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Learning from Excellence: The ''Yaytix'' Program

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Abstract:

Background and Aims:

Learning from error can have a negative impact on the staff involved in the error ('Second Victim' phenomenon[1]). We created a project, based on the principles of the Learning from Excellence project[2], to learn from excellence and correct the imbalance of negative to positive feedback in the context of hospital practice.

Methods and Results:

Using a questionnaire, we surveyed staff on existing feedback mechanisms and morale. We then introduced a system where staff recorded and commented on examples of excellence in practice. Recipients and their supervisors received copies of these reports and the feedback was analysed and discussed with senior staff (consultant, senior charge nurse, managers). We re-audited the staff two months after starting this project and noted improvements in staff morale and in positive reporting.

Conclusions:

This project has improved the process of giving and learning from positive feedback and had a significant impact on staff morale. We can also demonstrate an example of improved clinical practice (from feedback received) and will now attempt to measure clinical outcomes with a new prospective study. Finally, we hope to set up a regional program of reporting excellence in South-East Scotland.

Introduction

New staff are taught from an early stage about the Datix reporting program[3], an online tool used to report clinical incidents. Reporting of these incidents is vital to a hospital; however, recent evidence and practice from other hospitals suggests that the reporting of errors, though important, can have unintended consequences[2]. This is described as the 'second-victim phenomenon[1]', where the staff who are involved in an error may subsequently suffer negative consequences; for example, punitive action, psychological damage or an increased fear of further errors. There may even be 'third and fourth' victims, namely the team and department who suffer alongside the member of staff.

Conversely to reducing error, (known as Safety-I concept), there is the Safety-II concept which describes the impact of 'improving excellence'[4]. We note the benefits from reporting this excellence, for example, from a project beginning in Birmingham, the 'Learning from Excellence'(LFE) project[2]. This project introduced an 'excellence' counterpart to the IR1 incident reporting form in the shape of an IR2 form. In their project, 93% of staff felt that learning from excellence improved morale and 87% believed it would improve clinical care[2]. After this project's initiation, gold-standard anti-microbial prescriptions significantly increased from 18% to 35%.

We therefore created a similar program reporting excellence, following the principles of the Learning from Excellence project; we named our 'Yaytix'. The idea of this project was to introduce a positive reporting counterpart to the Datix program. We first audited staff opinions on the balance of negative to positive feedback, morale and if they felt an improvement in morale could affect clinical outcomes. We then implemented the Yaytix project allowing staff to record excellence. The feedback was collated and discussed, and the relevant staff members received acknowledgement. After the project, we re-audited the ward staff to see if "Yaytix" introduction had any measurable impact and if so, whether the impact was positive.

Methods and Results:

Methods:
We surveyed the staff on a surgical ward at the Royal Hospital for Children, Edinburgh, including nurses, doctors, porters, auxiliary healthcare assistants, pharmacists, dieticians and administrative staff. The questionnaire shown in Fig. 1A was distributed over a one-week period (October 2017). The questionnaire included information on confidentiality. After two months of project implementation we located the same staff to give them the same questionnaire to determine the effect Yaytix had on their responses.

The reporting forms (Fig. 1B) asked for a free-text description of what they considered an episode of excellence and who was involved in it. It also asked for an email contact for the proposer. These forms were placed in a box and collected weekly. We then inputted the details onto Microsoft Excel (V15.38). We sent out monthly certificates to the recipient by email and to their supervisor. We also emailed a copy to the proposer. The feedback recorded on the forms were discussed with the consultants at the monthly surgical M&M (morbidity & mortality) meeting. Feedback for nursing staff and non-clinical staff were discussed in their respective meetings with senior staff.

(A)

YAYTIX program: Does it work?

Thank you very much for being a part of this project. We have had lots of feedback and would now like to hear your opinions. We appreciate you taking the time to be a part of this. We will ask for your name to match a post-project study, however all data will be confidential to the Yaytix team.
Any question, please email: yaytix1@gmail.com

NAME & ROLE:

Question 1: How much positive feedback is given out on the ward?
(1=not at all, 9=100%) _____

Question 2: Do you feel positive to negative feedback is well balanced?
(1=not at all, 9=100%) _____

Question 3: Do you feel you would benefit from more positive feedback?
(1=not at all, 9=100%) _____

Question 4: Do you feel valued on the ward?
(1=not at all, 9=highly valued) _____

Question 5: How would you rate your personal morale?
(1=no morale, 9=as good as is possible) _____

Question 6: How would you rate the team morale?
(1=no morale, 9=as good as is possible) _____

Question 7: Do you feel this project could/has [delete as appropriate] improve your ability to give feedback?
(1=not at all, 9=absolutely) _____

Question 8: Would you welcome this project being expanded to the hospital?
(1=not at all, 9=100%) _____

Question 9: Do you feel this project could/has lead [delete as appropriate] to improved clinical care?
(1=not at all, 9=100%) _____

Question 10: Do you know how to officially record observed excellence?
(1=not at all, 9=100%) _____

FIGURE 1: B

YAY-TIX

Developing Clinical Excellence

This form can be used to nominate a colleague who has demonstrated clinical excellence.

Who would you like to nominate?

What did they do?

How can we learn from their practice?

Thank you for filling out a YAY-TIX form. Please submit to the box on ward 4.
You will receive a copy of this form to use as evidence of reflective practice.
Additionally, your nominated colleague will receive a certificate outlining their

FIGURE 1: (A) The questionnaire (B) Yaytix Form
These figures describe (A) the questionnaire that staff filled out before and after the project and (B) the free text forms filled out after excellence was observed.

Results:

Our pre-project questionnaire yielded 40 replies, and two months after our project was started, a further questionnaire yielded 36 replies. The four members of staff who did not complete the follow-up had moved to a different hospital. We estimate 60 staff members rotated through the ward during the one week we were conducting our survey, indicating a 67% response rate before, 60% after. 90% of the original staff cohort completed both questionnaires.

Significant changes were observed in survey responses between pre- and post- project implementation. (Figure 2). This significance was similarly observed when analysing the data from only those who completed post parts of the questionnaire (i.e. 36/40 responses).

The answers to questions 1 and 2 suggested the project was perceived as increasing the amount and quality of positive feedback. The questionnaire provided evidence that both individual and team morale was improved by the project, and that inclusion of positive feedback was perceived by the respondents as having potential to improve hospital care. Finally, after the project there was strong support for rolling out the project to other parts of the hospital.

During the initial three months of the Yaytix project there were 42 forms submitted (50% from nursing staff, 31% by doctors and the remaining by auxiliary health professionals). The feedback highlighted staff members who had made a positive contribution and gave detailed information on well-managed clinical scenarios, including well organised cardiac arrests or well-handled patient complaints. One piece of feedback discussed at the surgical meeting, highlighted a particular doctor's practice of routinely assessing day surgery cases at the start of the day, rather than just prior to surgery. This then reduced delays and prompted early management of any issues that might affect the surgery. The success of this practice then changed the practices of the ward, improving the efficiency of patient management.

Another example of feedback affecting clinical practice commented on a patient's deterioration only becoming evident through excellent inter-disciplinary communication. This led to a weekly MDT (multi-disciplinary team meeting) with the different ward teams.

Finally, we received a regular piece of feedback highlighting accuracy of insulin management for diabetic patients. This led to a proforma being created for new admissions' insulin, which over the course of one month led to six fewer errors in the prescribing than the month before.
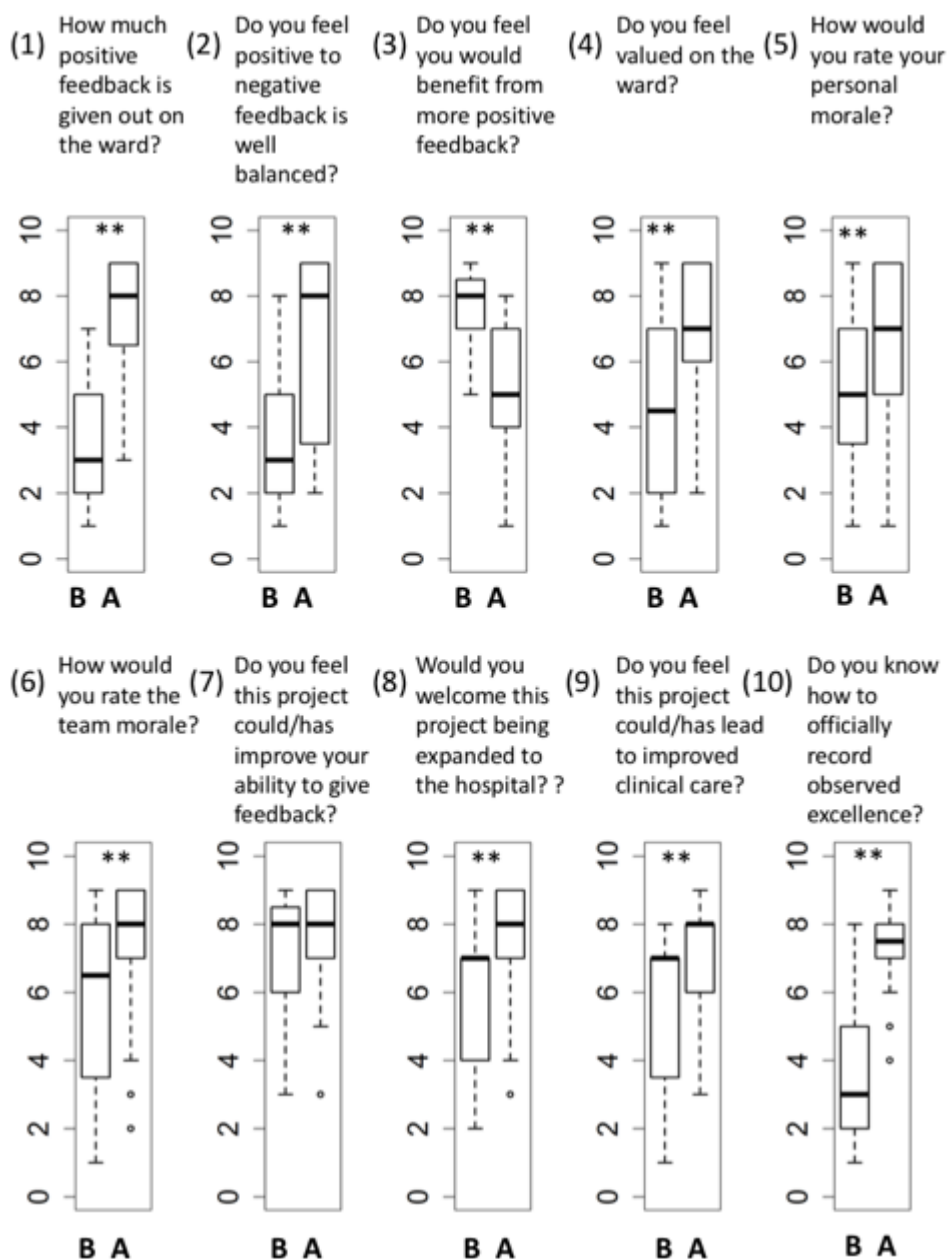
Figure 2: Results
*The answers to each question of the questionnaire before (B) and after (A) the pilot study was implemented are summarised as box-and-whisker plots. Boxes are median and interquartile range. Whiskers show total range (highest to lowest). ** = p <0.01 Mann-Whitney non-parametric test, with corrections for multiple testing.*

Discussion & Conclusions:

Prior to this study, no formal means of positivity reporting existed in our hospital. Positive comments were made informally but this feedback was not recorded or analysed. This led to an imbalance as negative feedback was consistently recorded and discussed. The data collected via the questionnaire strongly suggests that this imbalance was addressed and reduced via the Yaytix project. It is worth noting that some of the feedback we received

seemed to highlight practice that is more 'expected' than 'excellent'. However, with a heavy work-load it can be hard to maintain even expected levels of communication and we believe identifying these practices as 'excellence' encourages their continuation.

We faced two challenges during our pilot. The first was to decide which of the submissions we received needed to be discussed within the department and the second was how to encourage engagement in the project. We aimed to improve the quality control of the submissions by having the analysis of the feedback being led by senior staff. In addition, when feedback was being completed by senior staff, this encouraged junior staff to similarly engage with the project.

Following this pilot project, we merged into the Learning from Excellence program[2]. We have now begun rolling out this program hospital wide. Should this be successful, we hope to share the outcomes of our experience with other hospitals in the South-East region of Scotland and develop a universal data collection system.

The pilot study reported here was not powered to address the impact of positive operating on clinical outcomes. Furthermore, it suffered from the limitation that the survey collected subjective reporting on the perceived benefit of the scheme, from the individuals taking part in the scheme. This opens the possibility of introducing unconscious bias into the results. We would therefore like to measure independently the impact this project could have on clinical outcomes. This would require a new prospective study analysing hospital outcomes before and after LFE was implemented.

In conclusion, our pilot study has provided additional support for the hypothesis that recording clinical excellence may be a crucial part of the feedback process. This, coupled with reporting errors, can allow a healthcare system to learn from past experience, and drive improvement in the future.

References:

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3.   Kelly N, Blake S, Plunkett A. Learning from excellence in healthcare: a new approach to incident reporting. *Arch Dis Child* 2016; 101: 788–791.
4.   Hollnagel E, Wears R, Braithwaite J. From safety-I to safety-II: a white paper. 2015; 1–32.