

SECTION 6
primary care office
organisation



SECTION 6

primary care office organisation

6.1	Results And Screening Recommendations	45
6.2	Records - Manual And Computerised Systems	47
6.3	Primary Care And ICSP Paperwork	50

6.1 Results And Screening Recommendations

Each woman should fully understand the significance of her smear result without generating unnecessary anxiety.

It is estimated that:

- 84% of screening smears will have a normal result
- 10% of screening smears will be inadequate
- 6% of screening smears will be 'not normal'
- 2% of screening smears will require referral for colposcopy

6.1.1 Normal Results

Only normal smear results should be advised to the woman by telephone or in writing.

There is a false negative rate but, if women have regular cervical smears, it is unlikely that a high-grade lesion will be missed.

6.1.2 'Not Normal' Results

Face-to-face consultation is recommended for advising a woman of a 'Not Normal' smear results. Adequate time should be allowed for questions and explanation.

A 'Not Normal' smear result rarely means cancer. A result that is not normal is usually an early pre-cancerous cell change. Not all pre-cancerous changes will progress to invasive carcinoma of cervix (See Section 2 for Natural History of CIN).

6.1.3 Referral For Colposcopy

The clinically responsible doctor is responsible for referral for colposcopy. The woman should be provided with appropriate counselling. A Colposcopic Referral Form should be completed and a copy of the referring smear result attached to the referral, to facilitate accurate completion of cytology forms in the colposcopy clinic.

It is estimated that 15% of women fail to attend for a first colposcopy appointment. It is important that the doctor identify these 'at risk of not attending' women during pre-referral counselling so as to identify and address any barriers of concern and stress the importance of attendance.

6.1.4 Recommendations


 Cytology Laboratory Codes	
Cytology Pattern (P Codes)	Management Recommendation (R Codes)
P1 Unsatisfactory/Inadequate	R6 Repeat smear in 1-3 months R7 Refer for Colposcopy after 3 consecutive R7 Refer for Colposcopy - single unsatisfactory / inadequate after treatment
P2 Negative/NAID	R1 No recommendation (women exiting programme) R2 Normal recall R3 Repeat smear in 12 months (either previous history available or first ever smear or scanty) R4 Repeat smear in 6 months if first negative after treatment of a high grade lesion R7 Refer for Colposcopy opinion if suspicious cervix
P3 Borderline Nuclear Abnormalities (Squamous) or HPV	R4 Repeat Smear in 6 months R7 Refer for Colposcopy after 3 consecutive BNA (sq)
P4 Mild Dyskaryosis	R4 Repeat Smear in 6 months R7 Refer for Colposcopy after 2 consecutive R7 Refer for Colposcopy - single mild dyskaryosis after treatment in colposcopy R7 Refer for Colposcopy - 3 untreated (i.e. not attend appointment) in 10 years
P5 Moderate Dyskaryosis	R7 Refer for Colposcopy
P6 Severe Dyskaryosis	R7 Refer for Colposcopy
P7 Query Invasive Carcinoma	R7 Refer for Colposcopy R8 Refer for specialist gynaecology opinion
P8 Borderline Nuclear Abnormalities (Glandular)	R5 Repeat Smear in 3 months R7 Refer for colposcopy after 2 consecutive BNA (gl)
P9 Query Glandular Neoplasia	R7 Refer for Colposcopy R8 Refer for specialist gynaecology opinion
P10 Broken or Damaged Slides	R6 Repeat Smear 1-3 months

Figure 21: ICSP Management Recommendations 2002

6.2 Records - Manual And Computerised Systems

A system for record keeping must be in place. Records should be made:

- 1 At the time of smear taking
- 2 When the smear result is received
- 3 For all follow up contacts related to the smear result

6.2.1 Clinical Records

Clinical details should be recorded in the woman's Patient Notes and on the Cytology Referral Form. A stamp for quick recording in manual patient notes may be useful. Results of smears should be recorded in the woman's clinical notes.

6.2.2 Laboratory Records

The middle sheet of the ICSP Cytology Request Form is sent to the laboratory accompanying the prepared slide or LBC vial. The date of posting of the smear to the laboratory should be recorded.

The clinically responsible doctor, will receive the result(s) directly from the laboratory.

6.2.3 Tracing Smear Results

There are a number of ways for tracing smear results to ensure that:

- 1) All smear results have been received
- 2) All laboratory recommendations are followed
- 3) Payment for all smears is received

Examples of two manual methods and two of the most commonly used Practice Computerised Systems are outlined below.

6.2.4 Manual Record Systems

A. Using a Manual Log Book

SMEAR TAKEN COMPLETE	DATE POSTED	RESULT RECEIVED	SMEAR FOLLOW UP	RECOMMENDATION
Name: <i>Ann C Murphy</i> DOB: <i>20/07/1975</i> Date: <i>16/10/01</i>	Date: <i>18/10/01</i>	Result: <i>No abnormal cells.</i> <i>Repeat smear in</i> <i>12 months as first</i> <i>ever smear test.</i> Date: <i>16/12/2001</i>	Action: <i>Ms Murphy advised</i> <i>of result.</i> Date: <i>18/12/2001</i>	
Name: <i>Mary B Ryan</i> DOB: <i>30/03/1960</i> Date: <i>1/2/2003</i>	Date: <i>01/2/01</i>	Result: <i>Inadequate smear.</i> Date: <i>1/4/2003</i>	Action: <i>Letter sent to Ms. Ryan</i> <i>advising repeat smear</i> <i>within 3 months from</i> <i>date of original smear.</i> Date: <i>2/4/2003</i>	Repeat smear taken. [Note: Log this new smear as a separate entry in record book] Date: <i>20/5/2003</i>

A person with assigned responsibility must ensure that all stages are completed for each smear.



primary care office organisation

B. Manual 'Yellow Card' Records System

Figure 22: Yellow Card' box in practice

The 'yellow leaf' of the ICSP Cytology Referral Form is retained. The 'yellow copies' are better kept separate to the woman's Clinical Notes. This facilitates easy checking that all results have been received. It allows for a system of 'yellow cards' of smears needing a specific action to be retained until that action has been carried out and completed. The cards can be divided into the 'smear done', 'result received', 'result acted upon' and 'payment made'.

A manual record-keeping system for Smear Forms can be created using small storage boxes with alphabet dividers. At least 2 boxes are used:

- 1 Smear done - awaiting result
- 2 Result received and acted upon

Additional, separate 'Action taken' and 'Smear fee received' boxes may be of value for some larger practices.

The cards are stored alphabetically in each box and moved from one box to another as appropriate. Only when each action is complete is the form transferred to the next box. At every level the action taken must be documented. When the woman is recalled and attends for her 'recall' smear the 'yellow card' can be the 'activated' again.

Responsibility for following all smears should be formally assigned to one member of the general practice team.

6.2.5 Computerised Record Systems

A. Health-One GP Computer System

The consultation is entered as any other consult.

- a. A smear is identified as the reason for the consult
- b. Smear is documented in the clinical notes
- c. A plan of action window is opened and the date of smear event is entered
- d. The person responsible for follow up is identified
- e. The time is specified for follow up as a planned action (in this case expected time within which result will have been received from the laboratory)

The result arrives at the surgery and is checked by the doctor.

- a. The result is keyed into the computer. The recommendation is written into the clinical notes along with the recall date
- b. A plan of action window is opened again
- c. The date of this event is entered
- d. In the planned action section again the person with responsibility is identified
- e. The time for follow up identified

A regular check can easily be made to ensure that all planned actions have been carried out by the date specified. This acts as an alert system for receiving the result and after this for ensuring that recommended follow up has happened. All contacts with the woman relating to the smear result must be documented.

B. GP Clinical GP Computer System

- a. The smear is documented in Clinical Notes
- b. Cervical smear is highlighted under 'Investigations'
- c. Choose the Quick Add command & exit 'Investigations'. This causes "cervical smear awaiting results" text to appear under the consultation notes
- d. When the result is to hand, highlight the 'Investigation' box and choose "Add"
- e. This changes "awaiting result" to "doctor's review"
- f. When the doctor inspects the result, the cervical smear is deemed completed
- g. The cervical smear payment box may be filled separately to track payments
- h. Enter the result, and the interval for recall
- i. The result may also be scanned into the patient's file when it will be viewed under scanned letters and reports
- j. The Reports section may be evoked to ensure follow up requirements



primary care office organisation

6.3 Primary Care And ICSP Paperwork

GP and Practice Nurses wishing to participate in the cervical screening programme must be registered with the ICSP as smertakers.

6.3.1 Smertaker Registering Requirements

To become an ICSP-registered provider, the following documents must be completed and sent to ICSP Office.

1. Smertaker Contract (GPs)
2. CSP Smertaker Registration Form (GP and Practice Nurses)
3. Copy of current GP medical insurance
4. Copy of current professional registration (GP and Practice Nurses)

Copies of medical insurance and professional registration certifications must be supplied to ICSP yearly. GP registrars and locum GPs working for more than one month need to submit all the above documents to the ICSP Office.

Nurses are registered as associate smertakers within a general practice or service and must have a clinically responsible doctor over viewing their screening activity.

6.3.2 Payment For ICSP Smears

Only registered doctor-payees can receive payment for eligible smears taken, from the date of initial registration. Nurses are required to identify a doctor for payment for the smears they undertake. Future payment will be suspended if the doctor or nurse taking the smear has not submitted current medical insurance and/or professional registration certification.

A 'one off' payment is made for the taking of a smear. This covers any counselling or follow up that the woman's smear result entails.

Delays in payments occur when there are errors or omitted information supplied on the ICSP Cytology Referral Form. Common errors or omissions include:

- Incorrect date of birth
- No payee number or Smertaker ID number