Putting the Patient in the Picture
GENERAL PRACTICE CLINICS

PHN BRISBANE SOUTH
An Australian Government Initiative
Putting the Patient in the Picture
GENERAL PRACTICE CLINICS

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Map of our service area and postcodes
About Brisbane South PHN

Brisbane South PHN (BSPHN) supports primary health providers – GPs and allied health professionals – to provide coordinated, efficient and effective medical services to patients, particularly those at risk of poor health outcomes ... the right care in the right place at the right time.

These objectives will be achieved by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to ensure improved outcomes for patients.

BSPHN is one of 31 PHNs created across Australia that works to address local health needs and national health priorities for targeted work: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

Our role

- Identify and address local health needs
- Determine priority areas relevant to primary healthcare
- Create a more equitable system
- Identify gaps in service delivery
- Work collaboratively with health and community service partners to provide the best patient-centred care outcomes
- Ensure GPs are active participants in the design and delivery of local primary healthcare services
- Boost frontline services to address areas of local need and service/market failures
- Make it easier for patients to navigate the health system and receive health services when and where they need them
- Improving patients’ transitions in or out of hospital.

Community-focused health

Our staff works with our local communities and stakeholders to ensure that important health messages and programs are promoted widely.

Brisbane South PHN recognises the diversity within our community and offers several programs and activities targeted to specific population groups including culturally and linguistically diverse, older Australians and Aboriginal and Torres Strait Islander people.
Introduction

Patient clinics in general practice focus on building a partnership of care between the patient and the health professionals involved in their care.

Patient clinics should be person-centred, enhance the self-management capacity of individuals and facilitate linkages with other community-based supports to achieve positive health outcomes for our patients.

The *Putting the Patient in the Picture - GENERAL PRACTICE CLINICS* manual is a combination of checklists and resources for the practice champion who wishes to establish a patient clinic.

The manual includes a number of established resources that will support evidence-based practice and facilitate the embedding of self-management principles.

Delivering patient-centred care requires focus right across the continuum of care – commencing with preventative screening through to chronic disease management.

A change of approach in the delivery of care and patient education will move healthcare from a reactive approach to a proactive approach and ensure improved health outcomes for our patients.

This resource has been funded to enhance patient outcomes in primary care practice.

There is significant gain for both patient and practice in establishing patient clinics in general practice:

- improved patient health outcomes
- enhanced quality of care for patients
- access to additional self-management support
- increased range of services and support – linking in with the community based organisations
- satisfaction for both patient and health professionals
- opportunity for skill enhancement of health professionals
- implementing a proactive approach to health rather than reactive thus reducing the burden on our current health system
- improved efficiency in General Practitioner’s (GP) time dedicated to chronic disease management
- increased access to SIPs and PIP income
- higher utilisation of care plans - GPMP and TCA
- opportunity to develop patient skills and knowledge
- enhanced working relationships within primary care promoting multi-disciplinary approach to care
- generation of additional practice income providing sustainability of roles in general practice and contributing ongoing viability of the practice
- opportunity to evaluate the delivery of patient care and health outcomes.
1. Getting started

• Checklists for a successful clinic
• Additional resources
• Practice team support
Checklists for a successful clinic

**CLINIC FOUNDATION CHECKLIST**

- Decide which communication methods best suit your practice e.g. one-on-one, staff meetings, internal email and memos
- Actively listen to suggestions and concerns of all staff
- Determine the most appropriate time for clinics to be held e.g. day, time, and frequency – weekly, monthly
- Agree on who will be responsible for running the clinic
- Choose whether the clinics will be for groups or individuals
- Discuss and agree on the allocation of protected hours the practice nurse (PN) will dedicate to clinics – ensure the time is scheduled accordingly
- Audit staff skills and knowledge
- Decide what systems need to be put in place e.g. appointments, recalls and reminders
- Develop an action plan with timeframes and allocated responsibilities
- Develop an evaluation process – to measure the impact of the clinic on patient outcomes and service delivery
- Source the allied health professionals (AHP) who will partner in care. Collaborate with AHPs to determine how their services will be included in the clinic plan

**Allied Health Professions Australia (AHPA)**
The AHPA website has valuable information regarding AHPs, their roles in chronic disease management, communication tips, reporting templates and a national directory of allied health professionals.

www.ahpa.com.au

**Practice Health Atlas**
The Practice Health Atlas (PHA) is a decision support and practice planning tool for general practice designed by Adelaide Western GP Network. It encourages general practice teams to reflect on their activities and develop business models for more effective healthcare services and health outcomes. The PHA is based on the analysis of the practice’s current patient population data. Contact Brisbane South PHN for further information.
CLINIC PLANNING CHECKLIST

☐ Clean up patient data e.g. active, inactive, deceased, correct patient details, correctly coded

☐ Find and identify patients

☐ Establish required register for patient e.g. diabetes, asthma, pap smear, immunisation

☐ Create appointment schedule for clinic

☐ Set up recall and reminder system

☐ Register the practice with the Practice Incentive Program for PIP and SIP

☐ Provide relevant training for staff to improve patient outcomes

☐ Develop a library of readily available best practice guidelines

☐ Organise orientation to occupational health and safety practice procedures for external PNs and AHPs involved in clinics

☐ Ensure appropriate templates for care planning and referral are available

☐ Ensure referral pathway information is available e.g. directory of specialists and services

☐ Order required resources e.g. brochures, pamphlets, pharmaceutical samples

☐ Formalise agreement with AHP or contracted PN e.g. memorandum of understanding outlining expectations and obligations of parties involved

☐ Contact eligible patients to inform them the practice is offering clinics and additional services e.g. letter, phone call, poster, brochure, practice newsletter

Pilot your clinic to identify and minimise unforeseen issues – for example, the chosen location for the clinic may not be a suitable environment.

Not sure which referral pathway or template to use?
Go to www.bsphn.org.au for information on referral pathways and templates

Not sure which AHP to include?
Refer to AHPA website ahpa.com.au

Training for practice staff
Register for the BSPHN Bulletin - which is emailed or faxed to your practice fortnightly and advertises upcoming training opportunities and educational events.
Additional resources

Check your practice library for existing resources including:

- Registers, Recalls, Reminders Manual
- RFiles
- Navigating Item Numbers Chart
- Immunisation Manual
- Data extraction tools: PenCAT, Canning Data Extraction Tool and Practice Health Atlas.

Please refer to the Brisbane South PHN Resources in your practice or visit the Brisbane South PHN website at www.bsphn.org.au
Practice team support

Establish staff roles within the practice

The role of the practice nurse
Identify patients to be included on the register
- Operate the register, recall, reminder system
- Recall patients to clinics
- Coordinate care provided within clinic
- Patient education
- Conduct clinic
- Initiate MBS billing
- Inform practice manager, General Practitioners and practice staff of the clinic processes and progress.

The role of the allied health professional
Provide in-service for the practice nurse as required
- Patient education
- Provide advice to the practice as required
- Support the process of establishing the clinic
- Assist in entering patient data into the database – to be approved by practice
- Schedule clinic if appropriate.

The role of the reception staff
- Identify appropriate patients for the clinic
- Promote additional services available – patient clinics
- Schedule patient appointments
- Call and confirm patient appointments
- Complete any additional requests as required.

The role of the General Practitioner
- Refer appropriate patients to the clinic
- Follow up on concerns documented in patient records by AHP or PN
- Practice team support.
2. Systems and data management

• Systems

• Registers

• Clinical audit tools
**Systems**

Appropriate scheduling of session times will depend on the type of clinic being conducted. Consult with the practice nurse or AHP to determine how much time is required per patient e.g. initial assessment may require a longer consultation than a review appointment. Additional time may be needed for non-English speaking patients or complex cases.

**PATIENT APPOINTMENT CHECKLIST**

- Set up separate booking system for clinic patients
- Maintain a balance of new patients and review patients attending the clinic
- Ensure consecutive bookings – patients booked in back to back
- Avoid double bookings
- Regularly check that appointments for new patients are being filled – if not, GPs should be prompted to make referrals to the clinic
- Contact patients e.g. phone call, SMS 24 hours before appointment to remind and confirm them of their clinic appointment to minimise ‘no shows’
- Rebook patients for their next appointment at the end of their clinic appointment
- Ensure all patients that cancel an appointment are given another appointment
- Check appointment list at end of session and contact ‘no shows’ to reschedule appointment

**CLINIC BILLING CHECKLIST**

- Ensure all relevant MBS item numbers are programmed into the billing software
- Ensure reception staff are familiar with the relevant MBS item numbers for the clinic
- Decide how the clinic patients will be billed e.g. bulk billed, gap payment

Please refer to the chronic disease page of our website for more information bsphn.org.au
**Registers**

A register is a list of patients in the practice that contains specific demographic information such as date of birth, address details, gender and clinical information. These registers allow tracking of patients’ clinical information and their need for ongoing care.

The clinical software in your practice enables you to create a register of patients that will be targeted for patient clinics.

The clinical software may have built in registers e.g. diabetes or asthma, or include a search facility to find specific patient groups to include in the register.

An accurate register can only be developed if the data in the practice is managed and well maintained.

**Basic tasks to be undertaken before creating registers:**

- Inactivate deceased patients
- Inactivate patients who no longer attend the practice
- Archive patients with no clinical data.

**To maintain an accurate register:**

- Educate all GPs and staff on appropriate coding – essential data to code
- Encourage all GPs and staff to accurately record data in medical software.

**Data cleansing**

The practice champion will need dedicated time to work on patient data to ensure the data is accurate. A whole of practice approach is required to maintain a clean and accurate database.

- Please refer to your practice library for RFiles, Register, Recalls, Reminders Manual and Data Base Health Check – The ABC of Data Cleaning for more information on managing your data. Educate all GPs and staff on correct use of the recall/reminder system.

**Coding**

Registers are generated using coded diagnosis in patient clinical records.

To ensure an accurate register of patients they need to be correctly coded in the past history.

Refer to Brisbane South PHN/SPHN - RFiles resource for further coding information.
 Clinical audit tools

Appropriate patient care and important practice decisions can be made from the data entered into the patient and practice population record however this requires high quality data.

Clinical audit tools, such as Pen Computer Systems CAT4 and the Canning Data Extraction Tool assist the practice to use patient data in a valuable manner - improve patient management and outcomes.

Clinical audit tools can be used to:

• undertake data cleansing and improve data quality
• assist with chronic disease management
• identify patients at risk
• identify practice income opportunities.

PenCAT4 and the Canning Tool can produce a list of patients, patient registers, and related clinical data to enhance management of patients and ease in measuring outcomes.

Clinical audit tools

Contact Brisbane South PHN for access to and installation of clinical audit tools.

Brisbane South PHN provides the required training.
3. Setting up and implementing the clinic

- Room set-up
- Clinical implementation
Room set-up

ROOM SET-UP CHECKLIST

☐ Room with sufficient space to conduct a practical and confidential assessment

☐ Access to patient records

☐ Telephone for internal communication with GPs and external communication with patients, other health professionals and support organisations

☐ Hand washing facilities

☐ Resource library e.g. patient education material

☐ Access to occupational health and safety practice procedures

☐ Access to general and clinic specific equipment

General equipment:

• Gloves
• Sphygmomanometer
• Stethoscope
• Scales
• Height measurement device
• Measuring tape
• Clinical guidelines
• Patient education and self-management resources.

Diabetes clinic equipment:

• Blood glucose monitoring equipment
• Monofilament
• Specimen collection equipment
• Insulin pens
• Hypo kit.
Immunisation equipment:
- Vaccines
- Needles
- Syringes
- Band-Aids
- Anaphylaxis kit
- Distraction items for children – toys, rewards
- Temperature controlled environment to store vaccines – dedicated vaccine fridge.

Respiratory clinic equipment:
- Spirometer
- Mouth pieces – preferably one way
- Salbutamol – for reversibility testing
- Spacer
- Placebo inhalers.

Don’t forget equipment needs to be maintained and calibrated regularly e.g. scales, spirometer, tag and test all electrical equipment.

Set a reminder in email calendar when equipment is due for servicing.

National Diabetes Service Scheme (NDSS) - outlets can be found at osd.ndss.com.au/search/
Clinic implementation

The running of the clinic may vary depending on the type of clinic conducted.

Clinic implementation checklist

- Obtain history from patient
- Perform clinical measures and/or assessment
- Discuss what the patient would like to set as goals and agree on the assistance and treatment required to achieve goals
- Communicate to GPs the areas that need addressing
- Document your findings in the patient’s notes, together with any action that is taken or planned
- Refer to group-based programs if appropriate, such as the Chronic Disease Self-Management Program or Living Strong
- Provide contact details of relevant organisations to patient for additional support

Patient history

Clinics provide an ideal opportunity to obtain or update a comprehensive family and social history.

This may reveal underlying or contributing issues affecting the patient.

Patient history may include such things as smoking status, alcohol and drug use, immunisation status, allergies, family and social situation.

For clinic and chronic disease resources please visit bsphn.org.au
4. Self-management and prevention

- Patient-centred care
- Patient priorities
- Generic behaviour change pathway
- The Transtheoretical Model
- Setting SMART goals
- Examples of SMART goals
- Prevention
- Not sure which allied health provider to involve in patient care
Patient-centred care

Definition of self-management:

The engagement of individuals in activities and practices that sustain and promote health and wellbeing by:

• making, and/or participating in decisions
• building and sustaining partnerships
• having the capacity (knowledge, resources, confidence) to manage the impact of their health
• monitoring and managing signs and symptoms


By including the patient in decision making regarding their care you are not only acknowledging them and their ideas but facilitate the building of a partnership between the patient, family and health professionals involved in their care.

Ensure there is follow up with support staff about establishing recalls and reminders and that they are aware of your clinic goals.

For further information and training in patient-centred care, please contact our education coordinators at Brisbane South PHN.

Health behaviour change training is available through:

• motivational interviewing
• health coaching
• Flinders and Stanford Model courses
PATIENT-CENTRED CHECKLIST

☐ Have you asked the patient what they would like to change, what is a priority for them?

☐ Have you asked the patient if they would like to receive suggestions from the clinician?

☐ Have you asked the patient what they are capable of managing?

☐ Are you telling the patient what to do? Remind yourself that nobody likes to be told what to do

☐ Does the patient understand the information you have provided e.g. pathology results or diagnosis?

☐ Have you explained the importance of particular behaviour changes?

☐ Have you acknowledged and validated the changes a patient has already made or is maintaining?

☐ Are you both being realistic in your approach to change?

☐ Have you placed a recall or planned a review with the patient to monitor their progress?

☐ Remember one off interventions often don’t work

☐ Have you planned how to capture patients who slip through the cracks?

☐ How are you going to measure improvements in patient outcomes?
  - clinical measures – weight, waist, blood pressure, HbA1c etc
  - survey patient knowledge at baseline and at follow up e.g. three months post intervention
  - subjective data is very important in the measurement of patient outcomes – how does the patient feel when goals are achieved?
Patient priorities

As clinicians our objectives are to meet the needs of our patients, however ‘putting the patient in the picture’ can be a challenge when time is limited and valuable for both yourself and the patient. The patient may not always be prepared or ready to deal with health issues and behaviour change. This is a gentle reminder that when we are dealing with people they like to be heard and understood.

Accepting and acknowledging your patient’s stages of change will positively influence the outcomes for your patient during the clinic. It is important to recognise where the patients priorities lie and to acknowledge that your clinic priorities may not be a priority for the patient. This is the key to building rapport and trust with your patient.

Recognising an individual’s physical, social and emotional needs is fundamental to supporting them on their self-management journey. Remember to ‘put the patient in the picture’ and address their needs and concerns, not just the clinic’s outcomes. Health and behaviour change will only occur in your patients if they are engaged and active participants. The goals need to be patient goals not clinician goals!

There are a number of community and state based agencies available to provide additional support to your patients – please refer to the Tools and Resources section for more information.

Brisbane South PHN provides mental health programs that offer free access to psychologists and support networks.

Contact Brisbane South PHN on 07 3864 7555 for details.
Generic behaviour change pathway

The Transtheoretical Model (Prochaska et al, 1992) identifies five stages of change. The five stages, pre-contemplation, contemplation, preparation, action and maintenance were designed to assess a patient's readiness to change a particular behaviour.

The most appropriate approaches for the health professional to take to support the client is listed in more detail overleaf.

By assessing a patient's readiness to change, you will be better equipped to facilitate the appropriate level of support to your patient.

Further studies have suggested another stage of relapse or repetition (Cassidy, 1999). In any behaviour change, relapse is a common occurrence and should not be viewed as a failure but as part of the change process and an opportunity to learn from the experience.
## The Transtheoretical Model

Stages of change and approaches that are most appropriate at each stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>Explanation of stage</th>
<th>Approach suitable to stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-contemplation</strong></td>
<td>• Stage during which the person does not even consider the need to change</td>
<td>• Reflective listening&lt;br&gt;• Empathy&lt;br&gt;• Effective questioning&lt;br&gt;• Provide objective information in a non-judgmental manner&lt;br&gt;• Explore barriers&lt;br&gt;<em>Action oriented messages are not appropriate at this stage</em></td>
</tr>
<tr>
<td><strong>(not thinking of change)</strong></td>
<td>• Have not had sufficient experience with negative consequences&lt;br&gt;• Tipped towards –negative of change</td>
<td></td>
</tr>
<tr>
<td><strong>Contemplation</strong></td>
<td>• Beginning to seek relevant information&lt;br&gt;• Re-evaluating behaviour&lt;br&gt;• Obtaining help of others to support future attempts</td>
<td>• Reflective listening&lt;br&gt;• Empathy&lt;br&gt;• Effective questioning&lt;br&gt;• Provide objective information in a non-judgmental manner&lt;br&gt;• Encourage person to accept ownership of the problem&lt;br&gt;• Increase awareness of negative consequences&lt;br&gt;• Recognise how situations affect illness</td>
</tr>
<tr>
<td><strong>(thinking of change)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preparation/ Determination</strong></td>
<td>• Ready to take action in the next 30 days&lt;br&gt;• Need to set goals and develop priorities in order to manage their condition&lt;br&gt;• The stage where a person makes a serious commitment to change</td>
<td>• Encouragement&lt;br&gt;• Empathy&lt;br&gt;• Goal setting&lt;br&gt;• Support of self-efficacious behaviour</td>
</tr>
<tr>
<td><strong>(ready for change)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>• Efforts made to modify habits and environment&lt;br&gt;• Increased use of behavioural processes change e.g. removing alcohol&lt;br&gt;• Change begins (this can be large or small changes)</td>
<td>• Encourage stimulus control&lt;br&gt;• Skills training interventions&lt;br&gt;• Encourage support from others</td>
</tr>
<tr>
<td><strong>(changing behaviour)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>• Substituting alternatives for problem behaviours e.g. relaxation&lt;br&gt;• Take responsibility for actions&lt;br&gt;• Susceptible to relapse. Need to remain aware of stimuli that may trigger problem behaviours&lt;br&gt;• Change is sustained over a period of time.</td>
<td>• Do not view relapse as failure, but as a way to gain knowledge of triggers&lt;br&gt;• Increase awareness of environmental and internal stimuli that trigger problem behaviours</td>
</tr>
<tr>
<td><strong>(maintaining change)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Setting SMART goals

In order to achieve your goals, we need to work out the specific steps that you need to take to achieve them. You are more likely to reach your goals, if you make them **SMART** goals:

- **SPECIFIC** - what will you do?
- **MEASURABLE** - how much? how many?
- **ACHIEVABLE** - are you able to do it?
- **REALISTIC** - will you be able to do it? cost/time etc.
- **TIMELY** - is there a timeline? by when?

By building the five components of SMART into goals there is great evidence to suggest you will be more likely to achieve your goals. Now go one step further and ask the patient to rate how confident they feel in achieving their goals on a scale from 1 – 10, where 1 is not very confident and 10 is really confident.

By completing the confidence scale it helps patients decide if what they have set out to do is achievable and realistic.

If a patient rates their confidence as under 4, get them to choose another goal or review the goal and reduce the number of sessions to be more realistic, as their confidence level is not high enough and you will set them up to fail.
Examples of a SMART goal

I will walk around the block every Monday, Wednesday and Friday morning - starting on Monday.

I will aim to have ½ of my dinner plate filled with free vegetables 3 – 4 dinners per week, starting tomorrow.

When will we review these goals?

Encourage the patient to write their goals on the Action Plan themselves during the clinic session – this creates greater ownership of the goals and actions.

Encourage the patient to write their achievements, no matter how little, and review progress at the follow up session.

Finish each consultation by asking the patient the three key points to take home from the session e.g. ‘what are the three things you are going to concentrate on until our next session?’
Prevention

Have you thought about how your practice could further enhance your preventive approach to healthcare?

How often do you screen your patients?

Utilising the specific health checks is a great way of screening patients and facilitates a preventive approach. There are a number of disease, age and gender specific health checks to assist in the identification, diagnosis and management of specific conditions of individual patients.

PREVENTION CHECKLIST

☐ Identify eligible patients as they present to the practice

☐ Advertise availability of relevant health checks and services on offer to patients e.g. posters and pamphlets in waiting room, or mail out

☐ Search clinical database for eligible patients

☐ Contact identified patients

Additional support services and organisations can be located in the My Community directory mycommunitydirectory.com.au
Not sure which allied health professional to involve in patient care?

Please refer to Allied Health Professions Australia Chronic Disease Management under the chronic disease tab at bsphn.org.au

Find a....

- Physiotherapist physiotherapy.asn.au/
- Dietitian daa.asn.au/
- Podiatrist apodc.com.au/
- Credentialed diabetes educators adea.com.au/
- Exercise physiologist essa.org.au/
- Psychologist psychology.org.au/
- Audiologist audiology.asn.au/
- Dentist ada.org.au/
- Indigenous health healthinfonet.ecu.edu.au/
- AHAP email: closingthegap@bsphn.org.au

Have you linked in with other community based organisations for support?

- 10 000 Steps – 10000steps.org.au/
- Endomondo application – Endomondo is a sports community, based on free real-time GPS tracking of running, cycling, etc. Bring your mobile on the track and get a complete training log endomondo.com/download/

Please refer to the tools and resources section for full list of support organisations.
5. Evaluation

• Evaluation

• Patient feedback form

• Evaluation for clinic sustainability
Evaluation

How often do you stop and wonder how well a clinic or group of patients is really doing, yet don’t have the data to tell you?

There are a number of ways to evaluate clinics

Quantitative data
Monitor objective clinical data such as HbA1c, weight, blood pressure, hospital admission rates. These items can be readily accessed and put into meaningful data tables using any of the data tools such as PenCAT4 or Practice Health Atlas (PHA).

Qualitative data
Captures what patients have learned and changed in their day to day living to improve their health outcomes and self-management capacity.

There are a number of validated tools available on the internet that can be used to survey patients prior to any intervention point. ie: (education at clinic) and following interventions. This allows you to gauge the effectiveness of the clinic and is a great way to obtain valuable patient feedback.

There is a sample survey on the following page.

Why evaluate?
Completing regular evaluation and surveying of your patients allows you to see where you could further improve your services and highlight what is working well. Ensure that you complete the evaluation process and communicate the outcomes, good and bad, to your patients and the practice staff – this way all involved feel more valued and willing to participate in future surveys.

EVALUATION CHECKLIST

☐ Identify the need for collecting data specific to your clinic

☐ Decide on data to be collected (quantitative versus qualitative) and what tool will be used

☐ Decide how often to collect data

☐ Decide how the data will be used e.g. patient feedback, practice improvement, identify area of need, justify ongoing need and benefit of clinic

For assistance with data extraction call Brisbane South PHN on 1300 467 265 to arrange access and installation of PenCAT or the Practice Health Atlas.
Examples of a Patient feedback form and Evaluation for clinic sustainability are provided below:

Patient feedback form

To assist in providing a better service we would greatly appreciate your feedback about your experience with your dietitian.

Please tick the most appropriate response below.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have noticed that my daily blood sugar readings have improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having MULTIPLE sessions with the dietitian was beneficial to my overall health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The education provided met my health needs (e.g. low GI principles, ideal plate portions etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt that my needs were addressed during our sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. How many serves of fruit do you eat each day? A serve is defined below in the box:

   1 Medium piece (e.g. apple) = 2 small pieces (e.g. apricots) = 1 cup chopped or canned fruit

2. How many serves of vegetables or salad do you eat each day? A serve is defined below in the box:

   ½ cup cooked vegetable or cooked legumes = 1 medium potato = 1 cup salad vegetables

3. How many minutes of planned exercise do you complete each week?

4. Any other comments?

5. Evaluation
Evaluation for clinic sustainability

Please enter the information below:

Type of clinic established: .................................................................

Date: / /

Time period since clinic commencement:
☐ 1 month  ☐ 6 months  ☐ 12 months  ☐ 18 months

Does your practice still have a nurse-led or allied health professional led clinic?
☐ Yes  ☐ No, reason for ceasing?

If yes, how often is the clinic held?
☐ Weekly  ☐ Monthly  ☐ Fortnightly  ☐ Other

Number of hours spent conducting/coordinating clinics: ........................................

Clinic format:
☐ Individual  ☐ Group  ☐ Acute (e.g. immunisation clinic)
☐ Chronic disease  ☐ Clinic prevention

Compliance in %: ..........%

Attendance: ...............................................................

Did not attend (DNA): ...............................................................

Cancelled: ...............................................................

New: ...............................................................

Review: ...............................................................

Who is responsible for coordinating the clinic?
  e.g. patient booking
  ☐ Practice nurse  ☐ GP  ☐ Reception staff  ☐ Allied health professional

Who is responsible for conducting the clinic?
  e.g. seeing patients
  ☐ Practice nurse  ☐ GP  ☐ Allied health professional
1. What are the successes of the clinic? 
   *e.g. supportive management, confident up-skilled nurse.*

   .........................................................................................................................................................
   .........................................................................................................................................................
   .........................................................................................................................................................

2. What were the barriers experienced in conducting a clinic? 
   *e.g. nurse time not protected, other priorities within the practice, staff not confident.*

   .........................................................................................................................................................
   .........................................................................................................................................................
   .........................................................................................................................................................

3. What patient management and care improved in the practice since having the clinic?

   .........................................................................................................................................................
   .........................................................................................................................................................
   .........................................................................................................................................................

4. How have you measured outcomes of the clinic from quantitative and qualitative perspective? 

   .........................................................................................................................................................
   .........................................................................................................................................................
   .........................................................................................................................................................

5. How often have you collected this data?

   .........................................................................................................................................................
   .........................................................................................................................................................

6. What changes could you make to the running of your clinic using the outcomes of this data?

   .........................................................................................................................................................
   .........................................................................................................................................................
   .........................................................................................................................................................

7. When will you next collect data?

   .........................................................................................................................................................

---

**Collect both subjective and objective data.**

Data extraction tools exist to measure data – PenCAT4.

Remember to provide patients and staff with feedback about the progress of clinic outcomes 
   *e.g. newsletter, display in waiting room, presentation at staff meeting.*
6. Tools and resources

- Resources
- Action plan for anaphylaxis
- Vaccination clinics
- Free nutrition resources
- Mini nutritional assessment
- Eating awareness record
- The hunger score
- Healthy shopping list
- Ideal plate
- Snacks and mid-meal ideas
- Sharing healthcare
- To change or not to change
- Personal goal and action plan
Resources

We have put together a list of tools and resources to assist you with your clinics. If you would like further information or assistance with these tools and resources, please don’t hesitate to contact Brisbane South PHN on 1300 467 265.

1. **Action plan for anaphylaxis**  
   (Page 40)

2. **Vaccination clinics**  
   A checklist to support your practice.  
   (Page 41)

3. **Free nutrition resources**  
   E.g. The Australian Dietary Guidelines, facts on fat etc. These resources can be ordered and delivered free of charge. Further details visit www.eatforhealth.gov.au.  
   (Page 43)

4. **Eating awareness record and hunger score**  
   Includes behaviour measures to assist patients in recognising why they are eating in the first place i.e. out of physical hunger or due to boredom, habit, and emotion (stressed/sad etc.). The Hunger Score helps patients identify how to limit over eating and tuning into satiety cues.  
   (Page 45 and 46)

---

**Mini nutritional Assessment (MNA)**  
For patients aged over 65 years to identify those at risk of malnutrition. e.g. you may have noticed rapid or gradual weight loss in patients frequenting your practice. Further details visit: www.mna-elderly.com/forms/mna_guide_english_sf.pdf.  
(Page 44)
5. **Healthy shopping guide**
Provides a summary of each section of the supermarket, highlighting what macronutrients patients should worry about for what product. There is also a label reading guide on this resource to assist patients in making healthier choices. *(Page 47 and 48)*

6. **Ideal plate**
This pictorial representation depicts what you want patients dinner plates to look like. Encourage patients to adopt the three sides of the plate at lunch and dinner to assist in meeting their vegetable requirements. On the reverse side, each side of the plate is summerised into protein, starchy foods, free foods and dressing ideas. *(Page 49 and 50)*

7. **Snack and mid-meal ideas**
A quick summary of snack ideas, broken into food groups. *(Page 51)*

8. **RACGP Sharing Health Care and Chronic Condition Self-Management Guidelines**
A desktop guide for nurses and allied health professionals. *(Page 52 and 53)*

9. **To change or not to change questionnaire**
To change or not to change identifies reasons “for and against” change. *(Page 54)*

10. **Personal goal and action plan**
A take home action plan for patients to keep them focused on personal goals. *(Page 55)*
ACTION PLAN FOR Allergic Reactions

Name: 
Date of birth: 

Photo

Confirmed allergens: 

Family/emergency contact name(s):

Work Ph: 
Home Ph: 
Mobile Ph: 

Plan prepared by: 
Dr: 
Signed: 
Date: 

MILD TO MODERATE ALLERGIC REACTION

• Swelling of lips, face, eyes 
• Hives or welts 
• Tingling mouth 
• Abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

ACTION

• For insect allergy, flick out sting if visible. Do not remove ticks.
• Stay with person and call for help
• Give medications (if prescribed) ..................................................
  Dose: ..........................................................
• Phone family/emergency contact

Mild to moderate allergic reactions may or may not precede anaphylaxis

Watch for any one of the following signs of Anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

• Difficult/noisy breathing 
• Swelling of tongue 
• Swelling/tightness in throat 
• Difficulty talking and/or hoarse voice 
• Wheeze or persistent cough 
• Persistent dizziness or collapse 
• Pale and floppy (young children)

ACTION

1. Lay person flat. Do not allow them to stand or walk.
   If breathing is difficult allow them to sit.
2. Phone ambulance - 000 (AU), 111 (NZ), 112 (mobile)
3. Phone family/emergency contact
4. Commence CPR if there are no signs of life

Additional information

Note: This is a medical document that can only be completed and signed by the patient’s treating medical doctor and cannot be altered without their permission.

This information has been reproduced from the ASCIA website www.allergy.org.au with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA), the peak professional body of clinical immunology and allergy specialists in Australia and New Zealand. Please check the ASCIA website for the latest version of this information as ASCIA resources are regularly reviewed and updated.
Vaccination Clinic Checklist
to support your practice

Hold a practice meeting to:
- Appoint team leaders
- Have the numbers of eligible and ‘at risk’ clients available
- Decide if dedicated vaccination clinics will be:
  - Nurse only clinic
  - GP and nurse clinic
  - GP only clinic
- Examine staffing capacity - may need extra nursing staff
- Plan and schedule the clinics (e.g. am/pm/Sat am clinics)
- Discuss how to promote clinics to patients
- Discuss vaccine ordering for funded patients
- Decide the best way to deal with private patients and the cold chain management of their pharmacy
- Plan vaccination of staff
- Make staff aware of your infection control policy, including hand hygiene, cough etiquette and social distancing

Search for the number of eligible patients
- Use medical software and clinical audit tools to search for eligible patients
- Download and collate data utilising this opportunity to data cleanse (e.g. inactive and deceased patients)

Promotion to patients may include:
- Mail out to eligible patients/clients
- Waiting room posters
- Telling patients about vaccination when they ring for appointments
- Pre-recorded message on practice phone
- Practice newsletter

Staffing and space
- Consider increasing nursing hours over the flu season for efficient running of nurse led flu clinics
- Based on staffing arrangements, space may be an issue, revise roster and room allocation

Bookings
- Set up 10-minute appointments in medical software and ensure signage and all promotional material advises patients that their clinic appointment is for vaccination only

Ordering and cold chain management
- Order vaccines regularly
- Ensure staff are familiar with cold chain management procedures and necessary checks are completed
Risk management

- Check if Anaphylaxis Response Kit contents including adrenaline, is unexpired. Additional ampoules of Adrenaline 1:1000 should be available
- Revise emergency procedures with all staff

Medicare Australia – MBS item numbers

- Ensure all staff are aware of the billing arrangements for private patients attending the clinics
- MBS items cannot be claimed for workplace vaccination programs

Run clinics

- Commence clinics and review systems at next scheduled practice meeting
- Document all vaccinations given in practice software immunisation tab

Resources

- Use websites, NCIRS fact sheets for staff training, Standing Drug Orders
- Consent procedures (use the Consent Resource Folder from the Immunisation Section, Department of Health SA to streamline the consent process)
- Provide an Immunisation commonly observed reactions sheet from the tear off pads resource available on Immunisation Australia website to patients post vaccination.
  Advise them to wait for 15 minutes following vaccination (The Australian Immunisation Handbook). The NHMRC recommends clients should also be warned of the risk of driving for at least 30 minutes following vaccination
- Have adequate supplies of tissues, antibacterial hand lotion, masks and gloves

Useful websites

- Immunise Australia Program

- Queensland Health Immunisation Schedule

- Department of Health South Australia – Immunisation calculator

- For recommended doses of vaccine refer to the current edition of
  The Australian Immunisation Handbook
## Free nutrition resources

<table>
<thead>
<tr>
<th>Brochures</th>
<th>Publisher</th>
<th>Resource information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shape Up Australia</td>
<td>Australian Government</td>
<td><a href="http://www.shapeup.gov.au">www.shapeup.gov.au</a></td>
</tr>
</tbody>
</table>
| Australian Guide to Healthy Eating             | Department of Health             | 1800 300 113  
health@nationalmailing.com.au                |
| How do you measure up?                         | Department of Health             | 02 6214 1224                                   |
| The Right Mix  
Your Health and Alcohol                    | Department of Veterans’ Affairs   | 13 32 254                                     |
| Heart Foundation  
Various items / resources                    | Heart Foundation                 | 1300 362 787  
www.heartfoundation.org.au                    |
| Dietitians Association of Australia            | DAA                              | 02 6163 5200  
nationaloffice@daa.asn.au                    |
| Kids Good Health Cook Book  
Good Health Recipe Book 2                      | Dairy Australia                  | 1800 655 441  
| Recipes, tips, menu planner                    | Healthy Food Guide               | www.healthyfoodguide.com.au                   |
## Mini Nutritional Assessment (MNA)®

### Screening

<table>
<thead>
<tr>
<th>A</th>
<th>Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>severe decrease in food intake</td>
</tr>
<tr>
<td>1</td>
<td>moderate decrease in food intake</td>
</tr>
<tr>
<td>2</td>
<td>no decrease in food intake</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Weight loss during the last 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>weight loss greater than 3 kg (6.0 lbs)</td>
</tr>
<tr>
<td>1</td>
<td>does not know</td>
</tr>
<tr>
<td>2</td>
<td>weight loss between 1 and 3 kg (2.2 and 6.6 lbs)</td>
</tr>
<tr>
<td>3</td>
<td>no weight loss</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>bed or chair bound</td>
</tr>
<tr>
<td>1</td>
<td>able to get out of bed / chair but does not go out</td>
</tr>
<tr>
<td>2</td>
<td>goes out</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Has suffered psychological stress or acute disease in the past 3 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>Neuropsychological problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>severe dementia or depression</td>
</tr>
<tr>
<td>1</td>
<td>mild dementia</td>
</tr>
<tr>
<td>2</td>
<td>no psychological problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F1</th>
<th>Body Mass Index (BMI) (weight in kg) / (height in m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>BMI less than 19</td>
</tr>
<tr>
<td>1</td>
<td>BMI 19 to less than 21</td>
</tr>
<tr>
<td>2</td>
<td>BMI 21 to less than 23</td>
</tr>
<tr>
<td>3</td>
<td>BMI 23 or greater</td>
</tr>
</tbody>
</table>

**F2** Call circumference (CC) in cm

| 0 | CC less than 31  |
| 3 | CC 31 or greater  |

### Screening score (max. 14 points)

0-7 points: Malnourished

8-11 points: At risk of malnutrition

12-14 points: Normal nutritional status

---


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For more information: www.mna-elderly.com
<table>
<thead>
<tr>
<th>Time</th>
<th>With whom and / or where</th>
<th>Thoughts feelings before eating</th>
<th>Hunger/fullness before eating (See Scale 0 - 10)</th>
<th>Food / Drink eaten</th>
<th>Hunger/fullness before eating (See Scale 0 - 10)</th>
<th>Do you feel satisfied? If not, is there a food that would have satisfied you?</th>
<th>Speed of eating (e.g. slow, moderate, fast)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Activity:**

**Hunger / Fullness scale:**

10 Stuffed Full
8 Overfull
5 Full
2 Getting empty
0 Absolutely empty
The Hunger Score

Dr Rick Kausman, author of “If Not Dieting, Then What?”, suggests using a hunger and fullness scale to be more aware of our hunger and fullness signals.

A score of 0 means that you are extremely hungry, you might feel like this if you have missed a meal or not eaten for several hours. A score of 10 means you are not hungry at all, you might feel like this after eating a large meal.

Using this scale, what would you say your hunger score is right now?

• If you give yourself a score of 1 or 2 then you are starving hungry, do take care if you feel like this, try to pace your eating so you don’t have too much. When you feel this hungry you have less patience for preparing or cooking food, and so are more likely to choose something that offers a quick but not necessarily a healthy fix. Where possible try to avoid arriving this far on the hunger scale.

• Most people choose a score around 3 or an 4 when they want to eat something and

• If you choose a figure on the scale of 6 or above you aren’t really hungry enough to eat, instead have a think about what might have prompted you to eat.

Practice using the hunger scale every time you feel like eating and try to be honest with yourself.

THE STAGES OF HUNGER

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>You are weak with hunger, you haven’t eaten for a long time.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>You are still at risk of overeating once you start.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>This is the ideal stage to eat.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Only a few more bites needed.</td>
</tr>
<tr>
<td>Stage 6</td>
<td>You have eaten just the right amount.</td>
</tr>
<tr>
<td>Stage 7</td>
<td>The last few bites were unnecessary, you could have eaten less.</td>
</tr>
<tr>
<td>Stage 10</td>
<td>Your insides are crammed full to the point of bursting. You experience pain rather than discomfort.</td>
</tr>
</tbody>
</table>
Healthy Shopping Guide

GROCERIES

CANNED FRUIT
In natural juice

CEREALS
• Aim for 6g fibre/100g
• Low fat under 10g/100g
• Sugar under 15g/100g such as: All Bran®, Weet Bix Hi-Bran®, and oats

CONDIMENTS
• Pickles, relish, chutney, jam, fruit conserves
• Crackers, biscuits, breads and cereals:
  ✓ under 10g total fat/100g,
  ✓ under 15g sugar/100g,
  ✓ less salt under 400mg
  e.g. Vita Weats®, rice crackers

DRIED FRUIT
• In moderation
• 1½ Tbsp = 1 serve

DRINKS
Choose water, diet varieties/soda/mineral water, coffee, tea, green/herbal tea and Milo®

EGGS
Free range, omega-3 enriched

HERBS
Fresh or dried/ground

FLOUR
Choose wholemeal varieties

NUTS
• In moderation – unsalted, unroasted, mixed variety
• 1 serve = 12 nuts or 30g

FISH
• Fresh and tinned varieties, in spring water

PASTA AND NOODLES
• Choose wholegrain varieties
• Check fat on noodles
• ½ cup cooked = 1 serve

RICE
• Basmati, Doongara, classic
• ½ cup cooked = 1 serve

SALT
Choose iodised salt, however limit use. Regardless of the type SALT is SALT

SAUCES
Preferably tomato/vegetable based, avoid cream/cheese/oil, and choose salt-reduced varieties

STOCK
Choose salt reduced varieties

TINNED VEGETABLES
All types, look for salt-reduced tomato, corn, baked beans, lentils, kidney beans, chickpeas, etc

EVAPORATED MILK
Use in place of cream and coconut milk in creamy dishes e.g. Carnation Light & Creamy®

FREEZER or FRIDGE

FROZEN FISH
No crumb, check % of fish on ingredients list (the higher the % the better)

FROZEN VEGETABLES
All types
• Healthy Choice® oven baked sweet potato chips
• Frozen fruit
• Low fat frozen yoghurt and low fat ice cream
• Pastry: Choose filo or reduced fat varieties

BAKERY

Aim for:
• 6g fibre/100g
• Less than 10g total fat
• Less than 15g/100g sugar
• Wholegrain varieties

Grain and seed bread varieties, rye, heavy breads, sourdough etc
• Fruit loaf
• Wholegrain English muffins
• Wraps and flat bread
• Pizza bases
• Pikelets
**THE IDEAL PLATE**

- Ensure you have balanced meals
- inclusive of 5 food groups
- Limit confectionery and takeaways to once per week treats

**For dairy products look for:**
- Total fat under 3g/100g
- Saturated fat under 1.5g/100g

---

**Quick guide to label reading**

<table>
<thead>
<tr>
<th></th>
<th>Good Choice (per 100g)</th>
<th>Excellent Choice (per 100g)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fat</td>
<td>less than 10 g</td>
<td>less than 3 g</td>
</tr>
<tr>
<td>-saturated Fat</td>
<td>less than 3 g</td>
<td>less than 1.5 g</td>
</tr>
<tr>
<td>Sugar</td>
<td>less than 15 g</td>
<td>less than 10 g</td>
</tr>
<tr>
<td>Sodium</td>
<td>less than 400 mg</td>
<td>less than 120 mg</td>
</tr>
<tr>
<td>Fibre</td>
<td>more than 3 g</td>
<td>more than 6 g</td>
</tr>
</tbody>
</table>

---

**This is a generic guide to healthy shopping, if you suffer from a particular illness, please consult your Dietitian**

---

**VEGETABLES**

- All fresh vegetables (include a variety of colours) 5 serves per day
- Limit starchy vegetables like potato to 1 serve and fill up on greens/salad vegetables
- 1 serve = ½ cup cooked vegetables
  OR 1 cup of salad vegetables

**MEAT AND SEAFOOD**

Limit deli varieties
No visible fat (white bits) such as pastrami
These are the best choices:
- Lean ham
- Silverside
- Roast meats
- Short cut bacon
- Heart smart, lean mince and meat varieties
  (avoid fat, skin, marbling)
- Skinless poultry
- All fresh seafood and fish varieties

**DAIRY**

- Low fat cheese
  Ricotta, cottage, low fat cream cheese,
  Bega Super Light® slices, Kraft Live Free®
- Other cheese
  All high fat, use in moderation only or use
  small amounts of flavoursome cheeses like
  parmesan or pecorino
- Yoghurt/natural yoghurt
  Use instead of sour cream, look for no fat,
  diet or reduced-fat natural varieties.
- Diet dairy desserts
  Low fat custard, Fruche® etc
- Margarines/spreads
  Look for less saturated fat and trans fat,
  choose Olive Grove®, canola, Nuttelex®,
  use in small amounts
- Milk
  Light or skim, UHT varieties are cheaper,
  low fat soy fortified with calcium, or
  buttermilk

---

Adopted from Elliott & Coleman, NWQPHC 2007

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PO Box 6435, Upper Mt Gravatt Q 4122  T: 07 3390 2466  F: 07 3330 2399  or 1300 467 265

www.bsphn.org.au

Adopted from Elliott & Coleman, NWQPHC 2007
The ideal plate

Remember to enjoy your meal

- Salad or Free Vegetables
- Protein Foods
- Low GI Carbs
- 1 tbsp low fat dressing or sauce

An Australian Government Initiative
The ideal plate

Protein Foods
- Lean red meat • Poultry • Fish • Egg • Tofu
- Legumes - soy beans, baked beans, lentils, chickpeas etc.

Low GI Carbohydrates
- Sweet Potato • Peas • Corn • Basmati or Doongara Rice
- Pasta / Rice Noodles • Multigrain Bread
This segment may also contain occasional amounts of new potatoes, pita bread, parsnip, pumpkin or beetroot, being medium GI carbs.

Salad and Free Vegetables
- Alfalfa • Artichoke • Asparagus • Bamboo Shoots • Beans (green)
- Bean Sprouts • Broccoli • Brussel Sprouts • Cabbage • Capsicum
- Carrots • Lettuce • Marrow • Mushrooms • Onions • Radish
- Rhubarb • Rocket • Shallots • Silverbeet • Spinach • Spring Onion
- Squash • Swede • Tomatoes • Turnips • Watercress
- Water Chestnut • Zucchini

Low Fat Sauce / Dressing
- Commercial low fat dressings or those based on fruit juice or low fat mayonnaise • Skim milk sauces • Low fat Gravox® mixes • Apple
- Honey Soy • Oyster • Mint • Plum • BBQ • Tomato
- Soy Hoisin • Teriyaki • Worcestershire • Chili
- Sweet Chili • Black Bean
- Life Cheese Sauces
Snack and mid-meal ideas

Breads and cereals
- High fibre breakfast cereal with low fat milk
- Untoasted muesli
- Raisin/fruit toast or muffin
- Toasted crumpet or wholemeal muffin
- Toast with grated low fat cheese
- ½ toasted sandwich filled with creamed corn, low fat cheese, baked beans etc.
- Low fat crackers (Vita-Weat®, multigrain Salada®, Ryvita®)
- Plain sweet biscuit (Shredded Wheatmeal®, Highland Oatmeal®)
- Fruit biscuits (Snack Right®, Rich Tea® Biscuits)
- Scones (no cream, ideally wholemeal)
- Pikelets (ideally wholemeal)
- Low fat, high fibre homemade muffin
- Air popped popcorn (no salt)
- Pita chips (homemade)
- Rice paper rolls
- Creamed rice
- Wrap or flat bread
- Rice cakes or corn thins

Dairy and alternatives
- Milkshake on low fat milk
- Smoothie on low fat milk
- Low fat yoghurt - try adding fruit or muesli
- Low fat custard - try adding fruit
- Low fat cheese / cottage cheese
- Low fat milk iceblocks
- Low fat milk with Milo®
- Fruche

Spreads and others
- Low fat cheese
- Hommous
- Beetroot dip
- Tzatziki
- Salsa
- Chutney
- Peanut butter (not too much)
- Tuna
- 100% fruit spread or diet jam
- Cottage cheese
- Boiled egg

Fruit and vegetables
- Fresh fruit, fruit salad, frozen fruit
- Canned fruit in natural juice
- Stewed fruit
- Dried fruit and nut mix
- Vegie sticks (carrot, celery, capsicum) and dip
- Vegetable soup
- Corn on the cob
- Fresh fruit smoothie
- Fruit and low fat yoghurt
- Cold Cooked potato (lower GI if cold
- Vegetable fritters / zucchini slice

Takeaway snacks
- Sandwich (plain or toasted)
- Small plain hamburger with extra salad, (no margarine)
- Baked potato (no sour cream, low fat cheese)
- Salad (look out for the dressing)
# Sharing Health Care Sample Care Plan

**Patient Name:**

**Existing Care Plan Y/N:**

**Care Plan review Date:**

**Authority to proceed with care plan:** My GP has explained the purpose of the care plan and I give my permission to prepare a care plan and discuss my medical history and diagnosis with the members of a multidisciplinary team. I do not request specific medical or other information to be withheld from other participants (noted in GP notes). I am aware that there is a fee for the preparation of this care plan and a Medicare rebate will be payable.

**Patient Signature:**

---

## Things that affect my health

**Impact of Illness** (Feelings, ideas function, expectations)
- Difficulty getting around (mobility)
- Difficulty with gardening and golf
- Unhappiness because he is feeling isolated and not very mobile

**Symptoms of Illness** (e.g. pain, shortness of breath, objective measures)
- Shortness of breath (dyspnoea)
- Asthma as per symptom diary
- Pain (generalised) and acute in left hip
- Overweight
- Tiredness

**Lifestyle factors** (diet/nutrition, weight, smoking, stress, physical activity)
- Smoker
- Reduced physical activity due to pain and tiredness
- Reduced awareness of healthy eating habits

**Capacity to self-manage** (e.g. self-efficacy, motivation, knowledge, health beliefs)
-acks confidence
- Motivated and family supportive (non-smokers)
- Knowledge of symptom action plan (or asthma

## My goals

- To be able to play nine holes of golf within two months
- Maintain watering and weeding of front garden and potplants
- Visit grandchildren weekly

- To be able to walk for 30 minutes without shortness of breath within next month
- Use medications as indicated on asthma symptom action plan
- Reduce pain in left hip to an average of 2/10 in one month
- Reduce weight by 2kg in one month
- Maintain BP and BSL within normal limits (monitor IGT)

- Stop smoking in one month
- Physical activity (walking) for 15-30 minutes per day, 3-5 days a week within one month

- To be able to take one day at a time
- To improve my confidence in meeting the necessary lifestyle changes

## What can I do to improve my health?

- Cease smoking
- Attend social functions at golf club
- Garden within pain and fatigue limits 3-5 times a week

- Cease smoking
- Refer to physiotherapist
- Refer to community walking/exercise group
- Refer to dietician for weight loss and healthy diet information
- GP/nurse to monitor BP and BSL 3 monthly
- Provide information related to diabetes, diet, and physical activity

- Walk to beach 3-5 times a week
- Nicotine replacement therapy
- Monthly GP support

## Who can do this?

- Client
- Client
- GP nurse, client

- Client
- GP nurse
- Physiotherapist
- GP nurse/physiotherapist/community exercise group
- GP nurse
- Dietician

- Client
- Client
- GP

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6. Tools and resources
To change or not to change 
making a decision one way or the other...

Making a lifestyle change involves making tradeoffs and this can put us in two minds about whether or not to even try to change. Exploring these tradeoffs can help you to make up your mind. The questions below can help you to make a decision, one way or the other. In the end, it is your choice entirely.

**What is the decision that you are contemplating?**

I am considering whether or not to ..............................................................
......................................................................................................................................................
......................................................................................................................................................

1. There are good reasons why you are currently doing what you are doing. For example, it usually takes less time and effort to keep things as they are. What would the good things be about not making any changes at all?
........................................................................       ........................................................................
........................................................................       ........................................................................
........................................................................       ........................................................................

2. If you don’t make any changes at all and keep on doing what you are already doing, what will happen in the long term? How will this impact on your life?
........................................................................       ........................................................................
........................................................................       ........................................................................
........................................................................       ........................................................................

3. If you do make some changes to your lifestyle, small ones at first, then gradually adding to these over time, what benefits do you think you would gain? How would your life be different? How would it impact on the things or people that are important to you?
.......................................................................       ........................................................................
........................................................................       ........................................................................
........................................................................       ........................................................................

4. There can be a downside to making lifestyle changes too. What would be not so good about making the changes you are thinking about making? How might you be able to make it easier on yourself to make these changes?
.......................................................................       ........................................................................
........................................................................       ........................................................................
........................................................................       ........................................................................

5. Does this help you to make a decision one way or the other? □ Yes □ No
Personal goal and action plan

Personal goal ............................................................................................................................................................

For the personal goal, write in one or two sentences: What actions are you going to take? How often? When will you start? When will you review your progress to see if you need to change this goal?

Action plan

• Write down all the things that you will need to do in order to achieve your personal goal.
• How will you remember to do these things?
• What might get in the way of achieving your personal goal? What can you do to avoid this?
• What is your back-up plan if some of your strategies do not work?
• How do you need to be thinking to maximise your chances of doing what you plan to do?
• What do you need to do to increase your confidence in achieving your personal goal to at least 7 out of 10?
• Who or what else can support your efforts?

Fill in only as many steps as you need. Tick when achieved

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How much do you want to achieve this personal goal?
(not at all) 1 2 3 4 5 6 7 8 9 10 (very much)

How confident are you that you will achieve this personal goal?
(not at all confident) 1 2 3 4 5 6 7 8 9 10 (very confident)

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