Summary: Guide to Co-developing a Restorative Just and Learning Culture

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This guide has been developed by the Clinical Excellence Commission to assist NSW mental health services develop a restorative just and learning culture as part of the Zero Suicides in Care initiative. This guide explains why a Restorative Justice Culture is an important step in the continuing development of safety culture in health organisations. To emphasise the learning and improvement elements inherent in Restorative Just Culture, and so important for healthcare, we refer to this paradigm as a Restorative Just and Learning Culture (RJLC).

The safety of patients and staff and the harms that occur in health services arise from the complex adaptive human and technical health care systems. Safety in health care must be created through the interaction of people and complex processes, and this requires paradigms additional to Safety I. These include different perspectives on complex systems (Safety II and Resilient Health Care) and different approaches to organisational leadership and culture incorporating generative and dialogic approaches (Restorative Just and Learning Culture). A resilient organisation anticipates and is flexible and responsive to unusual conditions and predicaments. A generative approach, where stakeholders are engaged in conversations empowering them to develop new ideas that make sense of their situation and generate actions that can be tested using data, is more likely to promote agile responses to complex problems than a top-down, compliance-focused, programmatic approach.

Our understanding of harm in the health system continues to develop. A Restorative Just and Learning Culture aims to heal harm and address impacts on relationships, building trust and confidence in each other and the system. This approach is mindful of the potential for compounding harm to patients, families and staff, including compound harms that are inherent in the linear cause-and-effect (Safety I) and the hierarchical, compliance-focused procedural approach to organisational leadership and management.

Co-developing a Restorative Just and Learning Culture is essentially a relational and collective exercise. Each leadership group needs to consider where to start and how to proceed on their organisational culture development journey. Implementation of RJLC has shown improvements in stakeholder inclusion, the experience of clinicians involved in critical incidents and the strength of incident review recommendations. Work on key areas can proceed simultaneously once the frame and shared vision for a Restorative Just and Learning Culture are set:

1. Setting and maintaining ‘The Frame’

'The Frame' is the safe and supportive environment that enables a shared vision of safety culture through psychological safety, respect, trust, care and support. Psychological safety is the shared belief that the team is safe for interpersonal risk-taking. When psychological safety extends beyond individual teams, it becomes the enabling atmosphere for organisational learning. Leaders have an important role to play in establishing a psychologically safe environment that extends to patients and their families.

2. Group engagement and conversations

Every organisation will determine how to best introduce and work towards a Restorative Just Learning Culture. Restorative Just Learning Culture requires building shared understanding and co-developing

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new approaches with staff; therefore, group engagement and group conversations are logical starting points. Senior leadership should enable distributed and collective leadership for safety through behaviour, dialogue, and co-production, while the middle leadership group are important custodians and ambassadors of the safety culture by overseeing team processes, maintaining situational awareness, and managing relationships.

3. Responding and healing

Responding to patients and families: A Restorative Just Learning Culture approach prioritises understanding and responding to patient and family needs, appreciating, and learning from their perspective, and facilitating trust and relationship healing with healthcare providers and the wider health service.

Responding to Aboriginal and Torres Strait Islander people: Restorative practice recognises the importance of healing inter-generational trauma and loss for Aboriginal and Torres Strait Islander people, and views Indigenous suicide and its impact within a social and historical context. In a Restorative Just and Learning Culture, the patient, family, and community members define and determine what is required for healing and the rebuilding of trust with the support of their community and Aboriginal health professionals.

Responding to staff: Staff involved in serious adverse events are impacted in various ways. A three-tiered approach to respond to the harm that clinicians and staff experience includes: basic-level training for all staff to act as first responders; trained clinician peer responders; and referral to external professional care and assistance.

Responding to the team/ward and the wider service: The response of senior and middle leaders to a team involved in a serious patient harm incident is important and needs to occur at the microsystem and service level. This includes providing support and acknowledging the experience of the team, understanding, and responding to their needs, and ensuring incident reviews and analysis are co-developed with staff to improve systems of care.

4. Learning and improving (incident review and analysis)

Restorative Just and Learning Culture approaches to reviewing a serious incident aim to capture the system and human complexity of healthcare and use methods such as constellation diagrams to achieve a deeper understanding of the underlying issues that contributed to an adverse event. A restorative response involves those affected by an adverse event coming together to speak openly about what happened and clarify responsibility for healing and learning. Clinicians and teams involved in care should be involved in reviewing and improving practices and systems of care delivery.

The review or investigation of a serious harm does not guarantee that the learning from that incident will translate to effective system improvement and the prevention of similar harm. Attention must be directed to formulating feasible, measurable recommendations for system improvement, the sharing of this learning, and implementation and monitoring of change ideas.

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5. Learning and improving (system improvement)

Safety intelligence is the use of data to accurately anticipate, correctly diagnose and drive targeted interventions to improve patient safety. Data that constitutes safety intelligence come from a range of sources, including patient outcomes and experience, the findings of incident reviews, and process data relating to the systems of care. Safety intelligence uses data differently to performance data such as KPIs. It looks at data for system improvement rather than judgement about performance.

The Improvement Method: Successful improvement efforts rely on involving the team and understanding the local context, with rapid cycle small tests of change ideas based on safety intelligence data driving change that results in measurable improvement.

6. Evaluating outcomes and experiences (safety and organisational intelligence)

The aim of safety culture is that everyone (patients, family, staff) is safe and feels safe. While the measurement and evaluation of patient outcomes and experience is central, these things are interdependent on other components of the human and technical processes of the healthcare system. Mental health safety dashboards, in addition to priority patient outcomes, should also incorporate measures of culture and leadership, safety governance, safety and improvement capability, and safety systems improvement activity.