QI program and Accreditation

RACGP standards for General Practice (5th Edition) and SNHN Quality Improvement Program

The purpose of this document is to demonstrate how practices can meet areas of the 5th edition by participating SNHN QI program.

Notes: ► indicates a mandatory indicator

Criterion **Indicator**	C3.1-Business operation systems C3.1 B Our practice evaluates its progress towards achieving its goals.
Evidence	QI program reports: • Baseline and most recent data report benchmarked against SNHN boundary and RACGP criteria. • Action plan for improvement presented quarterly and reviewed in 6 weeks.

Criterion	C7.1 – Content of patient health records
Indicator	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 ►E Our practice routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record. C7.1 F► Our practice routinely records the cultural backgrounds of our patients in their patient health record. C7.1 ►G Lifestyle risk factors
Evidence	• Cat Plus software is able to identify missing information as per indicator C7.1 B which allows practice members to review missing information for patients. • TopBar can reminder practice staff about missing information during patient visits. Admin staff have access to and can update demographic, emergency contact and next of kin. Clinical staff can record or review lifestyle risk factors such as smoking status, alcohol intake, BP, allergy, etc. • QI program reports present accreditation health record items including ethnicity and lifestyle risk factors. • SNHN PCAIT team work with participating practices to set PDSAs which focus on changes to improve data input and improve coding within patients' files.

Criterion	C8.1 – Education and training of non-clinical staff
Indicator	C8.1 ►A Our non-clinical staff complete training appropriate to their role and our patient population.
Evidence	• SNHN PCAIT team provide on time PENCAT and TopBar training to non-clinical staff for participating practices.

Criterion Indicator	QI1.1 – Quality improvement activities QI1.1 ►A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.
Evidence	• SNHN provide training to QI program practices about their role and responsibility in the program, whereby they will formulate their action plans or PDSAs and assign tasks to their practice staff.
Indicator	QI1.1 ►B Our practice team internally shares information about quality improvement and patient safety.
Evidence	• Practices are encouraged by PCAIT team to list QI program as an agenda at their staff meetings. • Primary contacts in the QI program shares their QI report at staff meeting and discuss their action plans or PDSAs for that quarter. • Primary contacts will delegate tasks to individual team members and monitor the progress to make sure the plan is executed completely and properly. • Meeting minutes are recorded and shared among team members post meeting.
Indicator	QI1.1 ►C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.
Evidence	• Practice members are encouraged to give feedbacks during their staff meeting about the status and progress of QI program. • Practices are also encouraged to share their feedbacks with SNHN PCAIT team which can facilitate with change management and offer suggestions when necessary.
Indicator	QI1.1 ►D Our practice team can describe areas of our practice that we have improved in the past three years.
Evidence	• QI data is collected and reported to practices every quarter indicating changes in focus areas. • Practices keep QI quarter reports in accreditation folder for future use.

Indicator	QI1.3 ►B Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).
Evidence	• Benchmark report data is coloured reflecting practice data to the RACGP guidelines. Yellow or red indicates the indicator is below the standards, indicating areas for improvement. • QI report presents data in chronic disease area including number of patients for one certain disease, number of claimed item numbers, items that need to be completed for chronic cycle of care.

Criterion	QI2.1 – Health summaries
Indicator	QI2.1 ►A Our active patient health records contain a record of each patient's known allergies.
Evidence	• QI benchmark reports contain data on percentage of active patients with allergy status recorded. This is in line with RACGP guidelines which requires 90% active patients should have allergy status recorded.
Indicator	QI2.1► B Each active patient health record has the patient's current health summary that includes, where relevant: • adverse drug reactions • current medicines list • current health problems • past health history • immunisations • family history • health risk factors (e.g. smoking, nutrition, alcohol, physical activity) • social history, including cultural background.
Evidence	• QI program adopts CAT 4 and Topbar tool to indicate missing items of the health summary. • TopBar alerts missing patient health summary items during visit. • QI benchmark reports contain health risk factors status, such as alcohol intake, smoking status, blood pressure, BMI, waist and physical activity. • CAT 4 can identify other health summary items for practices.

Criterion	GP2.1 – Continuous and comprehensive care
Indicator	GP2.1 ►B Our practice provides continuity of care and comprehensive care
Evidence	• CAT 4 can identify patients who are eligible, yet have not completed cycle of cares, GPMP, TCA, Health assessments etc.