EIS Health Ltd.

Clinical Audit "Self-assessment 75+ Health check"

CESPHN has developed a 'self-assessment' audit to help GPs and the practice team identify whether there is room for improvement in their general practice's 75+ Health Assessment. This is an accredited RACGP Category 1, 40 point activity with an optional additional 10 point QI component.

Time Frame

To be completed and returned to CESPHN Friday 12th May 2018

How do I gain RACGP points for this activity?

Please complete the reflective questions on the template provided and fax to 8322 8918 (Attention CPD Team). A CESPHN CPD Program Officer will upload your details to RACGP allocation of Cat 1. 40-points and additional 10-points QI (if applicable).

What are the steps to participate in this activity?

The Clinical Audit QI activity is described below:

a) **Mapping patient journey**: Find 10 older community dwelling people aged 75 years or older in the general practice who have been admitted to hospital or attended an Emergency Department in the last 12 months. You may wish to:

- Recall patients who may have been admitted with an unplanned admission
- Request local hospital to send a list of practice/GP patients who may have attended the ED or been admitted with an unplanned admission in past 12 months (Hospital GP Liaison may be able to provide)
- Use you practice software to identify 10 patients with unplanned admissions (If you require assistance contact CESPHN)

b) Create a list and allocate each patient a number 1-10

c) Review the situation which surrounded the circumstances pre/post the admission/ED attendance. What could have been done differently to avoid the admission/ED attendance? (Either at the practice, or by the patient or by other healthcare providers) (Write your reflections for each patient)

d) If a 75+health assessment (home or surgery) had been done in previous 2 years, or, the following were assessed during clinical encounters at your practice please review the following areas:

1. How accurate was the medical summary in the health assessment?
2. How up to date was the medication list in the health assessment?
3. If a cognition screen was performed, what was the cognition screen used?
4. Was the screen appropriate for the person's education level or language? (MMSE is not suitable for people with English as not their primary language, or with levels of education lower than year 11 school https://www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas
5. What recommendation had occurred if a deficit in cognition was noted?
6. If a cognition screen was not performed, why was it not done?

7. If a nutrition screen was performed, which nutrition screen was used?
8. What was the result of the nutrition screen, if one was done? What recommendation occurred? A useful link is https://www.mlahealthymeals.com.au/globalassets/mla-healthy-meals/documents/brochures/live-well.pdf
9. How many weights have been recorded for the person in the previous 18 months? What was the trend? What action had occurred if weight loss was noted?
10. If a nutrition screen was not performed, why was it not done? https://www.ncbi.nlm.nih.gov/pubmed/23538653
11. How often has the person's height been reviewed?
12. Has the person previously had a minimal trauma fracture? *Defined as fall from standing height resulting in bony injury (e.g. forearm/hip/humerus/pelvis) or a 20% reduction in height of lateral vertebra)*
13. If a fracture has been documented, is the person taking medication to improve bone density and reduce fracture risk (e.g. bisphosphonates) + taking vitamin D and calcium?
14. When was the older persons last DEXA Bone Mineral Density? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2685234/ and https://www.osteoporosis.org.au/sites/default/files/files/Bone%20Density%20Testing%20in%20General%20Practice.pdf
15. How was the person's mobility function assessed? http://www.bgs.org.uk/gait-assessment/cga-toolkit-category/how-cga/cga-assessment/cga-assessment-functional/cga-function-mobility/gait-and-balance-assessment
16. What mobility deficit was noted?
17. What actions occurred if a deficit was noted?
18. How was the person's balance function assessed?
19. What actions occurred if a deficit was noted?
20. How many medicines is the older person taking?
21. Which medications require monitoring of blood levels or require monitoring for potential side effects? https://www.nps.org.au/australian-prescriber/articles/therapeutic-drug-monitoring-which-drugs-why-when-and-how-to-do-it (e.g. warfarin, digoxin, thyroxine, amiodarone, frusemide (electrolytes), antiplatelet/anticoagulants (CBP/platelets)
22. When was the last blood level of a medication requiring monitoring checked?
23. When was the last discussion reviewing the need to continue/discontinue some medications? (https://www.mja.com.au/system/files/issues/201_07/sco00146.pdf
24. When was the older person's renal function last checked?
25. What is the patient's most recent measurement of eGFR?
26. If the eGFR is less than 60, has a diagnosis of "Chronic Kidney Disease" been documented in the medical software health summary? (stage 3a or worse) (Clinical Tip: *CKD in itself is not a diagnosis. Attempts should be made to identify the underlying cause of CKD* http://kidney.org.au/cms_uploads/docs/ckd-management-in-gp-handbook-3rd-edition.pdf
27. Has an annual Kidney Health Check been recommended? (Testing for: serum Creatinine, eGFR, Blood pressure and urinary ACR). Indications include a history of diabetes, hypertension, cardiovascular disease, family History of kidney disease, previous acute kidney injury, ATSI, or Obesity (BMI > 30).

28. Is the person taking any renally cleared medications? (commonly prescribed renally cleared medications are found) https://www.racgp.org.au/afp/2013/januaryfebruary/prescribing-for-older-people-with-cri/

29. What documentation of the medication management technique has occurred? (e.g. self-administers, weekly self/carer filled dosette/pharmacy packed medication management aid)

30. Was a Home Medicine Review requested? If not, why not?

31. If a Home Medicine Review was done, what were the recommendations?

32. How was the older person's mood assessed? What was noted? What was recommended? http://www.bgs.org.uk/mental-psychological/cga-toolkit-category/how-cga/cga-assessment/cga-assessment-mental/cga-mental-health

33. If there is a Diagnosis of COPD, has a COPD action plan been reviewed and provided to the older person? https://lungfoundation.com.au/health-professionals/clinical-resources/copd/copd-action-plan/

34. If there is a diagnosis of heart failure has a heart failure action plan been reviewed and provided to the older person? https://www.heartfoundation.org.au/images/uploads/publications/CHF_IS-346_InfoSheet_LivingWell_CHF_FINAL.pdf

35. Review the older person's immunization history, and reflect if all age appropriate immunizations are up to date (http://www.bgs.org.uk/good-practice-guides/resources/goodpractice/vaccinationbpg

36. What is documented in the social history of the person? Has this been updated to reflect changes such as:

    - Widowed/living alone/has carer
    - Wife has dementia
    - Requires mobility aid
    - Has care package with aged care provider/case manager name..
    - And others https://www.nia.nih.gov/health/obtaining-older-patients-medical-history#socialhistory

37. Does the older person drive? What tool was used to assess fitness to drive for the older person? http://elderlydrivingassessments.com/trailmaking.php

38. What legal documents have been documented to support the older person's choices should a loss of capacity occur ? e.g. Advance Directive, EPOG, EPOA https://www.myagedcare.gov.au/legal-information/powers-attorney-enduring-powers-attorney-and-enduring-guardians

39. What are the goals of the older person? What matters to them? http://www.ihi.org/communities/blogs/are-you-missing-opportunities-to-improve-care-for-older-adults

40. How is the self-reported health of the older person asked in the assessment? https://www.medscape.com/viewarticle/719816_1

41. Which frailty screening tool is used in the health assessment? http://frailty.net/diagnostic-tools/

42. If the older person has had a care plan completed in the past 2 years, how well does it cover the holistic health and wellness of the older people rather than being single disease focused?

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GP Name: _____ RACGP Number: _____

Reflective Practice Template: Please answer the questions below after completing the Clinical Audit and Quality Improvement activity and fax to 8322 8918 (Attention CPD Team).

What gaps have you encountered in your case audit/ What could be done differently in the practice?
What needs to change?
Who needs to do this?

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What are the barriers to making this change?
Write a plan to improve the care of older people in your practice based on the identified gaps, and barriers.
How will you optimise the General practice over 75 year Health assessment template?