

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:** | Referring diabetic patients to the High Risk Foot Service (HRFS) - QIA Level 2 | | | |
| **Activity goal:**  *What to improve and timeframe* | Over the next 12 months, to refer diabetic patients with active foot ulcers to the SLHD High Risk Foot Service within 4 weeks of diagnosis. | | | |
| **Activity measures:**  *What data is used to monitor progress* | Track number of SLHD letter responses to individual patient referrals. | | | |
| **Initial benchmark:**  *Baseline data prior to QI activity* | We currently do not refer any diabetic patients to the HRFS | | | |
| **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. GPs to identify and compile list of high risk diabetics with active ulcers to the HRFS: [HRFS SLHD](https://sydney.communityhealthpathways.org/47131.htm) OR [HRFS - SESLHD](https://sesydney.communityhealthpathways.org/47131.htm)  2. Before referral, discuss expectations regarding HRFS with patient  3. Doctors to share appropriate resources to patients and carers e.g. [NDSS fact sheet](https://www.ndss.com.au/wp-content/uploads/fact-sheets/fact-sheet-looking-after-your-feet.pdf), [Diabetes and your Feet](https://www.diabetesaustralia.com.au/living-with-diabetes/preventing-complications/foot-care/), [Foot Forward for Diabetes](https://www.footforward.org.au/)  4. Put on agenda at staff meetings to discuss as a team  5. Education sessions/staff training held for doctors and nurses  6. Arrange follow up appointment with referred patient  7. Ensure all GP's record foot assessment COC completion for patients in clinical software. | | | |
| **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*