



QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Patient Population Groups

Last days of life / Palliative care
MODULE

Version 2

February 2021



PALLIATIVE CARE AND LAST DAYS OF LIFE CARE

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients. The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply
- Reduced risk by starting small
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change implementation into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

There is an example using the MFI with increasing the number of Home Medicines Reviews (HMRs) claimed on patients with dementia and a blank template for you to complete at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please [contact](#) Brisbane South PHN if you have any feedback regarding the content of this document.



This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; Medical Director, CAT4 and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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Brisbane South PHN would like to acknowledge the contribution of Palliative Care Queensland in the production of this QI toolkit.

Brisbane South PHN, 2021

Contents

PALLIATIVE CARE AND LAST DAYS OF LIFE CARE	6
Definition of phases of palliative care	6
Palliative care.....	6
Palliative approach	6
Last days of life (and terminal phase).....	7
GP’s role at the last days of life	7
Chronic complex illness	8
Stages of a chronic condition.....	8
How common are chronic conditions?.....	8
Chronic diseases in Aboriginal and Torres Strait Islander People	8
Leading causes of death by sex, 2018	9
Key goals and objectives for using this toolkit	9
How to use this toolkit.....	9
Planning your QI activity.....	10
For more support.....	12
Activity 1 - Important conversations	13
Important conversations and chronic medical conditions	13
Shifting to a palliative care approach	13
PEPSI COLA – Holistic patient assessment tool	15
Activity 1.1 – Activity – Training in palliative approaches	16
Advance care planning.....	16
Advance care planning forms	17
Information and resources available to support implementation of advance care planning with patients.....	17
Brisbane South PHN advance care planning QI toolkit.....	17
Important conversations for non-English speaking patients.....	17
Activity 1.2 – Activity – Advance care documentation	18
Activity 2 – Referral pathways.....	19
Palliative care team members	19
The Metro South Palliative Care Service (MSPCS).....	19
MSPCS services provided include:	19
Palliative care and SpotOnHealth HealthPathways.....	20
SpotOnHealth HealthPathways and Topbar.....	20
Activity 2.1 – Activity – Referral pathways	21
Activity 3 - Assistance for patients to live at home longer	22

My Aged Care	23
Medical APPS	23
Activities of daily living – health assessments	23
Dying to Talk	24
Activity 3.1 – Activity – Assistance for patients to live at home longer	24
Activity 4 - Medicare Benefit Schedule (MBS) items	25
Activity 4.1 – Data Collection from CAT4.....	25
Activity 4.2 – Understanding your practice’s MBS claiming	26
Activity 5 - Marking patients deceased in your clinical software	27
GPs and death audit	27
Activity 5.1 – Marking patients deceased in your clinical software	27
Activity 6 - Resources & training.....	28
Best practice tools	28
Brisbane South PHN chronic disease toolkits	29
QI activities using the MFI and PDSA.....	30
Example PDSA for palliative and end-of-life care	30
MFI and PDSA template EXAMPLE	32

PALLIATIVE CARE AND LAST DAYS OF LIFE CARE

Palliative care aims to improve quality of life for patients with life-limiting illnesses. It is often linked to the care of people with cancer; however, patients with non-cancer end-stage, chronic or complex conditions also have significant needs.

The symptom burden and care needs for patients with end-stage, non-malignant illnesses are similar to those of patients with advanced cancer. These patients benefit from a palliative approach, comprising management of the underlying condition and attention to symptoms, psychosocial needs and carer support. Advance care planning provides an opportunity to prepare for future illness episodes, including provision of end-of-life care. General practitioners are well placed to provide palliative care for patients with advanced non-cancer illnesses.¹

Where there is capacity, the GP should be positioned as central to the palliative care continuum wherever their patients are, to ensure that care is coordinated (e.g., primary care, acute care, aged care and all other services in community).

It is important to incorporate family in discussions with the patient as they get to the point of needing more care and less cure.

Topics that will be included in this toolkit include:

- chronic complex illness
- important conversations including interpreter services
- assistance to live at home longer
- palliative care teams
- Medicare Benefit Schedule (MBS) items
- resources.

Definition of phases of palliative care

Palliative care

- World Health Organization – Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual.
- Palliative Care Australia – Palliative care is person-centred and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life.

Palliative approach

- A palliative approach recognises that death is inevitable and focuses on the care rather than cure of a person with multiple chronic conditions, frailty and/or a life-threatening or life-limiting illness. The goal of a palliative approach is to improve or optimise a person's level of comfort and function and to offer appropriate treatment for any distressing symptoms. A palliative approach addresses a person's psychological, spiritual, social, emotional and cultural needs. Family members and loved ones are welcomed as partners in this approach. A palliative approach recognises that for older people with multiple chronic conditions, frailty and/or a life-threatening or life-limiting illness, this is often the last chapter of their life, the length of which is unknown.

¹ Palliative care for the patient without cancer, Nov 2018, Mounsey, Ferrer & Eastman

Last days of life (and terminal phase)

- Last days of life or terminal phase is the last phase of life in which a patient with a life-limiting illness is rapidly approaching death. The needs of patients and carers are higher at this time. (Please note: last days of life care can be interpreted differently between organisations, services and resources. It is important for you to understand this definition with the services you're coordinating patient care with).
- This phase of palliative care is recognised as one in which increased services and support are essential to ensure quality, coordinated care from the healthcare team is delivered.
- Last days-of-life takes into account the terminal phase – when the patient is recognised as imminently dying, their death and extends to bereavement care.²

GP's role at the last days of life

As patients approach the last days of life, the GP's role is to apply the principles and approach to care of older people presented throughout the [RACGP aged care clinical guide \(Silver Book\)](#). There is a sharper focus on:

- person-centred care to support wellbeing and quality of remaining life, respecting the person's values, goals and treatment choices
- proactive clinical care planning to anticipate and provide care as the person's clinical condition deteriorates, and as goals of care shift from treating the illness towards comfort and managing death.

All GPs who care for older people are engaging with issues their patients face towards the last days of life. Emphasis towards anticipating and planning to minimise the effect of predictable problems can improve the care offered, and the quality of life experienced by patients and carers. For example, a high-quality handover to the GP who will care for the patient on admission to a Residential Aged Care Facility (RACF) can enhance continuity of care and future care planning.

Chronic disease prevention and management are already established as major routine parts of general practice. The rationale is compelling for GPs to extend management of progressive chronic diseases to meet patients' needs for community-based end-of-life care and a 'good' death.

The number of patients seeking GP care at the last days of life is increasing because of multiple interacting factors, including:

- an ageing population
- technological advances that prevent premature death and extend life
- a growing number of general practice patients with progressive chronic life-limiting diseases, and associated disability and cognitive impairment
- patients seeking to avoid medical and hospital treatments that are of limited benefit and not wanted at the last days of life
- a greater proportion of the population selecting palliative care at home or in RACFs
- the current gaps in services for end-of-life care in the community (e.g. inequality of access and service provision, lack of integration and communication between services)
- increased patient awareness of advance care planning for voicing their preferences for end-of-life care and place of death.³

² <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care>

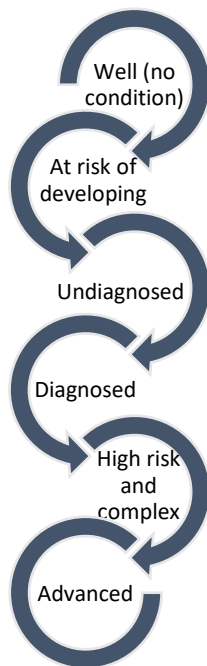
³ <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care>

Chronic complex illness

Chronic diseases are long lasting, often life-limiting conditions that warrant end-of-life planning. End-of-life planning should occur before conditions progress to later stages where a person’s ability to make end-of-life choices may be impeded.

Stages of a chronic condition

There are different stages for chronic conditions:



How common are chronic conditions?

Chronic conditions are becoming increasingly common and are a priority for action in the health sector. They are long lasting conditions with persistent effects and their social and economic consequences can impact on peoples’ quality of life. The [Australian Institute of Health & Welfare](https://www.aihw.gov.au/reports/indigenous-australians/contribution-of-chronic-disease-to-the-gap-in-mort/contents/summary) commonly reports on 10 major chronic condition groups: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, mental health conditions and osteoporosis.

Many people with chronic conditions do not have a single, predominant condition, but rather they experience multi-morbidity.

Chronic diseases in Aboriginal and Torres Strait Islander People

There is a substantial gap in life expectancy between Aboriginal and Torres Strait Islander people and other Australians — currently estimated at 12 years for males and 10 years for females.

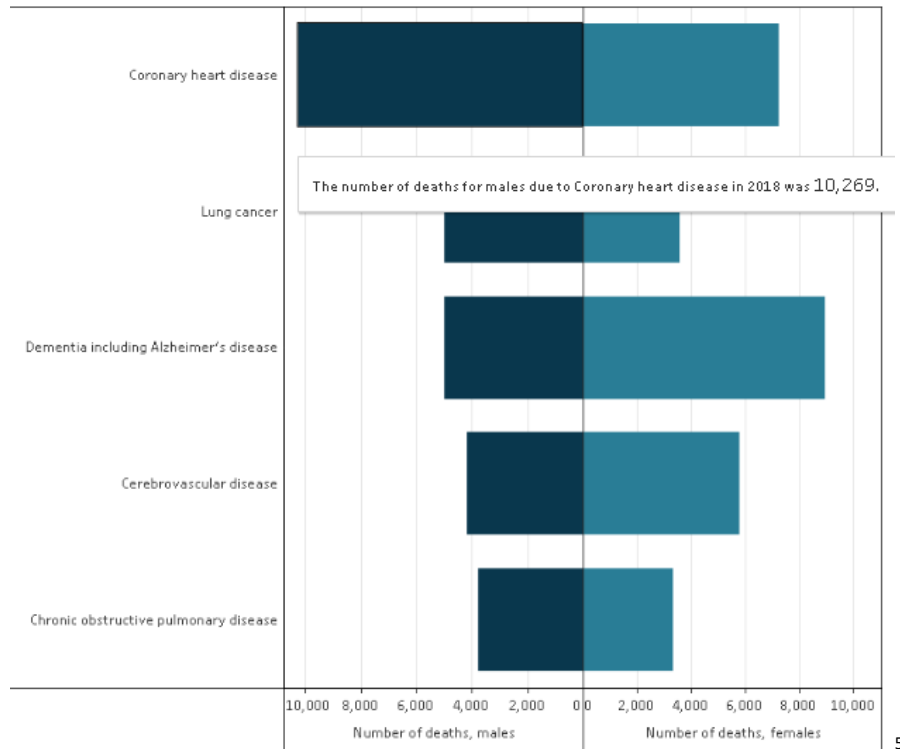
Chronic disease is known to be a major contributor to this gap for adults.

About 80 per cent of the mortality gap between Indigenous and other Australians aged 35–74 years is due to chronic diseases.⁴

⁴ <https://www.aihw.gov.au/reports/indigenous-australians/contribution-of-chronic-disease-to-the-gap-in-mort/contents/summary>

Leading causes of death by sex, 2018

In 2018, the leading cause of death for males was coronary heart disease. Dementia, including Alzheimer’s disease, was the leading cause of death for females, closely followed by coronary heart disease. Cerebrovascular disease (which includes stroke), lung cancer and chronic obstructive pulmonary disease (COPD) make up the remaining top 5 underlying causes of death in Australia for males and females of all ages combined.



Key goals and objectives for using this toolkit

This toolkit is to be used in general practice to:

- ensure systems are in place at your practice to assist patients with end-of-life conversations and implement planning
- identify systems to assist patients to remain in their own homes longer
- review how to involve the palliative care team at the appropriate time
- identify MBS item numbers available for patients.

How to use this toolkit

There are checklists included below that will guide you and your practice.

- identify a sample group of patients by reviewing data measures from your practice population
- use this toolkit to guide you along the journey
- set yourselves timelines to achieve your goals


⁵ <https://www.aihw.gov.au/reports/australias-health/causes-of-death>




- consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season
- review your progress regularly
- if you find your process is not working and you are not seeing improvements, then review your process and start again.



Planning your QI activity



The aim of this activity is to work through the suggested steps to support the successful implementation of palliative care in general practice.

Stage	Steps	Details	Completed
<i>Before you begin</i>	To ensure your practice database is as accurate as possible it is suggested that you review your database to identify if you need to complete any quality patient record activities.	Identify and archive patient medical records - before completing a bulk archive of patients, it is important to follow practice policy on the agreed timeframe for the last visit of the patient to the practice. The following instructions outline the process to bulk archive inactive patients within the clinical software Best Practice , MedicalDirector , PractiX and Genie .	<input type="checkbox"/>
		Identify, merge and/or archive duplicate patients - follow the duplicate patients report instructions . This search will look for matches on surname, first name initial, gender and date of birth; and produce a report.	<input type="checkbox"/>
		Identify patient’s records missing a date of birth - follow the instructions to identify patient records missing date of birth.	<input type="checkbox"/>
<i>Plan your activity</i>	Arrange a practice meeting for practice team members to discuss a potential focus group of patients for palliative care.	QI activity could be added as a standing agenda item on your usual team meetings; OR Form a QI team within your practice and schedule meetings to discuss options and strategies. Which area of your practice would benefit from a QI activity – clinical or administrative?  <i>TIP: To meet PIP QI requirements, you must undertake QI as a team.</i>	<input type="checkbox"/>

Stage	Steps	Details	Completed
	Identify and establish key practice team members to implement this QI activity.	<p>Suggested team members include:</p> <ol style="list-style-type: none"> 1. General practitioner (GP) 2. Practice manager 3. Practice nurse 4. Receptionist  <p><i>TIP: Specify roles and delegate responsibilities for each team member and ensure these are documented in the PDSA.</i></p>	<input type="checkbox"/>
	Identify who will be the QI Lead at your practice.	<p>Who is this person? _____</p> <p>Do they understand their role?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  <p><i>TIP: The QI Lead provides day to day leadership to support ongoing activity, maintain progress, delegate tasks and ensure QI processes are embedded into routine over time.</i></p>	<input type="checkbox"/>
	How long will the activity need?	Set timeframes to achieve your goal.	<input type="checkbox"/>
	How will your practice measure success?	<p>Decide and document what a successful outcome will look like for your practice.</p> <p>How will you measure your success? <i>This may be seeing improvements with data measures, or it may be a change in practice processes.</i></p>	<input type="checkbox"/>
	Confirm sample group of patients.	<p>Identify your patients. It is suggested that you start with 10-20 patients initially.</p>  <p><i>TIP: You need to generate a list with individual names who are identified as most appropriate for reviewing palliative care systems.</i></p>	<input type="checkbox"/>

Stage	Steps	Details	Completed
	<p>Discuss and document your practice approach, targets and expected outcomes as a result of completing your QI activity.</p> <p>PDSA examples are available in each QI toolkit.</p>	<p>Document agreed strategies, actions, baseline data, timeframes and targets in PDSA template.</p> <p> <i>TIP: Consider potential factors that may negatively impact the activity and factor these into timelines. (E.g. accreditation, staff leave, global pandemic, influenza vaccination season).</i></p> <p>Refer to the PDSA blank template.</p> <p>Use the PDSA example below as a guide:</p> <ul style="list-style-type: none"> • increase the number of patients with advance care directives <p> <i>TIP: Completing a PDSA template will form part of the evidence that is required to ensure your practice meets the criteria and is eligible for the PIP QI payment.</i></p>	□
	Upskill practice team members (if required).	Ensure all relevant team members understand about palliative/last days of life care. Refer to palliative approaches , health professional resources or information on beginning the conversation as required.	□
	Identify and order any resources or publications required.	Refer to the resources section.	□

For more support



support@bsphn.org.au



1300 467 265

Activity 1 - Important conversations

Important conversations and chronic medical conditions

Early in the patient's diagnosis or illness it is important to offer to discuss what is likely to occur in the future. Patients can then plan their health care, time and life. The amount of information a particular patient will want to hear will vary. Having a conversation as someone is dying is much harder than discussing plans earlier in the process.

Useful resources - The Dying to Talk Discussion Starters.

- [The Aboriginal and Torres Strait Islander Discussion Starter](#)
- [Dying to Talk Discussion Starters](#).

Shifting to a palliative care approach

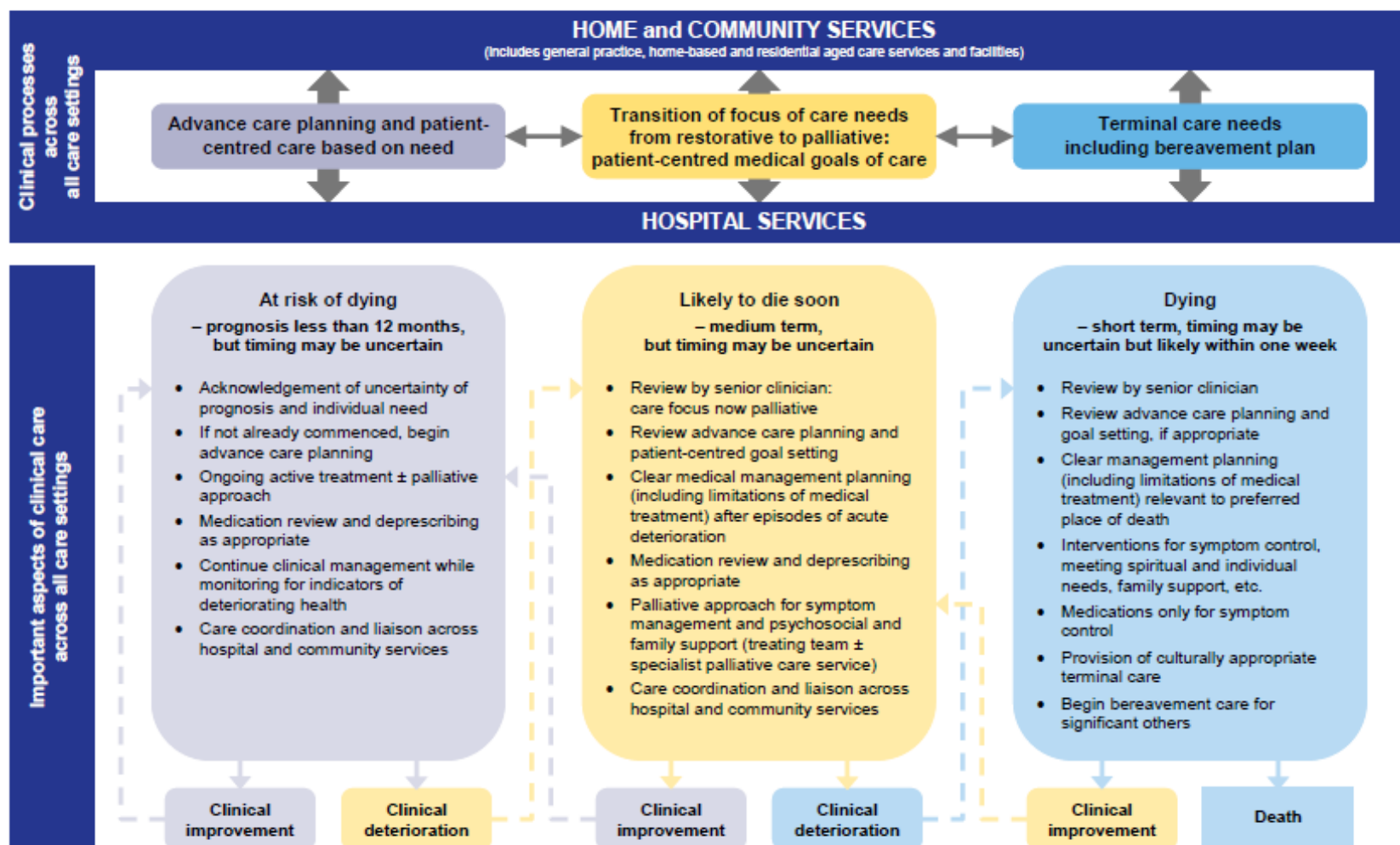
There comes a time in treating any patient with a progressive chronic illness when death becomes likely in the foreseeable future. The focus shifts from the illness to the person and providing the care they want and a good death.

The end-of-life care framework (see illustration) for GPs providing palliative care for community-based older patients supports GPs to:

- assess palliative care needs
- use available tools
- develop proactive person-centred management plans that reduce the need for decision-making in emotionally charged situations.⁶

⁶ <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care>

END-OF-LIFE CARE FRAMEWORK – LAST 12 MONTHS OF LIFE



Adapted from: 1. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: essential elements for safe and high-quality end of life care. Sydney: ACSQHC, 2015
2. Alfred Health. Guideline End of Life Care Management. Alfred Health Prompt Doc No: AHG0001555 v1.0, February 2015
3. Reymond L et al. End-of-life care: Proactive clinical management of older Australians in the community. AFP 2016; 45(1-2)



© The State of Queensland (Metro South Health End-of-Life Care Steering Committee) 2016

7

⁷ <https://metrosouth.health.qld.gov.au/sites/default/files/content/end-of-life-care-framework.pdf>

PEPSI COLA – Holistic patient assessment tool

The PEPSI COLA structure is a tool to support practitioners in carrying out patient assessments. It promotes communication and support to patients and their families and provides a framework to consider patients’ holistic needs.

Table 1. The PEPSI COLA structure for palliative care clinical planning¹¹

Domain	Issues to consider
Physical	Symptom control Medication – regular and as needed Compliance/stopping non-essentials Complementary therapies
Emotional	Understanding expectations Depression and adjustment Fears/security Relationships
Personal	Spiritual/religious needs Inner journey Quality of life Patient/carer agenda
Social Support	Benefits/financial Care for carers Practical support
Information/ communication	Within team Between professionals To and from patient To and from carers
Control	Choice, dignity Treatment options/management plan Advance directive Place of death
Out of hours/ emergency	Continuity Provision of out-of-hours care to patients/carers Carer support Medical support Drugs and equipment
Late	End-of-life/terminal care Stopped non-urgent treatment Patient and family aware Comfort measures/spiritual care Rattle, agitation
Afterwards	Bereavement follow-up/others informed Family support Assessment/audit Support team

8

⁸ <https://www.racgp.org.au/afp/2014/august/end-of-life-care-for-patients-with-cancer>

Activity 1.1 – Activity – Training in palliative approaches



The aim of this activity is to identify training needs for relevant team members on palliative approaches.

Description	Status	Action to be taken
Have relevant team members participated in training on palliative approaches?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to Palliative Care Education and Training Collaborative or Palliative Care Online Training . How will this information be communicated to the relevant practice team members?
After reviewing your training needs on palliative approaches, are there any changes you would like to implement in the practice to help manage palliative approaches to patients over the next 12 months?	<input type="checkbox"/> Yes, see action to be taken to help set you goals. <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Advance care planning

Advance care planning involves thinking about and making choices in the early stages of chronic illness to guide the future of the patient’s health care. It is also a process of them communicating their wishes. If they have strong beliefs about what they want to happen in the future, it is particularly important for the patient to make their plans and wishes known now. This can be done by having a conversation and writing down the individual’s preferences.

Effective advance care planning involves ongoing communication between the person, those closest to them, and a multidisciplinary healthcare team to optimise the person's current treatment, care and quality of life.

Advance care planning can be carried out at any time and will be driven by the person's care needs and their willingness to participate. It is an iterative process and should be integrated into clinical practice and routine care. Regular review ensures plans remain consistent with the person's values, beliefs and preferences for health and personal care.⁹

Advance care planning documents will only be used if a person is no longer able to make or communicate their decisions. However, people can change their mind, their plans, their Statement of Choices and legal documents at any time while they have decision-making capacity to do so.

The [Queensland Capacity Assessment Guidelines 2020](#) provide general information about capacity, capacity assessment and the legal tests of capacity in Queensland.

⁹ <https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/improving-care-end-life-queensland/advance-care-planning/advance>

Advance care planning forms

Advance care planning documents will only be used if a person is unable to make or communicate their decisions. People can change their mind, their plans, their Statement of Choices and legal documents at any time while they have decision-making capacity to do so. There are a number of forms available to assist people to communicate their decisions.

These are:

- [Statement of Choices Form A](#)—for people who **can** make their own health care decisions.
- [Statement of Choices Form B](#)—for people who **cannot** make their own health care decisions or who require support with decision-making.
- [Statement of Choices Form A and B combined](#)—for health care providers.
- [Advance Health Directive form](#)—for people who have decision-making capacity.

Some patients may initiate end-of-life discussions with you and it is best that you are prepared for these unexpected questions from patients or relatives.

Information and resources available to support implementation of advance care planning with patients

- [My Care, My Choices](#) – is a useful website that has information on the importance of advance care planning, the associated forms, information for GPs and FAQs.
- [Resources to support staff with important conversations.](#)
- [Dying to Talk](#) has tools to guide advance care planning, including a discussion starter, card game and Aboriginal and Torres Strait Islander-specific resources
- [Life Circle](#) has information and resources to help people with advance care planning conversations
- [MyValues](#) allows you to create your own values profile
- [Advance Care Planning Australia](#) provides information and resources.

Brisbane South PHN advance care planning QI toolkit

Brisbane South PHN have a dedicated [advance care planning QI toolkit](#) available. This toolkit allows you to review your practice systems to identify patients who would benefit from having an advance health directive completed. It also helps to identify any relevant team members who would like training on conducting end-of-life conversations.

Important conversations for non-English speaking patients

It is important to use an interpreter when required for these conversations to ensure that the patient's wishes are correctly recorded. An interpreter can be arranged via [Translating and Interpreting Service \(TIS\)](#). For patients who do not speak English the [Appointment Reminder Translation Tool](#) (available online) allows you to translate appointment details into your patient's language.

More information in relation to interpreter services is in [Brisbane South PHN patient population QI toolkit](#).

Activity 1.2 – Activity – Advance care documentation



The aim of this activity is to ensure relevant people in your practice know the importance of last days of life conversations and planning.

Description	Status	Action to be taken
Do all relevant practice team members know where to locate advance care planning documentation?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to forms from Office of Advance Planning. How will this information be communicated to the relevant practice team members?
Do any of the practice team require training/assistance on having end-of-life conversations?	<input type="checkbox"/> Yes: see action to be taken. <input type="checkbox"/> No: continue with activity.	Training available at End-of-Life essentials . Or Caresearch . How will this information be communicated to the practice team?
Are relevant team members aware of the appointment translation tool to assist patients who do not speak the primary language of the GP?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to the Appointment Reminder Translation Tool . How will this information be communicated to the practice team?
After reviewing your end-of-life conversations/documentation processes, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, see action to be taken to help set you goals. <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 2 – Referral pathways

No one health professional has all the skills and knowledge to address and manage all end-of-life needs for patients, their families and carers. Effective teamwork is crucial in strengthening against moral distress and ensuring that care is coordinated across the palliative care continuum e.g. primary care, acute care, aged care and all other services in community.

Palliative care team members

Palliative care is provided by a team of healthcare professionals with a range of skills. The palliative care team works together to meet the physical, psychological, social, spiritual and cultural needs of the patient. The team also help the family and carers.

The members of the palliative care team may include:

- doctors
- nurses
- allied health professionals (such as social worker, physiotherapist, occupational therapist)
- volunteers
- carers.

The Metro South Palliative Care Service (MSPCS)

The [MSPCS](https://metrosouth.health.qld.gov.au/palliative-care) provides a specialist palliative care service with consultancy, shared and direct care elements that work in collaboration with primary and tertiary care providers to enhance quality end-of-life care and ease the suffering of people diagnosed with advanced progressing life-limiting conditions. MSPCS comprises multidisciplinary teams that provide face-to-face, telephone and telehealth consultations. The MSPCS incorporates:

- a community service
- in-reach medical consultancy
- inpatient public palliative care beds
- in-reach consultancy palliative care service to Residential Aged Care Facilities (RACF's) within Metro South Health.

MSPCS services provided include:

- pain and symptom management
- end-of-life care
- equipment advice
- palliative care education
- practical support for patients and family to enable them to access relevant community resources
- emotional support for patients, family and friends registered with MSPCS
- access to grief and bereavement support for patients, family and friends registered with the service
- facilitation of transition between hospital and community care
- 24-hour telephone on-call service for patients registered with MSPCS.¹⁰

¹⁰ <https://metrosouth.health.qld.gov.au/palliative-care>

Palliative care and SpotOnHealth HealthPathways

[SpotOnHealth HealthPathways](#) provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral of over 550 conditions.

It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

It boasts a range of benefits including:

- best available information on how to assess and manage common clinical conditions, including when and where to refer patients
- easy online access to clinical and patient resources for in-consult use – peer-reviewed and localised to our region
- an integrated, concise system and saving you time.

The screenshot displays the SpotOnHealth HealthPathways website interface. On the left is a navigation menu with the following items: Home, COVID-19, About HealthPathways, Localised Pathways, Acute Services, Allied Health and Nursing, Child and Youth Health, End of Life (highlighted), End-of-life Care Overview, Advance Care Planning (ACP), Certification of Death, and Organ and Tissue Donation. The main content area shows a breadcrumb trail 'Home / End of Life' and a large heading 'End of Life'. Below this, there are two sections: 'In This Section' containing links for 'End-of-life Care Overview', 'Advance Care Planning (ACP)', 'Certification of Death', and 'Organ and Tissue Donation'; and 'See Also' containing links for 'Advanced or End-stage Heart Failure', 'Chronic Kidney Disease (CKD)', and 'Palliative Care'.

SpotOnHealth HealthPathways and Topbar

The [Topbar app](#) provides a simple one-click access to the HealthPathways website. Topbar will show the app name on top of your screen

The screenshot shows the Topbar app interface. At the top, there is a row of navigation icons including a home icon, social media icons (Facebook, YouTube), a COVID-19 icon, a multi-colored dot icon, an MBS icon, a pharmacy icon, a heart icon, a pip icon, and a thumbs up icon. Below this is a light blue bar with the text 'Home - Community HealthPathways SpotOnHealth (B...'. At the bottom, there is a dark blue bar with a hamburger menu icon, the text 'SpotOnHealth (Brisba...', and a search bar with the placeholder text 'Search HealthPathways'.

Activity 2.1 – Activity – Referral pathways



The aim of this activity is to ensure relevant team members know who to refer patients to.

Description	Status	Action to be taken
<p>Do all relevant practice team members know who to refer a patient to for palliative care services?</p>	<p><input type="checkbox"/> Yes: continue with activity.</p> <p><input type="checkbox"/> No: see action to be taken.</p>	<p>Refer to Metro South Health palliative care team.</p> <p>How will this information be communicated to the relevant practice team members?</p>
<p>Do all relevant practice team members know how to access SpotOnHealth HealthPathways end-of-life/palliative care resources?</p>	<p><input type="checkbox"/> Yes: continue with activity.</p> <p><input type="checkbox"/> No: see action to be taken.</p>	<p>Refer to SpotOnHealth section.</p> <p>How will this information be communicated to the practice team?</p>
<p>After reviewing your practice’s referral process, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?</p>	<p><input type="checkbox"/> Yes, see action to be taken to help set you goals.</p> <p><input type="checkbox"/> No, you have completed this activity.</p>	<p>Refer to the MFI and the Thinking part at the end of this document.</p> <p>Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.</p>

Activity 3 - Assistance for patients to live at home longer

The current Australian health care system does not meet patient preferences for care at the last days of life. For instance, the low proportion of people dying at home is at odds with the stated preferred place of death of patients; and is half that of comparable countries such as New Zealand, the US, Ireland and France. Place of death is a key indicator for quality end-of-life care. Preferred place of death is influenced by many factors, including:

- connectedness to community
- family
- availability of services and equipment
- complexity of caregiving and decision-making.

Preference for receiving care at home during the last months of life for end-of-life care is stronger than for death at home. Transfer from home may occur in the last few days due to rapidly escalating patient care needs, patient safety risks or carer exhaustion.

Principles of a 'good death' have been summarised from surveys of people approaching death and their relatives. Patient priorities for end-of-life care include:

- knowing when death is coming and what to expect
- having reasonable control of what happens
- ensuring wishes are respected
- the choice to leave when it is time
- avoid prolonging dying
- the choice and control over where death occurs
- who will be present and who shares the end
- time to say goodbye
- arrangement of important affairs
- access to 'hospice-style' quality care in any location
- necessary information and expertise
- control of pain and other symptoms
- dignity and privacy
- spiritual or emotional support
- strengthening of relationships, and relieving burdens placed on the family.

Australia's healthcare system is facing the challenge of shifting away from a hospital-centric provision of treatment at the last days of life towards better support for people who wish to receive care within their community during their last months of life.¹¹

¹¹ <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care>

Living well is a daily choice. Dying well takes planning and health, social and community support.¹²

For most people, living as independently as they can in their own home as they age is what they want. But sometimes they might need help with daily tasks that they can no longer manage. For example, they might need help with home maintenance, need aids and equipment, or they might need help with tasks like dressing or preparing meals. Palliative Care Qld have [information](#) available for families and carers who are caring for an older person with a life-limiting illness in Queensland.

My Aged Care

Aged care services are designed with the aim of meeting the changing needs of the older population. My Aged Care is a service that provides assistance for people aged 65 years and older. This includes:

- help at home
- short term care in an aged care facility (respite)
- permanent placement at an aged care facility.

To access these services, patients need to be assessed in their home via [My Aged Care](#).

Medical APPS

There are a number of apps that health professionals can access for a palliative care approach including:

- [caring@home app](#) - this app assists health professionals, supporting families, carers and patients, to assist with caring for people at home. There are resources, in English and nine other languages, for both carers (including training videos) and health professionals.
- [palliAGEDgp app](#) - this app provides nurses and GPs with easy and convenient access to information to help them care for people approaching the end of their life.
- [palliMEDS app](#) - developed by NPS MedicineWise, this app familiarises primary care prescribers with eight palliative care medicines that have been endorsed by the Australian & New Zealand Society of Palliative Medicine (ANZSPM) for management of terminal symptoms.

Activities of daily living – health assessments

Under the Medicare Benefit Schedule (MBS), GPs are able to complete health assessments on all patients aged 75 years and older or 55 years and older for Aboriginal and Torres Strait Islander patients. As part of this assessment GPs and nurses are to assess the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months.

A health assessment can also provide an opportunity to plan and discuss the person's needs and wishes for the future including advance care planning. For more information on health assessments, please refer to the [MBS criteria](#), [My Aged Care national screening and assessment form](#) and RACGP [The Silver Book](#).

¹² https://palliativecareqld.org.au/wp-content/uploads/2021/03/PalliativeCaring_QLD.pdf

Dying to Talk

[Dying to Talk](#) is a Palliative Care Australia initiative encouraging Australians of all ages and levels of health to talk about dying.

Having a conversation about end-of-life wishes will help people to communicate their wishes and assist with decision-making should patients be unable to communicate their preferences. The [Dying to Talk Discussion](#) starter, guides end-of-life conversations.

With more conversation comes better support for people nearing the last days of life.

Activity 3.1 – Activity – Assistance for patients to live at home longer

The aim of this activity is to ensure relevant practice team members know who to refer patients to for assistance to live in their own home longer.

Description	Status	Action to be taken
Do all relevant team members know who to refer patients to get assistance to live in their own home longer?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to the My Aged Care . How will this information be communicated to the relevant practice team members?
Are all health professionals aware of the various medical apps available to download to assist with management of patients?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to SPiCT tool or caring@home or palliAGEDgp or palliMEDS .
Do relevant team members know who to refer patients to if they require assistance living in their home longer?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to PalAssist . How will this information be communicated to the relevant practice team members?
After reviewing your assistance for patients to live at home longer processes, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, see action to be taken to help set you goals. <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 4 - Medicare Benefit Schedule (MBS) items

The following MBS item numbers *may be* used for palliative/end-of-life patients. Brisbane South PHN have a comprehensive [Medicare QI toolkit](#) available. This toolkit allows you to review your MBS claiming history and assist to identify patients who may benefit from a specific item number.

MBS items Complete appropriate MBS item numbers:

- [Health assessment](#)
- [Aboriginal and Torres Strait Islander health assessment](#)
- [Home medication review](#)
- [GP management plan](#)
- [Team care arrangements](#)
- [GPMP/TCA review x 3 times per year](#)
- [Nurse chronic disease item number](#)
- [Case conference](#)
- [Mental health treatment plan](#)



TIP: GPs are required to make sure each patient meets the

MBS criteria prior to claiming each item number

MBS items in a residential aged care facility

Patients in an RACF may be eligible for the following MBS item numbers.

- [Comprehensive medical assessments](#)
- [Care plan contribution](#)
- [Residential medication management reviews](#)
- [Case conference](#)
- [Mental health treatment plans](#)

Activity 4.1 – Data Collection from CAT4



Complete the below table by collecting data from CAT4. Instructions on how to do this can be found at: [MBS items](#) or [MBS attendance](#).

The aim of this activity is to collect data to determine the number of MBS claims made for the specific items at your practice over the past 12 months.

	Description	Total
4.1a	Number of health assessments claimed in the past 12 months	
4.1b	Number of HMRs claimed in the past 12 months	
4.1c	Number of RMMRs claimed in the past 12 months	
4.1d	Number of GPMP claimed in the past 12 months	

	Description	Total
4.1e	Number of TCA claimed in the past 12 months	
4.1f	Number of nurse chronic disease item numbers claimed in the past 12 months	
4.1g	Number of Aboriginal and Torres Strait Islander assessments claimed in the past 12 months	
4.1h	Number of MHTP claimed in the past 12 months	

Please note: You may wish to change the dates of your searches to compare previous years &/or different time frames. You may also wish to look just at patients who fit the last days of life/palliative criteria as identified in activity 1.1. You may also wish to search by a particular [provider](#).

Activity 4.2 – Understanding your practice’s MBS claiming



The aim of this activity is to increase your understanding of the MBS item number claiming at your practice.

Description	Status	Action to be taken
After completing activity 4.1 are there any unexpected results with the number of MBS items claimed at your practice?	<input type="checkbox"/> Yes: see action to be taken. <input type="checkbox"/> No: continue with activity.	Please explain: (e.g. low number of health assessments completed, higher rate of GPMP than expected) How will this information be communicated to the practice team?
Is your practice’s MBS claiming similar to other practices in the Brisbane south region (compare information from benchmark report)?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Outline the differences – is it active population, age group differences, male/female populations? How will this information be communicated to the practice team?
After reviewing your patient MBS claiming, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, see action to be taken to help set you goals. <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 5 - Marking patients deceased in your clinical software

Once a patient has died, it is important for a GP to review the patient file and to ensure that a staff member marks the patient as deceased in your clinical software package. This is to ensure accurate information is kept for each patient and reminder letters/contacts are not made with a deceased patient’s family. Instructions are available for [Best Practice](#) and [MedicalDirector](#) on marking patients deceased.

GPs and death audit

The GP may wish to complete a [death audit](#). This helps to review the treatment, services and if the health needs of the patient were met.

Activity 5.1 – Marking patients deceased in your clinical software



The aim of this activity is to increase your understanding of the MBS item number claiming at your practice.

Description	Status	Action to be taken
Are all relevant team members aware of how to mark patient files as deceased in the practice clinical software?	<input type="checkbox"/> Yes: continue with activity. <input type="checkbox"/> No: see action to be taken.	Refer to instructions for Best Practice and MedicalDirector . How will this information be communicated to the practice team?
After reviewing your systems for marking patients file as deceased, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	<input type="checkbox"/> Yes, see action to be taken to help set you goals. <input type="checkbox"/> No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 6 - Resources & training

- [Palliative Care Queensland](#) provides information, education, advocacy and linkages for health professionals, consumers and community members requiring support with palliative care.
- [The Advance Project](#) is a practical, evidence-based toolkit and training package, specifically designed to support Australian general practices to implement a team-based approach to initiating advance care planning (ACP) and palliative care into everyday clinical practice.
- [PallConsult](#) has been designed to boost the ability of local healthcare teams to deliver patient-centred palliative care.
- [Palliative Care Education & Training Collaborative](#) contains a GP online learning module which can be accessed through PEPA's free Learning Management system. GPs will be required to create a free login and then can commence learning on the following palliative care modules:
 - Principles of Palliative Care
 - Communicating with people with life-limiting illnesses
 - Advance Care Planning
 - Assessing and Managing Symptoms
 - Assessing and Managing Pain
 - Awareness of Self-Care.
- [End-of-Life essentials toolkit](#) - This website provides online learning opportunities and practice resources for doctors, nurses and allied health professionals to improve the quality and safety of end-of-life care.
- [End of Life law for Clinicians](#) - *End of Life Law in Australia* provides accurate and practical information to assist you to navigate the challenging legal issues that can arise with end-of-life decision-making. It is a broad introduction to end-of-life laws in each Australian state and territory to help you know the law, and your rights and duties.
- [Palliative Care Online Training](#) – this is an online training program to help aged and community care workers, carers, volunteers, family members and health professionals who provide palliative care to aged persons in the community. The modules will help you develop your skills and confidence, so that the next person you care for at the end of their life will benefit.
- [PalliLearn](#) - aims to build community knowledge, death literacy, compassion literacy and community capacity in relation to serious illness, dying, death and grief by providing quality and easy to understand courses. Courses include: knowledge sharing about the topic, relevant key research findings, practical ways to put these into action, tips for connecting with your local supports and ideas for how to continue your learning.

Best practice tools

- [SPICT TOOL](#)/Surprise question - Supportive & Palliative Care Indicators Tool is a clinical tool to help identify people with deteriorating health and prompt holistic assessment and future care planning.
- [caring@home app](#) - this app assists health professionals, supporting families, carers and patients to assist with caring for people at home. There are resources, in English and nine other languages, for both carers (including training videos) and health professionals.
- [palliAGEDgp app](#) - this app provides nurses and GPs with easy and convenient access to information to help them care for people approaching the end of their life.
- [palliMEDS app](#) - developed by NPS MedicineWise, this app familiarises primary care prescribers with eight palliative care medicines that have been endorsed by the Australian & New Zealand Society of Palliative Medicine (ANZSPM) for management of terminal symptoms.

Brisbane South PHN chronic disease toolkits

Brisbane South PHN have a number of chronic disease toolkits available that assist you and your practice to review specific conditions. These toolkits are designed to assist practices conduct quality improvement activities and set goals to see some improvements in patient health care.

The toolkits are under continual development. Chronic disease topics include:

- Asthma
- Cardiovascular disease
- Chronic Kidney disease
- COPD
- Diabetes
- Mental Health
- Osteoporosis

The toolkits can be found [here](#).

QI activities using the MFI and PDSA

After completing any of the toolkit activities above you may identify areas for improvement in the management of patients who are approaching end-of-life. Follow these steps to conduct a QI activity using the MFI and PDSA. The model consists of two parts that are of equal importance.

Step 1: The **‘thinking’** part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

Step 2: The **‘doing’** part is made up of PDSA cycles that will help to bring about rapid change. This includes:

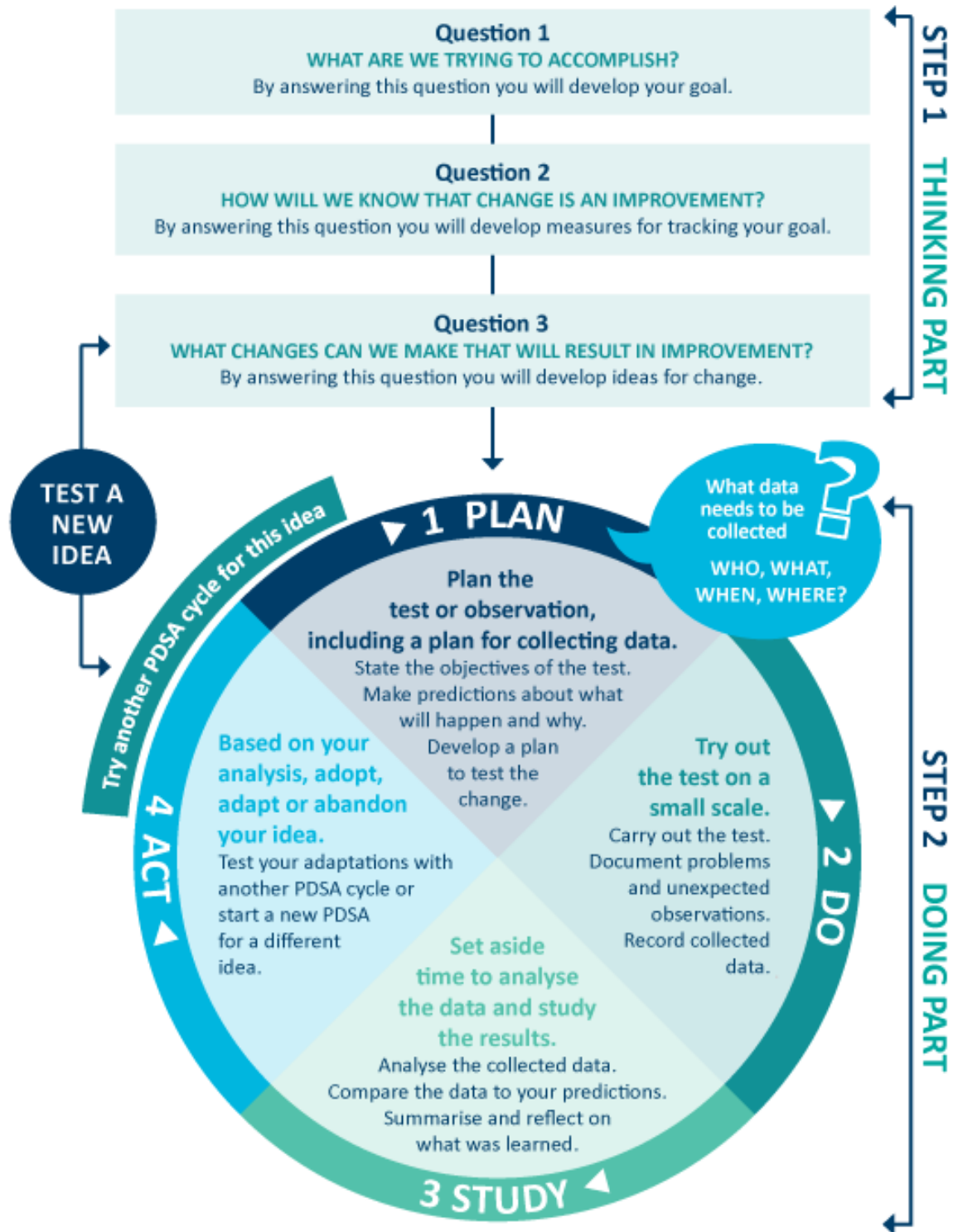
- helping you test the ideas
- helping you assess whether you are achieving your desired objectives
- Enabling you to confirm which changes you want to adopt permanently.

Example PDSA for palliative and end-of-life care

See below for suggested goals related to palliative and end-of-life care patient’s you may wish to achieve within your practice.

GOAL	HOW YOU MAY ACHIEVE THE GOAL
Ensure 90% of clinicians are familiar with the SPICT app	Identify which clinicians are familiar with the app and provide information to those that are unaware.
Ensure 90% of clinicians are familiar with the palliMEDS app	Identify which clinicians are familiar with the app and provide information to those that are unaware.
75% of patients with dementia will have an advance health directive completed	Refer to CAT4 instruction on identifying patients with dementia and review their medical record to find who has an active advance health directive.

Model for Improvement diagram



Source: <http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	Date:
Team members:	
Q1. What are we trying to accomplish? (Goal)	
By answering this question, you will develop your GOAL for improvement. Record this as a S.M.A.R.T. goal (S pecific, M easurable, A chievable, R elevant, T ime bound).	
Our goal is to: ensure all our patients with dementia have had a HMR claimed. <i>This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.</i>	
Our S.M.A.R.T goal is to: increase the number HMR's on patients with dementia by 10% by 30 th October.	
Q2. How will I know that a change is an improvement? (Measure)	
By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.	
We will measure the percentage of active patients with dementia who have a HMR recorded in the past 12 months. To do this we will:	
A) Identify the number of active patients with dementia.	
B) Identify the number of active patients with dementia and a HMR claimed in the past 12 months.	
B divided by A x 100 produces the percentage of patients with dementia who have a HMR recorded in the past 12 months.	
BASELINE MEASUREMENT: 23% of active patients with dementia have a HMR recorded in the past 12 months.	
Q3. What changes could we make that will lead to an improvement? (List your IDEAS)	
By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.	
IDEA: Identify active patients with dementia who do not have a HMR recorded in the past 12 months.	
IDEA: Collaborate with local pharmacies to discuss options of notifying concerns with medication management for patients.	
IDEA: Provide training to any relevant staff members on how to complete a HMR	
IDEA: Ensure practice staff know where to complete a HMR in the practice software.	
IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).	

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, *The Improvement Guide*, Jossey-Bass, San Francisco, USA.

MFI and PDSA template EXAMPLE

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? (Refer to Q3, step 1 above)	
Identify active patients with dementia who do not have a HMR recorded in the past 12 months.	
PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
<p>WHAT: Sally (receptionist) will set aside an hour on a Tuesday afternoon to conduct a search on CAT4 of all active patients with dementia and no HMR recorded. She will generate individual lists for each GP. The GP can use the lists to identify patients who may benefit from a HMR. Sally will then contact the patient’s next of kin to discuss this opportunity with them. When a patient books in for an appointment, they will be asked to bring all medications with them to the practice and the practice nurse will see the patient prior to the GP consult to update patient measures including: BP, height, weight, BSL, urine analysis and contact details.</p> <p>WHO/WHEN/WHERE:</p> <p>Who: Sally (receptionist) When: Begin 1st October. Where: Dr Brown’s office.</p> <p>DATA TO BE COLLECTED: Number of active patients with dementia and number of active patients with dementia who have not had HMR completed in the past 12 months.</p> <p>PREDICTION: 33% of the active patient with dementia will have had a HMR completed in the past 12 months.</p>	
DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
<p>Done – completed 20th October – lists of eligible patients were generated from CAT4 and distributed to individual GPs. Each GP identified eligible patients. The next of kin was contacted for these patients. Uptake was limited as patients preferred to have the referral organised at the next appointment rather than making a special trip. An appointment reminder was created for these patients to ensure they were booked in for a longer appointment at their next visit. However, there were 5 patients who attended that the practice nurse identified were due for a GPMP review, so this was co-ordinated for the patient as well.</p>	

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
<p>At the end of the focus on HMRs for patients with dementia, 26% of patients with dementia had a HMR completed. This has only resulted in a 3% increase in results which is 7% lower than our goal. Results have been shared with the whole practice team. Whilst we didn't achieve our goal, we can see the benefit in discussing this with eligible patients. Sally will generate another report from CAT4 in six months' time to see if the numbers have increased. The practice principals were very pleased to hear about the 5 people who came in for a GPMP review.</p> <p><i>Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.</i></p>	
ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. <i>ADOPT: record what you will do next to support making this change business as usual; ADAPT: record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.</i>
<p>ADOPT: The practice will review reports from CAT4 in six months' time to monitor if the appointment reminders have assisted to increase the number of HMRs completed on patients with dementia.</p> <p>ADAPT:</p> <p>ABANDON:</p>	

Repeat step 2 to re-test your adapted plan or to test a new change idea

MFI and PDSA template

Step 1: The thinking part - The 3 fundamental questions

Practice name:	Date:
Team members:	
Q1. What are we trying to accomplish? (Goal)	
By answering this question, you will develop your GOAL for improvement. Record this as a S.M.A.R.T. goal (S pecific, M easurable, A chievable, R elevant, T ime bound).	
Q2. How will I know that a change is an improvement? (Measure)	
By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc). Record and track your baseline measurement to allow for later comparison.	
BASELINE MEASUREMENT:	DATE:
Q3. What changes could we make that will lead to an improvement? (List your IDEAS)	
By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.	
IDEA:	
IDEA:	
IDEA:	
IDEA:	

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, *The Improvement Guide*, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? (Refer to Q3, step 1 above)	
PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (<i>if applicable</i>); the data to be collected; and predictions about the outcome.
<p>WHAT:</p> <p>WHO/WHEN/WHERE:</p> <p>DATA TO BE COLLECTED:</p> <p>PREDICTIONS:</p>	
DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
<p><i>Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.</i></p>	
ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. <i>ADOPT: record what you will do next to support making this change, business as usual; ADAPT: record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.</i>
<p>ADOPT:</p> <p>ADAPT:</p> <p>ABANDON:</p>	

Repeat step 2 to re-test your adapted plan or to test a new change idea

