Episode four – Insights from experiences of implementation of RJC

Debbie Draybi: I'm Debbie Draybi from the Clinical Excellence Commission and am pleased you can join us for this four-part podcast series with Dr Nick O'Connor and Dr Kathryn Turner. This podcast is part four of a four-part series on Restorative Just Culture.

In this segment, Insights from experiences implementing RJC, including a reflection on the barriers and challenges for health services that are wanting to implement a restorative justice culture, Kathryn talks about the significant challenges of building that understanding of RJC and the level of accountability required across the organisation.

Feedback from clinicians involved in the implementation have expressed that they have felt safe really being engaged in a different approach where they feel heard and considered in building the understanding what actually happened.

Kathryn also described some positive changes in the Gold Coast Mental health service with positive outcome related to fewer people fearing disciplinary action; it seemed that there was more trust in the organisation and those people who had had involvement feel a greater sense of organisational support. This is a tremendous shift particularly when people have felt traumatised by incidents in the past and strengthening the individual and relational resilience following incidence.

There has also been a shift in the quality and strength of recommendations which will continue to grow through sustaining and keeping to the principles of RJC and the challenges of maintaining what Katherine describes is a tough accountability.

I hope you enjoy this conversation.

Nick O'Connor: There are some barriers and challenges for health services that are wanting to implement a restorative justice culture.

If you go to a local health district or a sector service and you want to implement this, they exist within the bigger health system, which then also exists within the politics of government and the wider society and, in some ways, people in society and often within their health bureaucracy, don't really understand the language or the sort of mental model of restorative justice. What are some of the barriers that you have encountered in implementing this?

Kathryn Turner: I think it's very true that many people don't understand what it's all about and what they don't understand is that it's actually a more accountable process than the traditional Just Culture approach or retributive approaches. It actually requires significant investment by everybody into the process. We've had some wonderful feedback from clinicians, and they don't say this is a lovely process that they've enjoyed doing, they say it's a tough process but it's so much better than what they used to have because they felt safe to be able to really comprehensively review and really understand what actually happened. So, getting people to understand the concept is a challenge, particularly for people at the higher levels in the organisation.

It was very much a response to all the ideas that our clinicians had. There wasn't much resistance from clinicians around it, although from a past experience point of view, there was probably a wariness about whether we were actually going to do what we said we were going to do and people have been traumatised by incidents in the past, and it's very hard to let that go until you've really experienced a different approach. So, the challenge for us was to at least get permission or allow us to proceed. People above us didn't necessarily have to understand the

intricacies of it, but the fact that they gave us permission to be able to do a slightly different process was really important.

The challenge is also about sustaining and keeping to the principles as well because that is actually a tough accountability. Some people might be reluctant to do that, and some people might fear bringing certain stakeholders in or might feel that a family may not want to be part of the process or are too angry to be part of the process. But in in our experience, if we work with them and they understand that we are being open and transparent and we want to learn, in nearly every occasion we've been able to engage families in that.

So, you actually have to be quite firm about maintaining the principles as it does require that ongoing effort. It's not a project that you do and then everything's changed as you go along. It's actually an ongoing conversation all of the time.

Nick O'Connor: What have been the outcomes for Gold Coast mental health and specialist services where this approach has been implemented over the last few years?

Kathryn Turner: So, we looked at a range of ways of measuring that. We've conducted a staff survey (at least three times) as part of the Zero Suicide implementation. In the second staff survey, we inserted a couple of tools to measure Just Culture and Second Victim experiences, and then we were able to repeat that in the third staff survey. We were also able to insert a question about whether someone had been a recipient of the 'Always There Pure Responder' and what we were able to demonstrate in the staff survey was that there were significant improvements in a sense of Just Culture and Second Victim distress. Fewer people feared disciplinary action; it seemed that there was more trust in the organisation and those people who had had involvement with 'Always There' had a greater sense of organisational support for them.

The other things that we looked at were the triage register. We kept a register of all the incidents to see if we were doing what we said that we were doing or were we moving away from RCAs? Were we looking at a broader range of incidents? Were we looking at a broader range of ways to review those incidents as well? Were we engaging all stakeholders in that? And certainly, we demonstrated that we'd had a huge change in moving away from RCAs and we had a much broader range of incidents that we were learning from.

We also did an audit of the process which demonstrated that we were engaging stakeholders, etc. Then we also looked at the quality and strength of recommendations. We did a pre- and post-audit of the strength and the quality in terms of smarter outcomes for the state - the recommendation statements - and what we demonstrated was that there were some improvements in the quality and the strength of recommendations, improved effectiveness and evaluation, more specific recommendations and also an improvement in the strength of recommendations, but the literature would tell you that the strength of recommendations is often very low. So, we started from very low, and we improved it a bit, but there were lots that weren't strong recommendations. And I think that is another piece of work to really think about and really question our concept of strength of recommendations as well.

That's probably a very linear concept - the hierarchy of hazard controls - that we measure the strength of recommendations and there may be more resilient health care approaches to care that may actually be stronger recommendations, or you may actually - and this is our experience - have a number of less strong recommendations that build on one another and that can be a very significant impact on the service.

So, I think we do need to rethink what makes a good recommendation and how can we embed resilient health care principles more into that? And I think that's an ongoing piece of work.

Nick O'Connor: That is an ongoing piece of work and the thing that I have been wondering about is whether this approach - in addition to producing fairly standard recommendations that are usually about processes and procedures - might also have an effect in terms of strengthening the individual and relational resilience? The ability for clinicians and teams to initiate and take initiative when required, even if you're stepping outside of that established procedure. But that's what the situation requires.

Kathryn, thank you so much for a really wonderful discussion about restorative justice culture and the benefit of your experience in leading, what is now, your second service on that quest. So, thanks very much.

Kathryn Turner: Thank you.

Debbie Draybi: Thank you for listening to this podcast with Dr Nick O'Connor and Dr Kathryn Turner on RJC. I hope you enjoyed it. Please note this is one of a four-part series and I hope you listen to the other three segments as Nick and Kathryn continue to take us on a journey exploring their experience and insight into RJC.

This four-part series includes conversations around practical implementation of RJC and what this looks like in health care. Kathryn will share her experiences of RJC framework in mental health and the impact this has on management of incidents. I hope you enjoy the remainder of the series.

I'm Debbie Draybi from the Clinical Excellence Commission and am pleased you can join us in this conversation with senior leaders on Guiding principles of effective Morbidity and Mortality in action. This podcast series aims to explore the experiences and insight from leading M&M meetings.

Look out for more podcasts as we continue this conversation and clinicians share their journey and learning. I hope you find it useful and if you would like to contribute to this conversation, please contact me.