

Context for learning from adverse events and consumer, family and whānau experience project

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In this presentation

- Provide an overview of the impetus for this project and activities to date
- What are the issues?
- What is the evidence?
- What outcomes do we want to achieve?





- Why?
- This is a challenging area
- There are opportunities to improve





Sector engagement with regional workshops held in 2017

- Processes
- Staff culture
- Communication
- Consumer and whānau voice





Evidence Review

- An overview of international approaches to learning from adverse events in MHA services and a selection of related tools and resources
- Recent evidence relating to learning from adverse events and consumer experience in MHA services

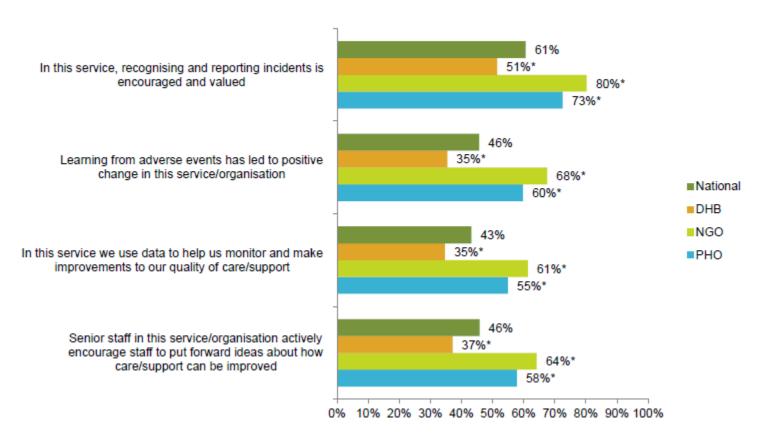


- Leadership Group made recommendations
- Increase learning from adverse events
- Minimise harm and maximise benefit
- Establish consistent processes
- Include in National Adverse Events report (within the framework of the NZ National Adverse Events Reporting Policy 2017)



Ngā Poutama: staff

Figure 5: Learning and changing the care and support provided – national, DHB, NGO and primary mental health care results





- March workshop for QMs, QIN
- Stocktake on what DHBs currently do
- Equity issues
- June workshop for MHA Leaders



HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND Kupu Tatengi Henra o Antearoa

Key themes from 21 March and 26 June workshops

What is the problem from your perspective?

- Inconsistent involvement and interpretation of consumer, family and whānau in adverse event processes
- Length of time of entire process
- Not enough trained investigators and lead reviewers
- Repetition with the same top five findings
- Differing methodology and level of investigation
- Lack of process to disseminate learning
- Multiple concurrent reporting requirements (i.e. DHB, HQSC, ACC, Coroner, HDC, Office of Director of MH)



Key themes from 21 March and 26 June workshops

What does good look like?

- Consumer, family and whānau (or representative) involved in a transparent and meaningful way
- Streamlined and timely adverse event processes
- Skilled staff familiar with adverse event management and investigation
- Recommendations are focused, succinct and result in improvements
- Shared learning across an organisation and sector
- Incident is matched to a review process that will deliver the best outcome for all involved
- Consumer, family and whānau represented on governance of process



Dr Arran Culver's paper

- Appraisal of the evidence
- Safety-I
- Safety-II
- Resilient Healthcare
- Charles Vincent





Outcomes

- What do we want to achieve?
- For consumers
- For whānau
- For staff
- For our communities





Learning from adverse events

Learning from adverse events and consumer, family and whanau experience project timeline Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau



Evidence review

Communications

Partnerships

Engagement

National engagement workshop for QMs, QIN

Wellington: 21 March 2019

- Setting the scene: why, what and how?
- Stocktake
- Mapping
- Learning from Adverse **Events Report and policy**

Assemble team. consumer and Māori engagement,

understand processes

Zoom coaching 18 April, 16 May, 20 June, 18 July, 15 Aug

National workshop for MHA leaders

Wellington: 26 June 2019

- Current state
- What do we know
- Learning from others
- Exploring how to move forward

Supra-regional workshop/QIN meeting

Auckland: 12 Sept 2019 Wellington: 13 Sept 2019

- Launch
- Co-design
- Opportunities for improvement
- Reduce variation

Co-designing change ideas. preparation for testing in

quality improvement

Zoom coaching 17 Oct 21 Nov

Supra-regional workshop/QIN meeting

Auckland: 11 Dec 2019 Wellington: 12 Dec 2019

- Co-design
- Develop change ideas ready for testing consistent with national guidelines

Preparatory and co-design phase to establish team, review current processes, consider opportunities for improvement

Prework



Develop framework and changes

Learning Session 1:

Auckland: Wed 12 Feb 2020 Christchurch: Thurs 13 Feb 2020

- Project charter
- System of profound knowledge
- Quality improvement tools
- Developing change ideas
- Data collection



Learning Session 2:

Via Zoom: Wed 6 May 2020 Time: 10.00am - 12.00pm

- Review of driver diagrams
- Plan-do-study-act cycles
- Measurement



Learning Session 3:

Wellington: Wed 29 July 2020



- Updating your theory
- Monitoring
- Sharing learning
- Spread and sustainability



Action period 2 Action period 3

Action period 1

Six-month quality improvement phase – testing, modifying and implementing change ideas

Learning from adverse events and consumer, family and whānau experience project teams

> **2019 MHA QIF** participants

Learning from adverse events and consumer, family and whanau experience project outcomes:

- Develop a suite of key outcome, balancing and process measures (provisionally by November 2019)
- Support DHBs to produce standardised, simplified processes and protocols for triaging, investigating, reporting, learning from and following up adverse events in MHA services aligned with the National Adverse Events Reporting Policy (by July 2020)



Thank you....Any questions

