Interview Guide

Before conducting any interviews:

- review the just assessment process steps and questions to determine what information will be required.
- Plan the sequence of interviews: If possible, the patient and family members should be interviewed first as they have insight into the events leading up to the events.
- If peers or subject matter experts will be interviewed, consider what situational information about the events will be provided to them.
    - The purpose of interviewing people who were not involved in the events is to gather additional information and perspective. This may be influenced by the amount of information they are provided about the events.
    - As a general rule they should be provided with the same situational information the person who is being assessed had when events were unfolding. For example, how many other patients the person was caring for, the availability of needed personnel or equipment, to name just a few.

Before asking interview questions:

- explain to the interviewee what the purpose of the interview is, how the information will be used, and how it will remain confidential.
- start with a clear view of what information is required.
- use open-ended, nonleading questions; avoid rhetorical questions.
- if interviewing peers or subject matter experts, explore any biases the interviewee may have about the case and how much they are aware of it. If they are aware of the outcome for the patient, coach them not to consider it in their answers.

During the interview:

- collect information specifically about:
    - the events leading up to the patient safety incident
        - what happened and how the interviewee was involved
        - when things happened – record this information in the C**hronology of Events Table**
        - show the interviewee the current chronology[1] so they can be asked to provide additional details about events already recorded and also so they can see what is missing.[2]
    - which specific problem(s) they considered were the greatest contributors to the patient's outcome or close call.
    - the context of care which will help the assessor to identify system factors
        - review the System Factors guide and use it to formulate questions
        - record what was learned in the **System Factors Table**
    - problems that appeared to have occurred
        - review the problem analysis sheet
            - ➢ be prepared to answer the questions about an action or inaction and about the three steps in the information processing sequence that preceded the decisions that were made to act or not to act

[1] Developing a chronology is iterative. It often is initially developed with information obtained from a patient's chart and added to with information from interviews.

[2] An interviewee may have a different idea of what and when events happened compared to what is currently recorded in the chronology. Therefore, it is advisable that if they are shown the chronology then the third column (source) must not be revealed. If an assessor ends up having more than one version of events, keep all of the different versions in the 'master chronology' and keep them separated by highlighting them with different colors or use different fonts.

        - understand
        - observe and monitor
    - what appeared to be the primary motivation for the individual's action(s) or inaction(s) – did it seem they were done more for the patient's benefit or the individual's benefit?

- If the interviewee is a peer or subject matter expert who is providing insights that will be used to assess action(s) or inaction(s) evaluation step
    - review the guide for peer review.
    - select an appropriate peer for this test
    - have available an accurate summary of the chronology of events and the important system factors that could have influenced the actions of the individual under assessment that the individual would have been aware of at the time events took place

A note about peers and subject matter experts

Peers may be helpful sources of information about standards or rules that govern the types of decisions and actions that were undertaken and may provide perspective about how often most people adhere to them. Subject matter experts (SMEs) may yield additional information, particularly in cases in which the decisions made and the actions undertaken by the individual were not expected. SMEs may also be able to suggest which one or more system factors might have contributed to the event, particularly those that could interfere with workers' abilities to follow standards or rules.