phn BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Prevention

Wellness Strategy

MODULE

Version 3

November 2021

WELLNESS STRATEGY

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 into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted. There is a bowel cancer screening example using the MFI 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; MedicalDirector, 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.

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Brisbane South PHN would like to acknowledge Gold Coast PHN for the use of the Wellness Strategy. They have provided the program framework and this has been customised and adapted to meet the needs of general practices in the Brisbane south region.

Brisbane South PHN, 2021

Contents

WELLNESS STRATEGY

The wellness strategy allows general practice to provide a person-centred approach to improve the care quality of patients. The strategy is divided into four sections: burden of care, quality patient records and data management, advanced care planning and prevention. Details are listed below to ensure important aspects of care are offered to patients annually.

Burden of care

1. Deprescribing of medications
2. Review the care team including specialists and allied health professionals to ensure relevance.

Quality patient records & data management

1. Consistent disease coding
2. Update patient details including: NOK, emergency contact, allergy status & ethnicity
3. Lifestyle risk factors including: smoking, alcohol, BMI
4. Update patient consent
5. My health record – upload shared health summary

Advanced care planning

1. Details of enduring power of attorney
2. Advance health directives

Prevention

1. Vaccinations including: influenza, pneumococcal, shingles, pertussis, COVID
2. Falls risk
3. Fracture risk
4. Kidney risk
5. Confusion & poor self-control
6. Cancer screening
7. Mental health

MBS items

Complete appropriate MBS item numbers:

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

TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Aim of this QI toolkit

Toolkit aim - to ensure your patient population is provided with preventative healthcare with the right care, at the right time, by the right person to support a person-centred approach to their care

The toolkit is designed…

- to support medical practices to make easy, measurable and sustainable improvements
- to provide best practice care for their patients
- to assist practice's to complete Quality Improvement (QI) activities
- to assist practices to meet the Practice Incentive Program Quality Improvement Incentive (PIP QI)

The following checklists and activities will help guide you through the process at your own pace. Once you understand your patients, you will be able to easily identify how your patients are being managed and what needs to happen within the practice to optimise patient care.

How to use this toolkit

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

- identify a sample group of patients (between 50-100 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
- 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.

For more support


support@bsphn.org.au


1300 467 265

Activity 1 – Wellness strategy checklist

Activity 1.1 – Wellness strategy checklist

The aim of this activity is to guide the practice to ensure that each patient included in your sample group is up to date with relevant preventative health measures.

The following activities are general with a focus on people with chronic disease and may not be relevant for all patients. Full details of prevention activities are available in the RACGP Red Book or Brisbane South PHN have a number of QI toolkits with a focus on chronic diseases.

Focus Area	Activity	Completed
Burden of care	Review the care team including specialists and allied health professionals to ensure current relevance.	☐
	Review and update medication list (consider whether patient still needs listed medications)	☐
Quality patient records	Are all chronic diseases coded in past history using drop down menu supplied?	☐
	Are patient details up to date including: • address and phone number • next of kin • emergency contact • allergy status • ethnicity	☐
	Update lifestyle risk factors including: (refer to your practices benchmark and trend reports supplied by Brisbane South PHN) • height, weight & BMI • waist circumference • smoking status • alcohol status • physical activity assessment	☐
	Update patient consent	☐
	Update and upload shared health summary (	☐
Advanced care planning	Does the patient have a documented enduring power of attorney? (check testamentary capacity where appropriate, is recorded and set reminder if needed).	☐
	Does the patient have a documented advanced health directive? (where appropriate)	☐
Prevention	Is the patient up to date with the following immunisations: • influenza • pneumococcal (if appropriate) • shingles (if appropriate) • DTPa • COVID	☐

Focus Area	Activity	Completed
	Older patients: • falls risk assessment • vision assessment • hearing assessment	□
	Relevant measures, investigations and exacerbation plans (if appropriate): • blood pressure • bone mineral density test • eGFR • HbA1c • microalbuminuria • lipids • ECG • spirometry • Absolute cardiovascular risk assessment • Diabetes risk assessment	□
	Chronic disease plans (if relevant) • asthma action plan • COPD action plan • diabetes sick day action plan • my heart failure action plan	
	Cancer screening (as appropriate): • cervical • breast • bowel	□
	Mental health assessments • mini mental examination (where appropriate) • K10 (where appropriate) • Mental health treatment plan (where appropriate)	□

Activity 2 – Planning your CQI activity

Activity 2.1 – Continuous Quality Improvement (CQI) checklist

The aim of this activity is to work through the suggested steps to support the successful implementation of the wellness strategy. Once you've completed this activity, set yourselves a goal of meaningful improvement (e.g. 5% increase in a benchmark or trend line from your practice report).

Stage	Steps	Details	Completed
Plan your activity	Arrange a practice meeting for key practice team members to discuss potential focus group of patients for the wellness strategy.	CQI activity could be added as a standing agenda item on your usual team meetings; OR Form a CQI team within your practice and schedule meetings to discuss options and strategies. *TIP: To meet PIP QI requirements, you must undertake CQI as a team.*	☐
	Identify and establish key practice team members to implement the wellness strategy.	Suggested team members include: 1. General practitioner (GP) 2. Practice manager 3. Practice nurse 4. Receptionist Refer to the practice team roles and responsibility activity. *TIP: specify roles and delegate responsibilities for each team member and ensure these are documented.*	☐
	Identify who is the CQI Lead at your practice.	Who is this person? _____ Do they understand their role? ☐ Yes ☐ No *TIP: The CQI Lead provides day to day leadership to support ongoing activity, maintain progress, delegate tasks and ensure CQI processes are embedded into routine over time.*	☐

Stage	Steps	Details	Completed
	Conduct searches on CAT4 to identify appropriate sample group of patients to focus on. (*You may wish to conduct your searches prior to holding a practice meeting).*	Practices may focus on any QI areas informed by your clinical information system data that meet the needs of your practice population. Alternatively, the following recipes can be used as a guide to assist practices identify achievable QI activities. • All patient aged 75+ with existing chronic conditions • patients eligible for GPMP/TCA – cross tabulated • patients with COPD who have not had an influenza vaccination recorded in the past 15 months *(you can choose any chronic condition)*  *TIP: you may have already identified your sample group of patients from previously prepared CAT4 recipes reports.* *TIP: reviewing and analysing data is a PIP QI requirement.*	☐
	Confirm sample group of patients.	Identify your patients, it is suggested that you start with 50 -100 patients initially.  *TIP: you need to generate a list with individual names who are identified as most appropriate for the wellness strategy.*	☐
	Discuss and document your practice approach, targets and expected outcomes as a result of completing your CQI activity. PDSA examples are available in each QI toolkit.	Document agreed strategies, actions, baseline data, timeframes and targets in PDSA template.  *TIP: Consider potential factors that may negatively impact the activity and factor these into timelines. (e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season).* Refer to PDSA example below: • increase recording of physical activity in patient files • increase number of patients with bowel screening results • PDSA blank template  *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.* *TIP: Refer to activity 3 – strategies for improving patient measures in your practice.*	☐

Stage	Steps	Details	Completed
Implement your activity	Communicate details of the focused CQI activity to the practice team.	Share the updated PDSA template with the whole practice team to ensure everyone is aware and knows their role to support implementation of the activity.	☐
	Hold meetings and document minutes and outcomes as you progress through the activity.	Holding regular meetings will assist the practice maintain momentum and keep people on task to achieve CQI targets. *TIPS:* • *minutes of meetings from part of the PIP QI documentation* • *PDSA can be edited and updated as you progress through the activity* • *plan meetings in advance to ensure availability of key members.*	☐
	Contact Brisbane South PHN for support (if required).	Brisbane South PHN can assist your practice to achieve your goals. Contact the team on support@bsphn.org.au to assist with using data extraction tools, suggest CQI strategies and tips.	☐
Review your activity	Review PDSA and targets to assess progress or success.	You must duplicate your data search on CAT4 to assist you to report on any improvements. Consider: • What worked? • What needs more work? • What did you learn on the way? • What have you updated or changed to support this activity? *TIPS:* • *conducting a review of your process and data forms part of the requirements for PIP QI.* • *ensure you document your findings to continue to meet the PIP QI guidelines.* • *if you have changed your systems and processes ensure these are documented in your practice policy & procedure manual.*	☐
	If outcomes not achieved.	Review PDSA and propose a new strategy.	☐
	Hold a whole of practice meeting.	Communicating the results of your QI activity with your whole team is important.	☐
	Completion is a success whether outcome is achieved or not.	Celebrate all achievements, big or small. Use learnings to inform your next activity or repeat this one with a different plan.	☐
Next steps	Determine if this activity needs to continue as is, or requires changes.	If you have achieved your outcomes, ensure this activity continues within your usual processes. Consider options for a new activity.	☐

Activity 3 – Strategies for improving patient measures in your practice

Ideas for improving patient measures in your practice

It is suggested that when you meet in your practice team, you discuss how at your practice you can improve patient measures. Some suggestions you may consider include:

- ask the practice nurse to opportunistically see patients prior to their GP appointment to obtain height, weight, waist measurements, BP, smoking and alcohol status
- ask patients to complete a summarised new patient form with their height, weight, waist measurements, BP, smoking and alcohol status and also check their address, contact details, NOK and emergency contact details
- actively contact patients who do not have measures recorded e.g.: proactively contact patients with COPD who have not yet had their flu injection and/or GPMP in the past 15 months
- ensure Topbar is installed on every workstation and fully operational
- create Topbar prompts for patients identified whilst conducting searches
- provide training to the medical receptionist to review the MBS app on Topbar to identify item numbers patients are eligible for when booking an appointment. If the receptionist identifies an assessment is due, offer to book a longer appointment
- utilise practice reminder system by ensuring all reminders for the year are entered for each patient.

Successful teams

Engaged and effective practice teams are the absolute foundation for achieving sustainable improvements.

Consider how your team currently operates. Is your team working together effectively and efficiently? To achieve sustainable improvement, you will likely need to do some work on achieving a whole of team approach to improving PIP QI measures.

Documented role clarity is of high importance to ensure efficiency and accountability. Below is an example of how responsibilities could be shared across the team. As there is a great deal of diversity between practices, consider what will work best for your team.

General Practitioners (GP)

- respond to recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients
- perform clinical review on each patient
- arrange any relevant tests or investigations
- support eligible patients to participate in screening or vaccinations, including addressing potential barriers (e.g. fear, embarrassment, lack of knowledge, access etc)
- perform measurements, screening, immunisations and/or work with Practice Nurses to do so
- maintain RACGP Standards for General Practice - Criterion GP2.2 - Follow up systems

Practice Nurses

- work with reception staff to promote the programs
- respond to recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients
- perform immunisations (if requested by the GP)
- perform data measures on patients including height, weight, BMI, blood pressure, smoking or alcohol status

Practice Manager

- maintain up to date patient registers
- undertake audits of practice records to identify eligible patients due for investigations, immunisations or screening
- establish and oversee recall/reminder systems
- support GPs with the flow of information in relation to PIP QI
- support/manage reception staff responsibilities
- manage succession planning
- document policy and procedures
- monitor progress against PIP QI improvement measures

Reception Staff

- order and maintain supplies of resources
- display brochures, flyers and posters
- respond to recall/reminders opportunistically when a patient phones for an appointment and/or by handing relevant resources to patients in the waiting area
- send GP signed recall/reminder letters (and/or text messages and phone calls) to eligible (or soon to be eligible) patients to encourage participation
- provide resources and support information in alternative languages as needed.

Medical and Nursing students (if relevant)

- consider any of the above tasks that Medical and Nursing students may be able to complete and delegate. Ensure training is provided.

Activity 3.1 – Practice team roles in wellness strategy

Based on the example above, identify the person responsible for each part of the process required to improve practice and patient measures whilst completing in an activity as part of the wellness strategy. Document each person's responsibilities in the table below.

Tasks for (insert QI Activity Name)		
	Name	**Responsibilities**
GP 		
Practice Nurse 		
Practice Manager 		
Receptionist 		

Activity 3.2 – Review task allocation

The aim of this activity is to review task allocation for team members in your practice

Description	Status	Action to be taken
After completing **activity 3.1** have you considered how the patient bookings will be made?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. receptionist will phone each patient to make the appointment or patient will be sent a reminder letter and they will need to contact the practice to make an appointment)* How will this information be communicated to the practice team?
Have you considered how long to allocate for each appointment (for GP and nurse time)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider holding a team meeting to decide on the length of time for each clinician – will this be on the same day or separate days? How will this information be communicated to the practice team?
Have you included how all the practice team (admin, nurse & GP) will be able to identify the nature of the appointment in the appointment book?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Please explain: (*e.g. our practice will use appointment icons to identify patient attending for a reminder or we will type in the appointment comments what the appointment is for*). How will this information be communicated to the practice team?

Description	Status	Action to be taken
Have you included who will update the patient reminder system to ensure continuity of care for the patient?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Outline who has the responsibility to update reminder system – is it GP, Practice Nurse, Manager or receptionist. How will this information be communicated to the practice team?
Do all team members understand their roles and responsibilities?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Provide training to individuals or groups within your practice.
After reviewing your practice roles and responsibilities for managing cancer screening at your practice, are there any changes you would like to implement over the next 12 months?	☐ Yes, **see action to be taken to help set you goals**. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 4 – Wellness strategy and MBS item numbers

Patients may be eligible to access health assessment and chronic disease item numbers within the Medicare Benefit Schedule. These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number. Please ensure the GP understands these prior to claiming the item number/s.

Please note: Brisbane South PHN has a comprehensive toolkit looking at MBS items.

The item numbers that patients ***may be*** eligible for include:

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

Activity 4.1 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's systems for claiming MBS item numbers.

Description	Status	Action to be taken
Do relevant staff know where to find appropriate templates for GPMP/TCA	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to templates.
Do relevant staff know what the criteria are for completing HMR, health assessments and management plans through Medicare?	☐ Yes: continue with activity . ☐ No: **see action to be taken.**	Refer to MBS criteria at: • HMR criteria. • Health assessments. • Management Plan criteria.
Does the practice have a system for tracking Medicare item number claiming?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Do GPs have access to their day sheets to identify MBS item numbers claimed? Does the practice nurse check that any assessments completed have the correct billing? Are item numbers checked against appointment diary prior to batching?

Description	Status	Action to be taken
Do you know the contact details for any MBS related questions?	□ Yes: continue with activity. □ No: **see action to be taken.**	Email: askMBS@health.gov.au. Provider Enquiry Line - 13 21 50.
Do relevant staff know that Medicare provides online training modules?	□ Yes: continue with activity. □ No: **see action to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the system for claiming MBS item numbers, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	□ Yes, **see action to be taken to help set you goals**. □ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Resources

Wellness strategy resources

- RACGP – The Red Book – Guidelines for prevention activities in general practice
- RACGP – Green Book – Putting prevention into practice
- Heart Foundation - Hypertension clinical information and guidelines.

Links to other QI toolkits

Brisbane South PHN have a suite of QI toolkits available for general practice. The toolkits are designed to:

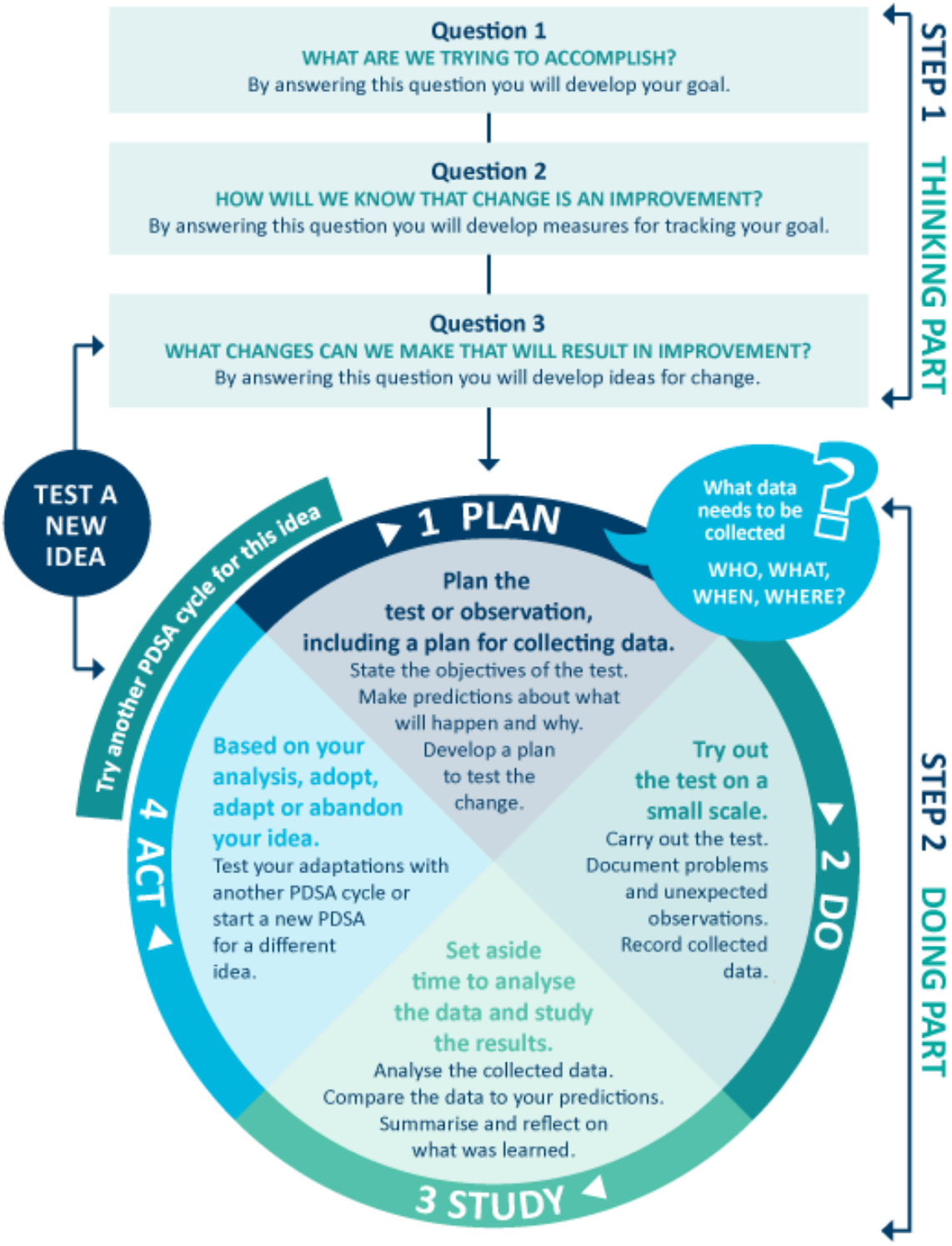
- improve patient care and outcomes
- generate increased revenue for General Practitioners (GPs)
- help practices fulfil their quality improvement requirements under the Practice Incentive Program Quality Improvement Incentive (PIP QI)
- each toolkit is designed to complete at your own pace
- the toolkits are available so that you choose your own adventure – you choose which topic/toolkit you would like to work on.

After completing this toolkit, you may benefit from choosing one of the following:

- Quality patient records– this toolkit assists you to review your practice data to ensure your patient records are maintained at the highest quality. It also includes activities to ensure your practice is meeting the e-health PIP criteria and another activity on PRODA.
- MBS items – this toolkit assists you to review your practice's use of a number of MBS item numbers. You can also generate reports to identify the number of eligible patient's vs the number of MBS item numbers claimed.
- Older people population - this toolkit is designed to assist you to manage your older patient population. Key topics include health assessments (75+ and Aboriginal and Torres Strait Islander), medication reviews (via a Home Medication Review), management plans (for patients with a chronic medical condition), advance care planning, dementia screening, falls prevention, vaccinations including influenza, pneumococcal and shingles, smoking, alcohol & physical activity, osteoporosis and cancer screening.
- Cancer screening – this toolkit allows you to review patients eligible for cancer screening (breast, bowel and cervical) and ensure you have systems in place to manage these patients.
- Influenza, shingles & pneumococcal vaccination toolkits are available to help you review patients at your practice eligible for the particular vaccination.

The full suite of toolkits are available on Brisbane South PHN's website.

Model for Improvement diagram



Source: http://www.ihi.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:
Increase the number of people who undertake bowel cancer screening.
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.
So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to increase the proportion of our patients aged 50 (first timers) that participate in bowel cancer screening by 15% by 31 December.

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 aged 50 years that participate in bowel cancer screening. To do this we will:

A) Identify the number of active patients aged 50 years.
B) Identify the number of active patients aged 50 years with a FOBT result.

B divided by A x 100 produces the percentage of patients aged 50 years who have a FOBT result recorded.
This is a good measure, however, please note that as you measure this over time, some people who were included in earlier results will have turned 51 and will not be included. In later measurements, people who have just turned 50 will be included.

BASELINE MEASUREMENT: 27% of active patients aged 50 years have a FOBT result 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: Identify patients aged 49 by completing a search on CAT4. Contact these patients via letter, phone, SMS etc. to encourage participation in the bowel screening program.

IDEA: Contact eligible patients aged 50 years and 6 months who have not had an FOBT recorded to discuss options for testing.

IDEA: Add bowel cancer screening to templates for chronic disease management and 45-49 year old health assessments.

IDEA: Clinical team develop a system for flagging eligible patients and addressing screening opportunistically.

IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).

IDEA: Run an awareness campaign for bowel cancer awareness month in June.

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)*	
Contact eligible patients aged 50 years and 6 months who have not had an FOBT recorded to discuss options for testing.	
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.
WHAT: John to use Sue's office to conduct search on CAT4 and identify active patients aged 50 years who have not had a FOBT result recorded. Searches will be conducted on CAT4 to identify the number of active patients aged 50 years who have not had a FOBT result recorded. Lists of patients will be provided to each GP for review. A Topbar prompt will be created for eligible patients for the vaccine. WHO/WHEN/WHERE: Who: Receptionist. When: 17 November. Where: Dr Brown's office. DATA TO BE COLLECTED: Number of active patients aged 50 years and the status of their FOBT result.	
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).
Done – completed 17 November – while the test went smoothly, the receptionist needed to contact PHN for support with the Pen CS search and the export function. A Topbar prompt was created which assisted the practice team identify patients who did not have a FOBT result recorded when they attended for an appointment. John contacted patients via SMS who did not have a FOBT results recorded, which resulted in 5 people making an appointment to see their GP.	
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.
At the end of the focus on FOBT testing, 38% of patients aged 50 years have had a FOBT result recorded. This has resulted in an 11% increase in results which is 4% 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. John has been commended for his work in identifying eligible patients. *Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.*	

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. *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.*

ADOPT:

The practice will regularly monitor FOBT rates via the monthly benchmark report supplied by Brisbane South PHN to ensure the rates are increasing.

John will ensure a Topbar prompt has been created for all patients aged 50 years and 6 months who do not have a FOBT result recorded.

ADAPT:

ABANDON:

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

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