

**The evaluation of an MSWord[®] Summary
Patient Record (SPR) for communication
between hospitals, patients and primary care
facilities.**

Paper No. 51.0

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COMMUNICATION OF MEDICAL CARE IS BASED ON THE AVAILABILITY OF AN ADEQUATE MEDICAL RECORD.

Ed Shortliffe-Stanford University Shortliffe E, Perreault L. Medical Informatics-Computer Applications in Health Care. Adisson-Wesley. 1990

SUMMARISATION:

1. Communication is maintained

Fries. J. Alternatives in medical record formats. Medical care. 1974;12:871-881

2. Can serve as the sole source of clinical information in OP follow-up encounters.

Decision Support tool.

Whiting-O'Keefe QW, Simborg DW, Epstein WV, Medical Care 1980;18:842-852

COMMUNICATION DEFECTS

[HOSPITALS TO P.CARE-*Kripalani, Feb2007.*]

Direct communication	3-20%
Discharge summary	
First post-discharge visit	12-34%
At 4 weeks	51-77%
Quality of care affected	25%
PCP dissatisfaction	
Diagnostic results missing	33-63%
Hospital Treatment missing	7-22%
Discharge medications missing	20-40%
Pending Test results –absent	65%
No Patient / family counselling	90-92%
Follow-up plans documented	2-43%

2007-

Interventions, including computer-generated discharge summaries and using patients as couriers, shortened the delivery time of discharge communications.

Use of standardized formats to highlight the most pertinent information improved the perceived quality of documents.

Kripalani, Sunil MD, MSc; LeFevre, Frank MD; Phillips, Christopher O. MD, MPH; Williams, Mark V. MD; Basaviah, Preetha MD; Baker, David W. MD, MPH. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians Implications for Patient Safety and Continuity of Care JAMA. 2007;297:831-841

Discharge summaries should include:

1^o and 2^o secondary diagnoses

Pertinent Medical History and Physical findings

Hospitalization Dates, Rx, brief Hospital course

Results -procedures / labs

Recommendations of subspecialty consultants

Information given to the patient and family

Patient's functional status at discharge

Reconciled medication regimen

Details of FU arrangements / needs

Contact information of responsible hospital physician.

Discharge summaries :FORMATS

Structured - subheadings

Highlight pertinent information for FU care

Ensure that all essential topics are addressed

Use IT where possible

Extract information (Summarisation)

eg, medication names and doses

Facilitate rapid completion of summaries

Patients should be given a copy

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Surname: _____ Given Name: _____ DOB: _____ URN: _____
Address: _____ Phone: _____

THIS COPY REPLACES ALL PREVIOUS VERSIONS OF THIS RECORD

Hyperlinks to record subpages: FOLLOWUP, DIAGNOSIS, TREATMENT, HISTORY, SYSTEM REVIEW, EXAMINATION, REFERRING
HYPERLINKS to subpages: On To Link, RADIOLINK, On To Link, Report only, On To Link

Patient's Email:

ALLERGIES:

MEDICATION	DOSE	ADMIN TIMES	0600	0800	1200	1400	1800	2000	2200	COMMENTS

PATIENT REFERRED: _____ Provide No. 026948B TO: _____ DATE: _____

Print: Patient: YES NO Print Doctor(s): YES NO Email Patient: YES NO Email Doctor(s): YES NO

ADMISSION DATE: _____ DISCHARGE DATE: _____ IN HOSP VISITS: _____

FOLLOW UP:

Purpose of Review: _____
Assessment: _____
Investigations: _____
Management: _____
Review: _____

DIAGNOSES LIST

Principal Diagnosis (FOR LATEST ADMISSION)	DATE (IF KNOWN)	ACTIVE Y/N

Co-morbid Diagnosis	DATE (IF KNOWN)	ACTIVE Y/N

Date: _____ Procedures: _____ Results if known: _____

DATE: _____ (of initial history)

INITIAL HISTORY: _____

SYSTEM REVIEW:

Occupation: _____
Smoking: _____
Alcohol: _____
Family: _____
5/10/10-20/20:
SOCIAL, MODERATE, HEAVY (Gms/6 or 10 Serves/7 Teas/6 spoons)
F | M | SIBS | CHILDREN |

CARDIAC	RESP	GIT	RENAL	ENDO	NEURAL	HEMAT	RHEUM	DERMAT
ANGINA	ASTHMA	GERD	CRF	DIABETES	CVA/TIA	WARFARIN	OA	PSORIASIS
ARRHYTHMIA	COPD	BARRETT'S	ARF	THYROID	DEMENTIA	BLEEDING	RA	MALOCY
HT	EDF	PUD	CALCULI	STEROIDS	EPILEPSY	VTE	GOUT	

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Surname: _____ Given Name: _____ DOB: _____ URN: _____
Address: _____ Phone: _____

THIS COPY REPLACES ALL PREVIOUS VERSIONS OF THIS RECORD

CABG	OSA	NSAID/COX GASTRITIS	PROSTATISM	OPOROSIS	NEUROPTHY	LYMPHOMA	PSORIASIS	
STENT	STERIOD RX	BD	INCONTINENCE	OBESITY	MYOPATRY	MPO	ANK SPOND	
VALVE	MALIGNANCY	BS	HEMATURIA	PCOS	PARKINSONS	LEUKEMIA	SLE	
C/MYOPATHY	ASBESTOSIS	CERROSIS	NEPHRITIS				SCLERODERMA	
PVD	EXPOSURES	MALIGNANCY	MALIGNANCY					
CVD	TRANSPLANT							
CONGENITAL	CYSTIC FIBROSIS							
OTHER	OTHER	OTHER	OTHER	OTHER	OTHER	OTHER	OTHER	OTHER
MEDICATION COMPLIANCE								

INITIAL EXAMINATION DATE:

GENERAL APPEARANCE: _____ HEIGHT(CM): _____ WEIGHT(KG): _____

CARDIAC
ECG
RESPIRATORY
CAROTIDS
ABDOMEN
RENAL
ENDOCRINE
RHEUMATOLOGY
HEMATOLOGY
DERMATOLOGY
LEGS
NEUROLOGICAL

REFERRING PRACTITIONER: JERRY.HANNAN@LTHSA.GOV.AU

NAME: _____ ADDRESS: _____ PHONE: _____ FAX: _____

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Hyperlinks to record subsections: [FOLLOWUP](#); [DIAGNOSIS](#); [TREATMENT](#); [HISTORY](#); [SYSTEMREVIEW](#); [EXAMINATION](#); [REFERRING](#)

HYPERLINKS to databases: [Go To Labs](#); [RADIOLOGY](#); [Quality Report.mdb](#); [GasO2.mdb](#)

Patient's Email:

ALLERGIES:

MEDICATION	DOSE	ADMIN TIMES	0600	0800	1200	1400	1800	2000	2200	COMMENTS

Launceston LIVE - Microsoft Internet Explorer

Date Collected : 03/03/08 31/01/08 10/12/07 24/09/07
Time Collected : 12:23 11:30 16:47 11:40
Episode : L69032 L58098 L41629 L14671 Units Reference Range

HAEMATOLOGY

Hb	: 122 L	118 L	130	124 L	g/L	(130-180)
RCC	: 4.8	4.5	4.9	4.7	10 ¹² /L	(4.0-6.3)
Hct	: 0.38	0.35 L	0.39	0.37 L	L/L	(0.38-0.52)
MCV	: 78 L	78 L	80	80	fL	(80-96)
MCH	: 25 L	26 L	27	27	pg	(27-34)
Platelets	: 271	229	268	253	10 ⁹ /L	(140-440)
TOTAL WCC	: 6.7	6.5	10.4	7.7	10 ⁹ /L	(4.0-11.0)
Neutrophils	: 6.9	4.7	8.2 H	5.9	10 ⁹ /L	(2.0-7.5)
Lymphocytes	: 1.2 L	1.1 L	1.3 L	1.1 L	10 ⁹ /L	(1.5-4.0)
Monocytes	: 0.5	0.5	0.7	0.5	10 ⁹ /L	(0.2-1.0)
Eosinophils	: 0.1	0.1	0.1	0.2	10 ⁹ /L	(<0.5)
Basophils	: 0.0	0.0	0.0	0.0	10 ⁹ /L	(<0.3)

Date Collected : 03/03/08 31/01/08 10/12/07 24/09/07
Time Collected : 12:23 11:30 16:47 11:40
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SERUM CHEMISTRY

Sodium	: 138	138	140	140	mmol/L	(136-145)
Potassium	: 4.1	3.4 L	3.8	4.1	mmol/L	(3.5-5.1)
Chloride	: 97 L	100	105	111 H	mmol/L	(98-108)
Bicarbonate	: 29	25	26	23	mmol/L	(23-29)
Creatinine	: 116	129 H	145 H	104	umol/L	(60-120)
Urea	: 7.2 H	8.1 H	5.5	4.5	mmol/L	(2.5-6.4)
eGFR	: 56 L	50 L	46 L	>60 L	mL/min/1.73m2	
CRP	: 8 H	6 H	7 H	7 H	mg/L	(<5)
Random Glucose	: 5.6	6.3		9.8 H	mmol/L	(3.5-7.9)
AST	: 18	16	19	17	U/L	(5-34)
ALT	: 32	26	29	31	U/L	(10-35)
Bilirubin	: 9	8	9	9	umol/L	(<17)
ALP	: 117	107	114	122	U/L	(53-128)
Gamma GT	: 45	37	37	50 H	U/L	(10-49)
Total Protein	: 70	66	68	64	g/L	(60-83)

Carestream Client (Newy Hannan) - EDWARDS DAVID WILLIAM, 584642, 07/07/2006 (Read) - Open For Viewing - (Reading is prohibited.)

File Edit View Processing Windowing Graphics Sessions Tools Help

Viewer/Viewer (1) - EDWARDS DAVID WILLIAM, 07/07/2006 (READ)

AM.Lossy (1/2): Ratio = 14.00 07/07/2006 11:23:15 AM SW 8.00 mm Tech ID: MRL NONE 55% Pixel

WILLIAM.Lossy (1/2): Ratio = 14.00 07/07/2006 11:23:16 AM SW 8.00 mm Tech ID: MRL NONE 55% Pixel

Neutral Film Preview Viewer/Viewer [NU]

Examples of *Hyperlink* functionalities.

SURNAME:	COOKE	GIVEN NAMES:	BRYAN	DOB:	08/01/1946	URN:	111111
ADDRESS: 121 COOKE ROAD RIVERSIDE 7250							

PRIVATE AND CONFIDENTIAL-TO BE READ BY ATTENDING MEDICAL OFFICER(S) ONLY.

Hyperlinks to record subsections: FOLLOWUP; DIAGNOSIS; TREATMENT; HISTORY; SYSTEM REVIEW; EXAMINATION; REFERRING
HYPERLINKS to databases: GO TO LAB; RADIOLOGY; SHARE TRIAL; TREAT TRIAL; GEP DOSE CALCULATOR

Patient's Email: hcooke@bigpond.com.au

ALLERGIES: ACEI-COUGH; STATINS-MYOPATHY;

MEDICATION	DOSE	0600	0800	1200	1400	1800	2000	2200	COMMENTS
Atacand 16mg	16mg		16mg						
Cartia 100mg	100mg		100mg						
Lamis	As directed		As directed						
Nexium 40mg	40mg							40mg	
Neurotin 600mg	600mg		600mg		600mg			600mg	
Vitamin									Cease 14/09/2006
Oxycodone									Ceased
Alodorm 5mg	1.25 mg							1.25mg	
Humalog	As directed		As directed		As directed				Ceased
Protaphane	As directed		As directed		As directed				Ceased

<http://ehr.nlm.nih.gov/condition=familialadenomatouspolyposis>

PATIENT REFERRED BY AND DATE OF REFERRAL: (OROP) Dr Someone 14/09/2006

PATIENT REFERRED	Provider No.	TO:	DATE:
	0124545B		

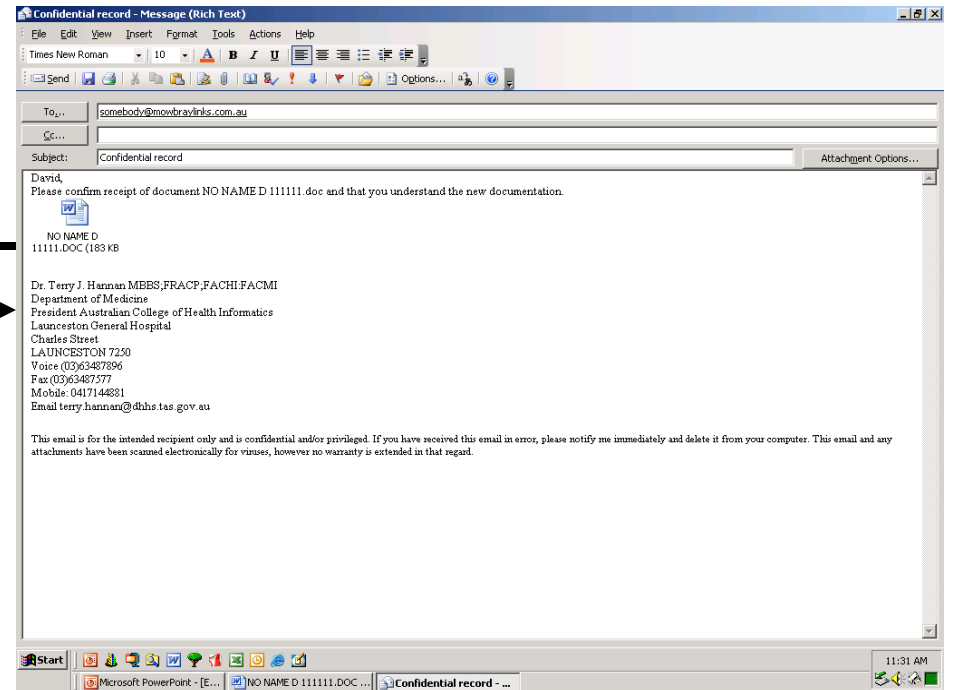
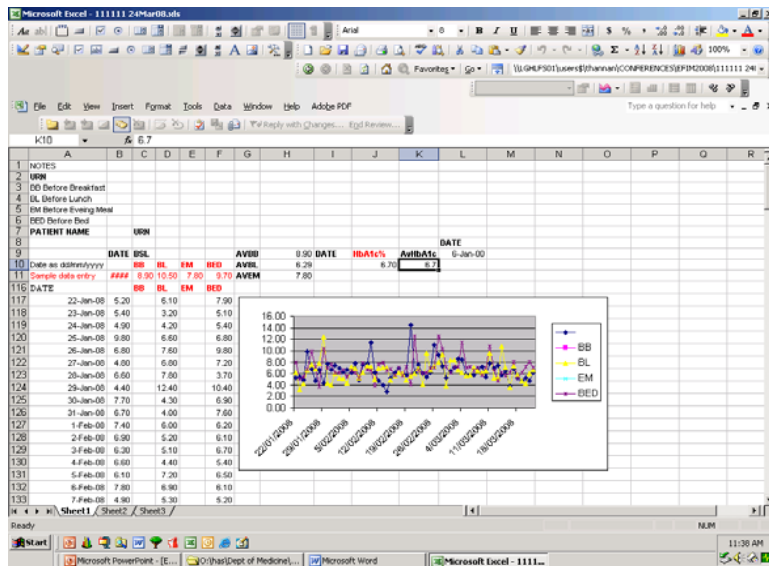
ADMISSION DATE: DISCHARGE DATE: IN HOSP VISITS

GUIDELINES FOR INSULIN ADJUSTMENT:

BSL: 10-15 mmol/l. Add 2 Units of insulin every 2nd day till BSL < 10 mmol/l
BSL: 15-20 mmol/l. Add 4 Units of insulin every 2nd day till BSL < 10 mmol/l
BSL: >20 mmol/l. Check you are not unwell. E.g. Urinary infection, temperature, dietary breakout etc. CALL the clinic or local doctor.
IF in isolated situation and re-testing confirms BSL >20 mmol/l give 10 Units of Novorapid Intramuscularly and repeat BSL every hour for 4 hours.
BSL <3.5 AND awake take Glucose (sugar) drink or sweets. Repeat BSL in 1 hour.
BSL <3.5 AND altered mental state or unconscious give IMI Glucagon 1mg immediately. If no response call ambulance.

GUIDELINES FOR INSULIN THERAPY FOR INTERNATIONAL TRAVEL:

1. Obtain a letter of documentation stating you are an insulin dependent diabetic and MUST carry needles and syringes.
2. Take insulin and other diabetic therapy as per normal on day of departure.
3. Arrange airlines to provide your meal "ON AUSTRALIAN TIME" for the duration of your travel e.g. to Europe/USA.
4. On Arrival try and set your insulin schedule to the day-time schedule of your ARRIVAL country. There will be some discrepancy in the hours but



Familial adenomatous polyposis - Genetics Home Reference - Microsoft Internet Explorer

Address: <http://ehr.nlm.nih.gov/condition=familialadenomatouspolyposis>

Genetics Home Reference
Your Guide to Understanding Genetic Conditions
A service of the U.S. National Library of Medicine®

Familial adenomatous polyposis

On this page: [Description](#) [Genetic changes](#) [Inheritance](#) [Treatment](#) [Additional information](#) [Other names](#) [Glossary definitions](#)

What is familial adenomatous polyposis?

Familial adenomatous polyposis (FAP) is an inherited disorder characterized by cancer of the large intestine (colon) and rectum. People with the classic type of familial adenomatous polyposis may begin to develop multiple noncancerous (benign) growths (polyps) in the colon as early as their teenage years. Unless the colon is removed, these polyps will become malignant (cancerous). The average age at which an individual develops colon cancer in classic familial adenomatous polyposis is 39 years. Some people have a variant of the disorder, called attenuated familial adenomatous polyposis, in which polyp growth is delayed. The average age of colorectal cancer onset for attenuated familial adenomatous polyposis is 55 years.

In people with classic familial adenomatous polyposis, the number of polyps increases with age, and hundreds to thousands of polyps can develop in the colon. Also of particular significance are noncancerous growths called desmoid tumors. These fibrous tumors usually occur in the tissue covering the intestines and may be provoked by surgery to remove the colon. Desmoid tumors tend to recur after they are surgically removed. In both classic familial adenomatous polyposis and its attenuated variant, benign and malignant tumors are sometimes found in other places in the body, including the duodenum (a section of the small intestine), stomach, bones, skin, and other tissues. People who have colon polyps as well as growths outside the colon are sometimes described as having Gardner syndrome.

A milder type of familial adenomatous polyposis, called autosomal recessive familial adenomatous polyposis, has also been identified. People with the autosomal recessive type of this disorder have fewer polyps than those with the classic type.

EVALUATION

Measured:

35% patients use email . 17% > 65 years of age.

Other:

Clinic record preparation 1-2 hrs saved

Original SPR compilation- 5-7 minutes

Preparation of SPR at FU 1-2 mins

No dictation

Patient takes record with them or emailed

Clinic-PCP communication & acknowledgement- 1min

Email/printed web resources for patient education

Reduced number of visits to Clinics

Less travel

Real time communication- e.g. BSL

No “excess email communications”

References (1)

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