Best Practice
An evolution in medical software

nKPI

Data Reference Manual for Best Practice

SEPTEMBER 2019

QAIHC
Queensland Aboriginal and Islander Health Council

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nKPI: PI 01

Birthweight recorded

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months whose birthweight has been recorded at the primary health care service.

Current %	
National Current %	69%
National Target %	100%

Primary Responsibility

- New Directions
- Nurse/AHW
- GP

Improvement Strategies

- Data entry training with staff
- New Directions to follow up clients
- Seek hospital discharge summary

Evidence Base

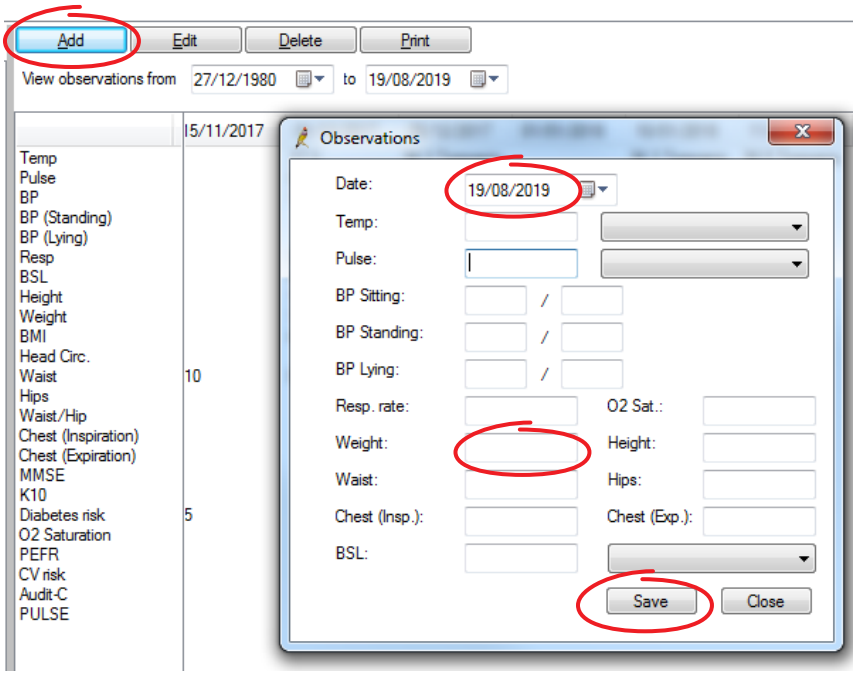
AIHW Report – 'Birthweight of babies born to Indigenous mothers'

Action:

Ensure all babies (ie. any child aged 2 years or younger) registered with AICCHO have a birth weight recorded in MD. Birthweight is defined as the first weight of a baby obtained after birth and must be recorded with the same date as the baby's birth date. The weight must be entered as kilograms (kgs). For example, 5.46kgs if the birthweight was 5460 grams (gms) and must be entered using the date of birth.

Data Entry Field:

1. Observations
2. Add
3. Enter date as birth date
4. Enter weight in kilograms (kgs)
5. Save



nKPI: PI 02

Birthweight result (Low, normal or high)

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months whose birthweight results were categorised as one of the following:

- low (less than 2,500 grams)
- normal (2,500 grams to less than 4,500 grams)
- high (4,500 grams and over).

Current %	
National Current %	Low 13%
National Target %	n/a

Primary Responsibility

- New Directions
- Nurse/AHW
- GP

Improvement Strategies

- Referrals to New Directions
- Antenatal visit follow ups
- Strong linkages with local hospital and health services

Evidence Base

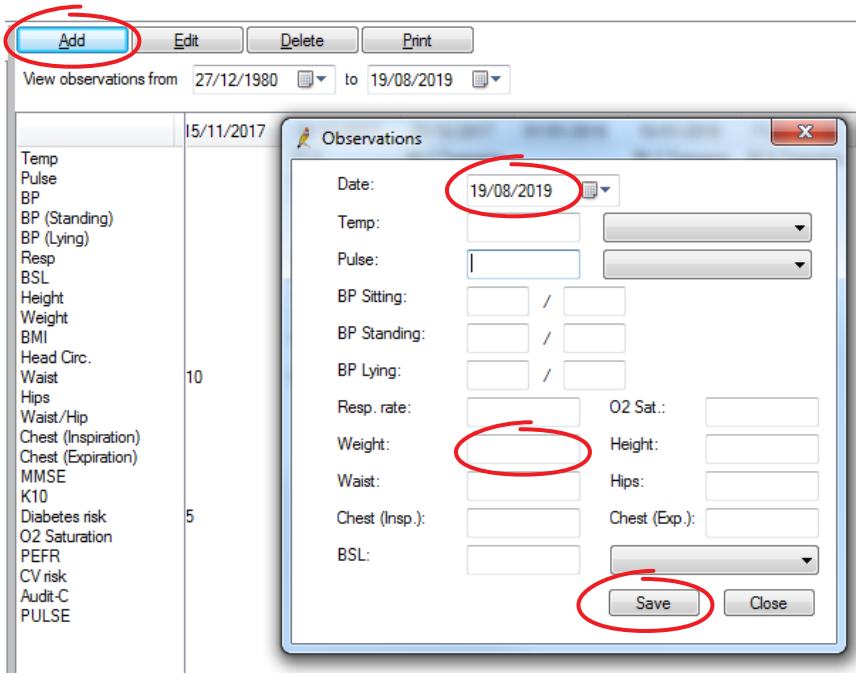
AIHW Report – 'Birthweight of babies born to Indigenous mothers'

Action:

The indicator looks at all birthweights entered and inserts them into each category. To ensure that the data is accurate the weight must be entered correctly. In the mother's obstetric record the birthweight is entered as grams, in the baby's file it is entered as kilograms (kgs). Incorrect entry will provide incorrect data.

Data Entry Field:

1. Observations
2. Add
3. Enter date as birth date
4. Enter weight in kilograms (kgs)
5. Save



nKPI: PI 03

Health assessment (MBS item 715)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 0–4 years** and for whom a Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People was claimed within the previous 12 months AND number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 25 years and over** and for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People was claimed within the previous 24 months.

Current %

National Current %	0–4yrs 33% +25yrs 46%
National Target %	0–4yrs 69% +25yrs 63–74%

Primary Responsibility

- All clinic staff

Improvement Strategies

- ICHW to assist families to clinics
- Separate program/clinic data in BP
- Continue to develop new incentive shirts

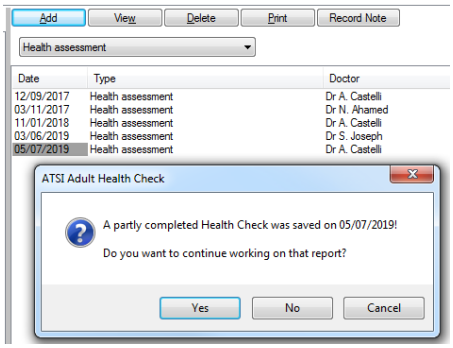
Evidence Base

Item 715 Medicare Fact Sheet

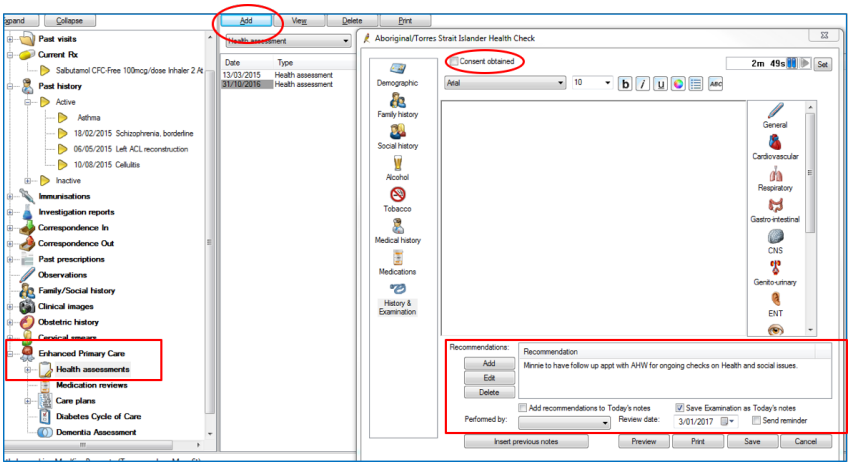
Action:

- The data looks for all Aboriginal and/or Torres Strait Islander patients who have had a MBS item 715 billed in the past 12 months in both the 0–4 and over 25 years age brackets.
- All Aboriginal and Torres Strait Islander patients attending the clinic must be offered the opportunity to have a MBS item 715 health assessment completed.
- The patient eligibility must be checked with Medicare before billing the MBS item 715 (an MBS item 715 can only be billed once every 10 months). A pop up screen will appear in BP if the patient has had an MBS item 715 here in the previous 10 months.

Data Entry Field:



1. Enhanced Primary Care
2. Health Assessment
3. Add (check for pop up box)
4. Complete
5. Tick for patient consent
6. Complete all sections
7. Add recommendations including follow up with AHW
8. GP to bill MBS item 715
9. Reception to complete billing which will be sent to Medicare.



nKPI: PI 04
Fully immunised children

Description:

Number and proportion of Indigenous children who are regular clients, and who are 'fully immunised' aged:

- 12 months to less than 24 months
- 24 months to less than 36 months
- 60 months to less than 72 months;

Current %	
National Current %	74%
National Target %	88%

Primary Responsibility

- New Directions Team
- Nurse/AHW
- GP

Improvement Strategies

- ICHW follow up on unvaccinated children
- Partner with research groups
- BP links with AIR to translate data

Evidence Base

Immunisation: Reducing health inequality for Indigenous Australians

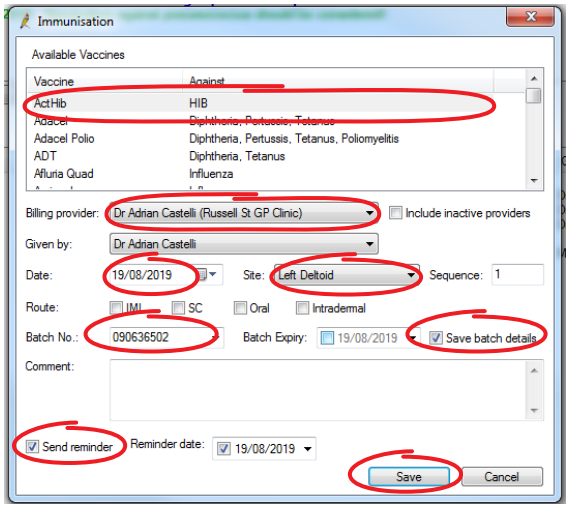
Action:

- All immunisations are to be entered into the file even if they were not administered at the clinic (just note as 'not given here').
- Reminders for immunisations are to be entered into each patient file with a designated nurse in charge of recalling overdue
- Each patient is to be contacted at least three times and notes added into the patient file.

Data Entry Field:

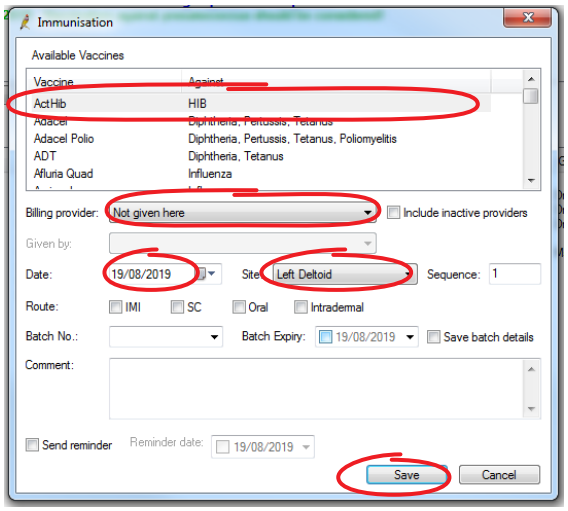
Administered at clinic

1. Immunisation
2. Add
3. Select vaccine
4. Select Provider
5. Select Site
6. Enter Date
7. Enter Batch Number
8. Tick Send reminder
9. Tick Save batch details
10. Save



Not given at clinic

1. Immunisation
2. Add
3. Select vaccine
4. Select Provider 'NOT GIVEN HERE'
5. Enter Date
6. Do not save Batch Number
7. Enter comments
8. Save



nKPI: PI 05

HbA1c recorded (Type 2 Diabetes clients)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and who have had a HbA1c measurement result recorded at the primary health care service within the **previous 6 months** AND number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and who have had an HbA1c measurement result recorded at the primary health care service within the **previous 12 months**.

Current %	
National Current %	6 mths 53%
National Target %	6 mths 69%

Primary Responsibility

- GP
- AHW
- Nurse

Improvement Strategies

- Screening updated
- DCC updated every visit
- Increase nurse visits

Evidence Base

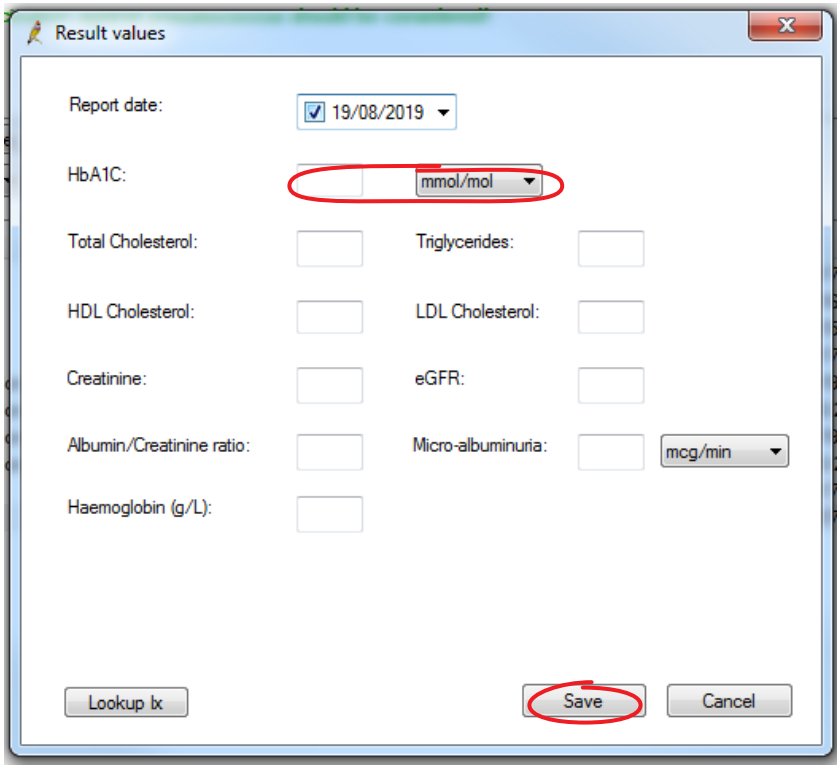
Journal of Diabetes Research Study

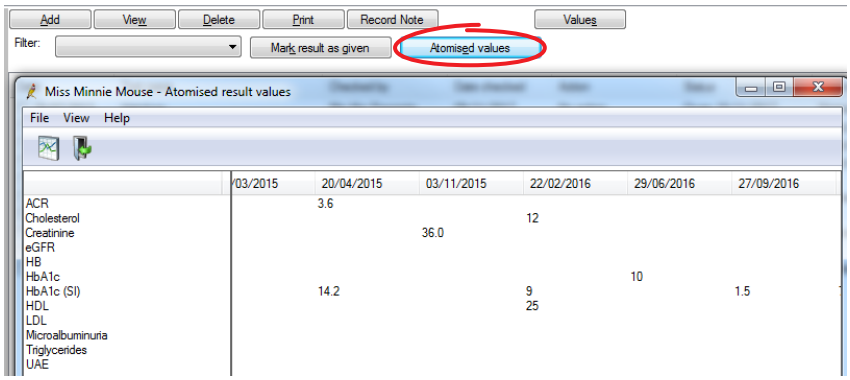
Action:

All Indigenous clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded **every 6 months**.

Data Entry Field:

1. Investigation reports
2. Values
3. Enter in HbA1c level
4. After entering HbA1c – Atomised values will allow it to be graphed





nKPI: PI 05

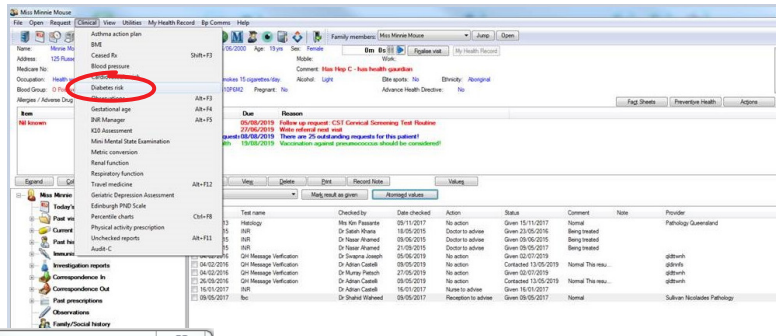
HbA1c recorded (Type 2 Diabetes clients)

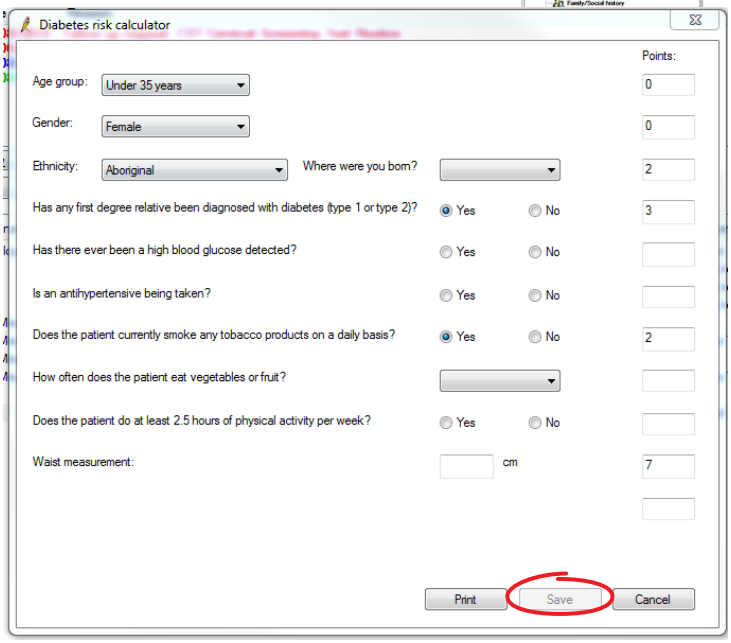
Action:

Clients at risk must have a diabetes risk assessment completed and saved on file **every 12 months**.

Data Entry Field:

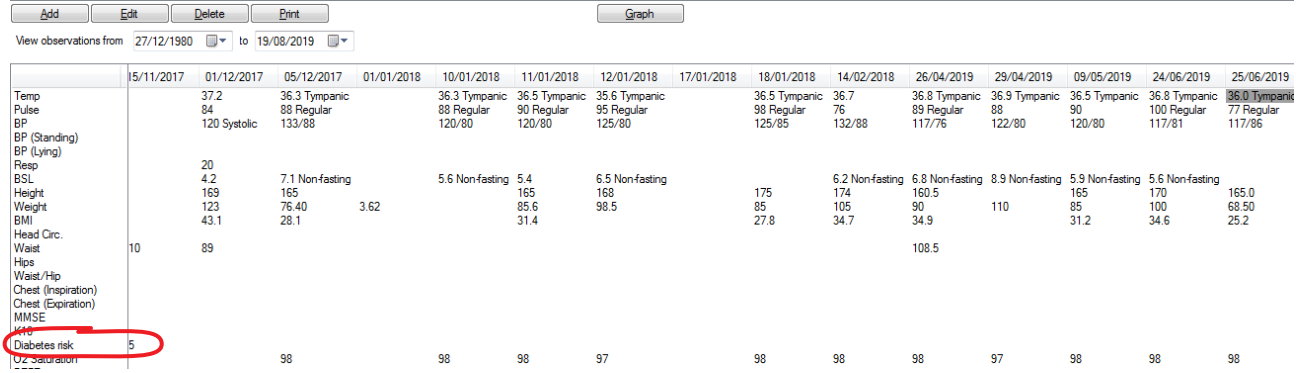
1. Clinical Tab
2. Diabetes Risk
3. Complete Question
4. Save





Result:

Appears in Observations; Diabetes risk; and records the score and date.



nKPI: PI 06

HbA1c results (Type 2 Diabetes clients)

Description:

Number and proportion of regular Aboriginal and/or Torres Strait Islander clients who have Type 2 Diabetes with a HbA1c measurement result, recorded within either the previous **6 months or 12 months** categorised as one of the following:

- < or = 7% (less than or equal to 53 mmol/mol)
- >7% but < or = 8% (greater than 53 mmol/mol but less than or equal to 64 mmol/mol)
- > 8% but < 10% (greater than 64 mmol/mol but less than 86 mmol/mol) or greater than or equal to 10% (greater than or equal to 86 mmol/mol)

Current %	
National Current %	<=7% 35%

Primary Responsibility

- GP
- AHW
- Nurse

Improvement Strategies

- Diabetes education
- Recall diabetic patients
- DCC updated at every visit

Evidence Base

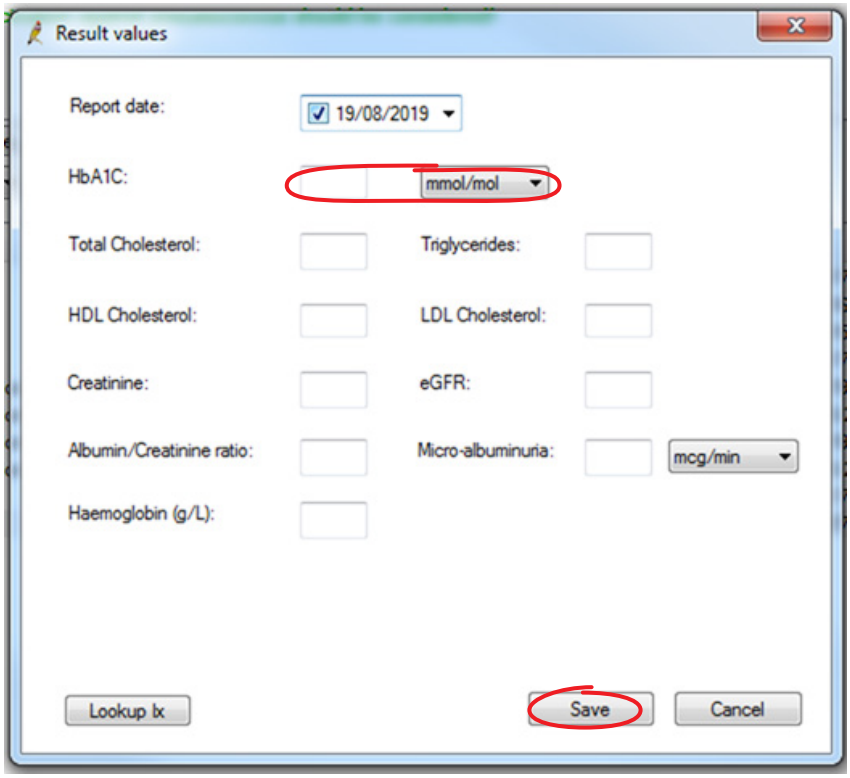
Diabetes the silent pandemic

Action:

All Indigenous clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded every 6 months.

Data Entry Field:

1. Investigation reports
2. Values
3. Enter in HbA1c level
4. Save



nKPI: PI09

GP management plan (MBS item 721)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have a chronic disease (Type 2 Diabetes), and for whom a GP Management Plan (GPMP) (MBS Item 721) was claimed within the previous **24 months**.

Current %	
National Current %	51%
National Target %	

Primary Responsibility

- GPs
- AHW
- Nurse

Improvement Strategies

- Appoint Chronic Disease Team Leader
- Expand Integrated Team Care team
- Followup MBS item 81300 visits

Evidence Base

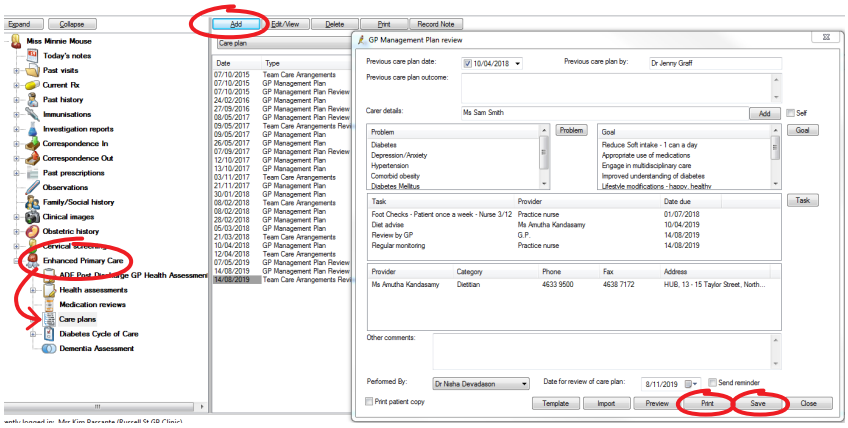
Care Planning for Chronic Diseases

Action:

All Aboriginal and/or Torres Strait Islander clients who have a chronic disease should be offered a GP Management Plan (GPMP).

Data Entry Field:

1. Enhanced Primary Care
2. Care Plan
3. Add (check for pop up box, select GPMP)
4. Complete Care Plan
5. Add recommendations including referrals to allied health if required and follow up with AHW
6. Print a copy for the patient to sign to ensure that they understand the plan you have created and they agree
7. Save a final (untick save as draft)
8. GP to bill MBS item 721
9. Reception to complete billing which will be sent to Medicare.



nKPI: PI08

Team Care Arrangement (MBS item 723)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have a chronic disease (Type 2 Diabetes) and for whom a Team Care Arrangement (TCA) (MBS Item 723) was claimed within the previous **24 months**.

Current %	
National Current %	48%
National Target %	

Primary Responsibility

- GP
- AHW
- Nurse

Improvement Strategies

- Appoint Chronic Disease Team Leader
- Expand Integrated Team Care team
- Followup MBS items 10987 and 81300

Evidence Base

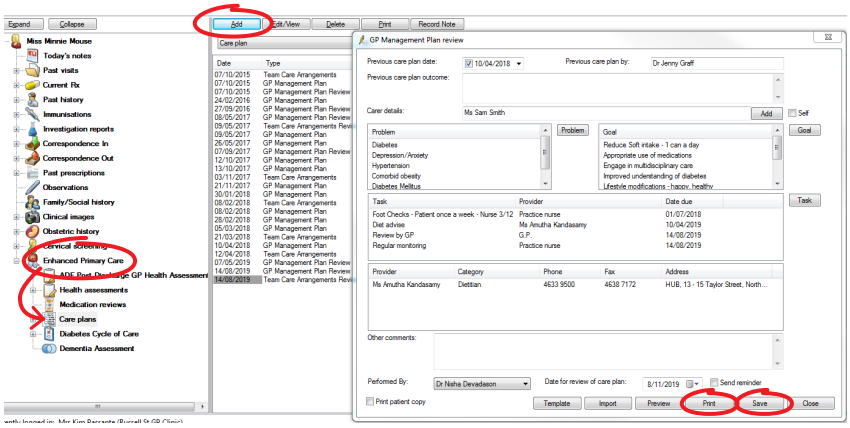
Care Planning for Chronic Diseases

Action:

All Aboriginal and/or Torres Strait Islander clients diagnosed with a chronic disease should be offered a TCA.

Data Entry Field:

1. Enhanced Primary Care
2. Care Plan
3. Add (check for pop up box, select TCA)
4. Complete all areas
5. Add recommendations including referrals to allied health if required and follow up with AHW
6. Print a copy for the patient to sign to ensure that they understand the plan you have created and they agree
7. Save a final (untick save as draft)
8. GP to bill MBS item 723
9. Reception to complete billing which will be sent to Medicare.



nKPI: PI 010
Smoking status recorded

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, and whose smoking status has been recorded at the primary health care service.

Current %	
National Current %	80%
National Target %	

Primary Responsibility

- All clinic staff
- New Directions
- TIS

Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings
- Extract clients who have no data for follow up

Evidence Base

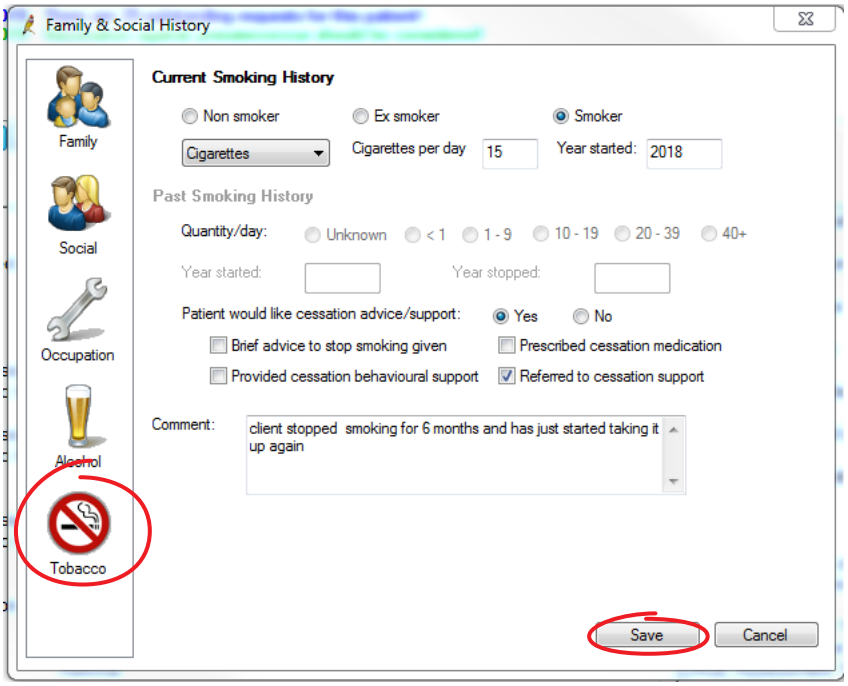
Prevalence of Tobacco use among ATSI

Action:

All clients attending the practice are to have their smoking status recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. Family & Social History
2. Tobacco
3. Enter details
4. Save



nKPI: PI 10
Smoking status result

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, and whose smoking status has been recorded as one of the following:

- current smoker
- ex-smoker or
- never smoked.

Current %	
National Current %	53%
National Target %	40%

Primary Responsibility

- All clinic staff
- New Directions
- TIS

Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings

Evidence Base

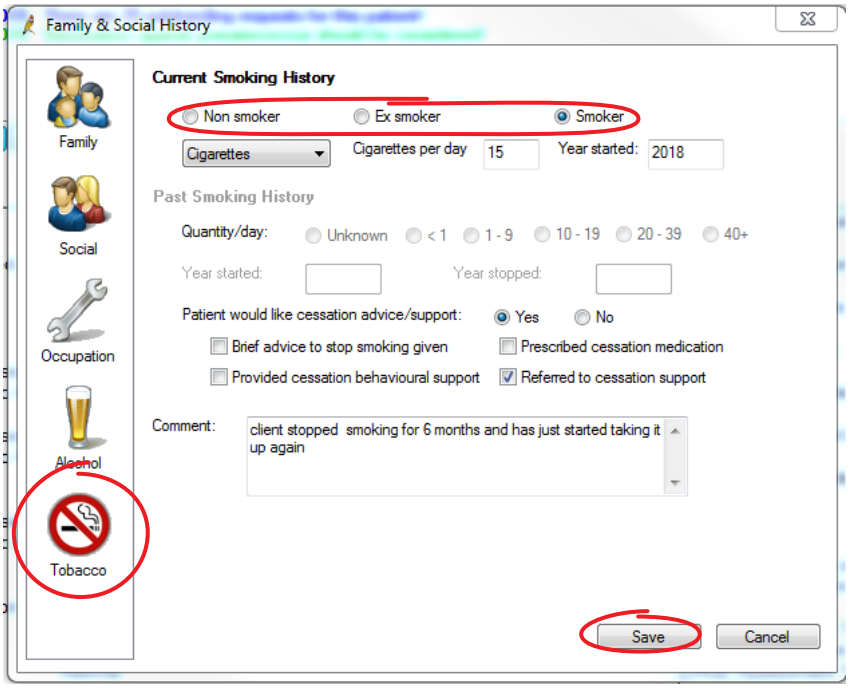
Prevalence of Tobacco use among ATSI

Action:

All clients attending the practice are to have their smoking status recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. Family & Social History
2. Tobacco
3. Enter details
4. Save



nKPI: PI 11
Smoking during pregnancy

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, who gave birth within the previous 12 months and whose smoking status has been recorded as one of the following:

- current smoker
- ex-smoker or
- never smoked.

Current %	
National Current %	50%
National Target %	37%

Primary Responsibility

- New Directions
- Nurse/AHW
- GP

Improvement Strategies

- Expand reach of TIS — targeted
- AHW include in screenings
- Partner with New Directions

Evidence Base

Tobacco smoking during pregnancy

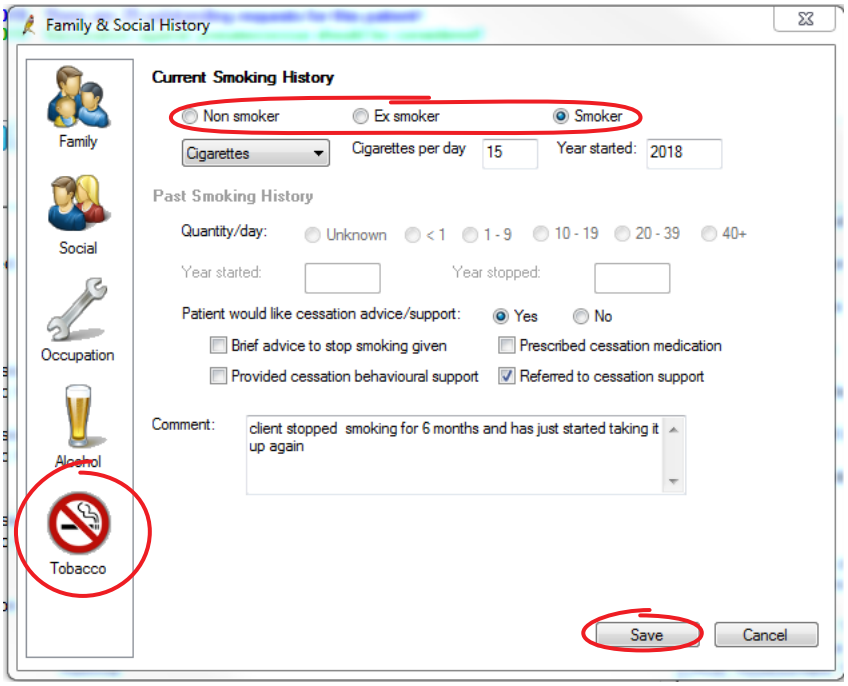
Action:

All clients attending the practice are to have their smoking status recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

Pregnancy must be activated in Obstetric tab, not just in condition.

1. Patient
2. Details
3. Smoking
4. Enter details
5. Save



nKPI: PI 12

Body Mass Index (BMI) (overweight or obese)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 25 and over,** and who have had their BMI classified as overweight or obese within the previous 24 months.

Current %	
National Current %	70%
National Target %	

Primary Responsibility

- AHW
- GP
- Nurse

Improvement Strategies

- Screening updated
- Offer nurse or MBS item 81300 followup
- Diet education

Evidence Base

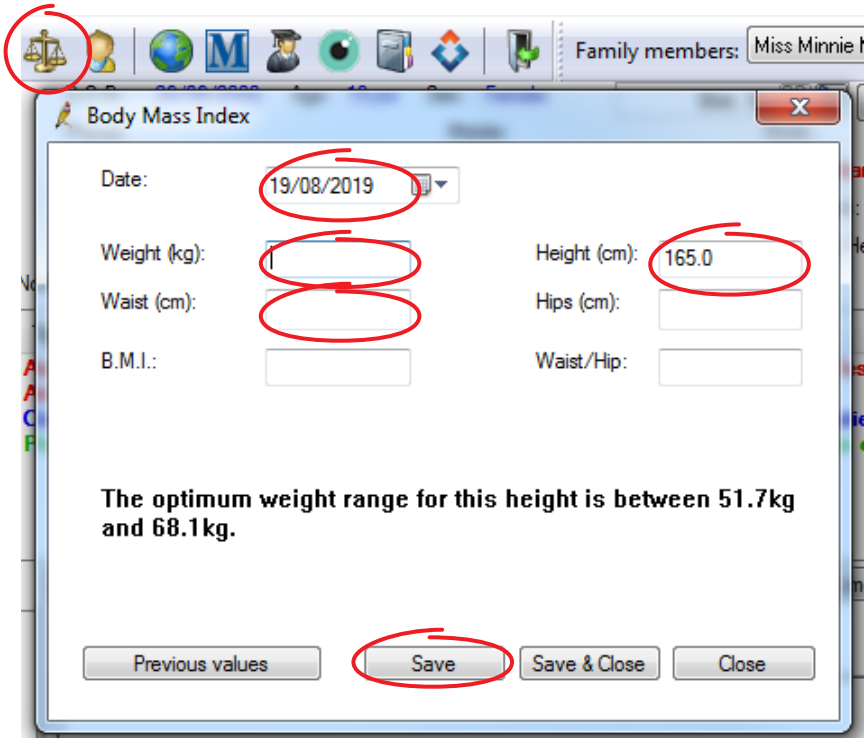
Overweight and Obesity

Action:

All clients attending the practice have their height, weight and waist circumference recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. BMI Calculator
2. Enter details
3. Save



nKPI: PI 13
First antenatal care visit

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, who gave birth within the previous 12 months and who had gestational age recorded at their first antenatal care visit with results either:

- less than 13/40 weeks
- 13/40 weeks to less than 20/40 weeks
- at or after 20/40 weeks or
- no result.

Current %	
National Current %	37%
National Target %	60%

Primary Responsibility

- GP
- Nurse/AHW
- New Directions

Improvement Strategies

- Doctor education on importance
- Clinic staff education
- New direction education

Evidence Base

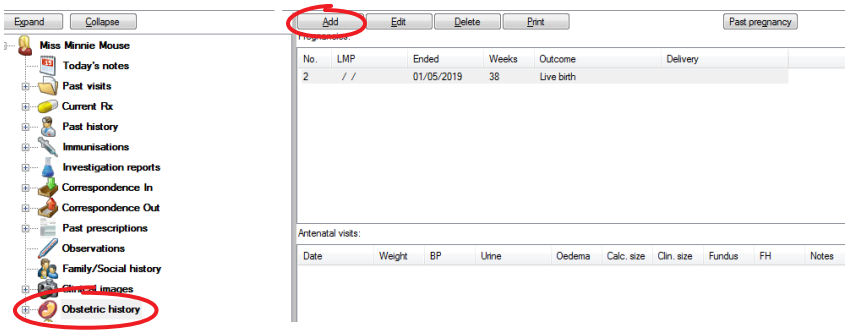
Antenatal Care

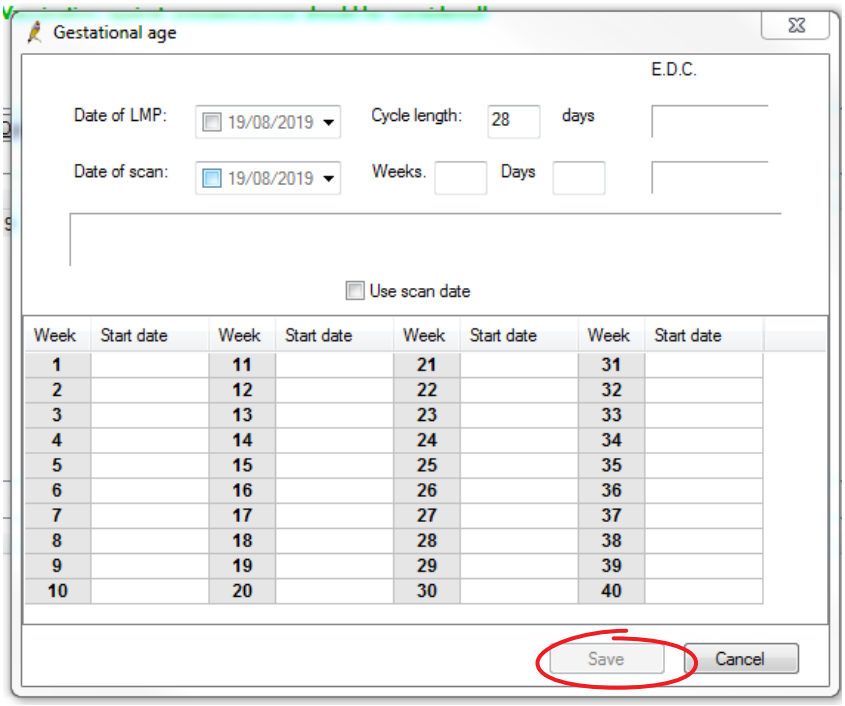
Action:

When a client has a confirmed pregnancy test the obstetric record is to be commenced in the BP clinical file at that visit.

Data Entry Field:

1. Obstetric History
2. Add
3. Complete details to predict the gestational age
4. Save





nKPI: PI 14

Influenza immunisation (50 years and over)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 50 and over**, and who are immunised against influenza.

Current %	
National Current %	34%
National Target %	64%

Primary Responsibility

- All Clinic Staff

Improvement Strategies

- Dedicated Flu Days
- Partner with local hospital
- Offer incentives

Evidence Base

Immunisation: Reducing health inequality for Indigenous Australians

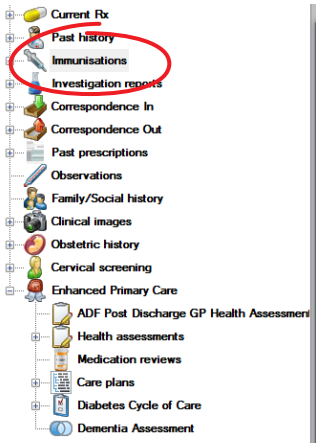
Action:

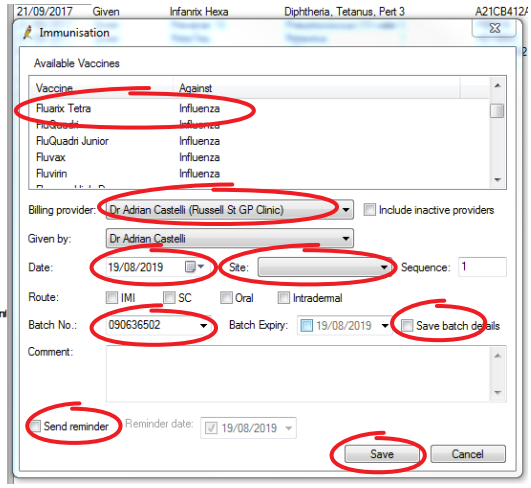
- All clients aged 50 and over are to be offered a Flu vaccine.
- Vaccines are usually available from March to September each year.
- All immunisations are to be entered into the file even if they were not administered at the clinic (just note as 'not given here').

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

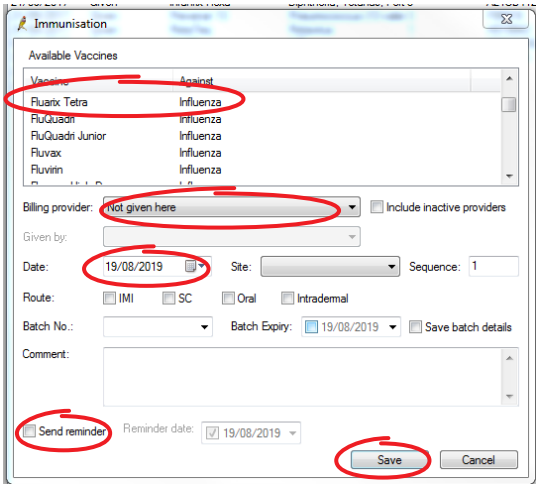
1. Immunisations **2.** Add **3.** Select Vaccine **4.** Select Provider
5. Select Site **6.** Enter Date **7.** Enter Batch Number
8. Tick Send reminder **9.** Tick Batch Number **10.** Save





IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Add
3. Select Vaccine
4. Select Provider 'NOT GIVEN HERE'
5. Enter Date
6. **Do not save** Batch Number
7. Enter comments
8. Send reminder
9. Save



nKPI: PI 15

Influenza immunisation (Type 2 Diabetes or COPD)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15–49**, are recorded as having type 2 diabetes or chronic obstructive pulmonary disease (COPD) and are immunised against influenza.

Current %	
National Current %	T2 Diabetes 34% COPD 35%
National Target %	

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- Dedicated Flu Days
- Partner with local hospital
- Offer incentives

Evidence Base

Vaccination for COPD Immunisation

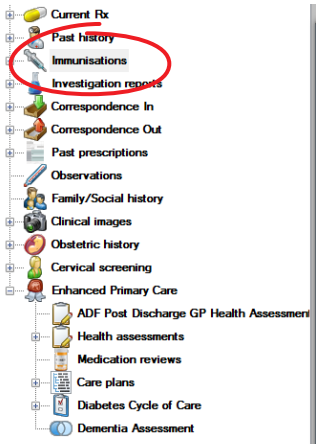
Action:

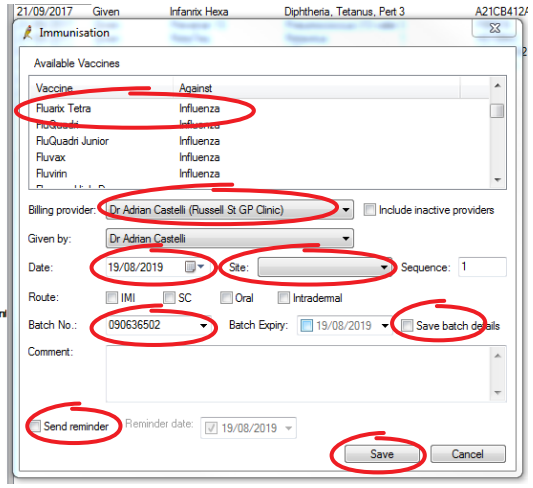
- All diabetic and COPD clients are to be offered and recommended to have a Flu vaccine
- Vaccines are usually available from March to September each year.
- All immunisations are to be entered into the file even if they were not administered at the clinic (just note as 'not given here').

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

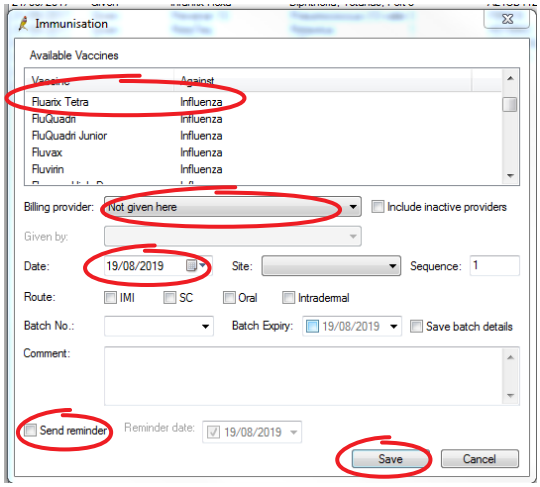
1. Immunisations **2.** Add **3.** Select Vaccine **4.** Select Provider
5. Select Site **6.** Enter Date **7.** Enter Batch Number
8. Tick Send reminder **9.** Tick Batch Number **10.** Save





IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Add
3. Select Vaccine
4. Select Provider 'NOT GIVEN HERE'
5. Enter Date
6. **Do not save** Batch Number
7. Enter comments
8. Send reminder
9. Save



nKPI: PI 16
Alcohol consumption recorded

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, and who have had their alcohol consumption status recorded at the primary health care service within the previous 24 months.

Current %	
National Current %	57%
National Target %	

Primary Responsibility

- Nurse/AHW
- GP
- New Directions

Improvement Strategies

- Screening updated
- Staff nKPI education

Evidence Base

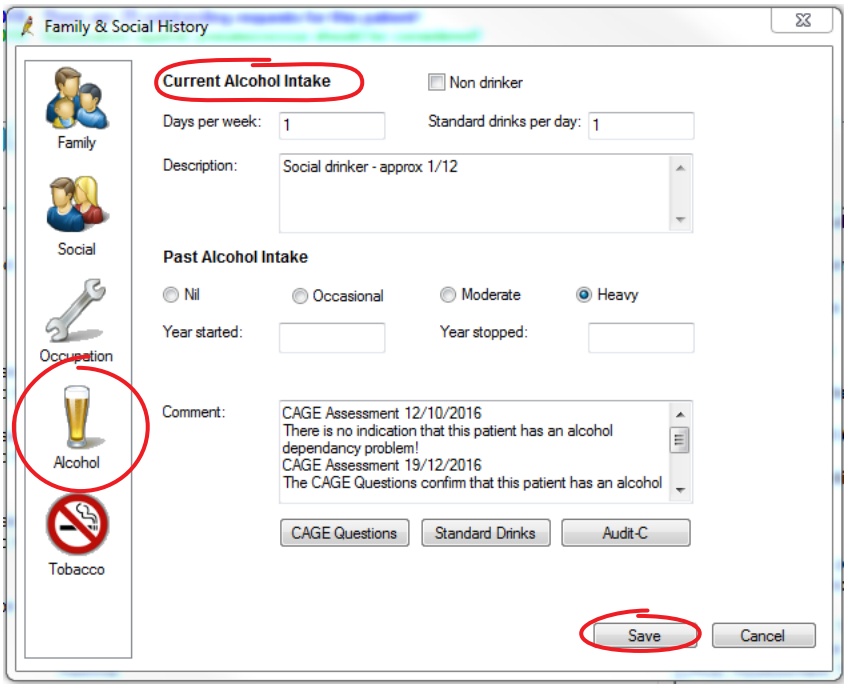
Alcohol use among Indigenous people

Action:

All clients, aged 15 and over, attending the practice are to have their alcohol consumption recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. Family & Social History
2. Alcohol
3. Enter details
4. Save



nKPI: PI 17

Alcohol consumption result

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, and who have had an AUDIT-C result recorded in the previous 24 months with a score of:

- greater than or equal to 4 in males and 3 in females; or
- less than 4 in males and 3 in females

Current %	
National Current %	
National Target %	

Primary Responsibility

- Nurse/AHW
- GP
- New Directions

Improvement Strategies

- Alcohol education
- Clinical staff updated on tool
- Staff nKPI education

Evidence Base

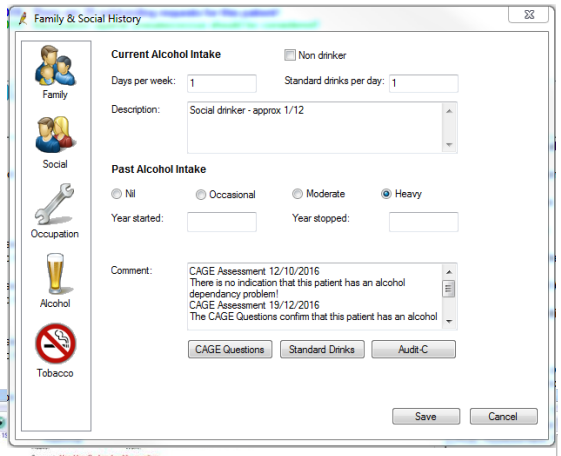
Audit-C overview

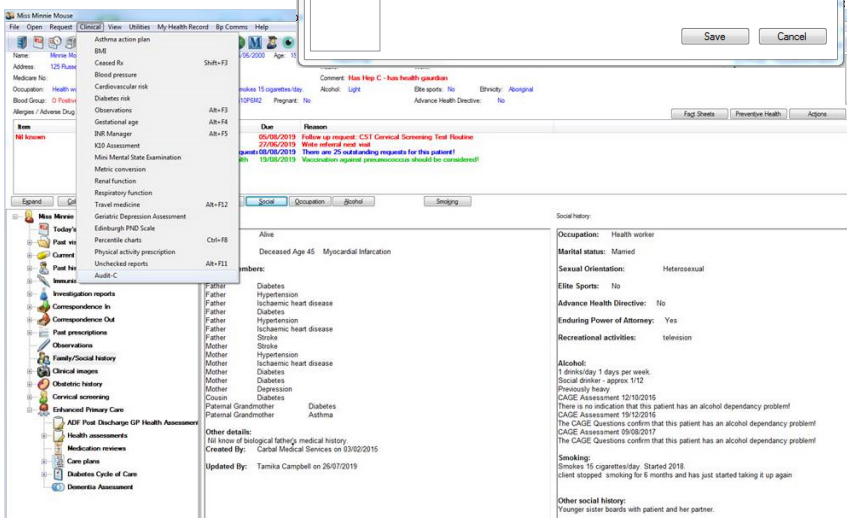
Action:

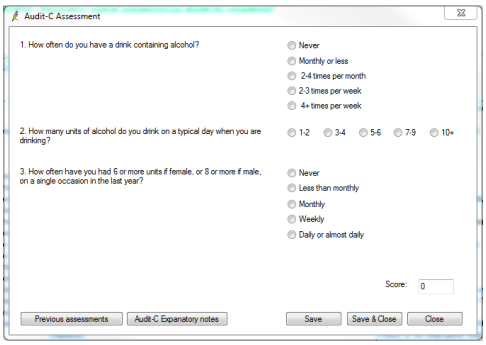
All clients, aged 15 and over, attending the practice are to have their alcohol consumption recorded during screening. This is to be checked and updated at each visit.

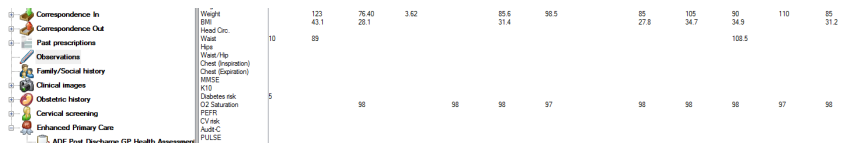
Data Entry Field:

1. Family & Social History
2. Alcohol
3. Enter details
4. Save









nKPI: PI 18

Kidney function test recorded (Type 2 Diabetes or CVD)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, who are recorded as having type 2 diabetes and have had an estimated glomerular filtration rate (eGFR) recorded AND/OR an albumin/creatinine ratio (ACR) or other microalbumin test result recorded within the previous 12 months.

AND

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, who are recorded as having cardiovascular disease (CVD) and have had an eGFR recorded within the previous 12 months.

Current %	
National Current %	Type 2 67% CVD 63%
National Target %	Type 2 69%

Primary Responsibility

- Nurse
- GP
- AHW

Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

Evidence Base

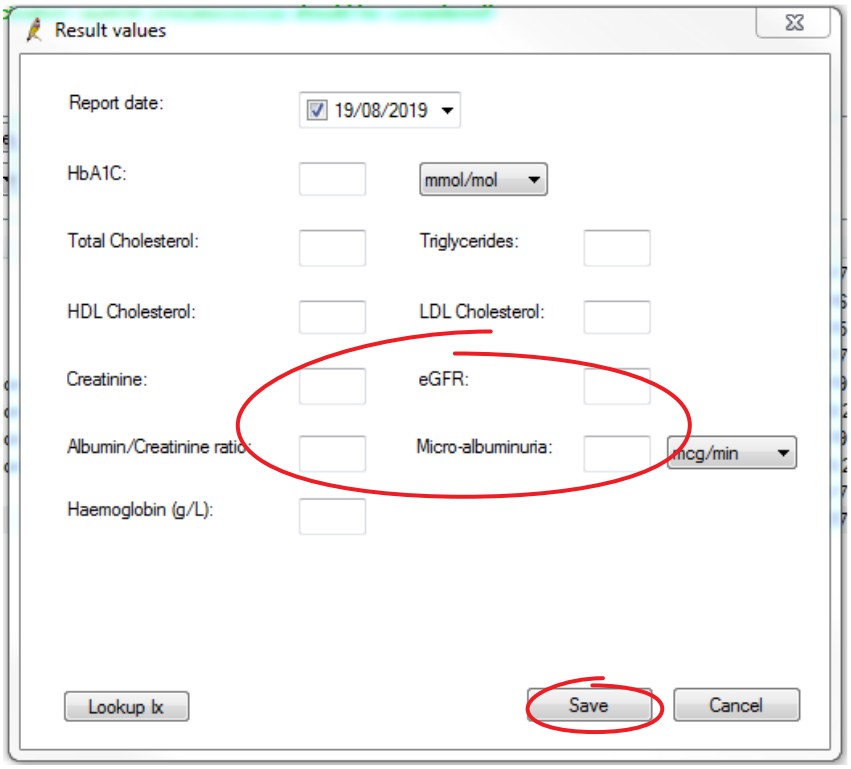
Chronic Kidney disease ATSI

Action:

All Diabetic and CVD clients are to have the eGFR recorded AND/OR an ACR or other microalbumin test result recorded. This is to occur at least once in a 12 month period.

Data Entry Field:

1. Investigation Reports
2. Values
3. Complete details
4. Save.



nKPI: PI 19

Kidney function test result (Type 2 Diabetes or CVD)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, are recorded as having Type 2 Diabetes or cardiovascular disease (CVD) and who have had an estimated glomerular filtration rate (eGFR) recorded within the previous 12 months with a result of (ml/min/1.73m²):

- ≥ 90
- 90 ≥ 60
- 60 ≥ 45
- 30 ≥ 45
- 30 ≥ 15
- < 15

or

Number and proportion of regular clients who are male, Aboriginal and/or Torres Strait Islander, **aged 15 and over, who are recorded as having Type 2 Diabetes and who have had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):

- < 2.5
- 25 ≥ 2.5
- > 25

or

Number and proportion of regular clients who are female, Aboriginal and/or Torres Strait Islander, **aged 15 and over, who are recorded as having Type 2 Diabetes and who have had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):

- < 3.5
- 35 ≥ 3.5
- > 35

Current %	
National Current %	Type 2 67% CVD 63%
National Target %	Type 2 69%

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

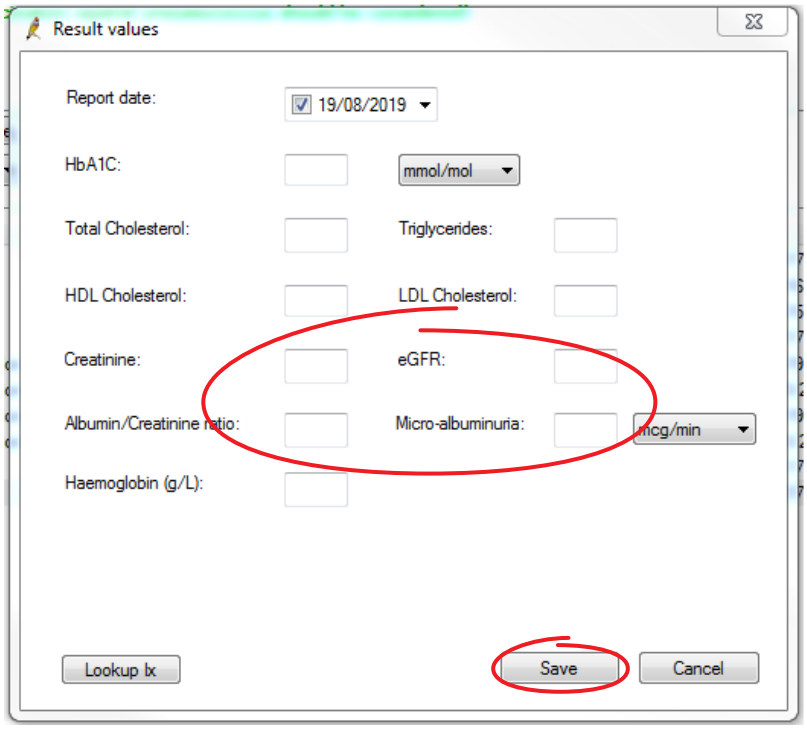
- Screening updated
- Clinic staff training
- Staff nKPI education

Action:

All Diabetic and CVD clients are to have the eGFR recorded AND/OR an ACR or other microalbumin test result recorded. This is to occur at least once in a 12 month period.

Data Entry Field:

1. Investigation Reports
2. Values
3. Complete details
4. Save.



nKPI: PI20

Cardiovascular disease (CVD) risk assessment

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander regular clients, with no known cardiovascular disease (CVD), **aged 35–74**, with information available to calculate their absolute CVD risk.

Current %	
National Current %	38%
National Target %	

Primary Responsibility

- GP
- Nurse
- AHW

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Evidence Base

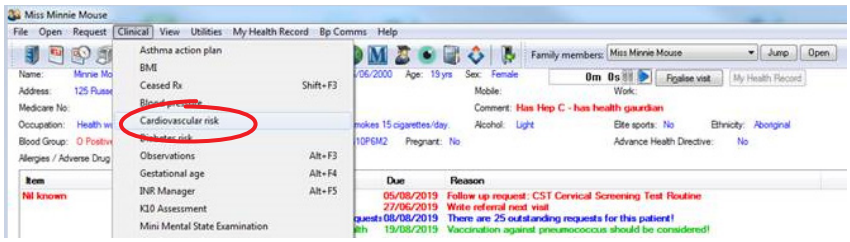
Cardiovascular risk profile ATSI

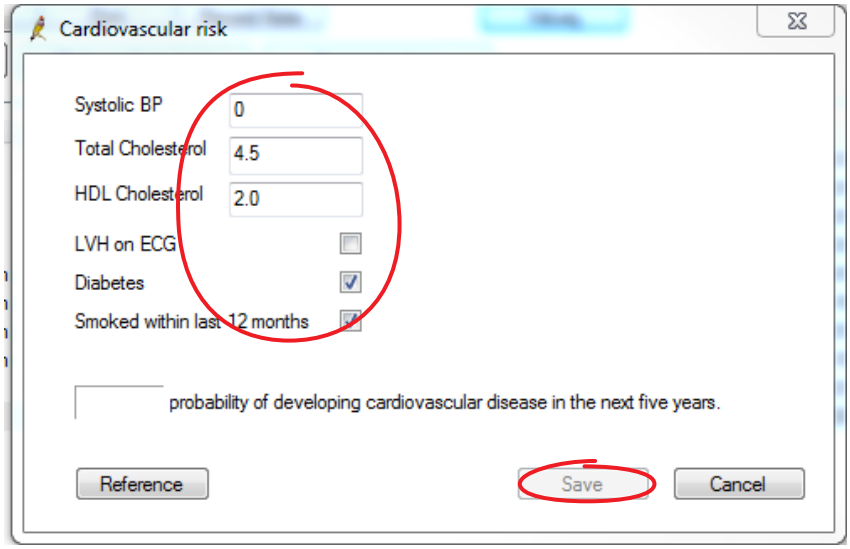
Action:

Clients that are suspected of having any CVD risk factors must have a cardiovascular risk assessment.

Data Entry Field:

1. Clinical Tab
2. Cardiovascular risk
3. Complete Details
4. Save





nKPI: PI21

Absolute CVD risk assessment result

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander regular clients, **aged 35–74**, and with no known history of cardiovascular disease (CVD), who have had an absolute CVD risk assessment recorded within the previous 2 years and whose CVD risk was categorised as 1 of the following:

- high (greater than 15% chance of a cardiovascular event in the next 5 years)
- moderate (10%–15% chance of a cardiovascular event in the next 5 years)
- low (less than 10% chance of a cardiovascular event in the next 5 years).

Current %	
National Current %	36%
National Target %	

Primary Responsibility

- GP
- Nurse
- AHW

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Evidence Base

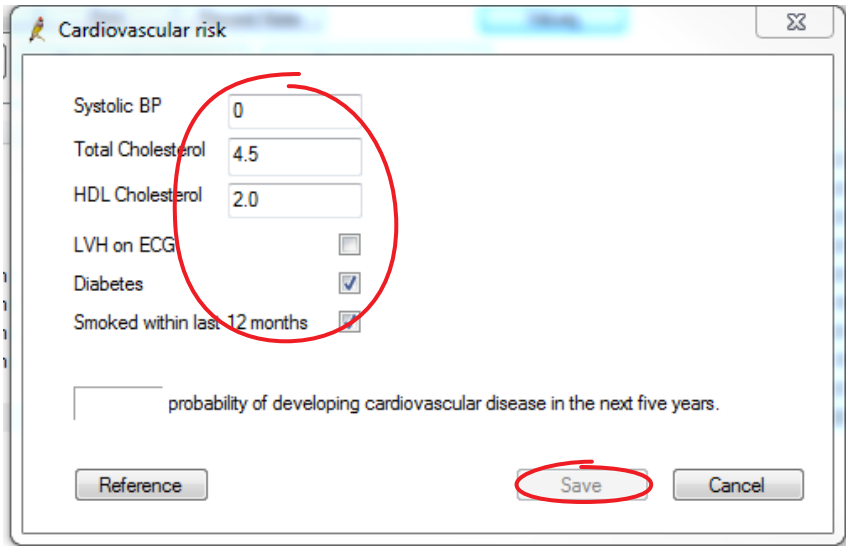
Absolute Cardio Risk resources

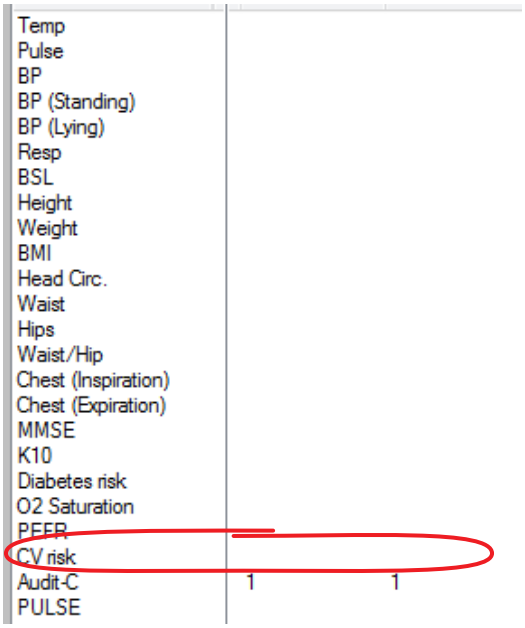
Action:

Clients that are suspected of having any CVD risk factors must have a cardiovascular risk assessment entered into their clinical file. The result appears with observations as CV risk.

Data Entry Field:

1. Clinical Tab
2. Cardiovascular risk
3. Complete Details
4. Save





nKPI: PI22
Cervical screening recorded

Description:

Number and proportion of female regular clients who are Aboriginal and/or Torres Strait Islander, **aged 20–69**, who have not had a hysterectomy and who have had a cervical screening within the previous 2 years, 3 years and 5 years.*

Current %	
National Current %	30%
National Target %	

Primary Responsibility

- Nurse/AHW
- GP
- New Directions

Improvement Strategies

- Womens wellness clinics
- Screening updated
- Staff nKPI education

Evidence Base

Summary of cervical cancer among indigenous women

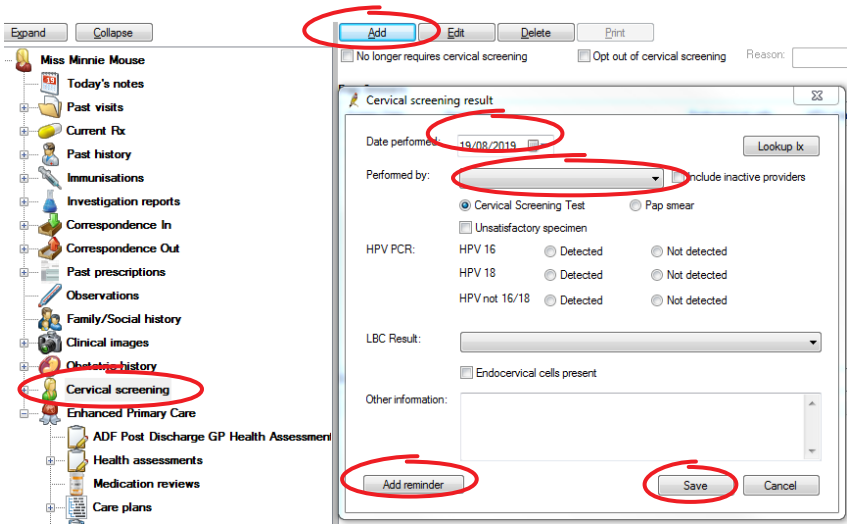
** Cervical Screening record does not reflect current guidelines. You can download the National Guide to a preventive health assessment here. https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Resources/National-guide-3rd-ed-Sept-2018-web.pdf see page 105: Prevention and early detection of cervical cancer.*

Action:

- All female patients aged 20-69 years are to be asked during screening when they had their last pap smear
- If unknown the patient is to be offered the opportunity to have a pap smear done at the clinic. Mark performed by as 'Not performed here'.

Data Entry Field:

1. Cervical Screening
2. Add
3. Date Performed
4. Performed by – enter provider details or 'Not performed here'
5. Add reminder
6. Save



nKPI: PI23

Blood pressure recorded (Type 2 Diabetes)

Description:

nPI23 Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and who have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months.

Current %	
National Current %	68%
National Target %	70%

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- Screening updated
- Equipment regularly calibrated
- Staff nKPI education

Evidence Base

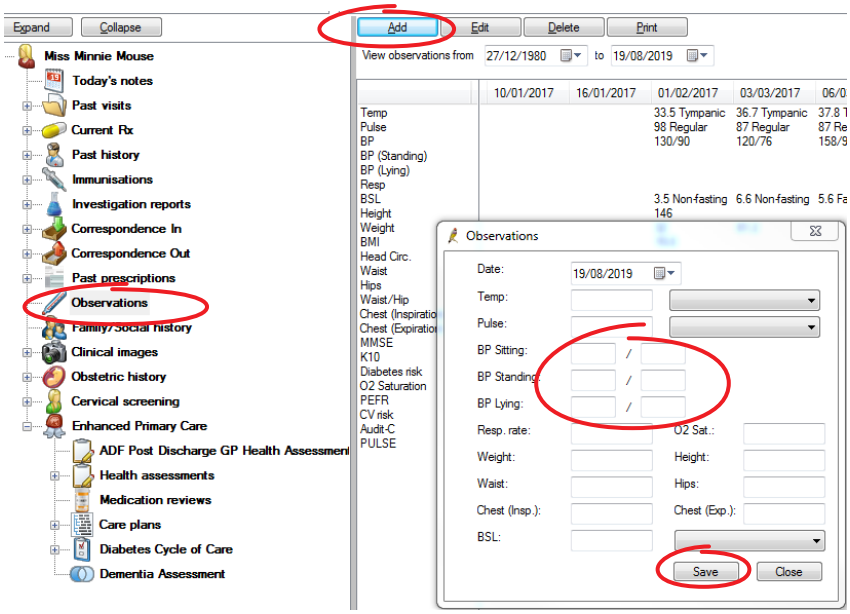
Measured High blood Pressure
Summary of ATSI health

Action:

Every patient who has an active diagnosis of Type 2 Diabetes must have a blood pressure recorded at every visit.

Data Entry Field:

1. Observations
2. Add
3. Enter BP Details
4. Save



nKPI: PI24

Blood pressure ≤130/80 mmHg (Type 2 Diabetes)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and whose blood pressure measurement result, recorded within the previous 6 months, was less than or equal to 130/80 mmHg.

Current %	
National Current %	43%
National Target %	

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- DCC updated each visit
- Screening updated
- Staff nKPI education

Evidence Base

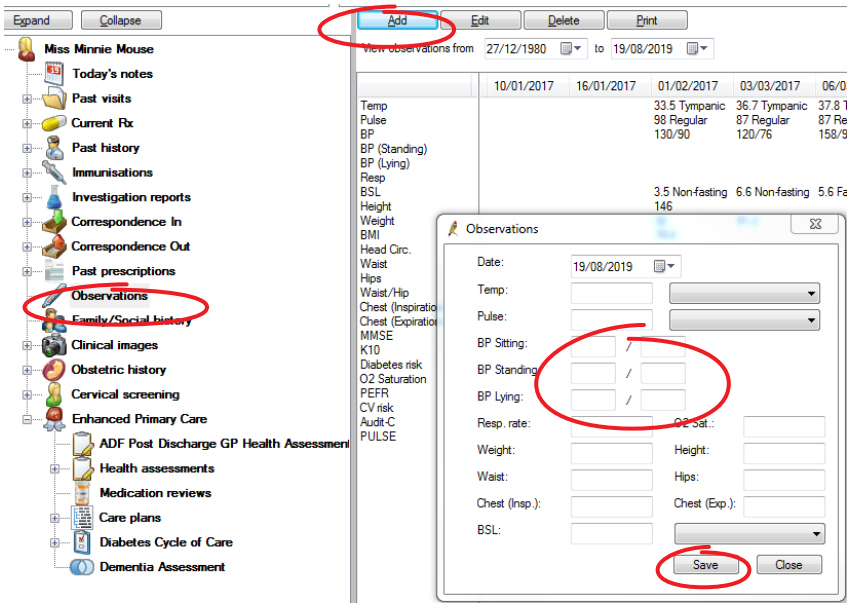
BP
BP Resources

Action:

Every patient who has an active diagnosis of Type 2 Diabetes must have a blood pressure recorded at every visit.

Data Entry Field:

1. Observations
2. Add
3. Enter BP Details
4. Save



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QAIHC

36 Russell Street
South Brisbane Q 4101

P: **07 3328 8500**

qaihc.com.au

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