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| --- | --- | --- | --- |
| Practice Name  |  | Cycle number |  |
| Staff initiator:  |  | Position title: |  |
| Start date: |  | End date: |  |
| Purpose | What are we trying to accomplish?What do you plan to do? |
| Improved waist measurement and HbA1c levels of our Type 2 Diabetes patients. Have a sustainable health coaching model utilising our Practice Nurse. Engage a Practice Nurse to provide health coaching and care plans 1 day a week for our Type 2 Diabetes patients and engage local allied health providers to refer our patients to.  |
| How will we know that change is an improvement? What do you hope to achieve? (include measurement/outcome) |
| Type 2 Diabetes patients will have improved waist measurements and HbA1c levels evidenced via the clinical audit tool and the Practice Nurse role/time involved will be sustainable.  |
| What change can we make that will result in improvement? |
| Health coaching and care plans for patients with Type 2 Diabetes to improve coordination of care, patient engagement and encourage patients to make lifestyle changes to improve their health and wellbeing. Raise community awareness Engage with local allied health professionals to ensure patients receive holistic coordinated care that is aimed at improving their health  |
| PLAN | By answering this, you will develop the GOAL for improvement. The goal must be SMART - Specific, Measurable, Achievable, Relevant, Time-limited |
| Write a concise statement of what you plan to do, and the steps involved | From the questions/answers above, write your statement or aim of what you are attempting to achieve. |
| Improve patient indicators of waist measurement and HbA1c level by 5% in Type 2 Diabetic patients over the next 6 months by utilising the skills of a practice nurse to provide health coaching to our Type 2 Diabetes patients  |
| How are you going to do this? (list the steps to be implemented) |
| Steps | By whom | By when |
| Consult with the PHN practice facilitator, develop a plan of action and present it at staff meetings. |  |  |
| Form a QI team, discuss workflow and allocate roles & responsibilities. [ideally – practice manager (can include PHN practice facilitator) and at least one GP, nurse and admin staff.] |  |  |
| Recruit Practice Nurse 1 day per week to provide one on one health coaching and care plans to Type 2 Diabetes patients (from existing staff)  | PM  |   |
| Analyse baseline data to identify eligible Type 2 Diabetes patients | PM PN |  |
| Recall and reminders for Type 2 Diabetes patients who are due for GPMP/TCA and Review of GPMP/TCA - book them in with Practice Nurse  | PM |  |
| Ensuring clinical staff are using Topbar to record missing waist measurements and HbA1c referrals for patients attending the clinic.  | All staff  |  |
| Ensure relevant Allied Health are included in GPMP/TCA to refer patients to.  |  |  |
| Refer patients to Allied Health that are conducing group programs to utilise the Medicare Group items for Type 2 Diabetes.   | PN  |  |
| At completion of specified QI period, measure change by repeating data reports using Pen/clinical software.  | PM PN |  |
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| DO | This may include how the patients react, how the doctors react, how the nurses react, how it fits in with your system or flow of the patient visit. You will ask, “Did everything go as planned?” |
| **Implement your plan and write down observations you have during your implementation.**  | What did you observe? |
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| Where there any unexpected events? |
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| STUDY | You will ask, “Do I have to modify the plan” |
| **After implementation you will study the results and record how well it worked, if you met your goal and document areas of improvement.**  | What did you learn? |
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| Has there been an improvement? |
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| Did you meet your measurement goal? |
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| What could be done differently? |
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| ACT | If it did not work, what you can do differently in your next cycle to address that. If it did work, are you ready to spread it across your entire practice? |
| **Here you will write what you came away with for this implementation, whether it worked or not.**  | What did you conclude from this cycle? |
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