Criterion QI1.3 – Improving clinical care

Indicators

QI1.3A Our practice team uses a nationally recognised medical vocabulary for coding.

QI1.3▶B Our practice uses relevant patient and practice data to improve clinical practice (eg chronic disease management, preventive health).

Why this is important

Using a nationally recognised medical vocabulary helps you to collect structured data that can be used to review clinical practices in order to improve quality and safety.

Collecting structured clinical data can help improve patient care because it can be used when:

- carrying out quality improvement activities, such as practice audits and plan, do, study, act (PDSA) cycles
- implementing processes that identify patients with particular medical conditions (eg registers for chronic diseases such as diabetes).

Meeting this Criterion

Standardised clinical terminology

Using a nationally recognised medical vocabulary means that:

- key details of a consultation (eg why a patient attends the practice, the problems managed during a consultation, referrals and requested investigation) are recorded in a standardised way
- data can be retrieved for auditing, quality improvement and continuity of care
- analysis of your practice's data is more accurate and reliable
- there will be less ambiguity, which is sometimes the case when free text descriptions are used in a patient's health record.

Nationally recognised medical vocabularies, such as the World Health Organization's (WHO's) International Classification of Primary Care (ICPC) and SNOMED CT, help to ensure that data is recorded consistently and can be used for multiple purposes, such as chronic disease registers and population health research.

Most general practice clinical software systems in Australia use a recognised medical vocabulary (eg DOCLE, PYEFINCH, SNOMED CT, ICPC and ICPC2+).

If you are using a software system that does not use a nationally recognised medical vocabulary, you might consider how you could include one in your patient health records.

You do not necessarily need to re-code existing information previously recorded as free text, particularly if there are important details in a patient's medical history that are difficult to formally code, but adding some standardised vocabulary might be useful.

You could also develop a policy and process to implement a recognised medical vocabulary to ensure consistency in newly created records and when updating records.

Improving clinical practice

Quality improvement is an essential part of routine care, which involves making changes that will increase quality and safety for patients.

Quality improvement activities can include activities specifically designed to improve clinical care or the health of the entire practice population, such as changes to:

- rates of immunisation
- how the practice cares for patients with diabetes or hypertension
- systems used to identify risk factors for illnesses that are particularly prevalent in the practice's local community (eg cardiovascular disease)
- antibiotic prescribing to improve clinical care and/or the health of the entire practice population.

Improving clinical practice through clinical audits

You can undertake a clinical audit in order to improve your clinical practice. A clinical audit is a planned medical education activity designed to help practitioners systematically review aspects of their own clinical performance against defined best practice guidelines. The two main clinical audit components are:

- an evaluation of the care that a practice and its individual practitioners provide
- a quality improvement process.

Research indicates that the process of audit and feedback is widely used to improve professional practice. The process of audit and feedback can be used on its own or as part of multifaceted quality improvement intervention, and can often lead to small but potentially important improvements in practice.[2]

Improving clinical practice through PDSA cycles

You could also choose to complete a PDSA cycle to improve your clinical practice. PDSA cycles encourage the individual practitioner or the practice team to implement a planned improvement by breaking it down into small, manageable stages. The PDSA stages are completed one at a time, and small changes achieved at each stage are tested to make sure that improvement has occurred without wasted effort before moving to the next stage.

PDSA cycles emphasise starting on a small scale and reflecting and building on the learning that occurs during each stage. PDSA cycles can be used to quickly and easily test suggested improvements that are based on existing ideas and research, or to implement practical ideas that have been proven to work elsewhere.

It is a cyclical model because the benefit you planned is not always achieved after one PDSA cycle. Therefore, the initial PDSA can be refined and the cycle repeated as many times as necessary to reach the desired benefit.

A PDSA cycle can be undertaken by an individual practitioner, a group of health professionals, and/or a multidisciplinary team. For example, an individual practitioner can complete a PDSA cycle to improve their individual clinical knowledge and skills.

Further information on clinical audits and PDSA cycles is available in the RACGP's *QI&CPD Program: 2017–19 triennium handbook for general practitioners* (www.racgp.org.au/education/qicpd-2017-19-program).

Other sources of information

To improve the targeting and use of your prevention activities (eg smoking cessation, weight management), you may wish to collect data from other sources, such as:

- your clinical software or paper-based systems about, for example, smoking status
- your diabetes register
- pathology services that provide, for example, diabetes screening and cervical screening
- reviews and analysis of data relating to particular Medicare Benefits Schedule (MBS) claims to identify gaps in the delivery of comprehensive primary healthcare to priority populations (eg items 715 and 723)
- data reports that you can use as benchmarks to identify gaps, areas and opportunities for improvement to assist in health service planning. You can access these reports by participating in quality improvement programs that are provided by regional healthcare coordination organisations.

Meeting each Indicator

QI1.3A Our practice team uses a nationally recognised medical vocabulary for coding.

You could:

- use patient management software to code patient health information
- keep clinical data and reports, such as rates of childhood vaccinations, completed adult health checks and updated risk factors.

QI1.3▶B Our practice uses relevant patient and practice data to improve clinical practice (eg chronic disease management, preventive health).

You must:

- show evidence that you have conducted a quality improvement activity, such as a PDSA cycle or clinical audit, at least once every three years.

You could:

- use coded patient health information to audit patient health records and compare clinical practice
- maintain a continuous improvement register
- maintain a clinical audit based on a quality improvement plan completed by the practice team
- participate in an audit on antibiotic prescribing.