Safer Care Victoria

Institute for Healthcare Improvement

JULY 2022

Creating Age-Friendly Health Systems in Victoria

Guide to using the 4Ms in the care of older people

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Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

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In addition, we extend our thanks to the local team who have assisted in localising this guide, please see team details in Appendix A.

For more than 25 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilise health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

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Background

The Australian population is ageing with the number of adults aged 65 years and older growing rapidly. As we age, care becomes more complex. Health care services are frequently unprepared for this complexity, and older people suffer a disproportionate amount of harm while in the care of a health care service or residential aged care facility.

To address these same challenges in the USA, in 2017 the John A. Hartford Foundation (JAHF) and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), set a bold vision to build a social movement so that all care for older people is age-friendly care. According to our definition, age-friendly care:

- Follows an essential set of evidence-based practices;
- Causes no harm; and
- Aligns with What Matters to the older person and their family or other carers.

In 2018, with funding from Better Care Victoria, the Indigo Consortium and its partner agencies refined the Age-Friendly Health Systems 4Ms framework to create the Indigo 4Ms framework; combining the strengths of the IHI 4Ms Framework with WHO ICOPE guidelines to deliver better care for all older people living in rural and regional Victoria. To read more about this please visit Building an age-friendly Indigo health system - Final report to Better Care Victoria.

In 2021, Safer Care Victoria and the Institute for Healthcare Improvement partnered with a faculty of local clinical and consumer experts and seven Victorian public and private hospital and residential aged care sites to further test and adapt the 4Ms framework for further spread across the Victorian health system. Their participation, successes, challenges and feedback have all contributed to this Guide.

Using this Guide

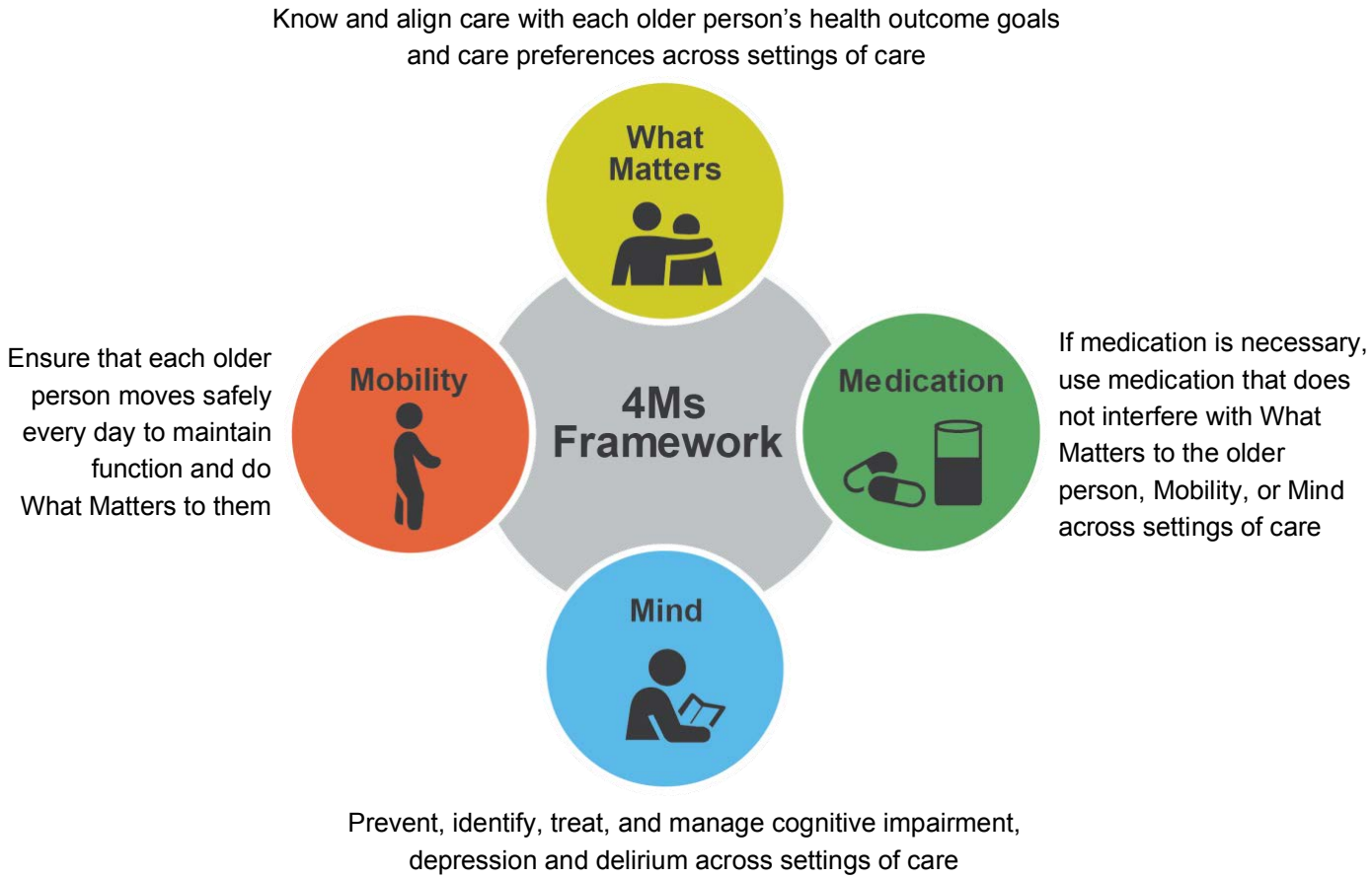
With active participation with the materials in this document, you can expect that at the end of 12 months, your team will have adapted and implemented the Age-Friendly Health Systems 4Ms framework and will be recording the number of older people that are receiving age-friendly care in your service. Your service will also be leaders in a state-wide movement of Age-Friendly Health Systems, committed to ensuring that all care for older people is age-friendly.

What is an Age-Friendly Health System?

Becoming an Age-Friendly Health System involves reliably providing 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 your service. When implemented together, the 4Ms represent a broad shift by health care services to focus on the needs of older people (see Figure 1). The 4Ms identify the core issues that should drive all decision making in the care of older people. They organise care and focus on the older person's wellness and strengths rather than solely on disease. The 4Ms are relevant regardless of an older person's individual disease, the number of functional problems they may have or that person's cultural, racial, ethnic, or religious background.

The 4Ms are a framework, not a program, to guide all care of older persons wherever and whenever they encounter your health care service. The intention is to incorporate the 4Ms into existing care, rather than layering them on top, to organise the efficient delivery of effective care. Many health care services have found they already provide care aligned with one or more of the 4Ms for many older people. Much of the effort, then, involves incorporating the other elements and organising care processes so that all 4Ms guide every encounter with an older person and their family or carer.

Figure 1. 4Ms Framework of an Age-Friendly Health System



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4Ms Framework: Not a program, but a shift in care

- The 4Ms identify the core issues that should drive all decision making in the care of older people. They organise care and focus on the older person's wellness and strengths rather than solely on disease.
- The 4Ms Framework is not a program, but a shift in how we provide care to older people.
- The 4Ms are implemented together (i.e., all 4Ms as a set of evidence-based elements of high-quality care for older people).
- Your system probably practices at least a few of the 4Ms in some places, at some times. Engage existing champions for each of the 4Ms, build on what you already do, and spread it across your system.
- The 4Ms must be practiced reliably (i.e., for all older people, in all settings and across settings, in every interaction).

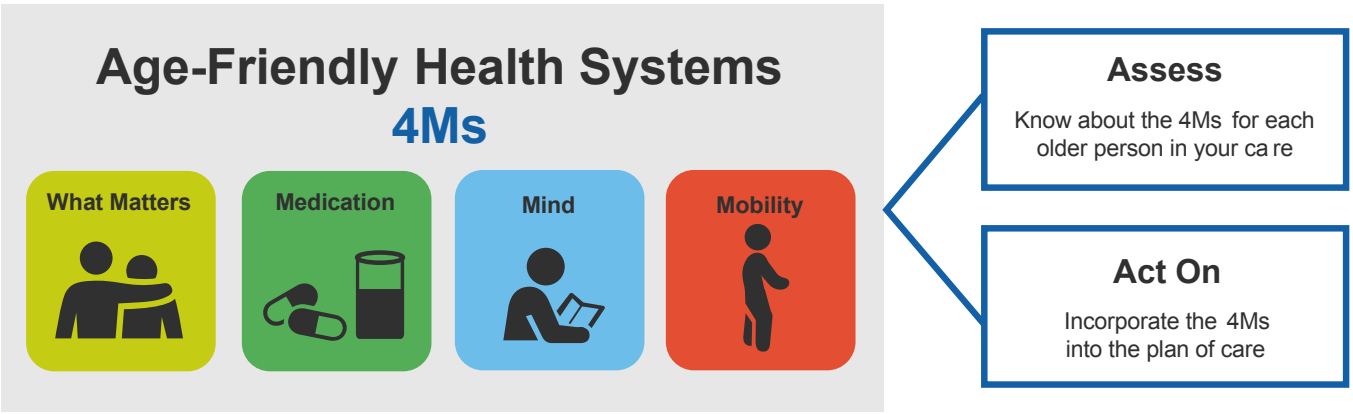
Drivers of age-friendly care

There are two key drivers of age-friendly care:

- Knowing about the 4Ms for each older person in your care ("Assess"), and
- Incorporating the 4Ms into the plan of care accordingly ("Act On") (see Figure 2).

Both must be supported by documentation and communication across settings and disciplines.

Figure 2. Two Key Drivers of Age-Friendly Health Systems



This Guide to Using the 4Ms in the Care of Older People is designed to help care teams test and implement a specific set of evidence-based, geriatric best practices that correspond to each of the 4Ms. This Guide begins by outlining the 4Ms for hospital-based and residential aged care settings.

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Measures for improvement

Project teams will track their progress as they test changes to increase the number of older people receiving care consistent with each of the 4Ms. Table 1 includes a set of measures that teams have found useful to monitor the impact of tests and guide action.

We refer to these measures as a family of measures which include:

- Outcome measures
  - Relate to the aim
  - Provide a measure of whether we have achieved what we set out to do
  - Outcome measures reflect system performance.
- Process measures
  - Reflect the workings of the system
  - Capture the changes that are made to achieve our aim.
- Balancing measures
  - Help to detect unintended impacts on the system from changes being made
  - These may be positive or negative.

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Table 1 outlines the family of measures that will be used to understand the impact of tests and guide action as you create Age-Friendly Health Systems.

Measure	Health care site	Residential aged care site
Outcome		
% of older people receiving 4Ms care as a set		
Process measures (as defined by care descriptor worksheet)		
% of older people where What Matters is assessed for and acted upon		
% of older people where potentially inappropriate medications and polypharmacy are assessed for and acted upon		
% of older people where delirium is assessed for and acted upon		
% of older people where depression is assessed for and acted upon		
% of older people where cognitive impairment is assessed and acted upon		
% of older people where mobility is assessed for and acted upon		
Patient / resident satisfaction		
Balancing measures		
30-day all-cause readmission rate		
Rate of ED visits		
Length of stay		

Harm measures

Teams in collaboration with their Executive Sponsors will also identify one or more measures of harm (such as falls, delirium, pressure injuries) that are most important to their organisation that they will also measure.

Refer to the Victorian Age-Friendly Measurement Guide for full details of the measurement strategy.

Putting the 4Ms into Practice

To ensure an effective start for your team, we have outlined key activities to complete.

Integrating the 4Ms into your standard care has steps and ingredients, much like a recipe. These steps include:

Step 1

Understand your current state

- Set up a team ☐
- Know the 4Ms in your health service (process walk through) ☐
- Select a care setting to begin testing ☐
- Know the older persons in your care setting ☐
- Set an aim ☐

Step 2

Describe care consistent with the 4Ms

- Complete the Care Description Worksheet ☐

Step 3

Design or adapt your workflow

- Design your age-friendly care workflow change to test ☐

Step 4

Provide care

- Test your workflow change using Plan-Do-Study-Act cycles ☐

Step 5

Study your performance

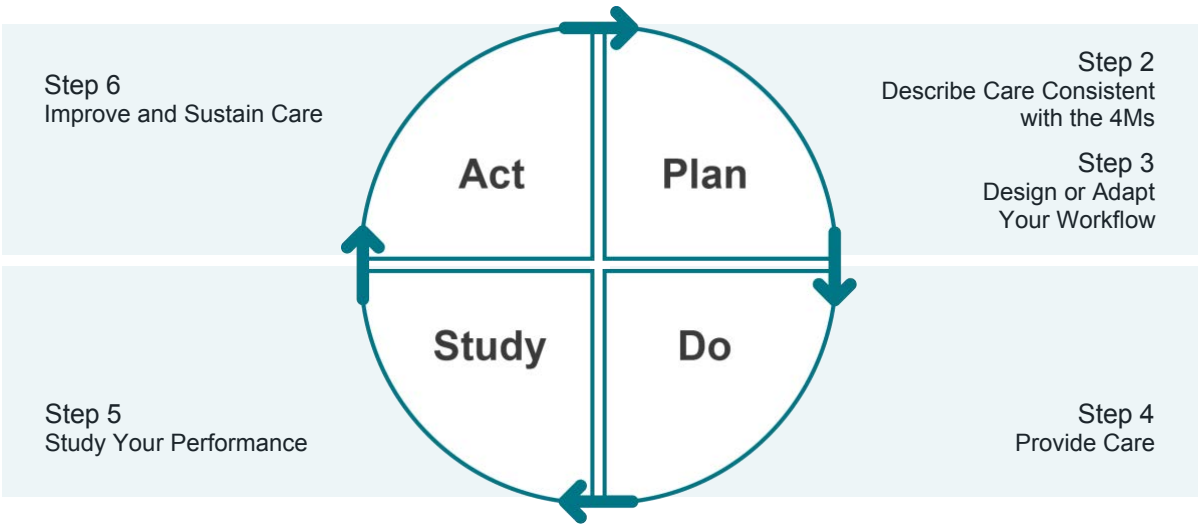
- Collect and record data ☐

Step 6

Improve and sustain care

While we present the six steps as a sequence, in practice you can approach steps 2 through 6 as a loop aligned with Plan-Do-Study-Act cycles (see Figure 3 and Appendix B).

Figure 3. Integrating the 4Ms into care using the Plan-Do-Study-Act cycles



Step 1. Understand your current state

1.1 Set up a team

To succeed with your improvement efforts, a team approach is needed. Based on our experience, teams that include certain roles and functions are most likely to succeed. These include:

Table 2. Team Member Roles

Role	Responsibility	Please enter the name and role of your team member below
Executive sponsor	• Accountable for your organisation's participation in the initiative, ensuring it aligns with organisational values and strategic plan, and the delivery of project outcomes (ongoing) • Visible champion of the project with the management team and the ultimate decision-maker, with final approval on all phases, deliverables, and project scope changes	
Care setting lead	• Leader in the care setting (ward or unit) and represents the disciplines involved in the 4Ms working effectively with clinicians, other technical experts, and leaders within the organisation • We recommend placing the manager of the care area where changes are being tested in this role	

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Role	Responsibility	Please enter the name and role of your team member below
Improvement Advisor (person with quality improvement experience)	• This person supports the quality improvement, improvement methodology, measurement strategy and data collection • This person, and the rest of the team, will be supported in developing their capability in improvement methodology by SCV and IHI Improvement Advisors	
Clinical champions (relevant medical, nursing, allied health staff including pharmacy)	• These individuals may include medical staff, nurses, physiotherapists, occupational therapists, social workers, pharmacists, nurse practitioner, clinical nurse specialist, assistant staff and/or others who represent the 4Ms in your context • We strongly encourage interprofessional representation on your team and urge you to enlist more than one clinical champion • These champions should have good working relationships with colleagues and be interested in driving change to achieve an Age-Friendly Health System • You will need 3-5 clinical champions to achieve the best outcomes	
Consumer representative/ lived experience leader	• Older people and families or other carers bring critical expertise to any improvement team. They have a different experience with the system than staff and can identify key issues • We highly recommend that each team has at least one older person, family member, or other carer (ideally more than one), or a way to elicit feedback directly from these individuals (e.g., through a Consumer Advisory Group) • Additional information about appropriately engaging patients and families in improvement efforts can be found on the Health Issues Centre website	
Wider team members	• Influencers in the organisation who can drive commitment and attention to the work and support the frontline clinicians to test and measure changes • These team members may assist with communication and knowledge translation across the department, unit or organisation • These members do not need to be registered • You will need 6-12 wider team members to achieve the best outcomes	

Team governance

Structure your team by establishing governance structures early. This will include the team leader and key team members, meeting dates and times and the meeting content to ensure that the team learns, has direction and shares the wins and challenges.

Schedule Executive update sessions and promote reporting to the organisational Executive Board on progress in achieving age-friendly goals.

1.2 Know the 4Ms in your health service, complete a process walk through

To identify where the 4Ms are in practice in your health care service, complete a walk through as if you were an older person, carer or family member. In an inpatient and residential aged care setting, go through access points an older person would take, spend time on a unit and sit quietly in the hall. Look for the 4Ms in action. You will find aspects that make you proud and others that may leave you disappointed. Note the gaps or challenges that you see or hear. Find bright spots, opportunities and champions of each of the 4Ms in your health service.

Some discussion points below may assist with deeper enquiry with your walk through:


What experience do your team members have with the 4Ms?


What are current activities and services related to each of the 4Ms?


What processes, tools, and resources to support the 4Ms do you already have in place?


Where is the prompt or documentation available in the medical record or elsewhere for all clinicians and the care team?


What internal or community-based resources do you commonly refer to, and for which of the 4Ms?


Do your current 4Ms activities and services appear to be having a positive impact on older people and/or family or other carers?


Do you have a way to hear about the older persons' experience?


Do your current 4Ms activities and services appear to be having a positive impact on the clinicians and staff?


Which languages do the older people, and their family or other carers speak and read?


Do the health literacy levels, language skills, and cultural preferences of the older person match the assets of your team and the resources provided by your health service?


What works well?


What could be improved?

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Use the form below to note what you learn during your observations.

Table 3. Process walk-through worksheet: know the 4Ms in your service

4Ms	What to Look For	Current Practice and Observations
 **What Matters** Know and align care with each older person's health outcome goals and care preferences, including, but not limited to, end-of-life care and across settings of care	• Ask the older person and their carer What Matters, document it, and share What Matters across the care team • Align the care plan with What Matters • Advance care directives and medical decision makers	
 **Medication** If medication is necessary, use appropriate medications that do not interfere with What Matters to the older person, mobility, or mental and cognitive health across settings of care	• Review for potentially inappropriate medication use and document it • Deprescribe and dose-adjust potentially inappropriate medications • Comprehensive medication review once 5 or 9 or more (depending on setting) medications are prescribed, or when an older person's condition changes significantly • Medication reconciliation to ensure older people receive all intended medicines and to avoid errors of transcription, omission, duplication of therapy, and drug–drug and drug–disease interactions • Medication reconciliation at transition points of care to reduce unintended changes in medication regimes and other medication errors	

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4Ms	What to Look For	Current Practice and Observations
 **Mind** Prevent, identify, treat, and manage cognitive impairment, delirium, and depression across settings of care	• Ensure sufficient oral hydration and appropriate/varied diet, sensitive to the older person's likes and needs • Ensure that older people have easy access to their personal adaptive equipment (e.g., gait aids, glasses, hearing aids) • Prevent sleep interruptions; use nonpharmacological interventions to support sleep, where appropriate • Ensure that family and carers are involved in the older person's care, where appropriate • Offer appropriate cognitive stimulation to all older people with or without cognitive impairment • Offer opportunities for social interaction and activities • Ensure environment is orientated to the older person's comfort, capability, and calm	
 **Mobility** Ensure safe mobility and prevent falls to maintain function and support What Matters to the older person	• Assess mobility and mitigate any limitations to safe mobility • Assess for individual falls risk • Document and implement: – recommended mobility program – exercise programs – individualised falls prevention strategies. • Implementation of best practice falls prevention, exercise, and physical activities for older people • Assess physical environment to ensure that it supports older people to mobilise safely	

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1.3 Select a care setting to begin testing

Once you know about your older people and identify where the 4Ms currently exist in your health service, select a care setting in which to begin testing age-friendly interventions. Some questions to consider when selecting a site:

	Is there a setting where a larger number of older people regularly receives care?
	Is there will at this setting to become age-friendly and improve care for older people? Is there a champion?
	Is this setting relatively stable (i.e., not undergoing major changes already)?
	Does this setting have access to data? (See the "Study Your Performance" section below for more on measurement)
	Can this setting be a model for the rest of the organisation? (Modelling is not necessary, but useful to scale-up efforts)
	Is there a setting where your team members have experience with the 4Ms either individually or in combination? Do they already have some processes, tools, or resources to support the 4Ms?
	Is there a setting where the health literacy levels, language skills, and cultural preferences of your patients match the assets of the staff and the resources provided by your health care service?

Name of care setting where age-friendly testing will begin

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1.4 Know the older people in your care setting

Before commencing improvement work to create an Age-Friendly Health System at your organisation, it is important to understand the older people that make up your care setting. This includes gaining an understanding of the language, health literacy, race/ethnicity, religious and cultural preferences of the older people in your care. Don't worry about having perfect data, this is about getting to know your older person population using what you have access to, which may require estimation.

Record what you find in the worksheet below.

In the last month, estimate the number of adults receiving care in each of these age strata.

Table 4. Adults cared for in the last month (by age group)

Strata	Number	% Percent of total patients
18-64 years		
65-74 years		
75-84 years		
85+ years		
Total number of adult patients		100%

Using available data, learn about the:

Table 5. Language, race/ethnicity, and religious and cultural preferences of patients 65 years and older

Languages	% Percent of total patients/residents ages 65+

Race/ethnicity	% Percent of total patients/residents ages 65+

Religious and cultural preferences	% Percent of total patients/residents ages 65+

Table 6.

Health literacy levels	% Percent of total patients/residents ages 65+
Low	
Moderate	
High	

A key consideration with your care for older people – please provide an estimate based on your knowledge of the older people in your care

1.5 Set an Aim

Given your current state, set an aim for this initial effort. An aim articulates what you are trying to accomplish — what, how much, by when, for whom. It serves as the focus for your team's work and enables you to measure your progress. Below is an aim statement template that requires you to think about the reach of 4Ms. We suggest starting with what you want to accomplish in the next 12 months.

By _____date_____, _____organisation/team_____ will deliver age-friendly care by increasing the percentage of older people that receive 4Ms care (as a set) to % or more.

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To achieve this, % or more of older people will be assessed and acted upon (where indicated) for:

- **What Matters**
- Delirium, depression and cognitive impairment (**Mind**)
- **Mobility**
- Potentially inappropriate **Medications** and polypharmacy

Step 2. Describe care consistent with the 4Ms

What changes can you make that will result in improvement? There are many ways to improve care for older people. However, there is a finite set of key actions that touch on all 4Ms and dramatically improve care, when implemented together (see Table 5).

Using the 4Ms Care Description Worksheet below, describe a plan for how your health care service will describe and provide care consistent with the 4Ms. This worksheet helps you to assess, document, and act on the 4Ms as a set, while customising the approach to practicing the 4Ms for your context.

To be considered an Age-Friendly Health System, your health care service must assess older people for all 4Ms, document 4Ms information and act on the 4Ms accordingly. As you test the 4Ms, you will make updates to your Care Description Worksheet based on what you learn about the tools and methods from your tests.

In this step, describe the initial plan for 4Ms care for the older people you serve.

4Ms Age-Friendly Care Description Worksheet

Hospital and Residential Aged Care Facility

This table is to be completed at the commencement of your Age-Friendly Health Systems journey to determine the current status of your health care service, and as an outline of what your service describes as age-friendly care.

Health Care Service Name	
Ward or Care Setting Name If you are describing how the 4Ms are practiced across multiple care areas, please list each care area in a separate worksheet.	
Location	
Key Contact (Name, Email)	

	What Matters	Medication	Mind	Mobility	Identified gaps or areas for improvement
Aim	Know and align care with each older person's health outcome goals and care preferences, including, but not limited to, end-of-life care, and across settings of care	If medication is necessary, use appropriate medications that do not interfere with What Matters to the older person, Mobility or Mind across settings of care	Prevent, identify, treat, and manage cognitive impairment, delirium, and depression across settings of care	Ensure safe mobility and prevent falls to maintain function and support What Matters to the older person	Identify any processes that require adapting – this will inform your change ideas/PDSA cycles Some ideas for getting started are provided in the Appendix B at the end of this document
Assess Please tick the boxes to indicate items used in your care Add details if you tick "Other"	List the question(s) you ask to know and align care with each older person's specific outcome goals and care preferences: ☐ Older person is asked a "What Matters" question Details:	☐ Medication reconciliation is completed at admission ☐ Medication review occurs at other transitions of care (e.g. ward transfer) Please identify at what other transition points medication review takes place:	Tick the tool you use to screen for cognitive impairment: ☐ Mini-Mental State Examination (MMSE) ☐ Clock drawing test ☐ CAM ☐ Nu-DESC ☐ MOCA If further assessment is required: Tick the tool you use to screen for depression ☐ GDS (Geriatric Depression Scale) ☐ CSDD (Cornell Scale for Depression in Dementia) ☐ Other:	Tick the assessment process you use to screen mobility: ☐ Functional assessment • Sit to Stand • Transfer to chair • Mobilise short distance (usual gait aid) ☐ Timed Up & Go (TUG) ☐ 6 (or 10) Metre walk test ☐ de Morton Mobility Index (DEMMI) ☐ Refer to physiotherapy ☐ Environmental assessment (including clothing, footwear, flooring, lighting, furniture and fittings such as hand holds)	

	What Matters	Medication	Mind	Mobility	Identified gaps or areas for improvement
Assess Please tick the boxes to indicate items used in your care Add details if you tick “Other”	☐ Older person is asked if they have an Advance Care Directive If **Yes** – It is clearly documented and communicated to care team If **No** – There is an established process to develop and document an ACD that aligns with older persons care preferences Minimum requirement: One or more What Matters question(s) must be listed Question(s) should not only focus only on end-of-life forms For older people unable to speak for themselves, your What Matters engagement should include interaction with an appropriate carer or family member to understand What Matters	Tick the number of medications prescribed that initiates medication reconciliation or review ☐ Five ☐ Nine Minimum requirement: At least one of the first six boxes must be ticked If only “Other” is ticked, will trigger review	Tick the tool used to screen for delirium: ☐ UB-2 ☐ 4AT ☐ CAM ☐ 3D-CAM ☐ CAM-ICU ☐ bCAM ☐ Nu-DESC ☐ SQiD (Residential Care only) ☐ Other: Minimum requirement: At least one of the first six boxes must be ticked If only “Other” is ticked, will trigger review	Other: Minimum requirement: At least one of the first six boxes must be ticked If only “Other” is ticked, will trigger review	

	What Matters	Medication	Mind	Mobility	Identified gaps or areas for improvement
Frequency	☐ Once per stay ☐ Daily ☐ Other: Minimum frequency is once per stay	☐ Once per stay ☐ Daily ☐ Other: Minimum frequency is once per stay	**Cognitive Impairment** ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: **Delirium** ☐ 12 hourly ☐ Daily ☐ Other: **Depression** ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: ☐ Delirium frequency ☐ Hospitals Minimum frequency is every 12 hours ☐ Residential Aged Care Minimum frequency is daily	☐ Daily ☐ Weekly ☐ Monthly ☐ Other: Minimum frequency is once per week	

	What Matters	Medication	Mind	Mobility	Identified gaps or areas for improvement
Documentation	☐ Medical Record ☐ EMR ☐ Other: One box must be ticked; preferred option is Medical Record If "Other," will trigger review to ensure documentation method is accessible to other care team members for use during the health care service	☐ Medical Record ☐ EMR ☐ Other: One box must be ticked; preferred option is Medical Record If "Other," will trigger review to ensure documentation method is accessible to other care team members for use during the health care service	☐ Medical Record ☐ EMR ☐ Other: One box must be ticked; preferred option is Medical Record If "Other," will trigger review to ensure documentation method can capture assessment to trigger appropriate action	☐ Medical Record ☐ EMR ☐ Other: One box must be ticked; preferred option is Medical Record If "Other," will review to ensure documentation method can capture assessment to trigger appropriate action	
Act On Please describe how you use the information obtained from Assess to design and provide care Refer to pathways or procedures that are meaningful to your staff in the "Other" field	☐ Align the care plan with What Matters most to the older person ☐ A documented Advance Care Directive is in place and care team and family/carers are aware of this ☐ Other: Minimum requirement: First box must be ticked	☐ Adjust or deprescribe potentially inappropriate medications if possible (includes potential dose increase, reduction, discontinuation as appropriate) ☐ Prioritise medications (increase or reduce specific medications) to support What Matters to the older person (such as end of life)	Management of Cognitive Impairment and Depression, and Delirium prevention and management protocol. This may include, but is not limited to: ☐ Orient older person to time, place, and situation on ever clinical contact ☐ Avoid potentially inappropriate medications ☐ Ensure sufficient oral hydration	Support safe activity-based mobilisation and ambulation: ☐ Getting out of bed ☐ Leaving room for meals ☐ Incidental walks ☐ Mobility and falls prevention program ☐ Balance and gait training program ☐ Exercise program ☐ Physiotherapy intervention	

What Matters	Medication	Mind	Mobility	Identified gaps or areas for improvement
Act On Please describe how you use the information obtained from Assess to design and provide care Refer to pathways or procedures that are meaningful to your staff in the "Other" field	☐ Consider if medications being used PRN are indicated, or should be prescribed regularly ☐ Indication for medication prescription is discussed with older person and/or their carer ☐ Pharmacy review ☐ Other: Minimum requirement: First box must be ticked	☐ Offer cognitive stimulation with or without cognitive impairment ☐ Involve the carer in supportive activities ☐ Care environment is orientated to individual's capability, comfort and to promote calm ☐ Ensure that older person has easy access to and utilise their appropriate clean personal adaptive equipment (e.g., glasses, hearing, dentures, walkers) ☐ Prevent sleep interruptions; use nonpharmacological interventions to support sleep ☐ Clearly established pathway in place for new signs of delirium ☐ Other: Minimum requirement: multiple boxes must be ticked	☐ Avoid physical restraints to prevent falls ☐ Remove catheters and other tethering devices, if medically appropriate ☐ Avoid potentially inappropriate medications, if medically appropriate ☐ Other: Minimum requirement: Must tick first box and at least one other box	

	What Matters	Medication	Mind	Mobility	Identified gaps or areas for improvement
Primary Responsibility Indicate which care team member/s have primary responsibility for assessing and making any referrals relevant to each M?	☐ Nurse ☐ Social Worker ☐ Medical staff ☐ Geriatrician ☐ Pharmacist ☐ Physiotherapist ☐ Occupational Therapist ☐ Personal Care Attendant ☐ Other: Minimum requirement: One role must be selected	☐ Nurse ☐ Social Worker ☐ Medical staff ☐ Geriatrician ☐ Pharmacist ☐ Physiotherapist ☐ Occupational Therapist ☐ Personal Care Attendant ☐ Other: Minimum requirement: One role must be selected	☐ Nurse ☐ Social Worker ☐ Medical staff ☐ Geriatrician ☐ Pharmacist ☐ Physiotherapist ☐ Occupational Therapist ☐ Personal Care Attendant ☐ Other: Minimum requirement: One role must be selected	☐ Nurse ☐ Social Worker ☐ Medical staff ☐ Geriatrician ☐ Pharmacist ☐ Physiotherapist ☐ Occupational Therapist ☐ Personal Care Attendant ☐ Other: Minimum requirement: One role must be selected	

■ Step 3. Design or adapt your workflow

You may have many ideas for improvement already. You can maintain, improve, and expand these ideas where necessary. Other ideas you may still need to test and implement utilising the Plan-Do-Study-Act cycle. The key is to ensure that these practices are reliable — happening every time, in every setting for every older person in your care (and their carers and family).

Table 5. Age-Friendly Health Systems Summary of Key Actions

	Assess	Act On
	Know about the 4Ms for each older person in your care	Incorporate the 4Ms into the plan of care
Site	**Key Actions (to occur at least daily)**	
Hospital	• Ask the older person What Matters • Document What Matters • Ensure that care aligns with preferences documented in any existing Advance Care Directive • Review potentially inappropriate medications and polypharmacy • Screen for cognitive impairment on admission • Screen for delirium every 12 hours • Assess mobility and falls risk	• Align the care plan with What Matters • Deprescribe, adjust dosage or do not prescribe potentially inappropriate medications whenever possible • Ensure sufficient oral hydration and nutrition • Identify and manage factors contributing to delirium and depression • Orient older people to time, place, and situation • Consider further identification and evaluation of needs to support patients with cognitive impairment and dementia • Ensure older people have access to their clean personal sensory adaptive equipment • Prevent sleep interruptions; use nonpharmacological interventions to support sleep • Ensure early, frequent, and safe mobility to mitigate falls risk and prevent falls-related injury

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Site	Key Actions (to occur at least annually or after change in condition)	
Residential Aged Care	• Ask the older person What Matters • Document What Matters • Determine if older person has a documented Advance Care Directive. • Review potentially inappropriate medications and polypharmacy • Screen for cognitive impairment • Screen for depression • Assess mobility and falls prevention	• Align the care plan with What Matters • Ensure end of life care is consistent with older persons Advance Care Directive • Deprescribe, adjust dosage or do not prescribe potentially inappropriate medications whenever possible • Ensure sufficient oral hydration and nutrition • Identify and manage factors contributing to delirium and depression • Orient older people to time, place, and situation • Consider further identification and evaluation of needs to support patients with cognitive impairment and dementia • Ensure older people have access to their clean personal sensory adaptive equipment • Prevent sleep interruptions; use nonpharmacological interventions to support sleep • Ensure early, frequent, and safe mobility to mitigate falls risk and prevent falls-related injury

Supporting Actions:

- Use the 4Ms to organise care and focus on the older persons, wellness and their strengths rather than solely on disease or lack of functionality.
- Integrate the 4Ms into care or existing workflows.
- Identify any activities you can stop doing to reallocate resources to reliably practice the 4Ms.
- Document all 4Ms and consider grouping the 4Ms together in the medical record.
- Make the 4Ms visible across the care team and settings.
- Form an interdisciplinary care team that reviews the 4Ms in daily huddles and/or rounds.
- Educate older people, carers and the community about the 4Ms.
- Link the 4Ms to community resources and supports to achieve improved health outcomes.

Overall, look for opportunities to combine or redesign activities, processes, and workflows around the 4Ms.

With this work, you may find that you can stop certain activities and reallocate resources to support age-friendly care.

If you have process flow diagrams of your daily care, edit these views of your workflow to include the key actions above and your description of age-friendly care.

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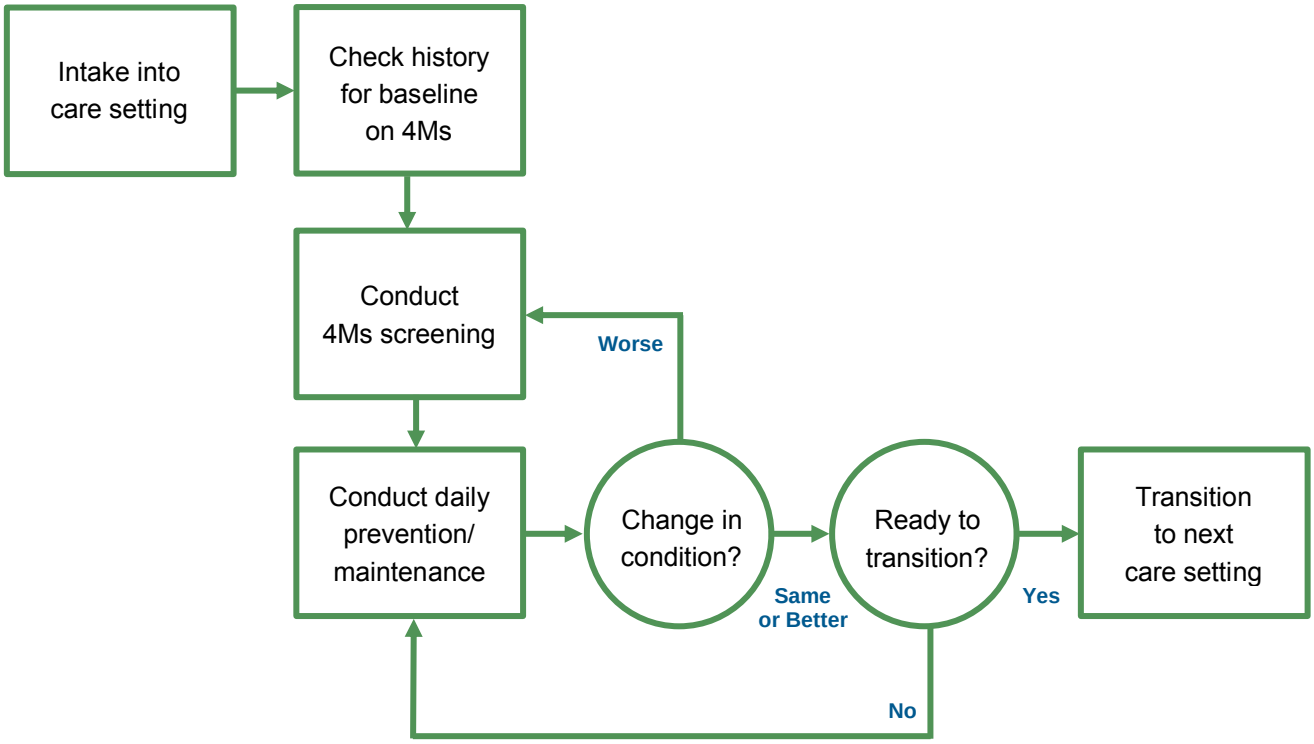
You may start with a high-level workflow like the examples shown below (see Figure 5).

Figure 5. Age-friendly Care Workflow Example for Hospitals: Core Functions



Work through the details in the space below each high-level block to show how you will incorporate the 4Ms.

Be specific about who will do what, where, when and how and how it will be documented. Examples are included below. Outline what you still need to learn and identify what you will test (e.g., using the Timed Up & Go Test to evaluate mobility and falls risk; screening all older people for signs of delirium at least once every 12 hours in a hospital setting).

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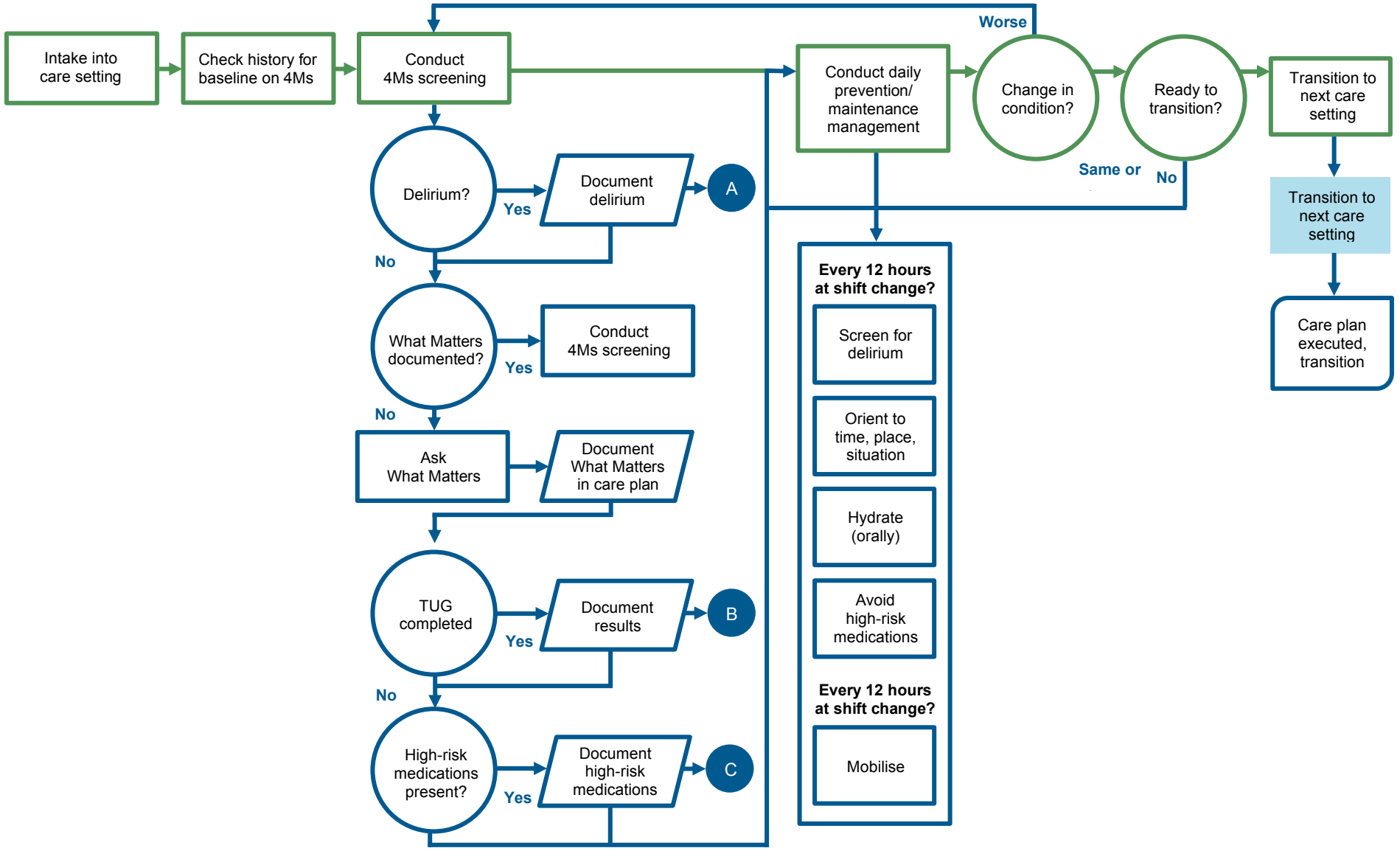
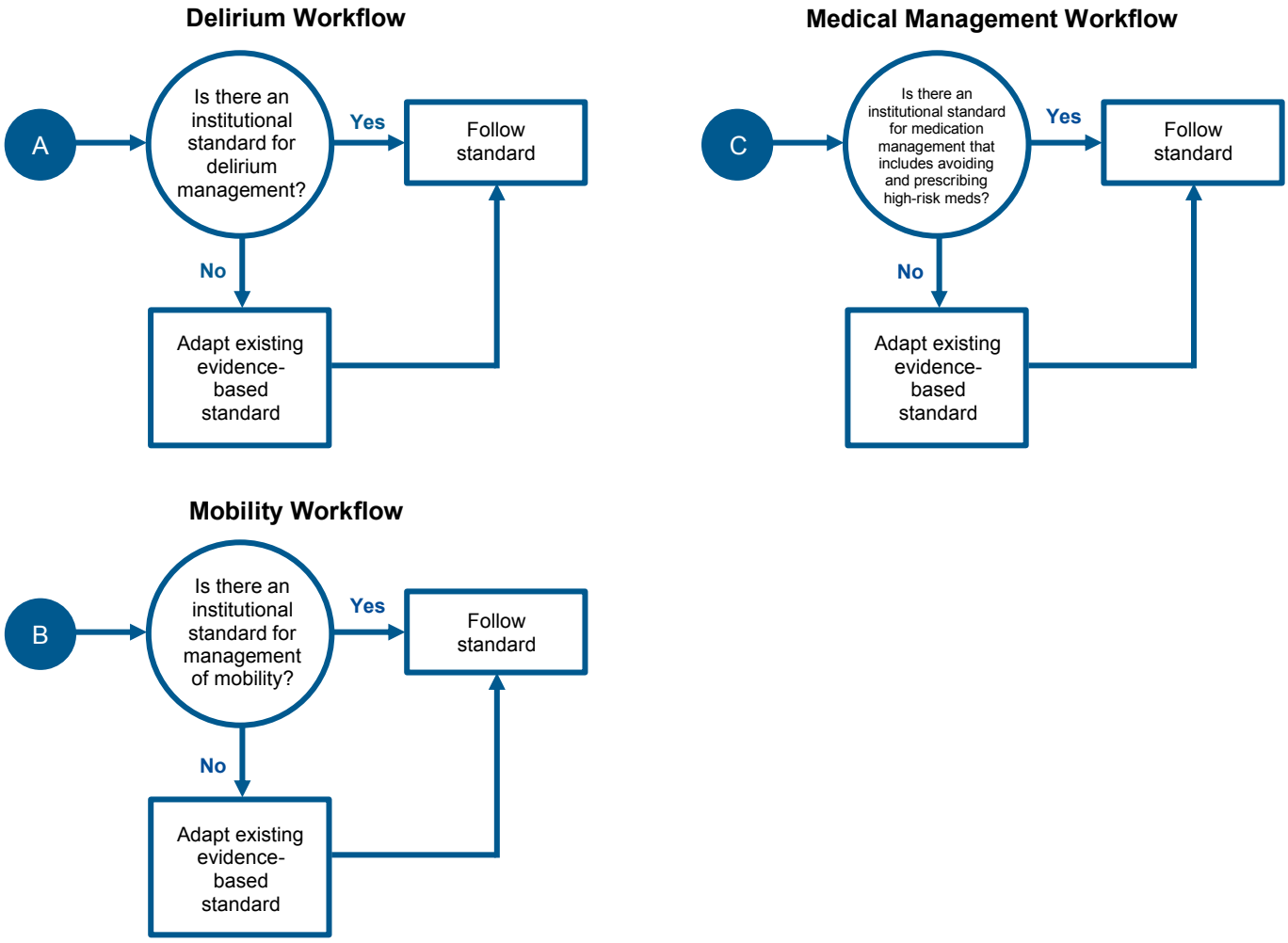
Age-Friendly Care Workflow Examples

Hospital-Based Care Workflows: Core Functions





■ Step 4. Provide care

Learn as you move toward reliable 4Ms care. Begin to test the key actions with one older person and their family or other carer as soon as you have notes for Step 2: Describe care consistent with the 4Ms, and Step 3: Design or adapt your workflow.

You do not need to wait for your forms to be finalised or your environment to be right before you test with one older person. Use the Plan-Do-Study-Act tool to learn more from your tests. Then, scale up your tests.

For example:

- Apply your draft process and workflow with one older person initially. Can your team follow the procedure in your work environment? Can your team successfully assess and act on the 4Ms?
- Ask the older person about their care experience in relation to the 4Ms. See Victorian Age-Friendly Measurement Guide, Appendix B for further information on having conversations with older people about 4Ms care.
- If necessary, modify your procedure. Then, apply it with five older people. What lessons do you learn from applying 4Ms care with these people? What impact does learning about all 4Ms have on care plans?
- If necessary, modify your procedure. Then, apply with 25 older people and keep going. Are you getting close to being able to use your procedure for every older person? Are you getting good results?
- Examples of PDSA cycles can be found below.

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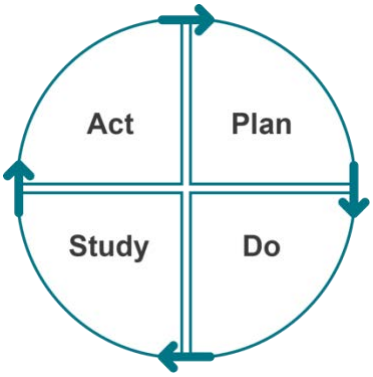
PDSA Cycles for Age-Friendly Care

Example: Testing What Matters Engagement with Hospitalised Older People

The following is an example of a PDSA cycle. A blank form has also been included to complete for older people in your care.

Plan-Do-Study-Act Record

NAME OF HEALTH CARE SERVICE: Grassroots Health Service
NAME OF PERSON COMPLETING FORM: Erin Rush, RN
DATE: March 29, 2019



Change Idea to ☐ develop or ☑ test or ☐ implement

Description:
Cycle 1: Test a What Matters engagement with a hospitalised patient.

Ask What Matters
- Who?
- When?
- Using what question(s)?

Document What Matters
- Who?
- What?
- Where?

Align the Care Plan with What Matters
- Who?
- How do we know if that has happened?

PLAN

Questions: What do we want to know?

- Can staff incorporate What Matters conversations into ward rounds with older people?
- Will staff learn something useful from What Matters conversations and incorporate it into the plan of care.

Predictions: What do we think will happen?

- Staff can incorporate What Matters conversations into rounds with older people.
- Staff can learn something useful from What Matters conversations and incorporate it into the plan of care.

Plan for the change or test: Who, What, When, Where, What are we going to do to make our test happen?

List the tasks necessary to complete this test (what)	Person responsible	When	Where
Orient Dr. M (geriatrician) to this test	Erin	Monday morning	4 South
Select older person for test	Erin and Dr. M	Monday morning	4 South
Ask older person, “What matters to you in the next few days as you recover from your illness?”	Dr. M	Monday	TBD
Debrief test and complete PDSA cycle	Erin and Dr. M	Tuesday morning	4 South

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Plan for data collection: Who, What, When, Where. How will we compare predictions to actual?

Erin and Dr. M to meet the next day to debrief test, capture what happened, impressions, how that compared to predictions, next steps.

DO: Carry out the change or test; collect data and begin analysis; describe the test/what happened.

- Dr. M asked 1, and then 4 more, older patients — went beyond testing with just 1 patient!
- Some answers were very health/condition related (e.g., a patient with shortness of breath/cough stated, "I just want my cough to be better and to be able to breathe.").
- Other answers were more life related, for example:
  - A patient being treated for stroke, who is a performance artist, shared a video of performance and indicated what matters is to be able to return to performing.
  - A patient with multiple falls wants to be able to stand to cook again.

STUDY: Complete analysis of data; summarise what was learned; compare what happened to predictions above.

- Asking a single question is not sufficient. Need the opportunity for follow-up questions and listening. For example: A patient with congestive heart failure and arthritis has an immediate goal to reduce swelling in her legs. Further probing revealed a desire to stay in her home and be able to cook to avoid delivered salty foods and to avoid rehospitalisation. Possible solution: Prescription for homemaker assistance.
- Dr. M regularly engages patients with What Matters in an outpatient setting. New for inpatient rounds, but feasible to include.
- Worthwhile if there is time for follow-up (not just one question and one answer in 30 seconds).
- No patients responded with goals or needs that could not be addressed somehow in the care plan.
- Asking a What Matters question feels awkward. Need to build a relationship first before asking an "intimate" question. For example, asking on the second day of rounding feels better than asking on the first day.
- Asking a What Matters question helped Dr. M bond with the patients.
- There was a lack of clarity on what to do with the information learned from the What Matters conversation (e.g., how to document, how to share).
- Still have a concern about not knowing what to do if a patient expresses a need or goal beyond the specific health condition or issues that the physician (Dr. M) is trained to address.

ACT: Are we ready to make a change? Plan for the next cycle.

- Test again. Questions to explore through more testing include:
- Is it better to ask the What Matters question at the beginning or end of the encounter?
- How can we get at What Matters for our patients with cognitive impairment?
- Where is the best place to document the information from the What Matters engagement?
- Whiteboard: "Anyone" can use the whiteboard. Can this be done effectively?
- Electronic Medical Records documentation agreement (meetings underway with EMR team to discuss options).
- Are the daily multidisciplinary rounds/huddles the best place to discuss what is learned from What Matters conversations?
- Do we need to coordinate our engagement about What Matters? Nursing, allied health, medical staff, etc., could all be asking variants of What Matters.
- Could nurses or allied health staff have a What Matters conversation and document it so that it is available for medical staff to reference?

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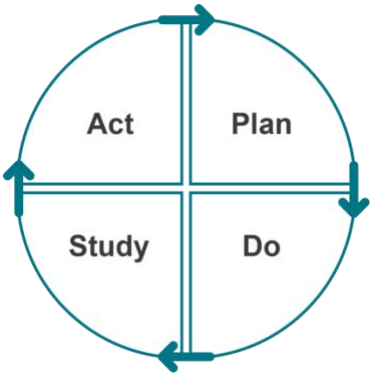
Plan-Do-Study-Act Record

NAME OF HEALTH CARE SERVICE:
NAME OF PERSON COMPLETING FORM:
DATE:



Change Idea to ☐ develop or ☐ test or ☐ implement

Description:
Cycle 1: Test a What Matters engagement with a hospitalised patient.

Ask What Matters	Document What Matters	Align the Care Plan with What Matters
• Who? • When? • Using what question(s)?	• Who? • What? • Where?	• Who? • How do we know if that has happened?

PLAN

Questions: What do we want to know?

Predictions: What do we think will happen?

Plan for the change or test: Who, What, When, Where, What are we going to do to make our test happen?

List the tasks necessary to complete this test (what)	Person responsible	When	Where

Plan for data collection: Who, What, When, Where. How will we compare predictions to actual?

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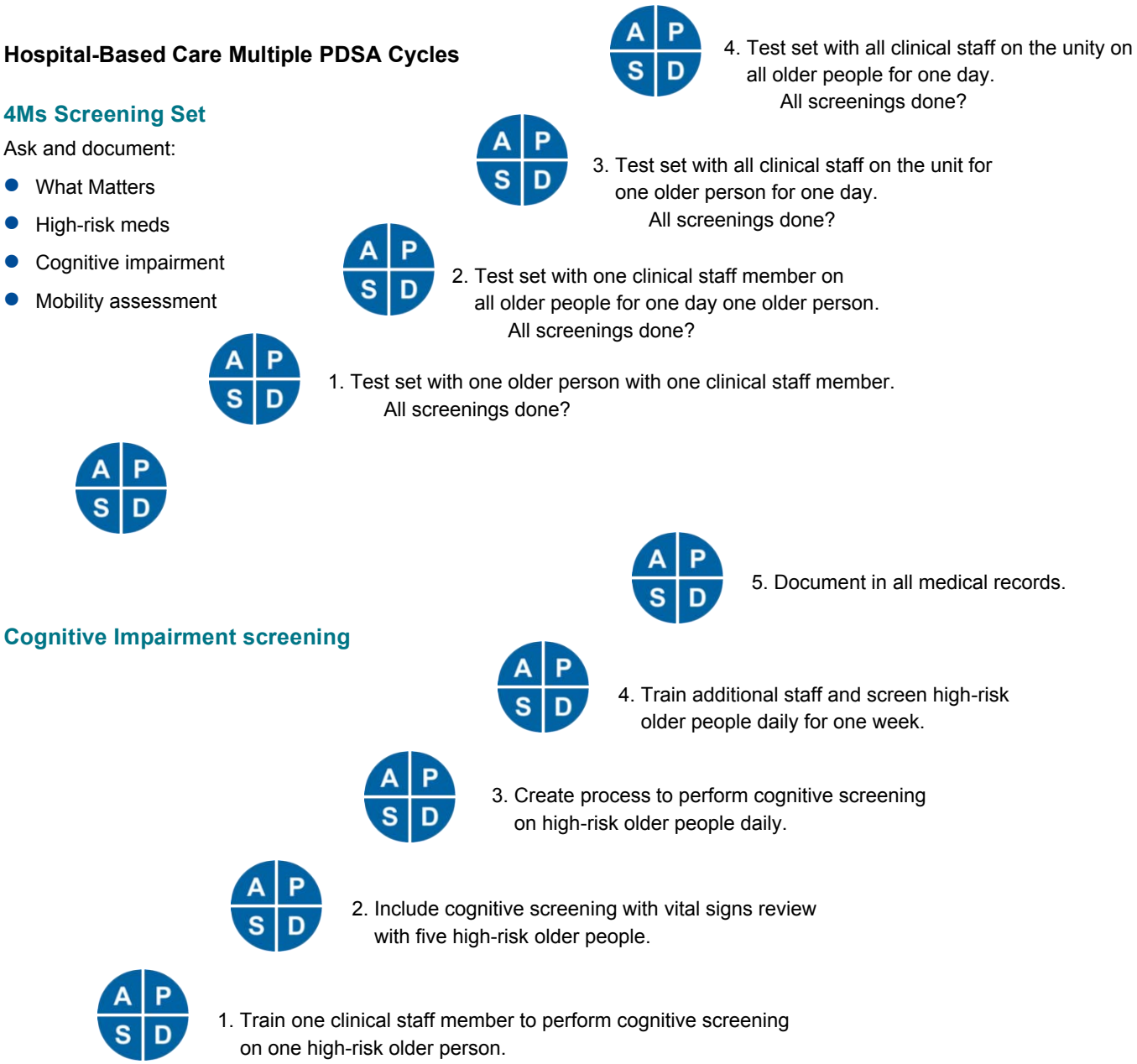
DO: Carry out the change or test; collect data and begin analysis; describe the test/what happened

STUDY: Complete analysis of data; summarise what was learned; compare what happened to predictions above

ACT: Are we ready to make a change? Plan for the next cycle

Test again. Questions to explore through more testing include:

Hospital-Based Care Multiple PDSA Cycles



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■ Step 5. Study your performance

How will you know that a change is an improvement? How reliable is your 4Ms care?
What impact does your 4Ms care have?

5.1 Measurement for improvement

Measurement is vital to understand whether your changes have led to an improvement.

Project teams typically track aspects of 4Ms care as they test changes to workflow and work to provide the 4Ms framework to every older adult in their care.

Refer to the Victorian Age-Friendly Measurement Guide for full details of the measurement strategy.

5.2 Measure how many patients receive 4Ms care

There are three options to start measuring the number of patient encounters that include 4Ms care.
We recommend Option 1 because it forces close attention to the 4Ms work and takes less effort than conducting retrospective chart audits or building a specific EMR report.

Real-Time Observation

Use real-time observation and staff reporting of the work to tally your 4Ms counts. An example for patients seen in the primary care clinic might look like the chart below (see Figure 5).

Figure 5. Example of Real-Time Observation in a Primary Care Clinic

Date	4Ms care according to our site description													
	All 4Ms		What Matters		Medication		Mind Depression		Mind Dementia		Mind Delirium		Mobility	
Patient/ Resident UR	If N, mark Y/N of M acted upon													
X123456	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Chart Review

At the start of your work using the 4Ms, review charts of older people with whom you have tested 4Ms care to confirm appropriate documentation.

If a total count is not possible, you can sample (e.g., audit 20 patient charts) and estimate the total number of patient/resident encounters using 4Ms care/20 x total number of patients/residents cared for in the measurement period. If you are sampling, please note that when sharing data. Using a tally sheet, like the example in Option 1 above, to review charts for evidence of 4Ms care.

EMR Report

You may be able to run electronic medical record (EMR) reports, especially on assessment of the 4Ms, to estimate the number of patient encounters that include 4Ms care in a particular time period. It may take a lot of effort to create a suitable report, so we do not recommend this option as your first choice. However, for ongoing process control, some organisations may wish to develop reports that show 4Ms performance; you can request report development from your IT service while starting with Option 1 or 2.

Routine Counting of Patients

Once your site provides 4Ms care with high reliability, then the estimate of the number of patient encounters that include 4Ms care is simple: Report the volume of patients receiving care from your site during the measurement period.

■ Step 6. Improve and sustain care

Laying the foundations at your organisation for ongoing and reliable 4Ms care is important for sustaining an Age-Friendly Health System. This may include evidence of:

- Staff understand why your site uses the 4Ms framework.
- Staff can explain how your site uses the 4Ms framework.
- Staff have documentation for the 4Ms framework; they can access your 4Ms Care Description and additional standard supporting operating procedures, flowcharts, and/or checklists.
- Training/orientation introduces new staff to the 4Ms framework.
- Job descriptions outline elements of the 4Ms framework as appropriate to the role.
- Performance evaluation refers to the 4Ms framework.

For more information about how to sustain your 4Ms care, please see the IHI White Paper, Sustaining Improvement.

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Appendix

Appendix A: Age-Friendly Health Systems Advisory Groups and Faculty

Creating Age-Friendly Health Systems co-design expert stakeholders

Mark Ashcroft, CEO, Beechworth Health Service

Mark Boughey, Director of Palliative Medicine, St Vincent's Hospital Melbourne

Andre Catrice, Senior Policy Officer, Health, Ageing Interface, Department of Health

Peter Hunter, Head of Unit Geriatric Medicine, Clinical Program Director of Rehabilitation, Aged and Community Care, Alfred Health

Shell Morphy, Director Excellence & Innovation, Beechworth Health Service

Meg Morris, Professor of Clinical and Rehabilitation Practice, Healthscope & La Trobe University

David Nguyen, Senior Pharmacist, Alfred Health

Stephen Peterson, Consumer representative

Mark Yates, Associate Professor, Deakin University;
Interim Clinical Director Aged Operations Medical Administration, Ballarat Health

Creating Age Friendly Health Systems faculty

Lester Sawyer, Consumer Representative

Stephen Peterson, Consumer Representative

Katerina Yakimov, Consumer Representative

Wendy Thomas, Consumer Representative

Amelia Crabtree, Geriatrician, Alfred Health; Older People Clinical Lead, Safer Care Victoria

Melanie Benson, Palliative Care Physician, Peninsula Health

David Nguyen, Senior Pharmacist, Alfred Health

Mark Yates, Associate Professor, Deakin University;
Interim Clinical Director Aged Operations Medical Administration, Ballarat Health

Meg Morris, Professor of Clinical and Rehabilitation Practice, Healthscope & La Trobe University

Mellissa Raymond, Stream Leader - Aged Care Physiotherapy, Alfred Health

Donna Fick, PhD, RN, Elouise Ross Eberly Professor of Nursing and Professor of Medicine and Director of Center of Geriatric Nursing Excellence, Pennsylvania State University; Editor, Journal of Gerontological Nursing

Andrea Schwartz, MD MPH, Assistant Professor, Harvard Medical School; Assistant Professor, Harvard T.H. Chan School of Public Health; VA Boston Healthcare System, Division of Geriatrics & Extended Care;
New England Geriatrics Research Education and Clinical Center

Nickle Brandt, PharmD, MBA, Professor, Department of Pharmacy Practice and Science, University of Maryland School of Pharmacy; Executive Director, Peter Lamy Center on Drug Therapy and Aging

Stephanie Rogers, MD, MPH Assistant Professor, Medicine, University of California, San Francisco

Christina Southey, Improvement Advisor

Malcolm Green, Improvement Advisor

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Appendix B: Process walk-through: know the 4Ms in your health system

Key Actions and Getting Started with Age-Friendly Care

Ideas and Resources for Acting on the 4Ms

What Matters

Aim: Know and align care with each older person's health outcome goals and care preferences, including, but not limited to, end-of-life care, and across settings of care.

Assess Know about the What Matters for each older person in your care	**Act On / Key Action** Act On What Matters for each older person in your care
• Ask questions addressing 'what matters' a minimum of once per stay in hospital, or at set intervals in residential aged care, and do not only address end of life care • Understand what matters including individual values, priorities, goals and care preferences, health, wellbeing and social context • Address wishes and desires about their life, how they are living on a daily basis and pursuing their interests • Document 'What Matters' clearly at the front of medical records in paper and electronic forms Routinely collect information on person-reported outcome measures (PROMS) and patient experience questionnaires (PRES) using validated tools	Describe and align care plans to the responses of the 'what matters' questions Act on what matters for current and future care, including current health and wellbeing and end of life If you do not have existing questions to start this conversation, try the following, and adapt as needed: "What do you most want to focus on while you are in the hospital/emergency department for_____ (fill in health problem) so that you can do_____ (fill in desired activity) more often or more easily?" For older people with advanced or serious illness, consider: • "What are your most important goals if your health situation worsens?" • "What is important to you about your capability, comfort and calm" https://valueinstitute.utexas.edu/outcomes-measurement

Getting Started Tips	**Resources**
• Health outcome goals are aligned to what matters to the older person, such as babysitting a grandchild, walking with friends in the morning, or continuing to work as a teacher. Health care preferences include the medications, health care visits, testing, and self-management tasks that an individual is able and willing to do. Also, consider what carers may need particularly when considering community health and primary care	"What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults Top 5 Sunflower tool Aboriginal ageing - NeuRA

What Matters

- When you focus on the older person's priorities, Medication, Mind and Mobility usually come up so the older person can do more of What Matters
- Consider how care while in the hospital can be modified to align with What Matters
- Consider What Matters to the older person when deciding to where they will be discharged
- Use What Matters to develop the care plan and navigate trade-offs. For example, you may say, "There are several things we could do, but knowing what matters most to you, I suggest we…"
- Use the older person's priorities (not just diseases) in communicating, decision making, and assessing benefits
- Use collaborative negotiations; agree there is no best answer and brainstorm alternatives together. For example, you may say, "I know you don't like the CPAP mask, but are you willing to try it for two weeks to see if it helps you be less tired, so you can get back to volunteering, which you said was most important to you?"
- Care options likely involve input from many disciplines (e.g., physiotherapy, social work, community organisations, and the older person themselves)
- Allow time and space to discuss What Matters
  - Consider your older person cohort and what might be important to them based on their condition. You may choose to segment people into groups such as healthy older people, those with chronic conditions, those with serious illness, and individuals at the end of life. How you ask What Matters of each group may differ
  - Consider starting these conversations with who matters to the older person. Then ask the older person what their plans are related to life milestones, travel plans, birthdays, and so on in the next six months to emphasise, "I matter, too." Once "who matters" and "I matter, too" are discussed, then what matters becomes much easier to discuss
  - Responsibility for asking and acting on What Matters can rest with any member of the care team; however, one person needs to be identified as responsible to ensure it is reliably done, and that the information is conveyed when the older person moves to another location

What Matter Most to Older Australians - Palliative Care Australia

Advance Care Planning Australia

International resources

The Conversation Project and "Conversation Ready"

Measuring What Matters

Patient Priorities Care

Serious Illness Conversation Guide

Stanford Letter Project

"What Matters to You?" Instructional Video

A Guide to Having Conversations about What Matters (Canada)

National Resource Centre on LGBT Aging (USA)
https://www.lgbtagingcenter.org

What Matters

- You may decide to include family members or other caregivers in a discussion about What Matters; however, it is important to also ask the older person individually
- Ask people with dementia What Matters. Ask people with delirium What Matters at a time when they are suffering least from delirium symptoms. It will be important to consider family or carers in these discussions
- It may be worth also considering a daily goal and a broader care goal
- Communicate back to key care staff, including primary and hospital-based care and across transitions of care
- Consider cultural and linguistic diversity when asking What Matters

There are a number of options regarding documentation – older people should be asked which way of communicating "What Matters" is acceptable to the older person;

- Convert whiteboards to What Matters boards and include information about the older people (e.g., what name they like to be called, the pronouns they use, favourite foods, favourite activities, what concerns or upsets them, what soothes them, assistive devices, and the names and phone numbers of family members or other caregivers). Identify who on the care team is responsible for ensuring that the information is updated. Ensure the older person consents to any information displayed
- Consider documentation of What Matters to the older person on paper that they can bring to appointments and other sites of care
- Identify where health and health care goals and priorities can be captured in your electronic health record and available across care teams and settings

Review What Matters documentation across older people to ensure they are specific to each person (i.e., watch out for generic or the same answers across all older persons, which suggests a deeper discussion of What Matters is warranted)

Medication

Aim: If medication is necessary, use appropriate medications that do not interfere with What Matters to the older person, Mobility or Mind across settings of care

Assess
Know if medications support What Matters to the older person, Mobility and Mind

- Identify older people with polypharmacy (as per care description worksheet)
- Potentially inappropriate medications may include:
  - Psychotropic Drugs
  - Neurological Drugs
  - Genitourinary Drugs
  - Allergy and Anaphylaxis Drugs
  - Analgesic Drugs
- Gastrointestinal Drugs Over-the-counter drugs, sleep aids, and sedatives. Specifically look for:
  - Benzodiazepines
  - Opioids
  - Highly anticholinergic medications (e.g., promethazine)
  - All prescription and over-the-counter sedatives and sleep medications
  - Tricyclic antidepressants
  - Antipsychotics
  - Muscle relaxants
  - Anti-epileptics
- NOTE: There are clinically appropriate uses for medications that may be potentially inappropriate individually and in combination
- Conduct regular medication reviews by medical/nurse practitioner or pharmacist
- Implement processes for medication reconciliation at all transition points of care
- Review medications following a fall incident

Act On / Key Action
Act On medication stewardship to support What Matters to the older person, Mobility and Mind

- Prescribe appropriate medication and, when appropriate, de-prescribe potentially inappropriate medications and adjust doses as appropriate
- Complete medication review and reconciliation for older people taking 9 or more medications
- Specifically avoid or deprescribe the medications in the list opposite
- If the older person takes one or more of these medications, discuss any concerns the older person may have, assess for adverse effects, and discuss deprescribing with the older person

Medication

Tips

- If you decide to limit the number of medications to focus on, identify those most frequently dispensed in your hospital or unit, or those for which there is a champion to deprescribe
- These medications, individually and in combination, may interfere with What Matters, Mind, and safe Mobility of older people because they increase the risk of confusion, delirium, unsteadiness, and falls
- Deprescribing includes both dose reduction and medication discontinuation.
- Deprescribing is a positive, person-centered approach, requiring informed consent, shared decision making, close monitoring, and compassionate support
- When possible, avoid prescribing these high-risk medications (prevention); consider changing order sets in the medical records to change prescribing patterns (e.g., adjust/reduce doses, change medications available)
- Your institution may also have delirium and falls prevention and management protocols that include guidance to avoid high-risk medications
- Offer non-pharmacological options to support sleep and manage pain
- Remove medications the older person can stop taking upon discharge
- Include a medication list printout as part of standard check-out steps and ensure that the older person and family or other carers understand what their medications are for, how to take them, why they are taking them, and how to monitor whether they are helping or possibly causing adverse effects
- Ensure older person and/or their carer understands the reason for the medication. Medicines information and education should be offered to all older people and should include both verbal and written information
- Inform the older person's General Practitioner of medication changes
- Consult pharmacy for pharmacological stewardship when providing an age-friendly approach to medications
- Identify who on your team is going to be the champion of this "M." The champion may not be a pharmacist, but it is vital to have a pharmacist or medical team, as well as an older person, work on the plan

Resources

Medication reconciliation (Clinical Excellence Commission)

- Valuable resource for sites to review their medication management processes, for both the Assess and Act On component of this M

National Prescribing Service – Prescribing Competencies Framework

National Prescribing Curriculum - Polypharmacy

Primary Health Tasmania Deprescribing guidelines

- Deprescribing guidelines for commonly used medicines (e.g. benzodiazepines, aspirin, statins

NSW Therapeutic Advisory Group Deprescribing Tools

- Deprescribing guidelines for commonly used medicines in older adults (e.g. proton pump inhibitors, long-term opioid analgesics)
- Deprescribing consumer information leaflets

International resources

Deprescribing.org - Resources for Patients and Health Care Providers

- Deprescribing resources to learn about deprescribing, whether it is the right choice for patients, when to have the conversation with health care providers, and how to reduce medication safely

Crosswalk: Evidence-Based Leadership Council Programs and the 4Ms

https://deprescribing.org/

https://www.therapeutics.scot.nhs.uk/polypharmacy/

American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

STOPP/START criteria for potentially inappropriate prescribing in older people: version 2)

STOPP-START Screening Tool of Older People's Prescriptions (STOPP) Screening Tool to Alert to Right Treatment (START)

Medication

- Review your setting or system's data, if possible, to identify medications that may be high-risk (e.g., anticoagulants, insulin, opioids) or potentially inappropriate (e.g., anticholinergics)
- Determine your goal(s) with respect to your medication(s) identified in the previous step
- Best Practice medication management includes the completion of a Best Possible Medication History and comprehensive Medication Reconciliation

Reducing Inappropriate Medication Use by Implementing Deprescribing Guidelines

Alternative Medications for Medications Included in the Use of High-Risk Medications in the Elderly and Potentially Harmful Drug–Disease Interactions in the Elderly Quality Measures

Mind

Aim: Prevent, identify, treat and manage cognitive impairment, delirium and depression across settings of care.

Assess
Know the cognitive status and mental wellbeing of the older person

- Screen, assess and manage cognitive impairment and depression using validated tool
- Assess for delirium using a validated tool every 12 hours when in hospital and daily in Residential Aged Car
- Consider how the following can impact on 'Mind':
  - Sensory impairment:
    - Screen vision and hearing annually for timely identification and management of vision and/or hearing loss
  - Continence
    - Screen for urinary and faecal incontinence using validated tool
  - Nutrition and hydration
    - Monitor oral fluid intake
    - Monitor for potential malnutrition and refer to a dietitian for those at risk
    - Screen for adequate nutrition and diet using a validated tool

Act On / Key Action
Act On identifying, treating and managing cognitive impairment, delirium and depression

- Review medication to remove possible pharmacological cause of delirium
- Orientate older person to time, place and situation at regular intervals, and in interactions with all members of the care team
- Offer psychological intervention, training and support to family members or informal carers of care-dependent older people
- Offer cognitive stimulation to all older people with or without cognitive impairment, appropriate to their level of cognition and intellectual capability and interests
- Offer brief, structured psychological interventions to all older people with depressive symptoms
- Provide information to older people and/or their carers on the prevention and management of depression and cognitive impairment
- Consider use of cognitive impairment identifier to ensure all members of care team/visitors are aware that an older person may have additional communication challenges
- Make sure day and date are updated on the whiteboard
- Provide an accurate clock with large face visible to older people

Mind

- Consider using tools such as an “All About Me” board or poster/card that shows what makes the older people calm and happy, who is important to them, names of pets, etc
- Make newspapers and periodicals available in older persons’ rooms
- Ensure that care environment is orientated to an older person’s capability and comfort to promote calm. Invite family or other carers to bring familiar and orienting items from home (e.g., family pictures)
- Ensure sufficient oral hydration
- Offer regular assistance to all older people with cognitive impairment to manage incontinence
- Offer pelvic floor training to all older women with urinary incontinence

Sleep

- Ensure adequate sleep-in care settings
- Provide non-pharmacological interventions to support sleep and prevent sleep disruption where possible

Sensory impairment

- Ensure older person has their personal adaptive equipment (hearing aids, glasses, dentures etc.) and that they are clean and in working order

Tips

- Decide on the tool that best fits your care team culture
- Be aware that low prevalence rates of delirium before the 4Ms are in place may indicate inaccurate use of a screening or assessment tool
- It is critical to use any tool only as instructed and to do ongoing training (yearly competency) to make sure it is being used correctly
- Ask questions in a way that emphasises the older persons’ strengths (e.g., “Please tell me the day of the week” rather than “Do you know what day it is today?”)
- Educate family members or other carers on the signs of delirium and enlist their support to alert the care team to any changes as soon as they notice them. Ask them if their loved one seems “like themselves”

Resources

Delirium Clinical Care Standard (2021)

Dementia care in hospitals

4AT

Confusion Assessment Method (CAM) and its variations: 3D-CAM for medical-surgical units, CAM-ICU for intensive care units, bCAM for emergency departments

Nursing Delirium Screening Scale (Nu-DESC)

Mind

- Document mental status in the chart to measure changes shift-to-shift
- Until ruled out, consider a change in mental status to be delirium and raise awareness among care team and family members or other carers about the risk of delirium superimposed on dementia
- Note: Delirium has an underlying cause and is preventable and treatable in most cases. Care teams must:
  - Remove or treat underlying cause(s) if it occurs
  - Restore or maintain function and mobility
  - Understand causes of behaviours of concern
  - Prevent delirium complications
- Engage older person's carer/s where possible in care
- Conduct orientation during at regular intervals by all members of the care team
  - For older people with dementia, consider gentle re-orientation or use of orienting cues; avoid repeated testing of orientation if the older person appears agitated
  - Establish a delirium prevention and management protocol that includes orientation
  - Identify person-centered environmental and personal approaches to orienting the older person
  - Consider unmet needs that may be a cause for delirium
  - Consider discharge planning in a hospital setting
  - Engage older people in cognitive stimulation activities and consider those with cognitive impairment as well as those who may require a high level of intellectual stimulation to keep their mind active
  - Consider plans for social interaction or social activities
  - Ensure that water and other individually preferred, non-caffeinated fluids are available at the bedside and accessible to the older person
  - Establish a delirium prevention and management protocol that includes oral hydration
  - Add straws to cups and water bottles for easier use by older persons

Geriatric Depression Scale (GDS): commonly used tool with people who have dementia, however most studies investigating the GDS have excluded participants with dementia

Cornell Scale for Depression: has been recommended for use with people in residential care (Sansoni et al, 2007), however training is required to use it

SQiD.pdf (deliriumnetwork.org)

Top5

National standards on cognitive Impairments

dementia.org.au

Identifying delirium – screening and assessment

Identifying and managing cognitive impairment (health.vic.gov.au)

Mobility

Aim: Optimise mobility, strength and balance, and prevent falls

Assess

- Assess mobility, strength, balance and falls risk with validated tools at admission and at regular intervals (at least weekly), and particularly after a fall or where there is a change in care needs
- All older people are at heightened falls risk. This risk increases further with dementia, delirium, balance problems, poor mobility, visual disturbance, multi-morbidity, polypharmacy, changed environment, poor footwear, and very old age
- All older persons at risk of falls in hospital should undergo a multifactorial assessment and intervention
- Ensure that any multifactorial assessment identifies the older person's individual risk factors for falling in hospital that can be treated, improved, or managed during their expected stay. These may include:
  - cognitive impairment
  - continence problems
  - falls history, including causes and consequences (such as injury and fear of falling)
  - footwear that is unsuitable or missing
  - health problems that may increase their risk of falling
  - medication
  - postural instability, mobility problems and/or balance problems
  - syncope syndrome
  - visual impairment

Act On / Key Action

Mobility

- Support ambulation where appropriate (may include activity-based mobilisation such as getting out of bed, leaving room for meals or incidental walks)
- Set and meet daily exercise, mobility, physical activity and falls prevention goals with each older person, considering multi-morbidity, diagnoses, aged and socio-cultural factors
- Encourage each person to walk as much as possible, and develop and implement personalised falls prevention, exercise and mobility plans and review these regularly

Falls Prevention

- Ensure that aspects of the older person’s environment (including flooring, lighting, furniture, and fittings such as hand holds) that could affect older persons' risk of falling are systematically identified and addressed

FOR INPATIENTS

Ensure that any multifactorial intervention:

- promptly addresses the older person's identified individual risk factors for falling in hospital and
- takes into account whether the risk factors can be treated, improved or managed during the older person's expected stay
- Mitigate falls risk by educating individuals and carers about falls risk and mitigation; remind to use the call-bell to avoid falls as needed (“Call Don’t Fall”); provide gait aids and assistive devices as needed; ensure a safe environment (including lighting, floor surface, rails, ramps, de-clutter etc); promote strengthening, regular exercise, mobility and physical activity; ensure use of glasses; ensure safe footwear; ensure supervision or assistance when mobilising if needed

Mobility

Tips	Resources
Mobility Assess and manage impairments that reduce mobility, for example: – Manage pain – Assess impairments in strength, balance, or gait – Remove catheters, IV lines, telemetry, and other tethering devices as soon as possible – Avoid restraints – Avoid sedatives and drugs that immobilise the older person – Ensure appropriate seating available – Assess for, and manage incontinence • Refer to physiotherapy; have physiotherapy interventions to help and improve balance, gait, strength, gait training, or an exercise program if needed. Engage wider care team in implementing safe and appropriate mobility with the older person (e.g., walking with older person to dining room if they require supervision) • Establish a delirium prevention and management protocol that includes mobility • Engage the older person and family or other caregivers directly by offering exercises that can be done independently or with family support (e.g., put appropriate exercises on a placemat that remains in the room) **Falls prevention** Promotion of regular and safe mobility needs to be managed in context of falls risk. Falls Risk Assessment Tools (FRATs) alone will not reduce rate of falls, merely the risk of falling. A comprehensive falls risk assessment and individualised mobility program with appropriate falls mitigation strategies is required for every older person	There are a number of useful tools and guidelines that will help to assess mobility, and inform appropriate management of mobility, balance impairment and falls risk **Additional Resources** Overview | Falls in older people: assessing risk and prevention | Guidance | NICE Johns Hopkins – Highest Level of Mobility (JH-HLM) Scale Performance-Oriented Mobility Assessment (POMA)1 Elderly Mobility Scale De Morton Mobility Index FIM BERG Assessment scale Tinetti test Give it a Go! Guide

[1] Tinetti ME. Performance-oriented assessment of mobility problems in elderly patients. J Am Geriatr Soc. 1986;34(2):119

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