Accreditation using MedicalDirector

- WentWest -

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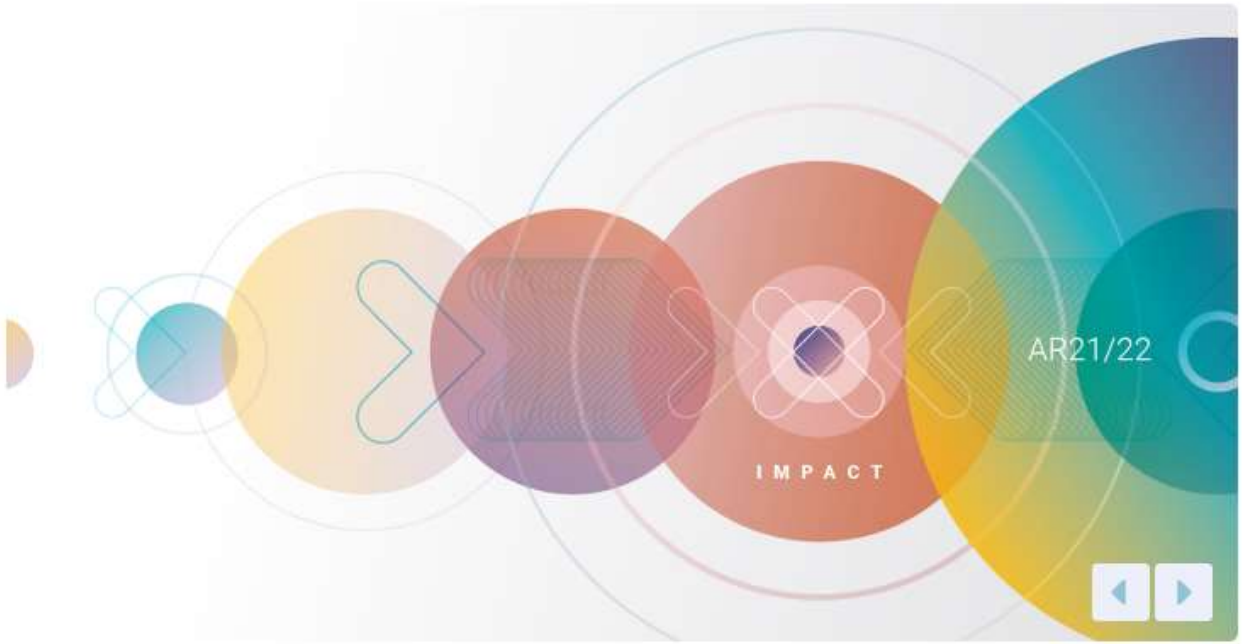

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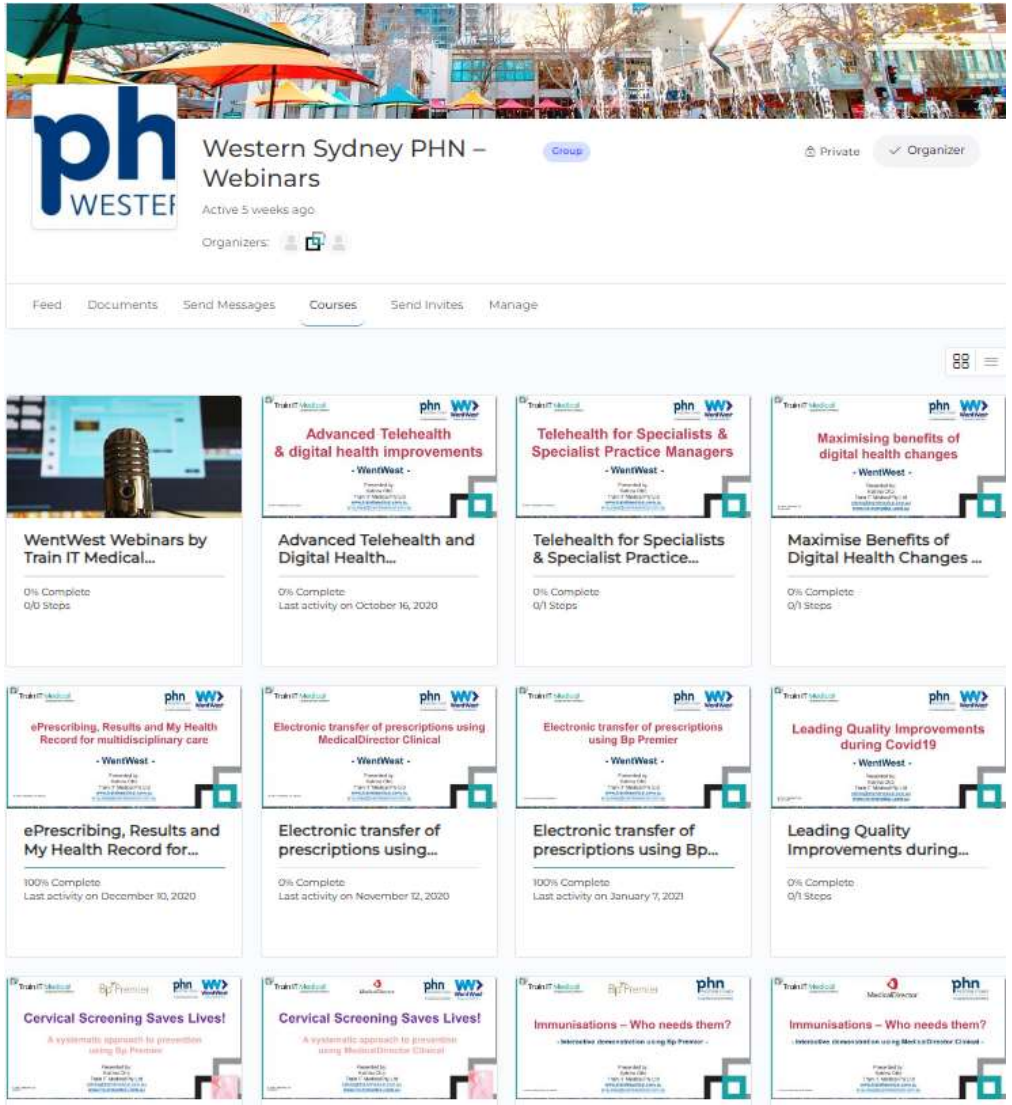
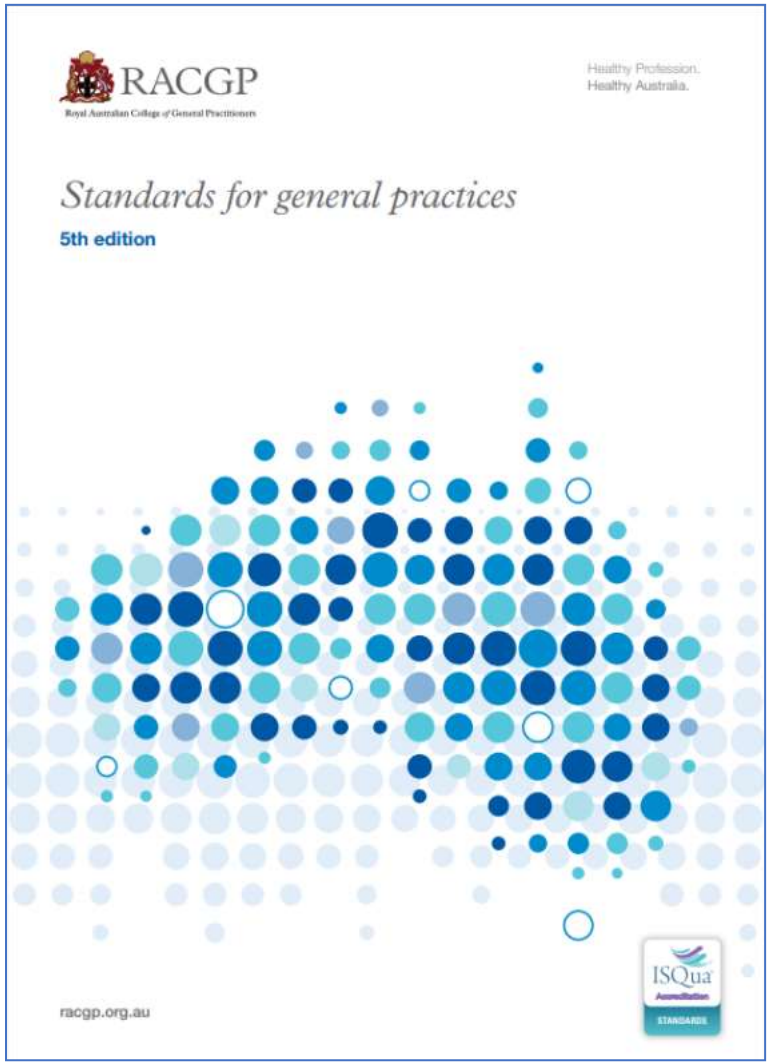




RACGP – Standards for General Practice (5th Edition)

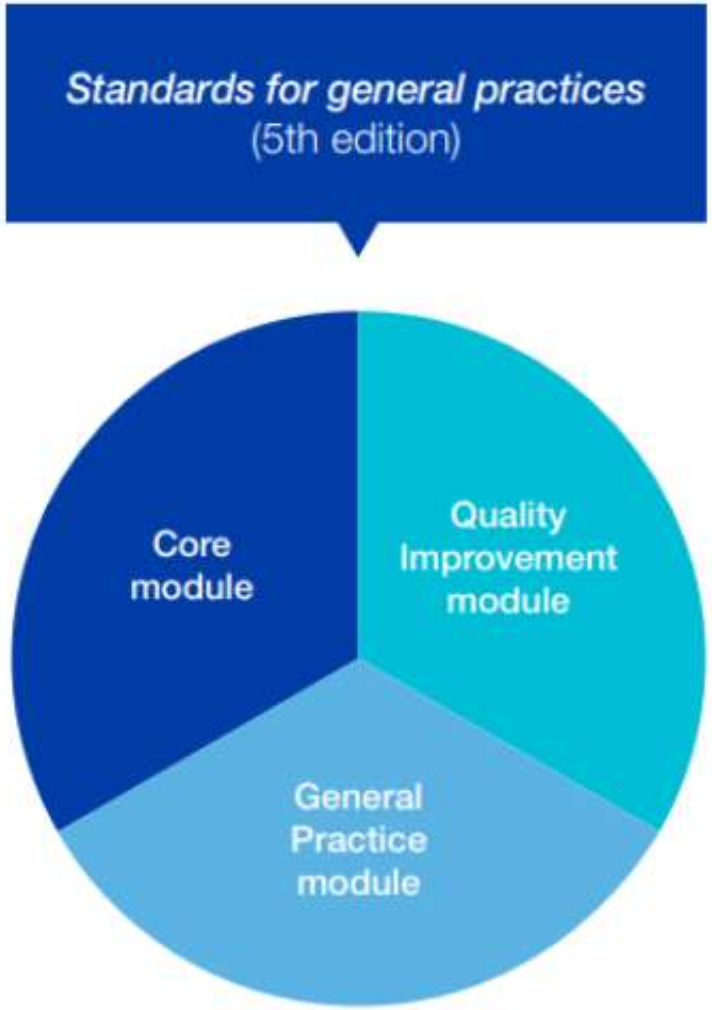
RACGP – Standards for General Practice (5th Ed) Resource Guide

Learning Outcomes:

1. Understand the benefits of accreditation for your practice.
2. Discuss your practice system for access to records as well as security, storage, retention & destruction.
3. Analyse data for health improvements and practice management using MedicalDirector.
4. Lead data driven improvements with confidence.

Top 7 Benefits of Accreditation

1. Indicates the practice meets high standards of clinical governance, patient care and safety.
2. Recognition from patients, insurers, peak bodies, enhances your practice reputation.
3. Gives you a competitive advantage and may help attract doctors, NPs, nurses to your practice
4. Encourages continual team collaboration and improvement of systems and processes.
5. Improved patient safety and health outcomes.
6. Provides a framework for effective risk management (think Pandemic policy!)
7. Access to funding and Initiatives – Practice Incentives Program (PIP), Quality Incentives, grants.



3 modules

17 standards
42 criteria
123 indicators

Accreditation format

Criterion C6.1 – Patient identification

Indicator

C6.1►A Our practice uses a minimum of three approved patient identifiers to correctly identify patients and their clinical information.

You must:

- use a minimum of three approved patient identifiers to confirm a patient's identity each time they attend or call the practice.

You could:

- keep a prompt sheet at reception to remind reception staff to ask for approved patient identifiers
- explain to patients the reasons for identifying them at each visit (eg safety reasons, keeping accurate patient details), particularly if you have a small practice or have patients well known to the practice team members.

1. Full name
2. Date of birth
3. Address

Accreditation for Practice Manager

- ✓ Clear policies and procedures to follow
- ✓ Consistently review our business processes.
- ✓ We create and work to a business plan
- ✓ Can review performance against procedures.
- ✓ Team meetings
- ✓ Include all staff to collaborate and share ideas for improvements.
- ✓ Consider all patient feedback and include evidence based surveys

https://www.5thmap.com.au/

Learning Objective 2:

Discuss your practice system for access to records as well as security, storage, retention & destruction.

Medical records

Medical records

- Your practice must ensure the health information it collects, uses or discloses is relevant, accurate, up-to-date and complete.
- Your practice must ensure health information that is no longer practically or legally needed is destroyed or de-identified.
- Medical records are usually owned by the practice, not the patient.

https://www.racgp.org.au/running-a-practice/security/managing-practice-information/privacy-of-health-information/information-management-for-gp/medical-records

Criterion C6.4 – Information security

Indicators

C6.4►A Our practice has a team member who has primary responsibility for the electronic systems and computer security.

C6.4►B Our practice does not store or temporarily leave the personal health information of patients where members of the public could see or access that information.

C6.4►C Our practice's clinical software is accessible only via unique individual identification that gives access to information according to the person's level of authorisation.

C6.4►D Our practice has a business continuity and information recovery plan.

C6.4►E Our practice has appropriate procedures for the storage, retention, and destruction of records.

C6.4►F Our practice has a policy about the use of email.

C6.4►G Our practice has a policy about the use of social media.

C6.4►F Our practice has a policy about the use of email.

You must:

- maintain an email policy.

You could:

- put your email policy on your website
- have an automated response to patient emails that advises them of when they are likely to receive a response.

C6.4►G Our practice has a policy about the use of social media.

You must:

- maintain a social media policy.

You could:

- put your social media policy on your website.

Let’s discuss:

- Staff access to records
- Access to clinical records
- Permission settings
- Tips for managing a hybrid system
- Storage of your hard copy documentation
- Protecting confidentiality
- Patient access to own records

Retention of Records

In general, adult patient records are typically retained for a minimum of **7 years** from the date of the last entry or, **if a minor, until the patient turns 25.**

Destruction of Records

- Secure destruction methods may include **shredding physical records** or **secure deletion** and disposal of electronic records.
- Destruction should follow applicable privacy and data protection laws and guidelines to prevent unauthorized access or misuse of patient information.

Confidentiality, Security, Access to records

- Practices should implement appropriate security measures, including **password-protected** electronic systems, **restricted physical access** to records, and **staff training** on privacy and security protocols.

- **Encryption and secure transmission** of electronic records are essential to maintain data security.

- Personal health information must be protected from unauthorized access, use, or disclosure. **It's your responsibility!**

Do patients own their record?

- No, however patients have a legal right to access their medical records under the Privacy Act 1988 and the Australian Privacy Principles (APPs).
- General practices should have processes in place to provide patients with access to their records upon request.
- Access can be provided electronically or in hard copy, depending on the practice's capabilities and patient preferences.
- Practices may charge a reasonable fee for providing access to records, as permitted by the APPs.

Learning Objective 3

Analyse data for health improvements and practice management using MedicalDirector

Criterion C7.1 – Content of patient health records

Indicators

C7.1►A Our practice has an individual patient health record for each patient, which contains all health information held by our practice about that patient.

C7.1►B Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact information.

C7.1►C Our patient health records include records of consultations and clinical related communications.

C7.1►D Our patient health records show that matters raised in previous consultations are followed up.

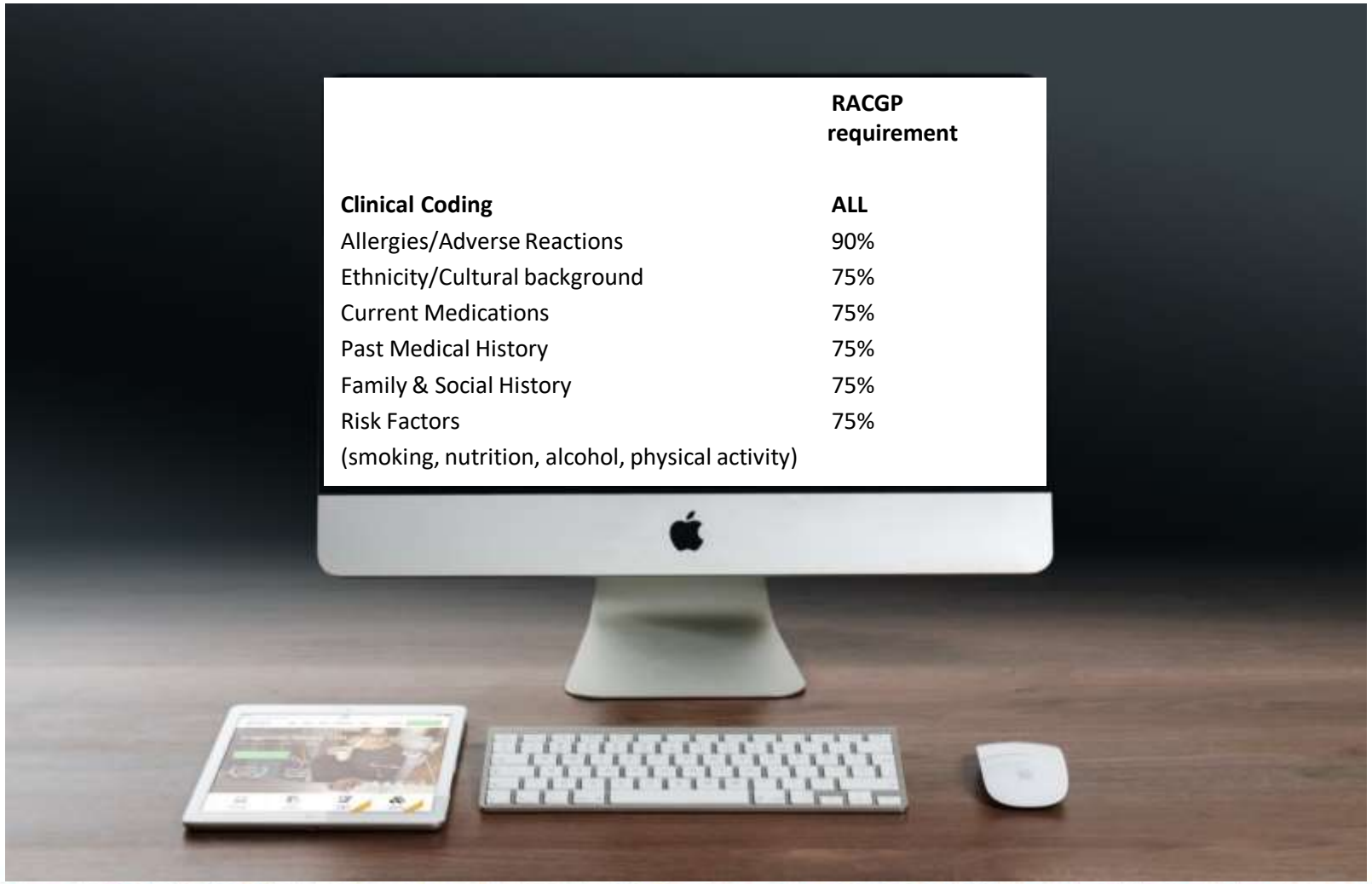
C7.1►E Our practice routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.

C7.1F Our practice routinely records the cultural backgrounds of our patients in their patient health record.

C7.1►G Our patient health records contain, for each active patient, lifestyle risk factors.

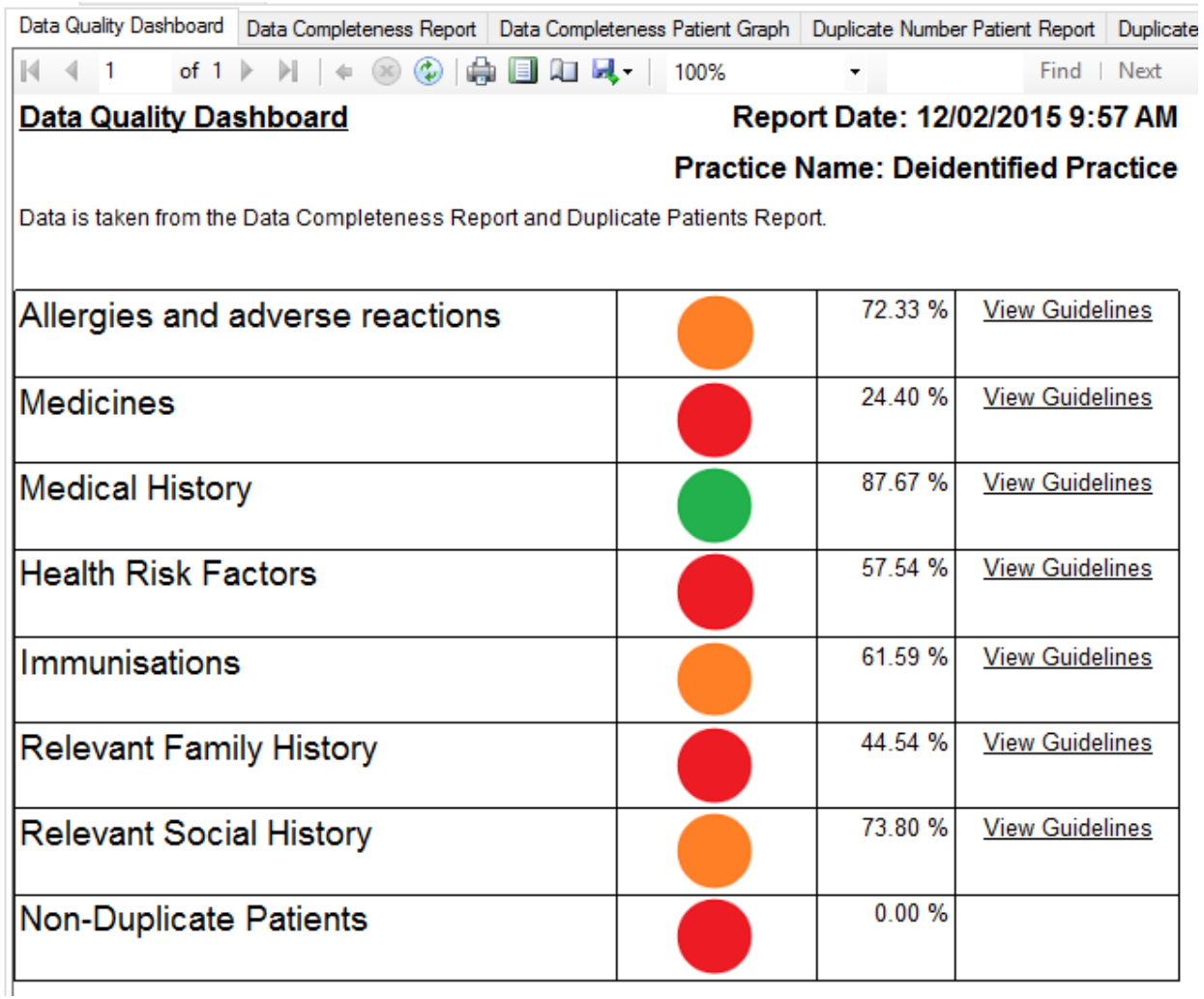
RACGP Standards

Do you meet the RACGP Standards for ‘active’ patients?



	RACGP requirement
Clinical Coding	**ALL**
Allergies/Adverse Reactions	90%
Ethnicity/Cultural background	75%
Current Medications	75%
Past Medical History	75%
Family & Social History	75%
Risk Factors (smoking, nutrition, alcohol, physical activity)	75%

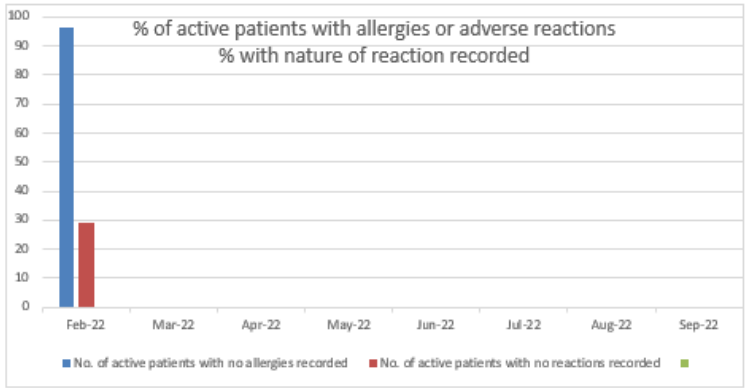
Data Quality Dashboard



Quality Improvement (PDSA) – PLAN, DO, STUDY, ACT

Allergies & Adverse Reactions

PLAN: What are our goals:	**IMPROVE PATIENT SAFETY**
1. Routinely record 'type of reaction' in relation to allergies and adverse reactions. 2. Meet RACGP standards by ensuring high quality data collection and routine questioning.	
IMPROVEMENT IDEAS from the team:	***Keep the ideas coming*** 😊
1. Clinicians to routinely ask and record allergies/ adverse reactions and type of reaction in medical records. 2. Change the patient registration form to enable patients to record type of reaction. 3. Provide education on allergies versus adverse reactions. 4. Provide case studies. 5. Add to agenda to discuss at next staff meeting.	
DO: Which ideas will we try in an attempt to reach our goals:	
1. Clinicians to routinely update allergies and adverse reactions in medical records and add 'type of reaction'. 2. Update patient registration forms (manual and electronic).	All doctors, nurses & MPA Managers
STUDY: How will we measure our progress:	
Improve the recording of 'nature of reaction' for active patients with allergies/adverse reactions recorded by 20% by end of December.	



ACT (Reflection): Is the change working? If not what else could we try to make this work more effectively:	

Please tell us your ideas and thoughts. | **All feedback gratefully received** 😊

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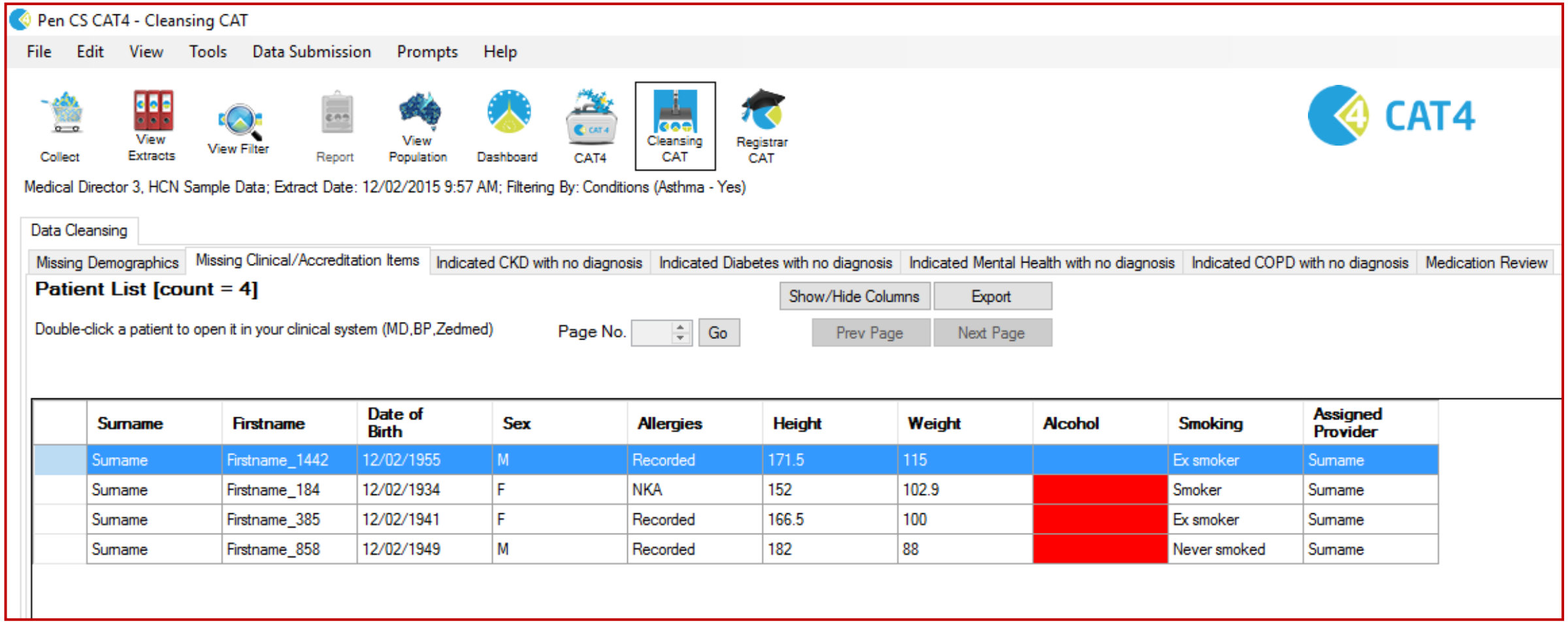
Search Queries | PEN CAT4 | Cleansing CAT | Cubiko



Surname	Firstname	Date of Birth	Sex	Allergies	Height	Weight	Alcohol	Smoking	Assigned Provider
Surname	Firstname_1442	12/02/1955	M	Recorded	171.5	115		Ex smoker	Surname
Surname	Firstname_184	12/02/1934	F	NKA	152	102.9		Smoker	Surname
Surname	Firstname_385	12/02/1941	F	Recorded	166.5	100		Ex smoker	Surname
Surname	Firstname_858	12/02/1949	M	Recorded	182	88		Never smoked	Surname

Clean up before you analyse your database:

1. Mark deceased patients as ‘deceased’.
2. Inactivate patients by searching for patients not seen for two years.
3. Delete Sample patients.
4. Delete records with no clinical data.
5. Merge duplicate patient records
   (and if you have a lot of duplicate records evaluate your processes)

Evidence has shown that
quality improvement activities lead to positive change in practices*,*
particularly when a
whole practice team
approach is adopted.

Accreditation – Quality Improvement Module

Criterion QI1.1 – Quality improvement activities

Indicators

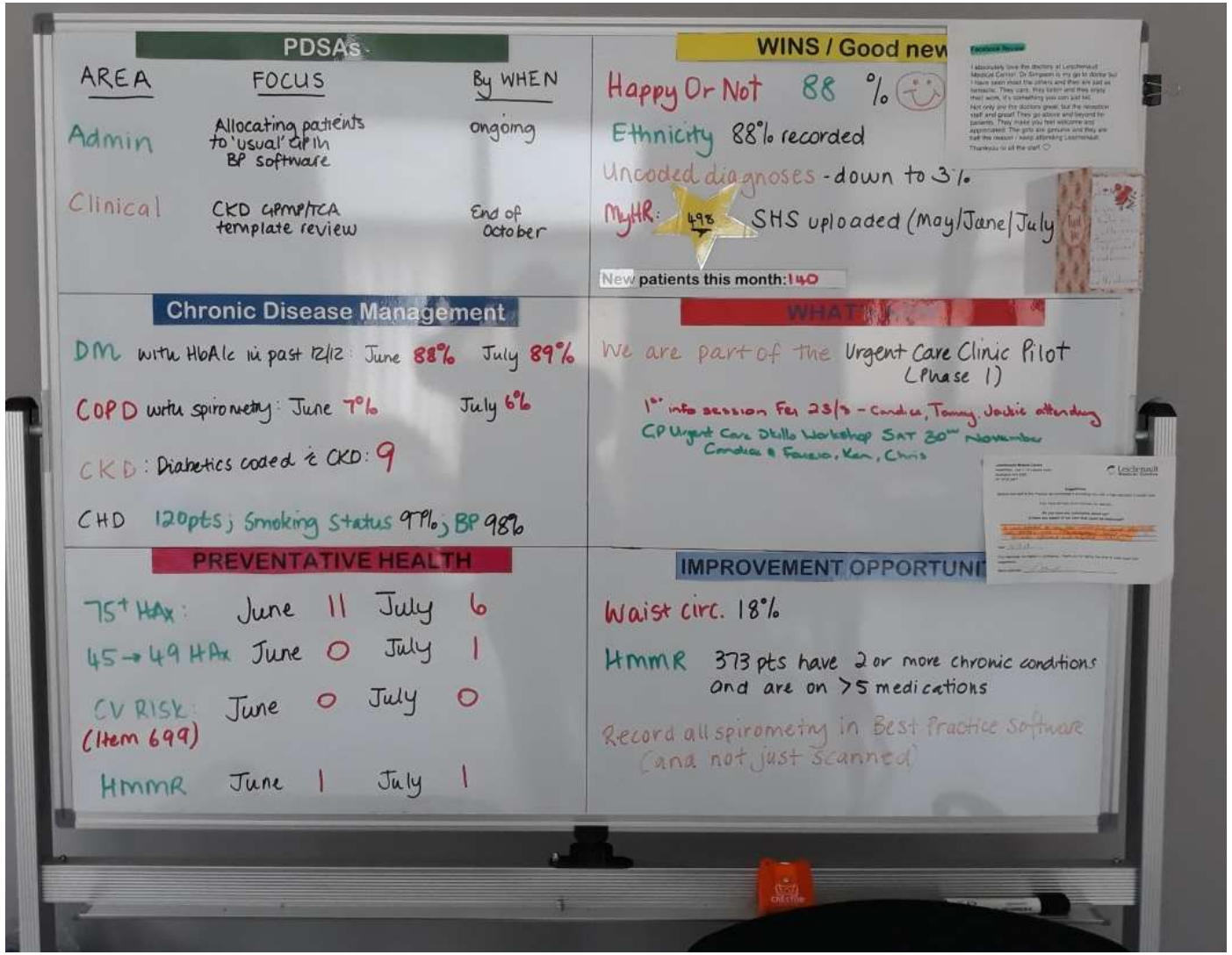
QI1.1►A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1►B Our practice team shares information internally about quality improvement and patient safety.

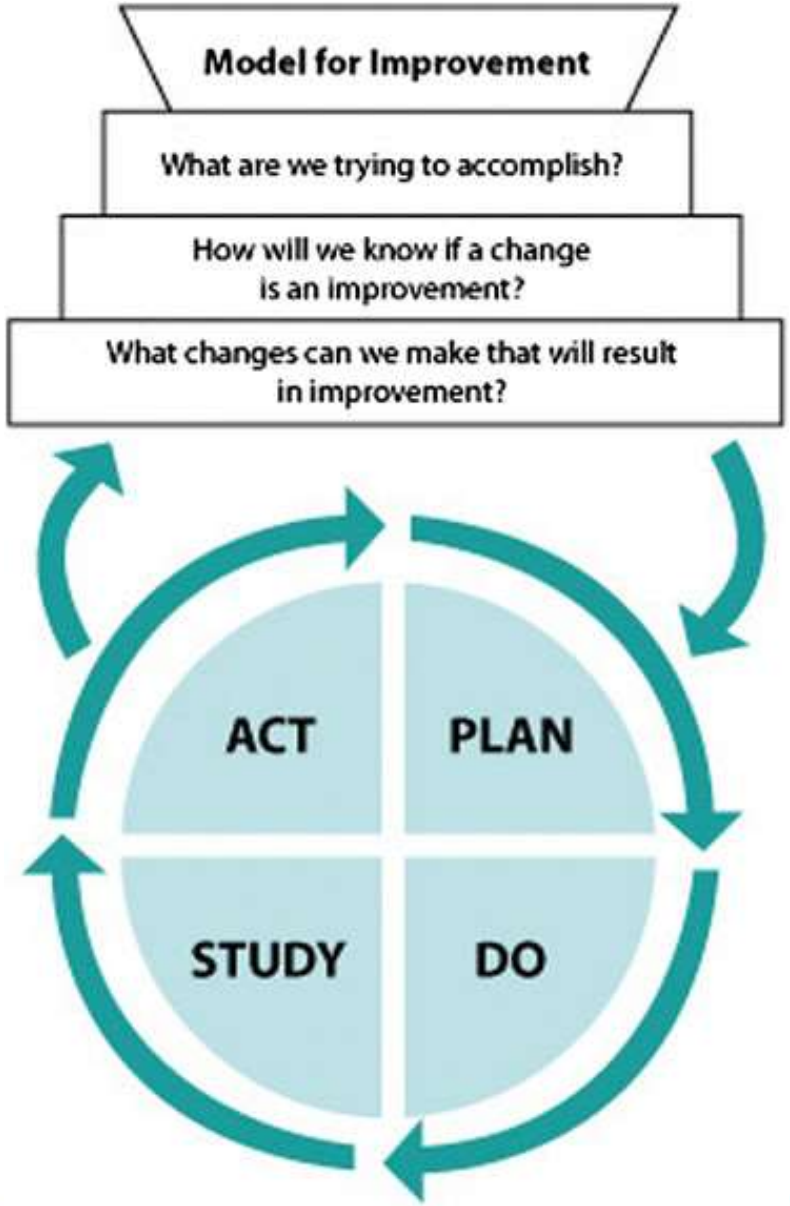
QI1.1►C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1►D Our practice team can describe areas of our practice that we have improved in the past three years.

[RACGP Standards]



Example from Leschenautt Medical, Bunbury, WA

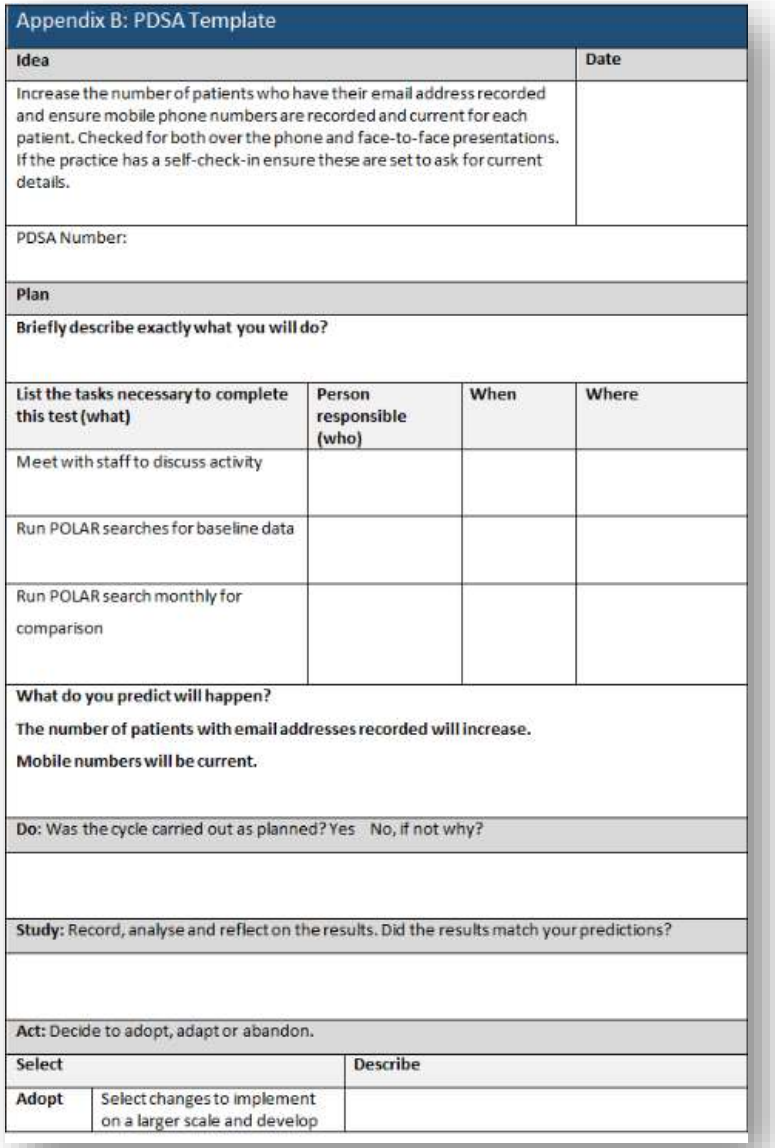

Model for Improvement
What are we trying to accomplish?
How will we know if a change is an improvement?
What changes can we make that will result in improvement?
ACT
PLAN
STUDY
DO

WentWest QI

mobile phone numbers
emails

carer details

NOK



Appendix B: PDSA Template

Idea	Date
Increase the number of patients who have their email address recorded and ensure mobile phone numbers are recorded and current for each patient. Checked for both over the phone and face-to-face presentations. If the practice has a self-check-in ensure these are set to ask for current details.	

PDSA Number:

Plan

Briefly describe exactly what you will do?

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
Meet with staff to discuss activity			
Run POLAR searches for baseline data			
Run POLAR search monthly for comparison			

What do you predict will happen?

The number of patients with email addresses recorded will increase.

Mobile numbers will be current.

Do: Was the cycle carried out as planned? Yes No, if not why?

Study: Record, analyse and reflect on the results. Did the results match your predictions?

Act: Decide to adopt, adapt or abandon.

Select		Describe
Adopt	Select changes to implement on a larger scale and develop	

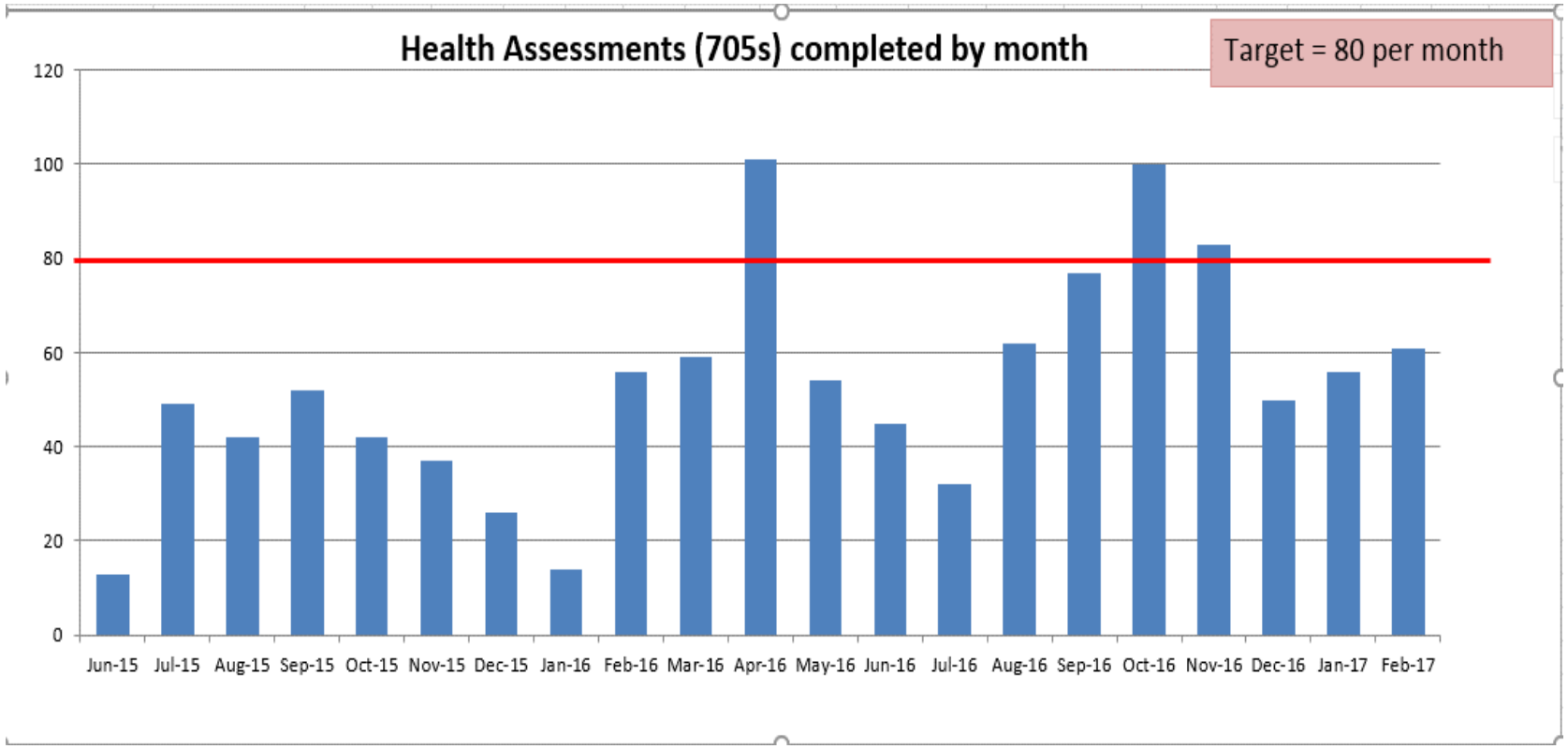
The PDSA

SAMPLE Quality Improvement (QI) Activity - Improve recording of Aboriginal and/or Torres Strait Islander status

What is our GOAL? **(what are we trying to accomplish)**	Improve identification and focused health improvement initiatives for patients who identify as Aboriginal and/or Torres Strait Islander. ▪ **Record Aboriginal and/or Torres Strait Islander status.**
What measures will we use? (i.e. data)	% of patients with Aboriginal or Torres Strait Island status recorded in the coded section of their medical record.
What ideas can we use? **(how are we going to achieve our goal)**	*List ideas here to work on in table below* • Pen CAT / Polar Data Quality Audit of records to measure baseline. • Assess current waiting room and process. • Learn correct place to enter information in software. • Attend education e.g. webinars / face to face sessions • Post-education follow-up team discussion • Team meeting to discuss the issue, benefits & any current barrier.

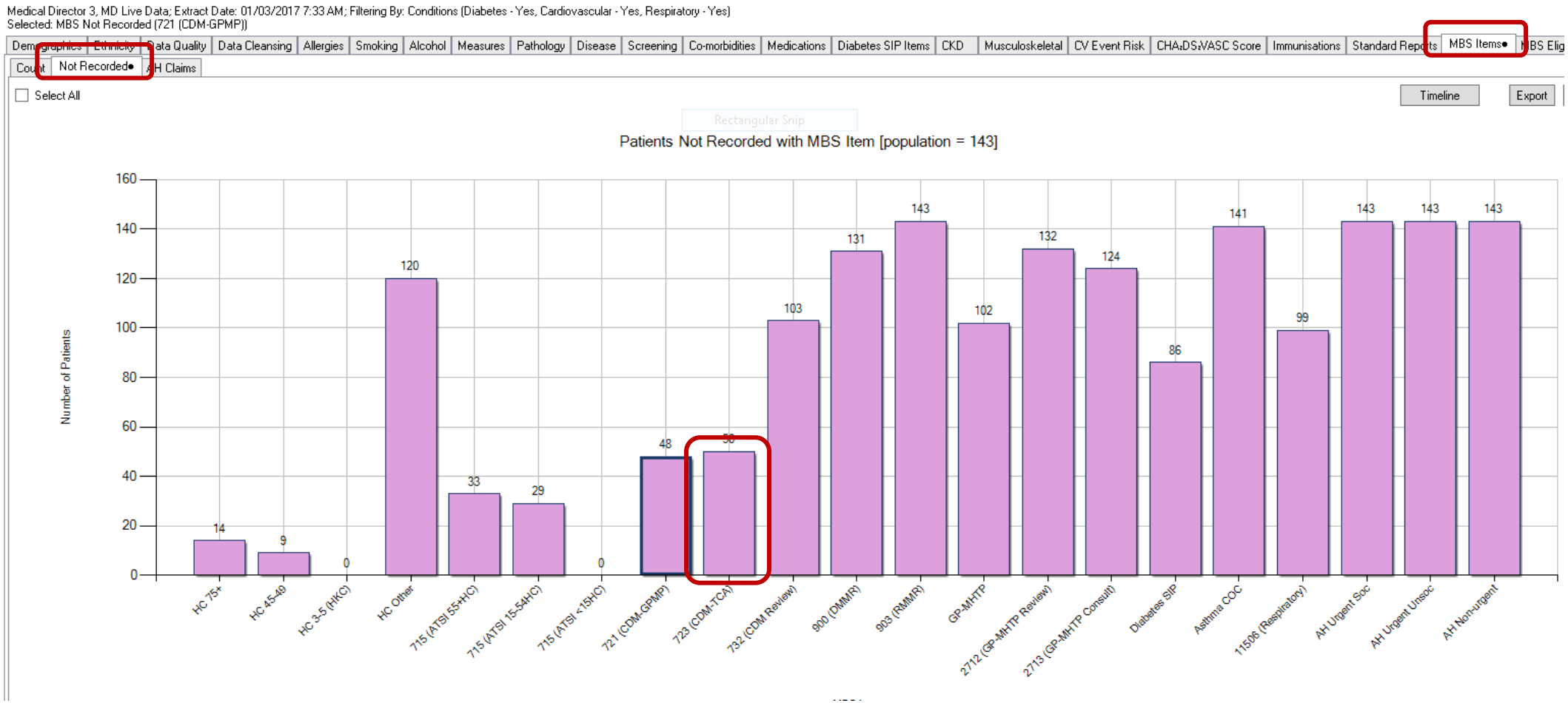
Possible ideas from brainstorming at team meeting:	*Prioritise on patient registration form.* *Double-check details are being transposed from patient registration form.* *Attend cultural competency training.* *Put up self-identification posters in waiting room.* *Have focus groups and include existing patients so staff can learn how best to ask.* *Design culturally appropriate 'dialogue' for front desk staff for how to ask based on recommended guidelines.* *Model how to ask with all front desk staff.* *Increase aboriginal artwork on walls.* *Put up Aboriginal and Torres Strait Islander flags.* *Hire an Aboriginal Health Worker* *Start an Aboriginal Health Clinic* *Add information relating to relevant services offered on our website.*

Your KPIs – track performance



Tips: Encourage a team effort to achieve the goals by setting a target on the graph & place graph in the staff room/noticeboard to encourage a proactive approach.

Identify patients with a chronic condition without a GPMP

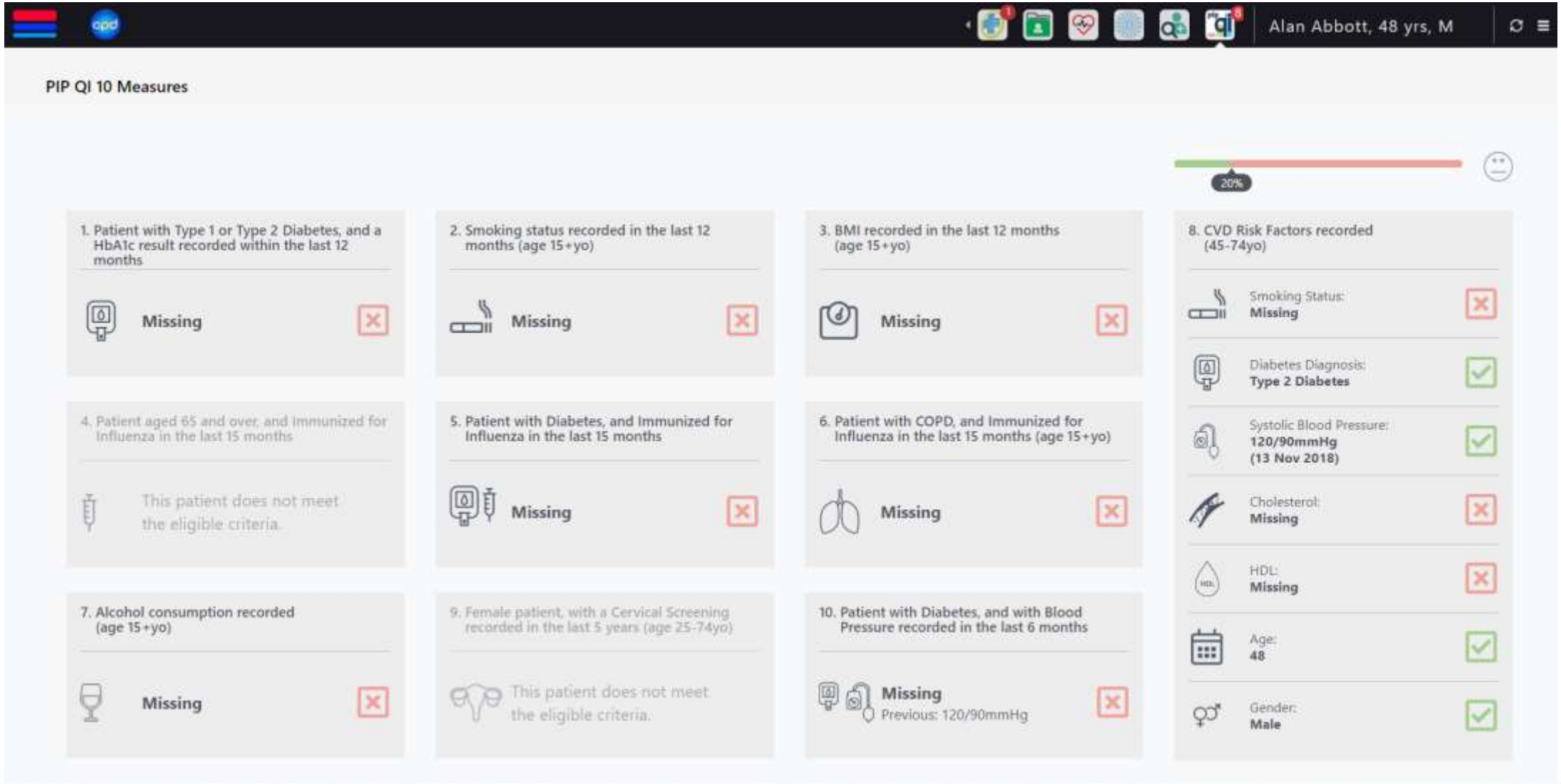


PIP QI – Eligible data set - Improvement measures

1. Proportion of patients with smoking status recorded
2. Proportion of patients with alcohol status recorded
3. Proportion of patients with weight classification.
4. Proportion of patients with up-to-date cervical screening.
5. Proportion of patients with diabetes with blood pressure recorded
6. Proportion of patients with diabetes with current HbA1c result
7. Patients with diabetes immunised against influenza
8. Proportion of patients COPD & immunised against influenza
9. Proportion of patients over 65 immunised against influenza
10. Proportion of patients with necessary risk factors to enable CVD assessment

Practices may focus their quality improvement activities on areas which are informed by their clinical information system data and meets the needs of their practice population.

Use your evidence to focus your improvements



Learning Objective 4

Lead data driven improvements with confidence.

Keys to success are:

1. Idea sharing
2. Teamwork
3. Energy

How do we identify areas for practice improvement?

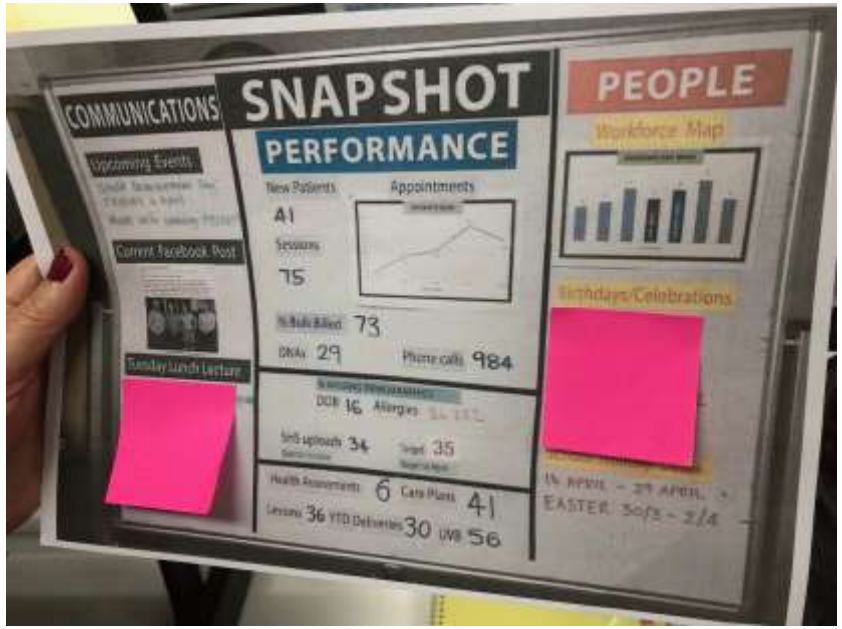
- Data quality dashboard
- Financial reports
- Staff feedback
- Near misses
- Patient surveys
- Patient complaints
- Patient Reported Experience Measures (PRMS)

PDSA station

Example from Leschenautt Medical Centre, WA

Engage your team

- **Create a culture of quality**
- **Clear constant communication (try huddles)**
- **Lead with positivity**



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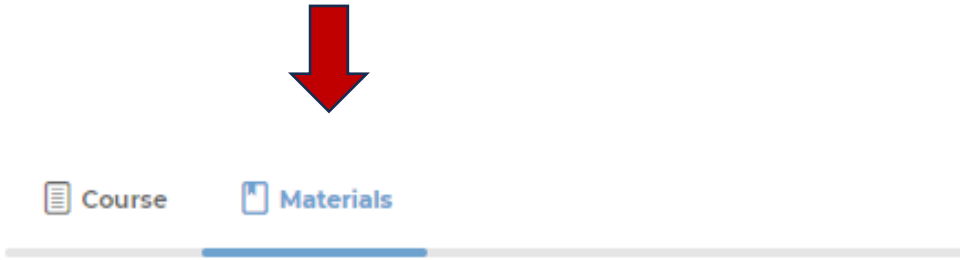

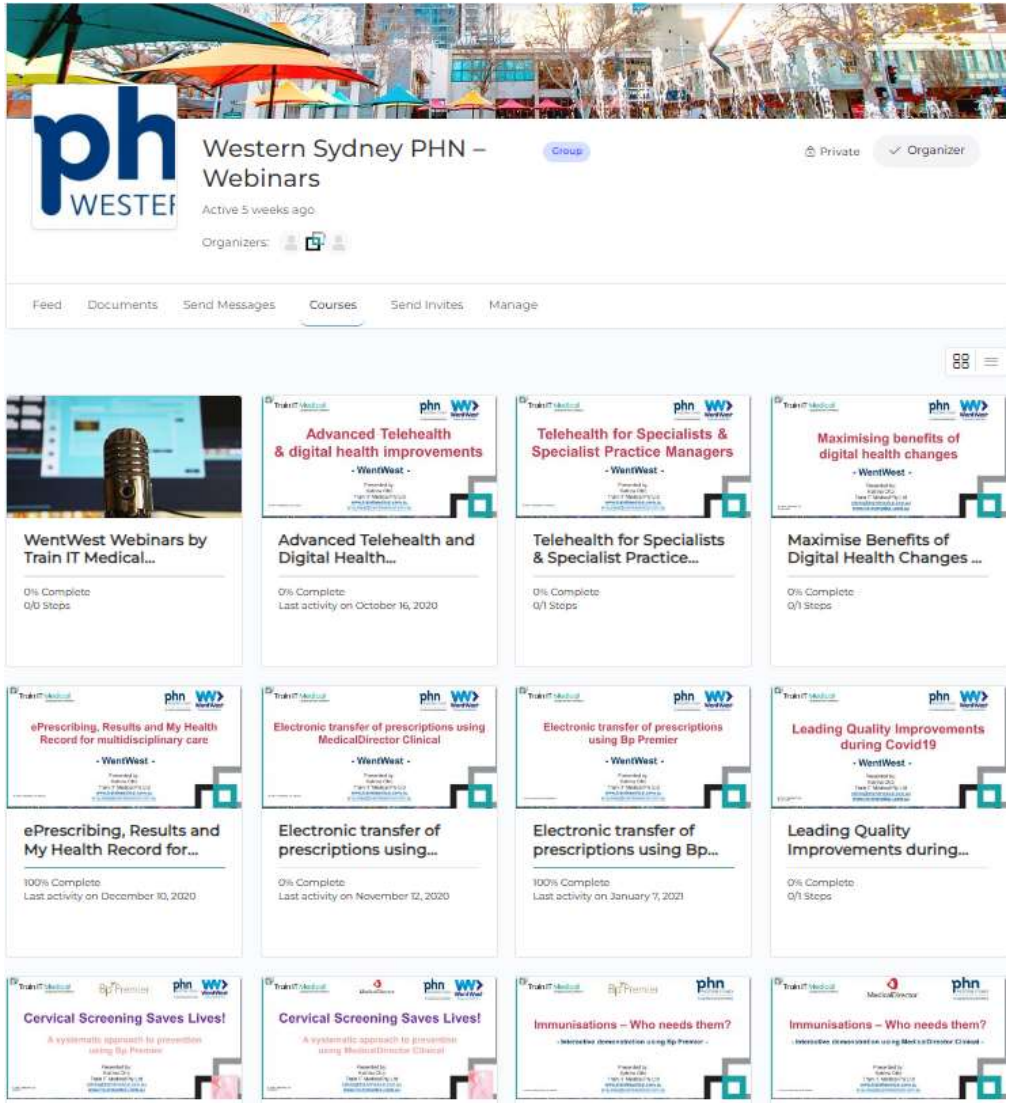

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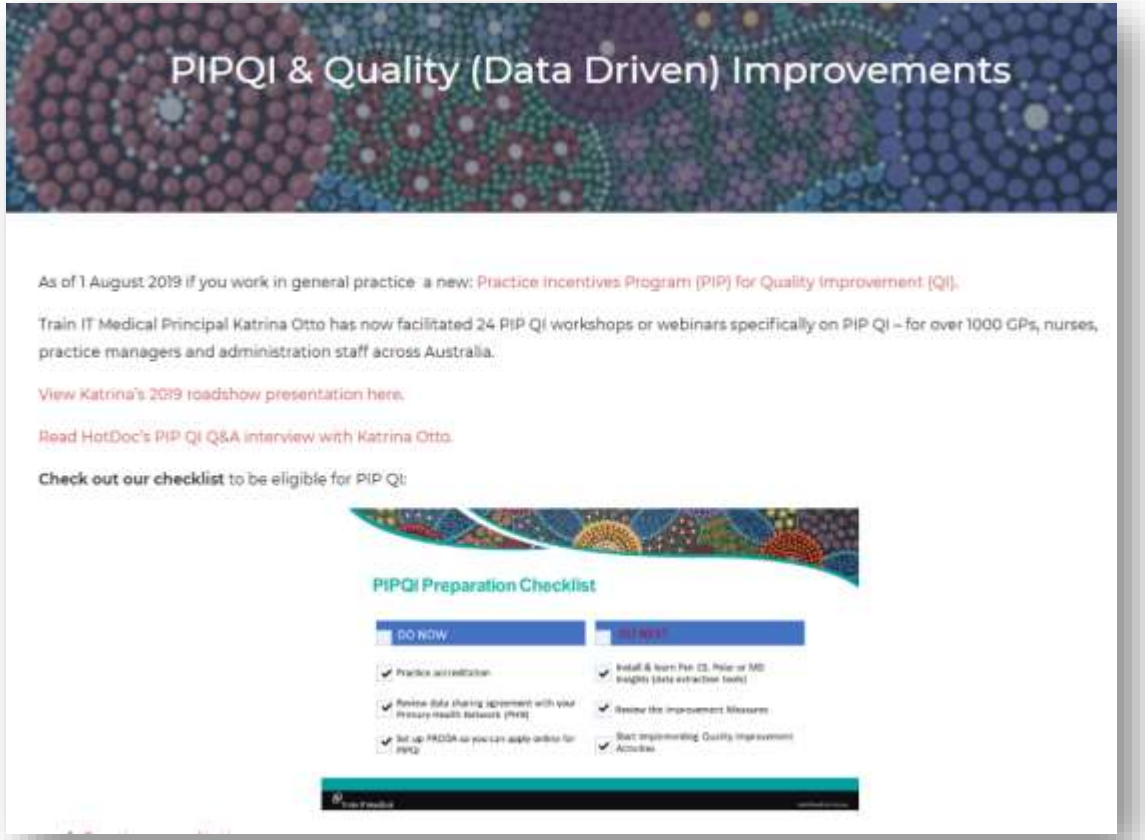

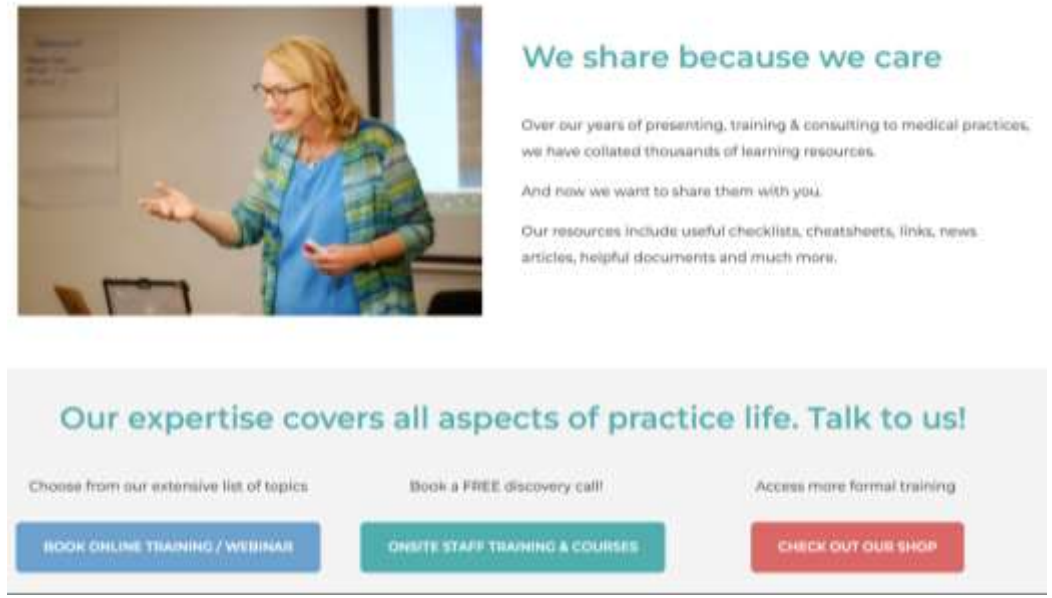

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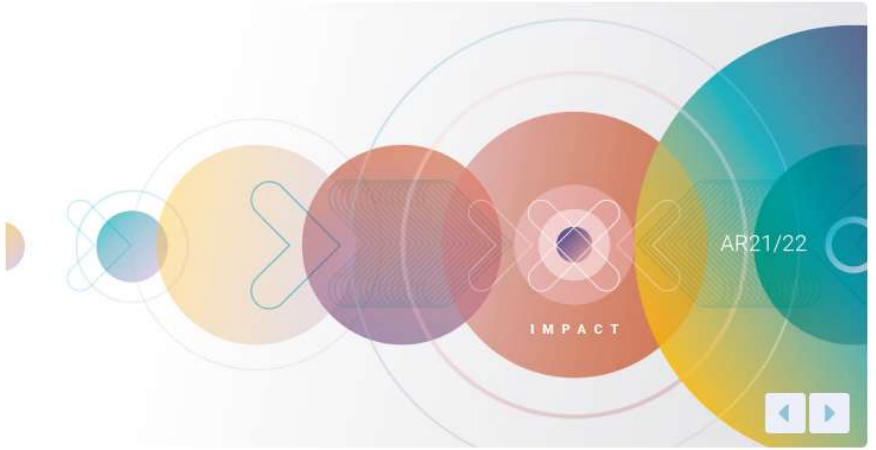

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