THE UNIVERSITY OF BRITISH COLUMBIA

CREATING SAFETY IN AN EMERGENCY DEPARTMENT

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PROVIDENCE HEALTH CARE
Research Institute
Pursuing **real life** health solutions

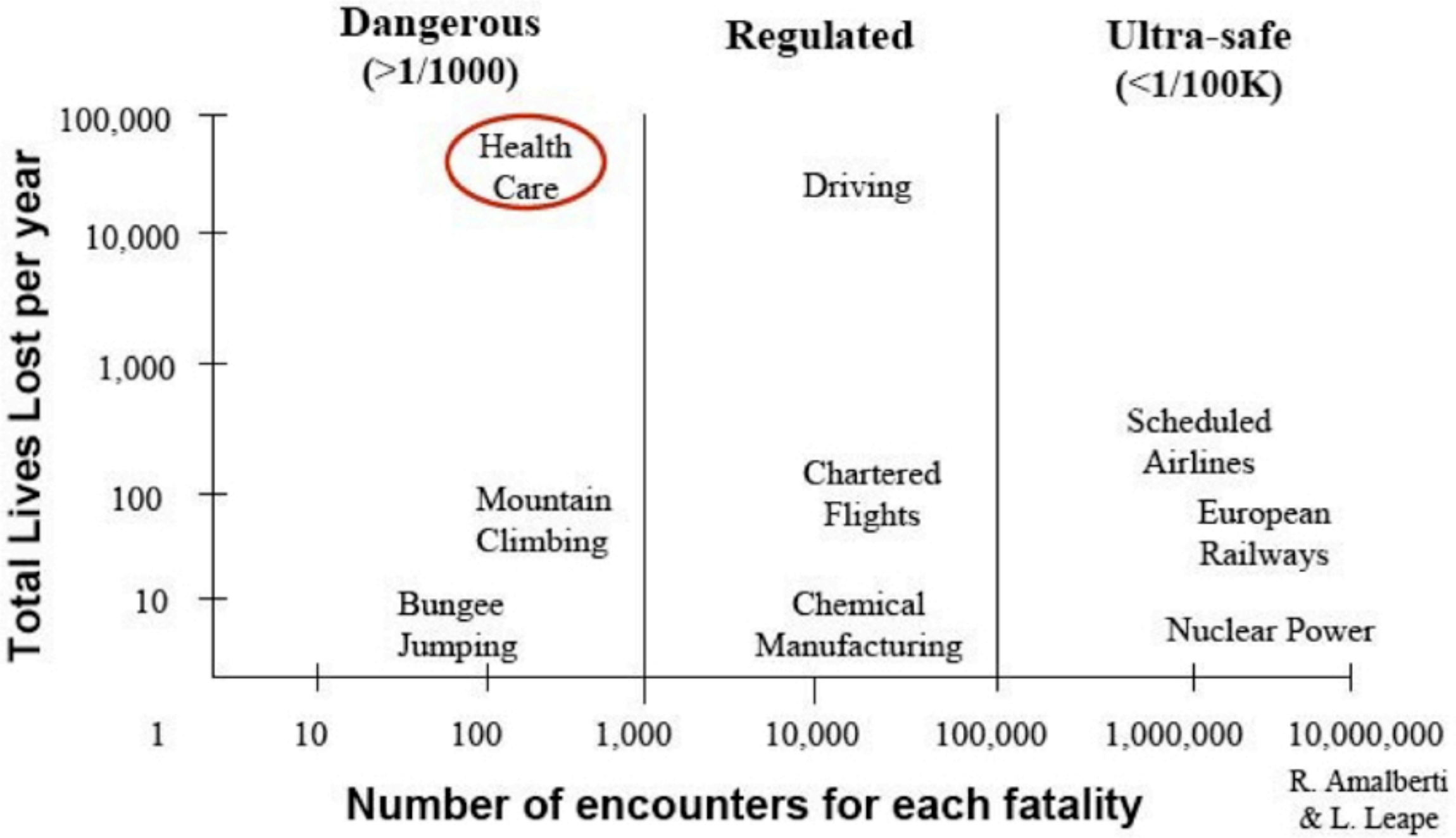
L'Association canadienne de protection médicale
The Canadian Medical Protective Association

"Remember that patient?"

The chief objective of education is not to learn things but to unlearn them

G.K. Chesterton

RISK


Dangerous
(>1/1000)
Regulated
Ultra-safe
(<1/100K)
Total Lives Lost per year
100,000
10,000
1,000
100
10
1
Health Care
Driving
Scheduled Airlines
Chartered Flights
Mountain Climbing
European Railways
Bungee Jumping
Chemical Manufacturing
Nuclear Power
1
10
100
1,000
10,000
100,000
1,000,000
10,000,000
Number of encounters for each fatality
R. Amalberti & L. Leape

EMERGENCY DEPARTMENTS: LIMINAL SPACE

unbounded, porous interface

uncertainty

time constraints

highest proportion of “preventable” patient harm

Brennan et al. (1991), Wilson et al. (1995), Thomas et al. (2000), Forster et al. (2004)

STATUS QUO SOLUTION

"RECOMMENDATION 5.2: development of voluntary reporting systems should be encouraged." Institute of Medicine (2000)

"an effective reporting system is the cornerstone of safe practice and a measure of progress towards achieving a safety culture" World Alliance for Patient Safety (2005)

"reporting tools are used to facilitate and foster a culture of safety in the attitudes and beliefs of healthcare providers" BC PSLS Annual Report (2008)

THE GAP: MAKING SENSE

limited evidence of the effectiveness of reporting systems - “black hole” syndrome

Wald & Shojania (2001); Thomas & Peterson (2003); Wachter (2004); Gandhi et al. (2005); Szekendi et al. (2006); Farley et al. (2008); Adler-Milstein et al. (2009); Benn et al. (2009)

‘safety’: polysemous, difficult to measure

Cardiff (2008); Landrigan (2010); Levinson (2010)

‘safety culture’: popular, political, problematic

Cox & Flin (1998); Pidgeon (1998); Hale (2000); Guldenmund (2000); Rosness (2003); Richter & Koch (2004); Guldenmund (2007); Antonsen (2009); Silbey (2009)

THE LENS OF 'PRACTICE'

modus operandi

product and context of social action

emergent and indeterminate

emphasis on "everyday"

Bourdieu (1990); Schatzki et al. (2001); Silbey (2009)

AIM

to explore how safety is created in the everyday practice of health care delivery in a hospital emergency department, and to describe the situated and distributed patterns of interaction that impact safety

CONJECTURES & CLAIM

safety emerges out of dynamic inter-actions embedded in shared (and contested) practice

safety is about giving account and learning in practice from success AND failure

safety is created through dialogic storying, resilience, and *phronesis*

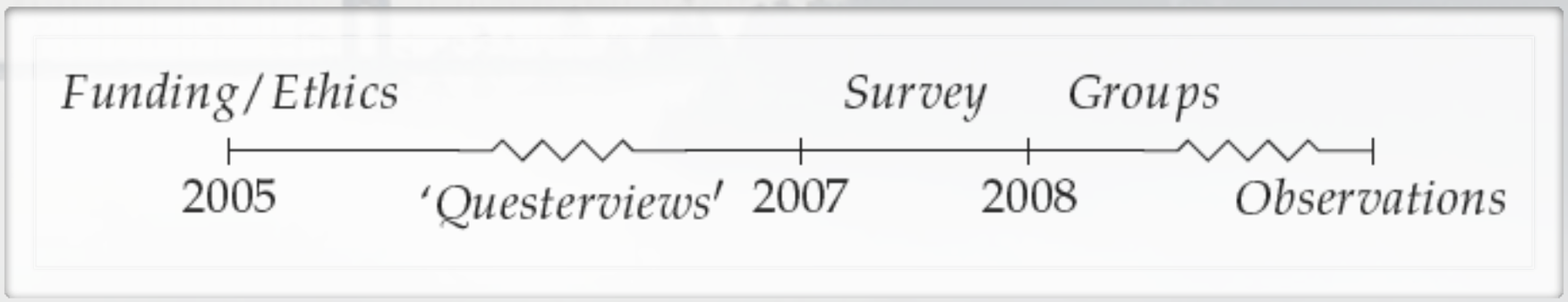
MIXED-METHOD ETHNOGRAPHY

phase I: questerviews [40.5 hours] - 26 participants, 2 tertiary hospitals

phase II: organizational survey - 40 participants

phase III: focus groups [6.25 hours] - 17 participants

phase IV: communication observation [28.5 hours] - 16 participants



PARTICIPANTS

role	number
emergency nurse	31
emergency nurse leader	12
emergency staff	15
emergency physician	24
administrator	3
TOTAL	85

QUESTERVIEWS

standardized questions or questionnaires within in-depth interview

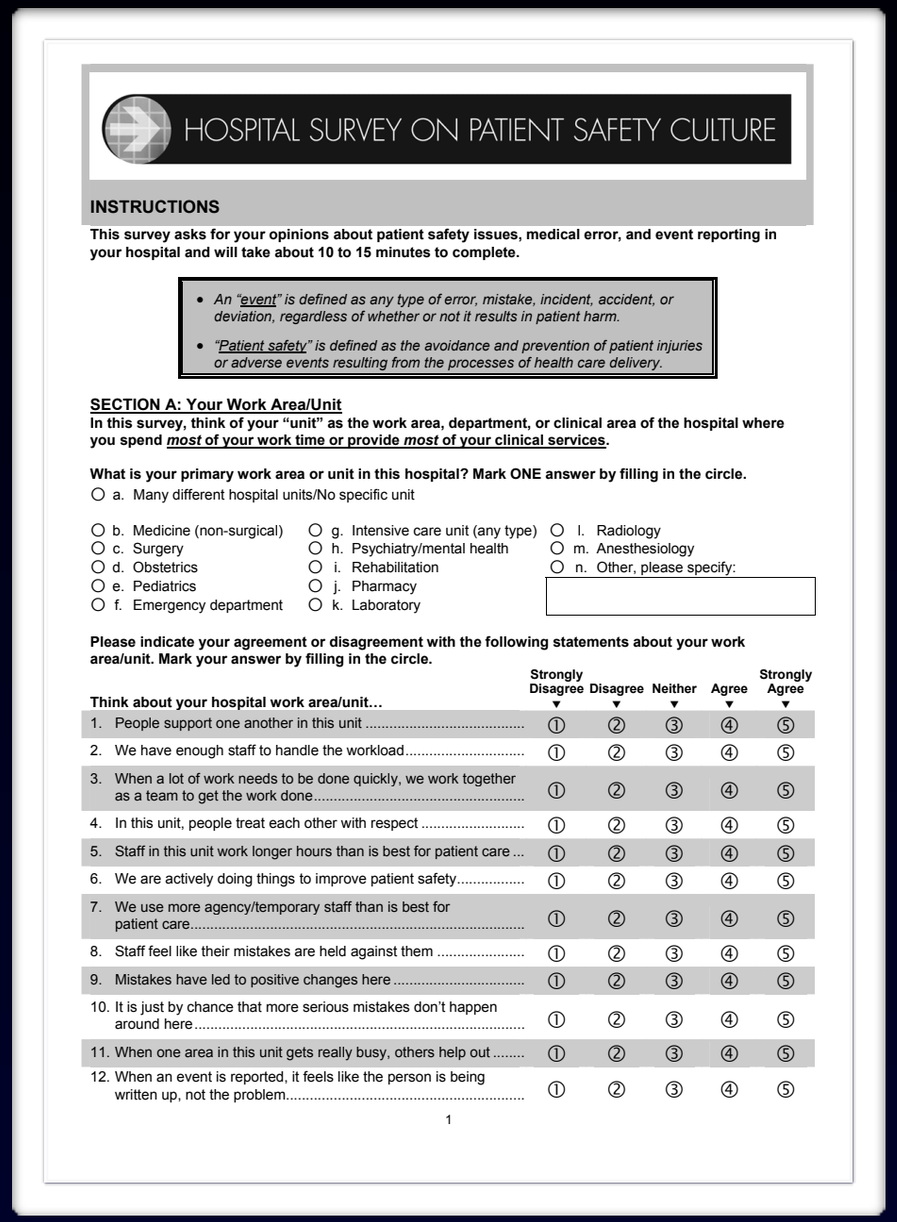
shared understanding of statements and response options (face validity)

draws out narratives

Adamson et al. (2004)

HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

management support
actions and expectations
response to error
feedback and
communication
communication openness
organizational learning
teamwork within unit
teamwork across units
hand-offs and transitions
staffing



HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

INSTRUCTIONS

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

- *An "event" is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.*
- *"Patient safety" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.*

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend *most* of your work time or provide *most* of your clinical services.

What is your primary work area or unit in this hospital? Mark ONE answer by filling in the circle.

○ a. Many different hospital units/No specific unit

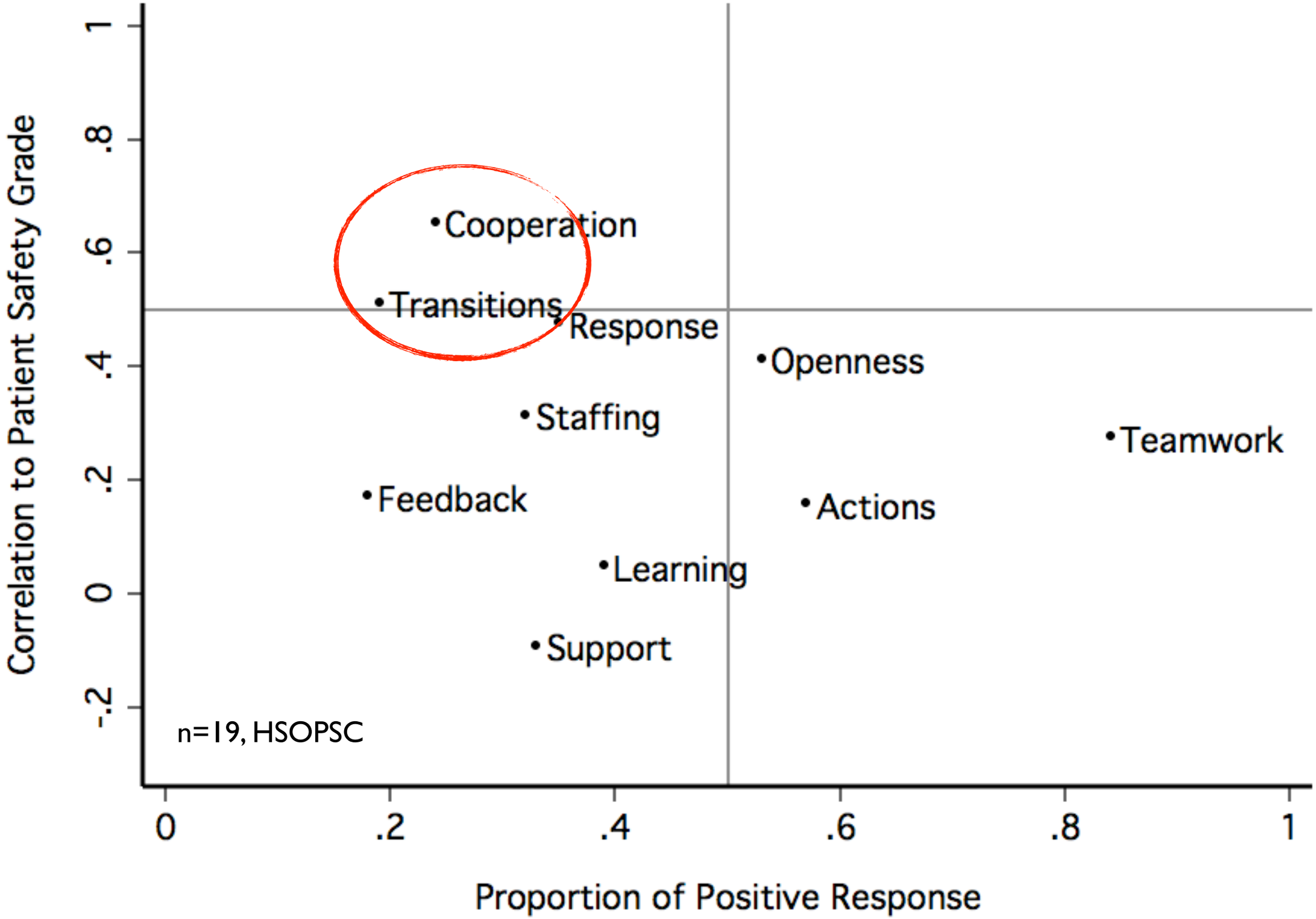
○ b. Medicine (non-surgical)
○ c. Surgery
○ d. Obstetrics
○ e. Pediatrics
○ f. Emergency department
○ g. Intensive care unit (any type)
○ h. Psychiatry/mental health
○ i. Rehabilitation
○ j. Pharmacy
○ k. Laboratory
○ l. Radiology
○ m. Anesthesiology
○ n. Other, please specify:

Please indicate your agreement or disagreement with the following statements about your work area/unit. Mark your answer by filling in the circle.

Think about your hospital work area/unit…	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. People support one another in this unit	①	②	③	④	⑤
2. We have enough staff to handle the workload	①	②	③	④	⑤
3. When a lot of work needs to be done quickly, we work together as a team to get the work done	①	②	③	④	⑤
4. In this unit, people treat each other with respect	①	②	③	④	⑤
5. Staff in this unit work longer hours than is best for patient care	①	②	③	④	⑤
6. We are actively doing things to improve patient safety	①	②	③	④	⑤
7. We use more agency/temporary staff than is best for patient care	①	②	③	④	⑤
8. Staff feel like their mistakes are held against them	①	②	③	④	⑤
9. Mistakes have led to positive changes here	①	②	③	④	⑤
10. It is just by chance that more serious mistakes don't happen around here	①	②	③	④	⑤
11. When one area in this unit gets really busy, others help out	①	②	③	④	⑤
12. When an event is reported, it feels like the person is being written up, not the problem	①	②	③	④	⑤

1

Sorra & Nieva (2004)


Correlation to Patient Safety Grade
1
.8
.6
.4
.2
0
-.2
Cooperation
Transitions
Response
Openness
Staffing
Teamwork
Feedback
Actions
Learning
Support
n=19, HSOPSC
0
.2
.4
.6
.8
1
Proportion of Positive Response

QUESTERVIEWS

responses vs reflections

qualification

D1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
[1 out of 5 downgraded]

HSOPSC Statement A15.

Patient safety is never sacrificed

"Enough checks and balances that mistakes are minimized"	"Bullshit...patient safety is sacrificed every single minute"
Providers try hard and work well together. Standards and processes are adequate to prevent serious mistakes from happening.	Competition for time and attention to deliver care to a heterogeneous population of patients within the dynamic of an ED places individual patients at risk of harm.

Despite a lot of limitations, *we do make it happen*... other disciplines or other facilities looking in on what we do on an average day, they'd probably say we're in crisis mode 24/7.

From our perspective though, I don't think we're operating in crisis mode all the time. We're able to step up to the plate, utilize what resources we have — even though some of them are limited — and we're able to think outside of the box. We're *flexible* and we're *adaptable*.

[Questerview, nurse leader, lines 538-540, 546-550]

We’re used to running flat out, but then we get somebody who’s really sick, then for a *brief period of time it’s brilliant*. People get moved, stuff happens, *people are creative*. Everybody’s on the same page and we’re *working well as a team*. . . But that doesn’t happen on a chronic basis. . . A *bomb has to go off* before you can get that sort of cooperation going.

[Questerview, physician, lines 530-532, 540, 553]

It’s one of the wonderful things about the specialty is that we have to think on our feet and *cope in unique ways* with all sorts of things every day.

Adhering to rigid rules, you know, “we never take more than four patients on as a nurse, therefore you can’t put that patient in the hallway,” “we don’t give medications in the waiting room”— you know this kind of thing is just frustrating. Those things are there for a reason and they *work well maybe in different environments but not in ours*, I think ours is unique.

[Questerview, physician, lines 489-498]

One of my great fears when I work is the feeling that my *ability to provide patient care is being sabotaged* by all of these things that don’t work. My propensity to make mistakes is being increased by all the stuff that doesn’t work. But *it’s going to be my mistake*.

[Questerview, physician, lines 1561-1567]

Everybody uses safety as really I think an *excuse to get resources*, and it's *not part of who we are*. We don't talk about safety like we talk about [things] that are ingrained in us like mission or our academic work.

[Questerview, administrator, lines 668-670]

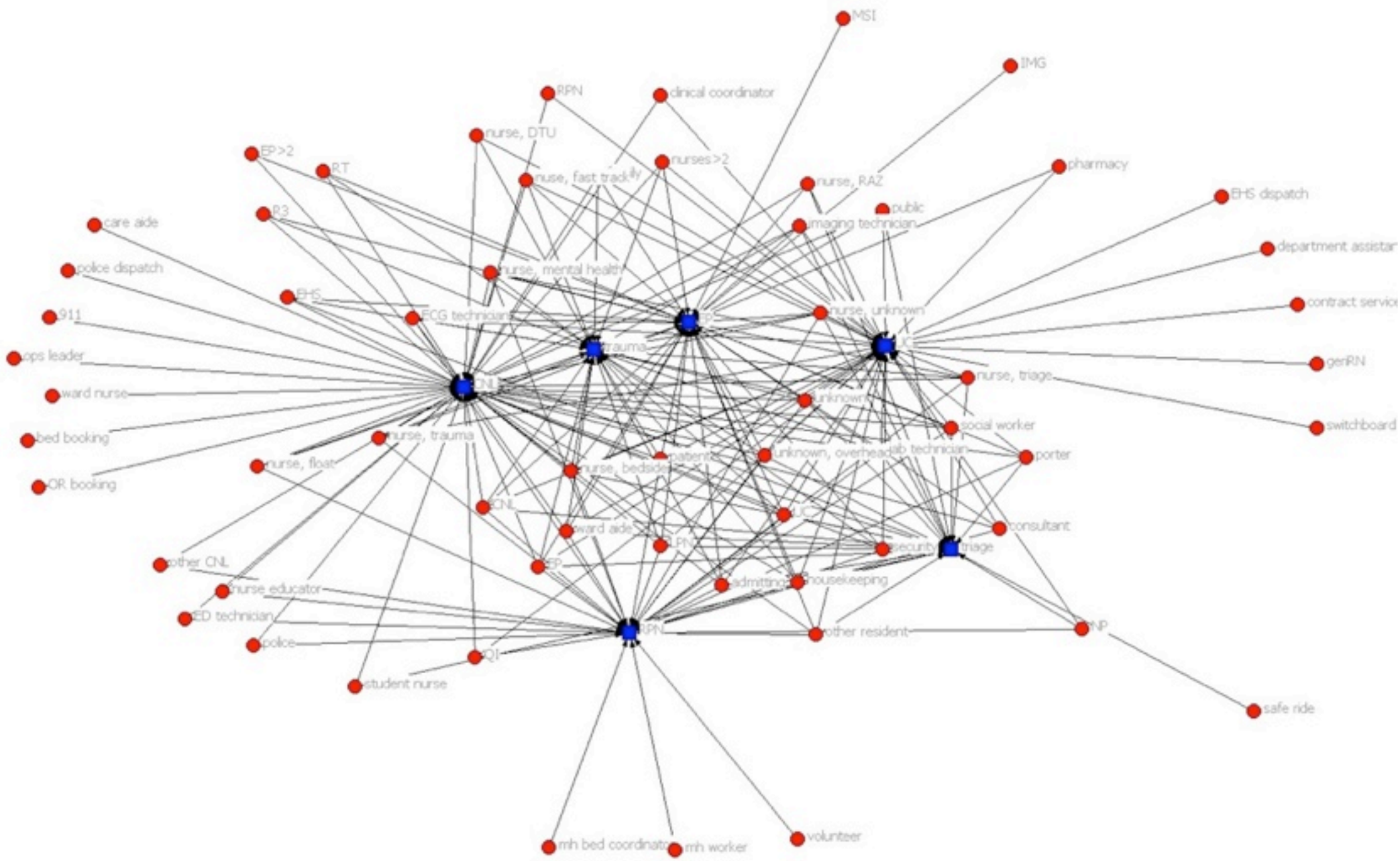
SAFETY NARRATIVES

Competence narrative of the individual, strategies to enhance professionalism, such as practice standards, education, and training

Capability narrative of the department; practitioners feel “unsafe” when their performance is stymied by system factors - space, staffing, support services

Sanctuary narrative of the department; security of the collective

INTERACTIONS



BARRIERS TO DIALOGIC SENSEMAKING

multiple, brief communication events - average 2.5 per minute/150 per hour

frequent interruptions (0.4 overall, 0.6 off-topic)

computer-mediated communication facilitates one-way (monologic) communication

“As the time frame shortens, there is less discussion between nurse and physician as to what’s going on.”
[Questerview, nurse, lines 1084-1085]

IMPROVISATION TO INNOVATION

capacity perceived to be the leading threat to safety in urban emergency departments Sklar et al. (2010)

waiting room and hallway care

improvisation (bricolage) to innovation

overcapacity protocols
assessment zones
observation units

RESILIENT STRATEGY
BRITTLE PRACTICE

overcapacity protocols

enacted *after* “free fall”

undermined by competing policies

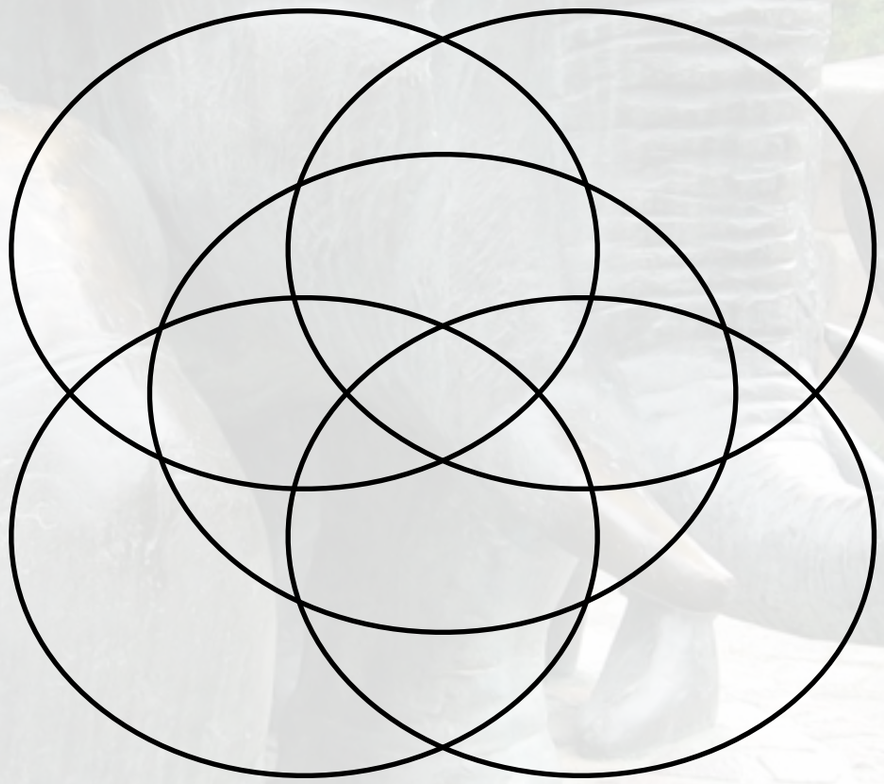
conflicting professional/organizational goals

SAFETY PRINCIPLES

‘Safety’ is...

enacted dialogically

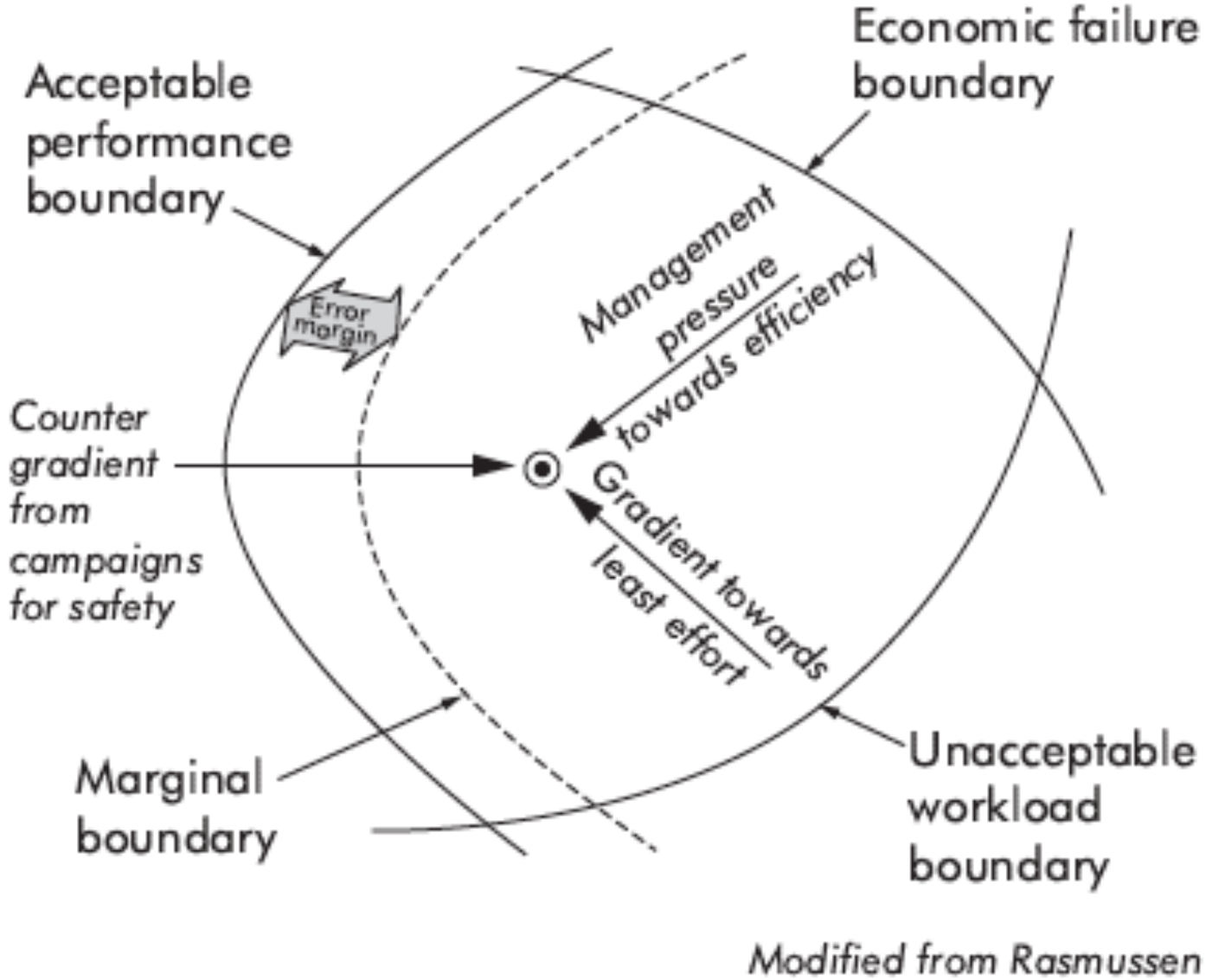
resilience



political

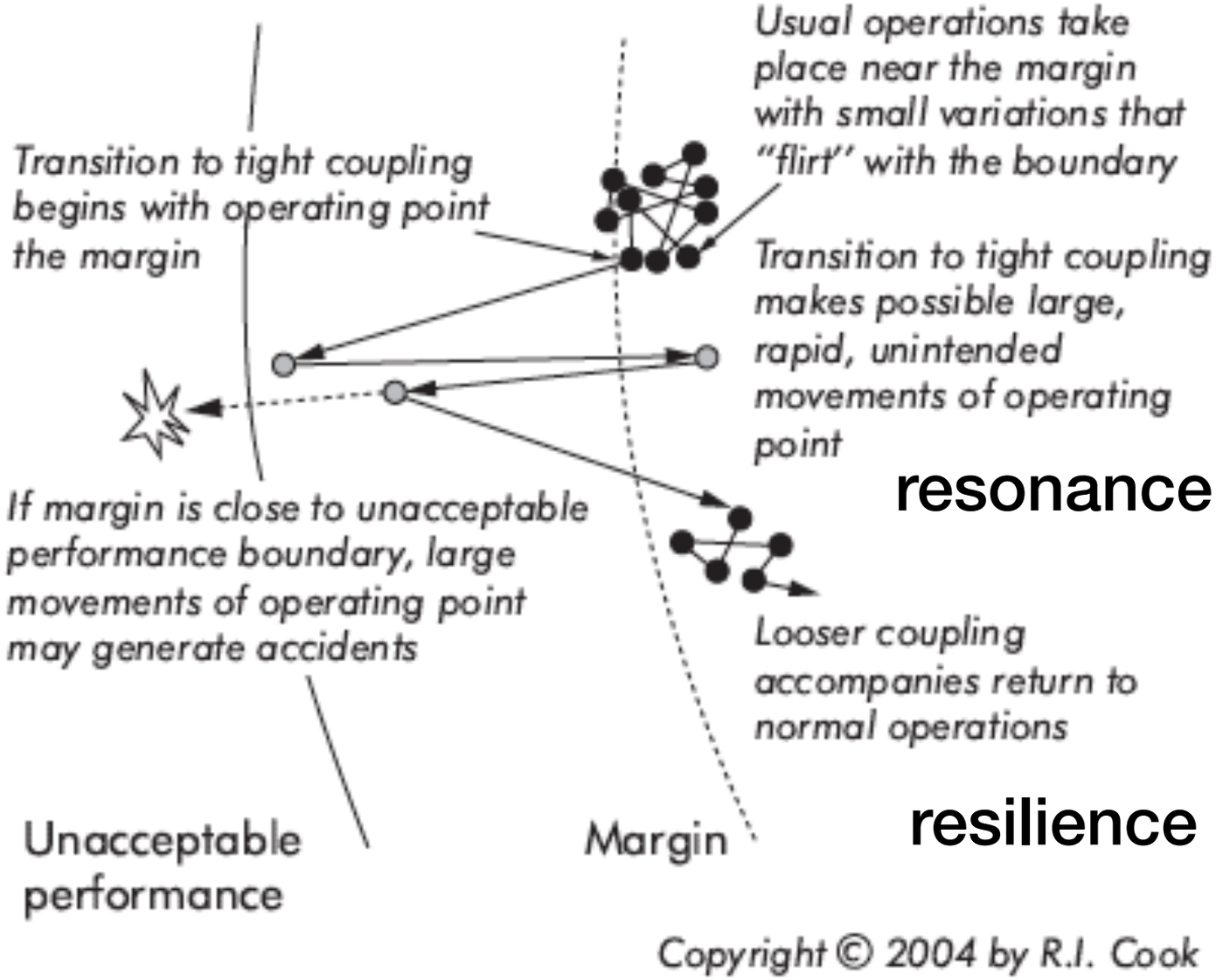
phronesis

DYNAMIC SAFETY MODEL



Modified from Rasmussen

dialogic storying



Cook & Rasmussen (2005)

CONTRIBUTIONS

theoretical
safety as action in practice

methodological
“measurement” of ‘safety culture’

operational
material anchors (tools), communicative space

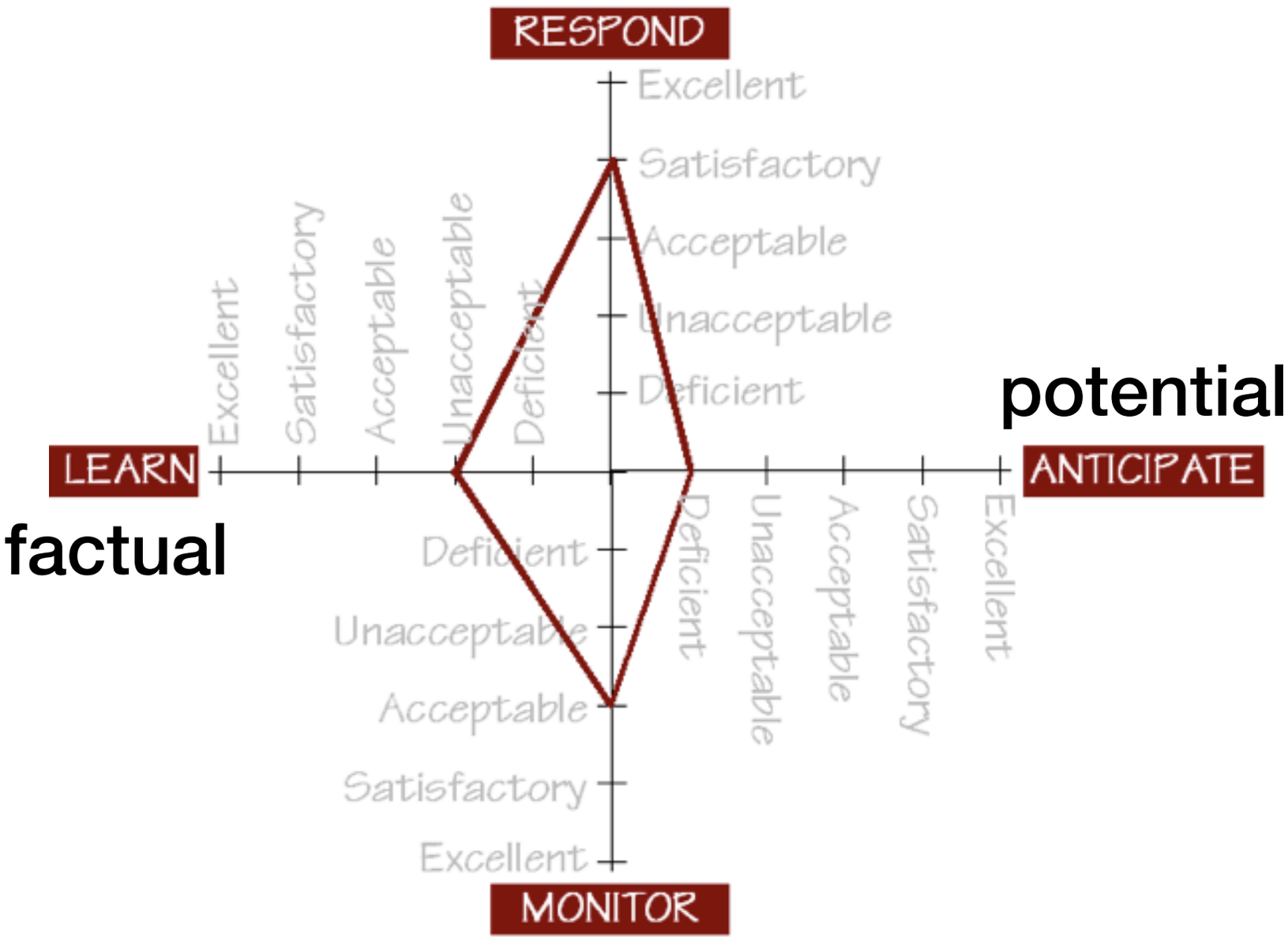
IMPLICATIONS

limitations of reporting as a way to create safety

greater emphasis on dialogic and resilient aspects of everyday normal work, and *phronesis* of successful practice

FUTURE DIRECTIONS

actual



potential

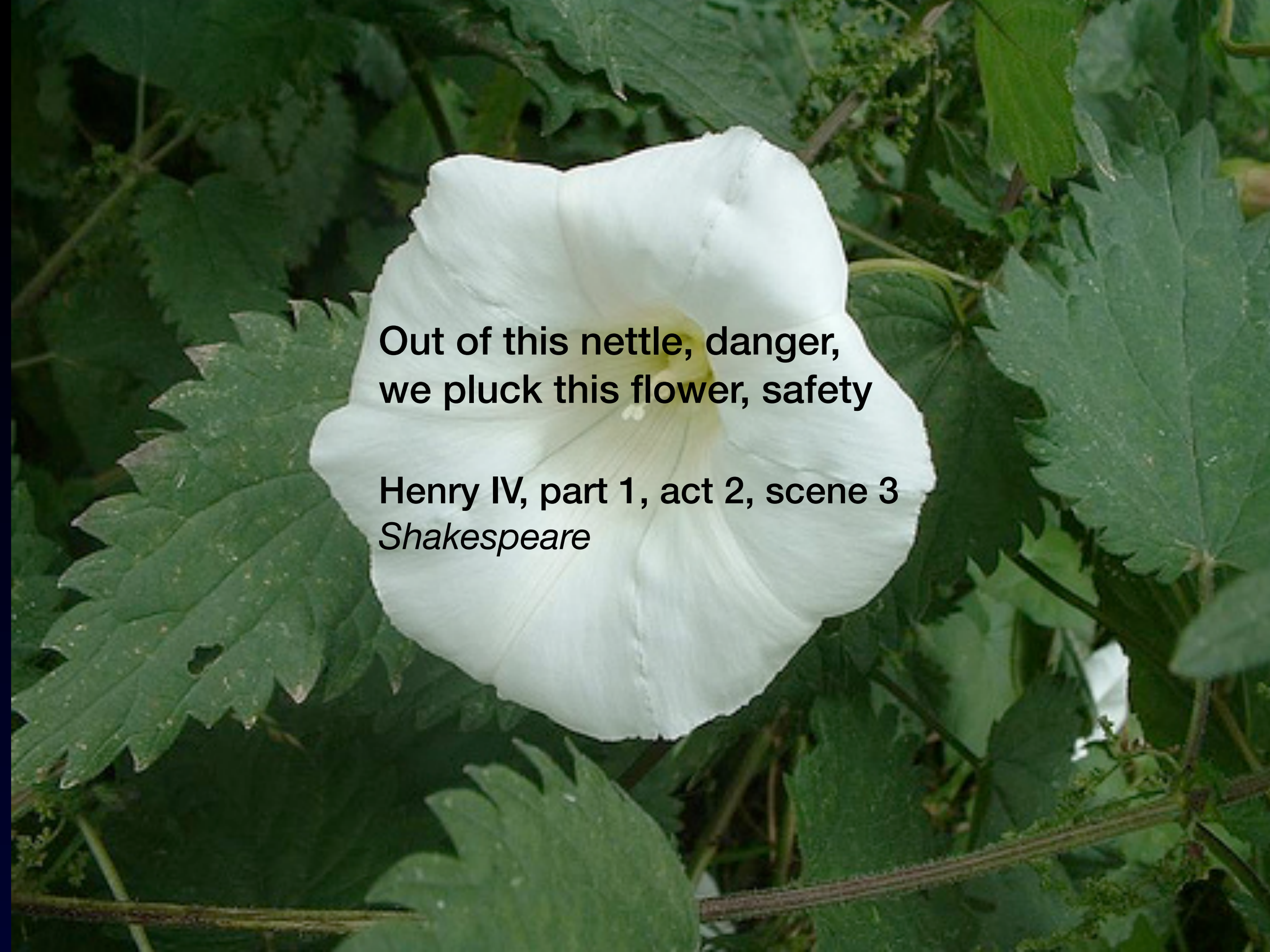
factual

critical

Hollnagel (2010)

"Remember that patient?"

Section 28
Form 4
Psychiatry nurse referral
Discharge
Lack of mental health beds
Not aware of safe space available on another unit
No 'safe' space
Assumption of containment
Left alone
Recent renovation, new door alarm
Security attending another patient


Out of this nettle, danger,
we pluck this flower, safety

Henry IV, part 1, act 2, scene 3
Shakespeare