**SDC: Table 1** Residents’ Perceived Facilitators to Event Reporting, Identified by Eight Focus Groups from Four Training Programs

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| **Theme** | **Description/Exemplar Quote(s)** |
| **Facilitators Related to Technical Factors** | **Facilitators having to do with the electronic reporting system or process of filing a report** |
| Easy system | “It is easy to get to [the reporting system] from the chart and it’s already auto-populated with the patient’s demographic information, which is so nice.”  “It has to be short and take less than a minute…. There should be a free-text box saying this is the patient, this is what happened, and then somebody else’s job is to go read the chart and figure it out, and they can ask you more specific questions.”  “It shouldn’t be so difficult that you need training.” |
| Telephone reporting system | “[Reporting by phone] was way easier and I was more likely to do it because you could do it while you were walking…and I don’t have to sit down.”  “You could type your [progress] note and…do something else while you’re talking about some event.”  “When you call and [make an event report] I feel like that made a big difference because I [can] just do it right then.… But when you have to actually type everything in, it definitely takes more time… I put it off.” |
| **A Culture of Safety and Proven Strategies to Build a Culture of Reporting** | **Specific interventions identified by residents who rotate at the pediatric hospital that have encouraged them to file more PSORs** |
| Building a culture of safety and reporting | “I think it’s very environmental…we talk about [reporting at PED]. Everyone does it…I think that encourages me more to do it.”  “We are taught…that anybody should be able to speak up. If the attending sees an error or we see an error, or a med student sees an error, or a nurse, or anybody should feel equally empowered to [report]…. They want anyone who thinks that there was a concerning issue, just feel like that’s their purview to [report].” |
| Non-punitive process | “I think in general, among the residents, perception of the [reporting] system is positive and they feel safe doing it. You feel like you’re not going to get yourself in trouble or get somebody else in trouble.”  “I was really paranoid [at first] ‘cause I thought I was like a terrible doctor. Then I realized that it’s not about judging people at all, it’s actually a really great way to make system changes and examine the Swiss cheese of it all.” |
| Follow-up on reports and visible changes | “Whenever I put up a report in, I do get confirmation, and someone says they’re looking into it. So that feels good, that someone is working.”  “There was a couple [PSORs] filed about kids who are TPN dependent, and not being able to find their TPN recipe, whenever they get admitted to the hospital. We ended up having a [discussion at] safety rounds about it. And it was recognized by everyone there that the system was not functioning…people were using all kinds of crazy workarounds. And they just sent this e-mail…the TPN recipes are now available in [the electronic medical record], here’s where you can find them.” |
| Transparency of the investigation process | “One thing that changed my opinion about [reporting is]…I had the opportunity to go to the patient safety meeting where they discussed all the [PSORs] reported in the last week that they’re reviewing and the process they go through.… I’m impressed that they actually do look at all the [PSORs]. They’re definitely following through on some things they think are important and they can change…. I never even knew this meeting was going on until I got invited…. I think it could’ve affected my reporting practice if I had done that earlier in my residency and known that people actually are at the committee meeting and discussed these reports.”  “One of the things that I learned from [the risk committee] meeting was that [the committee] have the [PSOR] and then they have to provide updates on what they’re doing for specific issues that they think are achievable, like unlocking the doors in the stairwells so patients don’t get locked in there…. So there’s a little bit of transparency, which I think is helpful in terms of a culture of reporting.” |
| Role modeling | “I learned to [report] the same way that I learned to update sign-out, and the same way that I learned to put in admission orders; people showed me how to do it and that was just like, what you do as a resident here.”  “I actually had an attending on our first day suggest each member of the team do at least one [PSOR] a week. And he said let’s promote the culture of safety, and really attempt to do this systematically.” |
| Routine safety education | “I think people appreciated at safety rounds when they got more information about what [PSORs] are used for, what are good examples of things that you should definitely be [reporting], what things that you should think about [reporting].... I think having more education about how to utilize this system is better.” |
| Familiarity with safety staff and administration | “[At PED] We all know [the safety administration and faculty] on a personal level. That’s why I think there’s more buy-in and there’s more trust; like if we report it, you’re not gonna get penalized and there’s not gonna be anything negative that’s gonna happen to you.” |
| Error disclosure training | “Sometimes if families become angered at you…[for] a mistake, I say ‘Well I’m filing a [PSOR]. This is something that brings it up to the system so that we can try to avoid this in the future’ and I think it’s something that families like to see is being done.”  “If it’s significant enough that I have to talk to the patient and family, I always [file a PSOR]. ‘Cause I tell them I’m gonna do that. ‘We have this error reporting system, this is how we’re going to prevent it from happening again.’” |

Abbreviations: PSOR, Patient Safety Occurrence Report; PED, Children’s Hospital; TPN, Total Parenteral Nutrition

Encouraging Resident Reporting of Adverse Events: A Qualitative Focus Group Study of Suggestions from the Front-Lines; Szymusiak, John