QUALITY AND AUDIT

Scott Arrol
General Manager – Community Services
Chair – HCNZ National Quality Group

Being Safe

HealthCare – Keeping People Safe at Home

Telehealth & Alarms

Residential Services

Integrated Care – case management

Disease Management Programmes

Specialist Therapist & Behavioral Support

Community Support Workforce development

Medication Management

Disability Services

Nursing services

<u>Organisational Capability and Culture</u>

- Technology Infrastructure
- Service and project delivery
- Client information and service management systems
- Quality Systems

Company Overview

Healthcare of New Zealand Limited

HealthCare NZ

- *Home support*
- *Integrated care services*
- *Mental health*
- *Nursing services*
- *Bureau services*

NZCare Group

- *Physical disability services*
- *Intellectual disability services*
- *Supported Living*
- *Respite Care*
- *Day Services*

Explore

- *Integrated approach to disability services*
- *Specialist team (trans-disciplinary)*

WellCare Education

- *Private Training Establishment*
- *NZQA accredited*
- *Nationally recognised certificates*
- *Training for support workers*

Freedom Medical Alarms

- *Personal medical alarm service*
- *Support HCNZ services where appropriate*

(Freedom Medical Alarms is a Joint venture Company between HCNZ and Wellington Free Ambulance)

Quality Governance and Management

- The challenge: How to embed a quality focused, no blame, culture throughout the organisation?

Quality Governance and Management

Healthcare of New Zealand Ltd

Board of Directors

Chair – Ken Douglas, ONZ

Mr Peter Hausmann, Managing Director

Dr John Wellingham

Rt Hon Wyatt Creech, CNZM

Sir Harawira (Wira) Gardner, KNZM

Mr Mike Copeland

Quality, Risk & Safety Board Sub-Committee

Chair – Dr John Wellingham

National Quality Group

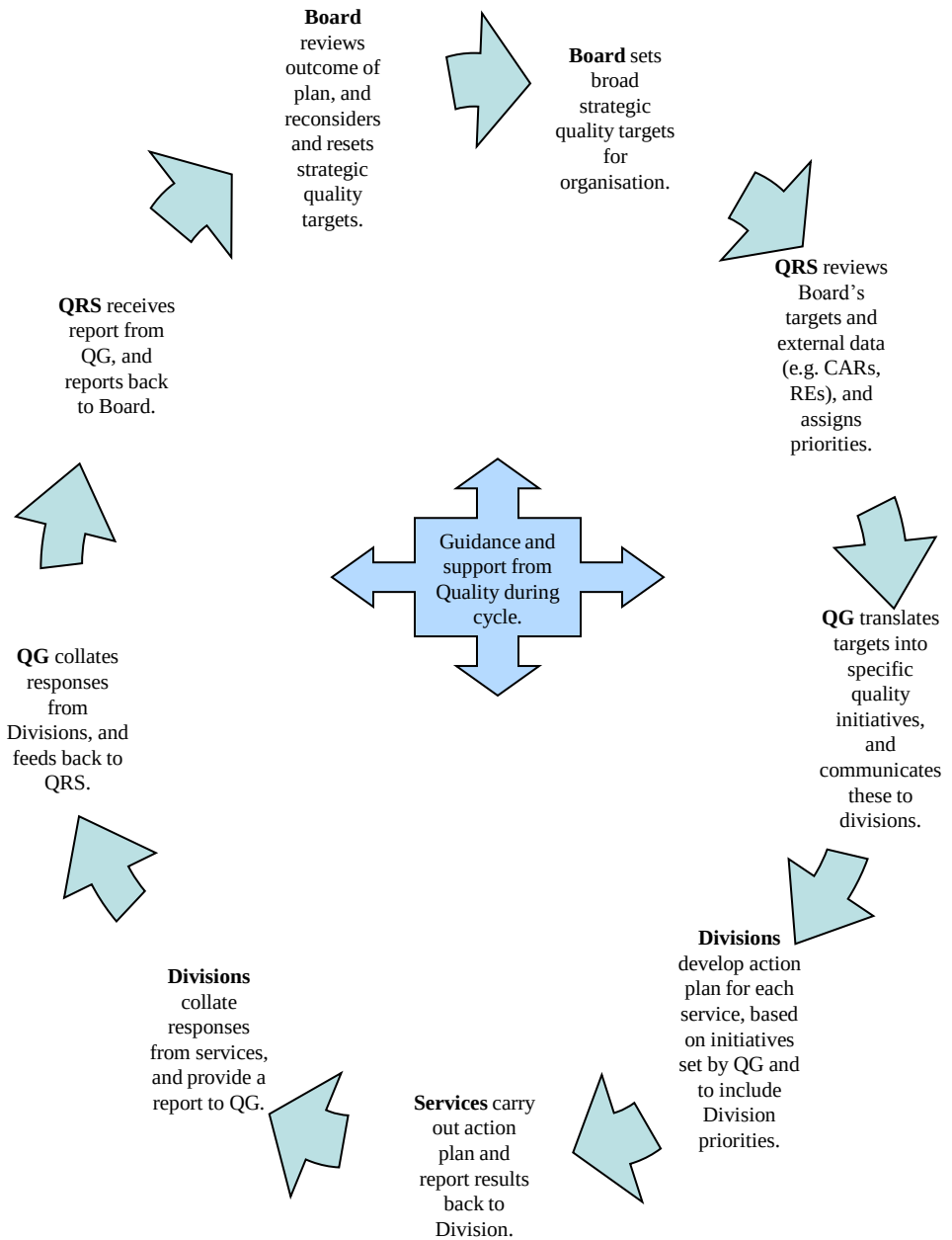
Representation from all operational areas of the organisation

Each Division's Quality Systems

Healthcare Quality and Audit Cycle

- Design structure
- Gather, analyse and report data
- Target need and take action
- Further analysis
- HCNZ is a large national organisation with a local focus that has to have clearly defined systems and processes
- However, size is not the point – all providers need to ensure a safe environment is in place

Organisational Quality Cycle



Divisional Quality Cycle:

HealthCare NZ – Community Services

- Largest provider of home support services in NZ – established in 1988
- Personalised to meet clients' needs, lifestyle, cultural values and spiritual beliefs
- 34 branches & satellite sites
  - approximately 17,000 clients
  - Over 6,500 employees
  - Approximately 6 million hours of support per year
- Services include:
  - home support
  - nursing support
  - mental health
  - bureau services
  - integrated care

CSD Quality Cycle

Quality and Risk Feedback Loops for Community Services Division

IDENTIFY an issue or area for review/improvement
EVALUATE your current performance
SET GOALS that would improve your performance
ACT on your goals
EVALUATE the effectiveness of your action
IDENTIFY… and on it goes[1]

NB: All staff meetings will have quality and risk as standing agenda items.

Support worker
Quality and risk information will be included in all newsletters
Forum to discuss any issues raised at the local branch meetings.

Branch meetings
Forum to discuss issues raised by support workers
Forum to discuss branch issues – reportable events, complaints, general quality improvements etc
Disseminate any information from area meetings
Feedback any issues to regional meetings
Develop Branch Quality Plan linked to Divisional Quality Plan
Develop Branch Risk Plan linked to Divisional Risk Plan

Regional meetings
Forum to discuss issues from individual branches
Feedback to branches
Forum to discuss issues from Area Managers
Feedback to Area Managers

National Area & General Managers meeting
Forum to discuss any issues from regional meetings and Community Services (CSD) Quality Representative
Disseminate information from CSD Quality Representative
Feedback any information to CSD Quality Representative
Develop Divisional Quality Plan and review 6 monthly
Develop Divisional Risk Plan and review 6 monthly

Community Services Quality Representative
Disseminate quality and risk information to Area Managers
Feedback to Quality Group information from each area

Healthcare NZ Quality Group

Via Quality, safety and risk subcommittee

Healthcare of NZ Board

[1] (Taken from: http://westcoasttafelibrary.pbworks.com/f/Quality_cycle_080219.pdf which has been derived from the Deming cycle)

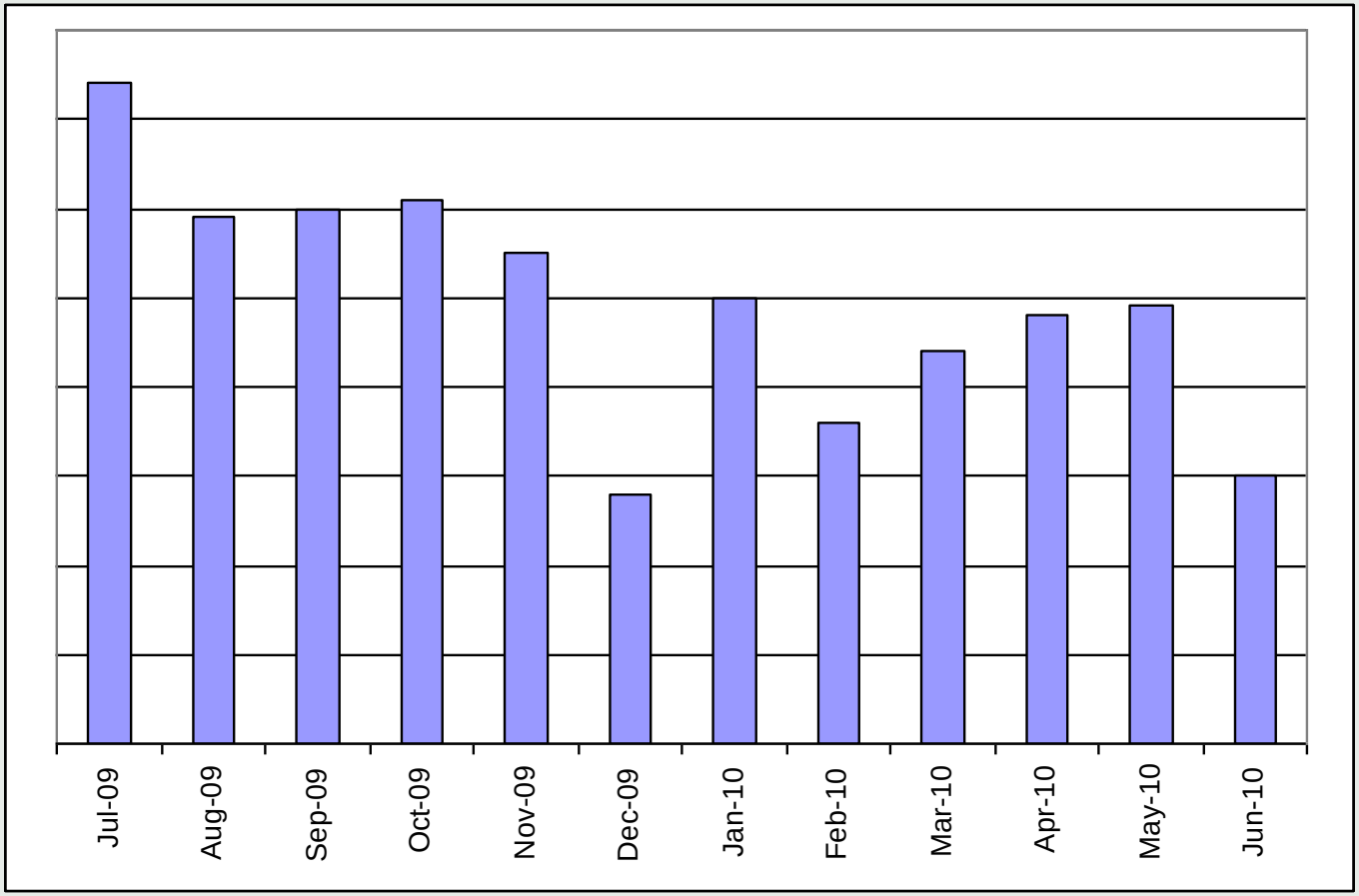
Requirements for Quality Cycle

- Designated staff with Quality as a role
- Reliable reportable event and serious incident management systems
- Audit support processes to manage activity before, during and after audits
- Targeted internal audit programme
- Regular reporting systems at operational and Board level, including high-level analytical skills
- Creating a no blame (just) culture that encourages analysis, action and reflection

Case Example

- Identified that drug administration errors by staff (DEBS) was an issue (generally across the operational divisions)
- Data was collected using reportable event system
- Data analysed to see if the issues were local or widespread (was the latter)
- Training was provided to target drug administration
- Frequency of DEBS was reviewed after a year

Case Example – "DEBS"



Summary

- Operating environment changing – service models evolving:
  - Restorative
  - IFHN/IFHC
  - BSMC
- Funding arrangements under pressure
- Contracts requiring providers to shoulder higher levels of risk – quality, clinical and financial
- Long-term sustainability of services and service providers being tested
- Operating safely in an increasingly complex and demanding environment is more important than ever