Quality Improvement Record

Practice Name:

PIP QI Quarter/s:

Topic:

Completed by:

Date:

**Goal Setting: Suitable for 1 PIP Quarter or 12-month strategic approach.**

***This record can assist with preparation for Accreditation.***

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| **Focus Area & Aim…. What are you trying to achieve? What is your goal by When?***e.g. to increase coding of smoking status, weight, alcohol intake and physical activity in patient’s clinical record within 90 days****SMART: Specific, Measurable, Agreed, Realistic, Time.*** |
| Improve the management of patients with Diabetes by attending to the Annual Cycle of Care and complying to the MBS minimum requirements.  |
| **What are the ways you can review and measure the activity?** *i.e., The practice nurse can use the PHN dashboard (or run a report) to see the starting data, which we can review each month and at the end of the quarter*  |
| This can be measured in patient outcomes (reduction of HbA1c which can be accessed in a Pen Cat extraction), and through the MBS billing item numbers for an Annual Cycle of Care for each patient. |
| **IDEAS…. What activities and changes can we make to help reach your GOAL?** *e.g.,* ***1.*** *Present QI activities at staff meeting, show baseline data 2. encourage clinicians to habitually of asking patients about these factors and implements ways to support new habit****…. 3.*** *present changes in data at meetings and to encourage and give feedback to staff.* |
| **Idea 1.**Provide in house training to all staff (admin and clinical staff) on the billing, minimum MBS requirements, and the use of the software to complete Annual Cycles of Care. This will create a team approach and a structured procedure on identifying and recalling patients for their Annual Cycle of Care.  |
| **Idea 2.**Use the clinical software, or Pen Cat, and/or PRODA/HPOS to identify patients who have Diabetes that have had an Annual Cycle of Care previously and are due for another one to be completed. This will create a list of patients to focus on as well.  |
| **Idea 3.**Create a list of patients through the clinical software and/or Pen Cat that have Diabetes who have never had an Annual Cycle of Care completed before. This can be cross checked through PRODA/HPOS. This will create another focus group of patients.  |
| **Idea 4.**Do a data extraction through the clinical software or through PenCat for patients with Diabetes that have not had a HbA1c done in 12months and use that list of patients as a focus group to have an Annual Cycle of Care completed.  |

Quality Improvement

**Plan, Do, Study, Act (PDSA) Cycle**

**Documenting the detail of your QI Ideas**

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| **Idea 1 (from goal setting page)**Idea one: Provide in house training to all staff (admin and clinical staff) on the billing, minimum MBS requirements, and the use of the software to complete Annual Cycles of Care. This will create a team approach and a structured procedure on identifying and recalling patients for their Annual Cycle of Care. |
| **Plan -** Who, When, Where*Who is going to undertake this activity, when are they going to do it, what resources, software will they need? e.g., Team leader to present data from PHN Dashboard at meeting on 23/8/2021 … add detail?* Who: All staffWhen: <insert date> Where: Practice PremisesData predictions: Majority of staff could benefit from the training session.Data to be collected: Questionnaire completed by staff to assess training needs |
| **Do (Did) -** Was the activity completed? Any unexpected events or problems? Record relevant baseline data.Staff training was held on <insert date> |
| **Study -** Review actions and reflect on outcome. Compare to predictions. Staff gave positive feedback to the training and a team approach on attending the Annual Cycles of Care was created. |
| **Act -** What now, what will you take forward, what is the next step?*e.g., PM to track changes on graph and make it visible for whole practice in lunchroom, PM to use CAT4 data extract between PHN dashboard to track changes and to be done end of month (put in calendar)* Continue to discuss the Annual Cycle of Care in regular clinical meetings. |

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| **Idea 2** Idea two: Use the clinical software, or Pen Cat, and/or PRODA/HPOS to identify patients who have Diabetes that have had an Annual Cycle of Care previously and are due for another one to be completed. This will create a list of patients to focus on as well |
| **Plan -** Who, When, Where*Who is going to undertake this activity, when are they going to do it, what resources, software will they need? e.g., Team leader to present data from PHN Dashboard at meeting on 23/8/2021 … add detail?* Who: Admin/Management and Clinical Staff When: Do the extraction and create list of patients per provider by <insert date>. Book <insert number> of patients in from the list by <insert date> Where: Practice PremisesDate predictions: There will be a large list of patients that are due or overdue for their Annual Cycle of Care.Data to be collected: Do the extraction and create list of patients per provider and make appointments. |
| **Do (Did) -** Was the activity completed? Any unexpected events or problems? Record relevant baseline data.Patients who were in the clinical software reminders system as over-due/due for an Annual Cycle of Care were identified. |
| **Study -** Review actions and reflect on outcome. Compare to predictions. <insert number> patients were identified as being due/over-due for an Annual Cycle of Care that has previously had one. <insert number> of these patients were booked in and had an Annual Cycle of Care completed. |
| **Act -** What now, what will you take forward, what is the next step?*e.g., PM to track changes on graph and make it visible for whole practice in lunchroom, PM to use CAT4 data extract between PHN dashboard to track changes and to be done end of month (put in calendar)* Continue to use the clinical reminders to measure who is due/ over-due for their Annual Cycle of Care. |

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| **Idea 3** Idea three: Create a list of patients through the clinical software and/or Pen Cat that have Diabetes who have never had an Annual Cycle of Care completed before. This can be cross checked through PRODA/HPOS. This will create another focus group of patients.  |
| **Plan -** Who, When, Where*Who is going to undertake this activity, when are they going to do it, what resources, software will they need? e.g., Team leader to present data from PHN Dashboard at meeting on 23/8/2021 … add detail?* Who: Admin/Management and Clinical Staff When: Do the extraction and create list of patients per provider by <insert date>. Book <insert number> of patients in from the list by <insert date> Where: Practice PremisesDate predictions: There will be a sizeable list of eligible patients for an Annual Cycle of Care. Data to be collected: Do the extraction and create list of patients per provider and make appointments. |
| **Do (Did) -** Was the activity completed? Any unexpected events or problems? Record relevant baseline data.It was more effective using a Pen Cat extraction and cross checking PRODA for eligibility and ensuring the service was not accessed at another practice. This was more time effective using multiple staff. A list of <insert number> patients were identified as being eligible for an Annual Cycle of Care. |
| **Study -** Review actions and reflect on outcome. Compare to predictions. From the <insert number> of patients, <insert number> of patients were booked in and had an Annual Cycle of Care completed. |
| **Act -** What now, what will you take forward, what is the next step?*e.g., PM to track changes on graph and make it visible for whole practice in lunchroom, PM to use CAT4 data extract between PHN dashboard to track changes and to be done end of month (put in calendar)* Ensure that patients that have recently been diagnosed with Diabetes have a clinical reminder for an Annual Cycle of Care in the software it can then be monitored. |

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| **Idea 4** Idea four: Do a data extraction through the clinical software or through PenCat for patients with Diabetes that have not had a HbA1c done in 12months and use that list of patients as a focus group to have an Annual Cycle of Care completed.  |
| **Plan -** Who, When, Where*Who is going to undertake this activity, when are they going to do it, what resources, software will they need? e.g., Team leader to present data from PHN Dashboard at meeting on 23/8/2021 … add detail?* Who: Admin/Management and Clinical Staff When: Do the extraction and create list of patients per provider by <insert date>. Book <insert number> of patients in from the list by <insert date> Where: Practice Premises Data Predictions: There will be a substantial number of diabetic patients identified as no having had a HbA1c in the last 12 months. Data to be collected: Do the extraction and create list of patients per provider and make appointments. |
| **Do (Did) -** Was the activity completed? Any unexpected events or problems? Record relevant baseline data.Plan was executed with a list of <insert number> patients who had not had a HbA1c done in 12 months. <insert number> of patients were booked in for an Annual Cycle of Care. Some patients declined the cycle of care- those patients were booked in with GP for a review of blood tests so they could still have the relevant pathology attended to and a review of their Diabetes with the GP. |
| **Study -** Review actions and reflect on outcome. Compare to predictions. There was a larger number of patients then expected without a HbA1c done within 12 months, therefore this activity will be repeated to achieve a reduction in that number. <insert number> of the patients on the list had an Annual Cycle of Care completed. |
| **Act -** What now, what will you take forward, what is the next step?*e.g., PM to track changes on graph and make it visible for whole practice in lunchroom, PM to use CAT4 data extract between PHN dashboard to track changes and to be done end of month (put in calendar)* Continue to work through the patient list and aim to have all patients with Diabetes to have had at least one HbA1c done in the last 12 months. |