Understanding resilient clinical practice in Emergency Department ecosystems

Jeffrey Braithwaite, PhD
Robyn Clay-Williams, PhD

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Australian Institute of Health Innovation

• Professor Jeffrey Braithwaite
  Foundation Director, AIHI; Director, Centre for Clinical Governance Research

• Professor Enrico Coiera
  Director, Centre for Health Informatics, AIHI, UNSW

• Professor Ken Hillman
  Director, Simpson Centre for Health Services Research, AIHI, UNSW

• Professor Johanna Westbrook
  Director, Centre for Health Systems and Safety Research, AIHI, UNSW
Resilient health care is taking root

• Two scholarly compendiums:

**but**

• There is much further to go to add to our understanding of when things go right

• We need to appreciate the *habituation* and *routines* that characterise clinical work
How?

- Complement theories to account for clinical coalface processes with a set of effective empiricisations

- Capture and report on salient examples of how, when nothing goes wrong, things are done
Why Emergency settings?

• Emergency Departments (EDs) are fascinating habitats which are:
  • time-critical, richly interactive
  • idiosyncratically hierarchical and heterarchical
  • intermittently time-pressured, and …
  • complex adaptive systems [CASs]

• EDs mostly get things right, despite
  • temporal demands
  • resource constraints
  • expansive casemix and
  • workplace complexity.
However most people have this mental model
But healthcare really looks like this …
ED Study #1 – flow structures

• Nugus et al – emergency clinicians create a “carousel” providing the greatest good for the greatest number of patients
  • ED clinicians are rationing time to provide beds to meet the needs of future patients
  • Work is therefore inherently clinical-organisational
  • Time and motion are chief characteristics
  • Therefore flow/trajectories of patients is what is really managed by ED [Nugus et al. Int Emerg Nurs, 2014]
The carousel model of the ED.
ED Study #2 – flow pressures

• Junior nurse perspective on role of Clinical Initiatives Nurse (CIN): “To save time; they speed things up, especially in sub-acute.”

• A senior nurse: “We take every chance we can get to free up a bed.”

• “For each patient as soon as they come in you’ve got to think of the best way to get them out.”
ED Study #3 – A riot of a study

• The Stanley Cup Riots, 2011, Vancouver, Canada
  • 500 people into city every 90 seconds by SkyTrain alone
  • Big surge of patients to ED
  • Key take-outs: capacities for Speedup, Slowdown, resource flex, margin for manoeuvre

[Hunte, In: The resilience of everyday clinical work, 2014]
ED Study #4 – tribal characteristics

• Micro-structural dimensions of interactive behaviours to reveal tribal characteristics

• Social network analysis to illuminate the social-professional structures

• An anaesthetist now working in ED: “I bag [criticise] anaesthetists even though I’m an anaesthetist.”
ED Study #4 – exposing tribes

- Problem solving networks in an ED

Nurses
Doctors
Allied health
Admin and support

[Creswick, Westbrook and Braithwaite, *BMC HSR*, 2009]
ED Study #4 – exposing tribes

• Medication advice-seeking networks in an ED
  Nurses
  Doctors
  Allied health
  Admin and support

[Creswick, Westbrook and Braithwaite, BMC HSR, 2009]
ED Study #4 – exposing tribes

- Socialising networks in an ED

Nurses
Doctors
Allied health
Admin and support

[Creswick, Westbrook and Braithwaite, BMC HSR, 2009]
ED Study #5 – external connections

• ED clinicians work in environment of flexible dynamic interconnectedness

• Negotiate with other departments and “package” the patient for a category [Aged care? Cardiology?]
  • Specialist ED physician: “We were trying to sell the patient for review. It’s easier to ask them to review. Admission comes later.”
  • Registrar: “Are you a medical registrar?” [No] “Oh well, I won’t try and sell you a patient.”

[Nugus, Bridges and Braithwaite, *BMJ*, 2009]
ED Study #5 – external connections

• Cardiology registrar: “We’re overloaded. I mean, I’m a human being … We’re just so … short of time what are you going to do? ... You try not to come down unless you’re convinced there’s a good chance it’s one of ours ….”

• ED registrar: “A frustration is that we have to do the work of the inpatient team. We do the ‘work-up’. It stresses us out and we turn that stress onto the nurses. We’re Cinderella. We do the dirty work but don’t get invited to the party.”
ED Study #6 – technology use

Supportive artefacts and technologies, e.g.:

• computers,
• pens-and-paper,
• stethoscopes,
• medical records,
• sticky notes,
• bed allocation boards,
• referral and discharge letters.
ED Study #7 – secret second handover

• Ambulance paramedics determine when a secret second handover is needed with cubicle nurses
• Eschews formality in favour of informality
• An adjustment strategy
• Constitutes a dynamic trade-off between efficiency and thoroughness

[Sujan, Spurgeon and Cooke, In: The resilience of everyday clinical work, 2014]
ED overall – a “resilient ecosystem”

• ED clinicians demonstrate:
  • Handling of complexity
  • Discursive competence
  • Communicative flexibility
  • Working organisational-clinical interfaces
  • Sacrificing lower for higher order goals
  • Future-orientation in their work
  • Nuanced understanding of interdepartmental working
The rich tapestry of EDs … 😊.

- Other ED-focused work in *The resilience of everyday clinical work* is:
  - Nakijima on blood transfusions in ED
  - Stephens, Woods and Patterson on patient boarding and capacity for manoeuvre [CfM] in EDs
Lessons

• Lots of knowledge operates to create resilience in EDs moment-to-moment, day-to-day, week-to-week

• Resilience is continually created in such circumstances

• People exercise their capacity for manoeuvre amongst the ebbs and flows of patients, tribal relationships, internal and external connections and varied modes of operating
Finally …

• We have our own ideas on the next generation of research questions to ask
• But what’s the next set of questions *you* would ask if you were doing work on the resilience of EDs?
Selected References


Selected References


Contact details

Jeffrey Braithwaite, PhD

**Foundation Director**
Australian Institute of Health Innovation

**Director**
Centre for Clinical Governance Research

**Professor, Faculty of Medicine**
University of New South Wales
SYDNEY NSW 2052
AUSTRALIA

Email: j.braithwaite@unsw.edu.au
Web: [http://www.aihi.unsw.edu.au](http://www.aihi.unsw.edu.au)