Episode two – Why is RJC important

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 two of a four-part series on Restorative Just Culture.

In this segment, Why is RJC important, Nick explores with Kathryn why we need a different approach to responding to incidents. Both Kathryn and Nick highlight the emergent properties of complex adaptive systems in health care and the importance of actively changing our culture to better understand and consider these systems when errors occur.

This includes a deep commitment to restoration and identifying who is hurt and how the whole of the system is accountable for this. A key issue that often happens is the perception that when the emphasis is on the system and away from individuals there is risks of no accountability and disempowering victims. Kathryn describes how RJC enables a deeper accountability and responsibility of the whole of the system.

This conversation also highlights the importance of psychological safety of staff and using RJC in supporting all harm caused by incidents including harm to staff. Kathryn describes an example of implementing RJC by addressing the safety and wellbeing of staff and through concept of a clinician peer support model. I hope you enjoy this conversation.

Nick O'Connor: So, Kathryn, why do you think we need a different approach to responding to incidents?

Kathryn Turner: I think certainly for me, personally, I was concerned about a culture of blame and the responses and root cause analyses didn't make me feel that they were leading to good learnings and good improvements in the service. I must admit, I found myself feeling defensive on behalf of clinicians who were going through this process. I knew that we had to do something differently because being defensive was not going to get us anywhere in terms of learning.

I think that Virginia Sharpe, whom you mentioned before, really articulates it well about some of the reasons that we need to have this different approach to how we respond to incidents.

Part of it is about the complexity of our services and that we imagine - like root cause analysis or the old ways of looking at incidents - that things are happening in a very linear way, whereas we know that individuals and individuals' actions are the causes of incidents. We know that we actually work in complex adaptive systems and that unpredictability is a core feature. The actual reality is that you can have lots of interactions, as well as very non-linear ones. Understanding that systems are probably more to blame for incidents than individuals means that we need to look at the whole system.

I really like the argument that Virginia Sharpe makes that - and people still do get a bit stuck on this - if it's a system problem, people could say "Well, what's it got to do with me? It's a system problem and I don't have a role in this so don't blame me." And people were therefore concerned about a sense of accountability.

Virginia Sharpe really articulated that we need a different way of approaching how we respond to incidents, understanding that it's usually the system that is the cause of the issues and problems and we need to have that mindset. But if we just take a no blame culture, there is no accountability for individuals to be part of a learning and improvement process and it also, really importantly, disempowers victims in this. In the traditional approach, which is more of a retributive approach, the victims have the ability to seek justice through retribution.

But if we say, there's no blame, there's a certain sense of disempowerment of victims. So, a different approach is a restorative just culture approach, which is about a forward-looking accountability - and it's actually a very deep accountability - that we are all responsible for.

All of us have a part to play in having a safe service - from clinicians to administrators to IT people, everyone. And those people who have been affected can all have a part to play in the process of learning and then accountability for improving in a forward-looking way. So, I think that concept of complexity and, of course, Safety II are resilient health care concepts and restorative just culture is very interlinked. And people conceptualise it a bit differently from what I've seen.

I conceptualise it by looking at what we actually did was apply more Safety II principles and restorative just culture. A restorative just culture really helps us, as a great facilitator of using more Safety II approaches, to respond to incidents. Some people would say that restorative just culture is a combination of Just Culture and Safety I and Safety II principles. And that is a restorative just culture. So, I guess you can conceptualise it in different ways, but I think it's always important to pull those together when we're thinking about how we respond to incidents.

Nick O'Connor: That's wonderful and really aligns with the way that I understand it too. I don't think that there's sufficient understanding that harms in the health system - and for that matter, safety -are both emergent properties of complex adaptive systems, often a number of complex adaptive systems interacting, and that the accountability that I think Virginia Sharpe and Sidney Dekker referred to is actually a deeper and more demanding accountability. It's the accountability that we're all concerned with safety - at every level of our organisations, including the administrators and the finance guys - safety for patients and safety for staff.

The accountability, therefore, is to try and always be thinking about that and anticipating and building it in, but when something bad happens, we have to respond in a meaningful and human way (and we'll later get on to the human aspects of this). We have to learn about the complex harms and things that went on and we also have a commitment to improve wherever possible.

One of the things that I think is also important about the restorative just culture is that patient safety is paramount and central but actually safety, in all meanings of that word, including psychological safety for staff, is also key.

I was very impressed with Diana Grass' description of the Always There program that you implemented in the Gold Coast and I wondered if you'd say a few words about staff safety, psychological safety included, and that program.

Kathryn Turner: The other thing that we did as part of this journey was, we went out to every team across the service and sought feedback from them about their perspectives and ideas for improvement.

So, we came up with a whole lot of recommendations which we implemented and when you look back now, all of those recommendations aligned so well with restorative just culture. We didn't know it at the time, but that's basically the answer the staff gave us. So, part of it was how traumatising it can be for staff who can be very harmed through incidents. And our response as an organisation wasn't particularly consistent.

Sometimes we'd come in there and support staff, sometimes we wouldn't or sometimes we would come and

support for a little while. And then everyone goes away and forgets that when these things happen and don't get resolved quickly, the person is left coping with that by themselves.

So, we decided to really do a stream of work around how we support staff in the workplace, particularly following incidents, but also, I'd have to say that the staff also said we need that baseline. One of the recommendations was actually about having opportunities for more reflective practice and how we embed that across the service as well. And then it's how we respond to incidents, so Diana led a piece of work around that.

They looked at the literature on best practices around this and certainly one of the most evidence-based responses to people - to clinicians, say, following an incident - is the concept of a peer support model.
So, they developed some clinician peer support. They looked at various models and developed a model that was largely based on Scott's three tier model, with some adaptations to it, working closely with education and simulation training, etc, to be able to train staff in this.

Essentially, it's about the three-step process. The third step is probably what we've always had there and that's the referral to employee assistance services or for people that particularly need that onward referral to your GP or whatever. The first tier is really about awareness of these issues in the workplace and the ability to respond to your colleagues in the moment or from line managers.

The most significant addition was really the second tier, and that's the peer responder program and it's based very much on psychological first aid. Interestingly, we had a whole variety of staff involved including administration officers, peer workers, other clinicians, psychiatrists, etc. The clinicians had to really change their mindset - that they weren't there to provide clinical care, but there as part of psychological first aid so they required some training in this approach.

We had volunteers from across the service that were trained in this process and then it became a hard-wired process in our response to incidents. When there was a significant incident, the 'Always There' team would be triggered, and someone would be sent out to the team to spend some time with them to offer support with follow up as well. If further help is required, that might involve a referral to a more specialist agency.

I think it's been incredibly well received. What probably surprised me a little is that because we were so focused on incident reviews/incident responses, we knew that response but what we also saw was that a lot of people put up their hand to get some support from peer responders - more for cumulative stress or distress. It didn't have to be from one particular incident. There were probably just as many 'warm' responses as there were 'hot' responses. So, I think that was an interesting result.

Nick O'Connor: This is probably something that's very relevant in the stresses that people have been under during the pandemic in the health system.

You started off with something that I just wanted to highlight for people who may be wondering how to go about implementing restorative just culture in their service. You said that you went out to your teams and just asked them about what happens following an incident and explored how they felt about that. In a sense, your staff/teams led you back to this restorative justice model.

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.