APPENDIX: ADDITIONAL EMPIRICAL DATA

1. Error reporting	
1.1.	'The big changes in the past fifteen years come from how mistakes are seen. Before, you had to respond to your mistake in a different way than you do now (...). Now, we talk about errors without judgment. Whereas there was a time when errors often came with accusation.' (Healthcare Executive)
1.2.	'Reporting is a way of protecting the unit and the institution. Because, honestly, I can't see our managing director receiving a complaint from a family without having previously been informed, without the unit reporting anything. It protects everyone. (...) If you'd like, you need to have a culture of reporting. (...) We teach nurses that they have to make reports. There is a newsletter from the quality unit where we ask them to make reports, [Explaining] that it is a good thing. And that it is there to change practices. So, they understand [it] quite easily. Because they know there won't be consequences. It's for their wellbeing as nurses. Because it is something that allows them to see what was done and to change so it won't happen again. But, at the same time, [it] is for protection, because if ever something is not reported and a family goes to court, it is not in their own interest.' (Healthcare Executive)
1.3.	'There are differences even between the three institutions within the hospital (...). There is one that is a bit behind in terms of reporting (...). There are also differences among the clusters. And I have noticed that it is, in part, due to management. If the director of care, for example, understands and approves of reporting, then the other professionals follow along more easily. If you have a director of care who scolds senior staff or managers because there were several reports in their unit, then of course the unit later tries to hide them.' (Quality and Risk Management Engineer)
1.4.	'On days where we don't have time, we don't necessarily make a report. We tell ourselves "we'll do it later", and then we realize that we don't do it at all. Sometimes I have the impression that there isn't enough time. Even though we know it is essential, that it is important to report, we still don't see it as something that is as important as care (...). I think that if we had to make a choice in how we organize our working time, it's maybe KaliWeb that we would do less diligently.' (Nurse)
1.5.	'If something exceptional and/or with serious consequences happens, in any case, it gets reported, error tolerance (or not). If you operate on a patient and you amputate the wrong leg, that is going to escalate to us. Inevitably. Because it's too serious. No one covers up for that sort of thing. What will get covered up is a slip up, a mistake that didn't have any consequences (even if it could have been serious, if there were no consequences), that could get hushed up. For the unit's reputation, etc. (...). The day when an child died (because of a mix-up with medicines), it seems rather unlikely that it would be covered up. This kind of serious error gets reported (...). The debate moves onto the legal field generally when there is this kind of thing.' HR Director
2. Announcement to the families	
2.1.	'When an AE occurs, disclosure is a legal obligation. You are at fault if you do not inform the patient. So, this is an argument that we try to have with our professionals: we are required to inform the patient, that is part of our obligations, and we also have to track this information in the medical file. The patient must be able to access their file and know what happened (...). It's a requirement, so normally there is no question whether to inform the patient (...). Until now, we have always reported the SAEs of which we have been aware. So that means that we inform the patient, and we open ourselves up to legal action (...). It's a risk that is accepted.' (Quality and Risk Management Director)
2.2.	'We offered a training course in announcing damage related to care; that was actually one of the issues the HAS had brought up during the last certification visit. In the certification report, there was the idea that our professionals were not trained enough in announcing damages related to care. So, we implemented an institutional training course with identified credits.' (Quality and Risk Management Director)
2.3.	'I think that the first thing to remember is that this is important information that must be prepared ahead of time. You don't improvise, go off the cuff, in the corridor, no! You must prepare this information, so you have to have gathered the facts.' (Quality and Performance Director)
2.4.	'I can think of a situation where I have opposed (the professional meeting the family). Because, for me, the staff member was not yet ready for it. It was not safe. However, once we determined that it was possible and there was really this demand on both sides, it happened with a mediator (...). For me, it's not really relevant to have the professional and the family sit face-to-face, just like that. Finally, it must be heavily supported so that it is something that is very secure. So that it has meaning. So that it has a goal. But it is possible! (…). Whether or not the professional is present, for me, it really depends on the event, the consequences of the event, on what happened.' (Occupational Health Psychologist)
2.5.	'I think that the more we communicate, the more we explain what we do, the better the families feel, and they can understand that sometimes mistakes can happen.' (Healthcare Executive)

2.6.	'We must be as transparent as possible with patients to whom this happens or their families. Because, in fact, we can see that most trials that happen in the healthcare field are due to a lack of information. People go to trial because they have not gotten answers. Because you have tried to hide things, etc. So, they don't feel comfortable, and they go to trial. So, when we have made a mistake and we go see people and explain to them: "Yes, we made a mistake, and here's why it happened. And here are the consequences. And here is what we are putting into place. And we are doing everything so that it doesn't happen again", in this case, people may not be happy (of course!), but they won't go to trial. Because they know that people make mistakes. I think they—quote-unquote—"thank" the institution for their candor." (Medical Advisor – ARS)
3. Feedback	
3.1.	'As for the time for analysis, for very serious situations where there was a particular consequence—I'm thinking about situations with children, for example, or particularly dramatic things—oftentimes, we will suggest taking some time. So we don't pounce on people to make an analysis. In general, at least fifteen days pass, sometimes one or two months, to do this in-depth analysis work.' (Quality and Performance Director)
3.2.	'We review the details of the error, how it happened. And then the context (...). Our approach is to critically analyze the situation. To try to make sure that it doesn't happen again. That means identifying what happened that allowed the mistake to happen at that time. For example, if I take the mistake that I made in reading a medicine label. We tried to analyze and see why I read the wrong medicine. It was in an emergency context. And then, afterwards, to see what was possible to make sure it didn't happen again. So, we reviewed the entire installation of our pharmacy. How were emergency medicines stored? Shouldn't we redo how they are stored, how they are done? (...) We were really trying to share our thoughts to try to change our practices. But not judge what happened.' (Nurse)
3.3.	'A few years ago, I investigated the first serious case where a child died (it was a baby). It's never entirely the hospital's fault, but there were nevertheless errors that the hospital had made. And the mother, in fact, said: "Yeah, OK, I understand, but I would like a response about this analysis that was done. I would like you to take action so that it won't happen to anyone else". At first, I was stunned! But now, I have seen families who have reacted like that several times. Not always, of course. But I expected a lot more selfishness, things like: "But I don't care about the others! How could you do this to me?" But, in the end, it's not all that frequent.' (Quality and Risk Management Engineer)
3.4.	'Patients, who have more and more connections now, are more likely to have lawyers and whatnot. Hence the need to implement this quality policy. Because if you prove that you have implemented everything that you needed to and that you are trying to change, that means you have acknowledged what happened and that you want to change. That you aren't saying, "well, that happened, that is all...". So, it's positive for everyone! (Healthcare Executive)
4. Legal action	
4.1.	'(The Toulouse hospital affair), I was nearly beside myself when I read that! (…). In my opinion, the people who published that are people who really don't know about the field or the mistakes (...). People have no knowledge of the extent of the problem. And if you've never taken a look at it, if they say there were—I forgot how many there were in Toulouse—20,000 reports since 2017 (it's something like that), of course, they think it's enormous! (...) But I didn't think it was big, because I said, "oh wow, it's about what we have!". In that case, you could talk about any hospital that has implemented an error management process. It's about the same number (...). The fewer the reports, the lower the performance, in my view. But I wouldn't say that has become part of the culture yet. For the public, it's just, "lots of reports means lots of problems!".' (Quality and Risk Management Engineer)
4.2.	'The tolerance of error depends on the family. We meet all sorts of families. I've been (in this unit) for nine years. In nine years, I've met completely different types of people. There are tolerant people. And then there are those that are a bit less tolerant but because they are suffering enormously, and they don't have any tolerance to give.' (Nurse)
4.3.	'By taking part in the patients' committee, I work with the legal affairs department. (...) There is the (general care coordinator). There are the patients. And we review all the complaints (...). Parents that are upset with care or an error that could be attributed to the hospital result in a letter. Either a letter for a report and so that it doesn't happen again. Or a letter to explain what happened in writing. In these cases, we go back to each care unit (to the care manager) to try to shed light on what happened and to give these families the best answer possible. When a letter isn't enough, we can offer mediation (...). Sometimes, I am a medical mediator, and we meet families. We go over it with them, we listen to them, and we try to understand and shed light on things so that they understand. If it isn't enough and they want to go to court, then the case goes to legal affairs, to the DAJE.' (Healthcare Executive)
4.4.	'If it's an error related to care, I don't think that patients and their family will be accommodating. I think that will still turn against the institution, even if we don't know about it every time (...). There was a lady

	who was leaving the hospital. I helped her to her room. She fell and she had to stay in hospital longer. Later, I found out that the family filed a complaint. She requested damages from the institution (...). But nurses rarely have feedback. Rarely!' (Nurse)
4.5.	'The difficulty that we can have sometimes is medical secrecy. Particularly as concerns the press. When there is an article where a family is going to the media because they suffered damages (...), we're not on an equal footing. Because the family can speak freely about what happened to them, but we would be at fault if we tried to defend ourselves by sharing aspects of the medical file. Because we have to respect medical secrecy. If medical secrecy is broken, you can't blame the person themselves or their representatives (...). You also cannot blame the legal authorities when they are acting in a legal framework.' (HR Director)