  
Record of QI activity

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| PIP QI quarter: *please tick ✓* | Quarter 1  *Nov – Jan* | Quarter 2  *Feb – Apr* | Quarter 3  *May – Jul* | Quarter 4  *Aug – Oct* |
| **Date:** |
| **QI Activity:** | Diabetes cycle of care - Diabetic Foot Assessment - QIA Level 1 | | | |
| **Activity goal:**  *What to improve and timeframe* | To complete an annual cycle of care foot assessment on x% diabetic patients by x months and ensure all GPs within the practice are familiar with accurate recording of foot assessment in clinical software. | | | |
| **Activity measures:**  *What data is used to monitor progress* | Our data extraction tool to identify diabetics who have not had a foot assessment as part of their annual cycle of care in the past 6-12 months. | | | |
| **Initial benchmark:**  *Baseline data prior to QI activity* | Our current data shows we have x diabetic patients who have not had a foot assessment as part of their annual cycle of care in the past 6-12 months. | | | |
| **Activity overview:**  *What changes will we make that will lead to an improvement?*  *NB: These ideas are not practice specific and are designed to give you some general ideas.*  *The QI Team should develop these ideas together.*  *To assist with clinical decision making, consider using HealthPathways, see: HealthPathways Sydney:* [*https://sydney.communityhealthpathways.org/*](https://sydney.communityhealthpathways.org/) *OR*  *HealthPathways South East Sydney:* [*https://sesydney.healthpathwayscommunity.org*](https://sesydney.healthpathwayscommunity.org) | **1.** QIA team meeting to discuss how to record diabetic foot assessment within clinical software and ensure correct coding of diabetic ulcer in clinical software including external referrals to podiatrist.  **2.** Principal GP ensure all GP's involved in QIA are confident with examining diabetic foot ulcers. Education and training session.  **3.** QI Team Leader to run report and identify diabetic patients who have not had a foot assessment as part of their annual COC in the past 6-12 months and flag to nurses and GPs  **4.** Ensure appropriate diabetic foot assessment equipment is available at the practice e.g. the monofilament to help identify patient loss of protective sensation  **5.** Doctors to share appropriate resources to patients and carers Diabetes Australia – [Diabetes and your feet](https://www.diabetesaustralia.com.au/living-with-diabetes/preventing-complications/foot-care/) & [Foot Forward](https://www.footforward.org.au/)  **6.** Treat and/or refer appropriately - refer to HealthPathways: [Diabetes-related Foot Care](https://sydney.communityhealthpathways.org/25013.htm) (SLHD) or [Foot Screening in Diabetes](https://sesydney.communityhealthpathways.org/25013.htm) (SESLHD)  **7.** Put on agenda at staff meetings to discuss as a team  **8.** Education sessions/staff training held for doctors and nurses  **9.** Re-run report in 6 months’ time and review | | | |
| **30-day checkpoint:**  *Monitor progress at 30 days* |  | | | |
| **60-day checkpoint:**  *Monitor progress at 60 days* |  | | | |
| **Final 90-day checkpoint:**  *Results at 90 days – summarise improvement from baseline* |  | | | |
| **Reflection:**  *Reflect on achievements, challenges and lessons* |  | | | |

*\*Data extraction tools include: PenCAT, POLAR, clinical software reports, etc*