References

Acute Hospital Local Health Plan (2004) *NHS Ayrshire and Arran Health Board.* Ayrshire. South Ayrshire.

Albert, W, Wu *et al* (1997). "To tell the truth: Ethical and practical issues in disclosing medical mistakes to patients". *Journal of General Internal Medicine,* Vol12 (December 1997): 770.

Allinson, C. (2004), "The process of audit and control: a comparison of manual and electronic information systems", *International Journal of Police Strategies and Management*, Vol. 27, pp. 183-205

Amalberti R, Auroy, Y (2005) "Five System barriers to achieving ultra- safe health care". *Annals of Internal Medicine* (2005) May; 142 (9) pp. 756-64.

Ammenwerth E, Haux R, Kulikowski C, Bohne A, Brandner R, Brigl B, Fischer G, Garde S, Knaup P, Ruderick F, Schubert R, Singer R and Wolff AC (2003). "Medical informatics and the quality of health: New approaches to support patient care. Findings from the IMIA year book of medical informatics 2003". *Methods Inf. Med* 2003; 42; pp. 185-9.

Anderson J.D. (1999) Increasing the acceptance of clinical information systems. *MD Computing: Computers in medical practice* (1999) 16:62-65.

Arnold, J.A., Randall, R., et al. (2010*).* *Work Psychology: Understanding human behaviour in the workplace* (5th ed). Prentice Hall: London.

Ashcroft, D. M., Cooke, J. (2006) "Retrospective analysis of medication incidents reported using an online reporting system". *Pharmacology world & science*. 28, 359-365.

Aspden P. Corrigan J. et al (2004) *Patient Safety: Achieving a New Standard for Care*. Committee on Data Standards for Patient Safety. Board on Health Care Services. Insitution of Medicine. The National Academies Press. Washington.

Audit Scotland. (2005). "A Scottish prescription: Managing the use of medicines in hospital". Prepared for the Audit General for Scotland. Edinburgh. ISBN 1 904651 852.

Audit Scotland. (2009). "Managing the use of medicines in hospital: follow-up review". Prepared for the Audit General for Scotland. Edinburgh. April 2009

Barach P., & Small, S. (2000). "Reporting and preventing medical mishaps: Lessons from non-medical near miss reporting systems". *British Medical Journal*; 320:759.

Barling, J.,Loughlin, C. and Kelloway, E.K. (2002). “Development and test model linking transformational leadership and occupational safety”. *Journal of Applied Psychology*, 87, pp 488-496

Bates, D., Spell, N., Cullen, D.,J. (1997). “The cost of adverse drug events in hospitalised patients. Adverse Drug Events Prevention Study Group”. *Journal of the American Medical Association*, 277 (4), pp. 307-311.
Bates, D. W., (2002) *The quality case for information technology in healthcare.* BMC Medical Informatics and Decision Making, 2:7.

Bates D.W, Evans R.S., Murff H, Stetson PD, Pizziferri L and Hripcsak G (2003) “Detecting adverse events using information technology”. *Journal of American Medical Informatics Association*. (2003) 10:115-128.

Benson M, Junger A, Michel A, Sciuk G, Quinzio L, Marquardt K, Hempelmann G (2000) “Comparison of manual and automated documentation of adverse events with an Anesthesia Information Management System (AIMS)”. *Studies in Health Technology and Informatics*. 2000;77:925-9.

Berens, M. (2000). “Nursing mistakes kill, injured thousands”. *Chicago Tribume. 10th September 2000.*

Berg, M. (2001). “Implementing information systems in health care organisations: Myths and challenges*”. International Journal of Medical Informatics*. 64, pp. 143-156

Berwick, D. (1998). “The National Health Service: feeling well and thriving at 75”. *British Medical Journal*, Vol.317, 4 July page 57-61.

Bijker W.E., Law J. (1992) *Shaping Technology Building Society, Studies in Sociotechnical Change*, MIT Press, Cambridge.

Bogner, S. (1994). *Human Error in Medicine.* New Jersey. Lawrence Erlbaum Associates.

Braithwaite, J., Westbrook, M., & Travaglia, J. (2008). “Attitudes toward the large-scale implementation of an incident reporting system”. *International Journal for Quality in Healthcare*, 20, 184–191.

Bryman, A. (ed.) (1988). *Doing research in organisations* Routledge London UK.

Burns, C., Mearns, K. & McGeorge, P. (2006). “Explicit and implicit trust within safety culture”. *Risk Analysis,* 26(5), 1139-1150.

Carroll, J.S., & Quijada, M.A. (2004). “Redirecting traditional professional values to support safety: changing organisational culture in healthcare”. *Quality and Safety in Health Care*, 13, ii16-ii21.

Cherns, A. (1976). “The principles of sociotechnical design”. *Human Relations,* 29, 783-792.

Cohen M (2000) “Why error reporting systems should be voluntary: They provide better information for reducing errors”. *British Medical Journal* 2000; March 18; 320(728-729.

Coiera E. (1999) “The impact of culture on technology”, *Medical Journal of Australia*. 171 (1999) 508–509.

Coiera E. (2006) “Putting the technical back into socio-technical system research”. *International Journal of Medical Informatics*. Volume 76, Supplement 1. pp.S98-S103

Corrigan JM, Kohn LT, Donaldson MS, et al (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.

Creswell, J. (2007*) Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. (2nd Edition) Sage. California.

Cronbach, L.J. (1951). “Coefficient alpha and the internal structure of tests”. *Psychometrika*, 16, pp. 297-334.

Cullen, D.L., Bates, D.W., Small, S. D., Cooper, J., Nemeskal, A., & Leape, L.L. (1995). “The incident reporting system does not detect adverse drug events: A problem for quality improvement”. *Joint Commission Journal on Quality Improvement*, 21, pp. 541-561.

Cummings, T., and Worley C. (2001). *Organisation Development and Change*. South Western College Publishing, Cincinatti

Datix Ltd. (2012) *Datix : Software for patient safety*. Melbury House, 51, Wimbledon Hill Road, London, SW19 7Q

Department of Health. (2000). “An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer”. *The Stationery Office*, London

Dick R.S., Steen, E. B., Detmer, D.E. (1997*). The computer-based patient record: Revised edition: An essential Technology for Health Care*. Institute of Medicine. National Academy Press. Washington D.C.

Ennis and Harrington (1999).”Quality management in Irish healthcare”. *International Journal of Healthcare Quality Assurance,* Vol. 12., Issue 6, pp 232-244.

Evans, S.M., Berry, J.G., Smith, B.J., Esterman, A., Selim, P., O’Shaughnessy, J. and DeWit, M.(2006), “Attitudes and barriers to incident reporting: a collaborative hospital study”, *Quality and Safety in Health Care*, Vol. 15, pp. 39-43.

Evans, S.M., Berry, J.G., Smith, B.J., *et al.,* (2006). "Attitudes and barriers to incident reporting: A collaborative hospital study", *Quality and Safety in Health Care*, 15,pp 39–43.

Fazio, R. H., & Olson, M. A. (2003). "Implicit measures in social cognition research: Their meaning and use". *Annual Review of Psychology*, *54*, 297–327.

Figueiras, A., Tato, F., Fontainas, J., Takkouche, B., & Gestal-Otero, J.J. (2001). Physicians' attitudes towards voluntary reporting of adverse drug events. *Journal of Evaluation in Clinical Practice, 7,* 347–354

Firth-Cozens, J. (2004), "Organisational trust: the keystone to patient safety", *Quality and Safety in Health Care*, Vol. 13, pp. 56-6.

Flin, R. & Yule, S. (2004) "Leadership and safety in healthcare. Lessons from industry". *Quality and Safety in Health Care*, 13 (Suppl II), ii45-ii51.

Flin, R., Burns, C., Mearns, K., Yule, S. and Robertson, E.M. (2006), "Measuring safety climate in health care", *Quality and Safety in Health Care*, Vol. 15, pp. 109-15.

Force, M.V., Deering, L., Hubbe, J., Andersen, M., Hagemann, B., Cooper-Hahn, M. and Peters, W. (2006), "Effective strategies to increase reporting of medication errors in hospitals", *Journal of Nursing Administration*, Vol. 36, pp. 34-41.

Gallagher TH, Waterman AD (2003) "Patients' and physicians' attitudes regarding the disclosure of medical errors". *Journal of American Medical Informatics Association,* Feb 26, 289 (8) pp. 1001-7.

Garrett T. (2009) *Pharmacists' Reporting of Adverse Medication Incidents Australian Resources Centre for Healthcare Innovations*. Northern Sydney Central Coast Area Health Service.

Geels F.W.,Elzen B.,Green K. (2004) General introduction: System innovation and transition to stability cited in Elzen B., Geels F., Green K. (2004) *General introduction: system innovation and transitions to sustainability, Theory*, Evidence and Policy. Edward Elgar Publishing Ltd. United Kingdom.

General Medical Council (2009) *Regulating doctors: Ensuring good medical practice*. London. General Medical Council.

Hamilton-Escoto, K. H., Karsh, B., & Beasley, J. W. (2006). Multiple user considerations and their implications in medical error reporting system design. *Human Factors, 48,* 48–58.

Harper, M. L., & Helmreich, R. L. (2005). Identifying barriers to the success of a reporting system. In K. Henriksen, J. B. Battles, E. S.Marks, & D. I. Lewin (Eds.), *Advances in patient safety: From research to implementation*

(Vol. 3, pp. 167–179). Rockville, MD: Agency for Healthcare Research and Quality.

Hart, E., and J. Hazelgrove. 2001. "Understanding the organisational context for adverse events in the health services: the role of cultural censorship." *Quality in Health Care 10* (257-262).

Heeks, R., Mundy, D. and Salazar, A. (1999), “Why Health Care Information Systems Succeed or Fail. Information Systems for Public Sector Management”, Working Paper Series, Paper No. 9, available at: www.sed.manchester.ac.uk/idpm/research/publications/wp/igovernment/index.htm

Heeks, R.B and Davies, A. (1999). “Different approaches to information age reform”, in R.B. Heeks (ed.) *Reinventing Government in the Information Age*, London: Routledge.

Heeks, R.B, Mundy, D., Salazar, A. (1999). “Information Systems for Public Sector Management: Why Healthcare Information Systems Succeed or Fail*”. Working Paper Series, Paper No9*. Institute for Development Policy and Management. University of Manchester.

Heeks R.B. (2001) *Reinventing Government in the Information Age*. London, Routledge.

Heeks R.B. (2002) “Information Systems and Developing Countries, Failure, Success and Local Improvements” *The Information Society*. Vol. 18, No 2, pp. 101-112.

Heeks, R. and Bailur, S. (2007). “Analyzing E-government Research: Perspectives, philosophies, theories, methods, and practice”, *Government Information Quarterly* 24(2): 243–265.

Heifetz RA. (1994) *Leadership without easy answers.* Cambridge, MA: Bellknap Press; 1994. p. 113.

Heppner, P.P., Wampold, B.E., & Kivlighan, D.M (2008). *Research Design in Counselling* (3rd ed.) pp.31 Thompson Learning.

Holden R.J and Tzion Karsh B. (2007). A Review of Medical Error Reporting System Design Considerations and a Proposed Cross- Level Systems Research Framework. Human Factors, Vol.49, No2, April 2007, pp. 257-276. Human Factors and Ergonomics Society.

House of Commons Committee of Public Accounts. (2006). “A safer place for patients: Learning to improve patient safety”. House of Commons.
The Stationery Office. London.

House of Commons Committee (2009) Sixth Report: Patient Safety Report. House of Commons. Session 2008-2009. London. The Stationery Office. London

Hudson, P. (2003). "Applying the lessons of high risk industries to health care". *Quality and Safety in Health Care*, 12(Suppl. 1), i7-i12.

Institute of Medicine. (2001). *Crossing the quality chasm; A new health system for the 21st century.* Washington, DC; National Academy Press, 2001:25.

Johnson C (2002) "The Causes of Human Error in Medicine*". Cognition Technology and Work* (4).65-70.

Johnson, C. (2003). "How we get the data and what will do with it then? Issues in the reporting of adverse healthcare events". *Quality and Safety in Healthcare*. 12. ii64.

Kaplan B. (2001) "Evaluating informatics applications: Socio interactionism and call for methodological pluralism". *International Journal of Medical Informatics.* 64(1): pp39-56

Karsh, B., Holden, R. J., Alper, S. J., & Or, C. K. L. (2006). A human factors engineering paradigm for patient safety: Designing to sup-port the performance of the health care professional. *Quality and Safety in Health Care, 15* (Suppl. 1), i59–65.

Kennedy, I. (2001). "Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary". *The Stationery Office*, London , (Cmnd 5207).

Kingston, M.J., Evans, S.M., Smith, B.J. and Berry, J.G. (2004). "Attitudes of doctors and nurses towards incident reporting: A qualitative analysis". *The Medical Journal of Australia*. Vol. 181, pp. 36-9.

Kotak, D., Lawson, A.(2008). "Patient confidentiality and the intensivist". *The Intensive Care Society*. Volume 9, Number 2, July 2008

Kohn, L.T., Corrigan, J.M., Donaldson, M.S. (eds). (1999). *To Err is Human: Building a safer health system*. National Academy Press.

Lawton, R. and Parker, D. (2002), "Barriers to incident reporting in a healthcare system", *Quality and Safety in Health Care*, Vol. 11, pp. 15-18.

Leape, L., Lawthers, A.G., Brennan, T.A., Johnson, W.G. (1993)."Preventing medical injury." *Quality Review*. *Bulletin* 1993; 19: pp. 144-9

Leape L.L (1994) "Error in Medicine". *Journal of American Medical Informatics Association*, 1994, 272: pp.1851-1857.

Leape, L. (2000). "Institute of Medical Error Figures are not Exaggerated". *Journal of American Medical Informatics Association*, 284. pp. 95-97.

Leape, L. (2000). "Reporting of Medical Errors: Time for a Reality Check". *Quality in Healthcare.* 9. pp. 144-145.

Leape, L. (2002). “Reporting of Adverse Events”. *The New England Journal of Medicine*. Vol. 347 (20), November 14, pp. 1633-1638.

Lester, S (1999) *An introduction to phenomenological research*, Taunton, Stan Lester Developments. United Kingdom.

Lewin, K. (1951*) Field Theory in Social Science*, Harper and Row, New York.

Lluch, M. (2011). “Healthcare professionals’ organisational barriers to health information technologies – A literature review”. *International Journal of Medical Informatics*, 80, 849-862.

Milch C., Salem D et al (2005) Voluntary Electronic Reporting of Medical Errors and Adverse Events. *Journal of General Internal Medicine,* Vol.21. Issue 2. Pp.165-170

Milligan, F., Robinson, K. (2003). *Limiting Harm in Healthcare: A Nursing Perspective*. Pp. 1-16 Blackwell Publishing. Oxford.

Mumford E. (2003) *Can greater employee participation and humanisation of work help to make industry more efficient, people- friendly and better able to deal with the challenges of the future?* Idea Group Publishing. ISBN 1591401186

Murphy- Black, T (2000) *Questionnaires. In The Research Process in Nursing.* 4th (Ed.) Blackwell Science, London.

National Health Service Lothian. (2007). “Electronic adverse incident recording and reporting process”. Clinical Governance Department. National Health Service.

National Audit Office. (2003). “A Safer place to work: Improving the management of health and safety to staff in NHS trusts”. Report by the Comptroller and Auditor General. London, *The Stationery Office*.

National Audit Office. (2005). “A Safer Place for Patients: Learning to improve patient safety”. Report by the Comptroller and Audit General. House of Commons. London. *Stationery Office*. 3rd November 2005. (HC 456 Session 2005-2006)

National Health Service, Quality Improvement Scotland (2005) Clinical Governance and Risk Management: Achieving safe, effective, patient focused care and services. National Health Service, Quality Improvement Scotland. Edinburgh.

O’Daniel, M. and Rosenstein, A.H. (2008). Chapter 33. Professional Communication and Team Collaboration. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. In Hughes, R.G. (Ed.) (2008). *Patient safety and quality: An evidence-based handbook for nurses.* (Prepared with support from the Robert Wood Johnson Foundation). AHRQ Publication No. 08-0043. Rockville, MD: Agency for Healthcare Research and Quality; March 2008)

Pasmore, W.A., Francis, C., Haldman, J. and Shani, A. (1982). “Sociotechnical Systems: A North American Reflection on Empirical Studies of the Seventies”. *Human Relations*, 35 (12),1179-1204.

Reinertsen, J. L. (2000). Let’s talk about error – Leaders should take responsibility for mistakes. *British Medical Journal, 320, pp.* 730

Reinsertsen, J.L, Gosfield, A.G., Rupp, W., Whittington, J.W. (2007). “Engaging Physicians in a Shared Quality Agenda*”. Institute for Healthcare Improvement Innovation Series white paper*. Cambridge, Massachusetts:

Rosenthal, M. (1999), “How doctors think about medical mishaps”, in Rosenthal, M., Mulcahy, L. and Lloyd-Bostock, S. (eds), *Medical Mishaps*, Open University Press, Buckingham.

Ross, J., Plunkett, M., Walsh, K. (2010). “Adverse Event categorization across NHS Scotland”. *Journal of Quality Safety Healthcare*; 19, 1-4.

Rubenowitz, S. (1980) *Utrednings-och forskningsmetodik*. Gothenberg, Sweden: Scandinavian U Books. 1980.

Runciman W.B. et al (2006) “An integrated framework for safety, quality and risk management: an information and incident management system based on a universal patient safety classification”. *Quality and Safety in Health Care* 2006;15:i82-i90

Runciman, W.B., (2002). "Lessons from the Australian Patient Safety Foundation: Setting up a national patient safety surveillance system: Is this the right model" *Quality and Safety in Health Care*. 11(3): pp246 - 251.

Runiciman, W.B., Merry A.F., Tito. (2003). “Error, Blame, and the Law in Healthcare- An Antipodean Perspective”. *Annuals of Medicine*, Vol. 138, No.12. pp. 974-980.

Runciman, W.B. (2009). “Towards an International Classification for Patient Safety: Key concepts and terms”. *International Journal for Quality in Healthcare*. Volume 21, Issue 1, pp. 18-26

Saunders, M., Lewis, P., Thornhill., A. (2007).*Research methods for business students* 4th Ed Pearson Education Limited Essex UK.

Schectman, J.M. and Plews-Ogan, M.L. (2006), “Physician perception of hospital safety and barriers to incident reporting”, *The Joint Commission Journal on Quality and Patient Safety*, Vol. 32, pp. 337-43.

Schein, E. (1990). “Organisational Culture”. *American Psychologist*, Vol. 45(2), 109-119.

Schoen, C., Osborn, R., Doty, M., Bishop, M., Peugh, J., Murukutia, N., (2007). “High –performance health systems: Adults’ Healthcare experiences in seven countries”. *Health Affairs* 2007; W717-W734

Sheridan TB, Thompson JM. “People versus computers in medicine” in Bogner MS (ed). *Human Error in Medicine*. Hillsdale, NJ: Lawrence Erlbaum Associates, 1994, pp. 141–59.

Sheriff Determination. (1995). “Significant Adverse Incident Investigation”. *NHS Ayrshire and Arran*. South Ayrshire. Scotland.

Silverman, D (2001). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. (2nd ed.) Sage Publication. London.

Silverman, D (2005). *Doing qualitative research: A practical handbook*. (2nd ed.). London: Sage Publication.

Thomas E and Patersen (2003) Measuring Errors and Adverse Events in Health Care. *Journal of General Internal Medicine*, vol.18, no.1 pp. 61-67.

Taylor, J.A., Brownstein, D., Christakis, D.A., Blackburn, S., Strandjord, T.P., Klein, E.J., & Shafii, J. (2004). “Use of incident reports by physicians and nurses to document medical errors in pediatric patients”, *Pediatrics,* 114, pp. 729-735.

Uribe C. L, et al. (2002) Perceived Barriers to Medical-Error Reporting: An Exploratory Investigation*. Journal of Healthcare Management*. 2002; 47:263–279.

Vincent, C., Stanhope, N. and Crowley-Murphy, M. (1999), “Reasons for not reporting adverse incidents: an empirical study”, *Journal of Evaluation in Clinical Practice*, Vol. 5, pp. 13-21.

Vincent, C. (2010). “Understanding and Responding to Adverse Events”. *New England Journal of Medicine.* 348: 1051-1056

Walsh, K. and Antony, J. (2007), “Quality costs and electronic adverse incident recording and reporting system: is there a missing link*?” International Journal of Health Care Quality Assurance*, Vol. 20, pp. 307-19.

Walsh, K., Antony, J. (2009). “An Assessment of Quality Costs within Electronic Adverse Incident Reporting and Recording Systems: Some observations of key findings” *International Journal of Healthcare Quality Assurance*. Vol. 22, No. 3, 2009, 203-220.

Walsh, K., Burns, C., Antony, J. (2010). “Electronic Adverse Incident Reporting in Hospitals”. *Leadership in Health Services*, 23(4), 292-303.

Waring, J.J. (2005), “Beyond blame: cultural barriers to medical incident reporting”, *Social Science & Medicine*, Vol. 60, pp. 1927-35.

Westbrook, M.T., Braithwaite, J., Travaglia, J.F., Long, D., Jorm, C. and Iedema, R. (2007), “Promoting safety: varied reactions of doctors, nurses and allied health professionals to a safety improvement program”, *International Journal of Health Care Quality Assurance*, Vol. 20, pp. 555-71.

Wilson J. and Tingle J. (1999). *Clinical Risk Modification: A route to clinical governance*. Biddles Ltd. Guildford and King’s Lynn.

Woods DD, Johannesen L, Cook RI, Sarter N (1994). Behind human error: cognitive systems, computers and hindsight. Crew Systems Ergonomic Information and Analysis Center, WPAFB, Dayton OH,1994(at http:// iac.dtic.mil/hsiac/productBEHIND.htm)

Woolgar S. (1988) *Science: The Very Idea*, Ellis Horwood, Chichester, 1988.

World Health Organisation. (2005). “WHO Draft Guidelines for Adverse Event Reporting and Learning Systems: From Information to Action. Geneva: WHO Documentation Product Services.

Appendix 1 Questionnaire

Appendix 2: Information sheet

INFORMATION SHEET & CONSENT FORM

Research Title: **To critically evaluate the holistic development and application of an Electronic Adverse Incident Recording and Reporting Management System in an acute health care setting.**

You are being invited to take part in a research study. Before you decide as to whether you wish to participate, it is important for you to understand why the research is being undertaken and what it will involve. Please take the time to read the following information carefully and feel free to discuss it with others if you wish. If there are any questions that you may have or seek clarification on any part, please contact me to discuss. I would also like to highlight that you should take the time to decide whether or not you wish to take part.

Consumers for Ethics in Research (CERES) published a leaflet entitled 'Medical Research and You'. This leaflet provides more information about medical research and looks at some of the questions you may wish to ask. A copy of this will be made available to you on request.

What is the purpose of the study?

The purpose of the study is to establish obstacles and opportunities in the implementation of an adverse incident recording system within an acute hospitals setting. The research will look at potential opportunities and obstacles across managerial and professional bodies in order to support and manage a data recording system.

The research is to assess the effectiveness of professional and managerial commitment in sustaining the system to capture adverse incidences and near misses. Furthermore, the purpose, of the research would be to understand the strategic and operational barriers to the introduction of an adverse incident reporting system.

Why have I been chosen?

You have been chosen as you have been involved in the selection, implementation or review of NHS Ayrshire and Arran's Adverse Incident Recording System.

Do I have to take part?

It is up to you to decide whether or not you wish to take part. If you do decide to take part you, will be given this information sheet to keep and be asked to sign the consent form contained therein.

If you decide to take part, you are free to withdraw at anytime and without giving a reason. The decision to withdraw at anytime, or the decision not to take part, will not affect your status/work within NHS Ayrshire and Arran.

What will happen to me if I take part?

You will be interviewed on a one to one basis. All specific comments will reamin confidential, however, trends will be incorporated into the research, no individual identification will be recorded in the research.

What are the possible benefits of taking part?

The benefits to NHS Ayrshire and Arran will be to enable the system to move towards complying with the NHS Quality Improvement Clinical Governance National Standards. The research will assist in the further development of risk standards at a national level.

On an individual basis, you will have the opportunity to strengthen the current risk management process in order to safe guard and potentially improve direct patient care.

Appendix: 3

CONSENT FORM

Name of Research: Kerry Walsh

Title of Project: **To critically evaluate the holistic developement and application of an Electronic Adverse Incident Recording and Reporting Management System in an acute healthcare setting.**

	Please indicate Yes or No
1. I confirm that I have read and understand the information sheet dated May 2006 and that I have had the opportunity to ask questions prior to interview.	
2. I understand that my participation is voluntary and that i am free to withdraw at any time, without giving any reason, without my work/status being affected.	
3. I understand that the research information may be looked at by responsible individuals or from regulatory authorities where it is relevant to my taking part in the research. I give permission for these individuals to have access to my information at any time.	
4. I agree to take part in the above study.	

Name of participant **Signature:**

PLEASE PRINT

Date:

Researcher **Signature:**

PLEASE PRINT

Date:

Name of person taking research **Signature:**

(if different from researcher)

PLEASE PRINT **Date:**

Appendix 4: List of publications from this doctoral research

Journal Papers

1. **Walsh, K.,** Burns, C., Antony, J. (2010). Electronic Adverse Incident Reporting in Hospitals. Leadership in Health Services, 23(4), 292-303.

2. Ross, J., Plunkett, M., **Walsh, K**. (2010). Adverse Event categorization across NHS Scotland. Journal of Quality Safety Healthcare; 19; 17th June 2010, pp. 1-4

3. Antony, J., **Walsh, K.** (2010). The theory of constraints and patient safety in healthcare: An overview. Healthcare Risk Report, March, pp. 22-24

4. **Walsh, K.,** Antony, J. (2009). An Assessment of Quality Costs within Electronic Adverse Incident Reporting and Recording Systems: Some observations of key findings? International Journal of Healthcare Quality Assurance. Vol. 22, No. 3, 2009, 203-220.

5. **Walsh, K**., Antony, J. (2008). An Assessment of Quality Costs within Electronic Adverse Incident Reporting and Recording Systems: Case study & observations. International Journal of Healthcare Quality Assurance. June Vol. 22, No3. 2009. pp. 307-319

6. Collier, A., Ghosh, S., Dowie, A., **Walsh, K**., O'Leary, C. (2008). HIV Testing in Dementia: Key Clinical Ethical and Patient Safety Implications. British Journal of Hospital Medicine. September 2008. pp. 500-503

7. **Walsh, K.,** Antony, J. (2008). Critical success factors for Electronic Incident Reporting Systems. Healthcare Risk March 2008, Volume 14, Issue 4. pp.12-14

8. **Walsh, K.,** Antony, J. (2007). Quality costs and EAIRRS: Is there a missing link? International Journal of Healthcare Quality Assurance. Vol. 20. No. 2, 2007. pp. 307-319

9. **Walsh, K.,** Antony, J. (2007). Improving patient safety and quality: what are the challenges and gaps in introducing an integrated EAIRRS within healthcare industry? International Journal of Healthcare Quality Assurance. Vol. 20. No. 2, 2007, 107-115.

Conference Papers

- Speaker. 'Adverse Incident Reporting and Patient Safety: Tomorrows World'. Project Managers National Conference. MDDUS. Tuesday 25th February 2010. Fairmount, St Andrews. Scotland.

- Paper (presented to and chaired by the editor of the British Medical Journal) Title: EAIRRSs in NHS Scotland: Challenges and critical success factors from a clinical and managerial perspective. Walsh, K and Antony J. (2009) International Forum on Quality and Safety in Healthcare. 17-20 March 2009, Berlin Germany.

- Speaker with Hazel Borland (Head of Clinical Governance and Patient Safety at the NHS Quality Improvement Scotland) at the International Society for Quality in Healthcare. Title, Safer Today, Safer Tomorrow: Facing challenges, sharing solutions in NHS Scotland. Bella Centre, Copenhagen, Denmark. October 19-22. 2008.

- Speaker and paper: An Assessment of Quality Costs within Electronic Adverse Incident Reporting and Recording Systems in a Scottish Hospital. Proceeding of the 2008 International Industrial Engineering Research Conference, Vancouver. British Columbia, Canada. May 2008**.**

- Speaker at the International Industrial Engineering Research Conference (IERC). Title An Assessment of Quality Costs within Electronic Adverse Incident Reporting and Recording Systems in a Scottish Hospital. Vancouver, British Columbia. May 21-25 2008.

- Speaker at National Clinical Risk & Patient Safety Conference. Electronic Adverse Incident Reporting & Recording Systems: What is the Strengths & Weaknesses? 12th November 2007. Chapter House, London. Healthcare Events. 2007.

- Speaker at National Conference: Patient Safety: Institute of Health Record & Information Management. 1st October 2007. Beardmore Hotel & Conference Centre, Clydebank, Glasgow. 2007.

- Speaker at National Scottish Conference for Improving Patient Safety through local and National Incident Reporting: Practical insights and lessons from UK, USA and the wider international field of patient safety. NHS Scotland. 2nd. July 2007.

- Speaker at NHS Ayrshire & Arran Clinical Governance Symposium 30 April 2007. EAIRRSs: Quality Costing a missing link. 2007.

Posters

- Poster presented Title: EAIRRSs in NHS Scotland: Challenges and critical success factors from a clinical and managerial perspective. Walsh, K and Antony J. (2009) International Forum on Quality and Safety in Healthcare. 17-20 March 2009, Berlin Germany.

- Poster presented at the International Forum on Quality and Safety in Healthcare. Title EAIRRSs in NHS Scotland: A framework for maintaining a quality risk management system. 20-23 April 2010, The Nice Acropolis, Nice, France

- Poster presented at the NHS Scotland Health Conference. Title EAIRRSs in NHS Scotland: Challenges and critical success factors from a clinical and managerial perspective. Walsh, K and Antony J. (2009) Scottish Exhibition Conference, Glasgow. 16-17 June 2009.

- Poster presentation. Title: An Assessment of Quality Costing within Electronic Adverse Incident Reporting and Recording System: A Case Study. British Medical Journal International Forum on Quality in Healthcare. 22-25 April 2008. Palasis des Congres de Paris.

National Working Groups and National

- Chair of the Safer Today Implementation Group via NHS Quality Improvement Scotland, Scoping study: Incident / event definitions and datasets in use across NHS Scotland. Prepared by Ross Abernethy. April 2008.

- Member of a national workshop: Focusing on the developing National Clinical Audit for NHS Scotland. NHS Quality Improvement. Royal College of Physicians and Surgeons. Glasgow. 10 January 2008.

- Author of Safer Today, Safe Tomorrow: Making it Happen. Progress & future Report / presented to the NHS Quality Improvement Board, 25th October 2007**.** (Safer Today Safer Tomorrow Steering Group.)

- Member of the Working Group Steering Group for the Safer Today Safe Tomorrow Report. NHS Quality Improvement Scotland. 2005.

- Member of the Working Group for Risk Matrix. NHS Quality Improvement Scotland. 2005.

- Member of the National Working Group for Safety Action Notices. NHS Quality Improvement Scotland. 2005.

Awards

- First prize awarded for best poster in the category of Patient Safety. Title: EAIRRSs in NHS Scotland: Challenges and critical success factors from clinical and managers perspectives. NHS Ayrshire & Arran, United Kingdom. International Forum on Quality and Safety in Healthcare. Berlin, Germany. 17-20 March 2009.

- Prize awarded for best oral presentation in the Management & Strategy session at the Research Presentation Day. University of Strathclyde. Glasgow. Scotland. 2008.

Appendix 5: Selected Publications