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Changing the Culture Around Safety Event Reporting by Pediatric Residents

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Recognition that hospitals are not always safe for patients has led to robust movements to bolster patient safety wherever children are hospitalized including the use of safety event reporting systems.

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Recognition that hospitals are not always safe for patients has led to robust movements to bolster patient safety wherever children are hospitalized including the use of safety event reporting systems. At my institution, our children's hospital quality and safety team representative leads morning safety report, a daily report out by multidisciplinary unit leaders in inpatient and ambulatory settings across the health system about safety events for review and tracking. It is a sobering morning ritual. The attention to detail to keeping patients safe is real and over time, many safety measures have been put into place as a result of these reports. Like others, I have noticed very few safety events reported by our pediatric residents despite being critical front-line providers and I was eager to read the article in this month's *Hospital Pediatrics* by Mattes et al on this very issue (10.1542/hpeds.2020-001081).

Acknowledging low reporting by pediatric residents, investigators aimed to improve overall patient safety at their hospital by developing and implementing a sustained process to increase safety event submissions by residents. Authors used a quality improvement approach starting with the creation of a team led by pediatric residents that began with identifying barriers to submitting safety events followed by a roll-out of interventions focused on increasing safety event submissions by pediatric residents. The interventions included making the submission process user-friendly, creating a resident "safety champion" on the wards and associated friendly inter-resident competition, giving feedback to the reporter directly following their event submission and regularly sharing data on the number of pediatric safety event submissions entered by residents with residents. During the 12-month study period, the number of events submitted by residents increased from 0.9 to 5.7 per 14 days.

I highly recommend reading this article and commend the authors for their work to address an important gap in our efforts to improve the culture of patient safety in a hospital setting with some actionable concepts. Engaging our trainees in these efforts will be valuable to them and the patients they serve for the rest of their careers.

- Patient Characteristics Associated With Voluntary Safety Event Reporting in the Acute Care Setting
- Caregivers' Perceptions and Hospital Experience After a Brief Resolved Unexplained Event: A Qualitative Study
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