

COMMUNICARE

Standardised Data Coding using Communicare Learning Workbook



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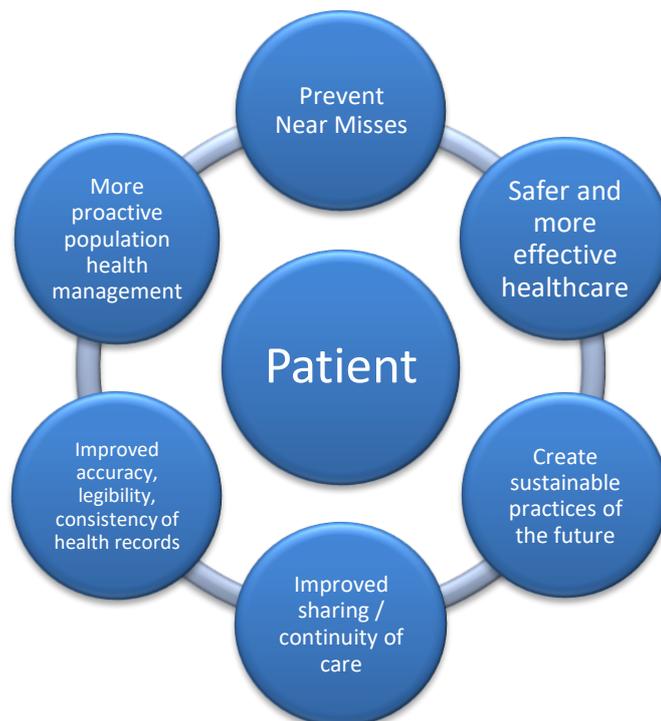
Learning Objectives

1. To increase awareness and understanding of the value of structured and coded health information.
2. To increase understanding of the most important areas in the record that should be structured and coded – core clinical data.
3. To increase the level of structured and coded information being entered into clinical information systems by practice staff.

The value of using coded / structured data

The value of using coded / structured data over free text data entry can be determined from the benefits that it provides. The benefits from coding data that is entered into clinical information systems include:

- To enable sharing of patient health information with other providers and patients for improved continuity of care
- To help create sustainable practices of the future that are more adaptable to change
- To facilitate safe and effective healthcare via improved accuracy and understanding of consistent terminology
- To enable more proactive management through the building of registers of patients with certain conditions
- To minimise adverse patient outcomes and prevent near misses
- Improved accuracy, consistency and legibility of patient health records by healthcare providers



Quality Improvement Activities

Continuous Quality Improvement is an essential element of high performing healthcare organisations as it facilitates sustainable businesses, high quality of care, consistent service delivery and improved revenue opportunities. General practices accredited to the RACGP Standards need to show regular commitment to quality improvement initiatives to successfully achieve the evaluation criteria and attain practice accreditation.

To measure the effectiveness of quality improvement activities, healthcare organisations need a method of measuring progress towards achieving their stated objectives. Consistent data coding systems drive meaningful quality improvement activities (RACGP Standards 4th Ed) by providing a method of measurement as this helps us to determine whether a planned change is successful or not.

For example, a quality improvement initiative aimed at building an accurate register of patients with 'COPD' will need to determine the current rate of recording / #of patients with a coded diagnosis of COPD in the patient's medical history. If the condition was entered as 'free text' this measurement will result in a very low baseline i.e. a low % of patients with a coded diagnosis of COPD.

Included below is an example of a template used for recording and managing quality improvement activities. This template can be used within a healthcare organisation by the practice team to develop a repository of practice improvement ideas, benefits and success stories. It can also be used as evidence to support the practice accreditation evaluation process.

The idea is to document the aims of the improvement activity, the ideas to achieve the aim and the steps that will be undertaken including how success will be measured. It is important to remember that not all improvement activities will lead to success. That's why we need to test our ideas, measure their impact on the aims of the activity and determine a course of action based on the measurable results. For example, a PDSA aimed at improving allergy recording may involve printing a list of all patients with no allergy information on their file. However, using this list as a means of identifying patients with missing allergy information may prove to be a time consuming approach to improving recording if it necessitates having to check the list each time a patient presents.

PDSA TEMPLATE WITH SAMPLE IMPROVEMENT ACTIVITY

| | | | | |
|---|--|-----------------------------------|--|--|
| <p>What is our GOAL (what are we trying to accomplish)</p> | <p>Raise Awareness of Clinical Coding</p> <ul style="list-style-type: none"> ▪ Code diagnoses | | | |
| <p>What measures will we use? (i.e. data)</p> | <p>% of diagnoses in Past Medical History for active patients that are coded rather than free text on their electronic medical record.</p> | | | |
| <p>What ideas can we use? (how are we going to achieve our goal)</p> | <p><u>List ideas here to work on in table below</u></p> <ul style="list-style-type: none"> • Team meeting to discuss the issue, benefits & how to address • Attend education e.g. webinars / face to face sessions • Post-education follow-up team discussion • GP & RN team review of clinical documentation • Use of Terms Converter tool to merge items entered in other systems with coded diagnosis in Communicare. • Pen CAT / Communicare Report Audit of records to measure baseline | | | |
| <p>IDEAS</p> | <p>PLAN How will we do it – who, what, where and when?</p> | <p>DO Did we do it</p> | <p>STUDY What happened?</p> | <p>ACT What is our next step?</p> |
| <p>1. Team meeting</p> | <p>Practice Manager to organise, staff room DATE</p> | | | |
| <p>2. Education</p> | <p>Watch videos Read cheatsheets Read workbooks</p> | | | |
| <p>3. Terms Converter</p> | | | | |
| <p>4.</p> | | | | |



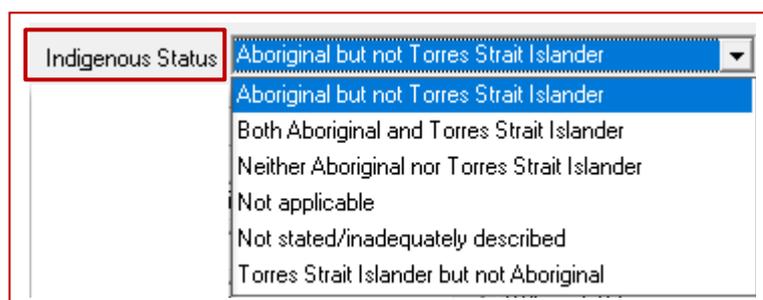
Activity – Use the blank PDSA form (Appendix A) to create a customised improvement plan for your practice.

Adding Aboriginal and Torres Strait Islander (ATSI) status

Aboriginal and Torres Strait Islander people are under-identified in many health-related data collections. Self-report in response to the standard Indigenous status question is the most accurate means of ascertaining a patient's Indigenous or non-Indigenous status and this information is recorded in the patient record as 'Indigenous Status'. The response to this question allows service providers to ensure that Aboriginal and Torres Strait Islander patients have an opportunity to access relevant services specifically designed to meet the needs of Indigenous Australians – if they choose. Ideally Indigenous status should be added as part of new client registration, however it can be added or modified at any time.

Adding Aboriginal and/or Torres Strait Islander status:

1. From the main toolbar click on the **Patient Biographics** icon.
2. Search for the client name and select **Change Details**
3. Select the **Indigenous Status** drop down box.
4. Select an **option** from the list.
5. **Save.**
6. Note: if you already have a client file open you can also click on the biographics icon at the top of the file and follow steps 3-5 above.



Question: *Are you [is the person] of Aboriginal or Torres Strait Islander origin?*

Response: Six standard response options are provided in Communicare as follows:

1. Aboriginal but not Torres Strait Islander
2. Both Aboriginal and Torres Strait Islander
3. Neither Aboriginal nor Torres Strait Islander
4. Not applicable
5. Not stated/inadequately described
6. Torres Strait Islander but not Aboriginal

Note: If the question has not been completed on a returned form, this should be followed up and confirmed with the patient. The Country of Birth field **Biographics >Social Tab** should also be completed.

Further Information: How to ask about ATSI status

[RACGP "Identification of Aboriginal and Torres Strait Islander people in Australian general practices"](#)

[RACGP "National Guide to a preventive health assessment for Aboriginal and Torres Strait Islander people"](#)

[AIHW "National best practice guidelines for collecting Indigenous status in health data sets"](#)



Activity – Adding coded Aboriginal & Torres Strait Islander status to the patient record

1. Open the demonstration version of Communicare
2. Find biographics information for Saul Albert (ID 14311) patient file (Click **Patient Biographics** on **Main Toolbar**, Search for Saul Albert and select **Change Details**).
3. Select the **Indigenous Status drop-down** arrow.
4. Select an **option** from the list.
5. **Save.**



Case Study: Adding coded Aboriginal & Torres Strait Islander status

Scenario:

Bobby is an Aboriginal male patient with a number of significant health issues who attended a mainstream GP clinic for the first time, visiting Dr Robinson.

As was Dr Robinson's standard practice, upon identification of Indigenous status, he spent time getting to know his new patient and talking in detail about his medical and social history. Through this broader discussion of Bobby's medical history, Dr Robinson found out that although previous doctors had given Bobby referrals for blood tests, he had never had the tests done.

When discussing the reasons for this, Dr Robinson found out about issues with transport and fears of the tests being expensive. Dr Robinson then discussed registering for close the gap to help with the cost of medicines and ways to assist Bobby with ongoing care.

Outcome:

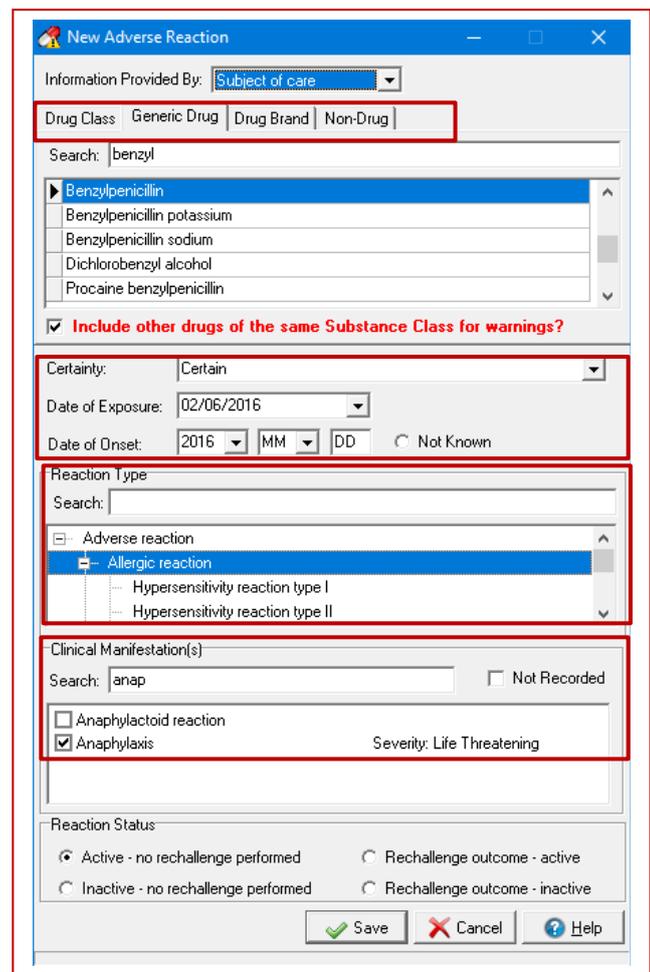
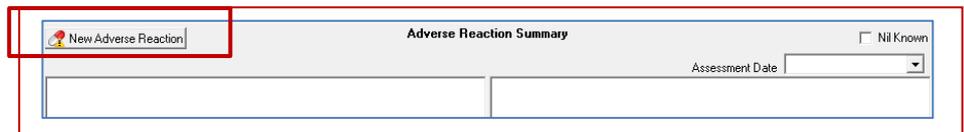
After the consultation, the practice manager called the laboratory, organised bulk billing and helped arrange transport to the laboratory. The blood tests indicated that further medical interventions were necessary.

Adding an allergy or adverse reaction

Allergy information can be entered in the patient record in the **Adverse Reaction Summary** field at the bottom left of the **Main Summary** tab. Allergic Reactions will display in red. If the patient has no allergies or adverse reactions, tick 'Nil Known' to indicate the patient has been asked about allergies. Entering a Drug Reaction by Class, Generic or Brand ensures that warnings are provided to prescribers if an attempt is made to prescribe a drug listed on the Adverse Reaction Summary.

Adding an Allergy / Reaction:

1. **Open** the patient record.
2. At the bottom left of the **Main Summary**, click on the **'New Adverse Reaction'** button.
3. **Select** where information was provided from (Healthcare Provider, Subject of Care or Carer).
4. **Select** the tab that best suits the type of reaction to be entered: Drug Class, Generic Drug, Drug Brand or Non-Drug.
5. Enter the first few characters of the item into the **Search** field. As you type a list is displayed matching the search. Click an item to select it. Tick the box below to include other drugs of the same substance class for warnings.
6. Enter the **Certainty** of reaction (Optional), along with the **Date of Exposure** and **Date of Onset**. Date of onset can be entered as Not Known, as a Year only, or Year and Month Only.
7. Select a **Reaction Type** (Allergic Reaction/Non-Allergic Reaction).
8. Enter **Clinical Manifestations** by typing the first few characters and then selecting. Select the **Severity** of the reaction from the dropdown list.
9. Enter the **Reaction Status** (active or inactive and rechallenge information).
10. **Save** to enter.





Activity – Adding coded allergy information to the patient record

1. Open the demonstration version of Communicare.
2. Open Saul Albert (ID 14311) patient file (Click **Clinical Record** on **Main Toolbar**, Search for Saul Albert and open file).
3. Click on the New Adverse Reaction button at the bottom of the **Main Summary** tab
4. Enter an allergy to Nitrates by Drug Class
5. Certainty = Certain
6. Date of Exposure = 2/6/2016 and Date of Onset = 2016
7. Reaction Type = Hypersensitivity reaction Type 1
8. Clinical Manifestation = Rash and Severity = Mild
9. Reaction Status = Active no rechallenge performed
10. Select **Save**.
11. Check that the new allergy has been added to the patient record.



Case Study: Adding an allergy or adverse reaction

Scenario:

Kate is a 53-year-old teacher and mother from Sydney. She had no known allergies until the day a nurse gave her an aspirin for a headache. Immediately after taking the medication she started to feel significantly worse. She began to experience shortness of breath and her eyes were completely bloodshot. She immediately returned to the nurse and said “Look at my eyes, they’ve gone completely red. I’m feeling worse. I don’t feel like I can get any air”. The nurse immediately called for the GP who administered adrenaline just as Kate started to collapse. That was the first anaphylactic reaction Kate had ever had.

Outcome:

Kate recovered quickly on treatment and was told she had experienced a life-threatening anaphylactic reaction. She was counselled as to the importance of never taking aspirin again. Kate was advised to wear an allergy alert bracelet at all times. The doctor added the aspirin allergy into the coded allergy section of her medical record and also doctor added detail of the reaction and severity. She also uploaded a shared health summary as Kate was soon to be travelling and this information would be accessible electronically via her My Health Record.

Adding a Coded Diagnosis

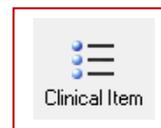
Diagnoses are added using the **Add Clinical Item** button at the top left of the clinical record in Communicare. The diagnosis should always be chosen from this coded list rather than using free text to record the condition in progress notes.

When a diagnosis is added there is an option to 'Display on Main Summary'. This places the item on the client's 'Active Problem / Significant History' tab and should only be selected when recording:

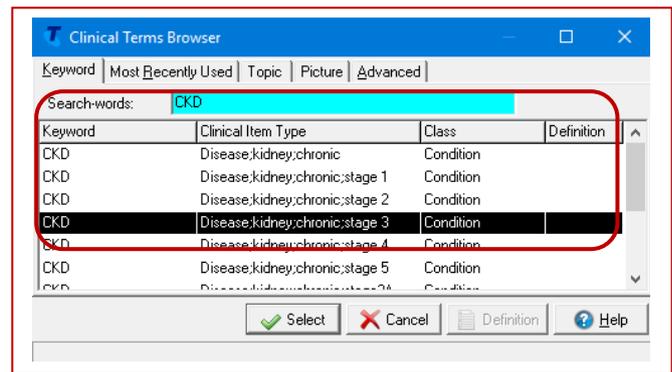
- Chronic conditions
- Significant events in the patient's medical history

Adding a coded diagnosis in the client file / consultation:

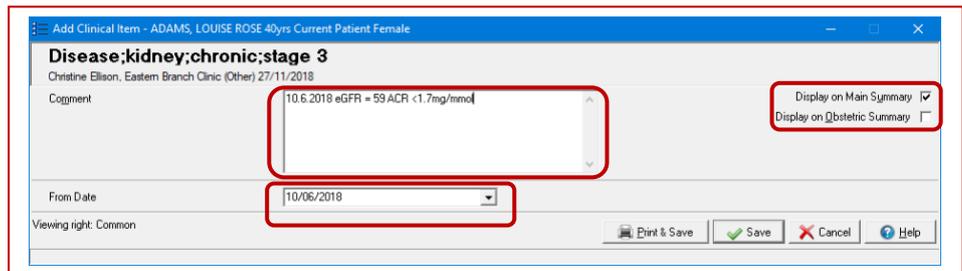
1. Open the patient record.
2. Click the 'Add Clinical Item' button or press 'F11'



3. Use the 'Clinical Terms Browser' to search for a condition. Type in the first few characters of the condition and then select an item with a class of **Condition**.
4. Enter the date the condition was first diagnosed in the date field. If a specific date is not known, enter an approximate date.



5. Enter **Comment/s** as required.



6. Tick 'Display on Main Summary' to indicate that the diagnosis is an active or significant problem and to include the diagnosis on health summaries and referrals.
7. Tick 'Display on Obstetric Summary' to display the condition in the **Relevant History Window** of the Obstetric Module.
8. **Save** to enter the condition.





Activity – Adding a coded diagnosis to the patient record

Saul Albert is visiting about a skin condition today that has yet to be diagnosed.

1. Open the demonstration version of Communicare.
2. Open Saul Albert (ID 14311) patient file (Click **Clinical Record** on **Main Toolbar**, Search for Saul Albert and open file).
3. Click the '**Add Clinical Item**' button or press '**F11**'
4. Search for and select ECZEMA and tick the box to **Display on Main Summary** as an active problem.
5. Select **Save**.
6. Go to the **Main Summary** tab and check that the condition is now displayed.



Case Study: Coding Past Medical History

Scenario: Jack, aged 63 is an active patient who has seen the same GP for many years. He experienced a heart attack when he was 55 years old and was successfully treated with the insertion of a stent. When his then paper records were converted to electronic medical records in 2005 details of this important diagnosis in Jack's medical history was entered using free text rather than coding a diagnosis of 'Coronary Heart Disease' in the patient electronic medical record.

In 2018, Jack's GP was participating in a research program aimed at improving medication adherence for people at high risk of a cardiovascular event. This meant that any patients with a past history of cardiovascular disease would be included in the study and potentially benefit from the use of a new combination medication to improve adherence to preventative medication. However, since Jack's disease was not entered into his file as a coded diagnosis, it meant that his medical record was not included in the group of patients considered high risk when a database search was done.

Outcome: Jack was overlooked for the purposes of inclusion in the study. This meant he was not flagged as being at high risk of a cardiovascular event and was not offered the opportunity of being prescribed the new combination medication to improve medication adherence & reduce the risk of further cardiovascular events.

Adding a Reason for Visit

The reason for visit is indicated using a tick box on coded clinical items that are entered into the patient service. It is possible to enter multiple reasons for the current presentation within a single service.

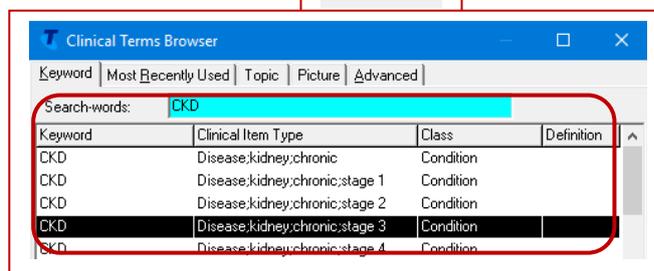
Note: The 'Reason for Encounter' system needs to be turned on in the 'System Parameters' menu for the described features to work. Talk to your Communicare Administrator to discuss if required.

Adding a coded reason for visit:

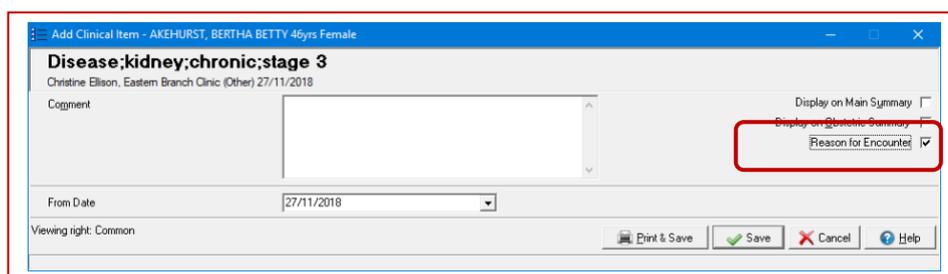
1. **Open** the patient record.
2. Click the '**Add Clinical Item**' button or press '**F11**'.



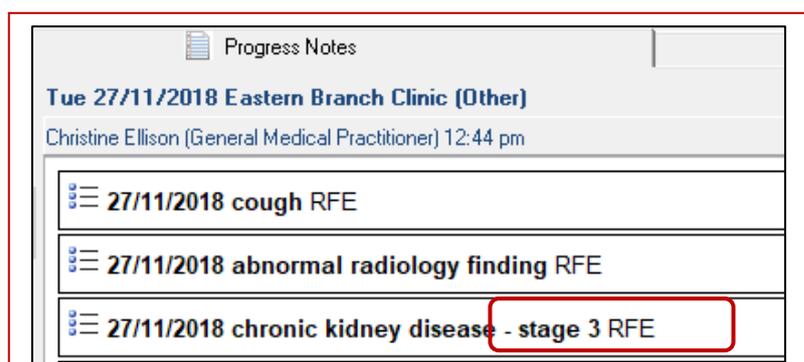
3. Use the '**Clinical Terms Browser**' to search for a condition or procedure. **Type in the first few characters** of the condition and then select.



4. The clinical item will open. **Enter a comment** if required and tick the '**Reason for Encounter**' box to indicate that the clinical item was a reason for the patient visit.



5. **Save** to enter the clinical item.
6. The clinical item will appear in the client progress note with '**RFE**' indicating that the coded item was set as a '**Reason for Encounter**'.





Activity – Adding a coded reason for visit to the patient record

Note: The 'Reason for Encounter' system needs to be turned on in the 'System Parameters' menu of the Communicare demonstration program for the described features to work. Talk to your Communicare Administrator to activate this feature in the demonstration program you are using if required.

Saul Albert is visiting about his pre-existing asthma condition today.

1. Open the demonstration version of Communicare.
2. Open Saul Albert (ID 14311) patient file (Click **Clinical Record** on **Main Toolbar**, Search for Saul Albert and open file).
3. Click the '**Add Clinical Item**' button or press '**F11**'
4. Search for and select Asthma and tick the box **Reason for Encounter**.
5. Select **Save**.



Case Study: Coding Reason for Visit

Scenario: 17-year-old Sally was in her final year of high school and presented to her local GP with an acute sore throat and temperature on a number of occasions during the past year. In fact on two occasions Sally was sent by her GP to the local hospital Accident & Emergency Department to receive treatment for her condition as her GP was concerned about how sick Sally was and thought intravenous antibiotics were necessary.

On each occasion, the GP entered a reason for visit in the Progress Notes by choosing a coded condition of 'tonsillitis'.

Several months before her final exams Sally became so unwell, she was hospitalised again and upon discussion with an ENT specialist was asked how many times Sally had experienced tonsillitis in the past 12 month period. Sally was not 100% sure of the answer but knew it was at least 4-5 times. However, on checking with her GP, she was able to provide the specialist with more accurate information, and she had in fact experienced 6 episodes of acute tonsillitis during the period.

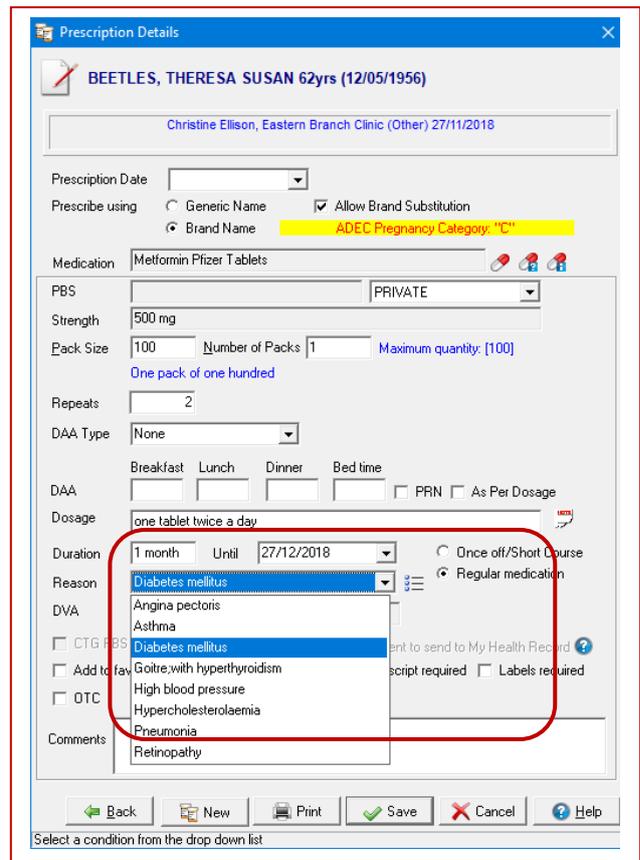
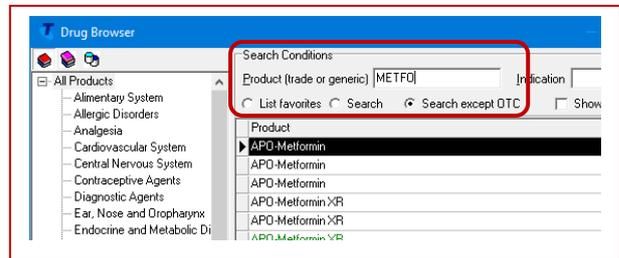
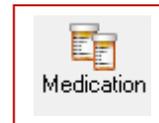
Outcome: The ENT specialist was satisfied that Sally met the criteria for a tonsillectomy based on the frequency and severity of her tonsillitis and this was evidenced by the accuracy of the notes kept by her GP and the fact that he had entered a coded Reason for Visit of 'Tonsillitis' on each occasion.

Adding a reason for medication

It is useful to be able to view the reason for a medication (i.e. the condition under treatment) in a patient’s medical record. The reason is added during the prescribing process and helps to reduce medication errors as it provides additional contextual information.

Adding a reason for medication:

1. **Open** the patient record.
2. **Click** on the **‘Prescribe Medication’** button at the top of the client file.
3. In the **‘Drug Browser’** enter the **first few characters of the drug** then select the formulation from the list displayed. The **‘Prescription Details’** window will open.
4. **Enter** repeats, dose and frequency, duration and indicate whether the prescription is once off or regular.
5. **Click** on the **‘Reason’** dropdown list. If the reason for medication is already available (previously entered condition for the client) then select this as the reason.
6. If the reason is not in this list, **click** on the **‘Add Condition’** button next to the list, **enter the first few characters of the condition** in the search field and add it.
7. **Save** to enter.





Activity – Adding a reason for medication when prescribing

Ashley Collins is presenting about a bronchitis condition today for which an antibiotic will be prescribed.

1. Open the demonstration version of Communicare.
2. Open Ashley Collins (ID 1697) patient file (Click **Clinical Record** on **Main Toolbar**, Search for Ashley Collins and open file).
3. Click the **Medication** button on **Main Toolbar** or press '**F9**'
4. Follow steps 1-7 above to prescribe Amoxicillin for this patient.
5. Enter 'Bronchitis' as the Reason.
6. Select **Save**.



Case Study: Adding a reason for medication

Scenario:

Alessandro is a 76 year old man who immigrated to Australia from Italy approximately 30 years ago. He was transferred to hospital from his general practice due to acute pneumonia. The GP practice sent a printed medication list (without reasons for medication listed) with Alessandro to be given to his treating doctors. Alessandro was taking Xarelto 15mg daily for his atrial fibrillation.

English is a second language for Alessandro, and he was not able to adequately explain his medical history or reasons for medication. When he was admitted to hospital, because there was no listed reason for medication, the doctors assumed he was taking Xarelto for DVT and doubled the dose.

Outcome:

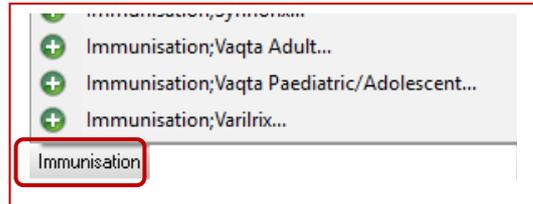
Alessandro's son, who is a Pharmacist, arrived shortly after and quickly assessed the severity of the change of medication, communicated with treating clinicians and helped resolve the error. The hospital discussed the case in their 'critical incident' meeting and discussed strategies around the importance of listing a reason for medication. They decided that all discharge summaries should include a medication profile that includes that actual indication for medications prescribed and where possible this should be requested from the patient's usual GP.

Adding an immunisation

Immunisations can be entered in the patient record using clinical items which are available from the Immunisations shortcut tab. These items can also be used to record immunisations given elsewhere. Age based “Immunisation Review” recalls should also be completed when a patient is up to date with immunisations as per the relevant age-based schedule.

Adding an immunisation:

1. Open the patient record.
2. Click the ‘**Immunisation**’ shortcut button (bottom of client file) and select the name of the Immunisation being recorded.



3. Enter a **comment** if applicable.
4. Enter the **Performed date** (will default to date set on service record).
5. Enter **Route and Site**.
6. Select the **Dose (this course)** from the drop-down box. **Note:** to ensure correct transmission to AIR always use 1st, 2nd, 3rd etc. Add a dose number if applicable.

7. If administered today tick the “**Performed at ...**” box. If performed elsewhere do not tick.
8. Enter **Vaccine batch** and **Vaccine Expiry Date** details.
9. **Save.**

10. Check the client **To Do** list for any outstanding age-based immunisation review items. If the immunisation recorded brings the client up to date with the schedule at this age, complete this recall.

| Filter To Do List | | To Do |
|-------------------|---|-------|
| Date | Item Description | |
| 09/07/2009 | <Recall> Check up:child development | |
| 01/11/2018 | <Recall> 12 years of age immunisations review | |

Note: Immunisation details will automatically send to the Australian Immunisation Register (AIR) if is administered at the clinic (“**Performed at ...**” box is ticked) and dose number entered. Incorrect entry of client address can also prevent submission in some cases. The “AIR Claims” tab in “Online Claiming” should be monitored for any transmission problems.



Activity – Adding a coded Immunisation to the patient record.

Ashley Collins is presenting for a flu vaccination today

1. Open the demonstration version of Communicare.
2. Open Ashley Collins (ID 1697) patient file (Click **Clinical Record** on **Main Toolbar**, Search for Ashley Collins and open file).
3. Click on the **Immunisation** shortcut tab at the bottom of the file and select “Immunisation bioCSL Fluvax”.
4. Select Add.
5. Select a Route and Site
6. Enter the dose (this course) as “First”
7. Tick the “Performed at Millennium Health Service” box
8. Enter a batch number and expiry date
9. Click **Save**



Case Study: Adding an Immunisation

Scenario: Ethan is a 19 year old 2nd year apprentice plumber. While working on a job site when he fell down a sewerage ditch trying to retrieve his shovel. He sustained a 5cm laceration to his leg when falling awkwardly on the shovel. He was taken to a nearby general practice and Ethan was asked when he last had a tetanus injection. Ethan said he does not have one usual doctor but did go to a medical centre recently and received vaccines in preparation for his Bali holiday. He was unsure of which vaccines were administered or the name of the medical centre.

The GP decided to look on Ethan’s My Health Record and noted tetanus vaccine details uploaded from the Australian Immunisation Register. He also noted Ethan’s significant antibiotic allergies, which Ethan had not remembered to disclose. He discussed and confirmed details with Ethan then altered his treatment plan based on this relevant new clinical detail.

The GP uploaded an Event Summary explaining the treatment provided on the day and communicated to Ethan recommendations for follow-up care.

Outcome:

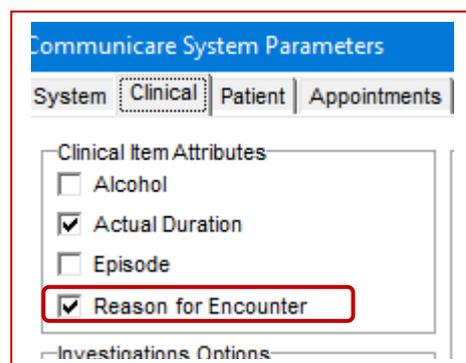
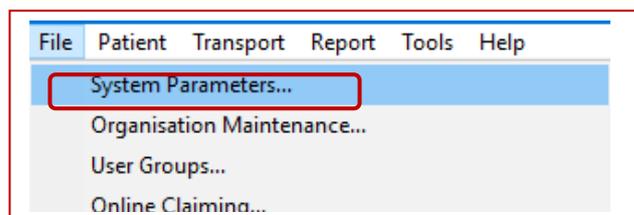
Due to coded information electronically available, Ethan did not receive another tetanus immunisation and was prescribed the correct antibiotics to minimise potential allergic or adverse reactions. He knew also that in future he could access information regarding his current immunisation status and wound treatment via his My Health Record. He was pleased he could access this via an app on his phone.

Configuring system parameters to help maintain data quality

Communicare Administrators can set system parameters to assist with data quality and collection within the clinic. These settings will apply to all users and cannot be tailored to individuals.

Activate the 'Reason for Encounter' system to allow tracking of reason for visit.

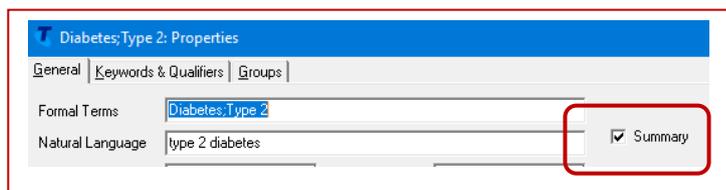
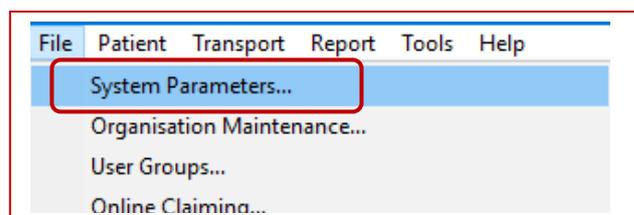
1. Select **File > System Parameters**.
2. Select the **Clinical** tab.
3. Tick the **'Reason for Encounter'** box in the **Clinical Item Attributes** section.
4. **Save** to enter changes. **Note:** you may need to call the Communicare helpdesk to obtain a code to save this change.



Change default option for display of coded clinical items on patient main summary.

This option allows for specified coded clinical items to be automatically selected for display on the patient main summary whenever they are entered.

1. Select **File > System Parameters**.
2. Select the **Clinical** tab.
3. Tick the **'Summary Items by Default'** box in the **Clinical Record Features** section.
4. Items can then be selected for default display on the patient main summary:
 - a. Select **File > Reference Tables > Clinical Item Types**
 - b. **Select** the clinical item
 - c. Tick the **'Summary'** tick box
 - d. **Save** to enter



Activity – Modifying system parameters to improve data quality



Modify the default configuration settings so that Asthma diagnoses appear on the main summary by default.

Note: while OK to practice this in the demonstration version of Communicare, this change should not be made to your live version without first discussing with key staff and fully understanding the impact this change will have on your system.

1. Open the demonstration version of Communicare.
2. Select **File> System Parameters > Clinical Tab**
3. Follow the instructions above for **Change default option for display of coded clinical items on patient main summary** (Steps 1-3)
4. **Save** (Note the Communicare Demonstration version will now restart).
5. Reopen the Communicare demonstration version.
6. Follow the instructions above for **Change default option for display of coded clinical items on patient main summary** (Step 4) and check that the “Asthma” clinical item is ticked to display on main summary.
7. Open Brian Akay (ID 16880) patient file (Click **Clinical Record** on **Main Toolbar**, Search for Brian Akay and open file).
8. Click the **‘Add Clinical Item’** button or press **‘F11’**
9. Search for and select Asthma and note that the **‘Display on Main Summary’** box is already ticked and has to be unticked if not required.
10. Select **Save**.



Further Learning

The following links can be used to supplement learning on this topic:

Communicare

[Client Portal and Training Videos](#)

RACGP

[RACGP Standards for General Practices 5th edition](#)

[Using Data for Better Health Outcomes](#)

[Improving Health Record Quality in General Practice](#)

[PIP eHealth Incentive](#)

Australian Digital Health Agency:

[Importance of Data Quality](#)

[Data Cleansing & Clinical Coding](#)

[Data Quality Checklist](#)

Train IT Medical

[5 Steps to Data Quality Success \(blog\)](#)

APPENDIX A- PDSA / Quality Improvement Activity Template

| What is our GOAL? (what are we trying to accomplish) | Description of GOAL ▪ | | | |
|---|---|---------------------|-------------------------|-------------------------------|
| What measures will we use? (i.e. data) | (This section is currently blank) | | | |
| What ideas can we use? (how are we going to achieve our goal) | <u>List ideas here to work on in table below</u> • | | | |
| IDEAS | PLAN How will we do it – who, what, where and when? | DO Did we do it? | STUDY What happened? | ACT What is our next step? |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |