Appendix 2 (as submitted by the authors): Matched family and provider reports

Matched Report	PSLS Description	Descriptive Match	Time Interval Between PSLS and BSO Reports
1	Parent asked RN to have IV removed from child's hand as he was complaining of pain. Tearful, unable to move limb. Parent asked repeatedly. Nurse refused, had another nurse check, but they told mom that they would keep an eye on it. IV therapy restarted IV at 1500. Noted old IV was still in and clearly interstitial (red, painful, unable to flush). IV nurse removed old IV. Told patient to elevate and apply warmth. Unable to find bedside nurse, so CNC notified.	Definitely	2 days
2	Hydromorphone infusion ordered shortly before shift change. Pre printed orders filled out incorrectly by ordering physician, as the pt weight in mg was ordered instead of the pt weight times 0.2. (5.8 mg in 100cc was ordered instead of 1.16 mg). Order had been scanned to pharmacy before noticing the error. The error was discovered at the point when 2 nurses were checking and preparing to make the bag. The physician was notified and	Very Likely	19 days

Appendix to Daniels JP, Hunc K, Cochrane DD, et al. Identification by families of pediatric adverse events and near misses overlooked by health care providers. *CMAJ* 2011. DOI 10.1503/cmaj.110393.

	the order was fixed and the sheet scanned to pharmacy by 2015h.The MAR for the following day still had the original order of 5.8 mg in 100cc. (the wrong order).		
3	Orders are to leave the G tube to straight drain during mobilization, and to low continuous suction while in bed. On may 5, pt's caregiver found the G tube clamped. She believes it was clamped the majority of the day. Dr. aware on May 6th. Dr. informed surgeon during morning rounds the same morning.	Very Likely	3 days
4	Medication hanging in minibag on secondary line not infusing. Medication was ampicillin, pt is allergic to ampicillin. It was ordered and then [stopped due to] allergy. It was signed and circled in the MAR and written not given.	Likely	7 days
5	Was approached by pts. Dr. stating that the IV tubing was accidently stepped on. On assessment of the pt, she was crying and stating that her hand was hurting. On assessment of the IV site, I noticed blood in the extension tubing. I pulled back the tape	Possible	8 days

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	to look at the IV site. I did not appear that the cannula had been pulled out. I then paused the infusion and attempted to flush the IV with NS. While the IV flushed well, the pt. screamed very loudly when I was flushing it. I determined that the IV may have become interstitial, so I saline locked the IV and immediately paged the IV nurse. IV arrived within 10 min and attempted to flush the IV. Again, the pt. screamed very loudly and stated that her hand hurt. The IV nurse said that the IV became interstitial, and took the IV out. IV was restarted on other hand.		
6	2030 dose of IV Abx (Tobramycin) given late at 0000. Pre+post tobramycin levels not done with dose (as scheduled) at 2030. The MAR IV Abx times were changed in pen, it appeared as though dose was already "signed for" as there is what appeared to be initials beside handwritten Abx time. I did not notice that the dose has been missed until 0000, pre-post tobramycin levels not done.	Possible	1 day

	Also, handwritten in the MAR was 2nd, 3rd dose, 3rd dose was at 1430 and tobramycin levels should have been done then. Pre-levels done only.		
7	CMI orders changed to Cont. Hydromorph orders just prior to shift change. Ketorolac was ordered q8h x 48 on the new order sheet as an "Other" med. Pt had received Ketorolac x 1 on the previous shift at 1600h as a one time dose. This was not noted by the person initiating the Ketorolac, and when it arrived from pharmacy, was given at 2200, 6 hours after the one time dose.	Possible	17 days
8	Hung correct medication at correct time to correct patient but forgot to open slider clamp and pt received the maintenance IV fluid instead of the medication. Discovered error when hanging next med and reported to preceptor RN and charge nurse.	Possible	Same day

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