**Quality, Safety**

**&**

**Improvement**

**Framework**



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# 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’.

This document ‘Quality improvement framework’ is based on the Commissions publication.

Organisations might want to introduce internationally acclaimed overarching quality principles, additionally 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 service users, non-clinical and clinical staff and those in management work collaboratively with a common purpose

as illustrated below (Triple Aim):

Best value for public health resources

Improved health and equity for everyone

Improved quality, safety and experience

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| --- |
| **Definitions – World Health Organisation**  “The extent to which health care services provided to individuals and service user populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred.”  Quality of care  Safe  Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors.  Effective    Providing services based on scientific knowledge and evidence-based guidelines.  Timely  Reducing delays in providing and receiving health care.  Efficient  Delivering health care in a manner that maximizes resource use and avoids waste.  Equitable  Delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.    People-centered  Providing care that takes into account the preferences and aspirations of individual service users and the culture of their community. |

# Guidelines, Standards and Legislation

The organisation will apply all relevant health and non-government organisation related sector and quality standards and legislation relevant to its services. [Ministry of Health](http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health-publications), [Health Quality and Safety Commission](http://www.hqsc.govt.nz/publications-and-resources/), [Te Pou](https://www.tepou.co.nz/resources) and other relevant guidelines will be implemented, appropriate to the services provided.

**Standards:**

* [ISO Quality Management Systems](https://www.standards.govt.nz/search-and-buy-standards/standards-information/quality-management-systems/)
* [NZS 8134:2008 Health and Disability Services Standards](http://www.health.govt.nz/system/files/documents/pages/81341-2008-nzs-health-and-disability-services-core.pdf)
* [NZS 8158:2012 Home and community support Sector Standard](http://shop.standards.co.nz/catalog/8158%3A2012(NZS)/view)
* [NZS 8153:2002 Health Records](http://shop.standards.co.nz/catalog/8153%3A2002(NZS)/view)

**Best practices and quality systems:**

* [BMJ Clinical Evidence](http://www.clinicalevidence.com/x/index.html)
* [Guidelines International Network](http://www.g-i-n.net/)
* [International Mental Health Collaborating Network](http://www.imhcn.org/)
* [International Society for Psychological and Social Approaches to Psychosis](http://www.isps.org/)
* [Kaizen Quality Improvement Systems](http://www.leanproduction.com/kaizen.html)
* [MAD in America](http://education.madinamerica.com/)
* [Research Review](http://www.researchreview.co.nz/nz/Clinical-Area.aspx)
* [SAMHSA](https://www.samhsa.gov/)
* [Six Sigma](https://www.graphicproducts.com/articles/six-sigma-principles/)
* [Te Pou Let’s Get Real](http://www.tepou.co.nz/supporting-workforce/lets-get-real)

**Legislation:**

* [Health Act 1956](http://www.legislation.govt.nz/act/public/1956/0065/latest/DLM305840.html)
* [Health and Disability Services (Safety) Act 2001](http://www.legislation.govt.nz/act/public/2001/0093/latest/DLM119975.html)
* [Health Practitioners Competence Assurance Act 2003](http://www.moh.govt.nz/hpca)
* [www.legislation.govt.nz](http://www.legislation.govt.nz)
* [Code of Health and Disability Services Consumers’ Rights 1996](http://www.hdc.org.nz/the-act--code/the-code-of-rights)
* [Human Rights Act 1993](http://www.legislation.govt.nz/act/public/1993/0082/latest/whole.html)
* [Mental Health (Compulsory Assessment and Treatment) Act 1992](http://www.legislation.govt.nz/act/public/1992/0046/latest/whole.html)
* [New Zealand Bill of Rights Act 1990](http://www.legislation.govt.nz/act/public/1990/0109/latest/DLM224792.html)
* [The Privacy Act 1993](http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM296639.html)
* [The Health Information Privacy Code 1994](http://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/Health-Information-Privacy-Code-1994-including-Amendment.pdf)

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# Relationship between Quality Assurance (QA) and Quality Improvement (QI)

The environment in which quality assurance and quality improvement activities occur has a major impact on their success. The principles of Quality Management will provide a context in which quality assurance and quality improvement will thrive. The chart below details and categorises the distinctions between QA and QI.

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| --- | --- | --- |
|  | **Quality Assurance** | **Quality Improvement** |
| Motivation | Measuring compliance with standards | Continuously improving processes to meet standards |
| Means | Inspection | Prevention |
| Attitude | Required, defensive | Chosen, proactive |
| Focus | Outliers: *"bad apples"*  Individuals | Processes  Systems |
| Scope | Service provider | Service user support/interventions |
| Responsibility | Few | All |

# Domains of the New Zealand quality and safety capability framework

Are in partnership with service providers to achieve their goals.

**Service users and their families/ whānau.**

Contributing to a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.

**Quality and safety culture**

Doing what is right. Setting an example for others to follow. Directing quality and safety improvements.

**Leadership for improvement and change**

The service delivery systems are dynamic, interrelated and interdependent. They include people and processes and are contextual.

**Systems thinking**

Across professional, organisational and cultural boundaries to achieve shared quality and safety goals.

**Teamwork and communication**

Using evidence and data to drive improvement and innovation.

**Improvement and innovation**

Using evidence based processes and practices to improve the quality and safety of care.

**Quality improvement and service user safety knowledge and skills**

**The framework identifies six health care groups:**

# Quality Objectives and Plans

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Enabling service users and their families/whānau as members of the health team | | | | |
| **Objective: Service users interact with service providers in order to participate in their service delivery and to achieve their identified health and wellbeing outcomes.**  Related image | | | | |
| **Service users and their family/whānau have knowledge of:** | **Service users and their family/whānau will:** | | **The organisation will provide the following:** | |
| How to develop and maintain a partnership with service providers. | Participate in their care and treatment by expressing their needs and preferences. | | * Provide service users with resources available at Health Navigator. [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/). * Provide an environment where service users can freely express how they prefer to have services delivered. * Provide service users with resources available:   Health Navigator: [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/).   * Pro-actively encourage service users and their family/whānau to express what they need and any issues they have with the treatment, interventions and supports they need. * Facilitate access to information 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)   * Encourage service users and their families to subscribe to newsletters from the above mentioned services. * Provide service users with information on how to access consumer advocates. * Inform service users and their families/whānau of treatment, interventions and support options, effects and side effects of those options and provision of diagnostic test results. * Inform clients of best practice or evidence based treatment, interventions and support that match their condition (s). | |
| How to make known and discuss their needs, care and treatment issues. | Ask questions and use the information and services provided to achieve optimal wellness for themselves or their family/whānau. | |
| How to access information and resources. | Communicate concerns with the service provider or agency with the support of consumer advocates. | |
| Potential harms and the benefits that may be associated with receiving health care and treatment. | Attend appointments with the health care team. 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/) | |
| **Objective: Service users interact with service providers in order to participate in their service delivery and to achieve their identified health and wellbeing outcomes.**  Related image | | | | |
| **Service users and their family/whānau have knowledge of:** | | **Service users and their family/whānau will:** | | **The organisation will provide the following:** |
| How to provide feed-back and comments about their experience of the services received. | | Participate in feed-back and consumer surveys. | | * Provide opportunities for REAL-TIME feedback or client satisfaction surveys. * Provide information in the preferred language of the service user and their families on the ‘Code’ throughout service delivery. * Client participation processes on all levels of the organisation: * 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 service providers when the ‘Code’ is not adhered to and engage an independent advocate for support. | |
| Best practice in service provision includes consumer and family participation on all levels of a health, disability and support services. | | 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 service users and their families/whānau**  ***Enable service users and their families/whānau to interact with health care providers to achieve their desired outcomes.*** | | | | |
| **All staff providing services have knowledge of:** | **Staff will:** | | **Action taken by the organisation:** | |
| The core concepts and values associated with service user-centred care including health literacy and cultural safety. | Reflect the values of service user-centred care as an integral part of their everyday practice | | * Provision of supervision, case reviews, information and training (examples):   + [Health literacy](http://www.health.govt.nz/publication/framework-health-literacy)   + [Cultural competency](http://learnonline.health.nz/course/category.php?id=84)   + [Service user centered 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) * Provide communication coaching and/or training to staff. * Identify barriers to communicating (transport, language, attitude). * Have an Interpreter policy and procedure. * Provide [training in culturally](http://www.ecald.com/) appropriate communication and understanding of health. * Assess the preferred communication styles of the service user and their families/whānau. * Provide an environment in which frank and open discussion can occur. | |
| The concepts of service user engagement and service user partnership across the spectrum of health care as a key strategy for improving health outcomes. | Identify the health literacy of the service user and adapt their communication style to ensure they and their families/whānau understand important information and are supported to ask questions. | |
|  | Partner with service users and their families/ whānau so their care is tailored to meet their expressed needs and preferences. | |
| **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 will:** | | **Action taken by the organisation:** | |
| The link between better service user outcomes 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 service user safety 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 will:** | | **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 management 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 rewarding scheme for staff who have contributed to improvements in service delivery. * Develop a team rewarding 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 will:** | | **Action taken by the organisation:** | |
| 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 service delivery related procedures. | |
| The health care system as 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 will:** | | **Action taken by the organisation:** | |
| 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. | |

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| **Improvement and innovation**  *Using evidence and data to drive improvement and innovation.* | | | | |
| **All health care providers have knowledge of:** | **Staff will:** | | **Action taken by the organisation:** | |
| 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:   + internal audits,   + service user outcome tools. | |
| 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.* | | | | |
| **All health care providers have knowledge of:** | **Staff will:** | | **Action taken by the organisation:** | |
| The principles of quality improvement and service user safety. | Meet their responsibilities for quality and safety. | | * Involve staff in service improvement projects. * Identify staff strength, knowledge and skills and utilise them. * Involve staff in the investigation of adverse events. * Inform staff of the outcomes of investigations of adverse event. * Involve staff in developing service improvement processes for specific adverse events. | |
| 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 service user 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 service users and their families/whānau**  *Enabling service users and their families/whānau to interact with health care providers to achieve their desired outcomes.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders will:** | | **Action taken by the organisation:** |
| The core values associated with service user centered care, including health literacy and cultural safety. | | Mentor and enable staff and colleagues to apply the principles of service user-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 service user centered practices. * Evaluate any reason for staff not adhering to the required processes. * Introduce a mentoring/buddy system were staff are able to learn from skilled staff how to communicate effectively with service users and their families/ whānau. |
| The concept of service user engagement and service user partnership across the spectrum of health care as a key strategy for improving health outcomes. | | Mentor and enable staff and colleagues to adapt their communication style to ensure service users and their families/whānau understand information and are supported to ask questions. | |
| The value of involving service users and their families/whānau in improving the design and delivery of care. | | Mentor and enable staff and colleagues to partner with service users and their families/whānau so that care is tailored to meet their expressed needs and preferences. | |
|  | | Facilitate service user and their families/ whānau involvement 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.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders will:** | | **Action taken by the organisation:** |
| Quality and safety culture and the link with better service user outcomes. | | Champion a quality and safety culture within their own work environment. | | * Ensure that the Adverse Event Management policy and procedure is 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 will:** | | **Action taken by the organisation:** |
| 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 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.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders will:** | | **Action taken by the organisation:** |
| 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 models 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 service users, families/whānau, health care workers and the work environment, and the implications for quality and safety. | |
| The health 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 will:** | | **Action taken by the organisation:** |
| 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 persons for leadership positions. (Utilising validated tests or other means of assessing the suitability). |
| 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 will:** | | **Action taken by the organisation:** |
| Evidence-informed practice methods and tools. | | Access and appraise evidence to inform practice. | | * Provide staff with best and evidence based practice guidelines. * Policies and procedures are informed on evidence based and best practice. * Provide staff in leadership positions with time and tools to explore validated outcome measures. * Support staff in leadership positions to implement outcome measures, surveys 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 service user experiences of care and monitor clinical outcomes. | |
| The importance of service user narratives and feedback. | | Publicise and act on service user and family/whānau 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.* | | | | |
| **Operational, clinical and team leaders have knowledge of:** | | **Operational, clinical and team leaders will:** | | **Action taken by the organisation:** |
| Improvement science and service user safety methodologies and tools. | | 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 service user safety. | | Operationalise the organisation’s quality and service user safety framework. | |
| Risk management (clinically and operationally). | | 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 service users, 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. | |
| Capabilities of quality and safety experts | | | | |
| **Partnerships with service users and their families/whānau**  *Enabling service users and their families/whānau to interact with health care providers to achieve their desired outcomes.* | | | | |
| **Quality and safety experts** **have knowledge of:** | | **Quality and safety experts will:** | | **Action taken by the organisation:** |
| The core values associated with service user centred care including health literacy and cultural safety. | | Mentor and enable staff and colleagues in applying the principles of service user-centred care as part of their everyday practice. | | * Provide solid data from service users 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. * Provide and support a work environment that is responsive to the communication needs of service users and their family/ whānau. * Monitor the implementation of the service user participation and family/ whānau participation policy and procedure. |
| The concept of service user engagement and service user partnership across the spectrum of health care as key strategies for improving health outcomes. | | Mentor and enable staff and colleagues to adapt their communication style to ensure service users and their families/whānau understand information and are supported to ask questions. | |
| The value of involving service users and their families/whānau in improving the design and delivery of care. | | Mentor and enable staff and colleagues to partner with service users and their families/whānau so that care is tailored to meet their expressed needs and preferences. | |
| Work with the organisation, teams and service users to promote and provide guidance about involving service users 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 will:** | | **Action taken by the organisation:** |
| Quality and safety culture and the link with better service user outcomes. | | Champion a quality and safety culture across the organisation. | | * Quality initiatives and service improvement plans are included in the organisations strategic, business/organisational plans that have input by the quality and safety experts. * The organisation has a quality and risk plan that is developed by the quality and safety experts and mandated by the organisational governance. * The organisation mandates 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 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. | | 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 safety concerns in a timely manner. | |
| How to analyse the quality and safety culture measurements 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 will:** | | **Action taken by the organisation:** |
| 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 quality and safety project that service delivery staff participate in. |
| 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 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. | |
| **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 will:** | | **Action taken by the organisation:** |
| 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) |
| The New Zealand Triple Aim. | | Teach about the complex interplay between service users, families/ whānau, health care workers and the work environment; and the implications for quality and safety. | |
| The health care system as complex and adaptive. | | Ensure human factors knowledge is used to improve the delivery of safe, service user -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 will:** | | **Action taken by the organisation:** |
| 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 will:** | | **Action taken by the organisation:** |
| 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 methodologies. * Maintain a system that includes data collection by staff and consultants in their KPI. |
| 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 service user narratives and feedback. | |
| How to analyse, interpret and present data to communicate results. | | Support best, and innovative, practice changes. | |
| The importance of service user 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 will:** | | **Action taken by the organisation:** |
| 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 reporting of safety concerns by staff and service users and their families/whānau. | |
| A systems approach to learn from failures, including the role of adverse event management and open communication. | | Be proactive in anticipating future system failures and work with staff at all levels, service users and the 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 service users, families/whānau and staff after adverse events. | |
| Facilitate the implementation and sustainability of quality improvement and service user safety initiatives. | |
| Lead innovative practice in service user-centred system change. | |
| Capabilities of senior and organisational leaders | | | | |
| **Partnerships with service users and their families/whānau**  *Enabling service users and their families/whānau to interact with health care providers to achieve their desired outcomes.* | | | | |
| **Senior and organisational leaders have knowledge of:** | | **Senior and organisational leaders will:** | | **Action taken by the organisation.** |
| The core values associated with service user centred care including health literacy and cultural safety. | | Apply the principles of service user -centred care to organisational decision-making and ensure staff apply these principles as part of their everyday practice. | | * Include service users in processes that affect them directly:   + admission   + support   + plan   + review   + transfers   + discharge   + hand-over * Include service users in processes that affect them and other service users:   + change in service delivery approaches   + building development and changes   + new service development. * Include family/ whānau representatives in the above activities. |
| The concept of service user engagement and service user partnership 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 service users and their families/whānau in improving the design and delivery of care. | | Ensure the involvement of service users 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. Communicating in a way that shows mutual trust and respect.* | | | | |
| **Senior and organisational leaders have knowledge of:** | | **Senior and organisational leaders will:** | | **Action taken by the organisation.** |
| 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 the organisation and ensure that all plans, policies and procedures reflect those values. * Support staff, service users and family in implementing their quality and safety projects. * Ensure risk and safety is a routine agenda at:   + service user, family, staff, management and Board meetings. * Have capability on the organisations website for service users, families, 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 patient 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 safety 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 will:** | | **Action taken by the organisation.** |
| 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; * attend local, regional and national meetings on workforce development. |
| 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 will:** | | **Action taken by the organisation.** |
| 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 safety systems. * Ensure there is a yearly budget for quality and safety system development and improvement. |
| The New Zealand Triple Aim. | | Ensure quality and safety improvements are coordinated. | |
| Quality and safety as integral system properties. | | Build organisational quality and safety capability and capacity. | |
| The 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.* | | | | |
| **Senior and organisational leaders have knowledge of:** | | **Senior and organisational leaders will:** | | **Action taken by the organisation.** |
| How to communicate effectively to solve problems how team building contributes to team functioning. | | 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. | |
|  | | 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 will:** | | **Action taken by the organisation.** |
| Evidence-informed practice methods and tools. | | Use evidence and industry benchmarks to evaluate organisational performance and inform decision-making 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 service user 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 service user and family/ whānau narratives and feedback. | |
| The requirement for a broad range of indicators to understand system performance and reliability. | | Ensure the quality and safety measure results are disseminated. | |
| The importance of service user 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 will:** | | **Action taken by the organisation.** |
| 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 service user safety goals, and build capability and capacity. |
| Clinical and operational risk management systems. | | Ensure and put into practice an effective organisational quality and patient safety framework. | |
| A systems approach to learn from failures, including the role of adverse event management and open communication. | | Ensure staff use appropriate safety practices to manage safety. | |
| How other organisations, nationally and internationally, have successfully improved. | | Ensure all service users and staff report operational and clinical safety concerns. | |
| How to implement, spread and sustain improvements. | |  | |
| Capabilities of governance/boards/director(s) | | | | |
| *Partnerships with service users and their families/whānau enabling service users and their families/whānau 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) will:** | | **Action taken by the governance/board/director(s) will:** |
| The concept of service user engagement and partnership across the spectrum of health care as key strategies for improving health outcomes. | | Apply the principles of service user -centred care to governance decision-making. | | * Ensure service user and family representation on the Board. |
| The value of involving service users and their families/whānau in improving the design and delivery of care. | | Apply the principles of health literacy and cultural safety in all governance communications with service users. | |
|  | | Champion and resource service users and their family/whānau involvement 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) will:** | | **Action taken by the governance/board/director(s) will:** |
| Quality and safety culture and the link with better service user outcomes. | | Ensure structures and processes are in place to support the strategic vision and direction for quality improvement and patient safety. | | * Ensure the organisational strategic plan clearly articulates the quality and safety vision for the 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) will:** | **Action taken by the governance/board/director(s) will:** |
| Current leadership theory and practice. | Structures and processes are in place to support organisational leadership and emerging leaders, including in community health consumer networks. | * Champion and support organisational change processes that target quality and safety improvements. * Actively communicate successful change that improves patient safety and health care delivery. |
| Organisational theory and management in health care (including strategic planning). | Empower change within their 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) will:** | **Action taken by the organisation:** |
| 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. | * Discusses the reports provided by the CEO/Manager. * The organisation has membership of regional, national and international associations. |
| The New Zealand Triple Aim. | Ensure the organisation actions the national agenda for quality and safety. |
| The health 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) will:** | **Action taken by the governance/board/director(s) will:** |
| 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) will: | **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 service user and family/ whānau narratives and feedback. |
| The importance of service user and family/ whānau 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 service delivery.* | | |
| **The members of the governance/board/director(s) have knowledge of:** | **The members of the governance/board/director(s) will:** | **Action taken by the governance/board/director(s) will:** |
| The current context of health care improvement and service user 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 service user safety goals. |
| The importance of a service user safety reporting system. |  |
| The key drivers of poor quality care: harm, waste and variation. |
| A systems approach to learn from failures, including the role of adverse event management and open communication. |

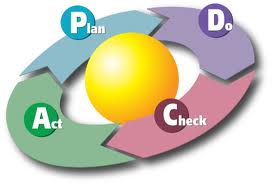
# Quality and Safety Improvement Processes

The identification of quality and safety issues are informed by:

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| **Monitoring activities** | **Practice** | **Feed-back** | **Events** |
| Internal audits | Performance management | Service user | Accidents |
| External audits | Supervision | Service user family | Adverse Events/  Incidents |
| Maintenance checks | Evidence/best practices | External service providers | Complaints |
| Hazard identification | Legislation | Employees | Near misses |

## Service improvement/corrective action processes:

Any service improvement identified will follow the overall quality assurance and improvement processes using this methodology:



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| **Plan** | **Do** | **Check/Analyse** | **Act** |
| Understand the gap between stakeholder expectations and what is delivered. Develop a plan to close those gaps. | Implementation of the plans will be time framed and responsibilities and accountabilities will be allocated. Collect data to determine if the gaps are closing. | Observe the changes and test them. Analyse the data collected and pinpoint any issues arising. | Study the results of the plans implemented and the analysis of the data collected. Re-design the system to reflect the learnings made.  Communicate the findings and changes. |
| Maintain a service improvement/corrective action log that includes the above processes. | | | |

## Mechanisms to communicate quality, safety and service improvement data and outcomes

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| **Mechanism** | **Audience** | **Information** | **Frequency** |
| Organisations website | Public | External audit results.  Satisfaction survey results.  Service improvement projects. | At least 6-monthly updates. |
| Intranet | Employees | Internal audit results.  Health and Safety issues and Hazards.  Updated policies and procedures.  Change in practices and processes. | monthly |
| Service user meetings | Service users | Meetings have routine agenda items that include:   * Health and safety. * Quality. * Safety and risk issues. * Infection issues. | monthly |
| Staff meetings | Staff | monthly |
| Management meetings | Leadership team members | monthly |
| Board meetings | Trustees/Directors | 3-monthly |

# Quality Plan 20.. to 20..

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| **Activity** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** |
| **Audit** | SU records | Employee records | Medication management processes | Laundry and cleaning systems | Environment | Spill-kit  Emergency supplies  First aid kit  PPE | SU records | Food plan and food preparation processes | Medication management processes | Laundry and cleaning systems | Environment | Spill-kit  Emergency supplies  First aid kit  PPE |
| **Collate and analyse SU**  **satisfaction surveys** |  |  |  | x |  |  |  |  |  | x |  |  |
| **Collate and analyse family satisfaction survey** |  |  | x |  |  |  |  |  | x |  |  |  |
| **Employee satisfaction surveys** |  |  |  |  |  | x |  |  |  |  |  |  |
| **Health and Safety** | Monthly submission of health and safety hazard identification. | Health and Safety meeting | Monthly submission of health and safety hazard identification. | Health and Safety meeting | Monthly submission of health and safety hazard identification. | Health and Safety meeting | Monthly submission of health and safety hazard identification. | Health and Safety meeting |  |  |  |  |
| **Quality**  **Meeting** |  | x |  |  | x |  |  | x |  |  | x |  |
| **Review** |  | 2 policies  and procedures |  | 2 policies  and procedures |  | 2 policies  and procedures |  | 2 policies  and procedures |  | 2 policies  and procedures |  | 2 policies  and procedures |
| **Monitor** | Weekly fridge, freezer and water temperatures | | | | | | | | | | | |
| **Surveillance** | Monthly infection surveillance | | | | | | | | | | | |

# Consultation

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| **Group/Role** | **Date** |
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|  |  |
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