Healthcare Safety and Quality Capabilities

An Occupation-Specific Set for Healthcare Workers in NSW Health

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

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We wish to thank the many who were involved in the design of the Healthcare Safety and Quality Capabilities, both internally and externally to the CEC. Through this collaboration, we can effectively describe how safety and quality is everyone’s role in healthcare.

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Foreword

“High-performing health care organisations build in-house capacity for quality improvement and in so doing learn from others.”

Ham, Berwick and Dixon (2015). Improving quality in the English NHS - A strategy for action. The King’s Fund: London.

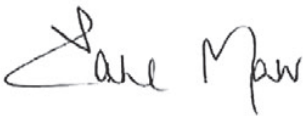
The Clinical Excellence Commission (CEC) seeks to promote and support improved clinical care, safety and quality across the NSW public health system. This is achieved by partnering with Local Health Districts (LHDs), Specialty Health Networks (SHNs) and other NSW Health agencies to help them to improve their services.

The CEC offers many programs of work to support safety management and quality improvement practices and to build a culture of safety across NSW Health.

For effective safety management and quality improvement, an organisation requires a workforce comprising individuals and teams with the right capabilities to ensure reliable, safe patient care and to continuously improve that care.

This document is a guide for Workforce, Clinical Governance, managers and employees in LHDs, SHNs and other NSW Health agencies to understand the capabilities (knowledge, skills and associated behaviours) needed at each level of an organisation to deliver healthcare safety and quality outcomes.

Understanding the workforce capabilities required for effective healthcare safety and quality will help organisations recruit, develop and succession plan for the right capability mix and create sustainability in roles and teams who deliver safe, reliable care.



Carrie Marr

Chief Executive

What is in this document?

Thank you for using the *Healthcare Safety and Quality Capabilities: An Occupation-Specific Set for Healthcare Workers in NSW Health* to improve safety and quality role clarity and expectations for the staff who work in your health organisation. The intention of the Healthcare Safety and Quality Capabilities is to describe the capabilities and associated behaviours that are expected of all NSW Health employees, leaders and Board members to engage in safety management and quality improvement to deliver safe, reliable care.

In this document you will find:

- A history of how the Healthcare Safety and Quality Capabilities evolved, from concept to delivery
- An explanation of how they complement the NSW Public Sector Capability Framework
- A glossary of terms to ensure clarity and readability
- Advice on how to identify and build safety and quality capability of your workforce
- Capability mapping to common NSW Health staff roles
- And of course, the capabilities, a definition and behavioural indicators across five levels (Foundational to Highly Advanced) ready to use in NSW Health position descriptions

The Table of Contents will assist in finding the information you need quickly. Should you require additional support in using the Healthcare Safety and Quality Capabilities in your organisation, please contact the Capability and Culture Directorate of the CEC.

We wish you all the best in building your organisation's safety and quality capability and increasing staff, from bedside to Board, role clarity in safety and quality responsibility.

Capability and Culture Directorate
Clinical Excellence Commission

Origins of the Healthcare Safety and Quality Capabilities

The development of the Healthcare Safety and Quality Capabilities was initiated in recognition that healthcare is a safety critical domain in the public sector with high variation in clinical processes and outcomes. Organisations with high chance of hazard occurrence have attempted to influence ways of working to transform into a high-reliability organisation (HRO).

High-Reliability Organisations

HROs can manage and sustain almost error-free performance, despite operating in hazardous conditions where the consequences of errors could be catastrophic, with a positive safety culture. In HROs, there is a high degree of interdependency between people, equipment and processes; the system interaction is either unpredictable or invisible and there can be catastrophic consequences as a result of mismanagement. The literature has shown the following key features and characteristics of HROs that need to be adopted by organisations to achieve ongoing high reliability and safety performance.

To ensure that patients reliably receive safe, quality care every time, we must be clear about every individual's safety and quality role in NSW Health. The goal of the Healthcare Safety and Quality Capabilities was to translate key healthcare safety and quality improvement concepts into the common language and format used in human resources and organisational development processes. For this reason, the document was designed to reflect the language and needs of those practitioners, rather than healthcare workers. It is also important to note that the capabilities are a guide for local Workforce and Clinical Governance teams to create a language for describing the safety and quality improvement behaviours for all staff, at all levels in NSW Health.

The Healthcare Safety and Quality Capabilities was designed to complement the Public Service Commission's (PSC) NSW Public Sector Capability Framework. The NSW Public Sector Capability Framework supports the public sector to attract, recruit, develop and retain a responsive and capable workforce. As a part of NSW's public sector, NSW Health uses the framework for a variety of workforce needs. The PSC's framework was selected as it was the most commonly used in NSW Health, although there is no one capability framework that is used universally across the sector.

Design process

The first step in the design process of the Healthcare Safety and Quality Capabilities was to identify the areas in the NSW Public Sector Capability Framework that articulate the healthcare safety and quality improvement roles for staff at all levels, as well as the gaps. To determine this, a review of NSW Health policy and academic and grey literature about healthcare quality improvement and safety management was completed (See References). A series of broad functional areas was identified that was not fully defined by the NSW Public Sector Capability Framework and subsequent additional capability sets.

The next step was to explore these functional areas with patient safety and quality improvement experts in NSW Health to identify the specific and critical patient safety and quality improvement functions and responsibilities (See Acknowledgements). This involved structured interviews with stakeholders to unpack concepts, as well as co-design of the definitions and behavioural indicators for each capability.

Then, the document was revised and released to Directors of Clinical Governance and Directors of Workforce across NSW Health for wider consultation in 2017. The Public Service Commission, the Health Education and Training Institute and the Ministry of Health were also consulted in the drafting process. Feedback from this process was integrated into the document, resulting in the final six capabilities, definitions and behavioural indicators.

In March 2018, the CEC endorsed the Healthcare Safety and Quality Capabilities for use in NSW Health.

Refreshing the capabilities

In July 2020, the Healthcare Safety and Quality Capabilities underwent a review to ensure language and concepts are at their most contemporary. The rationale for refreshing the capabilities is rooted in:

- The growth of literature on Safety I and II in healthcare
- The implementation of the revised Incident Management Policy
- The growth of the Clinical Excellence Commission Academy offerings to build patient safety and quality improvement capability
- The design of a Safety and Quality Workforce Model, which describes the human resource infrastructure of health organisations to support safety and quality locally

The current iteration of the capabilities supports every staff member with the language to describe the key patient safety and quality improvement knowledge, skills, abilities and behaviours they need.

Introduction to the Healthcare Safety and Quality Capabilities

The Healthcare Safety and Quality Capabilities complements the NSW Public Sector Capability Framework, which describes the capabilities and associated behaviours that are expected of all NSW public sector employees, at every level and in every organisation. The Healthcare Safety and Quality Capabilities are an occupation-specific capability set for NSW Health employees and comprise six additional capabilities:

- Contribute to High Reliability
- Manage Clinical Incidents and Risk
- Manage Individual Factors that Influence Performance at Work
- Uphold a Safety Culture
- Utilise Improvement Methodologies
- Utilise System Thinking

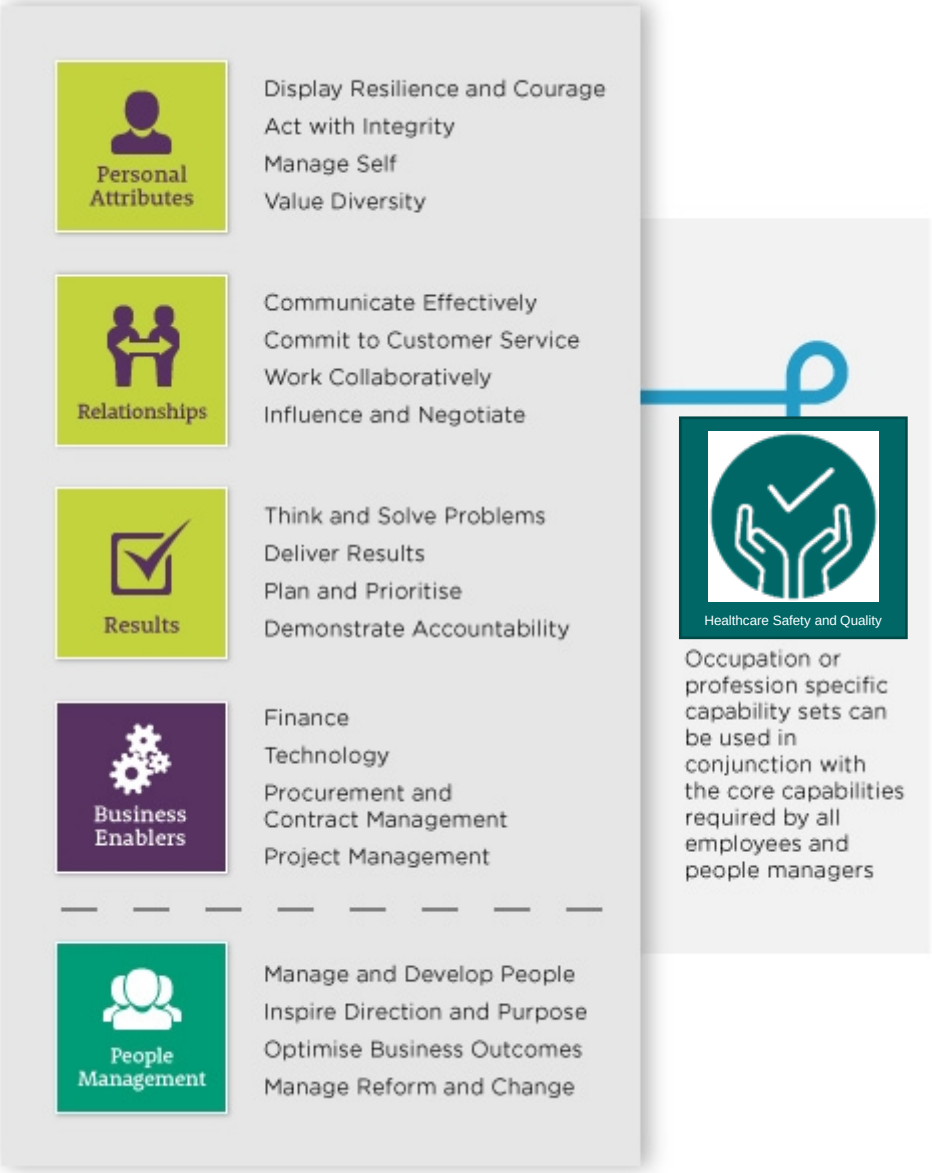
Most individuals will be familiar with capability statements from their position descriptions and performance development plans. However, capability frameworks support a much broader range of workforce and organisational development activities including:

- Providing role clarity
- On-boarding and induction
- Performance conversations
- Training needs analysis
- Learning and development
- Leadership development
- Workforce and succession planning
- Recruitment and selection

The PSC designed the NSW Public Sector Capability Framework as a recruitment and capability development tool to be applied to all public sector roles. However, using the framework is not a required practice in NSW Health and, further, is not designed to cover capabilities required uniquely by healthcare workers. One way in which health differs from the broader public sector is the high-risk, high consequence activities that represent our core business.

To prevent patient harm, ensure reliability and improve quality of outcomes, healthcare requires unique, additional patient safety and quality improvement capabilities. The CEC has therefore consulted with NSW Health stakeholders and subject-matter experts to develop the Healthcare Safety and Quality Capabilities. This occupational-specific capability set for NSW Health employees complements the original 20 capabilities defined in the NSW Public Sector Capability Framework. The intended use of the Healthcare Safety and Quality Capabilities is to guide LHDs, SHNs and other NSW Health agencies on improving safety and quality capability development, role clarity and succession planning for their workforce.

NSW Public Sector Capability Framework and the Healthcare Safety and Quality Capabilities



How to read the Healthcare Safety and Quality Capabilities

The capabilities' definitions and behaviour indicators by level are outlined in this document. The behavioural indicators are a series of statements that illustrate the knowledge, skills and associated behaviours that an employee should ideally demonstrate. Behavioural indicators are organised into level descriptors. The five descriptors range from 'foundational' to 'highly advanced', reflecting a progressive increase in complexity and skill, but not necessarily hierarchy. Level descriptors are mapped to role type depending on the complexity and skill required for the role. For example, a Junior Medical Officer will require capability at a different level to the Executive Director of Medical Services due to the differences in complexity of their roles.

Although this document focuses specifically on the new group of capabilities, it is important to recognise that many capabilities relevant to safety and quality are contained in the original PSC framework. For example, “be proactive to address risk” is included in the definition of *Demonstrate Accountability*. Similarly, the capabilities *Work Collaboratively* and *Communicate Effectively* are critical to building an environment of psychological safety where staff feel empowered to raise safety concerns. For this reason, the six new capabilities should only be used in conjunction with the 20 capabilities contained in the original framework.

There is a glossary at the end of the document, which explains any technical safety and quality language in the capabilities’ behavioural indicators.

Contribute to High Reliability

Understand and apply knowledge regarding how the organisational, team and individual conditions influence reliable service delivery to achieve safe, high-quality care

Foundational

Use the of Safety Fundamentals for Teams, or local equivalent

Employ techniques to communicate safety concerns assertively, e.g. PACE or CUSS in clinical settings

Employ techniques to share information and transfer knowledge that ensures the communicator knows they have been heard and understood, e.g. ISBAR in clinical settings

Be aware of safety and quality data sources and where to access them

Read and interpret charts used to display safety and quality data

Intermediate

Understand the characteristics of high-reliability organisations and how they apply in healthcare organisations

Lead the use of Safety Fundamentals for Teams, or local equivalent

Lead the use of communication tools and techniques to acknowledge others' safety concerns and to share information and transfer knowledge

Use safety and quality data to inform decision-making to deliver reliable care

Adept

Understand the concepts:

- The elements of a safety culture
- Safety I and Safety II
- Work-as-imagined versus work-as-done
- Efficiency-thoroughness trade-off
- Hierarchy of Intervention Effectiveness

Build teams with effective communication, psychological safety to raise concerns and ask questions, and demonstration of respectful behaviour

Discuss the interaction of safety and efficiency with team members to identify risk and ensure reliability of service delivery

Embed the use of Safety Fundamentals for Teams, or local equivalent in your unit or service

Monitor and use safety and quality data over time to ensure reliable service delivery in your unit or service

Advanced

Apply Human Factors' principles, tools, and methodologies in the design and evaluation of interventions, technologies or processes in the organisation

Provide expert guidance on how to build effective teams that understand the influence of human factors at work

Use simulation resources for improvement work and education

Lead organisation-wide discussions about the interaction between safety and efficiency to educate leaders about risk to reliability of service delivery

Implement safety and quality data systems to support the organisation to reliably deliver care

Highly Advanced

Collaborate with the Senior Executive to invest in expertise and staff capability in Human Factors' principles, tools, and methodologies, and their utility in healthcare design and service delivery

Promote the use of simulation resources for improvement work and education to clinical leaders

Provide expert guidance on the tension that efficiency and service delivery pressures have on safety and quality outcomes for staff and consumers

Provide expert guidance on how to use data systems to support the organisation to safely and reliably deliver care

Manage Clinical Incidents and Risk

Identify, communicate and manage clinical incidents and risk

Foundational

Follow NSW Health patient safety policies and practices

Take responsibility for error and harm and communicate where appropriate

Identify and notify incidents, near-misses and environmental hazards

Participate in team learning activities about incidents, near-misses and environmental hazards

Escalate incidents, near-misses and environmental hazards to the appropriate manager

Intermediate

Support your unit or service to monitor requirements regarding the organisation's safety and quality accreditation process and other safety assurance activities

Participate in unit or service-level incident reviews

Complete clinical risk and environmental hazard analyses requested of work environment in a professional manner

Adept

Explain the legislation and regulatory processes and policies relevant to incident reviews and clinical risk management to the team

Lead unit or service-level incident reviews

Monitor and meet requirements regarding the organisation's safety and quality accreditation process and other safety assurance activities

Track unit or service-level clinical risk and environmental hazard analyses and recommendations

Advanced

Understand patient safety concepts and incident review and clinical risk methodologies

Monitor and disseminate information on legislation and regulatory processes and policies relevant to patient safety

Establish appropriate teams to lead incident reviews

Generate and monitor recommendations for clinical risk and environmental hazard management strategies

Understand clinical risk management and its relationship to enterprise-wide risk management, and apply this to operational planning

Highly Advanced

Act as primary source of expertise in patient safety concepts and incident review methodologies

Ensure the organisation upholds all legislation and regulatory processes and policies relevant to incident reviews and clinical risk management

Lead the organisation's compliance with its relevant safety and quality accreditation process and other safety assurance activities

Provide expert guidance to teams completing incident reviews and clinical risk and environmental hazard analyses

Incorporate clinical risk management into strategic and operational planning

Manage Individual Factors that Influence Performance at Work

Be aware of thoughts, emotions and physical feelings that influence effective performance at work and adapt when necessary to deliver safe, reliable care

Foundational

Be able to recognise and name own emotions and physical feelings

Be able to recognise and name emotions and physical feelings displayed by others

Understand that emotions can have a positive and negative impact on work performance and relationships

Self-assess if you are fit for work and communicate this to your direct supervisor

Intermediate

Monitor own emotions and physical feelings, and adapt to ensure they do not negatively impact on work performance and relationships

Identify other people's emotions and physical feelings to understand their perspectives

Understand what a cognitive bias is and how it influences decision-making

Assess other staff's fitness for work and care for them to prevent negative outcomes

Adept

Practise self-reflection and emotional regulation, and understand the impact of own and others' emotions and physical feelings on safety

Critically reflect on own cognitive biases and how they influence decisions, behaviours and actions at work

Role-model reflective practice by leading discussions about learning for improvement

Lead open discussions about how team members' emotions and physical feelings impact safety

Advanced

Assist leaders to develop their Emotional Intelligence capability to be effective safety and quality leaders

Provide expert guidance on how to reduce cognitive biases' influence on leadership practice

Provide expert guidance on how to use critical reflection skills for learning for improvement

Review and improve organisational policies, procedures and guidelines to consider human factors

Highly Advanced

Role-model own Emotional Intelligence capability to set the expectation that it is an essential safety leadership behaviour

Lead the organisation to protect time for staff to engage in reflective practice for learning for improvement

Ensure human factors are considered in organisational policies, procedures and guidelines

Uphold a Safety Culture

Support staff, patients, families, and carers to feel safe, engage in learning and to acknowledge when an incident has occurred

Foundational

Contribute to a safety culture by asking questions, sharing ideas and concerns, and reporting incidents

Actively learn from mistakes, rather than assign blame

Provide authentic support to patients, families, carers, or other staff after an incident

Seek to understand what matters most to patients, families, carers, and customers and what drives complaints

Acknowledge the physical and psychological needs of staff involved in incidents

Undertake clinician disclosure or relevant disclosure process in collaboration with the health entity partner, including an apology, within 24 hours of an incident

Intermediate

Role-model psychological safety in your unit or service by speaking up when there is a safety concern

Assist less experienced team members to provide authentic support to patients, families, carers, or other staff after an incident

Participate in Open Disclosure following incidents

Assist less experienced team members to discuss what matters most with patients, families, carers, and customers and what drives complaints

Offer physical and/or psychological wellbeing support to staff involved in incidents

Adept

Recognise and reward staff for speaking up about safety and supporting others to do the same

Lead reviews following incidents and near-misses in a calm, logical and reflective manner so that others feel psychologically safe to contribute

Ensure there is authentic and appropriate support provided to patients, families, carers, or other staff after an incident

Ensure staff in your unit or service understand and participate in the Open Disclosure process

Set the expectation in the unit or service that understanding consumer or customer needs and complaints are essential for high-quality, reliable service delivery

Lead open discussions on how to support each other when involved in incidents and where to access organisational physical and psychological wellbeing resources

Follow up with staff who have been involved in incidents regarding ongoing need for support

Advanced

Recognise and reward units and services for engaging in learning practices, speaking up when there is a safety concern, and reporting and reviewing their incidents

Provide expert guidance on how to create an environment in the incident review that encourages learning, openness, transparency, and accountability so that others feel psychologically safe to contribute

Ensure no blame is placed on staff in incident reviews without proof of negligence of the offense

Design and implement systems, processes and resources that support a staff safety culture, and that support patients, families and carers who have been involved in incidents

Highly Advanced

Collaborate with the Senior Executive to ensure there are resources and processes to drive a culture of psychological safety and learning from a range of data sources

Safeguard the incident review process from blame by influencing the Senior Executive to commit resources to develop an environment that supports learning, openness, transparency, and accountability

Ensure there are organisational resources and processes available for staff psychological and physical wellbeing immediately and ongoing after an incident

Provide expert guidance on how to authentically restore trust between the health organisation and patients, families and carers who have been involved in incidents

Utilise Improvement Methodologies

Able to understand and utilise appropriate improvement, research and applied science methodologies to achieve change for healthcare improvement

Foundational

Be aware of the concepts of quality improvement in healthcare

Know where to find more information about the improvement resources available within the organisation

Think about different possibilities as to how service delivery works

Approach testing changes to service delivery from the perspective of making things better and safer

Be confident to offer ideas on service delivery improvement

Take responsibility for raising and fixing issues encountered at work

Understand a range of improvement data that exists in healthcare

Intermediate

Use knowledge, skills and experience that you have gained from other contexts to inform new ideas for service delivery improvement

Test ideas to demonstrate their worth for making things better and safer

Be confident to push boundaries and take measured risks when appropriate to improve service delivery

Understand what constitutes good aims and measures in improvement initiatives

Understand risk to improvement initiatives

Collect and analyse data to inform improvement conversations and initiatives

Be able and willing to participate in an improvement project that is underpinned by improvement methodologies

Recognise the importance of 'spread' of quality improvement initiatives and participate in this process

Adept

Apply quality improvement methods and tools to suit the context of the improvement needed

Understand the need for appropriate diversity in quality improvement teams

Provide guidance on quality improvement to others in your unit or service

Understand the importance of a Family of Measures for improvement initiatives

Read and interpret data presented in quality improvement tools/systems

Understand benchmarking, common cause variation and special cause variation as it applies to quality improvement work

Understand and apply the principles of Human-Centred Design

Support challenging conversations about change ideas with teams

Help to remove barriers to change for improvement

Critique improvement work as it relates to the organisation's strategic and operational plans and outcomes

Understand and apply evidence-based change management methods for service delivery improvement

Support spread of quality improvement initiatives

Advanced

Provide expert guidance about improvement methodologies and tools

Understand and interpret variation in data and how it relates to quality improvement

Provide expert guidance on benchmarking, common cause variation and special cause variation to improvement project leaders

Use data to understand if improvement is being achieved and to identify where opportunities for improvement exist

Teach others how to use Human-Centred Design

Support units and services to think creatively and innovatively about improvement and role-model creative and innovative thinking in your leadership practice

Provide resources to support creativity and innovation in units and services

Facilitate productive discussions about organisational change for improvement

Create networks to enable spread of improvement work that achieves safety and quality organisational objectives

Highly Advanced

Provide expert guidance on what a continuous improvement culture looks like

Provide expert guidance about data for improvement and how to use it to achieve strategic objectives

Champion the use of data systems to inform quality improvement work

Provide expert guidance on why it is critical to protect time for staff to actively engage in thinking creatively and innovatively about service delivery improvement

Collaborate with the Senior Executive to remove organisational barriers that prevent creative and innovative thinking

Collaborate with the Senior Executive to invest resources and time into testing new ideas for improvement

Endorse ideas that are creative and innovative at the highest organisational level, that are also underpinned by sound evidence, measurement and evaluation

Use change management strategies expertly to lead organisational change for safety and quality

Utilise Systems Thinking

Able to see the individual parts of the healthcare organisation, how they operate and interact, and their patterns of behaviour over time, and to use that information to contribute to change for safety and quality

Foundational

Understand the unit's and service's purpose, design and models of care

Understand how taking action to improve service delivery might impact patients, families, carers, and staff in your or other units or services

Recognise your role in a patient's journey and how your actions can affect patient experience in other units and services

Recognise your role in the unit or service and how your actions can affect other staff and leaders' ability to deliver services

Understand your role in the patient journey and how your role affects the patient's overall health outcomes

Enter information into data systems for reference along the patient journey

Intermediate

Anticipate the impacts of interactions between staff, teams, consumers and customers in your unit or service

Cultivate and maintain a network of relationships outside your unit, within the service or District/Network, which you can use to achieve safety and quality improvement outcomes

Connect patients, families, carers, or other staff and leaders with the support they need from other units or services where you work

Follow up with patients, families, carers, or other staff and leaders to see if they received the support they needed from other units or services where you work

Use all information from data systems to provide safe and efficient care

Adept

Determine and articulate approaches to achieve goals that consider

- Ambiguities
- Obstacles
- Changing circumstances
- Consequences in the service or District/Network

Utilise your network of relationships to understand the parts of the healthcare system and how it operates holistically to achieve safety and quality outcomes for your service and District/Network

Identify patient safety or work, health and safety practices that might impact innovative ideas for improvement and vice versa

Interpret when innovative ideas for improvement may pose new risks or introduce new harms

Understand and use analysis tools to learn about the contributing factors to how events occur in a complex system

Ensure your unit or service contributes to and references accurate and timely information

Advanced

Build decision networks and navigate politics to achieve outcomes that account for

- Ambiguities
- Obstacles
- Changing circumstances
- Consequences in the service or District/Network

Educate leaders about the parts of the healthcare system and how it operates holistically

Educate leaders about how to interpret when innovative ideas for improvement may pose new risks or introduce new harms

Provide expert guidance on how to use analysis tools to learn about the contributing factors to how events occur in a complex system

Ensure data systems are used to analyse information to contribute to improved patient outcomes and experience across the patient journey

Highly Advanced

Be able to consider situations, challenges or ideas regarding safety and quality in the widest context relevant to NSW Health

Provide expert guidance on the parts of the healthcare system and how it operates holistically, as well as how to change the system to deliver safe, reliable care

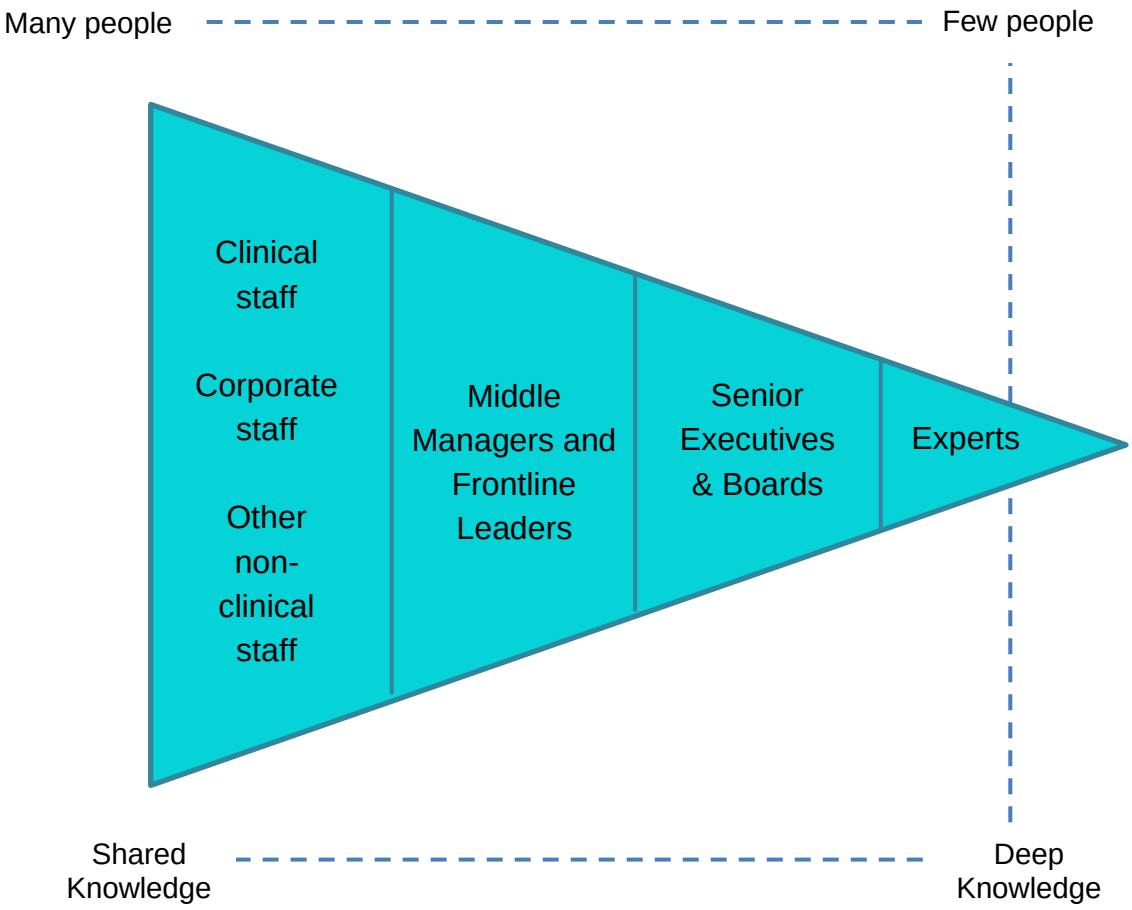
Provide expert guidance on the variety of analysis tools available to your organisation that support services to learn about the contributing factors to how events occur in a complex system

Provide expert guidance on the use of data systems to ensure a safe and efficient patient journey

Building Organisational Capability

This document has outlined the capabilities needed across the NSW Health workforce to deliver effective patient safety and quality improvement. It is not feasible (or necessarily desirable) for every employee in your organisation to meet a highly advanced level across all six capabilities. Instead, the goal is to develop both breadth and depth of capability across the organisation. Below is a useful guide for the level of safety and quality capability required across your organisation to achieve breadth and depth.

What level of capability do you need across your organisation to have breadth and depth?



Experts

Experts are those people in your organisation who have the highest level of knowledge, skills and abilities in safety and quality in healthcare. Their role is to teach, coach and support teams and individuals to improve the quality of their work to deliver safe, reliable care. This group serves a business support function and is usually, but not always, found in Clinical Governance Units. Organisations need expertise in patient safety management, quality improvement, safety culture, organisational learning, quality assurance and data analytics. The capabilities needed for such expertise differ for each of these roles. Experts also require skills to work collaboratively to support managers and staff.

Senior Executive

As key sponsors, senior leaders are the drivers of safety culture and endorse teams and individuals to engage in safety and quality work. They therefore need a working knowledge of safety and quality concepts, tools, methods and measures. They need to be able to make good management decisions based on this information. They are also role models for the rest of the organisation and create the conditions for others to engage in safety and quality work.

Board members

Board members need to agree on and understand the organisation's safety and quality strategies and plans to guide the organisation. Therefore, to make the best decisions for the organisation, they need to understand how data is used for safety and quality measurement and monitoring.

Middle Managers and Frontline Leaders

This group has the most diverse roles. Often, they are middle managers, frontline team leaders, or other roles that hold a level of influence with staff, whose work either identifies areas that affect safety and quality, or who are leading a group of staff who have identified such issues. They must also have significant capabilities but may get assistance from experts when needed. They require the ability to coach their teams through safety and quality work. This means helping to interpret data, identify problems, develop and implement strategies to prevent future harm or improve the quality of service.

Staff

This is the largest group in your organisation. This group is 100% of the NSW Health workforce, which includes clinical and non-clinical employees alike. It is expected that all NSW Health employees must have a foundational level of knowledge, skills and abilities in safety and quality. This facilitates shared understanding, helps identify more opportunities for change and is essential to build a culture of safety and improvement.

What level of capability is required?

Stakeholder	Capability	Level
Quality Improvement Expert	Contribute to High Reliability	Highly Advanced
	Manage Clinical Incidents and Risk	Advanced
	Manage Individual Factors that Influence Performance at Work	Advanced
	Uphold a Safety Culture	Advanced
	Utilise Improvement Methodologies	Highly Advanced
	Utilise System Thinking	Highly Advanced
Patient Safety Expert	Contribute to High Reliability	Advanced
	Manage Clinical Incidents and Risk	Highly Advanced
	Manage Individual Factors that Influence Performance at Work	Advanced
	Uphold a Safety Culture	Advanced
	Utilise Improvement Methodologies	Advanced
	Utilise System Thinking	Advanced
Consumer Involvement Expert	Contribute to High Reliability	Advanced
	Manage Clinical Incidents and Risk	Advanced
	Manage Individual Factors that Influence Performance at Work	Advanced
	Uphold a Safety Culture	Advanced
	Utilise Improvement Methodologies	Advanced
	Utilise System Thinking	Advanced

Safety Culture and Organisational Learning Expert	Contribute to High Reliability	Highly Advanced
	Manage Clinical Incidents and Risk	Highly Advanced
	Manage Individual Factors that Influence Performance at Work	Advanced
	Uphold a Safety Culture	Highly Advanced
	Utilise Improvement Methodologies	Advanced
	Utilise System Thinking	Highly Advanced
Strategic and operational leadership for safety and quality *Director Clinical Governance, or relevant senior safety and quality executive role	Contribute to High Reliability	Highly Advanced
	Manage Clinical Incidents and Risk	Highly Advanced
	Manage Individual Factors that Influence Performance at Work	Highly Advanced
	Uphold a Safety Culture	Highly Advanced
	Utilise Improvement Methodologies	Highly Advanced
	Utilise System Thinking	Highly Advanced
Senior Executive *Where there is a range, Senior Executive ideally should be at a minimum Advanced, but where capability can be built to Highly Advanced that is helpful to drive the safety and quality agenda. Not every Senior Executive needs to be Highly Advanced across each capability though.	Contribute to High Reliability	Advanced-Highly Advanced
	Manage Clinical Incidents and Risk	Advanced
	Manage Individual Factors that Influence Performance at Work	Highly Advanced
	Uphold a Safety Culture	Highly Advanced
	Utilise Improvement Methodologies	Advanced
	Utilise System Thinking	Highly Advanced
Board *We recognise that Boards are not considered employees	Contribute to High Reliability	Adept at a minimum
	Manage Clinical Incidents and Risk	Adept at a minimum

and therefore there are no capability requirements for this group. Board members should ideally be at a minimum Adept to be good stewards of the organisation's safety and quality agenda. Some behavioural indicators under Adept will not be relevant to all Board members as they are not healthcare workers.	Manage Individual Factors that Influence Performance at Work	Adept at a minimum
	Uphold a Safety Culture	Adept at a minimum
	Utilise Improvement Methodologies	Adept at a minimum
	Utilise System Thinking	Adept at a minimum
Middle managers and frontline leaders *Middle managers and frontline leaders ideally must be at a minimum Adept at the point of hire, and incumbents should engage in capability development to reach the Adept level. It is helpful to build capability to Advanced-Highly Advanced to drive the safety and quality agenda, but not every manager needs to be Advanced-Highly Advanced across each capability.	Contribute to High Reliability	Adept at a minimum
	Manage Clinical Incidents and Risk	Adept at a minimum
	Manage Individual Factors that Influence Performance at Work	Adept at a minimum
	Uphold a Safety Culture	Adept at a minimum
	Utilise Improvement Methodologies	Adept at a minimum
	Utilise System Thinking	Adept at a minimum
NSW Health employees *New NSW Health employees should engage in activities to build their capability to the Foundational level at the point of entry during onboarding processes. As they continue their career, they must grow to Intermediate before taking on any leadership roles. Health organisations must commit to developing all staff to the minimum Foundational level.	Contribute to High Reliability	Foundational-Intermediate
	Manage Clinical Incidents and Risk	Foundational-Intermediate
	Manage Individual Factors that Influence Performance at Work	Foundational-Intermediate
	Uphold a Safety Culture	Foundational-Intermediate
	Utilise Improvement Methodologies	Foundational-Intermediate
	Utilise System Thinking	Foundational-Intermediate

Example Position Description

This is a sample from a Position Description for a Nurse Unit Manager. This sample uses the NSW Public Sector Capability Framework and the CEC Healthcare Safety and Quality Capabilities to articulate the knowledge, skills and abilities required for the role.

CAPABILITIES FOR THE ROLE

The NSW Public Sector Capability Framework applies to all NSW public sector employees. The Capability Framework is available via the Public Service Commission website. Below is the full list of capabilities and the level required for this role.

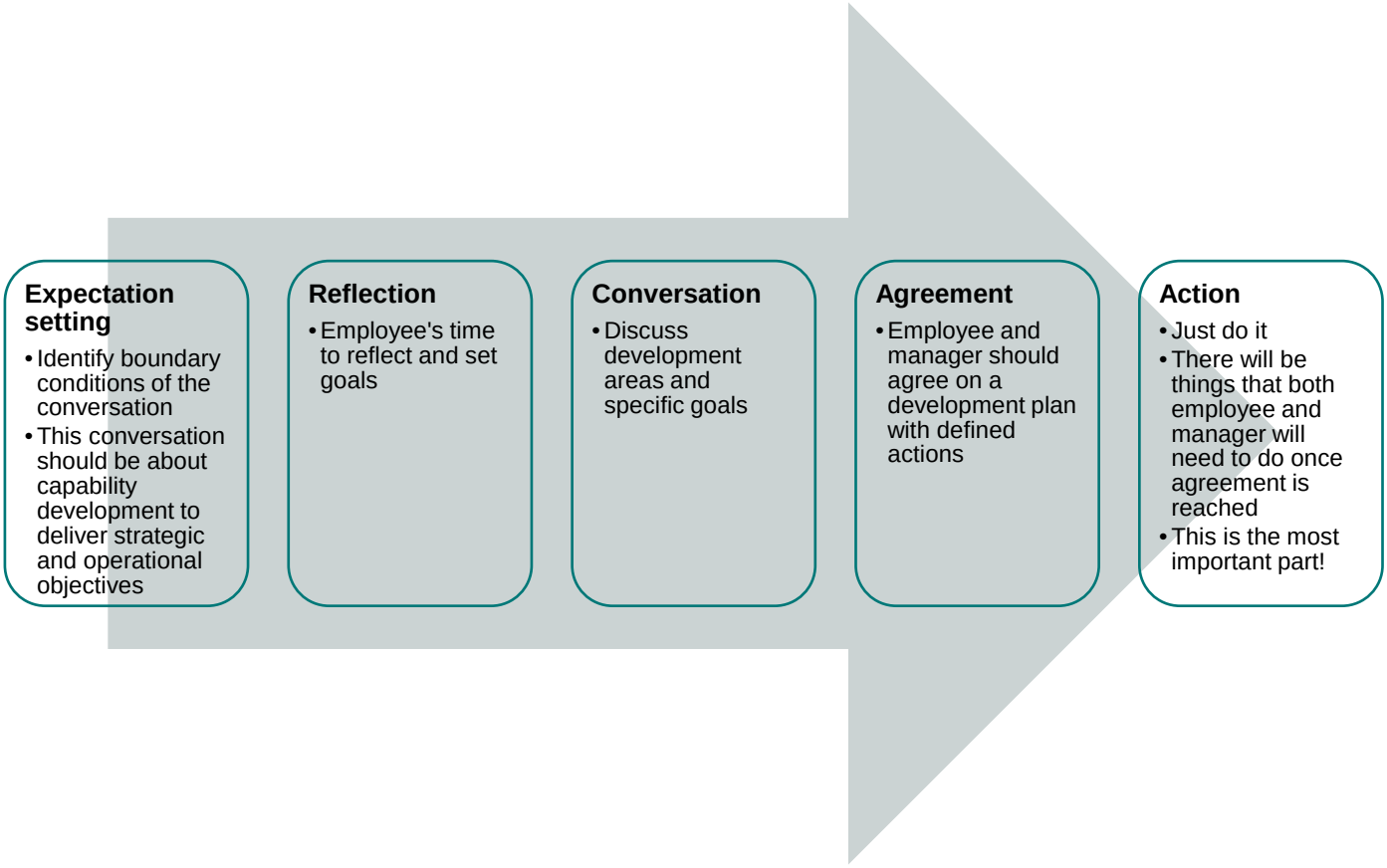
Nurse Unit Manager 3

Capability Group	Capability Name	Level
Personal Attributes 	Display Resilience and Courage	Advanced
	Act with Integrity	Adept
	Manage Self	Adept
	Value Diversity	Adept
Results 	Deliver Results	Adept
	Plan and Prioritise	Adept
	Think and Solve Problems	Advanced
	Demonstrate Accountability	Advanced
Relationships 	Communicate Effectively	Advanced
	Commit to Customer Service	Adept
	Work Collaboratively	Advanced
	Influence and Negotiate	Adept
Business Enablers 	Finance	Adept
	Technology	Adept
	Procurement & Contract Management	Adept
	Project Management	Adept
Healthcare Safety and Quality 	Contribute to High Reliability	Adept
	Manage Clinical Incidents and Risk	Adept
	Manage Individual Factors that Influence Performance at Work	Adept
	Uphold a Safety Culture	Adept
	Utilise Improvement Methodologies	Adept
	Utilise System Thinking	Adept

How to Develop Healthcare Safety and Quality Capability

There is no right way to engage in capability development. It can be as individual as the person building their capability. A useful way to approach capability development is to have a conversation between the employee and manager using the 70-20-10 rule.

The capability development discussion includes five steps:



The capability development discussion

What are the roles?

Employee

Employees are responsible for their development journey. This requires employees to be reflective, open-minded and confident about where they are and where they want to be. To prepare for 'the conversation':

- Read through the capabilities in this document
- Reflect on how you currently demonstrate the behavioural indicators of the capabilities at the relevant levels
- The best way to do this is to consider examples of times when you have demonstrated those behaviours and skills in your work
- Be honest with yourself about where your strengths are and where you could develop
- Also consider where you are demonstrating capability at a higher level
    - How can you leverage these strengths to support other goals?

    - What are your career goals and how are you using your strengths to attain them?
- Based on your reflections, devise 2-3 development goals. Consider one of those goals as a stretch goal. A stretch goal pushes yourself to the performance limits and tests what you believe you can achieve.

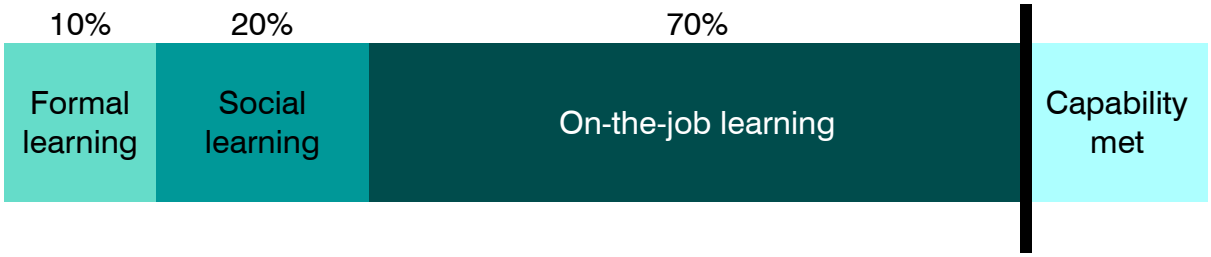
Manager

Managers have two roles. In the first conversation, the manager's role is to help the employee understand the boundary conditions for discussion. A simple boundary condition is anything that helps or hinders the achievement of the organisation's strategic and operational priorities in the context of your team's work plan. Beyond the boundary this could be anything that does not achieve those objectives.

In the second conversation, the manager's role is to actively listen, seek to understand and support the employee to meet their goals. The manager supports the employee by removing barriers that may obstruct their progress, identifies development opportunities not within the viewpoint of the employee and endorses protected time for them to meet their goal.

Capability Development Plans

All plans should use the 70-20-10 rule. This means approximately 70% of capability development should come from practise on the job, trial and error and self-reflection. The next 20% of development should occur through social or peer-to-peer learning approaches: learning with and through others in the form of mentoring, coaching, tapping into networks/streams and other collaborative and co-operative actions. Formal training, conferences and courses should comprise approximately 10% of the total time spent developing capability. This is because completion of training or a course does not mean that the employee will be able to demonstrate the capability. Acquired skills must be practised through on-the-job experience to solidify learning.



When writing capability development plans, staff and managers should discuss:

- 70%: What can be done through learning via practise, critical reflection and feedback? What challenging assignments can be undertaken? Where can the staff member get exposure to building capability?
- 20%: What developmental relationships can the staff member engage in, such as a mentor? What can be done through learning from another experienced individual (e.g. shadowing, coaching, observing and asking questions)?
- 10%: What requires formal training?

When writing the capability development plan, first identify what can be learned on the job and from peer-to-peer learning. This does not mean you are required to seek out opportunities only within your organisation. You have the whole of NSW Health to consider. Only seek out formal training, when the expertise needed for employee development exists beyond networks or there is a compelling reason to support team and organisational objectives.

Capability Development Activity Matrix

Below is a table with ideas for how to develop capability at each level. This list is not exhaustive but can be used to initiate conversations about potential capability building activities.

	Contribute to High Reliability	Manage Clinical Incidents and Risk	Manage Individual Factors that Influence Performance at Work	Uphold a Safety Culture	Utilise Improvement Methodologies	Utilise System Thinking
Foundational	Practise asking patients, families and/or carers about their care experience and how it can be improved Read about the Safety Fundamentals for Teams and participate in their use in your unit Seek feedback on your use of graded assertiveness techniques to communicate safety concerns Seek feedback on your use of structured and closed-loop communication during handover Ask to see your unit's safety and quality data and discuss how it informs your colleagues' and supervisor's decision-making to deliver reliable care	Find and read the unit's patient safety policies and practices Practise identifying and notifying clinical incidents, near-misses and environmental hazards that may affect patient safety Engage in discussions about clinical incidents, near-misses and environmental hazards that may affect patient safety in your unit Seek advice and reflect on escalating clinical incidents, near-misses and environmental hazards that may affect patient safety to your supervisor	Practise recognising and naming own and others' emotions during self-reflection Seek feedback and discussion on how positive and negative emotions impact on work performance and relationships Practise self-assessing if you are fit for work and communicating this to your direct supervisor	Practise asking questions, sharing ideas and concerns with others, and reporting incidents, and supporting others to do the same Engage in discussions with colleagues and supervisors to learn from mistakes, rather than assign blame Seek feedback from your supervisor on how you contributed to difficult conversations about clinical incidents Seek feedback on your ability to provide authentic support to patients, families, and carers after an incident Practise discussing what matters most to patients, families, and carers to understand what drives complaints Ask for feedback on whether you acknowledged the needs of staff involved	Participate in Foundations of Safety and Quality Ask your supervisor where to find more information about the improvement resources available Practise thinking about different possibilities as to how service delivery works Reflect on what changes to service delivery may make things better and safer Practise offering ideas on service delivery improvement Seek feedback on your level of responsibility for raising and fixing issues you encounter in you work where appropriate Request a colleague to show you the forms of improvement data management that exist in healthcare, such as QARS and QIDS Request to help collect data for a quality	Ask your supervisor about the unit's and service's purpose, design and models of care Reflect on how taking action to improve service delivery might impact patients, families, carers, and staff in your or other units or services Ask colleagues about how your service meets the needs of patients, families, carers and other staff and leaders Ask colleagues about how other services contribute to meeting the overall needs of your unit's patients, families, carers and other staff and leaders Reflect on your role in the patient journey and how your role affects the patient's overall health outcomes Seek advice about how to input patient information into

				in incidents and supported them where possible Practise clinician disclosure and identifying support for the patient, family, carer where possible	improvement project to understand how it informs decision-making Volunteer to participate in a quality improvement project	data systems for reference along the patient journey
Intermediate	Read about the characteristics of high-reliability organisations Practise identifying and self-reflecting on the markers of effective teamwork, which include effective communication, psychological safety to raise concerns and ask questions, and demonstration of respectful behaviour Practise assisting less experienced team members in asking patients, families and/or carers about their care experience and how it can be improved and seek feedback on your support Practise leading the Safety Fundamentals for Teams Practise leading the use of structured communication tools for handover and other significant communication processes. Practise using graded assertiveness in communication techniques to acknowledge others' safety concerns Volunteer to monitor safety and quality data over time	Participate in your organisation's patient safety capability development programs to understand the concepts, clinical incident review methodologies, and environmental hazard and clinical risk management methodologies Ask your supervisor to explain the legislation, regulatory processes, policies and insurance laws on incident reviews and clinical risk and environmental hazard management Practise supporting your unit or service to monitor and meet requirements regarding accreditation, legislation, regulatory processes, policies and insurance laws Volunteer to participate in unit or service-level clinical reviews following incidents of any type, as well as near-misses Volunteer to complete clinical risk and environmental hazard analyses requested of local work environment and seek feedback on performance	Participate in Readiness to Lead for Safety and Quality Seek feedback on your ability to adapt your emotions to ensure they do not negatively impact on work performance and relationships Practise discussing alternative perspectives with others and take an active interest in their concerns Read about cognitive bias and how it influences decision-making Reflect on how the way team members think (e.g. situational awareness and decision-making) and feel (e.g. stress and fatigue) impacts on patient safety Practise assessing if staff are fit for work (e.g. aware of staff illness, medication, fatigue, stress etc.) and seek feedback on your ability to care for them to prevent negative patient outcomes	Seek feedback on your ability to be a role model for psychological safety in your unit or service and how well you support others to do the same Practise assisting less experienced team members to provide authentic support to patients, families, and carers after an incident, and seek their feedback on your support Seek feedback on your performance of Open Disclosure following clinical incidents, and reflect on how you provided timely acknowledgement, and transparent and truthful communication Seek feedback on your participation in difficult conversations about clinical incidents and how that might impact organisational patient safety risks Seek feedback from others about how you supported them to seek to understand what matters most to patients, families, and carers and what drives complaints	Practise applying knowledge, skills and experience that you have gained from other contexts to inform new ideas for service delivery improvement Practise testing ideas to demonstrate their worth at making things better and safer Reflect on your confidence to push boundaries and take measured risks when appropriate to improve service delivery Ask about the resources available in your organisation on improvement methodologies and approaches Volunteer to participate in a quality improvement project	Reflect on the impacts of interactions between staff, teams and consumers within the context of your unit's and service's purpose, design, and models of care, and discuss this with colleagues or your supervisor Practise cultivating and maintain a network of relationships outside your unit, within the service or District/Network, and reflect on how you can utilise to achieve safety and quality improvement outcomes Practise connecting patients, families, carers or other staff and leaders with the support they need from other units or services where you work Seek feedback from patients, families, carers or other staff and leaders to see if they received the support they needed from other units or services where you work Reflect on how using all patient information from data systems helps you to provide safe and efficient care

	to ensure reliable care delivery			Practise empathising with staff involved in incidents, self-reflect on what you would need if you were in the situation, and ask for feedback on how you identified external support if needed		
Adept	Read about the science of Human Factors and its use in the design and evaluation of organisational activities and projects Participate in CEC capability development programs to learn about: • The elements of a safety culture • Safety I and Safety II • Work-as-imagined versus work-as-done • Efficiency-thoroughness trade-off • Hierarchy of Intervention Effectiveness Participate in CEC capability development programs to learn about the markers of effective teamwork to others, which include effective communication, psychological safety to raise concerns and ask questions, and demonstration of respectful behaviour Seek advice from your local patient safety experts about how to discuss the interaction of safety and	Practise applying patient safety concepts, clinical incident review methodologies, and clinical risk and environmental hazard methodologies in your unit or service Practise explaining to others about the legislation, regulatory processes, policies and insurance laws relevant to incident reviews and clinical risk and environmental hazard management. Seek feedback on your performance Volunteer to monitor requirements regarding accreditation, legislation, regulatory processes, policies and insurance laws in your unit or service to ensure they are met	Engage in development opportunities to enhance own Emotional Intelligence capability, such as enlisting a coach to build insight using a psychometrically valid and reliable measure of Emotional Intelligence Practise critical reflection on your own cognitive biases and how they influence decisions, behaviours and actions. Discuss your reflections with a coach or supervisor Seek feedback on your ability to role-model critical reflective practice and lead discussions about learning for improvement Practise coaching others to understand how team members' way of thinking (e.g. situational awareness and decision-making) and feeling (e.g. illness, medication, fatigue, stress etc.) impacts patient safety, and act accordingly to prevent negative outcomes. Seek their feedback on your performance	Participate in the Applied Program for Healthcare Safety and Quality Seek feedback on your ability to create a culture of psychological safety in your unit or service Practise leading reviews following clinical incidents and near-misses in a calm, logical and reflective manner so that others feel psychologically safe to contribute Seek feedback on your ability to ensure clinical reviews occur in an environment that encourages learning, openness, transparency, and accountability, rather than blame Seek feedback on your ability to ensure there is authentic and appropriate support provided to patients, families, and carers after an incident Practise assisting with and ensure others undertake Open Disclosure for clinical incidents. Seek coaching support from your local	Participate in the Applied Program for Healthcare Safety and Quality Lead a quality improvement project Participate in CEC capability development programs to learn about and apply the principles of Human-Centred Design to quality improvement projects Participate in CEC capability development programs to learn about and use tools for conducting systematic, proactive analysis of a process in which harm may occur, to predict and record where, how, and to what extent the system might fail, to learn how to prevent failures, especially those that are likely to occur or would cause severe harm to patients or staff Practise leading difficult conversations about improvement change ideas with teams Seek feedback on the structure you provide to	Create a project plan that identifies the potential • Ambiguities • Obstacles • Changing circumstances • Consequences in the service or District/Network and write suggestions on how each of those can be managed to ensure the goal is achieved Call on your network of relationships to understand the healthcare system, its parts and how it operates holistically, and reflect on how you have utilised them to achieve safety and quality improvement outcomes for your service and District/Network Seek advice from your local patient safety expert on how patient safety or work, health and safety practices might impact innovative ideas for improvement and vice versa Reflect on whether an innovative idea for improvement poses new risks or introduces new harms and discuss with your team

	efficiency with team members to identify risk and ensure reliability of service delivery Seek feedback from team members on whether they need support to understand how to ask patients, families and/or carers about their care experience and how it can be improved Seek feedback about the utility of the Safety Fundamentals for Teams in your unit or service Seek coaching from the dedicated experts in safety and quality data systems in your organisation on how to use them effectively to ensure your unit or service is reliably delivering care			patient safety expert when needed Seek feedback on your ability to facilitate difficult conversations with staff about clinical incidents and how that might impact organisational patient safety risks Seek feedback on your ability to lead the team to want to understand what matters most to patients, families, and carers and what drives complaints Seek feedback on your ability to coach others on how to support staff involved in incidents and how to access support where possible Seek feedback on your ability to check in with staff who have been involved in incidents, regarding ongoing need for support	support improvement initiatives Seek feedback and reflect on your ability to remove barriers to change for improvement Practise critiquing improvement work as it relates to the organisation's strategic and operational plans and outcomes Seek feedback on your ability to lead the spread of quality improvement initiatives. Seek coaching support from your local quality improvement expert to understand and apply evidence-based change management methods for service delivery improvement Reflect on the appropriate diversity within your multidisciplinary quality improvement team (e.g. consumers, experts, etc.) Seek feedback on your ability to provide guidance to others, including how to access resources	Practise using review and analysis tools to learn about the causes of and contributing factors to how incidents occur in a complex system. Seek advice from your local patient safety expert when needed Practise leading discussions about how your team contributes to and references accurate and timely patient information
Advanced	Participate in the CEC Safety and Quality Fellowship program Shadow or seek mentorship from a member of the Clinical Governance Unit, or other relevant safety and quality organisational support team Request a secondment to the Clinical Governance Unit, or other relevant safety and quality organisational support team, to learn about their work					

Highly Advanced	Request a secondment to the Clinical Excellence Commission to learn about statewide safety and quality leadership Shadow or seek mentorship from a member of the Senior Executive to learn about how to drive the organisational safety and quality agenda Undertake higher-degree study or research in Safety Management, Human Factors, Health Management, Consumer Engagement or Organisational Psychology to develop expertise in healthcare safety management, Human Factors design and analysis methods, valuable consumer-driven improvement, psychologically safe cultures, organisational learning, change management, human behaviour in the healthcare workplace, etc.

Glossary

Clinician Disclosure	Incident disclosure within 24 hours to a patient, carer or family by the treating clinician/team or staff member.
Cognitive bias	A cognitive bias is a systematic error in thinking that occurs when people are processing and interpreting information in the world around them and affects the decisions and judgments that they make. Cognitive biases are often a result of your brain's attempt to simplify information processing. Biases often work as rules of thumb that help you make sense of the world and reach decisions with relative speed.
CUSS	CUSS Tool - Improving Communication and Teamwork I am Concerned! I am Uncomfortable! This is a Safety Issue! Stop!
Emotional intelligence	Emotional Intelligence is the ability to identify and manage one's own emotions, as well as the emotions of others Includes three skills: • The ability to identify and name one's own emotions • The ability to manage emotions, which includes both regulating one's own emotions and influencing those of others • The ability to harness those emotions and apply them to tasks like thinking and problem solving
Environmental hazard	A source or situation with a potential for harm in terms of human injury or ill health, damage to property, damage to the environment or a combination of these.
Family of Measures	A series of areas of measurement to monitor the impact of quality improvement work: • Outcome - How does the system impact the values of patients, their health and wellbeing? What are the impacts on other stakeholders such as leaders, employees, or the community? • Process - Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system? • Balancing - Looking at a system from different directions/dimensions, are changes designed to improve one part of the system causing new problems in other parts of the system?
Harm	Patient harm is any unintended and unnecessary harm resulting from, or contributed to, by health care. This includes the *absence* of indicated medical treatment. Harm may include staff (workers), visitors and family (relatives) or damage to property or the environment. A score from 1 to 4 applied to clinical and corporate incidents based on the outcome and additional treatment and/or resources required.
Human-Centred Design	Human-centred design is an approach to interactive systems development that aims to make systems usable and useful by focusing on the users, their needs

	and requirements, and by applying human factors/ergonomics, and usability knowledge and techniques. This approach enhances effectiveness and efficiency, improves human well-being, user satisfaction, accessibility and sustainability; and counteracts possible adverse effects of use on human health, safety and performance. ISO 9241-210:2019(E)
Human Factors	Also known as Ergonomics, Human Factors is a scientific discipline focused on understanding the cognitive, emotional, social and physical interactions between people and their environments.
Incident	A clinical incident is any unplanned event which causes, or has the potential to cause, harm to a patient. NSW Health staff are required to report all incidents (both clinical and corporate), near-misses, and complaints so that risks to patient safety are recognised and action is taken to prevent recurrence.
Incident management	Actions and processes for immediate and ongoing activities following an incident. Review is part of incident management.
Incident review	A structured process to identify what happened; how and why it happened; what could be done to reduce risk and make care safer; and what was learned.

ISBAR	ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information. The CEC recommends the use of ISBAR as a communication tool for clinical handover.
	• Identify
	  o Who you are and what is your role?
	  o Patient identifiers (at least 3)
	• Situation
	  o What is going on with the patient?
	• Background
	  o What is the clinical background/context?
	• Assessment
	  o What do you think the problem is?
	• Recommendation
	  o What would you recommend?
	  o Risks - patient/occupational health and safety?
	  o Assign and accept responsibility/accountability

Near-miss	An incident that could have caused harm but did not or an incident that was intercepted before causing harm.
Open Disclosure	Ongoing communication process with a patient, carer or family about an incident and its management. Formal open disclosure involves multidisciplinary discussion/s with the patient, carer or family and senior clinical leaders and/or hospital executive.
PACE	Psychosocial Assessment and Communication Evaluation (PACE) is an intervention tool to improve communication between healthcare workers, patients, families and carers.

Psychological safety	Psychological safety is a shared belief that the team is safe for interpersonal risk taking or "being able to show and employ one's self without fear of negative consequences of self-image, status or career". Teams need psychological safety to perform, as healthcare work requires team members to communicate, ask questions and share ideas and concerns with colleagues in a multidisciplinary setting. If psychological safety is compromised, then conversations about patient care, patient safety and quality improvement can be stifled and engagement decreased.
Risk	Risk is the chance that any activity or action could happen and harm another person or group of people.
Safety I	A traditional approach to safety management with a focus on learning from clinical incidents or what went wrong and often uses a cause and effect methodology.
Safety II	An understanding of safety management with a focus on positive outcomes including understanding of systems that support good outcomes despite high complexity. An understanding of what went right and why.
Safety Culture	A culture of physical and psychological safety for staff and patients, families and carers. The culture is informed by how the organisation does the following things: • High-trust: staff and leaders demonstrate trustworthy behaviour (honesty, openness, consistency, dependability, respect, vulnerability) and have strong interpersonal work relationships, which enable psychological safety in discussions about harm, error and near-misses • Informed: organisations collect, analyse and learn from a range of data (health outcomes, harm outcomes, reliability in service delivery, staff experience indicators, consumer experience indicators) about the organisation's performance and compare this with best practice • Reporting: staff report safety and quality problems and feel safe to do so • Just: staff are treated fairly • Learning: organisations learn from mistakes and make improvements to the processes of care • Flexible: organisations adapt/make requisite changes to operations after an incident or near-miss • Restorative: organisations and staff aim to repair trust and relationships damaged after an incident, and allow all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm • Leadership is central to safety culture: o The highest standards leaders can expect from those they seek to influence are the lowest they exhibit themselves. o By ignoring low standards leaders are approving them - they are communicating the message that low standards are acceptable. o Leadership is the communication of the actions and standards they expect by words, deeds and silence.
Systems thinking	Systems thinking refers to the interacting dynamics between self, team, environment and patient and how they work together to contribute to outcomes. It is based on the concept that a system, not any one individual, is responsible for both good and bad outcomes. A system's function is more than the sum of its parts (of which people are just one part) and is the product of its interactions.

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