Guidance for recording problems and diagnoses in electronic health records: consultation survey results

November 2018
Anoop Shah and Nicola Quinn, RCP Health Informatics Unit

Table of Contents

Overview....1
Section 3: Definitions....2
Section 3.2: Structure of medical records....3
Section 4: Principles and Recommendations....5
Section 4.1: Creating Problem and Diagnosis Records....6
Sections 4.1.2 to 4.1.5....8
Section 4.1.6: Attributes of problems and diagnoses....9
Additional attributes of a problem....11
Section 4.2: Maintaining Problem and Diagnosis Records....11
Section 4.2: Active / inactive problems....13
Section 4.3: Communicating Problems and Diagnoses....14
Section 4.4: Using Advanced Features of Problem-Oriented Records....15
Any other comments....16

Overview

This document describes the results of a surveymonkey survey carried out between 4 October and 16 November 2018.

The responses were broadly positive (70-80%) in respect of each individual section, but there were some comments about the strength and feasibility of the recommendations, particularly given time constraints, the applicability to fields outside medicine (such as mental health), and the clarity of some of the wording.

There were 198 individual responses which we have broken down by category: general practitioner, secondary care doctor, other healthcare professional, and informaticians / administration staff. Some participants were classified under more than one category and were counted multiple times, giving a total of 224 responses by category.

Table 1: Survey respondents

General practitioner	54 (24%)
Secondary care doctor	63 (28%)
Other healthcare professional	47 (21%)
Info/ system	60 (27%)
Grand Total	224 (100%)

Respondents recorded the following as their specialties:

Acute Medicine
Addiction consultant
Anaesthesia
Cardiology
Chief Clinical Information Officer
Child and adolescent psychiatry
Clinical coding
Clinical pharmacology
Clinical psychology
Counselling psychology
Critical care
Gastroenterology
General medicine/endocrinology and diabetes
General Paediatrics and Neonatology
Geriatric Medicine
Haematology
Head & neck cancer & clinical voice disorder
Infectious diseases & gen internal medicine
Informatics Pharmacist
Intellectual Disability Psychiatry
Liaison Psychiatry
Mental Health Learning Disabilities
Midwifery
MSK physiotherapist
Nephrology
Nursing
Obstetrics & Gynaecology
Old age psychiatry
Oncology
Ophthalmology
Optometry
Orthodontics
Osteopathy
Paediatric Intensive Care Medicine
Paediatric Nephrology
Paediatric nurse
Paediatric speech and language therapist
Palliative Medicine
Paramedic
Pathology all disciplines
Perinatal Psychiatry
Physiotherapy
Podiatry
Psychiatry
Renal Medicine
Rheumatology
Sexual and reproductive health
Social Worker
Speech and Language Therapy
Stroke
Transplant and General Surgery
Unscheduled and acute care
Urgent and emergency care
Vascular Surgery
Whole patient medical care

Section 3: Definitions

Different electronic health record systems currently use different terminology to refer to diagnoses, symptoms and signs. We propose standardising the definitions.

Do you feel that the descriptions provided under section 3.1 DESCRIPTION OF TERMS are clear and easy to understand?

Row Labels	Yes	No	I am not sure	Total response
General practitioner	39 (72%)	11 (20%)	4 (7%)	54
Secondary care doctor	48 (76%)	11 (17%)	4 (6%)	63
Other healthcare professional	36 (77%)	5 (11%)	6 (13%)	47
Info/ system	38 (73%)	14 (23%)	8 (13%)	60
Grand Total	161 (72%)	41 (18%)	22 (10%)	224

If you answered ‘no’, which are you unhappy with and why?

Summary of responses:

- Too many subsets of diagnosis
- Symptoms may not be due to disease
- Needs to include psychological and social conditions
- Problem may not be chronic condition but may be one that requires ongoing attention
- ‘Sign’ should not be confined to physical examination (psychiatry)
- ‘Disease’ is not well defined and is inappropriate to use in mental health

Example responses:

Secondary care doctor: Sign: An abnormal finding on physical examination that is due to disease *this needs to be changed to ‘on examination’ - in psychiatry, we describe ‘signs’ observed on mental state examination which are part of ICD-10 defined diagnoses. Disease: A disorder of structure or function of the body* or mind - again, this needs to be added in as a condition does not need to have a ‘physical’ manifestation to be a disease

Secondary care doctor: The description of terms are limited and there are no references to developmental conditions or protective factors and strengths or preventative factors, therefore in child and adolescent psychiatry this is a limited formulation.

Allied health professional: ‘Disease’ does not seem a very good descriptor for many psychiatric conditons where there is no known pathological process.

Nurse, Healthcare administration/ management: Disease is not well described: Commonly a ““disease““ has a pathological cause such as bacteria or a virus. Abnormal investigation result uses the terms opacity and hyponatraemia - surely terms that are more general would serve as well and not exclude non-medical staff from understanding them i.e. a shadow on an x-ray, or use these terms and explian what they are i.e. hyponatraemia/ a low level of sodium in the blood

Implications for guidance:

The definitions need to be refined to make them more understandable.

Recommended change to document:

- Use the concept ‘Condition’ to encompass symptoms, signs, abnormal investigation findings and diagnoses, i.e. the underlying fact.
- Make it clear that ‘Problem’ is a marker for the healthcare task in relation to a condition. Whether a condition is an active problem may depend on the care setting.

Section 3.2: Structure of medical records

Do you feel that the descriptions provided under section 3.2 STRUCTURE OF MEDICAL RECORDS are clear and easy to understand?

Row Labels	Yes	No	I am not sure	Total
General practitioner	40 (74%)	8 (15%)	6 (11%)	54
Secondary care doctor	53 (84%)	4 (6%)	6 (10%)	63
Other healthcare professional	41 (87%)	1 (2%)	5 (11%)	47
Info/ system	45 (75%)	8 (13%)	7 (12%)	60
Grand Total	179 (80%)	21 (9%)	24 (11%)	224

If you answered ‘no’, which would you like to see changed and why?

Summary of responses:

- Definition of encounter problem is unclear
- Names of these items are not standardised

Example responses:

General practitioner: I’m not sure I fully understand the difference between problem-orientated and encounter-based records, Examples might help.

General practitioner, IT system supplier: As well as encounter and problem based, the medical record may be structured for service based such as health visiting and child health

General practitioner, Informatician: This is correct but incomplete. More of the structure of encounter records may relate to the problems dealt with. Consider using the term “”health problem“” rather than “”medical problem“”. The former is more inclusive. The later pushes people to include only diagnoses, symptoms and signs found in medical textbooks and away from life events and social factors.

IT system supplier: Encounter vs Problem bases are not mutually exclusive of each other and are simply differing axes of interest/focus. Whilst useful when situations warrant e.g. reporting activity for commissioning/billing, calling out such a separation within EHRs is artificial and likely to cause confusion when trying to provide guiding principles.

Informatician: I think both 3.2.1 and 3.2.2 should say that these names for data items are not standardised and they may have different names in different systems or may be grouped differently - these are only typical examples.

Implications for guidance:

Provide more explanation to make it clear that this is a description of paradigms used in current systems, and what the purpose of this section is (i.e. to explain to secondary care clinicians who are just starting to use problem based records). Use the term ‘health problem’ instead of ‘medical problem’.

Recommended change to document:

- Start with concrete examples of hospital and GP systems, and base the definitions on the descriptions.

- Add the option to view records in different ways (e.g. chronologically, or by problem).

Section 4: Principles and Recommendations

Accurate and precise recording of problems and diagnoses in electronic health records is essential for safe patient care, to support clinical decision making, for audit and research, and to enable accurate reimbursement. Problem lists should be complete, accurate, relevant, accessible, timely, unambiguous and linked to treatments and other information. The indicators for all medication and other treatments that a patient is currently receiving should be included in the problem list.

Do you agree with the above statement?

Row Labels	Yes	No	I am not sure	Total
General practitioner	38 (70%)	11 (20%)	5 (9%)	54
Secondary care doctor	46 (75%)	7 (11%)	8 (13%)	61
Other healthcare professional	39 (85%)	4 (9%)	3 (7%)	46
Info/ system	44 (76%)	7 (12%)	7 (12%)	58
Grand Total	167 (76%)	29 (13%)	23 (11%)	219

If you do not agree, what is it that you disagree with and why?

Summary of responses:

- Difficult to link treatments to problems
- Good target and lofty aim
- Should reimbursement be an aim?
- Will result in ‘punishment’

Example responses:

General practitioner: It’s a good target and a lofty aim, but it’s not helpful to set such a target without the resources to achieve it.

General practitioner: I’m not certain adding indications to medications adds much. I can guess normally and if I want to know more I search for the consultation it was initiated. Every extra thing we do takes time and this doesn’t add much value. Agree with the rest.

General practitioner, Informatician: I think the requirement about medication indication should be taken out of this. Medication management / recording of indications is a separate domain that could make use of a record standard.

Secondary care doctor: But I’m not sure that reimbursement is a requirement for a clinical system. Systems designed to manage the process of healthcare and inform billing may have features that make them unsuitable to be used as clinical records

General practitioner: good but I might also add the word ‘current’ indicating it has been curated and recently reviewed (as many lists are not)

IT system supplier: Whilst it is important to clearly record the relationship between Problems and interventions (medication, procedures etc), it is not uncommon for an intervention to relate to more than one problem and a problem may be related to multiple interventions. I don't believe this potentially complex set of related statements should form part of the problem list per se, but should be discoverable information through other user interfaces e.g. Medication lists displaying the indication, Procedure lists/history displaying related problem/indication. Problem lists should remain clear, concise and easily manageable.

Implications for guidance:

Aspirational – needs professional and organisation efforts to achieve. The high level of the ambition seems to be putting all the burden on clinicians as this document does not contain recommendations for system suppliers.

Recommended change to document:

- Tone down the recommendation for recording indications for 'all' medication.
- Use wording such as 'where appropriate and possible'
- Make it clear that it should be the aim of clinical systems to support the overall ambition, and that clinicians should aim to keep records as well as possible in order to support patient care.

Section 4.1: Creating Problem and Diagnosis Records

The guidance recommends that the following should be included when creating a problem list based on patient history or historical records:

- Any condition for which a patient is currently receiving care or follow-up
- Major past conditions that may have long term consequences or complications (e.g. myocardial infarction).
- Chronic medical conditions (e.g. diabetes, hypertension)
- Operations that may have long term consequences or complications (unless these are recorded separately in a surgical history section).
- Any issues that may impact on care, that are not recorded in immediately visible structured data areas. An example might be an abnormal test result which needs to be further investigated, and which would be useful to flag as a problem so that the next clinician taking over care is alerted to it.
- Allergies, medication, family history, social history and health behaviours should be recorded primarily in other structured parts of the electronic health record. This will ensure that the information is available to clinical decision support, and is aggregated correctly for audit and service planning. However, it may be useful to create problem list entries for information that needs to be brought to a clinician's attention quickly, such as a history of

anaphylaxis or heavy drinking, but absence of a problem list entry should not be interpreted as absence of information.

Do you agree that the above should be included in a problem list based on patient history or historical records?

Row Labels	Yes	No	I am not sure	Total
General practitioner	33 (65%)	13 (25%)	5 (10%)	51
Secondary care doctor	41 (76%)	7 (13%)	6 (11%)	54
Other healthcare professional	28 (67%)	5 (12%)	9 (21%)	42
Info/ system	31 (65%)	10 (21%)	7 (15%)	48
Grand Total	133 (68%)	35 (18%)	27 (14%)	195

If you do not agree, what is it that you disagree with and why?

Summary of responses:

- Include psychosocial problems
- Clarify active / inactive problems
- Not an exhaustive list
- Refer to SCIMP guidance for what to include in GP record summaries: https://www.scimp.scot.nhs.uk/guidance/summarising-medical-records

Example responses:

General practitioner: BUT In last sentence recommendation to construct a problem list for information to be brought to clinicians attention quickly e.g. heavy alcohol use. should be much stronger. Such information has potential to and to impact patient diagnosis and management for minor and major problems in ways that cause significant patient harm.

General practitioner: Critical that serious diagnoses, active or otherwise are visible Critical that clinician does not have to actively search for allergies Critical that clinician does not have to search for what patient has been told, shared decisions, preferences re care.

General practitioner: Bear in mind -this is a PROBLEM list and remember that in primary care we are dealing with many more conditions than secondary care so a problem list could easily become unmanageable Keep first three - and possibly fifth of the bulleted list Operations should be subsumed to inactive or an active problem but should feature in summary lists (which are different in primary Care IT systems to the ‘problem list’)

General practitioner: In addition to the above, to Past Problems I would include all operations (not just those mentioned above) and also add significant accidents and injuries as any could be relevant in the future and one cannot predict. (esp.if patterns emerge through a good longitudinal history, also any operative history may impact on future surgery)

Secondary care doctor: But perhaps avoid the word ""problem"" in the final nomenclature. A kidney transplant fits in the criteria above (correctly) but any patient who has experienced dialysis will not describe a transplant as a ""problem"" (and the term may offend a living donor who has donated that kidney).

Implications for guidance:

Confusion between listing a 'problem' and an 'active problem'.

Recommended change to document:

Use the wording 'condition' for the actual condition and 'active/inactive' or 'current/past' for problem status in relation to healthcare task management.

Sections 4.1.2 to 4.1.5

Do you agree with content of sections 4.1.2 ACUTE AND CHRONIC PROBLEM, 4.1.3 ACCURACY AND PRECISION OF PROBLEM TITLE, 4.1.4 SUSPECTED AND DIFFERENTIAL DIAGNOSES, 4.1.5 REFUTED DIAGNOSES?

Row Labels	Yes	No	I am not sure	Total
General practitioner	26 (51%)	16 (31%)	9 (18%)	51
Secondary care doctor	36 (69%)	9 (17%)	7 (13%)	52
Other healthcare professional	36 (88%)	-	5 (12%)	41
Info/ system	26 (57%)	13 (28%)	7 (15%)	46
Grand Total	124 (65%)	38 (20%)	28 (15%)	190

If you answered 'no' what changes would you recommend?

Summary of responses:

- Post-coordinated SNOMED CT
- How to 'delete'
- How to record if uncertain diagnosis or no exact diagnosis in SNOMED CT

Example responses:

General practitioner, Informatician: 4.1.5 Refuted diagnoses. If an incorrect diagnosis is deleted from the record which is not an uncommon requirement, the text term at least, and ideally the code, should remain visible in the record. Old consultation notes using the incorrect diagnosis must not be edited in retrospect and should ""read"" the same. Also refuted diagnoses sometimes turn out to be correct so it is important to be able to ""undelete"" a refuted and deleted problem title. … a patient with a refuted diagnosis must never appear in a search for patients with the disease, not should the code should not appear in any report published from the patient's record.

Informatician: 4.1.3 does not address the complexity of post-coordinated SNOMED CT expressions - deliberately? Where it is a single concept, the wording is fine. If the EHR allows post-coordination then I would also expect human-readable free text in case other EHRs cannot interpret the expression. 4.1.4 see earlier comment about differential ""diagnoses"" (plural) in the definition section 4.1.5 statement to ""delete any problems or diagnoses that are incorrect because they were entered in error"" needs to add something like ""subject to the EHR recording this in an immutable audit log"".

General practitioner, Informatician: Your concept of diagnosis correction is not lawfully valid. no entry made must ever be deleted. they can be removed from display and replaced by an updated and more accurate entry but the original must be retained along with the audit trail so that the record can be turned back to when the event occurred. ""Suspected condition"" is a valid read code entry and is used extensively by GPs.

Secondary care doctor: I have a problem for the 4.1.3 part that says the organism not to be recorded. This may be very important if you have a multi-resistant organism e.g. VRE, MRSA or an organism that you would only tend to find in immuno-suppressed people i.e. the full title give the added value of inferring extra issues with that patient. I thought that SNOMED-CT does incorporate organisms in the full diagnosis anyway?

Implications for guidance:

Recording episodes (first, new, continuing) is an alternative way of recording exacerbations. 'Delete/correct' still retains the audit trail. Reword the part about using the correct SNOMED term.

Recommended change to document:

- Change the wording of 'delete'
- More description about SNOMED CT coding

Section 4.1.6: Attributes of problems and diagnoses

The guidance recommends that the following information should be recorded for each problem or diagnosis, where possible:

Date of onset (record an approximate date if the exact date is not known).

- Which clinician, team or service is responsible for managing the problem, if not the general practitioner or the primary team looking after an inpatient.
- And for problems that are diagnoses, also record the following information about the diagnostic process, where possible:

Evidence for the diagnosis (e.g. history, or tests used to confirm it), if known.

- Which clinician, team or service made the diagnosis, if known.
- If it is a provisional or working diagnosis, rather than a confirmed diagnosis.

Do you agree that the above information should be recorded for each problem or diagnosis, where possible?

Row Labels	Yes	No	I am not sure	Total
General practitioner	28 (55%)	11 (22%)	12 (24%)	51
Secondary care doctor	40 (75%)	6 (11%)	7 (13%)	53
Other healthcare professional	33 (85%)	1 (3%)	5 (13%)	39
Info/ system	31 (65%)	6 (13%)	11 (23%)	48
Grand Total	132 (69%)	24 (13%)	35 (18%)	191

Summary of responses:

- Too much of a burden to record this evidence for all diagnoses
- Allow approximate dates
- Evidence may be available in other parts of records

Example responses:

General practitioner: Not possible or realistic in GP notes - the information is already there but in the open text - would start crowding and spoiling the problem list - date onset ok clinical team might be ok to add - but easily available as soon as you look at clinic notes anyway not possible to list diagnosis/tests etc - this is the notes not the problem list

General practitioner, CCIO: It becomes burdensome to include who is looking after a patient against each problem. The clinical correspondence includes that information.

General practitioner: problem should be a summary, not necessary to know what evidence/who made diagnosis will add too much information for a quick look

General practitioner: The issue is the recording. Ideally a common platform would be used with auditability of who added what. such as one gets in a computerized GP record. The danger that exists (and this is v real now in NI) is that there is a GP record computerized w summary morbidities & separately a NIECR to which hospital Drs can also add morbidities in the form of a problem list . This raises the question of which if any has primacy and whether there can be conflicting info between the two as important questions

Secondary care doctor, Informatician: Date yes. As per earlier comments I would advise against over-engineering the standards. Too much overheads on the EPR user will lead to non-interest in any standards. I disagree with an earlier perspective that outpatients is too busy, but inpatients is an environment where Problems should be recorded. … I would favour the key information being entry of a Problem with date.

Secondary care doctor: For date of onset, electronic patient records which demand exact dates often lack the flexibility of paper notes where a clinician can record e.g. '~10 years ago'. rather than an exact date.

IT system supplier, Informatician: Sentence: 'For problems that are diagnoses' we can say for Problems that can be converted to diagnoses as this line is unclear

Allied health professional: Often after a diagnosis is made there is not a single professional or team in charge of managing it. We also want to move towards self management so this follows an outdated model of healthcare.

Implications for guidance:

- Systems currently don’t have a structure for recording all this detail.
- This information could be linked rather than within the limited space available in the problem list.
- Information model for date of onset should allow approximate dates / durations
- Details of team managing may fit better in a care plan

Recommended change to document:

- Point to the location where the information is (e.g. link to investigation results) to avoid having too much information as part of the problem header.
- Recommend that this information is easy to find, but not that it has to be in the problem header itself.

Additional attributes of a problem

- Laterality
- What patient knows
- Past treatments
- Staging (cancer)
- Duration
- Formulation

Section 4.2: Maintaining Problem and Diagnosis Records

The guidance recommends that clinicians should perform a comprehensive review of all items on the problem list when they see a patient at the following points in a patient’s journey:

In primary care:

- First appointment after registration
- Review of chronic condition or medication review

In secondary care:

- Pre-admission clinic
- Admission to hospital
- Discharge from hospital

In any care setting:

- When writing a medical report based on the patient record, such as a transfer of care document
- When assuring the record for patient access
- When receiving a transfer of care document

Do you agree that a clinician should undertake a comprehensive review of all items on the problem list at these points in a patient's journey?

Row Labels	Yes	No	I am not sure	Total
General practitioner	26 (52%)	14 (28%)	10 (20%)	50
Secondary care doctor	32 (62%)	10 (19%)	10 (19%)	52
Other healthcare professional	30 (79%)	3 (8%)	5 (13%)	38
Info/ system	32 (67%)	11 (23%)	5 (10%)	48
Grand Total	120 (64%)	38 (20%)	30 (16%)	188

If you answered 'no', what point in the patient journey do you think should be omitted and/or what additional points in a patient's journey should a comprehensive review should take place?

Summary of responses:

- Not feasible within time constraints
- Unclear what 'comprehensive review' means

Example responses:

General practitioner, CCIO: It is impractical to review all items on the problem list in general practice at every chronic disease. Think should be limited to updating significant active problem list.

General practitioner: There's a degree of digging a hole here. If you say "should" then it becomes "must", which is impossible: Not in 10 minutes. Give me half an hour. Meds reviews get done more carefully (by me). You need many more GPs for this. Ideally problem lists get reviewed regularly and cleaned up, with patient involvement, but triggering reasons may be a referral or report to send.

General practitioner, IT system supplier: Increasingly, the electronic health record is not just visible to the organisation who are the data controller. For example in a GP setting, the record may be visible to patients via an app, GP connect, Summary Care Record Another crucial point is upon registration (ie before first appointment). Unfortunately GP2GP does not transfer equally translated problem lists eg group/combine/evolve and so the problem lists need tidying up at registration.

Secondary care doctor: It depends on the consultation – it's not possible to review all problems at all times

Allied health professional: but I think you need to define what a ""review"" comprises. Also primary and secondary care examples are easy as the patient and/or relatives and carers are likely to be present to confirm the details but not in the any care setting

examples. Also, there might be details that are not relevant or sensitive to discuss at certain points in a patient's journey.

Implications for guidance:

Define what a 'review' consists of, i.e. verifying that the list is correct versus reviewing the condition itself.

Recommended change to document:

- Define 'review' as 'verifying that the list is correct'
- Maybe change to 'clerking' as creating an up-to-date problem list is part of the process.
- Review and edit problems and conditions within domain

Section 4.2: Active / inactive problems

Do you agree with the content of sections 4.2.2 ACTIVE AND INACTIVE PROBLEMS, 4.2.3 PROBLEM LISTS IN INPATIENT SETTINGS, 4.2.4 PROBLEM LISTS IN SECONDARY CARE OUTPATIENTS?

Row Labels	Yes	No	I am not sure	Total
General practitioner	36 (73%)	5 (10%)	8 (16%)	49
Secondary care doctor	39 (76%)	7 (14%)	5 (10%)	51
Other healthcare professional	33 (87%)	1 (3%)	4 (11%)	38
Info/ system	34 (74%)	7 (15%)	5 (11%)	46
Grand Total	142 (77%)	20 (11%)	22 (12%)	184

If you answered 'no', what changes would you recommend?

Summary of responses:

- Problem lists should be kept up to date
- Unclear what 'remove' problems on discharge means
- Use wording of health professional, not just doctor

Example responses:

General practitioner: Yes, but some old ""inactive"" problems might prompt you to think again - or talk in a different way to a patient - miscarriages for instance. If primary and secondary care are sharing records, do we need different views, and should we be able to see the other view?

General practitioner: Again need to keep problems mainly limited to one screen full Will take a lot of education and buy in to get clinicians to do this

General practitioner: I always worry about some important diagnoses slipping on to the inactive list when they still have implications, eg. CVA and acute MI. Patients will be taking

medication as a result of these diagnoses, yet they frequently slip onto the inactive list (and get buried by other ‘problems’).

General practitioner, Informatician: 4.2.2 I think this is ideal but the functionality is dependent on the system so may not be possible or easy. The definition of active or inactive could maybe be expanded. 4.2.3 OK 4.2.4 OK but this is the only place where the time and resource constraints of generating and maintaining problem lists has been referenced. Guidance needs to be pragmatic and implementable, so consider when (as above) describing when comprehensive review of problem list should be undertaken.

Secondary care doctor, Informatician: 4.22 Active vs Inactive - I agree 4.23 I agree. Capture symptoms on admission if diagnoses not known. Problem diagnoses should be captured on or after ward rounds, with consultants and SpR’s guiding the junior doctor team, in which structured terms should be added to the record. They should start to build a discharge letter progressively during an inpatient stay, to ensure accuracy of information and to reduce the letter compiling burden at the point of discharge 4.24 I do not believe that Problems in structured term form should not be captured in outpatients. It is vital we develop extractable diagnosis data on our outpatient groups to be able to define disease cohorts and be able to manage cohorts better, including QA, and to support service re-design. Whilst casemix in very specialised casemix clinics can be implied, in general speciality clinics, that is not the case. This is one of the “”delta change“” areas, where we need to capture data, to add to the refined current GP data, to map whole system disease management. We cannot expect to pass this task and responsibility onto GP’s

Implications for guidance:

Must include a chronic problem for acute conditions with ongoing implications

Recommended change to document:

- Change the working of ‘on discharge’…
- Expand the definition of active / inactive

Section 4.3: Communicating Problems and Diagnoses

Encounter problems must be recorded on all discharge letters and clinic letters. Other problems should also be recorded if they impacted on the patient’s care during the episode, as this helps to ensure that coding and billing are accurate. However it is not necessary to include a comprehensive list of inactive problems that have no ongoing impact.

Do you agree with the above statement?

Row Labels	Yes	No	I am not sure	Total
General practitioner	39 (76%)	7 (14%)	5 (10%)	51
Secondary care doctor	43 (86%)	4 (8%)	3 (6%)	50
Other healthcare professional	33 (87%)	1 (3%)	4 (11%)	38
Info/ system	37 (77%)	4 (8%)	7 (15%)	48
Grand Total	152 (81%)	16 (9%)	19 (10%)	187

Summary of responses:

- May be helpful to include inactive problems if the GP does not know
- Too much emphasis on billing and coding

Example responses:

General practitioner: Pity, I see we are not going to have a seamless system between primary and secondary care and do away with letters, rather than a summary that is on the electronic record.

General practitioner, CCIO: Think “”other problems should be recorded if they impacted on the patient’s care during the episode“” should be a little more comprehensive and include something like “”…along with other major active problems“”. Agree that minor and inactive problems should not be included

General practitioner: “”as this helps to ensure that coding and billing are accurate “”. Billing should not be the primary concern for the patient record. “”as this helps to ensure that coding and targeted patient follow up are accurate “” would be more appropriate

Secondary care doctor, Informatician: Yes - GP’s need to know new Problems and Diagnoses and Procedures, relating to 2ry care. Known Problems relevant to the episode of care, should be included. We should not be regurgitating a whole lot of previous data the GP and GP system already knows. GP’s should be involved in the co-design of locality hospital e-discharge letters to ensure their needs are met, with a perspective on usability.

Implications for guidance:

Maybe need specific recommendations depending on the level of integration with the GP record.

Recommended change to document:

Change the emphasis from billing to quality data for follow-up, audit etc.

Section 4.4: Using Advanced Features of Problem-Oriented Records

Do you agree with the content of the sections 4.4.1 LINKING PROBLEMS TO OTHER DOCUMENTATION, 4.4.2 MAJOR AND MINOR PROBLEMS?

Row Labels	Yes	No	I am not sure	Total
General practitioner	33 (67%)	5 (10%)	11 (22%)	49
Secondary care doctor	34 (68%)	8 (16%)	8 (16%)	50
Other healthcare professional	29 (78%)	4 (11%)	4 (11%)	37
Info/ system	24 (51%)	13 (28%)	10 (21%)	47
Grand Total	120 (66%)	30 (16%)	33 (18%)	183

Summary of responses:

- Major / minor is difficult to define.
- Wording ‘significant’ may be better than ‘major’
- Overlinking can be a problem

Example responses:

General practitioner: yes definitely for 4.4.2 beware over-linking - e.g. causes problems if you change a diagnosis - and needs a more pragmatic approach to reduce bureaucracy

General practitioner: 4.4.1 - what about linking multiple problems to the same documentation? sometimes can be attribute to multiple conditions 4.4.2 - Please define what considered as ‘Major’ and ‘Minor’ problem - or you could set an estimated time of resolution of the problem, by which the problem automatically becomes inactive?

IT system supplier: 4.4.1 Linking problems to other documentation - Recommend adding the following bullet points: • Handover • Progress Notes • Discharge Summary

IT system supplier: 4.4.2 - There a feeling that differentiating between a major and minor problem on a problem list adds too much additional information given that they problem will also be associated to a diagnosis / condition. It would be good to have examples of positive use cases where this differentiation is appropriate in an electronic system in particular other than as a medium for filtering.

Implications for guidance:

- Remove the guidance on how to use major/minor and instead include the caveat that it is used differently in different settings and not to rely on it too much.
- Is major/minor really a useful feature? Is it more a feature of the diagnosis itself and should be built into diagnosis information models / clinical decision support?
- Some linking is helpful but a better search feature may be more useful than overlinking (e.g. look for all drugs that can be used to treat condition X rather than all prescriptions that have been manually linked to condition X.)

Recommended change to document:

- Start with the caveat that some systems have these features which are already in use.
- Suggest that linking may be helpful but overlinking not so.

Any other comments

Summary of responses:

- Mostly relevant to secondary care; GPs already doing this
- Good to improve quality of documentation
- Concerns about increased workload

Example responses:

General practitioner: My main concern is we are drowning delivering normal care. We need resources to tidy up problem lists and code better. It will seem low down list as it doesn't feel high priority compared to some areas

General practitioner: Very helpful to have guidelines. As a GP current data dumps from secondary care/ community very difficult to read. Coding has to be the answer to flagging key information but a massive education and prioritisation job to get clinicians and other users of notes to understand why they are being asked. Returning to what will be displayed as a new clinician and asking whether they will get relevant information easily displayed will be useful Asking patients views - they are the ones who are present at all encounters - might help

General practitioner: It's nice to have guidance, and for it to be aspirational. It should be used to campaign for better, more integrated IT systems with a shared record with patient read/write access. It should not be used as a stick to beat overworked clinicians with when they fall short of the guidance. I fear it will be used for the latter, not the former. P.S. I did not leave my details as Survey Monkey uses servers outside of the EU and therefore you can't guarantee the safety of my details.

General practitioner, Informatician: I suspect that most of the recommendations in this paper have more relevance to secondary care, as many of us in primary care have been keeping problem-oriented records that meet these criteria for at east 25 years. This guidance will be facilitated by clinicians completing the electronic records themselves, rather than relying on back-office coders, and this will have implications for training and other resources.

General practitioner: Useful document to read. held clarify how to code/document problems and major vs minor.

General practitioner, Informatician: For secondary care this may seem a giant leap forward, for GPs this is a non event. We are also unique in that we have our Good Practice Guidelines. These are professionally held guidance / instructions referred to in statute and every GPs contract. these are what we are practice to and are judged by. PRSB recommendations will thus have little relevance where we already operate under legislation. In addition much of this is set at a level that GP systems surpassed decades ago. Good that you are trying to catch up though!

Allied health professional: Overall, whilst I can see the logic behind using this type of system for physical health, I do not think that it works when applied to mental health or the crossover between physical and mental health. Mental health if incredibly complex, and I don't think it can or should be reduced to a diagnosis which is highly contentious. It does not look like the draft documentation has been thought about from a mental health perspective.

Implications for guidance:

- Maybe state that GPs already have guidance, and this is broader, particularly aimed at secondary care
- Maybe state the need for guidance now (shared records, EHRs in secondary care)

Recommended change to document:

- Make it more relevant to mental health
- Include reassurance that it should not mean taking more time, but using time and resources more effectively