Using restorative practice in health care

Sam Foster, Chief Nurse, Oxford University Hospitals, considers whether the principles of restorative practice can help in the process of dealing with the aftermath of patient safety incidents

The NHS's *A Just Culture Guide* encourages colleagues to treat staff involved in patient safety incidents with fairness, in a systematic way (NHS England/NHS Improvement, 2021). The guide supports conversations regarding whether staff involved in a patient safety incident require specific individual support or interventions to work safely.

The Williams review (2018), into *Gross Negligence Manslaughter in Healthcare* stated:

> **'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution … Generally in a just culture, inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues.'**

In a just culture, investigators aim to understand why failings occurred and how the system led to sub-optimal behaviours. A just culture does, however, hold people appropriately to account where there is evidence of gross negligence or deliberate acts.

In my experience, clinical teams meeting with families in response to complaints is common practice and can be mutually beneficial when handled well. I frequently interact with patients and families as part of a complaints or patient safety investigation, and often staff involved in serious patient safety incidents ask to meet with those affected. Equally, patients and families often ask to meet staff involved. Although, in my experience, duty of candour is well executed, as investigations progress, the process is led by senior trust staff. On reflection, this may be driven by a desire to protect staff from a feeling of blame as the emotional impact for staff involved in serious incidents has a significant personal and professional impact. Staff are often referred to as 'second victims'.

I was therefore interested to see that the Healthcare Safety Investigation Branch (HSIB) is reviewing the concept of restorative justice, exploring how key principles could be integrated into the investigations that its staff undertake. As reported by Bowie (2022) HSIB welcomed Jo Wailling, a senior research fellow from New Zealand, to their staff development programme. She is a recognised global expert in the field of restorative practice and justice in healthcare.

Restorative justice, as defined by the Restorative Justice Council (2022), brings those harmed by crime or conflict and those responsible for causing their harm into contact with each other.

This is said to enable everyone affected by a particular incident to play a part in helping to set right the hurt or injury caused, and hopefully find a positive way forward. Restorative practice, as described by Wailling (Bowie, 2022), is said to be a wider field and can be used anywhere to prevent conflict, build relationships, and repair harm by enabling people to communicate effectively and positively. Restorative practice is increasingly being used in organisations, including healthcare, in New Zealand. Wailling reflected that the restorative response to when something goes seriously wrong in healthcare provides a compassionate, respectful and caring way of responding to the problem that aims to foster healing, restoration and learning for everyone affected.

Much is written about the principles of restorative practice, Wailling shared 10 practical insights into implementing a restorative response to patient safety incidents and related learning and healing (Bowie, 2022):

- Process is voluntary – all participants consent to a facilitated meeting
- Active participation – the needs of all parties are clarified during preparation
- Respectful dialogue – ground rules established during preparation and at the start of a meeting
- Safe environment – access to emotional support before, during and immediately after a meeting
- Skilled facilitation – trained practitioners guide the co-design, preparation, restorative process, and debriefing. Experienced or external practitioners are used in cases of severe harm or when requested by the people involved
- Responsibility taking – responsible parties directly hear about the harm experience to identify responsibilities
- Collaborative problem solving – restorative practice conversations enable psychologically safe dialogue
- Collaborative decision making
- Outcomes documented and shared
- Ongoing relational response – ongoing communication, roles and responsibilities are agreed.

When I first read about this, I worried that it may challenge the 'no blame' culture that we promote. However, no blame does not mean no accountability, and with expertise I can see the potential benefits in restorative practice. Although there is much work to be done in terms of raising awareness of this field of practice, testing, and evaluating feasible approaches in the NHS, I think that it could be mutually beneficial to patients, families and staff. **BJN**

Bowie P; Healthcare Safety Investigation Branch. Integrating restorative justice into patient safety investigation. 2022. https://tinyurl.com/5n86ns9s (accessed 24 August 2022)
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