Table 2: Quality and Safety Gaps discussed in Pediatric Patient Safety Rounds			
QS gap Category	**Number of Events**	**Example**	**Improvement action(s)**
Medication	11	Near-miss event involving an insulin dosing conflict between medication reconciliation and the after-visit summary (AVS) for a patient with type 1 diabetes.	Modification to Type 1 diabetes discharge instructions.
Lab and specimen	7	Care delay without detectable harm related to specimen processing for high-yield neonatal HSV serum PCR, which automatically adjusted to adult titers. Care team received a message that the sample was "inadequate for diagnosis," delaying discontinuation of antivirals.	Specific neonatal HSV order set built.
Team Communication	7	Prospective safety gap identified related to variability in written resident handoff content and quality.	RN quality leader worked with pediatric residents to modify their written handoff template and implement this form across the program.
Care coordination (transitions of care, access, and flow)	6	Quality and prospective safety gap related to process delays in patient registration for inpatients, leading to inability to place timely medication orders due to missing insurance information.	Issue escalated to registration team; specific protocols built to prioritize pediatric population given short length of stay.
Evidence-based care pathway adherence/diagnostic challenges	4	Near miss involving an incomplete evaluation for fever in an infant at a community hospital; the infant was observed after complete fever workup at our hospital.	PGY3 resident reached out directly to community hospital emergency medicine leadership to provide feedback.
Care delay	4	Minimal harm event involving delay in acyclovir administration for an infant with HSV skin infection due to IV access. The family experienced distress both from access attempts and preventable waiting.	Case brought to an interprofessional workgroup to further inform ongoing work to redesign our pediatric vascular access protocol.

EHR and device	3	Prospective safety vulnerability involving lab tests being cancelled without provider notification.	Reported in PPSR, initiated a dialogue with laboratory medicine and informatics to resolve this priority system-wide issue.
Diagnostic error	1	Minimal harm event involving delayed recognition of hemorrhagic cystitis in a patient on chemotherapy.	Hematology-Oncology program working with pharmacy on an EHR order set to include a screening UA when on medications that pose this risk.