Note Summarising Policy

Document Details	
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Background

An adequately summarised set of medical notes contributes to the patient's effective and efficient management by the clinical team. A badly summarised set of clinical notes at best cause the clinical team an additional workload and at worst can be dangerous, increasing the chances of a patient being clinically mismanaged. With the time pressures that clinical staff face it is not possible for clinical staff to summarise notes and the job often falls to members of the admin team. This protocol sets out the procedure by which admin staff may summarise notes to ensure sufficient quality and consistency.

Training

All staff must have attended in house note summarisation training and be signed off as competent by a manager, kept on their personnel file, indicating that they reached the required standard. This applies to all non-clinical staff, including those who have attended externally recognised courses.

Alternative methods

All staff will use the note summarisation method outlined in this document and will not use or develop new note summarisation methods. If a member of staff has suggestions for improvement, please speak to your line manager who will ensure that the suggestion is brought to the attention of the Medical Director, and approved, before being implemented.

Receipt of notes

All notes need to be summarised as part of a systematic procedure rather than with staff just dipping in and out of notes as and when. This should ensure we stay up to date and that notes are done in chronological order.

Electronic transfer of records

As the NHS moves towards a more digital approach to healthcare records. More and more patient data is being collected electronically rather than on paper.

There is less of a requirement to summarise records when they come into the practice, as GP2GP transfers through EMIS Web import patient's medical history electronically. Staff should still be aware that checking patient records and GP2GP transfers is vital and that some records may still need to be summarised. All records coming into the practice should be checked alongside the patient's electronic records to see if we have received an electronic transfer of information and if this is correct. If it is, there isn't a need to summarise the paper notes.

If the electronic transfer fails or has inaccuracies, a suitably trained member of the non-clinical team should then summarise the paper records following the method in this document.

Questions

Notes should be summarised with 'accuracy' in mind. As an admin member of staff, should you have questions please ask a GP and never guess as to the correct code.

Note Summarisation Lead

The Lead GP in each practice will be the contact for any problems, concerns or questions that arise whilst notes are being summarised.

Protocol

1. Ensure the notes you have selected to summarise are complete. Are there any missing time periods etc? If there are, please double check with PCSE in the first instance. If there are still obviously missing notes this needs to be recorded as a warning alert pop up message for the benefit of the clinicians

2. Remove the paper notes from their Lloyd George wallet and tidy/flatten/unfold them briefly so that it is easier to see the information. Check if we have received any records via GP2GP and use this to cross reference previously coded data.

3. Check the latest GP summary contained in the notes. This needs to be viewed with a degree of suspicion as it can be secondary evidence but is a useful place to get an idea of the medical problems that the patient likely has. Place this summary to one side so it is visible at all times.

4. If the previously coded GP2GP data looks incorrect, double check with correspondence and amend/delete the code as necessary. (If in doubt, please check with a GP)

5. Find the earliest information in the notes so that you can work in chronological order from birth to the current date. This enables you to obtain the earliest date for each diagnosis and helps you to see a patient's medical history 'developing' over time.

6. Only include confirmed diagnoses. This means that care should be taken not to include working diagnoses. Diagnoses made in A&E should only be used if there is further documentary evidence from a speciality discharge letter. If this is missing, then please check with a GP.

7. The following data should be coded in the patient record with the date the event took place noting the problem 'significance'. Diagnosis, diagnostic testing, immunisations, smear results, operations, safeguarding information. See appendix A for further details of data that should be coded.

8. Free text may be added after a code but should be done so with care and only to add supplementary information – never to subtract from it. For example, if a patient has an MI coded, then free text could be used to say "anterior" but not to say, "thought to be MI in A&E but later turned out to be gastro related after admission". The same rules apply for free text in that it has to be confirmed information and not speculative – again, any questions please double check with a GP.

9. When all of the information has been coded, add the code 'note summary on computer'.

10. When you have been through all of the patient's notes in this fashion, replace the patients notes in the correct place in the filing system.

Appendix A – Abbreviations & explanations for note summarisers

COPD - Chronic obstructive pulmonary disease/Emphysema/Chronic bronchitis

Almost always diagnosed in patients over 30 who smoke

Causes cough, shortness of breath on exercise (SOBOE), then SOB at rest

Patients tend to be on inhalers and may need oxygen

Patients can have both asthma and COPD

Associated tests:

Spirometry - test used for diagnosis and monitoring of lung 'health'

FEV1/FVC - measured by spirometry

MRC dyspnoea scale - a way of grading how much someone is affected

For QOF:

Record spirometry tests in patients joining the practice with a new diagnosis of COPD

MRC score is worth recording if within last 12 months 1 (mild) to 5 (severe)

Pulmonary Rehab Referral is required if the MRC score >=3

ASTHMA

Can start at any age, childhood asthma often goes away with age

Patients are usually on inhalers

Spirometry is also used to diagnose asthma

PEFR - peak expiratory flow rate - a test to diagnose and monitor asthma

For QOF:

Only patients who have been prescribed drugs related to asthma within the last 12 months are included

If adding a code of asthma with a start date after 1st April, need to also add a code for the test used to diagnose it (unless patient is aged under 8 years)

If adding a code of asthma but patient does not seem to have had any problems with asthma in the last 12 months, the 'asthma resolved' code may be appropriate. Check with a clinician before adding this code

DIABETES MELLITUS (DM)

T1DM - Type 1 DM

Tends to be diagnosed under the age of 30 years

Patients are usually on insulin treatment and not on metformin, gliclazide etc

T2DM - Type 2 DM

Associated with obesity and increasing age

Patients are almost always on tablet treatments, some may also be on insulin

Associated terms and tests:

IGT - Impaired glucose tolerance - 'pre-diabetes'

IFT - Impaired fasting glucose - 'pre-diabetes'

OGTT - Oral glucose tolerance test - used to diagnose IGT

HbA1c - Test to measure how well diabetes is controlled

IFCC - The new way to record the result of the HbA1c

Patients with both types of diabetes often get problems with their eyes, feet, kidneys and heart.

For QOF:

Old summaries often don't specify T1 or T2 diabetes but our records MUST

If in doubt about which type it is - ask - it's important not to mix them up

Record retinal screening if done within the last 12 months

Record the foot exam if done within the last 12 months

Look out for 'micro-albuminuria' and/or proteinuria

Code any recent HbA1c results within the last 12 months

Code any recent frailty scores within the last 12 months

Code referrals to the diabetes structured education programme

DERMATOLOGY

BCC - basal cell carcinoma - a type of skin cancer but one that spreads very slowly and so is usually removed by a simple operation and fully cured. Therefore patients aren't usually added to the cancer register.

Psoriasis - a skin condition where the top layer of the skin grows too much and patients get scaly areas on their body. Can affect only the scalp 'scalp psoriasis' or only the nails 'nail psoriasis'. Chronic, treated with creams, sometimes tablets.

May be managed by GP or may see a hospital specialist. There are a few different types e.g. guttate psoriasis, pustular psoriasis. Can also be associated with arthritis (psoriatic arthropathy).

Eczema - very common, especially in children. Many people will have a 'resolved' history of eczema. Usually diagnosed and managed in General Practice.

Contact dermatitis - a form of eczema caused by contact with particular substances. May have been seen in hospital for 'patch testing' - useful to record this with the results if you can.

Acne vulgaris - common form of acne, usually managed by GP, may see hospital specialist if severe.

Not on the template:

Acne rosacea - different to acne vulgaris. Affects older people. Usually managed by GP with creams or tablets.

SCC - squamous cell carcinoma. More serious than BCC as it can spread rapidly to other parts of the body but usually cured by surgical removal.

Actinic keratosis/Solar keratosis - areas of sun-damaged skin that can progress to cancer. Often treated by 'topical' therapies (treatments that are applied directly to the skin, not skin surgery).

Bowen's disease - early SCC/SCC in-situ - usually treated with topical therapies

Marjolin's ulcer - SCC occurring in a chronic ulcer or damaged skin. Usually treated by surgery.

There are no QOF points for dermatology

RENAL

Chronic renal failure - the kidneys stop working for one of very many reasons. Often patients also have diabetes, hypertension or cardiovascular disease. Usually under the care of a hospital specialist, may be on dialysis - a treatment to replace kidney function with an external machine. This can be 'peritoneal dialysis' - this can be done at home or just 'dialysis' - patient goes into hospital several times a week

Acute renal failure - the kidneys stop working for a short time, usually as part of another illness or a kidney problem that recovers. Often seen in letters from hospital. Not on template but coding may be useful - ask if in doubt

Chronic kidney disease - NOT the same as chronic renal failure.

ONLY code patients with 'CKD 3, 4 or 5'. Letters from hospital will usually give an 'eGFR' - this doesn't need to be recorded. **CKD 3 may be entirely diagnosed and managed in General Practice - flag notes for review by doctor if not under care of specialist**

Ignore CKD 1

CKD 2 - may need early review in practice so flag notes for review by doctor

HAEMATOLOGY

Fe Def Anaemia - Iron deficiency anaemia/Microcytic Anaemia

Thalassaemia/sickle cell trait and disease - should all be clearly documented as diagnoses within hospital letters.

Von Willebrand disease, Haemophilia - these are important diagnoses and again should be clear in letters. Ask for help in coding as not on template.

Lymphoma, leukaemia, myelodysplasia, polycythaemia, - these, and other illnesses, will be clearly recorded in letters and must be entered into our notes. Ask for help as not on template

CARDIOLOGY

CHD - Coronary heart disease

IHD - Ischaemic heart disease

MI - Myocardial infarction / heart attack / NSTEMI / STEMI / ACS

Angina – Chest pain, often left sided, may go into left arm or up into left jaw. Tends to occur on exertion initially but can go on to cause pain at rest.

All of these terms refer to problems caused by narrowing of the arteries supplying blood to the heart.

IHD/CHD alone are not great codes as they don't give enough information. Aim to specify - angina, MI

These terms are often mentioned in previous summaries/ A&E / hospital discharge summaries BUT they shouldn't be entered into our clinical records without good evidence. If in doubt, ask!

FOR QOF: Code any ECHO results

Exercise ECG / Exercise tolerance test - commonly used to diagnose angina, ask a clinician if unsure whether positive or negative.

BB – Beta blocker - not indicated or refused (important for QOF)

PM check – Pacemaker check. Pacemaker fitted - record date of insertion.

Atrial Fibrillation (AF) - irregular heartbeat, often diagnosed and managed in General Practice.

Tachy-arrhythmia/Conduction Disorder - these problems are likely to be managed by a hospital specialist. Code according to letters by **if in doubt ask** as can be complicated and more precise codes than these may be better.

24 hr ECG (may be called a Holter Monitor) - a test that may be done to diagnose the problems above. Can be hard to tell from report what the result is so ask if you need to.

Amb BP Monitor - 24 hour recording of BP

Thallium Scan/myocardial perfusion scan/chemical stress test/myocardial stress perfusion scan/dobutamine stress test

- basically all the same - tests that aim to find out if there is a restriction in blood flow to the heart and/or if all parts of the heart muscle are working well. Should be clearly described in letters from specialist, if hard to interpret result, ask.

Coronary artery ops - this is a 'catch-all' phrase - more detail should be available from the letters

Coronary angiography ('angio') - test to look at the arteries supplying the heart and see if any narrowing or blockages

Coronary angioplasty/percutaneous transluminal coronary angioplasty (PCTA)/percutaneous coronary intervention **(PCI**) - procedure to widen a blocked artery - usually includes **'stenting'** - patients with stents need to take the medicine 'clopidogrel' for at least 12 months so it is important to enter the correct date of the procedure. Flag these notes for review by a doctor so that an alert can be entered

Coronary artery bypass graft (CABG) - operation to improve the blood supply to the heart. May be double, triple or quadruple

Valve repairs/replacement - Important to document the valve - mitral/aortic/pulmonary/tricuspid - and the type of replacement valve - tissue valve or mechanical valve. This should all be clear from letters but if in doubt ask

For QOF: OTC Aspirin - over the counter aspirin (i.e. patient buys it themselves), aspirin prophylaxis contraindicated, warfarin contraindicated

Left Ventricular Dysfunction (LVD) - Heart failure (HF)

Often, but not always, part of the same diagnosis. LVD can exist without HF and vice-versa

Often, but not always, looked after by a specialist nurse at the hospital.

NYHA class is often given in letters as a way of describing the severity of the patient's symptoms, not essential to enter into records as may change with time

Echocardiogram (ECHO) - the test most commonly used for diagnosing LVD. This may be requested by the GP without specialist involvement

Letters/ results will usually give an **ejection fraction**, this is a measure of severity

Where there are a lot of ECHO results in the notes, it is important to record the date of first diagnosis and then the date of the most recent test and ejection fraction

BNP level - a blood test also used to diagnose LVD

NEUROLOGY

Haem stroke - Haemorrhagic stroke / Intracerebral haemorrhage

(NOT subarachnoid haemorrhage - this is Sub Arachnoid Haem on template)

Non-haem stroke - Non-haemorrhagic stroke / Cerebral arterial occlusion/ CVA(cerebrovascular accident)

It may not always be clear from the notes which type of stroke a patient has had. It doesn't matter too much. If in doubt ask but non-haemorrhagic strokes happen a lot more often than haemorrhagic ones

TIA - Transient ischaemic attack / transient cerebral ischaemia

This is often called a 'mini-stroke' and the patient should get completely better within 24 hours. But they stay at high risk of having a more significant stroke.

Carotid dopplers - this test is often done in patients who have had a stroke or TIA. There will often be a freetext note giving a % stenosis

The patient may then go on to have an operation called a **carotid endarterectomy -** see the vascular section of the template

Sub Arachnoid Haem - this is a bleed around the brain. Usually patients will have had an operation related to this problem

Multiple Sclerosis (MS), Motor Neuron Disease, Muscular Dystrophy, Parkinson's Disease. These are important diagnoses and should all be backed up by hospital letters.

Headache - it can be hard to define the type of headache that a patient has. Usually headache is managed by the GP but sometimes patients do see hospital specialists

Common types of headache are: migraine, tension-type headache, chronic daily headache, medication overuse headache. **If any of these are diagnosed in hospital letters then they should be recorded, along with any investigations that were done.** If they are a recurrent problem within GP records then also important to document

GASTROENTEROLOGY

UC - ulcerative colitis / Chron's disease

These come under the general heading of IBD - inflammatory bowel disease - but they are managed differently so should be entered as specifically as possible

Hepatitis viral/alcoholic

If you think a patient has/has had a viral hepatitis, you should also look for the type - usually Hep B or Hep C **If in doubt, ask!**

Liver cirrhosis - often but not always a result of alcohol - patients usually see a specialist at the hospital and have had an ultrasound scan (USS) or liver biopsy

Pancreatitis - inflammation of the pancreas - usually caused by alcohol or gallstones. Can get chronic pancreatitis - usually see hospital specialist

Gallstones - usually diagnosed by USS, patients may have had a **laparascopic/open cholecystectomy** (operation to remove the gall-bladder)

PUD - peptic ulcer disease - usually diagnosed by endoscopy (see below)

GORD - gastro-oesophageal reflux disease

Barrett's oesophagus - diagnosed by biopsy during OGD - an important entry as patients need a yearly test to look for pre-cancerous changes

OGD - oesophago-gastro-duodenoscopy / gastroscopy - test to look at the stomach and upper part of the small bowel

PEG - percutaneous endoscopic gastrostomy - a feeding tube placed into stomach when patients cannot eat normally

H. pylori - Helicobacter pylori - a little bug that lives in the stomach and can cause indigestion and ulcers

Diagnosed by a stool test or by a CLO test - this is done during OGD

Barium meal - xray test to look at the oesophagus, stomach and duodenum

ERCP - endoscopic retrograde cholangiopancreatography - done when gallstones are causing a blockage

MRCP - similar to the above but done using a scanning machine

Colonoscopy - camera test to look at the large bowel

Sigmoidoscopy - camera test to look at the lower part of the large bowel

Barium enema - xray test to look at the lower part of the large bowel

USS - ultrasound scan

Colostomy - where the bowel is diverted to come out of the abdominal wall

IBS - Irritable bowel syndrome - may be diagnosed by GP or hospital specialist. **Record diagnosis if present within hospital letters along with any investigations that have been done.** Record diagnosis if seems to have been recurrent problem in general practice

VASCULAR

Arteriogram - test to look for narrowing of the arteries e.g. in legs

Aortic aneurysm - a weakness in the wall of the lower aorta. Patient usually has annual monitoring of size by USS. Usually under the care of a hospital team. May have a repair done once the aneurysm is above a certain size. If a decision has been made by the patient with GP or hospital not to repair the aneurysm this should be documented as free text

Thoracic (lower aorta weakness) and Intracranial (weakness of artery in the brain) should also be recorded

PVD - peripheral vascular disease. Narrowing of the arteries supplying blood to the legs. Often diagnosed and managed by GP

Carotid dopplers - an ultrasound test to look at the arteries in the neck for narrowing

Carotid endarterectomy - an operation to remove narrowed parts of neck arteries

DVT - deep vein thrombosis. A blood clot in one of the veins in the leg. May occur as the result of another injury or illness eg broken leg or cancer - and it is useful to record this if it is clearly documented. Diagnosed by USS of leg. (DVT is a cause of PE and so some patients will also have checks for this - see respiratory section)

Leg ulcers - often managed by general practice. May be subdivided into venous, arterial, neuropathic, diabetic. Give detail if clearly documented

Varicose veins - don't really need to enter these although do enter if patient has had operation to remove them

EPILEPSY

Lots of different types - give as much detail as possible. Often patients will be under the care of a hospital specialist

Tonic-clonic/Grand Mal seizures - the 'typical' seizure with loss of consciousness and 'shaking'

Temporal lobe epilepsy - may be referred to as 'simple partial seizures' or complex partial seizures

Absence Seizures/Petit Mal - usually in children

EEG - test used as part of epilepsy diagnosis, but often doesn't give conclusive result. Ask if unsure

IMMUNOLOGY

Immunodeficiency - bit of an odd code - where immune system not working properly. If patient has this sort of problem then they will be under the care of a hospital specialist and a more specific diagnosis should be available

Allergy skin testing/Pin prick testing/Patch testing - useful to record the results in some detail

RAST testing - a blood test to look for allergies

ENDOCRINOLOGY

Hypothyroidism - underactive thyroid gland. Congential (rare) or Acquired (very common). Usually diagnosed and treated in general practice.

Thyrotoxicosis - overactive thyroid gland. Usually see hospital specialist. May be associated diagnoses such as **Graves' disease** or associated treatments such as radioiodine. Ask if any queries

Disease of adrenal gland - too vague, will have hospital letters

Disease of pituatry gland - as above

Gout - usually diagnosed and managed in general practice

UROLOGY

Renal colic - severe pain caused by **renal stones**. Will usually see a hospital specialist. **IVU** - intravenous urogram - test to diagnose renal stones. May also have had procedures such as **Extracorporeal shock wave lithotripsy (ESWL)/Percutaneous nephrolithotomy (PCNL)/ Ureteroscopy**

Benign prostatic hyperplasia - enlargement of prostate. May be diagnosed and managed by GP or hospital specialist. May have had investigations e.g. transrectal ultrasound (TRUS), transurethral biopsy or surgery to reduce the prostate size e.g. transurethral resection of prostate (TURP)

Prostatic Inflammatory disease - usually referred to as acute or chronic prostatitis. Usually under specialist care

Orchitis and epididymitis - infection of testicle and epididymis. May be managed by GP or hospital specialist

Erectile dysfunction - inability to get/maintain an erection. Often managed by general practice. May have 'psychological' or 'physical' cause or a mixture of both. In men it can be a sign of narrowing of the arteries supplying blood and an early warning of narrowing elsewhere e.g. legs, brain, heart

Male infertility - can be primary - no children/pregnancies or secondary - already had children

Urethral stricture - narrowing of urethra - tube draining urine from bladder

Cystoscopy - camera test to look inside bladder

Urodynamic study - test to measure flow of urine

OBSTETRICS AND GYNAECOLOGY

Hysterectomy - operation to remove the uterus and cervix (may be 'abdominal' or 'vaginal

Sub-total hysterectomy - important as the cervix may have been left and the woman will still need smear tests

TAH + BSO - Total abdominal hysterectomy and bilateral salpingo-oophorectomy. Removal of uterus, cervix, both ovaries and fallopian tubes

Prolapse - can be prolapse of the uterus; bladder 'cystocele'; bowel 'rectocele' Useful to document if a ring or shelf pessary is used to control the prolapse, operations that have been done for the prolapse and/or agreement that surgical treatment is not appropriate

Colposcopy - a test to look closely at the cervix for signs of pre-malignant cells

Laser to Cx - laser treatment for pre-malignant cells of cervix (Cx). Done at colposcopy

Laparoscopy - 'keyhole surgery' to look inside abdomen and pelvis

Hysteroscopy - camera test to look inside the uterus

Female Infertility - can be primary (no children or pregnancies) or secondary (already has children or has been pregnant, even if miscarriage or termination)

Endometriosis - condition that can cause painful, heavy periods and infertility. May be treated by laparoscopy and laser, hormone treatments or hysterectomy

PCOS - polycystic ovarian syndrome - very common, may be under primary or secondary care. Often there will be an USS abdomen/pelvis to record.

Cystectomy - this can mean removal of a cyst - for example from the ovaries in endometriosis but it can also mean removal of the bladder (uncommon)

Fibroids - common condition causing painful heavy periods. May be diagnosed by an USS or during hysteroscopy

Ectopic pregnancy - pregnancy occurring outside of the uterus. Important to note that it has occurred and also any treatment that has been given eg removal of one of the fallopian tubes

Miscarriage - common, particularly in early pregnancy (up to 13 weeks). Should be recorded and if after 13 weeks, this should be noted as free text

LSCS - lower segment caesarean section - Csection

Breast - these codes aren't that useful. If in doubt about coding a breast condition, please ask. **Cancer** - see list attached to protocol

For QOF: Code last smear result

RHEUMATOLOGY

RA - rheumatoid arthritis - important to make sure that it really is RA not another form of arthritis. RA usually means that there will be hospital letters to confirm the diagnosis

CTD - connective tissue disorder - as above

ME/Chronic fatigue syndrome (CFS) - this may be diagnosed in primary or secondary care. Look for evidence that it has been a significant problem rather than a one-off label applied by a doctor during a consultation

Osteoarthritis (OA) - common form of arthritis, useful to note areas affected and any associated xrays with their results

FH - family history

Osteoporosis - reduced bone mineral density (BMD) 'thinning of the bones' May be managed in primary care only

DEXA bone scan - test for osteoporosis and **osteopenia** - reduced BMD but not yet osteoporosis. Useful to record that test has been done, results can be complicated to interpret

PMR - polymyalgia rheumatic - usually diagnosed and managed in primary care

PAEDIATRICS

Premature baby/Intubation/SCBU(special care baby unit) - useful to note in children

UTI - urinary tract infection - more significant in children than adults so useful to record in under 16s

DMSA - test used to look at kidneys if child has lots of UTIs. Will be letters from secondary care

Behavioural disorder - a bit non-specific. May be worth noting in under 16s. Sometimes secondary care are involved

Specific delay in development - a bit non-specific - there will be letters, look for diagnoses and add as free-text if possible

Bronchiolitis - common in younger children. Worth noting in under 16s

Cystic Fibrosis - there will be hospital letters

Congenital heart disease - there will be hospital letters

Child protection register - if you think this is relevant then flag to the safeguarding lead

For QOF: All childhood immunisations need to be coded

EAR NOSE AND THROAT (ENT)

Allergic rhinitis - very common condition 'hayfever affecting the nose'. If has been seen in secondary care, free-text any investigations that have been done

Grommets/Myringotomy - will be letters from secondary care, just note it has been done

Hearing loss - note if there is a letter about it, with details of any audiogram (hearing test) that has been done

Mastoidectomy - operation - will be letters from secondary care

Nose operations - probably too vague, add free-text if possible

Tonsil/Adenoidectomy - operation - will be letters from secondary care

Vestibular system - usually mentioned in letters about dizziness in secondary care. This code is very vague and probably not useful.

Meniere's Disease - should be letters from secondary care. If it seems to have been diagnosed and treated only in primary care, alert doctor

ORTHOPAEDICS

THR - Total hip replacement

TKR - Total knee replacement

RTA - road traffic accident - worth recording if within the last 12 months or if significant injury

Head injury - a bit vague. Might be worth recording if a child seemed to be having recurrent injuries but really in that situation the notes should be flagged to a doctor for review

- fracture

CTS - carpal tunnel syndrome - condition affecting the hand, may be diagnosed and managed in primary care. May have an operation to treat

Spinal stenosis - a cause of back pain, particularly in the elderly. Likely to be a documented in letters from secondary care

Rotator cuff disorder/Frozen shoulder - Common shoulder problems, often see physiotherapist. Sometimes have operation to repair

Dislocations/Subluxation - too vague, letters will give more detail

Arthroscopy knee - camera test to look inside the knee, sometimes some tissue is also removed

MENTAL HEALTH

Mental illness is managed mostly in primary care. Even when secondary care is involved, diagnoses can be a bit vague, or there can be more than one diagnosis.

Lots of people have episodes of mental illness, usually 'low mood' or depression. Lots of people have more than one episode of depression and it's important that we're aware that it's been a problem for a long time even if it's no all the time. If a patient has 'self harmed' it's important that we know this, particularly if it is a recent episode or if there have been lots of episodes. Self harm includes overdoses of medications.

It's important that we get the records right for patients so if in any doubt at all, please do ask for a doctor's review.

On severe mental illness register - certain diagnoses will lead to patient being on the QOF register so probably doesn't need to be added as a separate code

Neurosis/OCD - Neurosis is not a useful term. Obsessional compulsive disorder (OCD) is usually diagnosed by secondary care

PD - personality disorder - lots of different types. Usually there will be letters from the hospital and often there are lots of episodes of self-harm

Eating disorder - usually under secondary care. We should aim to give more detail of the type - anorexia nervosa or bulimia

Depression - if multiple episodes, consider entering the first episode with the appropriate date and then free-texting a summary of how many further episodes

Dementia - can be Alzheimer's, vascular, or a few other types. Give as much detail as possible, including tests that have been done eg CT brain

Psychotic illness - too vague, usually seen in secondary care and will be a more specific description

Suicide attempt - if multiple episodes of self-harm by cutting arms, overdose, consider entering the first episode and then giving an idea of how many further episodes with free-text.

If any episodes of attempted suicide by hanging, jumping from building, carbon monoxide poisoning or overdose leading to admission to ITU (intensive care) or HDU (high dependency care) make this clear in the notes

Alcohol/Drug dependency - very important, give details of drugs as possible, plus details of involvement with rehabilitation services if possible

Mental retardation - not a good code, use '**learning difficulty**' code instead

Sectioned under Mental Health Act - important to note if patient has been sectioned (taken to hospital without their consent) as it implies more serious mental illness

SURGERY

Thyroid +/- parathyroid - where patient has had surgery on the thyroid gland it is important to note if the parathyroid glands have also been removed. This should be clear from the letters

Cholecystectomy - removal of gall-bladder. Can be open or laparoscopic

Laparotomy - a large operation to open up the abdomen. You should be able to add why the operation was done from the letters - although the reason may be something that needs separate coding eg cancer

Appendicectomy - operation to remove the appendix - may be open or laparoscopic

Adhesolysis - usually done at laparoscopy (see O+G). An operation to get rid of scars inside the abdomen from previous surgery. Done for abdominal pain and infertility

Hernia op - repair of hernia - useful to note site of hernia also eg inguinal, femoral, umbilical

I+D of abscess - incision and drainage of abscess - worth recording if recurrent. Note site of abscess

OPHTHALMOLOGY

Glaucoma - abnormal pressure in the eye. Important to note as can mean that some medicines shouldn't be used. Can be 'open-angle' - common or 'acute closed angle'. There should be hospital letters

Registered partially sighted or blind - usually a letter from secondary care

Giant cell arteritis/Temporal arteritis - inflammation of arteries that supply blood to the eye. This diagnosis may also be made by a rheumatologist and it is linked to PMR (see rheumatology)

Retinal detachment - associated with **posterior vitreous detachment**. Important as can cause visual loss and can recur.

Cataract - often removed and replaced by surgeon

PLASTICS

Burns - include if significant and free-text the detail. May require skin-grafting operation to replace damaged skin

INFECTIOUS DISEASES

HIV - record if positive

PUO - pyrexia of unknown origin - usually there will be a lot of hospital letters and an eventual diagnosis so the most specific detail should be included

Chicken pox/Varicella - can be worth documenting if definite diagnosis

Shingles - different to chicken pox. Caused by the same virus lying dormant within the body after chicken pox years ago

GENITOURINARY MEDICINE

STD - Sexually transmitted infection, excluding chlamydia

Chlamydia - be careful to check that a diagnosis is recorded, rather than just the test being done

PID - pelvic inflammatory disease - important as may cause future sub-fertility, may be diagnosed and managed by GP