Adding Clinical Codes to a Patient's Medical Records		
Reference	**How To Guide 31**	
Version	**1.2**	
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1. Purpose

To accurately select and assign the appropriate clinical code to all relevant entries in a patient's notes. This facilitates an accurate, concise and auditable medical record. Inaccurate or missing clinical codes can increase risk to patients and clinicians. Staff other than practice clinicians should add codes only when instructed and trained to do so.

2. Procedure

- Select the patient
- Click on 'summary' at the top left of the page
- Click on the arrow under 'add'
- Select code required or type in the name of the term related to the code e.g. hypothyroidism
- Double click on the code that is needed
- Change 'date of entry' to correspond with the date of the event – this may be the date of adding the code or a previous date e.g. of a diagnosis from a hospital letter etc.
- Type a message in 'descriptive text' box if needed
- Only tick the box next to 'record as problem' if it is a diagnosis. Ask for advice on which to select e.g. active/past/significant/minor etc.
- Click ok