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Why being able to summarise medical records still matters in the digital age

High quality training for medical notes summarising remains vital for general practice says Hilary Andrews, Nurse Advisor/Freelance Trainer for HAT Training and Medical Services Training.

Summarising medical records is hardly a subject that induces excitement or a burning desire to participate in the summarising role, let alone talking about the need to have training on the subject. Over the past 13 years I have been training non-clinical staff in how to summarise. I reckon a good majority of the delegates have been sent by their practice managers in the vain hope that if they attend a course then they will record more Quality and Outcomes Framework (QOF) data. I do get a whole spectrum of delegates on this training – those who have never summarised any notes, those that have done a few sets and those who have been summarising notes for years and want to check if they are doing it correctly. Summarising has changed enormously from when I first started teaching the subject. Back then we were transferring previously un-coded records from paper onto the computer – often finding that there were gaps in a patient’s record where significant problems were missing. As the old Lloyd George notes get used less frequently, and since the implementation of GP2GP, the process of summarising has become one of housekeeping – tidying and editing the electronic record. In some areas of the country, where all practices are using the same software system, GP2GP appears to work beautifully as intended – meaning the summariser has little work to do for some newly registering patients. However, for most of us, as patients transfer from a practice using one software system to another using a different software system, the summariser must still check the paper records for accuracy. Despite the carrot of QOF points not being there anymore for summarising, accurately summarised notes are vital in today’s NHS where the clinicians simply don’t know their patients as well as in the old family doctor days. Plus, the time pressures on GPs and practice nurses mean that an accurate history on the screen is imperative for care, diagnosis, treatment and referral. With a reported 98% of practices now being able to add additional information to the Summary Care Record, an accurate medical summary is even more important. Training for non-clinical staff in summarising is key. These staff, sometimes with limited healthcare experience, have a daunting task on their hands in deciphering what is significant and relevant enough in a patient’s medical history to end up being in the summary. It is hardly any wonder that they are sometimes reluctant to take on the role. Until general practice is completely paperless, there will always be a job for the summariser and training continues to instil confidence in those new to summarising and provide a day out for those who want to check they are doing it right.