Continuous Quality Improvement

WORKBOOK FOR GENERAL PRACTICE

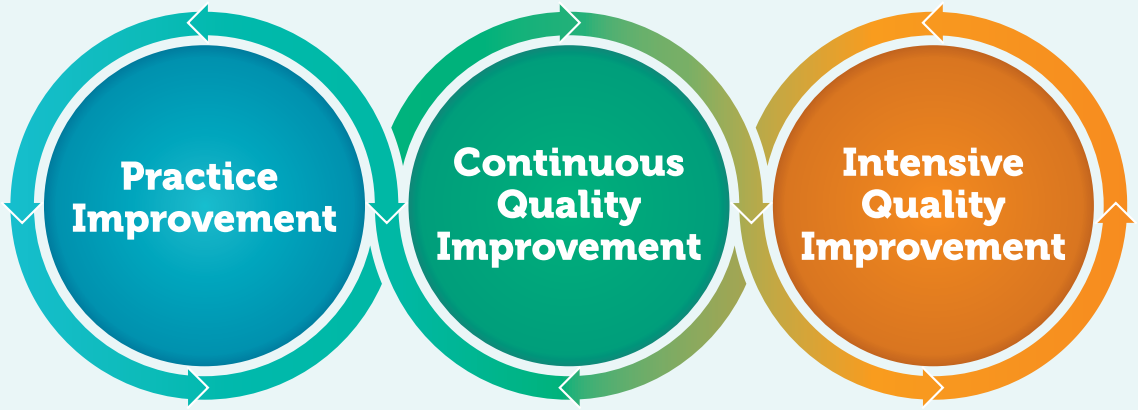
Caring for carers in general practice

EDITION 1 | DECEMBER 2020

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

A new model for general practice improvement

Our aim is to strengthen primary care to deliver integrated person-centred care that is comprehensive, accessible, safe and coordinated. Our new model has three modules of engagement. Your level of engagement will depend on your needs.



Focused on developing systems for quality improvement.

Focused on data-driven improvement. For accredited practices that share data and are new to quality improvement, or confident to implement quality improvement at their own pace.

A time-limited intensive facilitated quality improvement project for practices who want to further improve patient, clinical and whole of practice outcomes.

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Acknowledgements
North Western Melbourne PHN acknowledges the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

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The Carer Awareness in General Practice project developed education to improve recognition of the carer role and provide guidance for GPs to identify and support patients who are carers. The content was developed with input from GPs, carers, and Carers Victoria. We acknowledge and thank the Victorian Department of Health and Human Services, Carers Victoria and Northern Sydney Local Health District as key sources for the education.

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Contents

From little things, big things grow

This workbook will show you how to do the 'little' things on the way to achieving the 'big'.

This workbook will show you how to do the 'little' things on the way to achieving the 'big'.

It's a clear, four-step guide that draws on a proven approach, the Model for Improvement, with expert advice, activities and resources specific to carers.

The four steps are:

Step 1: Understand carers

Step 2: Analyse data, set goals and brainstorm potential improvements

Step 3: Create a plan and act on it, following the 'plan, do, study, act' cycle

Step 4: Evaluate and celebrate

These steps are complemented by links to resources and a comprehensive set of Appendices (p.41) covering:

- quality improvement and RACGP Standards (5th ed.)
- sample goals
- clinical software guides
- 'Plan, do, study, act' worksheet sample and template

Using the Model for Improvement, you'll learn how to start small with your changes. Then systematically review, refine and re-test your ideas as necessary before broader implementation. You'll find samples in Appendix 8 and a template for this system in Appendix 9.

It's a low-risk, high-return approach, and you'll have solid data to prove your achievements. But be warned — it's likely the process won't end there for your practice. Quality improvement can be a hard habit to shake.

Quality improvement (QI) workbooks

This workbook is part of a collection created by North Western Melbourne Primary Health Network (NWMPHN) to help general practices undertake self-directed quality improvement in a particular area of work, type of clinical practice or population group.

The workbooks have been created **by** general practice, **for** general practice, with input from NWMPHN teams and subject-matter experts, and through consultation with the community and the broader primary care sector.

They are designed to meet the particular needs of providers, patients and priority populations in the NWMPHN area. Links to appropriate local referral pathways are also included.

See a full list of QI workbooks on the NWMPHN website.

Before you start

The workbooks are designed to supplement the Quality Improvement Guide and Tools, **which we recommend reading first**. We've also included a primer below about the Model for Improvement (MFI), to refer back to while using the workbook.

About this workbook

This workbook is created as an interactive PDF. You can complete the tables in the book for your Priority 1 activity. Templates in the Appendix can be used for subsequent Priorities.

To complete this workbook, you will ideally use Adobe Acrobat or a similar compatible program to fill out the forms. If you add more content than what will fit in the text box, the text box will allow scroll for additional content to be added. Additional text will be shown with a + on the bottom of the panel. Please note that this additional content will not appear, however, if you print the document.

Your answers use only simple text formatting. You can paste into the text areas.

The Model for Improvement (MFI)

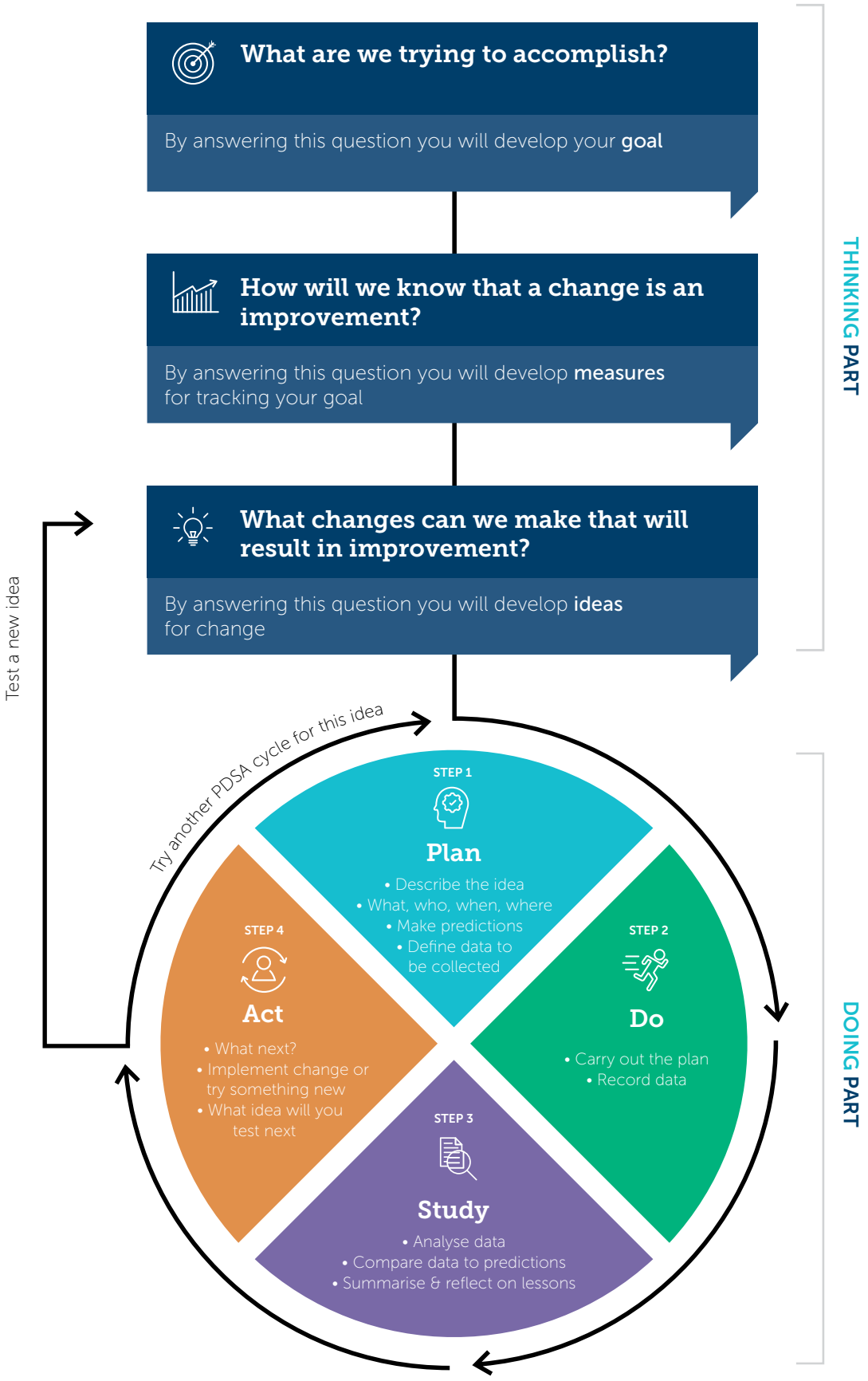
This is an evidence-based approach endorsed by leading health bodies, including the Royal Australian College of General Practitioners (RACGP) and the Institute for Healthcare Improvement (IHI).

It's easily applied and requires no specialist skills or background. It also has the advantage of encouraging creativity, collegiality and collaboration.

Starting small is key, with change broken down into manageable pieces. Within your practice, this not only helps to reduce clinical and administrative risks, but also to foster unity within the practice team and avoid resistance to change. Proven changes can then be implemented more widely across the practice, while refined or new ideas can also be run through the mill.

As illustrated in Figure 1, MFI comprises a 'thinking part' and a 'doing part'. In the 'thinking part', you step through 'Goal', 'Measure' and 'Idea' (GMI). The 'doing part' consists of the 'Plan, Do, Study, Act' (PDSA) cycle. It's not a linear process — the idea is to cycle back and forth through both parts as often as required. You'll see these concepts mentioned frequently in this workbook. (See Videos on the Model for Improvement in this workbook.)

Figure 1: The Model for Improvement and the Plan, Do, Study, Act cycle



General practice considerations

Quality improvement in general practice can address one or more of the following:

- **Safety** — Avoiding harm to patients
- **Effectiveness** — Providing evidence-based care and only providing services likely to be of benefit
- **Patient-centricity** — Providing care that is responsive to individual patients' preferences, needs and values
- **Timeliness** — Reducing waiting times for care and avoiding harmful delays
- **Efficiency** — Avoiding waste
- **Equity** — Providing care of the same quality regardless of personal characteristics such as gender, ethnicity, location or socio-economic status.

Benefits and outcomes of QI in general practice are often categorised into four areas, as shown in Figure 2. When benefits are seen across all four areas, change is said to have met the 'Quadruple Aim' — a useful target to keep in mind when developing your ideas.

Figure 2: The 'Quadruple Aim'

Improved Patient Experience

Better care: safe, quality care

Timely and equitable access

Patient and family needs met

Improved Provider Experience

Increased clinician and staff satisfaction

Leadership and teamwork

Quality improvement culture in practice

Population health

Better health outcomes

Reduced disease burden

Improvement in physical and mental health

Sustainable Cost

Efficient and effective services

Increased resources for primary care

Commissioning effectively

Links with PIP, accreditation and professional development

This workbook can be used by practices and individual professionals as evidence for:

- Practice Incentive Payment Quality Improvement (PIP QI)
- RACGP accreditation standards
- RACGP continuous professional development points

Appendix 1 has detailed information about how quality improvement activities included in this workbook can be used as evidence for RACGP continuing professional development (CPD) points for GPs and RACGP accreditation, including requirements relating specifically to carers.

Support from NWMPHN

For further support on implementing continuous quality improvement activities at your practice, contact your relationship manager at NWMPHN on (03) 9347 1188 or email primary.care@nwmphn.org.au

Your four steps to improvement

Step 1 Understand Carers

Carers provide support to partners, family members and friends. They may care for someone with a disability, mental illness, chronic illness, or an older person with care needs.

Victoria's carers are as diverse as the people they care for. Carers may be of all ages, ethnicities and cultures. It is estimated that one in eight patients in any general practice is a carer.

Carers provide a vital role, and enable patients to maintain their independence, wellness and quality of life. The care that they provide may range from emotional and practical support for a few hours a day (intermittent care) or around the clock (continuous care).

A carer may provide support in acute circumstances, whether this is a separate illness or an injury. The support they provide is both emotional and practical. They are able to triage when required, and can advise if first aid care or more acute care is needed. A carers role is also to interpret and reinforce medical advice provided by health professionals. They are able to assist the person they care for by reminding and helping the person to adhere to treatment protocols and attend follow-up appointments.

What motivates people to be carers? Carers are often motivated both by duty and affection. Some in a structured way through obligation, for example a person within a traditional cultural group or marriage see it as an expected duty of their identified role as a partner ("for better or worse"), or as a friend or as a relative. Some people become a carer driven by their affection for a person, however, some people who must provide care may see it as a burden.

Carers health and wellbeing

The carer role can be hugely rewarding, but it can also be enormously challenging. Carers themselves can experience a range of negative health, social and financial impacts as a result of their caring role. In addition, they can sometimes find it difficult to access services and forego their own health and wellbeing for that of the person they care for. They can experience 'burn-out' from their carer responsibilities when they have little respite or support to help them in their role.

The Victorian Carer Strategy 2018–2022, developed with input from 1,500 carers, found that many carers will spend a significant amount of time in health care settings but will rarely have their own health needs identified or addressed. The five priority areas in the Strategy are that carers:

- are healthy and well
- are engaged in education, employment and community
- can access respite and other supports they need when they want them
- have less financial stress, and
- are recognised, acknowledged and respected.

General practice support for carers

General practices are well placed to support carers by improving the identification of both carers and patients who have carers. Carers may support a patient of your practice and they may also be a patient of your practice. Conversely, they may be a patient of another general practice. In either case, there may be opportunities to support them through your practice or by contacting the carer's GP.

By better understanding the difficulties that carers may face in their roles, general practices can offer accessible services to support a carer's health and wellbeing, as well as provide other information or refer to other services that can support a carer to stay well.

Carers know the needs of the person they care for better than anyone else, so there is real value for general practices to involve carers in quality improvement work, and in seeking their feedback about services to ensure that they are appropriate for both the patient and the carer.

Use HealthPathways Melbourne to help and support carers

HealthPathways Melbourne (melbourne.healthpathways.org.au) is an online resource that gives clinicians up-to-date, localised clinical and referral information.

HealthPathways Melbourne provides clear, concise guidance for assessing and managing patients with particular symptoms or conditions, as well as outlining the most appropriate referral pathways.

We recommend reviewing the following pages before you start:

- Carers resources and support services
- Carer stress
- Carer support — mental health

Carers may support patients in many different situations, so there are various pathways for older people, mental health and chronic disease that may be useful, for example:

- Bereavement grief and loss
- Dementia resources and support services
- Community transport
- Cancer resources and support services

How do I access HealthPathways Melbourne?

HealthPathways Melbourne access requires a username and password. Request access online or complete this form to request automatic login.

To receive the monthly HealthPathways Melbourne Bulletin, email info@healthpathwaysmelbourne.org.au

Access is limited to health professionals in the North Western and Eastern Melbourne PHN catchments.

Step 2 Work as a team to collect data and develop goals

Now you've done your background research, it's time to establish a brains trust and start examining ideas. By the end of this section, you'll be able to answer these key questions:

Goal

What are we trying to accomplish?

Measure

How will we know that a change is an improvement?

Idea

What changes can we make that will result in an improvement?

Team up

Evidence shows that improvement is most likely when all staff support change, so adopt a whole-of-team approach from the outset.

Form a QI project team

Your project team should include representatives from your whole-of-practice team. It might include your practice manager, reception and other administrative staff, nursing staff, GPs and allied health practitioners.

For each project, you will need at least two project leads:

1. A lead GP to inform any clinical content
2. Another person in your team capable of managing the project, who will be given allocated time to complete the work required.

As your practice becomes more experienced with quality improvement, you may consider including a patient in your project team — they can provide great insight from a patient perspective, particularly if the focus of your QI activities includes measuring and improving patient experience. Page 15 of the Quality Improvement Guide and Tools provides more ideas on how to include patients in your QI activities.

Download the NWMPHN Team Health Check PDSA* and Improvement Foundation's Team Health Check Score Sheet* to help you assess your team culture and identify roles and responsibilities. Along the way, you might also identify team members who might resist change, as well as potential issues or matters to address before your project begins.

**Documents will download directly from the links*

Collect baseline data

There is a saying that 'what gets measured gets done'. So, collect and collate as much relevant data as you can. This will help you accurately assess the current situation and pinpoint exactly where you want to improve. It will also give you a 'baseline' against which success (and failure) can be measured objectively.

Some baseline data is straightforward, such as clinical data retrieved from CAT4 searches. By contrast, information such as 'staff knowledge' or 'patient experience' is harder to measure, but may be no less important. (See Videos on the Model for Improvement on page 40.)

Baseline data may include, but is not limited to:

- medical software data
- practice system audits
- environment audits
- measurement of patient experience
- measurement of staff experience
- measurement of current staff knowledge and confidence.

Note too, that NWMPHN will also send quarterly reports to practices on their performance in relation to the Improvement Measures, and in relation to the aggregated performance of other NWMPHN general practices. This information may also be useful in establishing your baseline data.

Stop and 'cleanse' your data

'Clean' data going in means 'clean' data coming out. Guides for undertaking a 'data cleanse' include:

- CAT4: Pen CS Data Cleansing Guide
- Medical Director: Data cleansing in Medical Director (Sydney North Health Network)
- Data cleansing in Best Practice: Best Practice's data clean up guide or Sydney North Health Network's Best Practice Data Cleansing Guide
- A Quality Improvement activity: Data Cleansing QI Activity (North Western Melbourne PHN).

Activity Table 1 will help you collate your baseline data.

Complete the table below with your data. Normally, the CAT4 data extraction tool would be utilised but unfortunately it does not currently extract specific information about carers. Please use your medical software to extract the data — there are examples for Medical Director and Best Practice provided in the appendices, but you may also be able to extract this data from other software systems. Consult with your PHN relationship manager if you need support.

Activity Table 1: Collating baseline data

Item	Question/Measure	Assessment of activity/status today Date:
1	**Does the practice have a policy to identify and record carers?**	○ Yes ○ No
2	**Does the practice have a policy or procedure about how to support carers?**	○ Yes ○ No
3	**Number of staff who have undertaken education and/or training about carers, for example, Carer Awareness in General Practice**	____ **out of** ____ **GPs** ____ **out of** ____ **nurses** ____ **out of** ____ **non-clinical staff**
4	**What resources in your practice promote carer health and support?** **Are your patients aware of local support services or groups for carers?**	
5	**Number of active patients in your practice**	____ **active patients**
6	**Number of carers in your active patient population** **Data Source:** Medical software See Appendix 3 and Appendix 5 (The Victorian Carer Strategy 2018–2022 estimates that 1 in 8 people (12.5%) are carers)	____ **carers**
7	**Number of patients with a carer in your active patient population** **Data Source:** Medical software. See Appendix 3 and Appendix 5	____ = ____ **%** **of our active population**

Activity Table 1: Collating baseline data (continued)

8	**Number of carers with chronic conditions:** • **Back pain** • **Depression** • **Anxiety** *These are conditions suggested by Carers Victoria to be commonly experienced by carers. You may search for data on any other conditions that interest you. **Data Source:** Medical software. See Appendix 3 and Appendix 5	**carers with back pain** **carers with depression** **carers with anxiety**

Add any other measures you think are relevant including any patient feedback you already have in hand — this is valuable baseline data!

Reflect on the data

Reflect on the information you've compiled. You might consider the following questions:

- Does any data surprise you?
- Are there clear areas for improvement that could form the basis of your QI project?

Based on this discussion, identify and prioritise key areas for improvement using Activity Table 2.

Remember — You don't need to improve in all areas at once. You might decide to concentrate on one measure at a time. How you do this is up to you. You can pick and choose ideas in this workbook to suit the approach that best meets your practices needs.

Activity Table 2: Analysing baseline data

Item	Identified area for improvement	Number each in order of priority for improvement (i.e. 1, 2, 3, etc.)
1		
2		
3		
4		
5		
6		

Completed by:	Date:

Set a goal

Now that you have identified the top priority area for your practice the next step is to work together to set a goal for this area. Goals should be 'SMART', so ask if each goal is:

- **Specific** — Does the goal say exactly what we want to achieve?
- **Measurable** — Have we included a measurable target, such as 'increase cervical screening rates among appropriate women by 50 per cent' or 'to achieve 100 health checks'?
- **Achievable** — Is it likely our practice will be able to accomplish the goal?
- **Relevant** — Does the goal align with our practice's broad vision and aims?
- **Time-based** — Do we have a clear deadline for achieving our goal? (Deadlines should be challenging but realistic.)

There are examples of goals you could set in Appendix 6.

Describe your goal

Once you have established your first goal, describe it in more detail in Activity Table 3.
(This table will also be used for any subsequent goals.)

Activity Table 3: Set a goal

Our priority for improvement is:	**Our target population is:**
Our goal is to:	**Check that the goal is:** ☐ Specific ☐ Measurable ☐ Achievable ☐ Relevant ☐ Time-based
We will use the following measures to know if we've been successful: Measure: Source: Measure: Source: Measure: Source: Measure: Source: Measure: Source: *add more as appropriate	
We want to achieve our goal by:	**We will collect our measures every:** For example: 1st of the month, two months, quarter, six months.

Brainstorm ways to achieve your goal

Now use Activity Table 4 to list activities that might help your practice achieve its goal or goals. Activities might include, but are not limited to:

- staff training and education
- system changes
- workplace/environmental changes
- regular reviews/audits/meetings.

There is no minimum or maximum number of activities. As a guide, we have provided room to record six.

See brainstorming tools for identifying a change idea, recommended by IHI, including:

- Affinity Tool
- Five Whys
- Driver Diagram
- Flow Chart
- Cause and Effect (Fishbone)

Activity Table 4: Brainstorm of ideas for implementing change

Idea no.	Activity	Expected outcomes
1		
2		
3		
4		
5		
6		

Completed by:	Date:

Suggested Quality Improvement activities for carers

General

These activities could apply to any goal:

- Introduce the new QI project at the next all-staff meeting and discuss it at regular meetings. Talk about rationale, targets, activities, and roles. Invite ideas for any other activities which may help achieve the goal.
- Discuss the new QI project at the next clinical meeting, to address clinical-specific issues and tactics. Add it to regular meeting agendas.
- Have relevant staff complete education/online training/online learning modules by a specified date.
- Develop a poster for the waiting room/consulting rooms about your interest in carers and how you would like to support them.
- Source patient information about your area of focus in English and other appropriate languages. See the Victorian Government's Health Translations and Better Health Channel websites or Carers Victoria or Carer Gateway
- Develop a reminder sticker for GPs' and nurses' computers to remind them about the area of focus.
- Add an update to the staff newsletter about the project, its aim and starting position, as well as updates on outcomes in subsequent newsletters.

Identify and record carer status

- Add questions to your New Patient Registration Form (remember that people may not identify with the word 'carer'):
    - 'Do you rely on someone for your care?'
    - 'Does someone else rely on you for their care?' Or 'Do you assist someone who has health, disability or age-related support needs?'
- Consider at-risk patients and ask them during a consultation, or at first diagnosis of a chronic condition who their main support person is. Examples of questions to ask can be found in the Carer Awareness in General Practice education module.
- Create posters encouraging carers or people with carers to let their clinician know that they are a carer or have a carer.
- Create a written protocol for carers and people with carers in your practice, including how to identify and record their status in the system.
- Discuss the method of identification and recording at a practice meeting.
- Train staff on how to record carer status in your practice management software.
- Record carer information in both the patient and the carer's file. See Appendix 2 and Appendix 4 for recommended methods of recording this information in both Medical Director and Best Practice.
- Hold a 'Caring for carers' month or event — make it a big focus in the waiting room — signs, resources, conversations to help identify people who have not been identified through other means.
- If clinicians can recall any current patients who are carers or have a carer, ensure carer status is recorded correctly in their medical records.

Please note

Many of the activities below apply to identified carers who are also patients of your own practice. If you identify a patient of yours who has a carer, but that carer is not your patient, we recommend you identify their usual GP and communicate with that doctor if you are concerned about their wellbeing (with the carer's consent only).

Improve patient experience and patient feedback

- Run a 'before' questionnaire asking for feedback from carers and the people they care for about your service, for example a suggestions box, email, focus group — see Appendix 7 for an example questionnaire.
- Design improvements that could be made to address this feedback (see sections below for suggested changes you could consider if the feedback indicates).
- Implement the changes to improve the access, services or support that you provide carers.
- Report back to the carer population about the changes you've made and seek their input again on whether they have been beneficial — run the same questionnaire in Appendix 7 'after' your changes. This could be displayed in public areas utilising frameworks such as "You said/asked, we did..."

Improve access for carers to primary care services

- Offer carers flexible appointments that work around their caring schedule.
- When carers book a GP appointment for the person they care for, offer the carer an appointment for themselves directly afterwards. If the carer says they don't need one suggest that the GP would like to check in with you and see how you are going.
- As these people are often under financial strain, consider offering a reduced fee.
- Consider your referral strategy and whether you can refer carers to no-cost or low-cost services.
- If carers rarely see the GP for themselves, provide them with information the next time they come into the practice with the person they care for, and encourage them to also care for themselves and book a GP appointment.

Improve primary care services for carers

- Develop a carer check-in shortcut in progress notes. Ask "How are you going/coping?" (mental health), "Are you having any back pain?" (physical health) as a quick check-in with them when they are attending with others.

  **Note that all carer-based medical information MUST be included in their OWN medical file and not included in the patient's file.*

- It may be preferable to encourage the carer to make their own appointment for the privacy and confidentiality of both parties, and also ensure we are not taking time away from one's consult with another's

  **Note that all carer-based medical information MUST be included in their OWN medical file and not included in the patient's file.*

- When carers have their own appointment, ensure you ask about how they are coping in their caring role — their answer may prompt you to consider other actions such as depression screening, provision of information about support groups etc.
- As so many carers undergo severe psychological stress, consider depression screening all carers and providing appropriate support or referral.
- Run a search of all carers on your list and use this list for an audit. Collect your baseline information of who has had each of the following assessments. Recall each person for the health checks/assessments that they are eligible for:
    - 45–49yo health assessment
    - 45–49yo Diabetes Risk Assessment
    - Aboriginal and Torres Strait Islander health assessment
    - 75+yo health assessment
    - Chronic disease management items
    - Mental health treatment plan
- Offer all carers, or people who have a carer, annual influenza vaccinations, as well as any other vaccinations they may be eligible for. Refer to the vaccination for people at occupational risk on the Commonwealth Immunisation handbook.
- Schedule follow-up appointments as necessary to check-in with carers and assess their health.

Improving referrals/other support information you can provide to carers

- Gather information/brochures about services which may support carers. HealthPathways Melbourne 'Carer resources and support services' page includes:
    - Information and education for carers
    - Carer support groups
    - Respite services and self-care
    - Practical services like meal support, gardening, transport.

** Remember that even if the carer is not a patient of your practice, you can still ask how they are going, whether their general practice is supporting them, and provide them with information about support services. You can encourage them to see their own GP for their health and wellbeing or identify their GP and communicate with their doctor.*

- Consider what carer supports are in your area. If there is not a local or easily accessible group nearby, consider hosting one at your practice. Reach out to Carers Victoria and your local community health organisation for support.
- Hold a morning tea or other event for carers and include relevant agencies (e.g. carers groups) to improve links between different carers, and also between carers and community support services.
- Ensure you have resources in other key languages.
- Discuss with your staff about the financial stress on carers and consider referring carers (and the people they care for) to no-cost or low-cost services.
- Support where possible applications for financial assistance such as carers allowances or payments.

Involve carers as partners in patient care

- Talk to patients routinely about the issues surrounding information-sharing and seek their permission for appropriate information about their care and treatment to be shared with their carer.
- Introduce agreements for information sharing and record them prominently in the patient's notes so other members of the team are aware of them.
- Encourage patients to bring their carers into the appointment with them when it is appropriate or potentially beneficial to do so — for example, bringing the carer-partner along when discussing lifestyle changes that will improve health outcomes may help to ensure both have a shared understanding of reasons for change and the recommendations given.
- When planning patient care, where possible ask carers first about any problems they may be having and their views about the best course of action to support the patient. Incorporate the carer's feedback/suggestions into your care planning where relevant.
- Ask the carer to feed back any difficulties encountered once a new care plan has been put into place.
- Consider including carers in case conferencing where possible and where the patient consents.
- Where a patient is reluctant for all information to be shared, talk through the consequences of this decision, as there may be some aspects of their condition that they are comfortable to share.
- Where a patient does not want any information given to their carer, ensure there is general information on relevant health conditions available, for example leaflets on medical conditions or the effects of medication.
- Actively involve carers in the planning and implementation of long-term management plans of those they care for, particularly when developing Advance Care Directives and discussing aspects of health in Advance Care Planning. Ensure a copy of these documents and other formal arrangements such as medical treatment decision maker is recorded and retained in the patient's file.

Understand whether carers are achieving improved clinical outcomes

- Implement an evidence-based screening tool to assess carer stress or mental health at the start, middle and end of the specified project period (an example tool might be a K10 questionnaire). During the project period:
    - meet with carers
    - record scores from the screening tool at each point to assess if there has been any improvement over the duration of the project
    - record at each stage what interventions have been provided in terms of GP/ nursing services and other support/referrals
    - review the data captured in conjunction with the scores from the screening tool and consider what has been effective in improving carer health and wellbeing.

In the "What it is really like to be a carer?" video, Carly, Brianna, Martin and Miriam share their experiences and talk about what they would like doctors to know, to improve a carer's health and wellbeing. Photos: Jasper Picture Company

Step 3 Plan, Do, Study, Act — time to get 'cycling'

You're now ready to take action, using a 'Plan, Do, Study, Act' (PDSA) cycle for each activity you've decided to implement in the previous activity.

Using Activity Table 5, take the activities listed in Activity Table 4 and assign a responsible person/persons, and intended due dates. Use Activity Table 5 to regularly check in on your team's progress. This will help inform the 'plan' part of the PDSA cycle in Activity Table 6. (You may also want to review the explanation of PDSA under The Model for Improvement heading in the introduction to this workbook.)

Activity Table 5: Timeframes and responsibilities

1	**Activity** **Person responsible** / **By when** **Expected outcomes**
2	**Activity** **Person responsible** / **By when** **Expected outcomes**

Activity Table 5: Timeframes and responsibilities (continued)

3	**Activity** **Person responsible** / **By when** **Expected outcomes**
4	**Activity** **Person responsible** / **By when** **Expected outcomes**
5	**Activity** **Person responsible** / **By when** **Expected outcomes**

Activity Table 5: Timeframes and responsibilities (continued)

6	**Activity** **Person responsible** / **By when** **Expected outcomes**

Next, create copies of this PDSA table and fill one out for **each activity**. This will help you to break your project down into manageable chunks, allocate responsibilities more easily, and accurately assess what's working and what's not. Ensure that each PDSA table includes details of who is doing what, and by when, to keep your project on track.

Note that you can run more than one PDSA at a time. This will depend on the change you're making, and the time it's likely to take before any measurable improvement. If results are likely to take longer (more than a month, for example, or a year), running separate, sequential PDSAs for each activity would mean the project would take too long.

PDSA cycle template

You've got your plan and are now ready for the 'doing' — that is, to start 'cycling' through PDSAs. Use Activity Table 6. See also Appendix 8: PDSA worksheet samples on page 59 for samples of completed forms.

Activity Table 6: PDSA cycle template

Priority area number	**Priority area goal**
Activity number	**Staff member responsible**
Date started	**Date completed**

Plan

Plan the test, including a plan for collecting data

Describe the brainstorm idea you are planning to work on. (Idea)

What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea (activity)

What (step-by-step)

Who

When

Where

Prediction

Data to be collected

Baseline

Do

Run the test on a small scale

Carry it out, and describe how you went (Action)

Was the plan executed successfully?

Did you encounter any problems or difficulties?

Study

Analyse the results and compare them to your predictions

Does the data show a change? (Reflection)

What does the data say?

Did you meet your predictions, or did you fall short?

Act

Based on what you learned from the test, plan for your next step

Do you need to make changes to your original plan? (What next?) OR Did everything go well?

If this idea was successful you may like to implement this change on a larger scale or try something new.

If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

Tip: Do your first lot of activities for your first goal and then proceed to manage and monitor your progress/success. Begin again on page 19 (Set a goal) when you're ready to tackle the process again for another area. See Appendix 9 for a PDSA workbook template.

Manage and monitor your project

Now you're in the swing of things, ensure you monitor the project regularly, with an eye on your 'baseline data'.

Ensure each PDSA template for each project activity is completed as the activity is completed. As soon as practical, reflect on how the activity went, and any obstacles, and decide whether to continue with the change, or amend it and try it again.

Look back at the data you collected in Activity Table 1, as well as any other measures you decided to collect as part of your project.

Now collect the same data again and complete Activity Table 7. As you do, assess whether there's any improvement since the last measurement. If not, consider why not. Is it too early to see change, or is an extra effort needed to push performance along? And what might be the best activity to tackle next?

Copy the relevant data results from Activity Table 1, but note the order of columns is different here.

Manage and monitor — tips for successful PDSA

- Allocate 'protected time' so that those responsible can effectively implement the changes.
- Set dates in the project team's calendars **now** for reviewing the project. Use the PDSA due dates as a guide, and also set regular review periods (perhaps monthly or quarterly). Regular monitoring is important so that the team can support and encourage each other to complete activities.
- Keep your project team and other practice staff well-informed.
- Catch-up with staff about their PDSAs and offer support where needed.
- Conduct regular check-ups, both to help encourage staff, and to iron-out issues.

Activity Table 7: Manage and monitor

1	**Measure**		
	Source of data		
	Start of project	3 months into project	6 months into project
2	**Measure**		
	Source of data		
	Start of project	3 months into project	6 months into project
3	**Measure**		
	Source of data		
	Start of project	3 months into project	6 months into project

Activity Table 7: Manage and monitor (continued)

4	**Measure**		
	Source of data		
	Start of project	3 months into project	6 months into project
5	**Measure**		
	Source of data		
	Start of project	3 months into project	6 months into project
6	**Measure**		
	Source of data		
	Start of project	3 months into project	6 months into project

Step 4 Evaluate and celebrate

Evaluation is, of course, a regular and integral part of the PDSA process. But it's also important to conduct broader evaluations of the overall project.

Once you have completed all of your activities, reflect on how the process went. Complete Activity Table 8 on the next page, as a team.

Celebrate and share

Celebrating your success doesn't just feel good — it will help you capitalise on your quality improvement efforts. Under the Model for Improvement, quality improvement is a 'virtuous cycle'. Each benefit has a positive effect on the next, leading to a 'snowball' of improvement.

By celebrating your 'wins', you'll engage your practice team more deeply with your QI project, enhance morale and foster a culture where striving for improvement is as integral as payroll — or lunch!

Depending on the stage and scale of your success, you could share results at staff meetings, hold a celebratory lunch, post your achievements in the waiting area, or even in local media or online.

Has your practice completed a quality improvement activity or project that you'd like to share?

Submit your case study, resources or photos to primarycare@nwmphn.org.au

What's next?

Now that you have completed these activities, it is time to tackle your next goal. Head back to Activity Table 2 on page 20 to identify the next goal for your practice and work through the activities again.

You can use the sample templates in Appendix 6.

Activity Table 8: Evaluate achievements

Did you achieve your goal?
What are you most proud of?
What were the things that helped you?
Were there any barriers?
How did you overcome these?

Activity Table 8: Evaluate achievements (continued)

What were the changes for: • Patients • Staff/Clinicians • Population • Business?
What would you have done differently?
What are your next steps for the changes that were made?

Date started	**Date completed**

Education and training about carers

Webinars and online learning modules

Carer Awareness in General Practice — Victorian-Tasmanian PHN Alliance

- Visit the Carer Awareness page or the online Carer Awareness in General Practice education kit, which consists of three webinars and covers the recognition of the carer role, identifying and supporting carer needs and involving the carer in patient care. Watch all three parts to claim two RACGP CPD activity points or one ACRRM professional development hour.
- Also see the introductory video 'What is it really like to be a carer?'

Tools and resources to build your skills and confidence

Resources about carers

- The Department of Health and Human Services has developed the Victorian Carer Strategy 2018–2022 (DHHS). This outlines the five aims for carers and is based on insights from 1,500 carers.
- HealthPathways Melbourne. Search 'carer' and peruse the relevant pathways, or refer back to the HealthPathways Melbourne section on page 13 for a list of links.

RACGP

- The RACGP aged care clinical guide (Silver Book) includes, Part B about families and carers and gives some information and guidance on how to support carers who care for aged relatives and loved ones.
- RACGP has published a number of online articles that also provide insights for general practices, such as: 'Helping those who care for people with dementia' and 'Who cares for the carer?'

Resources for carers

Carer Gateway provides a range of services and supports delivered in person via telephone and online including counselling, respite care, self-guided coaching, skills courses and practical help and advice. The Gateway can connect carers with an Australia-wide network of service providers and help find local services and support. Visit Carer Gateway or call 1800 422 737.

Peak bodies

Carers Victoria is the peak body representing all unpaid carers in Victoria. They provide education workshops, programs, events and advice for carers across the state as well as services for carers in the western region. Visit the Carers Victoria website.

Other peak bodies that could provide information and support include:

- Dementia Australia
- Amaze (for autism support)
- Mental Health Carers Australia

Other resources

My Aged Care is the Australian Government's starting point for the aged care journey. The website may be useful for older people needing help around the house or those who are considering the transition to an aged care home.

HealthPathways Melbourne is a free, web-based portal with relevant and evidence-based information on the assessment and management of common clinical conditions including referral guidance. This includes other supports and services in the Carer Resources and Support Services pathway.

General resources

Videos on the Model for Improvement

Short videos are available at IHI website. In particular, see:

- Model For Improvement — Part 1 (2 min. 54 sec.) — IHI — MFI — Part 1
- Model For Improvement — Part 2 (3 min.) — IHI — MFI — Part 2
- Plan Do Study Act — Part 1 (4 min. 45 sec.) — IHI — PDSA — Part 1
- Plan Do Study Act — Part 2 (3 min. 48 sec.) — IHI — PDSA — Part 2

Australian Bureau of Statistics

Access this page for questionnaire design advice.

Case Studies

Local examples of quality improvement success, as well as sample PDSA cycles, can be found on the NWMPHN primary care pages.

Appendices

Appendix 1: Quality Improvement and RACGP accreditation

RACGP's Standards for general practices (5th edition) now includes several QI requirements. Undertaking a QI activity helps demonstrate that a practice can meet or exceed the following:

*Indicator (> Denotes indicator is mandatory)

Criterion QI1.1: Quality improvement activities

Indicators

QI1.1>A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1>B Our practice team internally shares information about quality improvement and patient safety.

QI1.1>C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1>D Our practice team can describe areas of our practice that we have improved in the past three years.

The Standards also include a range of requirements relating to carers. Undertaking carers QI activities may help demonstrate that a practice can meet or exceed the following indicators:

Criterion C1.3: Informed patient decisions

Indicators

C1.3>A Our patients receive information about proposed investigations, referrals and treatments, including their purpose, importance, benefits, and risks.

C1.3>B Our patients receive information to support the diagnosis, treatment, and management of their conditions.

Criterion C1.4: Interpreter and other communication services

Indicators

C1.4>A Our practice endeavours to use an interpreter with patients who do not speak the primary language of our practice team.

C1.4>B Our practice endeavours to use appropriate communication services to communicate with patients who have a communication impairment.

C1.4>C Our patients can access resources that are culturally appropriate, translated, and/or in plain English.

Criterion C2.2: Presence of a third party during a consultation

Indicators

C2.2>A Our practice obtains and documents the prior consent of a patient when the practice introduces a third party to the consultation.

Criterion C2.3: Accessibility of services

Indicators

C2.3>A Our patients with disabilities or special needs can access our services.

Criterion C3.4: Practice communication and teamwork

Indicators

C3.4>A Our practice team has the opportunity to discuss administrative matters with the principal practitioners, practice directors, practice management, or owners when necessary.

C3.4>B Our practice encourages involvement and input from all members of the practice team.

C3.4>C Our clinical team discusses the practice's clinical issues and support systems.

Criterion C4.1: Health promotion and preventive care

Indicators

C4.1>A Our patients receive appropriately tailored information about health promotion, illness prevention, and preventive care.

Criterion C5.1: Diagnosis and management of health issues

Indicators

C5.1>A Our clinical team is able to access relevant current clinical and other guidelines that help diagnose and manage our patients.

C5.1>B Our clinical team supports consistent diagnosis and management of our patients.

Criterion C6.2: Patient health record systems

Indicators

C6.2>A Our practice has a system to manage our patient health information.

Criterion C6.3: Confidentiality and privacy of health and other information

Indicators

C6.3>A Our patients are informed of how our practice manages confidentiality and their personal health information.

C6.3>B Our patients are informed of how they can gain access to their health information we hold.

C6.3>C In response to valid requests, our practice transfers relevant patient health information in a timely, authorised, and secure manner.

C6.3>D Only authorised team members can access our patient health records, prescription pads, and other official documents.

Criterion C8.1: Education and training of non-clinical staff

Indicators

C8.1>A Our non-clinical staff complete training appropriate to their role and our patient population.

Criterion QI1.2: Patient feedback

Indicators

QI1.2>A Our practice collects feedback from patients, carers and other relevant parties in accordance with the RACGP's Patient feedback guide.

QI1.2>B Our practice analyses, considers and responds to feedback.

QI1.2>C Our practice informs patients, carers and other relevant parties about how we have responded to feedback and used feedback to improve quality.

Criterion QI1.3: Improving clinical care

Indicators

QI1.3>A Our practice team uses a nationally recognised medical vocabulary for coding.

QI1.3>B Our practice uses relevant patient and practice data to improve clinical practice (e.g. chronic disease management, preventive health).

Criterion GP1.1: Responsive system for patient care

Indicators

GP1.1>A Our practice provides different consultation types to accommodate patients' needs.

Criterion GP1.2: Home and other visits

Indicators

GP1.2 A Our patients can access home and other visits when safe and reasonable.

Criterion GP1.3: Care outside of normal opening hours

Indicators

GP1.3 A Our patients are informed about how they can access after-hours care.

GP1.3 B Our patients can access after-hours care.

Criterion GP3.1: Qualifications, education and training of healthcare practitioners

Indicators

GP3.1 A Members of our clinical team:

...actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and professional organisation's requirements

Claiming RACGP Continuing Professional Development Points

GPs who complete activities in this workbook may be eligible to accumulate 40 CPD Accredited Activity points. Speak to one of our Workforce, Education and Training team members about requirements before commencing your activities. For more information email education@nwmphn.org.au or call (03) 9347 1188.

Appendix 2: Recording 'carer' or 'patient with a carer' status in Medical Director

There are a number of ways to record carer status in Medical Director. The one below is our recommended approach, but there may be other ways that you prefer to use. The important things to keep in mind are to:

- choose one method of recording for your practice
- ensure that everyone knows the method and follows it (write it down)
- ensure you can easily see on a patient's record if they are a carer or have a carer
- be able to run a search on your system to get a list of all carers/patients with carers in your practice so that you can target interventions towards these important groups.

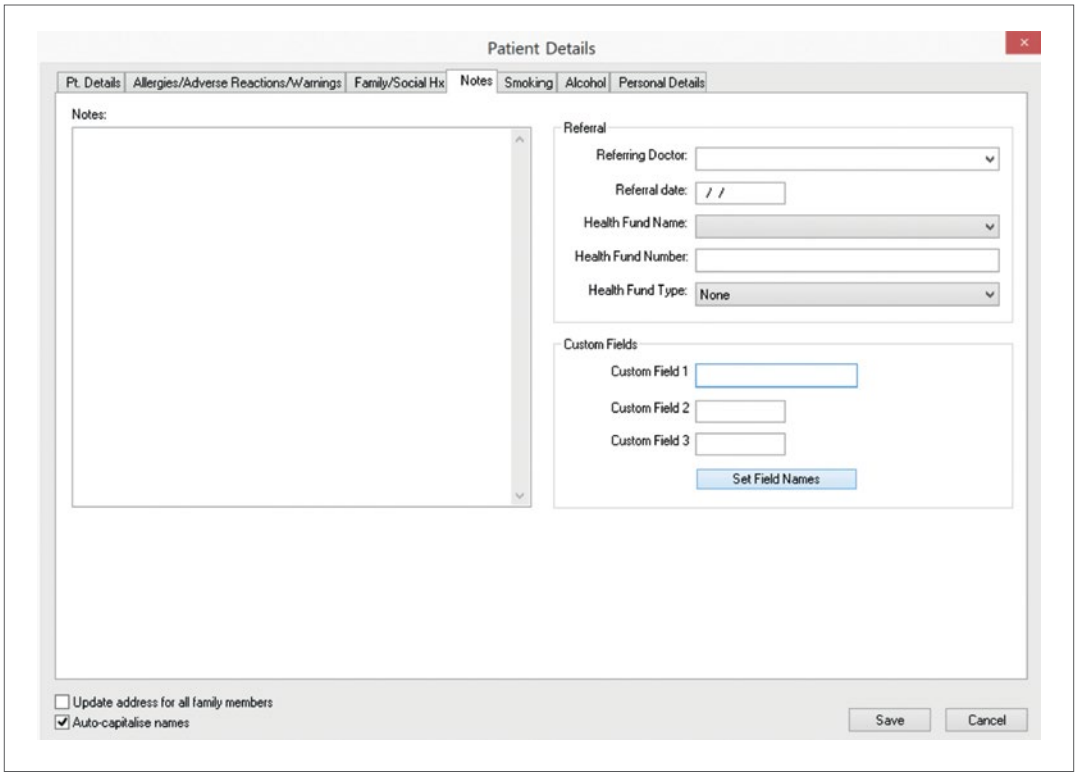
Note: Medical Director does not have a 'carer' tick-box. You will need to set up and use a custom field to record carer status — the information can then be extracted when you run a search for all your carers/patients with carers.

Set up your custom fields (Can be done by practice manager)

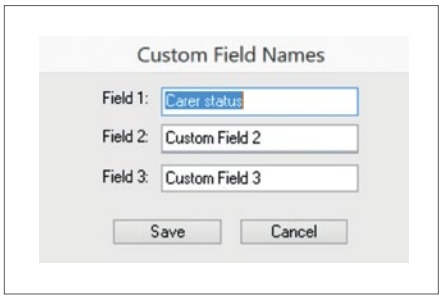
1 Open Medical Director Clinical.

2 Open any patient file. Go to **Patient details** and then **Notes**.

3 In the **Custom Fields** box click **Set Field Names**



4 In Field 1 (or any empty field) type in **Carer Status** and click **Save**



5 Click **Save** again on the Notes section of Patient Details and close the patient's file. You have now named one of the custom fields 'Carer Status' and this will be evident when you open any patient file in future.

Record carer status for a patient

1 By using your new patient registration form and then in discussion with your patient, you've confirmed that they are a carer for someone else.

2 Go to **Patient details** and then **Notes**.

3 Go to the **Custom Fields** section and under **Carer Status** type **Is Carer**. Alternatively, if your patient *has* a carer, type **Has Carer**.

4 On the left-hand side, add other relevant information in the Notes box

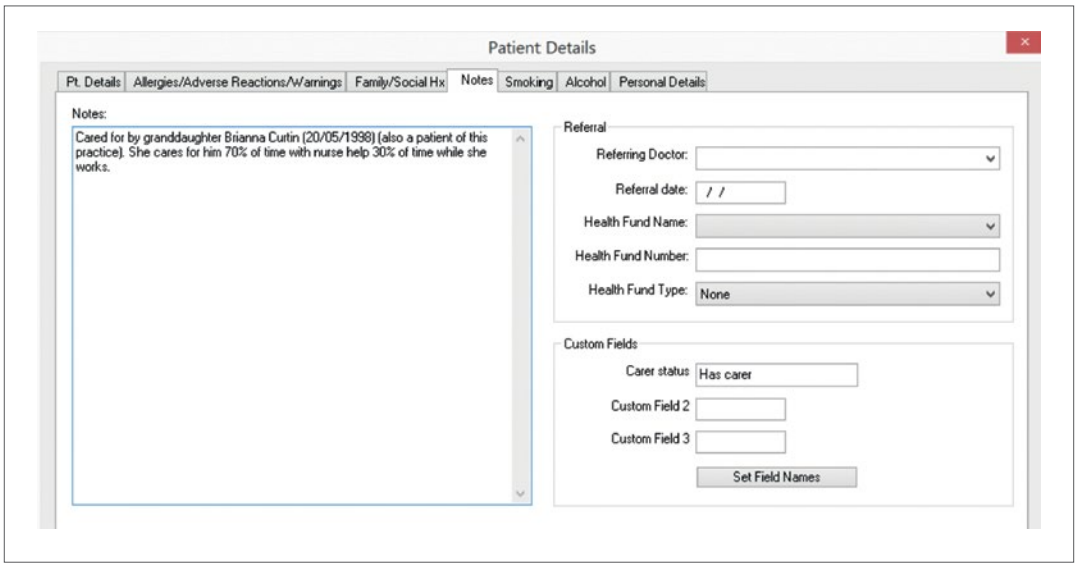
   1 If the person *is* a carer, add who they care for, and whether they are also a patient of your practice.

   2 If the person *has* a carer, add who their carer is, and whether they are also a patient of your practice.

   3 This is also a good place to add any other information they've noted/ concerns they've expressed about their role as a carer or as a patient supported by a carer.

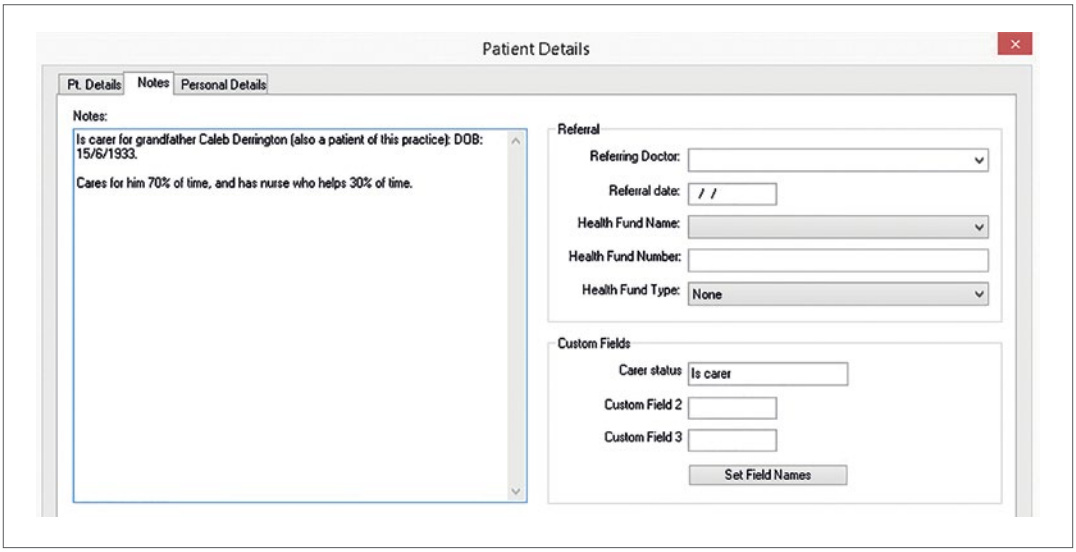
**Do not include any medical information about the carer in the record of the patient they care for, or vice versa.*

Click **Save**.

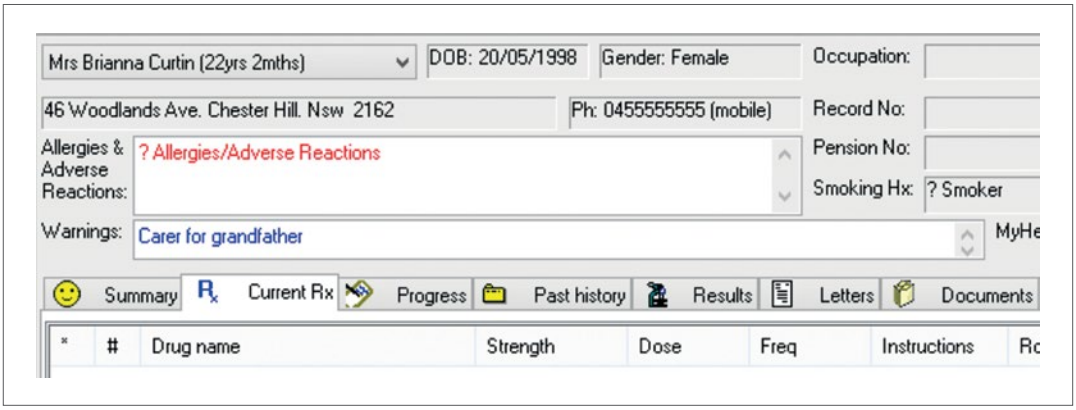


5 You may also want to amend contact details in the record — discuss this with the patient/carer.

6 If that other person is also a patient of your practice, add carer status details to their patient record as well.



7 Optional: You may add a note in **Warnings** so that carer status is immediately visible on the record. Double click **Warnings** and add your note. It might be as simple as typing in e.g. **Carer for grandfather**. Click **Save**.



NB: Typing in **Is Carer/Has Carer** into your **Carer Status** custom field will allow you to run a search on this in future. It is essential that every staff member types it exactly for it to be searchable.

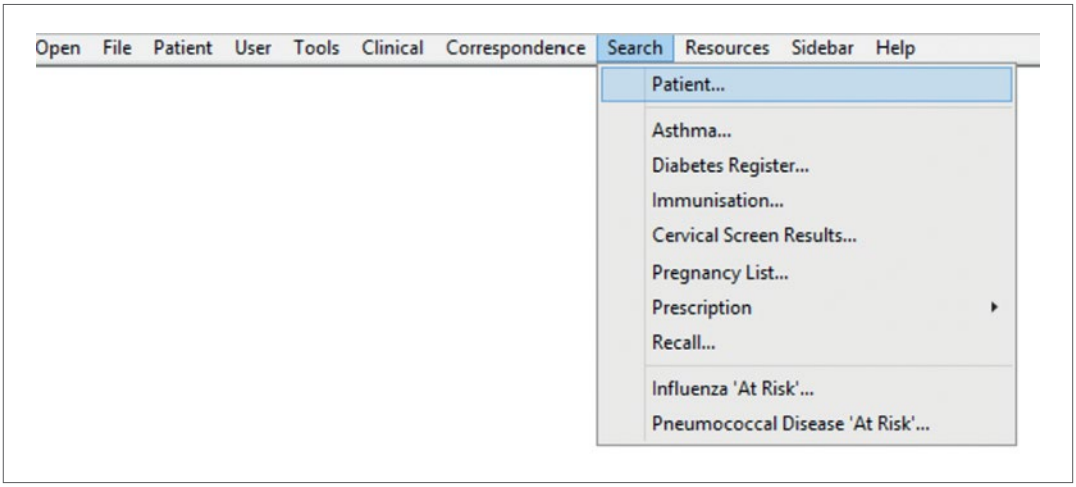
Typing something in the Warnings box is not searchable but it does make it immediately visible to the staff member accessing the record that this patient is or has a carer.

Appendix 3: How to retrieve a list of 'carers', or 'patients with a carer', in Medical Director

*These instructions only apply if you used the method of recording suggested in Appendix 2.

1 Open **Medical Director Clinical** but close any individual patient records.

2 Go to **Search** and then **Patient**.

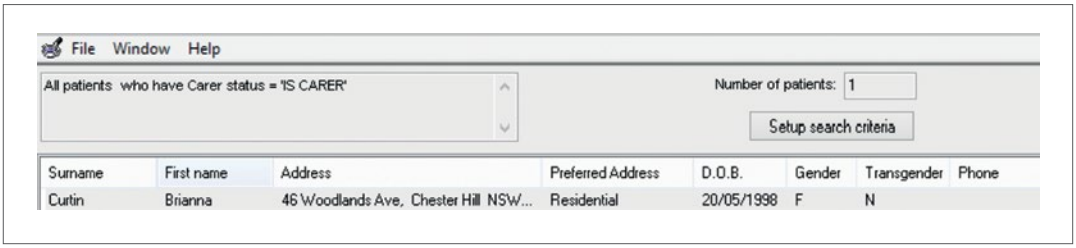


3 In the bottom left hand corner in the **Carer Status** box type

- A **Is carer** if you want a list of patients who are carers
- B **Has carer** if you want a list of patients who have carers.

4 Click **Search**.

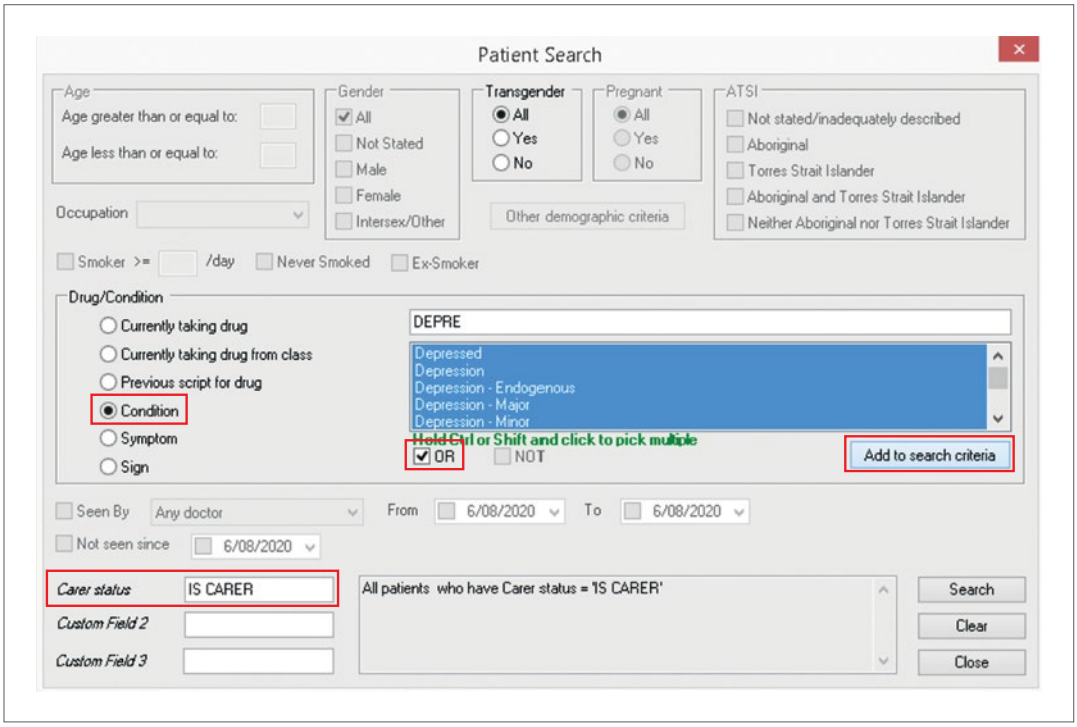
5 You will retrieve a list of patients who have **Is carer / Has carer** marked on their patient file. Remember that only this exact phrase is being searched for, so slight changes to wording like 'Is a carer' will not come up as a search result.



To search for carers who have certain diagnosed conditions

1 Follow the above instructions to step 3, typing **Is Carer** under **Carer status**.

2 In the **Drug/Condition** section click **Condition** and start typing the condition of interest e.g. 'depression'. A number of options will come up. You may choose a number of these based upon how your practice might record depression for your patients. To do this, click **OR** and hold down the **SHIFT** button while you select all the conditions you are interested in related to depression.



3 Click **Search**. You will be provided with a list of patients who are carers with depression.

4 Click **Save** (bottom of screen) to save your patient list.

5 Click **Setup search criteria** to run a new search e.g. for carers with anxiety, or carers with back pain, or carers with other chronic conditions. Note that you will have to add 'Is carer' to the Carer status field again.

Appendix 4: Recording 'carer' or 'patient with a carer' status in Best Practice

There are a number of ways to record carer status in Best Practice. The one below is our recommended approach, but there may be other ways that you prefer to use. The important things to keep in mind are to:

- choose one method of recording for your practice
- ensure that everyone knows the method and follows it (write it down)
- ensure you can easily see on a patient's record if they are a carer or have a carer
- be able to run a search on your system to get a list of all carers/patients with carers in your practice so that you can target interventions towards these important groups.

If your patient is a carer for someone else

1 Open Best Practice

2 Through your new patient registration form and then discussion with your patient, you've confirmed that *they are a carer* for someone else.

3 Open the patient's file and open **Family and Social History**. You can do this in a few ways:

- Double click where it says **Work** OR
- Select **Shift + F10** OR
- At the top of the page, select **Open** then **Social History**.

4 Click on **Social** and see the carer status boxes. Click **Yes** in the **Is Carer** dropdown box.

5 Optional — add an **On Screen Comment** e.g. **'Carer for grandfather'** — this will be immediately visible to any staff member who opens the main patient record screen.

6 If the person they care for is also a patient in your practice, ensure you add carer details to their patient record as well.

7 You may also want to confirm and amend contact details with the patient/carer.

If your patient has a carer

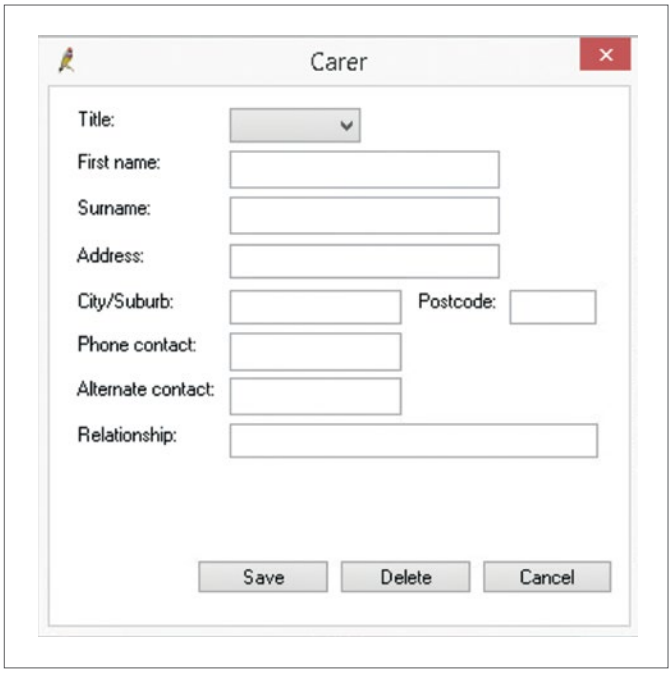
1 Open Best Practice

2 Through your new patient registration form and then discussion with your patient, you've confirmed that *they have a carer*.

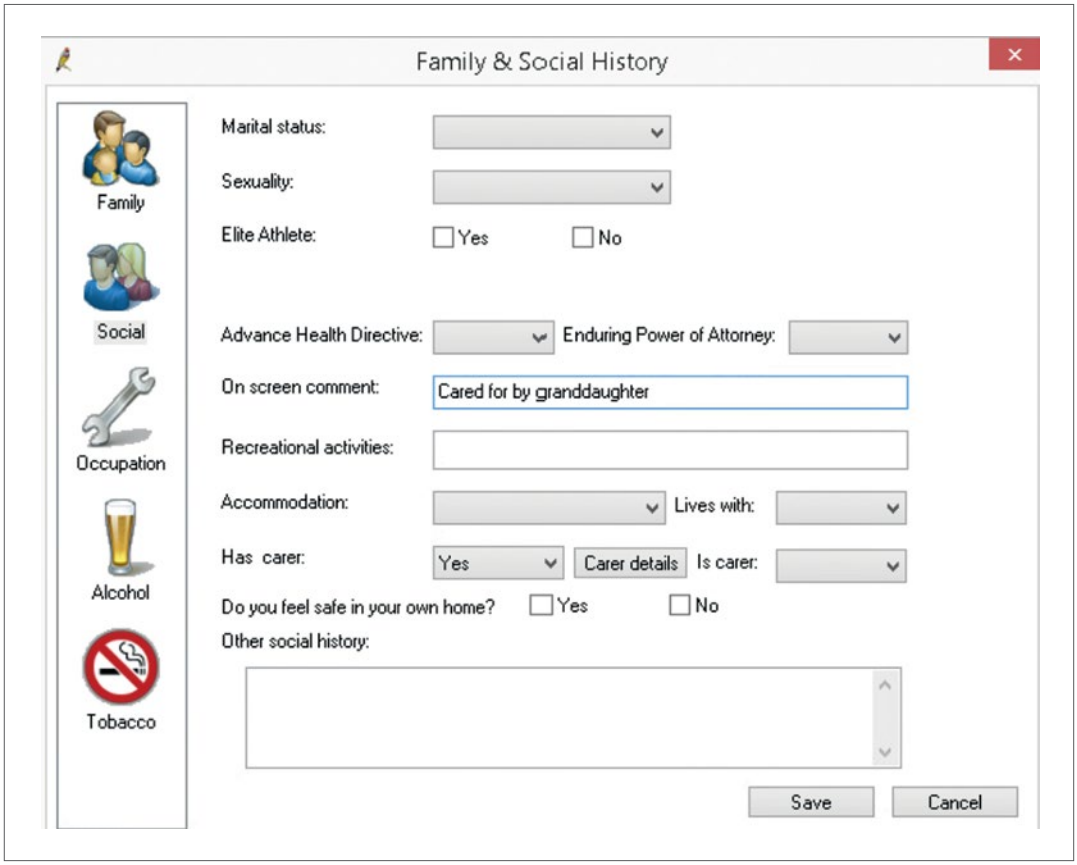
3 Open the patient's file and double click on their demographic details to open **Family and Social History**.

4 Click on **Social** and see the carer status boxes. Click **Yes** in the **Has Carer** dropdown box.

5 Click on **Carer details**, complete this information and click **Save**.



6 Optional: You may add a note in **On Screen Comment** so that carer status is immediately visible on the record. It might be as simple as typing in e.g. **Cared for by granddaughter**. Click **Save**.



Appendix 5: How to retrieve a list of 'carers', or 'patients with a carer', in Best Practice

*These instructions only apply if you used the method of recording suggested in Appendix 4.

Retrieving a list of patients coded as 'having' or 'being a carer at your practice

1 If you haven't previously run a .bpscript query, instructions are available on the Best Practice website, script runner export results page.

2 Click on the link to download a bpscript that you can run to show a list of all patients marked as 'having' or 'being' a carer in the database as per Appendix 4, along with carer details if they are supplied. Your IT team may need to assist depending on system security levels.

3 Save the list as a csv file (which you can then open in Microsoft Excel).

Appendix 6: Sample goals for a carers quality improvement project

Sample goal 1: Basic

Our priority for improvement is:

Identification and recording of carers and people who have carers

Our goal is:

To improve our identification and recording of carer status so that:

- we can create a list of each from our medical software system of carers and people with carers
- we have identified and added to our list at least 10 carers and 10 people with carers by 30 Sep 2020.

*We know that approximately 1 in 8 people are carers in Victoria

*We currently have no carers, or people with a carer, coded in our system.

Our target population is:

Carers and people with carers

Check that the goal is:

- [x] Specific
- [x] Measurable
- [x] Achievable
- [x] Relevant
- [x] Time-based

We will use the following measures to know if we've been successful:

*add more as appropriate

Measure:	Source:
Number of active patients in our population	Medical software
Number of active patients who are carers (and % of our active population)	Medical software
Number of active patients who have a carer (and % of our active population)	Medical software
We have a written protocol in place for identifying and recording carer status in our medical software	Written protocol

We want to achieve our goal by:

30 Sep 2020

We will collect our measures every:

1st of the month

Sample goal 2: Intermediate

Our priority for improvement is:

Improving primary care services for carers

Our goal is:

To achieve the following for carers in our population:

- 60% of eligible carers have received a 45–49yo assessment
- 60% of eligible carers have received a 75+yo assessment
- 80% of all carers have been screened for depression

By 31 December 2020

Our target population is:

Carers

Check that the goal is:

- ☑ Specific
- ☑ Measurable
- ☑ Achievable
- ☑ Relevant
- ☑ Time-based

We will use the following measures to know if we've been successful:

*add more as appropriate

Measure:	Source:
Number of carers in our active population	Medical software
Number of carers who have been screened for depression	Medical software
Number of carers between 45–49yo	Medical software
Number of carers between 45–49yo who have received a 45–49yo health assessment	Medical software
Number of carers over 75+ yo	Medical software
Number of carers over 75+yo who have received a 75+yo health assessment	Medical software

We want to achieve our goal by:	We will collect our measures every:
31 December 2020	1st of the month

Sample goal 3: Advanced

Our priority for improvement is:

Seeking feedback from carers and patients

Our goal is:

To run two focus groups to seek feedback from carers and the people they care for about the primary care services we provide, and use this to drive improvements in our practice by 31 December 2020.

Our target population is:

Carers and the people they care for.

Check that the goal is:

- ☑ Specific
- ☑ Measurable
- ☑ Achievable
- ☑ Relevant
- ☑ Time-based

We will use the following measures to know if we've been successful:

*add more as appropriate

Measure:	Source:
Number of focus groups run (Aim is one at the start to inform improvements, and one after the improvements have been implemented)	Manual count
Number of carers and people they care for involved in focus groups	Manual count
Finalised report of initial feedback.	Report completed
Number of changes implemented *Once you know what changes you are making, you may be able to add measures here to see if your changes are resulting in improvements — e.g. improvements in access, improved contact with carers, improved patient compliance, etc.	Manual count
Finalised report of feedback (about success of improvements)	

We want to achieve our goal by:

30 December 2020

We will collect our measures every:

1st of the month

Appendix 7: Sample questionnaire for 'before' and 'after' analysis of change in your practice

This is an example. Please adapt the questions for your own practice.

We would like to get your feedback on your experience at our practice. It will help us to understand what we do well, what we could do better, and what we could change to improve your experience.

Are you a carer? This means you help to care (e.g. emotionally, physically) for someone else (e.g. a partner, family member, friend) ○ Yes ○ No	**Do you have a carer?** This means you receive help (e.g. emotionally, physically) from someone else (e.g. a partner, family member, friend) ○ Yes ○ No

For carers only:

Please tick the box to rate how well the practice meets your needs.

	Very poor	Poor	Average	Good	Very good
Physical access to the practice	○	○	○	○	○
Access to appointments that suit you	○	○	○	○	○
Receiving information that helps you care for the other person	○	○	○	○	○
Receiving information that helps you in your role as a carer (e.g. carer support groups)	○	○	○	○	○
Talking about issues/things you are struggling with in your carer role	○	○	○	○	○
Talking about your mental health	○	○	○	○	○
Being involved in discussions about the person you care for	○	○	○	○	○

For people with a carer only:

Please tick the box to rate how well the practice meets your needs.

	Very poor	Poor	Average	Good	Very good
Physical access to the practice	○	○	○	○	○
Access to appointments that suit you	○	○	○	○	○

Receiving written medical information that you can give to your carer if they don't come into your appointment with you	○	○	○	○	○
Talking about how much information you want your doctor to share with your carer	○	○	○	○	○

Please tell us in your own words:

What makes your experience good when you come to see the doctor or nurse?

What could we do better?

What do you find most difficult to cope with / manage when thinking about your health and wellbeing?

How can our services be more welcoming and easier to use for you / your carer / the person you care for?

How can we help you to improve your health and wellbeing?

What other support do you think would help you?

If you would like us to send you the results of these questionnaires and what changes the practice will make, provide your name and email address or home address:

Name	**Email address or home address**

Appendix 8: PDSA worksheet sample

You will have noted your ideas for testing when you worked through earlier activities. Here are two samples of how to complete the PDSA template (provided in Appendix 9 on page 61) to test each new idea.

Sample A:

Priority area number	Activity number
1	2

Goal

Increase the number of SHSs uploaded to our active patients by 30 per cent, by 30 October 2020.

Staff member responsible

Date started	Date completed

Part 2: The doing part — Plan, Do, Study, Act

Plan	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea

Implement new way of recording carer status on our medical software system.

What (step-by-step)

1. Review Appendix 2 and Appendix 3 for use of Medical Director and at the next clinical meeting agree on the system that the practice.
2. Put the system into writing (as part of a practice protocol) and share it with all clinicians
3. Ensure all clinicians understand the process and how to implement it in the clinical software
4. Ask clinicians to identify any patients that they already know have a carer / are a carer (it may be recorded as free text in the medical record), and test the recording of this (and pulling out a patient list) in the medical software.

Who	When
Practice Manager (Sam)	Begin 1 July for two weeks

Part 2: The doing part — Plan, Do, Study, Act (continued)

Where

N/A

Prediction

Increase in the number of patients who are recorded as a carer, or recorded as a person with a carer. We aim for 10 each by 30 Aug 2020.

Data to be collected

Number of active patients on our list, number of patients who are recorded as carers, number of patients who are recorded as people with a carer.

Baseline

We currently have no patients who we can bring up in a search for 'carers' or 'people who have a carer'

Do

Run the test on a small scale

Who is going to do what? (Action)

Was the plan executed successfully?

Did you encounter any problems or difficulties?

Completed 25 July (slightly late) — clinical meeting on 10th cancelled, so caused delay in implementation, but all else went smoothly. We were able to correctly record carer status for a couple of patients that we know are carers and have carers to test out the method of both recording and extracting data.

Study

Analyse the results and compare them to your predictions

Does the data show a change? (Reflection)

What does the data say?

Did you meet your predictions?

If you fell short, suggest why.

As of 25 July we have a list showing 3 patients who have carers and 2 carers.

We predict achieving our goal of at least 10 carers and 10 patients with carers on our list by 30 August. This will be built upon in the weeks and months to come.

We are going to progress other activities which improve our identification of carers and patients with carers so that we can add to our list, and embed this process into our everyday work so that we continue to actively identify carers every day.

Part 2: The doing part — Plan, Do, Study, Act (continued)

Act	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	If this idea was successful, you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

The whole team is keen to continue with supporting the carers project work. No further work specifically here, except to progress the rest of our 'Carers and Patients with Carers' protocol so it includes everything including our overall aims to support carers, how we will identify them, record it in our system, how we will improve our contact with carers, questions we can ask to check if carers are coping, and services we will prioritise for carers.

Repeat Step 2 for other ideas. What idea will you test next?

Appendix 9: PDSA worksheet template

This is a blank PDSA worksheet that you can use to test each new idea.

Priority area number	Activity number

Goal

Staff member responsible

Date started	Date completed

Plan

Plan the test, including a plan for collecting data

Describe the brainstorm idea you are planning to work on. (Idea)

What exactly will you do? Include what, who, when, where, predictions and data to be collected.

Idea (activity)

What (step-by-step)

Who

When

Where

Prediction

Data to be collected

Baseline

Do

Run the test on a small scale

Carry it out, and describe how you went (Action)

Was the plan executed successfully?

Did you encounter any problems or difficulties?

Part 2: The doing part — Plan, Do, Study, Act (continued)

Study

Analyse the results and compare them to your predictions

Does the data show a change? (Reflection)

What does the data say?

Did you meet your predictions?

If you fell short, suggest why.

Act

Based on what you learned from the test, plan for your next step

Do you need to make changes to your original plan? (What next?) OR Did everything go well?

If this idea was successful you may like to implement this change on a larger scale or try something new.

If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.

Repeat Step 2 for other ideas. What idea will you test next?

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