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To Err is Human, But Are We Erring Less in the Care We Provide to Our Hospitalized Pediatric Patients?

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The importance of improving the quality and safety of the care we provide to our patients cannot be overemphasized.

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The importance of improving the quality and safety of the care we provide to our patients cannot be overemphasized. You might think that with the emphasis on improvement in the hospital setting, we would see fewer adverse events over time in hospitalized children—but think again—at least according to a new study we are early releasing by Stockwell et al. (10.1542/peds.2017-3360). The authors did a retrospective surveillance study of sixteen teaching and non-teaching hospitals spread across the United States and evaluated trends from 2007-1012 in adverse event (AE) rates using a validated safety surveillance tool, the Global Assessment of Pediatric Patients (GAPPS). The authors looked at 3,790 medical records and found 414 AEs (19.1 AEs per 1000 patient days), of which 210 (9.5 AEs per 1000 patient days) were considered preventable. In addition, teaching hospitals had higher AE rates than non-teaching hospitals, and chronically ill children had more AEs than inpatients who did not have an underlying chronic condition. Most notably there were no significant changes in AE rates for both types of hospitals over time.

On first pass, these are very disappointing results—or are they? We asked quality and safety experts Drs. Ricardo Quinonez and Alan Schroeder to weigh in with an accompanying commentary (10.1542/peds.2018-0954) to help us better understand why this study suggests we are not making progress in our efforts to improve the quality and safety of those we care for in our teaching and non-teaching hospitals. They offer some alternative explanations for the findings while still not denying we have a lot more work to do and the GAPPS assessment tool can help us better define just what that work is. You'll want to fill in the gaps in your own understanding of why AEs are continuing to occur without improvement in hospitals where your patients are cared for and perhaps share this study and commentary with your local hospitalists if these children are not directly under your care. Are you getting similar results in your own hospital? Is the hospital using the GAPPS tool? We welcome your comments on what you are doing to improve quality and safety in

your inpatients or outpatients by sharing your thoughts with a response to this blog, posting a comment on our website with the article or commentary or putting a post on our Facebook or Twitter pages.

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