



# BEST PRACTICE DATA CLEANSING GUIDE

**Quality Improvement Program**

**July 2019**

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### QUALITY IMPROVEMENT PROGRAM BEST PRACTICE HOW TO GUIDE

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#### DATA CLEANSING

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### 1. How to Inactive Patients

#### HOW TO INACTIVE PATIENTS - BULK INACTIVATION

1. From the main screen ensure no patient files open, click Utilities and select Search.
2. Select Visits
3. Select dates from & To and tick NOT (meaning NOT seen during that period)
4. Click Add then OK

Visits Immunisations Pap smears Observations Family/Social

Run query

**Search for visits**

Seen by: All users ☐ Include inactive providers

From: ☒ 1/10/2014

To: ☒ 1/12/2017

☐ AND ☐ OR ☒ NOT

Add

Condition

OK Cancel

5. Select Run query

6. From File select from the dropdown menu Mark as inactive
7. Select Yes to confirm that all patients on this list will all be inactive





### HOW TO INACTIVATE PATIENTS INDIVIDUALLY

1. Open patient file. F10 (edit screen) then mark as Inactive and Save.

**Edit patient**

Title: Miss  
Family name: Alberts  
Given name: Brittany  
Middle name:  
Preferred name: Brittany  
Date of Birth: 2/06/1996 Age: 21 yrs  
Sex: Female  
Ethnicity:  
Address Line 1: 10 Williams Road  
Address Line 2:  
City/Suburb: Darwin Postcode: 801  
Postal Address:  
City/Suburb: Postcode:  
Home phone: 08 23658491 Work phone:  
Mobile phone: Contact via:  
☐ Consent to SMS reminder  
E-mail:  
General notes:  
Appointment notes:

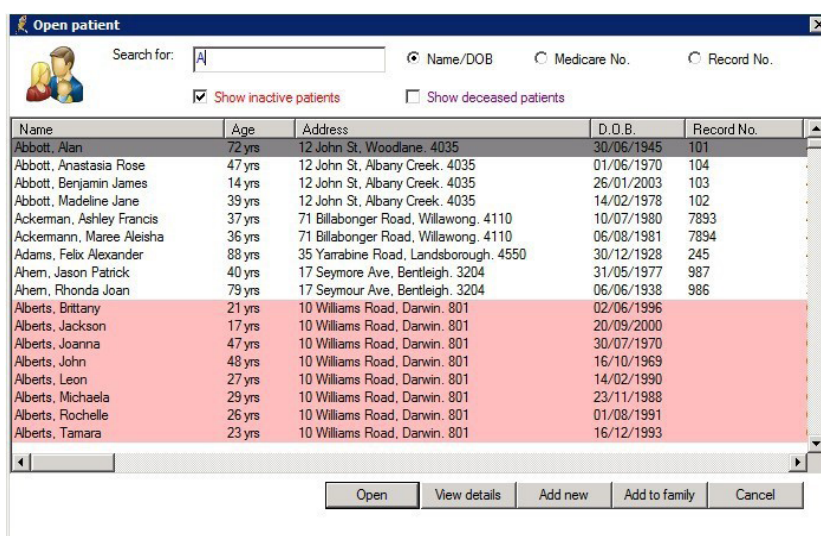
Health Identifier:  
HI Status:  
Medicare No.: 6500110501 IRN: 7 Expiry:  
Pension/HCC No.: Expiry: 1/12/2017  
Pension card type:  
DVA No.: Conditions  
Safety Net No.:  
Record No.: Patient ID: 21  
Usual doctor:  
Deny access to other users  
Usual visit type:  
Usual account: Practice fee  
Health Ins. Fund:  
Health Ins. No.: Expiry: 1/12/2017  
Religion:  
Head of family: John Alberts Set  
Next of kin: Set  
Emergency contact: Set  
Occupation: Set  
☐ Registered for CTG PBS Co-payment relief  
☒ Inactive ☐ Deceased  
Date of death: 1/12/2017 Cause  
Referral details Bank account  
Medicare/DVA eligibility check  
Save Cancel

☐ Update address of all family members  
☐ Update address of all currently at original address

\* These name fields are used for Health Identifier lookups.

### HOW TO VIEW INACTIVE PATIENTS

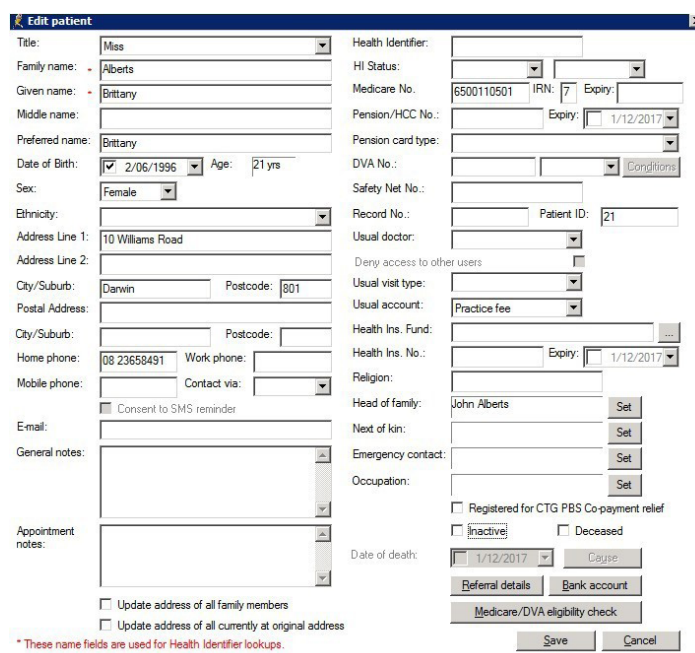
1. Main menu Select File and select Open patient from dropdown
2. Enter patient name and tick Show inactive patients



Name	Age	Address	D.O.B.	Record No.
Abbott, Alan	72 yrs	12 John St. Woodlane. 4035	30/06/1945	101
Abbott, Anastasia Rose	47 yrs	12 John St. Albany Creek. 4035	01/06/1970	104
Abbott, Benjamin James	14 yrs	12 John St. Albany Creek. 4035	26/01/2003	103
Abbott, Madeline Jane	39 yrs	12 John St. Albany Creek. 4035	14/02/1978	102
Ackerman, Ashley Francis	37 yrs	71 Billabonger Road, Willawong. 4110	10/07/1980	7893
Ackermann, Maree Aleisha	36 yrs	71 Billabonger Road, Willawong. 4110	06/08/1981	7894
Adams, Felix Alexander	88 yrs	35 Yarrabine Road, Landsborough. 4550	30/12/1928	245
Ahem, Jason Patrick	40 yrs	17 Seymore Ave, Bentleigh. 3204	31/05/1977	987
Ahem, Rhonda Joan	79 yrs	17 Seymore Ave, Bentleigh. 3204	06/06/1938	986
Alberts, Brittany	21 yrs	10 Williams Road, Darwin. 801	02/06/1996	
Alberts, Jackson	17 yrs	10 Williams Road, Darwin. 801	20/09/2000	
Alberts, Joanna	47 yrs	10 Williams Road, Darwin. 801	30/07/1970	
Alberts, John	48 yrs	10 Williams Road, Darwin. 801	16/10/1969	
Alberts, Leon	27 yrs	10 Williams Road, Darwin. 801	14/02/1990	
Alberts, Michaela	29 yrs	10 Williams Road, Darwin. 801	23/11/1988	
Alberts, Rochelle	26 yrs	10 Williams Road, Darwin. 801	01/08/1991	
Alberts, Tamara	23 yrs	10 Williams Road, Darwin. 801	16/12/1993	

### HOW TO ACTIVATE INACTIVE PATIENT

1. Find inactive patient- as seen in **How to view inactive patients**. Open patient file and select **F10** (to edit). From Edit patient screen, untick **Inactive** and **Save**.



**Edit patient**

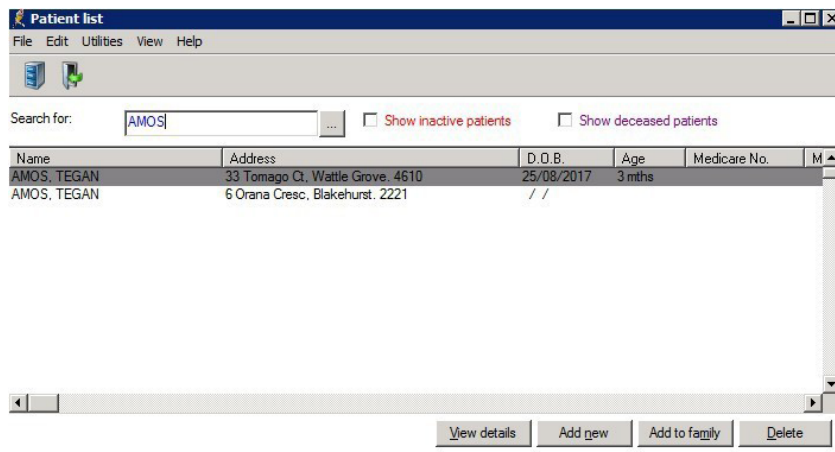
Title: Miss  
Family name: Alberts  
Given name: Brittany  
Middle name:  
Preferred name: Brittany  
Date of Birth: 2/06/1996 Age: 21 yrs  
Sex: Female  
Ethnicity:  
Address Line 1: 10 Williams Road  
Address Line 2:  
City/Suburb: Darwin Postcode: 801  
Postal Address:  
City/Suburb: Postcode:  
Home phone: 08 23658491 Work phone:  
Mobile phone: Contact via:  
E-mail:  
General notes:  
Appointment notes:  
☐ Update address of all family members  
☐ Update address of all currently at original address  
\* These name fields are used for Health Identifier lookups.

Health Identifier:  
HI Status:  
Medicare No.: 6500110501 IRN: 7 Expiry:  
Pension/HCC No.: Expiry: 1/12/2017  
Pension card type:  
DVA No.: Conditions  
Safety Net No.:  
Record No.: Patient ID: 21  
Usual doctor:  
Deny access to other users:  
Usual visit type:  
Usual account: Practice fee  
Health Ins. Fund:  
Health Ins. No.: Expiry: 1/12/2017  
Religion:  
Head of family: John Alberts Set  
Next of kin: Set  
Emergency contact: Set  
Occupation: Set  
☐ Registered for CTG PBS Co-payment relief  
☐ Inactive ☐ Deceased  
Date of death: 1/12/2017 Cause:  
Referral details Bank account  
Medicare/DVA eligibility check  
Save Cancel

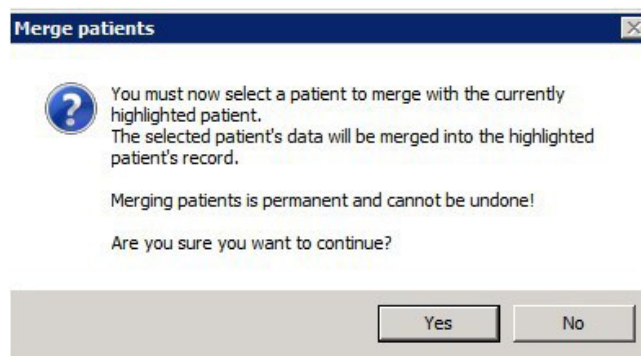


### 2. How to merge duplicate patient files

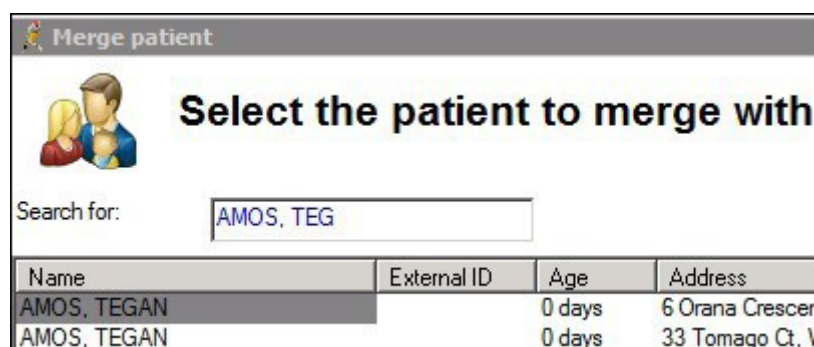
1. Main menu, F10 to view patient list
2. Search patient and highlight patient file you want to keep
3. Select Edit and from the drop down menu select Merge



4. Select Yes



5. Search patient name. Select file that will merge (no longer appear) and this will confirm merge



**Note:** In this case Amos Tegan with address 33 Tomago Ct, is the file that will remain.



### 3. How to Record Allergies

1. From patient screen click on Reactions

Mr. Test Test

File Open Request Clinical View Utilities My Health Record Help

Name: Test "Tes" Test D.O.B.: 20/10/1956 Age: 60 yr  
Address: Mjhfuisgiushguig Hgd fujhgd 2345 Phone:  
Medicare No: Record No.: 55 Pension No.:  
Occupation: Tobacco: Ex smoker  
Blood Group:

Allergies / Adverse Drug Reactions: Reactions

Item	Reaction	Severity
Nil known		

Notifications:

Type	Due
Reminder sent	13/02/2017

Expand Collapse

Seen by: Dr Frederick Findacure

2. If there are Nil Known Allergies tick the box to indicate this then click save

Allergies/Adverse reactions

Item	Reaction	Severity
------	----------	----------

Comment:

☒ Nil known

Add Edit Delete

Save Cancel

3. If the patients does have an allergy click on **Add** and select the allergy. Fill out the **Nature of the reaction** and the **Severity** then **save**. Repeat this step if the patient has multiple allergies.



**Add reaction**

Search:

☒ Drug class

☐ Ingredient

☐ Specific product

☐ Non drug

☐ Other

Nature of reaction:

Severity:

Comment:

## 4. How to record Height, Weight, Waist and Blood Pressure

Note: there are multiple ways to record Height, Weight, Waist and BP - as seen below

Option 1: from patient screen click on the stethoscope icon. Record relevant observations.

**Test Test**

Record No: 55

Address: 1234567890 (01/01/2015)

Phone: 01234 567890

Mobile: 09876 543210

Person No: 1234567890

Comment: 1234567890

Diagnosis: 1234567890

Advance Health Director: 1234567890

Regist / Advance Drug Treatment: 1234567890

Observations

Date	Temp	Pulse	BP Systolic	BP Diastolic	BP Pulse	Weight	Height	Waist	Chest (Circ)	BMI
25/08/2017	36.5	72	120/80	80	40	70	170	90	100	24.5

**Calculations**

Date: 25/08/2017

Temp:

Pulse:

BP Systolic:

BP Diastolic:

BP Pulse:

Weight:

Height:

Waist:

Chest (Circ):

BMI:



Option 2: Alternatively add in Observations from the right side of the screen by clicking on General then filling in relevant information.

Option 3: click on Observations on the left, then Add to fill in relevant information.

### 5. How to record Enter a Coded Diagnosis

To add in a coded diagnosis in past history

1. Open patient file and select Past history. Click Add

The screenshot shows the 'Past history' section for Mr. Alan Abbott. The sidebar on the left lists 'Today's notes', 'Past visits', 'Current Rx', and 'Past history'. The 'Past history' section is expanded, showing a list of conditions: Chronic Kidney Disease, Stage 1, Reflux oesophagitis, Hypertension, Diabetes, Asthma, Throat pain, Diabetes Mellitus, Type 2, and Head injury. The main table on the right has columns for Date, Condition, and Severity. The table contains the following data:

Date	Condition	Severity
	Chronic Kidney Disease, Stage 1	
	Reflux oesophagitis	Mild
	Hypertension	
	Diabetes	
02/03/2004	Asthma	Mild
25/03/2011	Throat pain	
13/10/2011	Diabetes Mellitus, Type 2	
06/06/2017	Head injury	

2. Search condition and select from the list

\*Tick **Include in summaries**- Unless it is already in past conditions- to avoid double up

\*\*Tick **Save as reason for visit** - If applicable

### TO ADD A CODED DIAGNOSIS WHEN PRESCRIBING A MEDICATION

1. Open patient file
2. Current Rx and click **Add**. Fill in all information and click **Next**
3. In **Reason for prescription** enter first few letters of the diagnosis and select from the list
4. Tick Save as Reason for visit
5. **Add to diagnosis** if needed
6. Tick **Add to Past History** - Unless it is already in past conditions- to avoid double up
7. Select **Finish**

**Note:** In cases where the condition you've searched is not on the list, please select the condition that is the closest match and use the 'further details' section to add comments



**New Rx - Warfarin 1mg Tablet**

Reason for prescription:

☒ From existing condition list ☐ New condition

Search:

**Reason**

- Abrasion
- Arthroscopic Meniscectomy
- Asthma
- Chronic Kidney Disease, Stage 1
- Diabetes
- Diabetes Mellitus, Type 2
- Head injury
- Hypertension
- Non insulin dependent Diabetes Mellitus
- Reflux oesophagitis

Further details:

**Keyword search**

☐ Left ☐ Right ☐ Bilateral

☐ Acute ☐ Chronic

☐ Mild ☐ Moderate ☐ Severe

**Fracture:**

☐ Displaced ☐ Undisplaced

☐ Compound ☐ Comminuted

☐ Spiral ☐ Greenstick

☐ Add to Past History

☐ Active ☐ Inactive

☐ Confidential ☐ Include in summaries

☐ Send to My Health Record

☒ Save as Reason for visit

☒ Add to diagnosis

**Product Information**

**CMI**

### HOW TO AVOID DUPLICATE CONDITIONS IN PAST HISTORY AND REASON FOR VISIT WHEN PRESCRIBING MEDICATIONS;

1. Main screen, click Setup, select Preferences
2. Click Clinical icon
3. Untick Always add to past history
4. Untick Always Save as Reason for Visit

**Bp Premier**

File Clinical Management Utilities View Setup Help

**User preferences**

User name:

Today's notes font:

Usual visit type:

Default temperature site:

Initial focus in Observations window: ☒ Pulse ☐ Sitting BP

☐ Allow blank notes

☒ Prompt if no notes recorded

☐ Enforce entry of Reason for Visit when closing patient record

☒ Prompt for Reason for Visit when closing patient record

☐ Don't start timer on opening record.

☐ Don't record visit length.

☐ Reason for visit at top of notes

☐ Use SOAP headings for History and Examination

☐ Load SOAP headings on opening notes

☒ Send reminder for influenza vaccination

**Diagnosis window:**

☒ Always 'Add to Past history'

☒ Always 'Save as Reason for Visit'

**Reason for Visit window:**

☒ Always 'Add to Past history'

☐ Show 'Non visits' in Past Visit list

☒ Display Outstanding requests in patient record

☐ Use bold font for Allergies and On screen comment

☒ Load PMH favourites on opening New PMH window

☒ Expand Current Rx and PMH in tree view

☒ Separate PMH into Active and Inactive in tree view

☐ Expand Inactive PMH in tree view

☒ Open the PMH window with the cursor in the date field

**Procedure window:**

☒ Always 'Add to Past history'

☒ Always 'Save as Reason for Visit'

**Past History window:**

☒ Always 'Save as Reason for Visit'

