Cleaning up your cancer screening data for Best Practice Software

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How to improve cancer screening data management in Best Practice to ensure accurate PenCAT information
Information for clinical staff, reception and health service managers

- The most effective and quick way is to ensure that **results are sent to you electronically**. This way PenCAT will automatically recognise the HL7 items, with no further action required.
- Ensure all your doctors are set up **with each** pathology and radiology company for receiving **electronic results**, and confirm this is in your orientation package.
- **Encourage patients** to list you as their **preferred GP** when having services provided elsewhere (Breastscreen Victoria or the National Bowel Cancer Screening Program).

If you receive results via **paper/fax/scan/email**, please ensure the following steps are done:

Bowel Screening – Faecal Occult Blood Test (FOBT)

To enter the results manually in BP: (this can be done WITH or WITHOUT the scanned document)

1. When scanning a document, it must be an **"investigation"** and enter one of the test names below:

Faecal Occult Blood ,Faecal occult blood screening ,Faecal Occult Blood Test, FOB, FOBT, Occult blood – faeces, Stool occult blood test, OCCULT BLOOD, faecal human haemoglobin, Insure FOBT, FOBT1, FOBT2, FOBT3, FOB1, FOB2, FOB3, BOW, OCCULT BLOOD (OCB-0), OCCULT BLOOD (OCB-1), OCCULT BLOOD (OCB-2)

We would advise selecting ONE of these only for your clinic, to keep it simple. For example, ask all staff to only write:

FOBT

2. For clinicians to add results manually, select '**Investigation reports'** from within the patient's file.
   (Nb. PenCAT will NOT read if this is only in 'Past History' or 'reason for visit')
3. Add a new investigation by clicking on '**Add'** (see below), with a free text option to write the result.
4. It will ask for the **date of test** to be entered. This is translated to the report.

Screenshot for entering **manual FOBT (or any pathology) results;**

Enter the test name exactly as one of the names listed above. Eg. "FOBT"

Breast Screening - Mammogram

When **scanning** a paper report, or if manually adding result to **investigation reports**, you must use the name:

"Breast Mammogram Screening" or "Bilateral Mammography"

We would advise selecting ONE of these only for your clinic, to keep it simple. For example, ask all staff to only write:

> **Breast Mammogram Screening**

Cervical Screening – Cervical Screening Test (CST)

Electronic results will be detected by PenCAT through HL7 coding. PenCAT will map the following terms from Best Practice: *HPV, %HPV%, Human Papillomavirus, Cervical Screening Test, Cervical Screening*

This is the same terminology required if document is scanned into investigation reports.

However, clinically it is strongly recommended that every cervical screening test is **also entered manually into the "cervical screening" tab by the doctor** when results are received.

1. When results are in the "inbox"- select **"Add CST result"** at the bottom of the inbox.

OR   In the patient file, click **"cervical screening"** tab in the left hand menu. Select **"add"** (as below, circled in red)

2. The date and clinicians name will automatically appear if the result is electronic, but the results (HPV PCR results +/- LBC) need to be selected. There is also a space for other information to be written, as required.

3. ***REMEMBER TO ADD A REMINDER FOR THEIR NEXT SCREENING (eg 5 years)*** This can be done directly from cervical screening results (as below, circled in blue), in the inbox, or on the patient home screen.

NB. Cervical screening exclusions are done when either: (1) "no longer requires cervical screening" or "opt out of cervical screening" tick-box (as below, circled in green)   or   (2) Coded condition of "hysterectomy" has been recorded in past history (not free text)

Any questions? Please contact us at healthevidence@vaccho.org.au or 03 9411 9411