



Evaluation Report | External

Creating Age-Friendly Health Systems in Victoria

Breakthrough Series Collaborative

June 2022 – June 2023

OFFICIAL

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Acknowledgements

Safer Care Victoria (SCV) partnered with the Institute for Healthcare Improvement (IHI) to design and deliver the Creating Age-Friendly Health Systems in Victoria - Breakthrough Series Collaborative ('the Collaborative').

We acknowledge Aboriginal and Torres Strait Islander people as the first peoples and Traditional Owners and custodians of the land and waterways on which the Collaborative was conducted. We honour and pay our respects to Elders past and present.

To the 18 health and residential aged care services (**Appendix A**. Participating Services) that dedicated their time to improving care for older people in their service, your time and energy has made all the difference, thank you.

We would like to acknowledge the contributions of the project team members listed in **Appendix B**.

The project team was also supported by an expert faculty (**Appendix C**) comprised of clinical and lived experience experts, who contributed to the design of the Collaborative and participated in learning sessions and action period calls to support the teaching and coaching of teams.

We would like to acknowledge the consumers who shared their stories with the Collaborative teams working to improve their wellbeing and reminded us why this work matters.

Title of Document: Creating Age-Friendly Health Systems in Victoria – Breakthrough Series Collaborative, External Summary Report

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Reviewed and endorsed by Faculty, SCV and IHI delegates.

Acronyms used in this report

BTS	Breakthrough Series
EOI	Expression of interest
IHI	Institute for Healthcare Improvement
PDSA	Plan-Do-Study-Act
RAC	Residential Aged Care
SCV	Safer Care Victoria

Background

The Age-Friendly Collaborative is part of the 100,000 Lives Program, which is a five-year program to reduce harm and improve health outcomes for Victorians. Through small and large-scale improvement projects, SCV are partnering with health services, consumers, and experts to identify specific problems and risks in healthcare. Ideas are then rapidly tested, studied and fine-tuned so that improvements can be implemented across the sector. The 100,000 Lives Program focuses on three areas including reducing harm in hospitals, ensuring patients are cared for quickly and in the right place, and reducing hospital admissions.

Older people are more likely to be admitted to hospital or an aged care facility than younger people, and are more likely to experience harm such as falls, physical deterioration, medication errors, infections, or confusion (AIHW, 2007). Older people and their carers often report inconsistencies between the way they are treated and what matters to them.

Age-Friendly Health Systems reliably provide a set of four evidence-based elements of high-quality care, known as the 4Ms (What Matters, Medication, Mind and Mobility) to all older people in their system. The 4Ms represent a shift by health systems to focus on the needs of older people. The 4Ms Framework was developed in the United States by IHI in partnership with the John A. Hartford Foundation, the American Hospital Association, and the Catholic Health Association. This system approach has been successfully implemented in over 2,500 clinical sites across the United States of America (USA), with improved outcomes including reduced length of stay, reduced readmission rate, and fewer falls (IHI, 2019).

The 4Ms Framework was piloted by SCV and IHI in Victoria between May 2021 and May 2022 with local expert faculty and seven partner health services. This resulted in local adaptations to the 4Ms Guide (SCV, 2022) by localising the language, assessment tools and clinical processes to Victoria.

This report provides a summary of the Creating Age-Friendly Health Systems Collaborative.

Consumer story – David

David was a resident at our Creswick Residential Aged Care (RAC) site. Staff from this team created a video showing the positive impact that asking What Matters had made on his and his family's experience in aged care. His story in full can be found [here](#).

Summary of David's story:

- David was born in Yorkshire, England, in 1937. He met Nancy at medical school. They married and had three daughters.
- They moved to Australia in 1965 and spent time living in Beijing, Jakarta, and Laos.
- David and Nancy enjoyed a grey nomad adventure after their retirement.
- Nancy passed away in 2018, and David got his beloved dog, Henry.
- David was having difficulty with cognitive decline and had become legally blind.
- After a couple of years of being in and out of hospital, his daughters were concerned about his wellbeing. David moved into Creswick RAC in 2022. He was diagnosed with Florid Psychotic Phenomena. He had trouble determining what was real and what was not.
- After multiple medical and geriatrician reviews, he was put on medication to help him to find clarity in his surroundings.
- Staff also learnt his triggers and how to respond to his needs.
- 'What mattered' to David was his family, and his 'number one boy', Henry. David's daughter Helen bought him a plush dog. David said, 'Oh Henry my boy, I love you' and started patting and cuddling him.
- Staff continued to ask David 'what mattered' to him, to which he responded with wine, whisky, coffee, cake, going outside, company, and sharing stories with family and staff.
- By asking 'What Matters', staff were also able to give David a bath instead of a shower when he wished.
- One day David said he would love to play the piano again, so he did.
- David's moments of clarity provided opportunity for him and his daughter Helen, to discuss his end-of-life choices and clarify his wishes.
- In Helen's words: 'Dad has received lots of love and care from staff, and you have all made a big difference to his life.'



What did we want to accomplish?

The aim that was established for the Creating Age Friendly Health Systems Collaborative was:

By 30 June 2023, we will create Age-Friendly Health Systems across Victoria, by increasing the percentage of older people¹ who receive 4Ms (What Matters, Medication, Mind and Mobility) care (as a set) to 50% or more at participating services.

To achieve this, 90% of older people will be assessed and acted upon for:

¹'Older people' refers to people aged 65 and over, or 45 and over for Aboriginal and Torres Strait Islander people

- What Matters
- Potentially inappropriate medications and polypharmacy (Medication)
- Depression, delirium, and cognitive impairment (Mind)
- Mobility

If we were successful in this aim, we also expected to see a reduction in avoidable harm and other measures which services self-selected, such as falls or other hospital-acquired complications, length of stay and readmissions. For further information on how measurement was used to determine whether there had been an improvement, please see the Measurement Strategy in **Appendix D: How did we measure improvement?**

What approach did we take?

Health and residential aged care service teams were invited to participate in a 12-month project which used a Breakthrough Series (BTS) Collaborative design. This design employs a collaborative model where multiple organisations come together to learn and implement best practices within a structured framework.

The process begins with identifying a significant healthcare issue and assembling expert panels to develop evidence-based change ideas. These ideas are then tested through Plan-Do-Study-Act (PDSA) cycles in real-world settings. The impact of changes that have been tested is evaluated using a series of measures designed to help participating services decide which changes are making a difference. The measurement approach used in the Age Friendly Collaborative is described in detail in **Appendix D: How did we measure improvement?**

Participating organisations share their experiences, data, and results in regular collaborative learning sessions, fostering a culture of collective learning and rapid iteration. The Age-Friendly Collaborative included three intensive events known as learning sessions which were supplemented by monthly virtual calls known as Action Period Calls.

The Age-Friendly Collaborative took place between 20 June 2022 and a summative event on 19 June 2023 and was attended by 30 teams representing 18 health services (**Error! Reference source not found.**)

What changes were tested?

Health and residential aged care services in Victoria tested and adapted the Age-Friendly Health Systems 4Ms Framework for use in their services. Figure 1 provides a summary of the theory of change (presented as a Driver Diagram) for this Collaborative.

The key areas of focus were:

1. To **assess** all older people in the care setting for each of the 4Ms.

Teams self-identified which tools they would use for assessment, the frequency and timing of assessment, the method of documentation and the staff members responsible, using their Care Description Worksheet (SCV, 2022).

2. To **act on** each M for every older person in the care setting.

This included incorporating each M into the plan of care, communicating each M amongst team members, and ensuring that each M is addressed, managed and treated appropriately.

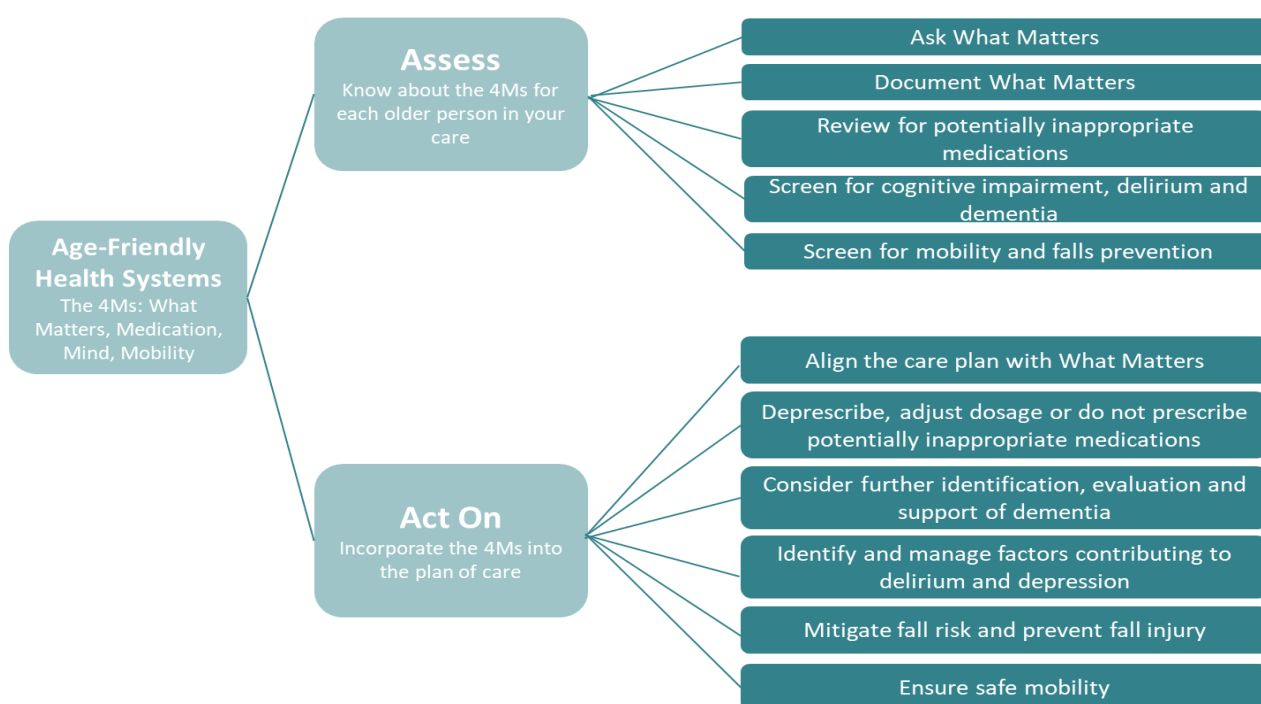


Figure 1. The change theory for the Creating Age-Friendly Health Systems in Victoria Collaborative. This is presented as a Driver Diagram.

The 4Ms Framework was well received, with teams motivated to use the framework to improve care for older people. Alignment of the 4Ms to organisational values, particularly patient-centred care, was identified by staff at several sites throughout the Collaborative.

What impact did we have?

There was a significant improvement in the percentage of older people reported as receiving 4Ms care as a set over the duration of the Collaborative as demonstrated in Figure 2. This equates to 4,233 older people receiving comprehensive Age-Friendly care which is evidenced to be safer, person centred and more effective. Figure 2 below shows the percentage of patients receiving 4Ms care as a set, based on data submitted across the Collaborative. Towards the end of the Collaborative, smaller rural hospitals and residential aged care facilities submitted data more regularly while there was a

reduction in larger units submitting data, therefore the number of patients represented in the data is lower in the latter months.

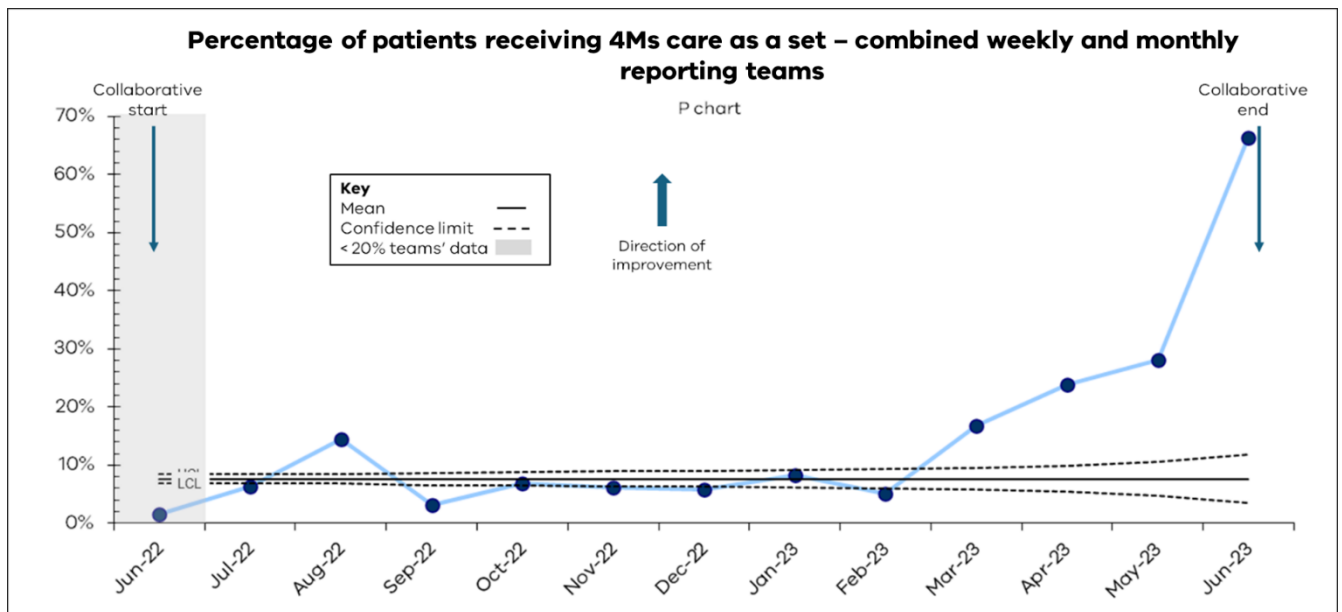


Figure 2. Aggregate data from participating teams for the percentage of older people for whom all 4Ms components were assessed and acted upon. 40% of teams on average reported this data each month.

Teams who achieved higher levels of 4Ms care reported improved staff relationships with patients and residents, an increase in positive feedback, early signs of improvements in processes, such as medication deprescribing, and in system impacts such as a reduction in length of stay. When participating teams were surveyed, 94% of the 35 respondents agreed or strongly agreed that the 4Ms Framework has positively impacted their clinical area. Teams also reported that embedding the 4Ms Framework aligned and supported work to meet accreditation requirements.

'...the care is the best and we are getting a lot of positive response from the community around us'
 (Focus group ID10, Metropolitan Health Service)

'Better engagement of staff with patients, more action on the little things we didn't know mattered and staff empowerment to action these (and feeling good about it!). Being able to action some reviews on our medication processes that have previously been in the too hard basket.'
 (Survey response ID12, Rural Health Service)

'The 4Ms have now been incorporated into all of our assessments, care plans, interview questions and embedded in our day-to-day actions'
 (Survey response ID21, Regional Health Service)

'Our assessment forms have all been updated now to reflect the 4Ms as a set and each resident is fully reviewed every 2 months or with changes in their care needs.'
 (Survey response ID 11, Regional, Nursing)

The Collaborative did not demonstrate a clear association between the adoption of the 4Ms Framework and a reduction in patient harm among older people. The 4Ms were implemented at the unit level rather than across the entire health service so aggregate impacts on the reduction in severe Hospital Acquired Complications (HACs) are too low to be able to be detected at any level of significance.

However, a notable reduction in falls among older patients was observed in one acute care ward (see Appendix E, Figure 7). In this ward, the 4Ms Framework was utilised to effectively communicate falls reduction strategies to both staff and patients.

What Matters

When looking at each of the Ms that make up the set, the biggest improvements were seen in patients being asked ‘What Matters?’ to them (Figure 3). This was a new process for most teams, and was embraced as a simple and effective change with notable benefits for both patients and staff. By the end of the Collaborative, 64.8% of older people were being asked ‘What Matters?’ to them.

‘Introduction of the “what matters” concept to all areas of the organisation ... is helping staff feel more connected with their patients/residents ... helping patients to feel more involved in their care and staff satisfaction in care delivery.’
(Survey response ID 23, Regional, Nursing)

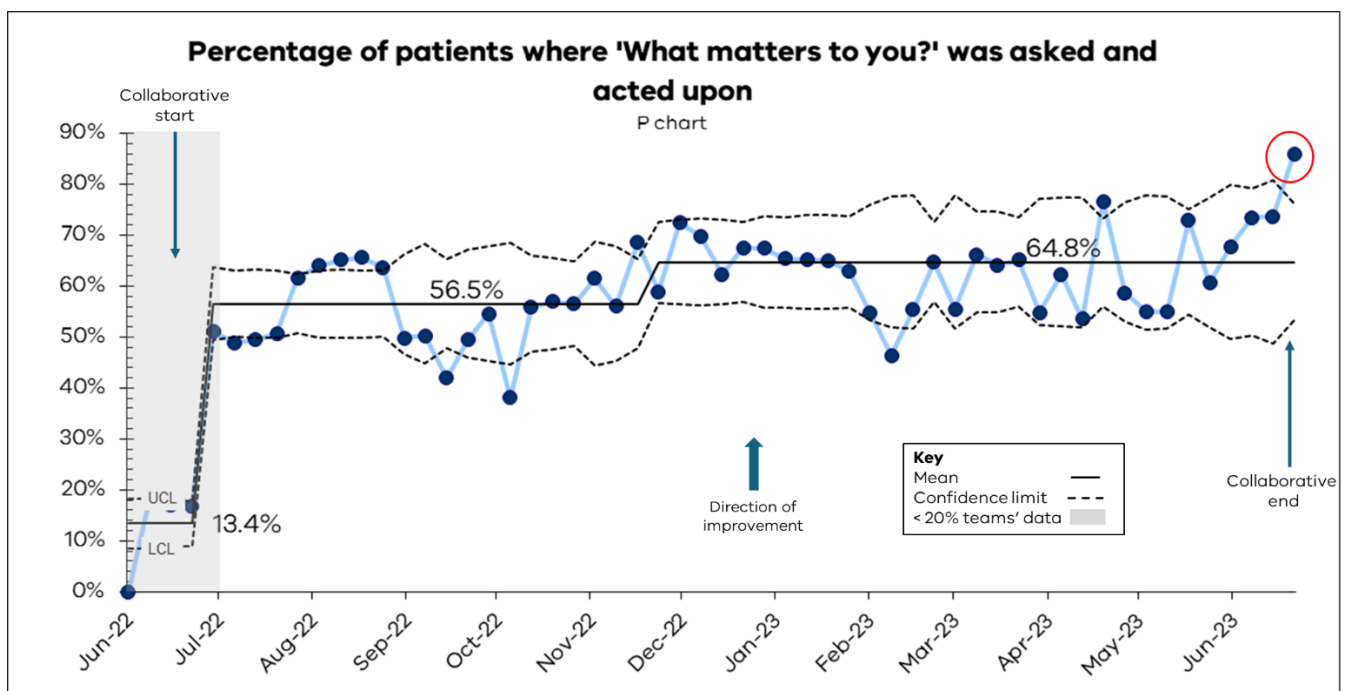


Figure 3. Aggregate data from participating teams for the percentage of older people for whom ‘What Matters?’ was asked and acted upon. On average, 38% of teams reported this data each week.

Medication

Teams reporting data on the Medication component of the 4Ms Framework was low and variable, with an average of 29% of teams contributing data (Figure 4). Most services reported that they had existing medication screening processes in place so had not prioritised this part of the Framework as an area of improvement. Despite this, a significant improvement can be seen from October 2022, with an average level of implementation of medication assessments of 80.7% by the end of the Collaborative.

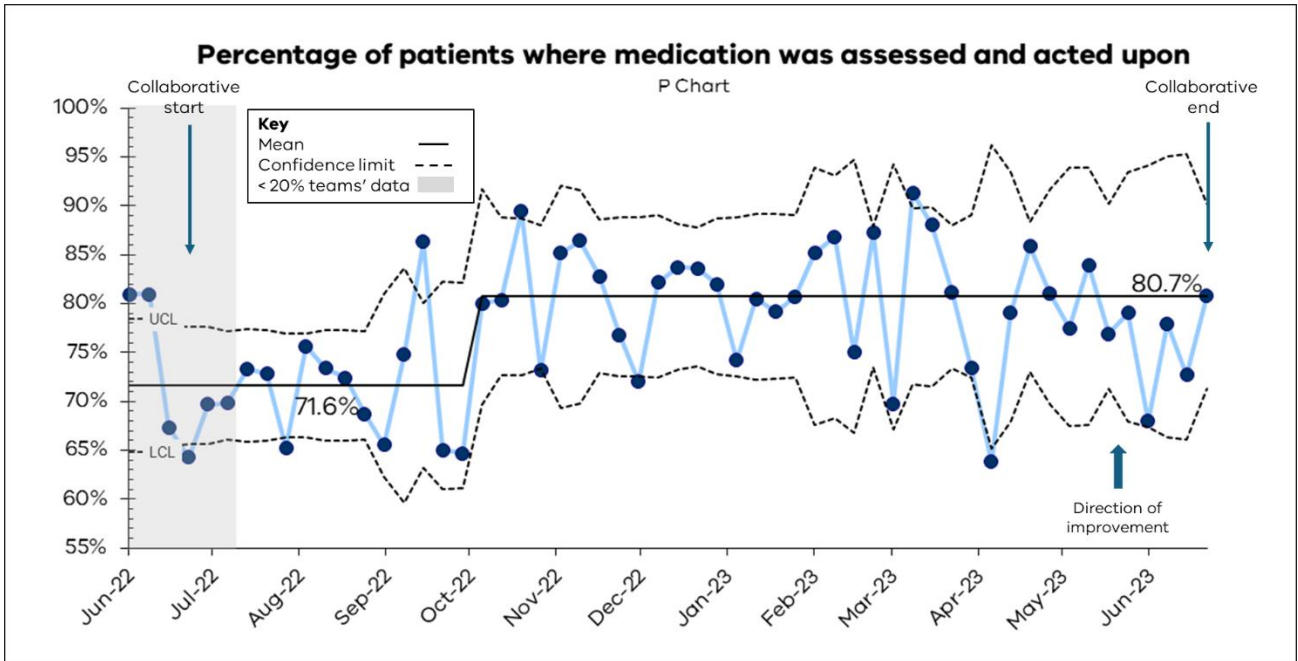


Figure 4. Aggregate data from participating teams for the percentage of older people for whom their medication was assessed and acted upon. On average, 29% of teams reported this data each week.

Individual health services demonstrated significant improvements; of note, an emergency department short stay unit improved from 4% to 45% (Appendix E, Figure 8), and a rural residential aged care service improved from 30% to an impressive 97% (Appendix E, Figure 9) across the duration of the Collaborative.

Mind

Improvement in delirium assessment and management was also observed (Figure 5). While initial rates of reported assessment appear high, it is of note that this dropped away a few months after the first learning session of the Collaborative, indicating that potentially there was over-reporting of delirium assessments at the start of the Collaborative. Once reliable reporting was seen (from August 2022), improvement in assessment rates began to be detected from January 2023. By the end of the Collaborative, there was an average rate of delirium assessment of 77.3%; however, there were fewer teams reporting this measure over time so there is caution in interpreting the data as indicating ongoing improvement.

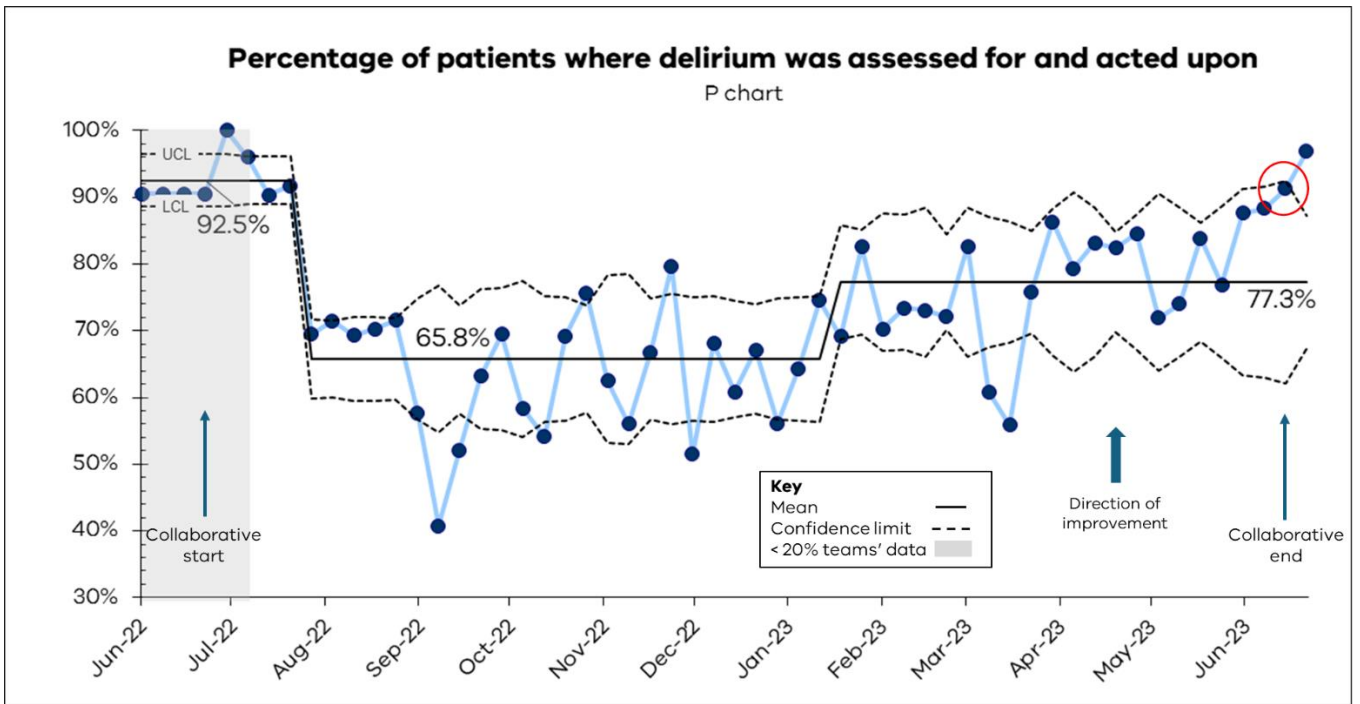


Figure 5. Aggregate data from participating teams for the percentage of older people who were assessed for delirium, and had this acted upon as needed. On average, 31% of teams reported this data each week.

An average of 26% and 24% of participating teams reported their rates of assessment for cognition impairment and depression respectively, and reporting rates were lowest at later stages of the Collaborative. Therefore, the aggregate data does not offer a reliable indication of progress in implementing these elements of the 4Ms Framework across the duration of the Collaborative. On an individual service level there were some significant improvements. Some examples of the improvements achieved are provided in Appendix E. Supplementary DataTwo residential aged care facilities made impressive improvements in depression screening (Appendix E, Figure 10 and Figure 11) and an acute unit and a residential aged care service improved cognitive screening rates (Appendix E, Figure 12 and Figure 13).

Mobility

Across the Collaborative, a small improvement (from 84.8% to 89.4%) was seen in the percentage of older people for whom their mobility was assessed and acted upon (Figure 6); however, there was variable reporting against this measure by health services so this data should be interpreted with caution. Focus group participants from health service teams reported this work gave them the opportunity to rethink and question the way mobility has historically been addressed in their settings. This included building staff confidence to participate in mobility with older people where they have been assessed as safe to do so, without a physiotherapist present.

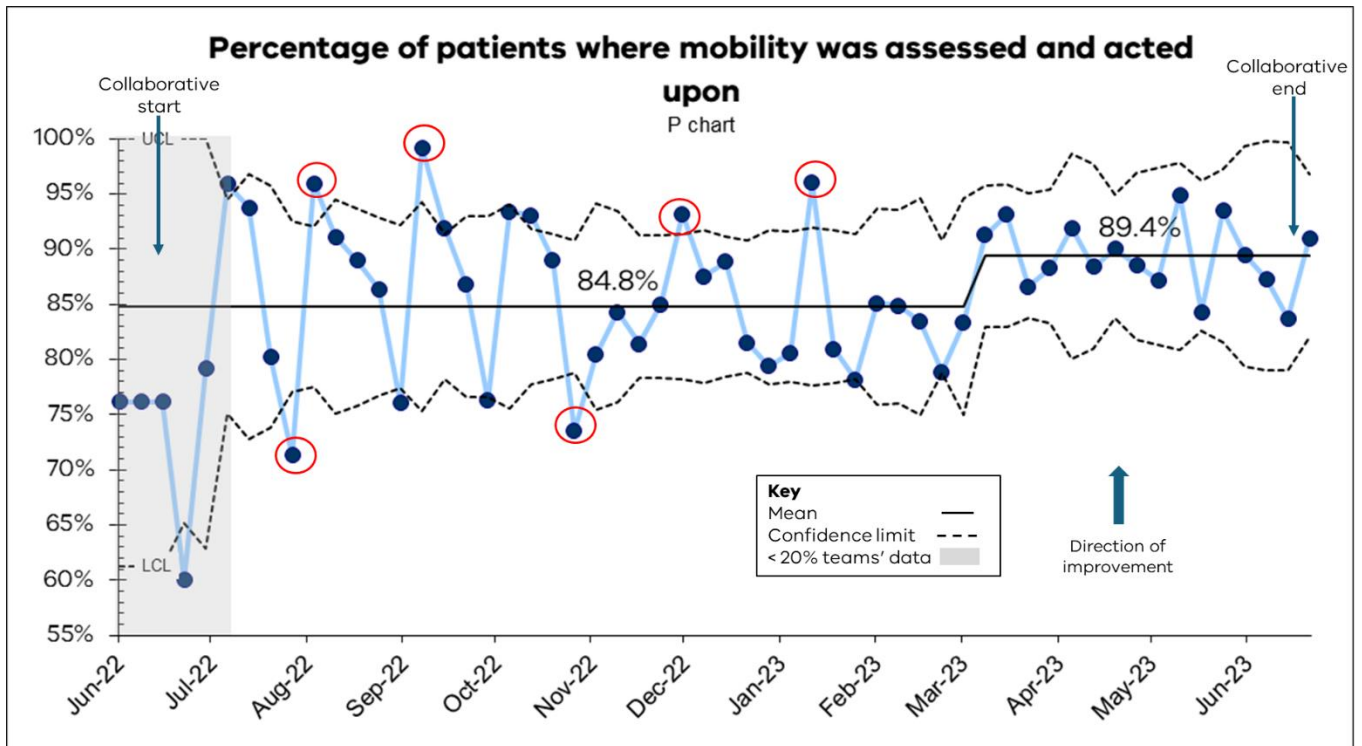


Figure 6. Aggregate data from participating teams for the percentage of older people for whom mobility was assessed and acted upon. On average, 33% of teams reported this data each week.

What did we learn?

As a result of the Collaborative, care for 8,763 older people was safer, more effective and person-centred, which was in line with SCV's Strategic Plan 2020-23, and Annual Plan 2022-23.

From the Collaborative, key lessons included:

- The 4Ms Framework was well-received and accepted by participating teams as a simple and effective framework for best-practice care. It was able to be appropriately adapted to the Victorian context, including for considerations of race, gender, cultural background, language, and First Nations status.
- The Breakthrough Series Collaborative approach was found to be an effective methodology to learn and share information between teams. Collaboration within and between teams was an enabler for success, and in-person sessions were more successful in facilitating this collaboration than virtual sessions. When team participants were surveyed, the Net Promoter Score was 49 in response to the question 'How likely are you to recommend involvement in an SCV/IHI improvement program to a colleague,' which is in the 'great' zone and indicates that participants had a positive experience and would recommend participation to colleagues (number of survey respondents = 35).
- Timing, organisational readiness, and competing priorities are important to establish at the beginning of a project. Some teams found the time commitment to participate in the Collaborative and to collect and submit data challenging in their current organisational context.
- A subset of teams remains very committed to the framework and confident that changes will be sustained. 40% of survey responders at the end of the project rated the likelihood of changes related to the 4Ms remaining in place in six months as 'very likely,' due to changed practices and processes indicating a strong commitment to the framework.
- The manual collection of data was a challenge throughout the Collaborative. This is reflected in the reporting rate for many of the measures. During site visits, it was common for the SCV project team to observe changes in care

that had not been reflected in the submitted data. For reliable data reporting and successful implementation and sustainability of the 4Ms, data collection should be built into clinical information and reporting systems to reduce the burden on front line staff, integrate 4Ms into daily processes, and to help organisations monitor their progress against the 4Ms elements.

Limitations of the Age-Friendly BTS Collaborative

When reviewing the results of the Collaborative there are several limitations for consideration:

- The amount of time and labour involved in participating in this Collaborative was too much for many teams. Future work should increase communication of the requirements of the project, targeting leaders and using an organisation-wide approach.
- The data burden for this project was high, particularly due to the manual data entry requirements for most measures. Attempts should be made to reduce or manage this burden in future work, through better utilising existing data sources and selecting fewer measures to study.
- Delivery of 4Ms care as a set required teams to test, implement and measure changes for six different processes, and many teams had no prior experience with the Model for Improvement. A 12-month Collaborative is therefore likely to have been too short of a timeframe for the aim to be achieved.

Conclusion

The Creating Age-Friendly Health Systems in Victoria Breakthrough Series Collaborative resulted in 11 teams recording an improvement in the number of older people receiving care consistent with all 4Ms, with the mean percentage of older people receiving 4Ms care increasing from 29% to 43% from the first to the second half of the Collaborative. The Age-Friendly 4Ms Framework was well received by both consumers and staff working with older people.

Feedback received indicated that the project was labour intensive, particularly for data collection and reporting. Staff frequently reported a lack of time to complete the project, perceived to be due to a lack of alignment with organisational priorities and staff shortages.

While the Age-Friendly 4Ms work is beneficial for Victorian health services and residential aged care facilities, there are opportunities to explore how the Age-Friendly 4Ms Framework can be spread through the sector in a less labour-intensive way that more closely aligns with organisational priorities and other quality improvement initiatives, and is integrated in other projects that impact care for older people.

Next Steps

SCV is committed to continuing to improve the safety and experience of older people accessing healthcare services in Victoria. Ongoing support and resources will be provided to the hospital and residential aged care sectors to continue to spread and strengthen the implementation of 4Ms care as standard best practice. This will be done by:

- Providing updated 4Ms resources for use throughout Victoria, and promotion of the successes of Collaborative teams in using the 4Ms.
- Integrating the 4Ms Framework across future SCV and Department of Health projects that impact older people.
- Building a stronger focus on equity to future Age-Friendly work, to ensure that participating services identify older people who are more at-risk in their care settings and take action to address these inequities.

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Appendices

Appendix A. Participating Services

Albury Wodonga Health	Grampians Health
Alfred Health	Mansfield District Hospital
Barwon Health	Melbourne Health
Bass Coast Health	Mildura Base Public Hospital
Benalla Health	Monash Health
Cabrini Health	NCN Health
Central Highlands Rural Health	St Vincent's Private Hospital
Colac Area Health	Tallangatta Health Service
Eastern Health	Western Health

Appendix B. Project Team

Collaborative role	Name and term
SCV Project Lead	Veronica Hope
SCV Clinical Fellow	Melanie Paykel (May 2022-March 2023), Leigh Seidel-Marks (August 2023-March 2024)
SCV 100k Manager	Laura Howell (May 2022-January 2023), Katie Petrie (April-December 2023), Caitlyn Berg (January-March 2024)
SCV Project Officer	Jo Nguyen (May 2022-August 2022), Eliza Tang (October 2022-current)
SCV Improvement Advisor	Caitlyn Berg (June 2023 – March 2024)
SCV Executive Sponsor	Rebecca Reed (May 2022-January 2023), Tracy Firth (January 2023-April 2023), Janelle Devereux (June 2023 – current)
IHI Executive Sponsor	Lisa McKenzie
IHI Project Director and Improvement Advisor	Robert Forsythe
Clinical Lead	Associate Professor Mark Yates
University of Melbourne evaluation partners	Brad Astbury, Alison Brown

Appendix C. Project Faculty

The project team was supported by an expert faculty, comprised of clinical and lived experience experts who were present at Learning Sessions and action period calls to support teaching and coaching teams.

Faculty Position	Name	Professional Title and Organisation
Clinical Lead	Associate Professor Mark Yates	Geriatrician, Grampians Health
Clinical Faculty	Professor Meg Morris	Physiotherapist, Healthscope
Clinical Faculty	Dr Melissa Raymond	Physiotherapist
Clinical Faculty	David Nguyen	Pharmacist, Northern Health
Clinical Faculty	Dr Amelia Crabtree	Geriatrician, Monash Health
Clinical Faculty	Dr Melanie Benson	Palliative Care Physician, Peninsula Health
Consumer Representative	Stephen Peterson	
Consumer Representative	Katerina Yakimov	
Consumer Representative	Wendy Thomas	
Consumer Representative	Lester Sawyer	

Appendix D: How did we measure improvement?

Measurement is a critical part of testing and implementing changes: measures tell a team whether the changes they are making lead to improvement. Determining if improvement has really happened and if it is lasting requires observing patterns over time.

The Age-Friendly measurement strategy was developed in consultation with the clinical faculty and the IHI, bringing together the best available evidence to create a comprehensive measurement plan that aimed to create a minimal burden on the health service whilst ensuring each 'M' was assessed and acted upon.

The measurement strategy included one outcome measure (outcome measures relate to the aim statement and demonstrate if changes made resulted in improvement) and six process measures (which show if the system is performing as planned). Teams were also asked to self-identify:

- one or more harm measures, which are measures of preventable incidents of harm in their settings (such as falls), and
- one or more balancing measures, which are measures of unintended consequences that occur due to changing the system (such as readmission rate or length of stay).

Convenience sampling was used as the data was used longitudinally for improvement. The aim of this work was not to generate research findings but to ascertain if improvement had occurred in participating services. The data was therefore not controlled for confounding variables, and consisted of data over time which were plotted on control charts (Lloyd, 2019). Teams reported their data using TeamAssurance, a cloud-based online collaborative platform that supports real-time, rapid improvement.

A summary of the measurement strategy can be found below in Error! Reference source not found..

Table 1: Summary of measurement strategy

Measure Type	Measure	Measure definition
Outcome	% of older people who receive 4Ms care as a set	Numerator: Number of older people who receive 4Ms care as a set according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
Process	% of older people for whom What Matters is assessed for and acted upon	Numerator: Number of older people for whom What Matters is assessed for and acted upon according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
	% of older people for whom potentially inappropriate medications and polypharmacy are assessed for and acted upon.	Numerator: Number of older people for whom potentially inappropriate medications and polypharmacy are assessed for and acted upon according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
	% of older people for whom cognitive impairment is assessed for and acted upon	Numerator: Number of older people for whom cognitive impairment is assessed for and acted upon according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
	% of older people for whom delirium is assessed for and acted upon	Numerator: Number of older people for whom delirium is assessed for and acted upon according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
	% of older people for whom depression is assessed for and acted upon	Numerator: Number of older people for whom depression is assessed for and acted upon according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
	% of older people for whom mobility is assessed for and acted upon	Numerator: Number of older people for whom mobility is assessed for and acted upon according to the unit's Care Description Worksheet Denominator: Number of older people on the unit during the measurement period
Balancing	30-day all-cause readmission rate (hospital sites only)	Numerator: Number of older people who are readmitted within 30 days of discharge from the measuring unit for any reason Denominator: N/A
	Rate of Emergency Department (ED) visits (RAC facilities only)	Numerator: Number of emergency department visits by older people in the denominator in the measurement month Denominator: Number of older people in the unit
	Length of stay (hospital sites only)	Numerator: Sum of length of stay for each patient in the denominator Denominator: Number of older people discharged from the health care service during the measurement period or who pass away during the measurement period
Harm measures	Falls rate - option 1	Numerator: Number of falls in older people Denominator: Number of older people on the unit during the measurement period
	Falls rate – option 2	Date of each fall recorded, charted as a 't-chart' of time between falls

The main tools used for displaying data to analyse for improvement are run charts and Shewhart (or control) charts. These charts utilise the rules of probability to detect when a change in a system has potentially occurred based on the variation of data from what would be expected in a stable system. Different types of data require the use of different control charts. In this collaborative P-Charts are utilised as the most appropriate control chart for analysing changes in categorical data. In this report, three control chart rules have been used to detect signals of system change.

These are:

- points outside the control limits of the chart (shown as Upper Control Limit [UCL] or Lower Control Limit [LCL])
- eight consecutive points above or below the mean
- six consecutive increasing or decreasing points.

When these patterns in the data are observed, it means that the change in the system is unlikely to have occurred by common cause (chance or random variation).

On a control chart, the centreline describes the mean of the observed values and the upper (UCL) and lower (LCL) lines indicate the control limits. Control limits are calculated from observed values in the data of the system you are studying and indicate the expected level of variation in the system. The control chart rules have been devised to maximise the sensitivity and specificity to special cause variation (that would not be expected as part of the normal performance of the system), to reduce the likelihood of false signals of random (chance) variation.

Appendix E. Supplementary Data

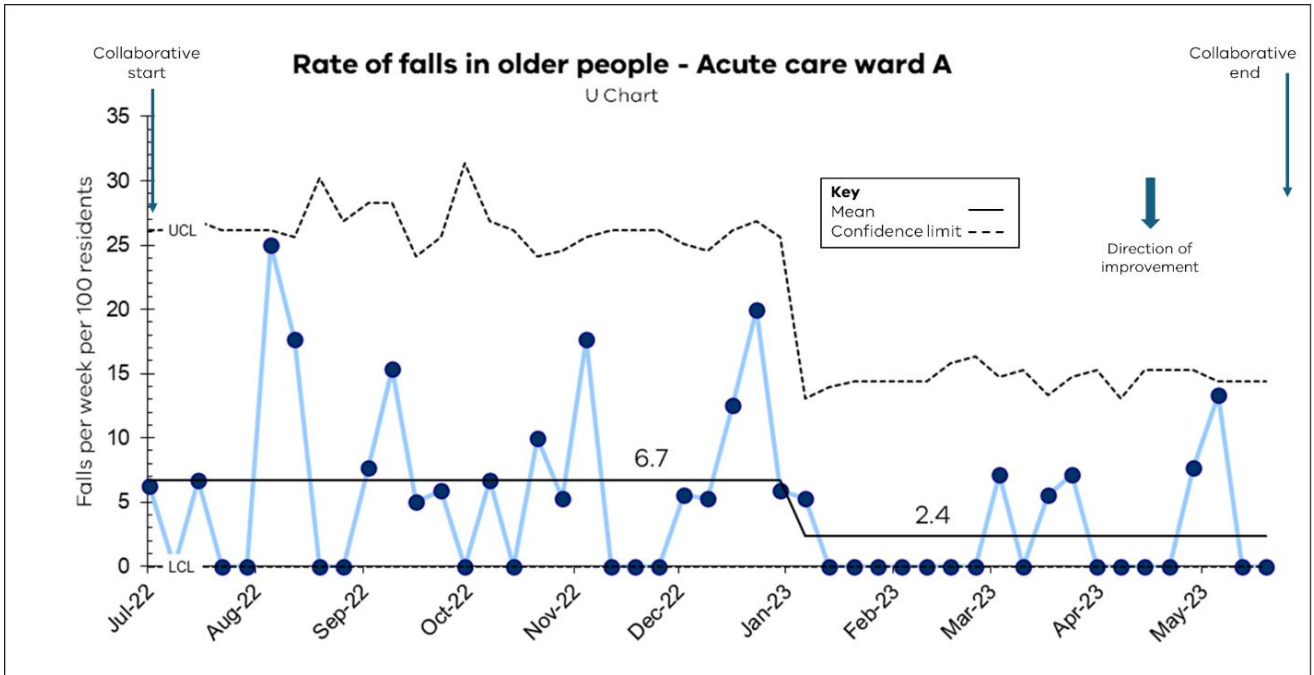


Figure 7. The rate of falls per week per 100 admitted older patients on an acute care ward at a participating hospital.

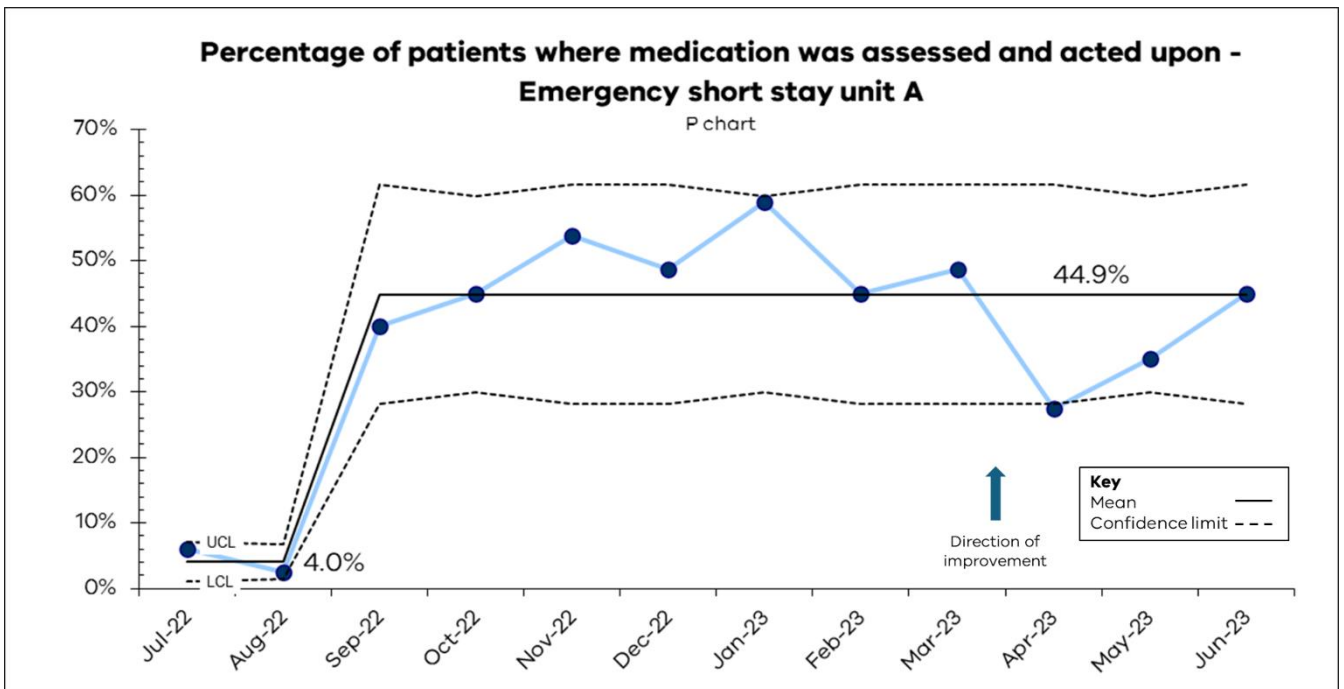


Figure 8. Rate of medication being assessed and acted upon in Emergency short stay unit A.

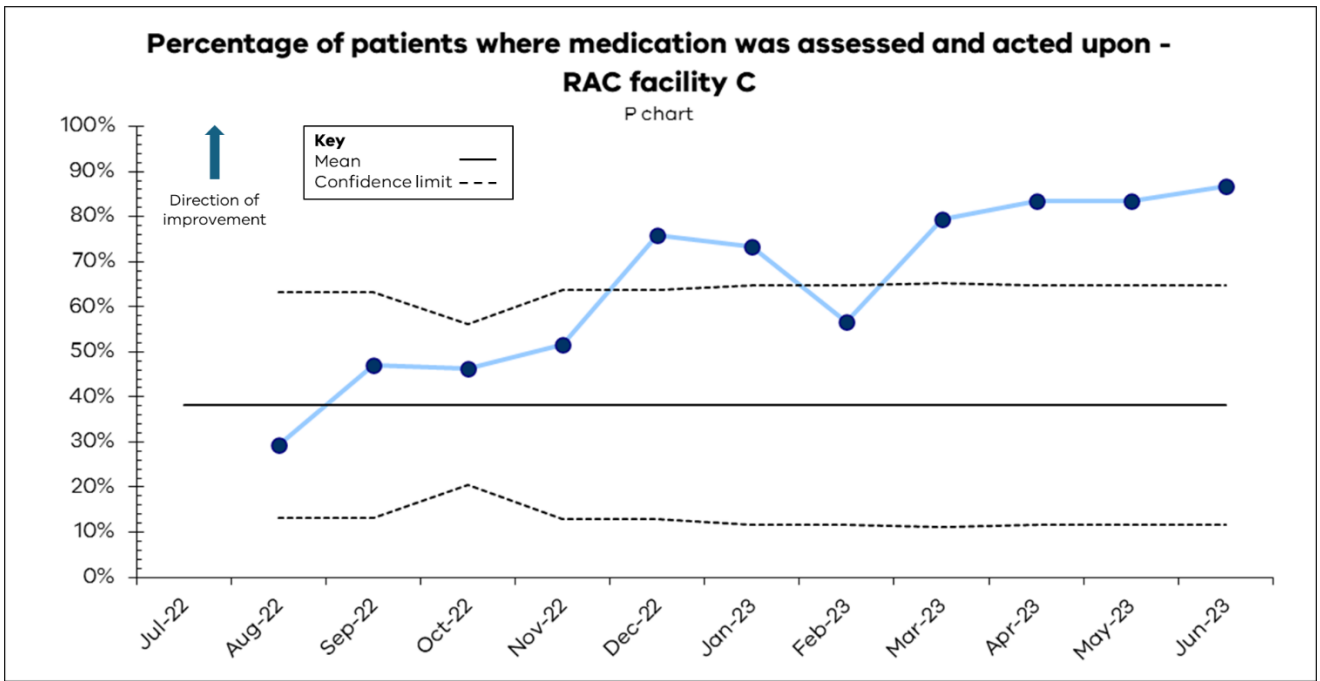


Figure 9. Rate of medication being assessed and acted upon at residential aged care facility C

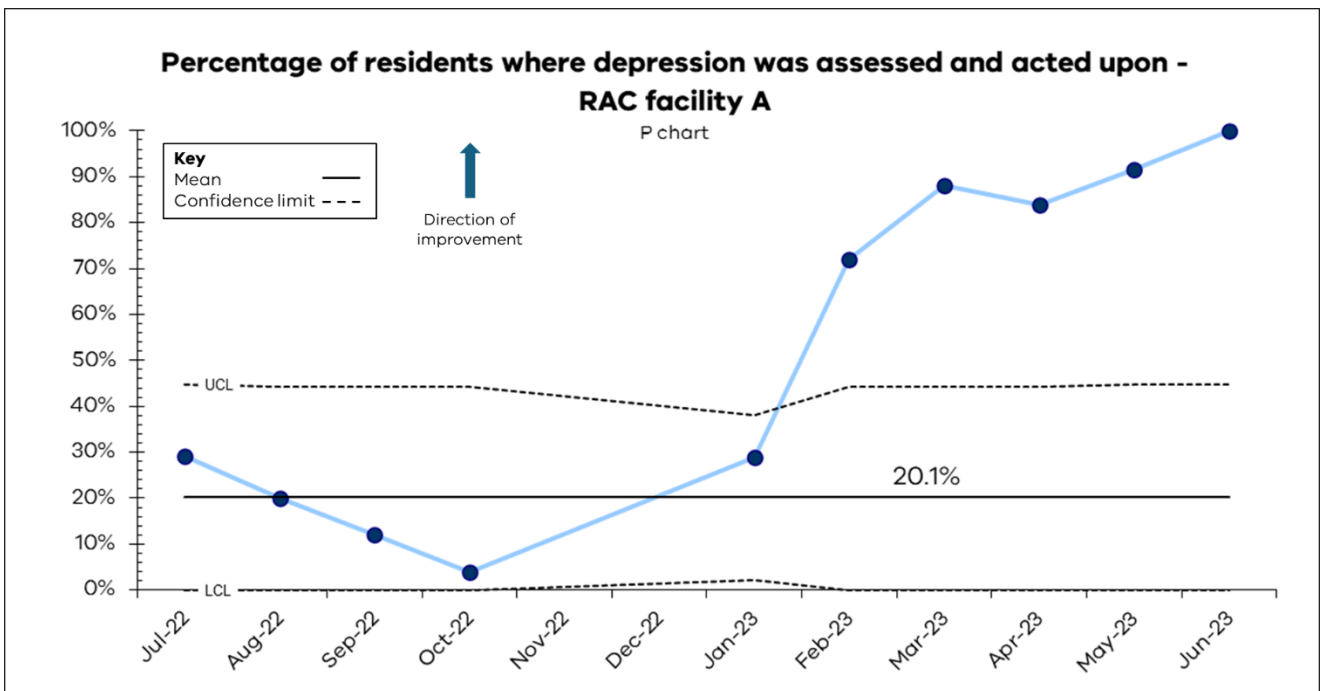


Figure 10. Rate of depression being assessed and acted upon in residential aged care facility A

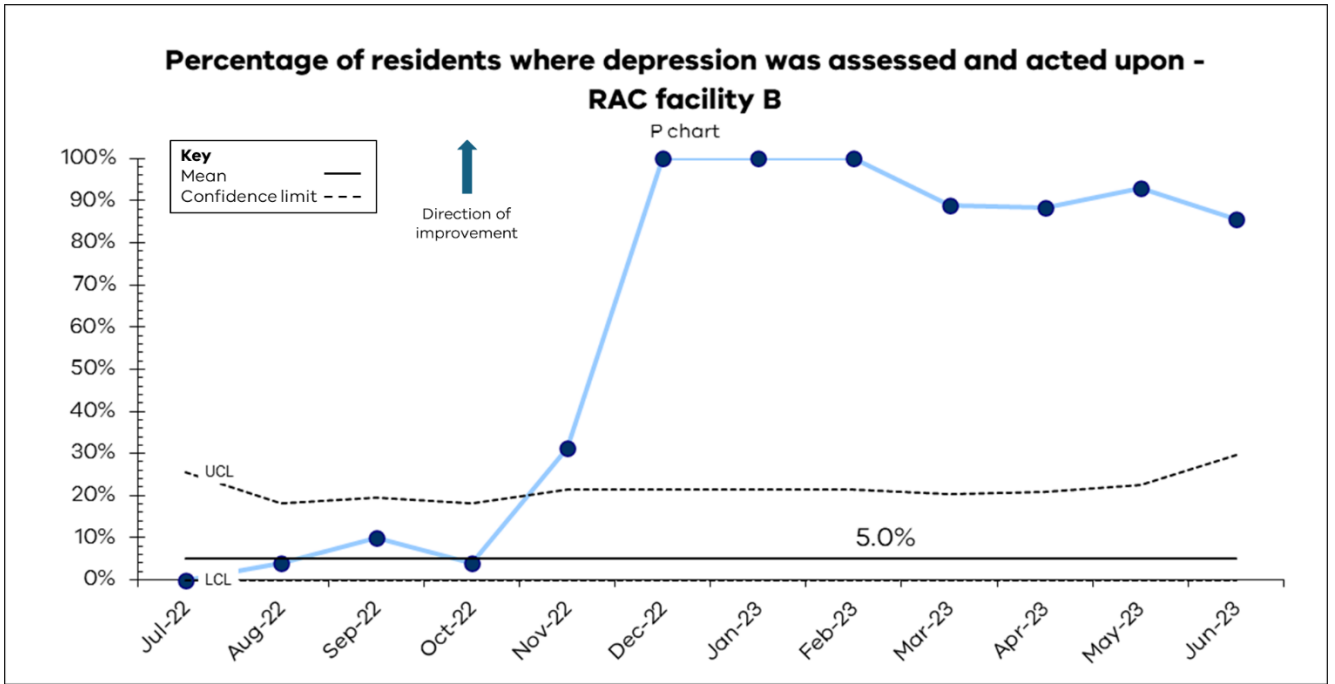


Figure 11. Rate of depression being assessed and acted upon in residential aged care facility B

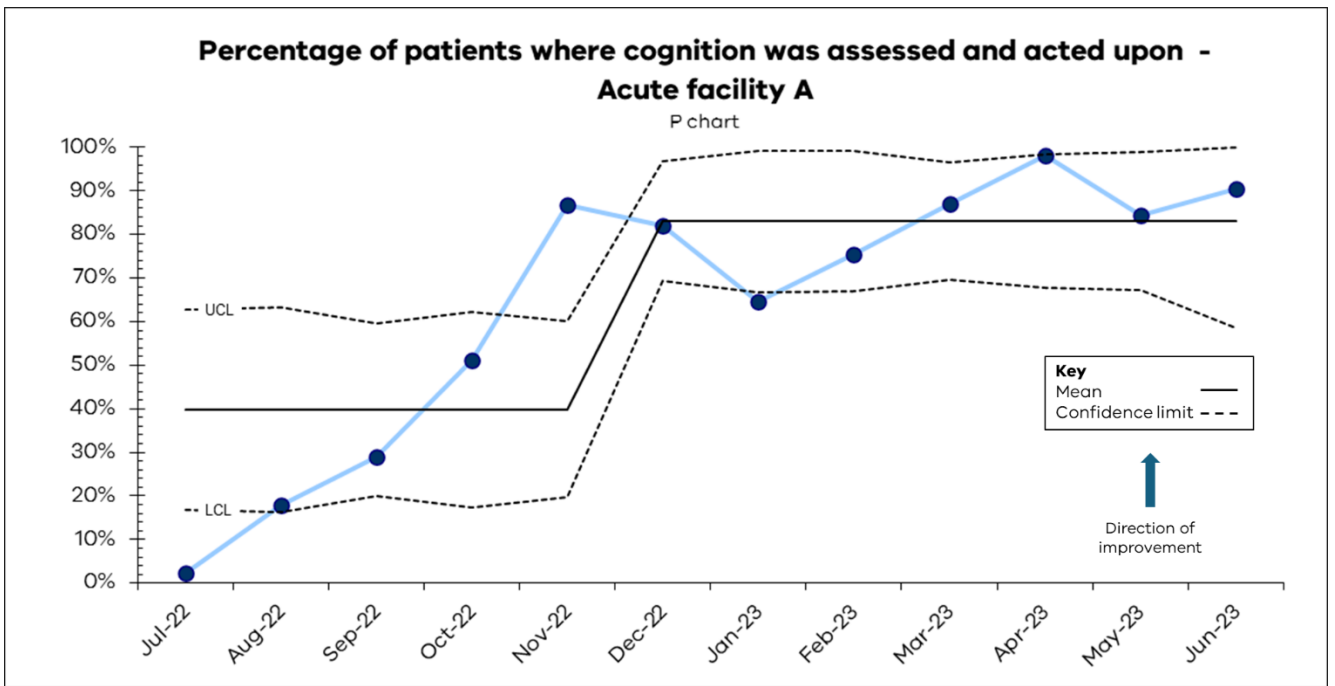


Figure 12. Rate of cognition being assessed and acted upon in acute facility A

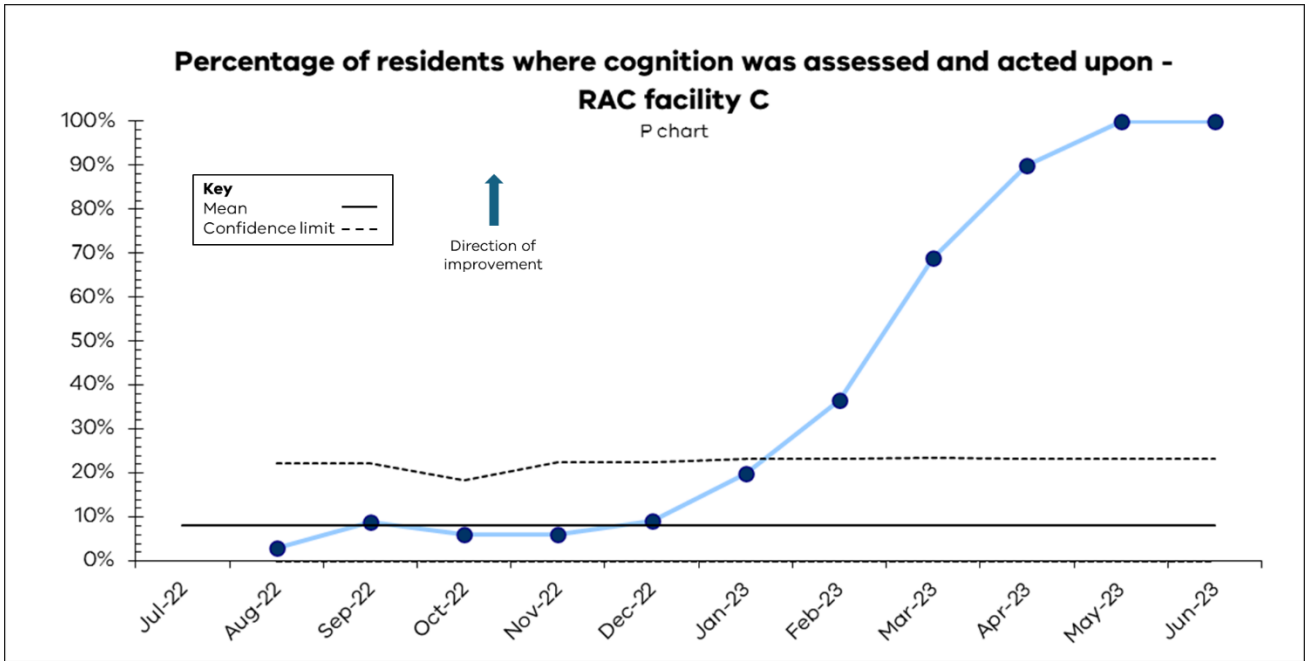


Figure 13. Rate of cognition being assessed and acted upon in residential aged care facility C