Summarising and Coding Advice

Adapted from the OSCAR Protocol (Version 8.0)

CONTENTS

1. INTRODUCTION

The first SCIMP list of Read Codes was developed for Scottish Practices in 1999 by amalgamating many code lists that were already in use. It was intended to 'help practices to do the right thing' by giving advice on coding and help for those just starting to summarise their records. It was not intended to be prescriptive or mandatory in any way.

The development of national clinical datasets and the requirements of the GMS Contract Quality Indicators have inevitably meant more changes to the original SCIMP lists. The recommended Read code list will be regularly reviewed to ensure it continues to comply with National Clinical Dataset developments and with GMS Contract requirements.

To accompany the new SCIMP recommended list this document has been developed to give advice on creating and maintaining clinical summaries. Some of the issues that may arise in relation to coding are discussed.

This document aims to give standardised advice to clinical coders within GP practices, both for retrospective coding of notes and for the continuing upkeep of the patient's electronic record. It has been adapted from the OSCAR (Optimal Summarising Coding and Accurate Records) project and provides support for the use of the Recommended Read Code list. It is intended as advice in order to provide a standard way of summarising notes to facilitate exchange of records between practices and reduce the need for repeat summarisation.

For practice moving towards paper-light record keeping, more detailed guidance can be found in the Good Practice Guide :- http://www.scimp.scot.nhs.uk/gpg.html

1a. WHY HAVE A DATABASE/ MORBIDITY REGISTER

- Good communication within health care requires accurate clinical summaries. This has increasing importance with electronic transfer of patient data
- Chronic disease management is a major part of primary care
  - An accurate/ complete database will enable practices to identify, track and treat patients more efficiently
- Essential for paperless practices
  - For clinicians to consult without paper records it is essential that all significant information is entered onto the practice computer system
- GMS contract
  - Payments for the Quality and Outcomes Framework depend on extracting accurate data from practice systems
  - Practices are required to have up to date patient summaries

- Practice procedures for data collection may be subject to review

- Research tool
  - Morbidity data from primary care has been limited in the past
  - Improved capture of primary care data could inform future healthcare and influence resource allocation

1b. BENEFITS OF USING A STANDARD CODING FORMULARY

- Fast, consistent and accurate selection of read codes
- Potential simplification of audit searches
- To enable future efficient electronic transfer of patients' clinical data or complete records both between practices and between community, primary care and secondary care environments
- Collection of morbidity data throughout primary care will be more uniform and easier to exchange electronically and to compare in analyses.

1c. CREATING AND MAINTAINING CLINICAL SUMMARIES

- Advice given is specific to the development of accurate clinical summaries within the patient's medical record
- Practices with more advanced data entry (e.g. paperless) may need to consider more complete coding systems within the practice

1d. DEFINITIONS AND TERMS

- Retrospective summarising – extracting relevant information from patient records from birth to present day
- Ongoing maintenance – coding of any new information, e.g. from hospital/ clinic letters, consultations, clinics, house visits
- Formulary – use of limited list of recommended read codes (e.g. SCIMP list). It may be necessary to utilise codes from the wider Read Code Thesaurus (dictionary) if there is no appropriate match in the Formulary

2. RETROSPECTIVE SUMMARISING

2a. WHERE TO FIND THE INFORMATION

- Hospital/ clinic letters: generally provide clear information, usually type written and including most major illnesses/ events in the patient history. Smoking status, family histories etc. may also be located in hospital/ clinical letters. Increasingly these letters may be found filed within the software system e.g. Docman
- Clinical notes/ pink sheets: equally important to check as items such as childhood illnesses, eczema, psoriasis, hypertension, depression, anxiety etc. are often only found in clinical notes/ pink sheets. Also significant illnesses such as asthma are often diagnosed and treated in primary care with no referral to secondary care required and therefore no hospital/ clinic letter.
- Lloyd George (if there is any): sometimes difficult to decipher. However information as noted above can often be found on Lloyd George notes.
- Mount sheets (as necessary): where investigation results are found. Coding of these will depend on the level of coding you require. However useful information such as barium meals/ enemas, CT scans and MRI scans etc. can be found here.
- Bacteriology forms (as necessary): diagnosis such as chlamydia infection, helicobacter pylori infection or recurrent urinary tract infections can be found on these forms. The date on the form can usually be matched with the entry in clinical notes/ pink sheets that may not initially have been picked up.
- Folder covers and previous summaries: may find information of allergies and special alerts recorded here.
- Previously completed hand written summary sheets (usually grey sheets): this information can be used as a reference but it is recommended that it is not automatically accepted as being fully accurate.
- Computer print outs from paperless/ paperlite practices: these will include letters, investigation results, encounters and previous summary information. This information should be treated in the same way as paper records.
- CDs/ Floppy Discs – occasionally notes and letters may be transferred between practices having been copied directly onto a CD or floppy disc. If not already printed out these will need to be checked
- Electronic transfer of notes (Docman). This may include a variety of different documents, depending on the systems within the previous practice. Typically Hospital / Clinic letters will be included and there may also be referral letters and results reports. Increasingly there will also be a scanned copy of the computerised record from the previous Practice. Usually Hospital / Clinic letters will start from a specific date unless back scanning of a patients notes has occurred in a previous practice. These electronic documents should be reviewed in the same way as for historic paper documents.

2b. SUGGESTED PROCESS FOR SUMMARISING AND CODING RECORDS

- Before commencing summarising/ coding, check the information already entered in the patient's electronic record.
  - Check for inaccurate coding, dates, duplications etc. Ensure that information already in the record is not re-entered.
  - Modifications/ deletions - only delete information that is clinically inaccurate and always enter text in 'comments box' stating why information has been deleted. Further advice on modifying and deleting existing information can be found later in this document (see Section 4. 'Deleting and Modifying Existing Data'). With future electronic transfer of records and practices increasingly paperless, this will become a more important process.
  - When finished checking and making necessary amendments to existing summary commence entering new information.
- Practices need to agree the level of coding required within their individual practices and whether they wish to follow a specific coding formulary.
- Enter relevant codes for illness/ events, other information (as appropriate) and date. Practices should follow the advice of their system supplier in relation to use of dates. However, it is important to ensure that the dating of codes accurately reflects the date of diagnosis/ event as closely as possible. In some instances this will have a direct impact on GMS QOF searches (See Section 2d. 'Dates').
- Practices need to consider how they set priorities for codes to enable selection of specific codes for clinical information, e.g. high priority may be reserved for clinical diagnoses. Priority systems may vary between the various GP software systems. The setting of priorities can be a complex area as it may influence what information is utilised in documents and transfer of information (e.g the medical history automatically populating referral letters).
- When finished summarising records, it is sensible to re-enter the record to check all information is now correct, again checking for inaccuracies and duplications.
- Enter 'notes summarised to computer' code (9344.). This is also now recommended for the GMS contract. If the practice is using Docman and this information has not being checked enter comment in text box, *e.g. 'paper records summarised to 01.01.2004'.*

2c. SPECIFIC CODING CONSIDERATIONS/ RECOMMENDATIONS

- 'ENDPOINTS' - Code as near to final diagnosis as possible. If no firm diagnosis has been made, then code the 'endpoint', i.e. the latest stage in the investigations. For past conditions with related operations it may not be necessary to code both, you may consider it sufficient to code the 'end point', e.g. tonsillectomy <u>not</u> tonsillitis.

- It should be a clinical decision when specific conditions such as angina, cancer, stroke, chronic kidney disease etc. should be added to the patient's clinical summary. In some cases when a diagnosis is uncertain, the receipt of investigation results may be required before a decision is made.
- Queries and possibles - for clinical summaries only definite diagnosis should be entered
    - Only code when clear clinical/ investigative diagnosis has been made, e.g. if written in records – '? angina' or if words such as probable, probably, potentially, suggestive of, query, etc. are used to describe a condition this should not be coded unless a clinical decision has been made that this is appropriate (for example the patient is clearly being treated as having the condition).
    - Never add the words 'negative, probable, possible', etc. as free text or modifier of a code. This may be lost in the transfer of data and in audits.
    - Care is needed with coding that may affect the GMS Contract clinical areas.
    - It should be a clinical decision when a resolved code is added to the patient's clinical summary.
- Wherever feasible, modify conditions with right, left or bilateral, e.g. arm/ leg fractures
- In general try to code avoiding the use of 'history of'' (H/O) codes where possible. Look for evidence in the records of condition or disease and date appropriately. If this is not found it may be advisable not to document until this can be checked with the patient.
- When using a general operation code, add the code for the diagnosis also if known, e.g. laparotomy and perforated DU – would code laparotomy (with 'perforated DU' in text box) and perforated DU.
- Code all significant family histories with information re the relationship, e.g. mother, father and if known the age of the relative when diagnosed added to text box. Some codes will have information relating to age already detailed, e.g. FH IHD > 60 years.
- If using a coding formulary and you are unable to find an appropriate code, but it is regarded important that the information is added to the clinical summary, code by searching for a suitable read code in the Read Code Thesaurus (dictionary).
- Ensure that the code relates directly to that patient and that the term is appropriate. Examples of errors that occur include codes such as 'pre-term baby' or 'adoption' being added to the parents record rather than the child's.
- Sensitive data – care may be needed in the coding of patient sensitive data such as sexuality, adoptions, terminations, child protection, sexual abuse, STDs and psychiatric problems. Some software systems provide mechanisms that allow certain codes to be entered but 'hidden' from routine display. The practice will need to consider which data this would be appropriate for. With increased electronic sharing of data (e.g. in referrals etc.) other practices may want to consider their priority settings for such codes.
- GMS Contract – specific considerations – certain diagnoses require investigations to be within a certain timescale of the earliest date of that diagnosis. For further information on coding for QOF please see the SCIMP guidance documents - http://www.scimp.scot.nhs.uk/coding_guidance.html

2d. DATES

- When entering a read code for a specific illness or event, enter the date this occurred. If it is recorded on a hospital letter, it is advised to use the date of admission rather than the date of discharge if no specific dates are noted for investigations/ operations etc.
- If a definite date for diagnosis or condition is unavailable, there is an accepted convention to enter the year only, e.g. 01.01.98 or likewise if only a month and year are available 01.05.98 can be entered. However attempts should always be made to date as accurately as possible.
- Dating diagnosis that are ongoing, recurring or single diagnosis, e.g.
  - Ongoing – asthma or COPD, etc. – code date of diagnosis as closely as possible. If several codes for the same disease are entered, reporting systems (e.g. for the GMS Contract) will select one specified code. For example the earliest dated COPD code.
  - Recurring – e.g. eczema – code date of diagnosis. It may be appropriate to add information to the text box such as 'recurring' and additional information as needed, e.g. ''ongoing intermittently – last entry 05.05.04'.
  - Single diagnosis – e.g. MI and CVA etc. – note each individual episode, e.g. if had MI 08.06.99 and 01.05.04, both would be entered as diagnosis with correct dates. Different software systems may have specific advice for their system in relation to the dating of single diagnosis codes.

  Care may be needed in relation to the GMS Contract where there are date limits relating to the diagnosis, e.g. diagnosed 'since 01.04.08'. If uncertain about the dating of these codes practices should seek advice from their individual software supplier.
- Codes for family history should be dated as recorded in the records and should be the date when the patient was asked, if possible. If the date is not known practices need to agree a suitable system to deal with this. It may be appropriate to enter the date as the registration date with a note that the date is uncertain and, where possible, this information should be updated with the patient.
- Codes for adverse drug reactions should be dated as either the date the allergy was detected or, if this is not known, the date that the patient was asked for drug allergies. If no date available, enter today's date.

3. MAINTENANCE CODING

Once a patient's summary has been updated either by paper or onto the computer, it is vital that good systems are established for the subsequent updating and maintenance of this summary. The level of coding may vary within different practices depending on the degree to which the patient's notes are computerised. Paperless practices will need to have a higher level of information entered. This section will concentrate on maintaining an accurate clinical summary with some discussion of other areas the practice may need to consider.

3a. INFORMATION YOU MAY WISH TO CODE

- Hospital correspondence/ clinic letters: in addition to diagnosis, other data such as investigations, smoking status, blood pressure results, family histories etc. may also be located in hospital/ clinical letters. Decisions should be made as to whether information should be coded from a discharge flimsy or await the formal letter. Coding from the flimsy ensures the information is entered and available as quickly as possible, but increases the possibility of duplicate entries.
- Investigation results: coding of these will depend on the level of coding required. However, it may be useful to code information such as barium meals/ enemas, CT scans and MRI scans etc. In addition, refer to bacteriology forms where you will find diagnosis such as chlamydia infection, helicobacter pylori infection or recurrent urinary tract infections.
- Diagnosis made within the surgery: for example conditions such as asthma, hypertension, diabetes and depression are often made within the practice. Associated with these may be investigations, such as spirometry or depression questionnaires, that also require entry for GMS contract purposes.
- Other data collected via patient contacts: these may include BP, family histories, allergies etc.
- Home visits by GPs and community staff may require specific systems to ensure consistent data is entered in the patient record.

3b. SUGGESTED PROCESS FOR MAINTENANCE CODING

- In all cases, successful maintenance coding depends on the practice identifying consistent systems within their practice that include decisions on what is to be coded, whether a formulary is to be used, and who enters the data. There may be different systems in place to cover the various sources of data as described above. For example, there may be a specific person who deals with coding from incoming mail but it may be all clinicians responsible for coding from direct patient contacts. Where multiple people are involved in data entry, as is increasingly the case, all should be aware of the systems within their practice.
- Before entering new information – check the information already entered in the patient's records.
  - Ensure that information already in the record is not re-entered. For specific events it may be appropriate to have multiple entries e.g. MIs, stroke, new episodes of depression.
  - Modifications/ deletions - only delete information that is clinically inaccurate and it is good practice to enter text in 'comments box' stating why information has been deleted. Further advice on modifying and

deleting existing information can be found further in this document (see Section 4. Modifying and Deleting Existing Data).

- Dating of codes. Practices should follow the advice of their system supplier in relation to use of dates. It is important however to ensure that the dating of codes accurately reflect the date of diagnosis/ event as closely as possible. In some instances this will have a direct impact on GMS QOF searches.
- Set priorities for codes to enable selection of specific codes for clinical information, e.g. high priority may be reserved for clinical summary conditions. Priority systems may vary between the various GP software systems. The setting of priorities can be a complex area as it may influence what information is utilised in documents and transfer of information (e.g the medical history automatically populating referral letters).
- The practice may need to consider the entry of code 9348. (Computer summary updated). This is now recommended for the GMS contract. However, entry of this code at each data entry episode would be impractical for practices.

3c. SPECIFIC CODING CONSIDERATIONS/ RECOMMENDATIONS

- "ENDPOINTS" - Code as near to final diagnosis as possible. If no firm diagnosis has been made, then code the "endpoint", i.e. the latest stage in the investigations. For past conditions with related operations it may not be necessary to code both, you may consider it sufficient to code the 'end point', e.g. tonsillectomy not tonsillitis.
- It should be a clinical decision when specific conditions such as angina, cancer, stroke, chronic kidney disease etc. should be added to the patient's clinical summary. In some cases when diagnosis is uncertain this may require the receipt of investigation results before a decision is made.
- Queries and possibles - for clinical summaries only definite diagnosis should be entered.
  - Only code when clear clinical/ investigative diagnosis has been made. If the diagnosis is still uncertain it would be preferable to code as symptoms initially.
  - Never add the words 'negative, probable, possible', etc as free text or modifier of a code. This may be lost in the transfer of data and in audits.
- Care is needed with coding that may affect the GMS Contract clinical areas.
  - It should be a clinical decision when a resolved code is added to the patient's clinical summary.
- Wherever feasible, modify conditions with right, left or bilateral, e.g. arm/ leg fractures.
- Avoid the use of 'history of'' (H/O) codes where possible. This causes doubt regarding the date of the diagnosis / event.
- When using a general operation code, add the code for the diagnosis also if known. For example, laparotomy and perforated DU would be coded as "laparotomy" (with 'perforated DU' in text box) and "perforated DU".
- Code family histories with information about the nature of the relationship (e.g. mother, father) and, if known, the age of the relative when diagnosed added to text box. Some codes will have information relating to age already detailed, e.g. FH IHD > 60 years.

- If a coding formulary is used and an appropriate code cannot be found, but it is regarded important that the information is added to the clinical summary, code by searching for a suitable read code in the Read Code Thesaurus (dictionary)
- Ensure that the code relates directly to that patient and that the term is appropriate. Examples of errors that occur include codes such as 'pre-term baby' or 'adoption' added to the parents record rather than the child's.
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- Attempts should always be made to date as accurately as possible. If a definite date for diagnosis or condition is unavailable there is an accepted convention to enter the year only, e.g. 01.01.98 or likewise if only a month and year are available 01.05.98 can be entered.
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  - Recurring – e.g. eczema – code date of diagnosis – it may be appropriate to add information to the text box such as 'recurring' and additional information as needed, e.g. ''ongoing intermittently – last entry 05.05.04'.
  - Single diagnosis – MI or CVA etc. – note each individual episode, e.g. if had MI 08.06.99 and 01.05.04, both would be entered as diagnosis with correct dates. Different software systems may have specific advice for their system in relation to the dating of single diagnosis codes.

  Care may be needed in relation to the GMS Contract where there are date limits relating to the diagnosis, e.g. diagnosed 'since 01.04.08'. If uncertain about the dating of these codes practice should seek advice from their individual software supplier.
- Codes for family history should be dated as the date when the patient was asked.
- Codes for adverse drug reactions should be dated as either the date the allergy was detected or, if this is not known, the date that the patient was asked for drug allergies. If no date available, enter today's date.

4. DELETING AND MODIFYING EXISTING DATA

4a. AMENDMENTS TO RECORDS

Practices need to be able to handle diagnostic amendments and ensure that patient records are accurate. The GPC and RCGP advise against simple deletion of previously entered codes unless those codes are wrong. It is not seen as good practice to simply remove medically relevant information from patient records.

There are differences between a diagnosis that is recorded inaccurately/ wrongly, a diagnosis that is subsequently found to be incorrect and a diagnosis that is refined over time as the correct diagnosis emerges, i.e.:

- Inaccurate/ wrong diagnosis – miskeyed, wrong code, wrong patient etc.

Inaccurate/ wrong data should be removed. Codes that are wrong and were never true should be corrected in accordance with good clinical practice and the Data Protection Act. There is no ethical difficulty with removing inaccurate/ wrong information or making a clearly identified addition to incomplete information.

- Incorrect diagnosis – e.g. diagnosis documented by GP in consulting room subsequently found to be inaccurate following investigation, e.g. stroke diagnosed by symptoms but now diagnosed as brain cyst

If a patient has had a code added that is clinically incorrect then that code should be amended but the date should be transferred to the new code, e.g. as above – original stroke code should be deleted and replaced with a brain cyst code with the original date

- A diagnosis refined over time – e.g. depression that develops into bipolar affective disorder

Where the full diagnosis emerges over time records should show all significant aspects of care, this patient should be coded as depression and then also bipolar affective disorder

Where codes have been deleted or amended it is good practice to add an explanation in the text giving the reason for the change.

4b. GMS CONTRACT IMPLICATIONS

In cases where a patient has a record of a condition putting them in the Quality and Outcomes Framework that is now shown to be incorrect, the original code should be replaced by an appropriately dated symptom code, e.g. CVA replaced by headache or dizziness, or angina replaced by chest pain. This preserves the reason and context of the original entry but removes the current implications of the original diagnostic code.

NB: In all cases – the reasons why any changes are made to the record should be clearly documented in the text box (for future audit purposes).

(Ref: SCIMP guide to creating disease registers, Jan 04)