

***Winner – APPD 2018 Research Award**

SPEAKING UP ABOUT TRADITIONAL AND PROFESSIONALISM-RELATED PATIENT SAFETY THREATS: A SURVEY OF PEDIATRIC TRAINEES

Jennifer Kesselheim MD, EdM, Children’s Hospital/Boston Medical Center, Boston, MA, Sigall Bell MD, Harvard Medical School, Boston, MA, Will Martinez MD, Vanderbilt University, Nashville, TN, Lisa Lehmann MD, Children’s Hospital/Boston Medical Center, Boston, MA, Julia Shelburne MD, University of Texas Health Science Center at Houston, Houston, TX, Jason Etchegaray PhD, University of Texas Health Science Center at Houston, Santa Monica, CA, Eric Thomas MD, MPH, University of Texas Health Science Center at Houston, Houston, TX

Background: Safe and professional patient care depends on a culture in which health professionals speak up regardless of authority gradient. **Objective:** To measure pediatric trainees experiences, attitudes and factors associated with speaking up about traditional versus professionalism-related safety threats. **Methods:** An anonymous, cross-sectional survey was administered to 512 pediatric residents and fellows at two large US children s hospitals in 2015. The survey queried attitudes about, barriers and facilitators for, and self-reported experience with speaking up. In addition, two safety vignettes (traditional vignette and professionalism vignette) assessed the likelihood of speaking up, anticipated assertiveness, and perceived potential for patient harm. **Results:** Of 223 participants (response rate 44%); 68% were female and PGY level was evenly distributed. Respondents more commonly observed unprofessional behavior (57%, 127/223) than traditional safety threats (34%, 75/223); $p < 0.001$, but reported speaking up about unprofessional behavior less commonly (48%, 27/56 vs 79%, 44/56; $p < 0.001$). Fear of conflict (45%, 100/223, for safety vs. 67%, 150/223, for professionalism; $p < 0.001$) and concerns over getting someone else in trouble (46%, 102/223, for safety vs. 39%, 88/223, for professionalism; $p < 0.001$) were the most commonly endorsed barriers to speaking up. Respondents more commonly indicated a high likelihood of speaking up in the traditional than the professionalism vignette (64%, 143/223, vs. 10%, 22/223; $p < 0.001$) and this difference persisted even among respondents who perceived high potential patient harm in both scenarios (69%, 56/81 vs. 20%, 16/81; $p < 0.001$). Respondents with a high likelihood of speaking up anticipated using assertive language more commonly in the traditional vignette than in the professionalism vignette (89%, 17/19, vs. 47%, 9/19; $p = 0.02$). **Conclusions:** Responding pediatric trainees commonly observed unprofessional behavior yet were less likely to speak up about it, and less likely to use assertive language when doing so, compared with traditional safety threats even when they perceived high potential patient harm. These data highlight unmet needs for the culture of safety in pediatric practice.

Table: Attitudes Regarding the Climate for Speaking Up about Patient Safety Concerns versus Unprofessional Behavior

Item	X=patient safety concern % (n) Agree* N=223	X=unprofessional behavior % (n) Agree* N=223	P-value†
1. Speaking up about X results in meaningful change in my clinical area.‡§	149 (67%)	112 (50%)	<0.001
2. In my clinical area, it is difficult to speak up if I have/observe X.‡	37 (17%)	109 (49%)	<0.001
3. The culture in my clinical area makes it easy to speak up about X that does not involve me or my patients.‡§	134 (60%)	84 (38%)	<0.001
4. In my clinical area, I observe others speaking up about X even if it does not involve them or their patients.‡§	139 (62%)	56 (25%)	<0.001
5. I am encouraged by my colleagues to speak up about X.‡§	152 (68%)	78 (35%)	<0.001
6. I would feel safe speaking up about X.	173 (78%)	117 (52%)	<0.001
7. I have the support I need to speak up about X.	164 (74%)	114 (51%)	<0.001

* Dichotomized strongly agree/slightly agree (agree) vs. neutral/slightly disagree/strongly disagree (disagree).
 † P-value for McNemar’s test comparing within-respondent differences in attitudes regarding the speaking up climates for patient safety and professionalism.
 ‡ Items from the Speaking Up Climate for Patient Safety (SUC-Safe) Scale.
 § Items from the Speaking Up Climate for Professionalism (SUC-Prof) Scale.
 || Negatively worded item.

3. BURNOUT IN PEDIATRIC RESIDENTS: FINDINGS FROM A NATIONAL LONGITUDINAL SURVEY

Maneesh Batra MD, MPH, University of Washington, Seattle, WA, John D. Mahan MD, Nationwide Children's Hospital/Ohio State University, Columbus, OH, Charles Schubert MD, Cincinnati Children's Hospital Medical Center/University of Cincinnati College of Medicine, Cincinnati, OH, Paria Wilson MD, MEd, UPMC Medical Education, Pittsburgh, PA, Betty B. Staples MD, Duke University Hospital, Durham, NC, Janet R. Serwint MD, Johns Hopkins University, Baltimore, MD, Hilary McClafferty, University of Arizona, Tucson, AZ, Alan J. Schwartz PhD, University of Illinois College of Medicine at Chicago, Chicago, IL, Kathi Kemper MD, MPH, Nationwide Children's Hospital/Ohio State University, Columbus, OH

Background: Resident burnout is common and associated with poor health and sub-optimal patient care. Previous studies have involved small and/or cross-sectional samples and gaps remain in understanding predictive factors. Objective: Determine the prevalence of burnout among pediatric and med-peds residents in a national sample over 2 years, and characterize potential personal & programmatic risk/protective factors. Design/Methods: The Pediatric Residency Burnout-Resilience Consortium, a nationally representative sample of 46 programs, conducted an annual anonymous survey of residents in April-June of 2016 and 2017 via APPD LEARN. The survey included demographics, debt, training year, recent experiences (eg, night call, patient deaths), and measures of burnout, stress, mindfulness, self-compassion, empathy, fatigue, and resilience. Rates of burnout were calculated by survey year and predictive factors were assessed by logistic regression. Results: 62% (1693/2723) of eligible residents from 34/46 programs responded in 2016, and 66% (2179/3273) from 43/46 programs in 2017. >80% of programs in 2016 and 2017 had >50% response rate, with 71% (22/31) of programs that participated for 2 years having >50% response in both years. Among respondents, 72% were female, 71% were white, 17% had children, 62% had >\$100,000 debt, 59% were married/partnered, mean age was 29 yrs and these characteristics did not differ among residents based on presence of burnout or survey year. Rate of burnout was 56% in 2016 and 54% in 2017. Burned out residents reported increased stress, worse mental health, and decreased: empathy, mindfulness, resilience, and self-compassion (all p<0.05). Protective programmatic factors included current rotation (ambulatory/elective), decreased sleepiness, recent vacation or weekend off, and lack of recent involvement in a medical error (all p<0.05). Conclusion: In this national longitudinal sample, burnout was prominent and remained persistent over 2 years. Several personal and programmatic characteristics were identified as potential targets for future interventions to prevent and/or reduce burnout.

4. IMPROVING TRANSITION TO OUTPATIENT CARE FOR HOSPITALIZED CHILDREN

Meaghan S. Wido MD, Kristan E. Madison MD, Natalie Burman DO, MA, Naval Medical Center San Diego, San Diego, CA

Background Transitions of care from inpatient to outpatient settings are critical to prevent readmission and optimize continuation of care by primary care providers (PCP). For patients admitted to our pediatric ward, there was no uniform approach to notification of PCP of discharges. Additionally, there was no system to ensure continuity of care for outpatient follow-up needs. Aim Statement Our aim is to improve discharge email notification to the follow-up providers and PCPs for pediatric patients admitted to 75% by May 31, 2018. Interventions Through our resident continuity clinic curriculum, the residents engaged stakeholders in both settings to create an interprofessional team consisting of nurses, providers, nurse managers, information technology specialists and clerk staff. This team created a structured system of daily list of discharges, confirmation of PCP, team nurse listserv, and electronic record modifications. Hospital course and follow-up data was transmitted to the medical homeport team via encrypted emails to the team nurse, follow-up provider and/or PCP.

Measures Our primary outcome measure was the percentage of patients for which emails were sent to providers. Progress was tracked monthly. Multiple PDSA cycles were performed to iteratively improve the process and transition from a manual to a more automated process. Results We increased the number of discharge emails for patients following-up at our hospital-based clinic from initially untracked prior to January 2017 to 63% in November 2017. We implemented an administrative process that transitioned from the residents to the clerk staff in February, improving consistency of provider notifications. We reviewed our progress quarterly and made revisions with

Discharge Communication sent for Patients Discharged from Pediatric Ward

