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# Study: Pediatric-care errors common in hospitals

By / June 7, 2004

Thousands of children die unnecessarily in hospitals because of medical errors stemming from patient-safety lapses, and the extra cost of care for pediatric patients exposed to 20 types of safety problems exceeds \$1 billion annually, according to a study in the June *Pediatrics*.

The study confirmed that medical errors are a significant problem for children as well as adults, and it identified the very young and the very poor as more vulnerable than children in general.

Researchers from the department of pediatrics at Johns Hopkins University, Baltimore, said the figures on patient deaths were conservative. The methods used to identify 4,483 unnecessary deaths from an analysis of 5.7 million records in 2000 "can detect only a small portion of the types of patient safety events that actually happen in hospitals," according to the article.

More than 51,000 cases of medical error were discovered, and four of the 20 types of treatment failure occurred at a rate exceeding 100 per 10,000 discharges. Those were failure to rescue a patient suffering from a threatening event, postoperative sepsis, and obstetric trauma with and without the use of instrumentation.

The study also recorded the financial cost of each of the 20 types of treatment failure. For example, each case of sepsis resulted in an average of 26 extra hospital days and \$118,000 in extra charges. Read the

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PEDIATRICS Vol. 113 No. 6 June 2004, pp. 1741-1746

## Pediatric Patient Safety in Hospitals: A National Picture in 2000

*Objective.* To describe potential patient safety events for hospitalized children, examine associated factors, and explore impacts of safety events.

*Methods.* The newly released Patient Safety Indicators (PSIs), developed by researchers at the Agency for Healthcare Research and Quality to identify potential in-hospital patient safety problems using administrative data, were applied to hospital discharge data. All 5.7 million discharge records for children younger than 19 years from 27 states in the 2000 Healthcare Cost and Utilization Project were analyzed for PSI events. Prevalence of PSI events and associations with patient-level and hospital-level characteristics were examined. Multivariate regression adjusting for patient severity of illness was used to estimate impacts of safety events in terms of excess length of stay, charges, and in-hospital mortality.

*Results.* The prevalence of pediatric patient safety events is significant. PSI events occurred more frequently in the very young and those on Medicaid insurance, some of the most vulnerable hospitalized children. Regression analysis found that almost all PSIs are associated with significant and substantial increases in length of stay, charges, and in-hospital death. Using the estimates derived here and the actual number of cases identified in the 2000 data, we estimate that patient safety events incurred >\$1 billion in excess charges for children alone in 2000.

*Conclusions.* Patient safety problems for hospitalized children occur frequently and with substantial impacts to our health care industry. Unmeasurable by this study are the additional "costs" and "burdens" of safety events that our patients are forced to handle. Additional work to describe and quantify better these outcomes in addition to ones measured here can help solidify the "business case" for patient safety efforts.

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