

Why record Reason for contact, reason for prescription

Filling out the *Reason for prescription*, (or the *Reason for visit* in Progress Notes) allows for a patient history and accurate summaries to be steadily built up. This is an example of good record keeping. It also directly impacts on your ability to use some of the other powerful features of Medical Director. Once your history summaries are up to date it makes electronic referrals, Care Plan and other templates much quicker to use as these types of templates gather the data directly from the database. You don't have to type in much of the information.

When you use the *Search database* feature, such as creating a list of all your diabetics or asthma patients, this is much more accurately achieved if the information is entered accurately in the first place. If this is not done it is known as *Rubbish In, Rubbish Out* (RIRO).

Why choose from a picklist

The pick list of DOCLE terms covers a broad range of terms used in general practice. The *picklist* is coded, meaning that you can use the *search database* function more efficiently. Free-type entries (uncoded) can still be used but limit the ability to cross reference and search, e.g.

- Drug-disease interactions need a disease to operate. Free text entries may not be recognised for interaction checking.
- Using consistent terms allows for better searching and summarizing of the patient database
- Choosing from a list means less typing (and more accurate).

Active

This should be checked if the patient is currently suffering from this condition.

Confidential

This should be checked if the patient has a "confidential" condition; it will not appear in printed summaries.

Save in the PMH

This will be saved in Past History as part of the Patient's medical history.

Save as reason for visit

This indicates the primary reason for a visit and will be recorded as the reason for visit in your Progress Notes.

Summary

This reason will appear on printed summaries and referral letters. You would check the summary box for major history items.



Using clinical software to better manage clinical data

Using Medical Director to clean up your clinical information

Clean up the patient database

1. Use the Maintenance program to remove patients with no clinical data
2. Use MD database to list patients not seen for last 3 years, then inactivate them
3. Remove duplicate patients
4. Decease patients in MD
5. Make sure patient gender is recorded (use Maintenance to match patient title with gender)

Clean up the patients' clinical records

1. Ensure medication lists reflect what the patient is currently taking
2. Ensure past history lists are accurate and that coded diagnoses have been used
3. Ensure that **ALL** clinicians know how the "Reason for contact", "Reason for prescription" and "Past history" interact with the history lists and Progress Notes "Reason for contact" – see centre page spread)

Clean up recalls

1. Delete unnecessary, duplicate or poorly worded recall reasons from the drop down list
2. Use the Maintenance program to rename your recall reasons
3. Ensure a recall system is in place to follow up pathology results and recalls. Patients should be contacted and not left to just turn up.
4. Ensure that all results are "Marked as notified" when GP discusses results with patient
5. Remove the "Outstanding actions" if not part of the recall system being used
6. Delete old recalls – begin by choosing a date range of between 3 and 6 years ago

Other

1. Clean up Address Book categories
2. Clean up the "Document category" of scanned or imported documents

Once this is done it will make it much easier to take advantage of:

- Collaboratives program
- Practice Health Atlas
- Pen Clinical Audit tool

Please Note:

- A "Data cleansing" checklist can be found on the NEVDGP website at: <http://www.nevdgp.org.au/?content=14#CheatSheets>
- A 28 page book, "Medical Director – Clean up your act!!" is available from the division
- You can arrange through Noel a "whole of practice" 2 hour evening workshop on data cleansing (GP CPD 2 points/hr and PN CPD 1 point/hr)

Building accurate Histories and Summaries and recording visits in Progress Notes

Reason for Prescription

Use when prescribing – this allows you to build up your history list and add to the Reason/Type list in the previous visits of Progress Notes

Save as reason for visit

Add the item to the Reason/Type of visit list in the previous visits of Progress Notes

Previous visits: ALL

Date	Recorded by	Reason/Type of visit
07/12/1999	Dr. A. Practitioner	
04/02/2000	Dr. A. Practitioner	
04/02/2000	Dr. A. Practitioner	Pain - arm
05/02/2000	Dr. A. Practitioner	
05/02/2000	Dr. A. Practitioner	Pain - arm
13/02/2000	Dr. A. Practitioner	
23/07/2003	Dr. A. Practitioner	
24/07/2003	Dr. A. Practitioner	Diabetes
06/08/2003	Dr. A. Practitioner	

Monday August 30 2004 12:00:52
Dr. A. Practitioner
Actions:
Letter written re Care plan Diabetes

Reason for contact

Use when in Progress Notes - the item is added to the Reason/Type of visit list in the previous visits of Progress Notes

Save in PMH

This will add the item to the history list in Past History

Year	Date	Condition	Side	Status	Summary	Confidential	Coded
1990		GLUTEN ENTEROPATHY		Inactive	Yes	No	Yes
1990		ARTHROSCOPY OF KNEE	Right	Inactive	Yes	No	Yes
1996		E30 VIRAL MENINGITIS		Inactive	Yes	No	Yes
1999	12/09/1999	MIGRAINE		Active	Yes	No	Yes
2000	13/02/2000	ECZEMA		Inactive	No	No	Yes
2002		HIATUS HERNIA		Active	Yes	No	Yes
2003	24/07/2003	DIABETES		Active	Yes	No	Yes
2003	19/11/2003	ERYTHEMA		Active	Yes	No	Yes
2003	19/11/2003	PARKINSONIAN GAIT		Inactive	No	No	Yes
2003	01/12/2003	URTI - BACTERIAL		Active	No	No	Yes
2004	29/03/2004	ECZEMA		Inactive	No	No	Yes
2004	05/08/2004	REFLUX - GASTRO-OESOPHAGEAL		Active	Yes	No	Yes

New History Item

Use when in Past History to record retrospective items that are added to the history list in chronological order

Summary

Tick the summary box for "major" history items – they will then be listed in Summaries and in referral letters to specialists – a Yes appears in the Summary column of the Past History items