Exnovation

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

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Why do things 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

Management
Monitor
Negative conditions
Controlling situations
Intervention
Detect and correct

My research

Complexity
Positive approach
Practice-based

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*)

(...)

(...)

(...)

(...
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

<table>
<thead>
<tr>
<th>Is not:</th>
<th>but</th>
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</thead>
<tbody>
<tr>
<td>Technique to know <em>more</em></td>
<td>to know differently</td>
</tr>
<tr>
<td>Analysis and deconstruction</td>
<td>openness</td>
</tr>
<tr>
<td>Formal knowledge and new things directives</td>
<td>enable to do and say new about the familiar</td>
</tr>
<tr>
<td>Formal resources</td>
<td>Informal resources</td>
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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
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
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  

Management  
Monitor  
Negative conditions  
Controlling situations  
Intervention  
Detect and correct  

RESEARCH  
Measuring  
Interviews  
Analyst  
Health care practice  
Models & classifications  

My research  
Complexity  
Positive approach  
Practice-based  

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

Understanding  
(Video-reflexive) ethnography  
collaborative research  
socio-cultural-political context  
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


Referred literature


