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CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Quality Improvement Toolkit

For General Practice

Dementia

Introduction

The Quality Improvement Toolkit

This Quality Improvement (QI) toolkit consists of modules intended to assist your general practice in implementing clear, quantifiable, and sustainable advancements to achieve optimal care for your patients. This toolkit uses the Model For Improvement (MFI) to aid in the completion of QI activities.

As you complete the modules, you will be given guidance on investigating your data to gain a deeper understanding of your patient population and care pathways available in your practice.

Observations received from the module activities and data will shape improvement ideas, which you can enforce using the MFI.

The MFI utilises the Plan-Do-Study-Act (PDSA) cycle, a known method for accomplishing successful change. The PDSA cycle has several advantages:

- An easy approach accessible to anyone
- Reduced risk by starting with small changes
- It can be used to implement, plan, and develop significant changes

The MFI helps break down the implementation of changes into more manageable components. These components are then systematically tested to ensure that the changes lead to measurable improvements, reducing wasted effort.

If you require further support regarding quality improvement in your practice, please contact practicesupport@cesphn.com.au.

Research and health guidelines constantly evolve. Therefore, the information in this toolkit will need to be updated. If you have any feedback on the content in this document, please reach out to Central and Eastern Sydney PHN.

Acknowledgements

Central and Eastern Sydney PHN (CESPHN) acknowledges the Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians and Sovereign People of the land across which we work. We recognise their continuing connections to land, water, and community, and pay respect to Elders past, present, and emerging.

CESPHN acknowledges Brisbane South Primary Health Network (BSPHN) for the development and sourcing of much of the content included in this toolkit. Other materials used and referenced in this toolkit have been extracted from organisations including Dementia Australia, the Australian Institute of Health and Welfare, the Department of Health and Aged Care, NSW Health, NSW Trustee and Guardian, the Department of Health, Disability and Ageing, Best Practice, Medical Director, and POLAR. These organisations retain copyright over their original work, and we have abided by the licence terms. Referencing to this material is provided throughout the document.

This information provided in this toolkit does not constitute as medical advice. Neither BSPHN nor CESPHN accepts any responsibility for information in the way this toolkit is interpreted or used.

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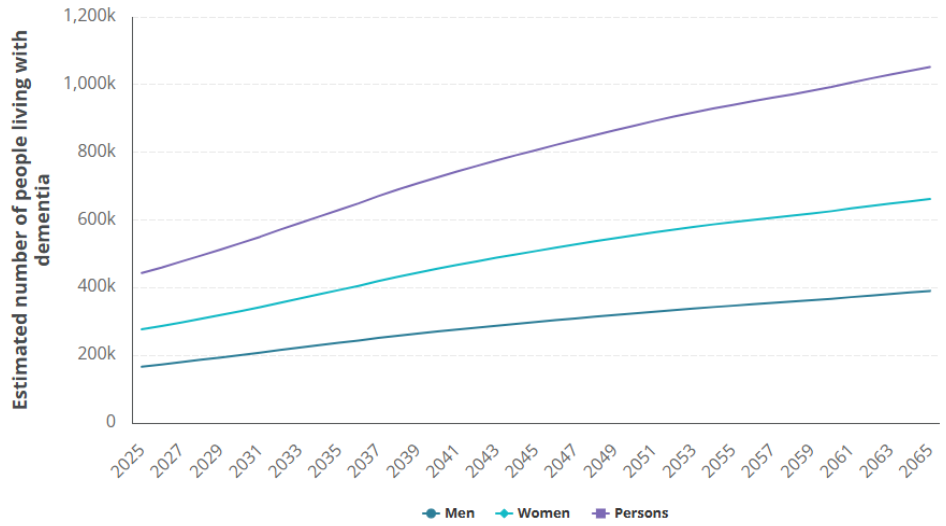
Contents

Dementia

Dementia is a brain condition characterised by a decline in cognitive function affecting memory, thinking, behaviour, and the ability to perform everyday tasks[1]. Dementia is not a single disease, but an umbrella term used to describe a range of conditions, including Alzheimer's disease, vascular dementia, and Lewy body dementia[1]. While dementia becomes more common with age, particularly from 65-years onward, it is not a natural part of aging[1,2].

In Australia, Dementia is a growing public health concern with significant impacts on the health and quality of life of people living with the condition, their families and carers[2]. Approximately 446,500 Australians are living with dementia in 2026, with this projected to more than double to 1.1 million by 2065 as our population ages and grows[2,3]. In New South Wales, an estimated 145,700 people are living with dementia in 2026, a figure expected to increase to 252,800 by 2054[3].

Australians living with Dementia by sex, 2025 to 2065[2]



Source: Australian Institute of Health and Welfare (2025)

According to the Australian Bureau of Statistics, dementia is the leading cause of death for Australians[4]. In 2024, dementia was the second leading cause of overall disease burden, the leading cause of disease burden for women, and the leading cause of disease burden for people aged 80 years and older[2].

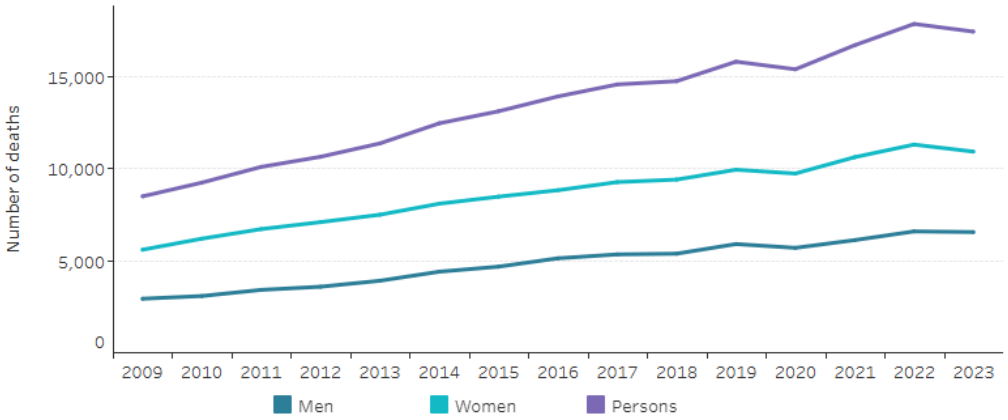
[1] Dementia Australia. About dementia [Internet]. Dementia Australia; [updated 2026 Jan 29; cited 2026 Apr 2]. Available from: https://www.dementia.org.au/about-dementia

[2] Australian Institute of Health and Welfare. Dementia in Australia: summary [Internet]. AIHW; [updated 2025 Dec 5; cited 2026 Apr 2]. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/summary

[3] Dementia Australia. Dementia facts and figures [Internet]. Dementia Australia; [Updated 2026 May 8; cited 2026 May 20]. Available from: https://www.dementia.org.au/about-dementia/dementia-facts-and-figures

[4] Australian Bureau of Statistics. Causes of Death, Australia [Internet]. Australian Bureau of Statistics; 2024 [cited 2026 Apr 2]. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release

Number of deaths due to Dementia in Australia by sex, 2009 to 2023[2]



Source: Australian Institute of Health and Welfare (2025)

Approximately 1.7 million Australians provide care for someone with dementia, and around 54% of people residing in permanent residential aged care are living with the condition[3].

Despite the scale of dementia, diagnosis is often delayed, with an average time from symptom onset to diagnosis of three years[3]. Furthermore, around half of people living with dementia in Australia never receive a formal diagnosis due to limited awareness, stigma, and fear surrounding the condition[5].

Primary care professionals play a central role in addressing this challenge through the early identification, diagnosis, and management of dementia. Early diagnosis of dementia improves the effectiveness of treatments and supports the timely planning of health, legal, financial, and care needs, enabling people to access appropriate services and maintain independence for longer[5]. GPs are also uniquely positioned to build longitudinal relationships with patients and families, initiate advance care planning, and coordinate multidisciplinary and community-based services.

[5] Department of Health and Aged Care. National Dementia Plan 2024-2034 [Internet]. Australian Government; 2024 [cited 2026 Apr 2]. Available from: https://www.health.gov.au/resources/publications/national-dementia-action-plan-2024-2034?language=en

Aim of the toolkit

Provide a user-friendly, practical tool to strengthen the capacity of general practices to deliver high-quality dementia care for dementia patients, their families, and carers.

Topics included in this toolkit

- Understanding your dementia patient population
- Dementia prevention and brain health
- Important conversations
- Support for patients to live at home longer
- Local Health District dementia care teams
- Medicare Benefit Schedule (MBS) Items for dementia patients
- Marking patients deceased in clinical software
- Recourses and training

How to use the toolkit

There are checklists included in this toolkit to guide you and your practice in assisting patients with dementia. This includes:

- Planning and preparation
- Identifying a sample group of patients
- Setting timelines to achieve your goals
- Implementing improvement actions
- Documenting your QI activities
- Reviewing your QI activities and evaluating if your process is working

Benefits of using the toolkit

The toolkit provides:

- A structured, easy, and quick approach to implement quality improvement activities
- A step-by-step guide
- Suggestions to identify suitable patients using data extraction tools
- Links to prefilled templates and resources
- Flexibility: activities can be started at any time of the year, and practice teams decide whether to implement a single improvement intervention, or a bundle of interventions.

Activity 1 – Understanding your patient population

Activity 1.1 – Data collection from Polar

Complete the table below by collecting data from your Polar Data Extraction Tool.

The objective of this activity is to identify the number of active patients who have dementia, alongside their Health Assessment, Home Medication Review (HMR), cardiovascular risk, shared health summary, dementia risk, and carer status.

Activity Table 1: Collect Polar data

For a detailed guide on how to collect data from Polar, please see the following link.

Description	Total Number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
Number of active patients with dementia		
Number of active patients with dementia aged 75 years and older who have NOT had a Health Assessment completed in the last 12 months		
Number of active patients with dementia who had a medication review in the previous 12 months		
Number of active patients with dementia with a BP and cholesterol in a healthy range recorded in the last 12 months (this is important for those patients with vascular dementia)		
Number of active patients with dementia who had a shared health summary uploaded in the previous 12 months		
Number of active patients who are at high risk of dementia		
Number of active patients with dementia who have a carer recorded *(Note: not found in POLAR)*		
Use this link for the polar guide or use the Polar Education Portal to identify the data required. If you need assistance, contact your Digital Health Officer digitalhealth@cesphn.com.au		

** The RACGP defines 'active' patients as individuals visiting three or more times during a period of two years. The search criteria does not include patients who may have come in for screening every two years, or twice in two years. Therefore, we have included a column to capture all active patients*

with dementia.

Reflection comments for **Activity 1.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 1.2 – Understanding your dementia population

The aim of this activity is to increase your understanding of the dementia patient population at your practice.

Description	Status	Action to be taken
After completing activity 1.1 are there any unexpected results with your practices dementia patient population?	☐ Yes: **see actions to be taken** ☐ No: continue with activity	Please explain: (for e.g. higher at-risk population than expected, practice has a high population of patients who have not completed a Health Assessment) How will this information be communicated to the practice team?
Does the practice have a system for contacting patients who have not had a health assessment completed?	☐ Yes: continue with activity ☐ No: **see action to be taken.**	Please explain: How will this information be communicated to the practice team?
Does the practice have a system for ensuring all patients with dementia have carer details recorded?	☐ Yes: continue with activity ☐ No: **see action to be taken.**	Identify patients with no carer details and develop a system of obtaining this information. How will this information be communicated to the practice team?

Does the practice have a system for identifying all patients with dementia who would benefit from a home medication review?	☐ Yes: continue with activity ☐ No: **see action to be taken.**	Hold a clinical meeting and discuss with relevant team members who would benefit from this service. How will this information be communicated to the practice team?
After reviewing your practice's dementia patients, are there any changes with the management of your patients you would like to implement over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 1.2:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 2 – Dementia Prevention and Brain Health

Dementia is not an inevitable part of ageing. An estimated 45% of dementia cases can be prevented by addressing modifiable risk factors, making prevention, early intervention, and brain health an important part of routine general practice[6].

There are 14 potentially modifiable risk factors for dementia, including high cholesterol, depression, physical inactivity, diabetes, smoking, high blood pressure, obesity, excessive alcohol use, and social isolation[7]. These risk factors occur across the life course, which means brain health is relevant for younger and midlife adults as well as older people.

Many of the things that are good for physical health are also good for brain health. Managing blood pressure, cholesterol, diabetes, physical inactivity, smoking and alcohol consumption can help reduce the risk of dementia while also improving overall health and wellbeing. General practice is well placed to have these conversations about brain health as many risk factors for dementia are already addressed during routine health assessments and consultations.

Activity 2.1 – Dementia Prevention and Risk Reduction

The aim of this activity is to review how your practice supports dementia prevention and to identify opportunities to build it into routine care.

Description	Status	Action to be taken
Are clinicians aware of the modifiable risk factors for dementia?	☐ Yes: continue with activity ☐ No: **see action to be taken.**	Consider discussing dementia prevention at a clinical meeting and sharing education resources with staff.
Does the practice routinely discuss brain health and modifiable risk factors with patients (for example, during health assessments, chronic disease reviews, or cardiovascular and diabetes checks)?	☐ Yes: continue with activity ☐ No: **see action to be taken.**	Identify which consultations are the best opportunities to raise brain health, and how a prompt or template could support this. How will this information be communicated to the practice team?
Does the practice have dementia prevention and brain health	☐ Yes: continue with activity	Make available printed and/or electronic prevention recourses

[6] Dementia Australia. Reduce your risk of dementia [Internet]. Dementia Australia; [cited 2026 Aug 13]. Available from: https://www.dementia.org.au/brain-health/reduce-your-risk-dementia

[7] Australian Government Department of Health and Aged Care. National Dementia Action Plan 2024-2034 [Internet]. Australian Government Department of Health and Aged Care; 2024 [cited 2026 Aug 13]. Available from: https://www.health.gov.au/sites/default/files/2025-08/national-dementia-action-plan-2024-2034.pdf

recourses available to give to patients (for example, pamphlets, fact sheets, flyers etc.)?	☐ No: **see action to be taken.**	for patients, including for younger and midlife patients. Consider putting up some posters or flyers within your practice waiting room or consultation rooms. See Activity 7 – Resources and Training for suggested resources.
Does the practice consider dementia risk reduction when managing patients with related conditions (for example, hypertension, diabetes, high cholesterol, obesity, hearing loss, or depression)?	☐ Yes: continue with activity ☐ No: **see action to be taken.**	Add brain health prompts to chronic disease management templates and recall and reminder systems.
After reviewing your practice's approach to brain health and dementia prevention, are there any changes you would like to implement over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 2.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Two opportunities for integrating brain health into routine care

The 45-49 Health Assessment and 75+ Health Assessment provide two valuable opportunities to discuss brain health with patients.

Brain Health Opportunity	Relevant dementia risk factors	Conversation prompts
Opportunity 1 45 – 49 Health Assessment	• Lifestyle risk factors ○ Smoking ○ Physical inactivity ○ Poor nutrition ○ Excessive alcohol consumption • Biomedical risk factors ○ High cholesterol ○ High blood pressure ○ Impaired glucose metabolism/diabetes ○ Overweight and obesity • Psychological risk factors ○ Depression	*"The things that reduce heart disease and diabetes risk can also help reduce dementia risk later in life."* *"Looking after your blood pressure, cholesterol and physical health helps support brain health as you get older."* *"It's never too early to think about brain health. Looking after your physical activity today can help reduce your risk of dementia later in life"*
Opportunity 2 75+ Health Assessment	• Lifestyle risk factors ○ Physical inactivity or reduced mobility ○ Decline in activities of daily living ○ Falls risk and frailty ○ Social isolation • Biomedical risk factors ○ High blood pressure • Psychological risk factors ○ Depression and low mood ○ Cognitive changes or memory concerns	*"Many of the things we do to stay physically healthy also help keep our brains healthy."* *"Staying active, socially connected and managing chronic conditions can support brain health."* *"Have you noticed any changes in your memory or thinking that you would like to discuss?"*

BrainTrack: A Practical Next Step for Patients

After a consultation, patients may benefit from using BrainTrack[8], a free brain health self-monitoring app developed by Dementia Australia.

BrainTrack allows people to:

- Monitor their cognitive health over time
- Learn more about brain health and risk factors
- Complete activities in their own time
- Become more aware of changes in memory and thinking
- Discuss any concerns and share data with their GP

Encourage patients to download the free BrainTrack app after their appointment and use it as part of their ongoing preventive health care.

Best practice tools to support the early identification of dementia patients

- General Practitioner Assessment of Cognition (GPCOG) is a dementia screening tool for cognitive decline, designed for primary care physicians, general practitioners, and family doctors[9].
- Standardised Mini-Mental State Examination (SMMSE) is a screening tool to determine cognitive decline in older patients[10].
- Montreal Cognitive Assessment (MoCA Test) is an early identification tool for mild cognitive impairment[11].
- Rowland Universal Dementia Assessment Scale (RUDAS) is a cognitive screening tool that aims to decrease the effects of cultural influence and language diversity on assessments of cognitive function[12].
- Kimberley Indigenous Cognitive Assessment Tool (KICA) is a culturally responsive screening tool for dementia, aimed towards Aboriginal and Torres Strait Islander people[13].

[8] Dementia Australia. BrainTrack. Dementia Australia [Internet]. Dementia Australia; [cited 2026 Aug 13]. Available from: https://www.dementia.org.au/braintrack

[9] General Practitioner Assessment of Cognition [Internet]. University of New South Wales; [cited 2026 Apr 8]. Available from: https://gpcog.com.au/

[10] Independent Health and Aged Care Pricing Authority. Standardised Mini-Mental State Examination [Internet]. Independent Health and Aged Care Pricing Authority; [Last updated 2024 Jan 17; cited 2026 Apr 8). Available from: https://www.ihacpa.gov.au/health-care/classification/subacute-and-non-acute-care/standardised-mini-mental-state-examination

[11] MoCA Cognition. MoCA Test [Internet]. MoCa Cognition; [cited 2026 Apr 8]. Available from: https://www.mocacognition.com/the-moca-test/

[12] Dementia Australia. Rowland Universal Dementia Assessment Scale (RUDAS) [Internet]. Dementia Australia; [Last updated 2025 Mar 19; cited 2026 Apr 8]. Available from: https://www.dementia.org.au/professionals/assessment-and-diagnosis-dementia/rowland-universal-dementia-assessment-scale-rudas

[13] Dementia Australia. Kimberly Indigenous Cognitive Assessment Tool (KICA) [Internet]. Dementia Australia; [Last updated 2025 Mar 19; cited 2026 Apr 8]. Available from: https://www.dementia.org.au/professionals/assessment-and-diagnosis-dementia/kimberley-indigenous-cognitive-assessment-tool-kica

- Mini-Cog is a screening test used to detect early-stage dementia[14].

Further dementia related resources and training are available in Activity 7 in this Toolkit.

Activity 2.2 – Reviewing your dementia care

This activity aims to guide your practice team through a structured reflection on how dementia is currently identified, managed, and supported across key areas of care. By working through this activity, your team can identify gaps and agree on targeted improvement actions.

Description	Status	Actions to be taken
1. Early Detection and Screening		
Are practice staff confident in recognising the early signs and symptoms of dementia (e.g. changes to behaviour, memory and thinking)?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Consider a brief team knowledge check or a discussion at the next clinical meeting. Refer to Dementia Australia or Dementia Training Australia (DTA) for recourses and staff education.
Does your practice routinely use validated cognitive screening assessments (e.g. GPCOG, SMMSE, RUDAS, MoCA, KICA, Mini-Cog)?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Please explain: Review which assessments are available in your practice. Ensure culturally appropriate tools are accessible when needed.
Is there a clear process for cognitive assessments and specialist referral within your practice?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Develop or review your practice's cognitive assessment pathway. Identify local specialists (geriatricians, neurologists) and document referral pathways. Refer to South Eastern Sydney HealthPathways or Sydney HealthPathways for further information.

[14] Mini-Cog. Mini-Cog [Internet]. Mini-Cog; [cited 2026 Apr 8]. Available from: https://mini-cog.com/

2. Care Planning		
Does the practice involve patients and their families or carers in shared decision-making about dementia care goals?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Review how care goals are currently documented and discuss at team meeting.
Are GP Chronic Condition Management Plans (GPCCMP) thorough, addressing physical, cognitive, functional, and psychosocial needs?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Audit a sample of existing dementia GPCCMPs.
Has advanced care planning been discussed, documented, and shared (e.g. with the practice, My Health Record, carer, POA)?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Refer to the CESPHN Advance Care Planning QI Toolkit for further information. Ensure advanced care documentation is uploaded to My Health Record.
3. Non-Pharmacological and Community-Based Support		
Is the practice aware of local non-pharmacological support options (e.g. cognitive stimulation programs, exercise groups, social activities)?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Compile a list of local dementia support services and share with the team. Refer to South Eastern Sydney HealthPathways or Sydney HealthPathways and My Aged Care for local service directories.
Are patients and carers routinely offered information about carer support services, respite care, and dementia-specific support groups?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Identify key carer support organisations (e.g. Carer Gateway, Dementia Australia) and make recourses accessible in consult and waiting rooms.
4. Medication Management		
Is there a clear process for prescribing, reviewing, and monitoring dementia-related medications (e.g.	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Assess your practice's medication review process for dementia patients.

cholinesterase inhibitors, memantine)?		Ensure Home Medication Reviews (MBS item 900) and Residential Medication Management Reviews (MBS item 903) are provided where appropriate.
Does the practice collaborate with specialists for complex medication management?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Consider Case Conferencing (MBS item 739) for complex patients.
5. Ongoing Care Coordination		
Are regular follow-up visits scheduled to monitor cognitive function and quality of life?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Review patient recall systems to ensure dementia patients are flagged for periodic review.
Does the practice engage with other health providers in the patient's care team?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Consider case conferencing (MBS item 739) for complex patients.
6. End-of-life Care		
Are end-of-life preferences discussed and documented for patients with advanced dementia?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Refer to CESPHN Palliative Care QI Toolkit for guidance. Ensure the practice team is trained and confident in having end-of-life conversations.
Does the practice collaborate with specialist palliative care services when required?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Refer to South Eastern Sydney HealthPathways or Sydney HealthPathways for palliative care referral pathways.

List your top three identified priorities for action:

1.	
2.	
3.	
Practice name:	**Date:**
Team member:	

Activity 3 – Important Conversations

Advance Care Planning assists patients in planning for their future care and is based upon the foundational principles of dignity, self-determination, and minimization of harm. Through evaluation and discussions, patients can document their preferences for future care if they are no longer able to make or communicate important decisions themselves.

For people with dementia, the capacity to make and express decisions about everyday living and healthcare declines as the disease progresses, making it challenging to plan for future care[15]. This often means that family members or carers are required to make difficult health decisions, sometimes without clear knowledge of the patients' preferences[15].

Advance care planning is an effective way to enhance dementia patients care and is associated with reduced hospitalisation, increased use of hospice services, and improved psychological wellbeing for relatives[15].

Enduring Power of Attorney and Enduring Guardian

An enduring Power of Attorney (POA) is a legal document that allows a person to appoint someone to make financial and legal decisions on their behalf in the event they lose the ability to make decisions for themselves[16]. An enduring POA cannot make medical decisions, however, appointing an enduring guardian authorises someone to make these health, lifestyle, and medical decisions on the patients' behalf[17,18]. Health

[15] Brisbane South PHN. Quality Improvement toolkit for general practice: older people module [Internet]. Brisbane AU: Brisbane South PHN; 2021 [cited 2026 Apr 9]. Available from: https://bsphn.org.au/documents/qitoolkit_toolkit_older-people2021.pdf
[16] NSW Trustee and Guardian. Choose a Power of Attorney [Internet]. NSW Government; [Last updated 2025 Oct 30; cited 2026 Apr 9]. Available from: https://www.nsw.gov.au/family-and-relationships/planning-for-end-of-life/make-power-of-attorney
[17] NSW Health. Advance Care Planning [Internet]. NSW Government; 2025 [cited 2026 Apr 9]. Available from: https://www.health.nsw.gov.au/patients/acp/pages/default.aspx
[18] NSW Trustee and Guardian. Choose an enduring guardian [Internet]. NSW Government; [Last updated 2025 Oct 30; cited 2026 Apr 9]. Available from: https://www.nsw.gov.au/family-and-relationships/planning-for-end-of-life/choose-enduring-guardian

practitioners can encourage dementia patients and families to seek information on enduring POA and enduring guardian through NSW Trustee and Guardian (1300 109 290) or a solicitor. For further information, please see NSW Trustee and Guardian.

Important Conversations for Non-English-Speaking Patients

It is essential that you use an interpreter when needed for conversations with non-English speaking patients, so that the patient's preferences are correctly documented. Interpreters can be organised through Translating and Interpreting Service (TIS National). The Appointment Reminder Translation Tool is available online and can be used to translate appointments into your patient's language.

Activity 3.1 – Data Collection from Clinical Software

The aim of this activity is to collect data to identify patients with dementia who have completed an advance health directive.

For a detailed guide on how to collect data from Best Practice or Medical Director, please see the following links:

- Best Practice Guide – Dementia and Advance Health Directive
- Medical Director Guide – Dementia and Advance Health Directive

Description	Total Number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
Number of active patients with dementia (from activity 1.1)		
Number of active patients with dementia and a completed advance health directive		

Reflection comments for **Activity 3.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 3.2 – Review your dementia population's advance care documentation

The aim of this activity is to increase your practices understanding of dementia patients with an advance care plan and/or advance health directive.

Description	Status	Action to be taken
After completing activity 2.1 are there any unexpected results with your practice's dementia patients with a completed advance health directive?	☐ Yes: **see action to be taken** ☐ No: continue with activity	Please explain: (e.g. only one of our dementia patients had an advance health directive completed). How will this information be communicated to the practice team?
Are GPs aware that if they record the advance health directive as a reason for a visit or record it in the patient's history, it is easier to identify when completing a search on the practice database?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Communicate this information to all GPs as per practice communication policy. Discuss this at the next practice team meeting.
Do relevant team members know where to find more information about advance care plans?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Refer to Advance Care Planning. How will this information be communicated to the relevant practice team members?
Do relevant team members know how to support patients and families with completing a power of attorney (POA)?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Refer to Advance Care Planning and Enduring Power of Attorney for further information. How will this information be communicated to the relevant practice team members?

Do any of the practice team require training/assistance on having end of life conversations?	☐ Yes: **see actions to be taken** ☐ No: continue with activity	Training available at End-of Life Essentials Or CareSearch Health Professionals How will this information be communicated to the practice team?
Are GPs aware that advance care plans should be uploaded to a patient's My Health Record to coordinate care (important in the event a patient transfers to a RACH)?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Refer to My Health Record. Communicate this information to all GPs as per practice communication policy.
After reviewing your practice's end of life conversations/documentation processes, are there any changes with the management of your patients you would like to implement over the next 12 months?	☐ Yes: **set goals and outline in action to be taken.** ☐ No: you have completed this activity	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 3.2:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Central and Eastern Sydney PHN Advance Care Planning QI Toolkit

For more advanced activities, or further information on advanced care planning, please see CESPHNs Advance Care Planning Toolkit.

Activity 4 - Support for patients to live at home longer

Living in Their Own Home

People prefer to age and receive care in the comfort of their own home, close to familiar environments, friends, and communities. With appropriate and timely support, older people can maintain their independence, preserve their dignity, and stay connected to their communities as they age.

Although most Australians indicate a preference to die at home, only a small proportion do, highlighting a service gap that general practitioners are well positioned to address[19]. In Australia, dying is largely institutionalised, and there is a need to provide better support to individuals wanting to receive home care during their final months[20,21].

With appropriate support and adjustments, people living with dementia can continue to live safely at home. Creating a dementia-friendly home can make it easier and safer for people to maintain independence and remain in familiar surroundings[22,23]. For further information on creating a dementia friendly home, please visit Tips to create a dementia-friendly home and Home life Dementia Australia.

Support at Home Program

The support at home program replaced the Home Care Packages Program and Short-Term Restorative Care Programme from November 2025[24]. The program supports older people to remain at home longer by improving access to coordinated care and services[25]. For further information, please see the Support at Home program.

My Aged Care

[19] Reymond L, Parker G, Gilles L, Cooper K. Home-based palliative care. Aust J Gen Pract. 2018 [cited 2026 Apr 10]; 47(11). Available from: doi: 10.31128/AJGP-06-18-4607

[20] Swerissen H, Duckett S. Dying well [Internet]. Grattan Institute; 2014 [cited 2026 Apr 10]. Available from: https://grattan.edu.au/report/dying-well/

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[25] Australian Government. Support at Home program [Internet]. My Aged Care; [cited 2026 Apr 29]. Available from: https://www.myagedcare.gov.au/supportathome

My Aged Care provides a range of support for people 65-years and older. This includes:

- Help at home if a person is having difficulty with everyday tasks
- Short term care to provide a person care and support for a determined period
- Aged care homes if a person feels they can't live independently at home, even with supports
- Respite care for carers who need a time off

Health Assessments

Patients aged 75 years and older, or Aboriginal and Torres Strait Islander patients aged 55-years and older can complete Health Assessments under the Medicare Benefit Schedule (MBS). This assessment requires GPs and Nurses to assess the physical function of the patient, which includes the patient's activities of daily living. Refer to the MBS Criteria and/or the RACGP Silver Book for more information.

Activity 4.1 Support for patients to live at home longer

The aim of this activity is to investigate whether relevant people in your practice know how to refer patients for assistance living at home on their own.

Description	Status	Action to be taken
Do all relevant practice team members know how to refer patients to get assistance to live in their own home longer?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Referrals can be made through eReferral forms delivered by HealthLink through your practice's software programs (Best Practice, Medical Director etc.). For further information, please see Electronic referral (eReferral) forms.
Are relevant health professionals aware of the various medical apps that may be of assistance with the management of patients with dementia?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Please refer to the Activity 7: Recourses and Training at the end of this document. How will this information be communicated to relevant team members?
Do relevant team members know where to find further information about advance care planning for dementia patients?	☐ Yes: continue with activity ☐ No: **see action to be**	See Advance Care Planning and Advance care planning brochure for further information.

	taken	How will this information be communicated to relevant team members?
Do relevant team members know where to find further information about Enduring Power of Attorney and Enduring Guardianship with patients who have dementia?	☐ Yes: continue with activity ☐ No: **see action to be taken**	See Enduring Power of Attorney and Advance Care Planning for further information. How will this information be communicated to relevant team members?
After reviewing your assistance for patients to live at home longer processes, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set your goals** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 4.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 5 – LHD Dementia Care Teams

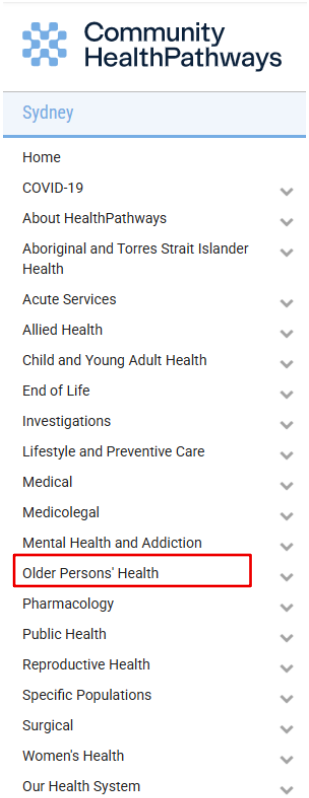
Dementia in HealthPathways

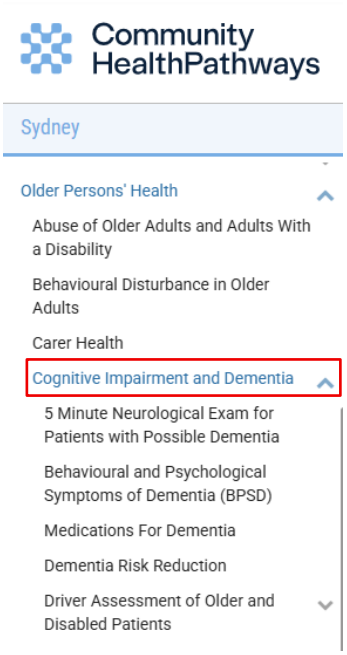
Sydney and South Eastern Sydney HealthPathways is an online portal aimed to support primary care clinicians to the point of consultation. It provides clinical decision support frameworks for accessing and managing health conditions and how to refer patients to local services effectively.

- For further information or gaining access to Sydney HealthPathways, email SLHD-HealthPathways@health.nsw.gov.au
- For further information or gaining access to South Eastern Sydney HealthPathways, email SESLHD-HealthPathways@health.nsw.gov.au

Sydney Local Health District

Dementia care pathways can be located under 'Older Persons' Health' on the left-hand side menu bar. Within this pathway, you can view information under the 'Cognitive Impairment and Dementia' dropdown.

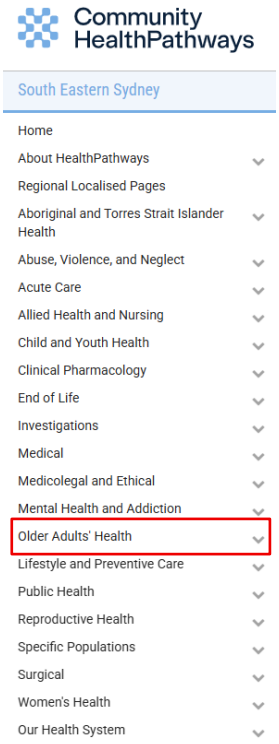


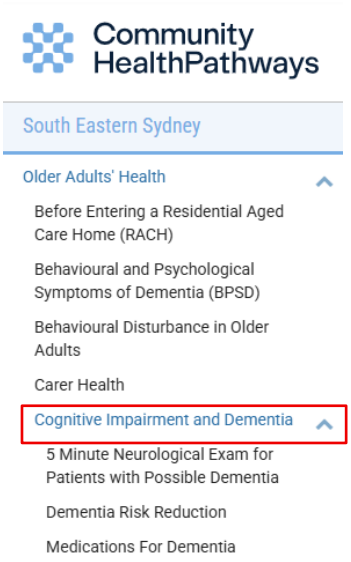


To access Sydney Local Health District HealthPathways, go to SLHD HealthPathways.

South Eastern Sydney Local Health District

Dementia care pathways can be located under 'Older Adults' Health' on the left-hand side menu bar. Within this pathway, you can view information under the 'Cognitive Impairment and Dementia' dropdown.





To access South Eastern Sydney Local Health District HealthPathways, go to SESLHD HealthPathways.

iREADi Programs

Integrated Rehabilitation for Early-Stage Dementia (iREADi) is an education and group rehabilitation program aimed to improve the knowledge, skills, and confidence of older people living with dementia alongside their family and carers.

These programs are run by Management of Dementia teams at the Uniting War Memorial (Waverly) and Calvary Hospital (Kogarah), who utilise rehabilitation and educational approaches to strengthen everyday functioning and quality of life for dementia patients.

Activity 5.1 – Activity – LHD Dementia Care Teams

Description	Status	Action to be taken
Do all relevant practice team members know who to refer a patient to for Dementia care services?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	How will this information be communicated to the relevant practice team members?
Do all relevant practice team members know how to access Health Pathways dementia resources?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Refer to SouthEasternSydneyHealthPathways or SydneyHealthPathways How will this information be communicated to the practice team?
After reviewing referral process, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes**, see actions to be taken to help set you goals.** ☐ No, you have completed this activity	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 5.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 6 - Medicare Benefit Schedule (MBS) items for Dementia Patients

Activity 6.1 – Data Collection from Polar

Complete the table below by collecting data from Polar. Instructions on how to do this can be found through this guide.

Description	Total
Number of health assessments claimed for active patients with dementia in the past 12 months	
Number of Home Medication reviews claimed for active patients with dementia in the past 12 months	
Number of Residential Medication reviews claimed for active patients with dementia in the past 12 months	
Number of GP Chronic Condition Management Plans claimed for active patients with dementia in the past 12 months	
Number of Nurse chronic disease item numbers claimed for active patients with dementia in the past 12 months	
Number of Aboriginal and Torres Strait Islander assessments claimed for active patients with dementia in the past 12 months	
Number of Mental Health item numbers claimed for active patients with dementia in the past 12 months	
Use this link for a polar guide or use the Polar Education Portal to identify the data required. If you need assistance contact your Digital Health Officer digitalhealth@cesphn.com.au	

Reflection comments for **Activity 6.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 6.2 – Understanding your MBS claiming

The aim of this activity is to increase your understanding of the MBS item number claiming at your practice.

Description	Status	Action to be Taken
After completing activity 6.1 are there any unexpected results with the number of MBS items claimed at your practice?	☐ Yes: **see actions to be taken** ☐ No: continue with activity	Please explain: (e.g. low number of health assessments completed, higher rate of GPCCMP than expected). How will this information be communicated to the practice team?
Is your practice utilising MBS claims as you expected?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Outline the differences – is it active population, age group differences, male/female populations? How will this information be communicated to the practice team?
After reviewing your patient MBS claiming, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set goals** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 6.2:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Medicare Benefit Schedule (MBS) items for Dementia Patients

The following MBS item numbers may be used for older patients with dementia. Please refer to the MBS guidelines if you require further information, found here MBS Online.

Health Assessments (items 701-707, 715)

A health assessment is the evaluation of a patient's health and wellbeing. Eligible practitioners can use it to determine if a patient needs:

- Preventive health care
- Education to improve their health and wellbeing

Please refer to the MBS online for more information on 75+ Health Assessments and Aboriginal & Torres Strait Islander Health Assessments.

Home Medication Reviews (item 900)

According to the Quality use of Medicines to Optimise Ageing in Older Australians resource, as our population ages, there will be more individuals living with multiple chronic diseases, with an associated increase in polypharmacy (use of multiple medicines). Medicine use requires a balance between disease management and avoiding medicine related issues.

GPs can claim a Medicare item number to complete a Home Medication Review alongside a community pharmacist. Please refer to MBS online for more information on Home Medication Reviews.

GP Chronic Condition Management Plans (items 965 & 967)

Older people often have complex diseases that require a variety of interventions and supports throughout their old age. This may include completing a GP Chronic Condition Management Plan. For further information, please refer to the MBS toolkit.

Practice nurse chronic disease (item 10997)

This item can be claimed by a medical practitioner when a practice nurse or Aboriginal and Torres Strait Islander health practitioner provides monitoring and support to a patient with a GP chronic condition management plan (GPCCMP) on the practitioner's behalf. This item is claimable up to five times per Calander year.

Further information on eligibility and claiming requirements is available on MBS Online.

Case conferences (item 739)

This item number is available to give a holistic, informed approach to ongoing care for providers,

family, and carers. The case conferences need to:

- Be organised by the GP
- Be twenty to forty minutes long
- Have the GP and at least two other health care providers present

For more details about the criteria, please visit MBS Online.

Mental Health treatment plan (if relevant)

There are several Medicare item numbers for GPs to claim for mental health consultations. Please see the Medicare Benefit Schedule for more details. The item numbers include:

Item Description	Medicare Criteria	Frequency of claiming
Mental Health Consultation (MBS item 2713)	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a Mental Health Plan.	No limits to the number of times this item number is claimed
Mental Health Plan (MBS items 2700, 2701, 2715, 2717)	A mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities The Mental Health Plan must include documenting the results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date in the patient's GP Mental Health Treatment Plan	A new plan can be completed every 12 months & at least 3 months after claiming an item 2712 – review Mental Health Plan After plan has been completed, the patient is entitled to up to 10 Medicare subsidised visits with a Psychologist per calendar year

Review Mental Health Plan (MBS item 2712)	The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation. A patient's GP Mental Health Treatment Plan should be reviewed at least once.	Can be claimed every 3 months or at least 4 weeks after claiming the Mental Health Plan item number

Medicare item numbers for patients in a residential aged care Home

Patients residing in a residential aged care home may qualify for following Medicare item numbers.

Comprehensive medical assessments (item 701-707)

This item number is available to residents when admitted into a residential aged care home. New residents should receive the health assessment as quickly as possible once admitted, preferably within six weeks. This item number is claimable every 12 months. For further information, please see MBS Online.

Care plan contribution (item 731)

GPs can be requested to contribute to an eligible multidisciplinary care plan from a RACH or other provider. The GPs contribution involves either giving advice, preparing or amending parts of the plan, and submitting a copy of the resident's medical records.

Once the claim for item 731 is submitted, residents may be eligible for five allied health services in addition to any funded by a RACH.

This item number is claimable every three months, with a recommendation of every six months. For more information, please see MBS Online.

Residential Medication Management Review (item 903)

A Residential Medication Management Review involves a review of medications alongside the pharmacist report, for residents at risk of medication-related issues or who have a large change in their medical condition. A GP initiates a RMMR with a pharmacist for permanent residents.

This item number is claimable one every twelve months. More information is available at MBS Online.

Case conference

Please see information above.

Mental Health treatment plans

Please see information above.

Activity 7 - Marking Patients Deceased in your clinical software

When a patient passes away, it is critical for a GP to review the patients file, ensuring a staff member marks the patient as deceased in your practice's clinical software package.

This ensures each patient has up to date information and correspondence, such as reminder letters, are not made with a deceased patient's family members.

GPs and Death Audit

GPs may want to complete a Death Audit to review whether the treatment, services, and health needs of the patient were met.

Activity 8 - Resources & Training

PROGRAM	DESCRIPTION
The National Dementia Helpline	The National Dementia Helpline is a free, confidential phone and email service that provides information and support to those who need it. The helpline provides emotional support, help connecting to services and programs, and guidance regarding government information, Carer Gateway, DBMAS, and the NDIS. **Phone:** 1800 100 500 For further information: The National Dementia Helpline
Dementia Australia	Dementia Australia (DA) is a leading organisation supporting people with dementia, alongside their carers and families. DA provides reliable information, education, and support services for professionals, dementia patients, their families, and carers. The organisation advocates for positive change within the community and government, supports research and the health workforce, and works with communities and people with lived experience to build dementia friendly societies, reduce stigma and support self-advocacy. More detail is available on their website: Dementia Australia.
Dementia Training Australia	Dementia Training Australia (DTA) is supported by the Dementia Training Program and funded by the Australian Government. It aims to strengthen the knowledge and capability of the workforce supporting people living with dementia and carers. DTA provides education and training for the workforce to improve dementia care. This includes free courses, commissioned training, free modules, webinars, and workshops. DTA also has a variety of free tools and recourses for practices to use, including guides for general practice, assessment tools, and fact sheets. They also offer tailored support for allied health professionals and general practitioners. This includes e-Learning and online courses, podcasts, and recourses and webinars. For further information, please visit their website: Dementia Training Australia (DTA). **Phone:** 1300 229 092

	My Aged Care is funded by the Australian Government and helps individuals access aged care services. It provides key information on the types of services available, what services people are eligible for, how to apply for an aged care assessment, referrals to health providers, and other support to help people navigate the aged care system. For more information, visit their website: My Aged Care **Phone:** 1800 200 422
	HealthLink is a healthcare technology organisation that provides a secure messaging network for the exchange of clinical information. It connects healthcare providers with the broader health system, allowing them to exchange patient information, eReferrals, results and reports. For more information, please see their website: HealthLink
	Carer Gateway is funded by the Australian Government and provides free support and services for carers in Australia. This includes peer support groups, counselling, support packages, online training, and access to respite services. For more information, please see their website: Homepage | Carer Gateway Carer Gateway also has a dedicated number, available during business hours, Monday to Friday 8am to 5pm: 1800 422 737
	The Australian Dementia Network (ADNeT) is a national collaboration bringing together scientists and researchers to improve dementia diagnosis, treatment, and care within Australia. Key initiatives include their Memory and Cognitive Clinics network and pathways to participate in dementia clinical research trials. For further information, please see their website: ADNet - Australia Dementia Network
	Advanced Care Planning Australia is an Australian Government Initiative seeking to strengthen advanced care planning, so people receive care that aligns with their personal wants and needs. They aim to increase awareness of advanced care planning, educate the aged care workforce, develop system improvements to support advanced care planning, and disseminate research. For more information, please see their website: Advance Care Planning Australia.

ELDAC End of Life Directions for Aged Care	End of Life Directions for Aged Care is funded by the Department of Health and is a national advanced care planning and palliative care advisory service. ELDAC gives information, guidance, and recourses to health providers within the aged care sector to support palliative care and advanced care planning, improving the care of older people. For more information, please see their website: ELDAC
caring @home	Caring@home is funded by the Australian Government and aims to strengthen the accessibility of end-of-life care for patients choosing to live or die at home. They provide recourses for health professionals to support carers and families in providing personal care and manage end-of-life symptoms when caring for people living at home. For more information, please see their website: caring@home
iREADi Integrated Rehabilitation for Early Stage Dementia.	Integrated Rehabilitation for Early-Stage Dementia (iREADi) is an education and group rehabilitation program aimed to improve the knowledge, skills, and confidence of older people living with dementia alongside their family and carers. These programs are run by Management of Dementia teams at the Uniting War Memorial (Waverly) and Calvary Hospital (Kogarah), who utilise rehabilitation and educational approaches to strengthen everyday functioning and quality of life for dementia patients. For further information, please refer to Central and Eastern Sydney Health & Community Services Directory.
Australian Government Department of Health, Disability and Ageing	The Focus on Dementia booklet, developed by the Australian Government Department of Health, Disability and Ageing, provides practical information to support people living with dementia, their families and carers. It includes information on understanding dementia, diagnosis, available supports and services, future planning, and strategies for living well with dementia. The booklet can be used by health professionals as a patient education resource. For further information, download: Focus on Dementia booklet

RACH Focused Recourses

Dementia Support Australia	Dementia Support Australia is funded by the Australian Government and aims to support carers and the aged care network in understanding the causes of behaviour in people living with dementia. They provide assessments and expert advice whilst working alongside the person with dementia, to target their needs and provide ongoing support. Whilst they provide services to people living at home and in acute care, they also provide services to people in residential aged care. For more information, please see: Dementia Support Australia.
Australian Government Department of Health, Disability and Ageing	The Dementia Training Program is funded by the Australian Government and aims to improve the care and well-being of people with dementia, alongside staff involved in their care. The program offers free dementia courses, onsite training, and an online training portal for workers in residential aged care and wider health care services. For further information, please see: Dementia Training Program.

Apps and Tools for Dementia

BrainTrack	BrainTrack is a free mobile app that helps people understand and monitor changes to their cognitive health. The app provides brain health information in the form of games that test people's cognition. The aim of the app is to increase earlier diagnoses of dementia through sharing data on the app with a GP. For more information, please see: BrainTrack.
Ask Annie app	The Ask Annie app is a free interactive training app designed to strengthen care workers ability to support patients with dementia. The app includes interactive modules through self-paced learning that covers topics across behaviour support and culturally diverse end-of-life traditions. For further information, or to download the app go to: Ask Annie app
Tell TiNA	Tell TINA is an analysis tool designed to identify strengths and skill gaps within your dementia workforce. The tool is purchasable within the Ask Annie app and is an interactive

	recourse that assesses staff's skills and highlights where skills may be improved. For further information, please visit: Tell TiNA.
My Dementia Companion	My Dementia Companion seeks to simplify the dementia journey and provide guidance on how to live and care well with dementia. The tool is available for carers and people living with dementia through the CARER tool, or for professionals within the workforce through the PRO tool. Professionals can also refer patients or carers to the CARER tool, with flyers and templates available on their website to ease the process. For further information, please see: My Dementia Companion.

Links to other QI toolkits

Central and Eastern Syndey PHN have a range of QI toolkits for general practice. The toolkits are designed to:

- Enhance patient care and outcomes
- Assist practices to fulfill their quality improvement requirements under PIP QI
- Allow you to choose the area of work you would like to focus on and enhance

The full suite of toolkits are available on Central and Eastern Syndey PHN's website.

Registering completion or submitting feedback

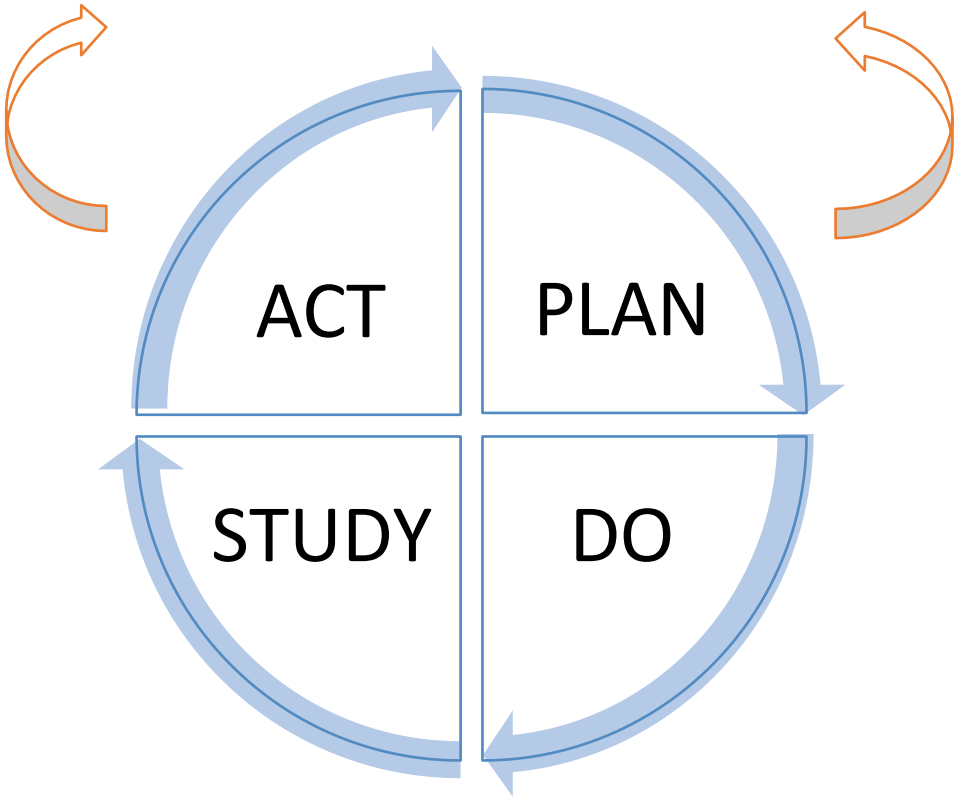
Following completion of the QI toolkit and/or to submit feedback please submit the Practice QI Feedback Form.

Model for improvement diagram

What are we trying to accomplish?

How will we know if a change is an improvement?

What changes can we make that will result in improvement?



Quality Improvement Activities using The Model for Improvement and PDSA

Name of Practice: Date:

Name of QIA:

Quality Improvement Team	
Names	**Roles/Responsibilities**

GOAL (Simple, Measurable, Achievable, Realistic, Timely) What are we trying to accomplish and when?	Identify active patients with dementia who do not have a GP Management Plan recorded in the past 12 months
MEASURES What data will we use to track our improvement? Eg POLAR	Collect information on Polar on the number of patients with dementia who have had or have not had a current GP Management Plan. Data to be collected over a 2-week period. Create list of patients who may benefit from having a GP Management Plan.
INITIAL BENCHMARK What is our current data saying?	Predicted 50% of patients with dementia have had a recent GP Management Plan
IDEAS 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/ Username: connected P/w: healthcare. HealthPathways South East Sydney: https://sesydney.healthpathwayscommunity.org Username: sesydney P/w: healthcare	1. Identify who in the team will collect the data. 2. Allocate protected time to collect the data. 3. Review if data meets initial benchmark. 4. Allocate GPs list of eligible patients- consider contacting these patients to book in an appointment for a GP Management Plan or ensure they are booked in for a longer appointment at their next scheduled visit.

PLAN How will we do it?				DO Did we do it? Unexpected problems?	STUDY Review/reflect on results Lessons learnt What did/didnt't work well?	ACT Next steps? Review or extend activity?
	What	Who	When			
1						
2						
3						
4						
5						
6						