Sources of safety
Reflexive practice

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‘Sources of safety’

• Bureaucratic – scientific resources & authorities
  – reporting
  – data, analysis & evidence
  – guidelines, protocols & policies

• Team initiatives and leadership
  – pathways
  – collaboratives

• Local resilience
  – frontline staff’s attentiveness to problematic / extreme situations
  – frontline staff’s ability to neutralise & displace risk
Sources of ‘unsafety’ / risk

- Under-regulation / lack of monitoring
- ‘Culture’ – beliefs, values and attitudes that are inimical to safe practice
- Inappropriate levels of autonomy & power
- Substandard skill, training, knowledge
- Lack of (effective) communication
- Complexity
Focus on what goes wrong

- incident reporting systems
- incident analyses / investigation

Knowledge thus derived becomes the basis for deciding what must (or must not) happen.

This is a deficit approach.
Deficit approach - problems

– incident categorizations are not self-evident
  • measurements of error occurrences aggregate complex and often disparate phenomena
– guidelines and protocols are frequently ignored and / or circumvented
– command / control orientation objectifies in situ work
  • ‘workarounds’ and practice dynamics made invisible
Connecting information about ‘what works’ to practice

• What happens:
  – Knowledge (evidence) is produced in one place (by researchers)
  – This knowledge is (to be) applied elsewhere by ‘non-researchers’

• What this means:
  – Idealisations of practice are our only point of reference
  – Non-researchers’ knowledge and their needs are ignored
The trajectory from unsafety to safety

INCREASINGLY INFORMED

PATHOLOGICAL
Who cares as long as we’re not caught

REACTIVE
Safety is important, we do a lot of every time we have an accident

CALCULATIVE
We have systems in place to manage all hazards

PROACTIVE
We work on problems that we still find

GENERATIVE
Safety is how we do business around here

INCREASING TRUST

Levels of complexity and risk

- Stable work routines and rituals
- Emergent work processes

Low complexity (‘known knowns’)

High complexity (‘unpredictable [un]predictables’)

- Stable work routines and rituals
- Emergent work processes
Complexity can defeat safety
Or ... complexity can be a natural part of effective team work
Do we train for complexity?

• We train staff to ‘inhabit’ complexity (through vocational training)
• We favour complexity-limiting solutions & interventions (pathways, ‘systems’, …)
• We direct staff to comply with idealised (complexity-averse) rules
• But … we don’t train for complexity because we don’t know what it looks like.
The locus of responsibility for un/safety?

- Unsafe work is …
  - a failure of the system
  - a ‘failure of [individuals’] purpose and desire’
- But much action is ‘automatic’!
  - action leads to errors
  - automaticity (not intention) is the problem

“We cannot reliably change our actions if we do not really know what we are actually doing ... most of us are unaware of our habitual modes of [...] behaviour”

“What we uncritically presume to be the freedom of spontaneous action is in fact enslaved by chains of habit that prevent us from acting otherwise.”

“True freedom of will thus involves freeing it [will] from spontaneity’s bondage to unreflective habit, so that one can consciously do … what one really wants to do.”

“... once we recognize that will is deeply enmeshed in habit, we should appreciate how inhibition can help us overcome the bad habits that express (and reinforce) themselves in spontaneous behaviour and that frustrate our will.”

“Safety is not bankable”: three prerequisites

1. Stop / inhibit
   • interrupt conventional habits through self-observation

2. Contextualise
   • link local practice and the overall system of practices

3. ‘Sense’ / mind
   • develop a feeling for safety risks
1: Inhibit habits
2: Contextualise practices
3: Sense safety risks
Complex high-risk organisations: creating ‘a learning space’

- Enabling staff to confront automaticity
- Ensuring that habits are ‘functional’ and do not detract from safety
- Regularly critically review the stock of habits

Safety in practice: HELiCS
Aims of the ACSQHC Handover study

1. elicit from staff what they regard as areas worthy of attention
2. confront frontline staff and their work practices with what they (might) look in the eyes of others
3. enable staff themselves to act on who they are and what they do
4. derive better ways of working for teams and their patients
5. capacity build clinicians into observing and deliberating about their own ways of being and doing
Conclusion

• Sources of safety:
  – inhibition
  – contextualisation
  – mindfulness

• Organisations & staff must assume responsibility for their work habits

• Staff need to reflect on and critique ‘the everyday work’
www.communicationsafety.org/

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