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Reflexive spaces in patient safety improvement

NSQH 2024, Oslo

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- PhD students, postdocs, collaborators, mentors, leaders, co-researchers, and colleagues
- Resilience in Healthcare Research Programme, colleagues, and partners
- Safe-Lead project, colleagues, and partners
- Research Council of Norway

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Background

- Patient **safety** as a **learning process**
- Learning from **successful outcomes** and processes to be repeated
- Learning from **unsuccessful outcomes** to avoid reoccurrence
- **Reflection** is key for learning individually and in organizations

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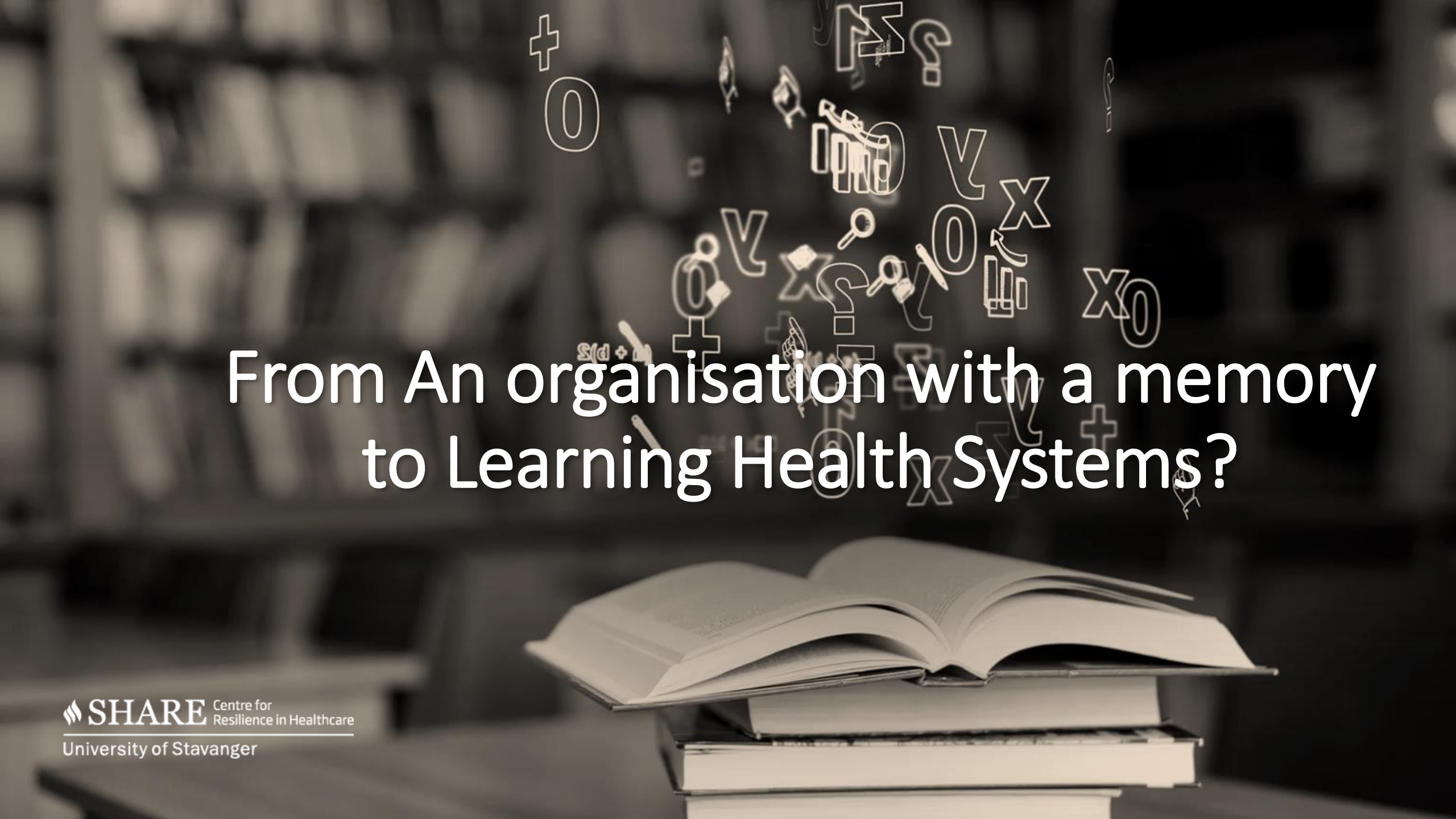
(DoH 2000; IOM 2000; Gherardi 2002; Donaldson 2002; Braithwaite et al 2015; Vincent & Amalberti 2016)



From An organisation with a memory to Learning Health Systems?

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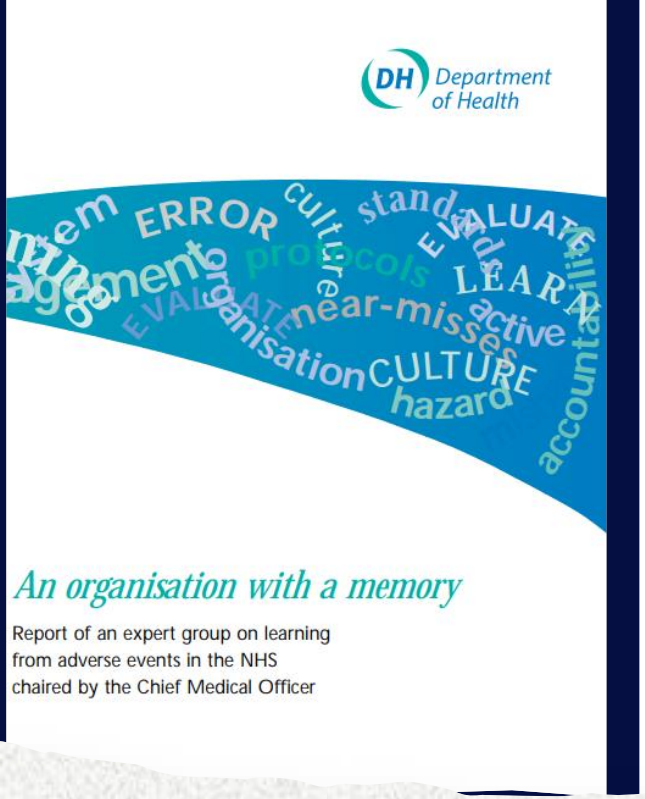

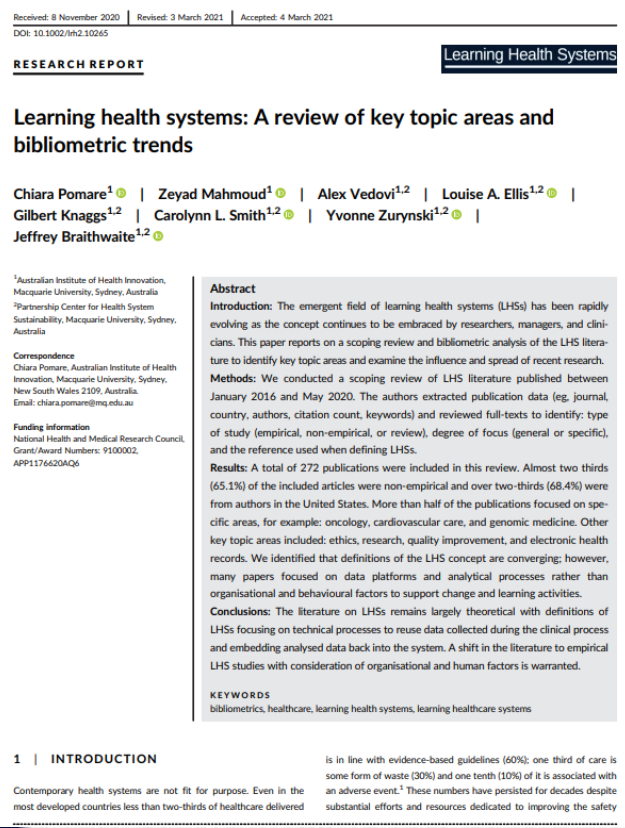

Advancement in the field?

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without destroying them.

Communities of Practice: The Organizational Frontier

by Etienne C. Wenger and William M. Snyder

TODAY'S ECONOMY RUNS ON KNOWLEDGE, and most companies work assiduously to capitalize on that fact. They use cross-functional teams, customer- or product-focused business units, and work groups – to name just a few organizational forms – to capture and spread ideas and know-how. In many cases, these ways of organizing are very effective, and no one would argue for their demise. But a new organizational form is emerging that promises to complement existing structures and radically galvanize knowledge sharing, learning,

Volume 7(2): 211–223

(London, Thousand Oaks, CA and New Delhi)

Practice-based Theorizing on Learning and Knowing in Organizations

Silvia Gherardi
Trento University

SAFETY SCIENCE Monitor
Issue 3 2007
Article 6
VOL 11

FALLIBLE HUMANS IN INFALLIBLE SYSTEMS? LEARNING FROM ERRORS IN HEALTH CARE

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♦ ♦ ♦

EUROPEAN SECTION

The Organizational Learning of Safety in Communities of Practice

SILVIA GHERARDI
University of Trento, Italy

DAVIDE NICOLINI
Tavistock Institute

Key features

- Learning as a collective process
- Learning through reflection
- Structures, leadership, and culture for learning
- Regulation to support learning
- Learning across system interfaces and levels

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Learning is part of everyday work, but it is not just happening – or always as planned

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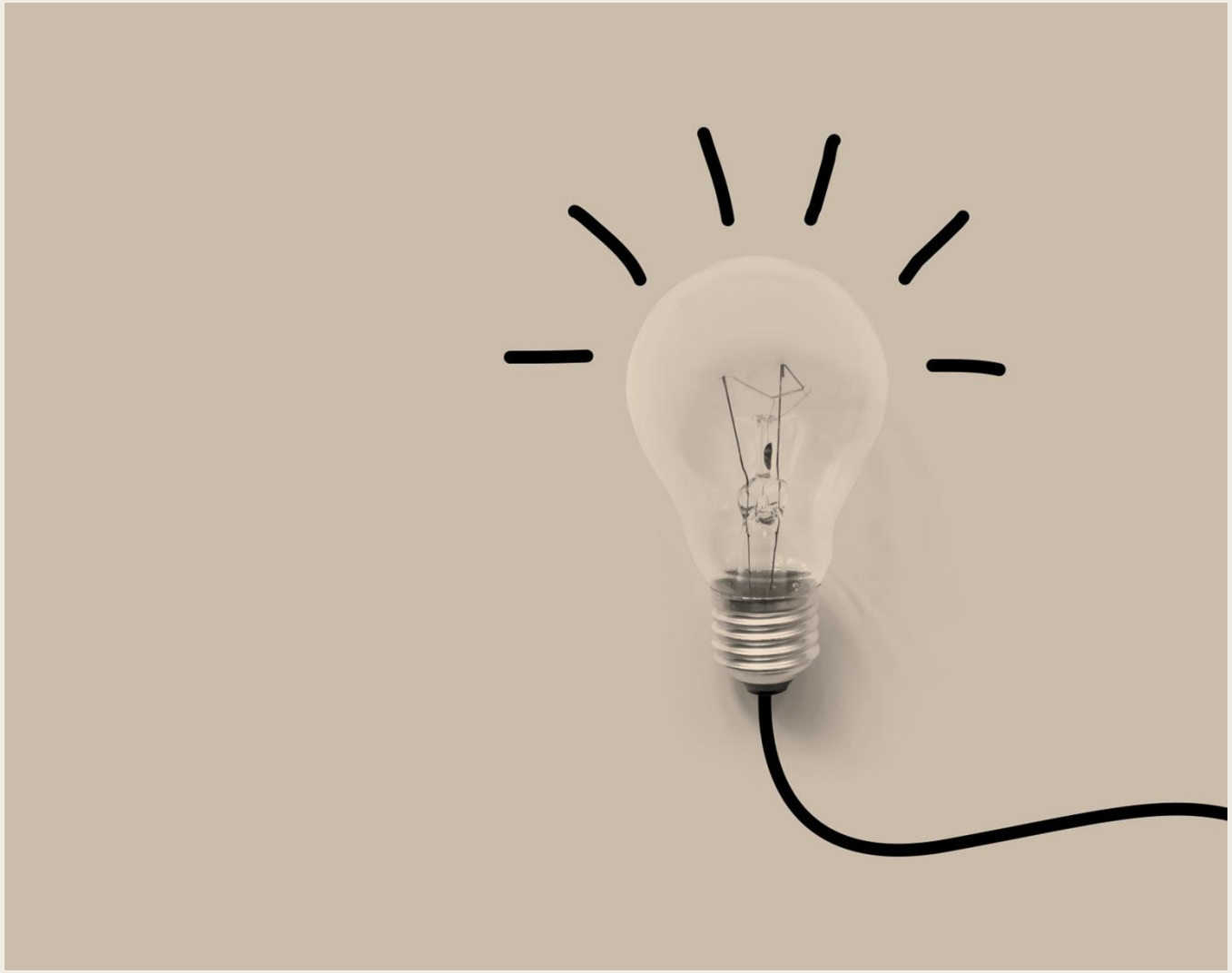
Reflexive spaces - What are they?



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Management Learning
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Vol. 38(5): 495–517
1350–5076

Article

David E. Gray
University of Surrey, UK

Facilitating Management Learning

Developing Critical Reflection Through Reflective Tools

Management Learning
Copyright © 2002 Sage Publications
London, Thousand Oaks, CA
and New Delhi
Vol. 33(1): 35–61

Ann L. Cunliffe
California State University, Hayward, USA

Reflexive Dialogical Practice in Management Learning

1999, Vol. 24, No. 3, 522–537.

AN ORGANIZATIONAL LEARNING FRAMEWORK: FROM INTUITION TO INSTITUTION

MARY M. CROSSAN
HENRY W. LANE
RODERICK E. WHITE
Richard Ivey School of Business

Although interest in organizational learning has grown dramatically in recent years, a general theory of organizational learning has remained elusive. We identify renewal of the overall enterprise as the underlying phenomenon of interest and organizational learning as a principal means to this end. With this perspective we develop a framework for the process of organizational learning, presenting organizational learning as four processes—intuiting, interpreting, integrating, and institutionalizing—linking the individual, group, and organizational levels.

The "clinalyst"

Institutionalizing reflexive space to realize safety and flexible systematization in health care

Rick Iedema
University of Technology Sydney, Sydney, Australia, and
Katherine Carroll
University of Sydney, Sydney, Australia

OPEN

Reflexive Spaces: Leveraging Resilience Into Healthcare Regulation and Management

Siri Wiig, PhD, MSc, Karina Aase, PhD,* and Roland Bal, PhD†*

Healthcare is increasingly seen as a complex, adaptive system in which resilience is a key factor in creating patient safety. A need exists to understand how organizations are able to perform with success under varying conditions, that is, to be resilient. So far, the attention in resilience research has been on the sharp end of the system, such as emergency departments and clinicians' adaptation of work practices to constantly varying conditions. However, we have limited knowledge about the role of regulators and managers in creating and supporting environments that cultivate resilience.[1,2] In this article, we argue that (*a*) regulators and managers need to understand and acknowledge reflexivity as a foundation for resilience in healthcare organizations and that (*b*) creating and supporting reflexive spaces are a key for leveraging resilience into healthcare regulation and management.

Reflexive spaces

Physical or virtual platforms in which reflexive dialogical practice occurs between people.

The reflexive dialogical practice is key in learning processes, because it bridges tacit and explicit knowledge.

(Cunliffe 2002; Gray 2007; Wiig et al 2020)

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Reflexive spaces

- Can **bring people together** to **reflect** on current challenges, adaptations, and needs in work practice.
- Are **forums** inviting **accountability and feedback** on concrete practices and effects.
- Are **collective** and mobilize experiences of relevant actors.

(Jerak-Zuiderent, 2015; Gray 2007; Cunliffe 2002; Wiig et al 2020)

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How are reflexive spaces created?

Formally and informally

Tools, processes, and structured arenas

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Key projects

- **Resilience in Healthcare** – developing, implementing, and evaluating a theoretical and practical resilience in healthcare framework (2018-2024)

- **SAFE-LEAD** - Leadership intervention in nursing homes and homecare (2016-2023)

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Resilience capacities

(Lyng et al 2022)

Learning tools' principles and logic models

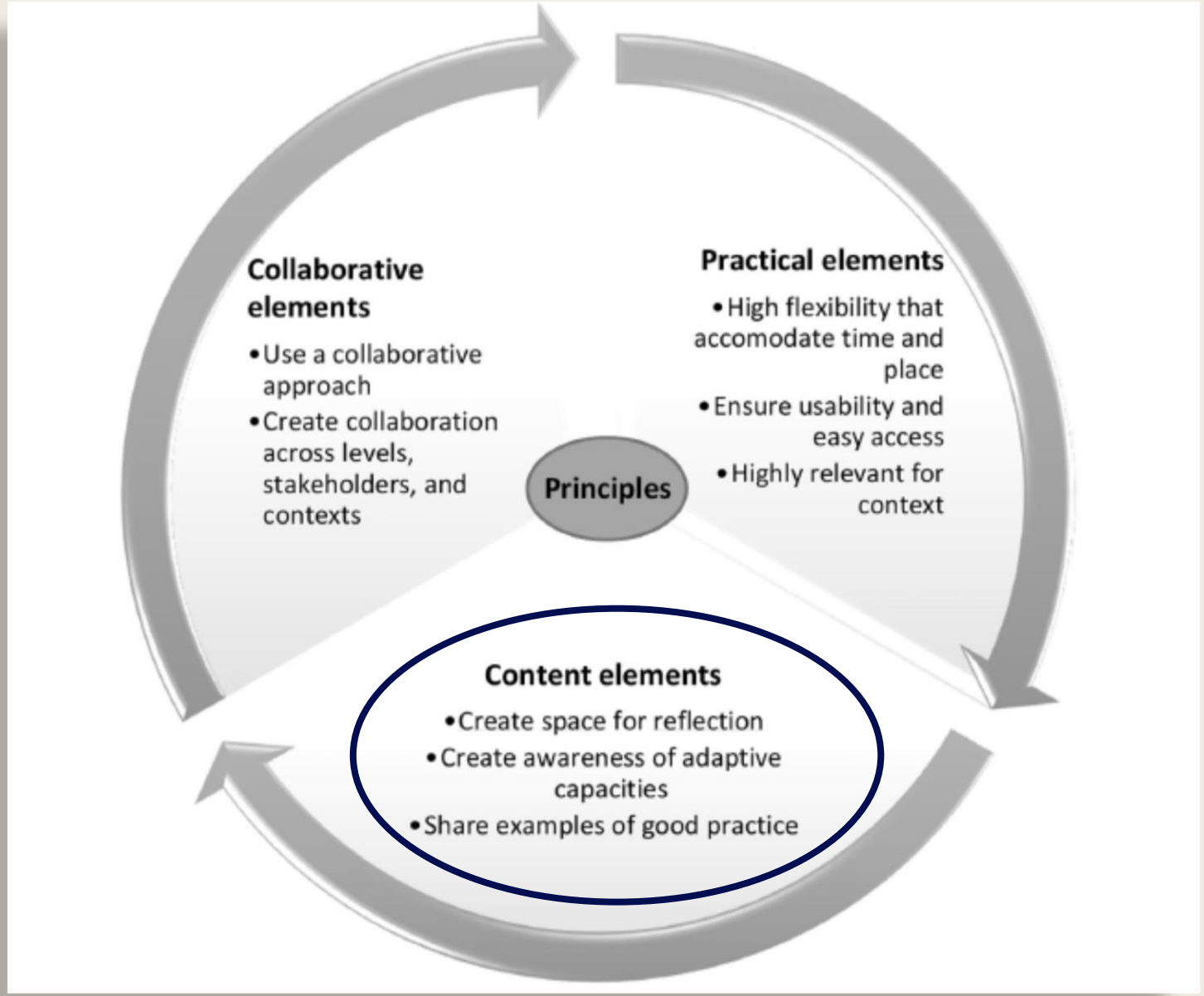
Haraldseid-Driftland *et al. BMC Health Services Research* (2023) 23:646
https://doi.org/10.1186/s12913-023-09653-8

BMC Health Services Research

RESEARCH Open Access

Learning does not just happen: establishing learning principles for tools to translate resilience into practice, based on a participatory approach

Cecilie Haraldseid-Driftland[1*], Hilda Bø Lyng[1], Veslemøy Guise[1], Hilde Valen Waehle[1,2], Lene Schibevaag[1], Eline Ree[1], Birte Fagerdal[1], Ruth Baxter[3], Louise A. Ellis[4], Jeffrey Braithwaite[4] and Siri Wiig[1]



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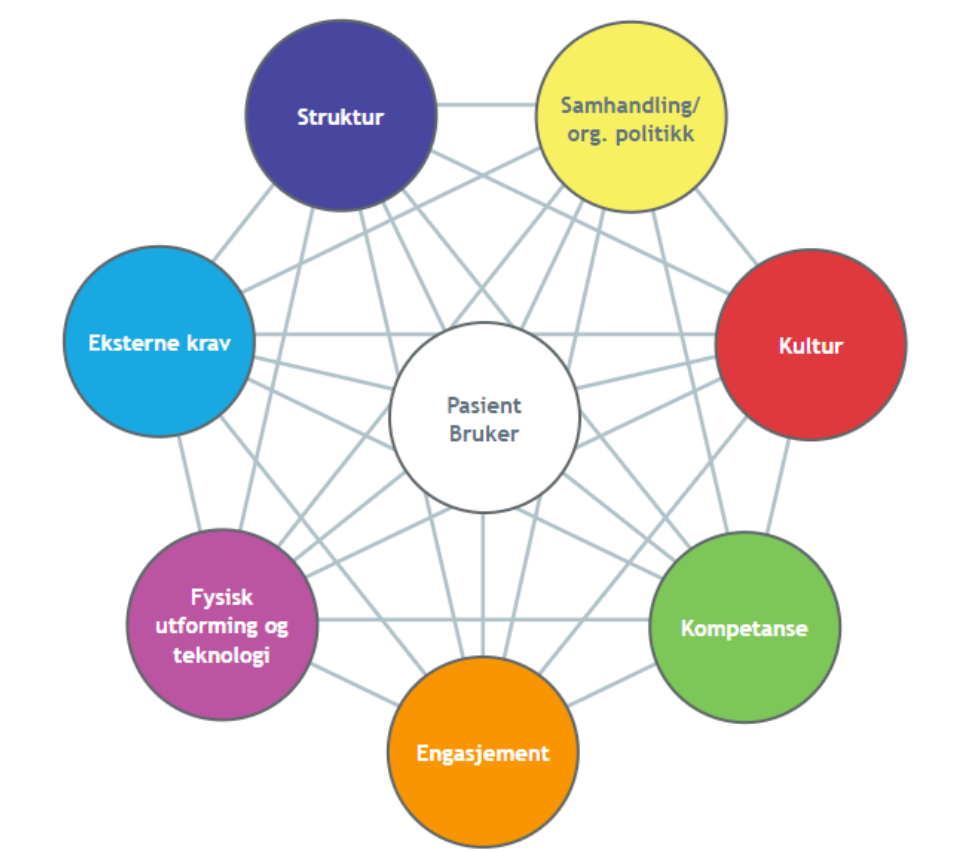
rih.uis.no/en

Welcome to the Resilience in Healthcare reflection tool - learning from what goes well

Background to the tool

Safe-Lead Guide



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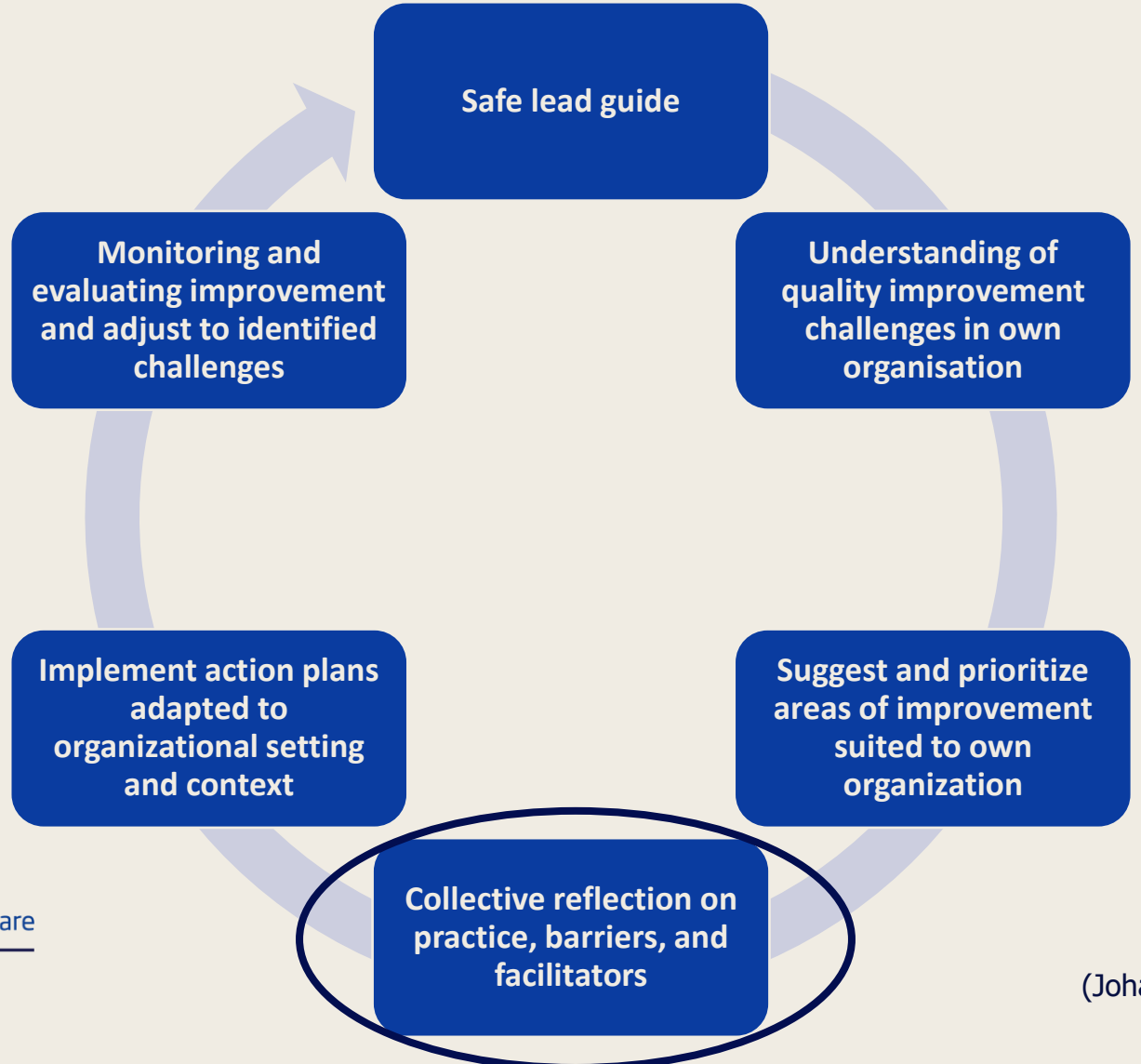
Safe-Lead logic model emphasising reflexive spaces in work practice



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(Johannessen et al 2019)

Haraldseid-Driftland et al.
BMC Health Services Research (2023) 23:890
https://doi.org/10.1186/s12913-023-09922-6

BMC Health Services Research

RESEARCH ARTICLE Open Access

Learning tools used to translate resilience in healthcare into practice: a rapid scoping review

Cecilie Haraldseid-Driftland[1], Heidi Dombestein[1*], Anh Hai Le[2], Stephen Billett[2] and Siri Wiig[1]

Open access Original research

BMJ Open Quality

Exploring managers' response to a quality and safety leadership intervention: findings from a multiple case study in Norwegian nursing homes and homecare services

Terese Johannessen [1], Eline Ree,[1] Ingunn Aase,[1] Roland Bal,[2] Siri Wiig[1]

frontiers | Frontiers in Public Health

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Making tacit knowledge explicit through objects: a qualitative study of the translation of resilience into practice

Hilda Bø Lyng[1*], Cecilie Haraldseid-Driftland[1], Veslemøy Guise[1], Eline Ree[1], Heidi Dombestein[1], Birte Fagerdal[1], Hilde Valen Wæhle[1,2] and Siri Wiig[1]

Reflexive spaces created through tools establish structures and meeting arenas, and foster understanding of work practice

- **Bring people together**
- **Talk about system safety**
- **Boundary objects**
- **Translate theory into practice**
- **Creates collective understanding of safety concepts and practices**

(Johannessen et al 2021; Lyng et al 2024; Haraldseid-Driftland et al 2024)

Other examples?

Handover, M&M, checklists, Green cross, team reflection, indicators, simulation, gaming, morning meeting, huddles, reporting systems, investigations, lunch talks, pandemic management meetings.....

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OXFORD Short Report

BJS, 2023, 1–5
https://doi.org/10.1093/bjs/znad111
Short Report

Surgical team dynamics in a reflective team meeting to improve quality of care: a qualitative analysis of a shared mental model

Merel J. Verhagen[1,*], Marit S. de Vos[2], Jan van Schaik[1], Joost R. van der Vorst[1], Abbey Schepers[1], Perla J. Marang-van de Mheen[3] and Jaap F. Hamming[1,*]

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Wahl *et al. BMC Health Services Research* 2022, **22**(1):1101
https://doi.org/10.1186/s12913-022-08462-9

BMC Health Services Research

RESEARCH Open Access

Experience of learning from everyday work in daily safety huddles—a multi-method study

Karina Wahl[1,2*], Margaretha Stenmarker[2,3,4] and Axel Ros[5]

Received: 8 February 2023 | Revised: 31 May 2024 | Accepted: 5 June 2024
DOI: 10.1111/nicc.13114

QUALITY IMPROVEMENT REPORT

BACCN Nursing in Critical Care WILEY

Learning from patient safety incidents: The Green Cross method

Hilde Kristin Jacobsen MSc, CPN[1] | Randi Ballangrud PhD[2] | Gørill Helen Birkeli MSc, CCN[3]

SPECIAL ESA LECTURE 2020

Taking Morbidity and Mortality Conferences to a Next Level

The Resilience Engineering Concept

Merel J. Verhagen, MD, Marit S. de Vos, MD, PhD,† and Jaap F. Hamming, MD, PhD**

Green Cross

- Proactive learning method enabling professionals to identify PSIs.
- Each day displayed in a cross shape and evaluated with a colour-code system

(Jacobsen et al 2024)

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Green Cross

TABLE 3 Findings before implementing the Green Cross method.

Subcategory	Category
Lack of openness hampers learning	Limited openness and learning
Adverse events were taken seriously	
Insufficient visible improvements	

TABLE 4 Findings 3 months after implementing the Green Cross method.

Subcategory	Category
Transparency increases learning	A learning environment is emerging
Increased patient safety awareness	
Committed to quality improvements	

(Jacobsen et. al 2024)

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Green Line

The **Green Line** is a **tool** to support daily conversations and to **promote learning** and improvement **based on ordinary** work in a patient safety **huddle**.

Theme	Code
Supporting factors	Seeing benefits with reflection
	Learning from what happens
	Finding improvements for a rewarding reflection
Hindering factors	Seeing difficulties with reflection
	The impact of the work climate

(Wahl et al 2022)

OXFORD Short Report

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Short Report

Surgical team dynamics in a reflective team meeting to improve quality of care: a qualitative analysis of a shared mental model

Merel J. Verhagen[1,*], Marit S. de Vos[2], Jan van Schaik[1], Joost R. van der Vorst[1], Abbey Schepers[1], Perla J. Marang-van de Mheen[3] and Jaap F. Hamming[1,*]

- Adapted M&M meeting to collectively discuss all cases (successful and complicated)
- Promoted shared mental model -> improving quality

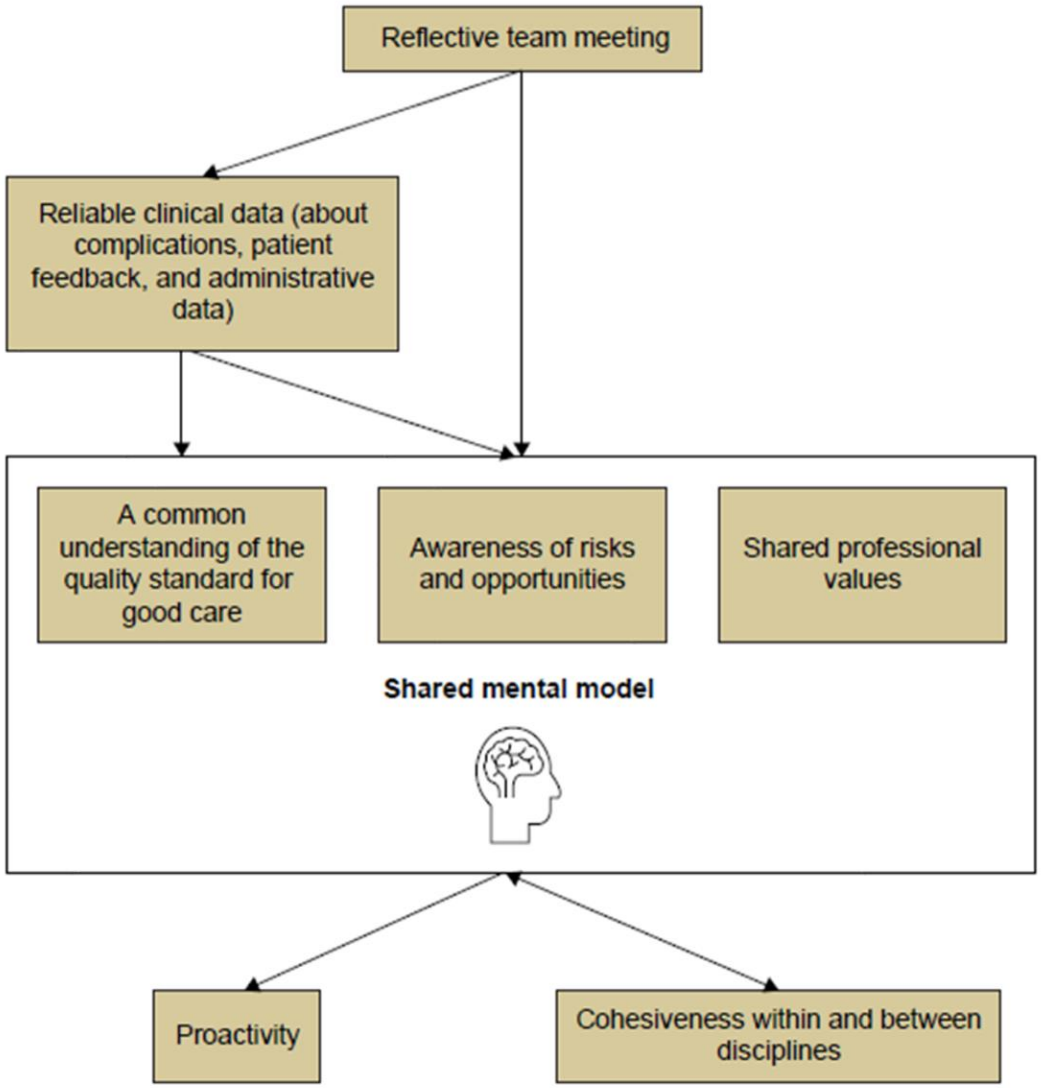

Fig. 1 How a reflective team meeting contributes to a shared mental model

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Who, why, and how

- Employees
- Leaders
- Regulators
- Policy makers
- Patients
- Unions
- Professional associations
- Health systems
- …

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Creating reflexive spaces between regulators and the regulated

- Responsive regulation adjusting methods to promote reflection
- Use incident investigation to generate team reflection
- Regulate user invovlement processes, structures, and meeting arenas
- Use soft signals as part of regulatory logic

(Kok 2021; Kok et al 2020; Øyri et al 2024; Wiig et al 2020;2024)

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Creating reflexive spaces between workers, leaders, patients and families

- Dialogue-based arenas
- Use checklists and indicators as foundations for reflexive spaces
- Encourage storytelling, reflexive conversations, metaphors, critical incident analysis, reflective journals, and focus groups.

(Kok et al 2020; Kok 2021; Wiig et al 2020; Seljemo et al 2023; 2024)

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Reflective Learning Health Systems?

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System

Data, infrastructure and standardisation

Integration of data and workflow

Culture and climate supporting ongoing learning

Health system worker

Evidence-based practice

Leadership and teamwork skills

Analytical and technological skills, data-science

Self-reflective capacity

Patient

Health literacy

Interact with technology

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(McDonald et al 2022)

What are the “risk areas”…?

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People are already multitasking…
They don’t have time!

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Slack is bad!? Rationalization processes may reduce opportunities for meetings, training, and tools

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Success criteria?

Trust, dialog, respect, and a psychologically safe atmosphere.

(Gray 2007; Cunliffe 2002; Wiig et al 2020; Wahl et al 2022; Jacobsen et al 2024)

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For those leading

1. Make reflexive spaces relevant and integral to work
2. Promote continuity in management positions
3. Ensure support and open climate
4. Use tools to structure and guide reflection

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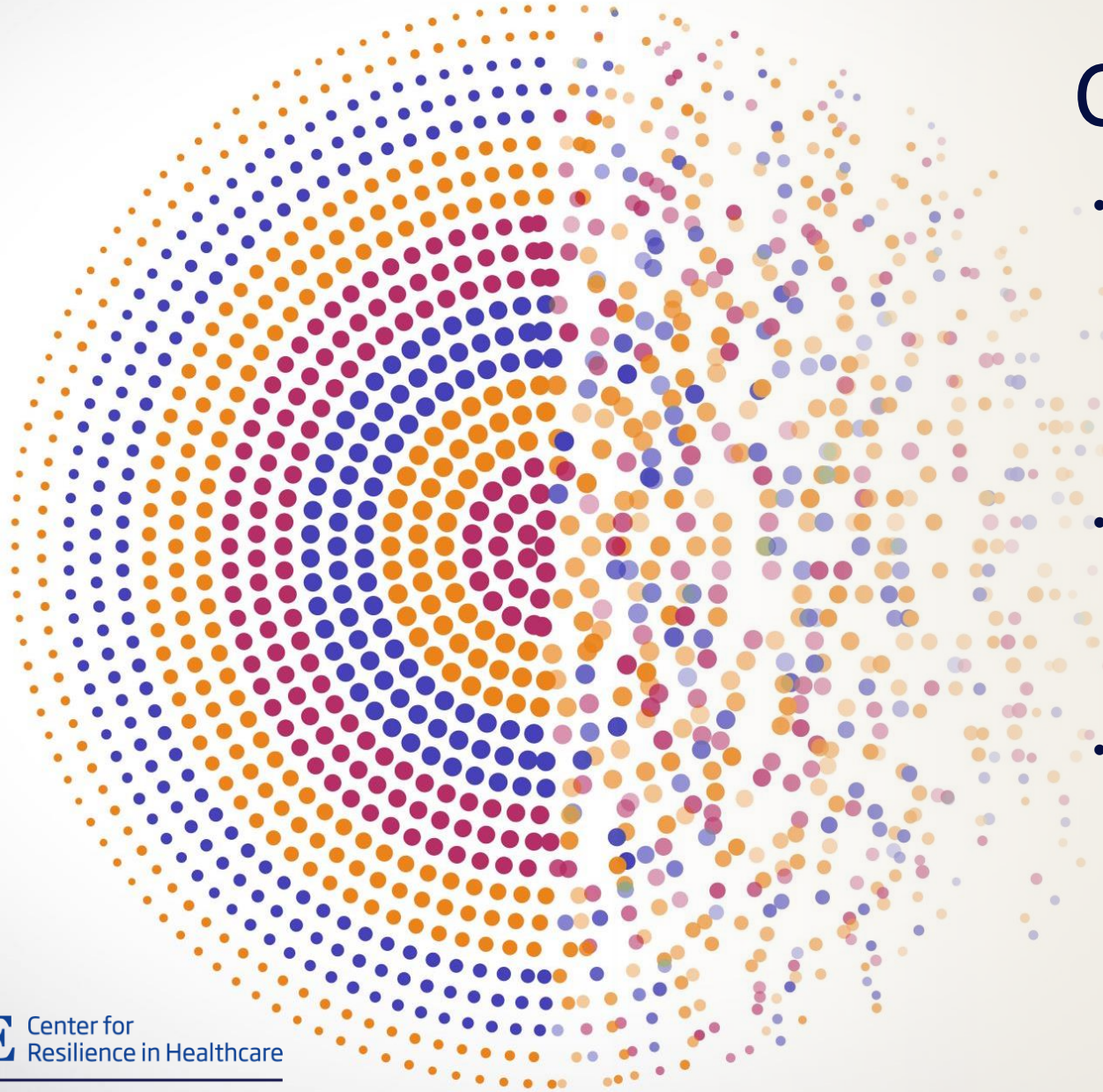
(Cunliffe 2002; Gray 2007; Idema & Caroll 2011; Wahl et al 2022; Jacobsen et al 2024; Øyri et al 2024; Wiig et al 2020; Johannessen et al 2021; Haraldseid-Driftland et al 2023; Lyng et al 2024; Seljemo et al 2023;2024)



Conclusion

- Creating different **constellations of reflexive spaces is a foundation** for promoting conditions that may cultivate **patient safety improvement**
- New **managerial and regulatory approaches can stimulate**, rather than curb, reflexive learning
- **Improvement** processes could benefit from **acknowledging reflexive spaces** where people **within and across organizations** meet, share experiences, and create opportunities for learning.

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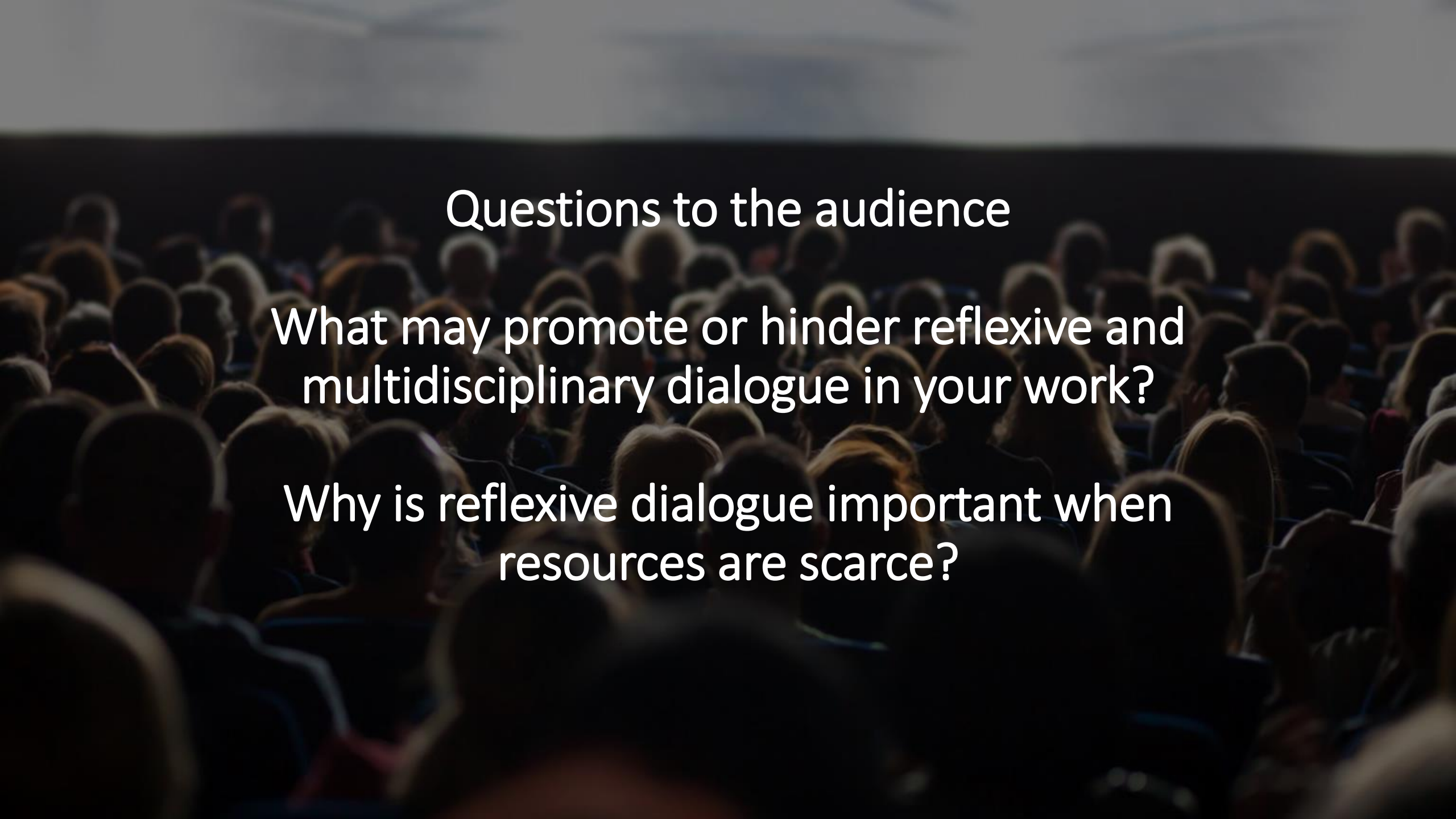

Questions to the audience

What may promote or hinder reflexive and multidisciplinary dialogue in your work?

Why is reflexive dialogue important when resources are scarce?