

The ICE Programme

An Essential Support Pack



MEDICAL RECORDS FOR THE 21ST CENTURY

Resource Booklet

Level 1: The ideal Manual Record

SIX STEPS FOR THE CREATION OF A
MEDICAL RECORD

*Preparing the manual record for
conversion to the electronic format*

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ICE SUPPORT PACK

THE WORKBOOK

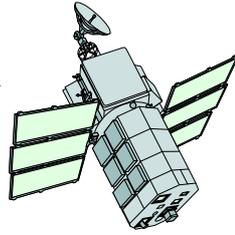
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*Acknowledgements of contributors will be found on page 22 of this **Resource Booklet***

MINIMUM STANDARDS FOR RECORD KEEPING IN PRIMARY CARE, IN BRO-TAF



AN OVERVIEW

What is the vision of general practice that arises from the Information Management & Technology Strategy document (ENGLAND)¹? All patients will have a person-based electronic health record, a longitudinal record of their health and their health care from cradle to grave. It will be created and maintained within primary care and will provide 24 hour access on a secure basis for all healthcare professionals. Clinical effectiveness and decision support software will be integrated into the record system. An agreed structure and methodology of coded data entry will allow clinical information to be meaningfully transferred between primary and secondary care. Clinical data from individual practices will be aggregated and matched against national standards and clinical pathways to inform local commissioning decisions. On-line services such as tele-medicine will support shared care schemes, whilst administrative matters such as booking appointments, referrals, discharge information, and test results will be routinely exchanged between organisations.

Success will depend on all practices conforming to the following minimum standards.

- All 24 hour patient contacts, either face-to-face or by telephone should be recorded.
- All practices should become virtually "paperless". Decision support and access to clinical effectiveness data will require keyboard or voice activated entry. As all data needs to be recorded, use of paper and computer is unlikely to be acceptable.
- All clinicians should use standardised codes for data entry. This will enable entered data to be readily exchanged with secondary care and be meaningfully aggregated.
- Booking slots for hospital appointments will require agreement as to local care pathways to underpin shared care and provide guidance as to appropriate referral.

LEVEL.1 - is the achievement of total recording of all patient contacts with clinical staff, during the 24 hour period; be that face to face or via the telephone.

THE STEPS

1. A Registration system to record demographic data using a permanent format.
2. Consultation notes, acute prescribing and repeat prescribing.
3. Results and letters
4. Summaries of main medical conditions
5. System to identify and retrieve lost notes
6. Visits and telephone calls

A system to hold and then transfer temporary data resulting from:-

- **Down time**
- **Daytime calls**
- **Daytime telephone contact**
- **Out of hours calls**
- **Out of hours telephone contact**

NB. Although many people, outside Primary Care, believe that these standards have already been achieved, we in the PAG know that the achievement of all these standards is present in very few, if any, practices. The spectrum of achievement in this respect is very wide.

LEVEL 2, - is the achievement of the "paperless" practice.

To achieve this level:

a) All practices will need to review their hardware and software resources in addition to achieving Level 1.

b) All items in the current records will need to be translated into electronic format.

1. Data entry via keyboard or voice recognition at each consultation
2. Appropriate demographic data, including postcode and telephone number
3. Summary of main medical conditions
4. Prescribing data both acute and repeat
5. Results in chronological order
6. "Letters out" in chronological order i.e. word-processed
7. System to deal with "down time"
8. Systems to hold and then transfer temporary data
 - Down time
 - Daytime calls
 - Out of hours calls
 - Daytime telephone contact
 - Out of hours telephone
9. "Letters in" in chronological order i.e. scanned, abstracted and stored.

LEVEL 3 - the standardisation of the information to be collected.

This cannot proceed without agreement of local practices and health groups. This work should draw upon the experiences of practices submitting data both for the Birmingham⁽¹⁾ and the all-Wales study^(2,3) The work of the West Wales Faculty on a formulary of Read codes is being debated widely and a series of meetings have been arranged.

LEVEL 4. Integration of information coming from primary care with that in the secondary sector and other parts of the health service. This is as yet no agreement between physicians in each sector- level 4 - as to the data to be commonly collected however a start has been made by the St Vincent Declaration and by an initiative in Taf Ely⁽⁴⁾. We await national initiatives on this topic, from whence local working parties will need to look at common shared care conditions to facilitate the exchange of meaningful information

The ICE Support pack has started with this straightforward approach to level 1. Further booklets for the higher levels will be added when the time is appropriate.

References:

1. *INFORMATION FOR HEALTH - an information strategy for A Modern NHS 1998-2005 A national strategy for local implementation.* (124 pages available on the internet at [www.imt4nhs.uk/strategy/index .htm](http://www.imt4nhs.uk/strategy/index.htm):)
2. *Better Information. Better Health Information Management and Technology for Health Care. Health Improvement in Wales. Strategic Framework 1998-2005 (Welsh Office 1999).*
3. General Practice Morbidity Database Project, Public Health Information Services, Welsh Health Common Services Authority & Breast Test Wales.
4. Personal communication with the Taf Ely IM & T Group, on commonly collected data.

PART TWO

SOMETHING TO THINK ABOUT



Here we bring you a potpourri of thoughts, tips and ideas that have been given to us by those who have seen the draft ideas for this booklet and others with a general interest in records, they were generous with their ideas and suggestions.

We have not attempted to make this booklet comprehensive. There follows a section for each of the steps, which will give additional material from many sources. Some are references to books and journals and others are reports of observations made to us at meetings or from participants in the pilot exercise. We have included relevant texts as annexes and have also commissioned some papers on subjects that we feel might be helpful.

We would welcome observations and material from those who use this booklet. These might be suitable for inclusion in our newsletter, or later editions. Through our own website we will have a “chat line” enabling us to continue the debate in an open way.

PART 3, on Page 21 of this booklet, contains a list of references for additional reading. Two of these are of particular importance and are repeated here:-

1. **“The IT files”**. Published by the Welsh Office, NHS Cymru Wales, 1997, and **circulated to all practices in Wales, this is a valuable resource which will apply mainly to later levels in this series.**
2. **“Medical Records__ in practice – Guidance for General Practitioners”**
RCGP – Practice Organisation series - No. 2. Edited by Bruce Lervy (of Swansea).
£20.00 for RCGP members. £22.00 for non-members.
A most useful reference book. (A new edition is currently in preparation, but is unlikely to be available for a year or so.)

RESOURCES FOR STEP 1

“Medical Records__ in practice – Guidance for General Practitioners”⁽¹⁾ Section 1, Chapters 1-5 provide useful background reading.

On page 1 the **function** of the medical record is listed:

- a record of patient details for registration purposes
- a record of past significant events
- a record for disease prevention/ health promotion purposes
- a record of contacts between doctor and patient which acts as an *aide memoire and facilitates communication* between the patient and other doctors and members of the primary health care team
- a record of points of medico-legal significance
- a file for storing referral letters ,hospital discharge letters, clinical letters and investigation results

.....

At Action Point 1 in the **Workbook** you were asked to complete figure 1 on page 6. Suggested comments for Steps 1a & 1b might be:

- a. "The patient has the security of being correctly registered with the practice."
- b. "The practice will know that capitation fees will have been maximised."

On **page 9** of the **Workbook**, at Action Point 4, you were invited to fill in the blank spaces in

Figure 3. The PAG's suggested solution is as follows:-

Registration activity	Person(s) responsible for completing activity	Time span expected to complete process or clinical examination	Completion checked by
a. Medical card or GMSI sent to Health Authority	<i>Reception staff</i>	<i>Same day</i>	<i>Senior receptionist</i>
b. GMS 1 and questionnaire Information combined to form a temporary record.	<i>Reception staff</i>	<i>Same day</i>	<i>Practice manager</i>
c. registration appointment offered by receptionist.	<i>Receptionist. (Then later, by doctor / Nurse)</i>	<i>Within 3 months</i>	<i>Receptionist</i>
d&e. Update clinical information (including repeat prescriptions) in 'Final manual record' and computer	<i>Doctor/Nurse. Doctor should be involved if a repeat prescription is entered)</i>	<i>ASAP</i>	<i>Doctor/Nurse; And receptionist or computer clerk</i>
f Ensure that 'Links' is working and inform practice computer of the receipt of the medical record envelope.	<i>Receptionist and/or computer clerk</i>	<i>Ideally Record arrives within 6 weeks. See note on HA * See registry problems in Step 1 of the resource booklet – p. 7&8</i>	<i>Practice manager</i>
g.& h. Medical record, from previous practice, received by post from HA, married up with temporary notes and filed as the permanent record. (Send anything relevant to computer.)	<i>Receptionist</i>	<i>Within 2 working days of receipt</i>	<i>Practice manager</i>
If a computer is in operation, upgrade accordingly – in particular, ensure that any summary is inserted into the 'Significant Medical History' screen. (If there is no summary available, now is the time to make one.)	<i>Practice manager / computer clerk</i>	<i>Within one week – preferably same day</i>	<i>Computer clerk or Practice Manager</i>

FIGURE 3 – PROFILE B

During the pilot phase of the project, discussion with practice managers raised certain problems. It was felt that inadequate publicity has been given to the **NSRA** number. It is not yet used as a unique number, except at the Health Authority. In time it could be of great use. Considerable resources have been deployed, by Primary Care, in getting the number onto all records. The fact that very little use is now made of it, should promote a move by the NHS as a whole, to ensure that those resources that have been used will not be wasted.

GP Registration LINKS – notes on problems



Many patients fail to inform the practice of a change of address or a change of name. Suggestions to improve this, ranged from a poster campaign to messages being placed on the repeat prescription counterfoil. A totally satisfactory solution has yet to be suggested. The incorrect spelling of names could result in registration being rejected by the Health Authority. One suggestion was to give each patient a printout of their registration details at reception, but there may not always be a printer available at this point. It may surprise some, who may be critical of our record keeping, to learn that some patients do not know their date of birth; many do not know their postcode. In high unemployment areas, patients are often reluctant to admit that they are unemployed.

Former names (maiden / previous marriage) may be useful if patients do not have their NHS card at registration, and the NSRA number may not be known to new patients at this point.

NSRA No.
??????



Patients who have been discharged from prison or the services may not have their clinical notes forwarded and these may even be destroyed before reaching the practice. Recent moves to integrate the Prison Medical Service with the NHS, may be helpful.

The offer of a health check by using a questionnaire, may pay rich dividends. An example of a questionnaire in current use is given on pages 21 - 23 of the Workbook.

Practice Managers stressed that it was important to enter the demographic details of temporary patients onto the computer, to avoid the loss of essential information.

Some practice managers complained that patients were sometimes allocated to them with inadequate information from the Health Authority.

We asked the Bro-Taf Registry Dept. for a simple outline of the view at their end of the LINKS process. This was their outline.

MEDICAL RECORD NOTE

It is important that medical records requested by the Health Authority are returned by the next **courier** collection whenever possible.

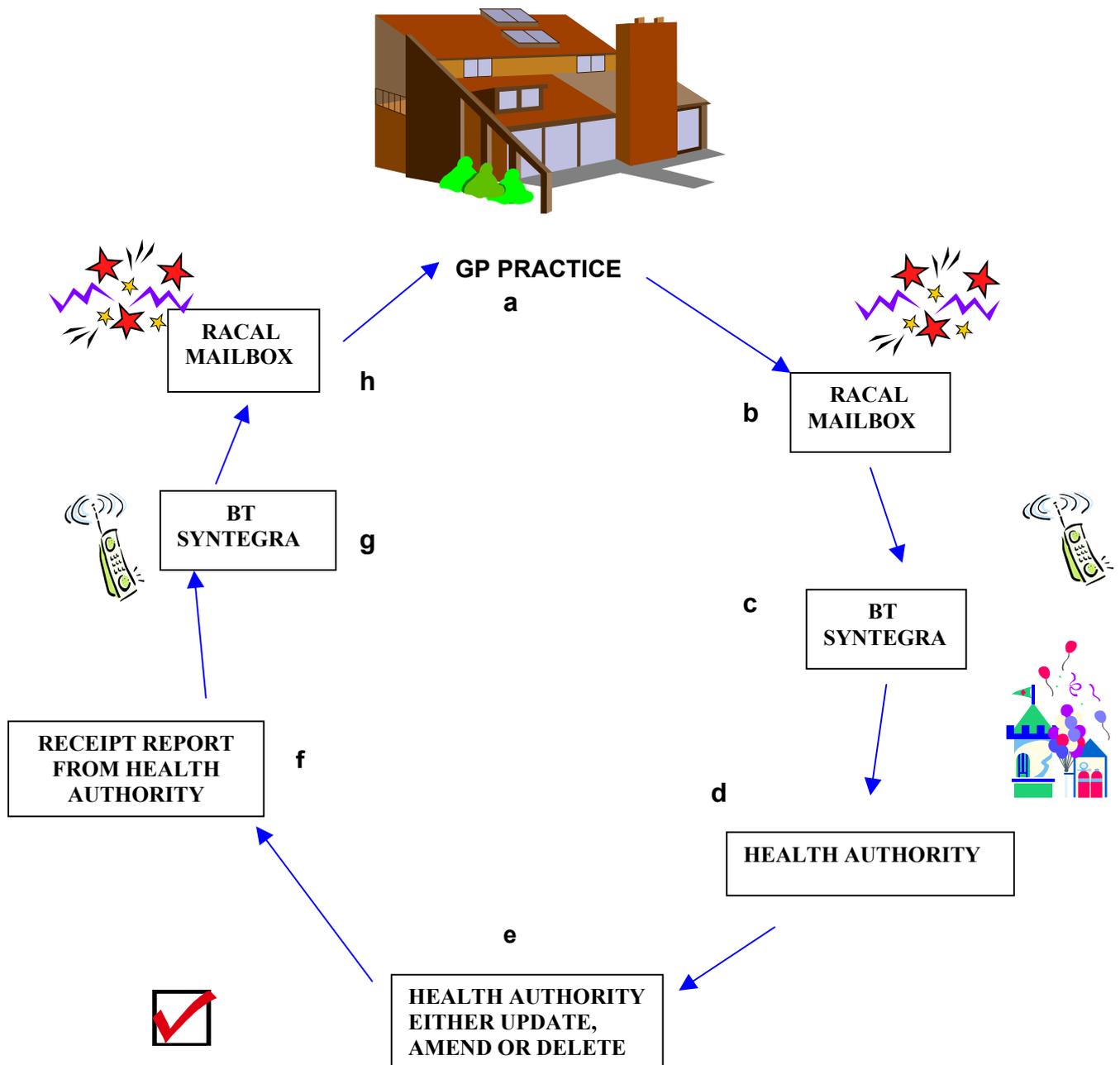
Other doctors in both Bro Taf and other Health Authority areas await many of these records. When a medical record is received by Bro Taf it has to be 'logged' off on the authority's computer system before it can be labelled and dispatched. Medical records are processed each day as a `priority. In cases of an internal transfer the records are placed in the new doctor's courier bag for delivery.

When a patient is moving out of Bro Taf the medical record is sent, in the first instance, to the new Health Authority. The new Health Authority will then 'log off' the record on their computer system before labelling and dispatching onto the receiving doctor.

These processes can be lengthy, but with regular submission of records and co-operation, the process can be speeded up. A working party between the LMC and the authority has been set up to explore the registration process with a view to suggesting solutions.

GP REGISTRATION LINKS FLOWCHART

- a) Patient registers or existing details are amended by doctors' practice.
- b) Racal assembles messages into interchanges for 'pickup', by BT Syntegra.
- c) BT Syntegra send to Health Authority.
- d) Health Authority receives interchanges from BT Syntegra for processing.
- e) Health Authority updates registrations on receipt of form GMS1. Amendments are updated immediately. Deductions and medical record flags are also sent back to practice.
- f) Receipt reports are transmitted to practices as a result of the above processes.
- g) BT Syntegra send to Racal.
- h) Racal dis-assembles interchanges into messages for 'pickup' by practice.



STANDARDISATION OF RECORDS:

Mr Stephen Allen, Practice Manager at St. David's Court Surgery was concerned about the lack of standardisation of patient records in Bro Taf. Here Stephen comments on the resource implications of achieving a common format for medical records.

On average practices in Bro Taf can expect to receive 5 new patient records per partner every week of the year. These files can be in either A4 or Lloyd George format. Regrettably a significant number of these are in the latter Lloyd George envelopes. Converting these records to the standard A4 format can take a considerable amount of practice staff time.

The structure of A4 records themselves varies considerably from patient to patient. For instance the Health Authority provides practices with standard inserts for A4 files yet the way that they are incorporated into the medical record varies from practice to practice. Ensuring consistency can be an extremely time consuming process

A recent practice based study established that it takes a receptionist 6 hours to convert 20 average sized files and construct history sheets. This is a heavily resource intensive exercise.

Should a standard format be agreed across Bro Taf many hours of staff time could be saved.

The next generation of patient record will be in the electronic format, this is assured and is the future, but it is a future that must be based on firm foundations. Good manual records are an essential first step; they are the basis upon which the records of the future will be built.

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HOLDING A COMPLETE RECORD

The importance of keeping an adequate and up-to-date record was reinforced by advice in the October '99 issue of *The Journal of the Medical Defence Union* ⁽¹⁾ a Judge is likely to favour a doctor's account of what was, or was not, discussed if it is supported by good, contemporaneous medical records⁽²⁾. On the other hand, if records are absent, or very sketchy, he is quite likely to favour the patient's version on the grounds that the patient is more likely to remember his/her specific consultation than the doctor for whom it was one of many."

References.

1. *Journal of the Medical Defence Union* Vol. 15, Issue 3 October 1999.
2. *The National Health Service (General Medical Services) Regulations 1992 Terms of Service for Doctor- Paragraph 36*

Resource Notes for STEP 2

Consultation Notes; Acute prescribing and Repeat prescribing

a. Ensure that useful data is entered at each consultation

A common approach on how to enter information into the notes should be adopted if possible. This is not always easy in a partnership, but some basic principles can be agreed.

- Entries should be **legible**.
- Notes should be entered in chronological order.
- An attempt should be made to record the presenting problem; the presumptive diagnosis and the course of action adopted. Such would be a **basic minimum**. More structured systems may be adopted, preferably by everyone in the practice. However, as long as the basics are maintained it may be acceptable for each clinician to use a different system.



The **SOAP** system is an example –

S = subjective; detail from the patient

O = objective; findings of doctor including investigations

A = assessment; of information obtained and hypothesis formulated

P = plan of management; including therapy and referral

Another example is the Problem Orientated Medical Records (POMR) system (Weed⁽¹⁾1969; Bjorn and Cross⁽²⁾1970) see chapter 22 of *MEDICAL RECORDS*⁽³⁾

Davis and Stott's paper "The exceptional potential in each primary care consultation"⁽⁸⁾ still has lessons for us today, particularly in the teaching situation. The full text of this paper is **reproduced as appendix C, page 30**.

We have asked Dr. Terry Davies, of Llandeilo, Dyfed, to write a note on "Writing in the record" to give you further food for thought. **This appears as appendix B, page 25**.

During the discussions on the pilot run, practice managers raised practical issues, such as: **When consulting sessions take place on more than one site, how can important notes be recorded in both (or all) the records? We have no clear answer for manual records.**

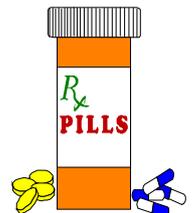
b. Prescribing data (information) - acute.

An acute prescription is usually given on a face-to-face basis although drugs may also be prescribed via the telephone.

Safe prescribing uses the following information:-

- **Characteristics of the patient**
- **Existing Medication**
- **Allergic history**

*Information is useful data,
presented in the right way -
at the right place and at the
right time..*



Ongoing responsibility is the prescribers in the case of many drugs. It may be necessary to:-

- Monitor **compliance**
- Monitor for **interactions** and increased **side-effects**
- Monitor **biochemical parameters** (e.g. renal function with ACE therapy.)
- Monitor **serum levels** where appropriate (e.g. Lithium. Anti-epileptic drugs.)

If any data regarding "current therapy" is not available to the prescriber; the more likely it is that the monitoring systems will fail. Figure 4 from the **Workbook** can be expanded to take account of the number of drugs that the patient is taking

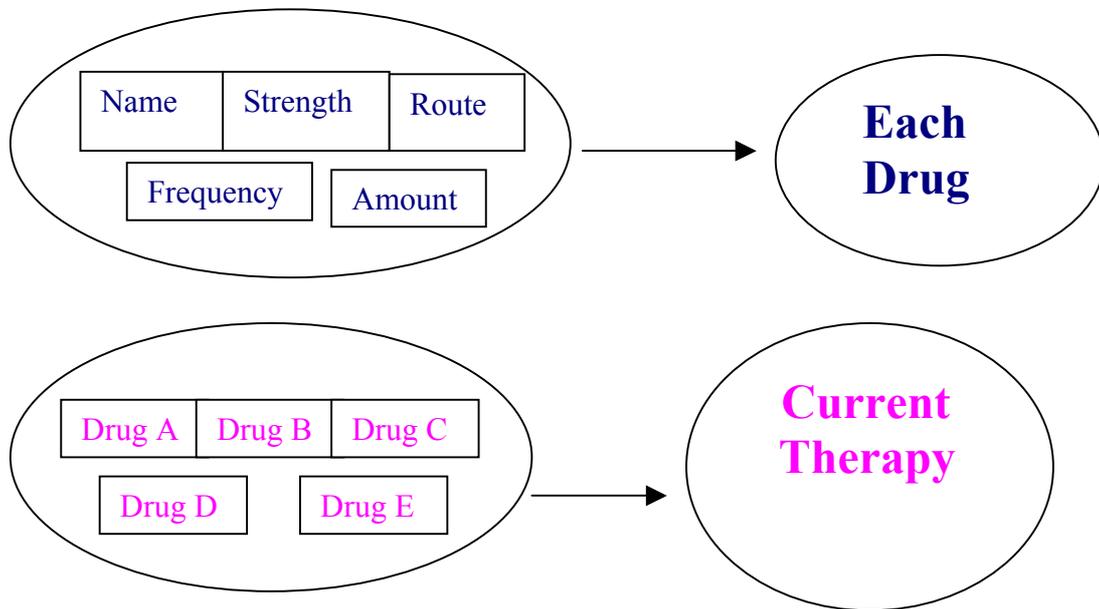


Figure 4. Information required to back up the prescribing of five drugs. (In this example 25 pieces of information could be required.)

R_x

c. Prescribing data (information) repeat

Concerns were expressed about repeat prescribing
In the main:-

- Practice managers wanted to know how systems coped with alterations in therapy, advised by the hospital
- They saw problems of recording clinical notes on two sites
- The addition and deletion of drugs on the repeat system
- How is the system for obtaining repeat prescriptions made clear to the patient?
- How are redundant drugs deleted from the side slip, whilst keeping a total record of what has been prescribed?
- When the patient completes the run of prescriptions prescribed (say 6), does he/she always have to make an appointment to see the doctor before a new run of prescriptions is generated?

If you feel the need to think more deeply about your repeat prescribing, there is quite a lot published which gives the experience of others. *The British Journal of General Practice* published two useful articles ^(4,5) in May 1996. The first "Who control's repeats" contains the model shown below. This, together with the second article, "The scale of repeat prescribing" makes stimulating reading. In his paper Zermansky proposes the following model:-

A MODEL OF REPEAT PRESCRIBING

Repeat prescribing involves three tasks:

- (1) **Production.** This is a straightforward task, usually delegated to a receptionist; it involves receiving requests and producing the prescriptions (usually on a computer).
It will not be considered further in this chapter.
- (2) **Management control.** This is generally the practice manager's responsibility. It comprises four elements.
 - Authorisation check – ensuring that all repeats have been authorised as such by the doctor.
 - Compliance check - identifying patients who overuse or under use their medication.
 - Review date – ensuring that every patient has a clear indicator of when therapy should be reviewed, and
 - Flagging – ensuring that each patient due for review is brought to the prescriber's attention.
- (3) **Clinical control.** This is the doctor's responsibility. It involves two tasks:
 - Authorisation – the decision that a repeat prescription is appropriate, the prescriber being satisfied that the drug is effective, appropriate, well tolerated and still needed.
 - Periodic review – a review of the patient and the medication by the prescriber to ensure that the treatment is still effective, appropriate and well tolerated. The prescriber makes an informed decision as to whether medication should be continued, changed or stopped. A model for the process has been suggested by the West Sussex Family Health Services Authority. It must involve either a consultation or some communication with the patient, since without this any evaluation of the effects of the drug can only be speculative.

References:

1. Weed LL,(1969) *Medical Records, Medical Education & Patient Care.* Cleveland Case Reserve, University Press
2. Bjorn and Cross, (1970); an account of which appears in chapter 22 of *MEDICAL RECORDS*
3. “*Medical Records __ in practice – Guidance for General Practitioners.*” RCGP – Practice Organisation series - No. 2. Edited by Bruce Lervy. £20.00 for RCGP members. £22.00 for non-members
4. Zermansky A. Who controls repeats ? *Br J Gen Prac* 1996; **46**, 643 – 647
5. Harris C, Dajda R. The Scale of Repeat Prescribing. *Br J Gen Prac* 1996; **46**, 649 – 653

RESOURCE NOTES FOR STEP 3 LETTERS AND RESULTS

During the pilot, one practice manager commented that she found the Pathology link was not always reliable and that locums were not accessing it. The printed stick-on labels to address specimens did not always match and, in her practice she had no mechanism to check un-returned results. Another manager leaves patient notes out until the results are back. In yet another practice problems only seem to arise when the doctor takes the blood and asks the patient to take it to the hospital. Sometimes the blood comes back and the doctors do not know why the blood was taken or who sent it! Sound familiar???



On page 14 of the **Workbook** Action Point 9 asked you to place some boundary lines in figure 5.

The PAG's solution is:-

Figure 5,

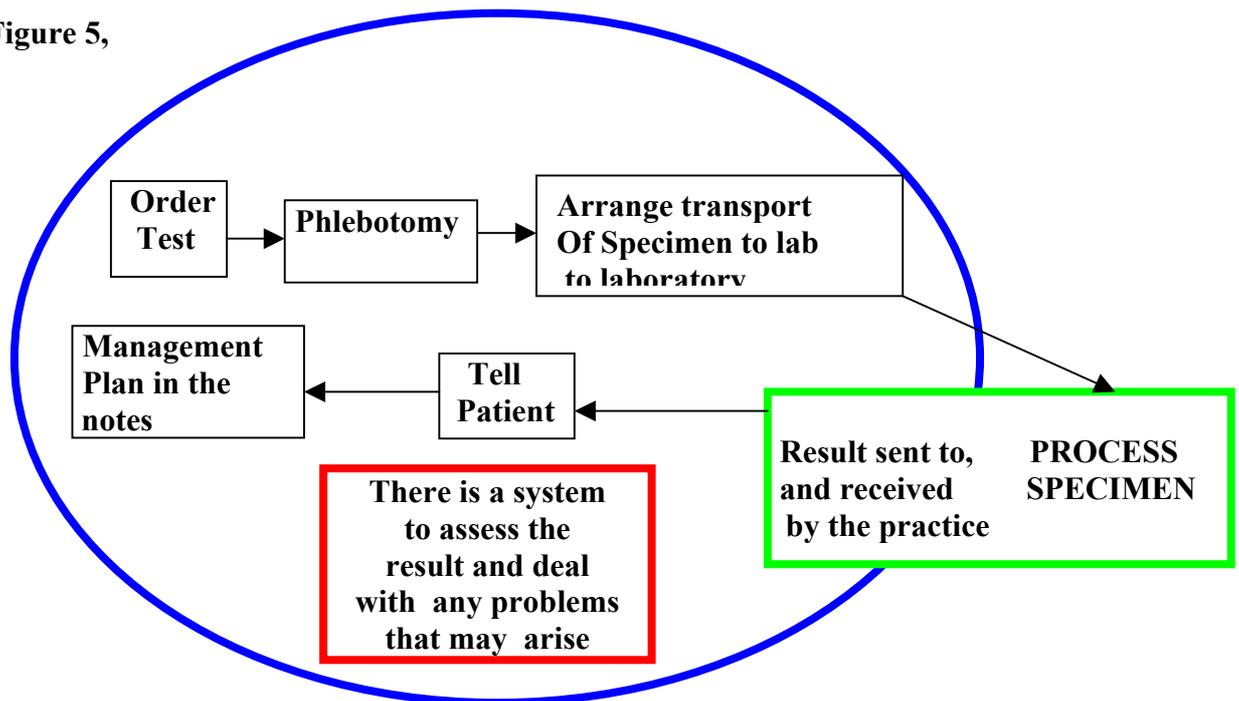


Figure 5, shows the steps that are taken from the moment a test is ordered to the point at which the result is entered in the notes.

The steps within the **blue** boundary are the responsibility of the practice. The area in **green** shows that during processing responsibility lies entirely with the laboratory; but ensuring results reach the practice is a shared responsibility.

Do you comply with the statement in the **red box**?

- The following practice protocol deals with a blood test (other tests follow a similar pattern)
- Test originated by Dr / Nurse etc.
- Labels are printed for patients who have appointments with nurse, specifically for a blood test – on a daily basis
- Clinical staff member takes blood sample
- In the case of acute (unscheduled) tests Dr. or Nurse will hand write the labels
- Samples are passed to receptionist who logs them on a Test Request Sheet. Each sheet will have 30 rows for the names of patients and 13 columns for – DOB;WHO?;WHY?FBC;ESR;RBL;U&Es;Glucose;Lipids;RFLATEX-CRP;TFT; and Other. The columns for specific tests are subdivided into compartments marked Taken and Back. A separate sheet is used for each day and the sheets are clearly dated and kept in a ring binder. (See example below)
- Samples are placed in a basket for collection by the sample service
- Results returned through post on a daily basis
- Results opened by receptionist, stamped (see eg above) and passed to nurse
- Nurse checks the results
- Results returned to receptionist and logged on Test Sheet ensuring all have been returned
- Tests needing no further action computerised and placed inside patients' notes
- If further action is required, receptionist ensures that all test results taken are back from the lab. If not, kept in basket and checked daily until they are
- When all tests are back they are attached to the front of the patient's notes and given to the doctor who ordered the test or who last saw the patient
- Doctor returns blood result to the receptionist for action i.e. inform patient, make appointment etc.
- Blood result recorded on computer (Saved as B Test on minutes disc) and filed in patients' notes

Detail of heading on TEST REQUEST SHEET

Date	DOB	Who	Why	FBC *	RBC *	U&E's *	Gluco *	Lipids *	CRP	TFT *		

* The columns are divided into two and headed Taken/Back

Critics of this protocol felt it was too complicated. One suggestion which, though not perfect, would reduce the time involved and would do the task

- Blood is sent to the laboratory
- On receipt of the pathology report, a designated clerk/receptionist separates the abnormal results from the normal. (The laboratory usually states this on the form.) In the case of any doubt, the clerk will treat the report as positive
- Normal reports are filed in the patient's notes
- Abnormal reports are passed to the duty doctor with the patient's notes
- The duty doctor makes a decision on each report and passes it for filing, action or referral back to the originating doctor
- The patient will have been asked to make contact with the surgery within a specified number of days or weeks. Another practice is undertaking a study to check on un-returned path results. We will learn of the results in due course.

Date stamps for incoming letters and forms have value, the design being for practice discussion. One example is shown on page 19 of *MEDICAL RECORDS*⁽¹⁾, and another shown below.

Date received: 01 JANUARY 2001	
Seen by:-	Please Initial
Doctor 1	
Doctor 2	
Registrar	
Nurse	
Practice Manager	
Health Visitor	
Community Nurse	



Consider why records should be stored and what information should be transferred to other parts of the record. (This need not be such a problem with computers, because automatic transfer can be achieved.)

Other questions are worthy of local practice debate.

- How is a test ordered?
- Are transport arrangements satisfactory?
- Is there a maximum time standard for receiving results and how is it monitored?
- What action is taken when time is over run ?
- How do you ensure that all results are seen and acted upon by one of the doctors?
- Have you an agreed format for writing a management plan in the notes?
- How do you identify when that management plan needs changing?
- How does the patient get to know the result and is the system watertight?

Strict directives from the Health Authority to implement these measures, are not appropriate. Practice discussion and agreement to a protocol is required; with subsequent peer pressure.

It is an interesting reflection upon the way that general practice has developed, that the letters out section of any medical record is much thinner than the letters in. This is because each referral generates only one letter and although the patient's condition may well change over the years it is unusual for this information to be sent to the consultant on a regular updating basis. With networked electronic records, consultants would be able to access such information on request.

References.

- 1: "Medical Records __ in practice – Guidance for General Practitioners." RCGP – Practice Organisation series - No. 2. Edited by Bruce Lervy £20.00 for RCGP members. £22.00 for non-members.

RESOURCE NOTES FOR STEP 4

Summaries

The better that summarised manual records are, the easier it will be to convert them to computerised records. Ultimately computerised records will prevail due mostly to the ease of updating. There is some very good software to help in coping with summaries.

We commend Part 3 of *MEDICAL RECORDS - in Practice* chapters 8 to 12 inclusive. Chapter 10 is titled “Summarising and coding case records: can the task be delegated?” It is perhaps the first consideration when considering this problem. The final answer is probably – Yes, it can be delegated – but only to properly trained people.

A cautionary tale

Success in summaries depends largely on local conditions and personalities. One of the managers in our pilot group recounted her own experience. It seems that none of the doctors had any appetite for change, so she (the manager) was obliged to steer through any new initiatives on her own. Initially the practice nurse would summarise the notes. It was thought that two hours a week would do the job, It transpired this was inadequate and they approached the health authority who agreed that funds would be available to employ someone to do the work. Neither she nor the practice nurse could come in for more hours, so they employed a nurse from outside the practice.

After 2 weeks, she withdrew her services and they were then unable to find another nurse to take it over. Something had to be done, so they decided that during “quiet periods” they would enter into the summary anything that the doctors or the nurse found relevant during their consultations. This worked well with the nurse as she was able to enter the information whilst the patient was with her. The doctors felt unable to do this and so the files would be given to the clerical staff to enter the data. All relevant data was extracted from the hospital mail before it was filed and then entered into the notes or the summary. At first clerical staff were unhappy at the extra work, but it soon became routine and an accepted part of their job; and significant medical events were continually updated. An unforeseen spin-off was that those involved felt increased job satisfaction and greater involvement within the Primary Health Care Team.



Some parts of this story may cause eyebrows to be raised; but it is something that has happened - out there in the real world. It was the best result that could be achieved in those particular circumstances. We asked the manager to summarise the lessons that could be learned from this experience and she came up with the following:

- Do not underestimate the time that it will take
- Remember that files have to be handled and this also takes time!
- If you have a computer as part of your system, this will also take time
- Read codes almost always cause controversy between partners – each will have their own ideas and several different codes may be used for one disease. **Be firm!**
Select your Read codes and **do not waiver from them**
- Begin with a positive attitude. It is a job that has to be done
- There is no easy way. She added - “In our practice, this project has proved to be of benefit to everybody. Each member of staff is involved with summarising the records, and each has been pleased to be part of the project. What appeared to be a mammoth task at the outset became, after about 3 months, an accepted way of life.”

How another practice tackled the problem.

In chapter 10 of *Medical records*, referred to above, a Principal describes a study (really a sophisticated audit) of how he and his practice nurse made a comparison of their individual summaries of 100 patient notes. They both made mistakes but they felt that the overall results were acceptable and that it was clearly in order for nurses to do this work. The account of their joint appraisal of the summaries makes fascinating reading.¹

Attempting to summarise too much data?

The UWCM practice, at Llanedeyrn found that they were attempting to enter too much data. They solved the problem in a novel way, shown to us by Professor Nigel Stott and illustrated on page 18.

Who, then, can create these summaries?

What qualifications are necessary for someone to write a summary? It is a lot of work and needs to produce accurate results. Nurses are good at doing this, but they still need some clear instruction as to what is expected and in particular, what constitutes a summary. Time needs to be set aside, in suitable working conditions. If a non-clinical person is used, then he or she needs adequate training to do the job.



We received much anecdotal information during the preparation of this booklet. One estimate of the resources required to summarise 4,500 records was – that one person working one afternoon per week for 4/5 months would be required. Once the job is done the Forth bridge syndrome comes into play, with the continual updating of summaries and the summarising of the records of new patients which have not been dealt with by the preceding practice. These latter instances will become less numerous when summarising becomes commonplace and virtually disappear with the arrival of the cradle-to-grave computerised record.

1. *MEDICAL RECORDS - in Practice*. Chapter 10 ; “*Summarising and coding case records: can the task be delegated.*” Porter, AMW; Tibbott, C. rcgp.1996

Perhaps, of all the anticipatory work that is required on manual records, prior to computerisation, summaries will pay the greatest dividend.

How One Practice Did It

On the previous page, paragraph 2 tells of how the Llanedeyrn Practice overcame their problem of trying to summarise too much. This example is a model of a page showing one method of how a summary can be generated. It is not intended to be an example of how notes should be written, that is up to you after discussion with your colleagues.

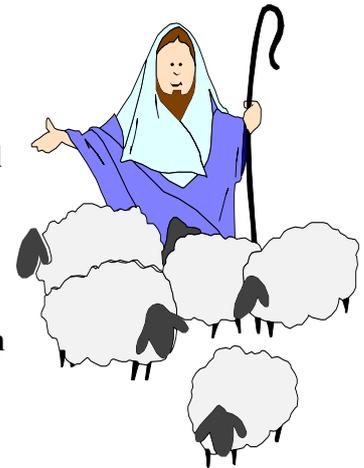
A one-inch column is drawn on the right hand side of the page, and when the consulting doctor or nurse considers an event to be worthy of inclusion in the summary, a CLEAR, BRIEF, LEGIBLE, NOTE is entered in the right margin. A careful, well-trained clerk enters the note on the summary card (or computer frame). If the note requires amplification from the main text of the notes, this is undertaken by the clerk and on those rare occasions where there may be an element of doubt, the relevant clinician should be consulted.

CONTINUATION HISTORY SHEET		SURNAME Mr/Mrs/Miss	CASE No.
		FIRST NAMES	
		FOUL	
		LINDA	
			Running Problem List
DATE	CLINICAL NOTES (Each entry must be signed)		
30.3.90	<p>Contraception advised Has G. S. ... Shaver x 10 ...</p>		FAMILY PLANNING
23.4.90	<p>Teel and fractured @ roof head Non - res. Cas. Cast 4/52</p>		# SCAPHOID
15.5.90	<p>S Jaded up with husband who is uncommunicative Up a down relationship for years. P Disten Expectant. Review mood etc 2/62. PA</p>		Mental diffc
11.11.90	<p>S Earache overnight - has been swimming O. L. Otitis externa - cleaned out - drum intact P. Advised with Treadent. PA</p>		Otitis Externa
	<p>(NB has been in Scotland for 6 months with mother --) (See family tree for details)</p>		
30.1.91	<p>S Request Gladh - new relation x 10 C</p>		F.P.
7.3.91	<p>Dressing foot wound - Sutures? CR1</p>		LACERATION
17.3.91	<p>111 sutures removed - healed. CL</p>		
21.4.91	<p>S WANTS OFC MENSES REG 5/22 PARP O O BP 110/70 WT 65kg HT 1.6m TV NAD P Rx SMEAR ✓ PPI101 ✓</p>		C.O.C Cx SMEAR
15.6.91	<p>S Sudden pain L side of chest. Now OK Was sharp & pleuritic. Pres well O P100/m approx BP 100/60 Leg ✓ Chest: ? L base for an entry P) Ad met for VA (? PE) PA</p>		Chest Pain Chest pain ? PE.
30.6.91	<p>HOSP LETTER - Not PE but instead small - NO F.U. arranged</p>		PNEUMOTHORAX

Resource Notes for STEP 5

LOST NOTES

Our practice managers, when discussing this subject, exhibited a mixture of anxiety ⁽¹⁾ and humour. One remarked that her last resort to finding a solution to this problem was to 'initiate a creep search; preferably at midnight'. The problem is entirely a local one and seems to vary according to the size and structure of the practice. The one manager that said she was satisfied with the situation was the one from a paperless practice; but even in this case there was considerable emphasis on the need for an obsessional, fail-safe, data backup system.



Another manager gave us these paragraphs from the practice's lost notes protocol.

- Each set of patient notes has a tracer card placed inside. This card has the patient's name and address, together with the date of birth, printed upon it.
- When notes are taken from the filing system, the card is taken from those notes.
- Date and details of where the record has gone are placed on the tracer card.
- The tracer card is placed back in the filing system where the notes had been.

The use of tracer cards has certainly got something to commend it. This protocol illustrates our view, expressed in Step 5 - figure 7, that the tracer card system is likely to be of value, if only one destination is involved.

In the text of Step 5 we say that the only real solution would seem to be a move to good, high quality, electronic records. After talking around the subject, we see no reason to change that opinion.

Reference

1. The Caldicott Report, 1999 Protection of Patient Data

RESOURCE NOTES FOR STEP 6

Visits and telephone calls

a. Daytime house calls.

It is difficult to be critical of general practitioners and their recording of house calls without having personal experience of the activity itself. We firmly believe that this is a problem that must be solved and we are aware that all manual systems are capable of error. Perhaps voice recording is the ultimate solution; even then, recorders can be mislaid and tapes can fill up without a spare being available. The point of weakness with portable recorders is the fact that they need a person to transcribe them on return to base. That person will not always be there and will always be expensive in terms of time. Speech recognition software (such as Voice Xpress and others) is already here and almost good enough for desktop entry of information. Software that will allow us to dictate onto a portable floppy disc that can be inserted into the computer on return to base, to update our records, is surely just around the corner. In the meantime the present manual systems will have to do. We hope to have more up to date information by the time the Level 2 booklet (Achieving the paperless practice) is ready for publication,

b. Daytime telephone contact.

With the massive increase in litigation, and the culture of complaint, we need to take the substance of every telephone call very seriously. The time has now come when we should probably be noting all telephone calls to the surgery and to the duty doctor's home. This could have resource implications and have two major outcomes.

1. The record will contain all the information, with regard to the clinical history, necessary for good patient care.
2. The information will be available to defend doctors from unjustifiable accusations. (Police and the ambulance services already do this, to good effect.)

c. Out of hours visits,

d. Out of hours telephone contact.

These days most out of hours contacts are made by a deputising service or via a Co-operative. One of our pilot managers had experience of more than one such service and they employed different methods of communication. One used carbon copies of the notes to report to the parent practice. Another sent daily faxes followed by a hard copy a few days later and a third only communicated positive findings.

Whatever the system used, it is vital that practices should receive a full report the next morning – these reports should always include details of telephone advice and calls of apparent trivia.

Telephone advice is the area where misunderstanding and confusion most commonly occur. Should the deputising service record a call, the patient's doctor should be able to obtain a transcript of the conversation.

In the October issue of *The Journal of the Medical Defence Union* ⁽¹⁾ members are advised to bear in mind 5 bullet points when asked for a visit:-

- Carefully question patients (ideally), or carers.
- Come to a clinical decision and decide whether or not the visit is necessary.
- Agree on a plan of action with callers, and make sure they understand what you are going to do and what they are going to do.
- If you are not visiting (and patients are not coming to see you), invite callers to ring again if there is no improvement.
- **RECORD THE CONSULTATION IN WRITING OR ON COMPUTER WHETHER VISITING OR NOT (These are our bold capitals)**

We would add that it is important to record the time of the call

PART THREE

REFERENCE TEXTS

a. Books on or containing chapters referring to, Medical Records

- i. Really Useful Read, Iechy Morgannwg Health, 1999
Primary Care Information Strategy Group
- ii. GP textbook on records:-
“*MEDICAL RECORDS__ in practice – Guidance for General Practitioners.*” RCGP – Practice Organisation series - No. 2
Edited by Bruce Lervy

b. Papers referring to Medical records

Isabel Puscas, the Health Authority Librarian, has undertaken a database search for us, on the medical record in Primary Care. Results - 19 papers, mainly referring to electronic records. 10 from the UK; 6 from the US or Canada and 2 from continental Europe. The list is available now, to Bro Taf practices on application. The collection will grow over time, and if appropriate, we will reference them in later booklets in this series.

Two of these papers are of relevance to manual records:-

- i. ‘*Integrated record keeping as an essential aspect of a primary care led health service.*’ Rigby et al. *BMJ* (3177158): 579-82, 1998
There is a comment on this paper in: *BMJ*. 1999 Feb 13; 318 (7181): 467
- ii. *The exceptional potential of each primary care consultation*
Davis, R.H. & Stott, N., has been reproduced in full as appendix C

c. NHS regulations and circulars relating to medical records

- i. NHS (Primary Care) ACT 1997 NHS ACT 1977.
- ii. Directions to Health Authorities concerning the implementation of pilot schemes. (Personal Medical Services). page 27: 20 (1)
- iii. O T H E R S



REFERENCES IN THE TEXT OF THE WORKBOOK

page 2 Chairman’s Introduction

1. “*INFORMATION FOR. HEALTH - an information strategy for the Modern NHS* 1998-2005 *A national strategy for local implementation.*” available on the internet at [www.imt4nhs.uk/strategy/index .htm](http://www.imt4nhs.uk/strategy/index.htm):
2. “*Better Information – Better Health. Information Management and Technology for Health Care and Health Improvement in Wales. A Strategic Framework 1998-2005.* (WHO 1999).
3. *Good Medical Practice, Protecting Patients, Guiding Doctors.* GMC, July 1998. www.gmc.uk.org

References in the Text of the **Resource Booklet**

PART 1. An Overview

- Page 4
1. "INFORMATION FOR HEALTH - an information strategy for the Modern NHS 1998 2005 - A national strategy for local implementation."
(124 pages available on the internet at [www.imt4nhs.uk/strategy/index .htm](http://www.imt4nhs.uk/strategy/index.htm);
 2. "Better Information – Better Health. Information Management and Technology for Health Care and Health Improvement in Wales. A Strategic Framework" 1998- 2005.(Welsh Office 1999)
 3. General Practice Morbidity Database Project, Public Health Information Services, Welsh Health Common Services Authority & Breast Test Wales
 4. *Personal communication with the Taf Ely IM & T Group, on commonly collected data*
- Page 5
1. "The IT files". Published by the Welsh Office, NHS CYMRU Wales,1997

PART 2. Something to Think About

- Page 9
1. Journal of the Medical Defence Union. Vol. 15, Issue 3 October 1999
 2. The National Health Service (General Medical Services) Regulations 1992 Terms of Service for Doctors - Paragraph 36
- Page 12
1. Weed L L,(1969)Medical Records, Medical Education & Patient Care. Cleveland Case Reserve, University Press
 2. Bjorn and Cross, 1970); see chapter 22 of *MEDICAL RECORDS*
 3. "*Medical Records__ in practice – Guidance for General Practitioners.*" RCGP – Practice Organisation series - No. 2. Edited by Bruce Lervy
 4. Zermansky A. Who controls repeats ? *Br J Gen Prac* 1996; **46**, 643 – 647
 5. Harris C, Dajda R. The Scale of Repeat Prescribing. *B J Gen Prac* 1996; **46**,
- Page 15
1. "*Medical Records__ in practice – Guidance for General Practitioners.*" RCGP – Practice Organisation series - No. 2. Edited by Bruce Lervy
- Page 17
1. "***MEDICAL RECORDS - in Practice etc.***"Ch10 ; "*Summarising and coding case records: can the task be delegated.*" Porter, AMW; Tibbott, C. *rcgp.1996*

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Prof. Nigel Stott; (UWCM). Dr. Terry Davies, GP, Llandeilo.
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Mrs Nicola Gardener; Practice Manager, Ely Bridge Surgery, ELY, Cardiff.
Mrs Nicola Gilbert; Practice Manager, Towers Surgery, Barry.
Mrs Diane Verghese, Practice Manager, Ogmores Vale Surgery, Ogmores Vale.
Mrs Barbara Daniels, Practice Manager, The Health Centre, Dinas Powis

PART FOUR

APPENDICES

These appendices are presented as separate entities and not intended to be essential parts of the exercise. They may help to stimulate or broaden discussion at practice meetings.

Page 24 [Appendix A](#)

WEBOGRAPHY

Some helpful web sites

Page 25 [Appendix B](#)

“The GP Medical Record; what should we put on it at consultation.”

Dr Terry Davies; General Practice Principal, Llandeilo

This article relates to Step 2a. It is not dogmatic and gives a practical and attainable account of what might be achieved in certain situations.

Page 30 [Appendix C](#)

“The exceptional potential in each Primary Care Consultation”

by NCH Stott & RH Davis

This classic paper, which came out of Wales in 1979, has had a marked influence on the development and structure of the consultation in general practice. It may not refer directly to GP records, rather it describes the scope of what may be generated at the consultation. It is of particular value in teaching practices.

Page 35 [Appendix D](#)

An audit of the Quality of Medical Records

An audit template for the internal assessment of the Quality of Medical Records

Page 37 [Appendix E](#)

Report on Child Health Surveillance Records: A report of a recent study undertaken by the Bro Taf PrimaryCare Audit Group (PAG)

Page 39 [Appendix F](#)

“Standards for Record Keeping in Training practices.”

From Dr David Wood, Bangor Senior Lecturer and Associate Advisor in General Practice for Wales

Page 41 [Appendix G](#)

The Calidcot Report, Executive Summary

A summary of recommendations for the protection and use of patient information

Other Appendices may be circulated at future dates, should relevant new information becomes available.

WEBOGRAPHY

RECORDS

When producing an ICE pack, we talk to as many people as possible and consult as many references as possible by asking the Health Authority Librarian to conduct a search for us. We also explore and consult some websites on the Internet.

*This **WEBOGRAPHY** lists most of the sites we have looked at so that those of you who are on line could also browse. Should you find any worthwhile sites, concerning the subject of this pack, which we have missed, we would like to hear from you.*

www.omni.ac.uk is one of our favourite search sites. This site gives a list of those medical sites that will deal with the words that are placed in the search box. Thus on entering 'Osteoporosis', we are given a list of 27 sites relevant to our search. The address of each website is shown in red and clicking on this will bring up the relevant site. The full address is not shown. If you want to save the address for future reference, when you might wish to go directly to the site without wishing to use omni, you need to go through to the site and note the full address from there.

Medical Records Institute *Description:* The homepage of the US Medical Records Institute. Details are provided of the aims and activities of the Institute, and there is a variety of information on the subject of electronic health records, including a summary document entitled "What is a patient electronic record?" There are synopses of the contents of issues of the Institutes newsletter "Toward an Electronic Patient Record". *Keywords:* [United States](#) ; [medical records systems, computerized](#); [Medical records](#)

Academic Journal Directory *Description:* The Academic Journal Directory contains a listing of over 400 professional journals in the fields of clinical nursing, nursing education, and nursing research. Each record contains the journal title, publisher, who it is aimed at, frequency of publication, contact details, types of manuscripts reviewed, links to website where available, and a purpose statement for prospective authors. The Directory is aimed at prospective authors in nursing and the healthcare community. Users can choose to browse journals by alphabetical list, subject categories, or search by keyword. Provided by the University of Texas **Medical** Branch School of Nursing at Galveston. *Keywords:* [Databases, Bibliographic](#); [Periodicals](#); [Nursing](#);

www.son.utmb.edu/catalog/catalog/catalog.htm

This is all that we have been able to identify on the internet, that concerns medical records so far. As we progress the PAG will build up a list of sites that will be made available to Bro Taf constituents, on request. Information concerning other sites, sent to us by constituents will be greatly appreciated.

Why not try our web site, www.bro-taf-ha.wales.nhs.uk/pag/cfm

The GP Medical Record; what should we put on it at consultation?

We invited Dr. Terry Davies of Llandeilo to contribute his view of what we should put on the record, at the time of the consultation

Three scenarios

a). Mr. Jones is in his mid fifties. He has long-standing hypertension and this has been difficult to control. Currently, his blood pressure is reasonably well maintained at around 140/90, but on multiple medication. He attends regularly for review.

b.) Mrs. Smith is in her early seventies. She presents with non-specific abdominal pain, which has been present intermittently for several years. This is sometimes accompanied by a bout of constipation and generally improves with some dietary changes. There is nothing else to record on specific questioning and on examination, nothing untoward is found. This is her first recorded consultation with a doctor for these symptoms.

c.) A three-year-old boy presents in morning surgery with an upper respiratory tract infection. On examination, he is found to have a bright red right eardrum. You record "ROM," in the notes and prescribe Amoxycillin.

Five hours later, he is on intensive care at the local hospital in critical condition, with a presumptive diagnosis of meningitis.

In an ideal world, a medical record should include complete details of the consultation. It is not always apparent at the time of initial presentation, what is, or could be, important to record in the interaction between patient and clinician. In fact, it could well be that it is only in retrospect that recording of not only positive, but also negative findings would be seen as vital. Such instances could be the early presentation of the serious illness, with subsequent possible serious medical or medico-legal consequences. Fortunately, for most of us, in the vast majority of consultations, (estimated 300 million GP consultations per year in the UK), such instances are rare. Thus, each of us develops what is in fact a pragmatic time and risk management strategy, with an attempt at completeness balanced by brevity.

Principally, the medical record is a fundamental part of the continuity of care of the individual patient. Thus, it is important that recording is comprehensible and legible. Abbreviations used should be universally familiar, for example "OM," is otitis media, "PUO," Pyrexia of unknown origin, "CT," continue treatment etc. However, diagnoses are often necessarily subjective and hypothetical and hence it is important to record signs and symptoms.

It is taken as read that the record already contains basic personal data such as name, address and date of birth; also, easy access to a summary history of major illnesses and possibly life crises would be of value. However, the main concern in this context is of what to enter at consultation.

Three separate scenarios are painted.

- a.) The routine care of a chronic disease involves a continuous care record. Hence, it is important to have a historical record of blood pressure reading, treatments and any relevant symptoms or investigations. Thus, it would be reasonable to record; 'BP 140/90; no problems; CT Lisinopril 10mg od & Bendrofluazide 2.5mg od; for annual lipid check next visit in 3/12.'

This is arguably an adequate summary of the *clinical* content of the consultation, but almost certainly does not include the complete dialogue – How are things at work? How is your son getting on at college? etc. It follows that in the care of the whole patient, especially in a chronic condition, it may be worthwhile to add a brief note, such as; 'going on holiday to Australia next month,' or 'brother in law just had a CVA.' Such statements enhance the doctor patient relationship considerably and can help make each patient contact part of a continuous consultation.

- b.) The second scenario is in a sense, an acute presentation within the continuous doctor patient relationship. The doctor may well feel that this is just a recurrence of a well-established, non-specific, recurring irritable bowel type condition. However, the presentation may well be of a more sinister new disease. He or she listens to the patient carefully, asks specific questions and does a thorough examination. This may take several minutes, with the explanation to the patient also taking time. Is there sinister illness or is there not? There is little time to enter a complete clinical record, let alone the social interchanges. Nevertheless it is vital, in order to facilitate the most appropriate care and set the foundation for any future activity and to protect the doctor if things don't go according to plan that an adequate record is kept. It could be even more important if the next health professional to see this patient is someone else. Thus, bearing in mind the constraints of time, it would be reasonable to record. 'Episode of diarrhoea, recurrent over many years, thought to be related to eggs, tho' this time lasted few days more; appetite, weight OK; last attack 3 months ago; O/E looks well; abdo soft; PR no masses; Impression, IBS. patient not keen on colonoscopy; Plan; fibre for 1 month and review; if no better, consider referral to exclude sinister pathology. R Regulan 60.'

This record, though necessarily brief, summarises the consultation and the treatment, records the thought processes of the doctor and suggests the next step if things do not go according to plan. Thus, both the patient and doctor are safeguarded.

- c.) It is a major dread for most clinicians that a child they have seen with a trivial illness is seriously ill with a septicaemia. We, as clinicians, are also aware that usually, there is little or no evidence that such a disease progression will take place. However, the public might see things differently and consequently, in practice, in order to protect the doctor, it is important to record negative as well as positive findings, accepting that in the vast majority of cases the data are superfluous. Thus, it could be acceptable to record; 'Sleepless night but bright and cheerful now; apyrexial; ENT RS, ROM; no neck stiffness; R Amoxycillin.'

Though brief, the record suggests that the child has been reasonably well examined and that there was no evidence of impending disaster. It protects the doctor, with relatively little to offer in the care of the patient.

In General Practice there are innumerable scenarios of patient doctor contacts. Relationships are not always good, and in such circumstances, it may be worthwhile considering spending a little more care with the medical record. The prime concern, however, must always be the patient and that any treatable or otherwise manageable condition is not missed and handled appropriately. There are also issues of continuing and holistic care, both in the current and 'another doctor' context. The conscientious doctor protecting his or her own interest by recording appropriate clinical detail must also be acknowledged.

Epilogue

*'Full many a gem of purest ray serene,
The dark unfathomed caves of oceans bear.
Full many a flower is born to blush unseen
And waste its sweetness on the desert air.'*

Thomas Gray; 1716-1771

Elegy Written in a Country Churchyard

Today I saw Mary.

She is a lady in her fifties, who was not dealt the best cards in life. Briefly, her father sexually abused her as a child, while the family protected and coddled her younger sister, whom she adores. Their mother abandoned them before they were ten and her tyrannical grandmother brought her up. She still hates her mother and father.

She subsequently had a stormy marriage, which has now been settled for many years. Her three daughters have had a variety of problems, including drugs, marriages and children (one granddaughter is deaf, another has anorexia). There have also been a myriad of other family disasters, with Mary acting as a cornerstone. She herself has had numerous physical illnesses, including hypertension, angina, arthritis and myxoedema. Her husband had a CVA fifteen years ago and has since been unable to work. I have known her for thirty years and admire her for her pragmatism and philosophical approach to life. She is not particular which doctor in the practice she sees, but from time to time, she makes a point of seeing me. I know that there is another life crisis.

Ostensibly, Mary presents with a painful knee. But, she tells me that her aged father has come back into her life and she *has* to feed and look after him. Her mother, who lives away has asked to see her - is dying. Her sister, whom she adores, has just had a second CVA.

The record reads;

'Listened; has been to see her mother (who is dying) and her sister is dying. Subsequent flashbacks; painful swollen L knee; takes Arthrotec with little benefit; CT. Chat.'

The record in no way reflects the whole consultation, which was, almost in its entirety, not strictly 'medical.' But it is enough for me and I suspect it is enough for Mary.

THE CONSULTATION

The exceptional potential in each primary care consultation

N. C. H. STOTT, **B.SC.MRCP**

Senior Lecturer, General Practice Unit, Welsh National School of Medicine

R. H. DAVIS, **DM.FRCCP**

Reader, General Practice Unit, Welsh National School of Medicine

SUMMARY: A four-point framework is described which has been found to be helpful for general practitioners who try to achieve greater breadth in each consultation. The framework has also provided a useful stimulus in undergraduate and postgraduate teaching, because it provides a nomenclature to identify four major components of clinical practice, which are particularly relevant to primary care.

Introduction

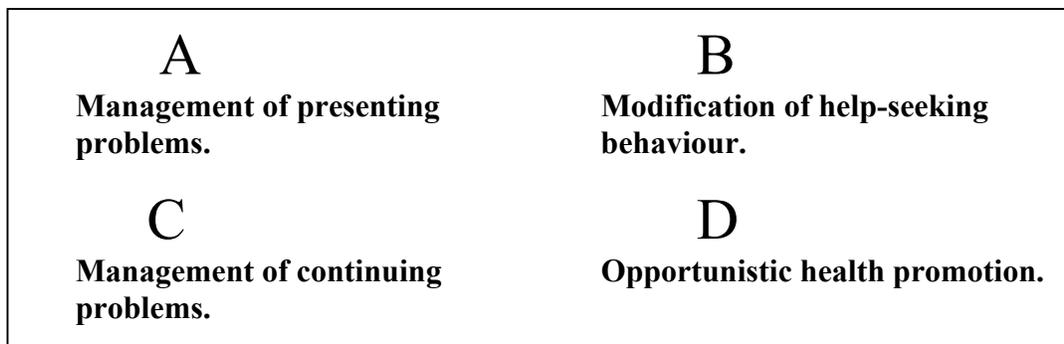
Comprehensive primary care' is an attractive concept with a growing descriptive literature but the principles involved are still difficult to present in a succinct and practical way. Even the students who appear to have understood the principles of comprehensive care often fail to apply them in the consulting room and the five areas' described by the Royal College of General Practitioners (1972) in *The Future General Practitioner* provide a conceptual framework of the content of primary care rather than an aid to individual patient care which can be applied simply and quickly. A rift still exists between understanding of the theory and practice of primary care and this has serious implications for teachers, patients and students. What appears to us to be missing is an acceptable concept of the practical potential in every single consultation in primary care which can be easily memorised, understood, and used. The basis of such a concept should be intimately related to the decisions which can face every primary care Physician, whatever his or her educational background and within whatever system of care he or she operates..

We present such a clinical framework which is designed to reveal the practical potential in each doctor/patient contact by highlighting four large areas, each of which embraces many skills which the primary clinician can use to his patient's benefit. The junior undergraduate can be expected to learn the basic outline, which is subsequently elaborated by the acquisition of appropriate knowledge, skills, and maturity.

Postgraduates can also be encouraged to consider the clinical decisions they take in every consultation against the framework because it clarifies the practical implications of many of the concepts and ideas which have been described in *The Future General Practitioner* (RCGP, 1972) and by the Leeuwenhorst Working Party of European Practitioners (1977) in 1974. The objectives of the framework are:

1. To provide a theoretical base from which a practitioner can develop the full potential in any primary care consultation.
2. To highlight some unique features of good primary care.

Figure 1. The potential in each primary care consultation —an aide-memoire.



3. To provide a basis for teaching in primary care which is simple enough for the undergraduate but equally valid for the postgraduate when more detailed knowledge and skills are included in the same basic structure.
4. To allow the philosophy, principles, and research achievements in comprehensive care to be discussed within a simple patient-centred framework.

The clinical framework shown in Figure 1 is not another classification of knowledge, skills, and attitudes. It is used to reveal potential skills which can be used in each doctor/patient contact and to be complementary to existing classifications of the content of primary care.

Use of the clinical framework

Realisation of the full potential in each consultation depends on the clinician's ability to communicate with his patients and on the organisation of the primary care services (Zola, 1973; Doyle and Ware, 1977). No clinical framework can be a fully successful *aide-memoire* if either of these general aspects of the primary physicians work is impaired.

The skill of active listening is much more than conventional history taking and it is appropriate that Primary care is becoming the laboratory of many who have the vision to research into and teach interview skills (Byrne and Long, 1976; Verby, 1976; Alexander et al., 1977).

However, primary health achievements are also partly dependent on individuals or agencies other than the doctor, and the World Health organisation is showing growing interest in innovative community health Projects which have demonstrated that effective teamwork between clinicians, paramedical workers, and lay leaders ~ create new potential for health Promotion (Newell, 1975; Barr and Logan, 1977). This widening of the primary care role is still little evaluated but it is probable that the primary consultation will become an important motivating instrument towards schemes which can be organised by the lay public, or by other Professionals, and which operate beyond the confines of the clinic (Stott, 1976).

Our framework (Figure 1) deals with the clinician's potential actions and comprehensive care blends the four inter-relating areas A, B, C, and D. The allocation of letters to the four areas aids recall and provides a useful shorthand. However in this Presentation A and C will be discussed first, and B last to avoid the repetition which would otherwise occur.

Areas A and C. The management of presenting and continuing problems

At the centre of every consultation is the patient's Problem or problems which have been brought to the clinician and most medical time is spent dealing with these Presenting problems (Area A). Indeed, most traditional clinical teaching is focused on the diagnosis and therapeutic processes and the evolving discipline primary care has emphasised, the importance of combining clinical acumen with insight into human behaviour. The development of comprehensive assessment of patients' problems (RCGP, 1972), integrates physical and psycho-social formulation relevant to every speciality but it is exceptionally important in primary care because techniques increasingly used by the trained family doctor depend on this widening of the diagnostic process.

The systematic supervision of continuing problem (Area C) has never been as attractive as Area A but increase in chronic disease and the remarkable efficiency of some medical treatments have forced clinicians to their present position of having to treat and monitor diseases which can persist for many decades.

At every consultation the primary care worker has to ask himself the question: What continuing problems are there to be dealt with while the patient is with me? For example, a four-year-old girl with a past history of squint presents to the general practitioner because she has earache. She has been seen only twice for minor ailments during the past three years. The doctor may deal with the acute otitis media alone (Area A) or take the opportunity to review or arrange to review the child's vision, even though her mother did not come to the doctor with this in mind (Area C).

The importance of primary care workers being willing to think in continuity terms (Area C) has to be stressed repeatedly because many students and young doctors find it irksome to widen the consultation deliberately from the presenting problems (Area A) to the often asymptomatic continuing problems (Area C). It demands a more comprehensive view of the patient and it can be time-consuming, so the time allocated for each consultation can have an influence on how successfully Area C is practised.

In the affluent nations there has been an attempt to develop computer recall systems to guarantee continuity of care for conditions such as hypothyroidism. Elegant as these systems are, they can cater only for a fraction of the problems requiring the clinician to be aware of Area C in every consultation. Other conditions which often exemplify this principle are: hypertension, anaemia, contraception, psycho-sexual problems, deafness following recurrent ear infections, antenatal care in the poor, and indeed any patient who is on regular therapy (repeat Prescriptions). In the UK, where the average general practitioner sees 90 per cent of his patients every three years, the potential for unobtrusive attention to the continuing causes of disability is enormous and proper use of the primary care team will make this process even more efficient.

Knowledge of the family and its environment is often helpful when forming management plans for continuing problems. The most obvious tool to help skill in applied continuity is a good medical record; but even in the absence of a record, the clinician who has been trained to be aware that continuity is necessary to deal with some clinical problems will use time, investigation, prescribing, and referral more appropriately.

High-risk groups are those who suffer hardship through discontinuity or who enjoy using discontinuity of care to gain drugs or episodic attention. It is too easy to treat each presenting problem but to fail to perceive the underlying factors behind successive acute episodes of minor illness. The existence of a personal doctor does not necessarily provide continuing care as the GP can fail to recognise what the patient is saying. Alternately the GP may fail to identify the signs revealed by the medical record, or overlook how much is hidden by a lack of records in a clinic which is too busy for methodical record keeping.

Sometimes continuity of care breaks down because of excessive demand, patient numbers, population mobility, shared care, or poor organisation. The appropriate strategy to overcome these problems will vary from place to place, although it seems likely that additional time per patient and improved skills in primary care will need to be coupled to a review of the clinic or practice organisation. This review will often lead to improvement of medical records and greater use of ancillary staff to reduce the load on clinicians (Stott and Davis, 1975; Marsh and McNay, 1974).

Area D. Opportunistic health promotion

One of the most exciting and controversial components in every consultation is the opportunity it provides for both the promotion of healthy life-styles and early or pre-symptomatic diagnosis. The former extends the traditional content of the illness interview to include helping the patient to identify one or more aspects of his/her life-style which could be changed. In the interests of better adaptation to his/her environment before disease develops; for example, dietary changes, appropriate exercise, attitudes to interpersonal relationships, or habit modification. The latter embraces the vexed question of pre-symptomatic diagnosis and treatment in patients who attend the clinician for some other reason and educationalists face a challenge to decide which diagnostic procedures are justified by their outcome (RCGP, 1972). For example, blood pressure measurement in the 40-and-over age group.

Modern understanding of disease pathogenesis has shown that many of the current major causes of morbidity and mortality have their origins in the lifestyle of individuals. Every student of medicine should appreciate the unique potential of the illness Interview for health promotion because the patient and relatives are often very receptive to advice from the doctor or nurse at this time (Russell, 1971; Truax and Mitchell, 1971; Stott, 1976; Elser, 1977). Furthermore, methods which involve individual teaching—one-to-one discussion.....are widely recognised as the most successful strategies in Producing health-related behavioural changes (MacQueen, 1975).

There is also abundant evidence that future improvements in the major causes of mortality and morbidity in most parts of the world are more likely to come through modification of personal life-style than through legislation (Belloc, 1973; Committee on Child Health Services, 1976; DHSS, 1976).

Unfortunately, many doctors, largely as a result of their training, are reluctant to use their influence to encourage health-promoting behaviour in the absence of disease. In contrast they have no difficulty in offering advice about diet, exercise, habits, or relationships once a diagnosis has been made which can be attributed to illness-inducing behaviour and when it is often too late for the behaviour change to be effective. A caring profession should not withhold its knowledge and influence to help patients make appropriate life-style choices if this will reduce the likelihood of later ill health.

However, the objective of Area D can be only to ensure that the patient leaves better able to make informed choices. The clinician can try to develop methods which help the patient to grasp the practical issues but he should not allow the patient's response to modify his caring role in future disease episodes. This implies mutual adult respect and a change of the traditional attitude towards patients who reject the advice proffered by the physician.

The application of Area D to every consultation will involve the question: Is it appropriate to try to help this patient to modify his/her life-style in the interests of long-term health? Where this is the case the clinicians should feel confident to use their influence by advice alone, but other strategies may enhance the likelihood of practical acceptance.

The well organised 'referral chain' extending outwards into the local community from the initial motivation by doctor or nurse is an example of a wider technique to help the patients step from 'knowledge' to 'behaviour change' (Stott, 1976). Self-help groups or clubs can also be utilised if informed leadership exists locally. Much more research is needed into Area D methods but the principles which have underpinned the development of a 'referral chain' into the community merit careful consideration by more affluent societies.

Area B. Modification of help-seeking behaviour

Area B embodies the assumption that each consultation may in some way influence the patient's future help-seeking behaviour and that recognition of this fact should lead to better patient care. The most straightforward illustration of this principle is Marsh's (1977) demonstration that a practice policy to stop prescribing for minor ailments coupled to a programme of patient education will lead to a lower demand for medical care for such illnesses. The incidence of coryza is not changed but the expectation for medical treatment may be altered and patients can begin to be more realistic about what doctors can or cannot treat effectively.

In Britain the implications of the medicalization of many social and trivial problems has been provocatively presented in *The Health Care Dilemma* in which the Office of Health Economics (1975) calls for a fresh philosophy and attitude towards ill health in the population. Similar views have been expressed by Crombie (1974), Illich (1977), and others and illustrate the rapid evolution of the theory and practice of Area B. However, consideration of the clinician's role in determining help-seeking behaviour embodies both inappropriate under-use of medical services and their over-use.

An objective of the framework in Figure 1 is to highlight the need for every clinician to consider whether his management plans take cognisance of future help-seeking behaviour. Kaolin for diarrhoea, antihistamines for colds, codeine for coughs, or aspirin for aches . . . each is sometimes justified, but each is much more than a symptomatic prescription; it is also a ticket to reinforce the patient's belief that the doctor has a solution for such minor ailments. Thus patients' expectations are set and the waiting room becomes so full that the practitioner has little time to explain what he is treating, or to ensure that the child with a urinary infection is adequately followed up, or the woman with a recurring dysuria has a proper psychosexual history taken, or that the child with iron deficiency anaemia or kwashiorkor is perceived as the clear indicator to a need for nutrition education in the home rather than a problem which can be cured relatively easily by traditional methods.

In Africa the phrase “the revolving door of malnutrition” has been coined to describe the failure of traditional medical services to overcome the high incidence of recurrent malnutrition because children are healed in hospitals and returned to the social conditions which caused their illness initially. A comprehensive sociomedical approach has been shown to stop the revolving door in Africa (Stott, 1976) and so similar Principles may be worth serious consideration to slow the revolving doors of the health care dilemma in Britain. Our experience suggests that we will be one step nearer to that objective if for every patient seen the doctor asks himself: What influence have I had on the future help-seeking behaviour of this patient and his/her family? When that question is posed thousands of times every day, primary care workers will probably begin to identify that they need fresh strategies. These may involve reaching out into the community, not just in terms of home visits as suggested by Pereira Gray (1978) but, more importantly, in terms of the establishment of realistic attitudes to the physical, mental, social, and spiritual development of our patients and their families. A major task ahead for the personal community health services is to give greater recognition to the methods that encourage the realisation of this potential and to have more insight into the activities which erode it.

Discussion

The framework described in this paper is complementary to existing analyses of the content of primary care, because it starts from the decisions and actions a doctor takes, rather than the underlying educational concepts or methods. This essentially practical approach is an extremely useful teaching aid because it widens the scope of every consultation by encouraging the clinician to consider the patient in a broad and practical way. One effect of this process is a growing awareness in the doctor of the limitations of short-term clinical solutions to many problems— particularly those that have their origin in human expectations and behaviour. For example, a young child with a dietary iron deficiency anaemia can be treated by giving iron therapy and diet advice (the traditional approach). However, as this anaemia is the product of faulty feeding habits, the family can learn more about the relationship between food and health by bringing their child back to health with judicious food choices alone. Furthermore, the child is less likely to become anaemic again if practical information rather than prescriptions are issued by the clinic (Area B).

The wisdom of this comprehensive approach extends well beyond the child’s management because the process of maternal diet education has a potential impact on the whole family, by shifting the emphasis from a medicine bottle to food choices. The growth and development of siblings, grandmother’s constipation, and perhaps even parental ischaemic heart disease risk factors could be modified by the skilled use of this child’s consultation to motivate the mother to consider new food choices (Area D). Field experiments have shown that even semiliterate communities can benefit greatly from this approach if practical demonstrations of appropriate food choices and food preparation are developed to support the clinician’s initial explanations to the patient (Stott, 1976).

An alternative strategy to prescribing is equally necessary to help many patients with problems involving anxiety, unhappiness, dyspepsia, loneliness, self-destructive habits, family conflict, and other common disorders. However, the example of the child with anaemia given above illustrates principles which may be difficult for the average practitioner to implement because he lacks the support of a nutrition education unit which has proved so successful in Africa. He may also be limited in his knowledge of alternative strategies and by the time he has with each patient. The goal of patient education may be unattainable without paramedical or lay support.

Nevertheless, the primary physician has an unequalled opportunity to balance long-term health needs against short-term clinical pressures. He can practise from a broad clinical base by integrating the psycho-social and biological components of each illness (Area A). He can implement applied continuity of care to a defined population by learning to use the skills and aids which are required to achieve this (Area C). He can also make maximum use of the opportunities for health promotion (Area D) and thereby begin to discover the need to modify the traditional clinical approach. Finally, he can permit his growing knowledge and skills in the modification of help-seeking behaviour (Area B) to influence his clinical decisions, his practice organisation, and his relationship with his patients. The larger number of patients coming to primary care, the nature of their problems, and the relationship they may have with their doctor—all reinforce these opportunities in a way not usually possible for other specialities.

Clinicians who feel nihilistic about Areas B and D are usually unwilling to concede that comprehensive care works on a much longer time-scale than traditional medicine and that our understanding of this young discipline is leading towards greater recognition for the need to have major re-orientation of our primary clinics ““f the relationship they can have with the community.

We have much to learn and test about the way in which we organise primary care and the relative emphasis placed on the four areas in Figure I will vary according to the availability of skills and resources; for example, in under-developed parts of the world, with severe under-doctoring, it is appropriate that the curative services should be seen mainly as a spearhead to primary prevention, although this is seldom achieved.

A nation’s ability to afford an expensive curative medical service does not, however, guarantee a comprehensive approach, because episodic care remains more common than continuing care and reluctance to ask the questions of Area B is as common as destructive negativism to Area D, often because medical education and clinic organisation have lacked these qualities and secondary care has dominated health service planning.

We believe that the potential in every consultation should be taught to undergraduates and postgraduates, so the next generation of doctors will begin to expect the skills and structures required to carry the special responsibilities of each primary care consultation and then organise their services accordingly.

This framework is intended to be an *aide-memoire* which encourages the primary physician never to forget the potential of each consultation, even if he cannot realise it fully owing to personal or organisational restraints.

References:

- Alexander, D. A., Knox, J. D. E. & Morrison, A. T. (1977)
Medical students talking to patients - *Medical Education*. **II**. 390-393
- Barr, A & Logan, RFL (1977)
Policy alternatives for resource allocation – *Lancet*, 1999. 96.205
- Belioc, N. B. (1973)
Relationship at health practices and mortality. *Preventive Medicine*, 2, 6741.
- Byrne, P. S. & Long, B. E. L. (1976). *Doctors Talking to Patients*. London: HMSO.
Committee on Child Health Services (1976). *fit for the Future*. London: HMSO.
- Crombie, D. (1974)
In *Benefits and Risks in Medical Care*. Taylor, D. (Ed.). London: Office of Health Economics. Department of Health and Social Security (1976)
Prevention and Health: Everybody's Business. London: HMSO.
- Doyle, B. J. & Ware, S. E. (1977). Physician conduct and other factors that affect consumer satisfaction with medical care. *Journal of Medical Education*, 52, 793-801
- Eiser, R. (1977) *Report on a Workshop on Health Education in General Practice*. London: Health Education Council.
- Leeuwenhorst Working Party (1977) - The work of the general practitioner. Statement by a Working Party appointed by the Second European Conference on the Teaching of General Practice. 1974. *Journal of the Royal College of General Practitioners*, 27. 117.
- Gray, D. J. Pereira (1978). Feeling at home. James Mackenzie Lecture, 1977
Journal of the Royal College of General Practitioners, 28, 6-17.
- Lilich, I. (1977) *Limits to Medicine. Medical Nemesis: The Erpropriation of Health*. London: Pelican.
- MacQueen, I. A. G. (1975)
The challenge of health education today. *Public Health*, 89, 93-96.
- Marsh, G N. (1977) 'Curing' minor illness in general practice. *BMJ*, 2, 1267-1269.
- Marsh, G & McNay, R. (1974) Team workload in an English general practice. *BMJ*, 1, 3 15.318.
- Newell, K. W. (1975). *Health by the People*. Geneva: WHO. Office of Health Economics (1975). *The Health Care Dilemma, or Am I kranken, doctor?* London: OHE.
- Royal College of General Practitioners (1972).
The Future General Practitioner—Learning and Teaching. London: *BMJ*.
- Russell, MAH (1971) Cigarette dependence: doctor's role in management. *BMJ*, 2. 393-395.
- Stott, H. H. (1976). *The Valley Trust Sociomedical Project for the Promotion of Health in a Less Developed Rural Area*. MD Thesis. University of Edinburgh.
- Stott, N. C. H. & Davis, R. H. (1975). Clinical and administrative review in general practice. *Journal of the Royal College of General Practitioners*. 25. 888.896.
- Truax, C. B. & Mitchell, K. M. (1971). In *Handbook of Psychotherapy and Behaviour Change*. Bergen, A. & Garfield, S. (Eds). New York: Wiley.
- Verby, J. E. (1976). The audio-visual interview. *Journal of the American Medical Association*, 236, 2413-2414.
- Zola, I. K. (1973). Pathways to the doctor—from person to patient. *Social Science and Medicine*. 7. 677-689. *Journal of the Royal College of General Practitioners*, April 1979

AN AUDIT OF THE QUALITY OF RECORDS

The ICE Support Pack is designed to look at the **structure and process** of record keeping. It is not concerned with outcome nor quality. Undertaking the exercise will have the effect of auditing the records structure and process. However if the practice is preparing for the **Sustained Quality Scheme Payments**, it will also be necessary to include an assessment of the **quality** of the records. It is understood that the Health Authority intend to use the '*standard for records in providing good medical care*', laid down by the GMC, in parallel with paragraph 40, of the NHS - GMS, Statement of Fees and Allowances.

The GMC statement states that Doctors must "*keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed.*"

It follows that any audit of records should, at least, include the elements of these standards.

THE AUDIT Part 1 - GMC Statement

A member of staff should take a sample of 20 notes at random, where there are three or less partners. For every additional partner an extra 10 notes should be included

1. Clarity

The record should be clear not only to the originators of the entries, but also to legitimate readers viewing the record for the first time. For the purpose of this audit the Practice Manager will need to ask the doctors:-

"Are you satisfied that the notes are legible and that any doctor or nurse who takes up the notes would be able to make good clinical sense from them? **YES/NO**

If **NO** what proposals do you have to improve the situation?

2. Accuracy

Without in-depth analysis the standard of accuracy is difficult to assess. (External opinion will only have access to clearly measurable criteria). The quality of other criteria may need to be taken on trust. It should be noted though that should the record come before a court or tribunal in a hostile atmosphere, with the patient present, quality and accuracy will be scrutinised. (see **Resource Booklet. Page.9**).

"Are you satisfied that the notes are legible and that any doctor or nurse who takes up the notes would be able to make good clinical sense from them? **YES/NO**

If **NO** what proposals do you have to improve the situation?

3. Contemporaneous notes

Defined as those notes written at the time of the consultation to which it refers. It does not mean that a note may only be written at such a time, but non-contemporaneous notes should be rare and clearly indicated as such. External visitors to the practice could request sight of the appointment book to confirm if the patient attended on that date. (This could also be applied to out-of-hours consultations.) We believe that visitors are unlikely to pursue this line, but internal practice auditors may wish to do so.

"Are the clinical records always available at the time of consultation?" **YES/NO**

4. **Relevant clinical findings**

There will not always be relevant clinical findings in a consultation and only the consulting doctor will know what is relevant. Ask the doctors to inspect all the records in the sample and determine if they feel that they demonstrate a reasonable standard for recording of clinical findings, during the last 5 years.

Standard 80%

YES/NO

If **NO**, what do they intend to do to remedy the situation?

5. **Decisions made**

These would usually be prefaced by 'Plan' or 'Acton'. Inspect all the records as in 4 above. Ask the doctors if they consider that they contain entries that would be considered reasonable by any sensible clinician

Standard 80%

YES/NO

6. **Noting the Information given to patients**

Inspect all the entries in the sample and determine whether the attempt to record the information given to the patient, in each case, is adequate.

“Does the practice consider this reflects an adequate standard of record keeping?”

YES/NO

If **NO** what plans do they have for improving the situation?

7. **Recording of drugs prescribed and other treatments recommended.**

This is dealt with under **condition iii** of the SFA, below.

THE AUDIT Part 2 - The Conditions in Section 40 of the SFA

Consider the records component of the SFA.- 40.1

Condition ii; THE PRACTICE should be able to show that each section of the patient record is in date order, joined with tags where appropriate and held in an adequate file or envelope. Practices where records are mostly computerised should be able to transfer an appropriately structured record to facilitate patient transfer between practices.

The benchmark for achievement is 80%

In relation to the **first sentence of condition ii**, consider the statement-"We have completed Step 1 and Step 3, of the **Workbook**. We are satisfied that our entry to the profile lines at 1a and 1b and 3 a, b, c, at action points 6 and 11, meet this standard." **YES/NO**

If **NO** what do we intend to do to correct this situation?

Check List:-

Notes contained in adequate file/envelope	Y/N
Investigations in date order	Y/N
Letters in date order	Y/N
GP Notes in date order	Y/N
Tagged	Y/N

In relation to the **second sentence answer the question** - Can we print a transfer note for a patient, within 15 mins? **YES/NO**

This condition excludes those practices where records are not normally held on computer.

The suggested minimum content for such notes should be –

- **ACTIVE PROBLEMS**
- **SIGNIFICANT (NON ACTIVE) PROBLEMS**
- **ALLERGIES**
- **HEALTH STATUS**
- **PRESENT MEDICATION**
- **PAST IMMUNISATIONS**
- **LAST CONSULTATION**
- **OPTIONAL ADDITIONAL INFORMATION**

Condition iii; THE PRACTICE should be able to show that for each patient care has been reviewed, at appropriate intervals and a current list of repeat or continuing medication and a record of current and recent drug treatments (inc dosage regimes) are in the patient record.

The benchmark for achievement is 90% **YES/NO**

We have completed Step 2 of the **Workbook** and entered the profile line for Step 2 a, b & c at action point 8. **YES/NO**

Checklist

List of Repeat Medications **Y/N**

*It may not be enough to produce a long list of prescriptions from the repeat script computer. The list should **mention each drug once only and indicate whether OR NOT it is being currently prescribed. Consider what further information is required? - e.g. dose, route, frequency etc - date first prescribed? See pages 11 & 12 of the Workbook.***

- Review within 6 or 12 months **Y/N**
- Record of current and recent drug treatments **Y/N**
- Dosage regimes **Y/N**

Condition v. THE PRACTICE can show as follows for **Chronic Disease Management.**

Diabetes - The production of a satisfactory audit, with evidence of its accuracy, should be sufficient to meet this condition. Can we do this? **YES/NO**

Otherwise it should be shown that, in at **least 80%** of the patients on the **diabetic register**, the following information is recorded.

- Blood Pressure **Y/N**
- HbA1C, Lipids, Glucose, Creatinine **Y/N**
- Vibration and Pinprick sensation **Y/N**
- Visual acuity and fundoscopy **Y/N**
- Circulation, Pulses and Ulceration **Y/N**
- Height and Weight (BMI) **Y/N**
- Smoking, diet and alcohol consumption **Y/N**

Asthma -The production of a satisfactory asthma audit, with evidence of its accuracy, should be sufficient to meet this condition. Can we do this? **YES/NO**

Otherwise it should be shown that, **in at least 80%** of patients on the **asthma register**, the following information is recorded.

- Supervision/assessment of inhaler techniques **Y/N**
- Smoking history/passive smoking **Y/N**
- Medication review **Y/N**

3rd CDM subject.

The information to be recorded could be agreed, at the outset, with the Medical Adviser. In cases where the 3rd subject has been chosen from a project offered by the PAG (e.g. the Aspirin project), full compliance with the protocol of that project should be sufficient to meet this condition. - **For which PAG Projects can we do this?**

1. Y/N
2. Y/N

Check list for other CDM subjects as agreed with the Medical Adviser:-

- Policy for regular monitoring Y/N
- Policy for managing the patients Y/N
- Existence of regular audit cycle Y/N

Condition vi; THE PRACTICE shall show it to have a current Age/Sex Register with mapping of one morbidity field, as well as diabetes and asthma and it is able, through having registers for asthma, diabetes and one other disease, to operate a call recall system.

We are able to comply with this condition for the following chronic diseases:-

- CDM Diabetes Y/N
- CDM Asthma Y/N
- Other Disease 1 Y/N
- Other Disease 2 Y/N

Check list for other CDM subjects as agreed with the Medical Adviser:-

- Policy for regular monitoring Y/N
- Policy for managing the patients Y/N
- Existence of regular audit cycle Y/N

Other Conditions - not directly related to records

- i. Consultation within 24 hrs (See note circulated by LMC)
- iv. Immunisation targets (Health Authority will advise)
- vii formulary and generic prescribing (Health Authority will advise)

{Not all practices will feel at home with this audit. The PAG as far as resources permit, would be prepared to assist practices, on request}

Acknowledgement

The Primarycare Audit Group are very grateful to Dr Brynley Davies and Dr Richard Quick, (Primary Care Medical Advisers, Bro Taf Health Authority) for their guidance, advice and support in the development of this audit.

Study of Child Health Surveillance Records

The PAG was invited to carry out a pilot study into the reporting mechanisms currently in existence in Bro Taf, for the exchange of patient data, between General Practice, Community Health Trusts and WHCSA.

The joint working group was chaired jointly by Professor Nigel Stott and Professor Joseph Sibert. The report of this pilot study is available, on request, from the PAG office.

A great deal of work will need to be undertaken in order to bring this section of primary care recording, up to the standard necessary to convert to full computerised status.

A Working Group has been set up to follow on from the pilot study and to make recommendations. It is hoped that Primary Care professionals who have views on the subject will e-mail us at - Russell.dyer@nphs.wales.nhs.uk

A tower of Babel seems to have evolved over the years, but this now needs to be tightened into one clear flow of data. The flow chart on the following page illustrates the potential for confusion that exists in the present system.

It is clear that primary care clinicians are not the only contributors to the wider system of child health surveillance. The diagram overleaf details the extensive number of professionals and groups of professionals who can potentially become involved in one or more aspect of health care provision to children.

The complexity of the system enables each child to have access to the multi-disciplinary skills necessary to ensure that every aspect of physical and developmental well-being is considered at regular intervals throughout the early years of life. However, the study revealed that inherent in this intricate system is the potential for failures in communication.

The CHS study uncovered a number of instances where good clinical surveillance was betrayed by poor record keeping. Only twelve records (taken from those with positive findings) were looked at in the pilot study. It is probable that a fuller study would uncover the true potential for error throughout Bro Taf. Some of the most common deficiencies that were found are indicated as follows.

- **Health Visitor Records** – Are kept entirely separate from the GP held records. This can lead to a disrupted flow of information for an individual child. Where there is a lack of continuity in the overall medical record it becomes difficult for clinicians to appreciate the full story.

There are geographical variations in the scheduling of development checks and the format of the schedule differs between North and South Bro Taf. However, the presence of a protocol does encourage a certain uniformity of recording within those areas. This record, however, is not routinely copied to the GP held record and there is no common protocol for such GP records.

The main conclusion of the Joint Working Group on Child Health Surveillance was that *“the electronic record will only emerge successfully if Health Visitors and Nurses keep common child health records with General Practitioners”*

- **Parent held Record** – this record was devised to provide documented evidence of a child’s development with contributions made by each of the health care professionals involved. The study found that this was not always a comprehensive record, as parents often neglected to bring the record to consultations. The record was not favoured by hospital and community based clinicians.
- **GP held Records** – It was found that while development checks were routinely recorded in the GP held notes, in several cases these were in the form of brief comments such as “hearing tested”. This leaves the reader to assume that if a problem had been noted then the patient would have been referred. Such a brief comment as “hearing tested” would infer that hearing had been tested and no problem had been noted.

In several instances there were notes missing for considerable periods of the child’s early life. On occasion immunisation records were also omitted from the patients’ notes.

Where these occurrences are to be found the overall picture of surveillance afforded to the patient is fragmented and incomplete.

Standard Of Records Required For Training Practices In Wales

Those who have undertaken the **Workbook** exercise will have met many of the standards in these teaching practices. However, there are some specialised areas in teaching practices, which require additional attention for record keeping. These criteria are included not only to those who wish to aspire to teaching, but also for those who may have a special interest such as research.

**From Dr David Wood, Bangor
Senior Lecturer & Associate Advisor in General Practice for Wales**

8. Clinical Records

8.1 It is particularly important for a GP Registrar to work with good records, since he/she must inevitably see patients who are also being seen by other doctors. If the patients are to receive any form of continuity when they consult GP Registrars it must be possible for them to extract information from the record without difficulty. Where computers are used for parts of the record system, the GP Registrar must receive instruction in the use of the computer at the beginning of his/her attachment and ongoing help and instruction as required.

Mandatory Criteria - Clinical Records:

- 8.2** Up to and including 1999, 80% of medical records of patients fully registered with a teaching practice that uses paper-based records must adhere to the following standards. After 1999, 90% of medical records of patients fully registered with the practice will be expected to meet the following standards:
- i. The record envelope must not be torn; gusset envelopes should be used for large volume records, and the name, address, date of birth and **NHS** number should be clearly legible on the outside.
 - ii. The continuation notes must be in date order and clearly legible. They should be fixed, preferably by a treasury tag or similar device, to prevent un-sorting during the consultation.
 - iii. Hospital letters must be in date order, with the latest communication easily identifiable. These must also be fixed by a treasury tag or similar method.
 - iv. Records in an informal format must not be in evidence later than three months after the first attendance, as registration should have been completed by this time.
 - v. A record of all consultations at the surgery must be kept in the notes.

- vi. A updated summary of the major episodes in the patient's history should be written on an easily identifiable (preferably by colour) separate sheet.
- vii. There must be easily discernible drug therapy lists for patients on long-term therapy, as part of a system for recording repeat prescribing. The list of long-term therapy must be available with the patient's notes at the time of consultation in the surgery. (NB if the long-term therapy list is kept on computer separately from written records, the computer record must be available to the practitioner during the consultation). Arrangements must be in place for practitioners undertaking daytime home visits to have access to repeat prescription details at the time of the visit.
- viii. Special investigations must be filed separately.
- ix. Typewritten referral letters with copies should be kept in the patient's medical record (or there must be some other method of keeping copies of the referral letters in the notes).
- x. The records must be filed in an alphabetical (or numerical) system so that a record can be easily withdrawn by any member of the practice team who has authorised access, at any time of the day or night.
- xi. There must be a means of recording risk factors relating to the individual patient in respect of past medical history, family history, lifestyle, etc. in a way which makes that information rapidly accessible upon inspection of the record.

8.3 Where practices use paperless records, the following standards should also be observed:

90% of computer records should include a summary that is easily accessible to the Registrar, and a list of repeat medication.

An adequate record of patient details, summary and medication should be available to the Registrar when undertaking routine home visits.

8.4 In addition to surgery consultations, a record of other consultations should be kept including home visits, consultations by the Practice Nurse and all significant telephone consultations.

8.5 There must be an age/sex register with evidence of practice use.

8.6 There must be an effective recall system for selected categories of patient and problem.

8.7 Where significant portions of the medical record (such as repeat prescriptions) are held on computer, the practice must ensure that appropriate training is available to CF Registrars upon joining the practice to enable them to use the computer system appropriately.

Guidance on Good Practice - Clinical Records

- 8.8** The current occupation of the patient should be shown clearly on the record.
- 8.9** Specific types of records should be in evidence either manually or on computer to demonstrate specific activities to Registrars (e.g. records for research, to facilitate administration, to identify special groups of patients or to assist in the selection of cases for teaching. etc.).
- 8.10** Special flow plans may be used to link specific systems such as ante-natal clinics, immunisation, cervical cytology and child health surveillance clinics.
- 8.11** There may be a disease (morbidity) register.
- 8.12** Photocopying facilities and fax facilities should be available.
- 8.13** Records may be kept relating to additional work, such as insurance medicals, industrial and private work, etc.
- 8.14** There should be readily identifiable records for special functions in the practice, e.g. ante-natal records, immunisation. etc.
- 8.15** It may be useful to keep duplicate home records held by the patient at home for selected chronic sick patients or patients receiving palliative care who are unlikely to attend the surgery so as to enhance continuity, especially for out-of-hours care.

PROTECTING THE PATIENT'S PRIVACY

THE CALDICOTT REPORT

EXECUTIVE SUMMARY

- i) The Caldicott Committee was established by the Chief Medical Officer in the light of the requirements in The Protection and Use of Patient Information (DoH, 1996). Its primary function was to review all patient-identifiable information which passes from National Health Service (NHS) organisations in England to other NHS or non-NHS bodies for purposes other than direct care, medical research, or to satisfy statutory requirements for information. In performing this task it had to take into consideration work undertaken by a joint Department of Health and British Medical Association Working Group, which has been assessing all aspects of NHS Information Management *and* Technology (IM&T) security and confidentiality.
- ii) The Committee was asked to review NHS information processes and ensure that patient identifiable information is only transferred for justified purposes and that only the minimum necessary information is transferred in each case. Where appropriate, the Committee was asked to advise whether action to minimise risks of breach of confidentiality would be desirable.
- iii) The work of the Committee was carried out in an open and consultative manner. Written submissions were sought from many organisations to identify existing concerns, *and* members of the Committee have met with representatives of a number of key bodies. Working groups containing a wide range of health professionals and managers were established to consider related groups of information flows and to take sounding on emerging findings.
- iv) Some 86 flows of patient identifiable information were mapped relating to a wide range of planning, operational or monitoring purposes. Some of these flows were exemplars, representing locally diverse information flows with broadly similar characteristics and purposes.
- v) The Committee was greatly encouraged to discover that, within the context of current policy, all of the flows identified were for justifiable purposes. However, a number of the flows currently use more patient-identifiable information than is required to satisfy their purposes. Also many of the patient-identifiers currently used (e.g. name and address) could be omitted if a reliable, but suitably controlled, coded identifier could be used to support identification.
- vi) It was recognised that some flows of information were likely to be missed and that flows commence, evolve or are discontinued with such frequency that specific recommendations could soon date. Although specific recommendations have been included where appropriate, in general the recommendations reflect this evolving picture by developing a direction of travel, outlining good practice principles and calling for regular reviews of activity within a clear framework of responsibility.

Good Practice Principals

Principle 1

Justify the purpose (s).

Every proposed use or transfer of person-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2

Don't use person-identifiable information unless it is absolutely necessary

Person-Identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3

Use the minimum necessary person-identifiable Information

Where use of person-identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable is transferred or accessible as is necessary for a given function to be carried out.

Principle 4

Access to person-identifiable information, should be on a strict need-to know basis

Only those individuals who need access to person-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

Principle 5

Everyone accessing person-identifiable Information is aware of their responsibilities.

Action should be taken to ensure that those handling person identifiable information - both clinical and non-clinical are made fully aware of their responsibilities and obligations to respect confidentiality.

Principle 6

Understand and comply with the law.

Every use of person-identifiable information must be lawful. Someone in each organisation handling confidential information should be responsible for ensuring that the organisation complies with legal requirements.

vii) ***Summary of Recommendations***

Recommendation 1

Every data flow, current or proposed, should be tested against basic principles of good practice. Continuing flows should be re-tested regularly.

Recommendation 2

A programme of work should be established to reinforce awareness of confidentiality and information security requirements amongst all staff within the NHS.

Recommendation 3

A senior person, preferably a health professional should be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information.

Recommendation 4

Clear guidance should be provided for those individuals/bodies responsible for approving uses of patient-identifiable information.

Recommendation 5

Protocols should be developed to protect the exchange of patient identifiable information between NHS and non-NHS bodies.

Recommendation 6

The identity of those responsible for monitoring the sharing and transfer of information within agreed local protocols should be clearly communicated.

Recommendation 7

An accreditation system, which recognises those organisations following good practice with respect to confidentiality should be considered.

Recommendation 8

The NHS number should replace other identifiers wherever practicable, taking account of the consequences of errors and particular requirements for other specific identifiers.

Recommendation 9

Strict protocols should define who is authorised to gain access to patient identity where the NHS number or other coded identifier is used.

Recommendation 10

Where particularly sensitive information is transferred, privacy enhancing technologies (e.g. encrypting identifiers or “patient identifying information”) must be explored.

Recommendation 11

Those involved in developing health information systems should ensure that best practice principles are incorporated during the design stage.

Recommendation 12

Where practicable, the internal structure and administration of databases holding patient identifiable information should reflect the principles developed in this report.

Recommendation 13

The NHS number should replace the patient's name on Items of Service Claims made by General Practitioners as soon as practically possible.

Recommendation 14

The design of new systems for the transfer of prescription data should incorporate principles developed in this report.

Recommendation 15

Future negotiations on pay and conditions for General Practitioners should, where possible, avoid systems of payment which require patient identifying details to be transmitted.

Recommendation 16

Consideration should be given to procedures for General Practice claims and payments which do not require patient-identifying information to be transferred, which can then be piloted.