The Quality Improvement Residency: a model to address the lack of pre-registration education in quality improvement in New Zealand healthcare professionals

Allan Plant

I read with interest Robb, Stolarek, Wells and Bohm’s article published in the recent edition of the NZMJ pertaining to the lack of education of our country’s future health professionals in the domains of quality improvement and patient safety. Like many readers I’m sure, I found it astounding that of 43 institutions surveyed, only two provided focused teaching on improvement science. In the spirit of systems improvement, I thought that I’d share our hospital’s model for improving education in this area.

Tauranga Hospital offers house officers in their second year of work the opportunity to undertake a supervised quality improvement (QI) residency with the support of our local service improvement unit. The residency offers junior staff the chance to choose an area where they feel that change is needed and to apply a QI methodology taught via the Institute for Healthcare Improvement (IHI) Open School online course. Practically, the residency entails one house officer completing their relief rotation taking one day a week out of the clinical roster to work on a QI project with 1:1 support from our change manager. Established in 2015 and with four residents each year, projects completed thus far have focused on a range of topics from the implementation of standardised weekend plans, the introduction of a hospital-wide ceiling of care form, to the trial of electronic devices to access results in real-time on surgical ward rounds. These projects are not always successful in terms of achieving systems change but they undoubtedly foster an understanding of QI methodology and an interest in improvement science among our junior staff; the success of this programme has subsequently prompted a rollout at Whakatane Hospital as well as the extension of a similar programme to nursing staff.

From personal experience—and having graduated from one of the two institutions surveyed who have formal teaching on QI science—I can confidently say that my understanding of QI pre-registration was limited to enough theory to pass an exam. While learning about tools such as PDSA cycles and small tests of change are a valuable framework for developing skills, it is the real-life application of these tools in a way that brings about tangible improvement to our patients and colleagues that fosters lifelong interest in the field. It is also the practicalities of managing a three-month project that challenges your colleagues to change their practice that offers true learning opportunities; I don't recall any of my pre-registration training arming me with the skills to tell my senior clinical colleagues that I feel our current practice is inefficient. Yet the residency teaches junior staff how to...
challenge and innovate without prompting disapproval, and it is this innovation which can keep healthcare fresh and receptive to new ideas.

Although I can’t offer solutions to the problem of providing pre-registration education to future healthcare professionals in the domains of QI and patient safety, I can encourage you not to give up on those who have already passed through an education system which has failed to prepare us to take up the mantle of improvement. The QI residency model has now been adopted by DHBs beyond our own, and we would encourage anybody interested in learning more to get in touch. Robb, Stolarek, Wells and Bohm hoped for a future where “improvement is an intrinsic part of [health professionals’] everyday work”, to which I leave the quote:

“Better is possible. It does not take genius. It takes diligence... It takes ingenuity. Above all, it takes a willingness to try”—Atul Gawande.

Competing interests:
Nil.

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REFERENCES: