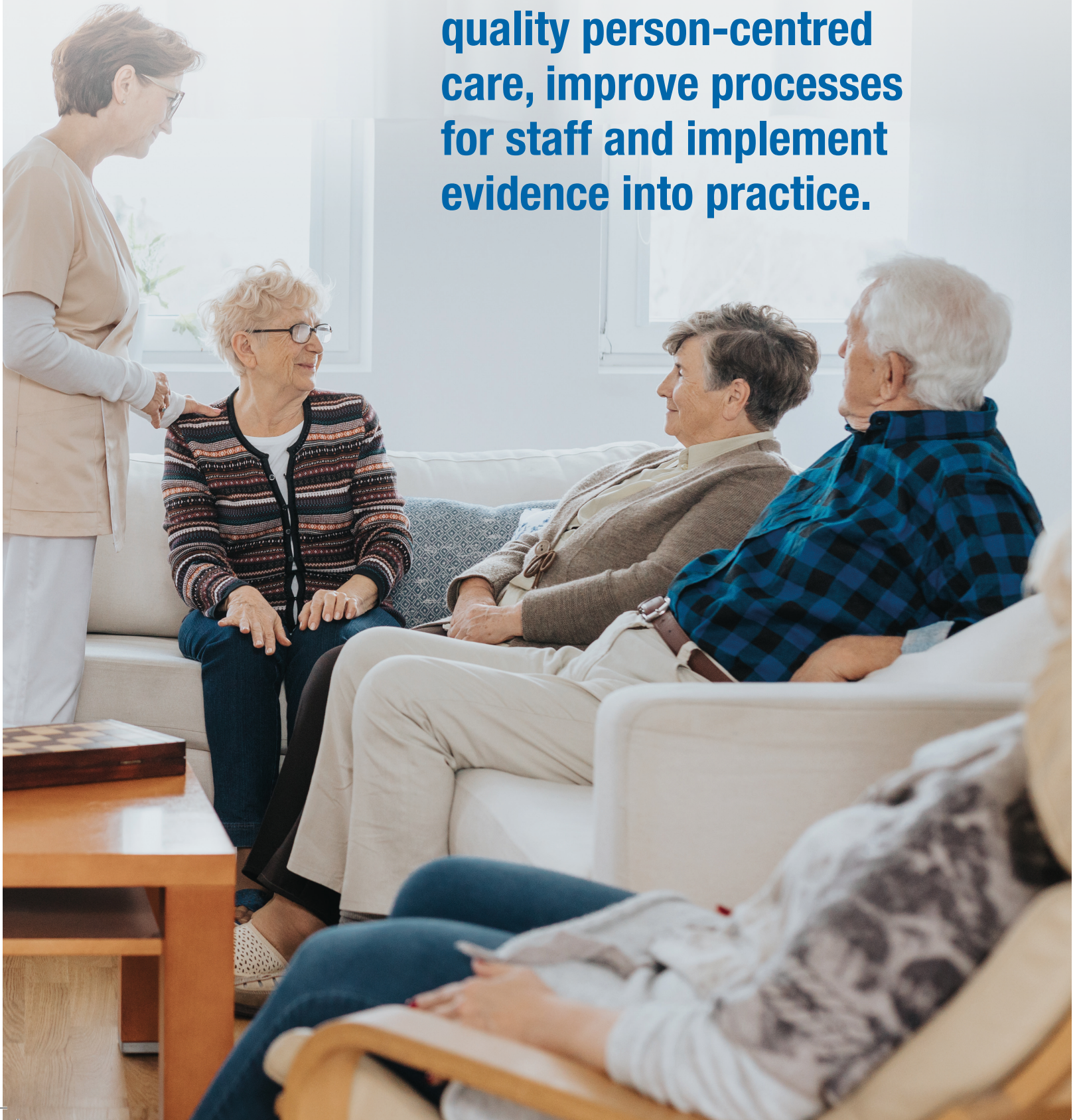


**Quality improvement
strengthens health
systems to deliver high
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Introduction

What is quality improvement?

Quality improvement strengthens health systems to deliver high quality person-centred care, improve processes for staff and implement evidence into practice. Quality improvement can lead to positive and meaningful change when teams collaborate throughout the quality improvement process, use data to inform their decisions and adopt an evidenced based approach to quality improvement.

What can we do?

The development of a Quality Improvement Collaborative (QIC) can support implementation of recommendations and guidelines in clinical practice. A Quality Improvement Collaborative brings together teams to learn, share, and implement evidence-based improvements, fostering sustainable change across sites. Quality Improvement Collaboratives have successfully been used in a range of different fields and settings to improve the quality of healthcare.¹⁻⁴

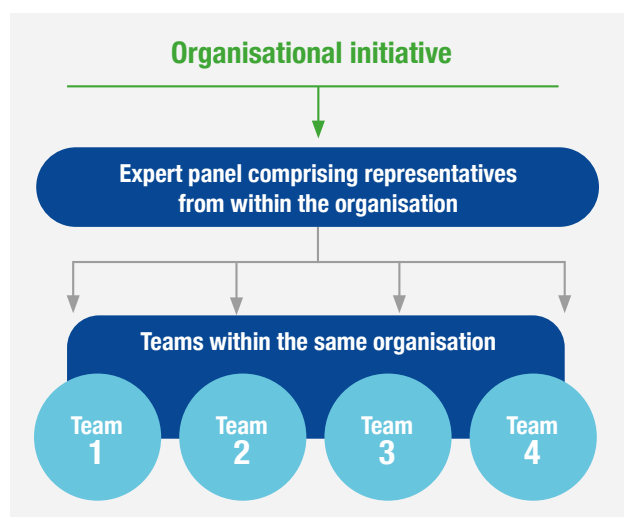
Who is involved?

A leadership group (called either a steering group or expert panel) is formed, comprising a mix of key stakeholders including management, people with expertise in quality improvement, multidisciplinary leaders and consumer representatives. The leadership group will be responsible for leading, coordinating, advising, supporting and evaluating the Quality Improvement Collaborative teams. Teams are responsible for developing individual implementation plans and making changes to clinical practice. They usually involve local managers and clinicians.

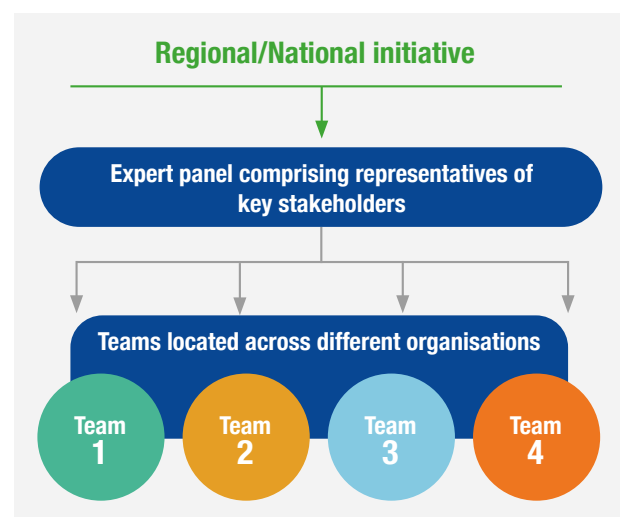
This guide can be used to establish a Quality Improvement Collaborative across a number of different settings and practice areas. For example, this guide could be used by:

- An aged care organisation who would like to lead quality improvement and assurance activities across multiple sites (Example A).
- A peak professional body or a health network who would like to bring teams from various sites and organisations together (Example B).

Example A: Within-organisation Quality Improvement Collaborative



Example B: Regional or National Quality Improvement Collaborative



The aim of this guide is to provide users with tools and simple steps they can take to support a Quality Improvement Collaborative.



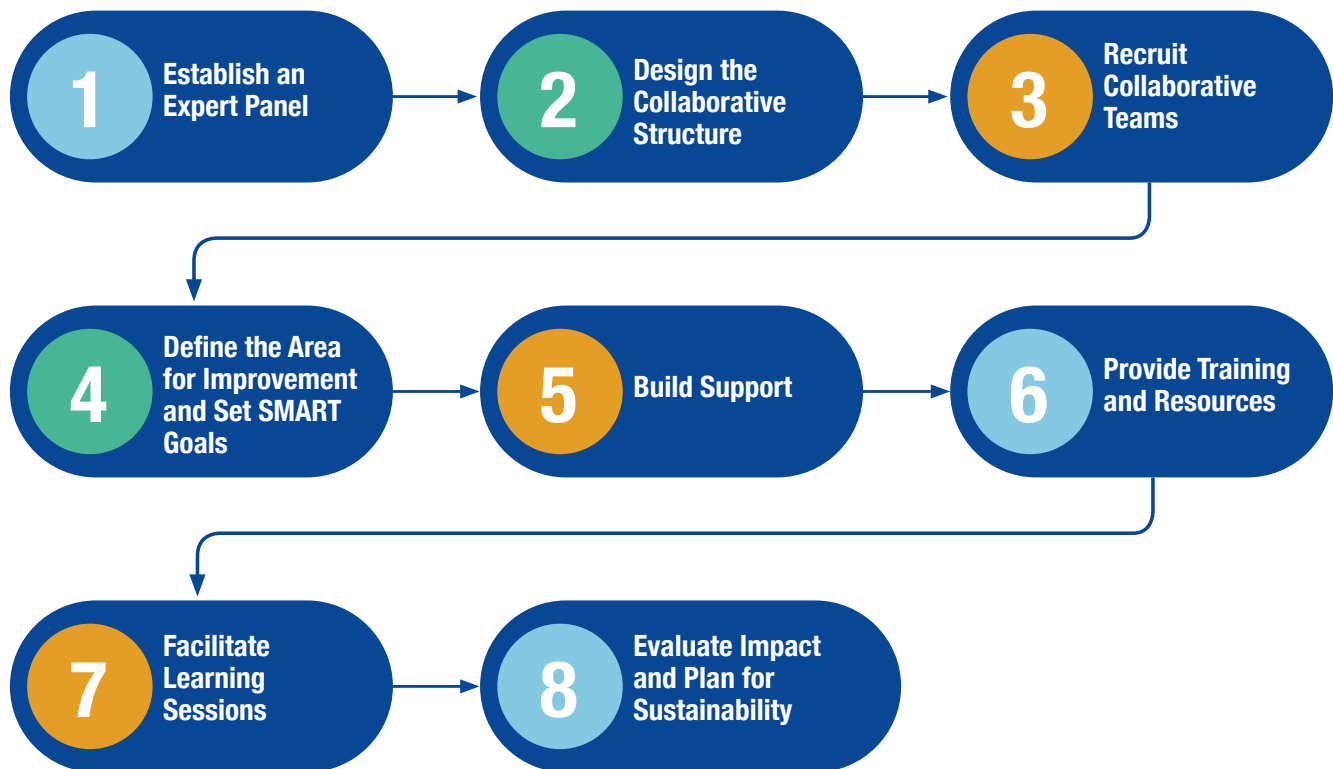
What is the aim of this guide?

The aim of this guide is to provide users with tools and simple steps they can take to support a Quality Improvement Collaborative.

The guide is designed to support managers and leaders who are seeking to improve medication management practices using an evidence-based approach.

The guide is informed based on real life case studies of implementing a Quality Improvement Collaborative to improve medication safety in the aged care sector enabling readers to learn from others.⁵

Overview of process



1

Establish an Expert Panel

Convene a group of key stakeholders who will oversee, guide and support the Quality Improvement Collaborative. This may include clinical experts, people with expertise in quality improvement, consumer representatives and influential leaders. The stakeholders will make up the composition of the Expert Panel (or you may prefer to use the term Steering Group).

Key Actions:

Have preliminary discussions about the area for improvement, its importance and how it might be measured.

2

Design the Collaborative Structure

Establish a clear framework for how the collaborative will operate. This includes deciding on the duration of the collaborative, timing of learning sessions, timing of action periods, communication methods and common measurements required.

Key Actions:

Use the guide in the table below to plan and document the design of your Quality Improvement Collaborative.

Element	General Guide	Your design
Duration	Typically 6–12 months	
Learning Sessions	Workshops every 2–3 months to share knowledge and progress	
Action Periods	Time between sessions for teams to test and implement changes	
Communication Channels	Online platform or email group for updates and peer support	
Measurement Framework	Define key, common indicators (e.g., error rates, resident satisfaction)	

3

Recruit Collaborative Teams

A Quality Improvement Collaborative typically involves multiple teams from different sites working on the area for improvement.

Key Actions:

1. Invite sites (e.g. residential aged care homes [RACHs] or regions) or organisations to participate.
2. Ensure each team includes a mix of roles who bring different knowledge and influence: e.g. nurses, care workers, pharmacists, and quality officers.
3. Clarify expectations: commitment to regular meetings, data collection, and testing changes.

Who are the key people who **definitely need** to be involved in each site team?

Who are some people who **could** be involved in each site team?

4

Define the Area for Improvement and Set SMART Goals

Convene the teams for the first time to discuss the area for improvement and set goals. It is important to be clear about the specific area for improvement you aim to address. Teams may be working together towards the same overall aim (e.g. improve medication safety) but have different SMART goals.

Key Actions:

1. Conduct a baseline audit of current practice (e.g., administration errors, polypharmacy, documentation gaps). This will help you measure the gap between current practice and best practice.
2. Define SMART goals (Specific, Measurable, Achievable, Realistic, Time-oriented). SMART goals are important because they turn intentions into actionable plans, and they will enable groups to measure their progress over time.



Case example

The Sunnyside Primary Health Network (PHN) identified that there were problems with medication management when patients were discharged from local hospital wards back to residential aged care homes. Medications were often changed during a hospital admission and there was not a consistent procedure in place to review these changes by the RACH healthcare team or visiting healthcare providers.

Baseline audit:

To help measure the area for improvement, the team reviewed the notes of 30 of their residents who had been discharged from hospital to the RACH in the last year. The RACH identified that they only received a timely discharge summary for 18 out of 30 residents who were discharged from hospital. This means important information at the transition of care may have been missed, increasing the risk of potential medication-related harm.

Goals:

The group set the following SMART goals:
To ensure 100% of residents receive discharge summaries at the point of discharge from hospital.

In your own organisation, describe your area for improvement here:

Explain why this is an area for improvement:

What is your overall aim of the Quality Improvement Collaborative? What do you hope to achieve?

What is your SMART goal?

5

Build Support

Strong leadership endorsement is critical for resourcing, staff engagement, and sustaining momentum.

Key Actions:

1. Ensure senior managers are aware of the area for improvement and need for change. Highlight the risks of not changing practice, link the area for improvement to relevant policies and standards that could be met.
2. Consider resources required to support teams to achieve change. The main resources are:
 - Time (for meetings, and time outside of meetings to advance the quality improvement work)
 - Additional resources (e.g. teams may require new training or new equipment)
 - Data support: may be required to access data or help analyse data

Describe the main resources that you require here:

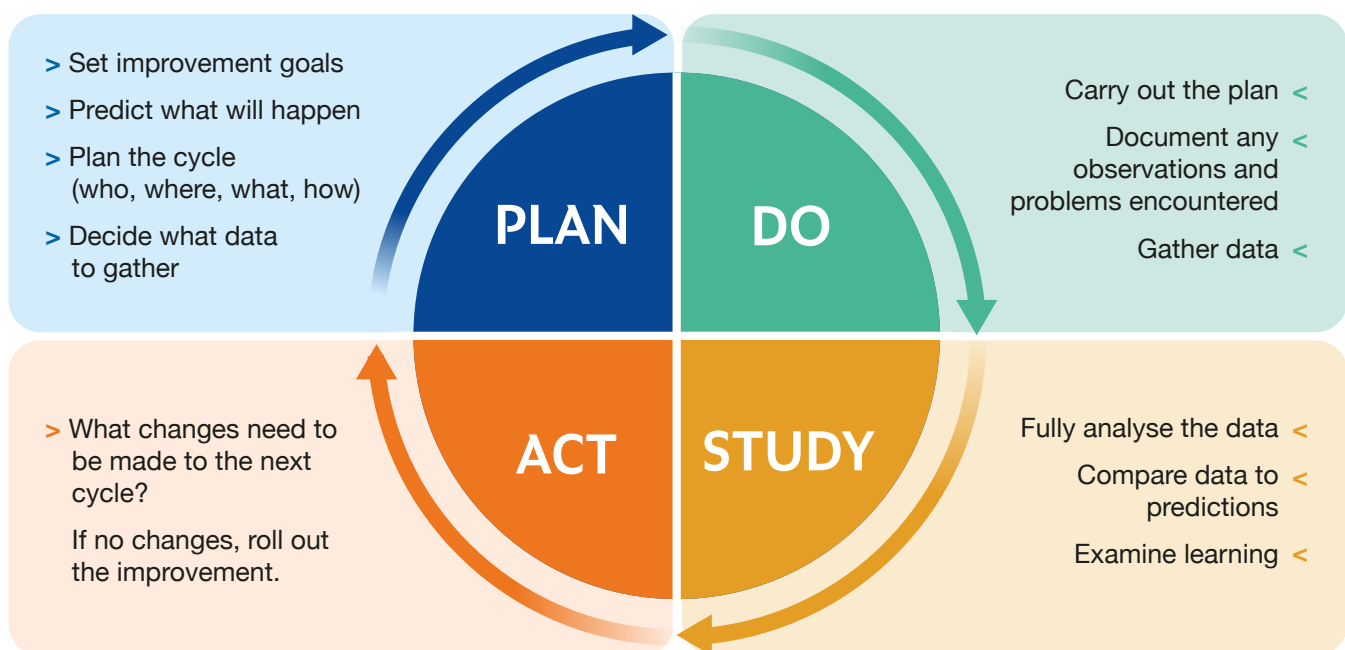
6

Provide Training and Resources

Equip teams with the knowledge and tools to succeed. The expert panel and teams will bring with them a range of expertise, but it is important to provide the teams with a framework which supports quality improvement.

One of the most common tools used to support quality improvement activities is the Plan-Do-Study-Act (PDSA) cycle as presented in the Figure below. The framework is designed to be used iteratively, meaning that each team may complete multiple PDSA cycles as part of their quality improvement work.

Plan-Do-Study-Act cycle



Key Actions:

1. Deliver training on quality improvement methods (e.g., PDSA cycles, root cause analysis). Training may be via workshops in person or online, existing online resources and courses (see resources listed at the end of this section). Ensure training is practical, informative and not too burdensome in terms of time commitment (e.g. no more than 2 hours).
2. Support teams with templates for data collection, run charts, and reporting.

7

Facilitate Learning Sessions

These sessions are the key to success; where teams learn, share, and reflect. At each session, a facilitator should discuss action and achievements to date, team progress including current challenges and successes, and next steps. The idea of the learning sessions is to support the teams to advance their quality improvement work. This may be through:

- Provide coaching and feedback to teams.
- Encourage documentation of tests and outcomes.
- Celebrate quick wins to build momentum.
- Include expert presentations, case studies, and peer sharing.
- Encourage open discussion of challenges and successes.

Key Actions:

1. Host in-person or virtual workshops every 2–3 months.
2. Facilitate groups to move through their quality improvement activities. Teams should be encouraged to test small changes using the PDSA cycle.
3. Consider de-identified data sharing – e.g. share monthly data from each of the sites on the agreed indicators. Use visual tools like run charts or dash boards. Share results across teams to highlight trends and inspire improvement.
4. Enable communication between sites in between learning sessions (e.g. online forums or messaging programs).

8

Evaluate Impact and Plan for Sustainability

As the Quality Improvement Collaborative concludes, assess its effectiveness and embed successful changes.

Key Actions:

1. Conduct a final evaluation: Were goals met? What changed?
2. Gather feedback from participants and other stakeholders.
3. Develop a sustainability plan.
4. Integrate successful practices into policies.
5. Continue data monitoring.

Important factors of quality improvement collaboratives

Factor	Why It Matters
Leadership Commitment	Drives engagement and resource allocation
Staff Involvement	Ensures practical, frontline-driven solutions
Data-Driven Decisions	Validates progress and guides adjustments
Peer Support	Builds morale and accelerates learning
Focused Scope	Prevents overwhelm and enables targeted improvements



CASE STUDY

Area for improvement:

The Eastern Rivers PHN meets regularly with stakeholders to understand local needs, challenges and potential areas for improvement. Aged care providers have identified that there are challenges in obtaining residents' vaccination status on admission. This is important to overcome as 1) it supports residents to have their vaccinations up to date to protect them from specific infectious diseases creating a safer environment for residents, families and staff, and 2) obtaining accurate vaccination status can be time consuming and frustrating for the resident, aged care organisation and general practitioners (GPs).

1. Establish Expert Panel

The PHN allocates a staff member (Sarah) to lead this initiative. Sarah forms an expert panel of key stakeholders including representatives from aged care organisations operating in the area, a nursing representative with quality improvement expertise, an aged care onsite pharmacist, an aged care GP, a local community pharmacist, an aged care nurse practitioner and two family members of people in residential care. The expert panel discuss how to address this issue. They decide the best way to reach the sites and bring about coordinated change is through a Quality Improvement Collaborative.

2. Design the Collaborative Structure

The expert panel decide to run the Quality Improvement Collaborative over 6 months and with three learning sessions. The desired outcome from the Collaborative will be increased ease and timely documentation of vaccination status on admission.

3. Recruit Collaborative Teams

The PHN and expert panel leverage their strong local networks to recruit aged care organisations, general practices, and pharmacies to participate. Each organisation forms a small team including a nurse from the aged care organisation, pharmacist and a representative from general practice (Practice Nurse or GP). Six teams across the region are formed.

4. Define the Area for Improvement and Set Goals

Collectively, the Quality Improvement Collaborative refine the problem statement:

“Vaccination status documentation on admission is often incomplete or delayed leading to increased risk for residents and frustration for providers.”

Each team undertakes an audit to identify the proportion of newly admitted residents who have their vaccination status documented on admission over the last 6 months. The Quality Improvement Collaborative decide to use the MEGA-MAC indicators to obtain this data in a structured and standardised way.

5. Build Support

Sarah and the expert panel engage executive leaders from aged care organisations and local health services to generate buy-in. They present the risks of poor vaccination status documentation on admission and the benefits of coordinated improvement. Consumer representatives share personal stories to highlight the human impact.

6. Provide Training and Resources

The PHN organises a training session for Collaborative Members on one of the most common quality improvement frameworks, the Plan-Do-Study-Act (PDSA) cycle. The PHN provides the groups with templates to document the PDSA process.

7. Facilitate Learning Sessions

During the first learning session, the Quality Improvement Collaborative discuss baseline data, current barriers and possible strategies to improve vaccination status documentation on admission. As a collective, the Quality Improvement Collaborative agree on measurable goals:

- To increase the percentage of newly admitted residents who have their influenza vaccination status documented within two weeks of admission to 80%,
- To increase the percentage of newly admitted residents who have their COVID-19 vaccination status documented within two weeks of admission to 80%.

One GP expressed,

“The RACH staff often rely on me. This can be time consuming when I am not familiar with the resident and I’m also balancing multiple other important responsibilities at the RACH”.

The group discuss strategies to overcome current barriers. One idea includes obtaining access to the Australian Immunisation Register (AIR) for quick access to up-to-date information. The group discuss how they could establish a new process at their RACHs and what they should consider.

During the second learning session, Collaborative Members share their early results and discuss barriers to improvement. One nurse explains,

“We organised nursing staff who complete admissions to have access to the AIR. But our MEGA-MAC indicator results around vaccination status haven’t improved. Our nursing staff identified that our admission form does not include a section about residents’ vaccination status. Thus, staff often forget to ask about vaccination status on admission.”

Other Collaborative Members share their experiences and strategies to updating admission forms and supporting uptake of the new process (e.g. education, reminder posters, alerts in the electronic system).

During the third learning session, Collaborative Members review their data, celebrate their successes, and plan for sustainability. The Collaborative Members expressed that the experience was incredibly valuable and that they would like to continue this model at the local PHN.

8. Evaluate Impact and Plan for Sustainability

At the end of the Collaborative, the PHN collects and analyses data from all participating organisations. Key outcomes include:

- 92% of residents had their influenza vaccination status documented on admission,
- 85% of residents had their COVID-19 vaccination status documented on admission

The expert panel develops a sustainability plan including embedding new processes into standard admission protocols, continuing peer learning via quarterly virtual check-ins and supporting consumer representatives to create a resident-friendly brochure that explains the importance of obtaining accurate vaccination histories and promotes ongoing engagement.

Based on positive Collaborative Member feedback, the PHN decided to meet with stakeholders to identify other quality improvement initiatives for their next quality improvement priority areas.

References

Resources to support quality improvement in health care

Institute for Healthcare Improvement: www.ihl.org/
World Health Organization, Improving the quality of health services: tools and resources: www.who.int/publications/i/item/9789241515085

Choosing Wisely Implementation Resources: [Choosing Wisely Quality Improvement Toolkit](#)

NSW Government Clinical Excellence Commission Quality Improvement Tools: [Quality Improvement Tools - Clinical Excellence Commission](#)

Relevant resources for medication management in aged care

[Strengthened aged care quality standards](#)

[National Medicines Policy](#)

[National Baseline report on Quality Use of Medicines and Medicines Safety – Phase 1: Residential aged care](#)

[Guiding Principles for Medication Management in Residential Aged Care Facilities](#)

[User Guide: Role of a Medication Advisory Committee](#)

[Audit tool and checklist for a Medication Advisory Committee](#)

[Monash University and NSW Therapeutics Advisory Group. Medication Management Indicators for Residential Aged Care Homes, 2025. Monash University and NSW TAG, Australia.](#)

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Further information

To read more about the MEGA-MAC quality improvement collaborative, please read the MEGA-MAC protocol⁵ or visit the [Monash University website](#).

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