Context for learning from adverse events and consumer, family and whānau experience project

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In this presentation

- Provide an overview of the impetus for this project and activities to date
- What are the issues?
- What is the evidence?
- What outcomes do we want to achieve?

2016

- Why?
- This is a challenging area
- There are opportunities to improve

2017

Sector engagement with regional workshops held in 2017

- Processes
- Staff culture
- Communication
- Consumer and whānau voice

Evidence Review

- An overview of international approaches to learning from adverse events in MHA services and a selection of related tools and resources
- Recent evidence relating to learning from adverse events and consumer experience in MHA services

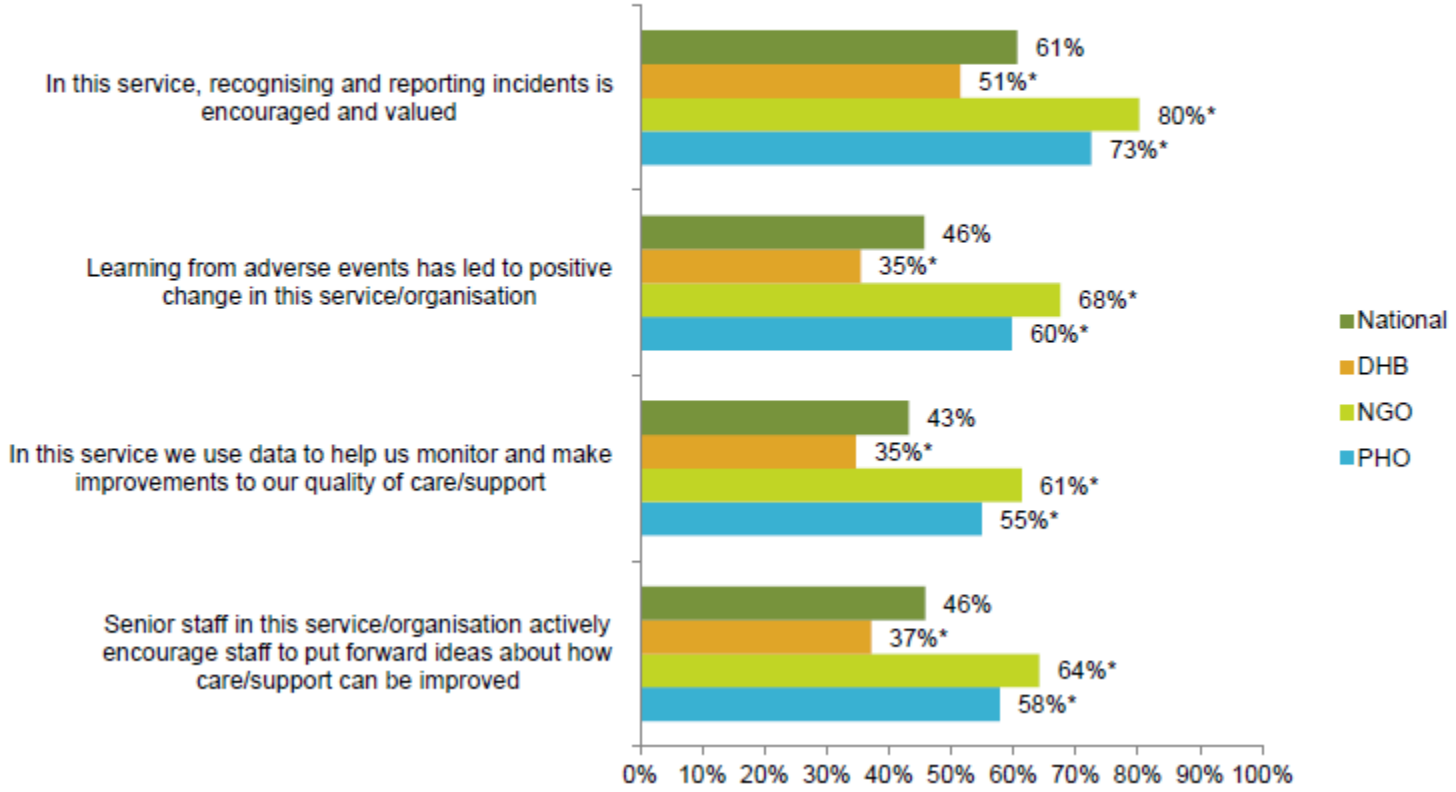
2018

- Leadership Group made recommendations
- Increase learning from adverse events
- Minimise harm and maximise benefit
- Establish consistent processes
- Include in National Adverse Events report

(***within the framework of the NZ National Adverse Events Reporting Policy 2017***)

Ngā Poutama: staff

Figure 5: Learning and changing the care and support provided – national, DHB, NGO and primary mental health care results



2019

- March workshop for QMs, QIN
- Stocktake on what DHBs currently do
- Equity issues
- June workshop for MHA Leaders

Key themes from 21 March and 26 June workshops

What is the problem from your perspective?

- Inconsistent involvement and interpretation of consumer, family and whānau in adverse event processes
- Length of time of entire process
- Not enough trained investigators and lead reviewers
- Repetition with the same top five findings
- Differing methodology and level of investigation
- Lack of process to disseminate learning
- Multiple concurrent reporting requirements (i.e. DHB, HQSC, ACC, Coroner, HDC, Office of Director of MH)

Key themes from 21 March and 26 June workshops

What does good look like?

- Consumer, family and whānau (or representative) involved in a transparent and meaningful way
- Streamlined and timely adverse event processes
- Skilled staff familiar with adverse event management and investigation
- Recommendations are focused, succinct and result in improvements
- Shared learning across an organisation and sector
- Incident is matched to a review process that will deliver the best outcome for all involved
- Consumer, family and whānau represented on governance of process

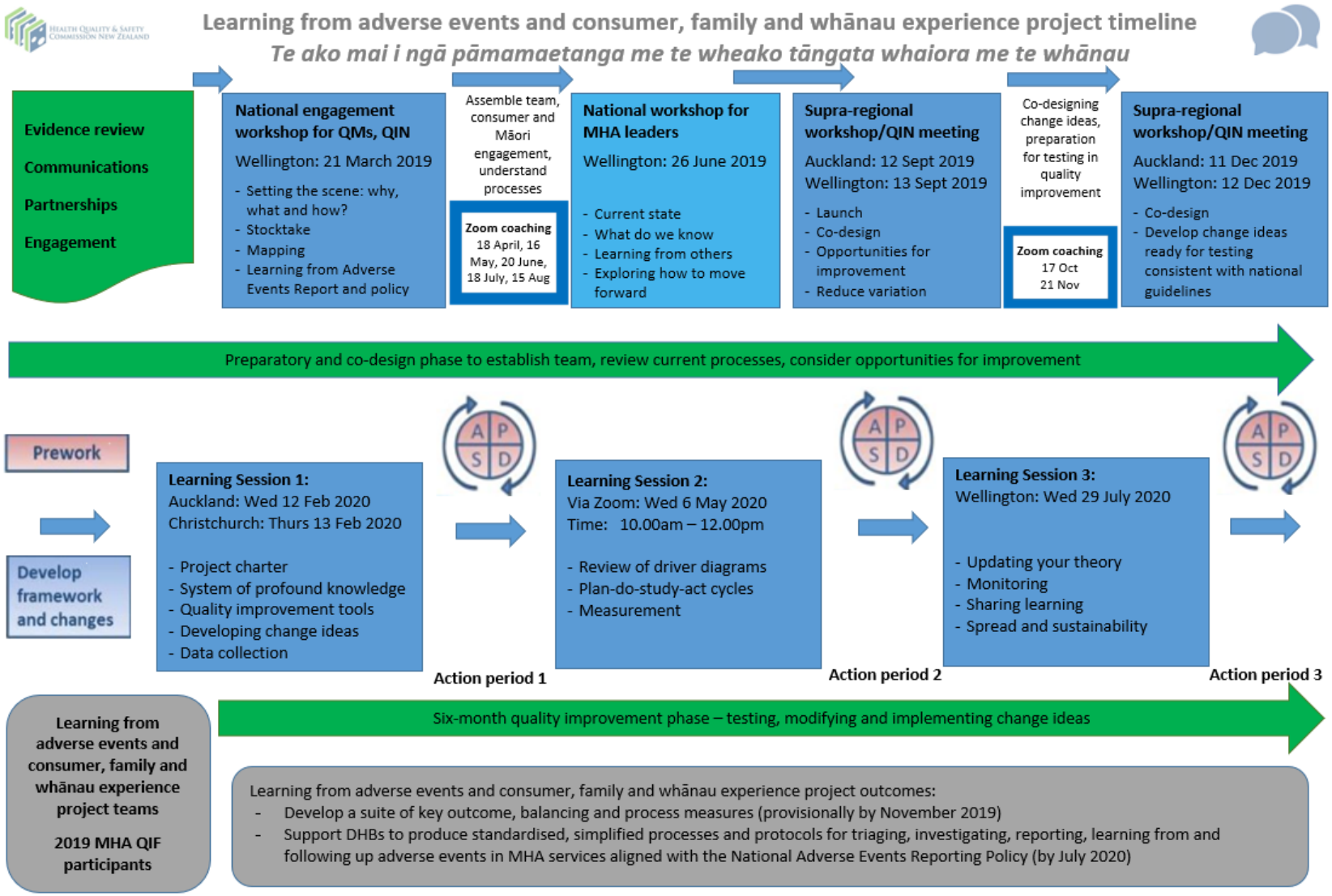
Dr Arran Culver's paper

- Appraisal of the evidence
- Safety-I
- Safety-II
- Resilient Healthcare
- Charles Vincent

Outcomes

- What do we want to achieve?
- For consumers
- For whānau
- For staff
- For our communities

Learning from adverse events



Thank you....Any questions