

# Quality Improvement (QI) Plan-Do-Study-Act (PDSA)

<b>QI activity focus / Objective</b>		Improving the proportion of patients with chronic conditions (Diabetes) who have an influenza vaccination recorded.  <i>Supporting:</i> 1. RACGP Standards 5th edition criterion: C4.1 Health promotion and preventative care 2. QI PIP QI measure  QIM 5- Proportion of patients with diabetes who have been immunised against influenza	
<b>QI activity lead/s</b>			
<b>Start measure</b>	Number of patients coded with Diabetes identified on Primary Sense Report who do not have a recorded influenza vaccine for 2026: _____	<b>End measure</b>	Number of active patients coded with Diabetes identified on Primary Sense Report who do not have a recorded influenza vaccine for 2026: _____
<b>Start date</b>		<b>End date</b>	
<b>Step 1: PLAN</b>  What do you plan to do/achieve		Over the next three months the practice team will increase the proportion of patients aged 15 years and over with coded Diabetes who have an influenza vaccination recorded in the clinical system by at least 15 percentage from baseline.  This will be achieved by embedding vaccination checks into routine appointments, chronic condition reviews, improving data quality, and clarifying team roles. Integrating influenza vaccination into routine chronic condition management supports a shift from reacting to illness toward preventing complications and improving patient safety.	
<b>Step 2: DO</b>  Outline the steps you will undertake		<ol style="list-style-type: none"> <li>1. QI lead (Practice Manager or Practice Nurse) to communicate activity and expectations to practice team.</li> <li>2. Run Primary Sense “Diabetes Mellitus” report, then export table “Patients with Diabetes who may be eligible for care occasions of service” to Excel. Filter table by “Fluvax Date” to identify patients with no recorded influenza vaccination and document the number of patients as baseline into PDSA.</li> <li>3. Review the list to identify patients who have an upcoming routine appointment booked (filtering most recent to the top) and document in ‘Appointment Notes’ to “Check Flu Vaccine status”.</li> <li>4. Clarify within practice team who is responsible for offering flu vaccine to patients not yet vaccinated (e.g; practice nurse and GP).</li> <li>5. When patient attends consult – the responsible team member reviews the appointment and asks the patient regarding influenza</li> <li>6. Document on generated list and within the correct section on patient file on clinical software when             <ul style="list-style-type: none"> <li>○ flu vaccine is offered and administered,</li> <li>○ flu vaccine is offered but declined by patient</li> <li>○ or if vaccine has been given elsewhere (ensure practice records are updated to reflect the entry on the Australian Immunisation Register to avoid repeatedly asking patient).</li> </ul> </li> </ol>	

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	<ol style="list-style-type: none"> <li>7. Our practice will work with the team responsible for rostering to establish flu vaccination clinics to ensure all patients can access this service in a timely manner.</li> <li>8. Our practice will promote these vaccinations by sending SMSs inviting these patients to attend the practice for an influenza immunisation.</li> <li>9. This initiative will be communicated to all staff in the practice so that GPs reviewing patients can also check immunisation status and offer the patients opportunistic immunisation.</li> </ol> <p><b>Consider:</b></p> <ul style="list-style-type: none"> <li>• Filtering report to provide GP with their own patient list to review</li> <li>• Prioritising patients with higher ACG scores for influenza vaccines</li> <li>• Utilise <b>‘Existing Appointment’</b> feature in report to add recall/reminder to opportunistically provide the influenza vaccine during scheduled appointment. Determine role/responsibility to complete this.</li> <li>• Downloading the Primary Sense Diabetes Mellitus Report every two weeks and send Influenza Vaccination promotion SMS to patients with Diabetes.</li> <li>• At conclusion of activity document End Measure on PDSA</li> <li>• Document activity on QI Register</li> </ul>
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<p><b>Step 3: STUDY</b></p> <p>What did you observe?</p>	<p><b>Review data:</b> Measurable Outcomes:</p> <p>Start Measure: __active patients coded with Diabetes identified on Primary Sense Report who do not have a recorded influenza vaccine for 2026</p> <p>End Measure: __active patients with Diabetes identified on Primary Sense Report who do not have a recorded influenza vaccine for 2026</p> <p>What is the proportion of patients with Diabetes who received an influenza vaccine in 2026:</p> <p><i>To calculate a percentage, divide the reduction in the number of patients without a recorded influenza vaccination by the original baseline number identified in the Primary Sense Diabetes Report, multiplied by 100.</i></p> <p><i>This figure is also available on the Primary Care Reporting Portal 10 QIMs report under QIM05 – Proportion of patients with diabetes who were immunised against influenza.</i></p> <p><b>Observations:</b></p> <p><u>QI Lead to facilitate discussion at team clinical meeting</u> Did you Achieve your <b>SMART Goal?</b> Evaluate whether the plan was executed successfully.</p> <ul style="list-style-type: none"> <li>• Has there been any patient feedback on this activity?</li> <li>• Has there been a decrease in influenza rates seen within the practice population?</li> <li>• Have there been any barriers to offering this service? (I.e. vaccine fatigue)</li> <li>• Has anything worked particularly well?</li> <li>• How effective are the different forms of communication amongst the various demographics?</li> </ul>
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<p><b>Step 4: ACT</b></p> <p>Will you adopt, adapt or abandon this change?</p>	<p>After evaluating outcomes and observations, choose an action below:</p> <p><b>Adopt:</b> The practice will adopt this QI activity and embed as part of our annual winter influenza vaccine strategy</p> <p><b>Adapt:</b> Amend activity and re-test with another PDSA cycle</p> <p><b>Abandon:</b> Record which change idea you will test next and start a new PDSA</p>
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## Any other information?

Examples: notes, screenshots, graphs, context information, resources, Brainstorming

LINKS EMBEDDED FOR QI QUINTUPLE AIMS, PIP MEASURES AND BUILDING BLOCKS.


### Questions, Links and information:

- What is a smart goal?: [SMART Goals Cheat Sheet](#)
- How to document a PDSA? [Guide to documenting a QI activity as a PDSA](#)
- Does this need to be documented in a PDSA or can it be captured in a QI log? [Identifying and undertaking QI activities using PDSAs](#)

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**QI Quintuple Aims for health care improvement:**



**10 PIP QI Measures.**

1. diabetes with HbA1c result
2. smoking status
3. weight classification
4. 65+ and Influenza Immunisation
5. Diabetes and Influenza Immunisation
6. COPD and Influenza Immunisation
7. alcohol consumption status
8. risk factors enable CVD assessment
9. cervical screening
10. diabetes & blood pressure

**Building blocks**

