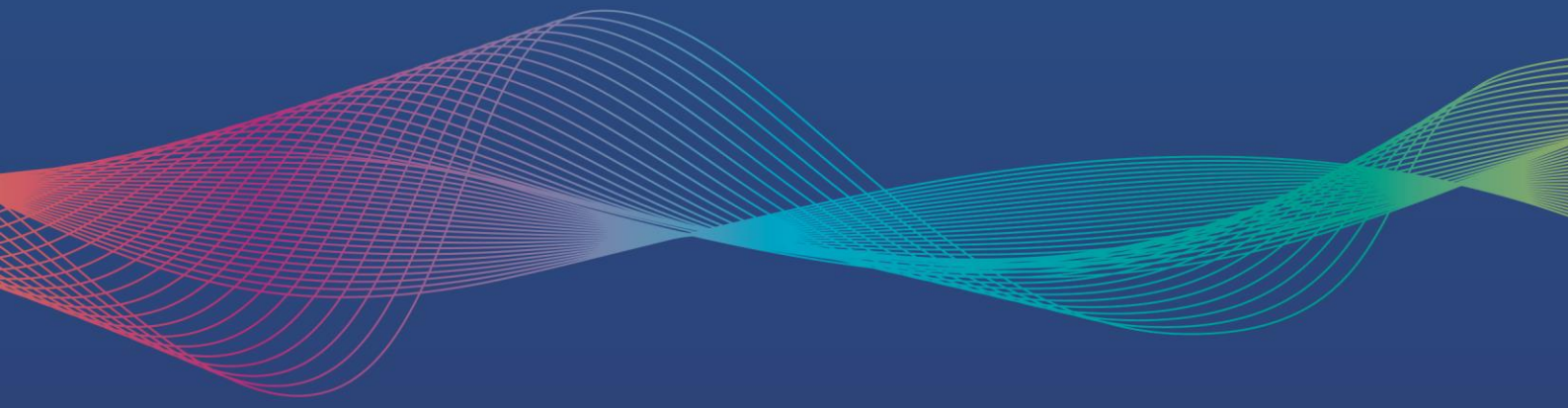
NHS
Midlands and Lancashire
Commissioning Support Unit

Note Summarisation and Data Input Guidance

MLCSU Data Quality Team

May 2021 v5.0



YOUR NHS PARTNER FOR **IMPROVING HEALTH** AND **INTEGRATING CARE**

Contents

Background

With the emerging world where patients are living longer with more complex needs, it has been recognised that the NHS must take decisive steps to break down the barriers in how care is provided between GP practices, hospitals, mental health, and social care. Sharing of patient data across organisations and with patients is therefore becoming essential.

The DQ Team Note Summarisation and Data Input Guidance is intended to provide a standard in the recording of patient information around the creation and maintenance of a robust electronic patient health record (EPR) within an electronic clinical system.

The EPR must contain all key pieces of information to facilitate the clinical care of the individual patient that can be viewed by approved service providers. This should include a clinical summary.

The information contained in the clinical summary should be an accurate, concise, uncluttered summary of all significant past and current medical events along with any relevant lifestyle information that would have an impact on their future care or treatment. This should allow any GP or locum, with no prior knowledge of the patient, to access the patient's relevant and significant information and make use of it, during the consultation quickly and easily.

Responsibility for the accuracy and completeness of the summary lies with GPs, and therefore regular validation of the clinical summaries should take place.

Practices should ensure that they:

- Use the computer system contemporaneously during consultations.
- Record findings in accordance with the standards set out in the 'Good Practice Guidelines v4.0 (2011)'.
- Apply clinical codes/terminology (SNOMED CT) in line with agreed standards within the practice.

Good data quality and an accurate and well maintained EPR help to ensure good patient care and should be Complete, Accurate, Relevant, Accessible and Timely (C.A.R.A.T).

Good data quality will allow any Clinician, with no prior knowledge of the patient; to access the patient's relevant and significant information quickly and easily during the consultation.

Pre-requisites for practices

Protocol

It is essential that the practice 'Summarising Protocol' is in place, reviewed on a regular basis and implemented consistently within the practice. It should clearly define how the summarising of the medical record is carried out. This should be agreed and signed by the doctors in the practice. An example of a practice protocol can be found at the end of this guide in 'Appendix A' and may be amended to suit the needs of your individual practice.

Clinical Coding

It is essential that a Summariser is familiar and competent at Clinical Coding. Training is available from your MLCSU Data Quality Specialist.

Use of clinical templates integrated into the clinical system (either nationally provided by your system supplier or locally created) helps standardise data entry. If GP practices create templates to be shared across multiple practices, they should first be shared with the Data Quality Team to ensure the coding is appropriate and in line with national guidance.

Regular audits and discussion of the use of Clinical Coding and data entry within practice meetings would be deemed good practice and help improve data quality.

Organisation Considerations

Practices must have at least one clinician who is responsible for the overall management of summarising within the practice. A clinical staff member should be identified and available to answer queries and review audits of completed summaries on a regular basis and should be built into the practice Summarising Protocol.

GP's or the Practice Manager should determine which members of staff will do the summarising of records and determine how much time is spent on summarising.

Practices need to have a business continuity process in place for summariser absence/leave.

The lead clinician should advise on visibility of coded information on the record and whether any information should be marked as confidential. Only a clinician can apply a confidentiality policy to this information.

It is recommended that summarisers have a prior knowledge of the electronic patient health record and should have been fully trained in clinical record keeping – this should include training on the clinical system, medical terminology, and Clinical Coding. Practices can contact their Data Quality Team Specialist, who can provide details regarding training and support available.

It may be useful for Summarisers to have access to a BNF, MIMS and a medical dictionary which can be a website.

Summarisers should only work on one set of notes at a time.

Your practice protocol should detail information to be summarised, for example are there different considerations when summarising a child vs an adult record, for older patients specific types of fracture need to be coded rather than a generic code as this may become important over time.

Be aware of common coding errors eg born by vs delivered on child/mother's record, male/female breast cancer.

If the medical record has been mixed-up, wrongly filed/labelled over time, or if another patients notes are found amongst the records, then these records should be removed and put to one side until the errors have been identified and amended or the notes replaced against the patient's records.

Summarisers should use their own smart card to log into clinical systems as this provides an audit trail.

Summarisers should not summarise more than 6 hours a day including adequate breaks, as it requires intense concentration.

Summarisers should have a quiet location to work in and should not be disturbed by phone calls or interruptions when working.

As more and more practices move towards digitisation of paper records there will need to be guidelines for summarisers in how to deal with this information. There are also plans in place to stop the movement of paper records, and from January 2021 PCSE stopped creating Lloyd George envelopes for new patients. Further updates and changes will be announced on their website - https://pcse.england.nhs.uk/help/

Summarising process (GP2GP)

GP2GP enables patients' electronic health records to be transferred directly and securely between GP practices. Within a short time following registration clinicians will usually have a full and detailed medical record available to them.

Registration

When a patient signs the GMS1 form to register at a practice, they are effectively instructing their new GP to retrieve their records, whether the records are paper or electronic.

The practice should have a process in place to verify the ID (it may need to be photographic for patient online access) and proof of address. Practices could consider asking for both former and current addresses if the patient has moved. This will then ensure a more successful PDS trace and increase the likelihood of finding the right patient.

To trigger a GP2GP transfer, practices need to ensure that they are logged into their clinical system with their Smartcard. Patients must be registered using the Personal Demographic Service (PDS) to run a patient trace. By using key information such as surname, forename, date of birth and NHS Number if available practices ensure the correct patient is identified on the PDS.

Once a patient has been successfully located on the PDS and registered at the practice, the Spine Directory Service (SDS) identifies the patient's previous practice and automatically checks whether it is GP2GP enabled.

Practices Not Enabled

If the previous practice is not GP2GP enabled, then the GP2GP process stops, and the registration process simply continues as a paper-based record transfer.

Practice Enabled

If the previous practice is GP2GP enabled, then a request for the patient's electronic record is sent and the system automatically transfers a copy of the record to the new practice. This is known as auto send.

Checking for electronic records awaiting import

Staff members need to be aware that the electronic record could arrive at the practice within minutes of being requested. This is important as one of the key benefits of GP2GP is having access to important clinical information as soon as possible.

- Staff should regularly access the system to check for incoming electronic records.
- Once the record is received, the practice will receive a message that the patients Electronic Health Record is available for filing and the practice should not hesitate in preparing the record for use.

Importing the clinical record

All GP clinical information systems have the facility to preview the incoming record before it is filed into the clinical system. Some systems provide facilities to filter this preview in various ways. (e.g., to identify drug allergy/medication degrades) to give an impression of the overall quality of the record. It is not possible to edit the record before it is imported. The user has the option to reject the record and opt to start building a new one from scratch, however this should only be done in exceptional circumstances (e.g., the wrong record is received, or it is of such poor quality as to be deemed useless).

There are certain steps that should be followed as soon as the incoming record is received:

- The practice must check that the record received is the correct one for the patient.
- Preview the file to check that it is of adequate quality to file into the clinical system.
- Once happy that the patient record is correct and of acceptable quality, the record should be imported as soon as possible.
- Any entries that have been made on the patient's new 'blank' record prior to importing the electronic record should then be checked after import. Any duplications or inaccuracies should be appropriately handled.

Drug allergy and adverse drug reaction degrades

Adverse drug reaction (ADR) data may not be interchangeable between different clinical systems eg EMIS to Vision. This is because different clinical systems employ different structures, use different terminologies, different drug dictionaries, and implement prescribing decision support in different ways. If any drug allergy degrades are present on the record the prescribing module of the clinical system will automatically disable.

- Any ADR data that is not recognised by the receiving system is degraded to 'human readable' text and added to the 196461000000101 Transfer-degraded drug allergy (record artifact) code. Any drug allergy degrades will be brought to the user's attention.

- If any ADR data are present on the record the practice must enter the drug allergy correctly onto their clinical system.

- Once the drug allergy (or allergies) have been re-entered appropriately, the 196461000000101 Transfer-degraded drug allergy (record artifact) code should be removed or replaced, the prescribing 'lock down' will then be removed.

- Drug allergy degrades should be actioned by a clinician, ideally with the patient.

Medication review and re-authorise medication

It would be inappropriate to permit repeat prescriptions from the sending practice to be re-issued without further clinical review by the receiving practice. The clinician issuing the medication has overall responsibility for prescribing decisions. Repeat medications are deactivated on import and the responsibility transfers from the previous GP to the new GP.

- Practices will need to deal with any degraded allergies in the incoming record.

- The new GP should re-enter any degraded medication, where necessary.

- The new GP should then review the patient's medication and re-authorise items they are happy to prescribe.

- New medication review dates for the patient will need to be set as these are not transferred from the previous practice.

Review of accuracy

Where possible it is always best to involve the patient when reviewing the accuracy of the electronic record therefore ensuring that the record is complete and accurate. Users should be aware of the possibility that the data on the sending system may have been inaccurate in the first place. It is acceptable to edit entries in the record where they are incorrect and having the patient's new patient questionnaire to hand can help with this validation.

- The incoming record must not be modified beyond what is necessary to make it safe and usable on the receiving system. The only degrades that need to be actioned are those that are linked to patient safety (e.g., drug allergies, medication, and other pertinent degraded information).

- The incoming record is never deleted unless it is deemed unsafe in terms of its accuracy and comprehensibility.

- Clinical summaries may need rearranging or amending according to local protocols. Practices will need to review their protocol for summarising new records and amend it where necessary. Whilst practices will have to continue with their current system for paper-based transfers, the protocol must be enhanced to include the handling of incoming records using GP2GP.

Consolidation of electronic and paper records

As not all practices are GP2GP enabled, nor are there arrangements in place for cross border electronic record transfers, practices remain contractually bound to follow standard practice for the handling of paper records. The patient's paper record will arrive at the practice several weeks after registration as normal. Practices will then be required to review the paper record in conjunction with the GP2GP electronic record. Practices should regard this consultation of the paper record as a data quality and validation process rather than a summarising and data input task.

- Validation of the imported electronic record against the paper record should take place to find important information in the paper record that was not entered onto the electronic record in the previous practice.

Filing of incoming results and correspondence

Practices should have in place a process for records leaving the Practice. Practices often have no advance warning that a patient has moved and registered elsewhere. GP2GP record transfer is an automatic process, so notification that the record has already been transferred to the next practice may be the first indication that the patient has moved. It is therefore good practice to ensure timely filing of all incoming blood test results and correspondence. If pathology results have been received at the sending practice and matched to the patient but not yet actioned, the GP2GP process will forward these results to the next practice. However, they will appear as actioned at the receiving practice. At the sending Practice the results will still be displayed as awaiting action as it is the requesting clinician's responsibility to action them.

- Any clinician who orders a test is responsible for following it up, checking the result and recommending further action if required.
- Sending practices should try to ensure that there are no unfiled results for recently transferred records.
- If any results are left unfiled and require action, the clinician who ordered the tests (at the sending practice) is still responsible for ensuring this takes place.
- The sending practice should try to contact the patient and/or the receiving practice to advise them of any further action that may be required.
- All practices should aim to keep pathology filing up to date, ensuring results are actioned as soon as possible after they are received.

Degrades:

Any clinical entries that are held on the electronic patient record that cannot be mapped to an existing SNOMED code, or other structured information, will be treated as a 'degraded' text. As a result of system migration, or GP2GP transfers, regular checks should be carried out in 'Legacy Data Mapping' to ensure that any 'degrades' are mapped appropriately according to your practice protocol. The original meaning of the degraded text is usually discernible and should not need to be edited out and will help to maintain the context of the information.

Practices should review any 'degrades' that are either linked to patient safety, e.g., drug allergies, medications etc. as soon as possible. Allergies need to be reviewed and amended as appropriate before any prescriptions are issued to a patient.

General principles

The quality of the GP2GP EHR can be improved by adhering to the following set of general principles:

- Practices should ensure that patient records are maintained in line with the "Good Practice Guidelines for General Practice Electronic Patient Records".
- The incoming record should be subject to validation checks.
- Practices should recognise the patients themselves are in general the most competent to judge the accuracy of their own record and should consider making a printed version available to their patients to review.
- Practices are provided with functionality in their clinical systems that will allow them to review (but not alter) incoming records before they are filed. They are currently presented with a choice of either filing the record into the practice database or rejecting it in which case it will exist as an attachment to the patient's new record. The choice to reject should only be exercised rarely.
- Clinical Information system functionality should be used to make essential changes to the record after filing (e.g., degraded drug allergies).
- There is a need to review and, in some cases, to make further alterations to the information in those records after filing. When doing this the responsible user should ensure that:
    - Incoming record information is not modified beyond what is necessary to make it safe and usable on the receiving system.
    - Incoming record information is never deleted unless deemed to be unsafe in terms of accuracy or comprehensibility. Any deletions should be agreed and authorised by a clinician.
- If it is necessary to significantly amend a record, the practice should keep a record of why there was need to amend such large amounts of data. An example of where this may occur is where a mother and daughters notes have been transposed and data has been entered onto the incorrect record accidentally.
- When paper records are subsequently received, they should be reviewed by a GP or another appropriately trained member of staff and amendments made to the electronic record where appropriate (see Section 4 on Paper Records).

For patients records transferred out via GP2GP the latest version of GP2GP enables the sending practice to see what, if any, printing is required.

Summarising process (Paper records)

When the Lloyd George paper notes have been received by the practice with a computer printout, they should be checked against the patient's electronic record and the summary updated with any missing, duplicated, or incomplete information as required.

The paper records should be organised into an agreed format before they are summarised. For example, collating the separate pieces of information by type (letters, results, continuation or summary cards and files etc.) and then into chronological order, most recent first.

Existing summary cards and miscellaneous cards should be examined, and any important findings noted down. Some of the notes will contain health and medication information details which will give an indication of what is happening to the patient, for example if the letter is from a cardiologist this can often help to interpret the letter. Always read through to the end of a particular disease story before recording as it may well be that the initial diagnosis is different from the final discharge diagnosis.

Letters and result forms should be examined, and dates checked against the GP notes of the same date.

The paper notes/letters may be difficult to understand – a check of the abbreviations (see Appendix B) symbols can highlight problems/diagnosis and indicate recurring episodes.

Electronic printouts or summaries should be cross referenced with correspondence and GP records to ensure significant items are not overlooked because of lost paperwork, missing files, or inappropriate disposal in the past. Reproduced scanned correspondence should also be scrutinised.

Date: Before you add a problem try to find a reasonably accurate onset date, as near as possible to the date the problem began. For events such as operations and investigations it should be the date they occurred. Occasionally you must estimate the date. As a rule of thumb, if the month is clear but not the day, choose the 1st of the month; if the year is clear but not the month, choose the 1st January. It may be necessary to amend the episode of a diagnosis to make sure entries are not duplicated.

Problem Orientation: What is a Significant Active or Past problem? As a general rule, if patients are receiving treatment for a diagnosis or problem it is regarded as "active'. If a diagnosis or problem has a profound effect on the patient's lifestyle, then the problem is 'significant'. Procedures and operations are all 'past' unless your practice protocol states a finite time eg 6 months whilst any follow up to the procedure is still ongoing or until the first post op review.

An active problem is one that is chronic and/or life threatening, has an impact on the quality of the patient's life, and is something that the consulting GP or nurse should be aware of. The highlighting of active problems should be done as part of the summarising process. Queries should be taken to the lead clinician for advice and guidance.

The practice protocol should also address how long a diagnosis/procedure/event etc. is deemed active e.g.

- 'Active Significant' (permanent) e.g., Diabetes or COPD

- ‘Active Significant’ (temporary) e.g., for 5 years Cancer (treatable), then move into ‘Significant Past’
- ‘Significant Past’ e.g., Angioplasty
- ‘Minor Past’ e.g., Fracture toe

Episode Types: Use of ‘episode’ types: e.g., new/review, within the clinical system should be correctly implemented to avoid duplicating entries.

It is important to record a definite diagnosis. If there is a query against a diagnosis, this should be entered as free text against the symptom of the condition e.g. *(Symptom)* 366979004 Depressed mood (finding) - Query diagnosis? *(free text entry).* To add diagnosis on next visit if appropriate after full assessment. (*Diagnosis*) 35489007 Depressive disorder (disorder)

Allergies: Practices must ensure that when they are recording a drug allergy they use both the clinical system codes e.g., EMIS system code, as well as an appropriate Clinical code. By entering the clinical system code this will generate a system alert to warn the clinician that the patient has an allergy or adverse reaction to that medication. The clinical code is required for GP2GP and sharing as a visible entry in the patient’s record.

When entering an allergy use consultation mode, select the allergy section and use the adverse reaction system codes.

For non-drug allergies only, a clinical code is required to be input into the system

The use of Free Text: The use of free text is useful to add context to the Clinical Coded entry, but should not be used to modify the meaning of a code: e.g. – using a diabetes code and then entering family history diabetes as free text – the patient will be coded as having diabetes, rather than having a family history of diabetes.

Ask: Sometimes interpretation can be difficult! The summariser should not guess but seek advice from a clinician within the practice.

Validation: Prevalence is a measure of the burden of a disease in a population at a particular point in time. The prevalence of specific diseases or conditions is a key element of QOF and enables CCGs to utilise information for planning purposes. Part of the summarisation process should be to ensure validation of chronic disease registers. Look out for any ‘missing’ diagnosis: e.g., patients on medication but no diagnosis. The Data Quality Searches can assist practices to validate their registers and identify patients possibly missing from chronic disease registers. In the case of repeat medication, this may indicate a chronic condition that may not have a specific diagnosis recorded. If there is a reference to a start date for the medication, this could be used as a starting point to examine the patient records from that time to obtain a possible diagnosis. Any new diagnosis should be confirmed by a clinician.

Amendments: If a diagnosis is identified to be incorrectly entered e.g., wrong patient, practices should have a policy that addresses how the deletion of information is handled. If information needs to be changed, then consideration should be given as to how to record this – for example, using the code **185981001 Error entry deleted** (finding) along with a free text description of why a diagnosis has been changed or deleted, by whom and authorised by: ‘Why, what, when.’ This will satisfy audit trails and also ensures a visible reason for deletion in the patient record as audit trails do not transfer with the patient record if they change practice. The “error entry deleted” code should be added with the same date as the deleted diagnosis and not with today’s date.

Diary entries/recalls: check appropriate diary entries for your practice recalls. Diary entries from GP2GP transfer may not match the diary entry codes for your own practice.

Medication prescribed by another provider: follow your practice policy regarding adding this to the patient medication screen so that the clinician is aware of all medication making clear it is not for issue by the GP practice.

Once the summary is completed the code **184229000 Notes summary on computer** (finding), should be used and remain on the system. If the summary is re-checked then code **413900009 Computer summary updated** (finding) should be used.

Data Flows and Data Sources

Consideration should be given to how the practice will handle all forms of communication regarding the patient that comes into the practice, and how the information is identified and then recorded appropriately against the patients' health record. This may come into the practice in various formats (hospital letters, emails/tasks/workflow, telephone calls) or as a result of face-to-face contacts (home visit). The practice should have a consistent approach to dealing with incoming communications, and this will be referred to within their summarising /data inputting protocols.

Data sources may involve information being provided from a range of individuals such as patients, carers, locums, practice nurses, specialist nurses, practice managers, administration staff, district nurses, and health visitors, community psychiatric nurses, midwives, social workers as well as the GP.

Typical sources of information that need to be considered include:

- Acute and repeat prescriptions
- Surgery consultations
- Other clinician consultations
- Community staff consultations
- Other contact – home visits, telephone, video consultations, MDT discussions
- Nursing home visits
- OOHS (Out of Hour Services)
- Incoming medical records from other practices paper records
- GP2GP
- Patient information - emails, phone calls, letters
- Referrals
- Appointments
- Diary entries
- Investigations and procedures carried out in surgery

- Requests for tests
- Test results
- Benefit medical reports
- Discharge letters and notifications
- Outpatient letters
- A&E & urgent care reports
- Correspondence with social service departments
- Social services staff contacts
- Cytology
- Radiology and histology reports
- Summary cards from Lloyd George records
- Clinic letters
- Immunisations
- Scans (e.g., bone density or MRI scans) and X-ray reports

Scanning

The practice should scan all incoming paper transactions in line with the practice scanning process. Clinicians may use a system of highlighting text on letters that can then be added by coding staff.

A method of capturing data from correspondence is required as simply scanning the document is not adequate from a data quality perspective; clinical codes and data should still be recorded from documents. All attachments should be coded indicating where the letter has come from and content.

When recording the date, ensure that the appropriate clinic or event date is used.

Always use appropriate clinical coding to record a patient encounter with outside organisations (**183665006 Discharged from hospital** (finding) codes, **183452005 Emergency hospital admission** (procedure) codes, **308021002 Seen in clinic** (finding), **308930007 Seen by health professional** (finding)). This allows the information to be searched upon - the practice may be required to submit the number of attendances in a particular department.

It is important to regularly review code mapping and ensure that the latest codes are up to date in the scanning software when new codes are released

Appendix A: Example: Summarising Protocol

The following Summarising Protocol is for guidance purposes only. Practices should check the content and adapt to suit their requirements and reviewed on a regular basis.

[Practice Name]

Aims and Objectives

1. To create and maintain an accurate, up-to-date summary
2. To maintain practice disease registers
3. To facilitate the process of clinical audit

GP2GP Transfer Procedure

Once the record has been accepted into the practice, medications cannot be prescribed from an incoming GP2GP record until all drug allergies degrades/adverse drug reactions have been processed. Repeat/current medications will be deactivated on import and need to be reviewed and, if required, re-authorised before any prescribing can take place.

Once the record has been accepted into the practice and the paper records have arrived, the following should be undertaken:

- Any entries that have been made to the patient's local record prior to integrating the patient's electronic health record received via GP2GP should be checked and any inaccuracies or duplications should be appropriately handled
- Review the electronic health record against the Lloyd George - the main objective should be to ensure important information in the paper record was entered into the electronic health record at the previous GP practice and to check that all attachments listed are present. If there are attachments not present these can be re-attached by scanning from copies from the paper record. The previous practice may only have summarised paper records for a certain number of years and you should refer to your practice protocol which may advise summarising paper records over a longer historical period.
- Tidy up the problem screen – Active, Significant, Minor
- Ensure any degrades are mapped to the appropriate Clinical Code
- Ensure diary entries are changed as appropriate to the practice
- Ensure patient alerts are accurate and up to date

Paper Notes Procedure

The paper notes should be placed in chronological order before any summaries are started and any unnecessary information dealt with appropriately.

- Read all letters, results, investigations. Check there is no further information on the back of letters.
- Make minimum notes as an aide-memoire, including dates, of relevant conditions/operations/social history/allergies etc.

- Read all doctors' notes adding any relevant further information, using the correct dates.
- Input all noted information into computer selecting Significant, Active, Minor, or Past according to the condition.

Before entering anything on to the electronic record ensure you have selected the correct patient.

Any of the following information should be recorded for each patient:

- Patient consent for information sharing should be recorded using the appropriate Summary Care Record consent codes which can be accessed through patient registration or in consultation along with consent for any local sharing preferences.
- The patient demographic details should be recorded onto the practice clinical system for all new patients registering with the practice including the below:
    - Carers (need to have appropriate Clinical Code in addition)
    - Occupation
    - Ethnicity - ensure you are using the correct codes from 2011 census
    - Language
    - Marital status
- Health Record
    - A&E/urgent care reports - code the initial 'symptom' (the confirmed diagnosis, if there is one, should follow on a further hospital letter)
    - Allergies and adverse reactions. Drug and non-drug allergies
    - Alcohol problems
    - At risk patients e.g., children on the at-risk register.
    - Baby - born by forceps delivery or born by caesarean section
    - Biochemistry – last three normal results and all abnormal results including values
    - Blood disorders or transfusions
    - Blood pressure systolic & diastolic, last three entries
    - Cancers including cell changes. Any important therapy especially for malignant illness, such as chemotherapy or radiotherapy.
    - Carer – has / is
    - Conditions linked to repeat medications / treatment
    - Chronic diseases (e.g., diabetes, asthma, hypertension)
        - All hospital admissions
        - Annual reviews - in past 12 months and diary entry

- Test results e.g., fundoscopy & visual acuity from optician's report
- Diagnostic investigations with result e.g., ECG.
- Lifestyle - BP, exercise, diet, smoking, alcohol and any advice given

- Disability and where relevant - housebound, wheelchair user, partially sighted, hearing aid use (bilateral) etc.
- DVT or thrombosis
- Endocrine disorders
- ENT/eye problems
- Falls
- Family history – first degree relatives
- Fractures and trauma (including side e.g., L or R) any procedure should be Clinical Coded separately.
- Haemoglobinopathies. Sickle Cell, Thalassaemia, Haemoglobinopathy or Haemoglobin Electrophoresis results. If the patient is reported as having a haemoglobinopathy then this should be displayed as a Significant Active problem, as this can have consequences for future health or during pregnancy.
- Health data – e.g., height, weight, BMI
- Hospital and emergency admissions (and the presenting symptom or, if available, diagnosis)
- Infections (e.g., mumps, measles, chicken pox)
- Immunisations and vaccinations
- Investigations and their outcomes, such as CT scans and endoscopies
- Mental Health:
    - Personality disorder
    - Depression (take care with new diagnosis after April-QOF)
    - Eating disorder
    - Psychosis – manic / depressive / bipolar, paranoia (drug induced)
    - Learning disability / Behaviour problems
    - Schizophrenia
    - Overdose /suicide attempts / self-harm
    - History of violent behaviour
    - Admissions, referrals

- Nursing/Care home
- Operations (including site and pathology). Any operative procedure needs to be entered with the reason for the procedure entered as a separate code e.g., hysterectomy for fibroids should have a code for hysterectomy and a code should be entered for fibroids
- Patient preferences (such as preferred place of care)
- Persistent skin problems e.g., eczema, psoriasis
- Peptic ulcers
- Recall, diary dates e.g., vaccinations, chronic disease monitoring
- Recurrent GI infections, abdominal pain, or problems without a determined cause
- Sexual health
- Significant burns
- Significant life events e.g., death of partner
- Significant infections
- Substance misuse
- Tests e.g., peak flow
- For women:
    - Cervical cytology – last three normal and any abnormal recall with outcomes e.g., dyskaryosis, CIN, inflammatory changes
    - Complications in pregnancy (if delivered pre-term <37 weeks)
    - IUCD insertions, removals and follow ups
    - Mammogram last normal and any abnormal
    - Miscarriages (including timing/procedure e.g., 12/40: ERPC)
    - Parity status, defined as the number of times the mother has given birth
    - Birth with a gestational age of 24 weeks or more
    - Post-natal check
    - Post-natal depression
    - Rubella immunity status (most recent)
    - Terminations (including medical reason e.g., foetal abnormality)
    - Type of delivery (including gender/weight e.g., male / 3250g)
- Virology e.g., Hepatitis A, Hepatitis B

- X-rays
- Any documents that have been scanned on to the electronic record and the scanned document checked after scanning

To preserve the integrity of the record, only one set of patient's notes should be worked on at a time. If incorrect information or information relating to another individual is found within a set of notes, this should be highlighted and dealt with according to the agreed procedure within the practice.

Once the summary has been completed, one of the appropriate codes should be used:

384071000000103 Electronic general practitioner medical record received (finding) – this would be used when you have imported the GP2GP record and merged it with your patient record.

In 3 months' time (give or take) when the paper notes have been received you should cross reference the paper and electronic notes updating as needed. When completed add the code **184229000 Notes summary on computer** (finding), to indicate summary is now completed.

If you have an existing record on your system and a patient has left and come back you now have the same GP2GP record to import and after checking you would then use the code **413900009 Computer summary updated** (finding).

Signed

Name

Date

Appendix B: Common Medical Abbreviations

(This is not an exhaustive list, but may prove useful)

Abbreviation	Description
# or Fx	Fracture
A&E	Accident and Emergency Department, Casualty
AA	Alcoholics Anonymous
AA	Attendance Allowance, Benefit for people aged 65+ who need personal care.
Ab, ab, abor	Abortion
Abdo	Abdomen
AC	Acromio Clavicular (JOINT)
ACE inhibitor	Angiotensin Converting Enzyme inhibitor
AD	Aural Dextrus (Right Ear)
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADR	Adverse Drug Reaction
AF	Atrial Fibrillation / Flutter
AFP	Alpha-fetoprotein (Blood or fluid test for foetal abnormalities)
AID	Artificial Insemination by Donor
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AN	Antenatal
ANS	Autonomic Nervous System
ANT	Anterior
AP	Artificial Pneumothorax
AP&L	Anterior, Posterior and Lateral
APH	Antepartum Haemorrhage
ARC	AIDS related Complex
ARMD	Age Related Macular Degeneration
ARMO	Age Related Macular Disorder
ASD	Atrial Septum Defect
AU	Aures Unitas (Both Ears)
Ba	Barium
Ba E	Barium Enema
Ba M	Barium Meal
BAWO	Bilateral Antral Washout
BBA	Born Before Arrival
BCC	Basal Cell Carcinoma
BCG	Bacillus Calmette Guerin Vaccination for TB
BD	Twice Daily
BINA	Bilateral Intra Nasal Antrostomies
BMI	Body Mass Index
BO	Bowels Opened
BNO	Bowels Not Opened
BNO	Bladder Neck Obstruction (Congenital)
BP	Blood Pressure

Abbreviation	Description
BPH	Benign Prostatic Hyperplastic Enlargement of the prostate gland
BPPv	Benign Paroxysmal Positional Vertigo
BS	Breath Sounds
BSE	Bovine Spongiform Encephalopathy. Mad Cow Disease.
BSO	Bilateral Salpingo-oophorectomy
BT	Blood Test
BUN	Blood Urea Nitrogen
Bx	Biopsy
C&S	Culture and Sensitivity (test to determine antibiotic use)
C/I	Contra-indicated
C/O	Complaining of
Ca	Carcinoma (Cancer)
Ca	Calcium
CA	Chronological Age
CABG	Coronary Artery Bypass Graft
CAPD	Continuous Ambulatory Peroneal Dialysis for people with kidney failure
CAT	Computerised Axial Tomography
CAT	Cognitive Behavioural Therapy
CCF	Congestive Cardiac Failure
CCU	Coronary Care Unit
CDH	Chronic Dislocation of Hip
CHD	Chronic Heart Disease
CHF	Congestive Heart Failure
CI	Contra Indicated
CIN	Cervical intra-epithelial neoplasia (Cervical pre-cancer)
CIS	Carcinoma in Situ
CJD	Creutzfeldt Jacob Disease
CKD	Chronic Kidney Disease
CLL	Chronic Lymphoid Leukaemia
CMV	Cytomegalovirus
CNS	Central Nervous System
CO	Carbon Monoxide
C/O	Complaining Of
COAD	Chronic Obstructive Airways Disease
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
CPR	Cardiopulmonary Resuscitation
CRF	Chronic Renal Failure
CS	Caesarean Section
CSF	Cerebro Spinal Fluid
CSM	Committee on the safety of medicines
CSOM	Chronic Suppurative Otitis Media
CSU	Catheter Specimen of Urine
CT	Computed Tomography
CTS	Carpal Tunnel Syndrome
CVA	Cerebrovascular Accident
CVP	Central Venous Pressure

Abbreviation	Description
CVS	Cardiovascular System
Cx	Cervix
CXR	Chest X-Ray
D&C	Dilation and Curettage of Uterus
D&V	Diarrhoea and Vomiting
DM	Diabetes Mellitus
DNA	Did not attend
DOB	Date of Birth
DSU	Day Surgery Unit
DU	Duodenal Ulcer
DUB	Dysfunctional Uterine Bleeding
DVT	Deep Venous Thrombosis
EBV	Epstein Barr Virus
ECG	Electrocardiogram
Echo	Echocardiogram
ECT	Electro-convulsive therapy
EDC	Expected Date of Confinement
EDD	Estimated Date of Delivery
EEG	Electroencephalogram
EL LSCS	Elective Lower Segment Caesarean Section
EM LSCS	Emergency Lower Segment Caesarean Section
EMR	Electro Magnetic Resonance
ENT	Ear, Nose and Throat
ERCP	Endoscopic Retrograde Cholangiopancreatography
ERPC	Evacuation Retained Products of Conception
ESR	Erythrocyte Sedimentation Rate
ETT	Exercise Tolerance Test
EUA	Examination under Anaesthetic
FB	Foreign Body (in orifice)
FBC	Full Blood Count
FBS	Fasting Blood Sugar
FEV1	Forced Expiratory Volume in 1 second
FH	Family History
FH	Familial Hypercholesterolemia
FHH	Foetal Heart Heard
FHNH	fatal Heart Not Heard
FMF	foetal Movements Felt
FNA	Fine Needle Aspiration
FNB	Fine Needle Biopsy
FOF	Fracture of Femur
FOS	Fibre Optic Sigmoidoscopy
FP7 / FP8	Continuation Card
FSH	Follicle Stimulating Hormone
FTND	Full Term Normal Delivery
FU	Follow Up
G&A	Gas and Air
GA	General Anaesthetic

Abbreviation	Description
GI	Gastro-intestinal
GIT	Gastro-intestinal Tract
GOA	Generalised Osteoarthritis
GORD	Gastro-oesophageal Reflux Disease
GTT	Glucose Tolerance Test
GU	Gastric Ulcer
GUM	Genito-urinary Medicine
H/O	History of
Hb	Haemoglobin
HbA1	Diabetes blood test
HDL	High Density Lipoprotein (Cholesterol)
HH	Hiatus Hernia
HI	Head Injury
HI	Hypodermic Injection
HIV	Human immuno Virus
HNPU	Has Not Passed Urine
HP	Helicobacter Pylori
HP	Health Promotion
H Pylori	Helicobacter Gastritis
HRT	Hormone Replacement Therapy
HS	Heart Sounds
HSV	Herpes Simplex Virus
HTLV	Human T Cell Lymphotropic Virus
HV	Health Visitor
HVS	High Vaginal Swab
IBD	Irritable Bowel Disease
IBS	Irritable Bowel Syndrome
I&D	Incision and Drainage (of wound)
IDDM	Insulin Dependent Diabetes Mellitus
IGT	Impaired Glucose Tolerance
IHD	Ischaemic Heart Disease
IM	Intramuscular
IMB	Intermenstrual bleeding
INR	International Normalised Ratio
IOP	Intraocular Pressure
ISQ	In Status Quo (no change)
IUCD	Intra Uterine Contraceptive Device
IUD	Intra Uterine Death
IUGR	Intra Uterine Growth Retardation
IV	Intravenous
IVF	In Vitro Fertilisation
IVH	Intraventricular Haemorrhage
IVP	Intravenous Pyelogram
IVU	Intravenous Urogram
Ix	Investigation
JCA	Juvenile Chronic Arthritis
L&D	Light and Dark Perceived

Abbreviation	Description
LA	Local Anaesthetic
LAP	Laparoscopic Sterilisation
LBBB	Left Bundle Branch Block
LBP	Lumbar Back Pain
LCL	Left Convergent Squint
LDL	Low Density Lipoproteins
LFTs	Liver Function Tests
LHF	Left Heart Failure
LIF	Left Iliac Fossa
LIH	Left Inguinal Hernia
LLETZ	Large Loop Excision Transformation Zone
LMP	Last Menstrual Period
LOC	Loss of Consciousness
LP	Lumbar Puncture
LRTI	Lower Respiratory Tract Infection
LSCS	Lower Segment Caesarean Section
LTH	Luteotropic Hormone (prolactin)
LUQ	Left Upper Quadrant
LVF	Left Ventricular Failure
LVH	Left Ventricular Hypertrophy
MAOI	Monoamine Oxidase Inhibitor Antidepressant
MC	Metacarpal
MC&S	Microscopy Culture and Sensitivity
MCU	Micturating Cystourethrography
MCV	Mean Cell Volume
MDI	Metered Dose Inhaler
ME	Myalgic Encephalitis
Mg	Milligram
MI	Myocardial Infarction
MI	Mitral Incompetence
mmhg	Millimetres of mercury (Blood pressure measurement)
mmol	Millimoles, a chemistry measurement
MMR	Measles, Mumps and Rubella Vaccination
MND	Motor Neurone Disease
MRE	Medical Record Envelope
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MS	Multiple Sclerosis
MSH	Melanin Stimulating Hormone
MSSU	Mid-Stream specimen of Urine (see MSU)
MSU	Mid-Stream Urine
MT	Metatarsal
MTX	Methotrexate
MUA	Manipulation Under Anaesthetic
MVTA	Motor Vehicle Traffic Accident
N&V	Nausea and Vomiting
NAD	Nothing Abnormal Detected / No Abnormality Detected

Abbreviation	Description
NAI	Non-Accidental Injury
NBI	No Bony Injury
ND	Normal Delivery
NEC	Not Elsewhere Classified
NG	New Growth
NG	Nasogastric
NIDDM	Non-Insulin Dependent Diabetes Mellitus
NMR	Nuclear Magnetic Resonance (also same as MRI)
NOF	Neck of Femur
NOS	Not Otherwise Specified
NP	New Patient
NRT	Nicotine Replacement Therapy
NSAID	Non-Steroidal Anti-Inflammatory Drug
NSU	Non-Specific Urethritis
NVD	Normal Vaginal Delivery
O/E	On Examination
OA	Osteoarthritis
OA	On Arrival
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
OD	Once Daily
OD	Oculus Dexter (Right Eye)
OD	Drug Overdose
OE	On Examination
OGD	Oesophagogastroduodenoscopy
OM	Otitis Media
OM	In the Morning
OME	Otitis Media with Effusion (Glue Ear)
ON	At Night
OOH	Out of Hours
OP	Out patient
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTC	Over the Counter Remedy
PA	Pernicious Anaemia
PAR	Perennial Allergic Rhinitis
PARA	Number of Live Births
PCA	Patient Controlled Analgesia (usually a morphine pump)
PCB	Post Coital Bleeding
PCO	Polycystic Ovaries
PDD	Prescribed Daily Dose
PE	Pulmonary Embolism
PE	Pre-Eclampsia
PEFR	Peak Expiratory Flow Rate
PET	Pre Eclamptic Toxaemia
PFR	Peak Flow Rate
Ph	Measure of acidic or basic character of substance

Abbreviation	Description
Ph	Past History
PID	Pelvic Inflammatory Disease
PID	Prolapsed Intervertebral Disc
PMA	Private Medical Insurance
PMB	Post-Menopausal Bleeding
PMH	Past Medical History
PMS	Premenstrual Syndrome
PMT	Premenstrual Tension
PN	Post Natal
PND	Post Nasal Drip
PND	Paroxysmal Nocturnal Dyspnoea
PNS	Post Nasal Space
PO	Per Oral by Mouth
POAG	Primary Open Angle Glaucoma
POD	Pouch of Douglas
POM	Prescription only Medicine
POP	Plaster of Paris
POST	Posterior
PP	Placenta Praevia
PPH	Post-Partum Haemorrhage
PPI	Proton Pump Inhibitor
PRN	Pro Re Nata (As required)
PSA	Prostate Specific Antigen
PTH	Parathyroid Hormone
PUVA	Phototherapy combining psoralens and UV light to treat skin disorders.
PV	Per Vaginum
PV	Plasma Viscosity
PVD	Posterior Vitreous Detachment
PVS	Persistent Vegetative State
Px	Prescription
QDS	Four Times Daily
RA	Rheumatoid Arthritis
RACPC	Rapid Access Chest Pain Clinic
RBBB	Right Bundle Branch Block
RBS	Random Blood Sugar
RCS	Right Convergent Squint
RCT	Randomised Control Trial
RDS	Right Divergent Squint
RDS	Respiratory Distress Syndrome
REM	Rapid Eye Movement
RF	Rheumatic Fever
RGP	Retrograde Pyelogram
Rh	Rhesus Factors
RHF	Right Heart Failure
RIF	Right Iliac Fossa
RIH	Right Inguinal Hernia
RNA	Ribonucleic Acid

Abbreviation	Description
RS	Respiratory System
RSI	Repetitive Strain Injury
RTA	Road Traffic Accident
RTC	Road Traffic Collision
RUQ	Right Upper Quadrant
RVF	Right Ventricular Failure
RVS	Respiratory Virus Syndrome
Rx	Denotes Treatment
Rx	Repeat Prescription
SAD	Seasonal Affective Disorder
SAH	Sub Arachnoid Haemorrhage
SAR	Seasonal Allergic Rhinitis
SB	Still Birth
SBE	Sub-Acute Bacterial Endocarditis
SCAN	Suspected Child Abuse or Neglect
SCBU	Special Care Baby Unit
SCC	Squamous Cell Carcinoma
SI	Sexual Intercourse
SIDS	Sudden Infant Death Syndrome
SLE	Systemic Lupus Erythematosus
SLR	Straight Leg Raising
SMD	Senile Macular Degeneration
SMD	Submucous Diathermy
SMR	Sub mucous Resection
SOB	Shortness of Breath
SOBOE	Shortness of Breath on Exertion
SPO	Salpingo-ophorectomy
SSRI	Selective Serotonin Reuptake Inhibitor.
STD	Sexually Transmitted Disease
STOP	Suction Termination of Pregnancy
SVCO	Superior Vena Cava Obstruction
SVD	Spontaneous Vertex Delivery
SVT	Supraventricular Tachycardia
SXR	Skull X-Ray
T&A	Tonsillectomy and Adenoidectomy
T1 to T12	Bones in the thoracic spine (upper back)
T3	Thyroid Function Test
T4	Serum Thyroxine Test for thyroid disease
TAH	Total Abdominal Hysterectomy
TB	Tuberculosis
TCAD	Tricyclic Anti-Depressant
TCC	Transitional Cell Carcinoma
TCRE	Transcervical Endometrial Resection
TDS	Three Times a Day
TENS	Transcutaneous Electro Nerve Stimulator
Tet	Tetanus
TFT	Id Function tests

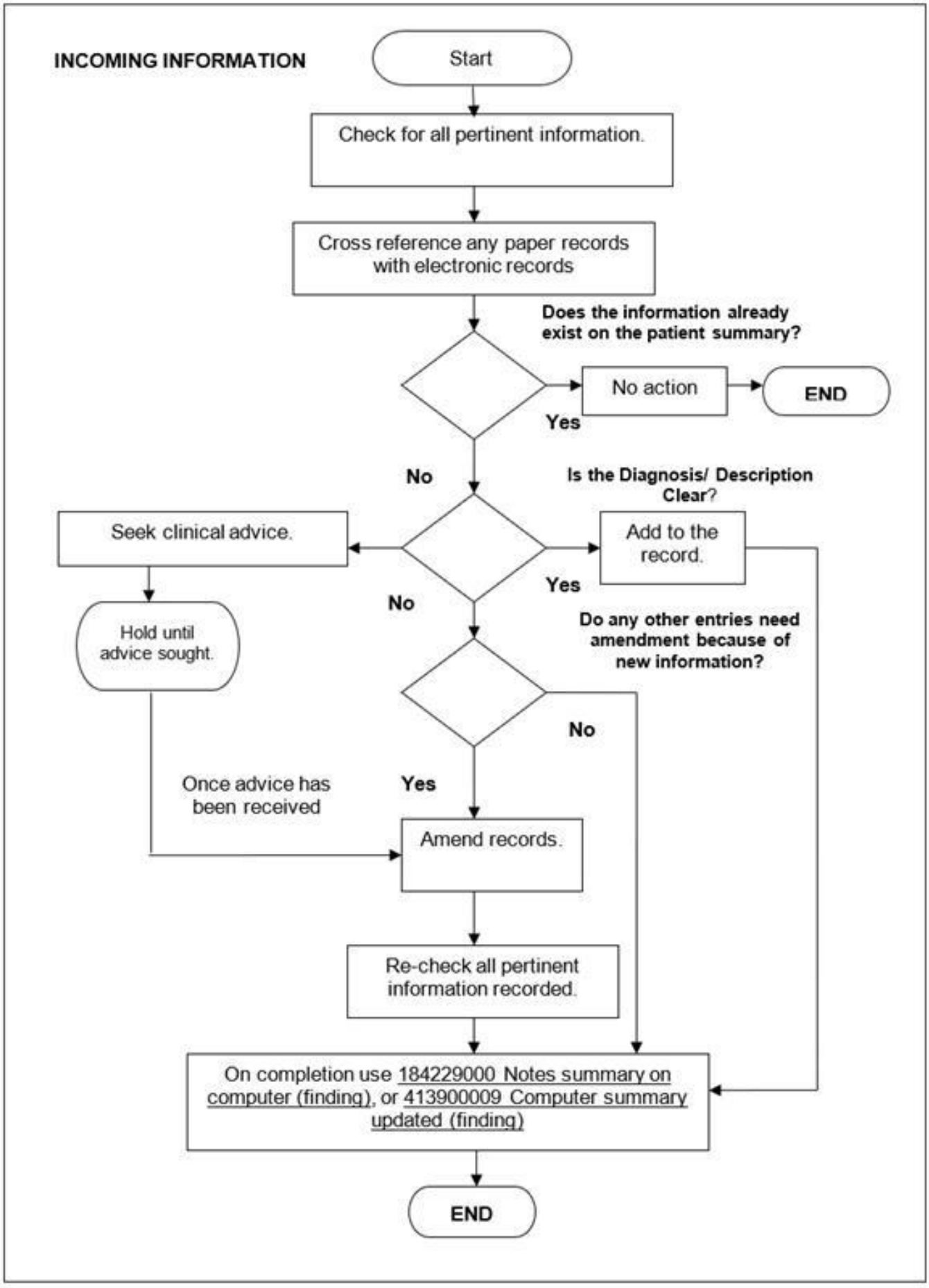
Abbreviation	Description
TFT	Thyroid Function Test
THR	Total Hip Replacement
TGs	Triglycerides
TIA	Transient Ischaemic Attack
TKR	Total Knee Replacement
TLE	Temporal Lobe Epilepsy
TMJ	Temporomandibular Joint
TOP	Termination of Pregnancy
TPA	Tissue Plasminogen Activator
TPR	Temperature, Pulse and Respiration
TR	Temporary Resident
TSH	Thyroid Stimulating Hormone
TURP	Transurethral Resection of Prostrate
Tx	Treatment
U&E	Urea and Electrolytes
UC	Ulcerative Colitis
UCO	Under Care Of
URTI	Upper Respiratory Tract Infection
US	Ultrasound
UTI	Urinary Tract Infection
UVPPP	Uvulopalatopharyngoplasty
V/Q	Lung Scan image produced by radio nuclide scanning of lungs; helps diagnose pulmonary embolism.
VA	Visual Acuity
VD	Venereal Disease
VH	Vaginal Hysterectomy
VV	Varicose Veins
XR	X-Ray

Appendix C: Common Medical Signs and Terms

Abbreviation	Description
Acronym	Word formed from initial letters of major parts of term i.e., LASER Light Amplification by Emission of Radiation.
Acute	An acute disease or symptom has rapid onset, and a relatively short duration, and may not necessarily be severe for example, acute tonsillitis.
Bacteria	Group of microscope unicellular organisms that cause disease in man.
Chronic	A chronic disease or symptom has a slow onset and progression but lasts a long time.
Diagnosis	The determination (i.e., discovery) of the nature of a disease. The clinical diagnosis is made by study of the signs and symptoms.
Differential Diagnosis	Used to recognise one disease, and eliminate others, amongst several presenting with similar symptoms.
Eponym	The name of a disease, structure, operation or procedure usually derived from the name of the person who first discovered, or described it e.g., Down's syndrome, Behcet's Disease
Pathogen	A micro-organism that can cause a disease.
Prognosis	Is a forecast or prediction of the probable course and outcome of a disease or disorder
Remission	Is the partial or complete disappearance of the symptoms of a chronic or malignant disease. A remission is usually temporary.
Sign	Evidence of a disease, such as a fever, that can be observed by the patient and others.
Symptom	E.g., pain, headache – can only be observed or measured by the patient.
Syndrome	A collection of signs and symptoms that occur together as part of a specific disease process.
Δ	Diagnosis
$\Delta\Delta$	Differential Diagnosis

Abbreviation	Description
<	Less than
>	Greater than
+ve	Positive
-ve	Negative
↓/↑	Increase / Decrease
3/7	Three days
1/52	One week
1/12	One month
1◦	Primary / first degree
2◦	Secondary / first degree
#	Fracture
1n	One at night
1prn	One as required
2qds	2 four times a day
c	with

Appendix D: Flow Chart: Note Summarising



Appendix E: Useful References

The Good Practice Guidelines for GP electronic patient records, *Version 4 (2011)*

The Summarising Protocol is subject to the provisions set out in the legislation and guidance listed below:

- Data Protection Act 1998
- Records Management NHS Code of Practice (Part 2)
- Human Rights Act 1998
- The Common Law Duty of Confidence
- Access to Health Records Act 1990
- Confidentiality: NHS Code of Practice 2003
- NHS Care Record Guarantee 2009
- HSC 1998/217: Preservation, Retention and Destruction of GP Medical Services Records Relating to Patients
- Freedom of Information Act

Get to know us or get in touch

 mlcsu

 Midlands and Lancashire Commissioning Support Unit

 midlandsandlancashirecsu.nhs.uk