Health and Social Care

The Regulation and Quality Improvement Authority

A Framework for Safety Culture within Health and Social Care in Northern Ireland

Summary Guide
Patients, Families and the Public

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Welcome to this guide

What is the Being Human Framework?

The Being Human Framework is about treating people as human beings first, rather than just relying on processes and systems. It places people's safety and experience at the heart of health and social care.

The Framework recognises that people do best when:

- Their needs are met
- They are treated with kindness, respect and understanding
- They feel listened to and valued
- They experience real human connection.

Why was the Framework developed?

The Framework's person-centred approach moves away from a 'one-size-fits-all' way of delivering services. It was informed by patients and families with lived experience who co-produced the Framework with HSC staff and partners.[1]

It was developed in response to past failures where care did not go according to plan, and poor safety culture played a part in people experiencing harm. The Framework recognises that people are human, and mistakes can happen.

Who is this guide for?

A series of guides has been created for different audiences to ensure the Framework is shared and used by everyone.

This guide is for patients, families and the public who access health and social care services.

Why does safety culture matter?

Culture is about the shared values, attitudes, and behaviours that shape how the health and social care system works and treats people.

The aim of the Being Human Framework is for a strong, safe, and caring culture to be the norm for everyone, not the exception.

A successful change in the culture will help deliver real improvements in patient safety and overall outcomes.

[1] Co-production means services are shaped together by professionals, carers, and people with lived experience, who are recognised as having valuable expertise and insights that should be part of the process.

About this guide

This guide explains the Being Human Framework so that you:

- Understand what a good safety culture looks and feels like
- Know what you should expect in the following three areas:

1: Commitment to patient safety and staff wellbeing

2: Compassion, civility and respect

3: Curiosity and constructive challenge

What is a good safety culture?

Our values of **Teamwork - Openness and Honesty – Compassion – Excellence -** informed the Framework's vision of what a good safety culture looks like:

Safe and compassionate

- ✓ Patients and families are listened to with kindness, respect and understanding
- ✓ Patients are treated as partners in decision-making
- ✓ Leaders encourage and value staff input
- ✓ Everyone feels comfortable raising concerns about safety or potential risks

Just and open

- ✓ Patients and families get early support and honest information when mistakes happen
- ✓ Harm is acknowledged and apologised for
- ✓ Staff are treated fairly if they raise concerns
- ✓ Leaders take responsibility for system failures

Continually learning and improving

- ✓ Mistakes are opportunities for learning, rather than blame
- ✓ Everyone is encouraged to ask 'why' and look for better ways of doing things
- ✓ Everyone's views matters, including patients and families
- ✓ Learning is shared and leads to real improvements in care

The next section sets out how this vision for good safety culture will be achieved, and what it means for you.

What you can expect from us

1. Commitment to patient safety and staff wellbeing

Theme: Promoting collective accountability

❖ Everyone working in health and social care has a role to play

HSC Trust Boards are responsible for how effectively a Trust manages risk and delivers services.

They have final responsibility for ensuring there is a strong safety culture.

- **Responsibility**

➢ Everyone 'floor to board' has a shared responsibility for keeping patients and staff safe, no matter what their role is. This includes frontline staff, managers, senior leaders and Trust Boards.

➢ Staff speak up for patients if something isn't right or could affect their care.

➢ Staff receive regular training so that they understand safety risks and how to manage them.

- **Ownership**

➢ Leaders show what is expected by promoting a safety culture, setting clear goals, and putting action plans into practice.

➢ Staff take patient safety seriously, not as a tick-box exercise.

➢ Staff have conversations about patient safety every day and are supported to work together to fix problems and improve care.

- **Being open**

➢ We check how safe our services are by gathering information from many places, including patient and staff feedback.

➢ Information is shared with the public about how effective our services are, including patient safety and staff wellbeing.

- **Learning from mistakes**

➢ We regularly check performance on safety and make sure risks are understood and acted on.

- We help staff improve in their role if needed, through early support and practical feedback.

❖ Patient care is informed by evidence-based practice

Decision-making on patient care can vary across Health and Social Care Trusts, leading to different experiences and outcomes. We aim to provide the same standard of safe, effective care for everyone:

- Decisions about care are based on the best available evidence and clinical guidance, not where patients receive care.
- Patients receive care in the right place, from the right professional, at the right time.

- We use our resources responsibly where they are most needed. If resources are limited, we are open and honest with patients and families, and discuss options and risks clearly.
- Decision-making about admission, assessment, treatment, patient transfers, and home discharge is based on each person's needs.
- Staff use standard guidance to ensure there is consistent good practice. If care differs from this guidance, staff discuss the reasons with patients.
- Staff receive regular training, to keep their skills and knowledge up to date.

❖ Health inequalities are reduced

Health inequality means some groups and communities are more likely to experience poor access to health and social care services, and have poorer health outcomes. We want every patient to receive the same high-quality care.

➡ This includes:

- People living in deprived areas
- Minority ethnic populations
- People who have experienced trauma
- People with multiple and complex needs
- Socially isolated people.

- Understanding and showing how health inequalities are being tackled is a safety priority at every level, from frontline staff to senior leaders.

- Population data and feedback from community organisations and under-represented groups is used to plan, design and improve our services.
- Staff are trained on how to:
  - provide care to people from different backgrounds, cultures, and experiences, including those with a disability.
  - support people who may find health information hard to understand.

Case study: Supporting patients with complex needs

Cathy is a clinical pathway nurse at the Ulster Hospital. She developed and leads the **Care Navigator Project** in the emergency department to support patients with complex needs, such as housing, mental health, or social issues. These needs are not always addressed in hospital, which can leave people vulnerable and lead to repeated visits. Cathy works with patients early to connect them with services who can provide practical and ongoing support. This helps reduce health inequalities and improves people's overall wellbeing.

Key outcome
In January 2023, the ten top emergency department users had 36 visits, dropping to just two by December.

Theme: Looking after staff well-being

❖ Staff are supported to perform at their best

'We look after our staff so that they can look after their patients.'

- We work to make sure services have safe staffing levels and the right mix of skills.
- Staff are supported to speak up when services cannot safely meet people's needs, and concerns are acted on.
- Staff can get support for work-related stress and trauma. We check staff wellbeing and make improvements where needed.

Equality, Diversity and Inclusion is promoted in the workplace to make teams more effective. This means creating safe, fair, and welcoming services where staff from all different backgrounds are respected, supported and feel that they belong. Staff with disabilities and additional needs have access to workplace adjustments so they can perform all their duties.

Theme: Listening to patients, families and staff

❖ Feedback is welcomed

'Through listening, hearing and acting we can avert crisis'.

Patients, families, and staff are often the first to notice safety issues.

Taking action early means services can fix problems before they become more serious.

Feedback comes from:

- Staff forums
- Staff surveys and focus groups
- Service user organisations
- Patient engagement forums
- Patient and family stories
- Complaints

➢ We make it easy for people to share their experiences, views, and concerns in different ways.

➢ Feedback is discussed by staff and leaders, not ignored or hidden.

➢ Feedback is taken seriously and used to improve the quality of care.

➢ People who raise concerns are told what has changed as a result.

Case study: Listening to patient voices to improve patient safety

This **Expert by Experience's** powerful story:

✓ Demonstrates the value of focusing on learning, not blame
✓ Highlights how patient and family voices can help prevent harm for others

"My mum suffered avoidable harm following a fall in the nursing home. She was left on the floor for 11 hours because she was on Warfarin and the nursing home staff were awaiting advice from the Ambulance Crew who were unavailable to attend. The Ambulance Crew eventually attended and lifted her off the floor but unfortunately by this time my mum had already vomited and aspirated, leading to a lung infection."

"I had a meeting with the Nursing Home Managers, COPNI, the Trust Social Worker and our GP afterwards. We persuaded Management that learning was all we wanted from this, not blame – we just wanted to ensure that this never happens to anyone again, that 'long lie' risks and consequences would also be considered and not ignored in the future. I raised this with the Chief Nursing Officer at the time, and I became involved in a Regional Falls initiative with Public Health Agency, DOH, NI Ambulance Service etc. This took a lot of learning from this incident and will hopefully ensure that this never happens to anyone again."

2: Compassion, civility and respect

Theme: Leading with compassion

❖ Culture comes from the top

Compassionate leaders:

- Fair
- Open and honest
- Listen carefully
- Understand
- Empathise
- Support others

➢ Leaders set the tone for how everyone works together. They are also visible and approachable.

➢ Leadership responsibilities are shared across staff teams, not just held by top management.

➢ Leaders keep improving, through training, feedback, coaching, and time to learn.

➢ Safe, effective leaders 'do what's right', including making unpopular decisions and holding others to account for their behaviour.

Theme: Empowering staff, patients and families

❖ Effective teamwork supports safe patient care

- ✓ Safe spaces
- ✓ Open communication
- ✓ Active listening
- ✓ Respect and trust
- ✓ Calm and supportive
- ✓ Collaboration to solve complex problems
- ✓ Learn from each other

➢ Staff feel safe to ask questions, share ideas, admit mistakes, or raise concerns without fear of blame or poor treatment.

➢ Staff teams meet regularly to discuss feedback, learn and improve together.

➢ Staff of all roles, backgrounds, and levels are encouraged to contribute to team meetings with confidence.

❖ Poor behaviour by staff is taken seriously

➢ Poor behaviour by staff in the workplace is challenged and dealt with quickly, including.

- Behaviour which can be more obvious such as disrespect, bullying, harassment or discrimination.
- More hidden or subtle behaviour, such as manipulation, controlling behaviour, spreading gossip, or isolating people.

- Staff understand that these behaviours can be harmful to people, teams, and patient safety. They are trained in what behaviour is expected of them, and know they are accountable for how they act.

Expected minimum standard of behaviour from everyone using HSC services
The Being Human Framework recognises that staff can also experience harmful behaviour from patients, family members, or visitors. This includes aggression, threats, intimidation, harassment, or being filmed. It often happens when people are anxious, distressed or frustrated, but is always unacceptable. We aim to improve staff understanding of how unmet need may impact on people; and to ensure that staff are trained in reducing the risks of harmful behaviour.

❖ Patients and families are partners in care

- Care focuses on the person and not just their condition. It considers the patient's medical, emotional, and social needs.
- Patients are involved in decision-making, and asked for their views, preferences and choices.
- Patients receive clear, honest information about their treatment options, including benefits, risks, and alternatives.
- Staff explain options in a way that patients can give informed consent:
  - They have the ability to make the decision
  - They are not pressured by others
  - They understand the information
- Patients can get extra support to make decisions. This includes access to easy-read information, interpreting services and support organisations.

Case study: Supporting people with learning disabilities to access care

People with a learning disability often find services hard to access, which can delay cancer diagnosis. To help, a visual **Story Book** with easy to understand information was created to show people what to expect when attending the North West Cancer Centre (NWCC). With assistance from the Macmillan Support Centre, the storybook was co-produced with people with learning disabilities, carers, and staff. The Story Book was launched to coincide with World Cancer day 2025, and helps people with learning disabilities take part in decisions about their care.

Theme: Enhancing openness, trust and mutual respect

❖ Staff listen, hear and act on concerns

'Any concern raised should be seen as vital information.'

➢ Staff welcome opinions and concerns raised within their team, and from other professionals.

➢ Patients and families are encouraged to ask questions or raise concerns about safety, during care or after a poor experience.

➢ Being asked by a patient or their family for a second opinion is welcomed by staff and not seen as a criticism. Staff understand that families can provide valuable insights into their loved one's condition.

❖ Everyone is treated fairly when mistakes happen

'Restorative' approach

- Open, honest and fair
- Sympathetic and caring
- Non-judgemental
- Access to counselling
- Encourages collaboration
- Solution-focused
- Learning and improvement

➢ Staff and leaders understand that honest human errors happen, and anyone can make a mistake.

➢ Serious wrongdoing is still taken seriously. Deliberate harm, negligence or dishonesty is dealt with appropriately.

➢ Everyone affected by patient safety incidents receive 'restorative' responses. Incident review panels are skilled and trained in restorative approaches.

Good practice in serious incident review panels also includes:

✓ Terms of Reference are created with family input
✓ Families are kept regularly updated and their questions answered
✓ Families give feedback on draft reports and their input is considered
✓ Various information is reviewed to understand what happened, and why

"The patient safety incident review process is the vehicle by which the ability to learn and implement change to prevent harm, and most importantly save life, should be efficiently and effectively demonstrated with full honesty and openness….." ***Expert by Experience***

❖ People receive an honest response when care goes wrong

Candour is about 'being open' and honest with patients and families when care has gone wrong.

For example, if a medication error occurs, openly explaining what happened to the patient and outlining the steps being taken to prevent such an incident from happening again can help rebuild trust.

➢ Leaders clearly show staff that being open and honest leads to support, learning, and safer care, not blame.

➢ Formal investigations are not used as a reason to delay an explanation or support. If something goes wrong with care, we:

- ✓ Talk to patients early
- ✓ Acknowledge what has happened
- ✓ Offer a meaningful apology
- ✓ Share what we know and don't know
- ✓ Explain what will happen next

➢ We recognise that most people want to know that harm won't happen to anyone else, so tell them how we have learned and made improvements.

'There is power in an apology – it is not an admission of guilt but rather an opportunity to heal and repair'

3: Curiosity and constructive challenge

Theme: Addressing fear and defensiveness within the HSC system

❖ Staff understand the investigations process

Defensiveness amongst staff impacts on the ability of people and organisations to learn and improve.

This can happen from a fear of the consequences when care goes wrong. Reasons may include blame culture, fixed mindsets, past trauma, and no previous experience of investigation processes.

➢ We recognise the impact on staff of past experiences and trauma.

➢ We understand that investigations can feel stressful, complicated, and lengthy.

Our processes are:

- o Used only when necessary
- o Applied fairly
- o Guided by openness, transparency and accountability

- Leaders develop effective strategies to move staff away from defensiveness towards a mindset of learning and improvement.
- We use feedback from complaints and review processes to improve how we apply our policies, and provide those impacted with support.

❖ Concerns and complaints are resolved early where possible

- When a concern is raised, we don't wait for things to escalate.
- Staff are trained in how to support early engagement with patients and families who raise concerns.
- Leaders share examples of early resolution and system improvement.

Theme: Making it safe for staff to speak up

❖ Constructive feedback is welcomed

- ✓ Helpful
- ✓ Practical
- ✓ Timely
- ✓ Professional
- ✓ Respectful
- ✓ Offers solutions

- Leaders welcome and respond positively to constructive criticism.
- All staff can share and receive constructive feedback as a way of learning and improving.
- We regularly ask ourselves what we can do better for patients, families and staff.
- Leaders learn from other organisations, reviews and inquiries. They are open about what we learn and how we will improve.
- When needed, we welcome external review and support.

❖ Speaking up is encouraged and valued

- There is training and awareness for staff, including access to safe and confidential ways of raising raise concerns, both formally and informally.
- Staff who speak up are offered support from a colleague throughout the investigation process, and are protected from unfair treatment.
- Leaders openly show staff that raising concerns leads to positive change.

Good practice example: RQIA has appointed a **Speak Up Champion** so staff have someone independent they can talk to in confidence about any concerns at work. The Champion's role is to listen and help staff find effective ways to

sort out their issues. What staff share is used to identify common themes for learning and improvement. Staff who have used this support say they felt heard and supported. The Champion's role has helped build a culture where speaking up is encouraged and valued.

Theme: Being curious to learn and improve

❖ Staff teams reflect on the delivery of care

- Leaders create **time and space** for staff to talk about:
  - What is working well
  - What could have been done better
  - How care and safety can be improved.

- Leaders look honestly at their own actions and decision-making, and are open to doing things differently.

❖ Learning leads to real improvement

- Key safety messages are not forgotten. They are shared widely with frontline staff so more patients can benefit. This includes:

  - Staff team meetings
  - Leader / Board meetings
  - Staff training, education and events
  - Leaflets and posters
  - Letters and emails
  - Videos, podcasts and infographics

- Leaders check that changes are making a positive difference. They share information about what has changed and why, and whether it has worked. Leaders learn from excellence as well as harm, and promote good practice.

"It is a learning process and if we don't do learning we are never going to move on … If you make a mistake, and you ignore the mistake … then you're only going to keep making the same mistake, time and time again … "

Norma Sparkes, Mother of Stephen Sparkes

Conclusion

Why Being Human matters for you:

- You are treated as a person, not a problem or a task
- Your safety, dignity, and wellbeing come first
- Staff are expected to be honest and open if mistakes are made
- You receive explanations, apologies, and answers when mistakes are made
- Services focus on learning and improving, not blaming
- Relationships, trust, and compassion are seen as essential to safe care.

Being Human is a living framework, which supports services to keep learning and getting better. The framework is meant to be:

- Used for reflection
- Talked about openly
- Improved over time

Further information

You can read the Being-Human-Framework-for-Safety-Culture here, or by visiting our website www.rqia.org.uk/beinghuman/

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