



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Strengthening a quality improvement culture in aged residential care

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Health Quality & Safety Commission

New Zealand Aged Cared Association Conference
12 September 2018



Statement of Performance Expectation

The Commission's intent to increase its focus on **aged residential care**, working with a range of partners across health and social care to reduce patient harm.



2017 – 2021 Strategic Priorities

Improving
consumer/
whānau
experience

Improving
health equity

Reducing
harm and
mortality

Reducing
unwarranted
variation in
patterns
of care

HELP





We do this by

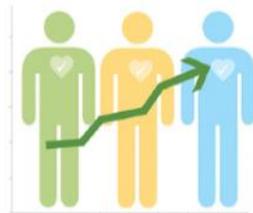
- monitoring and improving the quality and safety of services by **shining the light** (**Intelligence Hub** model)
- **providing a helping hand** to providers across the health and disability sector (**Improvement Hub** model)
- building capability and clinical leaderships across the health sector
- Priority commitment to equity / partners in care.



Health Quality Intelligence



Atlas of Healthcare
Variation



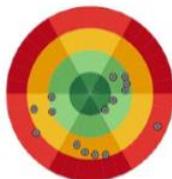
Open4Results: health
care transparency



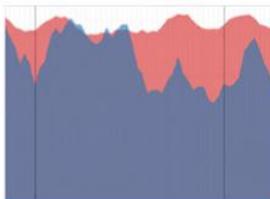
Window on the quality
of health care



Patient experience
surveys



Quality dashboards



Quality Safety Markers
(QSMs)



Improvement Hub

- **Patient Safety**
 - Adverse events
 - Medication safety
 - Capability building
- **Hospital Improvement**
 - Preventing infections
 - Safe surgery
 - Falls
 - Patient deterioration
 - Pressure injuries
- **Community Improvement**
 - Primary care
 - Whakakotahi
 - **ARC**
- **Mental Health & Addiction Improvement**
 - Seclusion
 - Transitions
 - Medication safety
 - Adverse events



What we do

- Engage consumers, whanau, clinicians and providers
- Consumer stories, co-design and resources
- Leadership & improvement networks
- Evidence based tools and guidance
- Leadership and QI capability building
- Improvement collaboratives & learning events
- International speakers
- Campaign focus – patient safety week (annual)
- Measurement and evaluation



Areas of focus based on sector input





Sector input has informed...

- Theory of change.
- Programme development and approach.
- Areas to prioritise.
- Development of foundational building blocks.
- A need to balance ‘soft’ and ‘hard’ topics and address how impact will be measured.
- 2018/19 foundation building year.
- A need to identify how capability building can be delivered ‘fit for the ARC’ context.



Leadership

- ARC leadership group
- QI open forum
- Other networks
- Leads / Champions

Promote resident (family & whānau) centred care

- Foundational document:
Lived experience of care in NZ (resident stories)

Building capability for quality improvement

- Capability development plan
- Partnership opportunity: QIA training for ARC sector workforce
- QIA support in facilities

Measurement for quality improvement

- Quality of life measures
- Making better use of existing data sources
- Supporting interRAI data translation into practice

Shared learning

- ARC webpages
- Repository for tools etc
- Frailty care guides
- Webinars and learning resource
- Networking platform

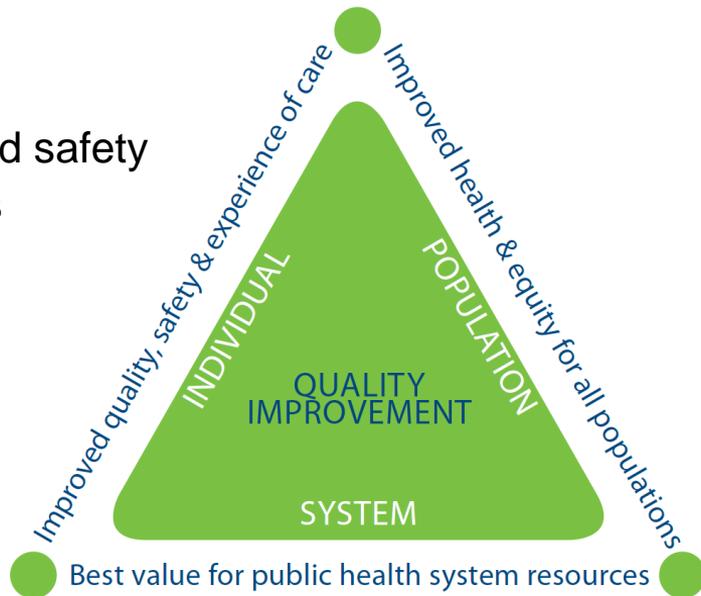
Building a quality & safety culture

- Blogs
- Webinar series: eg, learning from adverse
- Expert speakers
- Explore national 'staff culture survey'



The New Zealand Triple Aim

Sector quality and safety
outcomes





Quality assurance and quality improvement

Quality assurance	Quality improvement
Focus is on compliance against minimum standards	focused on processes and systems
QA tends to be defensive with a focus on providers	QI is proactive and preventive in nature, focusing on patient care
Regulatory approaches such as accreditation	Introduce changes in the care system (affecting inputs and processes of care)
Measure the extent of compliance to the standards	Identify gaps between actual quality and expected quality for that setting
Often conducted by independent individuals or organizations using standard tools	Frequently measuring the effect of those changes on health outcomes and system performance and mostly done by staff
Provide recommendations	Problem solving by staff



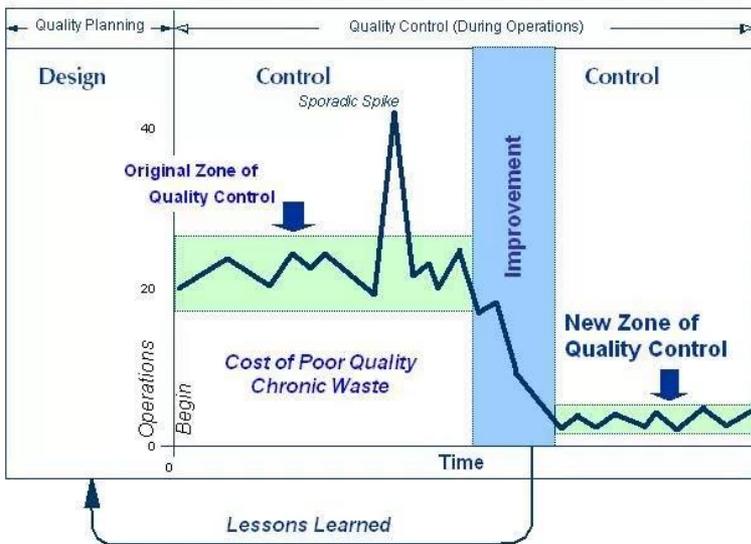


Continuum of quality



<https://blogs.mtu.edu/improvement/2014/02/27/the-juran-trilogy/>

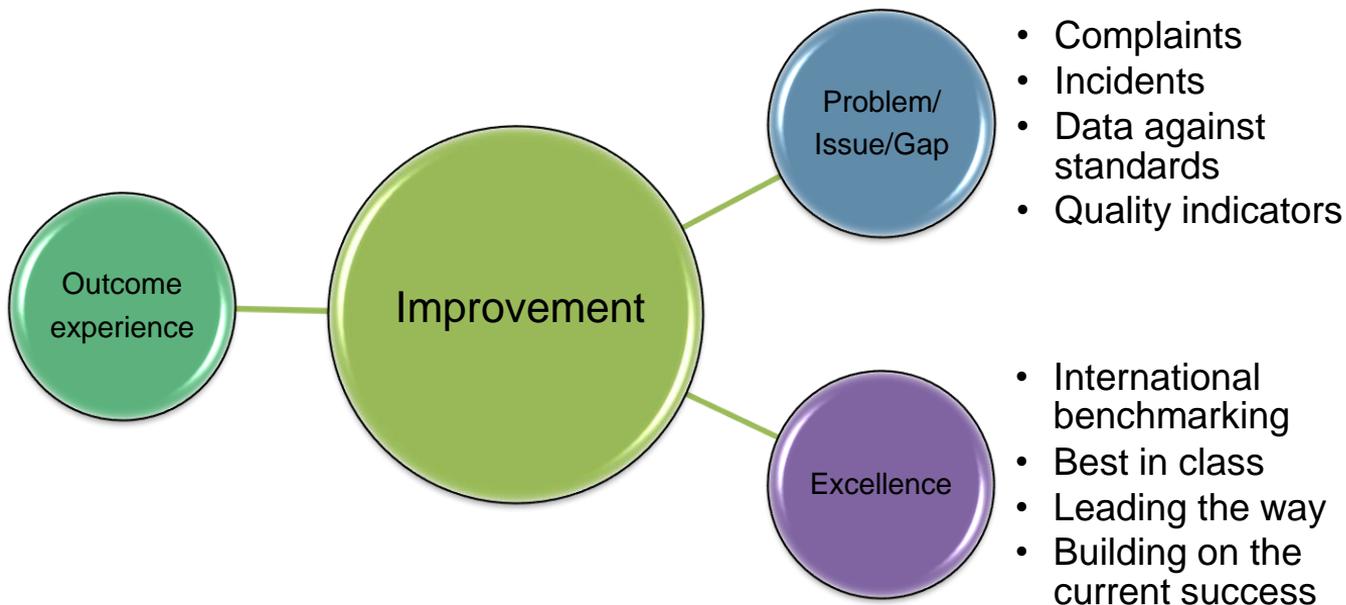
THREE UNIVERSAL PROCESSES OF THE JURAN TRILOGY[®]



<https://business901.com/blog1/does-the-juran-trilogy-pdca/>



Ways to think about improving quality





Are you too busy to improve?





Quality improvement culture in ARC

- Clear vision and objectives
- Leadership commitment, management and support
- Organisational culture
- Empowerment and motivation of staff
- Quality improvement infrastructure
- Teamwork / collaboration / MDT
- Continuous quality improvement
- Celebrating success



Improvement science

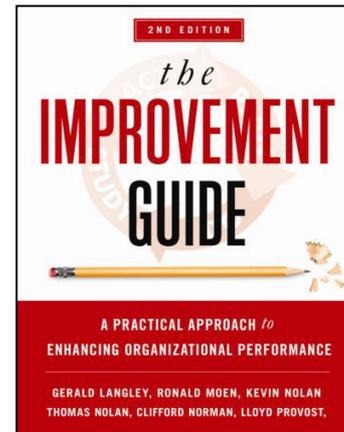
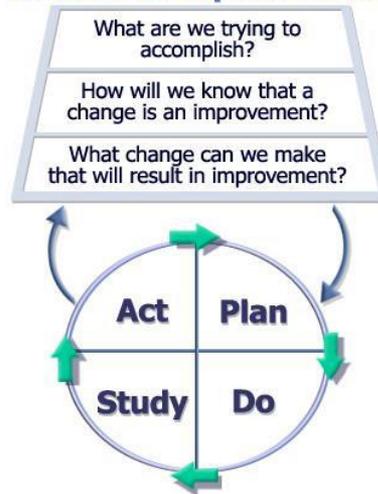
- Improvement science focuses on systematically and rigorously exploring ‘what works’ to improve quality in healthcare and the best ways to measure and disseminate this to ensure positive change. (Health Foundation, 2011)



Improvement science

- Improvement methodology
- QI tools and concepts
- Sustainability
- Scale and spread
- Implementation science
- Change management
- Measurement system
- Data analysis

Model for Improvement



G. Langley, et al *The Improvement Guide*. Jossey-Bass Publishers, San Francisco, 1996: xxi.



Capability building opportunities





Capability building resources

From knowledge to action: A framework for building quality and safety capability in the New Zealand health system (Health Quality & Safety Commission 2016b)



**From
knowledge
to action**

Governing for quality: A quality and safety guide for district health boards (Health Quality & Safety Commission 2016c)



Engaging with consumers: A guide for district health boards (Health Quality & Safety Commission 2015b)

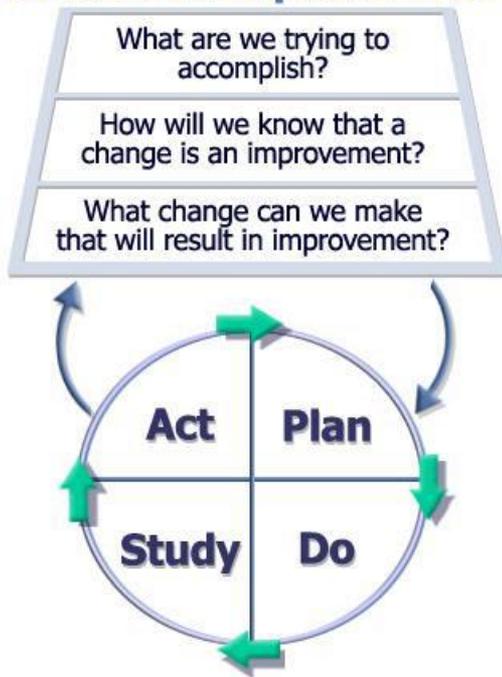


Improving Together e-Learning modules (Ministry of Social Development, Ministry of Education, Ministry of Health and Health Quality & Safety Commission 2015)





Model for Improvement

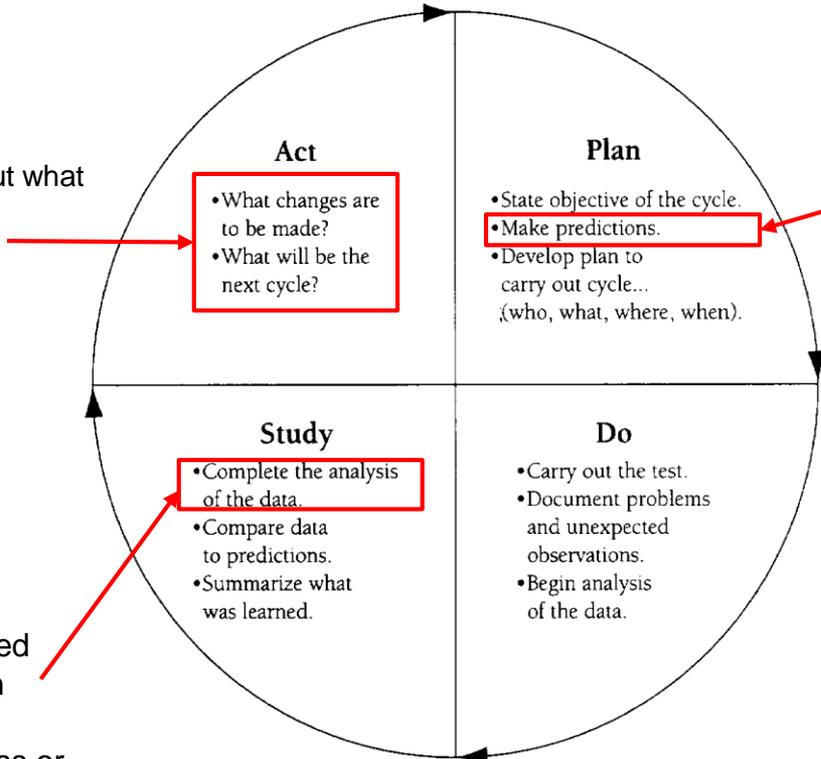


"All improvement will require change, but not all change will result in improvement!"

Testing a change



This comparison/ examination generates new knowledge about what change might work or what modification is needed



PDSA learning cycle:

Most important part of any PDSA cycle is the Prediction as it represents current knowledge about how a process or system will behave in the future.

When predictions are compared with actual outcomes they can reveal gaps in our current understanding of why a process or system behaves the way it does

Figure 4.1. Elements of the PDSA Cycle.

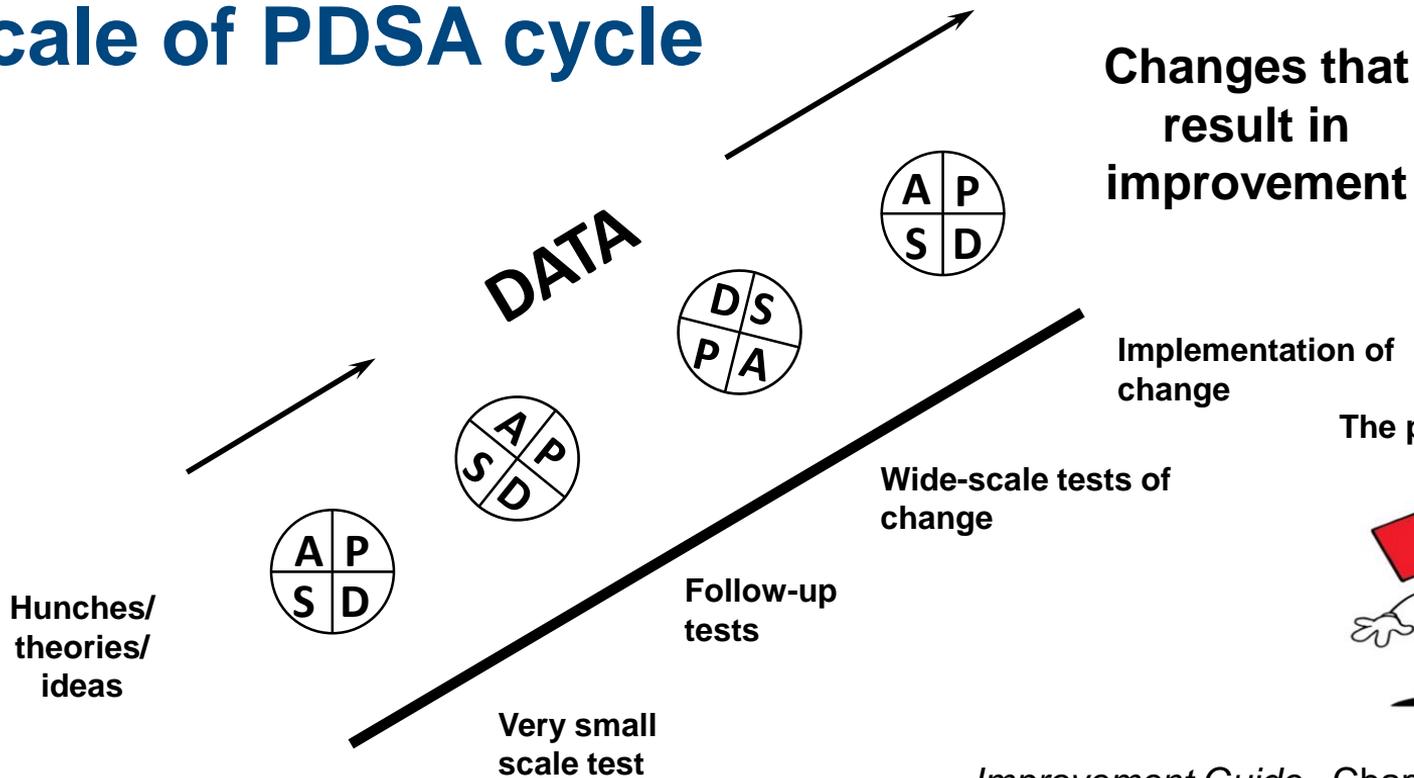


Why prediction?

- Prediction combined with a learning cycle interrogates our understanding of a system.
- It reveals gaps in our knowledge and provides us a starting place for growth.
- Without it, our learning is accidental at best, but with it we are able to direct our efforts toward building a more complete picture of how things work in the system.



Scale of PDSA cycle

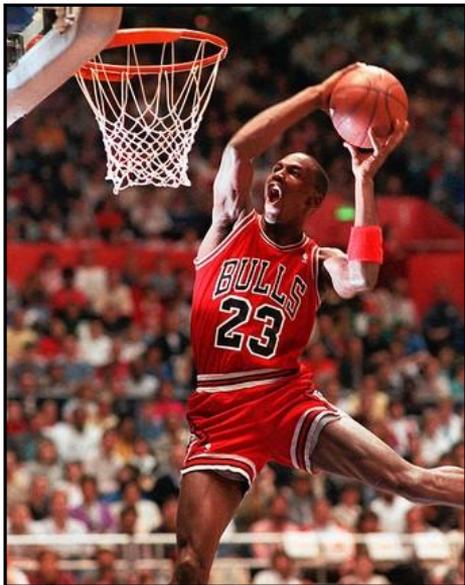


The power of one





Learn from 'failed' tests



'I missed more than 9000 shots in my career. I've lost almost 300 games. 26 times I've been trusted to take the game-winning shot... and missed.

I've failed over and over and over again in my life.

And that is why... I succeed."

Michael Jordan



Tennis ball exercise

I hear and I forget.

I see and I remember.

I do and I understand.

Confucius





Breakout

- Assign a time keeper/ball drop counter
- Identify birth date for each person in your group
- Your current process involves tossing the tennis ball provided from person to person, **following the sequence provided.**
- Sequence: pass the ball in ascending order of birth date. Don't leave your location.
- Practice your process one time – time keeper please time how long the team takes to complete the process and the number of times they drop the tennis ball.
- Facilitator will announce the start of first cycle after one round of practise.



Rules

1. Ball must pass both hands of each participant.
2. Fastest time to pass the ball through both hands of all group participants is the desired goal.
3. If ball comes into contact with the ground, prior to touching both hands of all participants the process must start over for all participants.
4. Time starts when called by referee.
5. You may not physically alter the shape, color or surface of the ball.



Breakout exercise

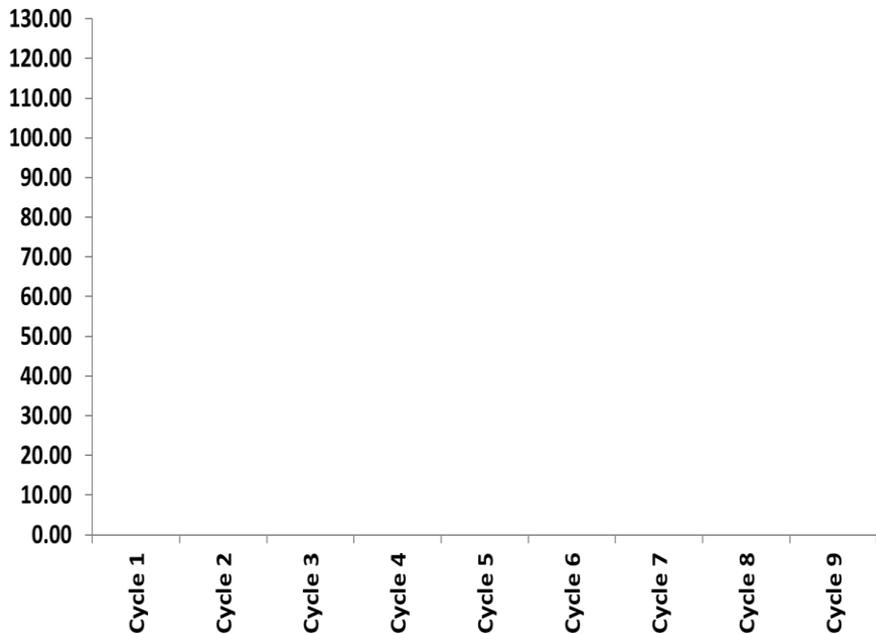
- Team aim: We aim to reduce the time taken for every person within the group to pass the ball by 50% from X to Y by 12 August 2018, 4:20pm .
- Come up with change ideas, and use the PDSA to test those ideas.
- Rules:
 - the initial sequence as provided must be adhered to
 - you may only test one change idea at a time.



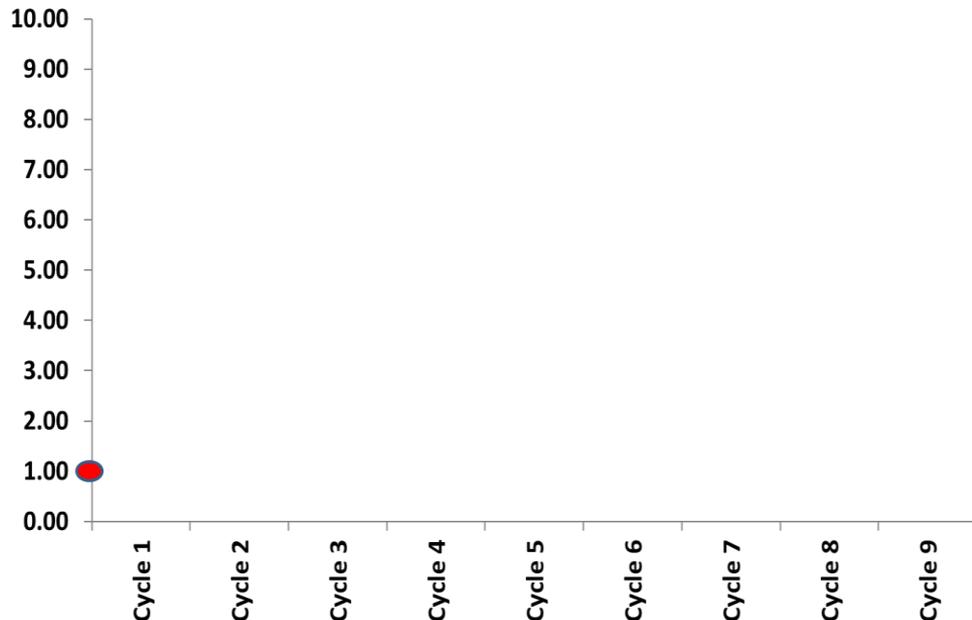
Test cycle #	Change idea	Time in seconds	Ball drops
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			



Graph the data



Recording seconds per cycle



Recording ball drops per cycle



Take home messages

- Partner to improve person-centred care.
- Enable culture change.
- Collaborate to build quality improvement capability.
- Leverage quality assurance for quality improvement.
- Make best use of available data to inform improvement.
- Test your ideas using quality improvement methods and tools.
- Build momentum.



Commission contacts



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