INTERVIEW PROTOCOL – PATIENT ADVOCATES

Introductory script

Thank you for agreeing to participate in this interview. My name is [Melissa Hafner or Stefanie Pietras] and I work as a researcher for Mathematica Policy Research. I estimate that this interview will take approximately 1 hour.

Background on cataract adverse events and project description:
The Betsy Lehman Center (BLC) issued an advisory bulletin in May 2015 in response to an increase in serious reportable events related to cataract surgeries reported by Massachusetts hospitals and ambulatory surgical centers in 2014.

The Betsy Lehman Center is conducting a project to better understand and address the risk of patient harm during cataract surgery and Mathematica is providing research support for this project. Some examples of patient harm include errors in administering anesthesia, implantation of the wrong intraocular lens, wrong site, wrong patient, and wrong procedure surgeries. The Betsy Lehman Center's goals are to identify critical patient safety risks using adverse event data and respond to them by raising awareness, understanding root causes, and sharing strategies to reduce future harm to patients.

Purpose of interview:
The Center has convened an expert panel on improving patient safety in cataract surgery. We are gathering information from a variety of sources for the expert panel. As part of the process we are interviewing a range of stakeholders including surgeons, anesthesiologists, patient advocates, and patient safety experts.

The purpose of this interview is to gather information about information about defining harm, engaging patients in their care, communicating medical errors to patients, and suggestions for how to involve consumers in patient safety efforts, and suggestions for how to communicate patient safety information.

How results will be used:
We will summarize the major themes and findings from these interviews to support the work of the expert panel which has been convened by the Betsy Lehman Center. The expert panel will produce a report of key findings from the information gathering process and develop recommendations for strategies to improve patient safety in cataract surgery. If we plan to attribute any statements directly to you in this summary or in the panel's final report, we will provide the statement to you for your review and approval. Do you have any questions?

We will take notes during the interview; however, we would like to audiotape the interview to ensure that we have accurately captured your responses. Do we have your permission to record the interview?

Patient safety overview

I'd like to ask some questions about the role of patients in cataract surgery, communicating with patients about adverse events, and also ask you about your suggestions for improving patient safety during cataract surgery.

1. Patient safety is a practice that prevents harm to patients resulting from the delivery of health care. The practice includes reducing mistakes, errors, near misses, incidents, events, or problems that lead to patient harm or could negatively affect patients. Have you or a family member been involved in an episode of patient harm during cataract surgery? If yes, please describe.

Definition of harm in cataract surgery

2. How would you define "patient harm" in cataract surgery? What constitutes harm?

   Probe: Does harm include only circumstances that cause lasting injury to the patient? Can you describe other types of harm?

Preventing harm during cataract surgery

3. Are you aware of any routine procedures surgeons and their teams use to prevent harm during cataract surgery? If yes, please describe.

   [If respondent mentions timeouts in this answer, skip question 4]

4. Are you familiar with the "surgical time-out" as a patient safety process? If no, provide definition:

   A time-out happens when the operating room team (surgeon, anesthesia provider, circulating nurse and OR technician or scrub nurse) stops all activities just before beginning a procedure to confirm the patient's identity, the correct surgical site, the planned procedure, and other key information.

   Now that we have an understanding of time-outs, what do you think are the potential benefits and limitations of engaging patients in processes such as surgical time-outs?

5. To what extent can patients reasonably participate in surgical processes such as time-outs or other interventions?

   Probe: Do you have any perspective on how patients prefer to participate in such interventions? Are there times when patients' preferences may not be feasible?

6. What is your understanding of the particular patient safety challenges facing the population most likely to have cataract surgery?

   Probe: Limitations such as cognitive or hearing issues, or comorbidities?

7. What do you think needs to occur to make cataract surgery safer for patients? Are there unique best practices around ensuring the safety of care for elderly patients?

8. In thinking about the changes that are required to reduce the potential for harm in cataract surgery, what would you say are the main barriers to implementing change?

   Probe, if needed: To what extent do you think the following issues might be barriers to improving patient safety in cataract surgery? Too many patients, doctors are too busy or do not put enough emphasis on the patient? Patient issues such as lack of awareness or knowledge, or being too sick.

The role of patients in cataract surgery

9. What are some ways to increase patients' engagement in their care to ensure safety during cataract surgery? What are the challenges to employing such practices?

10. Are you familiar with the term shared decision-making? If no, provide definition:

    Shared decision making has been defined as: 'an approach where clinicians and patients share the best available evidence when needing to make decisions about the patients' care or management, and where patients are supported so that they may consider the options, to achieve informed preferences.'

11. To what extent do you think that surgeons and anesthesiologists employing shared decision making could make cataract surgery safer? For example, if patients participated in the decision about the type of anesthesia.

Communicating with patients after errors occur

12. What specific information should be shared with patients following an adverse event or error in their cataract surgery?

    Probe: clear description of the error or adverse event, how the error occurred, who was responsible.

13. How should this information be provided to patients? Who should be responsible for discussing an error with a patient, including any follow-up conversations?

Best ways to disseminate information to stakeholders

14. Thinking about other advocates like yourself, what do you think are the best ways to reach them to share new information and best practices related to patient safety in cataract surgery?

15. What do you think are the best ways to reach patients to share new information and best practices related to patient safety in cataract surgery?

Probe: Are there any specific publications, newsletters, websites, or social media outlets that would help spread this information?

Conclusion

16. Is there anything else you would like to share? Can you suggest anyone else we should interview?

Thank you for your time. We know how busy you are.