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Accurate Recording of Clinical Information

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Session Overview

We will be concentrating on the better recording of...

- Medications
- Progress Notes
- Histories and summaries
- Allergies and Warnings
- Family and Social Histories
- Measurements
- Smoking and Alcohol

RACGP Standards for general practices (4th edition), criterion 1.7.2: health summaries. *Our practice incorporates health summaries into active patient health records. Health summaries assist in providing ongoing care, both within the practice and on referral to other healthcare providers*.

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Regulation 4 Health Insurance Act 1999, and Section 81 which says effectively that "each entry needs to be sufficiently comprehensible so another medical practitioner relying on the records can effectively undertake the patient's ongoing care…"

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Medication Lists

RACGP recommendations for the recording of medicines

This includes:

- ❑ diagnosis/problem as to why medicine prescribed (coded)
- ❑ all medicines (e.g. over the counter; complementary therapies; topical therapies) should be captured

It may be the case that there are no medicines to record. Record utilising the functionality of the software: unknown; none; or not asked.

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Medication Lists

Possible findings

- Many examples of expired medications (those in red) - could be partly explained that many may have been OTC
- Some GPs had a “Reason for medication” for all or most prescribed medications indicating that “Reason for medication” is enforced in the MD Options. Others had no or few “Reasons for medication”
- Samples and prescribed elsewhere medications not observed

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Medication Lists

Recommendations

- To achieve a 100% recording of “Reason...” for all medications a team meeting could discuss the pros and cons of recording “Reason for medication” for all medications. This could be achieved by forcing “Reason for medication” to be turned on:
  Tools >**Options** >**Prescribing** – tick in “Reason for Medication” box

- The “Reason for medication” column could be moved from the far right of the medication screen (you have to scroll across to see it) to where it is visible, so that scrolling is not necessary and being visible makes it more relevant – this would assist in retrospectively adding “Reason for medication”

- It is suggested that all GPs be made aware of the RACGP recommendations for the recording of medicines (see previous slide)
  - diagnosis/problem as to why medicine prescribed (coded)
  - all medicines (e.g. over the counter; complementary therapies; topical therapies) should be captured (perhaps draw the line at homeopathic remedies)

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Progress Notes

"Each entry needs to be sufficiently comprehensible so another medical practitioner relying on the records can effectively undertake the patient's ongoing care…"

Possible findings...

- Inconsistency among the GPs in the recording of "Reason for contact" for all encounters
- Hopefully rare use of uncoded items in "Reason for contact"
- Underuse of "Confidential"
- Inconsistency among the GPs in the amount of detail recorded in Progress Notes

Recording "Reason" makes it easy for the doctors to get a quick overview of a patient history by perusing the previous progress notes

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Progress Notes

"Each entry needs to be sufficiently comprehensible so another medical practitioner relying on the records can effectively undertake the patient's ongoing care…"

Recommendations...

- Consider "Mandate entering a reason(s) for contact for each consultation" to be turned on:
  No patient record open: **Tools** >**Options** >**Clinical** – tick in "Mandate entering a reason(s) for contact for each consultation" box. This will ensure that every visit will have a reason for contact recorded.

- It is suggested that all GPs be made aware of the RACGP recommendations for the recording of "Reason for contact"
  This includes:
  - problem/diagnosis/procedures and clinical interventions use coded text
  - comments and free text to provide further detail as relevant
  - record so as to protect patient confidentiality (e.g. for HIV status, mental psychosis)

Recording "Reason" makes it easy for the doctors to get a quick overview of a patient history by perusing the previous progress notes

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Histories and Summaries

"In my experience, this is the biggest problem area in General Practice. 50% of GPs don't know how to, or don't bother to record accurate histories" - Noel Stewart, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013,

Most likely findings...

- Poor understanding of how "Summary" works, resulting in:
  - Repeated items, e.g. Asthma 4-6 times on summary lists
  - All items "Active"
  - No "Summary" items at all
- Uncoded items (free text) misused
- Poor use of "Confidential"

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Histories and Summaries

Recommendations...

- A team meeting to discuss ways of assuring that history summaries of all doctors are kept up-to-date so that there is a **clear distinction of Current History (Summary box ticked plus Active) and Past History (Summary box ticked plus Inactive)** – this will mean that Health Summaries will be accurate (important for re-accreditation, the PCeHR and accuracy of referrals, Care Plans and Health Assessments)

- Maybe consider the use of "Confidential" in more cases where patient confidentiality needs to be respected (HIV, mental health conditions)

- It is suggested that all GPs be made aware of the RACGP recommendations for the recording of "Reason for contact"
  This includes:
  - comments and free text to provide further detail as relevant
  - problem/diagnosis/procedures and clinical interventions use coded text
  - record so as to protect patient confidentiality (e.g. for HIV status, mental psychosis)
  - it may be the case that there is no medical history to record. Record utilizing the functionality of the software: unknown; none; or not asked.

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Allergies and Warnings

Possible findings...

- Allergy status was recorded for all patient records seen.
- The allergic reaction was not always recorded
- Maybe overuse of free text in recording allergies

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Allergies and Warnings

Recommendations...

- Try and record reactions for all allergies and where the reaction is not known record it as “unknown”

- It is suggested that all GPs be made aware of the RACGP recommendations for the recording of Allergies and Warnings:
  - date of entry/update/review
  - substance/agent – where ever possible using available codes for medicines. This could be a drug class (e.g. betablocker,
  - beta-lactam), generic name or trade name
  - description of the reaction e.g. rash or anaphylaxis (codeable text – is a flexible data type to support various
  - ways of holding text both free and coded)
  - if reaction to description not known then record ‘reaction not known’
  - date of occurrence (to be recorded as --/--/---- or year only at a minimum)
  - record utilising the functionality of the software: known allergy; unknown allergy; not asked.

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Family and Social Histories

Findings...

- Not all doctors had consistently detailed recordings of Family and Social History.
- Quite a few family and social histories not dated

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Family and Social Histories

Recommendations...

- Family and Social History items should be dated so that other clinicians know when the questions were asked or when particular events occurred
- Use of “Reviewed plus date”
- If there is no significant family and social histories this should be recorded and dated when the entry is made, e.g. “Nil – 5/2/2013” or “No significant Fx”
- It is suggested that all GPs be made aware of the RACGP recommendations for the recording of family and social history.

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Family and Social Histories

RACGP Recommendations

Family History:

- disease/condition
- relationship to family member
- description (free text narrative to provide further detail as required)

Social History:

The following headings/questions may be used to capture information when available or applicable to the patient situation:

- date of entry/update/review
- living arrangements e.g. legal guardian, separated parents, or whether an elderly patient lives alone
- religion (where relevant to provision of care, e.g. Jehovah's Witness)
- ethnicity/Cultural background (where clinically relevant)
- whether the patient is a carer or has a carer
- occupation and employment status
- relationship status
- elite athlete
- dependents e.g. children/grandchildren
- what community services the patient receives, if any.

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Smoking and Alcohol

Findings...

Smoking:

- Question not asked or a number of years have passed and file not updated
- Inconsistency between the GPs in amount of recording

Alcohol:

- Less up to date compared to smoking
- Inconsistency between the GPs in amount of recording

Recommendations...

Smoking and Alcohol:

- Where the questions have been asked but no change has occurred (e.g. still smoking 20 a day) the Comments section could be used to state “reviewed plus date” so that we know that the questions have been asked, and when asked.

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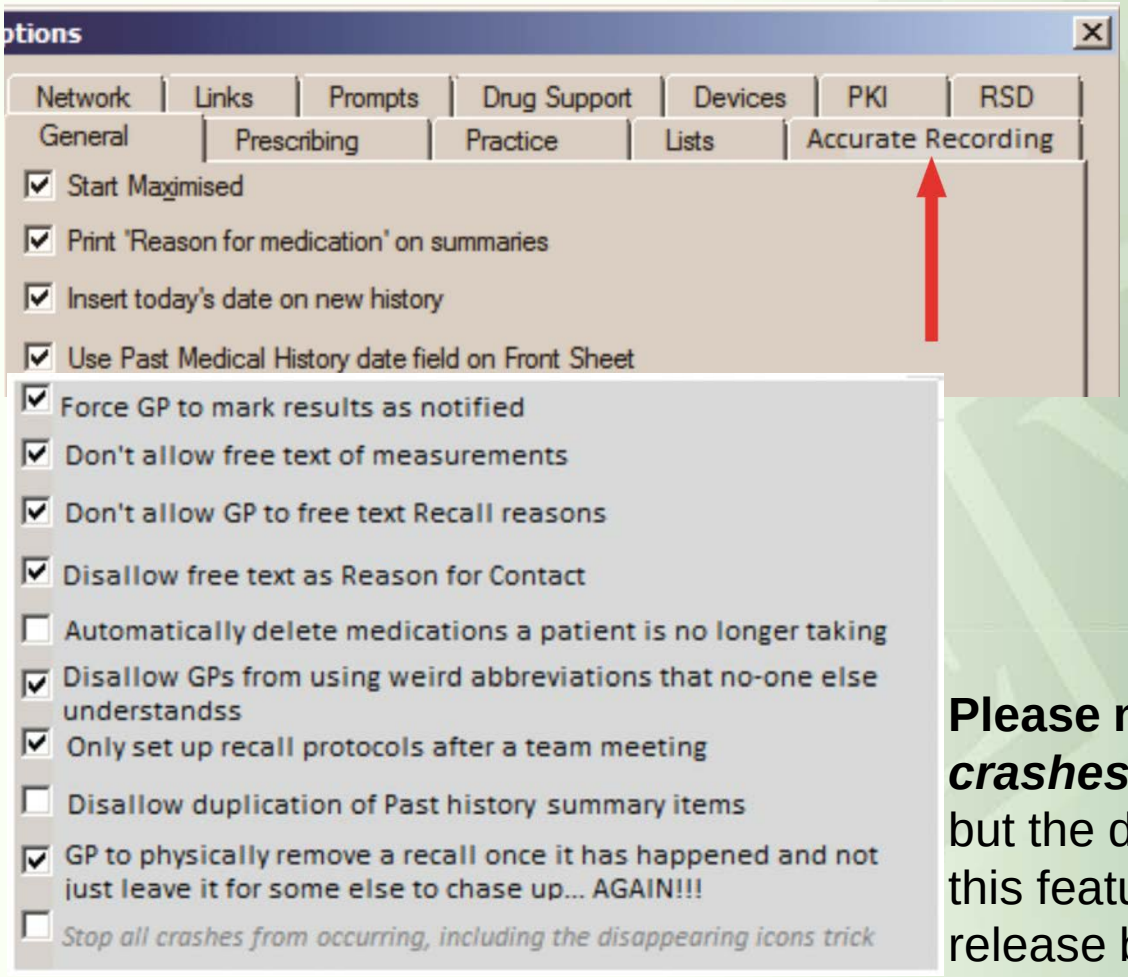
Clinical software

Software can help (MD Hint, April 1, 2010)



Please note: the ***Stop all crashes...*** is greyed out but the developers say that this feature is due for release by April 1 next year.

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Clinical software

Record keeping problems

- Patients not deceased or inactivated (kill and cull)
- Inaccurate diagnoses and histories
- Reason for contact not recorded in progress notes
- Allergies/smoking not recorded
- Inaccurate medication lists
- Poorly managed recall systems

- How do we solve this?
  - Accurately record clinical information (training booklet)
  - Start an on-going process of “data cleansing” (training booklet)
  - Use the CAT to analyse and fix problems
  - It’s not easy but there is assistance at hand
    - “data cleansing” checklist on NEV website (and in the handouts)
    - 28 page book “Clean up your act” available from NEVDGP website
    - Arrange “data cleansing” workshops with your ML eHealth Officer

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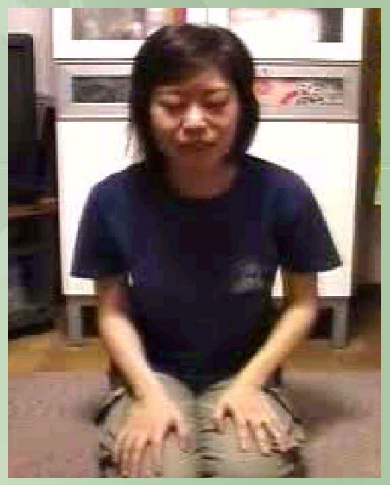
Problem solving session

3 learning rules

- 20/80 rule
- Learn by doing
- “Hands in Pockets” (computers)



How to fold a shirt

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Decision making session

Medications – how do we...

- delete medications a patient is no longer taking?
- enforce reason for medication?
- motivate colleagues (or non-compliant" GPs) back at the practice?

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Decision making session

Progress Notes – how do we...

- ensure there is a “Reason...” for all patient encounters?
- Ensure that all reasons are coded?
- motivate colleagues (or non-compliant” GPs) back at the practice?

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Decision making session

Histories – how do we...

- ensure the history lists are accurate?
- ensure that all reasons are coded?
- motivate colleagues (or non-compliant" GPs) back at the practice to keep histories up-to-date?

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Decision making session

Allergies – how do we...

- ensure that ALL patients have their allergy status recorded?
- ensure that all allergies have a recorded reaction?
- motivate colleagues (or non-compliant" GPs) back at the practice to keep allergies and warnings up-to-date?

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Decision making session

Family and Social Histories – how do we...

- ensure that ALL patients have updated family and social histories?
- ensure that all family and social histories are updated?
- make data entry consistent amongst the GPs?

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Decision making session

Measurements – how do we...

- stop free typing of measurements?
- improve the recording of BP, Height, Weight and Waist measurements?
- make data entry consistent amongst the GPs?

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Problem solving session

What we do

- How do you improve clinical record keeping?

PDSA – improve recording BP, Ht/Wt, smoking, allergies. Keep a cumulative record that shows improvement (Page 8 Noel's book)

PDSA - Team meetings to decide uniform recording

PDSA - Blitz of the month

PDSA – find those patients who have misdiagnosed Type II (LADA or Type I)

PDSA – find those patients that have not had a HbA1c in the last 12 months

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Problem solving session

What we do

- How do you motivate colleagues (or non-compliant" GPs) back at the practice?

PDSA – PM or PN to create a monthly report using PEN CAT of the performance of each GP and post on staffroom noticeboard

See Australian Doctor Article – "All Aboard for a Data Blitz"

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And now…

Taking up the challenge

- Team approach
- Small but achievable steps
- Comparative reports
- Change and improvement
- Training, training and training

Is it possible to herd cats?

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The CAT is out of the bag

Thank you

and time for me

to go home