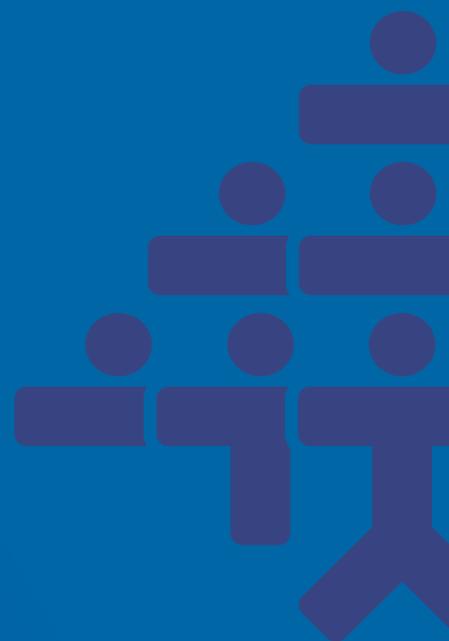


Quality Improvement Award Winners 2007–2014

EDITOR:

Dr Patrick O'Donnell, October 2014



ICGP QUALITY IN PRACTICE COMMITTEE 2014

Dr Paul Armstrong, Dr Patricia Carmody, Dr Harry Comber, Dr Mary Kearney, Dr Susan MacLaughlin, Dr Niamh Moran, Dr Maria O'Mahony, Dr Margaret O'Riordan, Dr Ben Parmeter, Dr Philip Sheeran Purcell, Dr Patrick Redmond

CORRESPONDENCE TO

ORCfeedback@icgp.ie

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This quality of care may be dependent on the appropriate allocation of resources to practices involved in its delivery. Resource allocation by the state is variable depending on geographical location and individual practice circumstances. There are constraints in following the guidelines where the resources are not available to action certain aspects of the guidelines. Therefore individual healthcare professionals will have to decide what is achievable within their resources particularly for vulnerable patient groups.

The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

Guidelines are not policy documents. Feedback from local faculty and individual members on ease of implementation of these guidelines is welcomed.

KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS

Scottish Intercollegiate Guidelines Network 2003, Homepage of Scottish Intercollegiate Guidelines Network, [Online]. Available: <http://www.sign.ac.uk/pdf/sign74.pdf>

LEVELS OF EVIDENCE

- 1++** High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
- 1+** Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
- 1-** Meta-analyses, systematic reviews, or RCTs with a high risk of bias
- 2++** High quality systematic reviews of case control or cohort or studies
High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
- 2+** Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
- 2-** Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
- 3** Non-analytic studies, e.g. case reports, case series
- 4** Expert opinion

GRADES OF RECOMMENDATIONS

- A** At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or
A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
- B** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 1++ or 1+
- C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 2++
- D** Evidence level 3 or 4; or
Extrapolated evidence from studies rated as 2+

Please note: The position/role of all of the authors was that at time of submission.

TABLE OF CONTENTS

Foreword	1
.....
<i>Implementing the Malnutrition Universal Screening Tool for the Prescription of Oral Nutritional Supplements</i>	<i>3</i>
<i>Advice for the Management of Febrile Illness in Young Children</i>	<i>5</i>
<i>Audit of Anti-Psychotic Prescribing in a Nursing Home</i>	<i>7</i>
<i>Acute Management of Wheezy Children in Primary Care</i>	<i>9</i>
<i>Practice Protocols for Warfarin Prescription</i>	<i>11</i>
<i>Reducing Antibiotic Use in General Practice</i>	<i>13</i>
<i>Audit of Statin Prescribing</i>	<i>16</i>
<i>Reducing Benzodiazepine Prescribing in the Practice</i>	<i>18</i>
<i>Safety Initiative for Patients Taking Methotrexate</i>	<i>20</i>
Chronic Disease Management	23
.....
<i>Patient Held Blood Pressure Record Card</i>	<i>24</i>
<i>Diabetes Interest CME Group</i>	<i>26</i>
<i>An Audit of the Management of Adult Coeliac Disease</i>	<i>27</i>
<i>Empowering the Diabetic Patient</i>	<i>28</i>
<i>A Breath of Fresh Air - Initiating a Nurse Led Asthma Clinic</i>	<i>30</i>
<i>The Introduction of Near Patient Testing Machines</i>	<i>32</i>
Screening	33
.....
<i>Chlamydia Screening & Patient Attitudes to STI Testing</i>	<i>34</i>
Practice Management	36
.....
<i>Implementation of GPIT Guidelines</i>	
<i>“No Data, No Business”</i>	<i>37</i>
<i>Patient Satisfaction Survey</i>	<i>39</i>
<i>Development of a Database of Patients on MC2 Social Welfare Certificates</i>	<i>42</i>
<i>Procedure for Deaths in the Practice</i>	<i>44</i>
<i>Influenza Vaccine Register</i>	<i>45</i>
<i>Remembering Deceased Patients in a Practice</i>	<i>47</i>

Foreword

It is a pleasure to introduce this second collection of prize-winning projects in practice quality improvement, sponsored by Medisec. The interventions presented here range from those which are simple but effective (the “why didn’t I think of that” ideas) to those which are quite complex and sophisticated, and clearly required a significant measure of commitment from all involved. However, all have succeeded in delivering their primary aim of providing better and safer health care to the patient. As with the previous collection of prize-winners, it is gratifying to see all participants in general practice taking an active role in quality improvement—primarily, of course, general practitioners, but also trainees, practice nurses, administrators; and there are few aspects of primary care which have not been covered.

The excellence and number of these projects in Irish general practice is a tribute to the commitment of the members of the Irish College of General Practitioners and their practice staff to the concept of quality improvement, and to the support and encouragement provided to them by the College. All practices, however excellent, can always do something to improve the quality of their care, and we hope that the example given by these prize-winners will act as an inspiration to many others to follow their lead.

Dr Harry Comber
Chair Quality in Practice Committee

Prescribing



Implementing the Malnutrition Universal Screening Tool for the Prescription of Oral Nutritional Supplements

Year: 2010 Winner

Brief description of the improvement:

The NICE guidelines of 2006 recommend that people who reside in long stay residential care homes should be screened with a validated tool on admission, and where there is a clinical concern that a person is at risk of malnutrition. Following a practice education session from our community dietician, I initiated the use of the Malnutrition Universal Screening Tool (MUST) for the prescription of oral nutritional supplements (ONS) to our patients residing in private nursing homes. This is a screening tool devised by the Malnutrition Advisory Group of the British Association for Parenteral and Enteral Nutrition. This is a multidisciplinary health professional group that includes GPs and nurses. Calculating the MUST involves the measurement of BMI, the percentage weight loss in the previous 3-6 months and the acute disease effect score. This allows calculation of the overall risk of malnutrition. The management depends on the risk of malnutrition according to the MUST and may involve referral to the community dietician if the patient is within the medium or high-risk categories. The dietician is the best-placed health professional to advise on extensive dietary interventions specific to the individual's needs and to choose the ONS most suitable for the patient. Research has shown that the use of ONS over long periods of time may lead to a decrease in the normal food intake of the patient, so that ONS becomes a food replacement rather than a food supplement. Ideally, no patient should be given more than a 3 month prescription before re-assessment.

Situation in the practice before the improvement:

Prior to the implementation of the MUST, a large number of ONS were being prescribed, or re-issued to residents of the nursing home which we look after. This was usually done without an objective assessment of the risk of malnutrition and was often unnecessary. As a result, significant costs were incurred, mainly to the HSE through the medical card scheme.

List of resources required:

I discussed the use of ONS with the other doctors in the practice after our education session from the community dietician and we decided to implement a new policy of malnutrition risk assessment using MUST prior to consideration of ONS prescription. I discussed the MUST and subsequent management plan with nursing home staff and explained that we could no longer prescribe ONS without an objective assessment of risk of malnutrition. Copies of the MUST and referral forms for the community dietician were distributed to nursing home staff. The MUST and dietician referral, if necessary, take just a few minutes to complete.

Effect the improvement had on the practice:

The initiative should lead to an improvement in nutritional standards and reduction in risk of malnutrition. It may contribute to increased quality of life for the patients through improved appetite and enjoyment of their meals. It has decreased dramatically the number of ONS being prescribed to our patients who reside in private nursing homes, and subsequently cut down on the associated costs. The estimated cost of 2 standard sip feeds per day under the GMS scheme for one patient is €1,600 per year. Another advantage is that it has reduced some of the workload of repeat prescribing. It is planned to conduct a re-audit in the coming months to assess effects of the above outlined initiative on: changes in MUST scores and risk categories, change in prescribing costs, patients' food intake records, and number of community dietitian referrals sent as a result. Currently this private nursing home is not serviced directly by the community dietitian but, if necessary, patients can be seen by the community dietitian in our practice. This is due to a lack of dietetic resources, however, it is hoped that service may be commenced if the results of the re-audit suggest it would provide a better quality service.

For further information please contact:

Name: Dr Muireann dePaor

Address: College Street Surgery, Mullingar, Co. Westmeath

Email: Available on request

Position: GP Registrar

Relevant link: www.hse.ie/eng/staff/PCRS/Online_Services/MUSTtool.pdf

Advice for the Management of Febrile Illness in Young Children

Year: 2012 Winner

Brief description of the improvement:

A large number of consultations involving the management of febrile illness in young children take place on a daily basis in general practice. Since commencing my placement in GP I have noticed that a large quantity of parents do not understand how to manage a fever correctly in their child, particularly when it comes to the administration of anti-pyretic medication. Parents often make mistakes in dosage and frequency of administration of anti-pyretics. In the hospital setting, anti-pyretics are generally administered as per the weight of the child as opposed to their age. In the community setting however, administration is usually as per the child's age which frequently leads to under-dosage of children and more frequent presentations of pyrexial children to A&E. I also discovered that if parents follow the instructions correctly on Paracetamol and Ibuprofen bottles, they are giving between 10-30% less anti-pyretic than they should be as per their child's weight. My study involved the development of a two page hand-out for use by GPs while in consultation with the parent of a pyrexial child. The first page allowed for calculation of the correct dosage of paracetamol or ibuprofen, using the algorithms provided (which are used in local hospitals), as per the child's weight. The second page consisted of a 24 hour table which allowed for the dosages of the antipyretics to be filled in at the required time of administration. The hand-out was given to the parents of 40 pyrexial children over a four week period beginning on 14 November 14 2011. A follow-up phone questionnaire was carried out with each parent approximately 5 days after the hand-out was distributed. Overall the hand-out was found to be extremely beneficial. Parents felt much more comfortable about managing pyrexia in their children and the numbers of re-presentations with uncontrolled pyrexia were reduced.

Situation in the practice before the improvement:

Before instituting my improvement, I noticed that a large quantity of parents were unsure of the correct use of anti-pyretics in their children. Very few knew that anti-pyretics could be administered as per their child's weight and many were administering these medications either too frequently or not often enough. Quite a number didn't realize that anti-pyretics could be administered in conjunction with an antibiotic. My findings were supported by my literature review which led me to find one study that revealed that 53% of children presenting to an emergency department had been administered the incorrect dose of anti-pyretic.

List of resources required:

In carrying out this innovation the following resources were used: My literature review involved researching papers online using PubMed, Medline and Athens. I also referred to the NICE guidelines of May 2007. Prior to designing my hand-out, I spoke with a Pharmacist at Portlaoise Hospital regarding dosage as per weight. With regard to maintaining this innovation, as the hand-out is now designed, no further resources are currently needed unless more up-to-date guidelines are published on pyrexial management in children. The hand-out can now simply be photocopied and used at will.

Effect the improvement had on the practice:

The results of my follow-up questionnaire revealed that 39 of the 40 parents found the hand-out useful. The majority thought it was easy to follow. 26 parents found it very useful to have the anti-pyretic doses written down to be administered at specific times over the course of the day. 27 parents stated that their anxiety levels regarding their child's fever was reduced and 18 liked how the hand-out was individualized to their child. Of the 40 parents who took part, only 1 parent re-presented to the practice with their child in the days following their initial presentation. None of the children needed to attend A&E in relation to their fever. The hand-out continues to be used in the practice today & parents continue to find it extremely beneficial.

For further information please contact:

Name: Dr Shonagh Mooney
Address: Medicentre, Portarlinton, Co Laois
Email: shonagh_m@yahoo.co.uk
Position: GP Registrar
Relevant link: www.icgp.ie/OIPAntipyretics

Audit of Anti-Psychotic Prescribing in a Nursing Home

Year: 2013 Runner-up

Brief description of the improvement:

A three doctor practice looked after a nursing home with 115-130 patients. One of the doctors visited the nursing home every day. An audit of the prescribing of anti-psychotic (AP) medications to the nursing home patients was carried out. The aim of it was to measure the number of patients on AP medication, the indications for initiation, the type of drugs prescribed and how recently the need for the drug had been reviewed. An audit template was designed using the NICE audit support tool and this was completed for each patient by chart and drug kardex review in December 2012. The local consultant psychiatrist, who also cared for these patients, was consulted before and after the first audit cycle. After the first cycle there was a practice meeting to discuss the results and a policy on antipsychotic prescribing in the nursing home was created. This included guidelines about starting and discontinuing these medications and was based on the NICE guidelines and the best practice guide from the Alzheimer's Society UK and RCGP. There was a meeting with the clinical nurse managers of the nursing home to discuss the results of the first cycle and the new policy document. A laminated copy of the policy was given to each doctor and posted on the wall in each ward. A re-audit was completed in May 2012.

Situation in the practice before the improvement:

In the first cycle of 123 patients;

- 39 (32%) were on AP medication.
- 14 patients (36%) had a review of need for drug documented in the past year.

List of resources required:

The only resource required to implement this improvement was clinician time spent in reviewing patient's medication and then in some cases time reviewing patients whose symptoms had changed after stopping AP medication. The NICE audit support tool and best practice guidelines from the RCGP and Alzheimer's society UK are both freely available online.

Effect the improvement had on the practice:

In the second cycle out of 115 patients;

- 24 (21%) patients were on AP medication.
- 20 (83%) patients had a review of need for AP medication in their chart.
- 10 patients had had their AP stopped.
- 8 patients had their AP dose reduced.

This audit shows that by implementing a policy on initiation and review of antipsychotic medication, prescriptions can be reduced by almost 30%.

For further information please contact:

Name: Dr Emer Shortall

Address: Northgate Surgery, 226 Pearse Park, Drogheda, Co. Louth

Email: Available on request

Position: GP Registrar

Relevant link: www.icgp.ie/OIPdementia

Acute Management of Wheezy Children in Primary Care

Year: 2014 Runner-up

Brief description of the improvement:

I have developed a take home written management plan that is given to parents of acutely wheezy children. This written plan encompasses the verbal advice routinely given to parents of these children. The management plan reinforces to the parent the correct medication use, what signs to monitor for indicating their child is improving or deteriorating and when to seek medical advice. Parents no longer have to remember all the verbal advice given to them by the GP but can use the written action plan as a management guide in the days following presentation to the practice.

Situation in the practice before the improvement:

Prior to instituting this improvement written management plans were not being used as part of the management of wheezy children. Instead, the General Practitioners were verbally advising parents about the further management of their wheezy child at home. Parents left the surgery with a great deal of information to remember, and had no written action plan to refer to. This often meant that parents failed to remember the advice given.

List of resources required:

I researched the use of written action plans in the overall management of wheezy children in 24 local General Practices, including the practice I am working in. I also evaluated the verbal advice that GPs give to parents of wheezy children. I subsequently reviewed the relevant literature, in particular the ICGP Asthma Guidelines, the Scottish Intercollegiate Guidelines Network (SIGN) and the Global Initiative for Asthma (GINA) guidelines. My research findings, in conjunction with these aforementioned guidelines facilitated my development of a written management plan for wheezy children. This innovation can be easily maintained by regular review of literature pertaining to management of acute wheeze in children.

Effect the improvement had on the practice:

Establishment of the written management plans for wheezy children has created great benefits for our practice. Firstly, the care of children presenting to us with wheeze has been enhanced. We are now practicing in line with national and international guidelines, recognizing the important role of a written action plan. Parents of these children have been empowered to actively participate in their child's care at home. We are now communicating more effectively with these parents as the written management plans are acting as a communication tool between parent and practitioner. In addition, parents appear very satisfied with the individualized management plans given to them, which is strengthening the doctor-patient relationship and fortifying their trust in their General Practitioner. These written management plans are enhancing the safety netting aspect to our consultations, which is paramount when faced with an acutely ill child.

For further information please contact:

Name: Dr Denise Catherine Duignan
Address: Mount Martin Surgery, 25 Old Hill, Leixlip, Co. Kildare
Email: deniseduignan@gmail.com
Position: GP Registrar
Relevant links: www.icgp.ie/QIP/Asthma www.sign.ac.uk/guidelines/fulltext/101/
www.ginasthma.org

WHEEZE MANAGEMENT PLAN FOR YOUR CHILD	
DAY 1	
Give blue inhaler (reliever inhaler) 2–4 puffs every 3–4 hours Give prednisolone _____mg (_____tablets) once daily Use brown inhaler (preventer inhaler) as usual (if this applies)	If my child is worsening what do I do? Give 2 puffs blue inhaler every 20 minutes and seek medical advice
DAY 2	
Give blue inhaler (reliever inhaler) 2–4 puffs every 4–6 hours Give prednisolone _____mg (_____tablets) once daily Use brown inhaler (preventer inhaler) as usual (if this applies)	If my child is worsening what do I do? Increase the blue inhaler to that used in Day 1 and seek medical advice
DAY 3	
Give blue inhaler (reliever inhaler) 2–4 puffs every 4–6 hours Give prednisolone _____mg (_____tablets) once daily Use brown inhaler (preventer inhaler) as usual (if this applies)	If my child is worsening what do I do? Increase the blue inhaler to that used in Day 1 and seek medical advice
DAY 4	
Give blue inhaler (reliever inhaler) 2 puffs when required Use brown inhaler (preventer inhaler) as usual (if this applies)	

<p>How do I know my child is getting better?</p> <ul style="list-style-type: none"> • Breathing slower and easier • Eating better • Drinking better • Talking better 	<p>How do I know my child is getting worse?</p> <ul style="list-style-type: none"> • Breathing is faster • Too breathless to walk/feed/play • Skin in becoming more pale/blue • Coughing more • Wheezing more 	<p>CONTACT NUMBERS</p> <p>GP surgery: 01 624 4549</p> <p>Out of hours GP: 1890 599 362</p> <p>Emergency: 999</p>
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Dr Denise Duignan, 2014 ©

Practice Protocols for Warfarin Prescription

Year: 2009 Runner-up

Brief description of the improvement:

We performed a retrospective audit on the prescribing of warfarin to 40 patients in the practice, in particular looking at relevant documentation in patient files, co-prescribing, and adverse events. We identified one patient with a bio-prosthetic cardiac valve replacement who remained on warfarin for more than five years post-surgery. We obtained written confirmation from the cardiothoracic consultant that this could be stopped. We identified 3 of our patients on both warfarin and aspirin and we communicated with the relevant consultants to make sure that this was intended. We identified 3 adverse events (9%) in the last year; one minor haemorrhagic event, two thrombotic events (one CVA and one TIA). In the last year 32% of patients had been prescribed a medication that had the potential to interact with warfarin. In the initial audit, we found that 55% of the INRs were in the therapeutic range. From this, we tried to establish reasons for these sub-optimal INRs. Based on the findings of the preliminary audit, we designed a revised practice protocol on warfarin prescription. In particular, prescribing doctors would now follow the ICGP guideline on warfarin in general practice. Three months after implementing changes, we re-audited our patient population and found an improvement; 66% of the INR results were now in the therapeutic range.

Situation in the practice before the improvement:

Prior to implementing the revised practice protocol, GPs within the practice did not follow guidelines on warfarin dosage or call-back intervals. The intended duration of treatment and recommended target ranges were not documented in patients files. It was unclear as to which patients would ring in for results and which should be contacted by the practice staff. It was unclear as to which member of staff had responsibility for this communication. Occasionally results were delivered by secretarial staff. There was no safety netting for non-attenders.

List of resources required:

The ICGP and British Committee Standards Haematology guidelines were used in the practice protocol. We have designed a practice register for all patients attending for INR tests on the day and this is now managed by the practice nurse. This has added to the work burden of the practice nurse, however, we feel it pays dividends in patient safety.

Effect the improvement had on the practice:

Vulnerable patients have been identified (e.g. those with poor compliance, risk factors), and a shorter time interval between INR checks (maximum of 3 weeks)

was agreed for this group. We have also highlighted that co-prescribing certain medications necessitates the patient being called back for an earlier review (1-2 weeks). A practice register of all patients attending for INR checks has been created with clear delegation of responsibility to practice staff on communication of results, dosage changes and arrangement of review dates. All non-attenders are now easily identifiable on the day. Warfarin has been shown to be of great clinical benefit but it is a high risk medication that requires the implementation of additional safety controls. We have improved the management of our patients on warfarin, ensuring that best practice is followed and patient safety is paramount.

For further information please contact:

Name: Dr Olivia Barry

Address: Park Clinic, Fermoy, Co. Cork

Email: Available on request

Position: GP Registrar

Relevant links: www.icgp.ie/OIPanticoagulation www.bcsghguidelines.com/documents/warfarin_4th_ed.pdf

Reducing Antibiotic Use in General Practice

Year: 2011 Winner

Brief description of the improvement:

A two part study to assess patient's knowledge and attitudes regarding antibiotic use for uncomplicated upper respiratory tract infections (URTIs) and the effectiveness of using a take home patient information leaflet during the consultation to reduce antibiotic prescribing in the practice. A patient information leaflet was designed to be used as an educational tool by the GP during the consultation to provide patients with the knowledge they need to understand the appropriate use of antibiotics, the side effects and potential risks associated with use of antibiotics when they are not indicated. The primary end point of the study was to ascertain if the use of the patient information leaflet reduced antibiotic prescribing for URTIs. The secondary end point was to evaluate if there was an increase in reserve prescriptions for antibiotics and advice only for all those patients presenting with URTIs. It is important to address the issue of antibiotic overprescribing and overuse as antibiotic resistance is a major public health concern and the cost of unnecessary use of antibiotics puts a huge burden on an economy and health service that is already facing great challenges. The savings made here could be redirected towards other sectors of primary care that need funding.

Situation in the practice before the improvement:

Prescribing patterns within the practice for URTI consultations were assessed for one week prior to implementing the change. A log of 40 consultations for URTIs was kept; recording demographics, the presenting complaint and management. An immediate prescription for antibiotics was given to 47.5% when they presented with a URTI (after certain exclusion criteria including focal chest signs, immunodeficiency, COPD and others were considered). A delayed prescription to be filled if they did not improve after 2 days was given to 15% of patients. No prescription was issued in 37.5% of these consults. As antibiotics have no role in the management of URTIs, this demonstrated significant inappropriate use of antibiotics. A questionnaire was distributed to patients to establish their personal management of URTIs to assess knowledge and attitudes of the general public regarding antibiotic use.

List of resources required:

- The innovation was easy to implement and the use of resources was minimal.
- The patient information leaflets were mass printed on a laser printer at minimal cost and were in each consulting room.
- The duration of the consultation was shortened through the use of the leaflet with a mean of 11 minutes for each consultation during the control week and 10 minutes for consultations that used the leaflet. It was felt those consultations that used the leaflet were easier to close than trying to explain without the aid of a leaflet why antibiotics were not indicated.

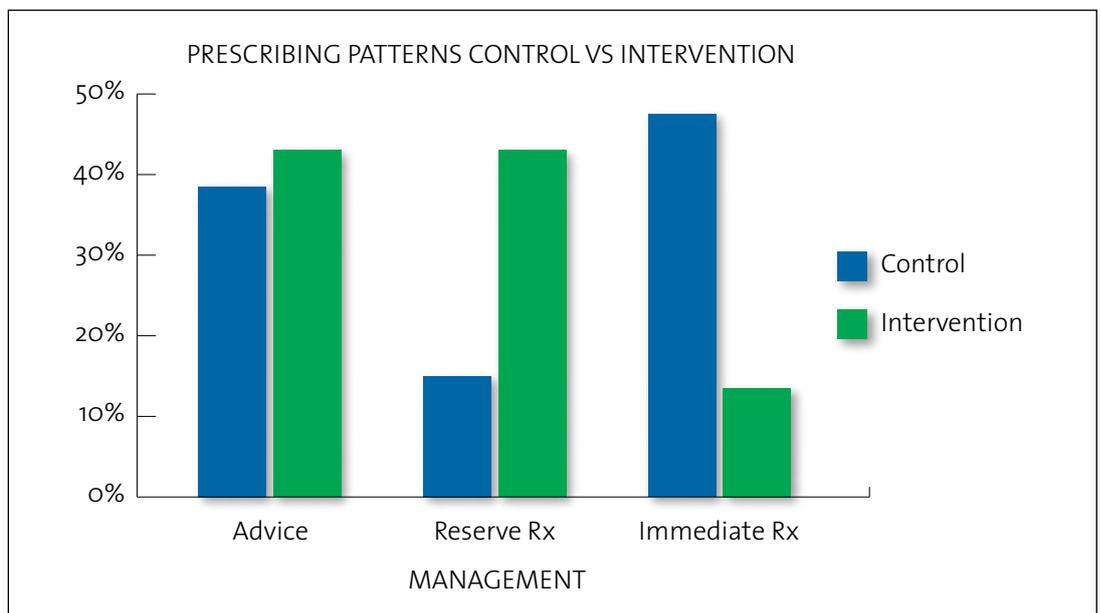
- The computerized system in the practice allowed easy auditing the results of this implementation.
- No extra resources have been needed to maintain this change.
- The leaflet could be easily implemented in other GP practices.

Effect the improvement had on the practice:

An overall reduction in prescribing of antibiotics was made. There was an increase from 37.5% to 43.3% in consultations where advice only was given. There was an increase from 15% to 43.3% in the issuing of delayed prescriptions and a reduction from 47.5% to 13.3% in the immediate prescribing of antibiotics. It was found that only 46.15% of delayed prescriptions were filled. These results are beneficial from two perspectives; concerns about antibiotic resistance and economically for the health service. The GPs found the information leaflet easy to use and reported that patients were satisfied. There was a small reduction noted in re-consulting (to same or different GP or out-of-hours services) within 14 days with the same symptoms noted after the implementation of the leaflet from 7.5% to 6.6%. In conclusion, after the implementation of a simple yet cost effective and resource saving innovation, the overall prescribing of antibiotics for uncomplicated URTIs reduced without an increase in re-consulting to other GPs or out-of-hours services.

For further information please contact:

Name: Dr Laura Noonan
Address: The Medical Centre, Barrack Street, Castlerea, Co. Roscommon.
Email: Available on request
Position: GP Registrar
Relevant link: www.antibioticprescribing.ie



Patient Information Leaflet

Name _____ Date _____

Your symptoms are likely to be caused by a virus. Viruses cause a variety of illnesses such as sore throats, coughs, colds and flu. Antibiotics are medicines used to kill bacteria (not viruses). By using antibiotics for viral illnesses you will not get better any quicker. One in five people who take antibiotics experience some side effects. They include upset tummy, diarrhoea and thrush. Bacteria change over time to “out smart” the antibiotics. The more antibiotics we use unnecessarily, the more resistance that develops and this is bad for you, your family and the wider community. By using antibiotics less often we can slow down the development of resistance.

The length of time you can expect most common infections to last is:

- Ear infection: approx. 4 days
- Sore throat: approx. 1 week
- Common cold: (runny nose) approx. 1 week
- Cough-which often happens after common cold: approx. 3 weeks.

You may need antibiotics if:

1. Your cold lasts more than 3 weeks or
2. You become breathless
3. You have pains in your chest
4. You already have a problem with your chest

The best way to treat most colds, coughs or sore throats is to drink plenty of fluids and rest. You can take paracetamol 4 times daily and/or ibuprofen 3 times daily to relieve headache, aches, pains and fever. Your pharmacist will be able to advise you about over the counter remedies such as cough bottles, throat lozenges and decongestants. If you are concerned or become more unwell contact us for another appointment or out of hours contact WESTDOC on 1850 365 000

Signed: _____

More information on antibiotics and resistance is available from:

www.hpsc.ie HSE Health Protection Surveillance Centre www.cdc.gov US Centre for Disease Control www.hpa.org UK Health Protection Agency

Audit of Statin Prescribing

Year: 2011 Runner-up

Brief description of the improvement:

We conducted an audit that aimed to establish the level of adherence to the 2007 European Society of Cardiology (ESC) guidelines in relation to the prescribing of statins in our Dublin practice. These guidelines on cardiovascular disease prevention highlight the fact that in estimating a person's 'total risk' of fatal cardiovascular disease (CVD) over 10 years, individual risk factors are weighted differently for each person. Euro Aspire data suggest that in the context of low risk patients who have not had a vascular event there is potential for overuse of drugs. A register of patients prescribed a statin was compiled including documentation of smoking status and blood pressure (BP). The 10-year risk of fatal CVD was calculated using Heart Score. The following high-risk groups were excluded:

- Known CVD
- Type II diabetes and Type I diabetes with micro albuminuria
- Cholesterol >8 mmol/l
- Systolic BP > 180 mmHg

Heart Score was calculated for each patient in the remaining group. Where the risk was <5% based on the pre-statin cholesterol level, a recommendation was made to stop the drug and an explanation was given to the patient.

Situation in the practice before the improvement:

- Prior to conducting this audit, 73% of low risk patients were inappropriately prescribed statins.
- For 59% of patients, documentation of BP and smoking status was incomplete in the electronic records.
- BP targets were not met in 9% of patients.
- 14% of patients did not achieve optimal risk reduction due to uncontrolled BP or smoking.
- Risk calculation was not routine.

List of resources required:

- The Heart Score risk calculator on the ESC website was an essential resource.
- Patients recommended to stop their statin were invited to a focused consultation with included explanation of risk calculation and demonstration of their 10-year risk of fatal CVD. Printed copies of their Heart Score with information on diet, exercise and BMI were provided.
- Smoking cessation was discussed and BP control addressed.

- Fasting cholesterol levels were measured after three months for all patients who stopped their statin. Their Heart Score was recalculated. Patient satisfaction was noted.
- No additional resources are required in the future. The change in practice will maintain the improvement.

Effect the improvement had on the practice:

- Cycle two demonstrated the effects on practice.
- Use of evidence based risk calculation is routine.
- BP and smoking status documentation is complete in 100% of electronic records.
- 100% of patients achieved BP control and smoking cessation.
- Inappropriate statin prescribing reduced from 73% to 38%.
- There have been financial savings for private patients and GMS funds.

For further information please contact:

Names: Dr A. Cox, Dr J. Peters.

Address: Littlepace Medical Centre, Clonee, Dublin 15

Email: Available on request

Position: GP Registrar & GP Principal

Relevant links: www.escardio.org www.heartscore.org

Reducing Benzodiazepine Prescribing in the Practice

Year: 2012 Runner-up

Brief description of the improvement:

We developed a simple, effective, quality initiative to reduce benzodiazepine prescribing in the practice. 10% of the medical card population currently receive a regular prescription for benzodiazepines and/or sleeping tablets. This number is growing annually and although useful for the management of anxiety and sleep disturbances in the short term, dependence can develop after 2-4 weeks of consecutive use. Long term use is associated with addiction, memory disturbances, falls and sleep disturbance. We identified 137 patients who were receiving regular prescriptions for benzodiazepines and contacted them by letter asking them to attend to discuss their prescription in person. This letter highlighted the risks with long term use of these tablets, and emphasized the benefits of reducing and eventually stopping them. We enclosed a simple patient information leaflet advising patients how they could gradually reduce medications themselves. A specific policy for benzodiazepine prescribing was also introduced in the practice. After three months 70% of those contacted had been reviewed and 40% had agreed to a dose reduction. 8% had stopped their medications completely. Of those who reduced, the average reduction was 50% of their starting dose.

Situation in the practice before the improvement:

Prior to implementation, repeat prescriptions were issued on a one or three monthly basis. Individual patient review was at the prescriber's discretion. There was no practice policy in place and, although it was known that there was a cohort of long term users, the exact number of such patients was not known.

List of resources required:

Considerable time went into the overall design of the initiative. Identifying the target group required considerable man-hours, and there were photocopying and postage costs, but this initiative was effectively cost neutral. Results achieved will have longstanding benefit to our patients, the practice and society. Maintenance will require commitment on the part of all staff to stick to the practice policy and to continue to encourage patients to reduce medications.

Effect the improvement had on the practice:

The practice policy has led to consistency and safer prescribing among doctors in the practice and therefore better care for patients. There is considerable evidence in the literature to support the benefit of any reduction in dose of long term benzodiazepines in terms of patient safety and wellbeing. We were encouraged by the level of reduction achieved after only three months. We received considerable

feedback from local pharmacies supporting our initiative and, following publication in Forum in December, we were contacted by 24 practices requesting further information and copies of the patient letter and information leaflet. Our audit was subsequently summarised and included as an example of good practice in the March edition of Therapeutics Today and some of our documentation has also been included in the recently circulated ICGP Benzodiazepine Prescribing Audit Tool, as examples of templates for others interested in tackling this area. We have been very happy to share these resources with other practices and are confident that this initiative will have an ongoing benefit to patients, individual practices and greater society.

For further information please contact:

Name: Dr Louise Campbell, Dr Kilian McGrogan

Address: Mercer's Medical Centre, Stephen Street Lower, Dublin 2

Email: gpreception@rcsi.ie

Position: GPs

Relevant link: www.icgp.ie/BenzoPrescribingSampleAudit

Safety Initiative for Patients Taking Methotrexate

Year: 2013 Winner

Brief description of the improvement:

- Development of a patient 'ALERT' card for those taking methotrexate.
- Surveyed all relevant patients about its impact on their use of methotrexate
- Presented our work to:
 - 168 GPs in Munster who committed to change practice.
 - MPS Spotlight on Risk conference in September 2012.
 - 120 pharmacists in Munster who committed to change practice and enhance methotrexate safety.
- We contacted 25 relevant consultants in Cork (rheumatologists, dermatologists, oncologists) who routinely initiate methotrexate. They were highly supportive of this initiative.
- Engagement with all ICGP accredited IT practice software providers; one has already incorporated safer prescribing templates for methotrexate. This will enhance dissemination and adoption of safer methotrexate prescribing, dispensing and patient awareness across Ireland. Smart use of existing IT resources to enhance patient safety.
- The manufacturer of methotrexate OrionPharma has committed to including enhanced safety notices.
- The initiative is equally applicable to other vulnerable patient groups e.g. those taking immunosuppressants or Lithium.

Situation in the practice before the improvement:

Ireland has four times more adverse incidents with patients taking methotrexate than in the UK (1). An audit of methotrexate use in the Glanmire in 2007 revealed inadequate monitoring (2). There is general non-compliance with current IMB methotrexate safety recommendations (3).

List of resources required:

The 'ALERT' initiative is simple, low-cost and highly original. Dissemination nationally across general practice is already facilitated by an IT provider. The 'ALERT' card is available in electronic format, for ease of dissemination, storage and printing. Engagement with OrionPharma will hopefully lead to further dissemination of this alert in Ireland and globally.

Effect the improvement had on the practice:

This is an ongoing extensive audit across all three Glanmire practices. Completed audit data shows appropriate (BNF recommended) blood testing improved from 21% to 95% of patients. In some patients excessive blood testing

Alert Card (front & back)

Surname	Clinical DIAGNOSIS;	<h1 style="text-align: center;">ALERT</h1> <p style="text-align: center;">This patient is currently on IMMUNO SUPPRESSING DRUG TREATMENT.</p> <p>If you feel unwell, or have a fever, sore throat, easy bruising, bleeding, mouth ulcers, shivering see a doctor urgently & request an urgent blood test. Consider NEUTROPENIC SEPSIS (See overleaf for details)</p>
Forename	Immune-suppressant;	
Address	1.	
	2.	
GP	3.	
Consultant	Talk to your GP about	
Pharmacist	FLU VAX	
Date	PNEUMOCOCCAL VAX	

<p>If the patient has received IMMUNOSUPPRESSANT drug treatment within the past 28 days and has ANY ONE OR MORE of the following:</p> <p>Fevers or hypothermia, Rigors, shaking or chills. Unexplained tachycardia, hypotension or tachypnoea. Any indwelling vascular access device. Feels unwell. (Signs/Symptoms may be minimal especially if taking corticosteroids)</p>	<p>Consider Neutropenic Sepsis; Treat as an EMERGENCY If <u>neutropenic</u> sepsis is suspected Admit to hospital & treat IMMEDIATELY with broad spectrum intravenous antibiotic and contact their treating hospital for further advice.</p> <p>ACTION-Neutropenic Sepsis; Urgent IV antibiotics. Urgent FBC. Temp, pulse, BP, SpO2 Blood cultures (peripherally and from each lumen of VAD)</p>	<p>Benefits & risks of immunosuppressant medication explained by doctor/nurse; signature</p> <p>Emergency Contact Details Hospital Tel No; Out of hours (6pm-8.30am); and ask for; "On Call _____ Dr"</p>
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Chronic Disease Management



Patient Held Blood Pressure Record Card

Year: 2007 Runner-up

Brief description of the improvement:

We designed and introduced a patient held blood pressure record card as an adjunct to continuous care of our hypertensive patients.

Situation in the practice before the improvement:

Hypertensive patients attended twice yearly for review following their initial diagnosis, investigation and management. We repeatedly emphasised the importance of compliance with follow-up checks and adherence to medication protocol. However, the occurrence of an adverse event in a patient who had discontinued his medication as he was asymptomatic led us to believe that we needed to adopt a shared approach to care, with the introduction of a brief instruction booklet for our patients.

List of resources required:

Having discussed the concept of introducing a blood pressure card we made a brief lay-out of the card initially by hand and later on computer. We sent the template to a local printer who provided 500 cards for our practice. Gradually following brief discussion and completion of the card with each hypertensive patient, we are progressing through our target population. No further resources are necessary to maintain this innovation.

Effect the improvement had on the practice:

This innovation has involved the patient in their own care, detailing the risk factors which are relevant to his condition. They are made aware that practically all risk factors (with the exception of family history) can be corrected or removed. The issue of alcohol is emphasised, as is smoking. The target weight and abdominal girth is also detailed. Yearly comparison of these measurements should increase awareness of the patient to his self-care. Yearly blood tests should be ticked so that he attends as arranged for same.

In summary we hope that the occurrence of CVA, myocardial infarction and chronic kidney disease will be significantly reduced in our hypertensive population.

For further information please contact:

Name: Nurse Stella Hogan, Dr P Carolan, Dr K Clerkin

Address: Weaver's Square, Baltinglass, Co. Wicklow

E-mail: Available on request

Position: Practice Nurse & GPs

Relevant link: www.icgp.ie/OIPCardio

Diabetes Interest CME Group

Year: 2008 Runner-up

Brief description of the improvement:

The formation of a disease-specific CME group (Diabetes Interest Group), designed to help the participants improve the management of diabetes in their practices. Membership of the group involves attending three educational sessions per annum and participating in an ongoing audit process. Practices receive their own audit results as well as collective results for the whole group. This allows participants to monitor their progress over time.

Situation in the practice before the improvement:

The incidence and prevalence of diabetes is rising. GPs are increasingly involved in the care of these patients. With a plethora of guidelines and ever changing evidence, the provision of 'best care' for diabetic patients provides a challenge to the busy generalist. Research shows that many patients with diabetes, both nationally and internationally, have sub-optimally controlled disease and related risk factors. The Diabetes Interest Group (DIG) was established in order to create an effective learning environment that would help GPs and Practice Nurses acquire the necessary knowledge and skills to provide this "best care" within their practices.

List of resources required:

The initial resource was the enthusiasm of the founding members. This sustained us for the start-up and initial phase. This year, the HSE agreed to fund a diabetes nurse facilitator who visits the participating practices to help set up management systems and the audit process. This has been vital in both maintaining and expanding the vitality and viability of the group. The funding has been approved for next year. The group have secured initial agreement to develop a joint community (80%) and hospital (20%) diabetes nurse position. The incumbent will help bridge the current wide gap between community and hospital provided care. Facilitating the initiation of Insulin therapy in the community and the care of difficult to manage patients will be an important part of this brief.

Effect the improvement had on the practice:

This model of problem-based, self-directed, disease-specific, small group learning is showing itself to be an effective method of improving overall diabetes care in the participating practices, as measured by the frequency and quality of monitoring, improved glycaemic control and risk factor reduction. The detection rate of both diabetes and pre-diabetes has improved also. The current group of twelve practices cares for 1200 patients at present. We anticipate this will grow to 2500 patients when a further ten practices join within the near future.

For further information please contact:

Name: Dr Joe Moran
Address: 61/63 McCurtain Street, Fermoy, Co Cork
E-mail: Available on request
Position: GP Principal & Chair, Steering Committee, Diabetes Interest Group
Relevant link: www.icgp.ie/QIPDiabetesType2

An Audit of the Management of Adult Coeliac Disease

Year: 2010 Runner-up

Brief description of the improvement:

I completed an audit on the management of patients with adult coeliac disease in Farranfore Medical centre. Patients were assessed using a standardized template based on UK Primary Care Society for Gastroenterology Guidelines on the Management of Coeliac Disease and the Northern Ireland CREST Guidelines for the Diagnosis and Management of Coeliac Disease in adults. Both these guidelines recommend that patients have an annual review. Patients were assessed for gluten free dietary compliance and were assessed for complications of their coeliac disease. Following the audit cycle a system was put in place for annual follow up of these patients based on an 'action plan' in their individual notes.

Situation in the practice before the improvement:

Prior to this audit and the development of a system to monitor patients with coeliac disease, they had no structured follow-up. Prior to the audit none of the patients had an annual review. 50% had their bloods checked but not all parameters had been checked. Patients had not been assessed for the complications of coeliac disease such as bone density loss and splenic atrophy.

List of resources required:

The search facility on our practice software was used to identify appropriate patients and these patients were invited to attend for review. A practice meeting was called to ensure all members were aware of the template which had been devised. The local consultant haematologist provided us with advice on the most cost effective monitoring for splenic atrophy. Depending on the outcome of review, patients were referred for DEXA scanning or dietetic review.

Effect the improvement had on the practice:

20/44 patients attended for a full review. Patients were assessed for the complications of coeliac disease. 3/20 patients had Howell Jolly bodies present on blood film indicating splenic atrophy and these patients were given advice on vaccinations. Patients were referred for DEXA scan to assess bone health. At the time of the re-audit, 4 patients had completed DEXA scans which showed varying degrees of bone density loss. Non-adherence to a gluten free diet was indicated in the blood test results of 4 patients. These patients were referred to the dietician. There is an action plan in place for each of these patients so this review will be carried out on a yearly basis. The remainder will be assessed opportunistically. The template ensures that all these reviews are standardized.

For further information please contact:

Name: Dr Audrey Russell
Address: Russlan, Church Road, Blackrock, Cork
Email: audreyjulieanne@gmail.com
Position: GP Registrar
Relevant links: ICGP Quick Reference Guide (in press) www.bsg.org.uk/images/stories/clinical/bsg_coeliac_10.pdf www.gain-ni.org/images/Uploads/Guidelines/Coeliac%20Disease%2028pp.pdf

Empowering the Diabetic Patient

Year: 2014 Winner

Brief description of the improvement:

- We used monthly educational evenings and primary care based diabetic clinics assisted by the diabetic nurse specialist to help patients take control of their diabetes care. By providing patients with relevant information in manageable portions at regular intervals, we improved their overall understanding and ultimately their control of the condition. This ultimately resulted in us seeing these patients less frequently with the many complications of diabetes. The educational evenings allowed us to target a large number of patients in a short period of time. This was assisted by primary care based diabetic clinics run by the diabetic nurse specialist. These clinics are integrated with the dietician, leg ulcer clinic and podiatry clinics where necessary.
- We devised a one page patient information leaflet to give to all patients during the consultation. This served as a check-list and also to determine the gaps in their understanding of the condition.
- We conducted an audit on diabetic patient care within the practice to determine what the current situation was and also to serve as a benchmark to see if this quality improvement intervention (QiP) actually had an effect. While we drew on NICE guidance for much of this improvement, we were not totally bound by them as they tend to be more cost driven when prescribing some of the newer therapies.

Situation in the practice before the improvement:

Buncrana Medical Centre has one of the largest numbers of GMS patients in one practice in the North West with approximately nine thousand patients. Our diabetes educational evenings are regularly attended by patients from the North. Prior to the QiP project we had no specific clinics for diabetic patients. When the local Emergency Department flooded in August of 2013, the already long waiting lists to attend the diabetic clinic were about to become even longer and so we as a practice decided to act.

List of resources required:

Our practice software was a fundamental resource for this QiP initiative. This contains patient's information including contact details and previous blood readings. We coded the patients as Type 1 or Type 2 Diabetics and now a diabetic patient list can be generated at the click of a button. We also sorted them in order of descending HbA_{1c} levels, targeting the most poorly controlled diabetics in the first round. The current set of NICE guidelines on diabetes was the other resource we relied upon. By using these guidelines we ensured that patients received the same information and same standard of treatment at our clinic as a diabetic clinic in a hospital. Our nurses also regularly take blood samples for both our

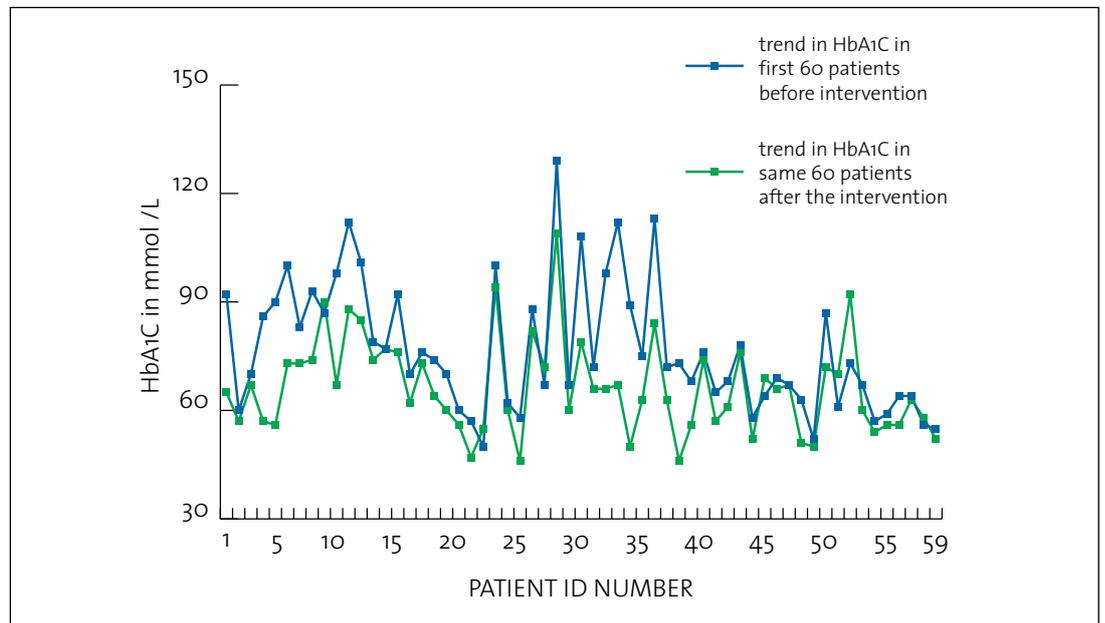
clinics as well as the hospital based clinic. In future, we would continue to use these resources, while adding to them by listing smoking status, cholesterol level, BP etc. We have introduced an automatic recall system for patients and are now focussing on a wider range of blood readings other than HbA1c.

Effect the improvement had on the practice:

Analysis of our results showed an overall decline in patients HbA1c levels, 86.3% had a decline in their HbA1c reading, 3.9% had no change and 9.8% had seen a slight increase. The average decrease in HbA1c level was 14.5 mmol /L. For the purpose of the QiP we selected data on the first sixty patients, (see graph below) though we are now gathering data on all our diabetic patients. The outcome of our QiP is certainly encouraging and in line with what we set out to achieve. For some patients however, they still have a high cardiovascular risk with unacceptably high HbA1c levels. Although the set up was initially challenging, the results speak for themselves and set achievable targets for other practices across Ireland to follow. Sincere thanks to all our staff for their extra hard work – a project of this magnitude would not have been successful without their cooperation.

For further information please contact:

- Name:** Dr Aidan Roarty, Nurse Kathleen Crerand
- Address:** Buncrana Medical Centre, Maginn Avenue, Buncrana, Co. Donegal
- Email:** aidanaroo@hotmail.com or maginnhealthcentre@hotmail.com
- Position:** GP with specialist interest in Chronic Disease Management and Diabetic Nurse Specialist
- Relevant links:** www.icgp.ie/QIPDiabetesType2 www.nice.org.uk/guidance/cg87/resources



A Breath of Fresh Air - Initiating a Nurse Led Asthma Clinic

Year: 2014 Runner-up

Brief description of the improvement:

The aim of this initiative was to empower patients to manage their own asthma confidently and effectively by providing an evidence based education program. The results demonstrated an increased level in control of asthma for our patients, a reduced need to visit the GP (with a presumed reduction in cost to the individual patient) and an unexpected increase in financial gain for the practice. We identified 232 patients by their coded asthma status and placed them on an asthma register. We then invited 103 GMS and 129 private patients for a 'first' asthma consultation with the practice nurse. Newly diagnosed patients and those with a historical diagnosis of asthma were included. Many had never received any formal asthma education. The nurse offered education, assessed inhaler technique and concordance with medication, in accordance with best practice (Asthma Control in General Practice- Adapted from the GINA Global Strategy for Asthma Management and Prevention). Control was assessed using the Asthma Control Test (ACT) which includes the peak flow measurements and a symptom history. Each patient was given a personal asthma action plan and categorized as; controlled, part-controlled or uncontrolled. Follow-up patient review was based on the assigned category. Of the first 50 patients; 38% were controlled, 18% were part controlled and 44% were uncontrolled.

Situation in the practice before the improvement:

Consultations were often ad hoc and patients were sometimes inappropriately sent to see the GPs, using up valuable appointment time with lengthy education sessions. Many asthmatics were attending with frequent exacerbations which could easily have been prevented with effective education. Conflicting advice on asthma care, lack of education and an inconsistency in delivery were also highlighted from a nursing perspective. In monetary terms, the impact on both patient and the practice was unclear.

List of resources required:

- An asthma register
- Annual audit of asthma care
- ICGP/GINA guidelines for Asthma management
- Asthma Control Test (A.C.T.)
- Education literature- Asthma Society
- Placebo devices/peak flow monitors
- Not essential, but definitely an advantage- Nurse completed Diploma in Respiratory Management

Effect the improvement had on the practice:

Twelve months after the initiative commenced, the same 50 patients were assessed for control:

- Of the controlled group; 89% were controlled, 5% were part controlled and 5% were uncontrolled
- Of the part controlled; 78% were controlled, 22% were part controlled and 0% were uncontrolled
- Of the uncontrolled; 86% were controlled, 0% were part controlled and 14% were uncontrolled

Although this was a relatively small sample, it clearly illustrates the positive achievements of the asthma clinics. Not only are the clinics effective, they appear to be reducing the incidence of exacerbations and so reducing the amount of GP visits. On analysis, the unexpected increased income to the practice is notable and makes the initiative more than viable. Each 'First' consultation lasted 30 minutes and follow up review visits, lasted 15 minutes. However, visits are now shorter and more efficient, as most patients have received up to date, research based education. The practice nurse is ideally placed to provide this quality care, within her scope of practice, whilst being an effective use of her time and skills. Going forward for 2014, our plan is to ensure 90% of patients have and are able to use, their Personal Asthma Action Plans.

For further information please contact:

Name: Nurse Caroline Maguire

Address: Wheaton Hall Medical Practice, Drogheda, Co. Louth

Email: wh.carolinemaguire@gmail.com

Position: Practice Nurse

Relevant links: www.icgp.ie/QIPAsthma www.asthma.ie www.ginasthma.org

The Introduction of Near Patient Testing Machines

Year: 2007 Winner

Brief description of the improvement:

The introduction of near patient testing machines for INR, HbA_{1c}, lipids (HDL and LDL), glucose and urinalysis for micro albumin-creatinine ratio.

Situation in the practice before the improvement:

Prior to the arrival of the near patient testing machines clients on warfarin (approximately 84), diabetic clients (approximately 240) and clients with abnormal cholesterol readings (well over 500) had to book a consultation with either the nurse or doctor to have blood sampling. Following this they had to wait roughly one week for results and depending on these it was often necessary to arrange a follow-up consult to discuss and introduce a change in medication. Care also had to be taken that all abnormal results were followed up and alterations to medication were implemented.

This process frequently required three separate consultations with the patient, with one of these typically being a phone consultation.

List of resources required:

To implement and maintain these near patient testing machines the practice nurses had to be trained in usage and quality control of these machines. The continuous maintenance of them required approximately 20 minutes of nursing time on a daily basis to conduct quality control, clean and keep records for our local Laboratory (who provided these machines).

Effect the improvement had on the practice:

Near patient testing has greatly reduced follow-up consultations in the areas of warfarin clinics, diabetic clinic and lipid clinic. Client satisfaction is almost guaranteed as they are receiving results, advice, education, any changes in medication, review appointment and any other appropriate intervention in one consult. Using these machines has improved client understanding and compliance of medication as the doctor or nurse can explain results, any changes in management, the expected outcomes and goals in this consult.

For further information please contact:

Name: Nurse Shirley Ross
Address: Medical Centre, Church Street, Moate, Co. Westmeath.
E-mail: Available on request
Position: Practice Nurse

Screening



Chlamydia Screening & Patient Attitudes to STI Testing

Year: 2010 Runner-up

Brief description of the improvement:

A study was carried out in our practice to determine the prevalence of chlamydia infection in female patients in a rural general practice setting and to determine the attitudes of patients to STI screening in general practice. Chlamydia screening was offered opportunistically to female patients between the ages of 16 and 55 years attending the practice over a three month period. Patients included those attending for cervical smears, contraception advice or for any other reason. 100 women were sampled with 6 positive results. This equated to a 12% positive rate in 21-25 year olds, and 10% in the 26-30 year olds. None of the positive patients had symptoms or had requested screening. A questionnaire which accompanied the screening process asked patients for their opinion on STI screening in general practice. A positive finding was the desire of patients to have screening performed locally without the need to travel to regional clinics. As a result of this, routine screening is now offered to all females under 30 years old when having a cervical smear or attending for contraception. Of note, our study found chlamydia was prevalent in the 26-30 year old group who would not be offered routine screening in countries such as the UK where national screening programmes are in place.

Situation in the practice before the improvement:

Prior to setting up routine chlamydia screening in the surgery, chlamydia testing was performed only on patients who requested screening or in patients who had symptoms of infection. The idea for this project came with the detection of chlamydia infection in two female patients who had requested testing in the few months after I had joined the practice. Given that chlamydia was being detected in our population without any formal screening, it seemed prudent to determine just how prevalent a problem this was.

List of resources required:

In 2009 the National Viral Reference Laboratory began using a new technique to detect chlamydia infection. The test can be carried out on a urine sample or an endocervical or urethral swab. As the sample does not need to be refrigerated and is viable for 30 days, the collection and delivery to the laboratory is flexible. The samples are sent to the laboratory by the same courier system already in place to transport other samples from the practice. This is at no added cost to the practice as sample vials are provided free by the NVRL. Both the practice nurse and doctors in the practice are involved in educating patients and offering chlamydia testing. There is no extra charge to the patient above the normal consultation fee and no extra charge for patients having a cervical smear performed. Practice protocols have been implemented for the management of positive results including

treatment, referral for further STI screening and contact tracing. Patients are charged accordingly for follow-up.

Effect the improvement had on the practice:

The study has highlighted the prevalence of Chlamydia infection in our practice and highlights how common a problem chlamydia is, even in rural Ireland. It also highlights the desire for women to attend their own GP for STI screening. Prior to the implementation of chlamydia screening in the practice, testing was rather hap-hazard and relied upon patients requesting testing rather than being offered, unless they had symptoms. The study carried out highlighted the age-group of patients who need to be targeted, including the 26-30 year olds. The prevalence rate found in our practice is comparable with other parts of Ireland and other countries where national screening takes place. The screening is easy to perform and patients are open and very responsive to having screening carried out. As chlamydia is so prevalent and it can have such devastating long term consequences for women, along with the fact that so many patients are asymptomatic and hence do not request testing, the screening and subsequent detection of infection is vital.

For further information please contact:

Name: Dr Jennifer Pugh, Dr Barry Boland, Nurse Roisin Doogue
Address: Rathangan Medical Centre, Rathangan, Co. Kildare
Email: Available on request
Position: GP Registrar, GP Principal, Practice Nurse

Practice Management



Implementation of GPIT Guidelines “No Data, No Business”

Year: 2008 Winner

Brief description of the improvement:

We have fully implemented the GPIT guidelines “No Data, No Business” into our practice. When we received the document “No Data, No Business” from the GPIT we decided to ensure that we would become 100% compliant with this guideline. To achieve this we carried out an audit of the existing computer systems in the practice. Using the GPIT guideline as the “gold standard”, we were able to compare this best practice standard with the IT systems we had already in place in our practice. This highlighted to us what we are currently doing well as well as what needed change or improvement so as to be fully compliant with the GPIT guideline.

Situation in the practice before the improvement:

We are a fully computerised group practice, paper light with what we thought were “faultless” IT systems. However when we carried out an audit of all of our IT systems using the GPIT guideline as the “Gold Standard” we discovered a number of issues that needed improving.

List of resources required:

We spent all lot of staff time initially doing the audit and then implementing the changes and training the appropriate staff members. The cost to the practice for the systems we needed to implement was as follows:

Cost of disaster recovery:	€2,387.85
Cost of backup tapes:	€602.58
Cost of safe:	€985.00
Cost of door:	€200.00
Staff time to implement	€500.00
Total cost to practice:	€4,675.43

As with all best practice policies these will need to be reviewed and updated regularly as the needs of the practice change and also with the rapid speed in which technology is changing.

Effect the improvement had on the practice:

This has had a motivating effect on all of our staff and overall we have found this process of audit and quality assurance to be extremely worthwhile. It has highlighted the need to continually review and update all our policies

and procedures so as to stay abreast of the rapidly changing general practice environment. With regard to Information and Communication Technology (ICT), this requires an investment of time, effort and resources. The new GPIT guideline “*No Data, No Business*” deserves to be taken seriously by Irish General Practice. After all, prevention is better than cure.

For further information please contact:

Name: Julie Rogers & Dr Mark Rowe

Address: Pairc Clinic, Lismore Park, Waterford

E-mail: Available on request

Position: Practice Manager & Managing Partner

Relevant link: http://www.icgp.ie/go/in_the_practice/information_technology/news_updates/E3E7417C-19B9-E185-833C5534D98B3B8C.html

Patient Satisfaction Survey

Year: 2007 Runner-up

Brief description of the improvement:

We carried out a patient satisfaction survey at our practice. A questionnaire consisting of ten questions relating to quality, interpersonal issues and access (including waiting times, telephone access etc.) was devised. We also wanted to offer a snapshot of patient's opinions on our practice by way of three open ended questions at the end of the questionnaire. 150 patients were selected to include a cross section of socio-economic backgrounds and aged between 20 – 85 years. These patients were asked to complete the questionnaire in the surgery. Having gone through each individual questionnaire a score of between 1 and 5 was issued using a weighted score system. This data was then entered onto an excel spreadsheet to obtain the overall average and percentage (see Appendix I).

Situation in the practice before the improvement:

Our practice has expanded rapidly over the last seven years from a 2 doctor to a 10 doctor general practice. It has many auxiliary services, including physiotherapy, dentistry, chiropody, counselling, speech and language therapy and a dietician. Other staff at the practice includes a full time practice nurse and 8 receptionists. We also moved into a new purpose built premises 5 years ago. Our aim for undertaking this survey was to see if we still provided the personal service to our patients that we prided ourselves on. We wanted to ascertain if patient satisfaction levels remained high even though the practice had grown so quickly, in a relatively short period of time.

List of resources required:

- Time of administration staff
- Excel spreadsheet

Effect the improvement had on the practice:

The findings from the survey were discussed by way of a practice meeting. It brought to light any areas which needed to be improved upon. It inspired changes and also highlighted areas that worked quite well at the practice. Areas we felt could be improved upon were the length of time patients had to wait to be seen by the doctor, producing a practice web site and we are looking into installing a lift in the future as the premises is on two floors. We felt that performing a patient satisfaction survey demonstrated to both staff and patients that the practice was interested in quality assurance and ways to improve our service. Although we were very happy with the overall patient satisfaction levels of 88% we are aiming to achieve a 90 – 95% satisfaction rate and therefore are still looking at ways to improve. A team approach and good communication

between all practice staff is essential in providing a quality service. This process is facilitated by good management, regular staff meetings and informal contact by staff members. A quality service should always be subject to audit and review. A lot of very encouraging comments and affirmative feedback was obtained from carrying out this survey:

- “The service is excellent from the moment of entry to exit. Level of service is very high in all aspects”.
- “Being friendly and getting great medical care and knowledge that you can trust in everyday language”.
- “Providing a good service to the people of Glanmire”.
- “I am very pleased; everything for me is and has been excellent, I couldn’t ask for more”.

It confirmed to staff at the practice that we are providing a good quality service and on the whole has given the practice a boost.

For further information please contact:

Name: Jody Cummins
Address: The Glanmire Medical Centre, Crestfield, Glanmire, Co. Cork
E-mail: jodycummins@hotmail.com
Position: Practice Administrator

Survey results

INTERPERSONAL ISSUES		%
Dealt with at Reception	4.33	86.6%
Caring and compassionate staff	4.42	88.4%
ACCESS ISSUES		
Patient waiting times	3.84	76.8%
Seeing doctor of choice	4.08	81.6%
Phone access	4.32	86.4%
Knowledge surgery hours/services	4.39	87.8%
Information displayed in the waiting area	4.42	88.4%
QUALITY ISSUES		
Quality of care received	4.49	89.8%
Premises and facilities at the surgery	4.73	94.6%
OVERALL SATISFACTION LEVEL	4.39	87.8%

Survey Questions

1. When you arrived, how did you feel you were dealt with at Reception?
2. Were you satisfied with the length of time you were waiting to be called by the doctor?
3. How would you rate the quality of care that you received?
4. How would you rate your satisfaction at getting to see your doctor of choice?
5. How do you view the premises and facilities at this practice?
6. Did you find it easy to get through to the practice by phone?
7. Did you think there was adequate information on display / provided in the waiting area?
8. How would you rate your knowledge about the practice – for example surgery opening hours, services available at the practice etc.?
9. How do you see the staff in relation to being caring and compassionate?
10. How would you rate your overall satisfaction with this practice?

We are interested in any other comments you may have.

- What do you like best about the Glanmire Medical Centre?
- What are we doing especially well?
- What can we do to improve?

Development of a Database of Patients on MC2 Social Welfare Certificates

Year: 2008 Runner-up

Brief description of the improvement:

A Microsoft Access database was designed with the principal objective to organise information and improve time management and efficiency in the issuing of MC2 Social Welfare (SW) certs. Patients in receipt of weekly, monthly, and six monthly SW MC2 certs are inputted onto the database along with their PPS number (the primary key id), day/date cert due, which GP signs, condition and contact number. The database can be accessed from each computer desktop and 3 tables in the database are in form view, colour coded, and named weekly, monthly and six monthly making it easier to differentiate between them. The weekly table can be filtered by weekday or GP. The process is as follows:

- On issuing the first (yellow) MC2 cert, the patient is inputted on the database providing their PPS and contact number. They receive a review date and designated day/date for cert collection (usually the day the first MC2 cert is issued). The patient is then given a practice leaflet explaining and highlighting practice policy on issuing of MC2 SW certs.
- A policy is in place for review dates and a general protocol is: weekly at least once a month, monthly at least every 3 to 6 months and six monthly at least once a year.
- Time is allocated each day by staff for completion of certs and for GP's to sign.
- When MC2 SW certs are completed by staff and GP's they are indexed at the front desk, ready for collection.
- If on the second week certs are not collected the patient is contacted to come in for review, therefore ensuring there is no build-up of certs not collected or subsequent voiding.

Situation in the practice before the improvement:

Prior to the creation of the database, SW MC2 certs had no designated time for signing. Patients came to the surgery when a new cert was required. Staff working on a rota basis did not always know all patients on SW certs or which GP signed the cert. It was not always known if the patient was due to be reviewed or on the cert for a specific length of time. GP's were frequently interrupted between consultations. Patients also regularly had to return with their PPS numbers, had a sometimes lengthy wait for a cert to be signed, were asked to return or had to wait to be reviewed. Lack of efficiency meant staff and patients wasted valuable time.

List of resources required:

- Microsoft Access software and training (using database, entering, deleting and filtering)

- MC2 certs
- Teamwork is required and has to be maintained between GP’s and staff - notification and data input on issuing first MC2 cert, giving review dates and informing staff/GP’s when final cert issued.
- Time allocated for completion of certs for designated day/date.
- Patient co-operation in collecting MC2 SW certs.
- Indexing of completed certs at front desk, ready for collection.

Effect the improvement had on the practice:

- Improved time management and efficiency: designated time given for issuing SW certs and no missing PPS numbers.
- Immediate recollection of patients.
- Less interruption for both staff and GP’s i.e. less stress.
- Better review of patient’s length of time on MC2 SW certs.
- Patient satisfaction - efficiency of service, with a given day/date that cert is ready for collection.

For further information please contact:

Name: Maire Daly
Address: Medical Centre, Hartley, Carrick on Shannon, Co. Leitrim
E-mail: Available on request
Position: Practice Manager

Example of Weekly MC2 SW Table in database

DAY	NAME	PPS NUMBER	PHONE No	CONDITION	GP	START DATE	REVIEW DATE
TUES	JOHN BLOGGS	1234567R	9645821	FRACTURED RIGHT LEG	OG	22.03.07	18.05.07
TUES	JANE TEST	1235874F	874562225	DEPRESSION	JC	22.03.07	18.05.07
THURS	TOMMY TEEN	12698753G	96325968	HAND INJURY	TN	14.02.07	11.05.07
FRI	MARY MARE	2147893T	9653217	POST OP	JC	28.03.07	15.05.07
TUES	MELISSA DAY	25874136D	96235690	PREGNANCY COMP.	TN	01.05.07	01.06.07
WED	LUKE BROOKS	3216549W	9632587	TORN LIGAMENTS	KG	26.04.07	25.05.07
MON	TERRY MERRY	45612398R	85623598	ARTHRITIS	TN	24.04.07	22.05.07
MON	JOHN DOE	52417892P	96523120	EYE OP	KG	01.03.07	01.05.07
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Procedure for Deaths in the Practice

Year: 2009 Winner

Brief description of the improvement:

- Use a black book to record recent bereavements in the practice and patients relatives who have died.
- Send letter to the family on behalf of doctors and practice staff. This includes a leaflet on bereavement and grief.
- Visit the patient's family if I am directly involved in the care of the deceased.
- Record the bereavement in the clinical notes.
- Inform other relevant medical services attended by deceased; hospitals, private consultants, hospice, PHN etc.

Situation in the practice before the improvement:

Death of a patient was responded to in an opportunistic way and nobody else was notified.

Death of the relatives of patients was not specifically acknowledged.

List of resources required:

- A black A5 slim book to record bereavements of patients and relatives of patients.
- Template letter set up on the computer which can be altered as needed.
- Vigilant and interested staff who read the death notices and makes connections to the practice population.

Effect the improvement had on the practice:

We have experienced great appreciation from all the patients who received our letters of condolence. It has genuinely had a positive effect on the relationship between the doctor and patients. My secretary types the letter therefore she is aware of the patient's loss which helps if they are upset or angry when they contact the surgery.

For further information please contact:

Name: Dr Gertrude Ronan
Address: 123 Lower Churchtown Road, Churchtown, Dublin 14
Email: Available on request
Position: GP Principal

Influenza Vaccine Register

Year: 2011 Runner-up

Brief description of the improvement:

For the 2010/2011 influenza season, we proposed to increase emphasis on eligibility criteria for the influenza vaccine and to form a register of all eligible patients in the practice. These steps were taken in an effort to increase uptake of the annual influenza vaccine. A practice meeting was held where all criteria for vaccination, including new target groups as per the 2010 HSE guidelines, were discussed. A large poster was placed in the waiting room listing groups eligible for vaccination and advising of the cost. In addition, posters were displayed in high visibility areas in all consulting rooms. A register of all eligible patients was formed. Most of the register was created by utilizing the reports feature on the practice software. Once the register was complete, any patient who featured on it was automatically tagged once they booked an appointment. When they attended an appointment with any of the doctors or practice nurses, their name was highlighted to indicate that they were eligible for the flu vaccine. When any patient on the register received the vaccine, this was recorded on the register. Once the initial rush for vaccination started to decrease, letters were posted to all remaining patients on the register who had yet to receive the vaccine, advising them that they were eligible.

Situation in the practice before the improvement:

Prior to the changes this year, administration of the influenza vaccine would have been solely opportunistic or administered at patient request if eligible.

List of resources required:

The register was largely formed using the practice software and so did not require any additional financial resources, but did necessitate the investment of time. Specific groups were searched for using the reports feature. Patients aged 65 years or older were identified. Pregnant women were identified by checking for registration on the antenatal protocol. Patients with chronic disease could have been identified by searching via stated diagnosis but in the absence of coded diagnoses, and in an effort to make the register as accurate as possible, most of these patients were found by searching via prescriptions. For example, a search was performed for all patients aged 18–65 years who had received a prescription for beclomethasone in the previous 18 months. The patients chart was then reviewed to confirm eligibility. Now that it has been created, it is hoped that the register can be utilized on an annual basis with minor adjustments for patients newly eligible, either due to change in age or health status or due to modifications in the HSE guidelines for vaccination. Posters will also need to be potentially updated if target groups for vaccination are increased. 352 letters in

total were sent to patients and this also involved time investment and cost in terms of postage. There was also the cost of printing the posters.

Effect the improvement had on the practice:

Vaccine administration rates increased from 380 in 2009/2010 to 862 in 2010/2011. Of the 1265 patients on the register, 808 received the influenza vaccine. Due to the formation of the register, it was also possible to estimate our vaccine uptake amongst target groups which was 63.87%. Of the 352 patients who received written reminders, 117 went on to have the vaccine giving a response rate of 33.24%.

For further information please contact:

Name: Dr Clare Leonard

Address: Clayton Hall Medical Centre, Staplestown Road, Carlow, Co. Carlow

Email: clare_leonard@hotmail.com

Position: GP Registrar

Relevant link: www.immunisation.ie/en/HealthcareProfessionals/Influenza

Remembering Deceased Patients in a Practice

Year: 2013 Runner-up

Brief description of the improvement:

The practice records the deaths of all patients in a computerised register. At the end of the year a card is purchased in the name of each deceased patient from the Irish Hospice Foundation as part of their 'Light up a Life' campaign. This is then sent to the next of kin of the patient. The card is handwritten and includes the message "thinking of you at this difficult time". The card is signed by the GP partners in the practice. The card also includes an invitation to the Christmas tree lighting ceremony held in Our Lady's Hospice Harold's Cross at Christmas time. The tree is adorned with thousands of lights; each one in honour of someone special who has died. A special non-denominational service is also in the hospice to remember the patients.

Situation in the practice before the improvement:

Patients' next of kin were not routinely contacted following the death of a loved one. GPs often did not contact the next of kin after the death of a family member and this could result in embarrassment and awkwardness at the next consultation. Families now regularly comment on the card and this can form a channel to explore bereavement issues in the consultation.

List of resources required:

- Computerised register of deaths.
- Purchase of "Light Up A Life" cards and donation to Our Lady's Hospice of €100
- GP time resource - hand writing cards with message (1 hour)
- These resources are needed annually.

Effect the improvement had on the practice:

The care of families where there has been a recent bereavement has been greatly enhanced. Patients who are dying and their families often experience intense contact with their GP up to the time of death and many families remark on the sense of isolation and loneliness when such frequent medical activity stops following death. This initiative provides both a structured and personal method of contacting recently bereaved families. Feedback has been overwhelmingly positive. Some have commented that this gesture was "one of the most thoughtful acts" that the families had experienced during a very difficult time in their lives. Bereavement issues are now easier to discuss with families.

For further information please contact:

Name: Dr Joseph Clarke & Dr Mary Taaffe
Address: Shandon House, Summerhill, Co Meath
Email: clarke.doc@gmail.com
Position: Principal GPs

