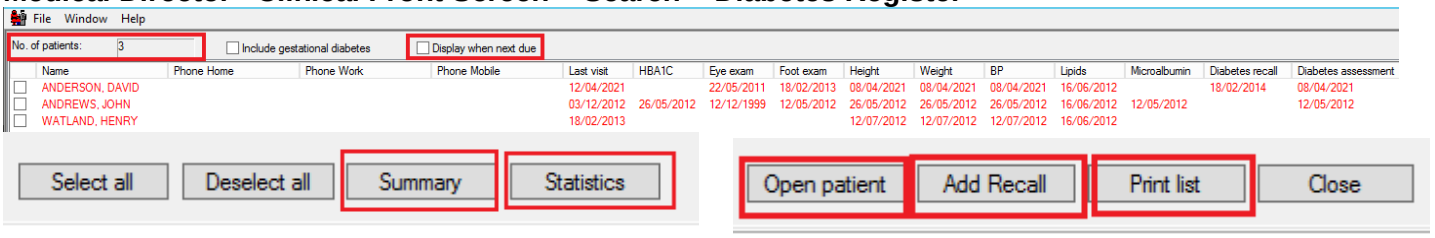
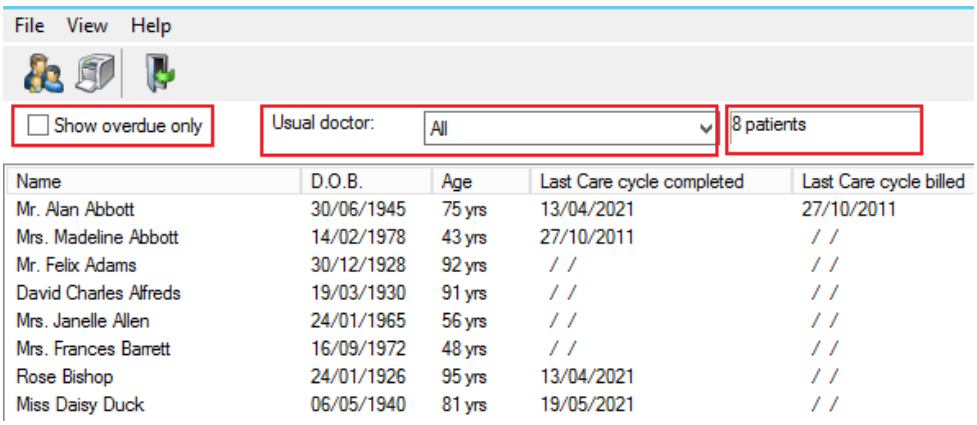
Quality Improvement Scenario 3: Diabetes Register in CIS

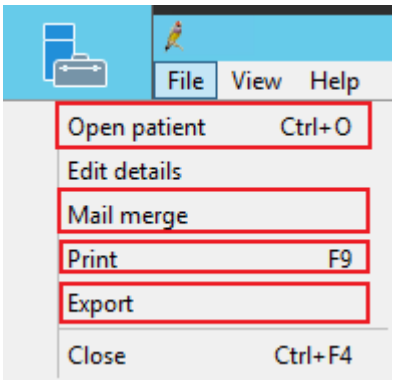
While looking at the **Diabetes Register list of all patients diagnosed with diabetes** in the Practice's clinical system, the Practice Nurse notices that there are patients whose Diabetes Cycle of Care is overdue (red font-**MD**), or without a completion date or a completion date more than 12 months ago (**BP**).

Medical Director Clinical Front Screen < Search < Diabetes Register



Best Practice Main Screen < Clinical < Diabetes Register





The Practice's Quality Improvement Team wish to improve their use of the navigation functions and use of the **Diabetes Register** to help improve rates of completion of Patients' Diabetes Cycle of Care.

The Practice picks this topic and creates a **Model for Improvement** for the PIP QI Quarter beginning 1 May.

The SMART goal is 100% of staff in the practice will be upskilled in navigation functions and use of the Diabetes Register by 31 July

Data Baseline:
Number of Practice Staff competent to navigate in the Diabetes Register/Number of Practice staff
Example: 5 of 10 practice staff competent

Review Date: End of July Quarter.

PLAN:

Idea 1: Find patients whose **Diabetes Cycle of Care** is next due or overdue.

TIP: Tick to select show patients whose Cycle of Care is overdue **(BP**).
TIP: Tick to display the next due date of a patient's individual activities in the Cycle of Care (**MD**).

Idea 2: Find patients cared for by **Usual Doctor**.

TIP: You can select a specific provider. (**BP**) See above screenshot.

Idea 3: Work through a **Patient List or Patient Summary** to contact to attend practice to complete their outstanding cycle of care activities.

TIP: You can print this list. (**BP) (MD**). You can export the list (**MD**). You can print a summary of each patients Cycle of Care (**MD)**.

Idea 4: Access a **Patient's File** to check their details.

TIP: You can open a patient file from the register (**BP) (MD**).

Idea 5: Determine the **Practice's Performance** on Cycle of Care Activities.

TIP: You can review/print Practice's aggregated statistics of meeting/not meeting criteria of each activity in Diabetes Cycle of Care. (**MD**).

Idea 6: Use a template to send a **Reminder** to all patients via File < Mail Merge. (A copy of the Reminder can be saved in Correspondence Out in patient record as template name (**BP**). You can **Add Recall** to patient's record (**MD**). You could send these reminders/recalls via a third-party vendor.

TIP: Use Reminder Clean-up Tool (**BP, MD**) or cease free-text reminders (**BP Configuration**).

By end of July quarter, the Practice Nurse and Quality Improvement Team complete the Improvement Cycle:

DO: What did you do?

STUDY: What were the reviewed results?

What can be added, continued, and removed from process?