THE UNIVERSITY OF BRITISH COLUMBIA

UBC DEPARTMENT OF FAMILY PRACTICE

Option 1: Quality Improvement (QI) Report Form Template

Date: _____

Resident's Name: _____

Topic: _____

1. **Quality Improvement Question:**
   "How are we doing compared to the recommended standard of care?" Practice audit questions usually specify the patients, the intervention and the specific performance criteria you are assessing.

2. **Standard of Care:**
   Based on your appraisal of evidence about best practices, what clinical criteria (standards of care) will you use to compare with your own practice and summarize AND APPRAISE the evidence BEHIND the current standard of care?

3. **Method:**
   Describe your method of practice assessment. (If chart audit, specify selection criteria, how do you achieved a random sample and number selected).

4. **Results:**
   Briefly describe, as percentages, averages etc. Attach your audit or results form (usually a spreadsheet or chart).

5. **Analysis:**
   Compare your findings with standard or other audits. Consider whether this truly reflects your actual practice and what biases may result from the way your assessed your practice. Describe whether there is a gap between your current practice and any evidence-based recommendations. If there is a gap, how important is it and what are the possible reasons?)

6. **Improvement Plan:**
   Based on what you have learned, what changes, if any, do you plan to make to your practice? Identify potential barriers and solutions to your implementation of these changes. Include a description of how this was discussed in a collaborative way with your preceptor.

7. **Follow up Assessment**
   How successful were you in implementing a change? What are your recommendations for the next PDSA cycle (next small step)?

_____

Resident Signature