PIP QI Measures
Accurately recording CVD risk factors using Medical Director

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 **Smoking History** • Review status • Select **New Assessment** and record details • **Save**. Note: If no change since previous smoking assessment, add a note in the 'Comments' field to indicate that the status was checked.
Blood pressure	• Open patient record **(F2)** • Click on **Tools > Toolbox > Blood Pressure** • Record both systolic and diastolic blood pressure values in the allocated fields. • **Save.**
Serum lipids	To enter cholesterol data manually: 1. Click **Tools > Toolbox > CVD Risk**: 2. Enter Total cholesterol – total cholesterol (in mmol/L) 3. Enter HDL Cholesterol – HDL (in mmol/L) Note: cholesterol results will automatically populate these fields when actioned from Holding File. **Tip:** In the 'Results' tab, view atomised results by clicking on 'Cumulative Results' button at the bottom of the page.
Waist circumference and BMI	• Click on **Tools > Toolbox > Weight** • Enter waist and hip measurements (in cm) to calculate waist/hip ratio • Enter height and weight (to calculate BMI) • **Save.**

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<table>
<tr><td>Nutrition</td><td>Document patient nutrition details in progress notes OR
Use the Nutrition Assessment brochure in Patient Education to document patient nutrition details:
• Click on the scholar icon
• Select General Information
• Select Nutrition Assessment > Mini Nutrition Assessment
• Complete the form (editable PDF)
• Save
• Print
Tip: Click on the Green tick ✓ on the patient education page to notate ‘patient education leaflet printed’ in progress notes.</td></tr>
<tr><td>Physical activity level</td><td>Select Assessment > Physical Activity
• Click Assessment and complete current activity level
• Save
• Click Prescribe and follow the prompts to create a physical activity prescription
• Print and Save</td></tr>
<tr><td>Alcohol intake</td><td>• Click on Patient > Details > Alcohol
• Click New Assessment
• Complete the Audit-C questions
• Save
Note: If no change to alcohol consumption status since previous assessment, add a note in the ‘Comments’ field to indicate that the status was checked.</td></tr>
<tr><td colspan="2">Non-modifiable risk factors</td></tr>
<tr><td>Age and gender</td><td>Age: Select Patient > Details. Ensure a date of birth has been accurately recorded on the patient record.
Gender: Select Patient > Details. Ensure the gender field has been completed.</td></tr>
<tr><td>Family history of premature CVD</td><td>Record Family history including Unknown or No significant Family History if applicable (to indicate this has been checked).
Click on Patient > Details > Family & Social History
Record family medical history details in the Family History box.</td></tr>
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Social history including cultural identity, ethnicity and socioeconomic status	Record social history 1. Click on **Patient > Details > Family & Social History** 2. Record as a comment in Social History box **3. Save** Record ethnicity in Patient Demographics: **1.** Select **Patient > Details** 2. Click the grey **box** to the right of the Ethnicity field ... 3. Enter the first few characters of the country in the search field and tick to select one or more ethnicities **4. OK** Record Aboriginal & Torres Strait Islander Status in Patient Demographics: **1.** Select **Patient > Details** **2.** Click **ATSI** 3. Select an entry from the drop-down list **4. OK**
Related conditions	
Diabetes	Enter a **coded diagnosis** of Diabetes in the Past History on patient record **1.** Click on **Past History** 2. Enter the **date of diagnosis** 3. Click the red '+' sign to Add a new diagnosis 4. Enter the first few characters of the condition and click to **select from the list** 5. Tick the relevant options (Active, Summary etc) **6. OK**
CKD (albuminuria ± urine protein, eGFR)	Enter a **coded diagnosis** of CKD in the Past History on patient record (see steps above) Albuminuria – urine test (will automatically populate to Results when actioned from Holding File) Urine protein – urine test (will automatically populate to Results when actioned from Holding File) eGFR – blood test (will automatically populate to Results when actioned from Holding File)

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Familial hypercholesterolaemia	Enter a 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

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