



HEALTH QUALITY & SAFETY  
COMMISSION NEW ZEALAND

*Kupu Taurangi Hauora o Aotearoa*

# Co-design themes

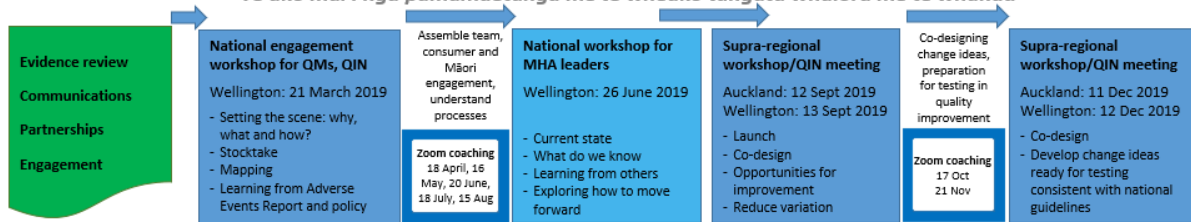
Jacqueline Ryan

Mental health and addiction quality improvement programme

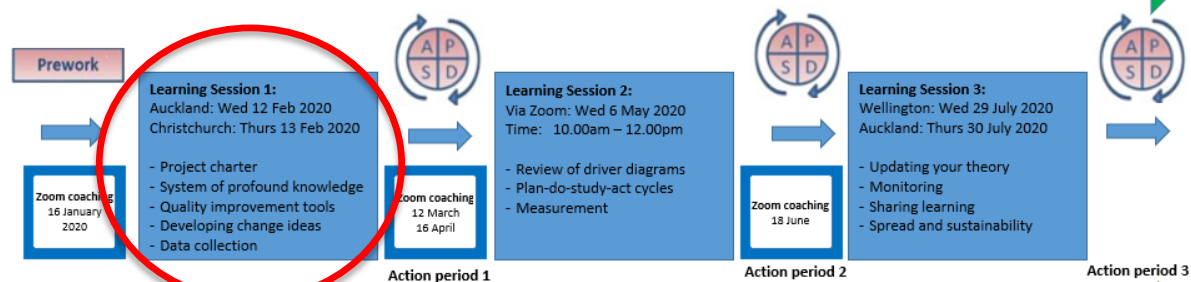
12 February 2020

## Learning from adverse events and consumer, family and whānau experience project timeline

*Te ako mai i ngā pāmamaetanga me te wheako tāngata whaiora me te whānau*



Preparatory and co-design phase to establish team, review current processes, consider opportunities for improvement



Six-month quality improvement phase – testing, modifying and implementing change ideas

Learning from adverse events and consumer, family and whānau experience project teams  
 2019 MHA QIF participants

Learning from adverse events and consumer, family and whānau experience project outcomes:

- Develop a suite of key outcome, balancing and process measures (provisionally by November 2019)
- Support DHBs to produce standardised, simplified processes and protocols for triaging, investigating, reporting, learning from and following up adverse events in MHA services aligned with the National Adverse Events Reporting Policy (by July 2020)



# Equity perspective

- Inequitable outcomes and disparities for Māori.
- Māori experience higher rates of seclusion.
- Higher rates of suicide for Māori youth in particular.
- Inadequate coordination of care between mental health and physical health services.
- Inadequate communication with family and whānau.
- Safety measurement must advance equity.



## **New Zealand's mental health and addiction services**

The monitoring and  
advocacy report of  
the Mental Health  
Commissioner

FEBRUARY 2018

# Preparatory workshop themes

What is the problem?	What does good look like?
Inconsistent involvement of consumer, family and whānau in adverse event review processes	Consumer, family and whānau (or representative) involved in a transparent and meaningful way
Not enough trained investigators and lead reviewers	Streamlined and timely adverse event review processes
Repetition with the same top five findings	Skilled staff familiar with adverse event management and investigation
Lack of process to disseminate learning	Focused and succinct recommendations that result in improvements
Multiple concurrent reporting requirements	Shared learning across an organisation and the MHA sector

# Preparatory workshop themes

Repetition with the same top five findings:

1. better communication
2. better engagement with families and consumers
3. improving documentation
4. sharing of documentation
5. better transitions and communications between services





# Preparatory workshop themes

Multiple concurrent reporting requirements:

- District health boards
- Health Quality & Safety Commission
- Accident Compensation Corporation (ACC)
- Coroner
- Health and Disability Commissioner
- Ministry of Health Office of the Director of Mental Health and Addiction Services.



# Co-design themes

## Co-design themes from project teams

No standardised way of reviewing MHA adverse events.

Need for clear guidelines for whānau involvement in the review process.

Whānau don't know who to contact.

Reports are delayed, 70 days is a long time to wait for answers.

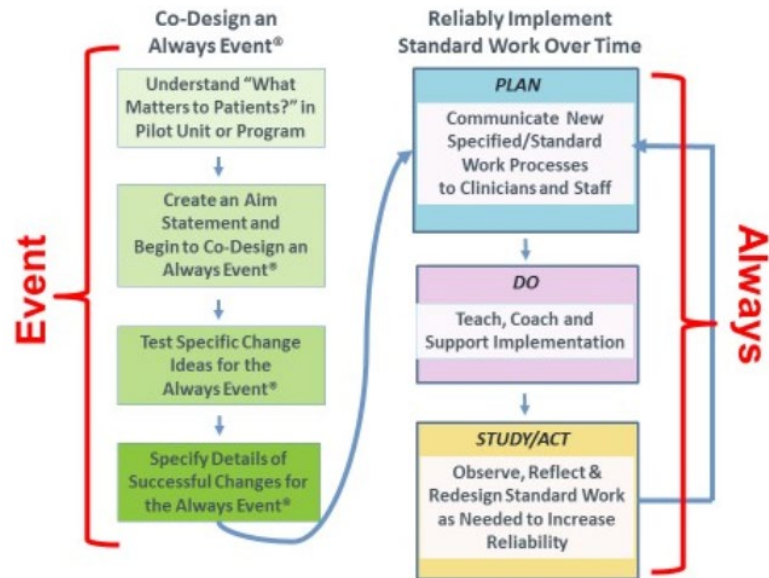
Staff feel anxious and unsupported as part of the review process.

Challenging to develop measureable and meaningful recommendations.

No consistent process to distribute outcomes or learning to the service or whānau.

# Always events framework

- Aspects of the consumer experience which are so important to consumers and whānau, that health care providers must aim to perform them consistently for every individual, every time.
- An always event must be:  
(1) important, (2) evidence-based, (3) measurable, (4) affordable and (5) sustainable.







# Involving consumers and whānau in co-design

- Whānau interviews
- Experience surveys, questionnaires
- Establish consumer council
- Pre-brief and post-brief (family advisors)
- Focus groups
- Want to go back and ask ‘how was that for you?’
- Want to extend to others involved – NGOs, staffing teams.



# Co-design workshop 1 and 2

- M** The co-design approach includes the following stages:
- E**
- A**
- S**
- U**
- R**
- E**
- **Project start up:** aim, scope, plan.
  - **Engage:** consumers, families and whānau, staff and stakeholders.
  - **Capture:** consumer, family and whānau and staff experiences using a range of methods.
  - **Understand:** emotions and ‘touch points’ along the journey of care.
  - **Improve:** work together to identify and prioritise what to improve.
  - **Measure:** check to see if experience is improving.

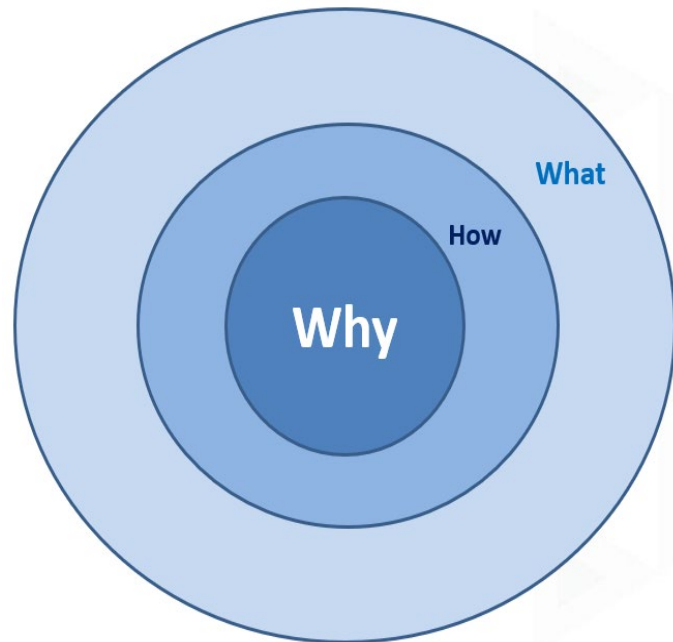
# Engagement

People need to understand why you want to engage with them.

Develop a concise narrative/information about what you are planning to do and the role consumers, whānau and staff can play (elevator pitch).

Communication needs to be informative and succinct.

[Watch: TedTalk How great leaders inspire action Simon Sinek](#)



# Ways to capture experience

Surveys

Observation

Shadowing

Comments cards

In-depth conversations

Focus groups  
and panels

Patient experience questionnaire

Patient Stories

Story Board

Diary

Complaints/compliments

# Link emotions

Link emotions to the point in the process where they occurred.



How people feel through their journey eg, safe or scared.



Link those emotions to the point in their journey eg, moving from inpatient care to home.

# Experience questionnaire

How do you feel?

**This experience questionnaire will help you think about how you feel at different stages in your journey.**

Circle the words that best describe your feelings at each stage, or write your own words at the bottom.

 See pages 54-55 for more information on experience questionnaires

## Why?

We'd like to know why you felt like this. Was it friendly staff, a nice conversation, or a long wait – whatever it is we'd like to know.

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Arriving/Checking in	Information	Waiting	Going to Theatre	Recovery	Check Ups	Leaving
happy	happy	happy	happy	happy	happy	happy
supported	supported	supported	supported	supported	supported	supported
safe	safe	safe	safe	safe	safe	safe
good	good	good	good	good	good	good
comfortable	comfortable	comfortable	comfortable	comfortable	comfortable	comfortable
in pain	in pain	in pain	in pain	in pain	in pain	in pain
worried	worried	worried	worried	worried	worried	worried
lonely	lonely	lonely	lonely	lonely	lonely	lonely
sad	sad	sad	sad	sad	sad	sad
Write your own words here	Write your own words here	Write your own words here	Write your own words here	Write your own words here	Write your own words here	Write your own words here
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# Experience map example





# What happens?

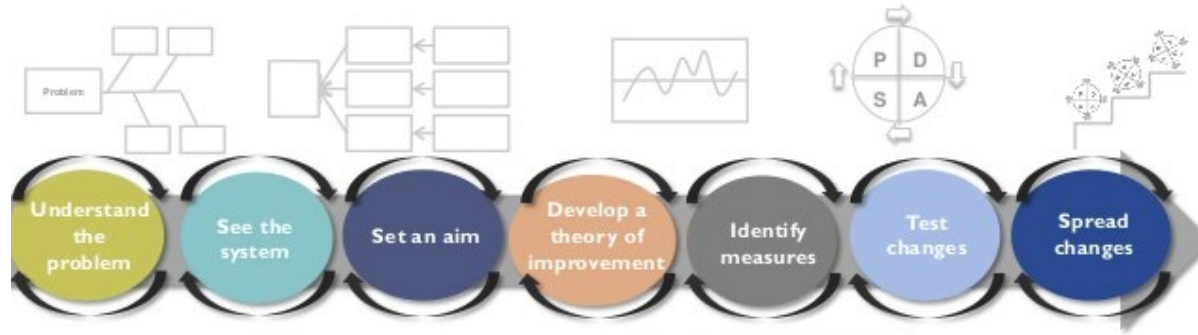
- Staff, consumers, family and whānau and other stakeholders come together.
- Review the learning.
- Identify themes.
- Review and add to the ideas.
- Use criteria to select some ideas for early testing.
- Form small project teams.
- Decide what ideas will be tested.
- Plan for testing/implementation.







# Improvement is a journey

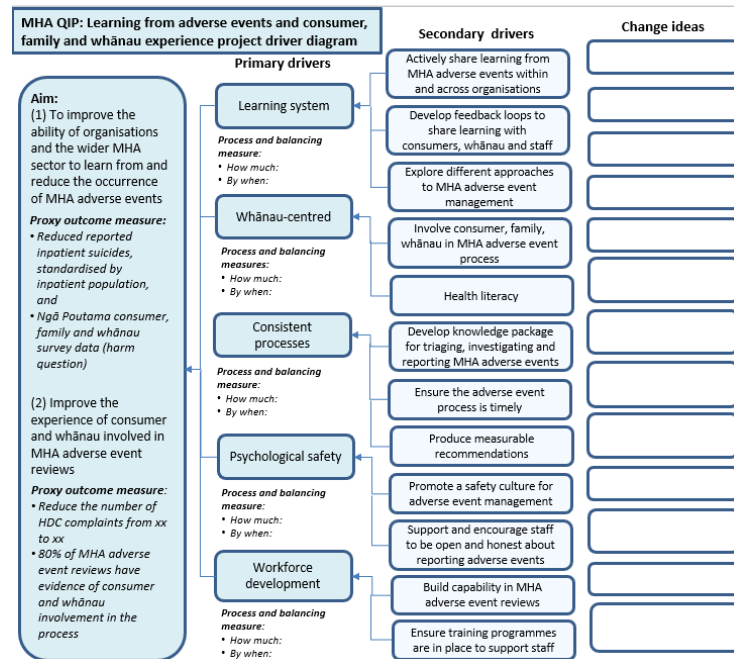


# What is your theory for improvement?

- A theory can be tested.
- We use theories to make predictions about the future, what we expect will happen, what we expect we will observe etc.
- A theory is a starting place for generating new knowledge – about a system, about a change, about a practice etc.

# Driver diagram

- Informs testing and refines your theory.
- Primary drivers:
  - learning system
  - whānau centred
  - consistent processes
  - psychological safety
  - workforce development.



# Any questions/discussion?

