Project close report

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

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Executive summary | He kupu whakarāpopoto

Te ako mai i ngā pamamaetanga me to wheako tangata whaiora me to whānau | Learning from adverse events and consumer, family and whānau experience was a priority area within the seven-year mental health and addiction (MHA) quality improvement programme coordinated by Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) that began in September 2019.

The purpose of the Learning from adverse events and consumer, family and whānau experience quality improvement project was to partner with former district health board (DHB)[1] teams in the MHA sector to look at ways to:

- improve the ability of organisations and the wider MHA sector to learn and heal from MHA adverse events[2]
- improve the experiences of consumers, family/whānau and staff involved in MHA adverse event reviews
- improve the safety culture for staff involved in MHA adverse event reviews.

There are improvement opportunities for MHA services when reviewing adverse events, particularly in terms of learning from events to improve future care. Reviews could be less variable in their quality, and processes could be simplified and shortened to reduce the risk of extending the harm experienced by those involved.

Preliminary workshops were held with the MHA sector in March and June 2019, after which, beginning in September 2019, multidisciplinary project teams were established in each DHB. All project teams completed a 4-month co-design phase and an 11-month (January–November 2020) quality improvement phase to test and implement evidence-based interventions. This work was supported by monthly videoconference coaching sessions. The project was extended by 6 months from July 2020 to November 2020 at the request of DHB project teams.

The availability of national data for this project was a challenge. A factor analysis was proposed that was dependent on outcomes of adverse event-related questions in the ‘Ngā

[1] This project was undertaken, and the report primarily written before the Pae Ora (Healthy Futures) Act 2022 came into force. As such, we refer to DHBs throughout for ease and consistency of reporting unless discussing results from specific health districts.

[2] An adverse event is ‘an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned (also referred to as ‘incident’ or ‘reportable event’). In practice this is most often understood as an event which results in harm or has the potential to result in harm to a consumer’. See page 7 of: Health Quality & Safety Commission. 2017. National Adverse Events Reporting Policy. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/learning-from-adverse-events-report-201617.

poutama oranga hinengaro: Quality in context in MHA services' staff survey,[3] repeated in May 2022, as well as the 'Ngā poutama: Consumer, family and whānau experience' survey.[4]

Unfortunately, the Ngā poutama consumer survey could not be repeated for technical reasons. This meant that a full data set was not available, and so the project was unable to progress this analysis.

Outcomes from the project include:

- release of a toolkit for triaging, reviewing and learning from adverse events in MHA services on 28 February 2022, aligned with the National Adverse Events Reporting Policy 2017
- increased co-design and quality improvement methodology capability in project teams.

Resources created as a result of the project include:

- a toolkit to assist DHBs and their non-governmental partners in triaging, reviewing and learning from adverse events in the MHA sector.
    - Mental health and addiction Severity Assessment Code (SAC) examples 2021–22
    - Always Report and Review list 2021–22
    - Overview of MHA adverse event review methods, types and approaches
    - Principles for engaging consumers and whānau in mental health and addiction adverse event reviews
    - Reporting and reviewing adverse events involving consumers of mental health and addiction services.
- two videos illustrating the lived experiences of consumers, family and whānau of the MHA adverse event review process
    - Anne-Marie Douglas shares her experience of mental health challenges that led to a review process
    - Nicola Peeperkoorn explores her family's experience of the MHA event review process.
- Lessons learned and top tips from provider project teams capturing the most important learning from project activities.

From November 2020, the project began a gradual transition to DHBs, with some support from the MHA quality improvement programme continuing until October 2022. This included:

- providing support to project teams on conducting adverse event reviews differently, including templates and tools, as outputs from the time-limited working group established as part of this project

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[3] Health Quality & Safety Commission. 2018. *Ngā Poutama Oranga Hinengaro: Quality in context survey of mental health and addiction services. National report*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/national-and-technical-reports-nga-poutama-oranga-hinengaro-quality-in-context-survey-of-mental-health-and-addiction-services.

[4] Health Quality & Safety Commission. July 2020. *National report for the Ngā Poutama survey for consumers of mental health and addiction (MHA) services, their families and whānau*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/national-and-technical-reports-nga-poutama-consumer-family-and-whanau-experience-survey.

- engaging in an extensive endorsement process for the working group outputs
- working with a small number of project teams, in partnership with the Te Ngāpara Centre for Restorative Practice, Victoria University of Wellington team, to explore the restorative practice approach further as a second phase of this project.
- providing MHA-focused adverse event education, in partnership with the Adverse Events Learning Programme team at Te Tāhū Hauora, introducing the Learning Review methodology
- undertaking quarterly networking sessions via Zoom to enable project teams to share successes and challenges
- coordinating an end-of-project event for project teams to be held on 20 October 2021 in Auckland for Northern and Midland regions and on 21 October 2021 in Wellington for Central and South Island regions. This was cancelled because of COVID restrictions, and, at the request of project teams, they completed an end-of-project storyboard in lieu of an in-person or online event.

Second phase of the project

Evidence is increasingly showing that restorative responses (restorative practice and hohou te rongo[5]) have the potential to improve learning from adverse events and better meet the needs of consumers, whānau and staff. In response to this, a second phase of this project focused on developing training opportunities in restorative responses (restorative practice and hohou te rongo) for a smaller number of self-selected DHB project teams.

In partnership with subject matter experts from Te Ngāpara Centre for Restorative Practice Victoria University of Wellington, three 1-day in-person learning sessions on restorative responses were planned to be delivered over a 9- to 12-month period starting in May 2021.

The training content was co-designed and based on evidence of what worked from the surgical mesh project,[6] as well as the findings from a semi-structured interview study with 21 key MHA stakeholders, including managers, clinicians, academic leaders, consumers and whānau, conducted as part of the business case for the second phase of this project. The study explored the stakeholders' perceptions of the MHA adverse events review process and the perceived benefits and limitations of using a restorative practice approach. The training introduced the principles of restorative responses within the health care context and developed capability in restorative practice.

Outcomes from the second phase of the project:

- As of March 2023, Te Tāhū Hauora has sponsored 60 people from the MHA sector to attend the Restorative Foundations and Restorative Responses micro-credential courses offered by Te Ngāpara. Another 40 have been sponsored and are scheduled to complete by December 2023. The learning from adverse events and consumer, family and whānau experience project, with support from Te Tāhū Hauora leadership and capability and

[5] Restorative practice is an approach to mitigating and responding to harm that is grounded in relational principles that uphold human dignity. See the section 'Second phase of project (2021/22) – focus on restorative responses | Wāhanga 2 o te kaupapa (2021/22) mahi haumanu' for further explanation.

[6] Wailling J, Marshall C, Wilkinson J. 2019. *Hearing and responding to the stories of survivors of surgical mesh: Ngā kōrero a ngā mōrehu – he urupare (A report for the Ministry of Health).* Wellington: The Diana Unwin Chair in Restorative Justice, Victoria University of Wellington.

systems safety programmes, has provided the foundations for significant capability and capacity building in this area within the MHA sector.

- Some of the DHB project teams shared their experiences at the 'Using restorative approaches to heal, learn and improve after harm' national hui (meeting) held on 28 March 2023 to disseminate learning from their involvement with the second phase of the project and support the ongoing growth in this area.

The work undertaken as part of this project was consistent with the National Adverse Events Reporting Policy 2017, which has recently been reviewed. The updated 'Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023',[7] effective 1 July 2023, now includes restorative responses as a principle. Additionally, the Te Tāhū Hauora system safety and capability programme is continuing to support capability building in restorative responses in the MHA sector.

The Learning from adverse events and consumer, family and whānau experience project has now been successfully transitioned to DHBs. As agreed by the MHA leadership group, this project is now closed.

Context | Te horopaki

The national mental health and addiction (MHA) quality improvement programme is a Te Tāhū Hauora initiative, funded and supported by district health boards (DHBs).[8] It is a 7-year programme that began in July 2017 and will run to June 2024. The programme uses an evidence-based approach, which includes identifying and testing different ways of improving health services, to enable people to receive high-quality, safe and equitable care and support.

The MHA quality improvement programme aims to:

- improve the experiences consumers and their families and whānau have with MHA services, resulting in better health
- reduce variability in the access to, and quality of, MHA services so that consumers receive the same high-quality care, no matter who or where they are
- build skills and a culture of quality improvement leadership in the MHA sector workforce and strengthen leadership
- share learning across service providers and encourage quality improvement and safety
- measure the impact and effectiveness of quality improvement initiatives.

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[7] Health Quality & Safety Commission. 2023. Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/national-adverse-event-policy-2023.

[8] This project was undertaken and the report primarily written before the Pae Ora (Healthy Futures) Act 2022 came into force. As such, we refer to DHBs throughout for ease and consistency of reporting.

The work of the programme is spread across five priorities:

- Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion: Safety and dignity for all
- Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga | Connecting care: Improving service transitions
- Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumer, family and whānau experience
- Te whakanui ake i te hauora ā-tinana | Maximising physical health
- Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing.

Te Tiriti o Waitangi responsibilities guide the programme. This means an integral part of the programme is to form strong partnerships with Māori, upholding the articles and principles of Te Tiriti. These two elements – articles and principles – are contained in the Treaty of Waitangi Health Equity Framework[9] developed under the guidance of the MHA quality improvement programme's Māori advisory group, Te Hiringa Kounga Māori.

The framework initiates the bicultural service approach, accurate collection and analysis of inequity data, co-designed care decisions – including consumers, families and whānau – and the science of the Institute for Healthcare Improvement's quality improvement methodology to test intervention effectiveness and deliver safe, effective health outcomes.

For further information, see the MHA quality improvement programme overview on the Te Tāhū Hauora website: www.hqsc.govt.nz/our-work/mental-health-and-addiction-quality-improvement.

Overview of the Learning from adverse events and consumer, family and whānau experience project | He tiro whānui o te ako i ngā pāmamaetanga me te kaupapa wheako tāngata whaiora me te whānau

Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumer, family and whānau experience is one of the five priority areas of the MHA quality improvement programme.

[9] The MHA quality improvement programme's Te Hiringa Kounga Māori advisory group developed the Treaty of Waitangi Equity Framework in 2019. It supports project teams' use of the bicultural approach, integrating holistic Māori and Western expertise and technologies and quality improvement methodology in co-designing service improvements for all consumers, families and whānau.

The purpose was to partner with former DHB teams in the MHA sector to look at ways to:

- improve the ability of organisations and the wider MHA sector to learn and heal from MHA adverse events[10]
- improve the experience of consumers, family/whānau and staff involved in MHA adverse event reviews
- improve the safety culture for staff involved in MHA adverse event reviews.

Background

An effective quality and safety culture at all levels of a health care system is fundamental to improving the experience of health care consumers and their families and whānau and ultimately achieving better outcomes. Nevertheless, as in many complex industries, a degree of harm in health care remains a persistent problem. The World Health Organization estimates that one in ten consumers, and by extension their families and whānau, will experience harm resulting from health care, a rate that has remained static for around 25 years.[11] However, what differentiates organisations, positively or negatively, is how they respond to an event that causes harm, balancing the needs of the consumer, whānau, health care staff and the organisation.[12,13]

As many as one in five New Zealanders experience mental illness or addiction each year, with between 50 and 80 percent living with a mental health or addiction condition at some stage in their lifetime[14] – this estimate being largely consistent with approximations of the burden of mental illness internationally.[15] Between 1 July 2019 and 30 June 2020, 218 adverse events in MHA services were reported to Te Tāhū Hauora.[16]

However, the current ways in which MHA services conduct adverse event reviews do not appear to be improving care or meeting the needs of those most affected. The quality of these reviews varies, and the harm can be extended by multiple, lengthy processes for all

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[10] Health Quality & Safety Commission. 2017. National Adverse Events Reporting Policy. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/learning-from-adverse-events-report-201617.

[11] World Health Organization. 2019. Patient safety. Geneva: WHO. URL: https://www.who.int/news-room/fact-sheets/detail/patient-safety.

[12] Braithwaite J. 2018. Changing how we think about healthcare improvement. *BMJ* 361: k2014.

[13] O'Connor E, Coates H, Yardley I, et al. 2010. Disclosure of patient safety incidents: A comprehensive review. *International Journal for Quality in Health Care* 22(5): 371–9.

[14] Oakley Browne MA, Wells JE, Scott KM (eds). 2006. *Te rau hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health. URL: https://www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey.

[15] Vigo D, Thornicroft G, Atun R. 2016. Estimating the true global burden of mental illness. *The Lancet. Psychiatry* 3(2): 171–8.

[16] Health Quality & Safety Commission. 2022. National summary of adverse events reported to the Health Quality & Safety Commission 1 July 2019 to 30 June 2020. URL: www.hqsc.govt.nz/resources/resource-library/national-summary-of-adverse-events-reported-to-the-health-quality-and-safety-commission-1-july-2019-to-30-june-2020.

those involved. Consumers, whānau and staff reflect these same concerns, along with a need for better openness and inclusion in the adverse event review process.[17,18,19,20]

At preliminary workshops held on 21 March and 26 June 2019 for this project, feedback from MHA sector leaders on MHA adverse event review processes identified there is currently:

- limited learning and lack of processes to disseminate learning
- inconsistent involvement of consumers and whānau
- concern that the process may perpetuate or increase harm (particularly to whānau and staff) rather than address harm.

In August 2018, a baseline national survey, 'Ngā poutama oranga hinengaro: Quality in context in MHA services',[21] conducted for the MHA quality improvement programme and coordinated by Te Tāhū Hauora, found that only 35 percent of MHA staff[22] in DHBs reported that learning from adverse events had led to positive change in their organisation (see Figure 1).This MHA staff survey was repeated in June 2022, but there was little change in this result at 36 percent.[23]

[17] Dekker S. 2013. *Second victim: Error, guilt, trauma, and resilience.* Boca Raton, FL: CRC Press.

[18] Paterson R, Durie M, Disley B, et al. 2018. *He Ara Oranga: Report of the government inquiry into mental health and addiction.* Wellington: New Zealand Government. URL: mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga.

[19] Moore J, Mello M. 2017. Improving reconciliation following medical injury: a qualitative study of responses to patient safety incidents in New Zealand. *British Medical Journal of Quality & Safety* 26(10): 788–98.

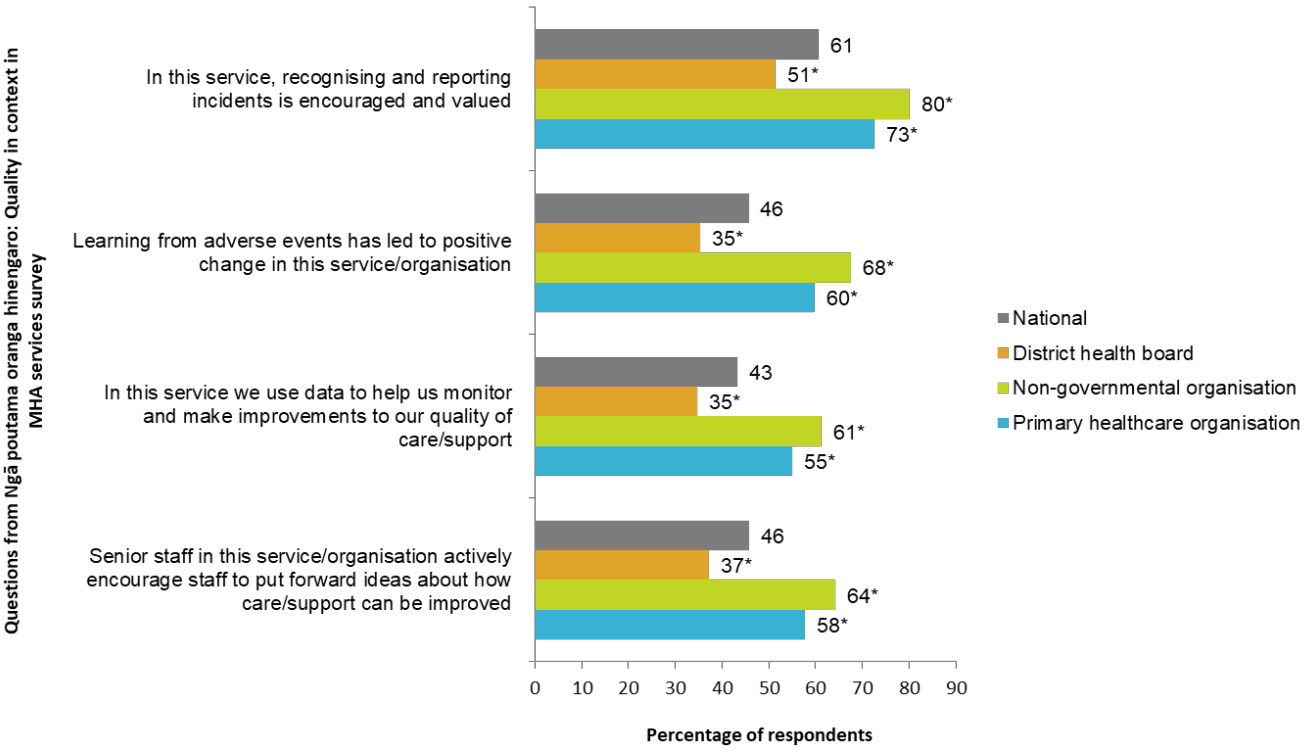
[20] Health and Disability Commissioner. 2019. *Complaints to the Health and Disability Commissioner involving District Health Boards: Report and analysis for the period 1 January to 30 June 2019.* Wellington: Health and Disability Commissioner. URL: www.hdc.org.nz/our-work/research/complaints-to-hdc-involving-dhbs-january-june-2019.

[21] Health Quality & Safety Commission 2018, *op.cit*.

[22] For the purpose of the survey, staff includes doctor, nurse, occupational health, support worker, manager in DHB inpatient services and community services.

[23] Health Quality & Safety Commission. 2023. *Ngā Poutama Oranga Hinengaro: Quality in context survey of mental health and addiction services national report*. Wellington: Health Quality & Safety Commission.

Figure 1: Learning and changing the care and support provided – national DHB, non-governmental organisation and primary mental health care results[18]



*Statistically significant difference compared with national result.

In November 2019, a national baseline survey, 'Ngā poutama: Consumer, family and whānau experience',[24] conducted for the MHA quality improvement programme and coordinated by Te Tāhū Hauora, asked consumers and family/whānau about any harm they had experienced as a result of care and support received in MHA services. In total, 267 respondents people responded, an estimated response rate of 3.3 percent. Some respondents indicated that aspects of their care/support were harmful. The most common type of harm experienced was emotional or psychological harm (59 people; 22 percent). People who reported harm had a less positive experience across most survey questions.

Similarly, common issues identified by the Health and Disability Commissioner's office on assessment of consumer complaints about MHA services included inadequate communication with family and whānau and failure to communicate openly, honestly and effectively with health care consumers.[25] The recent review of Aotearoa New Zealand's

[24] Health Quality & Safety Commission July 2020, *op.cit*.

[25] Health and Disability Commissioner. 2018. *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner.* Wellington: Health and Disability Commissioner. URL: www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf.

Health and Disability system also found that many consumers experience the health system as complicated and fragmented and that consumers want to be seen and listened to.[26]

There are improvement opportunities for MHA services when reviewing adverse events, particularly in terms of learning from events to improve future care. The quality of reviews could vary less, and processes could be simplified and shortened to reduce the risk of extending the harm experienced by those involved.

Methods

Co-design

Co-design is an important part of a process to identify a challenge or opportunity to engage consumers, families, whānau, staff and other stakeholders to:

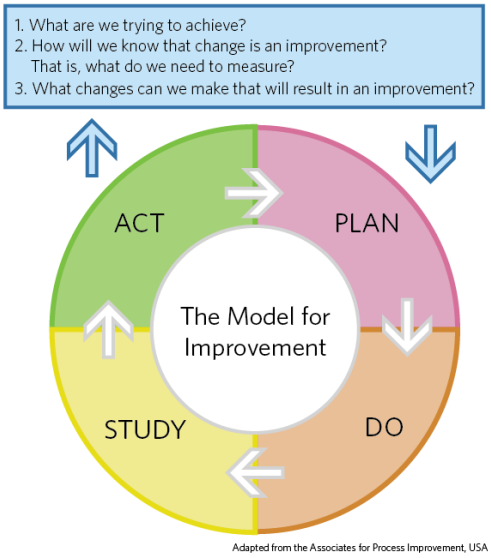
- capture their experiences and ideas
- organise the learning they bring to create new understanding and insight from their perspective of the care journey and their emotional journey
- continue together in partnership to review learning and ideas
- plan and implement improvements
- review what difference that change has made.

The Model for Improvement

The Model for Improvement provides a framework to structure improvement efforts.[27] The model is based on three key questions, known as the thinking components:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

These questions are then used in conjunction with small-scale testing of ideas for change. The 'doing' component is known as the plan–do–study–act (PDSA) cycle.



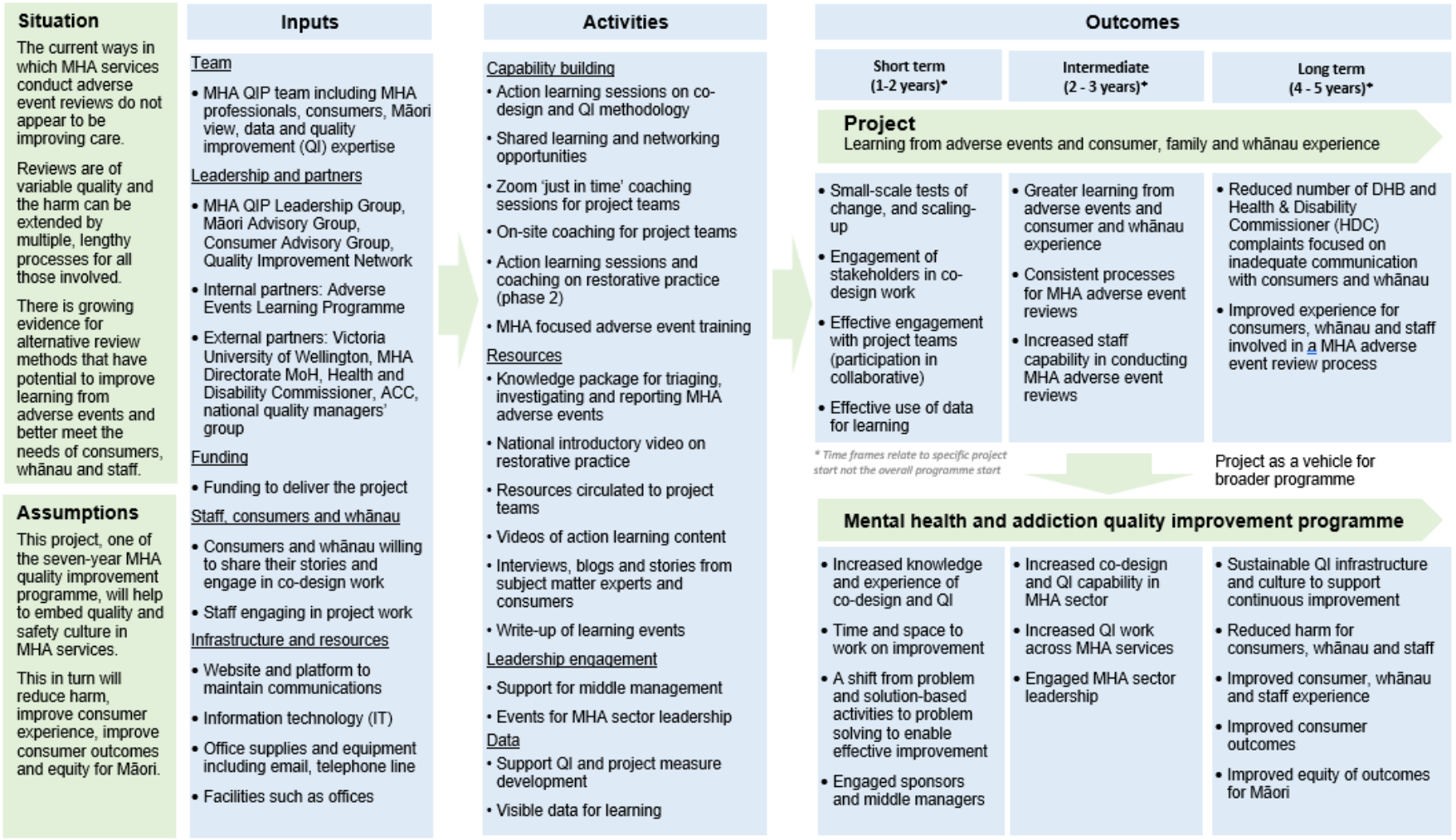
[26] Health and Disability System Review. 2019. *Health and Disability System Review – Interim Report. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā.* Wellington: HDSR. URL: www.health.govt.nz/publication/health-and-disability-system-review-interim-report.

[27] Langley GJ, Moen RD, Nolan KM, et al. 2009. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed). San Francisco: Jossey-Bass. (Chapter 5: Using the model for improvement, pp 89–108).

Figure 2: Learning from adverse events and consumer, family and whānau experience logic model

Project aim: The Health Quality & Safety Commission team will partner with district health board (DHB) teams in the mental health and addiction (MHA) sector to:

(1) improve the ability of organisations and the wider MHA sector to learn from MHA adverse events; (2) improve the experience of consumer and whānau involved in MHA adverse event reviews; and (3) improve the safety culture for staff involved in MHA adverse event reviews.



Project timeline

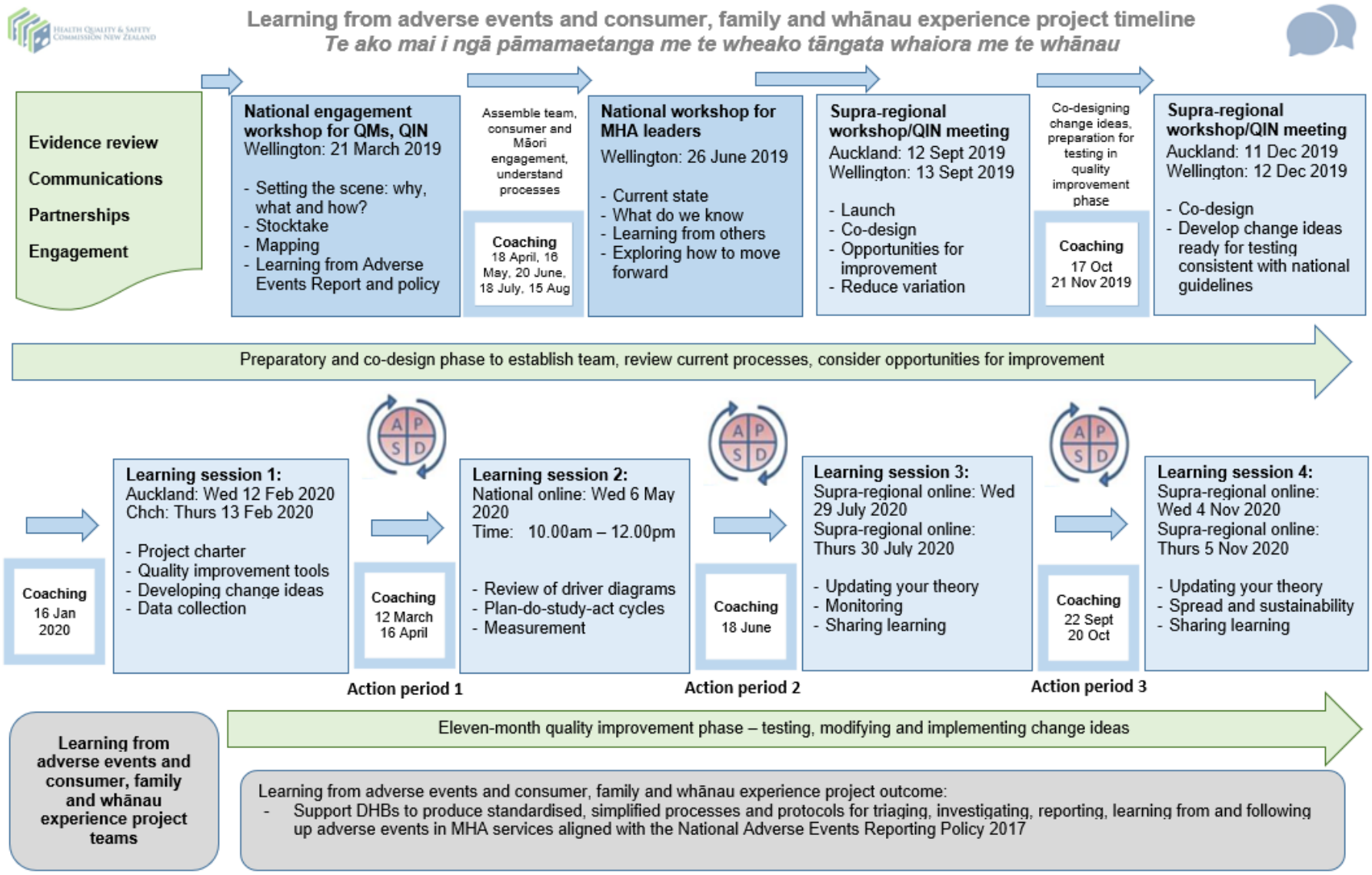
The project was initially proposed as a national 9-month DHB-led quality improvement project for the period September 2019 to July 2020, with preliminary workshops held with the MHA sector in March and June 2019.

Many of the project teams were to be led by graduates of the MHA quality improvement facilitator course or by quality managers familiar with quality improvement. Therefore, this project comprised a shorter, focused 4-month co-design phase to hear from consumers, whānau and staff on their experience of the MHA adverse events review process about what is working well and what could be improved and a 6-month quality improvement phase to test and implement change ideas.

As part of the learning session and collaborative model used in this project, the MHA quality improvement programme team provided DHB teams with information to help with the start-up of their project, including establishing their project team (see Appendix 1). They also provided tools to support their co-design and quality improvement phases.

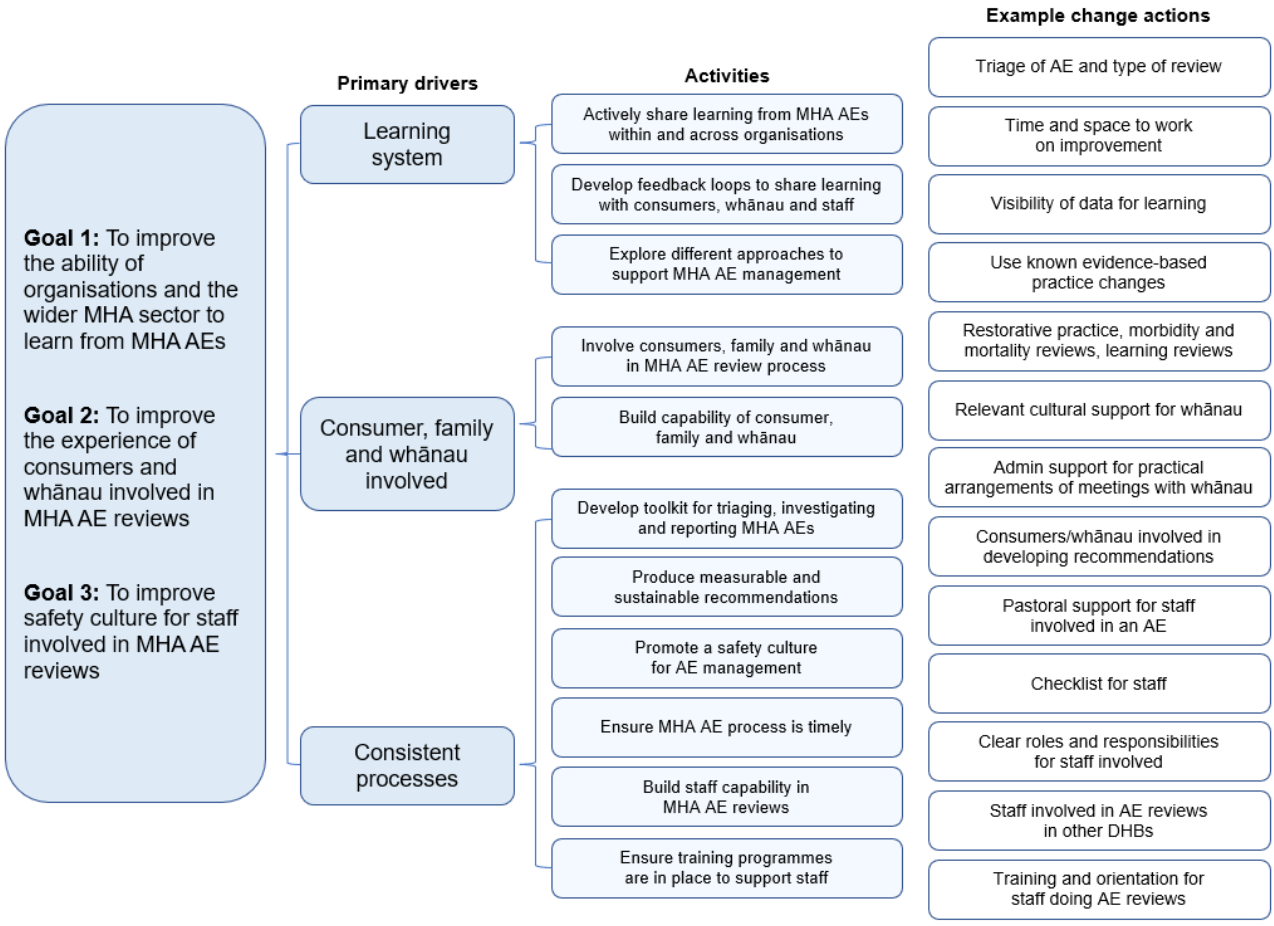
The timeline in Figure 3 outlines the project approach, which included two co-design workshops and three supra-regional learning sessions supported by monthly Zoom coaching, sharing and keeping in touch with progress sessions. The co-design workshops and learning sessions were held in person. DHB project teams completed and presented a storyboard outlining their progress at each event.

Figure 3: Learning from adverse events and consumer, family and whānau experience project timeline



The MHA quality improvement programme team developed a project theory for the project (see Figure 4). In consultation, the programme team and the project teams agreed that the project teams would focus their improvement and testing of change ideas on the 'learning system' and 'consumer, family and whānau involved' primary drivers, and the programme team would concentrate on the 'consistent processes' primary driver.

Figure 4: Learning from adverse events and consumer, family and whānau experience project theory



Learning session two took place on 6 May and was attended by 15 DHB project teams. The information provided by project teams on their storyboard and leading up to the proposed final learning session three on 29/30 July clearly indicated that most project teams were not ready to finish their project.

In May 2020, as a follow-up to learning session two, the MHA quality improvement programme team sent project team leads a project self-assessment scale (see Appendix 2), which uses a scale from 0 to 6, where 0 indicates intent to participate and 6 indicates outstanding sustainable improvement. Project leads were asked to complete the scale and associated questions (see Table 1) with their team and sponsor to indicate their project's

progress and whether they would have completed[28] their project by learning session three at the end of July 2020.

Table 1: Project team questions

1	Where is your team currently at with your Learning from adverse events and consumer, family and whānau experience project? Project self-assessment scale score (0–6 scale)
2	By Learning from adverse events and consumer, family and whānau experience learning session three on 29/30 July 2020, will your team have completed your project (ie, finished PDSA cycles, implemented your change, have evidence of improved outcomes)?
3	If you will not have completed your project by 29/30 July, what would you/your team like covered on the agenda of learning session three to help you continue to make progress?
4	Will information on scale-up and spread at learning session three be useful and timely?
5	If you will not have completed your project by 29/30 July, what ongoing support from the MHA quality improvement programme team after learning session three will be helpful (ie, monthly online coaching sessions, DHB project team coaching sessions, face-to-face events where possible) so your project continues to make progress?

Nine DHB project teams indicated that would not have completed their project (ie, completed PDSA cycles, implemented changes, have evidence of improved outcomes) by the July learning session. Teams assessed themselves on the scale as being more at the stages of '2.0: project planning progressing' and '3.0: activity and some change'. Project teams also indicated they would like further in-person learning events to hear from other DHB project teams.

The MHA quality improvement programme team decided to extend the project timeline for 4 months and hold a further supra-regional learning event on 4/5 November 2020, supported by 6-weekly coaching, sharing and keeping in touch with progress sessions via Zoom.

In response to travel restrictions in place due to COVID-19, learning session three on 29/30 July was held online and attended by 16 DHB project teams.

After learning session three, the MHA quality improvement programme team sent the usual post-event evaluations to all participants, asking what worked well and what could be improved, and sent a survey to project team leads and sponsors seeking their feedback on the ongoing support for this project to the end of 2020 (see Table 2).

[28] 'Completing' a project was defined as '5.0: Significant improvement' or greater on the project self-assessment scale as advised by the Chief Advisor Quality & Safety, Te Tāhū Hauora.

Table 2: Survey questions and responses after learning session three

	Survey questions	Response from 12 DHB project teams
1	Would you like support from the mental health and addiction (MHA) quality improvement programme team for the Learning from adverse events and consumer, family and whānau experience project extended to the end of this year?	Yes (all)
2	If you would like the support extended to the end of the year, would you like to meet again with other project teams for learning session four around November 2020?	Yes (all)
3	If you would like the support extended, would you like this to include six-weekly online coaching, sharing and keeping in touch with progress sessions between learning session three and learning session four?	Yes (10) No (2)
4	Would you like to continue having online or in-person Learning from adverse events and consumer, family and whānau experience project learning sessions?	Online (6) In-person (6)
5	Is your project team interested in exploring the restorative practice approach in 2021 (as a second phase of this project and subject to organisational approval)? Due to the nature of the restorative practice training workshop approach limiting numbers of participants, the three one-day learning session model will be available to approximately four DHB project teams in 2021/22.	Yes (8)

A total of 17 DHB project teams attended learning session four on 4/5 November 2020, after which they were again sent the project self-assessment scale to self-assess their progress with their project team and sponsor (Table 3).

Table 3: Survey questions and responses after learning session four

	Survey questions	Response from 16 DHB project leads/teams
1	We are looking to close the national Learning from adverse events and consumer, family and whānau experience project this year. Have you/your project team completed* your Learning from adverse events and consumer, family and whānau experience project? We recommend you discuss this with your project sponsor. **Completed defined as 5.0 or greater on project self-assessment scale*.	Completed project (2) Not completed project (14)
2	If you have not completed your project, will you require any support from the national MHA quality improvement programme team to do this?	Support requested from those not completed project (5 DHBs) No ongoing support required (9)
3	If you require support from the national MHA quality improvement programme team to complete your project, for how long and what should the support consist of? We recommend you discuss this with your project sponsor.	Support requested included: - networking opportunities - celebration in 9 months - conducting adverse event reviews differently - templates and tools - learning from other areas, improvement processes - leadership and ideas around how to conduct reviews differently - national leadership around the role of adverse event reviews in external investigations (adverse event reviews are intended to be used for learning and improvement).

Feedback from 16 DHBs indicated that two had completed their project. Most of those who had not completed their project responded that they did not require any ongoing support from the national MHA quality improvement programme team to do so.

Five DHB project teams requested support, which would largely be addressed by working group outputs and other planned activities as outlined in the transition section of this paper. Nine project teams did not request ongoing support, with responses including:

> Thanks for all your support. This project has identified many areas of improvement for us as a service and has provided great guidance on how to do this.

> We think that we have a strong methodology and organisational commitment and will be able to continue with the project without support.

Measures

The challenge with Learning from adverse events and consumer, family and whānau experience outcome measures

Establishing consistent, feasible, timely and meaningful measures for complex change programmes is a challenge experienced across the health sector, not just for this project. This challenge applies particularly to projects that cross multiple services and where evidence of the impact of changes only emerges sometime after the process change occurs.

For the Learning from adverse events and consumer, family and whānau experience project, outcomes were not clearly defined and proved difficult to measure. The project goals, as outlined on the driver diagram – to improve learning, experiences, and safety cultures – are all latent, hidden variables that are difficult to observe, and no direct measurement of the constructs was possible. Proxy measures[29] were considered, but – again – there were no clear indirect measures.

Instead, the Te Tāhū Hauora Health Quality Intelligence team investigated an alternative factor analysis[30] for this project, and this was presented to project teams for discussion at learning sessions three and four.

The proposed factor analysis was to take data from three sources, with 17 possible indicators as proxies for these three improvement outcomes (see Appendix 3 for information on data sources). None of the indicators were perfect, but all were potentially relevant. Ideally, some new sources of data collection would be established, but this was not feasible as it would have been time-consuming and expensive.

The factor analysis was also dependent on outcomes of adverse event-related questions in the 'Ngā poutama oranga hinengaro: Quality in context in MHA services' staff survey,[31] repeated in May 2022,[32] as well as the 'Ngā poutama: Consumer, family and whānau experience' survey.[33] Unfortunately, the Ngā poutama consumer survey could not be repeated for technical reasons. This meant that a full data set was not available and so the project was unable to progress this analysis.

However, DHB project teams also developed their own outcome, process and balancing measures and tracked these at a local level. Descriptions and examples of these measures as chosen by local project teams are as follows:

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29 A proxy indirectly measures what we are aiming to improve.

30 Factor analysis is a powerful data-reduction technique that enables researchers to investigate concepts that cannot easily be measured directly. By boiling down a large number of variables into a handful of comprehensible underlying factors, factor analysis results in easy-to-understand, actionable data. See: Factor analysis 101: The basics [blog]. URL: www.alchemer.com/resources/blog/factor-analysis (accessed 26 January 2023).

31 Health Quality & Safety Commission 2018, *op.cit.*

32 Health Quality & Safety Commission 2023, *op.cit*.

33 Health Quality & Safety Commission 2020, *op.cit.*

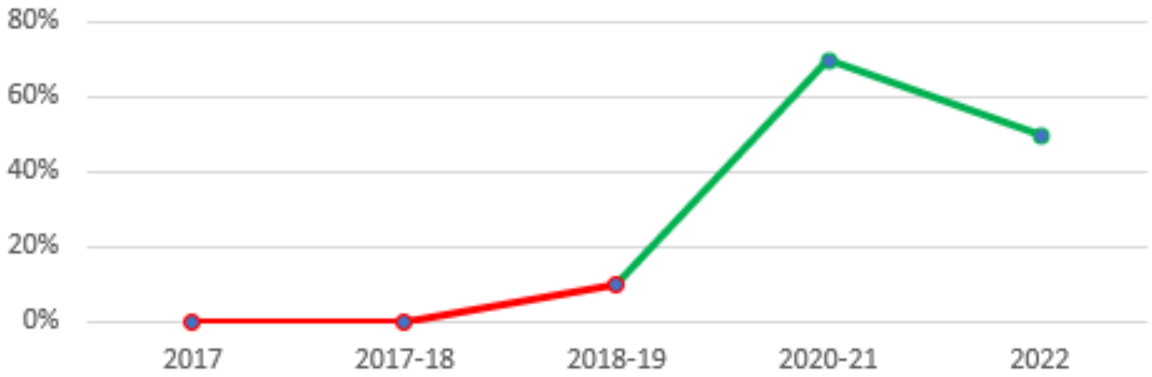
- **Outcome** measures are what the project is aiming to achieve – what is the system performance?
    - Local example: 80 percent of people involved in a serious adverse event investigation will be satisfied with the quality of the contact, reporting outcome and recommendation for quality improvement
- **Process** measures assess steps in a process that lead to the expected outcomes of a project.
    - Local example: 80 percent of consumers, whānau and family are engaged in the process of a completed adverse event review
    - Local example: family/whānau liaison person identified and makes contact within 7 days (target 100 percent within 7 days)
- **Balancing** measures monitor unintended consequences – are changes to improve one part of the system adversely affecting other parts of the system?
    - local example: time to complete severity assessment code (SAC) 1 and SAC 2 event reviews with Adverse Event Brief: Part B form sent to Te Tāhū Hauora increased.

Results

Local project teams reported improvements such as:

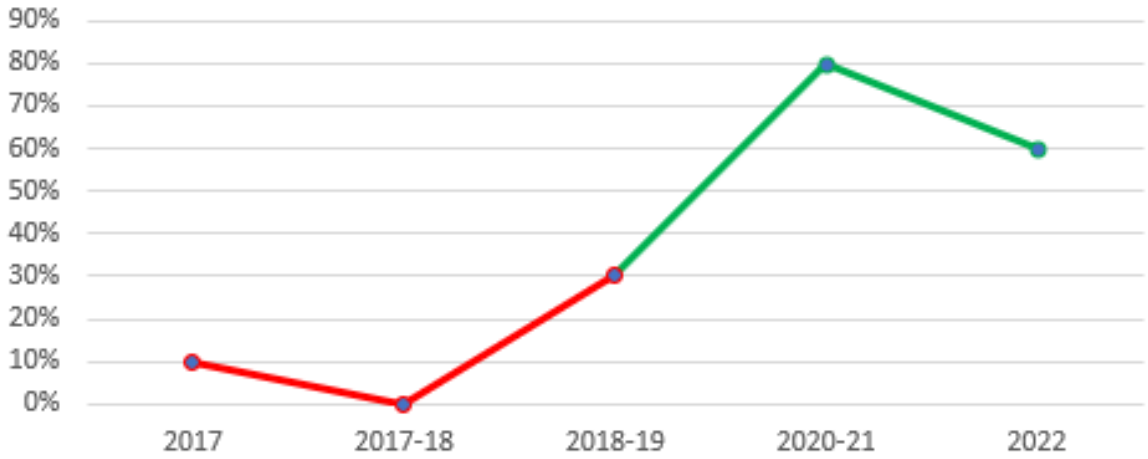
- increased staff knowledge and skills in adverse event investigation and management
- established process for the identification, notification, triage and investigation of adverse events
- improved and refined investigation report framework, with improved articulation of the events, findings and opportunities for service improvement
- established framework for the involvement of both consumers and family/whānau perspectives in the management and investigation of adverse events
- established endorsement/sign-off process that transitions the adverse event management from investigation to implementation of recommendations and is family/whānau inclusive
- increased family and whānau engagement and inclusion in the adverse event review process
- improved adverse event review team, including a consumer perspective (see Figure 5).
- improved adverse event review team, including a family/whānau perspective (see Figure 6).

Figure 5: Adverse event review team including a consumer perspective



Source: Hauora a Toi/ Bay of Plenty, Mental Health and Addiction services, with permission to publish.

Figure 6: Adverse event review team including a family/whānau perspective

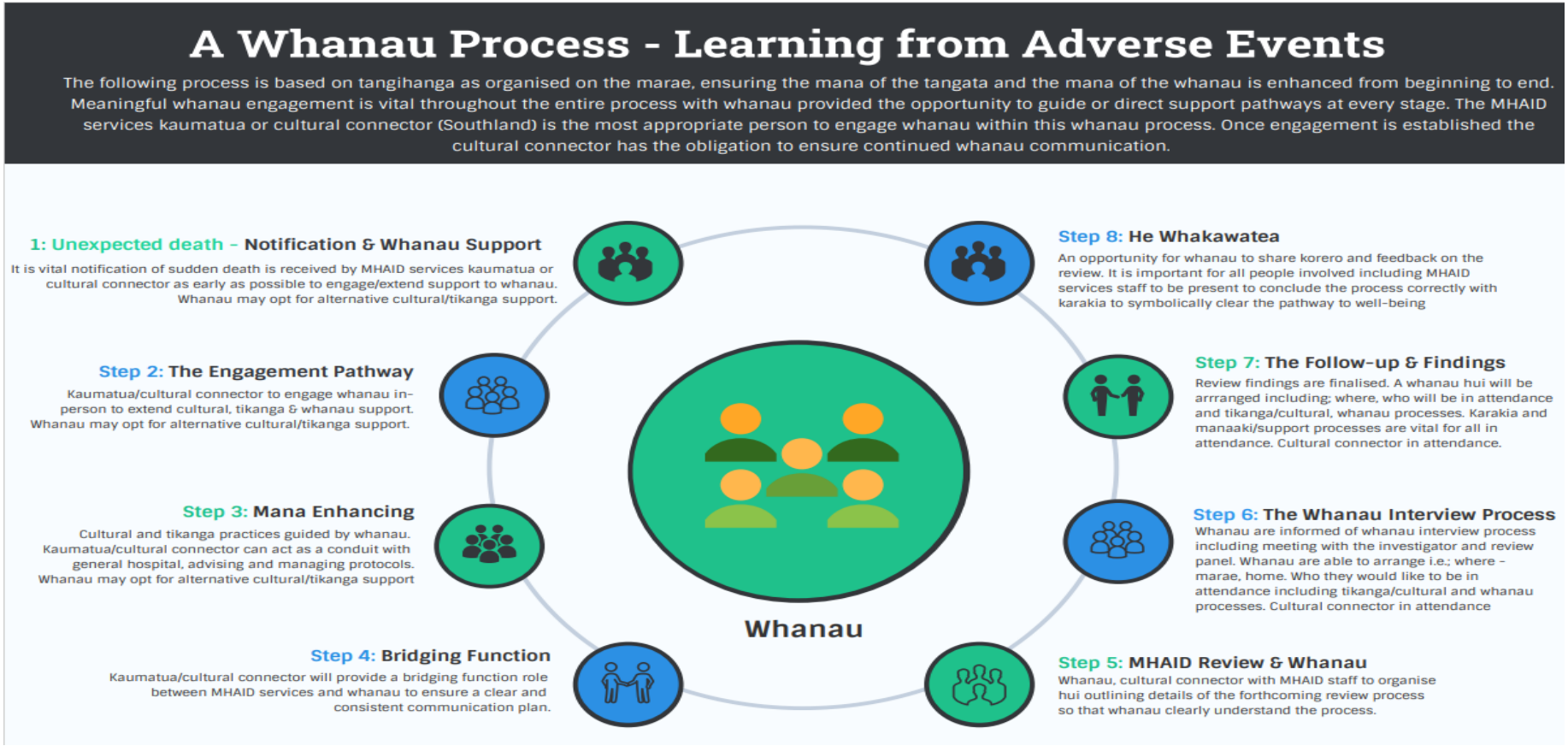


Source: Hauora a Toi/ Bay of Plenty, Mental Health and Addiction services, with permission to publish.

Project teams also shared how they had considered and addressed equity issues as part of their project. These included improvement activities such as:

- kaumātua included in adverse events review groups
- kaumātua might lead whānau liaison
- bereavement pack developed in partnership with Māori
- Asian mental health cultural support for bereaved family
- kaumātua to consult with adverse event review investigator(s)
- whānau involved in feedback from reviews prior to finalisation
- cultural supports developed for the process of review
- skilled cultural and whānau advisors included to support change ideas and implementation of new processes
- service cultural connector who is obliged to ensure continued communication with whānau nominated
- whānau process developed to support whānau engagement in the adverse event review process (see Figure 7).

Figure 7: Whānau process developed to support whānau engagement in the adverse event review process



Source: Reproduced with permission from Te Whatu Ora – Southern Specialist Mental Health and Intellectual Disability Services (Otago), with acknowledgment to Daniel Raniera Tawaroa – Pou Tātaki/Māori equity lead.

Transition to DHBs

Each project on the MHA quality improvement programme has a transition point, which is when the active support from the Te Tāhū Hauora MHA quality improvement programme team decreases.

Once active support decreases, a project is then transitioned to the DHB. The DHB will continue to consolidate the learning gained and embed the improvements into regular practices.

The Learning from adverse events and consumer, family and whānau experience project has been transitioning to DHBs since November 2020. Ongoing support from the MHA quality improvement programme team during this period included the following.

- The project working group outputs addressed some of the support requested by project teams about conducting adverse event reviews differently, including providing templates and tools (eg, SAC examples for MHA, review methodologies and guidance for consumers participating in MHA adverse event review process).
- The project continued with the second phase, working with four DHB project teams focused on exploring the restorative practice approach further.
- An MHA-focused adverse events training was held in March 2021, and repeated in May and December 2022, to introduce the learning review methodology. This training addressed some of the support requested by project teams asking for information about how to conduct adverse event reviews differently.
- MHA quality improvement programme team members were available to provide support to project teams on a case-by-case basis.
- Developed two videos illustrating a consumer's and a family/whānau lived experience during an adverse event process, which is a resource for project teams. This is part of the 'pono' consumer video series of the MHA programme for the different projects.
- Two such videos were produced:
    - Anne-Marie Douglas shares her experience of mental health challenges that led to a review process
    - Nicola Peeperkoorn explores her family's experience of the MHA event review process.
- Compilation of this end-of-project report to summarise the most important learning from the project.

Ongoing work | Te mahi o āpōpō

Some teams have completed their Learning from adverse events and consumer, family and whānau experience project and moved the team resource elsewhere. However, many continue to work on aspects of their project to reach their aim and integrate activities into the operating model of the service as an ongoing area of continuous improvement. Examples of this ongoing work include:

- continuing to monitor and refine changes to serious event review processes and the recommendations register

- communicating with and providing education to staff around serious adverse events and how they are rated
- improving the timeframe in which completed adverse event review reports are sent to Te Tāhū Hauora, within 70 working days
- exploring the possibility of restorative practice training or learning reviews
- providing training to investigators
- stating clear expectations for each review undertaken, eg, triage review, file review
- auditing that every serious adverse event recommendation is implemented and evaluated with follow-up with the consumer/whānau and shared for learning purposes.

Summary of lessons learned and top tips | Ngā mea i ako me ngā whakaaro rangatira

What follows is a summary of some of the top learning tips and examples that DHB project teams have offered from their Learning from adverse events and consumer, family and whānau experience project activities (September 2019 to November 2020). The examples are a summary of what the teams shared.

TIP: Involve the consumer, family and whānau in the review process

Te Whatu Ora – Hauora a Toi Bay of Plenty

- conduct adverse events management with the involvement of consumer and family/whānau representatives from start to finish.

Te Whatu Ora – Lakes

- whānau involvement in reviews has led to their involvement in driving change in the service.

Te Whatu Ora – Te Tai Tokerau

- engaging with whānau regarding participation and review findings promotes healing.
- acknowledgement of the person and their affiliations within adverse event reports has been highly valued by whānau.

Te Whatu Ora – South Canterbury

- whānau are now invited and supported to be a part of the [adverse event review] process; feedback from whānau is that they feel heard and able to partner in the process of investigation and seeking learning.
- whānau are supported by the crisis team or the Family Service in the initial period of grief; an information/support pack is readily available to all who have been impacted by the sudden death.

Te Whatu Ora – Southern

- it is important to gather information from families/whānau in person as they can provide valuable insight into the person's journey.

Te Whatu Ora – West Coast

- consumers are being given the opportunity to provide a patient story to be recorded regarding their experience

- all consumers are given the draft report to comment on or provide further information.

TIP: Involve staff in the review process

Te Whatu Ora – South Canterbury

- staff within the service are invited and supported to be a part of the [adverse event review] process, and this has helped to see the opportunities for learning without blame.

Te Whatu Ora – Southern

- staff need to feel supported following an adverse event and to know what is expected of them during a review.
- Investigators need dedicated time to complete their reports.
- being 'SMARTER' (specific, meaningful, achievable, relevant, time-bound, evaluate, readjust)[34] with recommendations and improvements in the completed reports has meant teams are more engaged in implementing any learning.

Te Whatu Ora – Waitematā

- have increased support for staff, recognising harm to staff and providing safety for staff involved.

TIP: Use good communication

Te Whatu Ora – Te Toka Tumai Auckland

- good communication is essential; you can't over-communicate.

Te Whatu Ora – Hauora A Toi Bay of Plenty

- communication with all affected – statutory organisations, health care staff, service users and family/whānau – is vital, albeit time consuming and challenging.

Te Whatu Ora – Southern

- learning bulletins are sent out to the teams from any service with recommendations and learning.

TIP: Keep processes clear and consistent

Te Whatu Ora – Te Toka Tumai Auckland

- having clear, documented processes available to everyone has been useful in achieving more consistent review processes.

Te Whatu Ora – Hauora A Toi Bay of Plenty

- establish a service framework and processes to ensure consistent and professional management of adverse event reviews.
- ensure all adverse events review processes have:
  - terms of reference, with named investigators
  - consumer, family/whānau and cultural perspectives in the investigation team
  - a structured report format that includes a timeline and relevant contributing factors
  - opportunities for service improvement (recommendations)

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[34] Kanaat R. Wanderlust worker. Setting S.M.A.R.T.E.R. goals: 7 steps to achieving any goal [blogpost]. URL: www.wanderlustworker.com/setting-s-m-a-r-t-e-r-goals-7-steps-to-achieving-any-goal.

- opportunities for clinical staff and family/whānau to contribute to the review and recommendations.

For more information, see: Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau | Learning from adverse events and consumer, family and whānau experience.

Second phase of project (2021/22) – focus on restorative responses | Wāhanga 2 o te kaupapa (2021/22) mahi haumanu

The evidence that restorative responses (restorative practice and hohou te rongo) have the potential to improve learning from adverse events and better meet the needs of consumers, whānau and staff is growing.

Restorative practice is an approach to mitigating and responding to harm that is grounded in relational principles that uphold human dignity. It is a voluntary, relational process where ideally all those affected by an adverse event come together, with the help of skilled facilitators, to speak about what happened and its impact on their lives, to clarify accountability for the harm experienced and to resolve together how best to promote repair and positive changes for all involved.[35,36,37,38]

Hohou te rongo is peace-making from a te ao Māori world view, and it is a kawa.[39] There are other local terms, including 'hohou to rongopai', 'houhou rongo' and 'hohou te rongo'. This kawa exists widely throughout Aotearoa New Zealand, and tikanga (practice) varies from iwi to iwi and from hapū to hapū.[40] A restorative response seeks to balance healing, learning, and improving by asking the following questions:

- what happened
- how were people affected
- what needs and obligations exist
- how can any harms be repaired

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[35] Turner K, Sveticic J, Grice D, et al. 2022. Restorative just culture significantly improves stakeholder inclusion, second victim experiences and quality of recommendations in incident responses. *Journal of Hospital Administration 11*(2): 8–17. doi:10.5430/jha.v11n2p8.

[36] Wailling J, Wilkinson J, Marshall C. 2020. *Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh. Kia ora te tangata: He arotakenga i te whakahaumanu.* Wellington: The Diana Unwin Chair in Restorative Justice, Victoria University of Wellington.

[37] Mannat J, De Boer R, Oates A, et al. 2019. *Restorative Just Culture: A study of the practical and economic effects of implementing restorative justice in an NHS trust.* Paper presented at the International Cross-industry Safety Conference – European STAMP Workshop & Conference 2018.

[38] Marshall C. 2019. Justice as care. *International Journal of Restorative Justice* 2(2): 175–85.

[39] Kawa is the collective and agreed values, principles and protocols that connect whānau, hapū, iwi and Māori communities. See: The National Collaborative for Restorative Initiatives in Health. 2023. *He maungarongo ki ngā iwi: Envisioning a Restorative Health System in Aotearoa New Zealand*. Wellington: The National Collaborative for Restorative Initiatives in Health.

[40] *Ibid.*

- what support is required to ensure a positive outcome
- how can the situation be prevented from happening again.

Given the potential for restorative responses, the tentative evidence for its use and the perceived interest from project groups, the project leads and their sponsors were asked whether they and their teams/organisations were interested in progressing with a second phase of the project to explore the restorative practice approach further in 2021.

The approach to the second phase was detailed in a business case presented to and approved by the MHA quality improvement programme leadership group in May 2020.

In partnership with subject matter experts from Te Ngāpara Centre for Restorative Practice Victoria University of Wellington (Te Ngāpara), three 1-day in-person learning sessions on restorative responses were planned to be delivered over a 9- to 12-month period starting in May 2021 (Figure 8).

The training content was co-designed and based on evidence of what worked from the surgical mesh project,[41] as well as the findings from a semi-structured interview study with 21 key MHA stakeholders, including managers, clinicians, academic leaders, consumers and whānau, conducted as part of the business case. The study explored the stakeholders' perceptions of the MHA adverse events review process and the perceived benefits and limitations of using a restorative practice approach. The training introduced the principles of restorative responses within the health care context and developed capability in restorative practice.

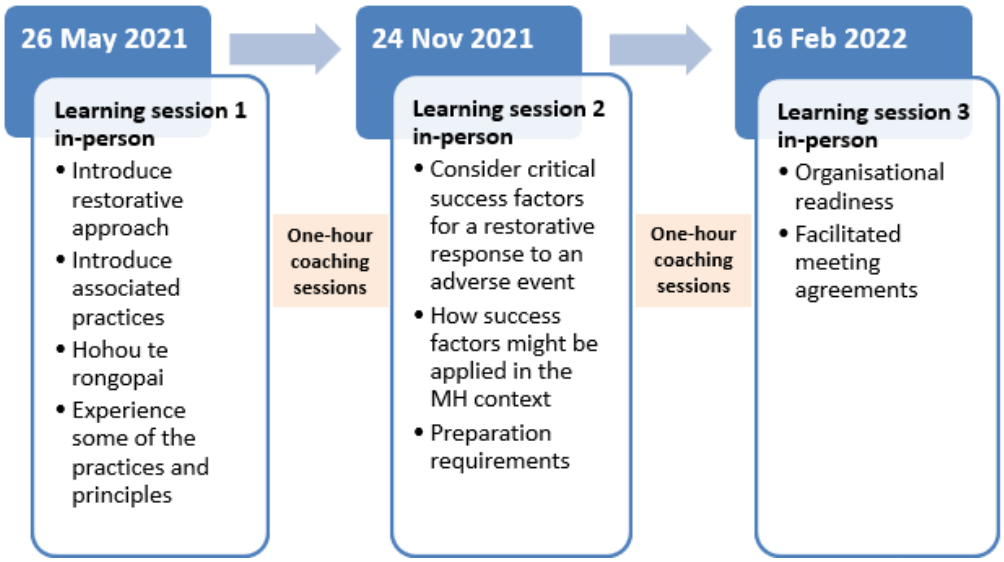
In between the in-person learning events, DHB project teams were offered regular online coaching sessions with experienced restorative practitioners, supported by reading material to enhance learning.

The nature of the workshop approach limited the numbers of participants, so these in-person workshops were available to approximately four DHB project teams in 2021/22.

Te Ngāpara and Stella Maris productions, in consultation with several health sector and Māori partners, developed the film Pou hihiri, Pou o te aroha | Healing and learning from harm that was released on September 2021. It features consumers, clinicians and researchers talking about the benefits of following a restorative approach after a harmful event occurs in health care. Restorative practice and hohou te rongo are described; both provide a response that recognises people are hurt and their relationships affected. The film was co-funded by Te Tāhū Hauora, the Accident Compensation Corporation (ACC) and Te Ngāpara.

[41] Wailling J 2019, *Op.cit.*

Figure 8: Proposed timeline for second phase of project



Eight DHBs expressed interest in progressing with the second phase of the project. The following four DHBs took part: Auckland, Nelson Marlborough, Northland and Waitematā.

What actually happened

- Learning session one went ahead in person on 26 May 2021.
- Learning session two was scheduled as an in-person event for 1 September 2021. The COVID-19 outbreak and associated lockdowns led to it being postponed four times and eventually cancelled on 9 March 2022.
- Instead, additional coaching sessions were provided to project teams. One-hour online coaching sessions were held per project team on 23 June, 7 July and 8 July 2021 and then again on 12 and 13 October 2021. Some of these focused on exploring a community suicide case through a restorative frame (restorative practice and hohou te rongo) because many of the teams had indicated this was a particular area of interest.
- Over this time, the restorative practice micro-credential courses offered by Te Ngāpara were formalised and are now seen as the way forward for anyone wanting to further their knowledge and experience in restorative responses.
- In place of learning session three, the MHA quality improvement programme sponsored the four DHB project teams who had taken part in the second phase (20 places, cohort 1) to complete the two micro-credential courses for the Health & Disability sector – Restorative foundations and Restorative Responses[42] – which began on 17 May 2022 and finished on 17 August 2022.
- As of March 2023, Te Tāhū Hauora has sponsored 60 people from the MHA sector to attend the micro-credential courses, and 40 more have been sponsored and are expected to complete by December 2023. The Learning from adverse events and consumer, family and whānau experience project, with support from the Te Tāhū Hauora leadership and

[42] The National Collaborative for Restorative Initiatives in Health 2023, *op.cit.* (Appendix 2).

capability and systems safety programmes, has provided the foundations for significant capability and capacity building in this area within the MHA sector.

- A wrap-up meeting to close the project was held with the four project teams on 25 October 2022.
- Each project team completed an end-of-project storyboard that included information on:
  - which of the practice principles and practices tested worked
  - what didn't work and why
  - plans for next steps with restorative practice in the service/organisation
  - learnings to share – five top tips that would be useful for others to know from involvement in the second phase of the project with a focus on restorative practice.
- Some of the district project teams shared their experiences at the 'Using restorative approaches to heal, learn and improve after harm' national hui (meeting) held on 28 March 2023 to disseminate learning from their involvement with the second phase of the project and support the ongoing growth in this area.

The second phase of the Learning from adverse events and consumer, family and whānau experience project has been completed. Project teams also continue to work on aspects of their project, with examples including:

- develop and provide a training package for staff in managerial and leadership positions that introduces the restorative practice framework and then specifically how to apply a restorative lens when managing complaints and providing apologies
- continually highlight positive features of restorative practice, advocate for its adoption and identify opportunities to innovate with these principles
- address the challenges of embedding restorative approaches within and across services amidst the health reforms and a context of staff turnover and constraints where reduced capacity limits the ability to transform
- share key learning in a variety of formats (ie, poster, presentation, videos, staff news) and ensure ongoing availability of information and resources in one place
- revise and update the MHA serious event analysis process to include restorative responses (restorative practice and hohou te rongo)
- recommend consideration of a whole district approach.

What follows is a summary of some of the learning shared by the project teams on the second phase of the project with a focus on restorative practice (May 2021 to August 2022).

Te Whatu Ora – Te Toka Tumai Auckland

- Understanding the power of an effective apology using restorative practice principles has been helpful.
- Thinking more deeply about harm from the perspectives of those involved and their perspective of what needs to happen for healing/mana enhancement/restoration to occur has been useful.

Te Whatu Ora – Nelson Marlborough

- At the beginning of the shift to a restorative practice approach, there must be a mandate for this work, a clear purpose and expected outcome(s), strong leadership/sponsor to monitor progress and reset the scope when required and service structure and resourcing to support the shift.
- An effective shift to use restorative practice principles needs to be aligned with specific areas of service delivery.
- A restorative transformation requires a dedicated champion with the responsibility contained within a specific role.
- Ensure a diverse group of employees from across services in a variety of roles (ie, clinical, advisory, organisational etc) is pulled together to work on this shift.

Te Whatu Ora – Te Tai Tokerau

- Practise with others regarding the restorative practice dialogue to be had in a review session.
- Personalise adverse event review reports acknowledging connections and lifestyle of the person who is the focus of the report.
- Measure the number of serious adverse event reviews with whānau engaged in the process as a performance indicator.
- Include senior leadership in whānau and staff feedback sessions.
- Ask all participants involved in an adverse event review directly about any harm experienced.

Te Whatu Ora – Waitematā

- Start using restorative practice with human resources and low-level complaints.
- Seek a prior organisational mandate to provide a whole contingent of support to learners of restorative practice and hohou te rongo.
- The restorative practice approach has huge potential for healing and preventing health care harm.
- Restorative practice could be one part of organisational safety.

Overall learning for the MHA quality improvement programme | Te ako whānui mō te hōtaka whakapai kounga o MHA

Some learning from this project is relevant to the wider MHA quality improvement programme. In particular, it is worthwhile spending more time in the project set-up phase to clearly define the measurement strategy. This work includes assessing whether the proposed measures are available and whether it is feasible to sustainably collect the required data, as the MHA quality improvement programme's mid-programme evaluation

report acknowledges.[43] A risk in persisting with the use of a national data set is that measures that are applicable to all projects may not be sensitive enough to evidence improvements. This could be because the measures are too clustered and/or too distanced from improvements.

In addition, clear timelines are needed to establish the point at which the MHA quality improvement programme team will reduce or complete its support, and the programme team should proactively work with project teams to establish their independent project plans beyond the life of the programme. The goal should be for organisations to commit to continuing to work on these project areas beyond the life of the programme, until the desired level of improvement has been sustained and can be considered part of 'business as usual' or is built into the operating model of the service as an ongoing area of continuous improvement.

Conclusion | He kupu whakakapi

In these high-quality projects, the project teams became increasingly familiar and comfortable with co-design and quality improvement methodology.

The transition of the Learning from adverse events and consumer, family and whānau experience project back to DHBs for the first and second phases of the project is complete and, as agreed by the MHA quality improvement programme leadership group, both phases of this project will now close. This transition process has been under way since November 2020, and the MHA quality improvement programme team has supported this in various ways, as highlighted in this report.

Some project teams have completed their Learning from adverse events and consumer, family and whānau experience project activities and moved project team resource elsewhere. However, many teams have stated they will continue to work on aspects of their project(s) for some time to reach their aim and integrate and embed activities, particularly those related to restorative practice, into the operating model of their service as an ongoing area of continuous improvement.

> Overall, we appreciated the opportunity to do the restorative practice learning. Even though we have not yet tried to implement restorative practice, it has influenced the way we approach adverse event review so that we are already more aligned with the new national adverse events policy.
>
> This is particularly evident in our understanding of harm: who has been harmed, how, and who is responsible for restoration. We encourage our team leadership to think about the person(s), their experience and their needs, with regard to tangata whai i te ora, whānau and staff. We see this as contributing to a broader, safer more connected response to adverse events. [Waitematā project team]

The work undertaken as part of this project was consistent with the National Adverse Events Reporting Policy 2017, which has recently been reviewed. The updated 'Healing, learning

[43] Health Quality & Safety Commission. 2020. *Summary Report for the Mid-programme Evaluation of the Mental Health and Addiction Quality Improvement Programme*. Wellington: Francis Health & Kahui Consulting.

and improving from harm (National adverse events reporting policy 2023) – Te whakaora, te ako me te whakapai ake i te kino,[44] effective 1 July 2023, now includes restorative responses (restorative practice and hohou te rongo) as a principle. Additionally, the Te Tāhū Hauora system safety and capability programme is continuing to support capability building in restorative responses in the MHA sector.

The MHA quality improvement programme is a 7-year programme of work (July 2017–June 2024). It has two remaining priority areas[45] for the team to turn its focus to, within its finite resource, with the aim of improving the experiences of consumers and their families and whānau with MHA services, resulting in better health.

[44] Health Quality & Safety Commission 2023, *op.cit.*

[45] Te whakanui ake i te hauora ā-tinana | Maximising physical health and Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki | Improving medication management and prescribing.

Appendix 1: Programme information for the project teams | Āpitihanga 1: He mōhiohio mō te hōtaka mā ngā rōpū mahi

Te Tāhū Hauora
Health Quality & Safety Commission

Local quality improvement team composition guidance

Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) has provided some key characteristics that have been associated with optimising the success of a team's performance and overall improvement effort from experience of quality improvement initiatives and a scan of the literature.

A pragmatic approach of having a limited number of team members who attend all project meetings, and a wider local improvement team may be required.

Skill area/ representation	Notes
Project lead	Co-ordinating project; contact point with Te Tāhū Hauora.
Senior project sponsor	Active support from senior leadership is key. See here for a resource on being a sponsor: www.hqsc.govt.nz/news/blog-zero-seclusion-and-my-project-sponsor-role
Consumer	Two representatives are preferable for support and continuity.
Whānau	Two representatives are preferable for support and continuity.
Care provider	Ensure key organisations who provide shared care of the cohort are included: • primary care (essential) • secondary care • non-governmental organisations (NGOs) • peer support workers Ensure representatives come from different professional groups/ backgrounds (ie, nursing, psychiatry, Māori health, Pacific Peoples health).
Clinical lead	Can be one of the care provider representatives. Someone with some dedicated time is preferred.
Subject matter expert(s)	Expertise in managing cardiovascular risk. May be included in the care provider and clinical lead categories above.
Cultural representatives	Māori and Pacific Peoples representatives – may also be included with other roles above.
Quality improvement	For example, a quality improvement advisor/manager/coordinator.
Data analytics	For example, a data analyst or those with adaptive learning focus and with access to and interest in the use of data to support the project.
Middle manager	Someone who can influence the culture and work processes and assist in the progress of the project within the organisation.

Key characteristics of a successful project team

- Diversity in the team using different professional skill sets.
- Thought leaders with effective communication and team skills.
- Ability to regularly run multiple tests of change.
- Key members who can be released to work on the improvement project each week.
- Interest or experience in experienced-based care design and/or quality improvement.
- Senior leadership support and an adaptive learning culture committed to data-driven quality improvement.

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Mills PD, Weeks WB, Surott-Kimberly BC. 2003. A multi-hospital safety improvement effort and the dissemination of new knowledge. *The Joint Commission Journal on Quality and Safety* 29(3): 124–33. DOI: 10.1016/s1549-3741(03)29015-8.

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Appendix 2: Project self-assessment scale | Āpitihanga 2: He tauine aromatawai ā-whaiaro

Te Tāhū Hauora Health Quality & Safety Commission

Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau
Learning from adverse events and consumer, family and whānau experience
Project self-assessment scale[1]

Assessment/ description	Definition	Proposed completion date for Sept 2019 – July 2020 project timeframe
0.5: Intent to participate	DHB committed to participating in national collaborative, team being assembled, no project charter. ***Supra-regional co-design workshop one 12/13 September 2019***	Preliminary workshops on 21 March and 26 June September 2019
1.0: Team established	Team assembled (consider equity, consumer, family and whānau engagement), sponsor confirmed. Individuals assigned project work and some work accomplished.	September 2019
1.5: Project planning started	Organisation of project begun (ie, clarifying what resources or other support is likely to be needed, where first focus will be, regular project team meeting schedule developed), co-design engage phase underway.	October 2019
2.0: Project planning progressing	Project team confirmed, project aim established, co-design engage and capture phases underway. ***Supra-regional co-design workshop two 11/12 December 2019***	November 2019
2.5: Activity but no change	Charter completed, co-design engage, capture and understand phases underway, starting to theme emotions/experiences from co-design. Regular reporting and updates provided to sponsor and staff.	Oct 2019 - Feb 2020
3.0: Activity and some change	Initial cycles for team learning have begun, co-design themes gathered, change ideas generated, thinking about outcome measure, obtaining baseline data, etc. Charter and driver diagram underway. ***Supra-regional learning session one 12/13 February 2020***	March 2020
3.5: Changes starting to be tested, no improvement yet	Change ideas generated from co-design ready for testing. Baseline data gathered. Most project drivers have a measure established to track progress. Charter and driver diagram completed and reviewed. Regular reporting.	April 2020
4.0: Signals of improvement	Small-scale tests of change underway related to primary drivers on driver diagram. Data collection underway for outcome, process and balancing measures. Anecdotal evidence of improvement exists. Driver diagram reviewed. Regular reporting. ***Supra-regional learning session two 6 May 2020 via Zoom***	May 2020
4.5: Some improvement	Testing of changes continues; additional improvement in project measures towards aim seen. Data collection. Some small-scale implementation started. Expected results are 20% complete.2 Regular reporting.	July 2020
5.0: Significant improvement	Expected results achieved for major subsystems. Implementation (training, communication, etc) for project begun. Project aim is 50 percent or more complete.3 Regular reporting. ***Supra-regional learning session three 29/30 July 2020*** ***Supra-regional learning session four 4/5 November 2020***	November 2020
5.5: Sustainable improvement	Data on key measures begin to indicate sustainability of impact of changes implemented in the system.	November 2020 onwards
6.0: Outstanding sustainable improvement	Implementation cycles completed and project aim and expected results accomplished. Organisational changes made to accommodate improvements and to make project changes permanent.	November 2020 onwards

1 Modified from the Institute for Healthcare Improvement. 2004. Assessment scale for collaboratives. Boston, MA: IHI.
2 This may mean that either 20 percent of your project aim has been met or each measure is showing 20 percent improvement towards your goal.
3 This may mean that either 50 percent of your project aim has been met or each measure is showing a 50 percent improvement towards your goal.

Appendix 3: Factor analysis | Āpitihanga 3: Tātari āhuatanga

The factor analysis proposed takes data from three sources.

1. **Learning culture** - Ngā Poutama Oranga Hinengaro: Quality in context survey of mental health and addiction services (seven indicators):
    - In this service, we involve tangata whaiora and family/whānau in efforts to improve future practice
    - I feel supported by my manager(s)
    - I have regular access to coaching or mentoring or supervision
    - We have effective systems for preventing or dealing with intimidating behaviour and workplace bullying
    - Senior staff in this service/organisation actively encourage staff to put forward ideas about how care/support can be improved
    - In this service, we use data to help us monitor and make improvements to our quality of care/support
    - Learning from adverse events has led to positive change in this service/organisation
    - In this service, recognising and reporting incidents is encouraged and valued.

2. **Consumer and whānau experience** – Ngā Poutama survey for consumers of mental health and addiction (MHA) services, their families and whānau (five indicators):
    - Staff communicated well with one another about my care and support
    - My care and support well-coordinated between DHB and other health services
    - I received information about my rights in way I could understand
    - I felt I could raise concerns or make complaints freely
    - Staff explained the side effects of medication prescribed in a way I could understand.

3. **Safety culture**: Adverse events database (three indicators):
    - Percentage of severity assessment code (SAC) 1 and SAC 2 events with Adverse Event Brief: Part B form sent to Te Tāhū Hauora on time (70 working days from internal notification date)
    - Percentage of SAC 1 and SAC 2 reported events where consumer and whānau informed of review outcome/recommendations
    - Ratio of SAC 1 to SAC 2 events.

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