Learning from Excellence

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Figure 15: Event probability and safety focus

Source: Eurocontrol.
From Safety 1 to Safety 2. A white paper
www.eurocontrol.int
Trying to understand **safety** by only looking at **incidents** is like trying to understand **sharks** by only looking at **shark attacks**

*Attributed to Bob Wears*
“...it is both easier and more effective to increase safety by improving the number of things that go right, than by reducing the number of things that go wrong.”

Eric Hollnagel,
Resilience Engineering in Practice
There's nothing worse than misplaced apostrophe's.
1 + 1 = 2
2 + 2 = 4
3 + 3 = 6
4 + 4 = 8
5 + 5 = 10
“I hate to lose more than I love to win.”

JIMMY CONNORS
Most Popular

<table>
<thead>
<tr>
<th>Shared</th>
<th>Read</th>
<th>Video/Audio</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Deadly serious' new tech bug found</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>'Sorry for algebra', and more</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
#MuslimApologies
| Cannibalism fetish nurse jailed | 3    |             |
| US hits IS oil targets in Syria | 4    |             |
| Branson offers staff unlimited leave | 5    |             |
| Jimmy Carr: My terrible error | 6    |             |
| Tesco made 'stratospheric' error | 7    |             |
| The Uncatchable | 8    |             |
| Apple apologises for update bug | 9    |             |
| Nine held on terror charges | 10   |             |

Market Data  
LAST UPDATED AT 16:38

<table>
<thead>
<tr>
<th>Index</th>
<th>Value</th>
<th>Change</th>
<th>% Change</th>
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<tbody>
<tr>
<td>FTSE 100</td>
<td>6625.39</td>
<td>-80.88</td>
<td>-1.21%</td>
</tr>
<tr>
<td>Dax</td>
<td>9493.72</td>
<td>-168.25</td>
<td>-1.74%</td>
</tr>
<tr>
<td>Cac 40</td>
<td>4347.68</td>
<td>-66.04</td>
<td>-1.50%</td>
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<tr>
<td>Dow Jones</td>
<td>17015.71</td>
<td>-194.35</td>
<td>-1.13%</td>
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<td>Nasdaq</td>
<td>4476.57</td>
<td>-78.65</td>
<td>-1.73%</td>
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<tr>
<td>Rank</td>
<td>Title</td>
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<td></td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mail columnist sorry for mocking Marr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Driver jailed for 160mph death crash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Cashier's kindness goes viral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Panama Papers database goes online</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The man who has photographed every train station in Great Britain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Leader of IS in Iraq's Anbar 'killed'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Takeaway nut death accused 'cut corners'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>The cave divers who went back for their friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Man jailed for 1984 Melanie Road murder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Only Fools and Horses producer dies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Positive vs. Negative Superlatives in Titles

- Positive (Always or Best): -29%
- No Superlative
- Negative (Never or Worst): +30%
"criticism is the backbone of the scientific method"
Negativity culture:

Adverse events
Error
Risk
IR1 / Datix
SIRI / SUI
Never event
Second victim effect
Third victim?
Fourth victim?
Figure 15: Event probability and safety focus

Source: Eurocontrol.
From Safety 1 to Safety 2. A white paper
www.eurocontrol.int
What do people report?

No one has reported themselves
Reports focus on what was DONE
Often ‘motivational > informational’
Many themes
... took her own initiative to design a bespoke care plan on ventilation weaning on a patient with complex needs that is clear for both her colleagues and parents to understand. This meant that everyone involved in this patient's care had a shared mental model.
“Great innovation and organisation of the ward-round with a new structure trialled that was more efficient and more enjoyable for the team”
“...during a busy shift ... took the time to communicate with family ... compassion and kindness... the family was comforted and reassured... Empathy, kindness, extremely supportive towards the whole family.”
“...was looking after a patient on PICU. During the morning ward round not only had he spotted a ten fold drug dose error which he flagged for our attention, he also challenged very appropriately and constructively about why a child with a viral infection was on antibiotics.”
Despite her fear of needles, agreed to have the flu vaccine in order to protect herself and others.
After making a human error, ... was the only member of staff who spoke to me personally, explained the situation and listened to what I had to say.

He made me feel positive about the learning aspect, he supported me with the care of the child.

...came in at 7am and instead of speaking with his colleagues he came to speak to me directly and heard my story and comforted me in the situation.

I don’t think he realised the difference his support made. Thank you
PRIP study

Effect of positive reporting on prescribing practice

Percentage of prescriptions

- 100%
- 80%
- 60%
- 40%
- 20%
- 0%

Study period

- Pre
- Post

Not gold standard
Gold standard
Rates of gold standard prescribing

Proportion of prescriptions vs. Months since start of QI project

- Blue line: Outside PICU
- Red line: PICU
Appreciative Inquiry

Asset Based

Look at what we've got!!

Look at what we're missing!!

Deficit Focused

© J. Logan 2012
DISCOVERY
Appreciating
“The Best of What Is”

DESTINY
Sustaining
“What Will Be”

Positive Topic of
CHOICE

DREAM
Envisioning
“What Could Be”

DESIGN
Co-Constructing
“What Should Be”
Imagine you had three wishes...
Staff survey
Perceptions of initiative
12 months post launch

Staff perceptions in 3 domains:

1. Impact on individual learning
2. Impact on quality of patient care
3. Impact on staff morale

229 responses

\( \frac{229}{339} = 68\% \)
<table>
<thead>
<tr>
<th>Domain</th>
<th>Question</th>
<th>Median score (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I learn best from studying good practice</td>
<td>4 (4-5)*</td>
</tr>
<tr>
<td>1</td>
<td>I learn best from studying others’ mistakes</td>
<td>4 (3-4)*</td>
</tr>
<tr>
<td>1</td>
<td>I learn best from reflecting on my own mistakes</td>
<td>4 (4-5)*</td>
</tr>
<tr>
<td>2</td>
<td>Excellence reporting (ER) can improve patient care</td>
<td>4 (4-5)</td>
</tr>
<tr>
<td>3</td>
<td>ER can improve motivation</td>
<td>4 (4-5)</td>
</tr>
<tr>
<td>3</td>
<td>ER can improve staff morale</td>
<td>5 (4-5)</td>
</tr>
</tbody>
</table>
Positive Reporting and Appreciative Inquiry in Sepsis (PRAiSe)

Lead organisation: Birmingham Children's Hospital

This project tackles sepsis management and antibiotic stewardship in paediatric intensive care. Using a modified form of Appreciative Inquiry to generate novel insights from frontline clinicians, the project is designed to influence clinicians' behaviour through positive reinforcement, share learning, promote good practice, and ensure appropriate antibiotic prescribing, management and review.
OUR PHILOSOPHY

Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand. Our preoccupation with avoiding error and harm in healthcare has resulted in the rise of rules and rigidity, which in turn has cultivated a culture of fear and stifled innovation. It is time to redress the balance. We believe that studying excellence in healthcare can create new opportunities for learning and improving resilience and staff morale.

We have been capturing and studying peer-reports on excellence in healthcare for over 2 years. This site is a source of open-access resources and ideas to promote this initiative and share experiences.

Additional information and resources are now available on the resources page. For our latest messages please visit our blog page.

Feel free to join our mailing list if you wish to receive regular updates from our team and our collaborators.

Name:
Name...

Email:
Email Address...

SUBMIT
“... The two most powerful words in the English language are ‘well done’”

Sir Alex Ferguson
“Saying ‘thank you’ or ‘well done’ might be the simplest quality improvement intervention of all”

Dr Emma Plunkett
Sharing Best Practice Conference
30 November 2016

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