Australian Doctor.

Benefit from record building

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History repeats itself if managed properly.

THE most misunderstood part of Medical Director, and most other clinical software programs, is how the patient history is built up and visits recorded in the progress notes.

There is also a widespread misunderstanding of how summary items work.

When running training courses for GPs I usually mention the 20/80 rule — you only take in 20% of what is being taught. However, when teaching how to build accurate patient histories, I stress that this is one area you must understand 100%.

If you don't record histories accurately this impacts on:

- The accuracy of your summaries and referrals.
- The capacity to create accurate disease registers.
- Disease/medication interaction warnings being issued.
- The ability to do meaningful database searches.

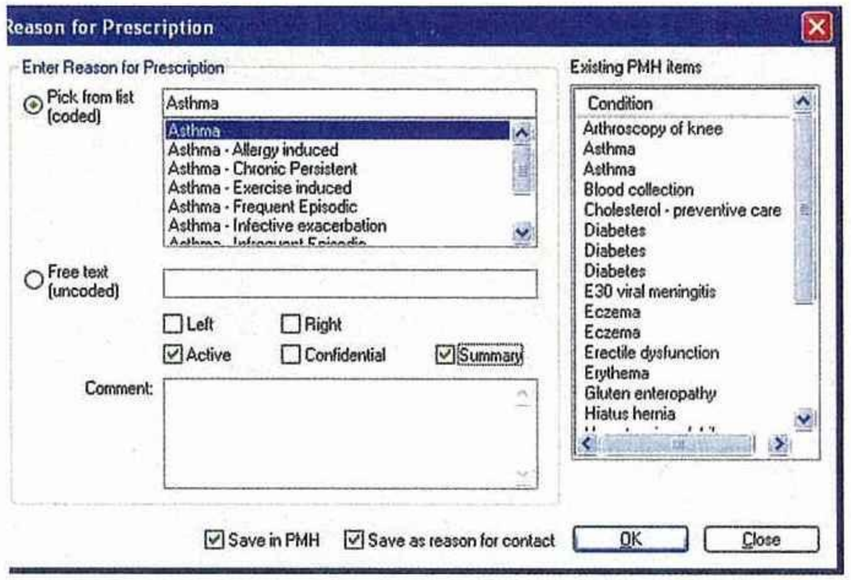
Pick from list

Pick from the coded list of drug/disease interactions to ensure they will be recognised. Free text (uncoded) entries may not be recognised for interaction checking and creating disease registers.

Summary

Tick the Summary box for 'major' history items and these will then be listed in summaries and referral letters to specialists. A 'yes' appears in the Summary column of the Past History items when this is done.

Some GPs insist they have added history items yet nothing appears under the History list in their referrals. This is fixed by clicking in the Summary box for the important history items.



Record a 'reason for contact' by ticking the 'save as reason for contact' box in the 'reason for prescription' window.

Save in PMH

This adds the history item to the patient's past history. Items will only appear on referrals and other documents if the Summary box is ticked.

Save as reason for contact

This indicates the primary reason for a visit and will be recorded as the reason for the patient's visit in your progress notes.

Hints

1. Always check the past history list before doing a referral, in particular check the Summary column. Only information with a 'yes' will appear in the printed history list. If you see a 'yes' where there should be a 'no', double click on 'yes' and this takes you to the Edit History Item window. Click in the Summary box to remove the tick and click okay — a 'no' will now appear next to that history item.
2. Avoid using free text in patient summaries.
3. Make sure a 'Reason for contact' is recorded in the progress notes for all visits. This is done by ensuring there is a tick in the 'Save as reason for contact' box when completing the 'Reason for Prescription' window. If not prescribing, go to the progress notes and click on the 'Reason' tab to open the 'Reason for contact' window. By filling this in you are ensuring the 'Reason for contact' is recorded for past visits.
4. To add retrospective history items click on the 'Past History' tab in the patient clinical screen. Right click and select 'New' item. Double click on the year (2007) and overtype with the correct year. Double click on the date (today's date) and delete, because you most likely don't know the date of the diagnosis or event. Complete the rest as you would for the 'Reason for prescription'.
5. Make sure that all GPs and other responsible staff are consistent in the way history items are added.

Mr Stewart has written 11 training books for Medical Director, trained more than 2000 GPs in clinical software and runs an IM help desk. He publishes a weekly 'IM problem solved' and 'Medical Director hint' in the division's weekly electronic newsletter available at www.nevdgp.org.au
His 'Computers' column will appear every month in *Australian Doctor*.