Aims Datix systems have a taboo attached to the investigation process. There was need to bridge the gap to ensure Datix review and feedback with learning in the workplace. Multi-disciplinary team (MDT) working groups have always provided greater skill mix and promoted and enhanced any learning strategy. MDT Datix group helped evolve the learning process into system based reviewing, reflecting, learning and responsibly changing working environments. Our team wanted to ensure effective Datix MDT system based process review and create a positive and visible learning in an open and transparent way.

Methods A specialist Datix club was started 1/4/2020 as a weekly one-hour MDT based discussion ‘teams’ meeting to review datixes, to help draw in system-based process reviewing strategies in the working environments (figure 1). There was good representation of consultants, junior doctors of all grades, senior nursing members, practice educators, governance, pharmacy, risk nurse and nursing students. Lessons learned was shared in grand rounds the same day. Monthly flyer/poster was introduced and circulated from 1/1/2021 to the entire MDT paediatric team to ensure more visibility (figure 2).

Results • Strategy of Change was to ensure good communications system digitally and flyers visibly, as a measure of quality improvement in dissemination and visibility of the system-based MDT learning process across the wider team.
• The weekly grand round learning meant that the entire team had an opportunity to reflect on events within the week, so the learning was timely and effective with real examples. The Taboo to datix was taken away with the MDT meeting discussions from Datix to Great-X process. The Datix themes fed into the MDT Quality Improvement journey for the team to ensure learning is embedded from August 20 -21 with 26 MDT QI projects.
• Visibility across teams with monthly Datix club themes helped build a positive system based process of learning engagement across the teams towards effective patient safety and ensure transparency of the learning process.
• Next Steps: We have set the scene to ensure a Great-X club with the Datix club so we look at the whole process of learning from experience and sharing the experience as an open journey towards excellence in care and ensuring patient safety as a system MDT.

Conclusion The project over the last 14 months has helped develop a continuing record of shared transparent learning, ensuring a no blame culture, transparency and openness to the system-based reviewing process rather than just incident review process. This also helped us to capture and share good practice and encourage positive behaviors and attitudes in patient care and safety creating a transparent and progressive culture.

REFERENCES
3. PICU Sedation and analgesia weaning Guideline, St George’s Health care NHS trust 2016.