

# Online Research @ Cardiff

This is an Open Access document downloaded from ORCA, Cardiff University's institutional repository: <http://orca.cf.ac.uk/101111/>

This is the author's version of a work that was submitted to / accepted for publication.

Citation for final published version:

Cooper, Jennifer, MacLeod, Natalie, Williams, Huw and Carson-Stevens, Andrew 2017. Learning from excellence and patient safety incidents. *Archives of Disease in Childhood* 102 (3) , pp. 295-296. 10.1136/archdischild-2016-312445 file

Publishers page: <http://dx.doi.org/10.1136/archdischild-2016-312445>  
<<http://dx.doi.org/10.1136/archdischild-2016-312445>>

Please note:

Changes made as a result of publishing processes such as copy-editing, formatting and page numbers may not be reflected in this version. For the definitive version of this publication, please refer to the published source. You are advised to consult the publisher's version if you wish to cite this paper.

This version is being made available in accordance with publisher policies. See <http://orca.cf.ac.uk/policies.html> for usage policies. Copyright and moral rights for publications made available in ORCA are retained by the copyright holders.



# Letter: Learning from excellence and patient safety incidents

## Authors:

**Dr Jennifer Cooper<sup>1</sup>, Dr Natalie Macleod<sup>1</sup>, Dr Huw Williams<sup>1</sup>, Dr Andrew Carson-Stevens<sup>1</sup>.**

<sup>1</sup>Primary Care Patient Safety Research Group, School of Medicine, Cardiff University, Cardiff, UK

## Corresponding author:

Dr Andrew Carson-Stevens

Division of Population Medicine, Cardiff University

Neuadd Meirionydd

Heath Park

Cardiff CF14 4YS

[carson-stevensap@cardiff.ac.uk](mailto:carson-stevensap@cardiff.ac.uk)

+44 29206 87136

*Key words: incident reporting, patient safety, Learning from Excellence.*

Word count: 267 words

Competing Interest: None declared

We agree with Kelly *et al.*'s characterisation of the prominent role and well-known limitations of incident reporting in supporting improvement in healthcare delivery. [1][2]

The positive principles espoused by the Learning from Excellence team, particularly the emphasis on moving away from a blame culture, which can hold back effective learning from adverse incident reporting, are to be encouraged. However, to completely “eliminate the negative” would ignore the human brain’s reliance on learning from past errors to improve future behaviours. [3] Therefore, healthcare organisations should aim to learn from *both* suboptimal and excellent care. The challenge for improvers is to invest the resources to: maximise the usefulness of data provided, analyse the data in a way that informs improvement agendas, feedback data and learning to reporters and demonstrate that their concerns have been addressed. [4] Kelly *et al.*'s approach addresses each of these four challenges by allocating significant resources to learning and, consequently, has shown promising results at a local level.

Our multidisciplinary team of researchers have analysed over 50,000 incident reports drawn from a national database to identify priority issues for improvement. [2] Our findings have been valuable in setting priorities in paediatric primary care, vaccination provision and hospital discharge. This work highlighted shortcomings in training, provision for vulnerable groups and IT infrastructure. [2]

This demonstrated that there is valuable learning to be gleaned from structured analysis of incident reports at a national level, whilst Kelly *et al* show the utility of such approaches locally. The ongoing challenge for policymakers is to allocate adequate resources to facilitate learning at all levels, whether from positive or adverse incidents.

1. Kelly N, Blake S, Plunkett A. Learning from excellence in healthcare: a new approach to incident reporting. *Arch Dis Child*. Published Online First 4th May 2016. doi:10.1136/archdischild-2015-310021
2. Carson-Stevens A, Hibbert P, Williams H, *et al*. Characterising the nature of primary care patient safety incident reports in the England and Wales National Reporting and Learning System: a mixed-methods agenda-setting study for general practice. *Health Serv Deliv Res* 2016;4(27).
3. Herzfeld DJ, Vaswani PA, Marko MK, *et al*. A memory of errors in sensorimotor learning. *Science* 2014; 345:1349-1353. doi:10.1126/science.1253138.
4. Williams H, Cooper A, Carson-Stevens A. Opportunities for incident reporting. Response to: 'The problem with incident reporting' by Macrae *et al*. *BMJ Quality & Safety* 2016; 25(2):133-134. doi:10.1136/bmjqs-2015-004962.