

Patient safety incidents involving sick children in primary care in England and Wales: a mixed methods analysis.

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Since the inception of the patient safety movement, most [research](#) has focused on the inpatient setting. Although the focus on [ambulatory safety](#) has grown in recent years, little is known about [adverse events](#) in outpatient pediatric care. In this mixed methods study, researchers analyzed incident reports involving sick pediatric primary care patients from the England and Wales' [National Reporting and Learning System](#) over a 9-year period. Using descriptive and thematic analysis, researchers sought to identify the most common and serious event types, reasons these events occurred, and opportunities for improving safety. They found that about one third of 2191 safety incidents represented cases of severe harm. Based on their analysis, the authors conclude that efforts should focus on building safer systems for medication dispensing in community pharmacies, enhancing the triage process for sick children, and improving communication between providers and parents. An accompanying editorial discusses the value of [incident reports](#) with regard to improving care for pediatric primary care patients.