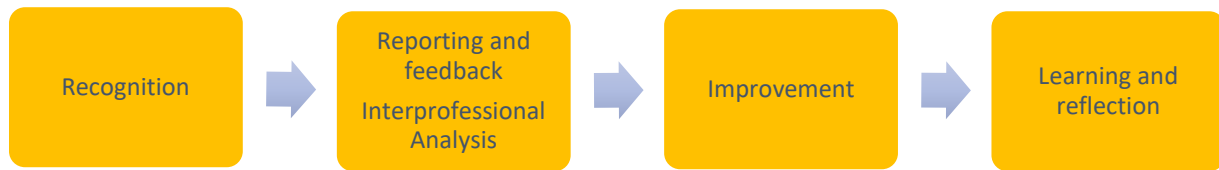


Figure 1: Qualitative learning themes across the spectrum of responding to safety events



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|---|---|---|--|
| <p><i>I think safety rounds has just made everyone more open to discussing these incidents. It has bolstered people's understanding that these are learning opportunities and not something to be punished.</i></p> <p>Culture of safety, learning health system</p> | <p><i>When a safety event is discussed as part of PPSR, multiple people in the program become aware of it vs. when only a [safety report] is made, in which case other residents or staff may not be aware of the safety concern until some changes have already been made.</i></p> <p><i>[PPSR] generally makes me aware of the sorts of mistakes that can be made, which makes me more mindful and deliberate about my choices.</i></p> <p>High reliability – sensitivity to operations and preoccupation with failure</p> | <p><i>It is encouraging to see that the outcome of a safety event analysis doesn't have to be huge, which was previously intimidating for me. Small changes as a result of a safety event are impactful.</i></p> <p>Continuous improvement</p> | <p><i>Reviewing all medication orders to make sure they are accurate and calling pharmacy to discuss when questions arise.</i></p> <p><i>Double checking all orders no matter how long a patient has been admitted/on a medication</i></p> <p><i>I review my AVS's more thoroughly.</i></p> <p><i>Following up with the lab when there are no results</i></p> <p>Practice-based learning and improvement, Systems-based practice, and Teaming</p> |
|---|---|---|--|