read Terms this is managed by having a 'Preferred Term' – the one that Read would like you to use - and 'Synonyms' (sometimes called 'Term Codes') that are different text descriptions of the same thing. For example some of the synonyms for 'G30..' are:

Read Code	Term Code	Term	
G30..	0	Acute myocardial infarction	Preferred Term
G30..	11	Attack - Heart	Synonym
G30..	12	Coronary Thrombosis	Synonym
G30..	14	Heart attack	Synonym
G30..	15	MI - Acute Myocardial Infarction	Synonym

C.ii.iv.xiv   *Incorrect Synonyms*

Over time some synonyms have been added to Read Terms that have a different meaning from the preferred term. For example, one of the synonyms for 'G30..' is:

"G30..13 Cardiac rupture following myocardial infarction (MI)"

This is simply incorrect as it is a different condition from the Preferred Term. Use of such synonyms where their meaning is different from the preferred term should be avoided. Wherever possible use the Preferred Term.

C.iii   *Avoid changing meaning in free text*

Users should never change the meaning of a Read Term with associated free text. For example, entering the code:

"G30..Acute myocardial infarction"

and then appending a free text comment of 'Absent' or 'Negative'.

The presence of the code 'G30...' in the patient's record will effectively state they have had a Myocardial Infarction when viewed elsewhere or used for reporting and decision support.

C.iv   *Use the correct term in the hierarchy*

It is essential that people adding clinical terms can understand their meaning in the context of the Read hierarchy. For example, entering the term 'A98z. Gonorrhoea' effectively states

that the patient has had this condition. It should not be used as a proxy for a test for Gonorrhoea, thus appending free text of 'Negative' will not, in computer terms, indicate the intended meaning. A user entering a test result must understand where in the hierarchy to look in order to avoid this type of error. In this instance the correct term would be "4JQ8. Gonorrhoea test negative".

C.v Local codes in EMIS

Users of the EMIS clinical system may be aware of various "local codes" that exist on the system. Local codes are not Read Codes so cannot be reliably shared across different computer systems. In the PCS application the following may exist on the system

- Codes of the form 'EMISxxxxx'

- Codes of the form 'EGTONxxxx'

  Both the above are the same on any EMIS system, but should **not** be used as there is usually a reasonably similar Read code or something that might be made to approximate.

- Codes of the form 'PCSDTnnnnn_ccc' where 'nnnnn' is the EMIS CDB number of the site and 'ccc' is the code number:; these are used to represent items that came over from a previous clinical system and have not (yet) been mapped to an appropriate read code. This type of code has no meaning outside the originating site.

  e.g. PCSDT19213_122 HbA1c date

- Codes of the form 'PCSnnnnnaac' where 'nnnnn' is the EMIS CDB number of the site, 'aa' is the first 2 letters of the code description, and 'c' is a number; these are local codes consciously created by the practice. This type of code has no meaning outside the originating site.

  e.g. PCS19213SP1 SPSP Outpatient Action