Families report adverse events in hospitalized children not tracked by health-care providers

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Families of hospitalized children can provide valuable information about adverse events relating to their children's care that complements information documented by health care professionals, states a study published in *CMAJ* (*Canadian Medical Association Journal*).

Hospitals in Canada have instituted systems to encourage reporting of adverse events — things that may negatively affect the recovery or health of a patient — in patient care. In pediatrics, it is estimated that 1% of children in hospital experience an adverse event and 60% of these are preventable. However, there is lower reporting of these events by health care professionals compared with those documented on charts.

Researchers from British Columbia conducted a study to determine whether an adverse event system involving families would result in a change in events reporting by health care providers. The researchers expected that reporting rates would increase and that families would provide useful information on patient safety.

The study included 544 families whose children were on an inpatient ward that provided general medical, general surgical, neurologic or neurosurgical care in British Columbia's Children's Hospital to babies, children and adolescents. Each family submitted a report and of these 544 participants, 201 (37%) noted at least one adverse event or near miss during hospitalization, for a total of 321 adverse events. Adverse events included medication problems such as a reaction or incorrect dosage, treatment complications, equipment problems and miscommunication.

Most of these events — 313 out of 321 — were not reported by the hospital.

However, "the results of this study showed that the introduction of a family-initiated adverse event reporting system administered at the time of discharge from a pediatric inpatient surgical ward was not associated with a change in the rate of reporting of adverse events by health care providers," writes Dr. Jeremy Daniels, University of British Columbia, with coauthors.

Only 2.5% of the events noted by families were documented by health care providers, although "almost half of the adverse events reported by families represented valid safety concerns, not merely reports of dissatisfaction," states the authors. In 139 cases, families received apologies for these incidents.

"The initiation of [the] family-based patient safety reporting system provided new opportunities to learn and improve the safety of health care provision without an additional reporting burden for health care providers," write the authors. "Giving families the opportunity to report patient safety events did not remove the barriers to reporting by providers (time pressure, culture of blame, fear of reprisal and lack of belief in the value of reporting) but served to complement such reporting."

The authors conclude that "further research is needed to delineate how best to harness the potential of families to improve the safety of the health care system."

In a related commentary, Drs. Charles Vincent and Rachel Davis, Imperial Centre for Patient Safety & Service Quality, Imperial College, London, UK, state that "paying close attention to patients' and families' experience of care and their reports of safety issues may be the best

early warning system we have for detecting the point at which poor care deteriorates into care that is clearly dangerous."

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