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# Learning culture

*"We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons learned to continually identify and embed good practices."*

# QS1: Learning culture

| Evidence categories | |
|---|---|
| **Feedback from partners**<br>• commissioners | **Processes**<br>• Duty of Candour records<br>• evidence of learning and improvement<br>• incident, near misses and events records |

## What this quality statement means

- Safety is a top priority that involves everyone, including staff as well as people using the service. There is a culture of safety and learning. This is based on openness, transparency and learning from events that have either put people and staff at risk of harm, or that have caused them harm.
- Risks are not overlooked or ignored. They are dealt with willingly as an opportunity to put things right, learn and improve.
- People and staff are encouraged and supported to raise concerns, they feel confident that they will be treated with compassion and understanding, and won't be blamed, or treated negatively if they do so.
- Incidents and complaints are appropriately investigated and reported.
- Lessons are learned from safety incidents or complaints, resulting in changes that improve care for others.

| Sub topics | | |
|---|---|---|
| Organisational learning and actions | Continuous improvement | Duty of Candour |

# Which fundamental standards are engaged?

## Reg 20: Duty of Candour

- Make sure your policy is up to date
- Make sure staff have had up to date training
- Make sure staff know what a “notifiable safety incident” is and when duty of candour is actually engaged / what is a day to day occurrence to notify family of
- Move away from language such as “duty of candour phone calls”
- Ensure wherever DoC has in fact been engaged, that you have followed the legal process and confirmed the position in writing – CQC are looking for that written confirmation.
- If DoC hasn’t technically been engaged, but you have treated it as if it has been, you need to be able to demonstrate you have followed the legal process and confirmed the position in writing

## Reg 17: Good governance

- Assess, monitor, and improve the quality and safety of services
- Assess, monitor, and mitigate risks in relation to health, safety, and welfare
- Maintain secure, accurate, complete, and contemporaneous records
- Seek and act on feedback
- Evaluate and improve your practice
- Audits
- Action plans
- Meaningful progress
- Don’t try to fix everything; identify key areas for improvement and work on them

## Reg 12: Safe care and treatment

- Assess risks
- Do all you can to mitigate risks
- Ensure persons providing care have qualifications, skills and experience
- Concerns about safety all stem back to risk assessments and how well those are carried out, how risks are mitigated, and how staff respond to the management of those risks

# Which fundamental standards are engaged?

## Reg 13: Safeguarding

- Service users must be protected
- Systems and processes must be established and operated effectively to:
- prevent abuse
- investigate potential abuse
- Outcomes of investigations form part of learning
- Quarterly analysis of complaints / incidents
- Identification of themes / trends

## Reg 16: Complaints

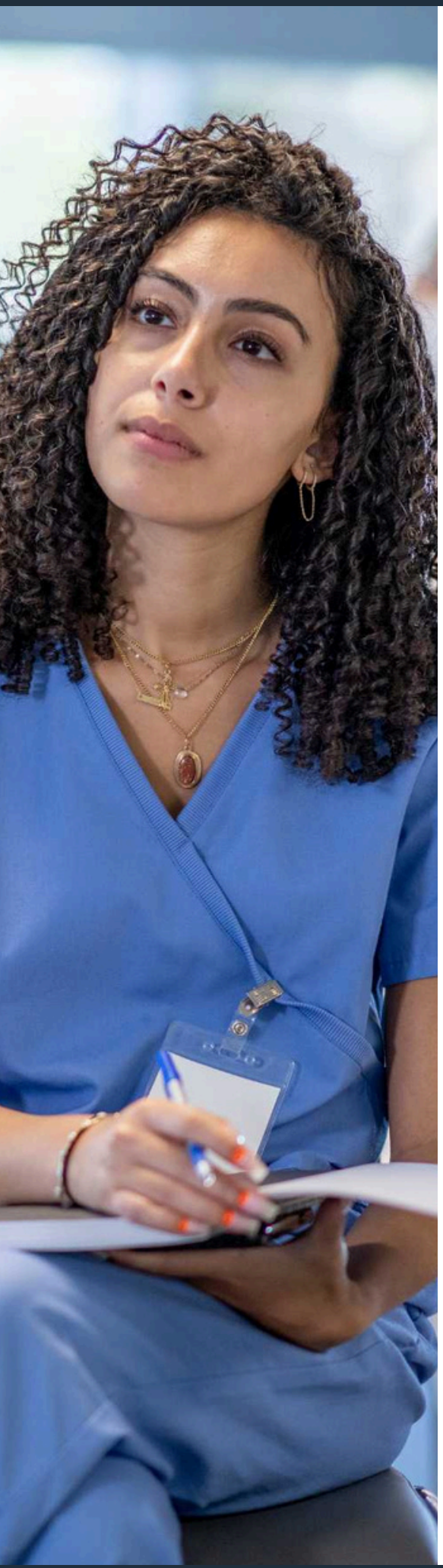
- Feedback to staff
- Show how the organisation has:
- analysed
- learned and
- changed practice
- Complaints must be investigated, and necessary & proportionate action taken

## Reg 18: Staffing

- Persons employed must receive support, training, professional development, supervision and appraisal

## CQC (Registration) Regulations 2009 Reg 18: Notification of other incidents

- Incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the activity
- Injuries
- Abuse
- Incidents reported to police
- Resident behaviours: demonstrate via care planning / PBS documents how behaviours are managed
- Review incident forms: have a free text box for a contemporaneous reason as to why a notification to CQC has not been sent



# Learning culture: conclusion

CQC are looking for the following evidence:

- Feedback meetings with staff following events
- Lessons learned exercises
- Changes in policy and procedure where appropriate
- Quarterly analysis of complaints / incidents
- Identification of themes / trends

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