# Quality improvement (patient safety) approaches and aligned capability/workforce development

IIMHL learning exchange

27 and 28 February 2017, Wellington, New Zealand

Hosted by: Quality Health and Safety Commission – Dr Janice Wilson and Te Pou o te Whakaaro Nui – Emma Wood

What **knowledge** was shared in the match?

The exchange provided an opportunity to understand some of the quality improvement programmes that are occurring for mental health in Scotland, New South Wales Australia and New Zealand. The presentations provided an overview of some of the programmes, how they are operating and what has been achieved so far. There were a number of examples provided to demonstrate successful changes brought about as a result of the QI programmes. Some examples of these were in reducing the use of seclusion and psychotropic drug administration. Change was demonstrated through data as well as many discussions about changing the culture of how people are working. Participants on the exchange were from Scotland, Australia, Canada and New Zealand.

What **innovations** were discussed? How have they been **validated**?

Some themes from the 2 days that emerged from the presentations and discussions included:

- Understanding 'harm' – how does this get applied to reframe people's engagement in understanding quality improvement
- Need to reframe the discussions around engaging people in quality improvement so that these are strengths based e.g.
    - What's getting in the way of doing your best?
    - What's the one pebble in your shoe you want to remove?
- As part of creating the culture for improvement it is important to respect the value that people bring. Need to provide permission for everyone to generate ideas for improvement, give things a go and test and if it didn't work try something else. Need to build the will for people to engage in quality improvement
- Need to adapt, lead and share
- Have learnt about balancing experience (years of experience in service and expertise) and contemporary practice (such as new graduates who bring fresh ideas and can influence a culture of change)
- Opportunities to share success and challenges across roles and teams is important
- Need to recognise that Improvement is a core competency. The use of PDSA cycles (Model for Improvement) has been a key focus for many
- The use of IHI methodologies has largely been applied – many have adapted for local use
- Measurement has been essential –data can show what has been measured and it is important to have the narrative to accompany the data

**How do participants plan to use and share this knowledge further?**

Some comments from participants at the conclusion of the exchange about next steps

- Opportunity to strengthen the quality improvement overlay in the least restrictive practice work
- Change language from seclusion reduction to least restrictive practice
- Need to consider how we grow consumer leadership for QI
- Need to build capacity and capability in clinical governance for quality improvement
- Consider how we understand the wellbeing of the workforce – how might the staff climate checks used in Scotland be used elsewhere
- Need to look at how to broaden our approach to QI so that it includes others
- Consider the concept of harm and how this applies to different aspects of practice e.g. if we don't do engagement well how much harm are we causing?
- Understanding the role of intermediary organisations as connective tissue
- Being clear about the difference between reporting data and using data for improvement.

Who are the **key actors and change agents** you are trying to influence?

- A key theme was the importance of creating a culture across roles and teams for quality improvement. This leads to collective ownership and engagement for quality improvement by many rather than relying on a small group of technical experts or leadership
- In leading change it is important to recognise the collaboration of different roles that include consumer leaders, technical expertise (e.g. quality improvement methodologies, data analysis), subject matter expertise and clinical leadership

How has your match **built leadership** for the future?

Our understanding was that this was the first IIMHL exchange that has occurred with a focus on quality improvement and mental health. It provided an opportunity to share information about some of the different programmes, successes and learnings. In doing this it identified a number of themes for leadership.

- It is important to have the leadership resource and commitment for QI. Clinical governance and leadership is important and can help to keep the momentum. Leaders need to be interested in people's work and what they are doing
- By having a broader focus of who is involved and who generates ideas helps to shift 'power' of who makes decisions so that it is not only leaders that are making the decisions or the ones generating ideas
- Successful initiatives have been led by a collaboration of professionals – consumer, clinical, and quality improvement leaders. It has been important to look at having subject matter expertise and technical knowledge for quality improvement.
- Quality improvement is the space the consumer leader's work in all the time, yet the work often isn't described in a quality framework. Need to grow the capability for quality improvement both consumer leaders

- Leaders need to be asking
    - How safe are you? How good are you?
    - How do we measure, improve year by year and how do we compare to the best?
- Leaders need to encourage a culture of change
- Leaders need to support the development of building confidence so that people have the opportunity and permission to generate ideas, test, re-visit, change, adapt
- Leaders need to be interested in the work that people are doing and value ideas, create permission to test, re-think and celebrate and share success.