**PDSA/Quality Improvement Activity - Sample**

**Topic –** Data Quality

**Area of Focus:** Recording family and social history in clinical software

**Step 1. The 3 Fundamental Questions**

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| **1. What are we trying to accomplish?**  **(By answering this question you will develop your goal for improvement)** |
| Improve the recording of family and social history information in clinical software |
| **2. How will we know that a change is an improvement?**  **(By answering this question you will develop measures to track the achievement of your goal)** |
| Improve measure – ‘proportion of patients with current family and social history recorded’ |
| **3. What changes can we make that can lead to an improvement? – list your ideas for change**  **(By answering this question you will develop the ideas you would like to test to achieve your goal)** |
| **Idea 1 –** Develop a checklist of questions to cover family and social history related issues to be used at each consult.  **Idea 2 –** Identify patients with no family and / or social history recorded and add an action to their file to prompt an update at their next visit.  **Idea 3 –** Add a message to TV screens in waiting room to educate patients about the importance of this information and advising them to tell their doctor / nurse if anything changes.  **Idea 4** – Recall active patients with missing data for a health assessment (as applicable) and take the opportunity to update their information including family and social history.  **Idea 5** – Include family and social history in data quality checklist and post checklist on all clinical noticeboards.  **Idea 6** – Baseline current measure and communicate progress / improvement via graph on staff noticeboard. |

**PDSA Template**

Please complete this template for each PDSA cycle you undertake.

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| **Idea #1** | *Describe the idea you are testing: refer to the 3rd fundamental question, ‘What are we trying to accomplish?* |
|  | Develop a checklist of questions to cover family and social history related issues   * Marital status * Live alone / carer? * Parents alive? * Cause of death etc? |
| **Plan** | *What, who, when, where, predictions & data to be collected.* |
|  | Team meeting – nurses to develop draft checklist for circulation and feedback |
|  | Data collection - measure ‘proportion of patients with family and social history recorded’ so that this can be tracked over time. Suggest split this measure into 2 measures if possible:   1. Family History proportion 2. Social History proportion   Ensure all non-active patients are regularly archived. |
| **Do** | *Was the plan executed? Document any unexpected events or problems.* |
|  |  |
| **Study** | *Record, analyse and reflect on the results.* |
|  | Baseline Measure/s  Proportion of patients with family history recorded =  Proportion of patients with social history recorded =  Current measure = X%. This shows an improvement / decrease in the proportion by X% in X months. |
|  | Assess effectiveness of checklist in improving the measures. |
| **Act** | *What will you take forward from this cycle? (next step / next PDSA cycle)* |
|  | Checklist not always being used. |
|  | Some staff find various questions difficult to ask the patient – rewording, further training required? |
|  | Need to ensure family and social history is current – ie don’t ignore just because its already recorded on the patient file as the questions still need to be asked regularly to keep it up-to-date. |