

Nine golden nuggets

Critical data for the electronic record and for GPRD

-  **Prescriptions:** Details of every prescription issued by the practice should be entered, whether the drug was prescribed at a surgery or at any other time.
-  **Events resulting in a prescription:** A computer record should be made of all events resulting in the prescription or withdrawal of a drug or other treatment, including:
 - indications for new treatments;
 - indications for first instance of a repeat prescription;
 - indications for any change or addition to treatment.
-  **Other significant events:** In addition to events which result in a prescription, a record should be made of all other significant morbidity events, including:
 - all events resulting in a hospital or specialist referral, and the outcome of the referral;
 - test results (significant normals and abnormals);
 - any unplanned withdrawal of a drug including adverse drug reactions, allergies and intolerances;
 - other events which are clinically important at a later date such as childhood diseases, pregnancy.Significant events identified by any member of the healthcare team, whether the consultation occurred at the surgery, on a visit or over the phone, should be captured on the system.
-  **Chronic and recurrent illnesses:** The date of the original onset of a chronic or recurrent condition should be recorded.
-  **Contraception and immunisations:** A record of contraceptives (oral, IUD or other) and immunisations should be included, whether these are prescribed or administered in the surgery or elsewhere, eg at a family planning clinic.
-  **Pregnancy outcomes and childbirth:** The outcome of pregnancy should be entered in the mother's clinical record, and the condition of each newborn should be recorded in the child's own record including normal births, prematurity and congenital malformations.
-  **Deaths:** When a patient has died, a record of the death and, when known, the cause of death should be entered.
-  **Lifestyle:** Current smoking status, alcohol intake and height/weight should be recorded for adults approximately every 3–5 years (adult height need be measured once only).
-  **Registrations:** Registration details for all patients should be accurately maintained, including date of birth, sex, registered GP, and registration status (permanent, applied, temporary and transferred outs) with dates.

General Practice Research Database

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