CREATING SAFETY IN AN EMERGENCY DEPARTMENT

Garth Hunte, MD PhD

Clinical Associate Professor
Department of Emergency Medicine
Research Scientist, CHÉOS
“Remember that patient?”
The chief objective of education is not to learn things but to unlearn them

G.K. Chesterton
RISK

- Dangerous (>1/1000):
  - Health Care
  - Mountain Climbing
  - Bungee Jumping

- Regulated:
  - Driving
  - Chartered Flights
  - Chemical Manufacturing

- Ultra-safe (<1/100K):
  - Scheduled Airlines
  - European Railways
  - Nuclear Power

Number of encounters for each fatality vs. Total Lives Lost per year.
EMERGENCY DEPARTMENTS: LIMINAL SPACE

unbounded, porous interface

uncertainty

time constraints

highest proportion of “preventable” patient harm

"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"
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
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

<table>
<thead>
<tr>
<th>role</th>
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<tbody>
<tr>
<td>emergency nurse</td>
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<tr>
<td>emergency nurse leader</td>
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<td>emergency staff</td>
<td>15</td>
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<td>emergency physician</td>
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<td><strong>TOTAL</strong></td>
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standardized questions or questionnaires within in-depth interview

shared understanding of statements and response options (face validity)

draws out narratives

Adamson et al. (2004)
management support actions and expectations response to error feedback and communication openness organizational learning teamwork within unit teamwork across units hand-offs and transitions staffing

A scatter plot shows the correlation between patient safety grade and the proportion of positive response. The variables included are Cooperation, Transitions, Response, Openness, Staffing, Actions, Feedback, Learning, Support, and Teamwork. The data is based on n=19 HSOPSC.
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”

Providers try hard and work well together. Standards and processes are adequate to prevent serious mistakes from happening.

“Bullshit...patient safety is sacrificed every single minute”

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]
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
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

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