NOTES SUMMARIES-

1. Sort through notes

- Read through medical records in date order start with letters and then GP notes
- Notes should already be sorted tidied and in date order
- Discard unwanted items
- Summarise significant probs on front sheet
- Place in date order- use date of onset of diagnosis
- Enter significant problems on the computer

2. Pruning the medical record

- discard and shred the following

- Any yellow hand written discharge letters
- Any GP letters
- DNA/confirm appt letters
- Old addresses
- Hospital pharmacy letters
- A+E letters-summarise problem if significant.
- Old NYED slips
- Insurance reports –keep any within 6m and last report.
- Out patient follow up letters where no actions-ie all well rv 6m letters
- Normal blood tests>2yrs
- All INR results

3. To keep in notes

- Any letters with diagnoses operative results,pathology
- Xray/scan results
- Smears
- Maternity cards
- Recent blood tests –past 2 years
- Abnormal old blood tests-esp if treatment ongoing-thyroid .cholesterol.
- Other test results eg endoscopy

4. What is a significant problem?

- Any medical problem that is sufficiently important to be seen on front sheet and relevant to future management.

(a) All operations needing hosp admission include histology where available-eg hemicolectomy L- freetext Dukes B
(b) Ongoing medical probs –asthma diabetes angina etc
(c) Chronic ongoing conditions needing reg review–hypertension .hypothyroidism, chronic skin problems,RA
(d) Psychiatric problems
(e) Life events with adverse effect on patients health eg death of spouse
(f) All cancer diagnoses
(g) Major trauma eg fractures not sprains;significant head injuries.
(h) Obstetric history eg NVD or forceps
(i) Inactive problems which are not chronic but may relapse in future and may have a bearing on future management eg polymyalgia rheumatica

5. What is not significant?

-it is important that minor or self limiting problems do not clutter the active problem list so to make it unreadable and irrelevant.

I. Normal investigations
II. All minor illness
III. Minor trauma
IV. Any self limiting condition –eg infection
V. Anxiety-but not depression
VI. Health admin problems-eg smears .imms
VII. Any symptom or sign

6. HOW TO INPUT

- Main menu
- Press MR- medical record
- P – problem title
- A- to add
- DATE: - enter date of problem e.g. 29.09.00 then RETURN
- ENTRY:- enter first few letters of diagnosis,then return eg ANG for angina,CHOLE for cholecystectomy
- Chose the appropriate READ code see list.find with arrow or letter
- TEXT: -freetext other important info eg grading of any cancer diagnosis,side of THR,bowel obstruction-freetext -conservative management. press return
- ENTER AS A PROBLEM- Y
- SIGNIFICANT- S or return if cursor on S
- ACTIVE OR PAST- usually PAST
- But if asthma /COPD,diabetes ,angina essential hypertension,epilepsy all active problems ie A for ACTIVE.
- Say NO if asks re template

- When summarised
- ADD -notes summary on computer 9344
- Health admin problem
- Freetext initials

7. READ CODING

The following require consistent coding for audit purposes-these codes may change with next upgrade

- COPD H3Z
- ASTHMA H33
- ESSENTIAL HYPERTENSION G20
- ANGINA G33
- STROKE G66
- DIABETES C10
- MYOCARDIAL INFARCT G30
- TIA G65
- SEE ADDED LIST FOR EXTRA CODES AND EXPLANATION RE READ CODES