Queensland Health

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Mental Health Alcohol and Other Drugs Quality Assurance Committee

Triennial Report
September 2020

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Queensland Government

Mental Health Alcohol and Other Drugs Quality Assurance Committee: Triennial Report September 2020

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Establishment

The Mental Health Alcohol and Other Drugs Quality Assurance Committee (MHAODQAC; the Committee) was established as a quality assurance committee by the Director-General of Queensland Health in September 2017, pursuant to Part 6, Division 1 of the *Hospital and Health Boards Act 2011*.

Committee Functions

The purpose of the MHAODQAC is to improve the safety and quality of public mental health alcohol and other drug (MHAOD) services through exercising the following functions:

- Obtain and review Queensland Health data on critical incidents as defined under relevant Chief Psychiatrist policies, including suspected suicides, and homicides of and perpetrated by a person with a mental illness, serious acts of violence, serious adverse clinical incidents and significant incidents involving consumers of public mental health, alcohol and other drugs services, to identify trends and system level improvements.
- Monitor and review qualitative and quantitative clinical and other information, including investigation documents (for example coronial reviews), as required, from relevant departments and entities to identify trends and system level improvements.
- Maintain confidential clinical data, reports and findings in a secure and confidential manner.
- Make recommendations to the Minister for Health on policy, standards, guidelines and quality improvement for public mental health, alcohol and other drugs services with the intent of improving patient safety and the quality of public sector mental health alcohol and other drugs services.
- Monitor the implementation of MHAODQAC recommendations.
- Guide and promote quality improvement activities by working in partnership with appropriate statewide, national, international key stakeholders, professional bodies and networks.
- Establish sub-committees to collect data/information, consider and make recommendations (where necessary).

Key achievements

Learning From Incidents Initiative

Queensland Health MHAOD services demonstrate a robust clinical incident management reporting culture and a commitment to preventing clinical incidents that occur in community as well as hospital settings. It is recognised the MHAOD services report a large number of incidents in comparison to other health service settings which may focus primarily on the inpatient environment. Given the high number of clinical incidents reported by services and focus on quality improvement, it was determined that the Committee's focus would be more effectively directed at strengthening and supporting review by Hospital and Health Services (HHSs) of incidents and improving systemic recommendations for improvement. The Committee therefore agreed to an initial program of work to enhance HHS capability to effectively complete clinical incident reviews: the Learning From Incidents Initiative.

Overview

Developed following consultation with the Dutch Health Inspectorate, the Learning From Incidents

Initiative (the initiative) comprised two components:[1]

1. A Governance and Process Self-Evaluation Questionnaire (G&PQ), which provided a snapshot of the clinical incident management practices, processes and governance structures used by MHAOD services to review the most severe category of clinical incidents, and
2. A Learning From Incidents Self-Assessment Questionnaire (LFIQ) which monitored the quality of clinical incident analyses over a six-month period.

The Committee developed the G&PQ and LFIQ for use with Queensland MHAOD services, refining the questionnaires with stakeholder input to capture and reflect best practice for clinical incident management as outlined in relevant standards and guidelines, and provide outcomes that would be meaningful for Queensland HHSs and also support and inform future work for the MHAODQAC.

Implementation

The Committee adopted a staggered approach to implementing the initiative. MHAOD service Clinical and Executive Directors were invited to complete the G&PQ in May 2019 or nominate an appropriate delegate to do so. The second tool, the LFIQ, was issued in November 2019 to HHS representatives who nominated to participate in the planned 12-month implementation of the LFIQ. HHSs were provided with resources, developed by the Committee, to support involvement in the initiative, outline the benefits and anticipated outcomes, and clarify roles and responsibilities.

Analysis

The Committee analysed and considered the G&PQ results to agree on significant points to feed back to HHSs and identify potential actions for the MHAODQAC workplan. Key findings were collated into a summary report for circulation to MHAOD service Executive and Clinical Directors to consider opportunities for improvement and standardisation of clinical incident management processes.

Combined outcomes from all HHSs who used the LFIQ during the first six months of implementation were considered by the Committee and collated into a summary report for circulation to assist HHSs to identify opportunities to improve local clinical incident review processes. To assist local quality improvement opportunities, participating HHSs were provided with reports outlining their own LFIQ results.

Outcomes

After considering the findings from the Learning From Incidents Initiative, the Committee provided the following guidance to HHSs.

- The Committee advocates for inclusion of principles and language in alignment with restorative just culture and promotion of strategies to align with this model to support learning, support our workforce and improve consumer outcomes. Education and awareness of restorative just culture principles by HHS Board and MHAOD service Executives will assist in promoting principles supporting a cultural shift in the role of clinical incident management by services.
- The Committee supports the promotion of good practice examples by HHSs in implementation of both just culture and restorative just culture initiatives to promote sharing across services.
- Whilst the challenges to standardisation of the review type for suspected suicides are acknowledged, the Committee supports a culture of reporting, monitoring and learning from these adverse incidents. It is also acknowledged that standardisation has benefits for aggregation of data and learning from the clinical incident review at both the HHS and at a

[1] Both questionnaires were adapted with permission from the Learning From Incidents Questionnaire developed by Leistikow, I., Mulder, S., Vesseur, J., Robben, P. (2017), Learning from Incidents in healthcare: the journey not the arrival matters. BMJ Qual Saf., 2017 Mar 26 doi: 10.1136/bmjqs-2015-004853.

statewide level.

- The Committee supports the use of structured tools and criteria to assess strength of recommendations resulting from clinical incident reviews to improve the suitability, quality and implement-ability of recommendations that more effectively target opportunities for improvement. The use of structured tools may also benefit from associated training and education to support staff involved in developing recommendations to more effectively drive improvements in their service.
- The Committee supports the involvement of consumers, family and carers in the review process where appropriate and encourages HHSs to document their inclusion in the clinical incident analysis report.
- Acknowledging the need to adhere to local processes and guidelines, the Committee emphasises the benefits of standardising review processes where possible and appropriate, particularly for Severity Assessment Code 1 incidents.
- The Committee supports an evidence-based approach to clinical incident analysis and reporting and encourages HHSs to complete a review of relevant literature as part of the incident review process, for documenting in the report.
- Consistent with a culture of learning and improvement, the Committee supports the use of recommendations as an outcome of the clinical incident review process and takes the position that a thorough, complete review will always result in lessons learnt, even in cases where formal recommendations for service improvement are not identified.

Review of the Implementation of the Queensland Health 2016 suite of safe environments guidelines

In response to Coronial recommendations, the MHAODQAC provided governance of work led by the Office of the Chief Psychiatrist, in collaboration with the Patient Safety and Quality Improvement Service, into the review of the implementation of the Queensland Health 2016 suite of safe environments guidelines by MHAOD services. The Committee provided guidance into the development of the methodology for the statewide review into local implementation of these guidelines and will endorse the final report and summary of findings for circulation to HHSs when they are available in the final quarter of 2020.

Summary of activities and outcomes

Year 1: September 2017 – August 2018

The Committee met five times between September 2017 and August 2018. During its inaugural year, the Committee completed foundational administrative activities, and consulted widely with expert stakeholders to establish a robust knowledge base to support its purpose and functions, and identify emergent work activities. Specific activities and outcomes from Year 1 are summarised in Table 1.

Table 1. Year 1 activities and outcomes

Administrative activities

- Privacy policy approved.
- Terms of Reference agreed.
- Instances to declare a conflict of interest agreed.

Consultation activities

- Patient Safety and Quality Improvement Service (PSQIS) Clinical Excellence Queensland
  - Quality Assurance Committees, legislative requirements and PSQIS role in coordinating committees.
  - PSQIS clinical incident management activities.
  - Methodology used by PSQIS to review clinical incidents.
  - Clinical incident data relevant to mental health and alcohol and drug incidents and/or cohorts.
- The Queensland Maternal and Perinatal Quality Council (QMPQC)
  - Overview of the QMPQC, key learnings, establishment of subcommittees, reporting.
- Sentinel Events Review Implementation Team (Office of the Chief Psychiatrist)
  - Recommendations from the *When mental health care meets risk* report with implications for the MHAODQAC.
- Metro South Hospital and Health Service
  - Concise clinical incident analysis tool being trialed in Metro South Addiction and Mental Health Services.
- Gold Coast Hospital and Health Service
  - Restorative Just Culture principles and clinical incident management.
- Clinical Governance Unit (Office of the Chief Psychiatrist)
  - Qualitative and quantitative sources for clinical incident data.
  - Preliminary results of the Queensland Multi-incident analysis of suspected suicides of people with recent contact with a health service.
- Dutch Health Inspectorate
  - Approaches to quantify and measure the quality of recommendations and culture.

Work activities initiated and progressed in Year 1

- Learning from incidents and clinical incident management
  - Agreement to focus on activities that influence the quality of data available for analysis by MHAODQAC, including the quality of clinical incident analyses and recommendations arising from clinical incident analyses.
  - Approval of a draft methodology to enable HHSs to evaluate incident analysis processes and agreement to implement once finalised.
- Promotion of standardised reporting definitions
  - Establishment of a working party to develop a briefing paper to promote standardisation of definitions of SAC1 and SAC2 incidents and provide guidance on classifying and recording community suspected suicides.
- Review of the implementation of the suite of Queensland Health 2016 safe environments guidelines
  - Establishment of a working group to provide input into methodology and review process.

- Development of a pilot for the implementation of the agreed review methodology to assess validity and seek feedback.
- Culture and clinical incident management
  - Agreement to uphold and promote the principles of a Just Culture and Restorative Just Culture.
- Communicating with HHSs
  - Agreement to communicate the role of the MHAODQAC to HHSs.

Year 2: September 2018 – August 2019

With a dedicated resource to support its functions, the Committee met nine times during Year 2 to progress activities commenced in Year 1, agree on further activities, and consider information from key stakeholders relevant to progression of its work. A face to face planning day was held in Year 2 to agree priority action areas and define work activities for the Committee's next phase. Specific activities and outcomes from Year 2 are summarised in Table 2.

Table 2. Year 2 activities and outcomes

Administrative activities

- 2018 Annual Activity Statement submitted.
- Changes to accreditation processes for services under the National Safety and Quality in Health Service Standards and National Standards for Mental Health Services noted.
- Annual self-evaluation completed and findings discussed.
- Face-to-face planning day held to:
  - Formalise role and function of the MHAODQAC
  - Evaluate progress towards purpose and functions
  - Identify data available on MHAOD service delivery
  - Identify aspects of MHAOD health care the committee is evaluating
  - Identify alignment and overlap with other governing mechanisms
  - Agree on preliminary workplan priorities
- Terms of Reference revised.
- Priority areas for progressing MHAODQAC's purpose and functions agreed.
- Draft workplan endorsed.

Consultation activities

- Dutch Health Inspectorate
  - Consultation to discuss work in the Netherlands to examine strength of recommendations and consider potential utility for clinical incident management work being progressed by MHAODQAC.
- Clinical Governance Unit (Office of the Chief Psychiatrist)
  - Update on outcomes from the Queensland Multi-incident analysis of suspected suicides of people with recent contact with a health service.
  - Overview of notification processes and monitoring of data pertaining to incidents captured under the Chief Psychiatrist policy *Notifications of critical incidents and non-compliance with the Mental Health Act 2016.*
- Australian Commission on Safety and Quality in Health Care
  - MHAODQAC member feedback on revised Australian Sentinel Events List invited.

Work activities initiated, progressed or completed in Year 2

- Learning from incidents and clinical incident management
  - Development, endorsement and implementation of the Governance and Process Self-Evaluation Questionnaire (G&PQ) and supporting documents to determine current practices and variations across HHSs in clinical incident management processes to identify improvement opportunities and promote standardisation.
  - Development, trial, revision and endorsement of the Learning From Incidents Self-Assessment Questionnaire (LFIQ) and supporting documents for HHSs to quantify the quality of clinical

incident reports.

- Promotion of standardised reporting definitions
  - Agreement to cease work in light of broader work priorities.
- Review of the implementation of the Queensland Health 2016 safe environments guidelines
  - Review methodology updated based on trial site feedback.
  - Updated review methodology endorsed by MHAODQAC.
- Communicating with HHSs
  - Agreement to consider a two-way communication process with HHSs based on a process for service escalation used by Canadian Patient Safety Institute.
  - Communication strategy outlining purpose and types of stakeholder communication endorsed.
  - Framework for developing Communiques endorsed.
  - Checklist for preparing Communiques developed.
  - Communique on the process of learning from incidents drafted.
  - Communique in response to a coronial finding considered and feedback on the Committee's approach discussed.
- Clinical Incident Data
  - Agreement for the Committee to review and assess the quality of incident analysis and recommendations from a defined cohort group in the future, for example suspected suicides and suspected homicides.

Year 3: September 2019 – August 2020

The MHAODQAC met eight times during Year 3, with a focus on recruiting new members, finalising a range of priority work activities commenced, ongoing stakeholder engagement to inform its approach to emergent work activities, and triennial reporting activities. Specific activities and outcomes from Year 3 are summarised in Table 3.

Table 3. Year 3 activities and outcomes

Administrative activities

- 2019 Annual Activity Statement submitted.
- Nominations for Deputy-Chair invited.
- Expressions of interest for several vacancies issued and new members recruited.
- Evaluation of progress against 2019-2020 workplan activities completed.
- Triennial Review of Functions completed.

Consultation activities

- Gold Coast Hospital and Health Service
  - Implementation of tools developed to improve the quality of recommendations and audit results.
  - Restorative Just Culture introductory concepts.
  - Experience of establishing a Restorative Just Culture in mental health services.
- Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation Macquarie University
  - Benefits and limitations of Root Cause Analysis for review of clinical incidents.
- Clinical Governance Unit, Office of the Chief Psychiatrist
  - Invitation to contribute to updating the National Safety Priorities in Mental Health, an action from the Fifth National Mental Health and Suicide Prevention Plan.
- Patient Safety and Quality Improvement Service (PSQIS)
  - Resources being developed as part of the PSQIS Clinical Incident Reform Project and opportunity for MHAODQAC to provide feedback.

Work activities initiated, completed or progressed in Year 3

- Learning from incidents and clinical incident management
  - LFIQ circulated to participating HHSs, data from first six months of implementation tabled and

discussed, key points to feed back to HHSs agreed, summary report for HHSs endorsed and circulated, individual HHS data reports circulated.
    - Data from implementation of G&PQ tabled and discussed, key points to feed back to HHSs agreed, summary report for HHSs endorsed and circulated, potential workplan activities for consideration for inclusion on the MHAODQAC workplan identified for further consideration. Findings from the G&PQ were provided to PSQIS.
- Review of the implementation of the Queensland Health 2016 suite of safe environments guidelines
    - Preliminary findings from the review considered.
    - Final report on the review pending.
    - Summary report prepared for circulation to HHSs, pending approval for circulation.
- Culture and clinical incident management
    - Panel discussion on clinical incident management within a Restorative Just Culture framework.
    - Advocacy to PSQIS of promotion of restorative just culture to HHSs.
    - Agreement on actions to support HHSs to embed Restorative Just Culture principles within business as usual practices.
    - Letter to the Queensland Chief Psychiatrist to propose OCP take a leading role in promoting and embedding Restorative Just Culture principles.
- Communicating with HHSs
    - Temporary work group established to finalise inaugural MHAODQAC Communique on the process of sharing lessons.

Privacy Policy

- Members of the MHAODQAC will receive information that is clinically confidential, has privacy implications or that may be commercial in confidence. All members of the MHAODQAC will acknowledge their responsibility to maintain confidentiality of information by signing a Department of Health privacy and confidentiality statement /non-disclosure agreement.
- Pursuant to s.23 of the *Hospital and Health Boards Regulation 2012*, MHAODQAC adopts, by resolution, a written privacy policy.
- Members of MHAODQAC and relevant persons are prohibited from making a record of, divulging or communicating to any other person, information obtained in the course of their involvement in the MHAODQAC activities, unless this is undertaken for the sole purpose of enabling MHAODQAC to perform its functions.
- Data and/or information released by MHAODQAC while performing its function will not disclose the identity of an individual who is a provider or recipient of mental health alcohol and other drugs services.

Current Membership

The Committee's members were selected to reflect the diversity of services, geographical regions, disciplines, professional groups, consumers and carers and other stakeholders involved in the operation of public mental health alcohol and other drugs serivces and patient safety and quality programs.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Dr John Reilly	Chair	Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Queensland, Department of Health	M.B., B.S., D.P.M., Grad. Dip. Epid. and Biostats., F.R.A.N.Z.C.P	Psychiatrist with experience in mental health legislation and mental health alcohol and other drug service clinical governance.
Dr Ankur Gupta	Member	Clinical Director, Mental Health and Specialised Services, West Moreton Hospital and Health Service	MBBS, F.R.A.N.Z.C.P (elect) CCT (Adult and Liaison Psychiatry, RCPsych) MRCPsych	Psychiatrist with a background working in acute mental health service settings and experience in patient safety, mental health service management, evaluation and improvement, clinical governance, clinical incident review.
Assoc Prof Balaji Motamarri	Member	Director Medical Services, Metro South Hospital and Health Service	MBBS, MD (Psychiatry), F.R.A.N.Z.C.P.	Psychiatrist with experience in clinical governance, patient safety and quality, change management, and medical administration.
Ben Freedman	Member	Team Leader Disaster Recovery, Townsville Hospital and Health Service	Master of Conflict Management and Resolution, Bachelor of Social Work.	Allied Health Clinician with experience in patient safety and quality, clinical governance, workforce culture, and investigating and analysing high risk clinical incidents.
Carmen Lehtonen	Member	Consumer Consultant, North West Hospital and Health Service	Bachelor of Education, Bachelor of Community Welfare and Social Work.	Consumer and carer representative with experience planning, developing, implementing and evaluating strategies to support recovery-oriented systems of care; representation on various groups and committees.
Diana Grice	Member	Director of Nursing, Gold Coast Hospital and Health Service	Master of Healthcare Leadership, Postgraduate Forensic Psychiatric Care Certificate.	Registered Psychiatric Nurse with experience in clinical incident management and initiatives to support improvements in mental health service clinical governance, quality and safety.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Donna Bowman	Member	Operations Manager, Metro North Hospital and Health Service	Master of Education (Leadership), Bachelor of Health Science (Nursing).	Registered General and Mental Health Nurse with experience in mental health service delivery, education, management and quality; experience with critical incident governance and review through involvement on a range of committees.
Joanne Stitt	Member	Director of Allied Health Services, Allied Health Services Division, Townsville Hospital and Health Service	Graduate Certificate in Clinical Education, Postgraduate Diploma of Clinical Psychology Bachelor of Psychology with Honours	Psychologist with experience in clinical service provision, clinical education, professional leadership and management roles; experience with a range of mental health populations across multiple service settings and contexts.
Kelvin Lindbeck	Member	Director, Systems and Support, Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, Department of Health	Master of Health Administration, Master of Science (Nutrition, Food Management), Graduate Diploma Dietetics, Bachelor of Education – Sciences (Biochemistry, Chemistry)	Experience managing datasets, data and reporting, risk management, clinical incident management reporting.
Mark Scanlon	Member	Nursing Director, Division of Mental Health and Alcohol and Other Drugs Service, Mackay Hospital and Health Service	Registered Nurse (Division 1), Graduate Certificate in Public Sector Management	Registered Nurse with experience in acute mental health and clinical incident management and review processes.
Paul Inglis	Member	Consumer Representative, Health Consumers Queensland	Certificate 4 in Mental Health Work, Certificate 4 in Mental Health Peer Work, Diploma of Professional Counselling, Bachelor of Human Services (current studies)	Consumer representative with experience working with consumers of government and non-government mental health services; membership on a range of Committees and Groups.
Richard Spence-Thomas	Member	Director, Psychology, Sunshine Coast Hospital and Health Service	Master of Clinical Psychology, Psychology Honours, B. Soc. Sci. Psych, Step-Up Queensland Health Leadership Development	Clinical Psychologist with experience in operational leadership and clinical service provision across the mental health services, including: acute care teams, forensic services, alcohol and other drug services, rehabilitation psychiatry and private practice and consultancy.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Robyn Bradley	Member	Executive Director, Mental Health and Specialised Services, Wide Bay Hospital and Health Service	Bachelor of Applied Science, Occupational Therapy, Commenced Units towards Master in Health Management	Occupational Therapist with experience as Deputy Chair for a quality review committee for significant incidents, resulting in policies and processes to support service improvement.
Ruth Heather	Member	Service Group Director, Rural Hospitals Service Group, Townsville Hospital and Health Service.	Master of Development Studies (Community), Post Graduate Diploma of Health Management, Registered Midwife, Registered Nurse with Current Practicing Certificate: Diploma of Comprehensive Nursing (including mental health)	Registered nurse with experience examining and using case data to inform the development of quality initiatives and full-scale system reform projects and programs; experience leading, initiating and implementing system and service reform.
Dr Sean Hatherill	Member	Clinical Director, Child and Youth Mental Health Academic Clinical Unit, Metro South Hospital and Health Service	MBChB, MRCP (Paediatrics), MRCPsych, FCPsych, Cert Child Psych, MPhil, FRANZCP	Psychiatrist working in child and youth mental health with experience with quality improvement in mental health service delivery.