

Summary Care Record – A quick guide

Summary Care Record (SCR) (not to be confused with the Shared Care or Surrey Care or Connected Care Records) is a national database that holds electronic records of important patient information such as current medication, allergies, and details of any previous adverse reactions to medicines, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care.

What is included in the SCR?

The core SCR dataset present in all records is:

- Allergies and adverse reactions to medication
- Current repeat medication
- Last 12 months of acute medication (unless otherwise stated)
- Last 6 months of discontinued repeat medication (unless otherwise stated)

What is **NOT** included in the SCR?

- Blood test results
- Discharge letters
- Clinic letters

How is it generated?

The SCR is sourced from the patient's GP record only. Therefore, it may not include the entire list of the patient's over-the-counter medications or items prescribed outside of the GP practice, unless the practice has manually entered these items into their GP system, or the information is part of a wider shared record from another organisation. These items will be labelled on the SCR (under Type) as 'Prescribed Elsewhere'.

Learning Points

Add medications or item prescribed outside of GP practice to the GP clinical system, and remove items no longer indicated. Guidance on how to do this can be found on the Surrey Prescribing Database (PAD) using the link below:

[Guidelines: Recording non-GP prescribed medications \(res-systems.net\)](https://res-systems.net)

When is it generated?

The SCR is marked with the last date and time that an update was sent by the GP practice.

A message will be displayed if a patient has recently changed their GP practice, as this could indicate that the SCR content is not yet fully up to date.

A message will be displayed if the SCR has been newly created or has not yet been created by the patient's new GP practice; either because the new GP practice does not yet hold information to overwrite the existing SCR, or because they have not yet started uploading SCRs.

Learning Points

- Viewers should check this to ensure that they understand when the record was last updated.
- These messages, in conjunction with the date and time stamp, should be used to assess how current the SCR information is.
- There are a number of differences in the way that information is recorded between the different GP systems and the different GP system supplier implementations. There are also differences due to local data quality, recording practices and patient preferences.

Examples of incidents

Parkinson's Disease medication not prescribed in recent months prior to hospital admission but had **not** been removed from GP clinical system "current medication screen". Medication was written on medication chart and administered to patient. This occurred twice, in two different hospitals.

Learning point – to remove items no longer clinically indicated.

Medication chart written up for dose 1.5ml of Toujeo insulin prefilled pen. This would mean if administered the patient would have received a dose of 450units of insulin.

Learning point – hospital prescribers to ensure familiarity with preparations being prescribed, primary care to consider clarity around documenting dose of insulins.

Summary and Key points

- **Ensure all medications the patient is receiving are listed in GP clinical system.**
- **Move all medications the patient no longer receives to past medications on the GP system.**
- **Double check all information when using SCR as a resource for medicines reconciliation including the date listed on SCR for date of last issue, and the dose of medications.**
- **Content of the SCR is reliant on the coding used by the GP practice, and the patient's preferences.**

Summary care record example

1.1 If the patient is either newly registered, no longer registered with the GP practice (see 3.4), or if items have been deliberately withheld from the SCR (see 3.4) the relevant message below will be clearly displayed in the SCR:
At the time this record was created, this patient had recently registered with the GP practice. GP Summary information may not be complete. Patient registration ended [date]. GP Summary no longer being updated One or more entries have been deliberately withheld from this GP Summary

1.2. Date and time when the SCR was last updated

1.3. Items prescribed outside the GP practice will only appear if entered by the GP practice. Their Type will be labelled as **Prescribed Elsewhere** (See section 3.2)

1.4. Last issued date may not appear for current repeat medication on every SCR. In this case the **Date First Added** will appear

1.5. If an SCR contains Additional Information it will appear under relevant headings beneath the core data (see section 4.7)

GP General Practice Summary Summary Created: 11-Nov-2014 10:52
 Sourced from the patient's General Practice record. This summary may not include all the information pertinent to this patient. [Tell me more](#)

Created By: TEST, Emla (Dr)
 XXX DO NOT USE XXX NIC TEST PRACTICE 14, C/O Nhs Npfit, Test Data Manager, Princes Exchange, Princes Square, Leeds, West Y

Allergies and Adverse Reactions			
Date	Description	Certainty	Severity
05-Apr-2011	Adverse reaction to Codeine Problem: First, drowsiness and confusion		
26-Sep-2009	H/O: erythromycin allergy Problem: First, rash and facial swelling		

Acute Medications (For the 12 month period 11-Nov-2013 to 11-Nov-2014)			
Type	Date	Medication Item	Dosage Instructions Quantity
Acute Medication	Prescribed: 19-Aug-2014	Glyceryl trinitrate 400micrograms/dose pump sublingual spray	Spray One Or Two Doses Under Tongue And Then Close Mouth As Directed 1 x 100 dose
Acute Medication	Prescribed: 24-Jul-2014	Paracetamol 500mg tablets	Two To Be Taken Every 4-6 Hours Up To Four Times A Day 32 tablet
Acute Medication	Prescribed: 16-Jul-2014	Amoxicillin 500mg capsules	One To Be Taken Three Times A Day 21 capsule
Acute Medication	Prescribed: 01-Apr-2014	Cetirizine 10mg tablets	One To Be Taken Each Day 30 tablet

Current Repeat Medications			
Type	Date	Medication Item	Dosage Instructions Quantity
Repeat Medication	Authorized (not issued): 10-Nov-2014	Beclomethasone 50micrograms/dose nasal spray	One Spray To Be Used In Each Nostril Twice A Day 1 x 200 dose
Repeat Medication	Last Issued: 29-Sep-2014	Aspirin 75mg dispersible tablets	One To Be Taken Each Day 56 tablet
Repeat Medication	Last Issued: 29-Sep-2014	Atenolol 50mg tablets	One To Be Taken Each Day 56 tablet
Repeat Medication	Last Issued: 29-Sep-2014	Lercanidipine 10mg tablets	One To Be Taken Each Day 56 tablet
Repeat Medication	Last Issued: 29-Sep-2014	Simvastatin 40mg tablets	One To Be Taken At Night 56 tablet
Repeat Medication	Last Issued: 15-Oct-2013	Amlodipine 5mg tablets	One To Be Taken Each Day 56 tablet
Repeat Medication	Last Issued: 08-Oct-2013	Ramipril 2.5mg capsules	One To Be Taken Each Day 28 capsule

Discontinued Repeat Medications (For the 6 month period 11-May-2014 to 11-Nov-2014)			
Type	Date	Medication Item	Dosage Instructions Quantity
Repeat Medication	Authorized (not issued): 29-Sep-2014 ***Date Discontinued: 10-Nov-2014***	Ramipril 5mg capsules	One To Be Taken Each Day 56 capsule

Clinical Patient Details

22-Apr-2014 Each Day

Current Repeat Medications

Type	Date	Medication Item	Dosage Instructions	Quantity
Repeat Medication	Last Issued: 12-Dec-2014	Bisoprolol 1.25mg tablets Reason for Medication: Heart failure	One To Be Taken Each Day	28 tablet
Repeat Medication	Last Issued: 12-Dec-2014	Citalopram 20mg tablets Reason for Medication: Anxiety with depression	One To Be Taken Each Day	28 tablet
Repeat Medication	Last Issued: 12-Dec-2014	Clopidogrel 75mg tablets Reason for Medication: Heart failure	One To Be Taken Each Day	28 tablet
Repeat Medication	Last Issued: 12-Dec-2014	Colecalciferol 200unit / Calcium carbonate 1.25g chewable tablets	One To Be Taken Each Day	112 tablet
Repeat Medication	Last Issued: 12-Dec-2014	Digoxin 62.5microgram tablets Reason for Medication: Atrial fibrillation	One To Be Taken Each Day	28 tablet
Repeat Dispense	Authorised: 12-Dec-2014	Hydrocortisone 1% / Clotrimazole 1% cream Reason for Medication: The medication reason is not currently included in SCR	Apply Evenly And Sparingly No More Than Twice Each Day	30 gram
Repeat Medication	Last Issued: 04-Dec-2014	Latanoprost 50micrograms/ml eye drops	One Drop To Be Used At Night In The Affected Eye(s)	28 drop
Repeat Medication	Last Issued: 30-Sep-2014	Aymes Shake powder (Flavour Not Specified)	one to be taken daily between meals	1596 gram
Repeat Medication	Last Issued: 30-Sep-2014	CareSens N testing strips (Spirit Healthcare Ltd)	Use as directed	50 strip
Repeat Medication	Last Issued: 02-Jul-2014	Zerobase 11% cream (Thomton & Ross Ltd) Reason for Medication: Type II diabetes mellitus	Apply To Dry Skin Areas Two Or Three Times Daily And Rub In Well	500 gram

Discontinued Repeat Medications (For the 6 month period 30-Sep-2014 to 30-Mar-2015)

Type	Date	Medication Item	Dosage Instructions	Quantity
Repeat Medication	Last Issued: 09-Dec-2014	Liquid Paraffin And Isopropyl Myristate Gel (Pump Dispenser) 15 % + 15 %	Apply four times per day as required to affected areas	500 gram

Date Discontinued: 03-Mar-2015

Diagnoses

Date	Description	Additional Information
05-Jan-2014	Diabetic retinopathy	Problem; First, end stage
05-Jan-2014	Glaucoma	Problem; First
17-Dec-2013	Recurrent urinary tract infection	Problem; First
06-Sep-2013	Type 2 diabetes mellitus with persistent microalbuminuria	Problem; First
28-Nov-2012	Chronic kidney disease stage 3	Problem; First
07-Jan-2012	Anxiety with depression	Problem; First
01-Mar-2011	Mitral regurgitation	
01-Mar-2011	Tricuspid regurgitation, cause unspecified	

2.1. If Additional Information is present, Reason for Medication will be included if recorded in the GP record

2.2. If the Reason for Medication is recorded in the GP system but is excluded from the SCR, then this is indicated

2.3. Additional Information appears below the core SCR grouped under Care Record Element headings. In this example, Diagnoses are the first information to be included in the SCR

2.4. Additional Information appears as individual rows (in reverse date order), comprising:

1. Date of the event (Date)
2. Text description of the clinical code (Description)
3. Supporting free text (Additional Information sub-heading)

In this example, the supporting text includes auto-generated information from the GP system indicating the problem detail of the coded item e.g. it is a Problem and this is the First Episode. The auto-generated information is system specific and will vary depending on which GP system produced that individual SCR. The successive text "end stage" is the supporting free text recorded by the GP practice when this information was recorded.

Diagnoses

Date	Description	Additional information
05-Jan-2014	Diabetic retinopathy	Problem; First, end stage
05-Jan-2014	Glaucoma	Problem; First
17-Dec-2013	Recurrent urinary tract infection	Problem; First
06-Sep-2013	Type 2 diabetes mellitus with persistent microalbuminuria	Problem; First
28-Nov-2012	Chronic kidney disease stage 3	Problem; First
07-Jan-2012	Anxiety with depression	Problem; First
01-Mar-2011	Mitral regurgitation	
01-Mar-2011	Tricuspid regurgitation, cause unspecified	See report
01-Jan-2011	Atrial fibrillation	Problem; First
01-Oct-2010	[X]Mixed anxiety and depressive disorder	
19-May-2010	Basal cell carcinoma	excision
19-Jan-2010	Heart failure	Problem; First
19-Jan-2009	Eczema NOS	
19-May-2007	Cataract	Laterality: Left
27-Jan-2006	[M]Squamous cell carcinoma NOS	Problem; First, Fully excised invasive squamous cell carcinoma on the chin of the patient. No cervical lymphadenopathy. Histology confirmed a keratoacanthomatous squamous cell carcinoma
08-May-2002	Type 2 diabetes mellitus	
08-May-2002	Type II diabetes mellitus	Problem; First
08-Jan-2002	Hypercholesterolaemia	
08-Jan-2002	Hypercholesterolaemia	Problem; First
01-May-2001	Second degree uterine prolapse	Problem; First, Has had the prolapse for many years, has become more prominent in early Feb 2001
01-Dec-1985	Essential hypertension	Problem; First
01-Jan-1985	Solar keratosis	nose (letter dated 25/01/85) star

Problems and Issues

Date	Description	Additional information
05-Jan-2014	Diabetic retinopathy	Significant Active, end stage
05-Jan-2014	Glaucoma	Significant Active
17-Dec-2013	Recurrent urinary tract infection	Significant Past, End Date : 09-Jan-2015
06-Sep-2013	Type 2 diabetes mellitus with persistent microalbuminuria	Significant Active
08-Jan-2013	GSE prognostic indicator stage B (green) - months prognosis	Minor Active
28-Nov-2012	Chronic kidney disease stage 3	Significant Active
08-Jan-2012	Patient's next of kin	Minor Active, Daughter's tel number is xxxxxx xxxxxx
07-Jan-2012	Anxiety with depression	Minor Past, End Date : 04-Mar-2015
01-Jan-2011	Atrial fibrillation	Significant Active
19-May-2010	Excision biopsy of basal cell carcinoma	Significant Past, End Date : 09-Jan-2015, Right cheek
19-Jan-2010	Heart failure	Significant Active
27-Jan-2006	[M]Squamous cell carcinoma NOS	Significant Past, End Date : 09-Jan-2015, Fully excised invasive squamous cell carcinoma on the chin of the patient. No cervical lymphadenopathy. Histology confirmed a keratoacanthomatous squamous cell carcinoma
01-Oct-2005	Excision biopsy of basal cell carcinoma	Significant Past, End Date : 09-Jan-2015, Right cheek
08-May-2002	Type II diabetes mellitus	Significant Active
08-Jan-2002	Hypercholesterolaemia	Significant Active
01-May-2001	Second degree uterine prolapse	Minor Past, End Date : 09-Jan-2015, Has had the prolapse for many years, has become more prominent in early Feb 2001
01-Dec-1985	Essential hypertension	Significant Active
02-Feb-1965	CONFIDENTIAL - Item not available	

Clinical Observations and Findings

Date	Description	Additional information
08-Dec-2014	Seen by continence nurse	
08-Jan-2013	GSE prognostic indicator stage B (green) - months prognosis	Problem; First
02-Feb-1965	CONFIDENTIAL - Item not available	

3.2 Problems and Issues is a special section that contains the patient's Active and significant past Problem items if they have been identified as **Problems** in the patient's GP record. These items also appear elsewhere in the SCR under their own relevant defined headings.

3.3 The supporting free text provides additional useful detail to supplement the coded information. It may include sensitive or third party information – see 3.14 and 3.15

3.4. Clinical Observations and Findings may include some observation values – such as blood pressure – but only if the GP system adds them systematically (which not all do) or if the GP practice mark the items for inclusion or because they were recorded in a relevant section of the GP record for inclusion in SCR.

In the example above, some information has been marked as **confidential or private** in the GP system and is therefore not included in the SCR. When this occurs in the SCR, a message is included indicating that one or more items have been withheld from this SCR.

Treatments		
Date	Description	Additional information
07-Oct-2014	Influenza vaccination	
02-Jun-2014	Admission avoidance care started	
02-Oct-2013	Influenza vaccination	
10-Oct-2012	Influenza vaccination	
19-May-2010	Excision biopsy of basal cell carcinoma	Problem; New, Right cheek
19-Oct-2009	Influenza vaccination	
01-Oct-2009	Influenza vaccination	
01-Oct-2009	Influenza vaccination	
01-Oct-2005	Excision biopsy of basal cell carcinoma	Problem; First, left side of forehead
17-Aug-2001	Repair of vaginal prolapse & amputation of cervix uteri NOS	
02-Oct-1995	Second hepatitis A and typhoid vaccination	
04-Mar-1995	First hepatitis A and typhoid vaccination	
24-Feb-1995	Third polio vaccination	
30-Jan-1995	Second polio vaccination	
09-Jan-1995	First polio vaccination	

Investigation Results		
Date	Description	Additional information
02-Mar-2015	Echocardiogram abnormal	

Care Events		
Date	Description	Additional information
08-Dec-2014	Seen by continence nurse	

Provision of Advice and Information to Patients and Carers		
Date	Description	Additional information
03-Jul-2014	Preferred place of death: discussed with family	

Personal Preferences		
Date	Description	Additional information
30-Jul-2014	Not for resuscitation	
30-Jul-2014	Preferred place of care - care home	
30-Jan-2014	Preferred place of death: patient undecided	

Services, Care Professionals and Carers		
Date	Description	Additional information
08-Dec-2014	Chiropody	Saw podiatrist in August 2013
08-Dec-2014	Chiropody	
08-Sep-2014	District nurse attends	1 times/week
08-Sep-2013	District nurse attends	1 times/week
10-Feb-2013	District nurse attends	2 times/week
21-Sep-2011	District nurse attends	1 times/week

Social and Personal Circumstances		
Date	Description	Additional information
08-Jan-2012	Patient's next of kin	Problem; First, Daughter's tel number is xxxxxx
03-Sep-2010	Main spoken language English	

Summary Sent: 30-Mar-2015 12:35

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4.1. The **Treatments** heading includes vaccinations. The example here shows the annual influenza vaccination which can contribute to repetitive information in the SCR.

4.2 **Investigations and Investigation Results** will only contain items specifically identified in the GP system for inclusion. More detailed information may be available in the GP record but not present in the SCR.

4.3. The **Personal Preferences** section contains patient preferences such as those regarding **End of Life care** and **Resuscitation status** – see section 3.12

4.4. This section can include details of **Next of Kin**.