Transcript: Implementing a relational approach when things don’t go to plan in the health care setting

Hello. So I'm going to take about 7 minutes to talk about what Nelson Marlborough has been doing in terms of adopting a more relational approach to when things don't go to plan in health care settings.

I'm going to talk about — a little bit about why we've embarked on this, what we've done, and a few key things that we've learnt.

So first of all, who am I? Well, I'm Elizabeth Wood and I'm a GP by training. I've been the clinical director for clinical governance at Nelson Marlborough Health for the past seven years.

Nelson Marlborough Health is a small health care system, a district health board, or at least it was until the 1st of July 2022 when our system changed.

We cover a 160,000 population. We've got about three and a half thousand staff and two main hospital sites separated by a mountain range, both of which have a very extensive rural hinterland also to cover.

So why did we embark on this journey?

Well, I'm sure that if you're watching this, then you will already have multiple reasons of your own why you think it's a good idea.

And I guess for me personally, my journey started probably in a cupboard in the back of the Wairau Hospital theatre complex when I was visiting some five or six years ago.

The charge nurse manager, on hearing that I was interested in adverse event processes, basically bundled me into what seemed like a cupboard and said, "You must talk to — I have a nurse here that, you must talk to this nurse.

She has a very important experience to share with you.”

So I waited and then the poor nurse got, you know, got brought in by the charge nurse manager and we got talking, and I knew — she was — she was in tears, basically. It was some five years since there had been a series of very tragic events for Wairau Hospital that's public knowledge.

There was a surgeon and some events went wrong. There were two deaths, and a young — including a young woman who died following surgery.

And of course, there was a major investigation, including a police investigation. And in the course of this investigation, this particular nurse had felt targeted and blamed for the series of events that happened.

In her experience, that was her experience of the review process. Of course, there was no way anybody could think that the nurse had any direct impact on what had happened or could possibly have done anything to prevent what had just happened. But, you know, health care workers often carry a feeling of guilt and blame, you know, almost on their shoulders.

They sort of carry that. It’s a heavy, heavy burden. And this had had a major impact on this particular nurse, and the story, her story, you know, it had a big impact on me.

And so that's — you know, a personal story is a very, very powerful way of prompting change. So we — in 2017, at Nelson Marlborough, we also had a staff survey, and our learning and development team, our human resources team also came to the conclusion that there must be a better way of having more useful, helpful, thoughtful conversations between staff to sort things out when things aren't going swimmingly.

And so we had — some 48 staff across lots of different disciplines were trained in using the restorative approach for workplace conversations.

And we have had a partnership with the Health Quality & Safety Commission and with Vic Uni Department of Restorative Justice. Thank you both very much. And we have run five workshops in collaboration with them using a circle process to really explore the impact of health care events that don't go to plan when bad things happen.

We included consumers in the workshops and the whole multidisciplinary team, including doctors, nurses, allied health, psychologists, the managers, and you know, it's a very powerful process to really understand just how much an adverse event impacts, not just the patient and their whānau, but everybody involved.

And of course even the organisation itself is impacted, and also sometimes the population of an area is impacted by an event that happens.

So we're pretty committed now to taking a more relational approach, but it's uphill work. It's not, it's not as easy as just saying, well, we should just sit down and have a conversation. It's a piece of work that takes preparation.

It takes skills and knowledge of how to run a process in a safe way. And it takes work afterwards as well.

It isn't just, oh, we'll just all sit and have a nice conversation and then the job will be done. It's not as simple as that.

So what — what have we learnt? Well, there's been a few — There's a few key things.

I suppose that one amongst them is that by and large, you know, our clinicians — I have immense respect for the clinicians that we have in our health system.

In terms of how hard they work and how much they care and the commitment to the roles that they have and to the safety of their patients, you know, it's — as I say, I have a lot of respect for that. And we, our clinicians are good at handling the open disclosure concept and also take it very seriously that patients will want to meet with them afterwards and go through things and find out more about what happened.

But quite often our clinicians are sort of really keen to have reviewed what happened first before they meet families.

So that's been awkward to sort of move over that little hummock. And it's easy for us, for clinicians to feel undermined if there's a sort of parallel process whereby patients and whānau are offered a conversation with reviewers or with people like a couple of steps removed from the direct frontline team so that they can really share their concerns and worries and difficult questions that they perhaps haven't been able to raise with their treating clinician. So, you know, of course, the last thing we want to do is to undermine our clinicians.

But however, whenever you try and change something, there's always — it's always not as simple as you think.

We've also learnt that it's really much more, much more can be learnt by having a review with all of the frontline clinicians involved in an event together, rather than interviewing them separately and getting maybe five different versions of what happened.

And so I've experienced this on a couple of occasions now, and it's really eye opening and heartwarming to see the unfolding of learning that happens when you put all the clinicians who were involved together to relate the story as it unfolded. And in doing so, of course, other clinicians in the room understand why this happened and why that happened and how come this came about and how come that came about.

And the recommendations that result have been so much more robust and helpful and practical and easy to implement than are things that are dreamed up by some external review team, you know, two years down the track, when everyone's really forgotten what was happening and everything.

So, I remain convinced that this is — even though there are wrinkles in the road, I remain convinced that this is much more efficient in terms of a time and action-oriented thing to do, as well as being much more likely to settle and calm and repair all of the people who have been impacted by the thing that has happened. Of course, we can never take back the fact that the thing happened.

But what we can do is stop the review process from continuing to damage and harm people for years and years and years afterwards.

So, I'd like to encourage you to take, to sign up for the micro-credentialing course run by Vic Uni over the next year or so and to dip your toe in the water and just to give it a go.

And be aware that it won't be straightforward, but when, when we treat everybody who is impacted by the event that has happened as equal participants in the subsequent journey to, you know, put ourselves back together, to pick ourselves up, to dust ourselves down, to carry on, to keep on living, keep on working, keep on contributing, and importantly, to learn something helpful that would make whatever happened less likely to happen in the future.

So be encouraged, and I wish you all well.