PIP QI Measures
Accurately recording CVD risk factors using Bp Premier

Note: In order to maintain a high level of data quality, regularly archive patients not seen by the practice within a specified timeframe e.g. 2 years.

Measure: Proportion of patients with the necessary risk factors assessed to enable CVD assessment	
Modifiable risk factors	
Smoking status	Regularly (at least once annually) update smoking status on patient record by: • Click on **Family/Social History** in menu tree > select **Smoking** • Review status • Record a new smoking assessment • **Save**. Note: If no change since previous smoking assessment, add a note in the 'Comment' field to indicate that the status was checked.
Blood pressure	• Open patient record **(F2)** • Click on the **Stethoscope** icon • Record both systolic and diastolic blood pressure values in the allocated fields. • **Save**.
Serum lipids	To enter cholesterol data, click **Clinical > Cardiovascular risk**: 1. Total cholesterol – enter total cholesterol 2. HDL Cholesterol – enter HDL **Note:** cholesterol results will automatically populate these fields when actioned from Inbox. **Tip:** In the 'Investigations' tab, view cumulative results by clicking on the 'Atomised Results' button.
Waist circumference and BMI	• Click on **Clinical > BMI** • Enter waist and hip measurements • Enter height and weight (to calculate BMI) • **Save.**

Nutrition	Document patient nutrition details in progress notes
Physical activity level	Select **Clinical > Physical Activity prescription** • Complete current activity level and add prescribed activity and level • Print • **Save**
Alcohol intake	• Click **Open > Alcohol & Smoking History** • Complete current and past alcohol intake details • Select Audit-C • Record answers to the 3 questions • Review the Audit-C score • Save & close • **Save** Note: If no change to alcohol consumption status since previous assessment, add a note in the 'Comment' field to indicate that the status was checked.
Non-modifiable risk factors	
Age and sex	Age: Select **Open > Demographics**. Ensure a **date of birth** has been accurately recorded on the patient record. Sex: Select **Open > Demographics**. Ensure the **sex** field has been completed.
Family history of premature CVD	Record Family history including Unknown or 'No significant Family History' if applicable Click on **Family & Social history in the** menu tree Add a coded diagnosis of CVD in Family History as relevant to individual family members
Social history including cultural identity, ethnicity and socioeconomic status	Record Social history ie record any relevant factors as a comment in Social History screen Record Ethnicity in Patient Demographics 1. Select **Open > Demographics**. Click **Ethnicity** and select an option form the list **2. Save** Record Aboriginal & Torres Strait Islander Status in Patient Details:

	1. Select **Open > Demographics** **2.** Click **Ethnicity** 3. **Select an entry from the drop-down list** as applicable to indicate the patient's Aboriginal and Torres Strait Islander Status (as applicable). 4. If 'Other' is selected, you will be prompted to select from a further list of ethnicities. 5. **Click to select** an entry. 6. **OK**
Related conditions	
Diabetes	Enter a **coded diagnosis** of Diabetes in the Past History on patient record 1. Select **Past History** **2. Add** 3. Enter diagnosis date 4. Type the first few characters of the condition nt he search field 5. Double click to select the condition from coded list 6. Tick the relevant options (Active etc) **7. Save.**
CKD (albuminuria ± urine protein, eGFR)	Enter a **coded diagnosis** of CKD in the Past History on patient record Albuminuria – urine test (will automatically populate to Investigations when actioned from Inbox) Urine protein – urine test (will automatically populate to Investigations when actioned from Inbox) eGFR – blood test (will automatically populate to Investigations when actioned from Inbox)
Familial hypercholesterolaemia	Enter a coded diagnosis of '**hypercholesterolaemia'** in the Family History on the patient record
Evidence of AF (history, examination, electrocardiogram)	Enter a coded diagnosis of **Atrial Fibrillation** in the Past History on the patient record (as applicable).