Episode three – 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 three of a four-part series on Restorative Just Culture.

In this segment, Implementation of RJC, Nick explores with Kathryn how does responding, learning and improving happen in a restorative, just health culture? Katherine gives practical examples of implementation of RJC in review of incidence guided by the key principles around who was hurt, what do they need, whose responsibility is it to meet those needs and engagement of all stakeholders.

Kathryn emphasises the significance of involving both families and clinicians directly involved in the incidents to fully understand why things happened the way that they did. This inevitably enables healing, learning and improvement bridging the gap from work as imagined and work as done.

Clinicians and families involved in the incident have a level of insight and understanding that can help generate practical and relevant recommendations and improvement ideas that reflect their experiences. Kathryn highlights how this really ensures clinicians and family do not feel dismissed or are defensive about the incident and we can always learn something when this happens. I hope you enjoy this conversation.

Nick O'Connor: So, Kathryn, how does responding, learning, and improving happen in a restorative, just health culture?

Kathryn Turner: I guess, certainly in the model that we developed, always going back to the principles of who was hurt, what do they need, whose responsibility is it to meet those needs and engagement of all stakeholders. I think if you keep to those principles that helps drive your actions and then conceptualising it in the healing process, the learning process and then the improvement process. In terms of the healing process, we think about who was hurt.

So, the consumer, and certainly the family, is hurt but also the clinicians and the organisation. And so how do we respond to that? We respond to families through a range of measures and that includes immediately reaching out to them, providing open and honest clinician disclosure, linking them in - particularly for suicides, although this isn't just about suicides - for postvention support, making sure that they're getting to those agencies. But it's also the beginning of a process when we link in with families that takes us through the learning and improvement process as well.

And I think that was one of the other changes that we made. We had an open disclosure process, but in many ways, it seemed very disconnected from everything that we did. There was this team that would come and do an open disclosure at the end, after everything had been done. What we've shifted it to is a continuous pathway where we start with that clinician disclosure and getting the support they need and sometimes that's multiple meetings. It's whatever they need from the service but also flagging with them that we will want them to be part of the learning process and we're really interested in their views/perspective of what happened and any ideas that they've got for improvement in our service.

Then we will meet with them at the end and answer the questions that they've posed to us as part of that process and let them know what our learnings are but also, very importantly, what we're going to do about it and how we're going to keep ourselves accountable for that.

So, staying on the learning process of the family response, what we don't do is bring the family and the team together at that point, but we do it by interviewing the family - separately from clinician disclosure and open disclosure - and gathering their perspectives. And sometimes their perspectives of the event and the care that led up to that will be very different from the team's recollections and I think that we have had such important learnings from families and sometimes it's tough for the team to hear that different perspective as well.

We need to make sure that we do that, and they get this information in a supportive process as well. So, the information from families is written up including any questions that they've got or ideas for improvement and that is presented to the team that does the review. Nearly always it has led to important recommendations and actions in our service. And then the open disclosure process comes at the end of that.

In terms of the clinicians and the healing process: We do need to do what we've talked about before with the local line manager response to this, the leadership response, and that peer response as well and providing sustained support for clinicians. The other part is that we are very strongly of the view that involving the clinicians that were actually involved in the incident in the review process is so important as part of that learning process.

And that was one of the most important reasons why we wanted to move away from commission to root cause analyses, which were more secretive and didn't have that process. And I think if you're thinking about Safety II concepts and the concept of work-as-imagined versus work-as-done, you need the team there to really understand what actually happened and why actions were taken and why certain things are done in ways that may actually be very productive.

But you know not all variation in practice leads to harm. Sometimes it's the adaptability of clinicians in the face of a lot of challenges. What we need to do is to create an environment where the clinicians feel absolutely safe to be able to reflect and don't feel defensive and can absolutely say "Well, I think maybe we could do something differently about that". And then the other thing about having the clinicians involved is that they are the ones who are going to be enacting the recommendations and making the changes to services so engaging them in that process and getting their ideas for improvements will give us much better outcomes in terms of actual improvements to the system.

We made some other changes to the way that we approached reviews, which I think for us has been really important. One really important change is the idea not to start with the event; let's actually look at the whole clinical care pathway and look for opportunities, regardless of the outcome, where we could improve. And let's learn anything - instead of just let's learn contributing factors - let's rectify that.

Now I know that this is different from traditional approaches but, in our experience, it really helped to drop the defensiveness and get people really focused on every part of our system as to how we could improve. And interestingly, the families' recommendations were often not necessarily related to the proximal issues of the incident but were often about relationships and communication and how we could better engage with them. So there have been various recommendations that have come out of this process that wouldn't have come out had we approached it in that more proximal, contributing factors way.

And I think, in suicide particularly, you can almost never say if we change this, you would definitely have changed the outcome. So, let's not get into those arguments. Let's not work out whether it's a contributing factor or not. You can almost always learn something that can lead to improvement in the service. We actually called it the comprehensive review of the clinical care pathway rather than an incident review to change that conceptualisation.

Nick O'Connor: Like in the Canadian model?

Kathryn Turner: I'm not actually sure about that but we did use the Canadian model in terms of the constellation diagram and that seemed to be possibly helpful to look at how various aspects of the care might connect with one another or contributing factors might connect with one another.

Nick O'Connor: We started off with the idea of how safety and harm are emergent properties of complex systems, and this approach is fundamentally relational, isn't it? And it's so important to understand the multiple perspectives on these complex sets of interactions that have happened.

Linking it back then, how does this process come back to the team, the morbidity and mortality meeting and the safety and quality committee? How do you close the loops there?

Kathryn Turner: So, in line with Safety II - resilient health care - what we also wanted to do is to not just look at the most severe outcomes. There's probably some things that can give us a lot more opportunity to learn from so we wanted to look at a range of incidents, near misses or less severe incidents that might have happened repeatedly in the service which included looking at multi- incident analyses as well.

Changing culture is not easy. How do you keep everyone focused on those basic principles? I think one of the most important things that we did was to create a triage meeting in the broader health service. There was a weekly triage meeting where we all got together – surgeons, ED physicians, mental health, etc - to talk about all of the serious incidents that occurred in the HHS and then we created that triage process within our service. We looked at a broader range rather than the narrow reportable incidents. We were able to set up a process where we could see anyone that touched our service for up to 12 months and died (including those by suicide).

We looked at suicide attempts for open consumers and we looked at any significant event that we thought was important to have a look at. It might be a violent incident, or it might be a non-compliance with the Mental Health Act or something like that. Anything that we could potentially learn from would come to this meeting of leaders at the service. And we'd have a discussion about whether it needed a review, what type of review we might want and who we'd engage in that review. So always coming back to the engagement of all stakeholders and sometimes that's really challenging to people to say that we will involve these people that you might be a bit concerned about because of their reactions. And sometimes we had to be quite firm about that, to keep that going.

So, there was a range of types of reviews that we could do. There was the comprehensive review which I've basically described, and we did that for reportable incidents, but also for what we called significant events. So, a near miss might have been a significant event and we would treat it just as if it was a reportable incident with all the accountability around closing the loop, etc.

Some might not require a comprehensive review but a review within an M&M process for example, or a local clinical review. And simultaneously some work was done to make sure that in each service line we had a multidisciplinary M&M, and that people were reminded of restorative just culture principles at every meeting. So, I guess that's another line of work that progressed.

A lot of clinicians and leaders were already trained in human error and patient safety - the Heaps approach and looking at human factors. And although clinicians don't like the term human error/Heaps, we've avoided using that term, but we thought that if people had already trained in that, we'd build on that and have that as the baseline. So, a local review might use the framework of a Heaps review to give people some structure to do those reviews.

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.