QI Activity

Tips for Maintaining Quality Health Records

Accreditation reference

RACGP Standards for general practices 5th edition
Core Standard 7: Content of patient health records Criterion C7.1 – Content of patient health records
Quality Improvement Standard 2: Clinical Indicators Criterion QI 2.1 – Health Summaries

Maintaining quality health records activity example

Ideas			
What changes can we make that will lead to an improvement? – small steps/ideas			
1. Data quality review		**Date Completed**	**Notes**
☐	Review importance of data quality and if action is required.		
☐	Use EMPHN practice report to identify areas for improvement in demographic and/or clinical data.		
2. Assign data quality roles			
☐	Allocate time in non-busy periods to check health records.		
☐	Allocate a dedicated staff member with medical knowledge to maintain health records.		
☐	Review active patient records to ensure known allergies are recorded (90% of active patients).		
☐	Review active patient health records to ensure the following is in the patients current health summary (75% of active patients) i.e.		

	• Adverse drug reaction. • Current health problems. • Past health history. • Family history. • Social history including cultural background. • Current medications lists. • Past health problems. • Immunisations. • Health risk (smoking, alcohol etc.).		
☐	Use a print out of the patient health summary to allow the patient to verify its accuracy with the clinician.		
☐	Inform the practice team of the activities required to maintain health records.		
Tips for maintaining health records			
☐	Review new patient registration forms to ensure the following information is captured: • Identification. • Contact details. • Demographic. • Next of kin. • Emergency contact. • Aboriginal/Torres Strait Islander status. • Cultural background.		
☐	Formalise clinical coding and agree standards and conventions for recording patient information on clinical software e.g. using drop down lists or standard terms		
☐	Record results and assessments in the right place, including those assessments completed by an allied health professional e.g. foot examination, eye testing.		
☐	Conduct scheduled audits of health records.		
☐	Archive inactive records as per the practice policy for data cleansing (active patient definition).		