**Primary Care Services**

**Summarising Medical Notes and Letters**

**Standard Operating Procedure**

**Version 1.0**

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**Appendix A – Record Sorting Order**

1. **Summarising Medical Notes**

**1.1 Introduction**

The purpose of this document is to provide practices with the basis of culling and organising paper-based patient notes, and an outline of a procedure to follow to effectively summarise the data onto the computer record and safe storage of Lloyd George notes

Surgeries will have computerised their patients notes at different times, using different clinical systems and until there is a system of transferring notes electronically than a manual procedure must take place. When notes are received they will be in the Lloyd George pockets, envelopes and ideally with a computer printout.

In some cases practices may receive details via encrypted CD-ROM, with a password entry that has to be obtained from the previous surgery. In such a case, the disc should also be kept within the Lloyd George notes.

**1.2 Record Preparation**

This will:

* Standardise patient records.
* Simplify the process of summarising patient records.
* Remove any unwanted correspondence, e.g. duplicated letters.
	1. **Procedure**
* Sort letters and tag into date order, with the most recent letter on top.
* Cut off any excess paper, ensuring any relevant information is kept. e.g. patient hospital number, reference information.
* Use “treasury tags” to put each set of correspondence in date order, with the latest referral on top, write speciality, with date range on the back of the record.
* Sort doctors’ clinical notes in date order - like a book - with the latest on top and secure at the top left corner with a treasury tag.
* Keep all smear results on a tag – latest on top
* Sort all path lab/x-ray results in date order
* Should it be necessary to replace the Lloyd George file, ensure all information is transferred onto a new file.
* Label the records to show that a data summary must be complete.
	1. **Discard**

If in doubt, it would be better to err on the side of caution and keep documents for possible future need.

* Old Lloyd George envelopes – **with no writing on** – trivial information.
* Only letters which are a direct duplication.

**1.5 Summary Cards Preparation**

* Capital letters.
* Date entries (year and month only).
* Keep heading general and enter **ONLY MAJOR** diseases or operations.
* Document appropriate investigations alongside heading, e.g. Renal
* Do record pregnancies (as relevant to future pathology in some cases).

**1.6 Summarising**

This highlights and categorises the relevant medical/social history and enables clinician to access the information in a speedy and accurate way.

**N.B.** Notes of newly registered patients should be summarised within 4 weeks of receipt by the practice.

**Procedure**

* Read all letters.
* Make note, including dates, of relevant conditions/operations/social history/allergies etc.
* Read all doctors’ notes adding any relevant further information, again, including dates.
* Read results and add any relevant information to list, e.g. last/abnormal smear, cholesterol.
* Add any abnormal investigations including dates, if not already noted and indicated in a letter or in doctors’ notes.
* Check there is no further information on back or front of file.
* Note date of pneumococcal vaccination if relevant and latest adult tetanus.
* Also enter on yellow vaccination card.
* Note latest smear and any abnormal results.
* Enter latest smear into template. This will ensure date of next follow-up will show automatically.
* Note latest mammogram and any abnormal results.
* Input all noted information into computer selecting Significant, Minor, Active or Past according to the condition.
* Print out summary and attach to Lloyd George.
* Add code **9344** to computer (Note Summary on Computer).
* Write year on front of notes in top left corner, indicating that notes have been summarised.
* Write any allergies in red on front of notes and enter alert on computer.
* See **Appendix 2** for record sequence order.
* Female patients - record the following: Parity status / Miscarriages / Terminations / HRT

Enter the last recorded entry for each of the following:

* BLOOD PRESSURE
* SMEAR RESULT
* SMOKING STATUS
* ALCOHOL STATUS

Enter any recorded family history of the following, or extract from New Patient Questionnaire or new patient health check.

* STROKE
* DIABETES
* CHD
* ASTHMA
* CANCER

Other entries:

* Immunisations for all patients, especially children under five
* Recall dates for new patient screen and smear tests
* If child is on Protection Register

*There is no need to record all minor complaints that patients attend surgery for on a regular basis i.e.: colds, fevers, rashes, tonsillitis, bronchitis bumps and scrapes, twists and sprains etc.*

N.B. All of the following information should be entered with the exact date (e.g. 08 12 1968). If the exact date is not known but the month is known then use 1st of the month (e.g. 01 12 1968); if only the year is known then use 1st January and correct year (e.g. 01 01 1968)

* The date that the summarisation is being entered on to the computer system.
* The date of when seen in clinic.
* The latest health template information should be recorded if not done so already.
* For chronic illness e.g. chronic obstructive airway disease, diabetes mellitus, heart disease, asthma etc. the commencement must be entered.
* Any illness that requires a referral to a hospital consultant must be entered, e.g. psychiatry, urology, cardiology etc.
* Any bone fracture needs to be entered including site of fracture i.e. left or right limb etc. and any treatment given. (NB any manipulation procedure should be entered separately).
* Any operative procedure needs to be entered with the reason for the procedure entered as a separate entry, e.g. a hysterectomy for fibroids should have an entry for Hysterectomy and a separate entry should be made for the fibroids.
* The commencement date of all Hormone Replacement Therapy (HRT).
* Any important therapy, especially for malignant illness, such as chemotherapy or radiotherapy.
* Any illness that requires more than four weeks away from employment.
* Any illness requiring repeat medication.
* Any family history of illness should be entered e.g. atopy, heart disease, CVA/stroke, breast cancer, glaucoma, cancers, diabetes, hypertension, heart attacks, Huntington’s Chorea etc. The deaths of any first-degree relative (parent, spouse or child) should be entered onto the system, with the cause of death if known.
* Enter any illness that may have any significance for future health e.g. genital herpes, haemoglobinopathy etc.
* In women, all pregnancies should be recorded including the mode of delivery e.g. normal delivery, forceps delivery, ventouse delivery, emergency/elective caesarean section. In the case of caesarean section, include reason for operation e.g. cephalo-pelvic disproportion, breech, fetal distress etc.
* Details of pathology results such as blood group, rhesus group, rubella status, Hepatitis B surface antigen.
* In under-16-year-olds, all immunisations should be entered on to the system. For over-16-year-olds, all recent vaccinations should be entered e.g. booster polio and tetanus, hepatitis A and B vaccinations, influenza vaccinations.
* All significant life-changing events should be included such as marriage, divorce, death of a relative etc., where available.
* All previous smear tests.
* All mammograms including result.

**1.7 Other Issues**

**Haemoglobinopaties.** Sickle Cell, Thalassaemia, Haemaglobinopathy or Haemoglobin Electrophoresis results. If the patient is reported as having a haemoglobinopathy, then this should be displayed as an active problem on the front screen, as this can have consequences for future health or during pregnancy.

If the result is negative then it should be reported as significant past.

**Virology** reports such as Hepatitis A, Hepatitis B and Rubella status should be included in the information added on to the system if it is not already present.

**Blood Transfusion reports**. Blood groups including rhesus and antibody status should be entered.

**Biochemistry**. If there is a report of previously raised cholesterol but there is no significant active problem recorded to account for this e.g. hypercholesterolaemia or the patient is not on medications for such a problem, the raised cholesterol test and value should be entered.

**Cervical Smear Tests, Cytology**. See Further Information Section

**X-ray Reports**. Enter if the report shows anything of future significance e.g. degeneration of

bone.

**Allergies and Intolerance**. All allergies should be entered, including a comment detailing the reaction that they caused e.g. rash, swelling, itching. These can very often be found on the patient record envelope.

N.B. It is very important to check that any details being added/changed are being made to the correct computer patient record - always check before any changes or additions to information are made*.*

N.B. Sometimes handwriting can be difficult to interpret! In such cases the summariser should not guess at the contents but seek advice from medical personnel within the practice.

**1.8 Coding**

It is recommended that practice coding is placed under the control of a clinical member of the practice who is familiar and competent in the technical use and application of the Read Code system.

A practice list of preferred Read Codes should devised and actively maintained, supported by quality audits and regular discussion of the use of coding within clinical policy meetings.

**1.9 Cervical Smear Tests and Cytology**

Record all previous cervical smear results e.g. dyskaryosis, CIN, Herpes Wart Virus and inflammatory changes. Record where the slide was taken e.g. GP surgery, hospital outpatients etc, the slide number, the date and the result. Enter using Cervical Smear template, using D, cervical screening.

1. **Summarising Medical Letters**

**2.1 Introduction**

The purpose of this document is to provide practices with the basis of culling and organising patient letters, and an outline of a procedure to follow to effectively summarising of the content of the letter onto the computer record.

**2.2 Summarising**

This will:

* Highlight any new diagnosis / allergies
* Change of medication
* Any other information relevant to the patient

**Procedure**

* Open post daily by team member which must be open within one working day / 24 hours
* Read through letters and allocate actions sort in piles:

GP – to action the points on letter

Pharmacist/Healthcare Professional – to action points on letter

Reception – to action basic discharge letters or DNAs

All letters to GP, Pharmacist and summarising all must be coded in accordance with each practices surgery key.

* Readcode any new diagnosis, medication, blood pressure, weight, height, procedures patient may have had or any other relevant information
* Create new major or minor problems for new diagnosis with the correct date
* Create new entries in to patient summary of any new diagnosis or procedures with correct date
* Highlight sentence within letter of new diagnosis, medication or procedures
* Allocate to Secretaries, General Practitioner or Pharmacist for any action or complete document if no actions required.

**2.3 Scanning Process**

* Sort through all letters to the practice and arrange letters into batches:
* Sort the letters into
	+ - * Single sided
			* Double sided
			* Multiple pages
* Select scanning module in your clinical system
* Scan document / image
* Select correct patient
* Enter any relevant codes into the patient record with correct dates
* Title all documents / images
* File scanned document to correct patient record and/or send to relevant clinician
* Take into consideration distributing letters amongst clinicians and be mindful of half days and annual leave.
1. **Review**

This policy will be subject to review every three years, or, in light of any changes to national standards or Trust policy.

 **Appendix A – Record Sorting Order**

MATERNITY

MALE SURNAME FORENAME

SUMMARY - PRESCRIPTIONS

SUMMARY OF TREATMENT

**ALLERGIES**

**MALE**

SURNAME FORENAME

Date of Birth National Health Service Number

Address

Patient out of the area allowed to stay on our list

Treatment Summary

Repeat Prescription Cards

SMEAR RESULTS

LETTERS

Last Referral

Correspondence

Ante Natal

Smear Results

Continuation Cards - Vaccination Card first