The synopsis record card: a stepping stone to the computer

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SUMMARY. A synopsis record card has been developed for use in general practice to provide ready reference to the important facts of the patient's record. When such a card is available in the record wallet it is used at 50% of all patient consultations and significantly reduces the time needed to retrieve past data essential to the consultation. The card contains clinical details, and data on medication, drug idiosyncrasies, immunizations, screening procedures, social, occupational and family history and practice research. As synopsis records are particularly important in teaching practices and when referral letters to hospital or personal medical attendant insurance reports are written, provision has been made for the inclusion of data relevant to those functions. So that the card may act as an intermediary for record computerization, all elements needed in the construction of a computer record have been taken into account. The prototype card was circulated to 3000 RCGP members for comment and the majority of replies were favourable. Suggested modifications have been incorporated in the final design of the card.

Introduction

MOST attempts to reform the patient's record in general practice are based on the principle that those facts which are most important to patient care should be disentangled from the mass of detail in which they are embedded, and displayed prominently.[1] The summarizing process needs to be applied to both the general practitioner's handwritten record notes and to the hospital reports received. The summary record therefore may take the form of an additional card in the patient's NHS medical record envelope, an extra sheet in the A4 record or a summary history display on the computer.

In its simplest form the summary record is a list of past diagnoses and operations with dates. It can be expanded, for example, to relate medication to the condition for which it was prescribed, or the name of a surgical operation to its indications and sequelae. The summary record can also be elaborated to incorporate special sections for drug idiosyncrasies, immunizations, screening procedures, social, occupational and family history, repeat medication and practice research data. When these features have been added, the document is no longer a mere summary history but a synopsis of the whole patient record.

When it is available, the synopsis of the record is accessed at 50% of all patient consultations and reduces the time taken for data to be retrieved.[2] Although its primary use is in patient management, the Joint Committee for Postgraduate Training in General Practice have emphasized the importance of the synopsis as a teaching instrument in training practices. Synoptic records are also useful when writing referral letters to hospital. Similarly, they can be accessed when preparing personal medical attendant insurance reports, and a survey of insurance companies suggests that the majority would be prepared to accept a copy of the modified synoptic record in place of an insurance questionnaire.

As yet, relatively few practices store their patient records on computer, both because of the cost of computers and because of the significant amount of work needed to abstract data from the existing manual record. Yet the progress towards computer records is relentless; multiple purpose-oriented records can be easily maintained from a single data entry, overflow in discrete record areas is less likely to be a problem, 'shoe horn' entry techniques can be used to speed data entry, and basic data can be automatically reformatted to produce letters and reports. A stepping stone is needed in the transfer of data from manual records to the computer. All important data needed for future patient management must be compiled on a single document before entry onto computer. A synoptic record card is the ideal transition phase, provided it can be designed to contain all the data needed as the basis for the new computer record.

The large number of different designs of summary records in current use with the NHS medical record envelope (the present survey identified more than 50) suggests that no single card meets with general approval. In an exercise to pool the features most commonly incorporated, and adapt the design of a synoptic record card so that it can fulfil its roles in teaching, insurance reporting and data transfer to computers, a prototype has been developed. After a pilot exercise in 10 general practices this prototype was circulated to 3000 RCGP members for their comment.

Design of the prototype card

The card was designed primarily for use with the FP5 and FP6 medical record envelopes, although it could also be incorporated in an A4 record if appropriately perforated. A single card folding in half to a rectangle measuring 4.5 inches × 7.0 inches was chosen so that it would fit the wallet, but protrude slightly above the 'continuation cards' at the open end of the wallet. This protrusion facilitates preferential use of the card at consultation and enables staff to identify those wallets which have been processed. A card of rather heavier quality than the record wallet was used to resist wear.

Structured general practice records commonly segregate each category of data into a discrete and limited area of the record. The results of this policy are either that enough space must be allocated within each category to satisfy the maximum possible requirements (in which case multiple summary cards are necessary), or else too little space is allocated and overspill problems arise. Many record envelopes are already too full, so that one card must suffice for most patient records and accommodate sufficient data for the summarization of old records and for continuing use at consultations for several years.

In order to optimize the use of available space a design of card is required which allows fixed details to occupy boxes, and other data to be added without constraint. Two expandable areas are provided on the card as vertical columns parallel to each other (Figure 1). The left hand column (clinical details) is shared

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by summaries of episodes of illness in general practice and hospital. The right hand column (general practice treatment) is used to record medication and also immunization.

The prefix H is used to distinguish hospital-based information and X prefixes X-ray reports. The symbol £ is used as a preface for repeat medication and ↑ for immunizations. Because the clinical observations and treatment columns run parallel to each other, medication can be clearly related to the condition for which it is used and a single date entry will suffice for both. The concept of expandable areas shared by several categories of data results in a record which is equally suitable for the contrasting data requirements of young and old, male and female, travellers and non-travellers alike.

The space allowed for expanding data on the card was calculated on the basis that both single diagnostic terms and compound term statements would be used in summary, that handwritten capital letters would be used throughout, and that each statement would begin on a new line. Thus 55 lines of 3.5 inches length (each line accommodating about 34 characters) provides sufficient room to accept the summary record entries in 98% of all general practice records. Most other summary cards designed for the medical record envelope are inadequate in this respect.

The expanding area for clinical observations is the most critical as regards space allocations — the general practice treatment entries will not occupy all lines, but here it is important to ensure that a single entry can always be accommodated on one line. By contrast a compound entry in clinical observations may occupy two or more lines. Boxed areas for the fixed details were selected so as to provide the classes of information regularly required for referral letter writing, insurance reports and record computerization. Computerization requirements must include those data needed for communication with the family practitioner committee and for prescribing.

The use of a single card synopsis of this type does not allow, for example, for summaries of pathology test results or surveillance of hypertension or diabetes. The solution is either to use a separate card of different design or one of the same design whose different role is clearly indicated by a symbol entered in the space provided at the top (Figure 1).

Assessment of the synopsis record card

The card was originally developed as an amalgum of a suite of summary cards used for converting manual records into computer records in a single general practice. Its advantages over the unstructured general practice record were apparent even before computerization. The card was then offered to 10 general practices for use and comment on an informal basis. The encouraging response to this pilot trial laid the foundation for wider appraisal.

In November 1985 3000 RCGP members were circulated with a copy of the prototype card accompanied by an explanatory letter, a short questionnaire and a free post envelope. Replies were received from 484 members: 315 (65%) respondents found the synoptic record card very suitable for use in their practice,

SYNOPSIS RECORD CARD:

IF ADDITIONAL CARD USED FOR SPECIAL PURPOSE, ENTER CODE P FOR PATHOLOGY H FOR HYPERTENSION - etc.

(FOR CASE ASSESSMENT — REFERRAL LETTERS PMA INSURANCE REPORT — TEACHING PRACTICE COMPUTER TAKE-ON)

Sex M/F Title	Surname — Forename(s)				Birth Date
Previous Surname	GP No.	NHS/Private	NHS No.	Date Reg.	Date NHS Record Began

Address and Postcode	First Change	Second Change
Telephone No.		

FPC Code if Practice deals with more than one FPC	Mileage Units	Hospital Nos.			

Prejudicial Family — Occupational — Social History/Tobacco Alchohol/Practice Research Data

Adverse Drug History

Clinical Details — Permanent Data Summary of Important Morbidity — Operations — Accidents — Confinements — Special Investigations Prefix H for Hospital Data — X for X-Ray Data		GP Treatment — Permanent Data Prefix £ Long Term Medication Prefix ↑ Immunisations
Date		

Urine Protein/Sugar First abnormal if any / / =	Urine Protein/Sugar Other Recordings / / =	/ / =	/ / =
Blood Pressure First Abnormal if any / / =	Blood Pressure Other Recordings / / =	/ / =	/ / =
Prepared by	Verified by	Input by	

Clinical Details — Permanent Data (Continued) Summary of Important Morbidity — Operations — Accidents — Confinements — Special Investigations Prefix H for Hospital Data — X for X-Ray Data		GP Treatment — Permanent Data Prefix £ Long Term Medication Prefix ↑ Immunisations
Date		

Figure 1. *Final format of the synopsis record card (front and back of card shown unfolded — broken line represents fold).*

both for the purpose of patient management and for teaching; 62 (13%) thought the card moderately useful; 107 (22%) thought it not very useful. The questionnaire provoked a considerable amount of constructive criticism and comment which was directed towards modification of the prototype card. In particular, the methods for recording drug idiosyncrasies, telephone numbers, standard urine tests and blood pressure readings on the prototype card were shown to be inappropriate and were modified as a result. Figure 1 shows the final format of the card.

The questionnaire also asked about current use of summary cards; 128 practices reported that they were already using summary systems. An unexpected finding was the number of individualized summary records used in practices. No less than 42 different records had been constructed to individual practice specifications to fit the medical record envelope. Forty-one practices reported using the unstructured NHS 'summary of treatment' card for summary data, three practices used the RCGP summary cards and a further 12 used a variety of other commercially available summary cards designed for inclusion in the medical record envelope. Fourteen practices reported using A4 summary sheets, and 14 practices were already using computer generated record summaries during consultation.

References

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