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Supporting a Transparent Culture of Fairness, Openness and Learning

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LEARN NOT BLAME

#learnnotblame | dauk.org

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The NHS Patient Safety Strategy

Safer culture, safer systems, safer patients

July 2019

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Developing a patient safety strategy for the NHS

Proposals for consultation

December 2018

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Openness and transparency

To improve the safety of healthcare we must acknowledge the things that can, and do, go wrong and that we need to make changes. Talking about incidents where people were harmed can be uncomfortable. Not talking about them is dangerous. We must support everyone to be open and transparent, including with the patients who are harmed and their families and carers. Openness is a prerequisite for sharing insight about safety: being open supports the kind of positive accountability needed for change, as well as being the right thing to do.

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Just culture

When things go wrong

Learning culture

Transparency and openness

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NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?

Yes

Recommendation: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

END HERE

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NHS Improvement

The future of NHS patient safety investigation: engagement feedback

November 2018

THE BEHAVIOURAL INSIGHTS TEAM

Behavioural insights into patient motivation to make a claim for clinical negligence

Final report by the Behavioural Insights Team

August 2018

NHS Resolution

Throughout our review, families and carers have told us that they often have a poor experience of investigations and are not always treated with kindness, respect and honesty. This was particularly the case for families and carers of people with a mental health problem or learning disability.

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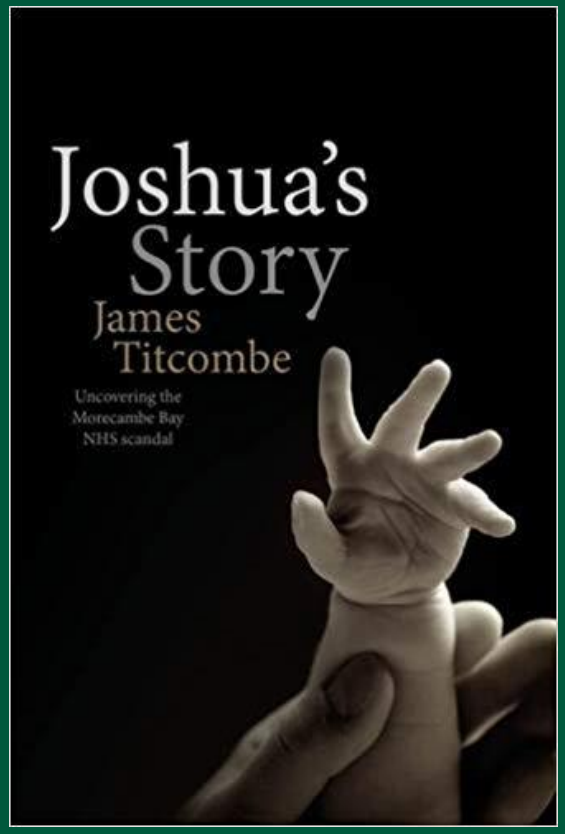

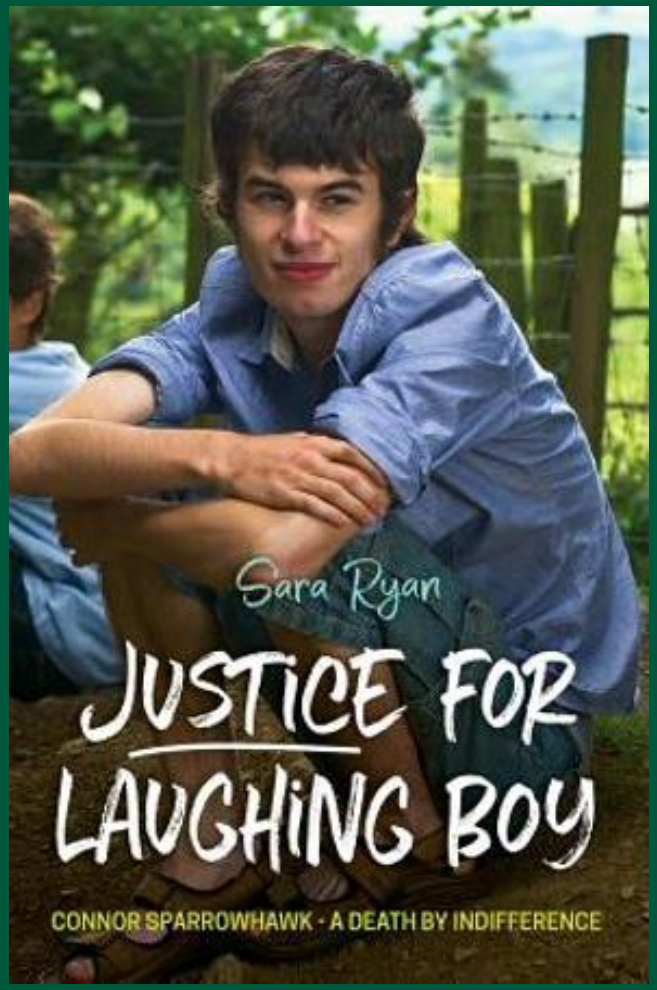

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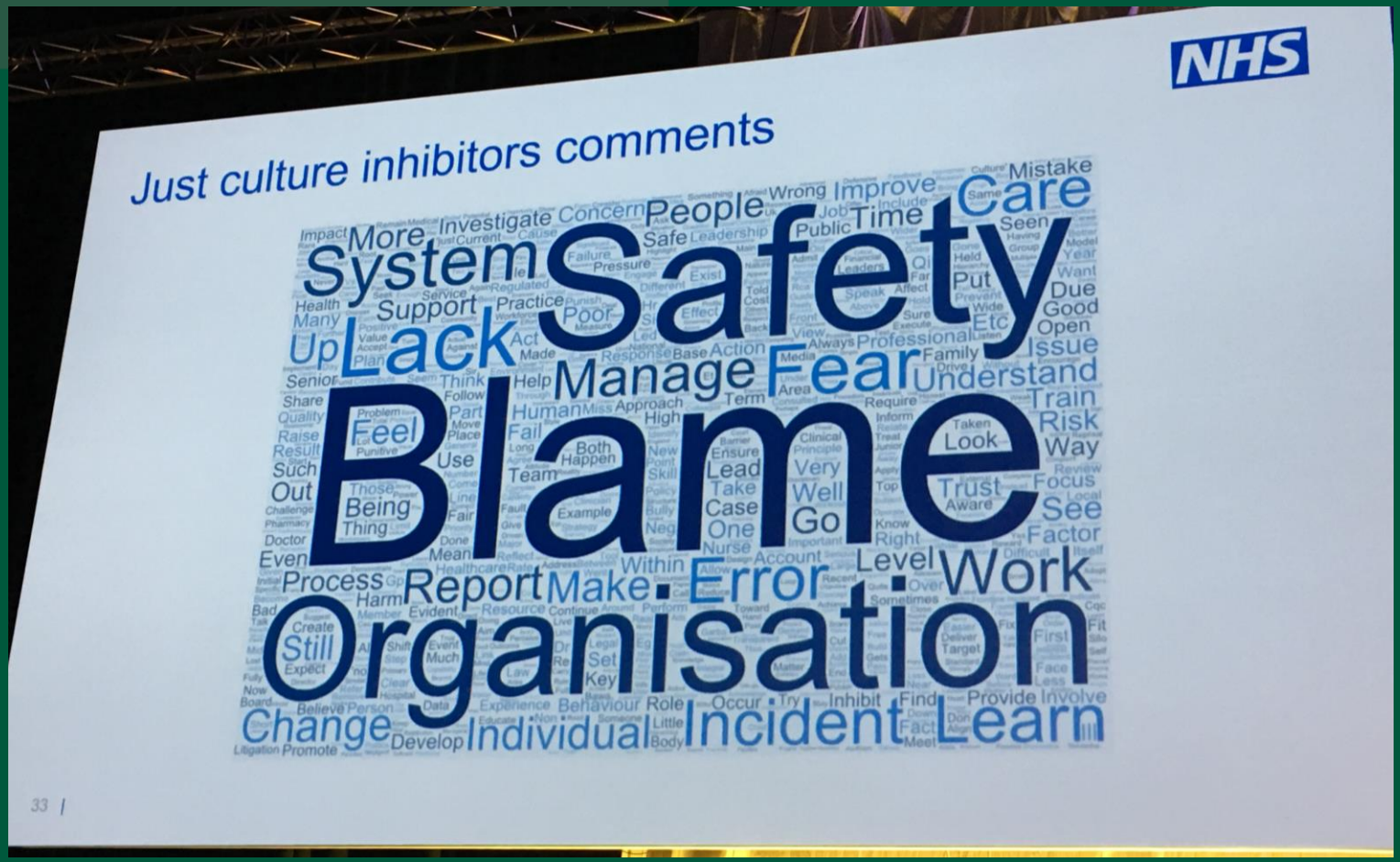

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2.3 Clarity, truth and accountability

An argument can often be observed in conversations on social media, or the comments sections of media stories, that families want someone to blame when things go wrong. Time and again families are at pain to point out that blame is not their motivation:

> "I don't apportion any blame for his death at all, its one of those things that happened but we're still not quite sure about whether he did fall or not. So many different stories there, some of them just didn't make sense. There was no blame involved but the way it was handled was dreadful, it was quite embarrassing to be a nurse at that period of time" (1-1 conversation).

http://www.georgejulian.co.uk/wp-content/uploads/2016/12/FamilyInvolvementExperienceNHSDeathInvestigationsFinal.pdf

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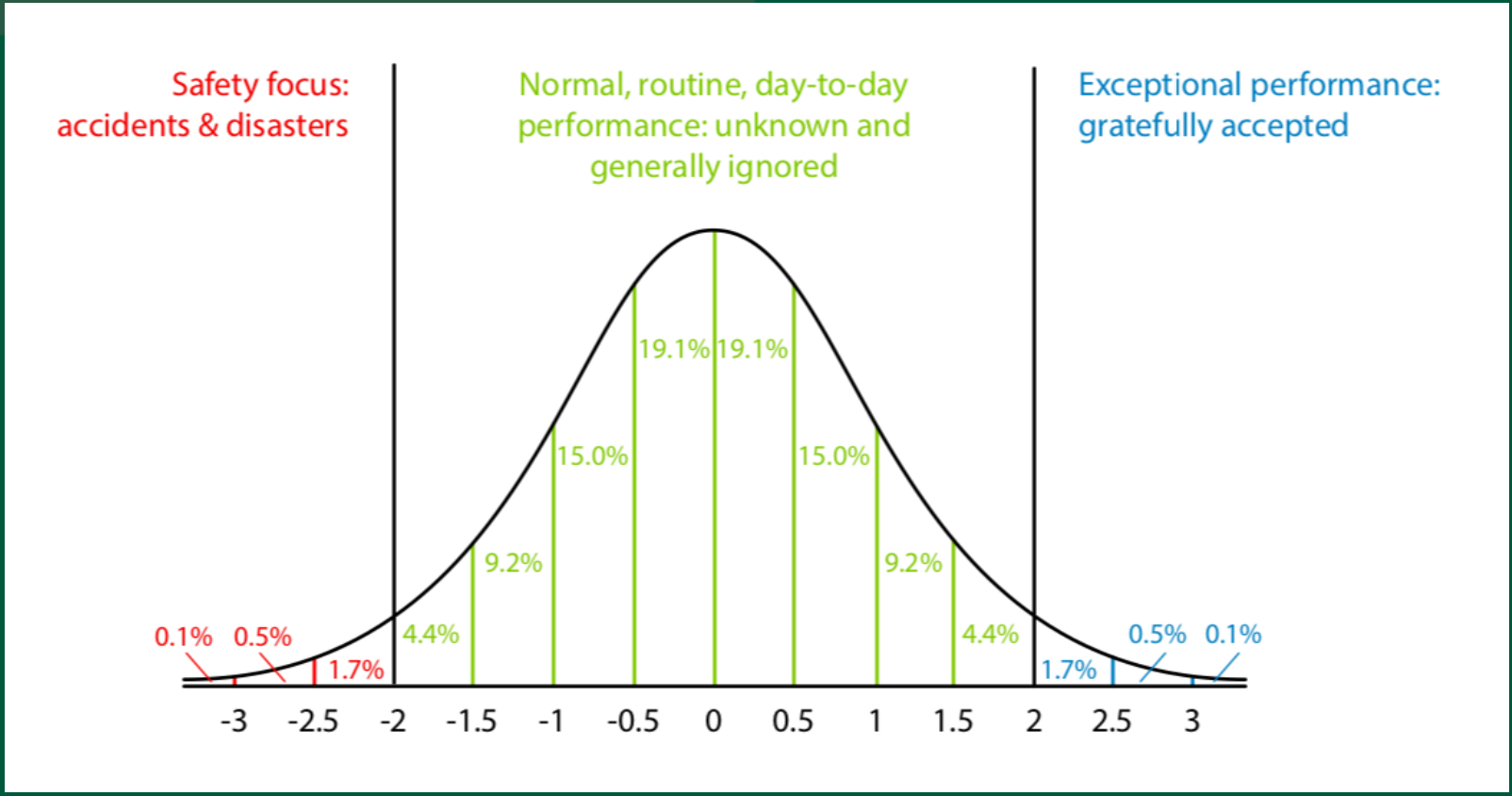

EUROCONTROL (2013). From Safety-I to Safety-II: A White Paper. Brussels. https://www.skybrary.aero/bookshelf/books/2437.pdf

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1st story	2nd story
Human error and violations	System vulnerabilities
Appears quickly after an event	Emerges slowly after delay
High personalisation	Lower personalisation
Low context	Higher context
Low complexity	Higher complexity
High newsworthiness	Low newsworthiness
Appears easily preventable and fixable (with hindsight)	No easy prevention or remediation

Steve Shorrock
@StevenShorrock

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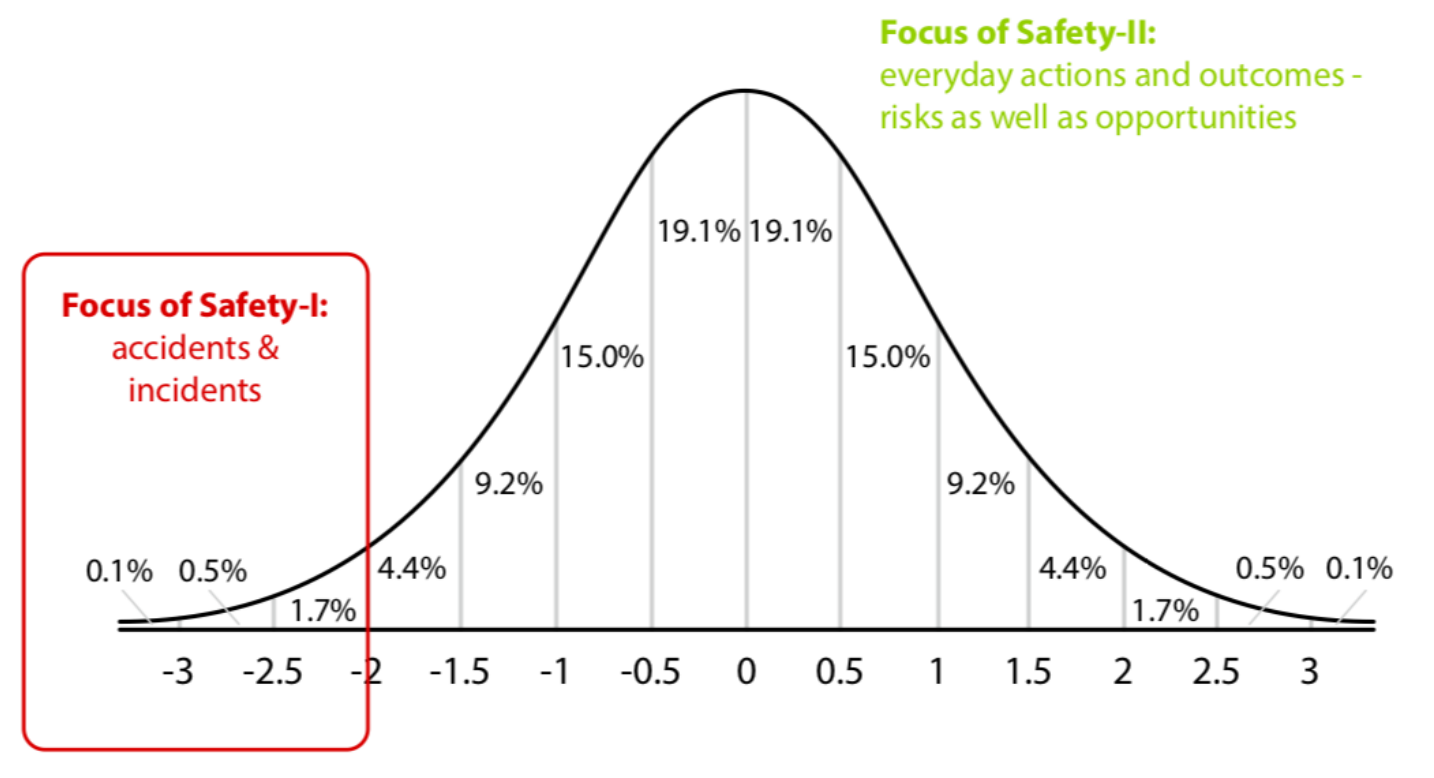

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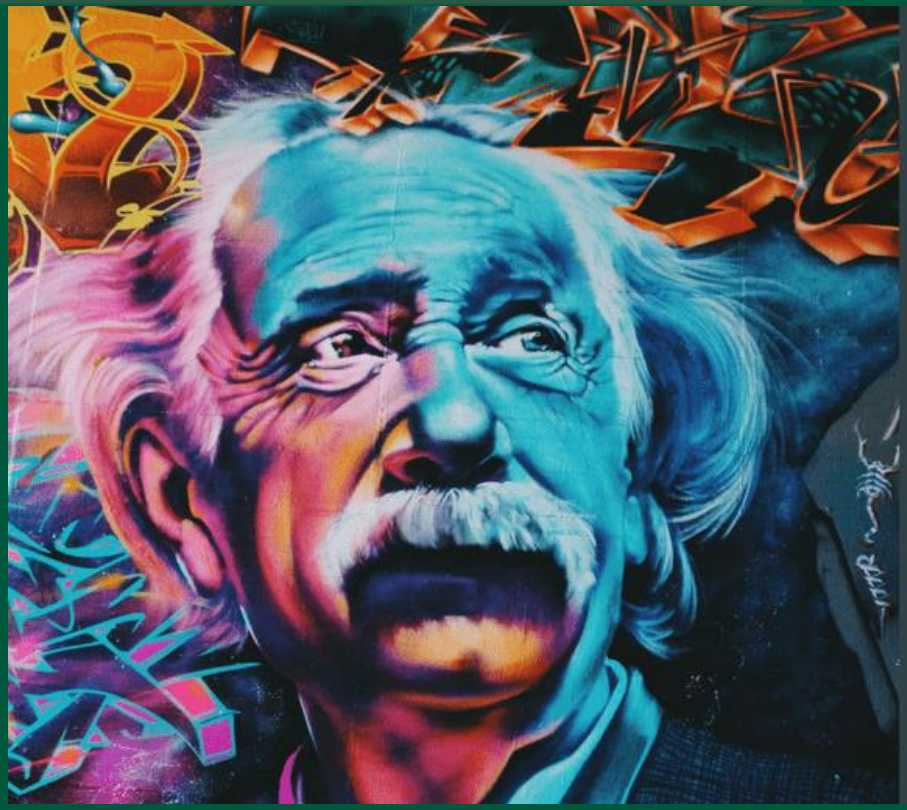

"I have no special talents, I am only passionately curious."

ALBERT EINSTEIN

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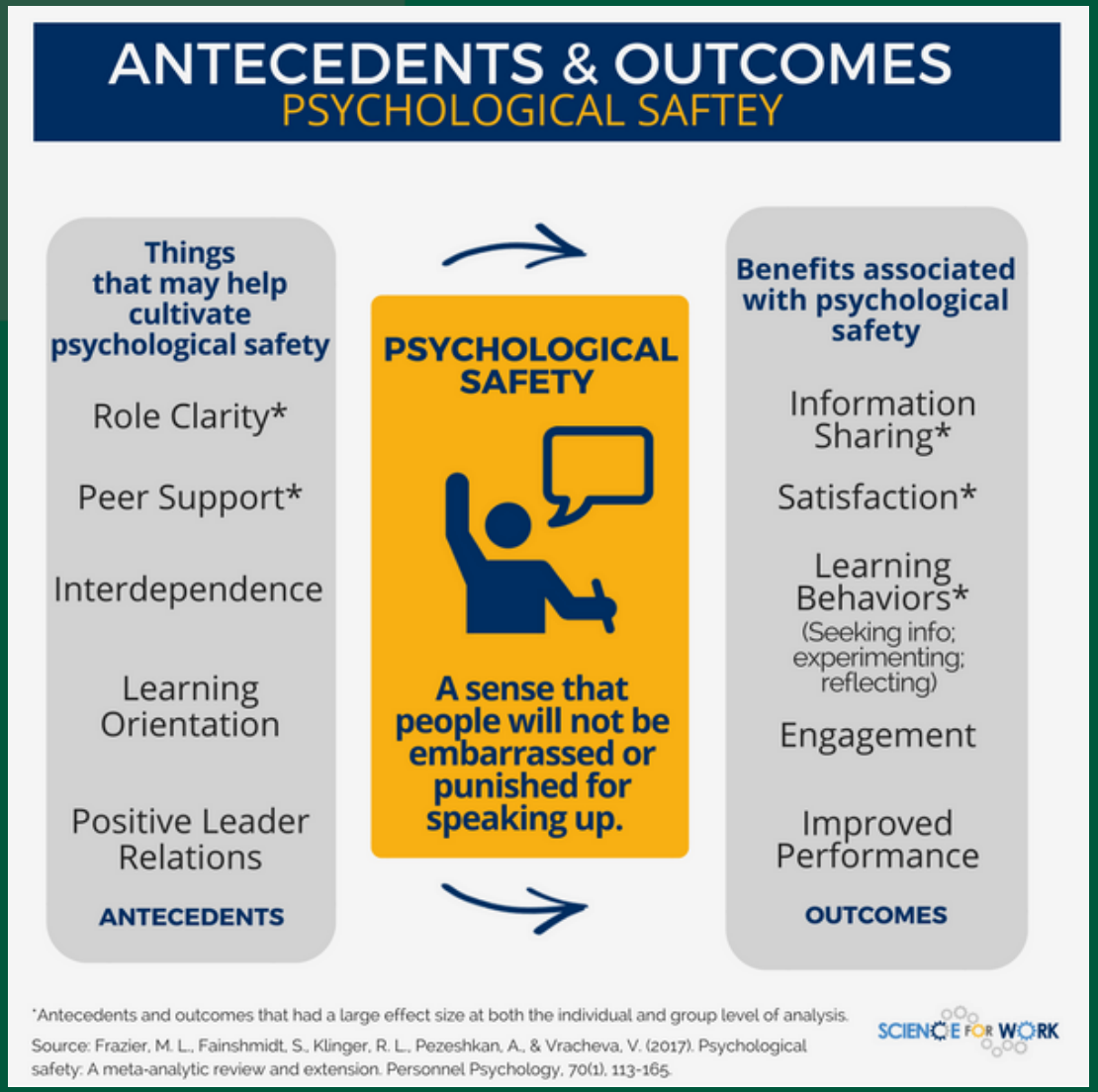

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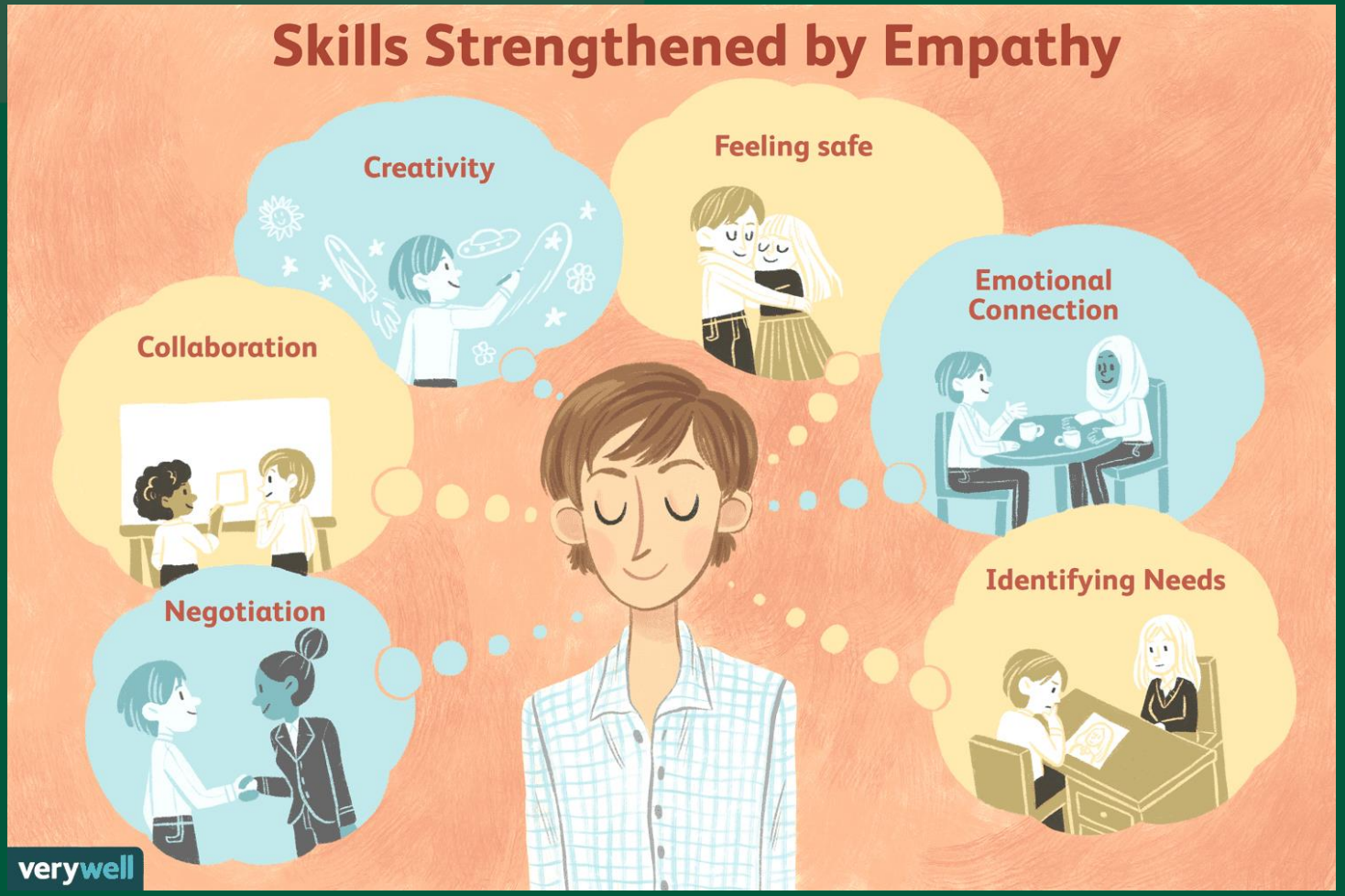

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andersonwallace
ETHICAL INQUIRY, INDEPENDENT VOICE

avma
action against medical accidents

CLEARERTHINKING
MAKING MORAL SENSE OF MEDICINE

How do we ensure that "just culture" does not become another meaningless platitude?

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RESTORATIVE JUST CULTURE CHECKLIST

Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm.

WHO IS HURT?

ACKNOWLEDGED: NO YES

Have you acknowledged how the following parties have been hurt:

- **First victim(s)** – patients, passengers, colleagues, consumers, clients
- **Second victim(s)** – the practitioner(s) involved in the incident
- **Organization(s)** – may have suffered reputational or other harm
- **Community** – who witnessed or were affected by the incident
- **Others** – please specify:.....

WHAT DO THEY NEED?

EXPLORED: NO YES

Have you collaboratively explored the needs arising from harms done:

- **First victim(s)** – information, access, restitution, reassurance of prevention
- **Second victim(s)** – psychological first aid, compassion, reinstatement
- **Organization(s)** – information, leverage for change, reputational repair
- **Community** – information about incident and aftermath, reassurance
- **Others** – please specify:.....

WHOSE OBLIGATION IS IT TO MEET THE NEED?

IDENTIFIED: NO YES

Have you explored the needs arising from the harms above:

- **First victim(s)** – tell their story and willing to participate in restorative process
- **Second victim(s)** – willing to tell truth, express remorse, contribute to learning
- **Organization(s)** – willing to participate, offered help, explored systemic fixes
- **Community** – willing to participate in restorative process and forgiveness
- **Others** – please specify:.....

READY TO FORGIVE?

NO YES

Forgiveness is not a simple act, but a process between people:

- **Confession** – telling the truth of what happened and disclosing own role in it
- **Remorse** – expressing regret for harms caused and how to put things right
- **Forgiveness** – moving beyond event, reinvesting in trust and future together

ACHIEVED GOALS OF RESTORATIVE JUSTICE?

ACHIEVED: NO YES

Your response is restorative if you have:

- **Moral engagement** – engaged parties in considering the right thing to do now
- **Emotional healing** – helped cope with guilt, humiliation; offered empathy
- **Reintegrating practitioner** – done what is needed to get person back in job
- **Organizational learning** – explored and addressed systemic causes of harm

BACKGROUND OF RESTORATIVE JUSTICE

Restorative Just Culture asks:

- **Who is hurt?**
- **What do they need?**
- **Whose obligation is that?**

Accountability is *forward-looking*. Together, you explore what needs to be done and who should do it

An **account** is something you tell and learn from

Retributive Just Culture asks:

- What rule is broken?
- How bad is the breach?
- What should consequences be?

Accountability is *backward-looking*, finding the person to blame and imposing proportional sanctions

An **account** is something you settle or pay

WHY AVOID RETRIBUTIVE JUST CULTURE?

A retributive just culture can turn into a blunt HR or managerial instrument to get rid of people.
It plays out between 'offender' and employer–excluding voices of first victims, colleagues, community.
A retributive just culture is linked with hiding incidents and an unwillingness to report and learn.
The more powerful people are in an organization, the more 'just' they find their retributive just culture.
A retributive response doesn't identify systemic contributions to the incident, thus inviting repetition.

GUIDANCE FOR USE OF *RESTORATIVE* JUST CULTURE CHECKLIST

On the checklist, mark where you think you are, like so: ✗ or so: |
Together, the marks reveal what you still need to do.

HURTS, NEEDS AND OBLIGATIONS

An incident causes (potential) hurts or harms. This creates needs in the parties harmed.
These needs produce obligations for the (other) parties involved.
Restorative justice allows parties to discuss their hurts, their needs and the resulting obligations *together*.
Incidents don't just harm their (first) victim(s). They also (potentially) harm the second victim, supervisors, the organization, colleagues, bystanders, families, regulatory relationships and the surrounding community. All these parties have different needs arising from the harms caused to them.
The checklist allows you to trace the harmed parties, their needs, and the obligations on them/others.

FORGIVENESS

Forgiveness is not a simple act of one person to another. Forgiveness is a relational process that involves truth-telling, repentance and the repair of trust. It takes time. Trust is easy to break and hard to fix. Some first victims may be unwilling or unable to forgive. Second victims can also have difficulty forgiving themselves. Parties need to have patience and compassion, and may end up going separate ways.

GOALS OF RESTORATIVE JUSTICE

- *Moral engagement* can mean accepting appropriate responsibility for what happened, recognizing the seriousness of harms caused, and humanizing the people involved. Incidents can overwhelm an organization (e.g. a legal, reputational, financial, managerial issue). It is easy to forget that it is also a moral issue: What is the right thing to do?
- *Emotional healing* aims to deal with feelings such as grief, resentment, humiliation, guilt and shame. It is a basis for repairing trust and relationships.
- *Reintegrating* the practitioner expresses the trust and confidence that the incident is about more than just the individual. Expensive lessons can disappear from the organization if the practitioner is not helped back into the job, and letting them go tends to obstruct the three other goals. If you fire someone, what have you fixed?
- Restorative justice is better geared toward *addressing the causes* of harm because it goes beyond the individual practitioner and invites a range of stories and voices. Forward-looking accountability is about avoiding blame, and instead fixing things.

Public Domain. By Professor Sidney Dekker—Griffith University, Delft University and Art of Work. sidneydekker.com

http://sidneydekker.com/wp-content/uploads/2018/12/RestorativeJustCultureChecklist.pdf

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