International Forum on QUALITY & SAFETY in HEALTHCARE LONDON

NIHR | Yorkshire and Humber Patient Safety Translational Research Centre

UNIVERSITY of BRADFORD Social Work & Social Care

NHS Bradford District Care NHS Foundation Trust

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Embedding a Restorative Just and Learning Culture: the Why, What and How

Dr Kathryn Turner MBBS, FRANZCP. Executive Director, Metro North Mental Health, Brisbane, Australia

Dr Helen Haylor: Service Evaluation Lead, BDCFT Acute Community Mental Health Services

Dr Tony Sparkes: Assistant Professor, Department of Social Work & Social Care, University of Bradford

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Metro North Health acknowledges the Traditional Custodians of the land upon which we live, work and walk, and pay our respects to Elders past, present and emerging.

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Aboriginal and Torres Strait Islander communities and other First Nations people have a long history of using Restorative approaches to respond to conflict and harm. Concepts of responsibility and accountability to community, relationship repair, family and community decision making are part of First Nations processes used to resolve conflict and respond to incidents harm. Restorative processes create the opportunity to understand the impact on families and community relationships, the hurt involved and who needs to be involved to acknowledge and repair harm to the extent possible.

Consumer and Carer Perspective

Metro North Health

in collaboration with

The ASPIRES Pathway

Impact of restorative just
and learning culture on families

We talk a lot about compassionate care. We talk
a lot about showing compassion to families and

Overview

Rationale for adopting a Restorative Just (and Learning) Culture

Serious Incident Investigations

Fundamental principles underlying the application of RJLC in healthcare settings.

Framework to navigate the initial steps in implementing RJLC

Emotional Safety

Handouts, Links and Introductions

Resource Website:

insight | Dovetail

eLearning | Workshops | Webinars | Videos | Toolkits | Resources | News | About

‹ Back to Toolkits

Embedding a Restorative Just and Learning Culture: The Why, What and How - Resources

A partnership between Metro North Mental Health and Bradford District Care. BMJ/IHI International Forum on Quality and Safety in Healthcare, London, 2024

Navigate to...
Overview

Overview

In April 2024, at the BMJ/IHI International Forum on Quality and Safety in Healthcare, Dr Kathryn Turner MBBS, FRANZCP. (Executive Director, Metro North Mental Health, Brisbane, Australia); Dr Helen Haylor: Service Evaluation Lead, (BDCFT

METRO NORTH MENTAL HEALTH RESTORATIVE JUST AND LEARNING CULTURE FRAMEWORK

Setting the Safety Culture: Building respect and trust, Learning, Systems improvement, Resilient Healthcare.

How can harms and relationships be repaired? How can we mitigate the risk of harm in the future?

Who is hurt and what are their needs? Who is responsible for meeting their needs?

	Immediate Response (Healing)	Review Process (Learning)	Formal Open Disclosure (Healing)	Implement and Evaluate (Improving)
Consumer, Family	Clinician disclosure (supportive, open dialogue); Referral for postvention support; Provision of information	Meet with the family to gain their account. Their questions for the panel. Their ideas for improvement.	Formal open disclosure. (Facilitated; supportive; open dialogue; agree and document actions going forward).	Evaluation of experience.
Service	Immediate actions for safety. Organisational response to first and second victims (Clinician disclosure; service response; peer response). Triage process. Identify stakeholders.	Meet with the family, document and input into the review. Review of care pathway, using Safety II and Resilient Healthcare principles. High quality and strength recommendations.	Facilitate formal open disclosure. (Facilitated; supportive; open dialogue; apology; agree and document actions going forward).	Accountability to implement recommendations. Evaluate impact of implementation. Share lessons across the service.
Clinician	Clinician disclosure. Support of other clinicians. Receive support. Identify immediate risk to be addressed.	Participate in the review process. Open. Give their account. Reflective. Supported. Look for opportunities to improve the system.	Formal open disclosure. (Facilitated; supportive; open dialogue; agree and document actions going forward).	Participate in the improvement process; implement recommendations; assist in sharing lessons.

Kathryn Turner, MNMH 2023

Resource Website:

Videos:
Impact of RJLC on Families and Carers:
Intro to RJLC for ASPIRES:

NHS Bradford District Care | Metro North Health | Queensland Government

Restorative Just and Learning Culture
METRO NORTH MENTAL HEALTH

- Clinician Disclosure
- Postvention Support
- Open Disclosure
- Staff Support including Peer Responder

HEALING · LEARNING · IMPROVEMENT

- Engagement of all those impacted in a restorative review process that includes consumers, family, clinicians and leadership
- Embed Safety II / Resilient Healthcare

- High Quality and Strength Recommendations
- Monitor and Evaluate
- Share lessons

Engagement of all stakeholders

Respect for all

Contact Details

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Turner K, Stapelberg NJ, Sveticic J, Dekker SW. Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework. Australian & New Zealand Journal of Psychiatry. 2020;54(6):571-581. doi:10.1177/0004867420918659

Haylor H, Sparkes T, Armitage G, Dawson-Jones M, Double K, Edwards L. The process and perspective of serious incident investigations in adult community mental health services: integrative review and synthesis. *BJPsych Bulletin*. Published online 2024:1-13. doi:10.1192/bjb.2023.98

Turner K, Sveticic J, Grice D, Welch M, King C, Panther J, et al. Restorative just culture significantly improves stakeholder inclusion, second victim experiences and quality of recommendations in incident responses. J Hosp Adm 2022; 11(2): 8–17.

Debby Morris , Jerneja Sveticic , Diana Grice , Kathryn Turner & Nicole Graham (2022) Collaborative Approach to Supporting Staff in a Mental Healthcare Setting: "Always There" Peer Support Program, Issues in Mental Health Nursing, 43:1, 42-50, DOI: 10.1080/01612840.2021.1953651

Wailling J, Kooijman A, Hughes J, O'Hara JK. Humanizing harm: using a restorative approach to heal and learn from adverse events. *Health Expect*. 2022; 25: 1192-1199. doi:10.1111/hex.13478

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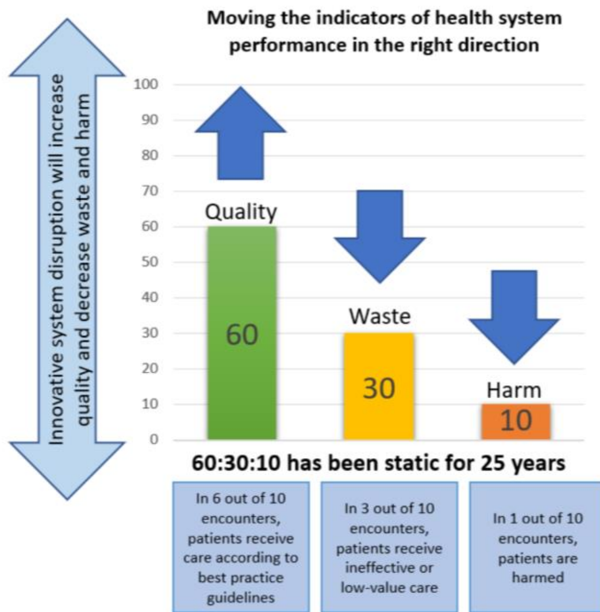

Braithwaite, J (2023)

"There is a growing realization that orthodox thinking has taken us as far as it can." Braithwaite Wears Hollnagel 2015

March 2024

Patient Safety Learning Chief Executive Helen Hughes said:

"It is vital that we create a culture in healthcare that supports raising, discussing and addressing the risks of unsafe care. Results of this year's and previous years' staff surveys, coupled with evidence from patient safety scandals and whistleblower testimonies, show that in too many parts of the NHS this is simply not the case.

Braithwaite, J., Glasziou, P. & Westbrook, J. The three numbers you need to know about healthcare: the 60-30-10 Challenge. *BMC Med* **18**, 102 (2020). https://doi.org/10.1186/s12916-020-01563-4

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Serious incident investigations following suicide in adult community mental health services

Dr Helen Haylor: Service Evaluation Lead, BDCFT Acute Community Mental Health Services

Dr Tony Sparkes: Assistant Professor, Department of Social Work & Social Care, University of Bradford

Professor Gerry Armitage: BDCFT Research Advisor and Emeritus Professor, University of Bradford.

Objectives for our presentation

1. Current research

2. Findings from literature review

3. Looking to the future

Current research: sequence and methods

1. Integrative review & narrative synthesis
2. Qualitative study (focus groups & 1:1 interviews)
3. Participants: carers; clinicians; investigators & senior managers
4. Thematic analysis

Findings (1): literature review

1. Dominance of Root Cause Analysis
2. Community based suicide
3. Lack of attention to the service user ***in context***
4. Shifting hierarchies of objective & subjective knowledge

Findings (2): literature review

5. Inclusivity?

6. Work as done vs work as imagined

7. Safety II embedded in a Restorative Just Culture & a Zero Suicide Framework

8. Formulation-driven approaches to suicide risk

Looking to the future

1. Inclusion and involvement for all
2. Emotional support & psychological safety
3. Adult community mental healthcare: complex & important
4. Evidence-based approaches to suicide risk

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Questions

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Bibliography

Haylor, H., Sparkes, T., Armitage, G., Dawson-Jones, M., Double, K. & Edwards, L. (2024) The process and perspective of serious incident investigations in adult community mental health services: integrative review and synthesis. *BJPsych Bulletin* 1-13. https://doi.org/10.1192/bjb.2023.98

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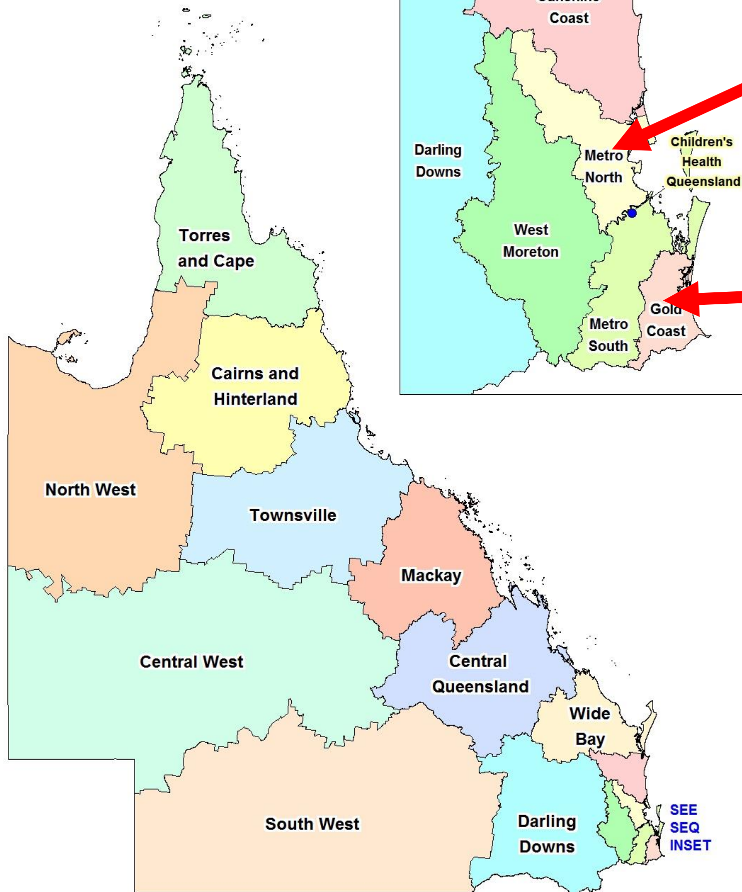

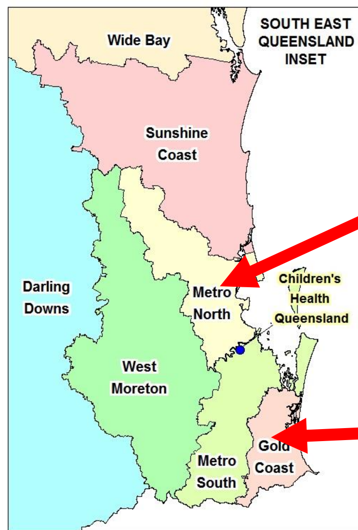

Metro North
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Gold Coast
660,000

“Inconvenient Truths in Suicide Prevention” – Why we need a change in paradigm

- **Needed a Change in paradigm:**
  - ”Zero Suicide” offered as promising.

- Concerns about **cultures of blame or limited learning** from incidents.

- Lack of consistent **support for staff** following incidents.

Key Review

ANZJP

Australian & New Zealand Journal of Psychiatry
2020, Vol. 54(6) 571–581
DOI: 10.1177/0004867420918659

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SAGE

Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework

Kathryn Turner[1], Nicolas JC Stapelberg[1,2], Jerneja Sveticic[1] and Sidney WA Dekker[3]

Abstract

Objective: The prevailing paradigm in suicide prevention continues to contribute to the nihilism regarding the ability to prevent suicides in healthcare settings and a sense of blame following adverse incidents. In this paper, these issues are discussed through the lens of clinicians' experiences as second victims following a loss of a consumer to suicide, and the lens of health care organisations.

Method: We discuss challenges related to the fallacy of risk prediction (erroneous belief that risk screening can be used to predict risk or allocate resources), and incident reviews that maintain a retrospective linear focus on errors and are highly influenced by hindsight and outcome biases.

Results: An argument that a Restorative Just Culture should be implemented alongside a Zero Suicide Framework is developed.

Conclusions: The current use of algorithms to determine culpability following adverse incidents, and a linear approach to learning ignores the complexity of the healthcare settings and can have devastating effects on staff and the broader healthcare community. These issues represent 'inconvenient truths' that must be identified, reconciled and integrated into our future pathways towards reducing suicides in health care. The introduction of Zero Suicide Framework can support the much-needed transition from relying on a retrospective focus on errors (Safety I) to a more prospective focus which acknowledges the complexities of healthcare (Safety II), when based on the Restorative Just Culture principles. Restorative Just Culture replaces backward-looking accountability with a focus on the hurts, needs and obligations of all who are affected by the event. In this paper, we argue that the implementation of Zero Suicide Framework may be compromised if not supported by a substantial workplace cultural change. The process of responding to critical incidents implemented at the Gold Coast Mental Health and Specialist Services is provided as an example of a successful implementation of Restorative Just Culture–based principles that has achieved a culture change required to support learning, improving and healing for our consumers, their families, our staff and broader communities.

Keywords
Suicide prevention, Restorative Just Culture, Zero Suicide Framework, second victim, hindsight bias, outcome bias, Safety I,

TURNER, K., STAPELBERG, N. J., SVETICIC, J. & DEKKER, S. W. Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework. Australian & New Zealand Journal of Psychiatry. Joesten et al., 2015; Newman, 1996; O’Beirne et al., 2012; Paparella, 2011; Sandford, Kirtley, Thwaites, O’Connor 2020.

Our responses to harm, compounds harm.

- Compounded harm emerges from the procedural responses that follow a harmful event or experience.
- *“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.”* (Wailling et al, 2022)

Wailling, J, Kooijman, A, Hughes, J, O'Hara, JK. Humanizing harm: using a restorative approach to heal and learn from adverse events. *Health Expect*. 2022; 25: 1192- 1199. doi:10.1111/hex.13478

How has healthcare harm impacted you? Or that you have observed in others?
What were the needs of the person impacted?

Self reflection
Discuss at your tables. (4min)

Incorporate our understanding of complexity into our reviews of incidents?

Move away from cultures of Blame?

Prevent compounded harm?

Accountability

- **complexity of systems rather than failures of individuals**.
- cease blaming individuals.
- Narrow consideration of accountability.
- “Don't blame me, it was a system problem”
- Victims powerless.

“We literally need new structures to account for and be accountable for what we now know about the occurrence of error in complex systems”. (p15)

Virginia Sharpe

- **Forward looking accountability** - balances system and individual accountability and empowerment of victims.

What is Restorative Just and Learning Culture

- Restorative Just and Learning Culture is a development in Safety Culture thinking that addresses the importance of people, relationships and trust and applies a complex adaptive systems approach to system improvement.
- A Restorative Just and Learning Culture merges a range of restorative approaches with a continually developing understanding of learning and improvement applied to complex systems of healthcare. RJLC is a deeply accountable, forward-looking process that recognises that we work in complex adaptive systems and that we need new systems approaches to leading, learning and improving following harm.
- Restorative practice is a ‘voluntary, relational process where ideally all those affected by a harmful 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’.(1)
- A Restorative approach emphasises the central role of our interconnectedness through a web of relationships and the central importance of equity and respect. It requires us to balance the perspectives and concerns of all parties to support the dignity of each person and to restore it when it has been diminished.(2)
- Restorative health organisations are guided by the principles, values, practices and priorities of a restorative framework. As well as handling conflicts, complaints and harm in a restorative manner, they develop policies and practices that recognize the needs of patients, families and staff as whole persons, exhibit a distributed style of leadership and inclusive decision-making, and proactively develop a culture of belonging and respect throughout the organisation.(3)

Nick O’Connor, Kathryn Turner, Jo Wailling

March 2024

1. Wailling J Kooijman A et al. Humanizing harm: Using a restorative approach to heal and learn from adverse events. Health Expectations. 2022:1-8.; 2.. Zehr H. The Little Book of Restorative Justice. New York: Good Books; 2015. 3.Marshall C. Towards a Restorative Organisation. Wellington NZ: Te Ngāpara Centre for Restorative Practice Victoria University Wellington; 2018. p. 1-6.

Embedded Response	Restorative Response
What happened?	What happened?
How and why did it happen?	Who has been hurt and what are their needs?
May ask who is culpable and/or what was the intent of the individuals involved.	Who is responsible and what are their obligations?
What can be done to reduce the likelihood of recurrence and make healthcare delivery safer?	How can harms be repaired and relationships be made right again?
What was learned? May ask who is to blame and/or how they should be punished or deterred from re-offending.	How can we mitigate the risk of harm? What would it look like to be free from this harm in the future?

(The National Collaborative for Restorative Initiatives in Health, 2023, p. 22).

A word about “Blame” / “No Blame”

- Lack of embedding understanding of complex systems – linear thinking persists.
- Very difficult not to think in linear terms.
- Results in Blame. (“Who is it that we are not blaming”?)

- **“Restorative Justice”**
  - a reactive process
- **“Restorative Practices” / “Restorative Approaches”**
  - broader concept and can be both proactive (aimed at strengthening relationships and sense of community before an event occurs) and reactive (after harm has occurred).
  - Important concepts:
    - **Continuum of Restorative Practices**
    - **Social Discipline Window**

RESTORATIVE CONTINUUM: Informal/minimal or no preparation → Formal/more perparation required

Affective Statements	Affective Questions	Informal Restorative Meeting	Restorative Circles	Formal Restorative Meeting
“I” statements inserting feeling, impact and consequence of behaviour e.g. “I’m worried when you use that language, it is upsetting for others”.	Asking who was affected and how. Using specific restorative questions with most directly impacted participants (separately) to explore impact and needs/hopes with future focus to reduce negative affect.	If safe and consensually agreed to by both/all participants bringing the people most directly impacted together in a facilitated way (by staff or RP support) to support understanding, communication and first steps to resolve.	Group discussion allowing all participants to have a say or participate in understanding more about a particular issue. Can be used for relationship building, goal setting, or to address issues of concern.	Bringing participants together (or proxy/rep if appropriate) together using a facilitator to promote relationship repair if possible and support healing. Facilitated shuttle (non face-to-face) communication between participants may be considered if suitable.
• Consumer and staff relationship building • ADL’s • Working with carers • Liaising with stakeholders	• After harmful incident e.g. consumer, treatment, family healthcare experience • Workforce interpersonalconflict • Stakeholder networking relationship building • Consumer/staff debrief	• On the wards • In staff areas • Between leadership • Stakeholder communication • Family/carer interactions with service • Between consumers	• Team relationship building and development • Consumer/group interactions • Process collaboration • Family meetings.. • Stakeholder meeting • Debrief	• Open disclosures • Critical incident • Clinician disclosure • Workplace conflict • Addressing serious incidents of harm to staff/consumers/ others

2014

RCA's are not working. Need to do things differently. Negotiate a move away.

2015

Our approach to Suicide Prevention is not working. Need a different way. Zero Suicide. But need to have a Just Culture.

2016

Leadership Commitment including Lived Experience. Engaged with Board. Engaged with staff and co-designed solutions. Met with Sidney Dekker.

2016

No – Not "Just Culture" – needs to be "Restorative Just Culture"

2017 – 2020

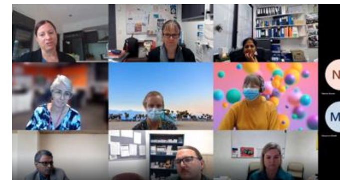
Conversations, Co-Design and implementation. Engagement of consumers, carers, family, staff. New approach to incident reviews; Always There staff support. Evaluation.

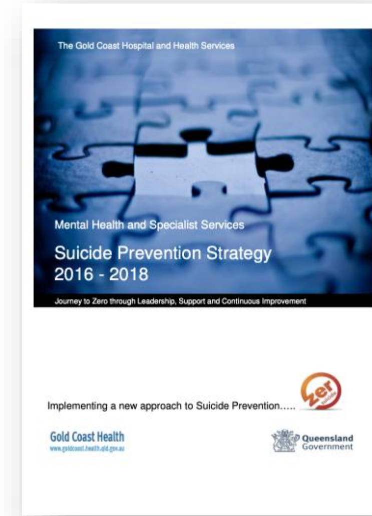
2021

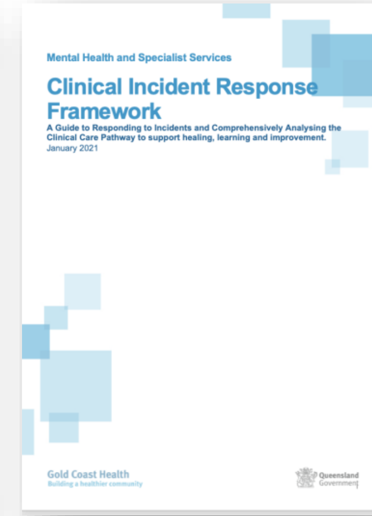
Metro North: "Freedom in a Frame". Engagement. New insights – TIC, Restorative Practices, Carer, Aboriginal and Torres Strait Islander.

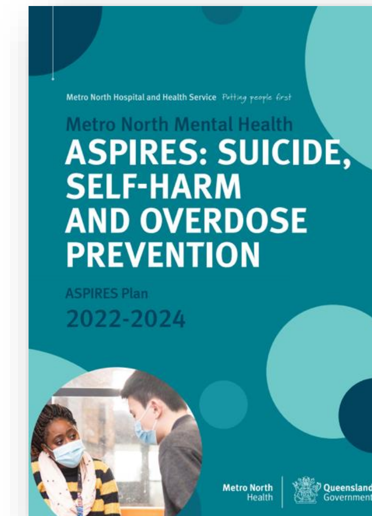
2022

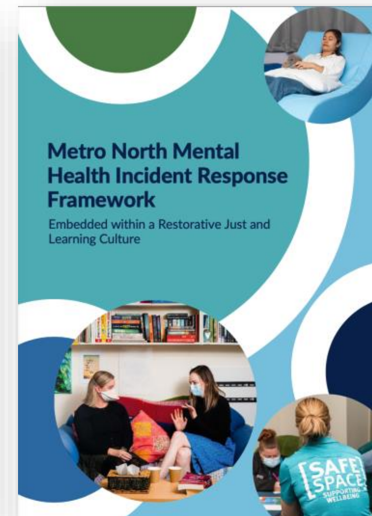
No – Not "Restorative Just Culture" – "Restorative Just and Learning Culture". Framework; Consumer, Carer Family Continuum of engagement; Incident Reviews – engagement of staff; systems approaches; Staff Wellbeing. Processes embedded, Evaluation.



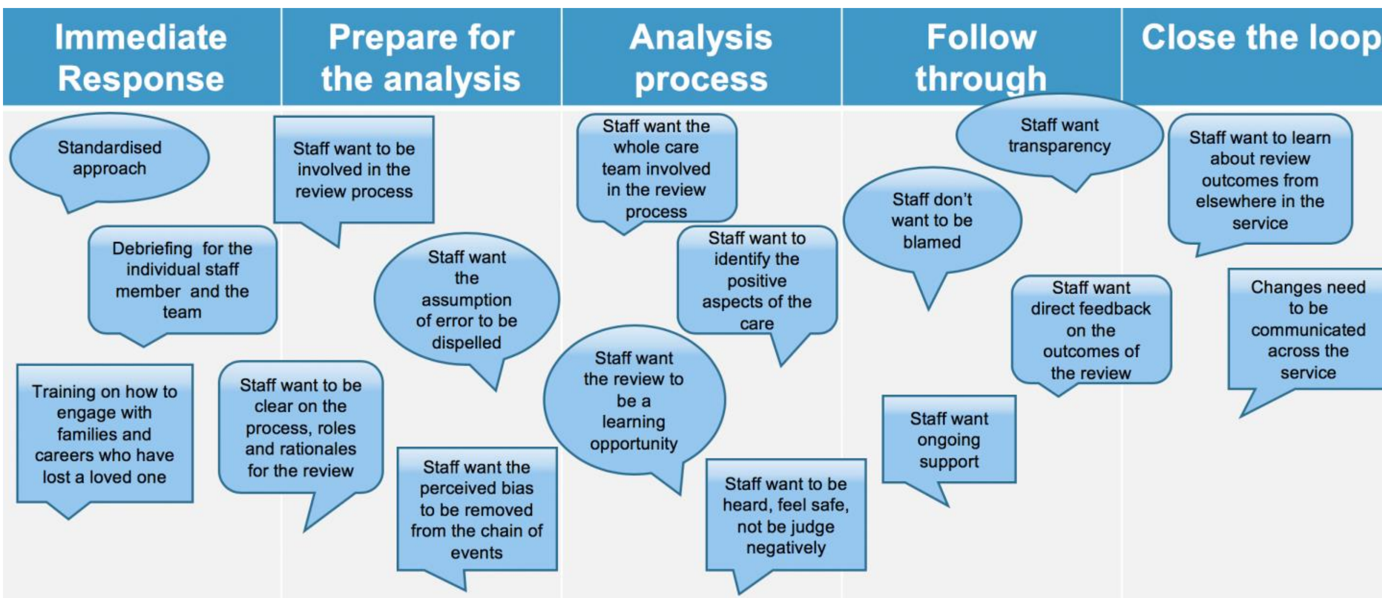








Gold Coast



Check for updates

Key Review

ANZJP

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Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework

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ANZJP

Abstract

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Keywords
Suicide prevention, Restorative Just Culture, Zero Suicide Framework, second vic
Safety II

Introduction

In the Margaret Tobin Oration at the 2018 Royal Australian and New Zealand College of Psychiatrists (RANZCP) Congress, Turner (2018) outlined the need for a paradigm shift in suicide prevention in mental health services. This includes a shift away from the pervasive pessimism regarding the ability to prevent suicides, the focus on assessment and categorical risk prediction, the lack of focus on meaningful interventions, disjointed training and

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Hospital and Health Se
Australia.
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Table 2. Responding to incidents using an RJC framework.

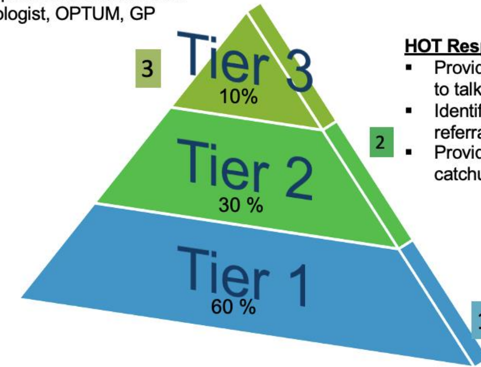
Who is hurt?	What do they need?	Obligations and Actions
Consumer/ Family/Carers	Support, Healing, Information Engagement in review and learning	**Clinician Disclosure following Incident** Train staff in clinician disclosure and engagement with family/carers following adverse incidents. **Referral to Postvention Support agency** Clinicians to have information and material available about the Postvention Support Services. **Engagement of the family in the in the Review process** Family interviewed to gain their perspective of the events; identify lessons they feel need to be learned from the incident; and gather any questions that would like answered within the review process. **Open Disclosure** Meet with family to communicate findings of the review; Structured interaction in the Open Disclosure format; feedback answers to any questions they have; feedback regarding the recommendations being made. **Evaluation** Obtain feedback from the family with respect to their experiences of the post incident process.
Clinicians	Support, healing and learning	**Develop Resilience and Reflective Practice prior to an event** **'Always There' Staff Support Programme** Three-Tier Staff Support Programme using trained peer supporters to provide psychological first aid following critical incidents **Active Engagement of involved staff in the Review process wherever possible** Avoidance of RCAs where possible to enable active involvement of the involved team in the review. Facilitators trained in all relevant components of the post-incident review process. Familiarisation for all staff in the process, including concepts of RJC. **Engagement in dissemination of findings, including Morbidity and Mortality Meetings for all service lines** **Introduction of a weekly MHSS Triage meeting to look at a broader range of incidents, including near misses, suicide attempts, suicides outside of the SAC1 timeframe, and developing themes across all incidents** Determination of most appropriate review process (e.g. comprehensive, concise, multi-incident)
Organisation	Support and learning	**Six-Step Post-Incident Process aligned with RJC principles that supports all measures:** Incorporates multiple perspectives (family, clinician and leadership). A forward-looking review of 'the clinical care pathway' rather than looking back from an incident. Considers review against best practice, considered exploration of Human Factors, and view of systems through the Constellation Diagram. Involvement of team ensures WAD is understood; Involvement of Leadership ensures WAI is understood. Consider what was done well. Use SMARTER to assist with the development of high-quality recommendations. Use a hierarchy of hazard controls tool to guide strength of recommendations. All learnings of relevance are incorporated into Recommendations, not just those deemed 'Contributory Factors'. **Continue development of Just Culture across the health service** **Overt support of staff following adverse incidents**

MHSS: Mental Health and Specialist Services; RJC: Restorative Just Culture; WAD: Work as Done; WAI: Work as Imagined.

GC Clinical Incident Response Framework(GC-CIRF)

“Always There” Response

Professional Resources:
Referral to professional assistance
e.g. psychologist, OPTUM, GP

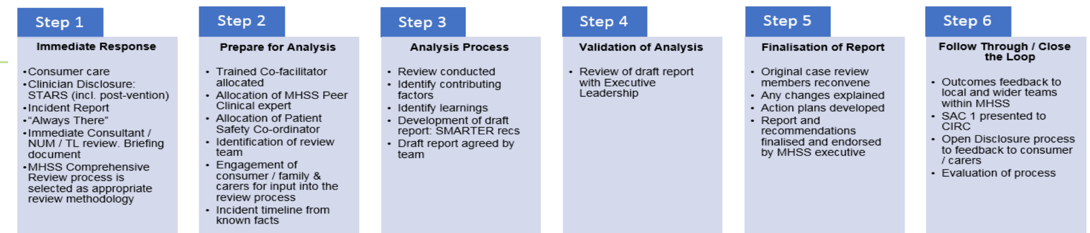


HOT Response: Psychological First Aid
- Provide a confidential listening ear to staff who want to talk about what happened
- Identify current needs, offer staff information and referrals resources if required.
- Provide follow up with staff and/or one on one catchup if requested.

WARM response:
- Promotes Psychological first aid.
- Caring presence within the work area.
- Awareness of colleagues experiencing difficulties.

Adapted from Scott (2010)

Incident Review Framework



Restorative Just and Learning Culture – Training Components

Table 2. Responding to incidents using an RJC framework.

Who is hurt?	What do they need?	Obligations and Actions
Consumer/ Family/Carers	Support, Healing, Information Engagement in review and learning	**Clinician Disclosure following Incident** Train staff in clinician disclosure and engagement with family/carers following adverse incidents. **Referral to Postvention Support agency** Clinicians to have information and material available about the Postvention Support Services. **Engagement of the family in the in the Review process** Family interviewed to gain their perspective of the events; identify lessons they feel need to be learned from the incident; and gather any questions that would like answered within the review process. **Open Disclosure** Meet with family to communicate findings of the review; Structured interaction in the Open Disclosure format; feedback answers to any questions they have; feedback regarding the recommendations being made. **Evaluation** Obtain feedback from the family with respect to their experiences of the post incident process.
Clinicians	Support, healing and learning	**Develop Resilience and Reflective Practice prior to an event** **'Always There' Staff Support Programme** Three-Tier Staff Support Programme using trained peer supporters to provide psychological first aid following critical incidents **Active Engagement of involved staff in the Review process wherever possible** Avoidance of RCAs where possible to enable active involvement of the involved team in the review. Facilitators trained in all relevant components of the post-incident review process. Familiarisation for all staff in the process, including concepts of RJC. **Engagement in dissemination of findings, including Morbidity and Mortality Meetings for all service lines** **Introduction of a weekly MHSS Triage meeting to look at a broader range of incidents, including near misses, suicide attempts, suicides outside of the SAC1 timeframe, and developing themes across all incidents** Determination of most appropriate review process (e.g. comprehensive, concise, multi-incident)
Organisation	Support and learning	**Six-Step Post-Incident Process aligned with RJC principles that supports all measures:** Incorporates multiple perspectives (family, clinician and leadership). A forward-looking review of 'the clinical care pathway' rather than looking back from an incident. Considers review against best practice, considered exploration of Human Factors, and view of systems through the Constellation Diagram. Involvement of team ensures WAD is understood; Involvement of Leadership ensures WAI is understood. Consider what was done well. Use SMARTER to assist with the development of high-quality recommendations. Use a hierarchy of hazard controls tool to guide strength of recommendations. All learnings of relevance are incorporated into Recommendations, not just those deemed 'Contributory Factors'. **Continue development of Just Culture across the health service** **Overt support of staff following adverse incidents**

MHSS: Mental Health and Specialist Services; RJC: Restorative Just Culture; WAD: Work as Done; WAI: Work as Imagined.

Gold Coast

Presentation to the Board and Executive

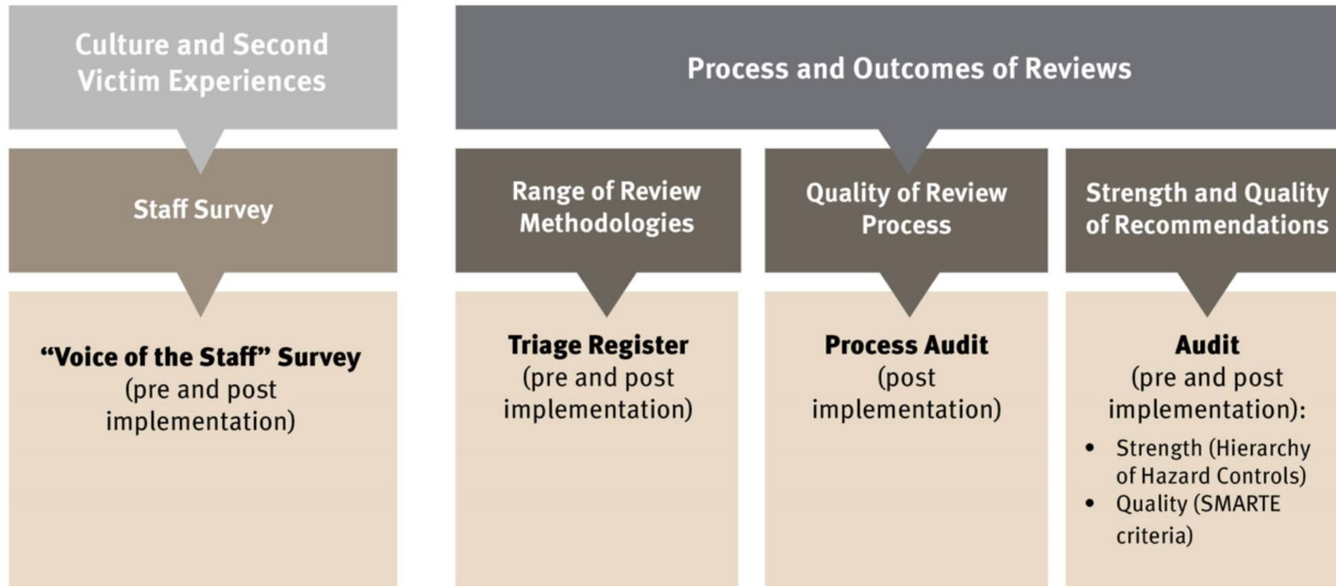
Presentation to All Staff (30-60min)
- RJC
- Clinician Disclosure
- Incident Review process
- Staff support process

Training in Formal Open Disclosure
- Senior Staff in Service

Training in Incident Reviews
- Facilitators and Co-facilitators

Training in "Always There" Peer Responders (including use of simulations
- Volunteer Staff Responders

Gold Coast



- Improved reports of JC and Second Victim Distress.
- Fewer fear disciplinary action, blame. More trust.
- "Always There" - increased organizational support.
- Involved in Reviews :
- ➢ Better perception of Just culture and perceived support;
- ➢ Less 'second victim' distress; intention to leave and reported absenteeism

- Larger range of incidents reviewed including less severe
- Greater variety of review methodologies
- Reduction in RCAs.

- Improved quality and strength of recommendations. Audit results incl:
  - Improved Effectiveness / Evaluation (64.8% to 96.0%)
  - Plan to evaluate the effectiveness of the recommendation (7.0% to 22.7%).
  - More specific recommendations (78.9% to 93.3%)
  - Strength of Recommendations.

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ORIGINAL ARTICLE

Restorative just culture significantly improves stakeholder inclusion, second victim experiences and quality of recommendations in incident responses

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Check for updates

Collaborative Approach to Supporting Staff in a Mental Healthcare Setting: "Always There" Peer Support Program

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Clinician Perspective (Acknowledgement to Cath King, Gold Coast HHS)

Cannot be copied from one organization to another – but - “Freedom within a frame”

Review of literature, and socialise in service.

Engagement and buy in from leadership.

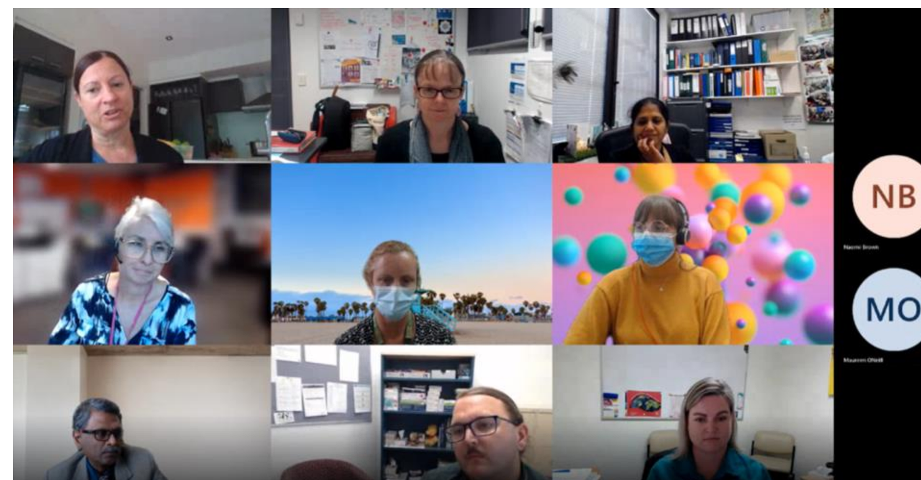
Staff Survey with measures of Restorative Just and Learning Culture and Second Victim Experiences.

Workstreams with representation from consumers, carers, clinicians, leaders, patient safety, researchers and educators.

Incident Response Workstream** Staff Wellbeing Workstream.

Service-wide reflective conversations exploring the meaning of RJLC and everyone’s role in this.

Development of process, training, resources, evaluation framework.



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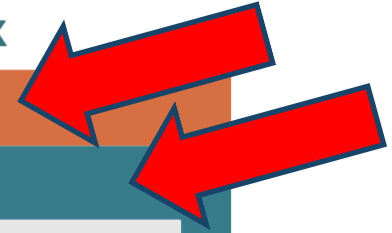
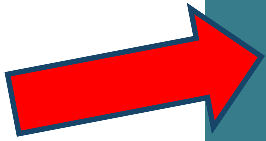
METRO NORTH MENTAL HEALTH RESTORATIVE JUST AND LEARNING CULTURE FRAMEWORK



Setting the Safety Culture: Building respect and trust, Learning, Systems improvement, Resilient Healthcare.

How can harms and relationships be repaired? How can we mitigate the risk of harm in the future?



Who is hurt and what are their needs? Who is responsible for meeting their needs?

	Immediate Response (Healing)	Review Process (Learning)	Formal Open Disclosure (Healing)	Implement and Evaluate (Improving)
Consumer, Family	Clinician disclosure (supportive, open dialogue) Referral for postvention support Provision of Information	Meet with the family to gain their account. Their questions for the panel. Their ideas for improvement.	Formal open disclosure. (Facilitated; supportive; open dialogue; agree and document actions going forward).	Evaluation of experience.
Service	Immediate actions for safety. Organisational response to first and second victims (Clinician disclosure; service response; peer response). Triage process. Identify stakeholders.	Meet with the family, document and input into the review. Review of care pathway, using Safety II and Resilient Healthcare principles. High quality and strength recommendations.	Facilitate formal open disclosure. (Facilitated; supportive; open dialogue; apology; agree and document actions going forward).	Accountability to implement recommendations. Evaluate impact of implementation. Share lessons across the service.
Clinician	Clinician disclosure. Support of other clinicians. Receive support. Identify immediate risk to be addressed.	Participate in the review process. Open. Give their account. Reflective. Supported. Look for opportunities to improve the system.	Formal open disclosure. (Facilitated; supportive; open dialogue; agree and document actions going forward).	Participate in the improvement process; implement recommendations; assist in sharing lessons.

Metro North Mental Health Incident Response Framework

Embedded within a Restorative Just and Learning Culture

Part 2

A Metro North Mental Health Framework for Responding to Incidents Using Restorative Just and Learning Culture.

Continuum of Consumer, Carer and Family Engagement

Clinician Tip

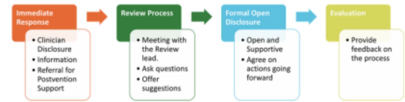


Figure 4 MNMH Consumer / Carer Engagement Continuum

Staff Wellbeing Response

Clinician Tip

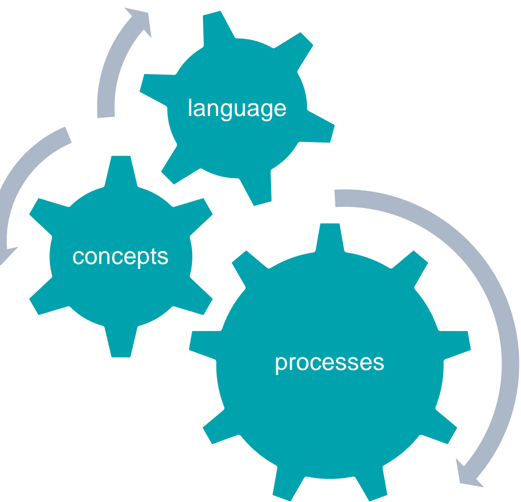
Clinician Tip

Immediate Actions of Leaders

Clinical Review Process - Comprehensive Review Process

Clinician Tip

Evaluation



Conversations

Online forums, Email Updates, Face to face conversations and reflections with teams, Engagement in Workstreams, Conversations in meetings (eg. Triage, IRC etc); Evaluation.

Training

Embedded in ASPIRES training - clear commitment from leadership; overview; consumer / carer perspective video; Incident Review training; Open Disclosure training.

Processes

Family engagement; Triage Meeting; Updated IRC and Legislation Committee; 2 step process for reviews; Concise Review; updating approach to open disclosure.

Restorative Approaches in Healthcare Community of Practice

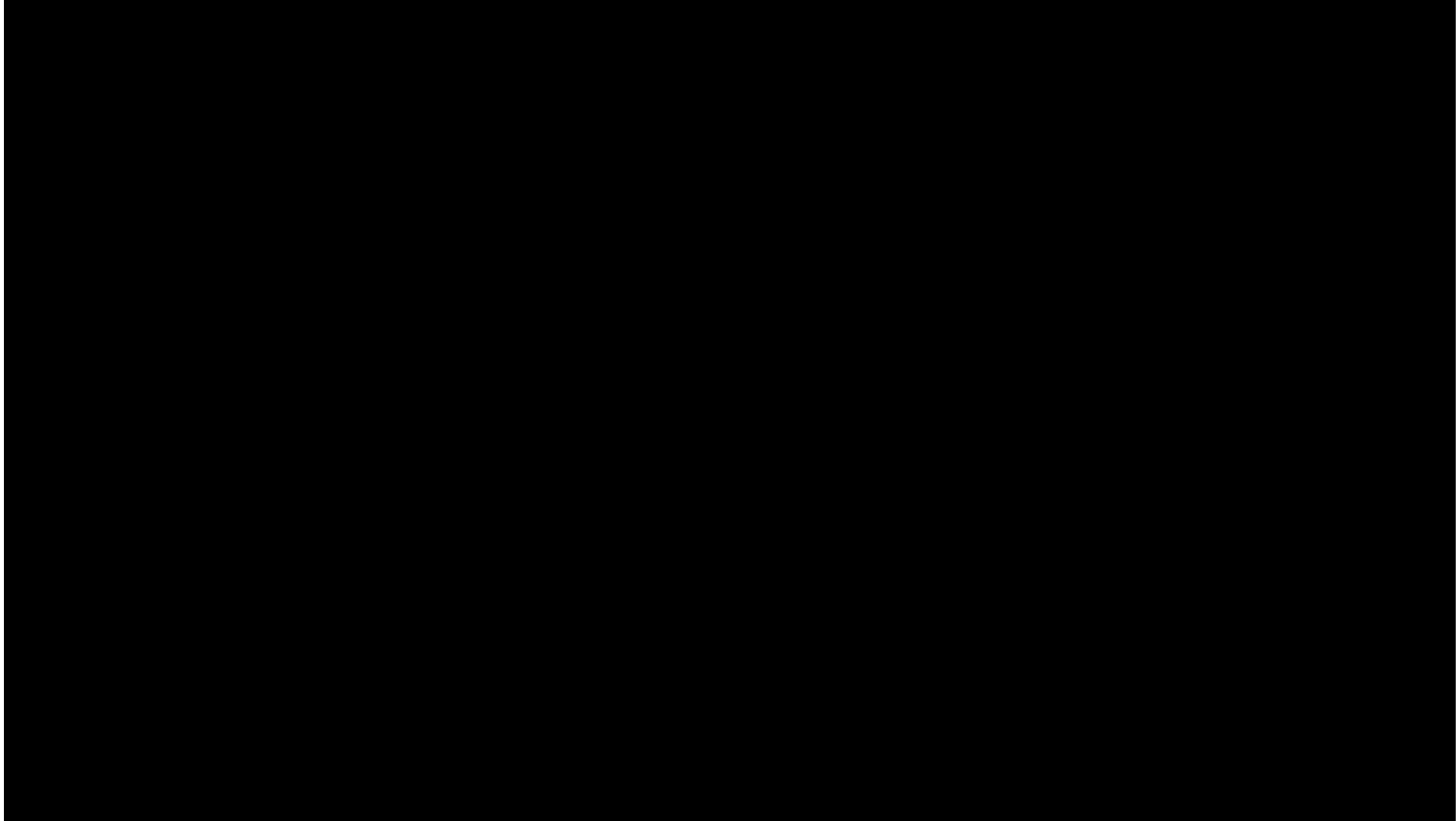
"Restorative Just and Learning Culture: But what does the Coroner think?"

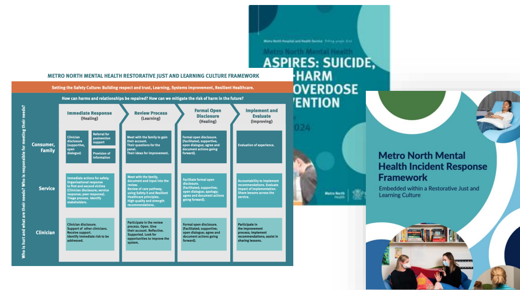
Wednesday 5th April 1pm-2pm.

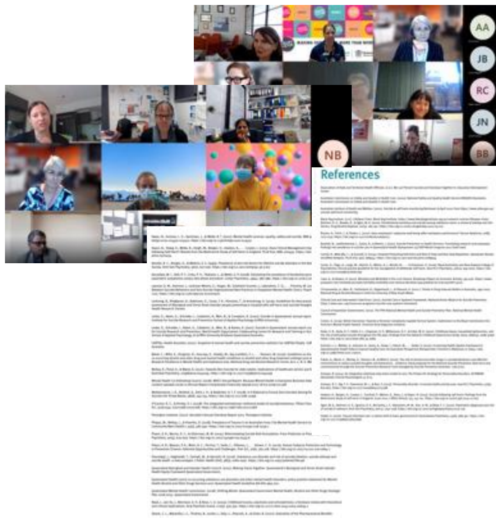
Join us for the next Restorative Approaches in Healthcare Community of Practice. We will present a framework for Restorative Just and Learning Culture in the context of responding to clinical incidents. One of the most frequent questions that we get asked when discussing RJLC is ***"But what does the Coroner think?"*** Join us to hear directly from **State Coroner Magistrate Terry Ryan**, where he will discuss what Restorative Just and Learning Culture means to him and the benefits of a Restorative approach in our services.

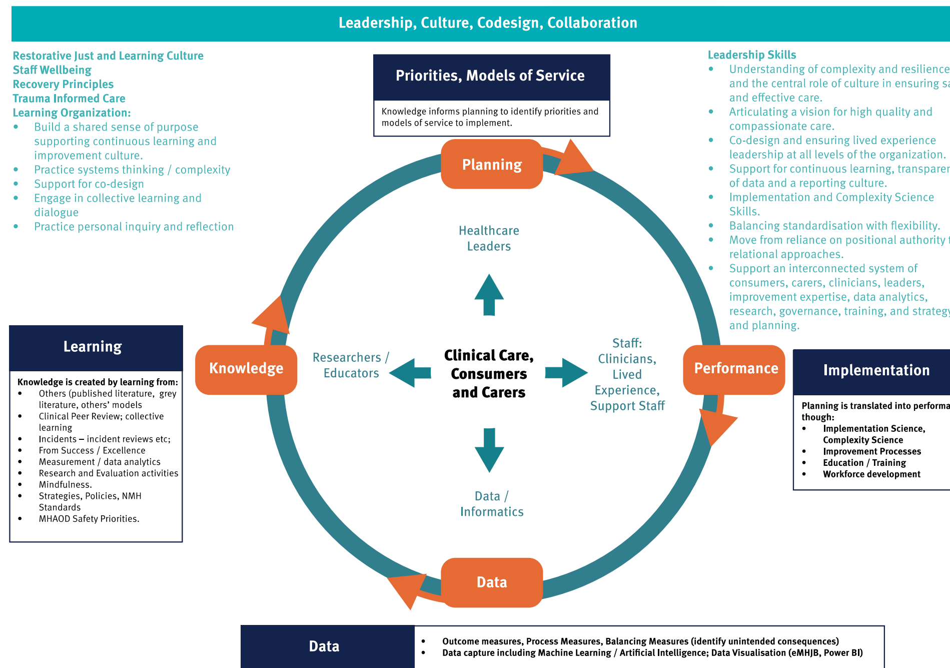
We will also present a summary of feedback from the COP on what you would like to hear about in future sessions.

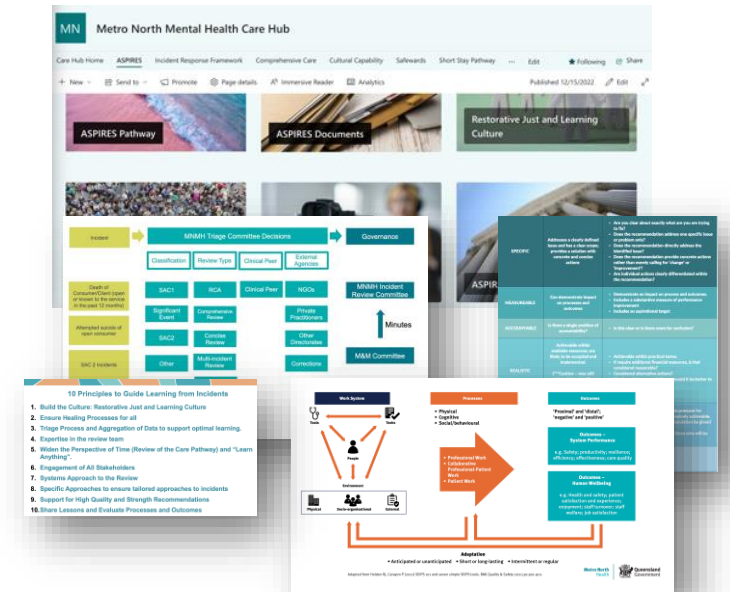
But what does the Coroner think? (Acknowledgement: Safeside)











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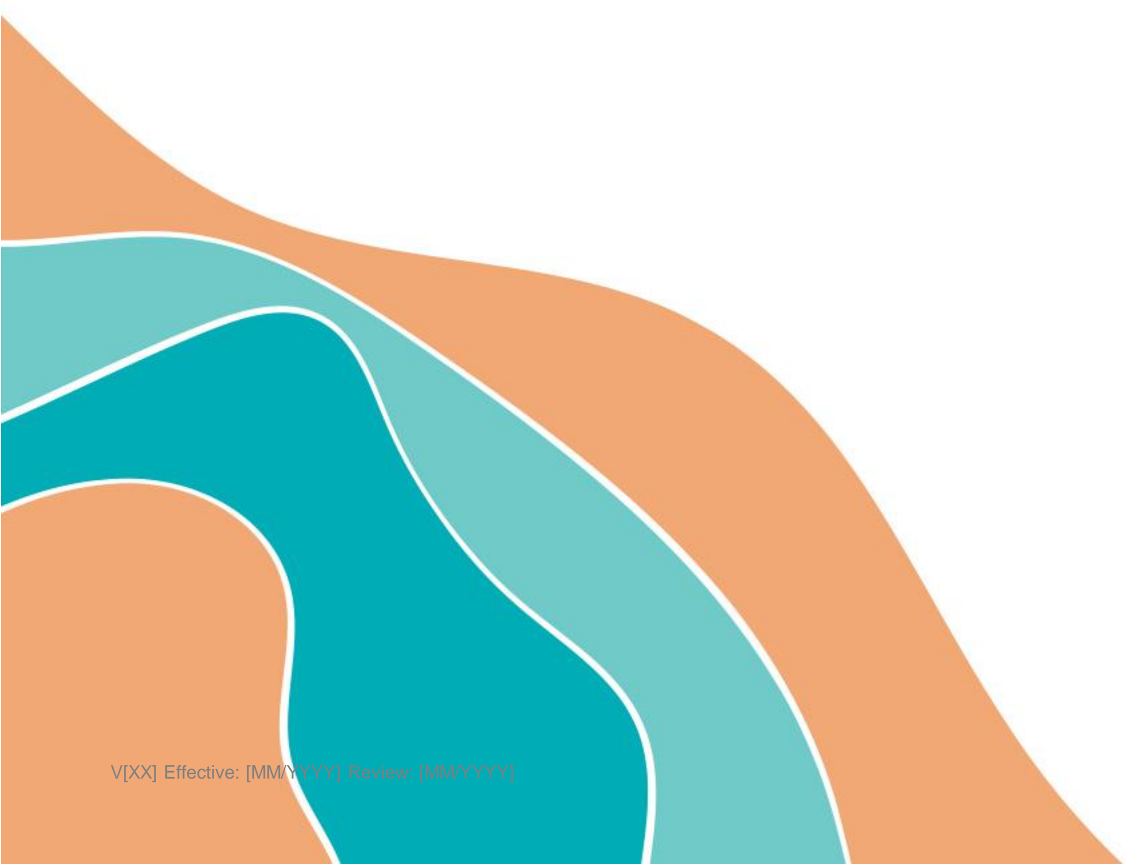
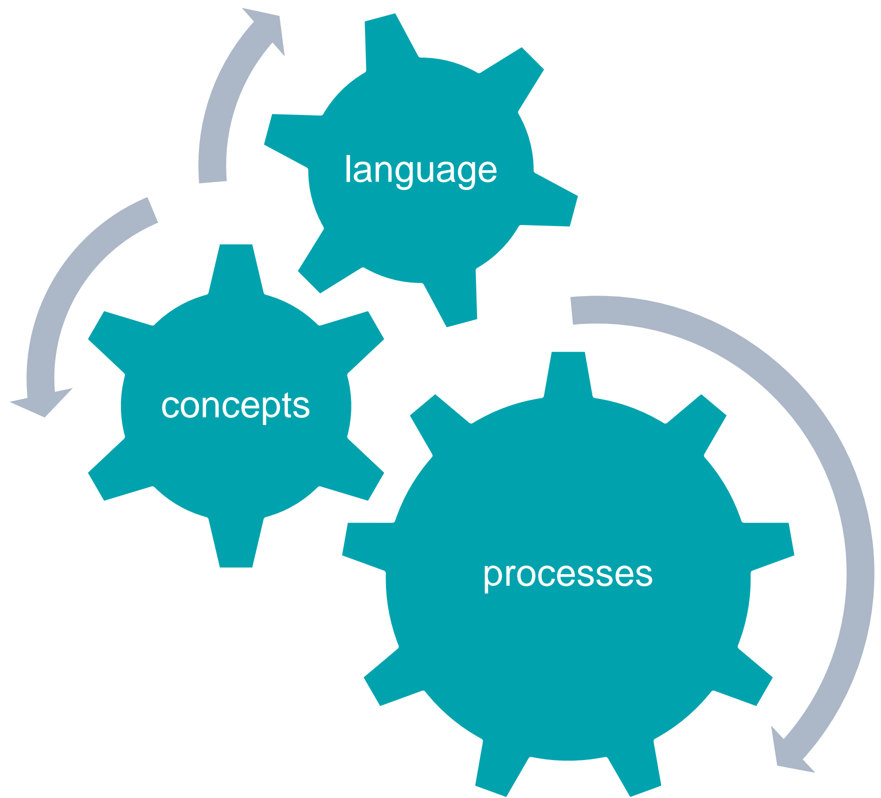
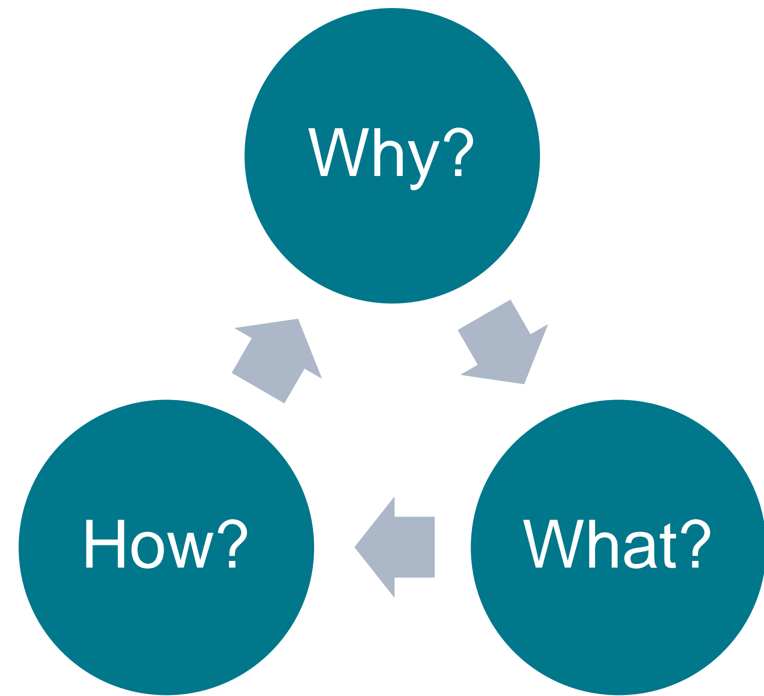
Reflections







Relational

Co-Designed

Engagement of All Stakeholders

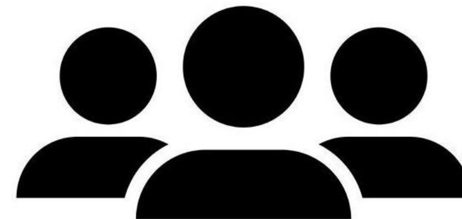
Respect and Dignity

Disconnect

What we think we do

“We already do that.”

What we experience.



Eg.
Leaders – Staff
Staff -Families

We don’t blame:

- Challenging to move away from linear thinking to true systems thinking.
- Result is unintended blame.
- Need to accept the challenges we have all had with this.
- Impacts from the past can be enduring.

We include families:

- Rationalise – it would be upsetting for the family; the family were not very involved; there were no family we were aware of.
- Often underlying anxiety / lack of confidence.
- Need to support staff (emotionally and through skills building).

Any questions?

Our Learnings:

- Constant conversation. Constant balance of focus on principles / concepts and focus on processes.
- Conversations adapted based on the audience.
- People will focus on elements that most resonate with their needs (eg. Staff support or learning) but need to ensure maintain focus on all elements. (“Healing first then learning”).
- Matrix Framework may assist people to understand how all of the components fit together.
- Continuing efforts to develop a ”definition” may be helpful for communication.
- Better quality learnings and improvements and improved outcomes for consumers, carers, family and staff. “Learn Anything”.
- But has been slow to spread within services. Many are still not doing reviews that are informed by complexity let alone restorative processes.
- Misunderstanding regarding accountability – deeply accountable process.
- Its not an “easy option”.
- Cultural change is tenuous – aspects can quickly shift with changes at leadership at higher levels.
- Need to look for opportunities to further embed RHC / Safety II principles. How do we do that in existing resources?

What would be your next steps to progress this in your team or organization?

Any questions?