Exnovation

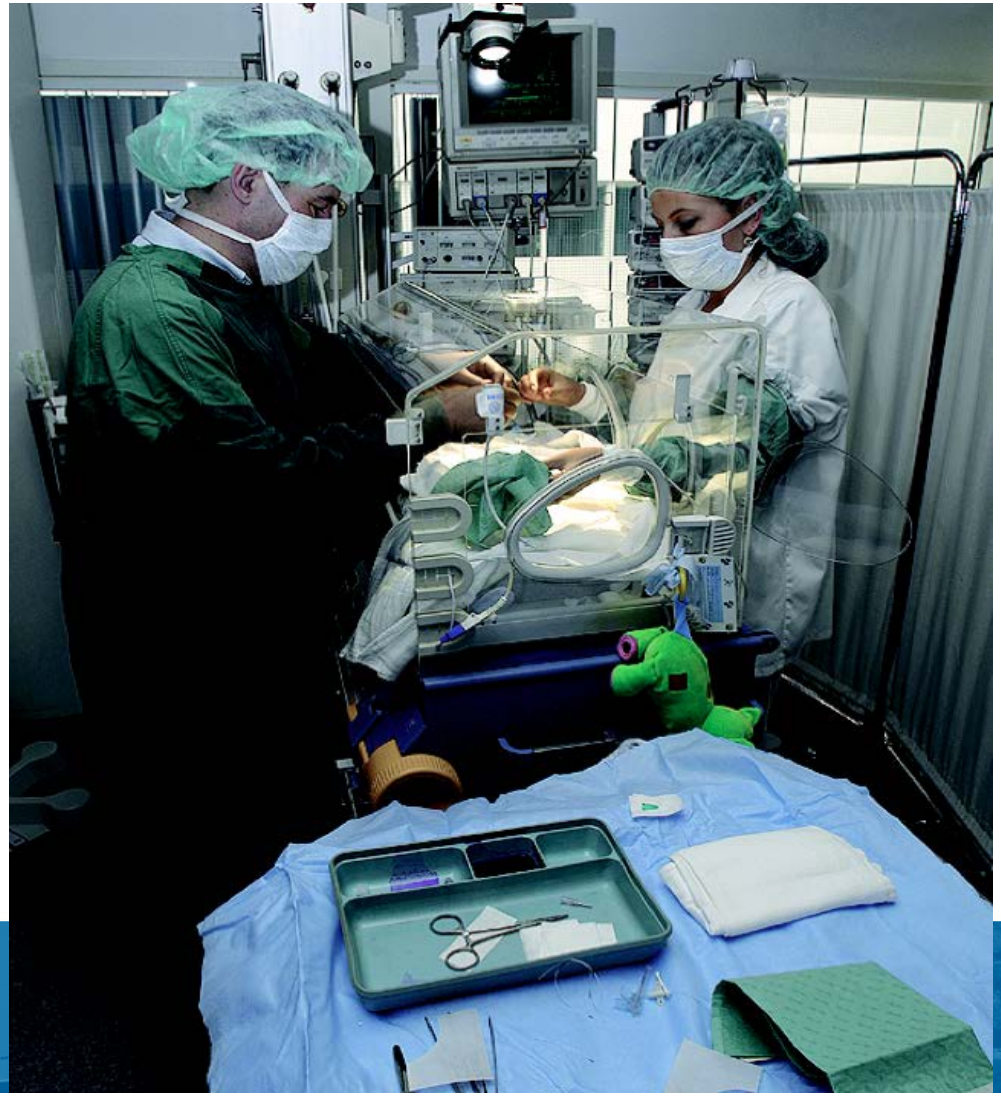
About ways of knowing and doing within real-life complexity in health Care

Jessica Mesman

Rotterdam, June 3, 2015

Universiteit Maastricht

Why do thing go well?



some background

WHAT:
Studying patient safety

Aim to making a difference

HOW:
Providing alternative conceptualizations of patient safety

Increase safety sensibility of health care professionals

Aim research

- To question dominant ways of understanding safety
- Provide alternative conceptualizations of patient safety
- To explicate hidden competence
- Increase safety sensibility of health care professionals
- Make a difference in practice

outline

- Part 1: A positive approach
- Part 2: Safety management
- Part 3: Exnovation
- Part 4: Video-Reflexivity

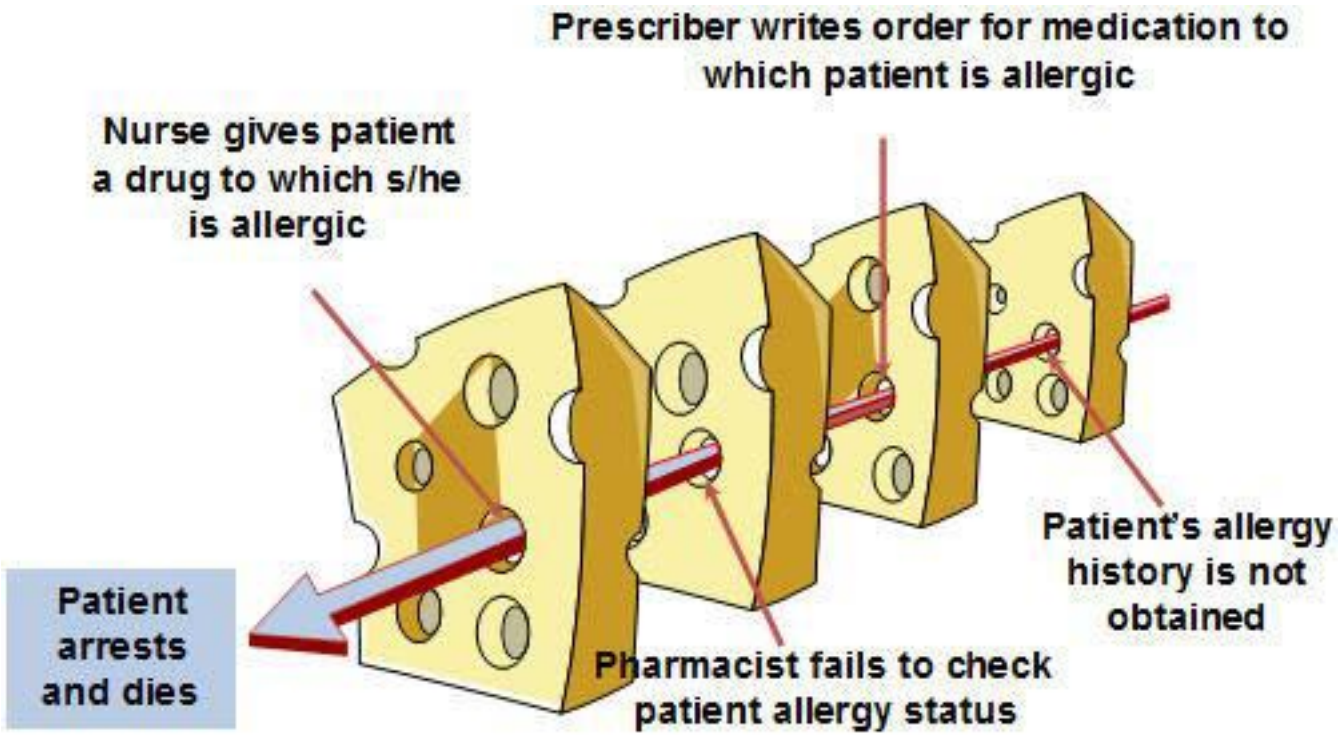
1. Positive approach

Individual approach

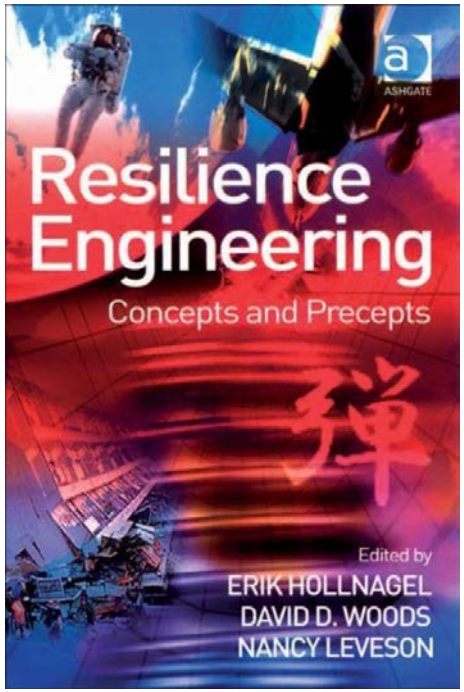
And this is nurse Jenkins...who we'll be blaming if the hospital kills your husband...

2. System approach:

James Reason: Swiss cheese model



Positive approach



Safety II

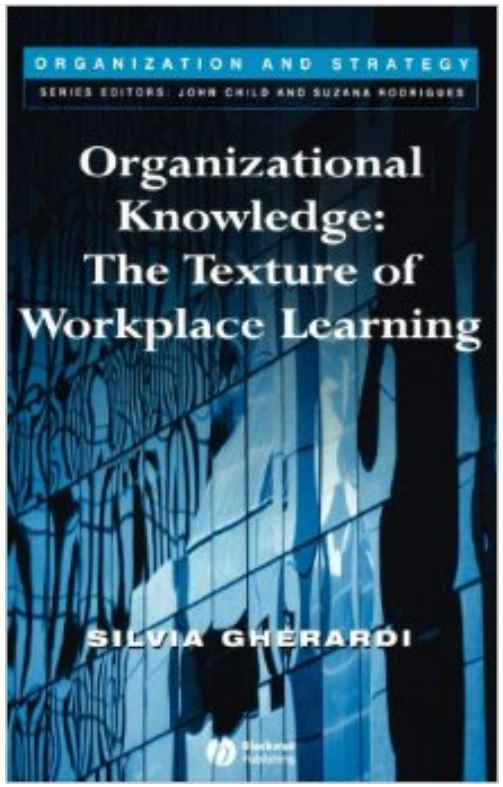
Safety is a condition where as much as possible goes right (p.134)

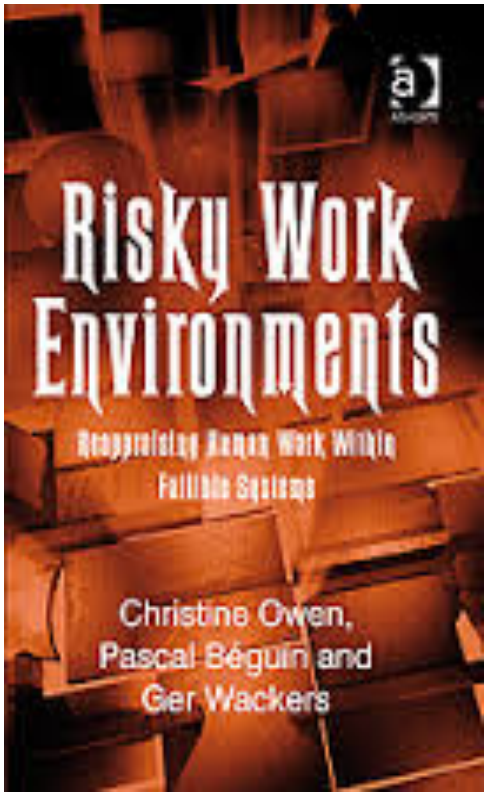
Why do things go right? How does it happen?

Performance variability and adjustments
re-active and pro-active

Work-as-done

Critical approach





3. Critical perspective on deficit approach

Simplification of context

Ignores…insights from anthropology and sociology about practices

Ignores… specificity of situation

Ignores… perception, interpretation and definition of situation

Ignores… constant flux and dynamics of reality

Ignores… complexity of work environment

My positive approach

Why do things go right?

Safety is a practice where as much as possible goes ‘right’

Safety as a verb: one is **doing** safety.
How is safety done?

Safety II

Complexity
Positive approach
Performance

My research

Complexity
Positive approach
practice-based

3. Safety management

Safety II

Safety is a condition where as much as possible goes right (p.134)

Why do things go right? How does it happen?

Performance variability and adjustments is source of success and is source of failure

Management:
control or protect against the *conditions* that make them necessary by devising various forms of prevention and protection (p.132)

Safety management in safety II

Framed in safety I logic:

Focus on **negative situations**: identify the situations where the performance variability creates unwanted effects

Measure and monitor how systems work: Measure and Manage; Prevent and protect; Detect and correct

Control and intervene when variability threatens to get out of control and check effect

Development of **models, procedures and classification** of manifestations

Safety I and Safety II are **complementary**

Safety II

Complexity
Positive approach
Performance

My research

Complexity
Positive approach
Practice-based

Management

Monitor
Negative conditions
Controlling situations
Intervention
Detect and correct

Self-management

Reflection
What goes right
Understanding of situations
Situated learning
Enhance in-situ intelligence

My positive approach

Why do things go right?

Safety is a practice where as much as possible goes right

Safety as a verb: one is doing safety.
How is safety done?

Follow protocols? Yes and no…**and more…**

my safety ‘management’

The mundane as an extraordinary accomplishment

Why things go right?

Power of the marginal (P.Sotolongo)

Habituation: disregard things that happen regularly
- stop noticing them - lack of attention to things that go right

3. Exnovation

innovation from within

Innovation as a form of '**ontological injustice'**
Existing practices are not less valuable simply because they already exist

Act of exnovation *(de Wilde, 2000)*

(…) pays attention to the mundane, to the implicit local routines, to what is already in place

(…) is the effort to foreground what is already present though hidden – in specific practices

(…) pays attention to the 'invisible', but necessary work; To the competencies that we forget because we use them every day

Act of exnovation

Improve practices on basis of ….

what is already in place

the mundane, to the implicit local routines
(Mesman, 2012; Iedema et al, 2013)

challenges the dominant trend to **ignore** existing practices in improvement processes

Exnovation

Is not:	but
Technique to know *more*	to know differently
Analysis and deconstruction	openness
Formal knowledge and new things directives	enable to do and say new about the familiar
Formal resources	Informal resources

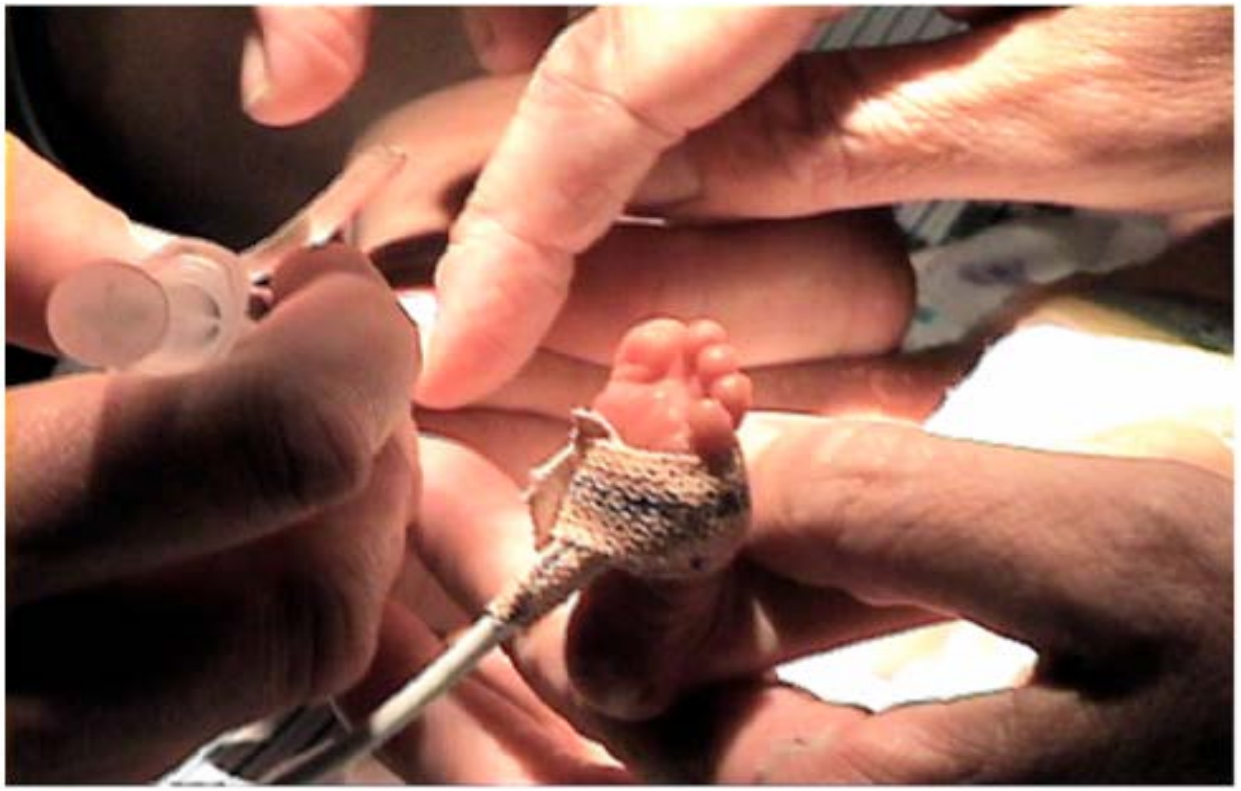
Exnovation of the mundane

What then is needed to see what goes into the ordinary?

outsider's perspective in order to see it

insider's knowledge to recognize it

Situated Distance



4. The Method of Video reflexivity

Filming in action

Selection of footage

academisch ziekenhuis Maastricht
azM

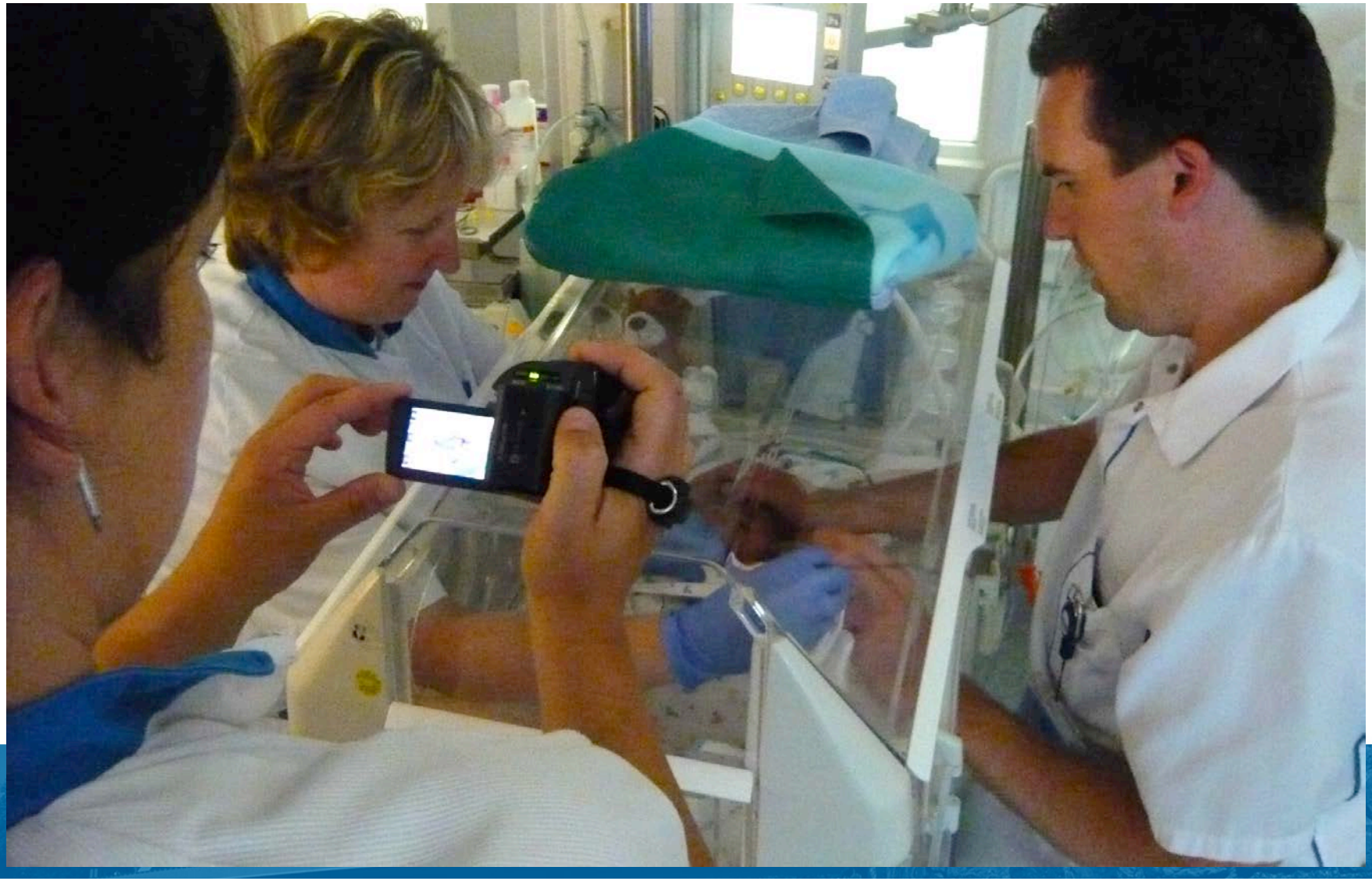
Universiteit Maastricht

Selected clips

Reflexive meeting

Project-based

Planned obsolescence



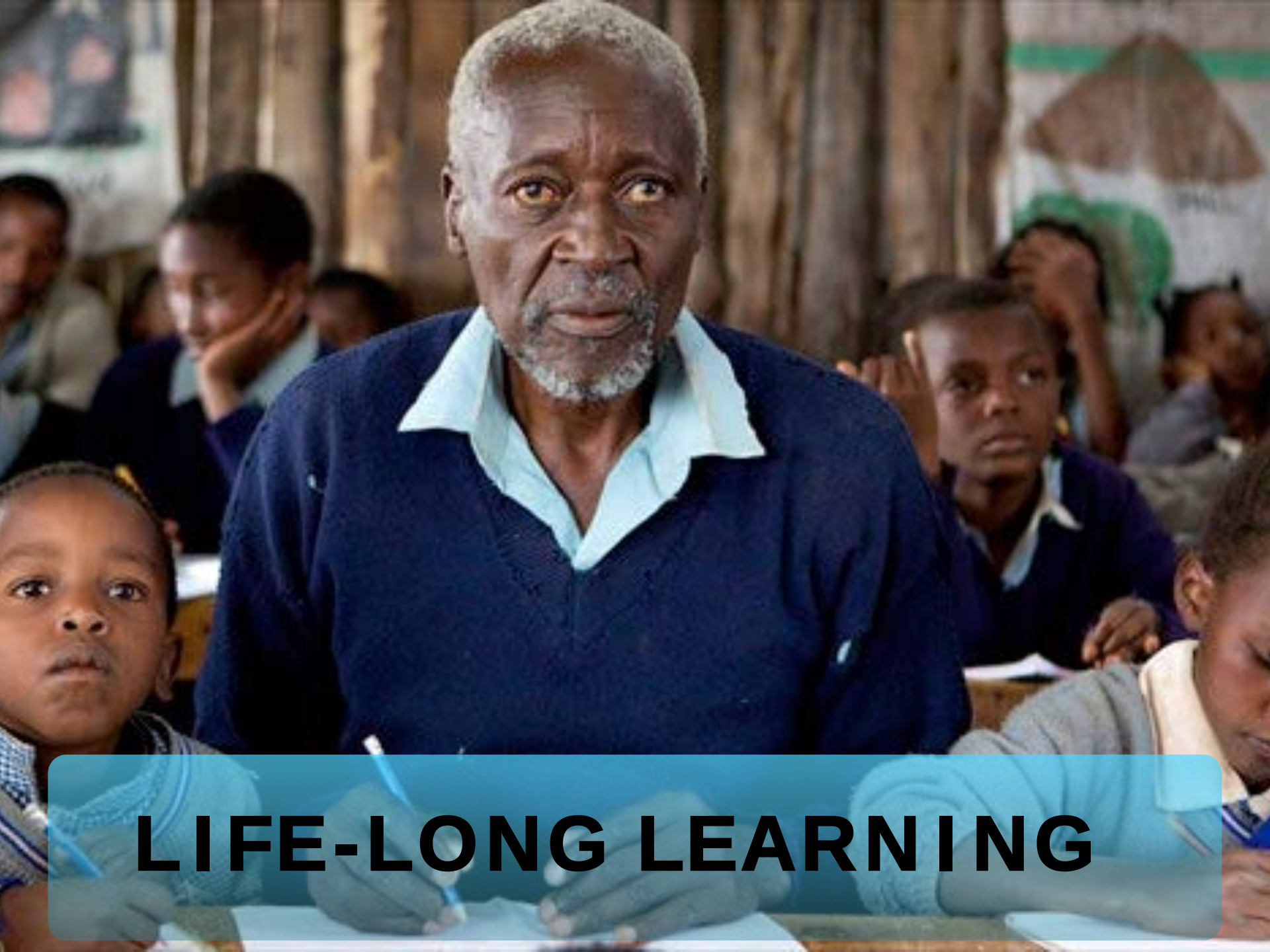
Video reflexivity contributes to practice improvement because…

- Passivity competence (Iedema, Mesman, Carroll, 2014)
- Another perspective on daily routines
- Triggers discussion
- Renewed awareness
- Tap into group wisdom
- Displays safety-as-action


BOTTOM-UP

TAILOR MADE

Enhancement of in-situ intelligence


LIFE-LONG LEARNING

What is required

Motivation

Nuanced forms of observing

Constructive discussions

Resources: time and money

Legal and ethical approval

Safety II
Complexity
Positive approach
Performance

My research
Complexity
Positive approach
Practice-based

Management
Monitor
Negative conditions
Controlling situations
Intervention
Detect and correct

Self-management
Reflection
What goes right
Understand situations
Situated learning
Enhance in-situ intelligence

RESEARCH

Measuring	Understanding
Interviews	(Video-reflexive) ethnography
Analyst	collaborative research
Health care practice	socio-cultural-political context
Models & classifications	contextualized research

Conclusive thoughts: Video Reflexivity and Safety II

1. Performance variability and adjustment is visualized and reflected upon
2. Thorough: directly observing analysing and interpreting how activities are carried out, it pays attention to what takes place
3. How to understand why things go right: Video-reflexivity
4. Situated distance solves the problem of habituation
5. Feedback using video of real-time practice
6. Supports necessary improvisation through learning

Conclusive thoughts: Video Reflexivity and Safety II

1. Self-monitoring through structural reflection (planned obsolescence)
2. Self-management through active engagement
3. Self-control through learning
4. Not measuring but understanding: qualitative research
5. Collaborative reflection: clinicians, patients, management; allied HC personnel, family

Conclusive thoughts: Video Reflexivity and Safety II

1. Policy: support learning and self-reflection
2. Policy: beyond top-down and bottom up: recommendations based on mixed reflections
3. Two vocabularies
4. Complementary perspectives
5. ~~Safety I – Safety II~~ error – safety

Referred literature

Ghirardi, S. (2006) *Organizational Knowledge: the texture f workplace learning*. Oxford: Blackwell Publishing

Hollnagel. E., Woods, D., and Leveson, N. (2006) *Resilience Engineering: Concepts and precepts.* London: Aldershot: Ashgate Publishing Ltd

Hollnagel, E. (2014) *Safety-1 and Safety-II: The past and future of safety management.* Aldershot: Ashgate Publishing Ltd

Mesman, J. (2012) Moving In With Care: about patient safety as a spatial achievement. *Space and Culture*, 15(1): 31-43.

Iedema, R., Mesman, J. & Carroll, K. (2013) *Visualising Health Care Practice Improvement: Innovation from within.* London: Radcliffe Publishers

Mesman, J. (2012) 'Resources of Strength: an exnovation of hidden competences to preserve patient safety'. In: *A Socio-Cultural Perspective on Patient Safety.* E. Rowley & J. Waring (eds.) Aldershot: Ashgate Publishing Ltd

Referred literature

Mesman, J. (2010) Diagnostic Work in Collaborative Practices in Neonatal Care. In: Buscher, M., Goodwin, D. and Mesman, J. (Eds.) *Ethnographies of Diagnostic Work: dimensions of transformative Practice.* Hampshire: Palgrave Macmillan.

Owen Ch., Wackers G., & Béguin, P. (eds). (2009) *Risky Work environment: reappraising human work within fallible systems*. Aldershot: Ashgate Publishing Ltd.

Rowley, E. & J. Waring (eds.) (2012) *A Socio-Cultural Perspective on Patient Safety.* Aldershot: Ashgate Publishing Ltd

Wilde de, R. (2000) *Innovating Innovation: a contribution to the philosophy of the future*. Paper read at the POSTI Conference 'Policy Agendas for Sustainable Technological Innovation', 1–3 December 2000