Quality Improvement Template

Practice name:	Dr Feelgood Medical Centre	**Date:**	1st May
QI team:	Tina (Receptionist), Jenny (Practice Manager), Josie (Practice Nurse) & Dr Feelgood (GP)		
Problem:	People diagnosed with Diabetes are at much higher risk of heart disease, stroke and kidney disease. High blood pressure (Hypertension) adds to that risk and can often have no symptoms, so regular measurement is the only way to detect it early. BP readings inform decisions on medication and lifestyle advice such as diet, exercise, salt reduction and tracking overtime allows the GP to adjust treatment quickly if needed. Best practice for patients with Diabetes includes GPCCMP and annual cycle of care requirements for diabetes and includes regular GP checks to ensure comprehensive care not just focused on blood sugar control.		
Problem Statement:	Processes and systems of care for patients with diabetes aren't based on best practice at the Dr Feelgood Medical Centre. This has meant that patients with diabetes have missing chronic care occasions of service, potentially impacting timely interventions and appropriate care planning.		

This document guides practice staff through the **Model for Improvement** (the Thinking Part) and the **Plan-Do-Study-Act** (PDSA) cycle (the Doing Part), a framework for planning, testing, and reviewing changes.

For guidance and support on conducting quality improvement in your primary healthcare services, please contact your local Primary Health Network (PHN).

Model for Improvement

Step 1: Thinking Part - Three Fundamental Questions
Complete the Model for Improvement (MFI) as a whole team.

AIM	**1. What are we trying to accomplish?**		
*By answering this question, you will develop your **GOAL** for improvement. It important to establish a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time bound) and people-crafted aim that clearly states what you are trying to achieve.*			
By 30th October, we will increase the number of active patients with Diabetes T1 or T2 who have had their blood pressure (BP) recorded in the last 6mths by 25 patients.			
MEASURE(S)	**2. How will we know that a change is an improvement?**		
*By answering this question, you will develop the **MEASURE(S)** you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison.* *Tip: Use a Run Chart to plot trends.*			
We will measure the number of patients with Diabetes (T1 or T2) who have a current BP recorded each month until the end of October. To do this we will initially run the Primary Sense report (Diabetes Mellitus) to establish our baseline (no. of patients with Diabetes (T1 or T2) who have a current BP recorded). We will then run the Primary Sense report at the end of each month and record our increases to track improvements.			
Baseline:	65 patients	**Baseline date:**	1st May
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**		
*By answering this question, you will develop **IDEAS** for change.* *Tip: Engage the whole team in formulating change ideas using tools such as brainstorming, driver diagrams or process mapping. Include any predictions and measure their effect quickly.*			
Idea 1	**Identify all patients with Diabetes (T1 or T2) who have not had their BP recorded. Recall the identified patients or place a flag on their clinical record if they already have an existing appointment.**		
Idea 2	Invite all active eligible patients with Diabetes (T1 or T2) but no CVD diagnosis to complete a Heart Health Check (699).		
Idea 3	Send reminder to patients with Diabetes (T1 or T2) who have an overdue care plan and book in for a GP Chronic Conditions Management Plan (CCMP).		
Idea 4	Review recall and reminder system to ensure routine patient care reminders are being initiated.		
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*		

PDSA (Plan-Do-Study-Act)

Step 2: Doing Part - Plan-Do-Study-Act
Once you have completed the Model for Improvement (MFI), use the template below to document and track your PDSA cycles (i.e. small rapid tests of change).

Idea	Plan		Do	Study	Act
#	**Plan the test**	**Prediction**	**Do the test on small scale**	**Analyse the results**	**Make a plan for next step**
	__How__ will we run this test? __Who__ will do it and __when__? __What__ will we measure?	*__Prediction__ or hypothesis on what will happen.*	*Was the plan completed? Yes or No. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.*	*Analyse results, compare them to predictions, and reflect on what you learned. .*	*Based on your learnings from the test, what will you do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?*
Change idea #1: Identify all patients with Diabetes (T1 or T2) who have not had their BP recorded.	Jenny (Practice Manager) will run the Primary Sense report Diabetes Mellitus on 6 May to identify the patients with diabetes who may be eligible for chronic care occasions of service (under table 3 of this report)	We predict that there will be 50 patients identified on the list with no BP recorded, however only half will come in once recalled.	**6 May** - Jenny ran the Diabetes Mellitus report in Primary Sense and filtered this report by GP. **8 August** – Jenny re-ran the Primary Sense report to see how things were tracking. They had recorded BPs for 15 patients. **15 October** – Jenny ran the Primary Sense report a 3rd time to analyse the data and see if the recall / follow up efforts had been successful. They had recorded a further 11 BPs for patients with Diabetes which took them to a total of 26.	This was better than we had expected. We originally expected 50 patients were identified with no BP recorded, however there was only 30 on the initial report.	ADOPT: Using the Primary Sense report assisted us to easily identify the patients we wanted to. We will adopt this approach.

Change idea #1.2: Recall the identified patients or place a flag on their clinical record if they already have an existing appointment	Using the list of identified patients from change idea #1, Tina (receptionist) will check the existing appointment field in the Primary Sense report. For patients who have an existing appointment, in this field will add a flag in their clinical record to collect a BP during this appointment. For patients without an existing appointment, the reception staff will contact and invite these patients into the practice for a review including a BP.	We predict that we will see an increase of 25 patients with Diabetes (T1 or T2) who have their BP recorded bringing the total to 90.	**8 May** –Tina set up an SMS communication for the patients identified on the report from Jenny, who didn't have existing appointment. **9 May** – Tina flagged identified patients with an existing appointment in the clinical record as a reminder to the clinical staff to do a BP. **20 August** – Using new Primary Sense report, another SMS communication was sent to patients identified, including a link to a QLD Health article which detailed the importance of patients with diabetes getting their BP checked and inviting patients to book an appointment. Tina also sent an email to the clinical staff and asked them to be vigilant in recording BP results for patients with diabetes and explained the PDSA project.	Of the 30 patients, 10 already had appointments. The SMS communication worked well for the other 20 patients. Overall, 26 patients had their BP taken and recorded; this was better than predicted. We now have a total of 91 patients diagnosed with Diabetes (T1 or T2) who have a BP recorded.	ADOPT: We will adopt this process moving forward. We were very proud of what we achieved so we included this in our monthly staff email to congratulate the team on what we achieved together.
Summary of Results	Our team valued the importance of checking and recording BP results for patients with diabetes and will continue to do this as part of the practice process when engaging with our Diabetic patients and will incorporate this into a business-as-usual approach for both change ideas on a quarterly basis.				