NRLS DELPHI STUDY APPENDIX 1

SEMI-STRUCTURED INTERVIEW PROTOCOL FOR STUDY 1

Expert panel INTERNATIONAL SAFETY ACADEMICS
MANAGERS OF REPORTING SYSTEMS

THEME A:
THE ROLE OF REPORTING WITHIN THE PATIENT SAFETY LANDSCAPE

Introductory statement
Preventable harm to patients is important to monitor, and prevent. Healthcare systems are high-risk environments prone to system error. There are several possible methods for monitoring when adverse events occur and obtaining useful information regarding mistakes in order to prevent harm in the future.

The role of reporting

1. In your opinion what is the optimum method for monitoring error and learning from mistakes in healthcare?

2. What role should the reporting of events play to enhance patient safety?

3. What other successful methods are available for monitoring and learning from error? How do they complement reporting systems?

The aims of reporting systems

1. What can be achieved through reporting? What can reporting not accomplish?

2. What are the strengths of reporting systems as way for monitoring and learning from error?

3. What are the challenges in using reporting as a method for monitoring error

4. What are the challenges in using reporting as a method for learning from error

5. Do you have a reporting system in your country/healthcare system? When the reporting system in your country was established what were its goals?

6. Has your reporting system achieved these goals?

THEME B:
WHAT SHOULD NATIONAL REPORTING SYSTEMS DETECT AND HOW SHOULD THESE SYSTEMS BE UTILISED?

Introductory statement

The National Reporting and Learning System (NRLS) captures approximately one million incident reports a year from hospitals in England and Wales. However it has been shown to have low sensitivity for recording harm, detecting only 5% of adverse events found through case note review. Only incidents leading to death and severe harm are analysed.
Monitoring and learning from error is a top priority for the NHS.

What incidents should be reported?

1. In your opinion, what should the national reporting systems be able to deliver? From your perspective, has the NRLS delivered this?

2. Regardless of the potential challenges the system currently faces how could national reporting systems be best used to fulfil its role?

3. What elements of the system would you change in order for it to fulfil its role

4. Should reporting be voluntary?

5. Should reports be kept anonymous?

6. Should all types of incident be reported including incidents where no harm occurred, i.e. “near miss” events?

Never events are serious adverse events that should “never” occur if all of the appropriate safety systems are in place. They include events such as wrong site surgery.

7. How should ‘never events’ be captured?

8. What types of incident should be a priority for reporting?

9. Who should be encouraged to report?

10. What role do patients have?

11. Who should take responsibility for dealing with the safety issues highlighted by the reports?