Guide to Co-developing a Restorative Just and Learning Culture

June 2023

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

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Guide to Co-developing a Restorative Just and Learning Culture

This guide has been developed by the Clinical Excellence Commission to assist NSWH's mental health services develop a Restorative Just and Learning Culture as part of the statewide Zero Suicides in Care initiative(1). The guide is a 'living document' and will be regularly updated as new evidence and examples of best practice emerge. The central importance of a Restorative Just and Learning Culture to zero harm approaches in healthcare described by Mokkenstorm et al(2), Gandhi, Feeley and Schummers(3) and Turner et al(4).

Acknowledgement of Aboriginal and Torres Strait Islander people

The Clinical Excellence Commission is on the land of the Cammeraygal People of the Eora Nation. We recognise that Aboriginal and Torres Strait Islander people are the First Peoples and Traditional Custodians of Australia, and the oldest continuing culture in human history. We pay our respect to Elders past and present and commit to respecting the lands we walk on, and the communities we walk with.

This is a time when Aboriginal and Torres Strait Islander people are inviting all Australians to a larger conversation about restoration, justice and learning. The Uluru Statement (5), Makarrata and The Voice to Parliament are parts of this journey. We have much to learn from the Aboriginal and Torres Strait Islander community.

This is a time when Aboriginal and Torres Strait Islander leaders (6, 7) are inviting us to come together and work with them to remove the many barriers that prevent equitable access and outcomes in health, mental health and social and emotional wellbeing.

In this Guide, the term Aboriginal is used for Aboriginal and Torres Strait Islander or First Nations people, in recognition that Aboriginal people are the original inhabitants of NSW.

Summary

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

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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 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.

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.

Guide to Co-developing a Restorative Just and Learning Culture

How to use this guide

This guide to a Restorative Just and Learning Culture (RJLC) assumes that those leading this journey have a commitment to a continually developing and reflective approach to their own language and behaviours, and the language and behaviours within the organisation.

There is no pure and universally applicable model for a Restorative Just and Learning Culture. All health organisations are unique in their history, culture, and capabilities. This type of organisational change cannot be established by legislation or policy directive, taught didactically, or copied and pasted between organisations. Each organisation must make its own commitment to their unique journey of transformation.

The nature of building a safety culture involves listening and engaging in conversations with staff and teams at every level of the organisation. Leaders model attitude and behaviours that build 'the frame'[1] of psychological safety and high trust.

This work is essentially relational, involving teams and groups and requires co-design. Implicit in this approach is leaders, including senior executives, having the courage to move to a more distributed, collective, and enabling style of leadership.

The relational and co-design nature of developing a Restorative Just and Learning Culture requires an initial step of a series of group conversations across and through the organisation, facility, or service. These conversations can be themed as:

- What is restorative, just and learning culture?
- Why is restorative, just and learning culture important for us?
- How shall we build our restorative, just and learning culture?

The Guide is a curated journey through the literature and the lessons from those who have made this journey. It is presented to stimulate conversations with your teams about the best co-design pathway for you.

[1] The 'frame' here refers to the underlying and supporting organisational atmosphere

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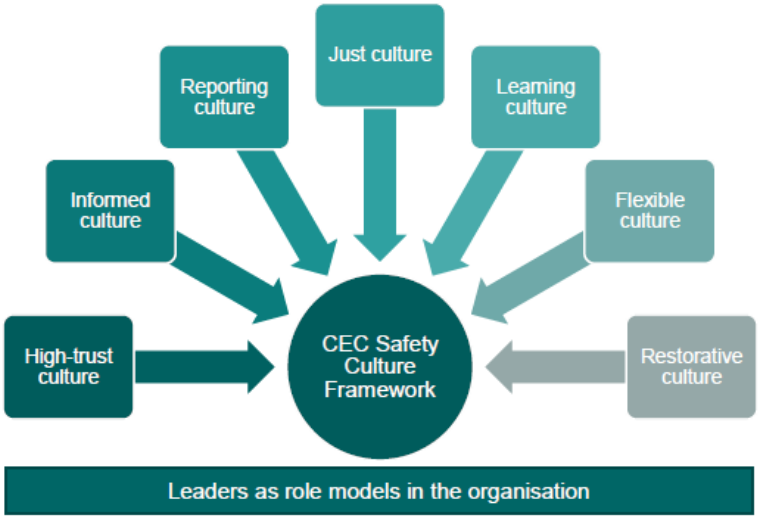
Introduction

Our understanding of patient safety and clinical governance continues to evolve and is informed by new evidence. It is incumbent on us to periodically ask the questions: Is our current paradigm still the most appropriate? How might it be improved? What would a safer health system look like?

In this guide, we explain 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). A Restorative Just and Learning Culture includes all the elements of the Clinical Excellence Commission's Safety Culture Framework(8):



Despite 25 years of investing resources in standardizing care, guideline development, policy directives and looking for causes and fixes when things go wrong (Safety 1 approaches), the rate of harm in healthcare has stubbornly remained at around 10% (9). The current clinical governance paradigm is clearly not sufficient if we want to further reduce harm (10, 11). This approach which rests on 'work as imagined' (12, 13) often enacts blame while asserting it supports a 'blame-free' culture (4), is disempowering of clinician adaptability (14, 15) and is a cause of distress to health workers in the system (15).

The safety of patients and staff and the harms that occur in health services arise from the complex adaptive human and technical systems that deliver health care (10, 16). Safety in healthcare 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 (15, 17) and a different approach to organisational leadership and culture incorporating generative(18, 19) and dialogic (20, 21) approaches (Restorative Just and Learning Culture). A resilient organisation anticipates and is flexible and responsive to unusual conditions and predicaments (12, 22). 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, programmatic approach (23).

We need to shift the safety management approach from ensuring "as few things as possible go wrong" (Safety-I) to "as many things as possible go right" (Safety-II) (8). This alternate approach relates to the system's ability to succeed under various conditions. It assumes that performance variability enables adaptations that are required to respond to a variety of conditions. This why the people in the system are the necessary resource for system flexibility and resilience (8). Hollnagel, Wears, and Braithwaite conclude that "we should acknowledge that things go right because clinicians are able to adjust their work to conditions rather than because they work as imagined" (8). Ultimately, such performance adjustments underpin both acceptable and adverse outcomes (8).

How people understand and deal with the situations they encounter within systems (that cannot be contained by standardised processes or risk mitigation) is a crucial determinant of safety in health care (17, 22, 24). All meaningful improvement is local, centred on natural networks of clinicians and patients(9). The clinical microsystems are the point-of-care frontline where standards, policies and guidelines are put into action(2 5). It follows that key to safer, more resilient healthcare systems are motivated, capable, and enabled staff working in a culture of safety, improvement, and high trust. Therefore the role of leaders at all levels of the health system (26) is to create the conditions for excellence in the frontlines of health care (25). These conditions include (27):

1. A commitment to safety culture: everyone is safe and feels safe
2. Psychological safety, trust, and empowerment
3. Distributed, mindful and role modelling leadership
4. Team cohesion and learning
5. System improvement capability

Restorative Just and Learning Culture provides opportunities for teams, services, and health organisations to mature their safety culture:

- to incorporate our developing understanding of Safety II principles
- to 're-humanise' our health systems by elevating people and human relationships above technical systems and processes
- to develop an inclusive, distributed, and collective leadership
- to co-develop processes of care that respond to, learn from, and prevent harm to patents, families and staff

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Restorative Just and Learning Culture: What is it?

"*Restorative justice is a process to involve, to the extent possible, those who have a stake in a specific incident* [2] *and to collectively identify and address harms, needs, and obligations, in order to heal and put things as right as possible*." (Zehr 2015)

Underlying Zehr's paradigm of restorative justice are the understanding of 'interconnectedness' and the fundamental importance of respect:

"*We are all connected to each other and to the larger world through a web of relationships. The primary elements of restorative justice - harm and need, obligation, and participation - derive from this vision*."(28)

"*Ultimately, however, one basic value is supremely important: respect." "Respect reminds us of our interconnectedness but also of our differences. Respect insists that we balance concern for all parties*."(28)

Sidney Dekker has championed the co-design of Restorative Just and Learning Culture in health organisations internationally. Dekker's view of restorative just culture focuses on shifting the paradigm of justice in health organisations and the larger society from a retributive-justice-by-algorithm to a new paradigm(29). Dekker contrasts the questions asked by a retributive justice paradigm with those asked by a restorative just culture paradigm:

Retributive justice	Restorative justice
• Which rule was broken? • Who is responsible? • How bad is the violation (honest mistake, at-risk acts, or reckless behaviour) and so what should the consequences be?	• Who was hurt? • What are their needs? • Whose obligation is it to meet those needs? Dekker 2017

Dekker's 4 minute presentation on Restorative Just Culture (30)

Virginia Sharpe articulated an important element of restorative just culture: it involves a deep and forward-looking accountability to improve and make the practices and systems of care safer(31).

[2] Howard Zehr's definition(16) of restorative justice referred to the corrections setting so the word 'incident' has been substituted for 'offence'.

"The point of forward-looking responsibility ascription is to specify the obligations entailed in achieving a safer health care environment."(31)

While Zehr, Sharpe and Dekker came to develop restorative just culture to address the harm done by violent crime and by serious adverse events in the healthcare setting, the paradigm can be applied more widely to conflicts, grievances, complaints, human resources policies and procedures and ultimately decisions about cultural safety and health equity(32), resources and funding(33).

What would a restorative, just and learning organisation look like?

Researchers and practitioners from the Te Ngāpara Centre for Restorative Justice at Victoria University, Wellington, Aotearoa/New Zealand provide some of the best descriptions of a restorative just culture:

"*In essence, a restorative organisation is one that is intentionally conditioned by the principles, values, practices and priorities of a restorative justice framework. As well as handling conflicts, complaints and failures in a restorative manner, it develops policies and practices that recognise the needs of its staff or clients as whole persons, exhibits a distributed style of leadership and inclusive decision-making, and develops a culture of belonging and respect throughout the organisation*."(34)

For a health service that has a restorative, just and learning culture, the questions after an incident involving serious harm are:

- What happened?
- Who has been harmed?
- What are their needs?
- Whose obligation is it to meet those needs?
- How can things be put right?

"*When an incident occurs, the people receiving and providing healthcare are hurt, and their relationships are affected. If this harm is to be adequately addressed—and safety enhanced—we contend that well-being must be restored, and trust and relationships rebuilt. Compounded harm arises when these human considerations are not attended to, resulting in shame, contempt, betrayal, disempowerment, abandonment, or unjustified blame, which can intensify over time. Public inquiries often illustrate the negative impacts of embedded investigative responses, including the erosion of public trust in institutions and relationships, and the diminishment of individual or community wellbeing*."(35)

"*Once we think about safety as a system that has to adapt to people's needs through trusting relationships, rather than one that seeks to lessen risk and enforce regulation alone, we can consider how best to support the needs of all the people involved, both consumers, family and whānau*[3]*, and health care professionals."(36)*

"Restorative approaches aim for a collective understanding, to clarify responsibilities, inform action and heal individuals and relationships. They recognise that including the voices of all those affected

[3] Whanau is a Maori word referring to extended family or a community of related families

by health care harm is more equitable, intending to meet the justice needs an adverse event creates." (36)

Psychological safety, high trust, care and support for staff

The culture of health care organisations and their microsystems are related to health outcomes(37). Everyone needs to be safe and to feel safe. Respect, trust, and psychological safety are the frame and foundation for a restorative, just and learning culture. Psychological safety as defined by Edmonson(38) refers to respect, trust and caring about others as people. Psychological safety is a necessary condition for team learning. Psychological safety is further described in the section on Co-developing a Restorative Just and Learning Culture.

Dekker(39) describes the importance of responding to and supporting the second victims[4] when there is a serious medical harm(40-44). Staff involved in serious adverse events, including those involved in review and management of incidents can be harmed. Sometimes this harm is cumulative and includes vicarious harm. Often organisational processes in response to serious adverse incidents compound the harm to staff. Restorative Just and Learning Culture organisations focus on not compounding harm and invest in and organise to support and care for their staff. This requires forethought, planning and structural staff supports(45-47).

Engagement and involvement of patient and family

When healthcare adverse events result in serious harm patients and families experience substantial emotional harm, healthcare avoidance and loss of trust in the healthcare system and this can persist for years(48). Open communication with patients and families about medical harm can reduce many, though not all these impacts. An apology plays and important and independent role in reducing the impact of medical harm(48). The expectations of patients and families harmed by serious healthcare incidents were investigated by Iedema, Allen et al (49). They provide some principles for effective communication and disclosure:

- If clinicians and services are to meet patients' and relatives' expectations, they prepare all concerned for the incident disclosure meeting(s)
- They investigate and agree on what went wrong and inform those harmed of the need for a discussion about the unexpected outcome
- Disclosure discussions benefit from a patient support person being present, and from those harmed presenting their own account, views, and questions about what went wrong and what needs to happen
- The disclosure discussion is performed as a two-way, exploratory dialogue that produces an explanation that satisfies all stakeholders, bolstered by a sincere apology, a care plan redressing the patient's harm, a strategy for preventing the incident from recurring, and a clear outline of whether, why, and how other agencies (such as a neighbouring health service or hospital, the police, or the coroner) are involved

[4] The term 'victim' has had utility in highlighting the impacts on multiple stakeholders, however is not always acceptable to families and clinicians. We use terminology such as "those impacted by an adverse event".

- Closure becomes feasible when the patient and family members feel they have asked everything they wanted to ask, have received adequate answers to their questions, and are satisfied that their concerns have been taken seriously
- To reassure them that incident disclosure links to practice improvement, they are informed about how the service has addressed the incident and what difference this has made or is making to care outcomes.

McQueen et al(50) thematically analysed the experience of 19 families that had experienced a serious adverse event and recommended a number of principles for family engagement and involvement, the APICCTHS Model (Apology, Person-Centred, Inclusive, Communication, Closing the loop, Timing, Heart of the review, Support for staff).

The engagement of the patient and family following an incident is established practice in most health services and Restorative Just and Learning Culture give this a central importance. The NSW Health Incident Management policy(51) includes a role description for a dedicated family contact (DFC) to engage and support the patient and/or family following a serious incident. The DFC can link the patient and/or family with the incident review team, convey information or questions to the review team, and support the patient and/or family in providing input to the review, and with the Open Disclosure team share the findings of the review with the family.

The NSW Health Open Disclosure policy(52) and the Open Disclosure Handbook(53) provide guidance on clinician disclosure and formal open disclosure following a patient safety incident. This includes (Section 4.2) the option of involving the patient or their family/support person as participants and informants in the incident review or investigation. The perspective of all who are affected by an incident is a central feature of the Restorative Just and Learning Culture approach. The Open Disclosure policy also includes careful consideration of the support needs of staff that were involved in the incident, an evaluation of the process from everyone's perspective and review at Morbidity and Mortality meetings of patient safety incidents, their management and patient, family and staff experience.

Relevance and importance of a Restorative Just and Learning Culture

The harm of a blame culture has recently been highlighted by two much publicised cases: the Hadiza Bawa-Garba case in the UK(54) and the Radonda Vaught medication error case at the Vanderbilt University Medical Centre(55). We need to understand the various 'pathologies' of blame(56), the many pressures that apply from society and within health organisations that work against truly just responses when things go wrong(57) and how this can undermine trust and damage the development of a safety culture(4, 58).

In health care, safety and harm are emergent properties of complex systems(4, 16, 59, 60). Policies, procedures and checklists (that aim to standardise practice) may not assure the best, safest care under all conditions(11, 58, 60). Human resilience fills the gap between work-as-imagined and work-as-required-by-the-situation(17, 59). When things go badly wrong restorative approaches are open to multiple accounts and perspectives and therefore more likely to identify the deeper conditions that allowed an incident to happen(57).

The forward-looking accountability of Restorative Just and Learning Culture includes the commitment to system improvement. Errors will occur in complex, high risk environments, and all staff are

responsible for active, committed attention to reducing error and harm. This responsibility includes: preventive steps - to design for safety and anticipate potential problems; and creating an environment where it is safe to: speak up; to take the initiative required by a situation; to review care processes when things go wrong; and to discuss and analyse error(31).

A restorative, just and learning culture is relevant and important for developing a mature safety culture because:

- **Psychological safety** is the essential bedrock for a culture of team learning and system improvement. Everyone is safe and feels safe: safe to speak up; safe to test a change idea; staff feel supported and enabled; and care, support and a way forward are there for everyone impacted when something goes wrong
- A shared commitment to Safety for all is supported by **collective and distributed leadership of a culture that responds, learns, and improves**
- **Empowerment of point-of-care teams** (the microsystem) and the co-development of care with patients and families fosters trust and builds healthcare resilience
- It recognises **the complexity of healthcare systems,** and that safety and harm are emergent properties of those complex systems that include people and processes
- **Healing relationships and restoring trust** offers a more meaningful engagement of patients, families, and staff when there has been serious harm
- It **builds system improvement capability**: improvement science is used to understand and compare system performance and to determine whether change leads to improvement

How to co-develop a Restorative Just and Learning Culture?

Marshall observes that restorative leadership is both visionary and grounded. It is motivated by a set of relational ideals and aspirations while working with the skills, experiences and potential already available in the people in the organisation.(34)

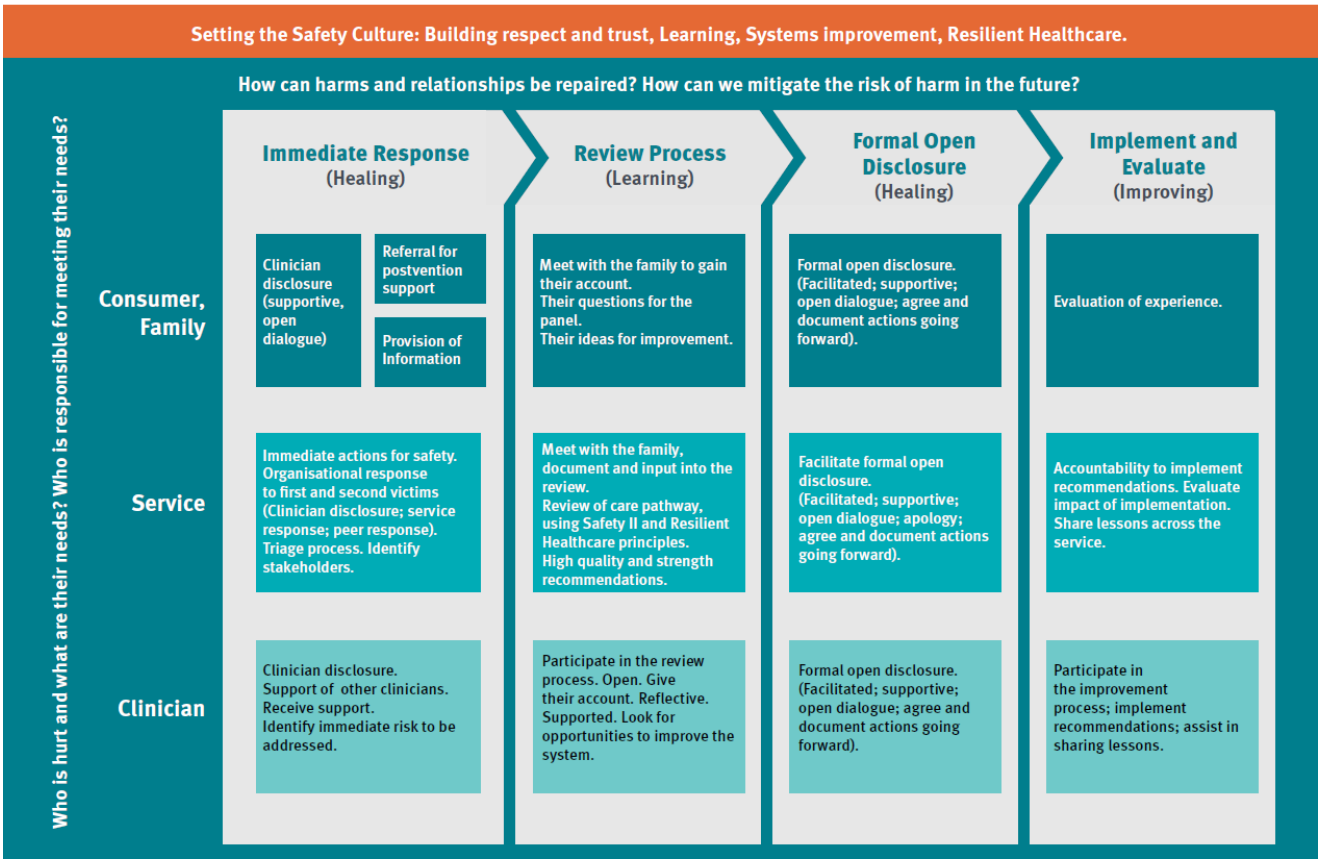
The vision of restorative leadership is fundamentally a relational vision. Rather than aiming to achieve optimal organisational performance in the abstract, this type of leadership focuses on “what *these* people, in *this* place, at *this* time, can achieve *together*. Power over others gives way to sharing power with them.”(34)

Co-developing a Restorative Just and Learning Culture is essentially a relational and collective exercise. The first two sections of this Guide provided a curated selection of readings from the Restorative Just and Learning Culture literature and emerging evidence base. Each leadership group needs to consider where to start and how to proceed on their organisational culture development journey.
In this section we provide some tactical approaches for co-developing a Restorative Just and Learning Culture:

1. **Setting and maintaining ‘The Frame’**
2. **Group Engagement and Conversations**
3. **Responding**
4. **Learning and Improving (incident review and analysis)**
5. **Learning and Improving (system improvement)**
6. **Evaluating outcomes and experience (safety and cultural intelligence)**

Work on these key areas can proceed simultaneously once the frame and shared vision for a Restorative Just and Learning Culture are set. For example, working groups can be working concurrently on developing consumer and family response following serious incidents, incident review and systems improvement processes, clinician and clinical team supports. Dr Kathryn Turner and her team at Metro North Mental Health, Brisbane developed the schematic matrix below to illustrate how these things fit into a restorative just and learning culture:

METRO NORTH MENTAL HEALTH RESTORATIVE JUST AND LEARNING CULTURE FRAMEWORK



Turner and colleagues have also described their implementation of a Restorative Just Culture in the Gold Coast Health and Special Services and shown improvements in stakeholder inclusion, the experience of clinicians involved in critical incidents and strength of incident review recommendations.(61)

1. Setting and maintaining 'The Frame'

Psychological safety

'The Frame' is the enabling environment, the underlying and supporting organisational atmosphere that supports the shared vision of safety culture: that everyone is safe and feels safe. Psychological safety, respect, trust, care and support constitute the frame for Restorative Just and Learning Culture.

Psychological safety is the shared belief held by members of a team that the team is safe for interpersonal risk-taking, and that members can challenge, question and disagree without suffering consequences to their image, reputation or career. The term stems from the work by Schein(62) and was investigated in hospital teams by Edmondson in the 1990s. Psychological safety research pulls together several insights about team effectiveness, resilience and organisational learning.(63)

"*A key insight from this work was that psychological safety is not a personality difference but rather a feature of the workplace that leaders can and must help create*."(64)

Here are some descriptions of psychological safety from Edmondson's original paper(38):

"*Team psychological safety is defined as a shared belief that the team is safe for interpersonal risk taking*."

"*The term is meant to suggest neither a careless sense of permissiveness, nor an unrelentingly positive affect but, rather, a sense of confidence that the team will not embarrass, reject, or punish someone for speaking up. This confidence stems from mutual respect and trust among team members*."

"*Team psychological safety involves but goes beyond interpersonal trust; it describes a team climate characterised by interpersonal trust and mutual respect in which people are comfortable being themselves*."

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, a safe environment that extends to patients and their families.

Leaders can build psychological safety by:

- Making their commitment to psychological safety explicit and behavioural modelling in group interactions(65)
- Careful attention to Restorative Just and Learning language and narrative
- Accessibility and presence
- Acknowledging fallibility and vulnerability
- Collective and distributed leadership
- Empowering others when interacting with teams and groups through humble inquiry(66) and proactive questions (64)

Here are some descriptions of how Restorative Just and Learning Culture was developed within Mersey Care in the UK by CEO Joe Rafferty, Director of Workforce Amanda Oates and Organisational Development practitioner Joanne Davidson:

"*Psychological safety has been continuously created through open and honest dialogue, creating a sense of inclusion and belonging in team-based working plans, safety in speaking up and out, mutual respect, civility, cooperation and accountability through our leaders and teams. Psychological safety is cited as a fundamental requirement for learning and improvement. At Mersey Care, we recognise that it is fundamental to the effectiveness of the Trust's Four Step Process in relation to the degree of honesty the staff member feels able to share in their account of when things do not go as planned*."

"…. *we knew we would need to create a culture of psychological safety, collective learning and continuous improvement to support sustainable high performance and quality. The most successful organisations cultivate cultures of inclusion, trust, psychological safety, teamwork, continuous learning and support*."(67)

2. Group Engagement and Conversations

Every organisation will determine how to best introduce and work towards a Restorative Just and Learning Culture. However, Restorative Just and Learning Culture requires building shared understanding and co-developing new approaches with staff, therefore, group engagement and group conversations are logical starting points.

The first step in the initial team conversation needs to be establishing 'The Frame'. The frame is the enabling environment that supports the shared vision of Safety culture: that everyone is safe and feels safe. Psychological safety, respect, trust, care and support constitute the frame for Restorative Just and Learning Culture. Team and organisational learning cannot thrive unless this frame is established and maintained. This guide has been structured to inform and support the group engagements that are necessary in the co-development of a Restorative Just and Learning Culture.

The next steps should be co-designed by the people involved in the journey with the support of a facilitator. Carefully consider who needs be in the group at every level. How will you involve the Chief Executive, Board Chair? Other key stakeholders will include: Director of Clinical Governance, Directors of Nursing, Allied Health and Medicine, Director of Workforce/Culture and Capability, Patient Safety and Quality, M&M Leads. How will you involve those with lived experience? At the clinical team level: how will you get medical staff involvement? How do you reach those on night shift?

The senior leadership team are the executive sponsors of a Restorative Just and Learning Culture because strategic, financial, human resources, and risk appetite decisions are made at this level. However, in a Restorative Just and Learning Culture a distributed and collective model of leadership is required. Therefore, another main responsibility of the senior leadership team is to ensure the conditions for this distributed and collective leadership for safety. This is achieved through behavioural modelling, dialogue and co-production:

- enactment of respect, trust, and commitment to improving the safety and quality of care,
- engagement and dialogue at every level of the organisation,
- co-development of the Safety culture plan with staff, patients and families

The middle leadership group are the most important custodians and ambassadors of the safety culture. The middle leadership group includes team leaders, nurse unit managers, senior medical staff, senior allied health staff. These leaders are the guardians of team culture, overseeing team dynamics, processes, supporting day-today situational awareness and managing internal and external team relationships.

In this distributed leadership model, leadership for safety is woven as a fractal pattern into the fabric of the service repeating to the level of the nurse-in-charge of shift or the registrar on call after hours.

3. Responding

Responding to patients and families

NSW Health has established processes for clinician disclosure which include a dedicated family contact, Open Disclosure, and feeding back the findings and actions from the review of an incident that resulted in harm. A Restorative Just and Learning Culture approach can go beyond this in the following ways:

- A stronger focus on hearing and appreciating their experience and perspective in relation to the incident and the healthcare they received
- Focusing on understanding and responding to the needs of the patient and family
- Facilitating the healing of trust and the relationships with the clinicians, the team and the wider health service

Responding to Aboriginal and Torres Strait Islander people

For many Aboriginal and Torres Strait Islander people, the need for healing includes overcoming inter-generational trauma and loss. Indigenous suicide needs to be viewed through a ‘trauma informed lens’ and within a social and historical context(68). Restorative practice recognises the diversity of Aboriginal and Torres Strait Islander peoples and communities and seeks to listen to and understand their experiences.

For Aboriginal and Torres Strait Islander people, their sense of self is grounded and intertwined with family and community(69). At the heart of a restorative, just and learning culture are respect and connectedness. The patient, family and community members define and determine what feels safe for them, and we join with them in a process of co-design of what is required for healing and the rebuilding of trust.

The person’s community and Aboriginal health professionals can provide support and ensure the restorative process is culturally safe(70), trauma-informed(71, 72) and responsive to community needs.

Responding to staff

Scott, Hirschinger et al(42) described the experience and natural history of clinician ‘second victims’ after serious adverse events. Morris, Sveticic, Grice et al(45) provide a detailed description of the staff support systems they set up to respond to the harm that clinicians and staff experience when there is a serious patient harm incident, in mental health services, usually a suicide. They based their approach on the three-tiered model of Scott et al(46):

- Tier 1: all staff receive some basic-level training on the impact on clinicians and can act as first responders to a colleague experiencing distress.
- Tier 2: trained clinician peer responders provide psychological first aid and support within 24 hours
- Tier 3: referral to external professional care and assistance

Responding to the team/ward and the wider service

The response of senior leaders to the team that has been involved in a serious patient harm incident is very important and needs to occur at the level of the microsystem and the wider service. This will usually involve:

- A calming and supportive presence on the ward or at the team meeting
- Listening to and acknowledging the experience of the team
- Understanding the needs of individual staff and the team as a whole
- Responding to those needs, (often in practical ways such as rostering additional staff, giving permission for staff to go home if they need to etc.)
- Checking in with the team in the following days
- Providing information to the wider health service (where appropriate) in a way that is respectful and caring in relation to the team most affected by the incident
- Ensuring that incident reviews and analysis occur according to processes that have been co-developed with staff, ensure psychological safety, and are focused on healing relationships, restoring confidence and improving the systems of care to prevent similar occurrences

Some resources to support the wellbeing of clinicians and teams following a death by suicide include:

Supporting team members after the suicide of a patient. RANZCP 2021 (73)

Coping with a patient suicide: For those in Psychiatry Training. RANZCP 2021 (74)

Supporting those in psychiatry training after the suicide of a patient. RANZCP 2021 (75)

Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework. RCPsych 2022 (76)

4. Learning and improving (incident review and analysis)

A Restorative Just and Learning Culture appreciates the systems complexity and human factors that give rise to both patient safety and harm incidents. Restorative Just and Learning Culture approaches to reviewing a serious incident generally try to apply a method other than root cause analysis to better capture the system and human complexity of healthcare. Constellation diagrams are a more useful tool for achieving a deeper understanding of the underlying issues that contributed to an adverse event (60, 77). A guide to developing a constellation diagram is in Appendix E of the NSW Health Incident Management Policy (51).

A restorative response to an adverse event is “a voluntary, relational process where all those affected by an adverse event come together in a safe and supportive environment, with the help of skilled facilitators, to speak openly about what happened, to understand the human impacts, and to clarify responsibility for the actions required for healing and learning.” (35)

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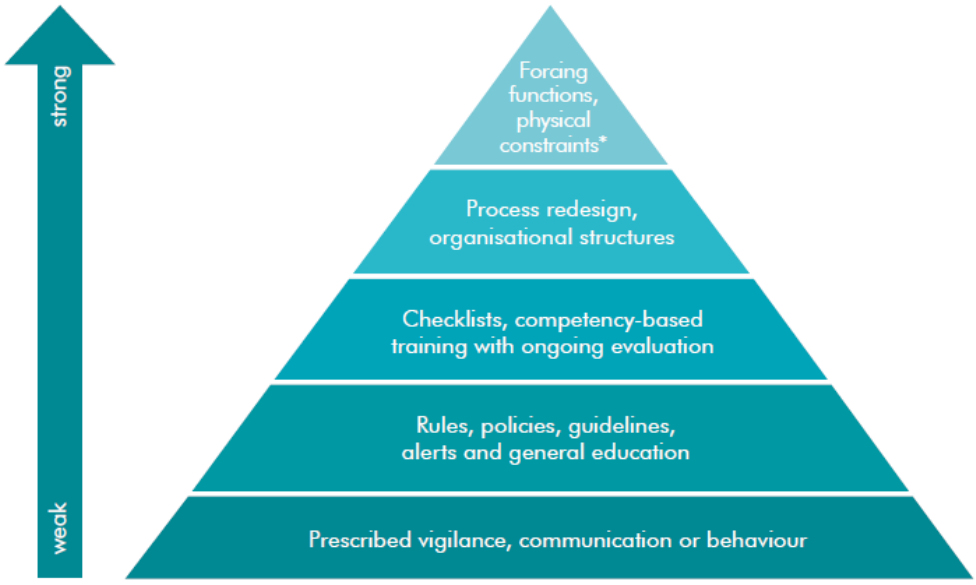
Jo Waillling has outlined Restorative Principles and Practice in the following article:

Bowie P (2022). "Integrating restorative justice into patient safety investigation." Retrieved 7 April 2023.

Translating learning to system improvement

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. Often recommendations for system improvement are weak, meaning that they are unlikely to result in true safety improvement(78-80), not all recommendations are implemented(80) and there is often poor communication and engagement with clinicians about the outcomes of serious incident reviews. Attention must be directed to formulating feasible, measurable recommendations for system improvement, the sharing of this learning, and implementation and monitoring of change ideas. Turner et al describe close attention to the quality and implementation of learning from incident reviews in a service that implemented a Restorative Just Learning Culture.(4)



*Forcing functions are behaviour-shaping constraints to assist users to do the right thing and avoid mistakes.

Strength of solutions to issues identified in RCAs (recommendations)(78)

It is important that clinicians and teams involved in the provision of care are also involved in the review and improvement of practices and systems of care delivery. The Clinical Excellence Commission Guidelines for Conducting and Reporting Morbidity and Mortality/Clinical Review Meetings provide guidance on how teams, departments and services can review the quality of care that is being provided to their patients and identify opportunities for improvement. The lead clinician chairing the M&M or Clinical Review Meeting has a responsibility to ensure the meeting occurs in an environment of psychological safety, respect and trust. The meeting Chair establishes 'the frame' and may also refer to the principles of Restorative Just Learning Culture as part of this frame.

The Clinical Excellence Commission's podcasts on development of Morbidity and Mortality/Clinical Review Meetings: here

"*A particular mental model of accountability is required for the teamwork and learning culture that is so desperately needed in the healthcare industry. In Leape's words, "Meaningful accountability is a collaborative, supportive and reciprocal activity"(81). Paul refers to 'contracting' and 'accountability conversations' in an atmosphere characterised by "respect, trust, inquiry, moderation, curiosity, mutuality."(82) Paul says, "accountability creates conditions for ongoing constructive conversations in which our awareness of reality is sharpened, and in which we seek to discover root causes, understand the system better and identify new actions*."(83)

"*We believe that better understanding of group accountability and the empowerment of clinician and clinician/manager teams and groups is important to improving patient care and safety. Group accountability requires: leadership, a strong culture of teamwork, clear delineation of individual roles and responsibilities, and a regular forum for the group to conduct its 'accountability conversations'. As Woods(84) says: "…people create safety at all levels of the socio-technical system by learning and adapting to information about how all participants can contribute to failure*".(83)

5. Learning and improving (system improvement)

Safety intelligence

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. This data will include 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:

- Improvement rather than judgement
- Anticipation and looking forward rather than retrospection
- System learning, - curiosity about what lies behind the data
- Determining when a change to a system results in improvement

The CEC and the Mental Health Patient Safety Program supports LHD/SHN mental health services to build Mental Health Patient Safety dashboards. These dashboards can enable analysis of real-time (or weekly data) over time, application of statistical controls to determine when there is a special cause for a data point or a trend or shift compared to normal variation. The CEC also supports building capability in improvement science and understanding data for improvement across NSW health services.

The Improvement Method

Safety intelligence data including the findings from reviews of serious harm incidents may point to areas that require improvement. Having a method to guide understanding of the local context and involve the team in the improvement effort is really important to successful change(85). Rapid cycle small tests of change ideas build the teams understanding of the situation, and direct effort to changes that result in measurable improvement.

The Institute for Healthcare Improvement's Improvement Method(86) is widely used across NSW Health and other Australasian and international Health jurisdictions.

Figure A1 Model for Improvement

Source: Institute for Healthcare Improvement 2017

The IHI's Improvement Method is a powerful tool for accelerating improvement. The CEC provides training, resources and tools to support the use of improvement science by teams across the health system. These include (amongst other things) the Quality Improvement Data System and the Quality Audit Reporting System: QIDS and QARS and The Improvement Science Step-by-Step Guide.

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

The aim of safety culture is that everyone: patients, family and staff are safe and feels safe. While the measurement and evaluation of patient outcomes and experience is central, as can be seen from the NSW Health Safety System Model below, these things are interdependent on other components of the complex socio-technical healthcare system. Mental Health Safety dashboards, in addition to priority patient outcomes should incorporate measures of culture and leadership, safety governance, safety and improvement capability and safety systems improvement activity.

The measure of safety culture used by the CEC is the Safety Attitudes Questionnaire (SAQ)(87). The SAQ measures safety climate, teamwork, job satisfaction, stress recognition, perceptions of management and working conditions. Organisations and teams within them can measure safety culture, evaluate their current priorities and plan improvement strategies. The CEC has developed a guide for administering, making sense of the feedback and planning actions using the SAQ.

Guide to Co-developing a Restorative Just and Learning Culture

NSW Health Safety System Model

How do you know your system is safe?

ACCOUNTABLE LEADERSHIP AND CULTURE

1. How can we assure ourselves that everyone understands their role and accountability to ensure safety in health care?
2. How do we know there is an organisation-wide culture for staff where there is high-trust, psychological safety, and shared sense of purpose?
3. How do we know if we are being open with patients and families when things go wrong?

SAFETY GOVERNANCE

1. How confident are we that we are meeting the Clinical Governance Standard 1 (NSQHS) every day?
2. As an organisation, how do we show we have centralised and coordinated responsibility and oversight of patient safety?
3. How do we know that we are learning from harm, error, and near-misses, as well as understanding and creating the conditions that support safe delivery of care?

EMBEDDING SAFETY STRATEGICALLY

1. To what extent is the organisation creating and sustaining the strategic elements required to create safety resilience?
2. How does the organisation strategically deploy its expertise in safety improvement to the priorities that need it most?
3. How does the Executive team role model accountable leadership and culture for safety and quality?

Reliable and Resilient Safety System

SAFETY INTELLIGENCE

1. To what extent do Clinicians, Managers and Executives understand where harm, waste and unwanted clinical variation exists today?
2. To what extent do Clinicians, Managers and Executives have access and use real-time, meaningful information for safety and improvement over time?
3. How is the organisation benchmarking itself against exemplars?

SAFETY AND IMPROVEMENT CAPABILITY

1. How do we know we have the necessary critical mass of safety and improvement expertise and leadership in our teams and organisation?
2. What is the organisation's plan to develop and maintain a faculty for essential safety and quality capability development?
3. To what extent are we a learning organisation that emphasises the importance of replicating what goes well, rather than what goes wrong?

SAFETY IMPROVEMENT

1. What are the organisation's current safety priorities and programs?
2. How are Clinicians, Managers and Executives implementing safety programs with the appropriate tools, resources, and required expertise?
3. How are the leaders engaging their frontline teams in improvement conversations?

NSW GOVERNMENT
CLINICAL EXCELLENCE COMMISSION

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