Government of **Western Australia**
Department of **Health**

Healthcare Safety and Quality Capabilities Framework

An Occupation-Specific Set for Healthcare Workers in WA Health

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Foreword

West Australians benefit from a strong and robust health system with a WA Health workforce who are dedicated, compassionate and highly skilled. Our staff already deliver safe, high quality healthcare whilst working in a complex, dynamic and demanding environment.

From these foundations, WA Health is continuing to build a systemwide safety culture based on courage, innovation and reliability. To achieve this, we are strengthening the Safety and Quality (S&Q) capabilities of our workforce, to deliver exceptional health care.

This WA Health Healthcare S&Q Capabilities Framework (known as the Framework) comprises six capabilities which will enable our WA Health workforce to further develop their knowledge, skills and behaviours at each level of the organisation. These S&Q capabilities include:

1. Contributing to becoming a high reliability organisation
2. Managing clinical incidents and risk effectively
3. Understanding and managing individual factors that influence how we perform our work
4. Upholding a safety culture in our workplaces
5. Utilising improvement methodologies to identify better, safer ways to deliver healthcare
6. Utilising a system thinking approach to our work.

The benefits of embedding Healthcare S&Q Capabilities will assist the WA Health workforce in:

- Managing, minimising and preventing errors whilst delivering safe, quality patient care.
- Further embedding a strong safety culture across our organisation
- Anticipating problems before they occur
- Developing an organisation that has a strong learning orientation
- Developing our staff to become mindful, compassionate leaders
- Establishing the practice of mindful management which employs a balanced and considered approach to safety.

This Healthcare S&Q Capabilities Framework describes the capabilities and behaviours that are expected of all WA Health employees, leaders and board members to engage in safety management and quality improvement practices that deliver safe, reliable care. Furthermore, strong workforce capabilities will also facilitate WA Health to recruit and develop our staff by acknowledging, supporting and guiding them to achieve their career potential.

WA Health is very excited to release this Healthcare S&Q Capabilities Framework which was developed by the NSW Clinical Excellence Commission (CEC) where it has been used by NSW Health for over seven years.

We sincerely acknowledge and thank the CEC for granting WA Health permission to use the *CEC Healthcare Safety and Quality Capabilities: An Occupation-Specific Set for Healthcare Workers in NSW Health, Sydney (2021)* document.

Dr David Russell-Weisz

Director General

Department of Health Western Australia

October 2023

Safety & Quality Capabilities in WA Health

Workforce culture and strong S&Q capabilities are important pillars of safe effective health care. Together, these support a positive staff experience and safety culture to ensure that patients receive safe, quality care every time.

Developing and embedding organisational S&Q and system capabilities into health care delivery, will assist Health Service Providers (HSPs):

- In the delivery of high quality healthcare and improved patient outcomes.
- In becoming a High Reliability Organisation (HRO) which is capable of managing, preventing and minimising errors whilst delivering safe patient care in a complex and dynamic health care environment.
- With evidence of their organisational S&Q maturity in relation to patient safety capabilities and the embedding of patient safety across all levels of the organisation.
- With evidence to assist in the development of the HSP's strategic goals and priorities.

Following a review of national and international literature, the S&Q Capabilities Program developed by the NSW CEC (2021) was identified as being most robust, reliable and reproducible for the WA Health context. The goal of the NSW Healthcare Safety and Quality Capabilities was to translate key healthcare safety and quality improvement concepts into a common language and format that could be used in human resources and organisational development processes. This model was endorsed by the Sustainable Health Review (SHR) Recommendation 23 Advisory Group (RAG) for state-wide implementation.

The ensuing WA S&Q Capabilities Framework thus adapts the CEC's S&Q Capabilities Program for WA's local context and processes, to describe the key patient safety and quality improvement knowledge, skills, abilities and behaviours needed by staff across all organisational levels.

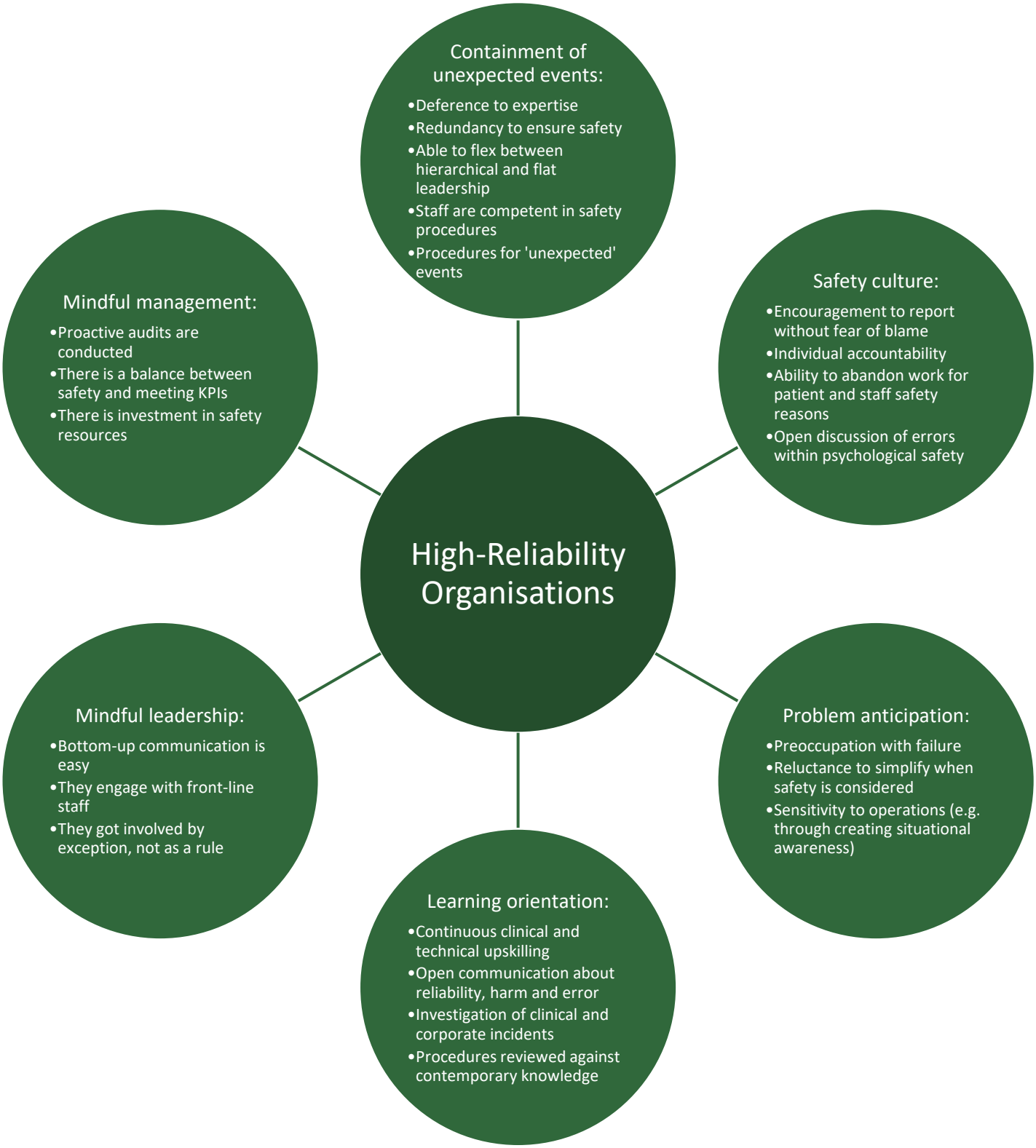
Understanding High-Reliability Organisations

Healthcare organisations have learnt to improve safety from processes used by high-reliability industries such as aviation, nuclear, gas and oil. A HRO is recognised for the ability to operate with minimal errors even in challenging, dynamic, and complex environments. The literature identifies that while all humans make mistakes there are some errors that are predictable and therefore if lessons are learned, risks can be mitigated and these errors can be better managed or prevented.

There are several key characteristics of HROs that need to be adopted if organisations are to achieve ongoing high reliability and safety performance. The key characteristics include:

- Containment of unexpected events/clinical incidents
- A strong safety culture
- Problem anticipation
- Learning orientation
- Mindful leadership
- Mindful management (see Figure 1).

Figure 1: High Reliability Organisations' key characteristics



Introduction to the Healthcare Safety and Quality Capabilities Framework

The intended use of the WA Healthcare Safety and Quality Capabilities Framework is to guide HSPs and the Department at an organisational level, on improving safety and quality capability development. Most WA Health employees 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 WA Healthcare S&Q Capabilities are an occupation-specific capability set for WA Health employees. It is important to recognise that many capabilities relevant to S&Q can also be found in the WA Public Sector Commission (PSC) Public Sector Capability Profiles (2020), which describes the capabilities and behaviours that are expected of all WA public sector employees, at every level and in every organisation. Specifically, the WA PSC Capability Profiles cover the following five key areas and includes 4-5 behavioural capabilities for each area:

- Shapes and manages strategy
- Achieves results
- Builds productive relationships
- Exemplifies personal integrity and self-awareness
- Communicates and influences effectively.

The WA Health S&Q Capabilities Framework comprise of 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.

How to read the Healthcare Safety and Quality Capabilities

This Framework outlines the capability definitions and behaviour indicators by level. 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 capabilities at a different level to the Executive Director of Medical Services due to the differences in the complexity of their roles.

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

It is acknowledged that this Framework should be read in conjunction with other frameworks/Policies such as the:

- WA Clinical Governance, Safety and Quality Policy Framework
- WA Aboriginal Health and Wellbeing Framework
- Work Health and Safety Policy Framework.

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	Intermediate	Adept	Advanced	Highly Advanced
Employ techniques for efficient communication and teamwork, e.g. safety huddles, multidisciplinary team rounds, morbidity and mortality reviews Employ techniques to communicate safety concerns assertively, e.g. ISoBAR, Speaking up for Safety. Employ techniques to share information and transfer knowledge that ensures the communicator knows they have been heard and understood, e.g. ISoBAR 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	Understand the characteristics of high reliability organisations and how they apply in healthcare organisations Lead the use of safety huddles, multidisciplinary team rounds, or morbidity and mortality reviews 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	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 team strategies for effective communication, e.g. safety huddles, multidisciplinary team rounds, morbidity and mortality reviews Monitor and use safety and quality data over time to ensure reliable service delivery in your unit or service	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	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	Intermediate	Adept	Advanced	Highly Advanced
Follow WA Health patient safety policies and practices Take responsibility for own actions when error and harm has occurred and communicate where appropriate Identify and notify clinical incidents and near-misses into the Clinical Incident Management database Identify and notify environmental hazards as per local endorsed processes Escalate clinical incidents, near-misses and environmental hazards to the appropriate manager Participate in team learning activities about clinical incidents, near-misses and environmental hazards and closing the loop outcomes	Support your unit, ward or service to monitor requirements regarding the organisation's safety and quality accreditation process and other safety assurance activities Participate in unit, ward or service level incident reviews Complete clinical risk and environmental hazard analyses requested of work environment in a professional manner	Understand and comply with legislation and regulatory processes and policies relevant to incident reviews and clinical risk management to the team Lead unit, ward or service level clinical incident reviews Effectively monitors and meets requirements regarding the organisation's safety and quality accreditation process and other safety assurance activities Track unit, ward or service-level clinical risk and environmental hazard analyses and recommendations	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	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

Recognition and Management of 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	Intermediate	Adept	Advanced	Highly Advanced
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	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	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	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	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	Intermediate	Adept	Advanced	Highly Advanced
Contribute to a safety culture by asking questions, sharing ideas and concerns, and reporting clinical incidents or other potential issues/problems Actively learn from mistakes, rather than assign blame Provide authentic support to patients, families, carers, or other staff after an incident or when concerns are raised 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 clinical incidents Undertake Open Disclosure process following clinical incidents, including an apology as soon as is practicable	Ensure to role-model psychological safety in your unit or service by actively speaking up at any time 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 clinical incidents Assist less experienced team members to discuss what matters most with patients, families, carers, and customers to understand what drives complaints Offer physical and/or psychological wellbeing support to staff involved in clinical incidents	Recognise and reward staff for speaking up about safety and supporting others to do the same Lead reviews following clinical incidents and near-misses in a calm, logical, reflective and just 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, ward 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 clinical incidents and where to access organisational physical and psychological wellbeing resources Follow up with staff who have been involved in clinical incidents regarding ongoing need for support	Recognise and reward units and services for engaging in learning practices, speaking up when there is a safety concern, and reporting and reviewing their clinical 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 Utilise ‘just culture principles’ to ensure no blame is placed on staff in incident reviews without proof of negligence of the offence Design and implement system improvement, processes and resources that support a staff safety culture, and that support patients, families and carers who have been involved in clinical incidents	Collaborate with the Senior Executive to ensure there are resources and processes to embed 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 clinical incidents

Utilise Improvement Methodologies

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

Foundational	Intermediate	Adept	Advanced	Highly Advanced
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	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	Apply quality improvement methods and tools to suit the context of the improvement needed Understand the need for appropriate diversity in quality improvement teams Support and provide guidance on quality improvement to others in your unit or service Understand the importance of a range 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 and removal of barriers with teams 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	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	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 behaviours over time, and to use that information to contribute to change for safety and quality.

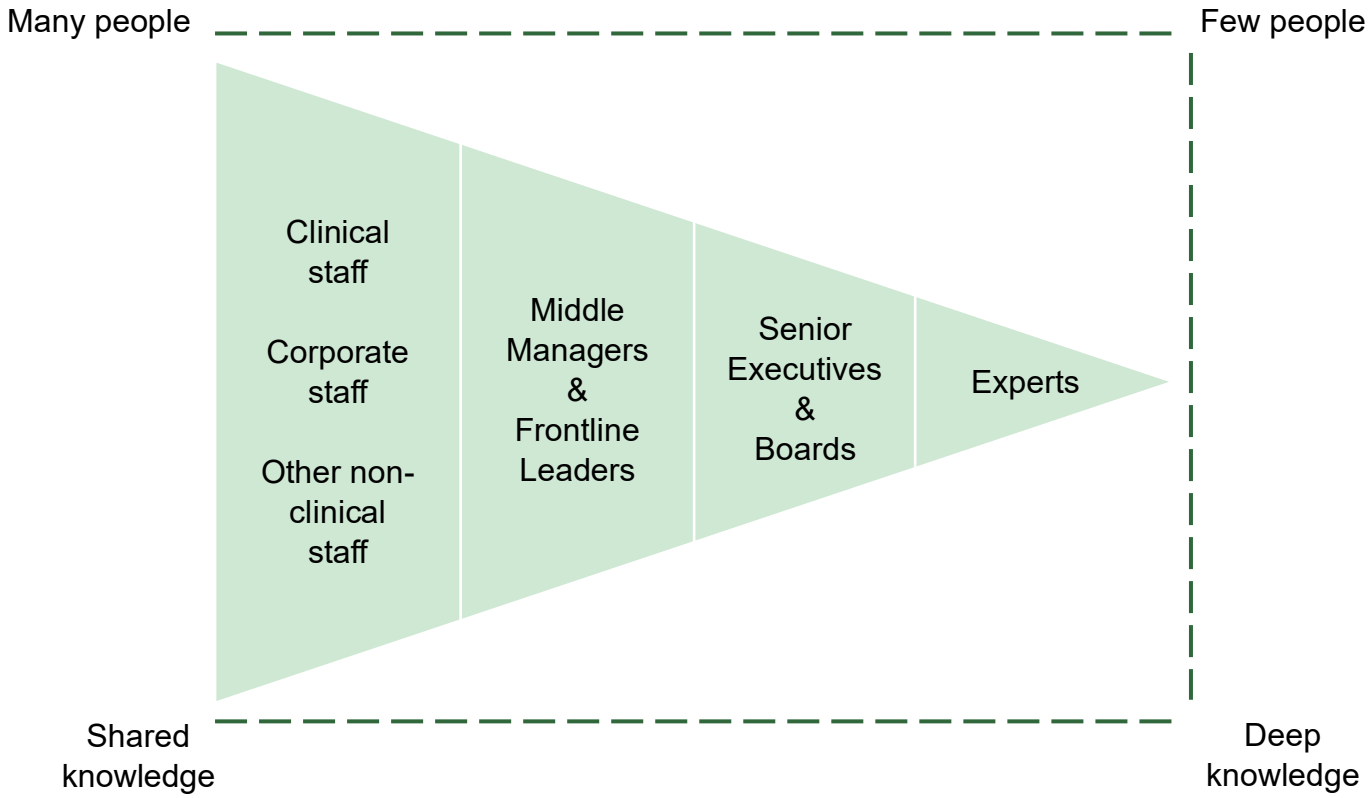
Foundational	Intermediate	Adept	Advanced	Highly Advanced
Understand the unit's, ward's and service's purpose, design and models of care Understand how taking action to improve service delivery might impact patients, families, carers, and staff in your or other units, wards or services Recognise your 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, ward 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	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 level or Health Service, 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	Identify patient safety or work, health and safety practices that might impact innovative ideas for improvement and vice versa Determine and articulate approaches to achieve goals that consider: • Ambiguities • Obstacles • Resources • Changing circumstances • Consequences in the service level or Health Service 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 level or Health Service 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	Build decision networks and navigate politics to achieve outcomes that account for: • Ambiguities • Obstacles • Changing circumstances • Consequences at the service level or at Health Service level 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	Be able to consider situations, challenges or ideas regarding safety and quality in the widest context relevant to WA 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 Framework has outlined the capabilities needed across the WA 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 capabilities 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?

Figure 2: Capability across the organisation



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.

Senior Executives

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.

Experts

Experts are those 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 found in Clinical Governance or Safety and Quality 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.

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 WA Health workforce, which includes clinical and non-clinical employees alike. It is expected that all WA 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.

Capability Expectations

The following section is intended to support consistency in capability expectations across WA Health.

Stakeholder	Capability	Level
WA Health Employees New WA Health employees should engage in activities to build their capability to the Foundational level during onboarding processes. Health organisations should commit to developing all staff to the minimum Foundational level.	Contribute to High Reliability	Foundational to Intermediate
	Manage Clinical Incidents and Risk	Foundational to Intermediate
	Manage Individual Factors that Influence Performance at Work	Foundational to Intermediate
	Uphold a Safety Culture	Foundational to Intermediate
	Utilise Improvement Methodologies	Foundational to Intermediate
	Utilise System Thinking	Foundational to Intermediate
Middle Managers and Frontline Leaders Managers and Frontline Leaders ideally should be at a minimum Adept. However, building capability to Highly Advanced is helpful to drive the safety and quality agenda *Not every Manager and Leader needs to be 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
Safety and Quality Expert	Contribute to High Reliability	Adept to Advanced
	Manage Clinical Incidents and Risk	Adept to Advanced
	Manage Individual Factors that Influence Performance at Work	Adept to Advanced
	Uphold a Safety Culture	Adept to Advanced
	Utilise Improvement Methodologies	Adept to Advanced
	Utilise System Thinking	Adept to Advanced

Capability Expectations (continued)

The following section is intended to support consistency in capability expectations across WA Health.

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

Capability Expectations (continued)

The following section is intended to support consistency in capability expectations across WA Health.

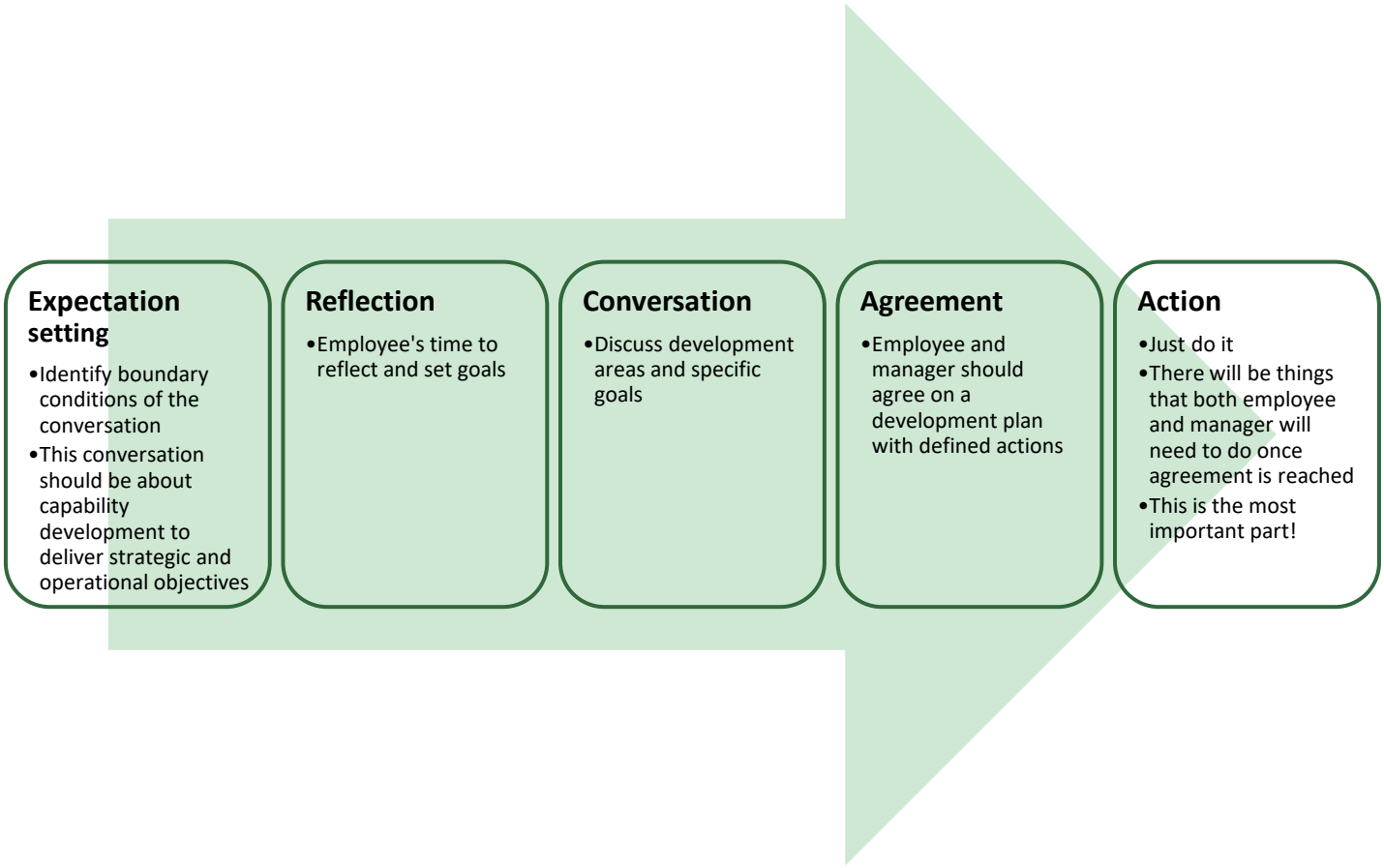
Stakeholder	Capability	Level
Director Safety and Quality Strategic and operational leadership for safety and quality. *Includes Director Clinical Governance, or relevant senior safety and quality executive role.	Contribute to High Reliability	Adept to Advanced
	Manage Clinical Incidents and Risk	Adept to Highly Advanced
	Manage Individual Factors that Influence Performance at Work	Adept to Advanced
	Uphold a Safety Culture	Adept to Advanced
	Utilise Improvement Methodologies	Adept to Advanced
	Utilise System Thinking	Adept to Advanced
Executive Director Safety and Quality Where there is a range, Senior Executive ideally should be at a minimum Adept. However, building capability to Highly Advanced is helpful to drive the safety and quality agenda. *Not every Senior Executive needs to be Advanced across each capability.	Contribute to High Reliability	Adept to Advanced
	Manage Clinical Incidents and Risk	Adept to Advanced
	Manage Individual Factors that Influence Performance at Work	Advanced
	Uphold a Safety Culture	Advanced
	Utilise Improvement Methodologies	Adept to Advanced
	Utilise System Thinking	Adept to Advanced
Board Board members ideally should be at a minimum Adept to be good stewards of the organisation's safety and quality agenda. *Some behavioural indicators will not be relevant to all Board members, as they are not frontline healthcare workers.	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

How to Develop the Healthcare Safety and Quality Capabilities

There is no right way to engage in capability development (See Capability Development Plan section). 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 following five steps (see Figure 3).

Figure 3: The Capability Development Discussion



What are the roles?

Employee

Employees are responsible for their development journey, which 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 Framework
- 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

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.

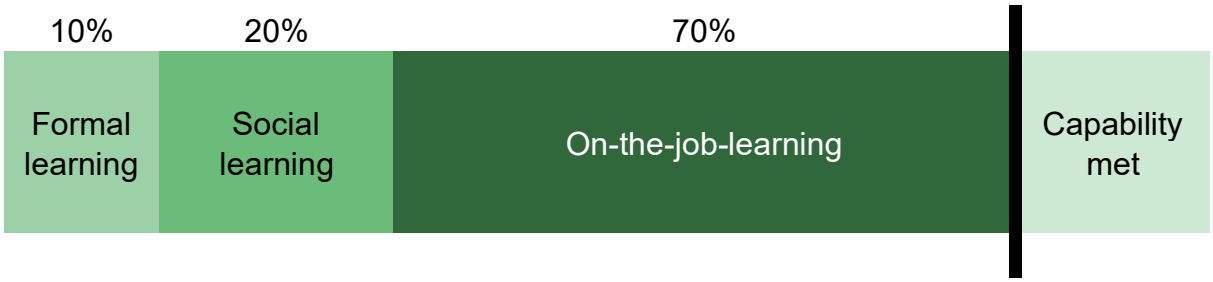
In the second conversation, the manager's role is to actively listen, seek to understand and support the employee to meet their goals. The manager supports the employee by removing barriers that may obstruct their progress, identifies development opportunities not within the viewpoint of the employee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

Figure 4: The 70-20-10 Rule



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 or WA Health. 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: Contribute to High Reliability

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.

Foundational	Intermediate	Adept
Practise asking patients, families and/or carers about their care experience and how it can be improved Participate in safety huddles, multidisciplinary team rounds, and morbidity and mortality reviews within your unit, ward or service Seek feedback on your use of techniques to communicate safety concerns Seek feedback on your use of structured and closed-loop communication during handover Ask to see your unit's ward's or service's safety and quality data and discuss how it informs your colleagues' and supervisor's decision- making to deliver reliable care	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 safety huddles, multidisciplinary team rounds, and morbidity and mortality reviews Practise leading the use of structured communication tools for handover and other significant communication processes. Practise communication techniques to address safety concerns (e.g. CUSS) Volunteer to monitor safety and quality data over time to ensure reliable care delivery	Read about the science of Human Factors and its use in the design and evaluation of organisational activities and projects Participate in your local service's education 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 IHL or your local service's education 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 Ask your local safety and quality experts about how to discuss the interaction of safety and efficiency with your team 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 huddles, multidisciplinary team rounds, and morbidity and mortality reviews in your unit, ward 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, ward or service is reliably delivering care

Capability Development: Manage Clinical Incidents and Risk

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.

Foundational	Intermediate	Adept
Find and read the unit's, ward's or service'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	Participate in your local health service's clinical incident management education and training programs to understand the concepts, clinical incident review methodologies, and environmental hazard and clinical risk management methodologies Discuss with your supervisor legislation, regulatory processes, policies on clinical incident, clinical risk and environmental hazard management Practise supporting your unit or service to monitor and meet requirements regarding accreditation, legislation, regulatory processes, policies Volunteer to participate in unit or service-level clinical reviews following clinical 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	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 relevant to clinical incident reviews, clinical risk and environmental hazard management. Seek feedback on your performance Volunteer to monitor requirements regarding accreditation, legislation, regulatory processes, policies in your unit or service to ensure they are met

Capability Development: Manage Individual Factors that Influence Performance at Work

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.

Foundational	Intermediate	Adept
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 Keep up to date with mandatory education and other learning opportunities to ensure the provision of safe, quality and equitable healthcare	Participate in the Readiness to Lead for Safety and Quality eLearning course 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 Keep up to date with mandatory education and other learning opportunities to ensure the provision of safe, quality and equitable healthcare	Engage in development opportunities to enhance own emotional intelligence capability e.g. read articles about emotional intelligence or find suitable courses. Practise critical reflection on your own cognitive biases and how they influence decisions, behaviours and actions. Discuss your reflections with a mentor 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 Keep up to date with mandatory education and other learning opportunities to ensure the provision of safe, quality and equitable healthcare

Capability Development: Uphold a Safety Culture

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.

Foundational	Intermediate	Adept
Practise asking questions, sharing ideas and concerns with others, and reporting clinical 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 acknowledge the needs of staff involved in clinical incidents and supported them where possible Practise Open Disclosure and identifying support for the patient, family, carer where possible	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 Practice empathising with staff involved in clinical 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	Participate in IHL education programs and masterclasses 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 incident 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 safety and quality 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 clinical incidents and how to access support where possible Seek feedback on your ability to check in with staff who have been involved in clinical incidents, regarding ongoing need for support

Capability Development: Utilise Improvement Methodologies

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.

Foundational	Intermediate	Adept
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 dashboards or clinical registries Request to help collect data for a QI project to understand how it informs decision making Volunteer to participate in a QI project	Participate in the Introduction to Improvement Science eLearning course 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	Participate in your local service's quality improvement education programs Lead a QI project in your area Participate in your local service's education programs to learn about quality improvement projects Participate in your local service's education 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 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

Capability Development: Utilise Systems Thinking

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.

Foundational	Intermediate	Adept
Participate in the Foundations of Safety and Quality eLearning course Ask your supervisor about the unit's, ward's or 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 Health 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 data systems for reference along the patient journey	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, ward, service or Health Service, 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	Create a project plan that identifies the potential • Ambiguities • Obstacles • Changing circumstances • Consequences in the service and Health Service 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 reflects on how you have utilised them to achieve safety and quality improvement outcomes for your service and Health Service Seek advice from your local safety and quality 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 Practise using review and analysis tools to learn about the causes of and contributing factors to how clinical incidents occur in a complex system. Seek advice from your local safety and quality expert when needed Practise leading discussions about how your team contributes to and references accurate and timely patient information

Capability Development: Advanced to Highly Advanced

Advanced

Shadow or seek mentorship from a member of the Clinical Governance or Safety & Quality units, or other relevant safety and quality organisational support team. Request a secondment to these units or other relevant safety and quality organisational support teams, to learn about their work.

Highly Advanced

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, Healthcare Redesign, 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

Clinical Incident	An event or circumstance resulting from health care provision which could have or did lead to unintended or unnecessary harm to a patient. Clinical incidents include: • Near miss: an incident that may have, but did not cause harm, either by chance or through timely intervention. • Sentinel events: a subset of serious clinical incidents that has caused or could have caused serious harm or death of a patient. It refers to preventable occurrences involving physical or psychological injury, or risk thereof.
Clinical Incident Management	The process of effectively managing clinical incidents with a view to minimising preventable harm.
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 is a technique that uses a graded assertiveness approach to communicating. Should someone be concerned with a process or intervention being put in place, they can: 1. Raise their **Concerns**, getting more assertive if their concerns aren't listened to. 2. State why you are **Uncomfortable** 3. State that this is a **Safety** issue. 4. **Stop** and take time out to discuss the situation.
Efficiency of Thoroughness Trade Off	The efficiency–thoroughness trade-off principle proposes that it is rarely possible for people and organisations to be both efficient and thorough. There is a trade-off between being efficient (consuming less time and resources) and being thorough (performing tasks at a suitable standard).
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.
High Reliability Organisation	High Reliability Organisation capable of managing and sustaining a near error free performance, delivered in a complex and dynamic health care environment.
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.
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.
Measures	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?
Open Disclosure	Open disclosure is the open discussion of an incident that results in harm (or might have resulted in future harm) to a patient while receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence.
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/concerns with colleagues in a multidisciplinary setting. If psychological safety is compromised, then conversations about patient care safety and quality improvement can be stifled and engagement decreased.

Quality Care	The World Health Organisation define quality care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge and implies that quality of care can be measured and continuously improved through the provision of evidence-based care”. Quality health services should be: • **Effective:** by providing evidence-based health care services to those in need • **Safe:** by avoiding harm to the people for whom the care is intended • **People-centred:** by providing care that responds to individual preferences, needs and values • **Timely:** by reducing waiting times and sometimes harmful delays for both those who receive and those who give care • **Equitable:** by providing the same quality of care regardless of age, sex, gender, race, ethnicity, geographic location, religion, socio-economic status, linguistic or political affiliation • **Integrated:** by providing coordinated care across levels/providers and makes available the full range of health services throughout the life course; and • **Efficient:** by maximizing the benefit of available resources and avoiding waste.
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:
	  ○ The highest standards leaders can expect from those they seek to influence are the lowest they exhibit themselves.
	  ○ By ignoring low standards leaders are approving them - they are communicating the message that low standards are acceptable.
	  ○ Leadership is the communication of the actions and standards they expect by words, deeds and silence.

Situational Awareness	Situational Awareness literally means knowing what's going on around you. Situational Awareness compromises of three stages in order: 1. **Perception:** of what's happening around us, using all of our senses 2. **Comprehension:** an understanding of those elements and their significance 3. **Projection:** being able to project future actions based on what we have perceived.
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.
Work-As-Imagined	Refers to the way in which work activities should be performed and reflects the desired standards.

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- Clinical Incident Management Policy
- Clinical Incident Management Guidelines
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- Work Health and Safety Policy
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