





Kidney Health

**PIP Quarter:** [ ]  Feb-Apr [ ]  May-Jul [ ]  Aug-Oct [ ]  Nov-Jan



1. **PDSA Example**

A sample activity using the PDSA Template to illustrate how to structure your quality improvement activity.

1. **PDSA Template**

The template to complete and store (for audit purposes) as part of your activity, guiding you through each stage of the PDSA cycle.

1. **CAT Recipe**

A step-by-step guide for filtering your patient cohort and running activity reports in CAT4 to support your activity.





**Kidney Health: A Silent Killer with No Cure**



Chronic Kidney Disease (CKD) is a significant and growing health burden, often under-recognised in its early stages. Accurate clinical coding is essential to ensure that patients receive appropriate care, are captured in practice recalls, and are eligible for relevant MBS items.

* Chronic kidney disease (CKD) is twice as common as diabetes.
* The number of Australians requiring treatment for kidney failure has doubled in the last 20 years.
* CKD contributes to 1 in 6 hospitalisations across the country.
* 3 in 4 Australian adults have at least one risk factor for CKD.
* 1 in 10 Australians and 1 in 5 Aboriginal and Torres Strait Islander adults (aged 18 and over) are living with signs of CKD.
* When detected early and managed appropriately, kidney function decline can be reduced by up to 50%.

**PHN Data Snapshot**

* Renal impairment patients in our region: 8,190
* Total active patients across our region: 514,173
* High blood pressure prevalence in our region: 23.54% (compared to QLD average of 23.07%)

**Relevant PIP QI Measures**

* QIM1 – Proportion of patients with diabetes with a current HbA1c result
* QIM8 – Proportion of patients with the necessary risk factors assessed to enable CVD assessment
* QIM10 – Proportion of patients with diabetes with a recorded blood pressure result

**Let’s Start with Clean Data**

* Before targeting the above PIP QI measures, let’s ensure the foundational data is accurate. This month’s PDSA activity focuses on:
* **“Indicated CKD with No Diagnosis**” – a data cleansing activity to identify patients who meet clinical criteria for CKD but do not yet have a coded diagnosis in their record. Ensuring these patients are correctly coded means they’ll be included in chronic disease registers, recalls, and eligible Medicare item tracking.
* **Optional Extra:**
If your practice has capacity, consider also running the **“Indicated Diabetes with No Diagnosis”** report. This is entirely optional and at your discretion.

**Resources**

<https://www.kidney.org.au>

<https://kidney.org.au/your-kidneys>

<https://assets.kidney.org.au/resources/KHA-CKD-Handbook-5th-Ed-July2024.pdf>

<https://kidney.org.au/health-professionals/professional-development>



A PDSA cycle is a structured, step-by-step method that helps teams actively work through an improvement activity while also recording the process and outcomes for reflection and learning.

|  |  |
| --- | --- |
| **Practice name:** Example Practice | **Date:** 01/05/2025 |
| **Team member:** P. Manager |

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| --- | --- |
| PLAN | Describe the brainstorm idea you are planning to work on. (Idea) |
| Decide what you want to improve, what changes you'll try, and how you'll measure success. |
| What do you want to achieve?Decrease the proportion of active patients who are indicated for Chronic Kidney Disease (CKD) but have no coded diagnosis recorded in the clinical software. This data cleansing activity aims to ensure vulnerable patients receive appropriate care and access to Medicare items they are eligible for.What will you change?Use PenCS CAT4 to identify patients with clinical indicators of CKD but no coded diagnosis, then conduct clinical audits and update records where appropriate. Opportunistically flag these patients for GP review and potential diagnosis coding.Who will help?QI Team, practice nurses, GPs, reception staff. Possible support from PenCS CAT4 and/or Topbar. What do you need?* Access to PenCS CAT4 for identification of "Indicated CKD – No Diagnosis" patients
* GP time to review and confirm diagnosis where appropriate
* Nurse or admin time for record checking and appointment scheduling
* Existing clinical protocols for CKD diagnosis confirmation
* Education resources if needed (e.g. CKD identification and staging)

How will you measure success?* Record baseline number of indicated-but-uncoded CKD patients at the start of the month
* Compare with post-cleansing numbers at the end of the activity period
* Use PenCS CAT4 reports to quantify reduction
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| DO | **Who is going to do what? (Action)** |
| Put your plan into action and collect data. |
| Actions at the beginning of the PIP quarter:* Hold a staff meeting to explain the purpose and importance of correctly coding CKD
* Allocate roles for report generation, clinical record reviews, and data entry
* Ensure GPs are aware of current CKD clinical guidelines (e.g. eGFR <60 and/or ACR >3.5/2.5)
* Establish a workflow for confirming and coding CKD diagnoses
* Provide refresher training for admin and clinical staff on accurate coding and chronic disease registers

During implementation:* Run CAT4 searches to identify patients flagged as “Indicated CKD – No Diagnosis”
* Segment the patient list into manageable groups for review
* Clinicians to review each case and apply diagnosis codes where appropriate
* Opportunistically confirm diagnosis during consultations when possible
* Update records to reflect accurate chronic disease status

At the end of the PIP quarter:* Run a follow-up report to measure change
* Hold a team review to assess outcomes and gather feedback
* Discuss refinements for future data cleansing cycles
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| STUDY | **Does the data show a change? (Reflection)**  |
| Look at the results. Did the change work as expected? What did you learn? |
| What data did you collect?Due to high numbers, we focused on patients who were overdue only.* Baseline (May 2025): 87 active patients indicated for CKD but without a coded diagnosis
* Result (July 2025): 39 patients remain without a coded CKD diagnosis
* Improvement: Reduction of 48 patients (approx. 55%)

What did you learn?* Many patients had long-standing abnormal results without follow-up
* Accurate coding improves eligibility for CDM items and supports continuity of care
* Nurse-led audits were particularly effective for managing and preparing GP reviews
* Opportunistic coding during regular appointments worked well
* Some patients required additional testing before diagnosis could be confirmed
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| ACT | **Do you need to adjust the plan, or did everything go as expected? (What Next?)** |
| Decide what to do next—keep the change, adjust it, or try something different. |
| What will you do next?* Adopt: Continue regular data cleansing for CKD and other chronic conditions using CAT4 for the time being
* Adapt: Embed nurse-led audits followed by GP review
* Abandon: Manual coding by staff. Every staff member should be using the practice software coded diagnoses. This process change should lead to cleaner data and in the future, we shouldn’t have to review, it should just be business as usual

Next Steps:* Repeat CKD data cleansing biannually
* Integrate this with GPMP reviews and chronic disease clinics
* Explore similar audits for other conditions (e.g. diabetes)
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**Please attach your data reports/results to this PDSA.**

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| Should your practice be audited, having these documents on hand will serve as evidence of the changes made, the data collected, and the outcomes achieved during the PDSA cycle. Ensure that the baseline data and result data are included, along with any relevant reports from PenCS CAT4 and HotDoc that were used to track the improvement. |



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|  |  |
| --- | --- |
| **Practice name:**  | **Date:**  |
| **Team member:**  |

|  |  |
| --- | --- |
| PLAN | Describe the brainstorm idea you are planning to work on. (Idea) |
| Decide what you want to improve, what changes you'll try, and how you'll measure success. |
| What do you want to achieve?What will you change?Who will help?What do you need?* …
* …
* …
* …

How will you measure success?* …
* …
 |
| DO | **Who is going to do what? (Action)** |
| Put your plan into action and collect data. |
| Actions at the beginning of the PIP quarter:* …
* …
* …

During implementation:* …
* …
* …
* …

At the end of the PIP quarter:* …
* …
 |
| STUDY | **Does the data show a change? (Reflection)**  |
| Look at the results. Did the change work as expected? What did you learn? |
| What data did you collect?* Baseline:
* Result:
* Improvement:

What did you learn?* …
* …
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| ACT | **Do you need to adjust the plan, or did everything go as expected? (What Next?)** |
| Decide what to do next—keep the change, adjust it, or try something different. |
| What will you do next?* Adopt:
* Adapt:
* Abandon:

Next Steps:* …
 |

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**Identify active patients indicated for CKD but have no coded diagnosis recorded**

**FILTER STEPS**

On the **‘General’** tab and select Activity **‘Active (3x in 2 yrs)’**.

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Now all filter criteria have been set, please click on **'Recalculate'** to apply the filter:



To see the full report, first minimise the filter panel by clicking on the     in the top left corner.

**REPORT STEPS**

Select the **‘Data Cleansing’** taband then select the **‘Indicated CKD with No Diagnosis > Indicated’** subtabs.

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The **"Indicated CKD with No Diagnosis > Indicated"** Report displays patients where the staging of CKD, as determined by the combined results of kidney function (eGFR) and kidney damage (the level of albuminuria using ACR), indicates the possibility of CKD.
The report displays:

* eGFR, ACR and the resulting Indicated Staging of CKD
* Colour code for the Clinical Action Plan to manage CKD
* Other CKD Risk Factors

Patients on dialysis are displayed as 'level 5' CKD.

Patients with an eGFR = 0 and no ACR are displayed without action plan level and just with the word 'Stage' to indicate that there is some data in their record that requires review.

|  |  |
| --- | --- |
| **Red** | Clinical Action Plan to be monitored 1-3 monthly |
| **Orange** | Clinical Action Plan to be monitored 3-6 monthly |
| **Yellow** | Clinical Action Plan to be monitored 12 monthly |
| **No Colour** | Patients without a CKD diagnosis and with a eGFR < 60 and no ACR |

For more information refer to Kidney Health Australia web site and the CKD Guideline Booklet available at [www.kidney.org.au](http://www.kidney.org.au/)
Detection of CKD requires follow up testing once an abnormal result is recorded. The outcome of 3 tests over a 3-month period will inform a diagnosis. CAT4 is only using the most recent eGFR and ACR, not the last 3 results. This will

* Inform a diagnosis if 3 tests have been done or
* Flag that a patient should be recalled for follow up testing if there are not 3 results in the Patient Record.

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**Note:** If your selected patient group is too large, refine your reporting criteria to keep numbers manageable for clinic staff. Practices may adjust filters and reporting methods at their discretion.

For assistance in narrowing reporting numbers, contact the PHN at practicesupport@ddwmphn.com.au.

This structured approach ensures that your cervical screening improvement plan is **measurable, actionable, and scalable** for future quality improvement initiatives.

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On the right-hand side of the Reports pane, you will see **‘Save As’** and **‘Export’** icons.

It is recommended that you highlight those patients who you wish to action as a priority i.e., those patients who have been prioritised in red.

NOTE: You can work directly with the report to clear it. If the clinician knows that the condition does not exist and they would like to remove it from the report, there is a **‘Confirm Condition Does Not Exist’** checkbox. Select all relevant patients and they will not appear in future reports.

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Be sure to attach your data reports to your PDSAs at the beginning and end of each quarter. If it’s not recorded, it didn’t happen! Should the Department come searching, you **MUST** have a record of your QI activities and the treasure trove of data to prove it. **X marks the spot—bury it somewhere you'll always find it!**





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You've conquered this QI Quest and **LEVELLED UP** your practice— but the journey doesn’t end here. A new challenge awaits in the next quarter... **Are you ready to embark on your next QI adventure?"**