

**PATIENT SAFETY AND QUALITY  
IMPROVEMENT CAPABILITIES  
GROUP**



CLINICAL  
EXCELLENCE  
COMMISSION

Appendix B: Case Study for  
Capability Mapping

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# Appendix B – Case Study for Capability Mapping

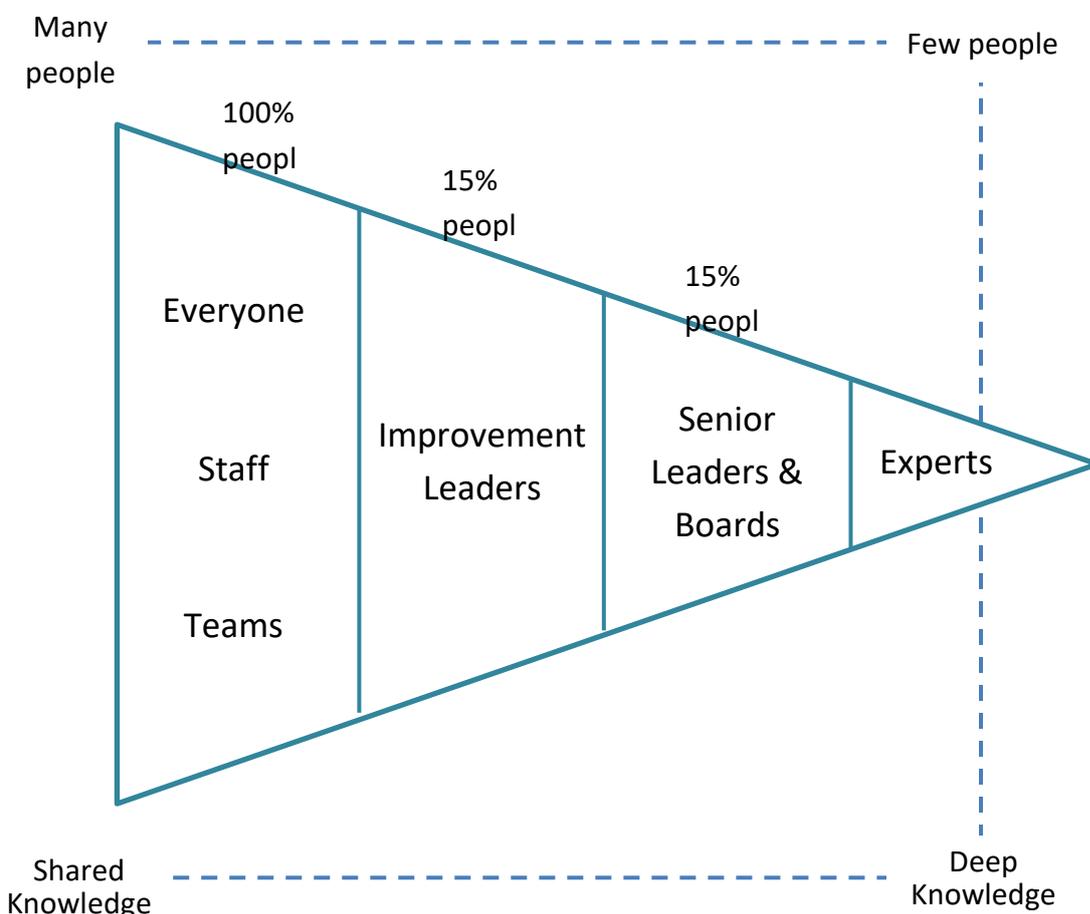
## Introduction

The purpose of Capability Mapping is to identify the workforce capabilities required by key healthcare roles to engage in patient safety management and quality improvement. Roles are mapped to the Patient Safety and Quality Improvement Capabilities and the Public Service Commission’s (PSC) NSW Public Sector Capability Framework.

This is a case study of how Capability Mapping has been applied to a Local Health District (LHD). It is one way to derive what is required of specific roles to engage in patient safety management and quality improvement.

The LHD elected to focus on the workforce capabilities required by Nurse Unit Managers (NUM) and Directors of Medical Services (DMS) to undertake clinical risk management and quality improvement. NUM and DMS positions were targeted based on agreement that individuals in these roles are potential ‘Improvement Leaders’ due to their large scope of influence over local processes.

It is not feasible (or necessarily desirable) for every employee to meet a highly-advanced level across all patient safety and quality improvement capabilities. Instead, the goal is to develop both breadth and depth of capability across an organisation. A useful guide for the level of capability required across your organisation to achieve breadth and depth is provided by the Kaiser Permanente triangle of organisational capability shown below (Schilling, 2010).



## Method

To map the patient safety and quality improvement capabilities required by NUMs and DMSs, both quantitative and qualitative methods were employed. The diagram below outlines a sample mapping process.

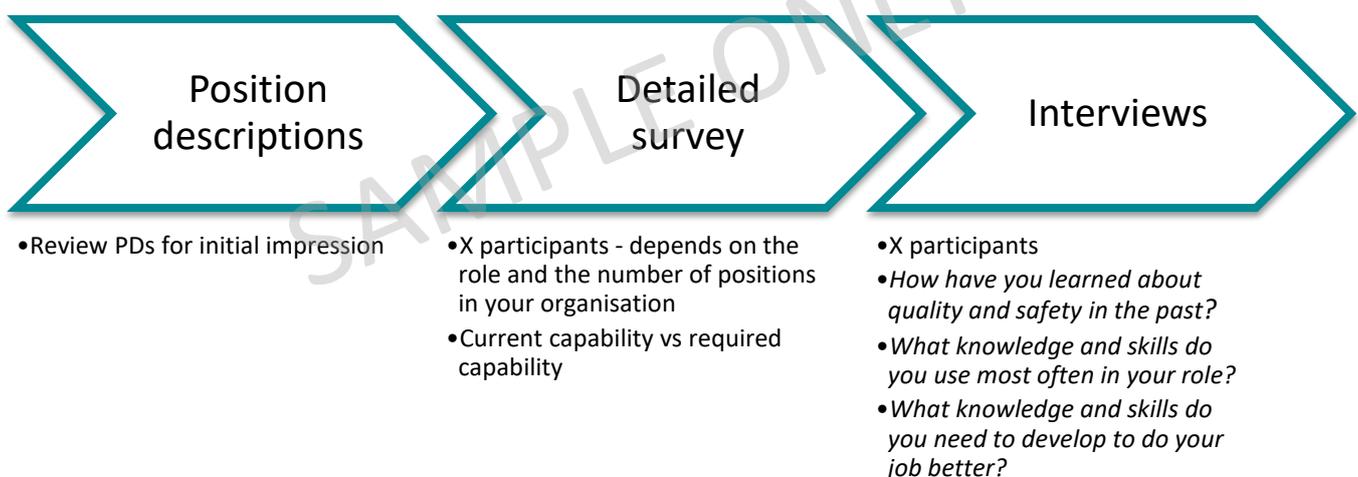
First, several sample position descriptions for NUMs and DMSs were reviewed. This information was used to derive possible levels for the four patient safety and quality improvement capabilities:

- Utilise Improvement Methodologies
- Think Creatively and Innovatively
- Manage Clinical Risk
- Manage Factors that Influence Human Performance

Next, a detailed survey was administered, where participants were given a series of capability statements to reflect on. The capability statements varied by complexity. The choice for the selection of capability statements by level was based on the outcome of the position description review. Participants were asked which statement expresses their current capability, and which statement expresses their required capability to do their job well.

Finally, participants were interviewed about their knowledge, skills and experience used most often in the role and their experiences learning about safety and quality in the past. All interviews were transcribed. Discourse analysis was used to uncover capability development opportunities. All data was de-identified and made only available to the organisation in an aggregated form.

### Sample Capability Mapping Process



## Implementation

The Capability Mapping exercise suggested that NUMs and DMSs should be demonstrating the four Patient Safety and Quality Improvement Capabilities at the following levels to be effective improvement change agents at their LHD.

	NUM	DMS
<b>Utilise Improvement Methodologies</b>	Adept	Adept
<b>Think Creatively and Innovatively</b>	Adept	Advanced
<b>Manage Clinical Risk</b>	Adept	Advanced
<b>Manage Factors that Influence Human Performance</b>	Adept	Adept

In addition to the guide on capability levels above, the LHD received a series of change ideas that were informed by the Capability Mapping exercise and advice based on the Patient Safety and Quality Improvement Capabilities. The change ideas were coupled with suggested methods for implementation according to the 70-20-10 approach to capability development.

This means approximately 70% of capability development should come from practice on the job, trial and error and self-reflection. The next 20% of development should occur through social learning approaches: learning with and through others from coaching, exploiting networks/streams and other collaborative and co-operative actions. Formal training, conferences and courses should comprise approximately 10% of the total time spent developing capability. This is because completion of training or a course does not mean that the employee will be able to demonstrate the capability. Acquired skills must be practiced through on-the-job experience to solidify learning.



These change ideas were not exhaustive and the District was not required to implement them in any specific way. The change ideas were shared as a means to support the LHD as it chose how best to address NUMs and DMSs capability gaps.

Change idea	Suggestions to enact change ideas
Create opportunities for on-the-job learning about safety and quality for NUMs and DMSs	<ul style="list-style-type: none"> <li>• Take opportunities to apply different methodologies to make improvements in their daily work</li> <li>• Take opportunities to manage change in a busy healthcare environment</li> <li>• Lead quality improvement spread within and across teams</li> <li>• Review clinical incidents</li> <li>• Monitor and conduct clinical risk analyses</li> <li>• Conduct Open Disclosure</li> <li>• Model the leadership behaviours that influence safe, reliable care</li> <li>• Understand the factors that influence human performance on patient safety</li> </ul>
Protect time to enable NUMs and DMSs to work within and across their professional groups to learn from each other	<ul style="list-style-type: none"> <li>• Identify how the organisation can protect time in NUMs' and DMSs' workload to be able to learn from each other</li> <li>• Identify opportunities for NUMs/DMSs to interface and learn from one another</li> </ul>
Orient new NUMs and DMSs to their safety and quality responsibilities and identify capability gaps in order to deliver on those responsibilities	<ul style="list-style-type: none"> <li>• Review orientation and onboarding program for new NUMs and DMSs</li> <li>• Identify capability gaps during the selection process, and create development plans once in post</li> </ul>
NUMs and DMSs who have a direct need to participate in formal learning programs should enrol and complete, e.g. Clinical Practice Improvement Program, Foundational or Executive Clinical Leadership Program, Root Cause Analysis (RCA) and RCA Team Leader Training	<ul style="list-style-type: none"> <li>• Inform NUMs and DMSs when the enrolments become available</li> <li>• Protect time to enable NUMs and DMSs to participate in formal learning programs that meet a direct need</li> </ul>

Support NUMs and DMSs to succession plan for their roles to ensure patient safety and quality capability continuity is achieved

- Educate NUMs and DMSs about the patient safety and quality capabilities and how to recognise and develop them in their teams

Ensure all staff come to understand the base-level expectations about patient safety and quality improvement

- Improve education on patient safety and quality improvement in orientation
- Ensure managers make this part of what new staff learn on-the-job and from their more experienced peers
- Ensure patient safety and quality improvement capabilities and expectations part of the performance review program for all staff

## Conclusion

This case study demonstrates *one* way to conduct Capability Mapping to determine the workforce capabilities required for key roles to deliver safety and quality improvement outcomes.

We review capability through conducting desktop reviews and qualitative data collection to identify the safety and quality improvement capabilities required for many key roles.

If your organisation wishes to examine whether a specific position or role type has the means to build and maintain their safety and quality improvement capabilities, the CEC can advise on how best to conduct Capability Mapping.

Please contact the Organisational Development and Human Factors team at the CEC for more information.

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