NHS
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NHS Foundation Trust

Primary Care Services

Standard Operating Procedure

Summarising Medical Notes and Letters

Version 2.0

Version	2.0
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Version Control Summary

Version	Date	Author	Comment
1.0	February 2021	?	Based on: Medical notes Summarising Protocol (LRS) and Medical Letters Summarising protocol (LRS)
2.0	October 2022	Kirsty West & Janice Brazier	GPSU SOP based on ELFT Medical Notes and Letter Summarising Policy

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Appendix A – Record Sorting Order

1. Background

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.

2. Purpose

This SOP will:

- Standardise patient records
- Simplify the process of summarising patient records
- Remove any unwanted correspondence, e.g. duplicated letters.

3. Scope

This Standard Operating Procedure (SOP) relates to the following staff groups who may be involved in the process of medical notes and letter summarising:

- Patient Record Coordinator team

4. Procedure

The patient record coordinators should always note the below when carrying summarising medical notes / letter summarising:

- If in doubt, it would always be better to err on the side of caution and keep documents for possible future need.
- When recording allergies, it is important to also note the reaction they caused e.g. rash, swelling, itching
- 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
- 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
- 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 must be devised and actively maintained, supported by quality audits and regular discussion of the use of coding within clinical policy meetings.

The below process should then be followed:

- 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

4.1 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.

4.2 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.

4.3 Procedure

- Read all letters.
- Make note, including dates, of relevant conditions/operations/social history/allergies etc.
- Promote to a problem any chronic illnesses / conditions when entering the patient details
    - Problems will be separated by major vs minor active illnesses headings
- Read all doctors' notes adding any relevant further information, again, including dates.
- Add any abnormal investigations including dates, if not already noted and indicated in a letter or in doctors' notes if recent and ongoing, not necessary for everything historically if no longer ongoing.
- Check there is no further information on back or front of file.
- Note date of all patient vaccinations
- Also enter on yellow vaccination card.
- Input all noted information into computer selecting Significant, Minor, Active or Past according to the condition.
- Add code **9344** to computer (Note Summary on Computer).
- Write any allergies in red on front of notes and enter alert on computer notes.
- See **Appendix 2** for record sequence order.
- Female patients - record the following: PARITY STATUS / MISCARRIAGES / TERMINATIONS

Enter the last recorded entry for each of the following, if not recorded from the registration docs, new patient checks or from the GP to GP information:

- 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
- 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.
  - Any operative procedures should also be promoted to the patient summary under the appropriate heading – Minor / Major.
- Any important therapy, especially for malignant illness, such as chemotherapy or radiotherapy.
- Any ongoing issues or past major where deemed appropriate
- Any current 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, ventose delivery, emergency/elective caesarean section. In the case of caesarean section, include reason for operation e.g. cephalo-pelvic disproportion, breech, foetal distress etc.
- Details of pathology results such as blood group, rhesus group, rubella status, Hepatitis B surface antigen.
- For all patients, all immunisations should be entered on to the system. 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.

4.4 Other Issues

Haemoglobinopathies. Sickle Cell, Thalassaemia, Haemoglobinopathy 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.

4.5 Coding

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 must be devised and actively maintained, supported by quality audits and regular discussion of the use of coding within clinical policy meetings.

4.6 Cervical Smear Tests and Cytology

The cervical smear tests and cytology results will be covered by the GP2GP process.

5. Review

This procedure 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