Preventive services clinical audit protocol

2014

First published 2009

Acknowledgments

One21seventy would like to acknowledge and thank the people who contributed their time to the revision of the Preventive health audit tool.

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Contents

Abbreviations

ABCD	Audit of Best Practice in Chronic Disease
ACR	albumin:creatinine ratio
BGL	blood glucose level
BP	blood pressure
CVD	cardiovascular disease
CVR	cardiovascular risk
EPDS	Edinburgh Postnatal Depression Scale
HDL	high-density lipoprotein
HIV	human immunodeficiency virus
K5	Kessler 5
K6	Kessler 6
K10	Kessler 10
LDL	low-density lipoprotein
MBS	Medicare Benefits Scheme
NAAT	Nucleic acid amplification tests
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
PHC	primary health care
PHQ2+	Patient Health Questionnaire 2
PHQ9	Patient Health Questionnaire 9
QI	quality improvement
RACGP	Royal Australian College of General Practitioners
SAT	systems assessment tool
SEWB	social and emotional well being
STI	sexually transmissible infection
Tg	triglyceride
WHO	World Health Organization
≥	greater than or equal to
≤	less than or equal to

Summary of changes

Table 1 Changes to 2014 protocol

Section/ Question	Description of change
All sections	Reference updates
5.9	Additional information about trichiasis screening, no change to question

Version control

Table 2 Version control

Version	Release date	Description
2.0	2005	Tool development
2.1	16/2/2007	Minor formatting adjustments only (no content change)
2.2	10/24/2007	Minor formatting adjustments only (no content change)
3.0	01/08/2010	Minor changes to formatting and content
2013 release	06/05/2013	Minor changes to formatting and content
2014	9/9/2014	Internal protocol update only

Introduction

This protocol should be followed closely and used in conjunction with *Improving the quality of primary health care: A training manual for the One21seventy CQI cycle* (version 2.0).

The data collected on each question are validated when entered on the One21seventy website. Invalid entries will prevent progression to the next section.

Eligibility of clients

To be eligible for inclusion in the preventive services clinical audit, a client must:

- be between 15 and 54 years old (64 years for Healthy for Life reporting)
- have been a resident in the community for 6 months or more in the last twelve months
- not have a diagnosis of diabetes, hypertension, coronary heart disease (CHD), chronic heart failure (CHF), rheumatic heart disease (RHD) or chronic kidney disease (CKD)
- not be pregnant or less than 6 weeks postpartum at time of audit.

Note: clients with a diagnosis of dyslipidaemia should not be excluded from participating in this audit. Dyslipidaemia is a potentially reversible condition and may be managed with medication.

Clients with asthma should not be excluded as it is a manageable condition that can be controlled.

Sample size and confidence interval

Refer to *Improving the quality of primary health care: a training manual for the One21seventy cycle*, version 2, Section 5, page 50, for more information on determining the sample size with regard to the population size for this audit, and the confidence interval required for the reported indicators.

The 'eligible population' referred to in this protocol is the number of clients who are deemed eligible by the criteria as described above.

Recommendations for sample size

- For services with up to 100 clients in the eligible population, we recommend a sample size of *at least 40 client records* per audit. This sample will provide an adequate estimate (for quality improvement purposes) of the proportion of clients receiving specific services. Services that require a less precise result may opt to audit 30 records.
- Health services with large eligible populations may wish to increase the sample size to reduce the confidence intervals around the sample estimates. Health services with smaller eligible populations (40 or fewer) should audit all client records and be cautious when using and comparing reported data.
- Be aware of the confidence interval for your results — this is important when interpreting the data in your reports.

Section 1 General information

1.1 Client ID

For each participating health service, the auditor will prepare a master list of participants that contains the participant name, date of birth, and participant number (client ID). This list will be marked 'confidential' and stored securely to prevent inappropriate identification of client records.

Assign a **unique three-digit** identification (ID) number for each client record audited. At data input, this three-digit number will be automatically prefixed with the tool and health centre IDs.

1.2 Medicare number

Much of the funding for community controlled health services is via Medicare (general practitioners or allied health). If the Medicare number is not on file or has expired then the claim for the service may be rejected. It is important to have up to date Medicare numbers on file to ensure claims are processed quickly.

Is a **current** Medicare number documented in the client's medical record?

Indicate **1-Yes** or **0-No**

1.3 Date of birth

Record the client's date of birth. Record as **dd/mm/yyyy**.

1.4 Sex

Record the gender of the client. Indicate **1-Male** or **2-Female**

1.5 Indigenous status

Record the client's Indigenous status as stated in their medical record. Indicate **one** of the following:

1- Aboriginal

2-Torres Strait Islander

3-Both Aboriginal and Torres Strait Islander

4-Neither Aboriginal nor Torres Strait Islander

5-Not stated if there is no clear documentation of the client's Indigenous status.

1.6 Auditor

Record the name (initial and surname) of the person doing the audit. You may want make a stamp if you are a regular auditor.

(e.g. J Smith).

1.7 Audit date

You may wish to use a date stamp. Record as **dd/mm/yyyy**.

Note that the audit date will be the same for all medical records being audited for preventive services in this cycle. Even if the auditing cannot be completed in a single day, continue to use the same audit date for all client records and audit the records retrospectively from this date.

Section 2 Attendance at health service

Attendance

By attending a health service, Aboriginal and Torres Strait Islander people can help to ensure they receive primary health care that is matched to their needs. Their attendance also encourages early detection, diagnosis and intervention for common and treatable conditions such as chronic diseases.

Time since last attendance is a useful indicator of the level of client engagement with the health service. Identifying which staff member was the first point of contact for the client at their last attendance can be used to measure clinic processes and Aboriginal and Torres Strait Islander health worker involvement with program delivery.

Studies show that advice from health professionals to Aboriginal clients is often the key reason the clients change their risky behaviours. The health service is often the client's major source of health advice, particularly in remote areas (Couzos and Murray 2008).

2.1 Date of last attendance

A record of attendance includes a record that the client was seen by a health professional (refer to Question 2.4 for types of health professionals). If the client made a visit to the health centre but left without an assessment by a health worker, this should *not* be recorded as having attended the health centre.

If a regular service is being provided (e.g. home visits for community nurses attending to leg ulcers or occupational therapy in the home), this can be included as attendance. It can also be recorded in the systems assessment tool (SAT) in the appropriate component or item to show that this service is provided.

It is acknowledged that some clients who receive care never visit the health service itself.

Record the date the client last attended the health service for care. Record as **dd/mm/yyyy**.

2.2 Location of date of last attendance

Some health services have a combination of paper and electronic records for client information. Client records should be easily accessible and available when needed (RACGP, 2013).

Is the location of the date last attended documented on a paper record?

Indicate **1-Yes** or **0-No**

Is the location of the date last attended documented in an electronic or computer record?

Indicate **1-Yes** or **0-No**

2.3 Follow up attempt since last attendance

All clients who have a health check should be followed up and/or provided with feedback (Queensland Health 2010). Health services may have a system in place to remind staff when a client is due to be seen again. If the documentation shows that the client has been notified of an appointment but has not presented to the health centre, this is classified as an unsuccessful follow up attempt.

If the client has **not** attended the health service in the last 24 months, is there a record of an unsuccessful follow up attempt by health service staff since last attendance?

Indicate **1-Yes**, **0-No** or

9-N/A if the client has attended in the last 24 months

2.4 Reason for last attendance

The reason for last attendance can shed light on the client's level of engagement in their ongoing health management. It can also identify opportunities for routine checks and tests that might arise in the context of other visits to the health service. If more than one reason is documented, record only one reason.

Indicate the reason for last attendance. If 'Other', provide a brief description of reason for last attendance.

Table 3 Examples of reasons why clients may attend the health centre

Reason	Examples
1-Well person's check	Self explanatory, the client presented for a check up.
2-Acute care	Infections, trauma
3-Mental illness	Follow up or acute episode of mental illness
4-Immunisation	Self-explanatory, the client presented for a vaccination
5-Antenatal	Pregnancy check up
6-Sexual health	Sexually transmissible infections (STI) follow up or screening
7-Other	Social issues, domestic violence
9-N/A	The client has not attended the health centre in the last 24 months

2.5 First seen by at last attendance

Identifying which health professional was the first point of contact for the client at their most recent attendance is a measure of clinic processes and of Aboriginal and Torres Strait Islander health worker engagement with program delivery. It is acknowledged that sometimes a health professional will meet more than one criteria, eg an Aboriginal nurse. Correct interpretation of the report is important for usefulness at the health service where the information was collected.

When the client last attended the health service, which health professional did the client see **first**? Some health services may have a clear policy on which type of health worker should be the first to see clients.

Table 4 Types of health workers who may be the first person a client sees

Type of health worker	Example
1-Aboriginal and Torres Strait Islander health worker	Aboriginal and Torres Strait Islander health workers working in tertiary institutions, local hospitals, health centres, or any primary health care services. Depending on the area of work, some health workers may need to obtain a licence or registration from their local authority in the state or territory where they wish to work
2-Nurse	Registered nurses, enrolled nurses and/or endorsed nurses who are registered/enrolled and/or endorsed by the Australian Health Practitioner Regulation Agency (AHPRA)
3-General practitioner	Doctors who work as the first point of call for medical care in the community
4-Specialist	A doctor who has specialised in a particular field and is registered with the appropriate specialist college (e.g. an ophthalmologist registered with the Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
5-Allied health professional	Audiologists, chiropractors, dieticians, occupational therapists, podiatrists, psychologists, radiographers, radiation technicians, sonographers, social workers, speech pathologists, physiotherapists, diabetes educators, cardiac rehabilitation therapists, pathologists
6-Other	Any health professional not identified above
7-No record	No record of which health professional the client first saw at the last visit
9-N/A	The client has not attended the health service in the last 24 months

If date of last attendance is more than 24 months before the audit date:

- audit ceases here, only complete section 1 and 2.

When entering answers into the website

- N/A will be preselected for the remaining questions
- complete sections 1 and 2, then go to the end of section 7 and select 'finish' to save the audit

Section 3 Key information in client medical record summaries

3.1 Chronic or recurrent medical condition(s)

Examples of chronic or recurrent medical conditions include, but not limited to: asthma, arthritis, chronic obstructive pulmonary disease (COPD), dyslipidaemia, epilepsy, eczema, mental illness, hypertension that is well controlled, Parkinson's disease, and thyroid disease. Clients with chronic or recurrent conditions may receive care not usually required by other clients.

Is there any documentation in the client's medical/health summary that indicates they have any chronic or recurrent medical condition(s) for which they attend the health service regularly?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Note: if the client has a diagnosis of type 2 diabetes, coronary heart disease (CHD), chronic heart failure (CHF), acute rheumatic fever (ARF) rheumatic heart disease (RHD) or chronic kidney disease (CKD) they are **not** eligible for this audit.

3.2 What is the condition(s)?

If evidence of chronic condition in Question 3.1, record the condition(s).

3.3 Health summary

A health summary may also be called a medical summary or problem list. RACGP (2013) suggest that health summaries are useful to quickly access important client information. An up to date health (or current) summary would contain a current medications list, allergies, current health problems, relevant past health history, health risk factors, and family history.

Is there an up-to-date health summary present in the client's record?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

3.4 Immunisation record

An up to date immunisation record is one that shows signs of being updated each time a client has an immunisation, either at this facility or another. If an immunisation record shows that immunisations are up to date, then the immunisation record should be considered up to date.

Is there an up to date immunisation record present in the client's record?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Adult health check

The federal government funds this health assessment as an annual service. The minimum time allowed between services is nine (9) months. This allows flexibility for very remote communities, where medical practitioner visits may be less frequent and may make it more difficult to follow a consistent schedule of health assessments (DoHA, 2010). It is suggested that the components of the adult health check (MBS item 715), are completed annually (QH 2010, NACCHO/RACGP 2012).

By knowing the percentage of the eligible population who have had an adult health assessment, or an alternative adult health check completed in the last 24 months, a comprehensive population health approach by health care providers will be enabled.

3.5 MBS Item 715 adult health check

MBS item 715 (or previously MBS item 710, 704 or 706) adult health check for Aboriginal and Torres Strait Islander clients (DoHA 2010).

If the client is Aboriginal, Torres Strait Islander or Aboriginal and Torres Strait Islander, is there documentation that an adult health check MBS item 715 has been completed in the last 24 months?

Indicate **1-Yes** if present and complete or

0-No if not present, **or** is present but not complete or

9-N/A if the client is not Aboriginal, Torres Strait Islander or Aboriginal and Torres Strait Islander, or if the date of last attendance is > 24 months before audit date

3.6 Alternative adult health check

An alternative adult health check may be a locally produced template that mimics the MBS 715. Is there an alternative adult health check similar to MBS item 715 (previously MBS item 710, 704 or 706) in the medical record, that has been completed in the last 24 months?

Indicate **1-Yes** if present and complete or

0-No if not present, **or** is present but not complete.

9-N/A if there is a MBS item 715 present and complete in Q3.5 or if the date of last attendance is > 24 months before audit date

Section 4 Risk factors and brief intervention

Risk factors

If a client's risk factors are documented, opportunities may arise during regular tests and checks to talk about the possible effect of the risk factors on their health (i.e. brief interventions).

Studies show that advice from health professionals to Aboriginal and Torres Strait Islander clients is often the key reason the clients change their risky behaviours. The health centre is often the major source of health advice, particularly in remote areas (Couzos and Murray 2008).

Brief intervention

A brief intervention is a discussion about health-related issues, or healthy lifestyle that takes very little time. Such an opportunity can be taken by anyone in the health team as part of day-to-day work, at any time when there is interaction with a client.

Brief interventions may be delivered in a variety of ways depending on the clinician's approach and the client's circumstances. Approaches to recording brief interventions will also vary.

4.1 Smoking status

NACCHO/RACGP (2012) recommends all people 10 years and over be assessed annually for smoking status. For the purposes of this audit, 'smoking' refers to smoking of tobacco only, and not to smoking any other substance. Chewing tobacco is not included here.

What is the client's current smoking status, as documented in the last 24 months?

Indicate **1-Smoker** if there is a record that the client currently smokes tobacco
2-Non-smoker, if there is a record that the client currently does not smoke
3-No record, if there is no record of the client's smoking status in the last 24 months

9-N/A only if the date of last attendance is > 24 months before audit date

4.2 Location of smoking status

Some health services have a combination of paper and electronic records for storing client information. Knowing where to find client information is important. It can reduce the number of times they get asked the same questions, ensure staff are aware of the current health status, and have information from other services (eg hospital) available in a timely manner (RACGP, 2013).

Is the location of the smoking status documented on a paper record?

Indicate **1-Yes**, **0-No** or

9-N/A if smoking status is not recorded in Question 4.1 or the date of last attendance is > 24 months before audit date

Is the location of the smoking status documented in an electronic or computer record?

Indicate **1-Yes**, **0-No** or

9-N/A if smoking status is not recorded in Question 4.1or the date of last attendance is > 24 months before audit date

4.3 Brief intervention for smoking

For the purpose of the audit, the record of brief interventions for smoking should at least indicate either that a brief intervention has been delivered, or that the client has been asked about their use of tobacco, and their intentions or interest in quitting.

If smoker is documented in Question 4.1, is there documentation that the client has received a brief intervention for tobacco use in the last 24 months on a paper record?

Indicate **1-Yes**, **0-No** or

9-N/A if the client does not smoke or smoking status is not recorded in Question 4.1, or if the date of last attendance is > 24 months before audit date

If smoker is documented in Question 4.1, is there documentation that the client has received a brief intervention for tobacco use in the last 24 months in a computer record?

Indicate **1-Yes**, **0-No** or

9-N/A if the client does not smoke or smoking status is not recorded in Question 4.1, or if the date of last attendance is > 24 months before audit date

Alcohol

It is acknowledged that discussion about recorded alcohol use is difficult to assess in some populations. This discussion can be done opportunistically, or as part of an annual health assessment.

To define a client's level of risk for alcohol consumption, it is suggested that health personnel ask and record a description of the client's stated general alcohol consumption. This can then be measured against the NHMRC (2009) guidelines.

4.4 Alcohol use

NACCHO/RACGP (2012) recommends all people 15 years and over be assessed annually for alcohol consumption status. For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol related disease or injury (NHMRC 2009a)

What is the client's current recorded use of alcohol, as documented in the last 24 months?

Indicate **1-Higher risk** if documented as more than two standard drinks in any one day,

2-Low risk if documented as two standard drinks or less in any one day,

3-Alcohol use, but risk level not stated if alcohol use is recorded but amount of alcohol is not stated,

4-No alcohol use if documented that client does not use alcohol or

5-No record if the client's alcohol use is not recorded.

9-N/A only if the date of last attendance is > 24 months before audit date

4.5 Brief intervention for higher risk alcohol use

For the purpose of the audit, the record of brief interventions for reducing alcohol-related harm should at least indicate either that a brief intervention has been delivered; or that the client has been asked about their use of alcohol, and their intentions or interest in reducing their alcohol consumption.

If 'higher risk' alcohol use is recorded in Question 4.4, is there documentation that the client has received a brief intervention for higher risk alcohol use in the last 24 months?

Indicate **1-Yes**, **0-No** or

9-N/A if the client's alcohol use is not recorded as higher risk in Question 4.4, or if the date of last attendance is > 24 months before audit date

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4.6 Referral to an alcohol program

Referral could be to a local alcohol support group, drug and alcohol service, Alcoholics Anonymous or counsellor. If the client is trying to reduce alcohol intake using any structured program, this is considered a referral to an alcohol program.

If 'higher risk' alcohol use is recorded in Question 4.4, is there documentation that the client has been referred to an alcohol program in the last 24 months?

Indicate **1-Yes**, **0-No** or

9-N/A if the client's alcohol use is not recorded as higher risk in Question 4.4, or if the date of last attendance is > 24 months before audit date

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4.7 Organic complications

Organic complications may include cirrhosis, pancreatitis, dementia, cardiomyopathy, GORD (gastro-oesophageal reflux disease), and alcohol related trauma. The diagnosis must be documented as being related to alcohol misuse.

Is there any documentation of organic complications from alcohol misuse?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.8 Weight

Many health services have a combination of paper and electronic records for storing client information. Different sections of the client's record may be stored in different locations. Knowing where to find particular client information is important. It can reduce the number of times they get asked the same questions, or have the same investigations, ensure staff are aware of the current health status, and have information from other services (eg hospital) available in a timely manner (RACGP, 2013).

Weight is a necessary part of calculating the client's Body Mass Index. Is the client's weight documented on a paper record in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Is the client's weight documented in a computer record in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Body mass index (BMI)

BMI is a measurement used to determine if a client has healthy weight for their height. BMI is calculated by: $\frac{weight\ (kg}{height^2\ (m^2}$

BMI calculators:

National Institutes of Health — www.nhlbisupport.com/bmi/ (Accessed March 2013)

Australian Better Health Initiative — www.measureup.gov.au/internet/abhi/publishing.nsf/Content/Body+Mass+Index-lp (Accessed March 2013)

Table 5 BMI interpretation with normal waist circumference CARPA (2014)

BMI	Result	Action
<18.5	Underweight	Medical consultation Advise healthy eating
18.5-24.9	Healthy weight	Advise to keep active
25-29.9	Overweight	Advise to lose weight or not gain more weight
≥30	Obese	Medical consultation Advise to lose weight

4.9 Body mass index (BMI)

NACCHO/RACGP (2012) recommends an annual assessment of BMI. A BMI is based on a person's weight and height, and is calculated to determine whether a person is in a healthy weight range. Note that a BMI doesn't distinguish between fat and muscle, so there can be some exceptions to this guideline. Note that some people have a normal BMI but larger-than-normal waist circumference, as described further below; these people are at risk and should be advised to lose weight and increase physical activity.

Is the client's BMI documented in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.10 BMI result

Record the BMI result (in kg/m², a whole number between 10 and 60).

If BMI is not recorded in 4.9 enter '**0**'

Waist circumference

The guidelines from CARPA (2014) (Table 6) are based on World Health Organization, and National Health and Medical Research Council recommendations for waist circumference measures.

Note: This table shows the recommended waist circumference measurements for Caucasian men, and Caucasian and Asian women. Recommended waist measurements have not been determined for all ethnic groups, or for children. The limited data that are currently available indicate that the risk factors for cardiovascular disease in Aboriginal populations with waist circumferences greater than recommended guidelines appear to be similar to those in Asian populations, and the risk factors for cardiovascular disease in Torres Strait Islander populations with waist circumferences greater than recommended guidelines appear to be similar to those in Pacific Islander populations.

Table 6 Waist circumference interpretation from CARPA (2014)

Waist circumference	Result	Action
Male <94 cm Female <80 cm	Normal	Advise to maintain healthy weight
Male 94 ≤102 cm Female 80 ≤ 88 cm	Increased risk of chronic disease	Advise to keep active Advise not to gain more weight
Male >102 cm Female > 88 cm	Greatly increased risk of chronic disease	Advise to lose weight

4.11 Waist circumference

Measuring waist circumference is a simple way to check the amount of body fat a person has (National Heart Foundation of Australia, 2009). NACCHO/RACGP (2012) recommends all people over 18 years have an annual measurement of waist circumference.

Waist measurement guidelines are used to increase clients' understanding of their likelihood of developing lifestyle-related chronic diseases, including cardiovascular disease, stroke, type 2 diabetes and some cancers. An 'at-risk' waist circumference for an adult **male** is more than 94 centimetres. An 'at-risk' waist circumference for an adult **female** is more than 80 centimetres.

Is the client's waist circumference measurement recorded in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.12 Waist circumference result

Record the waist circumference **measurement** in centimetres.

If no waist circumference is recorded in Question 4.11, enter '**0**'

4.13 Brief intervention for overweight/obesity

For the purpose of the audit, the record of a brief intervention for reducing overweight or obesity should at least indicate either that a brief intervention has been delivered, or that the client has been asked about their weight and their intentions or interest in reducing their weight.

If the client's BMI is ≥25 or if waist circumference is ≥94 cm for a male, or ≥80 cm for a female, is there a record that the client has received a brief intervention for overweight/obesity in the last 24 months?

Indicate **1-Yes**, **0-No** or

9- N/A if the client's BMI is <25 **and** if the client's waist circumference is < 94cm (male) **or** < 80cm (female), or if the date of last attendance is > 24 months before audit date

4.14 Referral for weight management advice or support

Referrals could be to a dietician, nutritionist, or for advice or support on weight loss, physical activity and/or dietary advice.

If the client's BMI is ≥25 or if waist circumference is ≥94 cm for a male or ≥80 cm for a female, is there a record that the client has received a referral for weight management advice or support in the last 24 months?

Indicate **1-Yes** or **0-No**

9- N/A if the client's BMI is <25 **and** if the client's waist circumference is < 94cm (male) **or** < 80cm (female), or if the date of last attendance is > 24 months before audit date

Absolute cardiovascular risk (CVR)

Absolute CVR is the numerical probability of a cardiovascular event such as an acute myocardial infarction (AMI) or stroke occurring in a five-year period (Framingham risk equation). It is expressed as a percentage and reflects a person's 'individualised' risk of cardiovascular disease (CVD), as opposed to the traditional method that considers various risk factors, such as high cholesterol or high blood pressure, in isolation (NVDPA, 2012). More widely used calculators are available from the following sites:

Absolute cardiovascular risk calculators
www.cvdcheck.org.au (accessed 29 August 2014)

National Heart Foundation
www.heartfoundation.org.au/Professional_Information/Clinical_Practice/Pages/default.aspx (accessed 26 August 2014)

Framingham
http://www.framinghamheartstudy.org/risk-functions/cardiovascular-disease/10-year-risk.php# (accessed 29 August 2014)

New Zealand Guidelines Group
www.nzgg.org.nz/resources/96/CVD_handbook_june_2009_update.pdf (accessed 29 August 2014)

CARPA (2014) Standard treatment manual
http://www.remotephcmanuals.com.au/publications/website/pdf/STM_web/Standard%20Treatment%20Manual%20-%204%20Chronic%20diseases%20(web).pdf (accessed 29 August 2014)

It is important that a standardised tool or calculator is used.

4.15 Absolute cardiovascular risk (CVR) assessed

For the purpose of this audit, eligibility for CVR risk assessment (using a Framingham style assessment) is described as:

- Indigenous, ≥35 years of age (NAACCHO/RACGP, 2012) and **not** a resident of the Northern Territory or
- Indigenous, ≥20 years of age and a resident of the Northern Territory (CARPA, 2014) or
- Non-Indigenous, 45 years and over (CARPA, 2014).

Which standard tool (or calculator) is used to assess absolute CVR assessment in the last 24 months?

Indicate **1-Heart Foundation**

2- Framingham

3- New Zealand

4- WHO

5- Other (if another standard tool is used, but not listed here)

6- Not assessed or

9- N/A if the client is not eligible for CVR assessment, or if the date of last attendance is > 24 months before audit date

4.16 Absolute cardiovascular risk assessment

If absolute CVR assessment is documented in question 4.15, indicate the absolute cardiovascular risk level:

1- <5%low risk,

2- 5≤9% low risk,

3- 10≤15% moderate risk,

4- 16≤19% high risk,

5- 20≤24% high risk,

6- 25≤29% high risk,

7- ≥30% high risk or

9- Not recorded

Management, treatment and reassessment of absolute cardiovascular risk should be undertaken according to clinical context and local guidelines.

4.17 Nutrition

The *Australian Dietary Guidelines* (AG, NHMRC, DoHA, 2013) recommends people eat a variety of foods in the five food groups and avoid foods containing too much added fat, salt and sugar. These healthy eating habits can reduce the risk of chronic diseases later in life. Recommendations from NACCHO/RACGP (2012) suggest providing brief advice to promote healthy eating opportunistically.

Regardless of the client's weight or waist circumference, is there documentation of brief intervention advice regarding nutrition discussed with the client in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.18 Physical activity

The National Heart Foundation of Australia (2009) recommends everyone should try to include 30 minutes or more of moderate-intensity physical activity on most days of the week. This can be accumulated activity in short bouts such as three 10-minute sessions each day. Recommendations from NACCHO/RACGP (2012) suggest annual assessment and discussion about physical activity.

Regardless of the client's weight or waist circumference, is there documentation of brief intervention advice regarding physical activity discussed with the client in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.19 Family relationships

This discussion should include family relationships and any assistance required being linked in with social services such as Centrelink, social workers or family counselling, local support organisations (e.g. meal delivery, home nursing or home help).

This should include an enquiry as to whether the client is a 'carer' or is being 'cared for' by someone. For the purpose of this audit, a carer is defined *as a person who, through family relationship or friendship, looks after a frail older person or someone with a disability or chronic illness. Carers look after these people in the community or in their own homes* (DoHA, 2006)

Is there documentation of brief intervention advice about family relationships discussed with the client in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.20 Substance use

For the purposes of this audit, 'substance use' refers to any legal, illegal, prescription or non prescription drug or substance used inappropriately and may include one or more of the following: marijuana(cannabis); pharmaceutical drugs such as pain killers, analgesics, tranquilisers or sleeping pills; inhalants; steroids; barbiturates; amphetamines or methamphetamines (speed); heroin; methadone; other opiates (opioids); cocaine; LSD or other synthetic hallucinogens; natural hallucinogens; ecstasy; ketamine; GHB; any injected drugs. Petrol or glue sniffing is also included.
Is there documentation of brief intervention advice about substance use discussed with the client in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.21 Environmental and living conditions

For the purpose of this audit, environment and living conditions may include social support, housing conditions (may include finance), employment status. Evidence of this may be documentation of a referral to an external service such as Centrelink, social worker, counsellor, local support organisations (e.g. meal delivery, home nursing or home help).

Is there documentation of brief intervention advice about environment or living conditions discussed with the client in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

4.22 Continence

Incontinence is a largely hidden condition, although within the general population up to 19% of children and at least 20% of women and 10% of men may be affected by some form of urinary incontinence (QH 2010). It can occur for many reasons, such as urinary tract infection, constipation, pregnancy and childbirth or side-effects of certain medications (QH 2010). For the purpose of this audit, continence includes documentation that the client has been asked about, or has discussed continence.

Is there documentation of brief intervention advice about urinary continence discussed with the client in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Section 5 Scheduled services

Prostate cancer screening

Prostate cancer screening questions are purposely not included in this audit tool.

It is acknowledged that prostate cancer is the third most common cause of cancer death among Australians (Cancer council, 2014). Population based screening has not been shown to be effective, and therefore is not recommended. However, prostate specific antigen (PSA) testing and digital rectal examination (DRE) should be individualised for all men (NACCHO/RACGP, 2012).

For more information:

http://www.prostate.org.au/

http://www.cancer.org.au/about-cancer/early-detection/prostate-cancer-screening.html

5.1 Pulse rate and rhythm

The pulse, or heart rate, is recorded in beats per minute. The rhythm is recorded as regular or irregular (i.e. it skips a beat, or some beats are fast and then slow) (Queensland Health 2010).

Is a pulse rate and rhythm documented in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

5.2 Pap smear (women only)

It is acknowledged that some women, due to age and sexual activity, may not need a pap smear. For the purpose of this audit, this question has been simplified to include all women eligible for the preventive audit.

Is there documentation of a pap smear in the client record in the last 24 months?

Indicate **1-Yes** or **0-No**

Indicate **9-N/A** if client is male, or if the date of last attendance is > 24 months before audit date

5.3 Mammography (women over 50 years only)

For the purposes of this audit, the recommended targeted age range is 50–69 every two years. Women 40–50 years old are eligible for a mammogram, but screening is not recommended (DoHA 2010a).

Mammogram results may be found in the radiology section of the medical record, in a discharge or referral letter, or in the progress notes.

Is there documentation of a mammogram being performed in the last 24 months?

Indicate **1-Yes** or **0-No**

Indicate **9-N/A** if the woman is <50 years of age, or if the date of last attendance is > 24 months before audit date

5.4 Sexual and reproductive health

This discussion may include, but is not limited to issues such as fertility, contraception, STI prevention and treatment.

Is there documentation of a reproductive and sexual health discussion being performed in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

5.5 STI: Nucleic acid amplification tests (NAAT) for gonorrhoea & chlamydia

NACCHO/RACGP (2012) recommends screening for STIs is completed according to local prevalence guidelines.

Is there documentation of a NAAT (for gonorrhoea and chlamydia) in the client record in the last 24 months?

Indicate **1-Yes, 0-No** or

2-declined only if there is documentation that this service was offered, but client declined

9-N/A only if the date of last attendance is > 24 months before audit date

5.6 STI: Syphilis serology

NACCHO/RACGP (2012) recommends screening for STIs is completed according to local prevalence guidelines.

Is there documentation of serology for syphilis in the client record in the last 24 months?

Indicate **1-Yes, 0-No** or

Indicate **2-declined** only if there is documentation that this service was offered, but client declined

9-N/A only if the date of last attendance is > 24 months before audit date

5.7 Oral health check

NACCHO/RACGP (2012) recommends annual dental checks for adult with poor oral health and/or risk factors. For adults with good oral health, annual dental assessments are adequate. For the purpose of this audit, oral health checks include assessment of gums, dentition and dental hygiene by any health professional.

Is there documentation of an oral health check being performed in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

5.8 Ears and hearing

NACCHO/RACGP (2012) recommends annual monitoring for hearing impairment. For the purpose of this audit, ear assessment is defined as ear assessment using otoscope, of both ears by any health professional. Hearing assessment is not necessarily a hearing test, but evidence that the person was screened for the need of a hearing test. A hearing assessment includes documentation of questioning about hearing ability, for example: *Do you have any trouble hearing?* A hearing test (audiometry) can be performed by any health professional trained in the use of an audiometer, and is also evidence of hearing assessment.

Is there documentation of both an ear and hearing check being performed in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Trichiasis screening

Aboriginal and Torres Strait Islander adults over 40 years of age years and who resided in a remote community during childhood should be screened annually for trichiasis by primary health care providers either opportunistically or as part of an adult health check (a required procedure in the Medicare Benefits Schedule for Aboriginal and Torres Strait Islander Adult Health Checks). It is important to continue to screen adults regularly as trichiasis is an indolent, slowly progressing condition (CDNA, 2014) NACCHO/RACGP (2012) recommends trichiasis screening every 2 years for adults raised where trachoma is endemic and should begin at age 40**.**

5.9 Trichiasis (>40 years, if regionally appropriate)

This eye examination should ascertain the presence of corneal scarring and/or the presence of trichiasis.

Is there documentation of a trichiasis assessment or screening in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

5.10 Visual acuity (>40 years)

NACCHO/RACGP (2012) recommends annual assessment of visual acuity for clients > 40 years (includes all clients who have turned 40 on audit date). If the client is 40 years or over, is there documentation of visual acuity being checked in the last 24 months?

Indicate **1-Yes** or **0-No**

9- N/A if client is < 40 years, or if the date of last attendance is > 24 months before audit date

5.11 Skin check

This includes assessment of the overall skin condition and /or enquiry about skin problems.

Is there documentation of a skin check being performed in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Section 6 Follow up of abnormal findings

6.1 Blood pressure (BP)

Is there documentation of a BP reading documented on **paper** in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

Is there documentation of a BP reading documented in the **computer** in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

6.2 BP reading abnormal

A blood pressure is abnormal if the systolic pressure is greater than or equal to 140 mmHg **and/or** the diastolic pressure is greater than or equal to 90 mmHg (≥140/90).

Is the most recent BP reading documented in question 6.1 abnormal?

Indicate **1-Yes** or **0-No**

9- N/A if no reading is documented in question 6.1, or if the date of last attendance is > 24 months before audit date

6.3 Plan for follow up BP

When a person has an abnormal BP reading it is important that appropriate follow up action is taken (see table below). At a minimum this should involve counselling of the client regarding BP control and more frequent monitoring. A repeated or especially high reading requires referral to a doctor for assessment and appropriate action, which may involve commencement and/or adjustment of medications (National Heart Foundation 2010 and CARPA, 2014).

If the most recent BP was abnormal, is there a documented plan for a follow up (including a repeat BP reading) in 2–4 weeks of this abnormal result?

Indicate **1-Yes** or **0-No**

9-N/A if no reading is documented in question 6.1**or** if the reading documented in question 6.2 was normal, or if the date of last attendance is > 24 months before audit date

Table 7 CARPA (2014) recommended follow up of BP

BP	Review
<130/80	check in 2 years, give healthy living advice
≥130/85 but <140/90	Check in 1 year, give health living advice
≥140/90 but <160/100	Check BP twice in next 4 weeks — if still high, see high BP management plan
≥160/100 but <180/120	See high BP management plan Medical review in 1 month
≥180/120	**Medical Consult straight away**, management plan

Urinalysis

End-stage kidney disease rates among Aboriginal populations continue to increase. New cases of end stage kidney disease occur in Aboriginal populations at 20-30 times the rate of non-Indigenous Australians.

In view of the burden of kidney disease, and the low cost of screening using dipstick urinalysis, urinalysis is recommended annually from age 15 onwards. A result of 'one +' or more of protein on dipstick urinalysis should be followed by albumin:creatinine ratio (ACR) (CARPA, 2014, Couzos and Murray 2008, Queensland Health 2010).

6.4 Urinalysis (dipstick test)

Is the result of a urine dipstick test documented in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

6.5 Urinalysis result abnormal

A urinalysis is abnormal if there is 1+ or more protein indicated on the dipstick.

Was the most recent urinalysis result in documented in question 6.4 abnormal?

Indicate **1-Yes** or **0-No**.

9-N/A if no urinalysis documented in question 6.4, or if the date of last attendance is > 24 months before audit date

6.6 Follow up abnormal urinalysis result

If the most recent urinalysis result is abnormal, was a sample for urine ACR collected **or** is there a documented plan to collect an ACR sample?

Indicate **1-Yes, 0-No** or

9-N/A if no urinalysis documented in question 6.4 **or** if test result is normal in question 6.5, or if the date of last attendance is > 24 months before audit date

Blood glucose level (BGL)

The high incidence of diabetes in the Aboriginal and Torres Strait Islander population suggests that screening for type 2 diabetes should start at an earlier age than the NHMRC recommendation of 35 years for the general population. NACCHO/RACGP (2012) recommends annual screening in adults from age 18 and above from regions with a high prevalence of type 2 diabetes.

Fasting plasma glucose has the highest sensitivity and specificity for screening for type 2 diabetes, but this may not be practical in some situations. Random venous blood glucose can be substituted as a screening test (NACCHO/RACGP 2012).

6.7 Blood glucose level (BGL)

A BGL test refers to a test of blood sugar level in a finger-prick sample (capillary blood) or venous blood glucose sample.

Is the result of a fasting or random BGL documented in the last 24 months?

Indicate **1-Yes** or **0-No**.

9-N/A only if the date of last attendance is > 24 months before audit date

6.8 BGL result abnormal

Results of either fasting or random blood glucose test should be further investigated if the BGL is ≥ 5.5mmol (Australian Diabetes Council, 2014)

Is the most recent BGL result abnormal (≥ 5.5mmol)?

Indicate **1-Yes** or **0-No**.

9-N/A if BGL is not documented in question 6.7 or if the date of last attendance is > 24 months before audit date

6.9 Follow up abnormal BGL result

If the most recent BGL reading is abnormal, is there a documented management plan for follow up to repeat blood glucose test?

Indicate **1-Yes, 0-No** or

9-N/A if BGL is not documented in question 6.7 **or** if test result is not abnormal in question 6, or if the date of last attendance is > 24 months before audit date

Cholesterol and lipids

Aboriginal and Torres Strait Islanders as a group have a higher risk of cardiovascular disease (CVD) than the general population. Queensland Health (2010) recommend commencing testing lipids annually from age 18 in the general Aboriginal population. NACCHO/RACGP (2012) recommends annual serum lipids from age 18 if any of the following is present: family history of premature CVD or chronic kidney disease, overweight/obesity, smoking, diabetes, elevated BP.

6.10 Lipid profile

A lipid profile includes total cholesterol, high-density lipoprotein (HDL), low-density lipoprotein (LDL) and triglycerides

Is there a documented lipid profile in the pathology section of the medical record in the last 24 months?

Indicate **1-Yes** or **0-No**

9-N/A only if the date of last attendance is > 24 months before audit date

6.11 LDL abnormal

CARPA (2014) and QH (2010) suggest a target level < 2.5 mmol/L.

For the purpose of this audit, low density lipids (LDL) are abnormal if reading > 2.0 mmol/L

In the most recent lipid profile, is the documented LDL level abnormal?

Indicate **1-Yes, 0-No** or

9-N/A if no reading is documented in question 6.10 or if the date of last attendance is > 24 months before audit date

6.12 HDL abnormal

QH (2010) and CARPA (2014) suggest a target level > 1.0 mmol/L

For the purpose of this audit, abnormal lipid levels are defined by QH, 2010 and CARPA, 2014

High density lipids (HDL) are abnormal if reading <1 mmol/L

In the most recent full lipid profile, is the documented HDL level abnormal?

Indicate **1-Yes, 0-No** or

9-N/A if no reading is documented in question 6.10 or if the date of last attendance is > 24 months before audit date

6.13 Tg abnormal

QH (2010) suggest a target level < 1.5 mmol/L.

For the purpose of this audit, abnormal lipid levels are defined as Triglycerides (Tg) reading > 1.5 mmol/L

In the most recent full lipid profile, is the documented Tg level abnormal?

Indicate **1-Yes, 0-No** or

9-N/A if no reading is documented in question 6.10 or if the date of last attendance is > 24 months before audit date

6.14 Follow up abnormal lipid profile

Repeated or especially high readings require referral to a doctor for assessment and appropriate action, which may involve commencement and/or adjustment of medications.

If **any** of the lipid levels documented in questions 6.11-6.13 are abnormal, is there a documented plan for **follow up** including repeat lipid profile?

Indicate **1-Yes, 0-No** or

9-N/A if no reading is recorded in question 6.10 or if **all** readings are normal in questions 6.11-6.13, or if the date of last attendance is > 24 months before audit date

Section 7 Emotional wellbeing screening and care

Emotional wellbeing

The increasing burden of mental illness in the Indigenous community is beyond dispute. Repeated health surveys over the past decade have shown rates of emotional distress in Indigenous communities to be twice the non-Indigenous average (Couzos and Murray 2008).

In 2004-2005, almost four out of five Aboriginal and Torres Strait Islander people reported having experienced significant stress in the previous 12 months, compared with around three out of five people in the total population (Australian Indigenous *HealthInfoNet*, 2011)

This provides compelling reasons to screen for emotional wellbeing at every opportunity, and to follow up those at risk using established best-practice pathways.

7.1 Screening for emotional wellbeing using a standard tool

Standard screening tools for emotional wellbeing (Appendix 1) can include:

- Kessler 5 (K5)
- Kessler 6 (K6)
- Kessler 10 (K10)
- Patient Health Questionnaire 2(PHQ2)
- Patient Health Questionnaire 9 (PHQ9)
- Edinburgh Postnatal Depression Scale (EPDS)
- another tool routinely used in your health service or jurisdiction.

Is there documentation of the client being screened for emotional wellbeing using a standard tool in the last 24 months?
Indicate **1-Yes** or **0-No**
9-N/A only if the date of last attendance is > 24 months before audit date

7.2 Score of the most recent screening

Record the **score** of the **most recent** screening in the column next to the appropriate tool.

NB: due to technical limitations, a score of 0 cannot be entered, please enter '1' instead. This does not affect the reporting.

Table 8 Screening tool scores and risk categories

Screening tool	Score range	At risk
K5	5–25	≥12
K6	6–30	≥12
K10	10–50	≥22
PHQ2+	1–3	Yes to either 1 or 2 PLUS Yes to 3
PHQ9	1–27	>5
EPDS	1–30	>10
Other tool		

At the **most recent** screening, (using a standard tool) is the client classified 'at risk'?

Indicate **1-Yes, 0-No** or

9-N/A if the client was not screened for emotional wellbeing in the last 24 months or if the date of last attendance is > 24 months before audit date

If a screening tool not listed has been used, also record the **name** of the other tool.

7.3 Other concern about emotional wellbeing

This can be documentation of formal or informal discussion about emotional wellbeing in the client record, as opposed to a formal screening tool used in Question 7.1. It may include the use of discussion prompts produced by AIMhi (for example, the AIMhi Stay Strong App), ATODS workforce, or other local or national programs.

If the client has **not** been screened using a standard tool in Question 7.1, is there documentation of concern about emotional wellbeing in the last 24 months?

Indicate **1-Yes, 0-No** or

9-N/A if screening is documented in Question 7.1 or if the date of last attendance is > 24 months before audit date

7.4 Actions within 3 months of assessment/recorded concern

If the client was assessed as being **at risk** in Question 7.2 or there is documented concern about emotional wellbeing in Question 7.3, indicate if the client has received any of the following actions by the health centre team within 3 months of being screened at risk:

- brief intervention — includes problem solving or goal setting or information sharing
- counselling — includes the above and/or motivational interviewing and/or a range of other therapeutic approaches
- cognitive behavioural therapy — includes exploration of thoughts and feelings linked with behaviours
- medication — includes antidepressants and/or antipsychotics or other
- other action — please provide a description of this action (e.g. referral to or link with other service, such as housing or employment).

Indicate **1-Yes** or **0-No**

9-N/A if there is no documentation of emotional assessment in 7.1, or the client is not at risk in 7.2 or there is no concern about emotional wellbeing recorded in 7.3, or if the date of last attendance is > 24 months before audit date

7.5 Subsequent review within one month of action taken

If an action was taken by the health centre team in Question 7.4, is there documentation of a subsequent review within a month of the action taken?

Indicate **1-Yes, 0-No,**

8-N/R if no documentation is present and the time since the action is less than one month or

9-N/A if there is no documentation of emotional assessment in Question 7.1, or the client is not at risk in Question 7.2 or there is no discussion about emotional wellbeing recorded in Question 7.3, or no action was taken in Question 7.3, or if the date of last attendance is > 24 months before audit date

7.6 Report from the external service within six months of referral

If referred to an external service in Question 7.4, is a report from the external service (dated within 6 months of the referral), present in the client record?

Indicate **1-Yes, 0-No**,

8-N/R if no documentation is present and time since the referral is less than six months or

9-N/A if there is no documentation of emotional assessment in Question 7.1, or the client is not at risk in Question 7.2 or there is no discussion about emotional wellbeing recorded in Question 7.3 or referral was not made in Question 7.4, or if the date of last attendance is > 24 months before audit date

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Appendix 1 Emotional wellbeing screening tools

Kessler 5 (K5)

K5 is a measure of psychological distress that consists of a subset of five questions from the Kessler psychological distress scale 10 (K10, see below).

The 2008 National Aboriginal and Torres Strait Islander social survey (ABS 2009) included five questions from the K10, providing a measure of the social and emotional wellbeing of the Indigenous population. The K5 questions were:

— How often did you feel nervous?

— How often did you feel without hope?

— How often did you feel restless or jumpy?

— How often did you feel everything was an effort?

— How often did you feel so sad that nothing could cheer you up?

Responses to the five questions are scored and combined, resulting in a minimum possible score of 5 and a maximum possible score of 25. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress (Kessler 1996).

Kessler 6 (K6)

K6 is a six-question format that is also referred to as the Kessler high distress measure (AIHW 2009). The K6 has been used in a number of international studies, including the United States National Health Interview Survey (NCHS 2007).

Kessler 10 (K10)

K10 is a nonspecific distress scale developed in 1992 by professors Ron Kessler and Dan Mroczek (Kessler 1996). K10 consists of 10 questions designed to measure levels of negative emotional states experienced in the four weeks prior to interview. It is a simple self-report measure of psychological distress that can be used to identify clients in need of further assessment for anxiety and depression (Kessler 1996).

This measure was designed for use in the general population to detect high-prevalence mental health disorders. K10 comprises 10 questions that are answered using a five-point scale (where 5 = all of the time and 1 = none of the time).

For all questions, the client circles the answer that best describes their feelings in the past four weeks. Scores are then summed: the maximum score of 50 indicates severe distress and the minimum score of 10 indicates no distress (Deady 2005).

The Victorian Population Health Survey (DHS 2001) adopted a set of cut-off scores for K10 as a guide for screening psychological distress and the likelihood of mental disorder. These are:

—10–19 Likely to be well

—20–24 Likely to have a mild disorder

—25–29 Likely to have a moderate disorder

—30–50 Likely to have a severe disorder.

Patient Health Questionnaires 2 and 9 (PHQ2 and PHQ9)

The Patient Health Questionnaire (PHQ) has two different formats. The PHQ9 is the complete questionnaire and screens for all nine symptoms of depression. If a client has any of the symptoms, the PHQ9 has an additional question (Question 10) that assesses the impact of those symptoms on the client's ability to function on a day-to-day basis (APA 2011).

The PHQ2 comprises the first two items of the PHQ9 and inquires about the degree to which the client has experienced a depressed mood over the past two weeks, to screen for depression. Clients who screen positive should be further evaluated with the PHQ9 to determine whether they meet the criteria for a depressive disorder (APA 2011).

Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a 10-item self-report measure that screens women for symptoms of emotional distress during pregnancy and the postnatal period. The EPDS includes one question about suicidal thoughts and should be scored before the client leaves the office to ensure this item has been checked. Further enquiry about the nature of any thoughts of self-harm is required to determine the level of risk (Cox et al 1987).

The EPDS reflects the client's experience of the last seven days; it may therefore need to be repeated on later occasions if this is deemed clinically necessary (Cox et al 1987).