



COMPASSIONATE

What?	Why?	How?
<ul style="list-style-type: none"> Engage meaningfully with those affected by patient safety incidents: <ul style="list-style-type: none"> Answer questions. Address concerns. Involve those affected in any learning response. 	<ul style="list-style-type: none"> Moral imperative to ↓ potential for compounded harm (which patients, families or staff can experience when patient safety investigations are handled in closed or defensive ways). Important to improve understanding of what happened. 	<ul style="list-style-type: none"> Consider the needs of patients, relatives and staff. Design systems and processes to ensure engagement efforts meet the needs of those affected. Duty of candour outlines requirements for openness, transparency, and candour.

SYSTEMS BASED

What?	Why?	How?
<ul style="list-style-type: none"> Looking beyond the decisions and actions of individuals. Consider wider system and complex interactions. These might include imbalanced/insufficient staffing levels, inefficient technology and outside factors e.g. lack of social care. 	<ul style="list-style-type: none"> Supports a just culture of learning. Allows meaningful insights, to inform improvements. Staff are more likely to be honest about events if they know they will be treated fairly, with consideration of outside factors. 	<ul style="list-style-type: none"> Understand how work is normally done in that department. Understand the context and what systems issues have been highlighted by the patient safety incident.

PROPORTIONATE

What?	Why?	How?
<ul style="list-style-type: none"> Not all incidents need a learning response. Focus responses on areas where there is most potential for learning and improvement. 	<ul style="list-style-type: none"> Maximise opportunities for improvement. Focus on quality not quantity: aim for good quality learning responses with effective, sustained improvement. 	<ul style="list-style-type: none"> Align responses with local/system patient safety priorities. Focus responses to safety events where there is most potential for new learning.

SUPPORTED

What?	Why?	How?
<ul style="list-style-type: none"> Focus on enabling improvement and collaboration. Enable a just culture; be clear that regulators will only be involved if clearly needed for safety purposes. Organisations are accountable for high quality learning responses to drive safety improvement. 	<ul style="list-style-type: none"> Shared learning is better when relationships are supportive. Bureaucratic/transactional approaches to safety take time and resources away from improvement activity. Leaders and regulators influence others' values; those who are supported as resident doctors will be supportive consultants and leaders in the future. 	<ul style="list-style-type: none"> Focus on engagement and empowerment to learn and improve. Avoid top down, punitive, performance management. Action singling out an individual is rarely appropriate. Learning responses would only be used to hold individuals or organisations to account where there is a clear intent to harm.