**Kounga me te mōrearea**

**-**

**Quality**

**&**

**Risk**

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# Introduction

|  |  |
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| **Policy** | We have effective and organisation-wide governance systems in place to ensure continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our staff. |
| **Scope** | The systems and processes described apply to all aspects of our organisation, the people engaged with our services and staff. |
| **References** | [Australian Commission on Safety and Quality in Health Care](https://www.safetyandquality.gov.au/standards)  [Health Quality & Safety Commission New Zealand](https://www.hqsc.govt.nz/)  [New Zealand Legislation](https://www.legislation.govt.nz/)  [Institute for Healthcare Improvement](http://www.ihi.org/Pages/default.aspx)  [He Ara Oranga : Report of the Government Inquiry into Mental Health and Addiction](https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/)  [Social Care Institute for Excellence](https://www.scie.org.uk/)  [The Health Foundation](https://www.health.org.uk/)  [Te Pou](https://www.tepou.co.nz/our-work/initiatives?publicationDate=&sort=a_to_z)  [Te Rau Ora](https://terauora.com/) |
| **Our organisation is committed to following the quality and risk principles (adapted from WHO publications) below:** | |
| **Quality of care**: The extent to which we provide services to individuals and populations of people to improve desired social and health outcomes. To achieve this, we must provide safe, effective, timely, efficient, equitable and people-centred services. | |
| Safe | Deliver services that minimises risks and harm to people, including avoiding preventable adverse events. |
| Effective | Provide services based on scientific knowledge and evidence-based guidelines. |
| Timely | Reduce delays in providing and receiving services. |
| Efficient | Deliver services in a manner that maximises resource use and avoids waste. |
| Equitable | Deliver services that do not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status. |
| People-centred | Provide care and support that takes into account the preferences and aspirations of individuals and the culture of their community. |
| Māori-centred | Our organisational and service delivery processes are firmly rooted in [Te Tiriti o Waitangi.](https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi) |
| Funding bodies  Advisory bodies  Best practice  Government  Legislation  People & whānau  Effective  Efficient  Equitable  People and whānau- centered  Safe  Timely | |

# Risk based quality approach

|  |  |
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| **Objectives** | * We adapt our quality management activities to the level of risk. This helps us to achieve the following objectives:   + Avoid unnecessary activities and quality management bureaucracy.   + Focussing resources on ‘critical’ aspects. |
| **Considerations** | * We avoid preventable quality issues with agile decision-making based on real time and centralised information/data. * We rapidly detect known and unknown risks on both critical and non-critical information/data, reducing ‘noise’ by filtering out less relevant information. * We prioritise monitoring resources based on information/data insights. |
| **Risk management, people’s safety, and quality improvement** | * We manage risk by utilising information from a variety of sources:   + Complaints.   + Adverse events.   + Health and safety incidents.   + Infection rates.   + Service review recommendations.   + Infections.   + Service delivery outcome information/data.   + Satisfaction surveys.   + Our strategic plan.   + Third party audit results.   + Reports from executive walkarounds.   + Legislation. * Risk management and quality improvement systems are both directed to providing a structured framework for:   + identification,   + analysis,   + treatment/corrective action,   + monitoring,   + review   of risks, problems and/or opportunities. |
| Actions To Address Risks And Opportunities Explained [with procedure] | |

# Quality and risk system: Roles and responsibilities

|  |  |  |  |  |  |
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| **Board/Governance** | | | | | |
| **Participants include: people with lived experience, staff, mana whenua, whānau representative, kaumatua, kuia.** | | | | | |
| Approve the quality and risk related documents. | | Resource quality initiatives. | | Monitor quality and risk outcomes. | |
| Have quality and risk issues on each meeting agenda. | | Monitor legislative and contractual compliance. | | Review the organisations quality and risk plan 6-monthly. | |
| **Executive – Senior Management** | | | | | |
| **Participants include: people with lived experience, staff, mana whenua, whānau representative, kaumatua, kuia.** | | | | | |
| Develop the quality plan. | | Develop the organisational risk plan. | | Manage the implementation of the quality and risk processes. | |
| Monitor the outcomes of the quality and risk processes. | | Report on legislative and contractual compliance. | | Have quality and risk issues on each meeting agenda. | |
| Update the quality and risk plan. | | Provide a Choose an item. report to the Board/Governance. | | Communicate with stakeholders, staff, people engaged with our service and their whānau about relevant quality and risk issues and outcomes | |
| Ensure the resources to maintain a quality and risk system are sufficient. | | Are informed of current government guidelines and directives | | Participate in regional and national quality and risk related fora. | |
| **Staff** | | | | | |
| **Participants include: people with lived experience, whānau representative, cultural practitioners.** | | | | | |
| Maintain the quality and risk processes. | | Monitor implementation of processes. | | Report on non-conformity and opportunity for improvement. | |
| Have quality and risk issues on each meeting agenda. | | Participate in quality initiatives and projects. | | Complete internal audits. | |
| **People engaged with our service** | | | | | |
| **Participants might include: independent advisors, cultural representatives, kaumatua, kuia.** | | | | | |
| Maintain the quality and risk processes. | | Monitor implementation of processes. | | Report on non-conformity and opportunity for improvement. | |
| Have quality and risk issues on each meeting agenda. | | Participate in quality initiatives and projects. | | Complete internal audits. | |
| **The habits of improvers (adapted from Health Foundation 2015)** | | | | | |
| Empathetic. | Facilitative. | | Comfortable with conflict. | | Optimistic. |
| Calculated risk taking. | Tolerating uncertainty. | | Generating ideas. | | Critical thinking. |
| Team playing. | Accepting of change. | | Synthesising. | | Connection making. |
| Reflective. | Problem finding. | | Questioning. | | Excellent communication skills |

# Quality improvement and risk management activities

|  |  |
| --- | --- |
| **Processes** | |
| **Third party audit** | An audit completed by an external agency or company. For example, audits done by our funders, or audits required by legislation such as HealthCERT certification audits. |
| **Internal audit - Routine** | Routine internal audits are planned processes of checking the compliance with our policies/procedures, standards, and contractual obligations. We implement a yearly audit schedule. |
| **Internal audit- Issue based** | In some instances, we do issues audits in response of an investigation; for example: adverse event reporting, complaint and incident, or a problem to gather information or evidence as to the circumstances and cause of the problem. This process is integral to our risk prevention and management process. |
| **Monitoring** | The ongoing process of regularly collecting and analysing relevant information to make sure we are doing what we set out to do. It tends to happen continuously, but sets of information may be gathered together at regular intervals. |
| **Evaluation** | Assess whether what we have been doing is really making the difference that we intended it to. It tends to happen less frequently, for example annually or at the end of a longer-term project. |
| **Clinical Audit** | A systematic evaluation of an aspect of service delivery. |
| **Review** | A formal assessment of something with the intention of instituting change if necessary. |
| **Projects** | We might carry out projects in response to new evidence in a specific area, change in guidelines or legislation. For example, in these areas:   * Māori-centred environment and service provision. * Diversity. * Equity. * Disability. |
| **Service Improvement Requests (SIR)** | Usually called corrective action requests. We have a system that identifies the result of the quality and risk activities above that show areas of non-compliance or opportunity for improvement and the measures we put in place to address the shortfall. |

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| **Overview for project and clinical audit processes**  **(Also the methodology for continuous improvement rating)** |
| Quality Improvement Process (QIP) Graphic | ePortfolio of Ann Bailey |

# Quality and risk processes

## Quality assurance and improvement activities

**Quality improvement activities**

**Service improvement required**

**no**

**yes**

Develop service improvement measure.

* Analyse how and why the process works.
* Discern how it can be utilised/generalised.
* Maintain the process.

Implement service improvement measure.

Monitor service improvement measures for effectiveness.

* Staff
* Quality Forum
* Other identified parties

Report findings and outcomes to:

* BOT
* People engaged in our services
* Cultural advisors
* Analyse trends
* Respond to trends

**Processes**

**Internal audit - routine**

**Responsibility:** Click here to enter text.

* Manager/team leaders.
* Service delivery staff.
* Administration staff.
* Representatives of specific groups (people engaged with our services, family, cultural, people with lived experience).

**As per risk based audit schedule**

**Implementation of policies/procedures**

**Pre-audit activities**

**Audit**

**Responsibility:** Click here to enter text.

**Designated group/person**

**As per audit schedule**

* Complete the audit as planned.
* Document the audit findings.
* Document service improvement requests (SIR).
* Confirm the processes being audited.
* Ensure the audit tool is developed.
* Confirm the date of the audit.
* Ensure people for interview and the documents are available.

**Post audit activities**

**At specified meetings:**

**Management/staff/people engaged with the service/cultural advisors/other relevant stakeholders**

**Responsibility:** Click here to enter text.

* Maintain and update the SIR log.
* Report SIR status to the relevant meetings.
* Collate the audit findings Choose an item.and analyse the information/data.
* Forward the information/data to the relevant meetings.
* Display the information/data on our website.
* Update our documents as required.

* Discuss the audit findings.
* Review and sanction the SIR.
* Allocate responsibilities for managing the SIR, risk and time frames (SIR plan).
* Monitor SIR plan.
* Final sign-off that SIR are implemented and are effective.

**Internal audit –issue audit**

**Allocated auditor(s)**

Within 4 weeks of the issue being identified

In response to an investigation showing:

* A process is not working as anticipated.
* Non-adherence with agreed standards and/or processes.
* Moderate to high risk repetitive non-conformance.

An issue audit may be conducted as the result of an incident, complaint, survey, or adverse/unexpected event.

The auditor/audit team will be selected considering:

* Qualifications.
* Skills.
* Expertise in the processes being audited.
* Having no conflict of interest.

We might contract someone into this role.

**Audit**

**Pre-Audit Activities**

**Audit Team**

**Responsibility:** Click here to enter text.

* Complete the audit as planned.
* Provide an audit report that includes:
  + Conformance and non-conformance.
  + Service improvement requests.
  + Recommendations.

**Within 4 weeks of the issue being identified**

* Define the scope of the audit.
* Confirm the processes being audited.
* Ensure the audit tool is developed.
* Confirm the date of the audit.
* Ensure people for interview and documents are available.

**Post Audit Activities**

**At specified meetings:**

**management/staff/people engaged with our service/cultural advisor/ other relevant stakeholder(s)**

**Responsibility:** Click here to enter text.

* Maintain and update the SIR log.
* Report progress with SIR and recommendations to the relevant meetings

* Discuss the audit findings.
* Review and sanction the report.
* Develop a plan to implement the SIR and recommendations using a risk based approach.
* Monitor the implementation of the plan.
* Final sign-off that the plan was implemented and effective.

**Monitoring**

**Responsibility:** Click here to enter text.

**According to the risk based schedule:**

Staff who have:

* Designated roles to perform the surveillance activities.
* Have qualifications or experience to perform the monitoring activities.

Will be implemented in the following areas using specific monitoring templates:

|  |  |
| --- | --- |
| Fridge/freezer temperatures | weekly |
| Medication room temperatures | weekly |
| Infection surveillance | monthly |
| Water temperatures | monthly |
| Health & Safety Hazards | 3- monthly |
| Emergency evacuations | 3 monthly |
| Emergency/spill kits | 3 monthly |
| First aid kits | 3 monthly |
| Tikanga guidelines implementation | 6 monthly |
| Calibration of equipment | yearly |
| Electrical equipment | 2-yearly |

**Monitor**

* Complete the monitoring templates.
* Document service improvement requests.

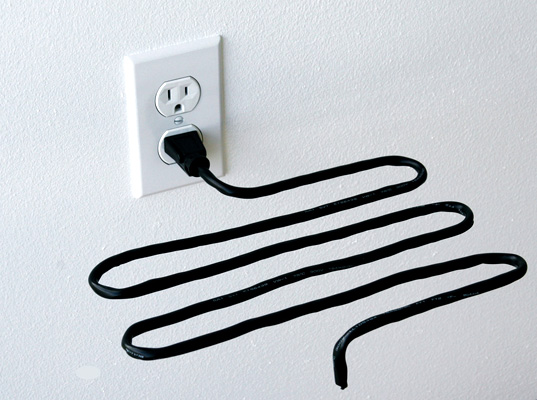
**Post Monitoring Activities**

**At relevant meetings:**

**Management/staff/people engaged with our service/cultural advisor/relevant stakeholder**

**Responsibility:** Click here to enter text.

* Maintain and update the SIR log.
* Report SIR status to the relevant meetings.
* Collate the Choose an item.data.
* Analyse the data and provide a report to the relevant meetings.
* Discuss the results.
* Review and sanction the SIR.
* Monitor of the implementation of the SIR and the outcome.
* Final sign-off that SIR are implemented and effective.



**Evaluation**

**Responsibility:** Click here to enter text.

**According to the evaluation schedule**

Routine evaluation will be carried out using the following processes:

|  |  |
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| [Māori health equity](file:///C:\Users\Sarah_2\Documents\jobs2021\navigate\quality\Equity%20of%20Health%20Care%20for%20Māori:%20A%20framework) | yearly |
| Service delivery outcomes | yearly |
| Satisfaction/people engaging with our service | yearly |
| Family/whānau satisfaction | yearly |
| Staff satisfaction | yearly |
| Board evaluation | yearly |
| [Equity assessment](https://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide) | yearly |
| Stakeholder satisfaction | 2-yearly |

Staff or contractors who have:

* Designated roles to perform the evaluation activities.
* Have qualifications or experience to perform the evaluation activities.
* Complete the evaluation.
* Collate the outcome.
* Analyse the information.
* Provide a report/summary.
* Identify SIR, recommendations and outstanding performance.

**Post Evaluation Activities**

**At relevant meetings:**

**management/staff/people engaged with our service/cultural advisor/relevant stakeholders**

**Responsibility:** Click here to enter text.

* Maintain and update the SIR log.
* Report SIR status to the relevant meetings.
* Have the evaluation report accessible on our

website.

* Discuss the results.
* Review and sanction the report and SIR.
* Develop a plan to address the issues identified.
* Monitor the implementation of the plan.
* Final sign-off that SIR are implemented and effective.

**Clinical/service delivery process audit**

**Responsibility:** Click here to enter text.

Examples:

* Treatments.
* Interventions.
* Care.
* Clinical pathways.
* Service delivery pathways.
* Clinical practices.
* Treatment outcomes.

**When a need has been identified**

**Selecting a topic**

Selection principles:

* Practice concern.
* Moderate/high risk.
* High volume.
* Practitioner/person engaged with our service/funder/MOH interest.
* Complex or difficult situation.
* High cost.
* Comparison with evidence based practices.

**Planning the audit**

Set objectives of the audit:

* Agreement what the audit is going to achieve.
* Concentrate on collecting specific data.
* List the questions that need to be answered.

Develop the audit tool:

* Decide what information/data need to be collected.
* Decide when the information/data will be collected.
* Decide who will collect the information/data.

Develop audit criteria:

* Use of existing standards.
* Use of existing guidelines.

Select audit samples:

* Specific group of people engaged with our service.

Analyse the data:

* Collate the audit results.
* Identify gaps between standards, best practice, guidelines and actual practice.
* Report the findings.

Audit:

* Coordinate the audit.
* Collect information.
  + Records.
  + Interviews.
  + Data.

Testing the audit methodology and tools:

* Consult with colleagues.
* Pilot the methodology and tool.
* Modify if necessary.

**Develop service improvement solutions**

**Responsibility:** Click here to enter text.

**Participants (options): people engaged with our service, people with lived experience, staff, cultural advisor, whānau, any other stakeholder.**

* Define service improvement solutions.
* Undertake diagnostic analysis.
* Document and implement changes and remedial actions.
* Develop a service improvement implementation plan.
* Monitor and evaluate the changes made.

**Reviews**

**Responsibility:** Click here to enter text.

**According to the review schedule**

|  |  |
| --- | --- |
| Quality and risk plans | 3-monthly |
| Pandemic response (during a pandemic) | 3- monthly |
| Māori health plan | 6-monthly |
| Business plan | 6-monthly |
| Infection prevention and antimicrobial stewardship plan | yearly |
| Health and safety plan | yearly |
| Strategic plan | yearly |
| Organisational values and mission | yearly |
| Financial viability | yearly |
| Policies and procedures (routine) | 3-yearly |
| Contracts | 3-yearly |

# Quality Plan 2022 – 2024

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| We structure our quality plan on the requirements of Ngā paerewa - Health and Disability Services Standards 2021 and relevant strategic documents and guidelines published or recommended by the government of Aotearoa. The quality plan is reviewed every three month and updated at least yearly. Ngā paerewa is a generic standard and can apply to any health and disability services setting, not only those who require certification.  Over the next two years, our priority is to familiarise ourselves with Ngā paerewa and ensure that our documentation and practices are in line with the standard. |
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| **Ngā paerewa**  All processes and activities are informed by the principles of Te Tiriti o Waitangi**.** | | | | | | | | |
| Ō Tātou Motika – Our rights. | | | | | | | | |
| Hunga Mahi me te hanganga – Workforce and structure. | | | | | | | | |
| Ngā Huarahi ki te oranga – Pathways to wellbeing. | | | | | | | | |
| Te aro ki te tangata me te taiao haumaru – Person-centred and safe environment. | | | | | | | | |
| Te kaupare pokenga me te kaitiakitanga patu huakita – Infection prevention and antimicrobial stewardship. | | | | | | | | |
| Here Taratahi – Restraint and seclusion. | | | | | | | | |
| Te Tiriti o Waitangi | | | | | | | | |
| We acknowledge the inequity of health outcomes faced by Māori. We uphold the principles of the [Treaty of Waitangi](http://www.nzhistory.net.nz/politics/treaty-of-waitangi) throughout organisational and service delivery processes to address the inequities. | | | | | | | | |
| **References** | | | | | | | | |
| * [Equity of Health Care for Māori: A framework](https://www.health.govt.nz/publication/equity-health-care-maori-framework) * ‘[He Ara Hauora Māori: A pathway to Māori health equity](https://www.mcnz.org.nz/about-us/news-and-updates/statement-on-cultural-safety/) * [Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan](https://www.health.govt.nz/publication/whaia-te-ao-marama-2018-2022-maori-disability-action-plan) * [Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice](https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx) * [Te Tiriti o Waitangi framework](https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi) * [United Nations Declaration on the Rights of Indigenous Peoples](https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html) * [Whakamaua: Māori Health Action Plan 2020-2025](https://www.health.govt.nz/our-work/populations/maori-health/whakamaua-maori-health-action-plan-2020-2025) | | | | | | | | |
| **Activities** | | | | | | | | |
| Tasks | | | | | Responsibility | Timeframe | | |
| Develop a Māori Health Plan that aligns with [Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan](https://www.health.govt.nz/publication/whaia-te-ao-marama-2018-2022-maori-disability-action-plan) | | | | |  |  | | |
| Performance Indicators: | | |  | | | | | |
| Ō Tātou Motika – Our rights | | | | | | | | |
| We ensure that people engaged with our service receive services of a high standard. We are committed to comply with consumer rights legislation, provide services in a manner that is respectful of people’s rights, facilitate informed choice, minimise harm, and uphold cultural and individual values and beliefs. | | | | | | | | |
| **References** | | | | | | | | |
| * [Equity of Health Care for Māori: A framework](https://www.health.govt.nz/publication/equity-health-care-maori-framework) * [Health and Disability Commissioner](https://www.hdc.org.nz/disability/easy-read-resources/) * [Māori Mental Health – Te Rau Ora](https://terauora.com/our-work/maori-mental-health/) * [New Zealand Disability Strategy](https://www.odi.govt.nz/nz-disability-strategy) * [Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025](https://www.health.govt.nz/publication/ola-manuia-pacific-health-and-wellbeing-action-plan-2020-2025) * [Health Equity](https://www.healthnavigator.org.nz/clinicians/e/equity/?tab=25114) * [United Nations Convention on the Rights of Persons with Disabilities](https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html) * Our people’s rights related policies and procedures | | | | | | | | |
| **Activities** | | | | | | | | |
| Tasks | | | | | Responsibility | Timeframe | | |
| Satisfaction surveys from people engaged with our services. | | | | |  |  | | |
| We provide people engaged with our service with current information on their rights in languages and by means that they can understand. | | | | |  |  | | |
| We develop a tikanga guideline. | | | | |  |  | | |
| We implement a quiz for staff and people engaged with our service to check their knowledge of people’s rights. | | | | |  |  | | |
| Performance Indicators: |  | | | | | | | |
| Hunga Mahi me te hanganga – Workforce and structure | | | | | | | | |
| **We have systems in place to ensure people receive quality services through effective governance and a supported workforce.** | | | | | | | | |
| **Mana whakahaere - Governance** | | | | | | | | |
| **References** | | | | | | | | |
| * [Service user, consumer and peer support workforce - A guide for managers and employers](https://www.tepou.co.nz/resources/service-user-consumer-and-peer-support-workforce---a-guide-for-managers-and-employers) * [Clinical Governance: Guidance for health and disability providers](https://www.hqsc.govt.nz/our-programmes/building-leadership-and-capability/publications-and-resources/publication/2851/) * [He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction](https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/) * [Healthy aging strategy](https://www.health.govt.nz/publication/healthy-ageing-strategy) * [Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan](https://www.health.govt.nz/publication/whaia-te-ao-marama-2018-2022-maori-disability-action-plan) * Our governance and management related policies and procedures | | | | | | | | |
| **Activities** | | | | | | | | |
| Tasks | | | | Responsibility | | | Timeframe | |
| Establish process for consultation with mana whenua as noted in the Māori health plan. | | | |  | | |  | |
| Establish people with lived experience and whānau participation terms of reference. | | | |  | | | |  |
| Provide information to people with lived experience how they can participate in the national [health forum](https://www.hqsc.govt.nz/our-programmes/partners-in-care/consumer-health-forum). | | | |  | | | |  |
| Performance Indicators: | |  | | | | | | |

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| **Kounga me te mōrearea – Quality and risk** | | | | | | | |
| A culture of ‘Quality is everybody’s business’ is fostered by our organisation. Awareness, understanding and commitment to a quality improvement and safety culture inform all service delivery and organisational processes. | | | | | | | |
| **References** | | | | | | | |
| * [National Adverse Events Reporting Policy 2017](https://www.hqsc.govt.nz/our-programmes/adverse-events/national-adverse-events-policy/) * [From Knowledge to Action HQSC](https://www.hqsc.govt.nz/our-programmes/building-leadership-and-capability/publications-and-resources/publication/2669/) * [ISO 31000:2018](https://www.iso.org/standard/43170.html) * Our policies and procedures related to quality and risks. | | | | | | | |
| **Activities** | | | | | | | |
| Tasks | | | Responsibility | | | Timeframe | |
| Include risk/safety and quality improvement communication and information in agenda items for the following meetings:  BOT  Clinical  Management  Staff  Health and safety  People engaged with our services  Whānau of people with lived experience | | |  | | |  | |
| Define how we measure outcomes of the service we provide. | | |  | | |  | |
| Performance Indicators: |  | | | | | | |
| **Whakahaerenga ratonga – Service management**  **Ngā kaimahi Tiaki hauora me ngā kaimahi taitoko – Health care and support workers** | | | | | | | |
| References | | | | | | | |
| * [Employment of Māori Staff](https://terauora.com/wp-content/uploads/2019/06/Employment-of-Maori-Staff-Tool.jpg) * [Health Practitioners Competence Assurance Act 2003](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act) * [Recruiting a Māori Health Workforce](https://terauora.com/wp-content/uploads/2019/06/Recruiting_Ma%CC%84ori_Health_Infographic_1BONLY.jpg) * [Retaining and advancing a Māori Health Workforce](https://terauora.com/wp-content/uploads/2019/06/Recruiting_Ma%CC%84ori_Health_Infographic_2ONLY.jpg) * [Te Rau Ora – Education and Training](https://terauora.com/our-work/education-training/) * [Workforce Development Outcomes Framework](https://terauora.com/our-work/workforce-development/) * Our human resource related policies and procedures | | | | | | | |
| **Activities** | | | | | | | |
| Tasks | | | | Responsibility | Timeframe | | |
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|  | | | |  |  | | |
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| Performance Indicators: | | * Staff Retention rate * Performance reviews are on target * Compulsory training is completed * Ethnicity of staff match ethnicity composition of people engaged with our service | | | | | |
| **Mōhiohio - Information** | | | | | | | |
| References | | | | | | | |
| * [Privacy Act 2020](https://www.legislation.govt.nz/act/public/2020/0031/latest/LMS23223.html) * [Health Information Privacy Code 2020](https://www.privacy.org.nz/privacy-act-2020/codes-of-practice/hipc2020/) * Our information management related policies and procedures | | | | | | | |
| **Activities** | | | | | | | |
| Tasks | | | | Responsibility | Timeframe | | |
| Our Privacy Officer has completed the learning modules on the new [Privacy Act](https://elearning.privacy.org.nz/) and the Health Information Privacy Code | | | |  |  | | |
| Cyber security measures are in place. | | | |  |  | | |
| Performance Indicators: | |  | | | | | |
| Ngā Huarahi ki te Oranga – Pathways to Wellbeing | | | | | | | |
| People engaged with our service determine their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs. | | | | | | | |
| References | | | | | | | |
| [Resources from Te Rau Ora:](https://terauora.com/our-work/publications-resources/)   * He Puna Whakaata 1 * He Puna Whakaata 2 * Indigenous Insight 1 * Indigenous Insight 2 * Kia Hora te Marino * Kaupapa Māori Mental Health and Addiction best practice * Te Pātūtū Oranga   [Resources from Te Pou:](https://www.tepou.co.nz/resources?publicationDate=&sort=newest)   * [Equally Well](https://www.tepou.co.nz/initiatives/equally-well-physical-health) * [Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa New Zealand](file:///C:\Users\Sarah_2\Documents\jobs2021\navigate\quality\Guidelines%20for%20gender%20affirming%20healthcare%20for%20gender%20diverse%20and%20transgender%20children,%20young%20people%20and%20adults%20in%20Aotearoa%20New%20Zealand) * Our service delivery related policies, procedures and guidelines. | | | | | | | |
| **Activities** | | | | | | | |
| Tasks | | | | Responsibility | Timeframe | | |
| Staff practice trauma informed care. | | | |  |  | | |
| We implement Te Ao Māori informed practices (for example *Waiporo me ngā Tarukino*) that enhance the mana of people engaged with our service. | | | |  |  | | |
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| Performance Indicators: | |  | | | | | |
| Te Aro ki te Tangata me te Taiao Haumaru – Person-centred and safe environment | | | | | | | |
| We provide a safe environment that matches the needs of the people receiving services, that facilitates independence, and meets the need of people with disabilities. | | | | | | | |
| References | | | | | | | |
| * [Disability action plan](https://www.odi.govt.nz/disability-action-plan-2/). * Our facility and emergency related processes and procedures. | | | | | | | |
| **Activities** | | | | | | | |
| Tasks | | | | Responsibility | Timeframe | | |
| We develop tikanga guidelines/kawa to ensure the environments we provide are culturally safe. | | | |  |  | | |
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| Performance indicators: | |  | | | | | |
| Te Kaupare Pokenga Me Te Kaitiakitanga Patu Huakita – Infection prevention and antimicrobial stewardship | | | | | | |
| We implement an infection prevention and antimicrobial stewardship programme informed by evidence, minimises infection risk and adverse effects from antibiotic use, such as antimicrobial resistance. | | | | | | |
| References | | | | | | |
| * [Infection Prevention and Control Training](https://learnonline.health.nz/course/view.php?id=393) * [Resources on infection control and prevention. MOH NZ.](https://www.health.govt.nz/about-ministry/leadership-ministry/expert-groups/healthcare-associated-infections-governance-group/resources-infection-control-and-prevention) * [Safe antimicrobial use – Health Quality and Safety Commission](https://www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/news-and-events/news/4163/) * [WHO antimicrobial resistance](https://www.who.int/health-topics/antimicrobial-resistance) * [WHO Infection prevention and control](https://www.who.int/infection-prevention/en/) * Our policies and procedures related to infection prevention and antimicrobial stewardship | | | | | | |
| **Activities** | | | | | | |
| Tasks | | | | Responsibility | Timeframe | |
| Development of tikanga guidelines that enhance infection prevention and control processes. | | | |  |  | |
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| Performance Indicators: | |  | | | | |
| Here Taratahi – Restraint and seclusion | | | | | | |
| We continue to maintain a restraint and seclusion free environment. | | | | | | |
| References | | | | | | |
| * [Communicating effectively](https://www.health.nsw.gov.au/mentalhealth/psychosocial/strategies/Pages/communicating.aspx) * Our policies and procedures related to the prevention of restraint and restraint | | | | | | |
| **Activities** | | | | | | |
| Tasks | | | | Responsibility | Timeframe | |
| Continue to learn from applying strategies to avoid restrictive practices. | | | | Click here to enter text. | ongoing | |
| Performance Indicators: | |  | | | | |

# Organisational risk management

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| **Policy** | We manage organisational risks by identifying, analysing, evaluating, treating, monitoring, and communicating organisational risk. |
| **Purpose** | The purpose of this document is to achieve:   * A confident and rigorous basis for decision-making and planning. * Identification of strengths, weaknesses, opportunities, and threats (SWOT analysis). * Gaining value from uncertainty and variability. * Pro-active rather than re-active management. * Effective allocation and use of resources. * Reduction in loss and cost of risk including insurance premiums. * Stakeholder confidence and trust. * Compliance with legislation. * Better corporate governance. |
| **Scope** | The processes described in this document apply to all parts and aspects of our organisation. |
| **References** | |
| **Legislation** | [Health and Disability Services (Safety) Act 2001](http://www.legislation.govt.nz/act/public/2001/0093/latest/DLM119975.html)  [NZ Legislation](https://www.legislation.govt.nz/) |
| **Guidelines/**  **Standards** | AS/NZS 4360:2004:Risk Management  [ISO 31000 – Risk Management](https://www.iso.org/iso-31000-risk-management.html)  [NZS 8134:2021: Ngā paerewa - Health and Disability Services Standards](https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards/nga-paerewa-health-and-disability-services-standard)  HB 266:2010:Guide for managing risk in not-for-profit organizations  [Communitynet Aotearoa Risk Management](http://www.community.net.nz/resources/community-resource-kit/2-7-planning-/)  [Institute of Directors - Risk](https://www.iod.org.nz/Governance-Resources/Resource-library/Risk) |



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| **Definitions** | |
| **Consequence** | Outcome or impact of an event. |
| **Control** | A process or strategy that acts to minimise negative risk or enhance positive opportunity. |
| **Event** | Occurrence of a particular set of circumstances. |
| **Hazard** | A source of potential harm. |
| **Likelihood** | General description of probability or frequency. |
| **Loss** | Any negative consequence or adverse effect, financial or otherwise. |
| **Monitor** | Check, supervise, observe critically, or measure the progress of an activity, action, or system on a regular basis to identify change from the performance level required or expected. |
| **Probability** | Measure of the chance of occurrence. |
| **Risk** | The chance of something happening that will have an impact on objectives. |
| **Benefits of risk management** | |
| * Fewer surprises. * Exploitation of opportunities. * Improved planning, performance, and effectiveness. * Economy and efficiency. * Improved stakeholder relationships. * Improved information for decision making. * Enhanced reputation. * Director/Board member protection. * Accountability, assurance, and governance. * Personal wellbeing. | |
| **Our Risk Management processes consider the following:** | |
| **Applications of risk management** | |
| **We develop and maintain a yearly risk management plan in the following areas:** | * Strategic, operational, and business planning. * Asset management and resource planning. * Business interruption and continuity. * Organisational, technological, and political change. * Environmental issues. * Ethics, fraud, and security. * Resource allocation. * Directors’, Board of Trustee and officers’ liability. * Compliance. * Operations and maintenance systems. * Health and safety. * Human resources. * Project management. * Purchasing and contract management. * Information management. |

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| **Risk Management Processes**  **Our risk management plan includes the following processes and systems:** | | |
| **Communication and Consultation** | We communicate and consult with internal and identified external stakeholders at each stage of risk management processes.  The following stakeholders have been identified for this process: | |
| **Internal Stakeholders** | **External Stakeholders** |
| Board of Trustees/Director(s).  CEO/Manager.  Management/leadership team.  Health workers.  Support workers.  People engaged with our service. | DHB Funding and Planning  DHB Provider Arm.  Local PHO.  Accountant.  Mana whenua.  Iwi organisations.  Other NGO’s /Navigate/Platform.  Contractors and suppliers.  Emergency services.  Financial institutions.  Family/whānau of people with lived experience.  Statutory agencies.  Government agencies.  Social agencies. |
| **Establishing the context** | External and internal and risk management context in which the described processes take place. | |
| **Internal Context** | **External Context** |
| * Organisational culture. * Internal stakeholders. * Company structure. * Resources:   + Human Resources.   + Systems.   + Processes.   + Capital. * Strategic plan. | * Regulatory and legislative requirements. * Competing organisation. * Political environment. * Social obligations. * Bi-and multicultural environment. * Council’s Resource Management Plan. * Financial environment. * Business environment. * External stakeholders. |
| **Risk Identification** | Where, when, why and how events could prevent, degrade, delay or enhance the achievement of organisational objectives. | |
| **Risk Analysis** | Identification and evaluation of existing controls. Determination of consequences and likelihood = level of risk. The analysis considers the range of potential consequences and how these could occur. | |
| **Risk Evaluation** | Comparison of estimated levels of risk against the pre-established criteria.  Consideration of the balance between potential benefits and adverse outcomes. | |
| **Risk Treatment** | The plan shows the development and implementation of specific cost-effective strategies and action plans to increase potential benefits and reduce potential costs. | |
| **Monitoring and Review** | The effectiveness of the Risk Management Plan is monitored.  (Examples: Board/Directors meetings, management meetings, strategic and business planning.) | |

**RISK MANAGEMENT PROCESSES - OVERVIEW**

ESTABLISH THE CONTEXT

COMMUNICATE AND CONSULT

MONITOR AND REVIEW

TREAT RISKS

IDENTIFY RISKS

ANALYSE RISKS

EVALUATE RISKS

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| **Organisational Risk Management Plan** Click here to enter text. | | | | |
| **Risk** | | **Risk Rating** | **Risk Management Strategies/Processes** | **Responsibilities** |
| **Strategic, operational and business planning** | | | | |
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| **Asset management and resource planning** | | | | |
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| **Business interruption and continuity** | | | | |
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| **Organisational, technological and political change** | | | | |
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| **Environmental issues** | | | | |
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| **Ethics, fraud and security** | | | | |
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| **Resource allocation** | | | | |
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| **Board of Trustees and officers’ liability** | | | | |
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| **Risk** | **Risk Rating** | **Risk Management Strategies/Processes** | **Responsibilities** |
| **Compliance** | | | |
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| **Operations and maintenance systems** | | | |
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| **Health and Safety** | | | |
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| **Human Resources** | | | |
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| **Project Management** | | | |
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| **Purchasing and contract management** | | | |
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| **Information Management** | | | |
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| **Risk Rating Guide** |

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| Extreme | The consequences would threaten:   * The survival of the service, possibly causing major problems for people engaged with our service and their families * The administration of the programme or for a large part of the Public Sector. * Revenue loss greater than 30% of total revenue being managed would have extreme consequences for the organisation both financially and politically |
| **Very High** | The consequences would threaten:   * The survival or continued effective function of the service * Revenue loss greater than 15% of total revenue being managed * Would have very high consequences for the organisation both financially and politically |
| **Medium** | * The consequences would **not** threaten the programme * But would mean that the administration of the programme could be subject to significant review or changed ways of operating. * Revenue loss greater than 8% of total revenue being managed * Would have ……consequences for the organisation both financially and politically |
| **Low** | The consequences would:   * Threaten the efficiency or effectiveness of some aspects of the service * Be dealt with internally. * A loss of revenue below the tolerance level of 5% * Would be of low consequence |
| **Negligible** | * The consequences are dealt with by routine operations. * A loss of revenue below the programme tolerance level of 3% * Would be of negligible consequence |

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| **Risk Rating Matrix** | | | | | |
| **Consequences** | | | | | |
| Likelihood | **Negligible**  **1** | **Low**  **2** | **Medium**  **3** | **Very High**  **4** | **Extreme**  **5** |
| **A (almost certain)** | N | L | M | E | E |
| **B (likely)** | N | L | M | H | H |
| **C (moderate)** | N | L | M | M | H |
| **D (unlikely)** | N | N | L | M | H |
| **E (rare)** | N | N | L | M | H |

**E:** Extreme Risk; immediate attention required

**H:** High Risk; senior management attention needed

**M**: Moderate Risk; management responsibility must be specified

**L:** Low Risk; manage by routine procedures

**N:** Negligible; unlikely to need specific application of resources.

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| Essential notifications | | | |
| **Reported to** | **Type of situation** | **Reported by** | **Time frame** |
| Our board chair person/director  Funding agency  (for example: DHB, MSD, MOH) | Serious harm event and sentinel event.  Breaches of legislation.  Situations that might be reported by the media.  Situations reported to HealthCERT.  If we are no longer able to provide the service we are contracted for. | Click here to enter text. | Within 24 hours |
| [HealthC](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31)ERT (only services that require certification). | Health and safety risk to people engaged with our service or a situation that puts (or could potentially put) the health and safety of people at risk.  Police investigation into any aspects of our service.  Death reported to the Coroner of a person to whom we have provided services or that occurred in any premises in which services are provided.  COVID-19 cases. | Click here to enter text. | Within 24 hours |
| Health Quality and Safety Commission **-** [central repository](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/306/) | Wrong consumer or wrong procedure that caused severe harm. | Click here to enter text. | SAC 1 and SAC 2: Within 15 days of the adverse event. |
| Privacy Commissioner | We use the [privacy breach assessment](https://www.privacy.org.nz/responsibilities/privacy-breaches/notify-us/evaluate). | Click here to enter text. | Within 2 working days. |
| [Responsible authorities](https://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/responsible-authorities-under-act) legislated for by the Health Practitioners Competence Assurance Act 2003. | As defined by each authority. | Click here to enter text. | Depends on the risk rating.  Refer to authority. |
| WORKSAFE – Mahi Haumaru Aotearoa | [As stated by WORKSAFE](https://www.worksafe.govt.nz/notifications/notifiable-event/what-is-a-notifiable-event/). | Health and Safety representative | Depends on the risk rating.  Refer to WORKSAFE. |
| Fire and Emergency NZ – Whakaratonga Iwi | [Breaches of regulatory compliance](https://fireandemergency.nz/about-us/regulatory-compliance/) | Click here to enter text. | Immediately or as required.  Refer to Fire and Emergency NZ. |
| [Public Health](https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/public-health-units) | [Notifiable and communicable diseases](https://www.health.govt.nz/our-work/diseases-and-conditions/notifiable-diseases). | Click here to enter text. | Immediately or as required. |

# Appendices

# Introduction

In October 2016 the Health Quality and Safety Commission New Zealand (HQSCNZ) published a comprehensive document that provides a structure for systemic quality improvement: ‘[From knowledge to action - A framework for building quality and safety capability in the New Zealand health system’.](https://www.hqsc.govt.nz/resources/resource-library/from-knowledge-to-action-a-framework-for-building-quality-and-safety-capability-in-the-new-zealand-health-system/)

This appendix is based on the Commission’s publication.

The Ngā paerewa guidelines recommend that this framework is considered by health and disability service providers.

Organisations might want to introduce internationally acclaimed overarching quality principles, additional to the HQSCNZ framework (for example: ISO, Kaizen, Six Sigma). Both the HQSCNZ framework and other quality systems can be integrated and can enhance each other.

Current best practice is based on the principle that safe and quality service delivery happens when people engaged in health and social services, non-clinical and clinical staff, and those in management work collaboratively with a common purpose as illustrated below (Triple Aim):

Improved quality, safety and experience

Best value for public health resources

Improved health and equity for everyone

# Domains of the New Zealand quality and safety capability framework

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| **Domain** | **Objectives** |
| **People engaged with our service and their families/ whānau.** | Are our partners to achieve their goals. |
| **Quality and safety culture** | Contributing to our culture where quality and safety are top priorities and communicating in a way that shows mutual trust and respect. |
| **Leadership for improvement and change** | We are doing what is right. We set an example for others to follow. We direct and lead quality and safety improvements. |
| **Systems thinking** | Our service delivery systems are dynamic, interrelated, and interdependent. They include people and processes and are contextual. |
| **Teamwork and communication** | We work across professional, organisational, and cultural boundaries to achieve shared quality and safety goals. |
| **Improvement and innovation** | We use evidence and data to drive improvement and innovation. |
| **Quality improvement and people’s safety knowledge and skills** | Using evidence based processes and practices to improve the quality and safety of care. |
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# Quality Objectives and Plans

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| Enabling people engaged with our service and their families/whānau as members of the health team | | |
| **Objective: people engaged with our service interact with us in order to participate in the way services are delivered and to achieve their identified health and wellbeing outcomes.**  Related image | | |
| **People engaged with our service and their family/whānau have knowledge of:** | **People engaged with our service and their family/whānau will:** | **We:** |
| How to develop and maintain a partnership with our service. | Participate in the care, support, and interventions by expressing and determining their needs and preferences. | * Provide an environment where people can freely express how they prefer to have services delivered. * Pro-actively encourage people and their family/whānau to express what they need and any issues they have with the interventions and supports they need. * Facilitate access to information including via internet. For example:   [Changing Minds](http://changingminds.org.nz/resources)  [Health Navigator](https://www.healthnavigator.org.nz/)  [Mental Health Foundation](https://www.mentalhealth.org.nz/get-help/resources/)  [Medsafe](http://www.medsafe.govt.nz/Medicines/infoSearch.asp)  [Peerzone](https://www.peerzone.info/toolkit)  [Māori services](https://www.tataihono.nz/)  [HealthEd](https://www.healthed.govt.nz/resource/helplines-and-mental-health-services)   * Provide information on how to access consumer advocates. * Inform people and their families/whānau of treatment, interventions and support options, effects and side effects of those options and provision of diagnostic test results. * Inform people of best or evidence based practices related to their condition(s). |
| How to make known and discuss their needs, care, and support issues. | Ask questions and use the information and services provided to achieve optimal wellness for themselves and their family/whānau. |
| How to access information and resources. | Communicate concerns with us with the support of advocates. |
| Potential harms and the benefits that may be associated with receiving our service. | Arrange and attend appointments with us. Ask questions using resources like:  [Template](https://www.healthnavigator.org.nz/media/1002/lets-plan-for-better-care.pdf) or [videos](https://www.healthnavigator.org.nz/videos/s/shared-decision-making/care-support-planning/).  [Comprehensive planning resources (Health Navigator)](https://www.healthnavigator.org.nz/healthy-living/self-care/care-plans-action-plans/) |

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| **Objective: people engaged with our service interact with us to determine (mana motuhake) the service they receive to achieve their identified health and wellbeing outcomes.**  Related image | | |
| **People engaged with our service and their family/whānau have knowledge of:** | **People engaged with our service and their family/whānau:** | **We provide:** |
| How to provide feed-back and comments about their experience of our service. | Participate in feed-back and consumer surveys. | * Opportunities for REAL-TIME feedback, surveys or focus groups. * Information on the ‘Code’ in the person’s preferred language throughout service delivery. * Participation of people with lived experience in: * Governance. * Peer support. * Strategic planning. * Policy development. * Service delivery. * Service development and design. |
| The Code of Health and Disability Services Consumers’ Rights. | Read or listen to the information on the ‘Code’.  Challenge us and other service providers when the ‘Code’ is not adhered to and engage an independent advocate for support. |
| How to participate on all levels of our organisation. | Participate in advisory roles by sharing their experience and contributing to discussions for improved quality and safety. |
| Capabilities of everybody participating in the health and disability workforce | | |
| **Partnerships with people engaged with our service and their families/whānau**  *Enabling people engaged with our service and their families/whānau to interact with us to achieve the outcomes they identified.* | | |
| **All staff providing services have knowledge of:** | **Staff:** | **Action taken by us:** |
| The core concepts and values associated with person-centred care including health literacy and cultural safety. | Reflect the values of person and whānau ora centred care as an integral part of their everyday practice. | * Supervision, case reviews, information, and training (examples):   + [Health literacy](http://www.health.govt.nz/publication/framework-health-literacy).   + [Cultural safety](https://www.hqsc.govt.nz/our-programmes/patient-safety-day/previous-psw-campaigns/psw-2019/cultural-safety-and-cultural-competence/)   + [Person- centred care](https://www.healthnavigator.org.nz/clinicians/p/patient-centred-care/).   + [Let’s get real](https://www.health.govt.nz/system/files/documents/publications/letsgetreal-sep08.pdf) * Communication coaching and training to staff. * Removing barriers to communicating (transport, language, and attitude). * Provide interpreters. * Provide [training in culturally](http://www.ecald.com/) appropriate communication and understanding of health. * Assess the preferred communication styles of the person engaged with our service and their families/whānau. * Provide an environment in which frank and open discussion can occur. |
| The concept of engagement and partnership with people who have lived experience as a key strategy for improving health outcomes. | Identify the health literacy of the person engaged with our service and adapt their communication style to ensure they and their families/whānau understand important information and are supported to ask questions. |
|  | Partner with the person engaged with our service and their families/ whānau so their care is tailored to meet their expressed needs and preferences. |

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| **Quality and safety culture**  *Contributing to and modelling a culture where quality and safety are top priorities and communicating in a way that shows mutual trust and respect.* | | | | |
| **All health care providers have knowledge of:** | **Staff:** | | **Action taken by us:** | |
| The link between better outcomes for the people engaged with our service and the quality and safety culture of an organisation. | Promote and contribute to a quality and safety culture within their own work environment. | | * Provide staff with posters, procedures, and training to maintain safe practices and a safe environment. * Provide training in open disclosure and effective communication. * Provide an adverse event/incident system that investigates the contexts in which the event occurs. | |
| The value of openness and transparency in health care and the implications for quality and safety. | Be open and transparent in words and actions. | |
| The importance of identifying, recognising, and reporting incidents and/or adverse events and near misses. | Recognise and report unsafe acts. | |
| **Leadership for improvement and change**  *Doing what is right and setting an example for others to follow. Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements. Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.* | | | | |
| **All health care providers have knowledge of:** | **Staff:** | | **Action taken by the organisation:** | |
| The broad principles of leadership for improvement. | Demonstrate leadership appropriate to their role. | | * Identify the leadership skills of staff through performance appraisal and review systems. * Allow staff to utilise and communicate their skills and knowledge. * Respond positively to staff suggestions for improvement. * Involve staff in projects and service re-configurations. * Develop a staff reward scheme for staff who have contributed to improvements in service delivery. * Develop a team reward scheme. | |
| The broad principles of change management and the impact of change on self and others. | Participate in and support change processes. | |
| When and how to step up and take action for quality and safety. | Adapt their own behaviour and attitudes to accommodate change. | |
| Enable change within their team. | |
| Actively communicate successful change. | |
| Model doing the right thing in both words and actions. | |
| Motivate and lead others to do the right thing in words and actions. | |
| **Systems thinking**  *Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim.* | | | | |
| **All health care providers have knowledge of:** | **Staff:** | | **Action taken by us:** | |
| The structure and function of their organisation. | Demonstrate an awareness of where their role fits in the context of the wider system. | | * Provide information on the organisational systems and how anyone fits into it during orientation. * Include quality improvement key indicators in staff position description. * Provide structures for case reviews and supervision. * Involve staff in the development of policies and procedures. | |
| The health and social care system as being complex and adaptive. | Work within their team or department to ensure their actions don’t have unintended consequences for others. | |
| **Teamwork and communication**  *Working with others across professional, organisational, and cultural boundaries to achieve shared quality and safety goals.* | | | | |
| **All health care providers have knowledge of:** | **Staff:** | | **Action taken by us:** | |
| How to communicate effectively. | Ensure written and verbal communications are clear respectful and logical. | | * Provide effective communication guidelines. * Monitor team cohesion. * Integrate team building exercises into staff and case review meetings. * Utilise performance appraisals for feed-back from a variety of sources. * Institute yearly staff satisfaction surveys. | |
| How to engage in active listening. | Engage in active listening. | |
| How team building contributes to team functioning. | Demonstrate understanding of the purpose of the team. | |
| How to give and receive constructive feedback. | Demonstrate understanding of their roles, strengths, and responsibilities as well as that of each team member. | |
| Plan and manage time and responsibilities to achieve team objectives. | |
| Adapt and adjust their own behaviour to meet team objectives. | |
| Show trust and respect for others in the workplace. | |
| Give, receive, and act on constructive feedback. | |
| **Improvement and innovation**  *Using evidence and data to drive improvement and innovation.* | | | | |
| **All health care providers have knowledge of:** | **Staff:** | | **Action taken by us:** | |
| How to locate evidence. | Implement practices that are consistent with current knowledge and evidence. | | * Ensure policies and procedures are in line with best/evidence based practices. * Implement outcome measures for defined processes. | |
| Simple measurement concepts to establish current performance. | Use objective evidence and measures to substantiate decisions and identify opportunities for improvement. | |
| **Quality improvement and service user safety knowledge and skills**  *Using appropriate tools, methods and techniques to improve the quality and safety of care and support.* | | | | |
| **All health care providers have knowledge of:** | **Staff:** | | **Action taken by us:** | |
| The principles of quality improvement and peoples’ safety. | Meet their responsibilities for quality and safety. | | * Involve staff in service improvement projects. * Identify staff strengths, knowledge and skills and utilise them. * Involve staff in the investigation of adverse events. * Inform staff of the outcomes of adverse event/incident investigations. * Involve staff in developing service improvement processes. | |
| Commonly used improvement tools. | Apply tools for improvement. | |
| Simple measures to monitor change. | Set a goal for improvement. | |
| Human factors that may compromise or impact on quality and safety. | Be able to develop a simple measure to evaluate an aspect of care or service delivery and use learnings to improve it. | |
| The key drivers of poor quality care: harm, waste and variation. | Participate in quality improvement and safety projects. | |
| How to report and learn from adverse events, incidents and near misses. | Anticipate and take steps to minimise risk and maximise safety. | |
| Capabilities of operational, clinical and team leaders | | | | |
| **Partnerships with people engaged with our service and their families/whānau**  *Enabling people engaged with our service and their families/whānau to interact with us to achieve the outcomes they identified.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational and services’ team leaders:** | | **Action taken by us:** |
| The core values associated with person-centred care, including health literacy and cultural safety. | | Mentor and enable staff and colleagues to apply the principles of person-centred care as part of their everyday practice | | * Provide guidelines and procedures that are easy to follow and that are based on evidence/best and person-centred practices. * Evaluate any reason for staff not adhering to the required processes. * Introduce a mentoring/buddy system where staff are able to learn from skilled staff how to communicate effectively with people engaged with our service and their families/ whānau. |
| The concept of engagement and partnership with people who have lived experience as a key strategy for improving health outcomes. | | Mentor and enable staff and colleagues to adapt their communication style to ensure people and their families/whānau understand information and are supported to ask questions. | |
| The value of involving people with lived experience and their families/whānau in improving the design and delivery of care. | | Mentor and enable staff and colleagues to partner with people engaged with our service and their families/whānau so that care and support is tailored to meet their expressed needs and preferences. | |
|  | | Facilitate people with lived experience and their families/ whānau involvement in improving the design and delivery of care and support. | |
| **Quality and safety culture**  *Contributing to and modelling a culture where quality and safety are top priorities and communicating in a way that shows mutual trust and respect.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders:** | | **Action taken by us:** |
| Quality and safety culture and the link with better outcomes. | | Champion a quality and safety culture within their own work environment. | | * Ensure that policies and procedures are in line with legislation, best practice, and relevant guidelines. * Integrate quality and safety components in hand-overs, case reviews, staff meetings and adverse event investigations. * Implement root cause analysis to distinguish between systemic issues and individual staff behaviours and practices. |
| How to assess the quality and safety culture. | | Assess the quality and safety culture and use the results to inform improvement. | |
| The value of openness and transparency in health care and the implications for quality and safety. | | Ensure their words and actions model and uphold the values of openness and transparency. | |
| The importance of reporting service user safety incidents and/or adverse events and near misses, and the mechanisms for reporting in their own organisation. | | Receive and act on incidents and/or adverse events and near misses and use the information for learning and improvement. | |
| The difference between system failures and deliberate unsafe acts. | | Use appropriate ways to manage system failures and unsafe acts. | |
| **Leadership for improvement and change**  *Doing what is right and setting an example for others to follow. Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements. Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders:** | | **Action taken by us:** |
| Current theory, practice, and tools for leadership. | | Set, communicate, and lead the strategic direction for quality improvement in collaboration with the senior leaders and governance. | | * Provide staff in leadership positions with leadership, change management and quality systems training. * Set up mentorship and/or clinical supervision systems to support clinical and team leaders. * Listen and respond to clinical and team leaders needs that support quality and safety processes. |
| Current theory, practice, and tools for change management. | | Assess the readiness and create the imperative for change. | |
| How to ask the right questions to advance learning and development within their team/service. | | Build good relationships and use networks across service and organisational boundaries to influence and engage others to bring about change. | |
| Social movement concepts in generating and sustaining commitment over time. | | Chair or participate in organisational committees that have a key influence on quality and safety. | |
| Principles of and techniques for spread and sustainability. | | Coach, mentor and empower others to improve capability in quality and risk leadership. | |
| Actively communicate successful change. | |
| **Systems thinking**  *Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim. Emphasising the whole with an awareness of the parts and their relationships to each other.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders:** | | **Action taken by us:** |
| The New Zealand health care context including the structure and function of national, regional, and local organisations. | | Demonstrate an awareness of the various roles they undertake and/or manage in the context of the wider system. | | Staff in leadership roles are supported to:   * Include in their time schedules on-going regional, national, and international reading on health and specific mental health and addiction service provision approaches and systems. * Participation in regional and national projects. * Participation in regional and national network meetings. * Subscribe to regional, national, and international newsletters that provide information on mental health and addiction care systems and forward them to the staff in leadership positions. |
| The New Zealand Triple Aim. | | Facilitate awareness of the complex interplay between people engaging with our service, their families/whānau, health care workers and the work environment, and the implications for quality and safety. | |
| The health and social care system as complex and adaptive. | | Use multidisciplinary input to analyse quality and safety improvement. | |
| Quality and safety as integral system properties. | | Ensure team or department actions don’t have unintended consequences for other areas. | |
| The application of systems theory and operational management in health care. | |  | |
| Systems and processes across the continuum of care. | |
| **Teamwork and communication**  *Working with others across professional, organisational, and cultural boundaries to achieve shared quality and safety goals.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders:** | | **Action taken by us:** |
| How to communicate effectively for improvement. | | Ensure written and verbal communications are clear, respectful, and logical. | | * Position descriptions are clear and identify the expectations of the role clearly. * People in leadership positions have access to a mentor or/and supervision. * Performance appraisals are designed to ensure strength and weaknesses are identified. * Staff in leadership roles have access to training relevant to their role. * Care is taken to recruit the right people for leadership positions. |
| How to engage in active listening. | | Engage in active listening. | |
| How team building contributes to team functioning. | | Demonstrate understanding of the purpose of the team. | |
| How to give and receive constructive feedback. | | Demonstrate understanding of their roles, strengths, and responsibilities. | |
| Conflict management and resolution. | | Demonstrate and clarify understanding of the roles, strengths, and responsibilities of team members. | |
| Foster a team culture that supports quality and safety. | |
| Adapt and adjust their own behaviour and strategies to meet service and organisational objectives. | |
| Give, receive, and act on constructive feedback. | |
| **Improvement and innovation**  *Using evidence and data to drive improvement and innovation.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders:** | | **Action taken by us:** |
| Evidence-informed practice methods and tools. | | Access and appraise evidence to inform practice. | | * Provide staff with best and evidence based practice guidelines. * Provide staff in leadership positions with time and tools to explore validated outcome measures. * Support staff in leadership positions to implement outcome measures, surveys, projects, and internal audits. |
| The role of quantitative and qualitative data for improving system performance. | | Use evidence and industry benchmarks to set performance standards and inform continuous improvement. | |
| Types of data, sampling methodologies, data collection and management. | | Use valid and reliable measures to evaluate aspects of service delivery and inform improvement, change and sustainability. | |
| The reliability, validity, and limitations of measurements. | | Use multiple information sources and a broad range of indicators to assess system performance and reliability. | |
| Basic data analysis, interpretation, and presentation to inform decision-making. | | Support best and innovative practice changes. | |
| The requirement for a broad range of indicators to understand system performance and reliability. | | Measure and act on people’s experiences of care and monitor clinical and support outcomes. | |
| The importance of narratives and feedback by people engaged with our service. | | Publicise and act on narratives and feedback by people engaged with our service and their family/ whānau. | |
| **Quality improvement and peoples’ safety knowledge and skills**  *Using appropriate tools, methods, and techniques to improve the quality and safety of care.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders:** | | **Action taken by us:** |
| Improvement science and safety methodologies and tools for people engaged with our service. | | Meet their responsibilities for quality and safety. | | * Training as already identified in previous action points. * Supporting practices that are already identified in previous action points. * Investigations of adverse events will focus on systems issues rather than blaming individuals for the errors identified. * Ensure that people in leadership positions are aware of and implement open disclosure. |
| Current context of health care improvement and people’s safety. | | Operationalise the organisation’s quality and people’s safety framework. | |
| Risk management (service delivery and operational). | | Operationalise the organisation’s clinical governance structure. | |
| The key drivers of poor quality care: harm, waste and variation. | | Use and model appropriate safety practices to manage risk and increase reliability across the continuum of care. | |
| A systems approach to learn from failures, including the role of adverse event management and open communication. | | Identify and define problems especially in relation to harm, waste and variation. | |
| How other organisations nationally and internationally have successfully improved. | | Participate in quality improvement and service user safety projects. | |
| How to implement, spread and sustain improvements. | | Work with senior leaders to ensure systems and processes are in place to support people engaged with our service, their families/whānau and staff after adverse events. | |
| Utilise quality improvement expertise where appropriate. | |
| Coach and mentor others to build capability in quality improvement and service user safety. | |

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| Capabilities of quality and risk/safety experts | | |
| **Partnerships with people engaged with our service and their families/whānau**  *Enabling service users and their families/whānau to interact with us to achieve their desired outcomes.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| The core values associated with person-centred care including health literacy and cultural safety. | Mentor and enable staff and colleagues in applying the principles of person-centred care as part of their everyday practice. | * Provide solid data from people’s and their families/whānau feed-back, complaints and adverse events to the quality and safety experts. * Ensure a budget to engage quality and safety experts is in place. * Monitor the implementation of the lived experience partners and family whānau participation processes. |
| The concept of engagement and partnership with people who have lived experience as a key strategy for improving health outcomes. | Mentor and enable staff and colleagues to adapt their communication style to ensure people engaged with our service and their families/whānau understand information and are supported to ask questions. |
| The value of involving people engaged with our service and their families/whānau in improving the design and delivery of care. | Mentor and enable staff and colleagues to partner with people engaged with our service and their families/whānau so that care is tailored to meet their expressed needs and preferences. |
| Work with our organisation, teams, and people with lived experience to promote and provide guidance about involving people engaged with our service and their families/ whānau in improving the design and delivery of care. |
| **Quality and safety culture**  *Contributing to and modelling a culture where quality and safety are top priorities and communicating in a way that shows mutual trust and respect.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| Quality and safety culture and the link with better outcomes for people engaged with our service. | Champion a quality and safety culture across the organisation. | * Quality initiatives and service improvement plans are included in our strategic, business/organisational plans that have input by the quality and safety experts. * We have a quality and risk plan that is developed by the quality and risk/safety experts and mandated by our governance group. * We mandate that the quality and safety experts lead service improvement measures. |
| The value of openness and transparency in health care and the implications for quality and risk/safety. | Ensure their words and actions model and uphold the values of openness and transparency. |
| The importance of reporting risk and safety incidents and/or adverse events and near misses and the mechanisms for reporting. | Provide organisational guidance and support by measuring the quality and safety culture and using the results for improvement. |
| The difference between system failures and deliberate unsafe acts. | Assist team and senior leaders with identifying, prioritising, and responding to quality and risk/safety concerns in a timely manner. |
| How to analyse the quality and safety culture and apply improvement methods to strengthen the quality and safety culture. | Use appropriate ways to manage system failures and unsafe acts. |
| **Leadership for improvement and change**  *Doing what is right and setting an example for others to follow. Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements. Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| Current theory, practice, and tools for leadership. | Work with senior and organisational leaders to set and lead the organisational strategic direction for quality improvement. | * Ensure that quality and safety experts are included when strategic directions and operational plans are developed. * Define input in meetings by quality and safety experts in the terms of references. * Include the requirements to engage quality and safety experts in CEO/managers’ position descriptions. * Support service delivery staff participate in quality and safety projects. |
| Current theory, practice, and tools for change management. | Provide expertise to facilitate continuous quality improvement with key stakeholders and across professional, organisational, and other boundaries. |
| Social movement concepts in generating and sustaining commitment over time. | Support senior and organisational leaders in bringing a quality and safety focus to organisational meetings. |
| How to ask the right questions to advance learning and development. | Chair or participate in organisational committees that have a key influence on quality and risk/safety. |
| Principles of, and techniques for, spread and sustainability. | Assess and communicate the readiness for organisational change. |
| Champion, support and communicate organisational change processes. |
| Build relationships and networks across professional, organisational and agency boundaries to influence and engage others to bring about change. |
| Challenge the status quo by asking the right questions. |
| Support and provide guidance to ensure organisational implementation and spread of effective quality and safety initiatives. |
| Actively communicate successful change and encourage participants to share their stories. |

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| **Systems thinking**  *Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim. Emphasising the whole with an awareness of the parts and their relationships to each other.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| The New Zealand health care context including the structure and function of national, regional, and local organisations. | Demonstrate an awareness of the various roles they undertake and/or manage in the context of the wider system. | * Enable quality and safety experts to participate in regional and national service improvement projects. * Ensure that the quality and safety experts receive newsletters from acknowledged quality related organisations.   Examples:  [Health Quality and Safety Commission](https://www.hqsc.govt.nz/)  [Institute for Healthcare Improvement](http://www.ihi.org/Pages/default.aspx)  [MOH Health Improvement and Innovation Digest](https://www.hiirc.org.nz/)  [Te Pou](https://www.tepou.co.nz/about)  [Te Rau Ora](https://terauora.com/) |
| The New Zealand Triple Aim. | Teach about the complex interplay between people engaged with our service and their family/whānau, health care workers and the work environment; and the implications for quality and risk/safety. |
| The health and social care system as complex and adaptive. | Ensure human factors knowledge is used to improve the delivery of safe, person-centred health care. |
| Quality and safety as integral system properties. | Apply systems thinking to the facilitation and coordination of quality and safety improvement initiatives. |
| The application of systems theory and operational management in health care. | Work with multidisciplinary teams and leadership to analyse system quality and safety improvement opportunities and prioritise strategies for action. |
| Systems and processes across the continuum of care. | Lead capability building to improve organisational quality and safety. |
| Tools to analyse the organisation and its systems and processes. |  |
| **Teamwork and communication**  *Working with others across professional, organisational, and cultural boundaries to achieve shared quality and safety goals.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| How to communicate effectively for improvement. | Model communication that is clear, respectful, and logical. | * Include team work and communication requirements in the position descriptions of the quality and safety experts. * Develop key performance indicators on core requirements of the quality and safety experts’ roles. |
| How to engage in active listening. | Engage in active listening. |
| How team building contributes to team functioning. | Demonstrate understanding of the purpose of the team. |
| How to give and receive constructive feedback. | Demonstrate understanding of their roles, strengths, and responsibilities. |
| Conflict management and resolution. | Demonstrate and clarify understanding of the roles, strengths, and responsibilities of team members for quality and safety. |
|  | Foster a team culture that supports quality and safety. |
| Adapt and adjust their own behaviour and strategies to meet service and organisational objectives. |
| Give, receive, and act on constructive feedback. |
| Model effective strategies for conflict management. |
| **Improvement and innovation**  *Using evidence and data to drive improvement and innovation.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| Evidence-informed practice methods and tools. | Promote the use of evidence-informed practice across the organisation. | * Support the quality and safety experts in implementing data collection and collation methodologies. * Maintain a system that includes data collection by staff and consultants in their KPIs. |
| Types of data, sampling methodologies, data collection and management. | Undertake robust data analyses and communicate the results promptly and effectively. |
| The reliability, validity, and limitations of measurements. | Act on people’s narratives and feedback. |
| How to analyse, interpret and present data to communicate results. | Support best, and innovative, practice changes. |
| The importance of people’s narratives and feedback. |  |
| **Quality improvement and service user safety knowledge and skills**  *Using appropriate tools, methods, and techniques to improve the quality and safety of care.* | | |
| **Quality and safety experts** **have knowledge of:** | **Quality and safety experts:** | **Action taken by us:** |
| Approaches to manage safety/ risks at the individual and organisational levels. | Work with organisational leaders to guide and support the application of appropriate safety practices to manage risk and increase the reliability of safe care. | * Ensure that relevant policies and procedures are developed, maintained, and implemented. * Example policies:   + Open disclosure   + Adverse events   + Health and safety   + Risk register   + De-brief |
| The key drivers of poor quality care: harm, waste and variation. | Model service delivery and operational risk awareness and support the reporting of safety concerns by staff and people engaged in our service and their families/whānau. |
| A systems approach to learn from failures, including the role of adverse event management and open communication. | Are proactive in anticipating future system failures and work with staff, people engaged in our service and their families/whānau to identify and take steps to minimise risk. |
| How to implement, spread and sustain improvements. | Lead/support adverse event reviews to address system vulnerabilities. |
|  | Support a system for sharing learning from failures and successes to improve system performance. |
| Ensure systems and processes are in place to support people engaged in our service, their families/whānau and staff after adverse events. |
| Facilitate the implementation and sustainability of quality improvement and safety initiatives. |
| Lead innovative practice in person-centred system change. |
| Capabilities of senior and organisational leaders | | |
| **Partnerships with people engaged with our service and their families/whānau**  *Enabling people engaged with our service and their families/whānau to interact with us to achieve the outcomes they identified.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders:** | **Action taken by us:** |
| The core values associated with person-centred care including health literacy and cultural safety. | Apply the principles of person-centred care to organisational decision-making and ensure staff apply these principles as part of their everyday practice. | * Include people engaging with our service in processes that affect them directly:   + Admission.   + Support.   + Plan.   + Review.   + Transfers.   + Discharge.   + Hand-over. * Include people with lived experience in processes such as:   + Change in service delivery approaches.   + Building development and changes.   + New service development. * Include family/ whānau representatives in the above activities. |
| The concept of engagement and partnership with people who have lived experience as a key strategy for improving health outcomes. | Ensure the principles of health literacy and cultural safety are embedded in the organisation’s systems and processes. |
| The value of involving people with lived experience and families/whānau in improving the design and delivery of care. | Ensure people with lived experience and families/whānau are involved in improving the design and delivery of care. |
| *Quality and safety culture contributing to and modelling a culture where quality and safety are top priorities. Communicating in a way that shows mutual trust and respect.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders:** | **Action taken by us:** |
| Quality and safety culture and the link with better service user outcomes. | Ensure the organisational strategic plan clearly articulates the quality and safety vision for the organisation. | * Develop and implement an operational/business and quality and safety plan. * Articulate the values of our organisation and ensure that all plans, policies, and procedures reflect those values. * Support staff, people with lived experience and family/whānau in implementing quality and safety projects. * Ensure risk and safety is a routine agenda at all meetings. * Have capability on the organisations website for people engaged with our service and their family/whānau, staff and other stakeholders to voice any safety concerns. * Implement an adverse event and incident management system. |
| The importance of measuring the quality and safety culture. | Ensure structures and processes are in place to support the strategic vision and direction for quality improvement and people’s safety. |
| The value of openness and transparency in health care and the implications for quality and safety. | Champion a quality and safety culture across the organisation. |
| The importance of a reliable near miss, incident, or adverse event reporting system. | Ensure their words and actions model and uphold the values of openness and transparency. |
| The difference between system failures and deliberate unsafe acts. | Ensure quality and risks are routinely considered as part of core organisational business. |
| Ensure the quality and safety culture is measured and the results are used to inform improvement. |
| Receive and act on quality and safety concerns and use the information for learning and improvement. |
| Use appropriate ways to manage system failures and unsafe acts. |
| *Leadership for improvement and change. Doing what is right and setting an example for others to follow. Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements. Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders:** | **Action taken by us:** |
| Current theory, practice and tools for leadership and change management. | Set, communicate, and lead the strategic direction for quality improvement in collaboration with the senior leaders and governance. | Support organisational leaders to attend:   * Training in change management and communication. * Local, regional, and national sector meetings. |
| Social movement concepts in generating and sustaining commitment over time. | Build good relationships and use networks across service and organisational boundaries to influence and engage others to bring about change. |
|  | Coach, mentor and enable others to improve capability in quality and safety leadership. |
| Actively communicate successful change. |
| *Systems thinking - Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim. Emphasising the whole with an awareness of the parts and their relationships to each other.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders:** | **Action taken by us:** |
| The New Zealand health care context including the structure and function of national, regional, and local organisations. | Use multidisciplinary input including quality improvement experts to analyse system quality and safety improvement opportunities and prioritise strategies for action. | * Provide the resources required to establish, maintain, and improve the quality and risk systems. * Ensure there is a yearly budget for quality and risk system development and improvement. |
| The New Zealand Triple Aim. | Ensure quality and safety improvements are coordinated. |
| Quality and risk as integral system properties. | Build organisational quality and safety capability and capacity. |
| The systems and processes across the continuum of care. |  |

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| *Teamwork and communication: working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders:** | **Action taken by us:** |
| How to communicate effectively to solve problems. | Ensure written and verbal communications are clear, respectful, and logical. | * Execute yearly employee satisfaction surveys to assess the team work and communication achievements. |
| How to engage in active listening. | Engage in active listening. |
| How to give and receive constructive feedback. | Demonstrate understanding of the purpose of the team. |
| Conflict management and resolution. | Demonstrate understanding of the purpose of the team and the team members’ roles, strengths, and responsibilities. |
| How team building contributes to team functioning. | Adapt and adjust their own behaviour and strategies to meet service and organisational objectives. |
| Give, receive, and act on constructive feedback. |
| *Improvement and innovation are evidence-informed and data-driven.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders :** | **Action taken by us:** |
| Evidence-informed practice methods and tools. | Use evidence and industry benchmarks to evaluate organisational performance and inform decision-making that encourage best and innovative practice changes. | * Ensure that electronic data collection systems are in place. * Engage university and PhD/ MA students to set up evaluation systems, collect data and evaluate it. |
| The role of quantitative and qualitative data for improving system performance. | Use valid and reliable measures to evaluate aspects of service delivery and inform improvement, change and sustainability. |
| Types of data, sampling methodologies, data collection and management. | Receive and act on information from multiple sources to drive organisational quality and safety. |
| The reliability, validity, and limitations of measurements. | Act on people’s experiences of care and monitor clinical outcomes. |
| Data analysis, interpretation, and presentation to inform decision-making and how to communicate results. | Publicise and act on people’s and their family/whānau narratives and feedback. |
| The requirement for a broad range of indicators to understand system performance and reliability. | Ensure the results of quality and safety measures are disseminated. |
| The importance of people’s narrative and feedback. |  |
| *Quality improvement and service user safety knowledge and skills Using appropriate tools, methods, and techniques to improve the quality and safety of care.* | | |
| **Senior and organisational leaders have knowledge of:** | **Senior and organisational leaders:** | **Action taken by us:** |
| The current context of health care improvement and patient safety. | Define their roles and meet their responsibilities for quality and safety. | * Ensure and resource an effective clinical governance structure. * Ensure resources and expertise are appropriately allocated to achieve quality improvement and safety goals. |
| Clinical and operational risk management systems. | Ensure and put into practice an effective organisational quality and risk framework. |
| A systems approach to learn from failures, including the role of adverse event management and open communication. | Ensure staff use appropriate safety practices. |
| How other organisations, nationally and internationally, have successfully improved. | Ensure operational and service delivery related safety concerns are reported. |
| How to implement, spread and sustain improvements. |  |
| Capabilities of governance/boards/director(s) | | |
| *Partnerships with people engaged with our service and their families/whānau enabling them to interact with health care providers to achieve their desired outcomes.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s):** |
| The concept of people’s engagement and partnership across the spectrum of health care as key strategies for improving health outcomes. | Apply the principles of person-centred care to governance decision-making. | * People with lived experience and family/whānau are represented on the board. |
| The value of involving people with lived experience and families/whānau in improving the design and delivery of care. | Apply the principles of health literacy and cultural safety in all governance communications with people engaged with our service. |
|  | Champion and resource people with lived experience and family/whānau in participating in improving the design and delivery of care. |
| *Quality and safety culture: contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s):** |
| Quality and safety culture and the link with better outcomes for people who use our service. | Ensure structures and processes are in place to support the strategic vision and direction for quality improvement and people’s safety. | * Ensure the organisational strategic plan clearly articulates the quality and safety vision for our organisation. * Ensure quality and safety are routinely considered as part of core governance business. |
| The value of measuring the quality and safety culture to inform improvement. | Uphold the values of openness and transparency. |

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| **Leadership for improvement and change**  *Doing what is right and setting an example for others to follow. Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements. Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s):** |
| Current leadership theory and practice. | Ensure that structures and processes are in place to support organisational leadership and emerging leaders, including those people with lived experience. | * Champion and support organisational change processes that target quality and safety improvements. * Actively communicate successful change that improves people’s safety and health care delivery. |
| Organisational theory and management in health care (including strategic planning). | Empower change within our organisation. |
| Current change management theory and practice. |  |
| **Systems thinking**  *Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim. Emphasising the whole with an awareness of the parts and their relationships to each other.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s):** |
| The New Zealand health care context including the structure and function of national, regional, and local organisations. | Ensure quality and safety is coordinated across organisational boundaries. | * Discuss the reports provided by the CEO/Manager. * We are members of regional, national, and international associations. |
| The New Zealand Triple Aim. | Ensure they action the national agenda for quality and safety. |
| The health and social care system as complex and adaptive. |  |
| **Teamwork and communication**  *Working with others across professional, organisational, and cultural boundaries to achieve shared quality and safety goals.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s):** |
| How to communicate effectively to solve problems. | Model communication that is clear, respectful, and logical. | * Adhere to the organisational values in internal and external relationships. * Review the organisational values yearly. |
| How to engage in active listening. | Engage in active listening. |
| How team building contributes to team functioning. | Give, receive, and act on constructive feedback. |
| **Improvement and innovation.**  *Using evidence and data to drive improvement and innovation.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s) will ensure:** |
| The role of quantitative and qualitative data for improving system performance. | Use evidence and industry benchmarks to evaluate organisational performance and inform decision making. | * Quality improvement is a routine agenda at Board meetings. |
| Data analysis, interpretation, and presentation to inform decision-making. | Publicise and act on narratives and feedback by people with lived experience and family/whānau. |
| The importance of people’s narratives and feedback. |  |
| **Quality improvement and people’s safety knowledge and skills.**  *Using appropriate tools, methods, and techniques to improve the quality and safety of service delivery.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s):** | **Action taken by the governance/board/director(s):** |
| The current context of health care improvement and safety. | Define their roles and meet their responsibilities for quality and safety. | Build board capability in quality and safety. |
| Operational risk management systems. | Ensure resources and expertise are appropriately allocated to achieve quality and people’s safety goals. |
| The importance of a risk/safety reporting system. |  |
| The key drivers of poor quality service delivery: harm, waste and variation. |
| A systems approach to learn from failures, including the role of adverse event management and open communication. |

# Quality improvement and safety activity schedule (examples)

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| **Activity** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** |
| **Audit** | Medication system | HR records | Health records |  |  |  |  |  |  |  |  |  |
| **Monitor** | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp | Water temp |
| **Evaluation** | Survey: staff |  | Survey: people engaged |  |  |  |  |  |  |  |  |  |
| **Review** |  |  | Quality/Risk plans | H & |  | Quality/Risk plans |  |  | Quality/Risk plans | Strategic plan |  |  |
| **Meetings** | Health and Safety  Staff  People engaged | Quality | Governance | Infection prevention and antimicrobial stewardship |  |  |  |  |  |  |  |  |
| **Policy review** | Infection P and AMS |  | Health and Safety |  |  |  |  |  |  |  |  |  |
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