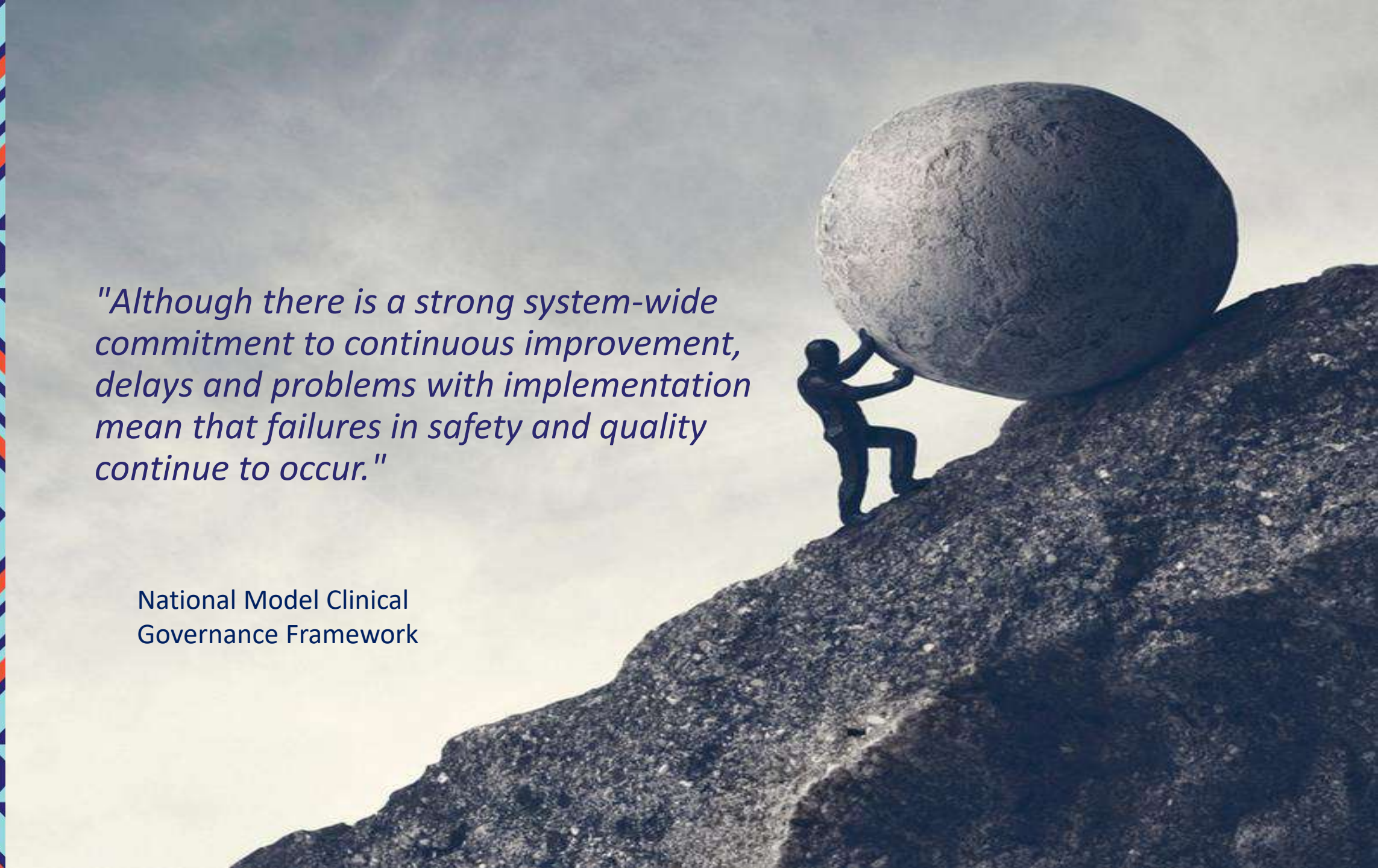
Te Tāhū Hauora
Health Quality & Safety Commission

Healing learning and improving from harm 2023

November 2023



"Although there is a strong system-wide commitment to continuous improvement, delays and problems with implementation mean that failures in safety and quality continue to occur."

National Model Clinical Governance Framework

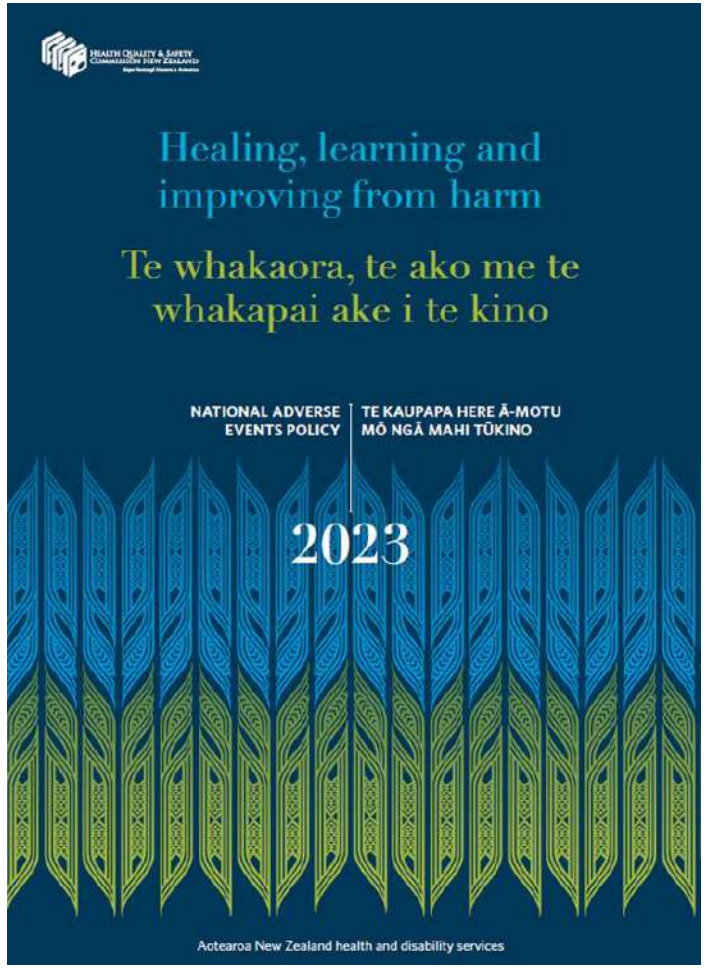
Not meeting the needs of those harmed…

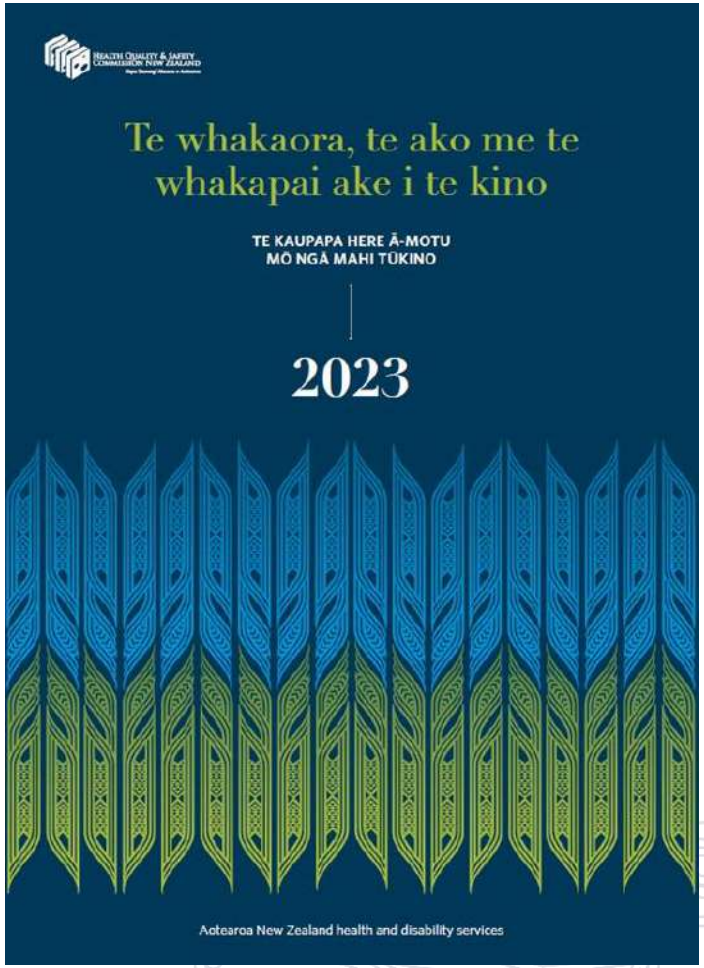
…including health care workers

Rationale

https://www.youtube.com/watch?v=jlV5Brtc4Uk

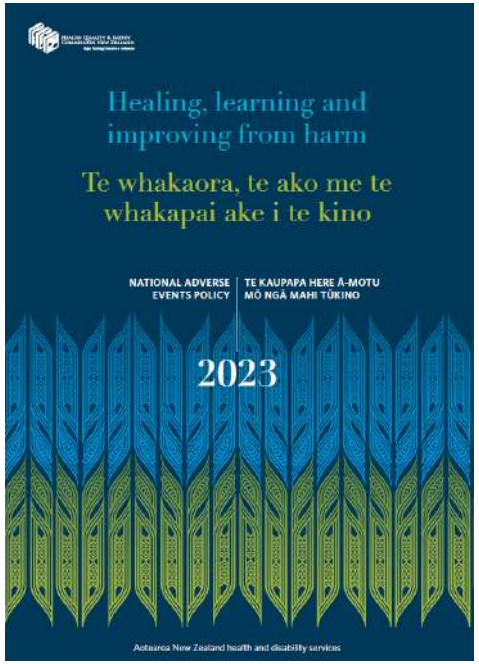
Healing, learning and improving from harm 2023





Revised policy principles

- Consumer and whānau participation
- Culturally responsive practice
- Equity
- Open communication
- Restorative practice and hohou te rongo (restorative responses)
- Safe reporting
- System accountability
- System learning



Definition of harm

Harm:

Negative consequences for consumers and whānau directly arising from or associated with plans made, actions taken or omissions during the provision of health care rather than an underlying disease or injury.

Harm may be…

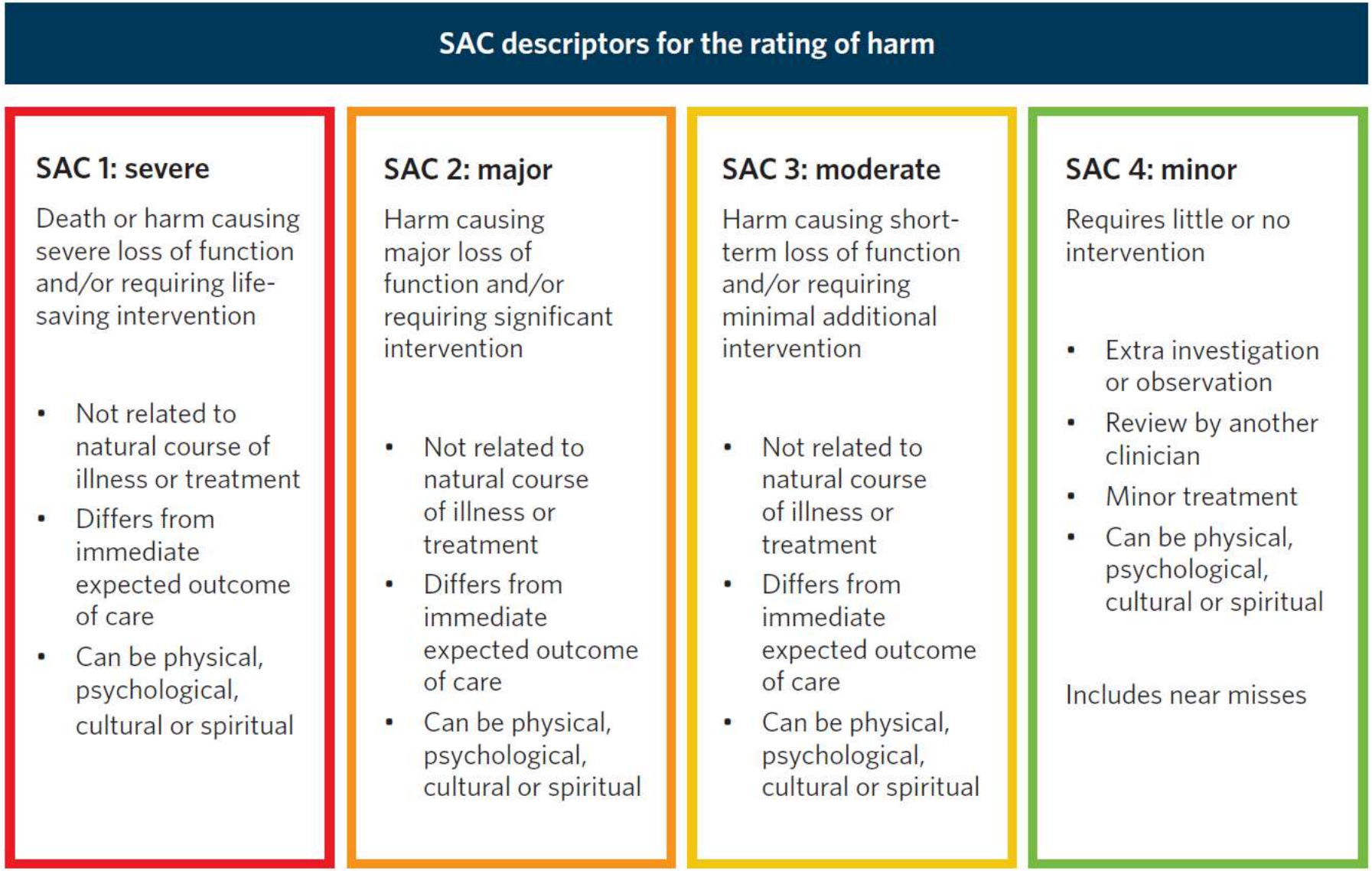
- **Physical:** harm that leads to bodily injury or impairment or disease. This includes limitations in cognitive functioning and skills, including communication, social and self-care skills

- **Psychological:** harm that causes mental or emotional trauma or that causes behavioural change or physical symptoms

- **Cultural:** the marginalisation of a consumer's belief and value systems

- **Spiritual:** (also known as spiritual distress) – a state of suffering, related to the impaired ability to experience meaning in life through connectedness with self, others, world or a superior being.

New SAC ratings



Embracing Te Ao Māori

- Māori involvement and oversight at all stages of development
- Incorporating the principles of WAI2575 Hauora Report
  - Partnership
  - Options
  - Tino rangatiratanga
  - Active protection
  - Equity
- Acknowledgement of *wairuatanga* as an important part of hauora

Patient safety and hospital visiting at the end of life during COVID-19 restrictions in Aotearoa New Zealand: a qualitative study

Aileen Collier,[1] Deborah Balmer ,[2,3] Eileen Gilder,[3,4] Rachael Parke [3,4]

Te Whakatara!—Tangihanga and bereavement COVID-19

Tess Moeke-Maxwell, Linda Waimarie Nikora, Kathleen Mason, and Melissa Carey

Elevating the voice of consumers and whānau

The need to be ‘seen’ through sharing experience

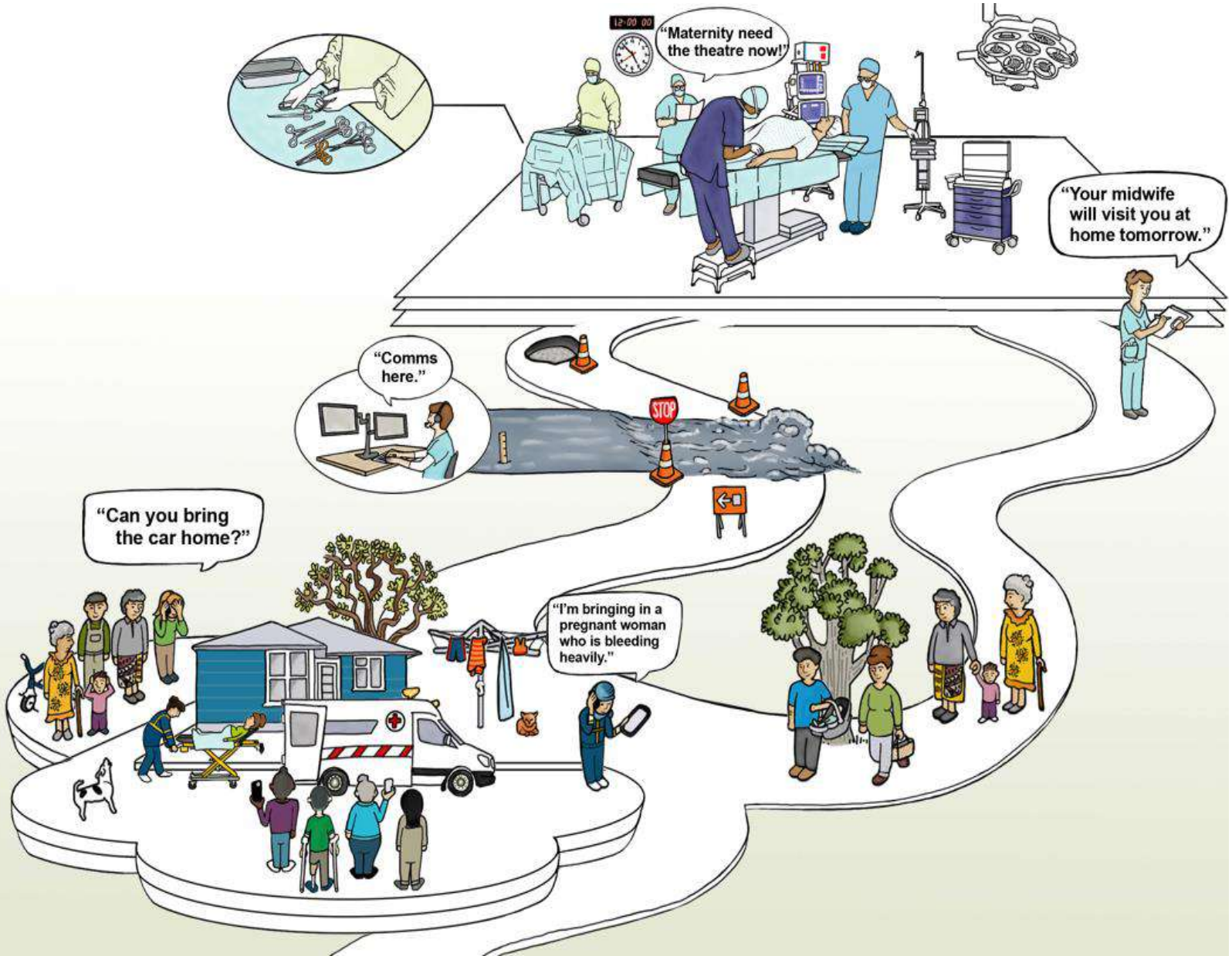
“It was initially very difficult for me to read. This was because it encapsulated what we would have liked to have happen for us, when ‘our voice’ was not sought and we felt ‘unseen’.

I sincerely hope that this new policy, if implemented well, will enable the voice of the consumers and whānau to be heard through a more robust, compassionate, restorative adverse event process.”

(consumer EY)

Restorative practice and Ho hou te rongo

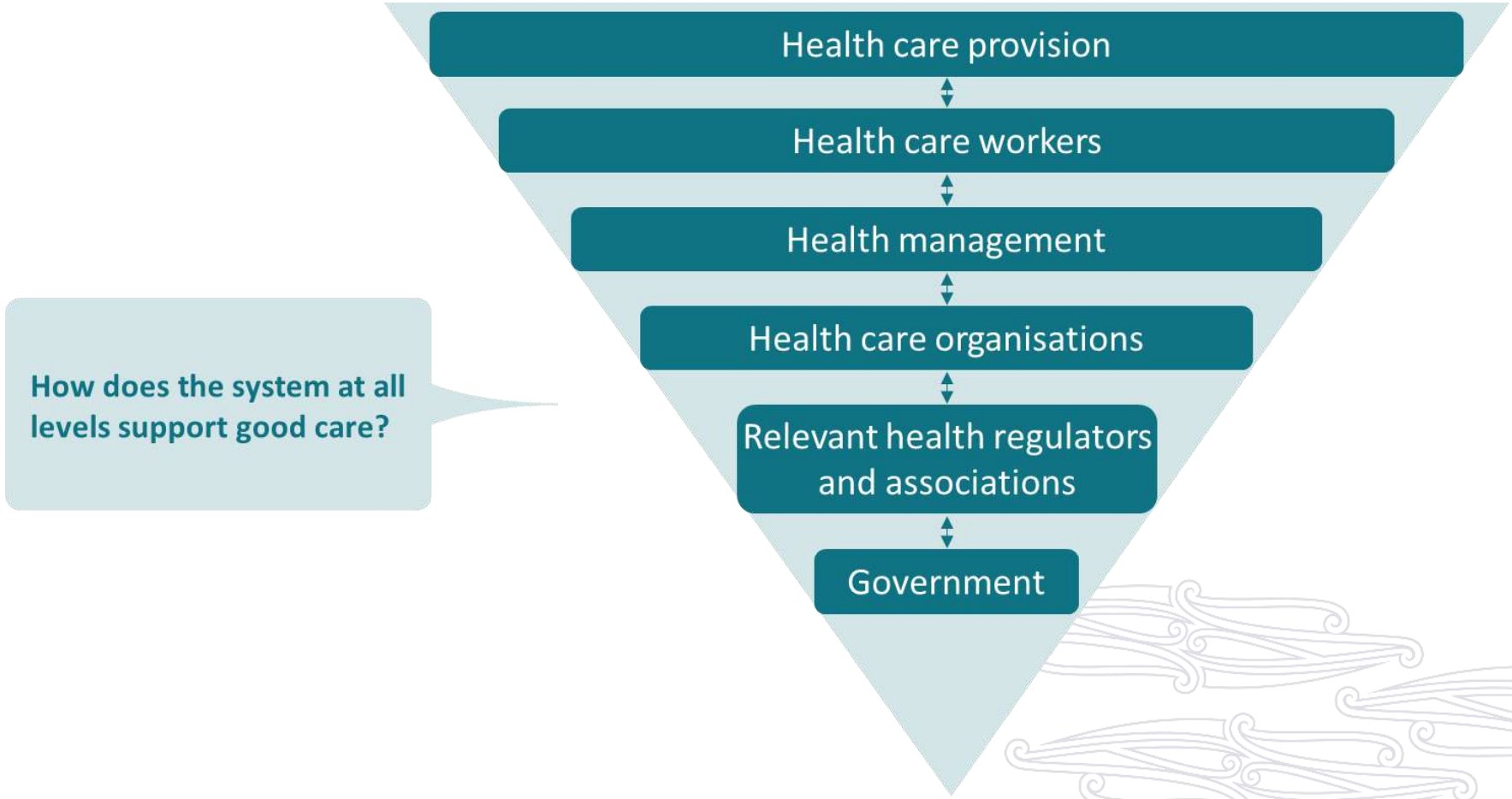

The new approach?



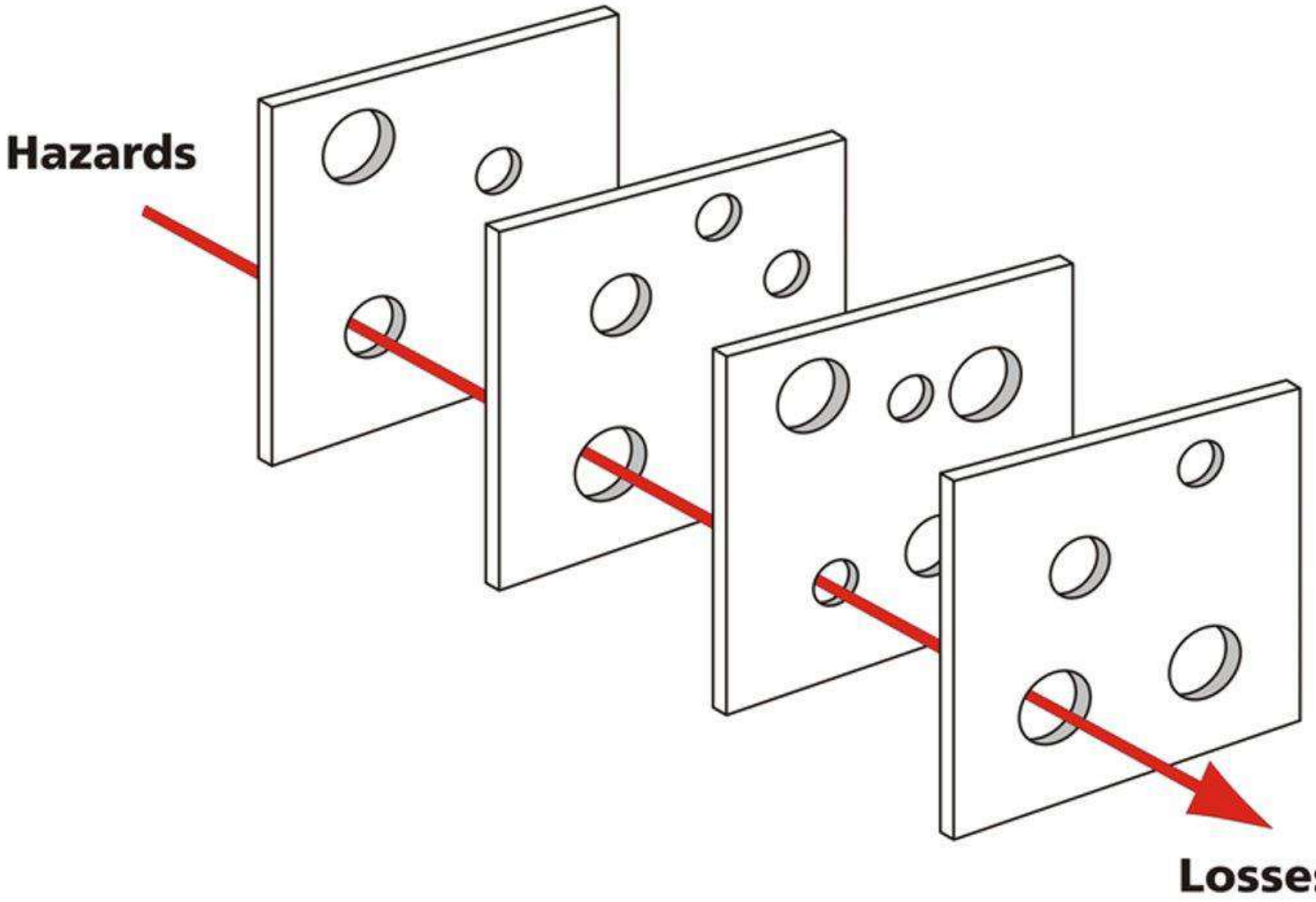
It's not about people or systems…

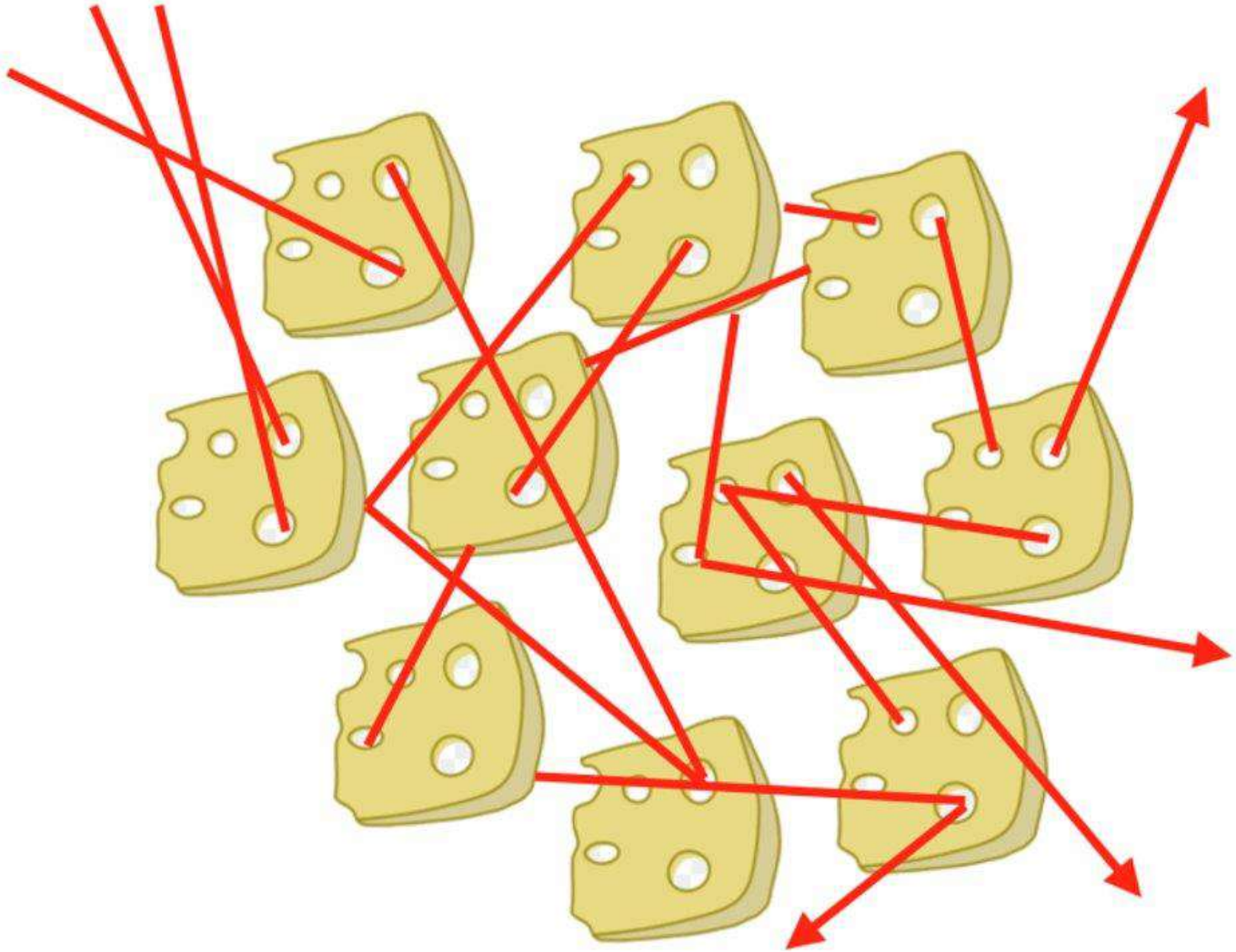
…it's about people in systems

…and thinking in Social Systems



Informed by Rasmussen J. 1997. Risk management in a dynamic society: a modelling problem. *Safety Science* 27(2): 183-213.

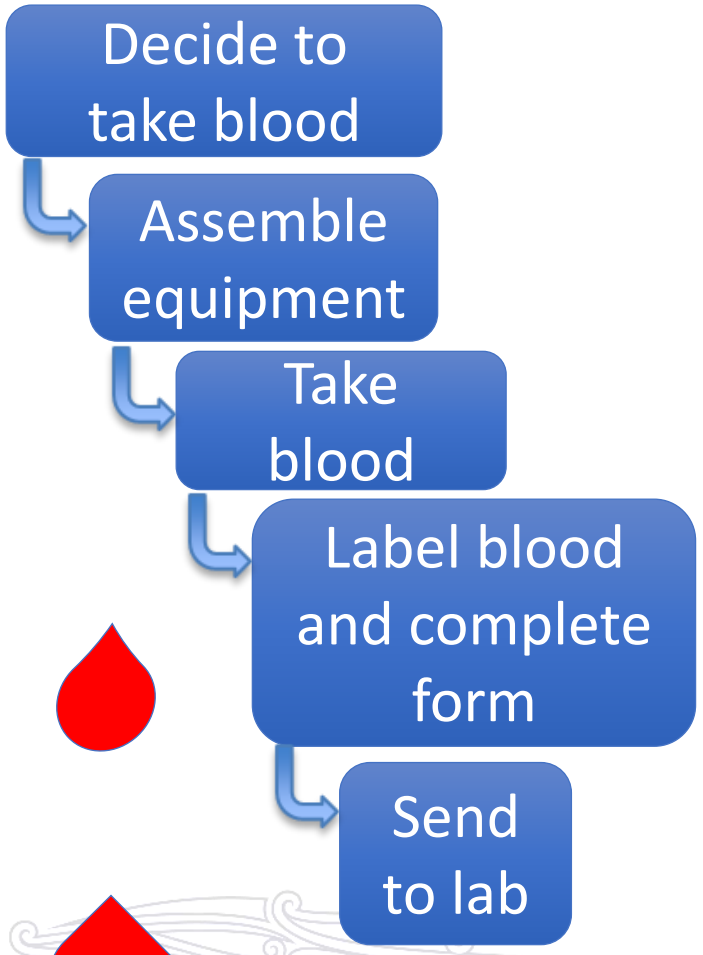

Hazards
Losses

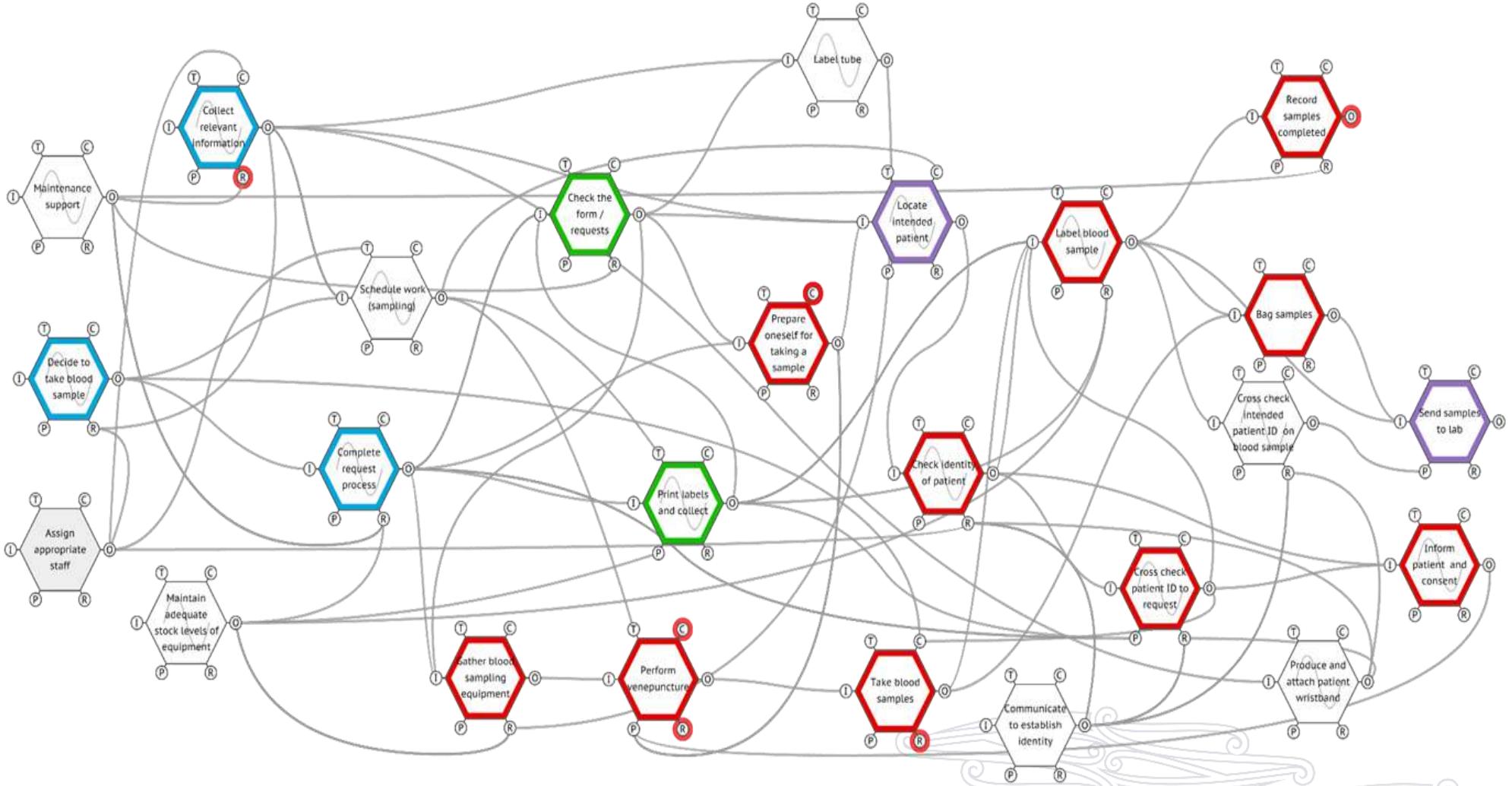


Rhizome model, Robert Long Australia

Health care complexity

‘Simple’ act of taking a blood sample

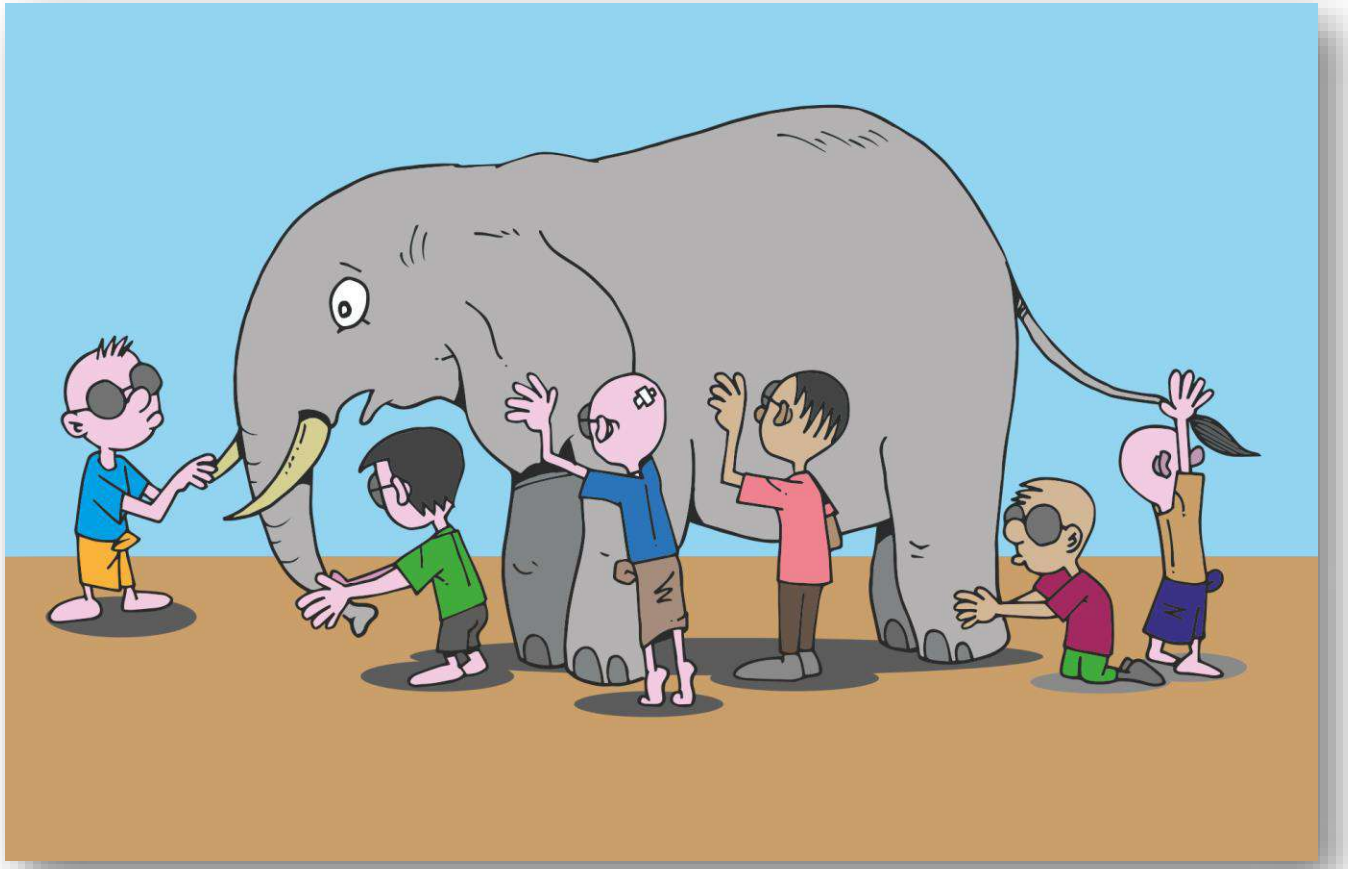




(Pickup L, Hollnagel E, Bowie P, et al. 2017. Blood sampling - Two sides to the story. *Applied Ergonomics*.)

Understanding

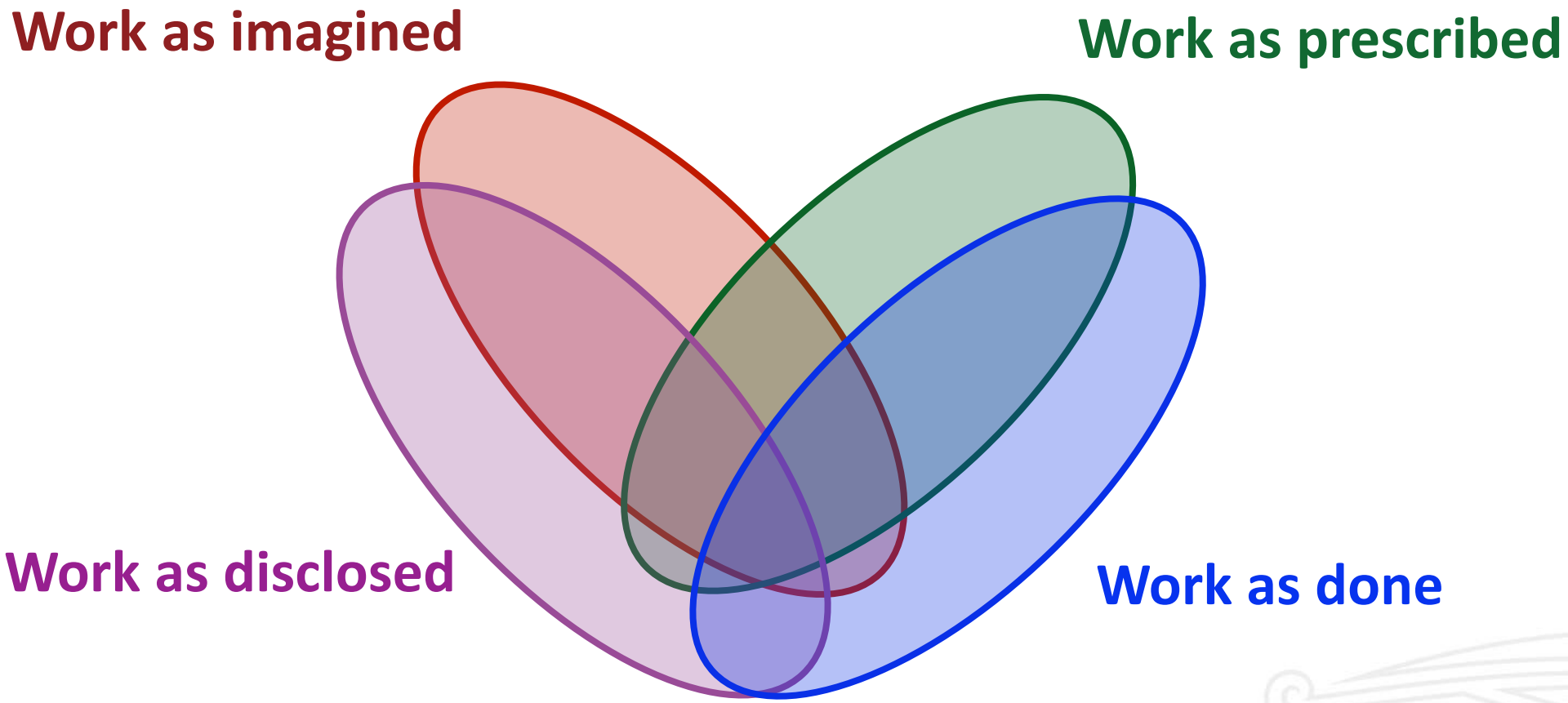
Why do the things we do make sense at the time?



“Work-As-Done”

the messy reality of everyday work as experienced by those who do the work

The realities of work as done



Reproduced with permission from Shorrock S. 2016. The varieties of human work. Humanistic systems.

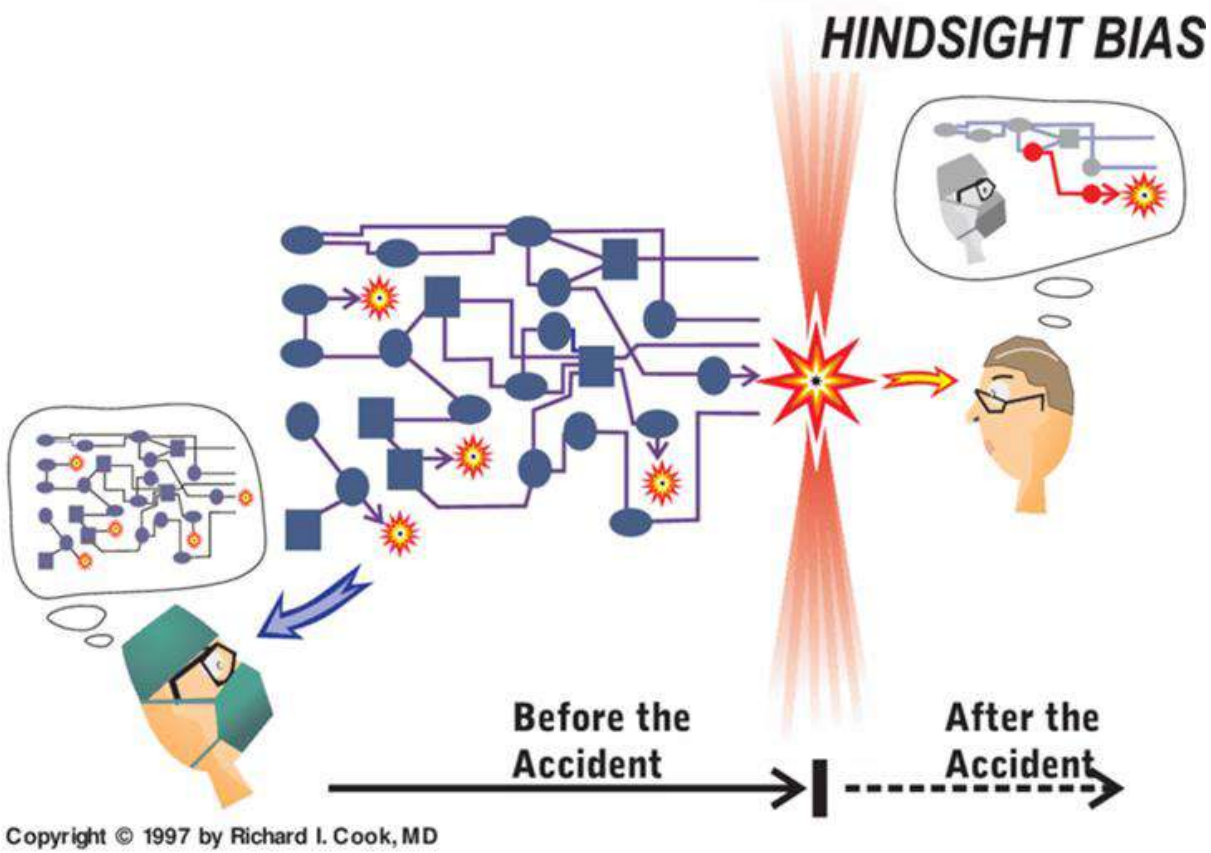

ARE YOU SURE WE HAVE THE RIGHT METHODOLOGY?

We discuss what **DIDN'T** happen rather than explain what **DID**

So why the learning review?

- Suited to events in complex sociotechnical systems
- Addresses the biases of traditional methods
- Shifts from **blame** to **understanding**
- Reduces compounded harm
- Values the work and insights of health care workers
- Incorporates human factors, systems safety and resilient health care

The illusion of learning



- Our understanding after an event is coloured by both hindsight and outcome bias
- We have the illusion that we understand the situation and would not make those same choices

Fischhoff, B. (1975). Hindsight is not equal to foresight: The effect of outcome knowledge on judgment under uncertainty. *Journal of Experimental Psychology: Human Perception and Performance, 1(3), 288-299. doi:10.1037/0096-1523.1.3.288*

The learning review

Collecting information	Building the story	Sense-making	Creating learning and improvement actions	Reporting

Putting it all together: moving from compliance to learning

- Understanding the experiences of harm
- Understanding what is needed to restore relationships
- Learning about what these events tell us about our systems
- Using this learning to understand where best to intervene in the system

Built on Modern Safety Science

Healthcare is a complex adaptive system

Risks are emergent and dynamic

Safety is created by the ability to navigate risk

“Underneath every simple, obvious story about ‘human error,’ there is a deeper, more complex story about the organization.”

S.W.A. Dekker, The field guide to human error

Any questions?