

CASE STUDY: EAST GEELONG MEDICAL CENTRE

Updating patient records to improve data accuracy and support better patient care

East Geelong Medical Centre analysed their smoking and allergy status records and could see they needed improving. They decided that to improve the accuracy of these records, and to meet the QIP/AGPAL accreditation standards, they would need to develop a patient information form that included not only general contact and patients details, but smoking and allergy status.

Location: Geelong, Victoria.

Staff 8 GPs, dietician (part time), podiatrist (part time), 4 practice nurses (including 1 accredited diabetes educator), 9 reception staff (full and part time).

Joined APCC Program: October 2009.

Goal: To cleanse the practice data and update patient records to provide more systematic and proactive care for their patients.

BACKGROUND

After attending a Pen Clinical Audit Tool (PenCAT) training session, run by their Division – the GP Association of Geelong, East Geelong Medical Centre developed a ‘Pen plan’ based on a template created by the Division. The **Pen Plan Template** aims to help practices cleanse their data; starting by addressing general missing information such as patient date-of-birth and gender, and then working more specifically on smoking and allergy records, before addressing chronic disease data. Analysis of their smoking and allergy status records showed a high percentage of ‘nothing recorded’, which encouraged the practice to address this information gap. This gap also meant that the practice would not meet the 90% records required for accreditation.

PROCESS

Practice nurse, Catherine is employed one day per week to update the clinical database, search the

PenCAT to pro-actively target specific patient groups, to manage the recall and reminder system, and to focus on the work required for the APCC Program. As part of her role, Catherine undertook the task of getting to know the business and it’s ‘customers’ better, by working on updating and improving the smoking and allergy status recording.

The first step to improving the data and the patient records as a whole, was for the practice team to decide how to reach their goal. The practice nurses had a meeting and worked closely with their Collaboratives Program Manager (CPM) at the Division. They decided to trial an a patient information update form, to be filled out by patients while waiting for their appointment. The CPM provided the practice with a template, to help them with the development of **their own template**. The form was adapted by the practice nurse to include questions about the patients’ contact details as well as smoking status and known allergies. Once the practice staff had reviewed and come to a consensus, the form was finalised and given to reception staff to distribute to patients.

To collect the updated patient information, the receptionists hand each patient the form upon entering the practice, requesting them to fill it out while waiting for their appointment and return it via the secure box. The response from patients so far has been very positive, with an average return of approximately 200 forms per month.

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Catherine enters all of the information collected from the forms into the patient's files in both the clinical and billing software. To ensure a patient only completes the information form once, the practice nurse created a system of adding the @ symbol in the 'special comments' section of the patient's file on Mediflex (billing software).

GPs are also reminded by sticky notes left on their computers, to check smoking and allergy status during consultations. The extra check by GPs has been an effective way of capturing data from those patients who chose not to complete the information form.

The smoking and allergy status records are monitored via PenCAT and through the APCC's monthly online data submission. In 2008, the practice had a patient population of 44,288, with 88.7% having no smoking status recorded, and 85% with no allergy status recorded. At 1 December 2009, after extensive data cleansing on their patient register, the active patient population was 10,289. Of these, only 53% of patients had no smoking status recorded and 36.4% had no allergy status recorded.

OUTCOMES

By implementing the patient information form and increasing their knowledge about their patients, the practice gained a variety of positive outcomes, including increased knowledge about their business, its records and their patient demographic.

Some of the outcomes the practice identified are:

- Improved smoking and allergy status recording assists in meeting accreditation.
- The information collected on the form has improved the accuracy of the practice's Coronary Heart Disease (CHD) and diabetes registers. Prior to the use of the form many of the patients on these registers did not have smoking or allergy status recorded.
- Improved patient demographic information.

- Reduced 'did not attends' as patients are easier to contact. Phone numbers have been updated, mobile numbers added and next of kin information recorded.
- Practice nurses and GPs have been able to provide better care to their patients by using the smoking status records to proactively identify eligible patients and discuss smoking cessation.

LOOKING FORWARD

East Geelong MC intends to continue distributing the patient information form for up to a year so as to capture a large portion of the practice's active population. Their goal is to continue making improvements in the accuracy of their smoking and allergy status records, and to keep their patient files and registers accurate. This will ultimately lead to more proactive patient care, as a result of a better knowledge of the patient's health and background.



CONCLUSION

The practice's decision to introduce a new patient information form provided unexpected and positive outcomes. While the process was driven mainly by the practice nurse, the whole team had input and continues to be involved.