## GP Full/Mini Audit

**WHAT IS AN AUDIT?**

## An audit is an activity designed to systematically review an aspect of the Practice or the Providers performance and identify areas for improvement. An audit may look at the care a provider (or group of providers) provides for patients as a whole or at sub-groups of the practice’s patient population (eg patients over 75 years of age, patients with Type II Diabetes). An audit may also review practice-based processes, procedures or systems.

**DO AUDITS CONTRIBUTE TO MY CPD POINTS?**

Audits contribute to the general practitioner's (GPs) continuing professional development (CPD) hours. RACGP recommends that the minimum time spent:

* mini audit is 6 hours
* full audit should take 10 hours.

The process for a full and a mini audit is basically the same however a full audit has longer data collection and review timelines. Audits can be completed in person, via telephone or via video conferencing.

**THE PROCESS**

An audit needs to be led by one GP and can also involve other General Practitioners, Specialists, Hospital staff, Allied Health Providers as well as practice-based Registered Nurse’s, Reception staff and/or the Practice Manager.

This template will take you through the Audit process step by step allowing you to document the process as you go.

**This template is pre-filled with a CVD audit to demonstrate how to use the document. To do another topic, delete the CVD information and add in your audit information.**

*Please remember - audits must consider ethical, privacy (Privacy Act 1988) and confidentiality issues around patient information, as required.*

### PRE-AUDIT ACTIVITIES

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| **Start Date:** |  | **Finish Date:** |  |
| **Audit Type:** | Full Audit (10 hours)  Mini Audit (6 hours) | **CPD Home:** | RACGP Member # 123123 |
| **Audit Subject /Title:** | *EG – Cardiovascular Disease* | | |
| **People Involved** | *EG – Name of GPs, Nurse, Reception Staff* | | |

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| **STEP 1 – IDENTIFY THE PURPOSE OF THE AUDIT AND THE PEOPLE INVOLVED** |
| Why you are undertaking the audit, what you are hoping to achieve and who will be involved. |
| Time required to complete this step: 1 hour (CPD Area - Reviewing Performance) |

**Why are you doing this audit?**

***EG -*** *CVD is the single leading cause of death in Australia, and growing evidence that COVID-19 is associated with worse cardiovascular outcomes 12 months post-infections. Of the approximately 1 million people living in the North Brisbane PHN region, only 43.2% of eligible patients have the necessary risk factors recorded to enable an assessment for CVD. General practitioners play a vital role in delivery of routine CVD risk assessment and management for at-risk patients.*

**What are you trying to achieve?**

*EG- I want to identify at-risk patients who would benefit from a heart health check and complete a Heart Health Assessment (MBS Item 699, 177) in line with Practice Improvement Program Quality Improvement (PIPQI) Measure 8: Proportion of eligible regular clients with a record of the necessary risk factors in their GP record for CVD risk assessment.*

**What are your specific goals for the audit? Make sure they are S.M.A.R.T (Specific, Measurable, Achievable, Relevant and Time-bound).**

*EG - Within the next 4 weeks, our team will use the Primary Sense or other clinical decision support tool to identify 10 -15 patients with a calculated cardiovascular disease (CVD) risk greater than 10% (High Risk) and engage with them in a Heart Health Assessment (MBS item 699,177).*

**Who else will you involve in the audit? You can do this activity independently or work with other GP’s, allied health professionals or staff working in the practice. If you are doing this in a team – who else will you involve and what will they do?**

| **ROLE** | **NAME** | **RESPONSIBILITIES** |
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| *Lead GP* |  | * *Champion the implementation of the Heart Health Check Initiative* * *Support the necessary changes in practice processes and systems* * *Approve and verify eligible patients* * *Opportunistically identify patients when presenting for other health reasons* * *Calculate CVD risk using the AUS CVD Calculator and enter into patient health record* * *Discuss the CVD risk score with the patient and recommend interventions* * *Ensure recall/reminder is entered so reception staff book a hearth health check* * *Perform heart health checks (Item 699)* |
| *Other GP’s* |  | * *Approve and verify eligible patients* * *Opportunistically identify patients when presenting for other health reasons* * *Calculate CVD risk and enter into patient health record* * *Discuss the CVD risk score with the patient and recommend interventions* * *Ensure recall/reminder is entered so reception staff book a hearth health check* * *Perform heart health checks (Item 699)* |
| *Practice Manager* |  | * *Implement processes to facilitate the introduction of Heart Health Checks* * *Support clinical team members with data management and reporting* * *Ensure the AUS CVD risk calculator can be easily accessed* * *Inform team members of the criteria and billing requirements of MBS item numbers 699 and 177* * *Develop communication and support strategies to keep all staff informed* * *Set up systems to identify, recall and follow-up eligible patients* * *Utilize BP, MD or other to automate recall and reminder notifications based on the 'cardiovascular disease risk factors' report from Primary Sense* * *Ensure the business requirements for PIP QI are met and forwarded to your PHN*   + *develop methods to regularly share a minimum set of deidentified data*   + *use available data to understand where the practice is performing compared to national and local benchmarks* |
| *Practice Nurse* |  | * *Run Primary Sense report and identify eligible patients.* * *Check against HPOS/MyHealth record to ensure patient has not had a 699/715 in other practice.* * *Work with the Practice Manager to develop processes to identify eligible patients* * *Work with reception staff to ensure invitations and reminders are sent to patients* * *Collect patient information and enter CVD risk factor data* * *Educate the patient about modifiable risk factors and provide advice on lifestyle programs* * *Use Heart Foundation resources to help educate and engage patients* * *Identify quality improvement activities in line with Practice Incentive Program Quality Improvement (PIP QI) incentive requirements* * *Understand the Medical Benefits Schedule (MBS) compliance requirements for item numbers 699 and 177* * *Identify opportunities for completion of GP Management Plan (GPMP)/Team Care Arrangement (TCA)* |
| *Reception Staff* |  | * *Be aware of the Heart Health Check activity and practice processes* * *Inform patients about what’s involved in the Heart Health Check* * *Assist with patient recall and reminder processes* * *Provide resources and information to patients as requested* * *Refer patients to practice nurse(s) for more information as required* |
| *Support Role eg Allied Health Professionals* |  | * *Contribute to the My healthy heart plan.* |

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| **STEP 2 – HOW WILL YOU MEASURE PROGRESS** |
| What you are trying to achieve and what data you will collect to track your progress. Ethical, privacy, accessibility and confidentiality issues are also considered. |
| Time required to complete this step : ½ hour (CPD Area - Reviewing Performance)  ½ hour (CPD Area – Monitoring Outcomes) |

**Complete the following table:**

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| **What are you trying to achieve?** | **Guidelines / Standards you will be working towards or resources you will use** | **What data will you collect**  **(Who, when, where, how)** |
| **Subject**: *Cardiovascular Disease Prevention*  **Goal:**  *I want to identify at-risk patients who would benefit from form a heart health check and complete a Heart Health Assessment (MBS Item 699, 177) in line with Practice Improvement Program Quality Improvement (PIPQI) Measure 8: Proportion of eligible regular clients with a record of the necessary risk factors in their GP record for CVD risk assessment*  **Patient Criteria:**  *Patients who are eligible for this clinical audit are:*   * *aged 45-79 years (or 35-79 years for people with diabetes, or 30-79 years for First Nations people)* * *have no history of CVD* * *have not had another health assessment in the last 12 months e.g. MBS items 701, 703, 705, 707 or 715 (in order to claim the Heart Health Check under the MBS)* | *The practice will follow the best practice guidelines outlined for managing cardiovascular disease risk detailed in the listed resources.*  *Heart Foundation, Heart Health Check Toolkit,* [*https://www.heartfoundation.org.au/bundles/heart-health-check-toolkit/templates-for-use-during-appointmenthttps:/www.heartfoundation.org.au/bundles/heart-health-check-toolkit?selectedfilter=The%20Toolkit*](https://www.heartfoundation.org.au/bundles/heart-health-check-toolkit/templates-for-use-during-appointmenthttps:/www.heartfoundation.org.au/bundles/heart-health-check-toolkit?selectedfilter=The%20Toolkit)  *Royal Australian College of General Practitioners. "Cardiovascular Disease Prevention." National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People, 2020,* [*www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/national-guide/chapter-11-cardiovascular-disease-prevention*](http://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/national-guide/chapter-11-cardiovascular-disease-prevention)*.*  *Commonwealth of Australia as represented by the Department of Health and Aged Care. Australian Guideline for assessing and managing cardiovascular disease risk. 2023.* [*https://d35rj4ptypp2hd.cloudfront.net/pdf/Guideline-for-assessing-and-managing-CVD-risk\_20230522.pdf*](https://d35rj4ptypp2hd.cloudfront.net/pdf/Guideline-for-assessing-and-managing-CVD-risk_20230522.pdf) | *GPs, Practice nurses and Practice managers will complete a pre-project and post-project data review.*  *Primary Sense will be used to prepare a report per participating GP “Cardiovascular Disease Risk Factors” which identifies patients who may be at increased risk of developing CVD and have potentially modifiable risk factors.*  *The practice nurse or practice manager check HPOS for any Heart Health Checks or Health Assessments (699, 177, 701, 703, 705, 707) completed outside of the practice and updating the clinical software prior contacting the patients.* |

**How will you ensure accessibility for all patient groups?**

*EG – We will access patient resources from* [*HealthPathways*](https://brisbanenorth.communityhealthpathways.org/LoginFiles/Logon.aspx?ReturnUrl=%2f) *including resources available in languages other than English.*

**How will you address ethical, privacy and confidentiality issues relating to patient information is considered and addressed?**

EG -*No identifiable data will be shared with the PHN while they are supporting the CVD project. The patients “usual GP” and the practice clinical data manager / practice manager will only have access to the identifiable data of the patients.*

### AUDIT ACTIVITIES

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| **STEP 3 – DATA COLLECTION** |
| What the number of patients will involved, why or how they are selected and/or the collection of other relevant data or information (policy, procedures, patients, etc.) for the project. |
| Time required to complete this step : ½ hour (CPD Area - Reviewing Performance)  1 hour (CPD Area – Monitoring Outcomes) |

**What data/information do you need to collect before you start the project?**

*EG -*

1. *GPs or Practice Nurse to identify patients have had a health heart check already this year. GP’s will opportunistically identify patients when presenting for other health reasons, will calculate CVD risk and enter into patient health record and discuss the CVD risk score with the patient and recommend interventions. They will discuss the benefits of a Health Heart check with the patients and will ensure recall/reminder is entered so reception staff book a hearth health check*
2. *In addition, the RN will identify patients who are eligible for a heart health but have not has one using the Primary Sense reports “Cardiovascular Disease Risk Factors”.*
3. *The RN/Senior Reception staff will review patients’ eligibility status for a Heart Health Check (item 699,177) in PRODA or MyHealth Record and make sure they have not had a health heart check at another practice*.

**What data/information do you need to collect during the project?**

*EG-*

1. *In addition to undertaking CVD activities opportunistically during appointments we are aiming to target an additional 10-15 patients through the Primary Sense Report.*
2. *For identified patients we will recall the patient as per our practice recall and reminder policies and procedures. Reception staff will outline the purpose of the appointment and explain that it is a bulk-billed appointment and there will be no charge to the patient.*
3. *During the appointment we will assess the patients risk using the new CVD risk calculator and assessment of the need to engage in a risk reduction activity.*
4. *For full clinical audits we will then re-measure their CVD risk after 6 months*

**What data/information do you need to collect at the end of the project?**

*EG -*

1. *GPs or Practice Nurse to identify patients have had a health heart check since the start of the project.*
2. *Compare list of completed healthy heart check to the previous data*

**Are there any factors that may negatively impact the timeline of the activity?**

*EG – The practice manager is on leave for 3 weeks during the project so I will make sure that the required data and communications are completed before they go on leave so as not to impact the project timelines.*

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| **STEP 4 – DATA ANALYSIS AND IMPLEMENTATION OF CHANGE** |
| Analyse the data against the project goals. Identify changes and improvements have been made and what changes are still required |
| Time required to complete this step : ½ hour (CPD Area - Reviewing Performance)  1 hour (CPD Area – Monitoring Outcomes) |

**Look at the data from before, during and after the project.**

**What improvements have you seen during the project period?**

*EG – 12 patients were identified opportunistically during appointments and the doctor entered a recall/reminder for them to come in for a health heart check. Eight of these patients booked a health heart check and seven attended the appointment. In addition, 10 patients were identified through the Primary Sense report. Reception contacted these patients, 4 attended and were billed a 699.*

**Are you happy with these improvements?**

*EG – 11 additional patients competed a health heart check during the period. In addition, the CVD risk calculator was used on patients opportunistically and GP’s are more aware of using this tool in day-to-day consultations.*

**Have these improvements become business-as-usual (ie will you continue with this process/improvement on an ongoing basis)**

*EG- Yes*

**Why/Why not?**

*EG – The CVD calculator has become a standard part of appointments and GP’s are mindful of the need/availability of a follow-up health heart check*

**What further improvements would you like to see? What further improvements are required to meet best practice standards?**

*EG – Running the Primary Sense report should become regular practice with the RN doing this quarterly. GP responsible for entering a recall/reminder in the system for regular follow up. Practice Manager to draft an SMS for the system to recall and remind patients to book for these appointments.*

**How are you going to share these learnings with your colleagues and practice staff?**

*EG – During doctors meetings, practice staff meetings, via the GP’s WhatsApp chat, distribution of the PDSA documentation to practice staff.*

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| **STEP 5 – REVIEW OF PROGRESS AND SUSTAINED IMPROVEMENT**  **NOTE –** **Step 5 is only required if you are doing a FULL audit.** **Skip this step if you are doing a mini audit and move on to Post Audit Activities** |
| For a full audit a continual review of progress and sustained improvement is required. This is done by repeating the data collection and reflection activities in Steps 3 and 4 on a regular basis |
| Time required to complete this step: 2 hours (CPD Area - Reviewing Performance)  2 hours (CPD Area – Monitoring Outcomes) |

**When are you going to review the data again:**

*EG –*

*6 months*

*12 months*

*18 months*

**At each review point what will you be looking for?**

*EG – at each review point I will review the data and consider:*

* *Number of CVD assessments being done opportunistically*
* *Number of recalls and reminders GP’s have entered into the system*
* *When the Primary Sense report was run*
* *How many patients were recalled*
* *How many patients attended*
* *What factors impacted the patient attendance rate*
* *Feedback from GP/GP’s about the process, resources and their findings*

**How will you know where this has been a long-term change in your practice?**

*EG – I will know that this has been a long term change*

* *When all eligible patients in the primary sense report have completed a healthy heart check*
* *When patients are attending for follow up healthy heart check*
* *When I am checking with all eligible patients when they had their last check*
* *When checking CVD risk factors is a routine part of my consultation*

### POST-AUDIT ACTIVITIES

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| **GROUP RELECTION ACTIVITY** | | |
| Time required to complete this step: 1 hour (CPD Area - Reviewing Performance) | | |
| **Was this project relevant/useful to your practice?**  Yes  No  Partially | **Where the goals of the audit met?**  Not met  Partially met  Fully met | **Has this initiative become business as usual?**  Yes  No  Partially  Not appropriate/Not applicable |

**What did you learn from the audit / mini audit? Reflect on the initiative and outline your key learnings. The following questions may help to shape your answer:**

**Audit Objectives and Relevance**

* What were the primary objectives of this audit and how do they align with health care priorities of your patient cohort?
* How relevant are the findings of this audit to your daily practice?

**Findings Interpretation**

* What are your key learnings from the project?
* How will you ensure you continue to find, screen and support at-risk patients?
* Did using these tools help to inform or change your clinical practice?

**Impact on Patient Outcomes**

* In what ways has the audit and its findings changed your approach to patient education and engagement?
* Can you describe any specific cases where insights from the audit directly impacted on patient management or health outcomes?

**Practice Improvement**

* As a result of the audit what permanent changes would you consider implementing in your practice to enhance patient health outcomes?
* How do you plan to address any identified barriers to lifestyle changes identified in your patient consultations?

**Challenges and solutions**

* What challenges do you foresee in implementing the changes identified in the audit
* What are possible solutions to overcoming these challenges?

**Reflecting on Tools and Resources**

* Are there additional tools or resources you believe could help in this space?
* How could the practice better utilise existing tools or modify existing processes to improve patient health outcomes?

**Learning and Feedback**

* What feedback from patients or colleagues has shaped your perspective on the audit’s findings?
* How has this audit influenced your personal learning or professional development?

*EG - The audit revealed several key insights*

1. ***Educational Tools****: We learned that visual tools significantly enhance patient understanding of CVD, emphasizing the importance of educational resources in patient care.*
2. ***Behaviour Change Resistance****: Despite available resources like "My Health for Life," there's noticeable resistance to adopting healthier behaviours, highlighting the need for more engaging and effective intervention strategies.*
3. ***Need for Proactive Measures****: Our current approach tends towards being reactive. The audit highlighted the essential need for a shift towards preventive care to address CVD more effectively.*
4. ***Emphasis on Prevention****: There's a clear necessity for increased preventive activities, suggesting that our efforts should be more focused on early intervention and risk factor management.*

**What ongoing changes or improvements will you implement because of the audit /mini-audit?**

*EG- Following the audit, we're implementing a new process to improve the recording of cardiovascular disease (CVD) risk factors. The key improvement involves using the Primary Sense report titled "Patients booked in with missing PIP QI measures" to actively identify and flag patients with incomplete CVD risk factors recorded. The Practice Manager will flag this with the Practice Nurse or GP, to discuss with all patients booked, to have their CVD risk factors assessed and documented accordingly. This initiative aims to enhance patient care by ensuring early identification and management of CVD risks, improving both the accuracy of our medical records and the overall health outcomes for our patients.*

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| **OTHER THINGS TO DO** |
| Don’t forget to:  Log your hours and supporting documentation with your CPD home.   * + Remember to report the hours   + Report all supporting documentation (PDSA plans, meeting minutes, certificates etc), to your CPD home.   Discuss the improved policy / process / systems at a Quality Improvement team meeting/doctors meeting/staff meeting.   * + Discuss the initiative you have undertaken and the key findings   + Outline any changes you put in place and the impact of these changes (good and bad)   + Discuss further improvements that could be made   + If you have achieved an improvement in care for in your at-risk patients, consider reviewing more patients in this cohort   + Consider how this change can become business as usual in the practice.   Ensure you document your findings to meet the PIP QI guidelines  If you have changed your systems and processes, ensure these are documented in your practice policy & procedure manual. |