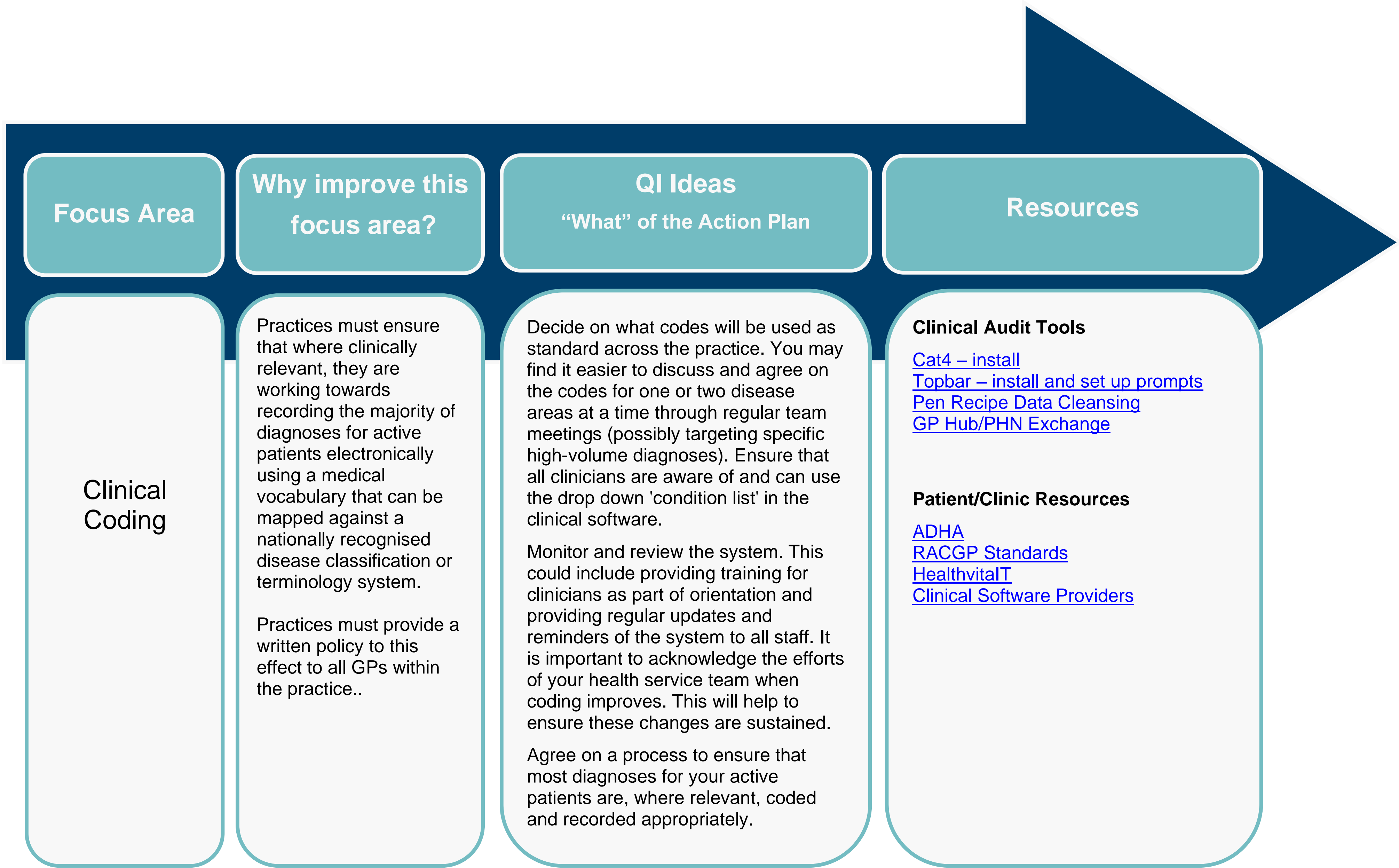

Focus Area	Why improve this focus area?	QI Ideas “What” of the Action Plan	Resources
Clinical Coding	Practices must ensure that where clinically relevant, they are working towards recording the majority of diagnoses for active patients electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system. Practices must provide a written policy to this effect to all GPs within the practice..	Decide on what codes will be used as standard across the practice. You may find it easier to discuss and agree on the codes for one or two disease areas at a time through regular team meetings (possibly targeting specific high-volume diagnoses). Ensure that all clinicians are aware of and can use the drop down 'condition list' in the clinical software. Monitor and review the system. This could include providing training for clinicians as part of orientation and providing regular updates and reminders of the system to all staff. It is important to acknowledge the efforts of your health service team when coding improves. This will help to ensure these changes are sustained. Agree on a process to ensure that most diagnoses for your active patients are, where relevant, coded and recorded appropriately.	**Clinical Audit Tools** Cat4 – install Topbar – install and set up prompts Pen Recipe Data Cleansing GP Hub/PHN Exchange **Patient/Clinic Resources** ADHA RACGP Standards HealthvitalT Clinical Software Providers