Management of Organisational Crises and Patient Safety: Towards A More Inclusive Approach

Deborah Kim Hill

A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University
for the degree of Doctor of Philosophy

Sheffield Hallam University

August 2011

ABSTRACT

The overall aim of the thesis is to realise a better, more holistic understanding of the management of smouldering crises and progress knowledge regarding the 'latent conditions' which underlie adverse patient safety incidents in healthcare organisations. In so doing, this thesis will move the debate concerning both the management of smouldering crises and patient safety in healthcare

The dominant approach in crisis management theory has been to consider crises from an organisational perspective. In spite of more recent developments in the understanding of smouldering crisis which causally attribute the emerging crisis to limitations in management's perspective, knowledge and capabilities, there has been insufficient emphasis upon understanding the contributory behaviour of grassroots level. Furthermore, whilst theory is empirically based, this has almost exclusively been founded on narratives offered by those who occupy senior management positions at the expense of considering employees who are closer to the crisis incubation point.

Errors in medicine are rare. However, the consequences of adverse patient safety incidents can be devastating. In the healthcare sector, legislative and policy initiatives in the UK during the early part of this century placed patient safety high on the agenda. Consistent with the dominant paradigm in crisis management theory, systemic human error is seen to underpin adverse patient safety incidents. However, whilst progress has been made developing an understanding and addressing aspects of the causal route to such incidents through 'latent conditions', the degree of understanding regarding contributory behavioural factors has been more limited.

This thesis rebalances the approach taken to date in the crisis management and patient safety literature by looking at smouldering crises from a less limited perspective than previously. It does so by exploring the views of individuals at grassroots level within an organisation. Adopting a qualitative research methodology and through purposive sampling, the research study utilises typical patient care scenarios in order to explore and understand the behaviour of employees in their workplace. The accounts of participants' working life are examined using narrative analysis and the findings are crystallised in the author's model of professional workplace behaviour, the 'Faces of Self'.

The author asserts that the limitations of management perspective, knowledge and capabilities which are responsible for the escalation of smouldering crises can be ameliorated if management are sensitive to and effective in the management of the organisation's climate. In addition, effective improvement of both 'hard' and 'soft' 'latent conditions' by policy makers, leaders within organisations and management generally will create a more effective, motivated and satisfied healthcare professional in the patient care setting and negate some of the conditions in which the adverse patient safety incidents promulgate.

ACKNOWLEDGEMENTS

I would like to thank all of the healthcare professionals who participated in the research underpinning this thesis; their openness was appreciated and their narratives were illuminating.

I am especially grateful to my Director of Studies, Professor Jim Bryant and Supervisor, Professor Isobel Doole, for their continued support, advice and guidance throughout this journey. I would also like to thank Professor Phil Johnson for his help in the early stages of this work, Sheffield Hallam University's Technical Support and Learning Centre teams for their assistance with the practicalities and Marilyn Gambles for her attention to detail.

Last, but by no means least, I would like to thank my family, particularly David, Emily and Rachael and close friends (you know who you are), for without their understanding and encouragement, I could not have completed this thesis. To my parents, Floss and Gerry, I would like to say thank you for being you, the qualities you instilled in me were there at the times when I needed them the most.

This thesis is dedicated to David, my wonderful husband – *tu sei la mia roccia*

CONTENTS

ILLUSTRATIONS

List of Figures

List of Tables

Chapter 1 An Introduction to the Thesis

This chapter is an introduction to my journey and the intellectual path of my thesis and establishes the scene for the remainder of this document. The chapter will begin by stating the aims and objectives of the thesis before explaining my personal motivations and defining moments in my journey. The business context of this work is then examined before an overview of the research methodology is set in place. The chapter concludes by presenting the structure of the thesis.

1.1 The Aim of the Thesis

The overall aim of the thesis is to realise a better, more holistic understanding, both theoretically, and practically, of the management of smouldering crises and progress knowledge regarding the 'latent conditions' which underlie adverse patient safety incidents in healthcare organisations. In so doing, this thesis will move the discourse concerning both the management of smouldering crises and patient safety in healthcare.

Crisis management developed as a discipline in an era of large-scale, socio-technological disasters such as Chernobyl, Three-Mile Island and Exxon Valdez. The dominant approach in management theory has been to consider crises from an organisational perspective; crises were largely seen as failures of management systems (Smith and Toft 2005) rather than being symptomatic of pervasive behavioural factors. In spite of more recent developments in the understanding of smouldering crisis conditions which partially address this limitation and causally attribute the emerging crisis to limitations in management's perspective, knowledge and capabilities (Smith 2005a, 2006c and Smith and Toft 2005), there has been insufficient emphasis upon understanding the contributory behaviour of grassroots level. Furthermore, whilst theory is empirically based, this has almost exclusively been founded on the narratives offered by those who occupy executive and senior managerial positions at the expense of considering employees who are closer to the crisis incubation point.

Everyday the healthcare sector effectively and safely treats almost 1m patients (NHS Choices 2011) and whilst errors in medicine are rare, the consequences of adverse patient safety incidents, which are symptomatic of a smouldering crisis, can be devastating (Department of Health 2000a). In the healthcare sector, legislative and policy initiatives in the UK during the early part of this century placed patient safety high on the agenda. Consistent with the dominant paradigm in crisis management theory, theoretical development has recognised that systemic human error underpins adverse patient safety incidents. However, whilst theoretical and practical progress has been made developing an understanding and addressing aspects of the causal route to such incidents through 'latent conditions', the degree of understanding regarding contributory behavioural factors has been more limited.

This thesis rebalances the approach taken to date in the crisis management and patient safety literature by looking at smouldering crises from a less limited perspective than previously. It does so by exploring the views of individuals at grassroots level within an organisation. Given the emphasis on patient safety, the specific business environment chosen is the healthcare sector where the management of smouldering crises, in the context of error in medicine, has become a key concern. The behaviour of individuals working in the healthcare sector is pivotal to understanding why, in organisations where the raison d'être is patient care, errors occur which are symptomatic of a smouldering crisis situation.

1.2 Thesis Objectives

In order to achieve the overall aim of this thesis, I specified the following objectives. A review of the degree to which these objectives have been achieved is undertaken in Chapter 9.

Objective 1 – To explore what is understood about organisational crises and how far this explains the evolution of smouldering events which incubate over time in the behaviours at grassroots level.

Objective 2 – To investigate how this knowledge is translated into meaningful advice concerning how smouldering crises can be best managed.

Objective 3 – To understand the contextual setting for this thesis as a means of establishing healthcare as a valid area of study of smouldering crises.

Objective 4 – To explore the knowledge regarding patient safety and investigate the extent to which this knowledge ameliorates adverse patient safety incidents in healthcare.

Objective 5 – To design and implement a research study in order to investigate and explore how and why individuals at grassroots level in healthcare behave, at times, in such a way that their actions lead to the errors which are indicative of smouldering crises.

Objective 6 – To contribute to the normative debate regarding smouldering crises and patient safety

This section has been concerned with stating the aim and objectives of the thesis which have provided my direction and discipline in terms of realising a better, more holistic understanding of smouldering crises and patient safety throughout the thesis journey. The next section will explore the pivotal role played by my personal motivation and defining moments in the thesis in influencing both the statement of the aims and objectives and the movement towards their achievement.

1.3 The Journey Towards the Thesis

At the outset of my journey, even before this thesis was conceived, events were happening which would drive me towards the desire to better understand why crises occurred. Within the journey itself, as my learning progressed and my knowledge and confidence grew, I would make judgements which, upon reflection, were defining and decisive moments in my pursuit of a contribution to knowledge. This section is concerned with both.

1.3.1 Personal Motivations

Beverley Allitt was a well loved nurse on Grantham and Kesteven's Children's Ward when she killed four of her charges and seriously injured another nine (Askill and Sharpe 1993, Davies 1993, Wooster 1994). She was tried and convicted of the murders and is held in Rampton Secure Hospital. However, the Public Inquiry into the events at Grantham and Kesteven's Hospital, the Clothier Report (Department of Health 1994), also attributed responsibility for the deaths to failures of management and communications in the hospital suggesting that these contributed to creating the conditions in which Allitt could attempt to cause harm.

At the time of the Allitt trial in the early 1990s, I was completing an undergraduate degree in business studies. My final year studies included a module on strategy where contemporary issues were considered from a strategic perspective. One such issue was crisis management. The literature tended to focus on high risk technologies and was dominated by the definition of crises, by the environmental context for organisational crises and by prescriptive crisis management responses for managers. While I found these dramatic, high profile cases fascinating, I was less convinced by the approach suggested in the literature and I was keen to understand how and why these incidents happened.

Following the completion of my degree, I was offered the opportunity by a tutor to research the case of Beverley Allitt from a crisis management perspective. While it was clear that Allitt was ultimately responsible for the deaths and injuries sustained, it appeared that there were also issues in terms of how the organisation operated. I became sensitised to cases in healthcare that shared the common characteristics of organisational crises. Some of these were deliberate acts of evil committed by individuals determined to cause harm such as Allitt and later Harold Shipman, the Hyde GP (Department of Health 2001a). However, whilst I continued to reflect on events such as these, I also became more aware of other prominent incidents such as the Bristol Royal Infirmary Children's Heart Surgery case (Department of Health 2001b) which seemed

symptomatic of the systemic failures at the heart of the crisis management literature. What I found particularly fascinating about the events at Bristol was that the organisational crisis had smouldered, unacknowledged, for a period of time, in the daily, often unintentional, behaviour of healthcare professionals. I became absorbed by the notion that in organisations where the raison d'être was 'first do no harm', humans, through no apparent evil intention, were committing errors that were causing injury to those in their care.

Almost concurrent with the above I discovered that the Department of Health had undertaken a significant project aimed at examining the nature and impact of injuries caused by clinicians in healthcare (Department of Health 2000a). The Department of Health's *Organisation with a Memory* (2000a) found evidence of serious adverse events with a potential liability for clinical negligence claims in excess of £2bn. The Report called for more openness in dealing with adverse events and established a universal system for the reporting of these. The report also recognised the role of a blame culture in preventing this openness and sought, over the longer term, to remedy this.

This report further persuaded me of the timeliness and legitimacy of focusing on organisational crises in healthcare, particularly those which were incubated over time in the behaviours at grassroots level. In addition, there appeared to be a compulsion to develop knowledge in order to better understand why crisis events happened and to identify ways in which their progression could be halted. I wanted to be part of this by contributing to academic knowledge and influencing policy makers and management, generally and in the healthcare sector in particular.

1.3.2 Defining Moments

Throughout the progression of this thesis, I made many decisions; some very practical, others more philosophical. The reasoning for many of these decisions and the ensuing decisions themselves are documented within the subsequent chapters of this document since they occupy a part in the journey of my thesis. However, I felt it also important to establish the details of judgements that I

made which played a more significant role in altering the course of my research and the development of my contribution to knowledge. These were decisive and defining moments in my work which, I reflected, represented key turning points in the development of my thesis. Specifically, they were concerned with the recognition that the incubatory period of a crisis represented what I have termed a 'smouldering crisis', the critical and contributory role played by management's limited perspective, knowledge and capabilities in allowing crises to smoulder, the role of 'latent conditions' within systemic error and finally, the empirical limitations of a grassroots perspective.

At the outset of the review of existing literature on organisational crisis, the identification that, whilst throughout the management literature there was an emphasis on large-scale, high profile crises, crisis-like incidents could smoulder within an organisation was a significant turning point for me as it paralleled with my area of interest and, most importantly, identified this interest as a legitimate area for further research. Section 1.3.1 explained my personal reasons for embarking on this thesis and highlighted that, in medicine, there appeared to be distinctive types of human errors from those which were deliberate acts of evil committed (such as the cases of the nurse Beverley Allitt and the GP Harold Shipman) to some which were more representative of systemic failures. Given the research I had already undertaken into the case of Beverley Allitt, my original thoughts were to develop crisis management knowledge by exploring further the motivation for such negative behaviour in an environment where the raison d'être was 'first do no harm'. However, I became sensitised to what appeared to be the concealed incubation of systemic management failures of what I later define as smouldering crises. Notwithstanding Ackroyd and Thompson's work on 'misbehaviour' (1999), it did not seem feasible to me that healthcare professionals who entered a caring profession, would be motivated to embark on behaviour which would adversely affect their patients. Thus, these considerations led me to shift my focus to smouldering crises and, in so doing, review the role of motivation within my work. As a consequence from a position where the motivation for behaviour was planned to be a central theme within the thesis, I judged that my focus would be the exploration of behaviour within the organisations. What is interesting, though, is that despite considering

that motivation would not occupy a prominent position in my thesis, taking the 'world as I see it' perspective of the healthcare professional in my approach to data analysis (the details of which are covered in Chapters 4, 5, 6 and 7 and my construction of the 'Faces of Self' model), highlighted the significant underpinning that motivation had on the positive behaviours of individuals in the healthcare sector (Georgellis and Tabvuma 2010, Moody and Pesut 2006).

In reviewing knowledge concerning smouldering crises, the work of several authors (Elliott and Smith 2007, Smith 2005a, 2006c, Smith and Toft 2005) was particularly useful to me as it defined the nature of management behavioural failures in the systemic problems that led to smouldering crisis conditions. Although aspects of the literature recognised 'operator error' as being the catalyst in the incubation of crisis conditions, the work of these authors levelled responsibility at management's limited perspective, knowledge and capabilities limitations. Furthermore, particularly within the literature concerned with smouldering crises, there was a movement towards improving knowledge so that management perceptions and interventions in these situations would be more effective and thus, the potential for the management failures associated with crisis conditions would be curbed. So whilst knowledge regarding smouldering crises had led me, in the first place, to consider unintentional behaviour in the working environment, the recognition that operational decision making and response had a significant bearing on the degree to which a crisis smouldered focused my attention on the pressing need to improve the management behavioural limitations that had been observed in the literature.

My attempts to better understand human error led me to seek and find further explanation in Reason's work (1987, 1990, 1997, 1998, 2000a, 2008). Reason (1987, 1990, 1997, 1998, 2000a, 2008) made a clear and critical distinction regarding the causal factors in error situations that management could influence (the 'latent conditions') through organisational systems and processes, compared to those it could not ('the active failures'). This was highly significant for me since, like the management literature on smouldering crisis, this placed responsibility for errors at the behest of management. Furthermore, within the business context of this thesis, I also identified that despite the challenges of an

error prone working environment and in spite of an acknowledgement that complete error-free healthcare was not an aspiration, the healthcare sector in the UK, under the auspices of the National Patient Safety Agency, had begun to take action to combat human error in medicine, so-called adverse patient safety incidents. This, for me, demonstrated the validity of investigating patient safety in healthcare and persuaded me to consider the significant influence that 'latent conditions' could have on the behaviour of an individual working within an organisation's systems and processes.

Within the exploration of the literature on patient safety, I found that knowledge concerning the nature of management behaviour underpinning systemic failures was less prominent, particularly in the policy driven literature as was a holistic understanding of the healthcare professional at work. Furthermore, in reviewing existing literature I observed that, to date, empirical evidence in terms of crisis management was centric towards the narratives of executives and senior managers and theoretical development exhibited a tendency to concentrate 'hard' knowledge. This seemed to me to be incompatible with the emerging, yet notable, movement to look at developing knowledge of a 'softer' more behavioural nature from those who were closest to the point of crisis incubation (House of Commons 2009, Smith 2005a, Smith and Toft 2005). These observations led me to conclude that patient safety in healthcare could be better managed (although probably never fully realised) if those who managed the organisation's systems and processes both achieved and acted upon an enhanced 'behavioural' perspective based on the views of those who were closest to the error incubation point.

Thus, the combination of these observations from a critical review of existing knowledge directed my research methodology and placed the focus of my work in improving management's perspective, knowledge and capabilities in smouldering crisis conditions through a better understanding of the contributory behaviour of grassroots individuals in the working environment who were closer to the incubation points of systemic failures. This is summarised in Figure 1.1 below.

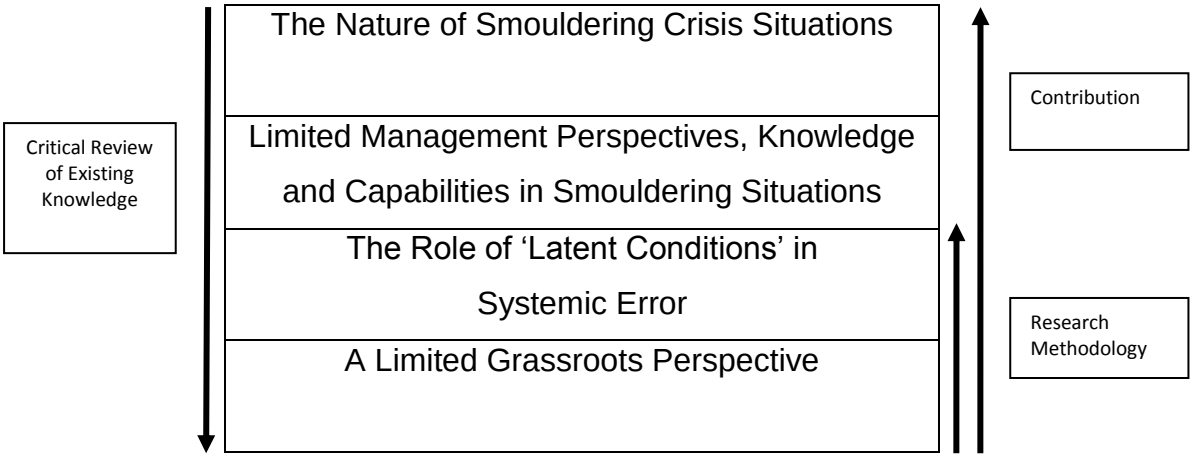


Figure 1.1 The Journey of this Thesis: Key Turning Points, The Research Study and the Contribution to Knowledge

Finally, I have outlined above how my work is placed within the limitations that I identified in the crisis management and patient safety literature. This directed the research focus towards developing a better understanding of the behaviour of grassroots individuals in their daily working life in order to generate a deeper knowledge base from which management could better deal with crisis and patient safety incubating conditions. However, in isolating the area of study as the grassroots individuals, I also considered whether my thesis and thus the associated contribution to knowledge could be positioned within the knowledge based of 'identity' literature (for example Lawler 2008, MacIntosh 2003, Pask 2005). Furthermore, by contextualising my study of grassroots individuals within the healthcare sector, I contemplated whether my work could also be placed with the literature concerning healthcare management (for example Goodwin, Reinhold Valerie 2006, Melanie and Mansour 2005, Walshe and Smith 2006). I reasoned that broadening the contribution to embrace both of these areas would not be appropriate as this would locate aspects of my work outside my area of interest and may compromise the strength of the synergies I was identifying between crisis management and patient safety. However, positioning this work in the body of knowledge concerning identity and healthcare management is identified in Chapter 9, Section 9.6 as an area for further research.

This section has shown how this thesis evolved into a study concerning the nature of smouldering crises, seen as control-breached management failures (Smith 2005a, Smith and Toft 2005), and specifically the contributory role played by grassroots individuals. The underlying rationale for this was a quest to provide deeper knowledge for academics and managers in the management of smouldering crises, particularly patient safety crises, for as Smith (2005a p2) stated "Under the conditions of crisis, managers need to ensure that they make sense of what is happening to the organisation". The next section is concerned with examining the business context of this thesis.

1.4 The Business Context: Healthcare in the UK and the NHS

The NHS is the largest publicly funded healthcare organisation in the world and the main healthcare provider in the UK. Ranking only below the Chinese People's Liberation Army, the Wal-Mart supermarket chain and the Indian Railways in terms of the number of staff it directly employs, the NHS employs 1.7m people half of which are clinicians including 120,000 hospital doctors, 40,000 general practitioners (GPs), 400,000 nurses and 25,000 ambulance staff. These staff deal with 1m patients every 36 hours. Launched in 1948 on a budget of £437m, the NHS now utilises £100bn of public money, 80% of which is distributed to local Primary Care Trusts (NHS Choices 2011).

The NHS is controlled by the Department of Health through 10 Strategic Health Authorities which in turn supervise the NHS trusts in their respective areas. Healthcare in Scotland, Wales and Northern Ireland is run through their own administrative areas. In terms of patient care, the NHS is separated into two parts. Primary care, involving GPs (General Practioners), dentists, pharmacists and optometrists, is where most patients go in the first instance to receive treatment. However, more acute care (secondary care) although commissioned by the Primary Care Trust is delivered, either on a planned or emergency basis, by for example acute care trusts (hospitals and specialist care facilities) and ambulance trusts (NHS Choices 2011).

The NHS also controls agencies outside its main structure including the National Institute for Health and Clinical Excellence (NICE) which is responsible for setting quality standards and, pertinently for this thesis, the proposed NHS Commissioning Board which will embrace the National Patient Safety Agency whose responsibilities include the management of the National Reporting and Learning Service (which collects, analyses and actions patient safety information) and the National Clinical Assessment Service (which ensures that individual clinical practice is safe) (NHS Choices 2011 and Department of Health 2010).

When Aneurin Bevan launched the NHS on July 5 1948, its foundations were that it should meet the needs of everyone, was free at the point of delivery and based on clinical need, not the ability to pay. These foundations remain in place today and have been extended through the following principles to provide standards that, today, direct Government policy concerning the NHS. Firstly, the NHS aspires to the highest standards of excellence and professionalism. Secondly, NHS services must reflect the needs and preferences of patients, their families and their carers. Thirdly, the NHS works across organisational boundaries and, in partnership with other organisations, in the interest of patients, local communities and the wider population. Fourthly, the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Finally, the NHS is accountable to the public, communities and patients it serves (NHS Choice 2011).

However, governing the NHS since its inception has not been smooth and is characterised by successive Government's attempts to address the perennial difficulties of managing funding and resources through workforce and patient delivery reforms (Ahmed and Cadenhead 1998, Brown, McCartney, Bell and Scaggs 1994, Smith 2004, The Telegraph 2011a, 2011b) and summarised in the following quotation from the Institute of Medicine "Healthcare today is characterised by more to know, more to manage, more to watch, more to do and more people involved" (Walsh and Antony 2007 p108).

In 1997 the new Labour Government promised a new future for the NHS advocating the creation of a hybrid strategy taking the best of previous initiatives. The internal market was abolished and the future was to be based on partnership and performance aiming, as it did, to address financial, human and asset resourcing, affect devolution and establish priority standards. Attention for the first time focused on patient safety and amongst its core principles was to work continuously to improve quality services and to minimise errors by ensuring that all those providing care worked to make the NHS a safe place. The culture would be supportive and engender learning from mistakes (despite the Finlayson (2002) and West's (2006) observations that a culture of blame remained intact in healthcare generally and the NHS in particular). In addition, the NHS vowed to support and value staff by amongst other things recognising that professionals would exercise their judgement (NHS Choices 2005). The Improving Working Lives initiative aimed to provide a better workplace for NHS staff as workplace research suggested that the erosion of autonomy, rigidity of hierarchy and organisational confusion were amongst the causes of stress (Department of Health 2000b). In addition Creating a Patient-Led NHS (Department of Health 2005a, p24) advocated staff having more authority and autonomy in order to "reduce professional divides and bureaucractic systems and inflexible processes". The current Government in its White Paper, Equity and Excellence: Liberating the NHS (Department of Health 2010) has vowed to put patients first through better choice and consultation, outcomes rather than process based accountability and improved safety and patient experience. Furthermore, the Government plans to decentralise commissioning decision making and budgetary management to local level and, effecting a 45% reduction in management costs, will redirect this money to frontline services. It is clear, thus, that healthcare in the UK, and the NHS in particular, has publicly placed patient safety high on the agenda. The literature review in Chapter 3 will explore the knowledge base supporting this direction and examine the degree to which this is realised in practice.

1.5 Methodological Overview

I have explained that the contribution of this thesis would complement the normative theoretical corpus by taking a more holistic and inclusive approach to understanding what happened in smouldering crisis situations and why, and contribute to the debate regarding patient safety and, in so doing, enhance management knowledge in the prevention of management failures that led to patient safety smouldering crises in healthcare.

Thus, in order to examine the gap in the knowledge concerning the management of smouldering organisational crises and patient safety, the research methodology focused on investigating and exploring the behaviour in the workplace of those at grassroots level in healthcare where there was the potential to cause a smouldering crisis through human error. Accordingly, the specific questions for the research study associated with this thesis were identified as being

1. What influences grassroots healthcare professionals in the work setting?

2. How does this affect how they behave in their job roles?

3. What effect does the behaviour of grassroots individuals have on their peers?

4. What effect does the behaviour of grassroots healthcare professionals have on patient care and how might this behaviour in the workplace lead to patient safety errors which are symptomatic of smouldering crises?

The research strategy centred on taking the structural phenomological approach of the critical theorist. I identified with the critical theorist philosophy and saw particular validity in an approach which explored contemporary pervading routines and their relative impact on the behaviours of the “disempowered” in organisational settings. In line with perceived limitations in the behavioural perspective of both the management of smouldering crises and

patient safety knowledge, the research adopted a qualitative approach considering several strategies before adapting the principles of critical incident technique to working life scenarios since this was considered to be most appropriate to the investigation. In determining the working life scenarios, I chose to take a patient oriented approach since this was highly influential in defining the work of healthcare professionals. Two scenarios were identified, one based on an acute patient care need and one based on a routine patient care need, and the research questions were sensitised to the perceived limitations in existing knowledge regarding smouldering crises and patient safety.

Several research methods were considered but discounted for both reasons of relevance and practicality before I decided to collect the data by conducting a series of interviews using a semi-structured topic guide which was based on the working life scenarios. A purposeful approach to sample selection was taken with participants being selected due to their ability to provide information that was important to the research that could not be provided by others and resulted in completed interviews with 20 participants, 2 of which were conducted on a one-to-one basis and 9 of which were conducted on a paired basis.

A narrative approach was taken to the analysis and I developed the final analytical framework through a series of 5 stages involving the development of descriptive and interpretative coding which is shown below in Figure 1.1.

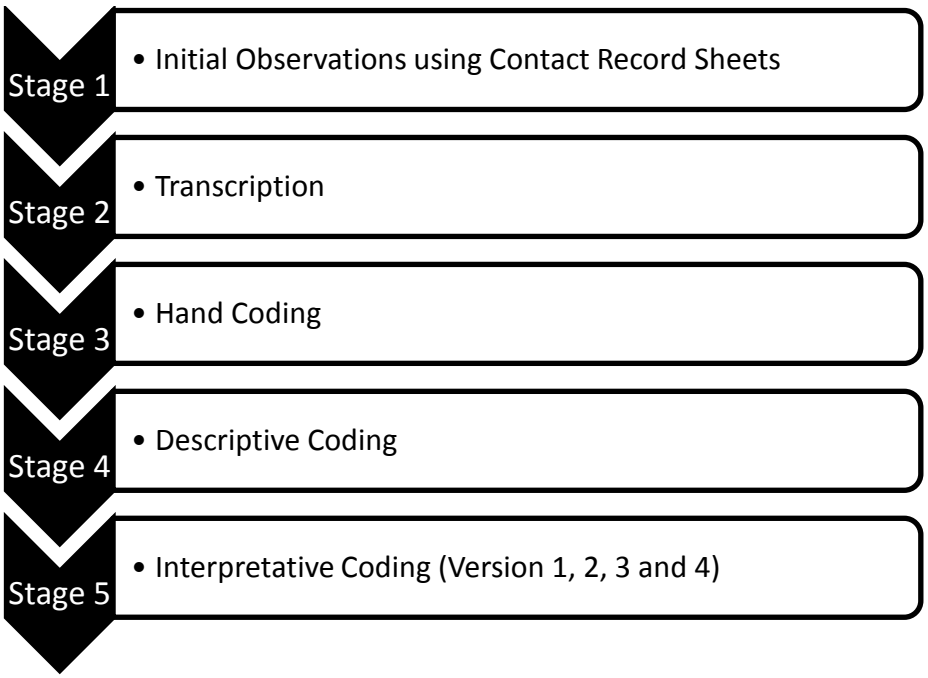


Figure 1.2 Sequential and Evolving Narrative Approach to Analysis

1.6 The Structure of the Thesis

Following this introductory chapter, Chapters 2, 3 and 4 detail the literature-based context of the thesis and associated research. With data from the empirical study being presented in Chapters 5 and 6 and the theoretical arguments following in Chapters 7, 8 and 9.

Chapter 2 examines the theoretical context of organisational crisis which this thesis develops and charts my analytical journey through the management literature on organisational crises. Specifically, I undertake a critical review of the literature's approach to the definitions of organisational crises and crisis types in order to arrive at a definition of organisational crises for this thesis, the smouldering crisis. The chapter continues by exploring the suggested root causes of crises, focusing on human error since this is seen as a dominant cause of systemic smouldering crises and is central to this thesis. An assessment is then undertaken concerning how the literature suggests that organisational crises should be managed, focusing on specific aspects which were felt, by me, to be pertinent to smouldering crises and thus, this thesis.

Finally, I conclude by exposing the limitations of existing literature and identifying the focus of the empirical research of this study.

Chapter 3 explores the patient safety context of this thesis. Patient safety was defined by Vincent (2006) as "the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare" (p14). The chapter focuses on reviewing the subject of human error in healthcare from an applied literature perspective before proceeding to explore patient safety within the healthcare context. Whilst the chapter demonstrates the complexity of the subject, the seriousness with which the healthcare sector views human error in medicine and the associated intent of healthcare organisations to understand and learn from error incidents, I conclude that there are areas of limitations which provide additional direction to the empirical research of this study.

Chapter 4 details the methodological approach taken in this thesis within the context of my critical theorist's philosophy. Whilst the relative merits of quantitative and qualitative data collection methods are considered within the context of the aims of the thesis, the chapter provides an account of the qualitative research choices made and the methods used to collect and analyse the data for this thesis. Throughout the chapter specific attention is given to the cohesive development of the empirical research and how the challenges of conducting research in the healthcare sector were managed.

Chapters 5 and 6 present the empirical data which resulted from the qualitative research within a framework of emerging themes. In undertaking the final stage of the research analysis, common themes in which participants expressed their working life were observed. Within these themes, participants were expressing their working life from two perspectives. The first perspective, presented in Chapter 5, concerned participants' observations regarding aspects of their working life which were shaped by management and the organisation and influenced how they felt and behaved at work. The second perspective, presented in Chapter 6, concerned participants' views about themselves and

their peers and the ways in which these influenced how they felt and behaved in the work environment.

It was my view that the data in Chapters 5 and 6 were building blocks in developing this understanding but it was vital to centre the data around the dynamics of a healthcare professional in order to create a stronger insight into the individual and their behaviours in the workplace. This evaluation is presented in Chapter 7. Chapter 7 presents my perspective on the healthcare professional, their motivation and behaviour as the three 'Faces of Self'; The 'Duty Self', The 'Professional Self' and 'The Collegiate Self'.

In Chapter 8, the interrelationships between the 'Faces' are explored as a means of creating a more complete understanding of the healthcare professional. Whilst strong undertones of an orientation for patients are exposed as a source of strength in the interrelationships, working conditions are identified as a weakening factor. The nature of these inhibiting working conditions is explored through the literature on organisational climate. The chapter proposes the contributory value of the thesis in terms of patient safety and the management of smouldering crisis situations. In the first case, I assert that improvements in the organisation's climate will address weaknesses in the fulfilment of the 'Faces of Self' that lead to adverse patient safety incidents. In the second case, I also assert that it is necessary for the normative theoretical corpus on organisational crises to embrace the knowledge that is found within the discourse on organisational climate if the limitations in management's perspective, knowledge and capabilities are to be addressed thereby curbing the potential for smouldering crises.

In conclusion, at Chapter 9, I reflect on the progression of the thesis before proposing the contribution to knowledge in the areas of smouldering crises and patient safety. In addition, I consider the practical implications for managers, reflect on the achievement of the research objectives, elaborate further on the limitations of the study, identify areas for further research and conclude with some brief personal reflections.

1.7 Summary

This chapter has set the scene for the thesis by stating the aims and objectives of the thesis before explaining my personal motivations and defining moments in my journey. The chapter also examines the business context of this work before presenting an overview of the research methodology and the structure for the remainder of this document.

The next chapter will present my analytical journey through existing literature concerning organisational crises.

Chapter 2 A Review of Existing Literature on Organisational Crises

The objective of this chapter is to examine the theoretical context of organisational crises which this thesis develops. The aim of this thesis is to advance the understanding of the management of smouldering crises, particularly those concerning patient safety within a healthcare organisation. In order to do this, it was necessary at the outset to explore previous literature on crisis management where the emphasis was on organisational crises. Chapter 3 which follows will examine the existing literature on patient safety.

This chapter presents the author's analytical journey through the crisis management literature. In Section 2.1 a critical review of the literature's approach to the definitions of organisational crises is provided. However, the characteristics of crises were felt by the author to be only part of what defines an organisational crisis. The definition of a crisis was also contextually based on specific types of crisis. Hence it was felt by the author that a definition of organisational crisis for this thesis could not be properly proposed until the literature concerning the taxonomies of crises had also been explored. Therefore, Section 2.2 examines the taxonomies of organisational crises offered by the literature and concludes with a definition of organisational crises for this thesis, the smouldering crisis. Section 2.3 considers the notion of smouldering crisis which is central to both the perspective and research context of this study whilst section 2.4 explores the suggested root causes of crises, focusing on human error since this is seen as a dominant cause of systemic crises. Finally, Section 2.5 assesses how the literature suggests that organisational crises, particularly those of a smouldering nature, should be managed.

The conclusions drawn from the author's review of the literature were that the origins of existing theory were to be found in high profile, large-scale crises, viewed from an organisational perspective where organisational crises were felt to be human failures within management systems and solutions were often technically based (Smith and Toft 2005). The author perceived that this perspective had several limitations. Firstly, the emphasis on the high profile culmination of crisis conditions neglected rising concern in the literature

regarding the evolutionary pathway of a crisis and the significant causative behaviour of managers therein (for example Smith 2005a). Secondly, whilst the dominant cause of organisational crises was recognised as systemic error, the focus on addressing the causal route through improved management systems diverted attention away from developing the understanding of the associated contributory behaviour of those at grassroots level. Finally, the empirical base for the development of theory was founded on the narratives of executives and senior managers at the expense of taking a more holistic approach by additionally considering the views of employees who were closer to the crisis incubation point. These identified limitations are where the author places her work, specifically the research study association with this thesis and the contribution to knowledge.

2.1 Defining Organisational Crises

As explained in Chapter 1, this thesis is concerned solely with organisational crises so it was necessary, at the outset, to critically explore the literature in order to arrive at a definition of organisational crises for this thesis. However, this proved to be problematical for researchers (for example Jacques 2010, Keown-McMullan 1997, Pearson and Clair 1998, Roux Duxfort and Metais 1999,) and a major dilemma for the author for a number of reasons. In the first instance, incidents that severely challenge organisations are of interest to a diversity of fields including psychology, sociology, political science, economics and management research. Pauchant and Douville asserted in their multidisciplinary review of crises (1992) that this resulted in definitions of crises which were diverse and biased towards particular fields of study, a view with which others (for example, Smith 1990, 2006b) concurred. Whilst the author acknowledges the influence that work in these fields has had in the management literature on crises, the review of literature for this thesis concentrates on exploring crisis management from the perspective of the management literature. In the second instance, in reviewing the management literature it was apparent that incidents which severely challenged organisations were labelled in a variety of ways, predominantly disasters and crises. Whilst there were some similarities in the inherent characteristics of these incidents,

for example the resultant high human impact, there were also areas where they were distinctly different, for example whether the incident was caused by nature or man. So the term disasters appeared to be bestowed upon natural incidents, whereas the term crisis was generally applied to outcomes that were caused by humans. Therefore, given the emphasis within the thesis on human behaviour and error, the author reasoned that the literature review would concentrate on examining the definition of man-made organisational crises in the management literature.

Shrivastava (1993) in his paper examining crisis management theory and practice advocated that the term crisis should be applied to "disruptive situations … where human choice could make a fundamental difference to the future" (p24), a view with which Fink (2002) and Roux-Dufort and Metais (1999) sympathised. Calloway and Keen (1996) and Keown-McMullan (1997) concurred in recognising the transformational nature of a crisis as a turning point in organisations. Pearson and Misra (1997) developed this argument in their consideration of the distinctions between everyday business problems which could be disruptive and transformational organisational crises. An organisation was experiencing a crisis, they suggested, when its capabilities were 'hyper-extended' and crucial yet novel decisions and actions were being instigated.

In examining the literature concerning how a crisis should be more explicitly defined, the author identified that the discussion had a tendency to centre on identifying the more detailed characteristics of an organisational crisis. The author found that these characteristics could be organised into five main areas. Firstly, there was a general consensus in the literature that organisational crises were systemic situations which affected a number of aspects of an organisation and its environment. Secondly, the resultant impact caused major damage to the financial and physical resources of an organisation and had the potential to destroy an organisation's reputation and image. Thirdly, crises occurred unexpectedly and whilst not containable, required a rapid organisational response. Fourthly, an organisation's stakeholders experienced physical and mental harm as a result of a crisis. Finally, crises forced individuals within and

beyond an organisation to question their basic beliefs. The remainder of this section will examine each of these aspects in turn.

In the first instance, there was widespread agreement in the literature that crises originated in the organisation's systems, that is the processes of its operations, and thus were systemic in nature (Mitroff and Harrington 1996, Mostafa et al 2004, Pauchant and Douville 1992, Shrivastava et al 1988, Smith 1990, 1999, 2004, Turner 1994, Udwadia and Mitroff 1991). Hickman and Crandall (1997) expanded on this, proposing a link with systems theory and suggesting that "the effectiveness of the organisation, or total system, is only as strong as its weakest link" (p 75). Mitroff and Anagnos (2001) broadly supported the systemic view and advocated that crises were unlikely to occur when a single element of a complex system fails but were representative of failures across the system. Pauchant and Mitroff (1992) concurred, proposing that it was a failure of the whole system that was characteristic of an organisation in crisis, a view echoed by Shaluf et al (2003).

In the second instance, there was a consensus that an organisational crisis resulted in major damage to the financial and physical resources of the organisation (Fink et al 1971, Kouzmin 2008, Mitroff et al 1996, Mostafa et al 2004,). Udwadia and Mitroff's (1991) research conducted across 60 different organisations emphasised that the impacts of a crisis would be felt, both in the short and long term, as the tangible and intangible effects evolved. Although the author would argue that the research of Shrivastava et al (1988) lacked clarity in establishing the boundaries between natural and man-made crises, the finer specification of the effects of crises that they develop particularly in terms of the financial and physical impacts was notable**.** The study of 1,000 corporations by Mitroff et al (1988) suggested that the widespread damage caused by a crisis had the capacity to endanger the viability of the organisation on two fronts; firstly, the severity of the financial impacts and, secondly, reputational damage. Keown-McMullan (1997) and Pearson and Clair (1998) in their reviews of the literature and Roux-Dufort and Metais (1999) and Shrivastava (1993) concurred proposing crises to be threatening for the organisation. Barton (1993) summarised the scope of crisis damage stating

that “the event and its aftermath may significantly damage an organisation and its employees, products, services, financial condition and reputation.” (p2).

In the third instance, aspects of the literature (Kouzmin 2008, Mitroff et al 1988, Mostafa et al 2004, Pearson and Misra 1997, Roux Dufort and Metias 1999) emphasised how the unexpected nature of crises required organisations to effect an urgent response. The notion of unexpectedness and surprise was linked by some research to the fact that crises were infrequent events of low probability (Barton 1993, Keown-McMullan 1997, Heath 1998, Pearson and Clair 1998) that could not be detected during the organisation’s conventional operations (Udwadia and Mitroff 1991). There was widespread agreement with this (Hwang and Lichtenthal 2000, James and Wootten 2005, Laws and Prideaux 2006, Parsons 1996). Shrivastava et al (1988) proposed that the suddenness of crises resulted in responses that were made at a time of severe pressure. According to Heath (1998) this created an intuitive pressure for immediate and urgent decision making and action so that order and control could be restored in the organisation and damage contained. Keown-McMullan (1997) agreed, considering that the ensuing need to take prompt action came out of a desire to contain what was happening. Heath (1998) emphasised the resulting shift in behaviours stating that in a crisis “people need to quickly shift from normal thinking and behaviours to non-normal approaches to dealing with a threatening situation” (p. 5). Mostafa et al (2004) concurred with this view stating that the urgency of crisis situations reduced the decision time and stimulated a prompt response. Udwadia and Mitroff’s (1991) study elucidated further, advocating that this was a result of the extremely condensed time span of a crisis. However, Smith (1990, 2005a), in citing research suggesting the inevitability of crises (for example Perrow 1984, Turner 1976, 1978, 1994), disputed the notion of surprise, believing crises to be inherent in organisations, unavoidable and thus to be expected. This is a view with which the author of this thesis concurs since the notion that inherent systemic problems go unnoticed until a crisis occurs contradicts aspects of the literature concerning crisis taxonomies. This is something that the author will return to in Section 2.2.

In the fourth instance, several authors (Pauchant and Mitroff 1992, Pearson and Misra 1997, Shrivastava et al 1988) suggested that crises caused physical and mental harm to stakeholder groups. Heath (1998) and Perrow (1984) developed the argument for considering stakeholders in the widest sense, emphasising that crises affected a multiplicity of stakeholders, some more directly than others, a view with which Shrivastava (1987) concurred stating that "the most profoundly affected stakeholders – and ironically sometimes the most easily forgotten because of their powerlessness – are the victims (of crises). These include workers .. consumers .. residents of communities .. even remote observers" (p 23).

In the fifth instance, and according to Pauchant and Mitroff (1992), crises could cause individual trauma at a deeply psychological level simply because they were completely outside human perceptions. This, they advocated, shattered an individual's basic assumptions of life and were thus, according to Turner (1978), threatening. However, Pearson and Clair (1998) were critical of the management literature's limited perspective concerning the effects of crises on individuals. The impact of crises on individuals is an important issue for this thesis. However, within the context of the thesis the emphasis will be on the effects of human error in healthcare. Whilst the author is sensitive to the impact human error can have on those who sustain injury, the focus will be on those who initiate or potentially initiate the errors through their workplace behaviours.

In summary, there was a consensus in the management literature that organisational crises were systemically originated transformational events which resulted in major damage to an organisation's resources, reputation and stakeholders. However, there was some discussion in the literature regarding the unexpectedness of crises and the extent of the systemic weaknesses that they exposed. The author felt that the view that crises occurred due to the cumulative impact of several weaknesses in the organisation's systems seemed more consistent with the literature regarding the resource and reputational impacts of crises. Furthermore, the author felt that this supported the commentary of several writers (Perrow 1984, Smith 1990, 2005a, 2006c**,** Turner 1976, 1978 and 1994,) that crises were not sudden events that happened

without warning but could also be evolving in inherent systemic problems which passed unnoticed in organisations. These points are explored further by the author in the following section concerning the taxonomies of crises.

2.2 Taxonomies of Organisational Crises

The previous section was concerned with exploring the characteristics of organisational crises. This was, however, felt by the author to be an incomplete picture in terms of the definition of crises without consideration of types of crises. Although it was recognised that crises could be natural or man-made (Quarantelli 1988), the literature concerning crisis typologies suffered the same lack of consensus problematic as that identified at the outset of the definition section above. As reasoned at the outset of Section 2.1 above, this thesis is concerned with organisational crises, therefore, it was felt necessary to restrict the exploration of types of organisational crises to those which were man-made as opposed to those which were natural.

Pauchant and Douville's review of crisis management literature (1992) utilised in excess of 30 different search terms in order to identify what the literature recognised as being types of crises. Whilst the author of this thesis recognised the limited contribution this methodology had as a means of classifying crises, it illustrated the challenges faced by management researchers in coming to a consensus regarding a taxonomy of crises. This was a view which was acknowledged by Shaluf et al (2003) in their review of the management literature and was evidenced in the diverse and idiosyncractic crisis cases (for example financial crises, hostile takeovers, industrial accidents, product defect crises, transport incidents) that were identified by some authors (Hwang and Lichtenthal 2000, James and Wootten 2005, Loosemore 1998, Mitroff 1988, Mitroff et al 1988, Mitroff and Harrington 1996, Richardson 1995, Roux Dufort 2000, Shrivastava et al 1988, Smith 1990, 1999, Watkins and Bazerman 2003).

Lerbinger's approach (1997) was to identify, through case analysis, a range of seven different types of crises. Whilst there was recognition of natural disasters within this classification, the remaining categories focused on technological and

management failures. Mitroff et al (2003), and later Mitroff (2004a, 2004b), took a similar case based approach but classified their repertoire of crises since 1979 according to whether they were natural disasters or normal or abnormal accidents. Mitroff (2004a, 2004b) supported earlier arguments from writers such as Mitroff and Harrington (1996), Pauchant and Douville (1992), Shrivastava et al (1988), Smith (1990 and 1999), Turner (1994) and Udwadia and Mitroff (1991) that a growing number of normal accidents occurred as a result of dysfunctionality within an organisation's systems or were abnormal accidents arising out of evil human acts. This was an influential observation for the author. Whilst the origins of this thesis could be construed as being domiciled in the acts of Beverley Allitt, what interested the author were the individual behaviours underlying what Mitroff identified as 'normal accidents'.

The approach of Shrivastava et al (1988), which was also based on case study observations, was to tightly define organisational crises within the context of industrial accidents and classify them according to their respective triggers. Shrivastva et al (1988) readily acknowledged the limitation of this approach, however, the foundations of their work, and that of Mitroff et al (1988), was apparent in later work developed by others (Mitroff 1988, Pauchant and Mitroff 1992).

Mitroff (1988) and later Pauchant and Mitroff (1992) focused on improving the understanding of distinctive types of organisational crises by proposing an empirically-led, two-way classification based on their research inventory of organisational crises. This taxonomy, which was recognised by others (for example Jacques 2009 and Keown McMullan 1997), focused on classifying crises based on their underlying causes and the relative extent of their impact. The proposition was that on one dimension, organisational crises were either caused by 'impersonal' technical or economic factors or by more human oriented factors (Section 2.4 will explore further the events that trigger crises). Whereas on the other dimension, the impact of the crisis might be relatively slight and handled within the organisation's daily routines and systems or severe and "outside of the range of normal, rational human behaviour" (Mitroff 1988, p17). This work held similarities with Perrow's classification of

organisational crises (1984). Although this taxonomy has been empirically developed over time and was acknowledged in the work of others, the author of this thesis felt that in recognising the scalar impact of crises, there was an apparent inconsistency with the work of others (Lerbinger 1997, Mitroff et al 2003, Mitroff 2004a, 2004b) and the characterisation of organisational crises outlined in Section 2.1 above since this model recognised that a crisis was not solely a high impact, sudden climax of problems within the organisation's systems. According to this model, crises could also be recognised as more common, yet significant, occurrences. There was a particular significance for the author in this finding. As previously stated in Section 2.1, and contrary to the dominant characteristics of organisational crises, Perrow (1984), Smith (1990, 2005b, 2006b) promoted the view, pioneered by Turner (1976,1978 and 1994), that crises could also evolve, unnoticed in systemic problems within the organisation. The author believed that the identification of common, yet significant occurrences as crises in Mitroff's taxonomy, added credence and validity to the argument that an organisation could be experiencing a crisis during this evolutionary period.

Shrivastava (1987) in his empirical study of the Bhopal Union Carbide case developed the notion that relatively minor yet significant occurrences were representative of organisational crises. Synonymous with the philosophies of Pauchant and Mitroff (1992), Perrow (1984), Smith (1990, 2005a, 2006c) Turner (1976, 1978 and 1994), his paradigm was based on the potential amplification of unnoticed yet inherent systemic incidents. Whilst some authors (Pearson and Misra 1997) were resolute that organisational crises could only be large-scale, high impact events, the author of this thesis identified a consensus in the literature to the notion of amplified incidents although authors utilise a number of terms for describing them; Quarantelli (1998) identified these as post-accidental crises; Parsons (1996) categorised them as emerging crises, Heath (1998) labelled them rippling crises, Hwag and Lichtenthal (2000) recognised them as cumulative crises, James and Wootten (2005) saw them as smouldering crises and Kouzmin (2008) classified them as creeping crises. As discussed previously, Smith (1990, 2005a, 2006b) recognised the significance

of emerging crises and was steadfast in his opinion that even emerging crises had the capacity to threaten the existence of the organisation (1999).

The literature's empirical evidence that an organisation could be experiencing a crisis as systemic problems smouldered was highly significant for the author of this thesis for a number of reasons. In the first instance, these incidents were reminiscent of the types of adverse events that were identified in Chapter 1by the author as an area of interest. In the second instance, and consistent with the discussion so far in Chapter 2, the characteristics of crises explored in Section 2.1 above could be applied to the healthcare setting in terms of systemic failure and wide ranging human, financial and reputational damage. More specifically, in organisations where the raison d'être was 'first do no harm', the fact that humans, through no apparent evil intention, were committing errors that were causing injury to patients in their care was unexpected and had the potential to shatter basic beliefs. In the third instance, the literature (Mitroff 2004a, 2004b) suggested a dominance of human-caused crises which had the potential to be contained (James and Wootten 2005). This had a particular resonance for the author, since it implied that there was a legitimacy in exploring the management of evolving crises further.

As outlined at the outset of this chapter, the author's initial intentions regarding the review of literature was to establish a definition of crises for this thesis. Accordingly, having explored the management literature concerning the characteristics and taxonomies of crises the author concludes that, within the context of this thesis, an organisational crisis is defined as a high impact occurrence with systemic origins which evolves over time and causes unexpected damage to the resources, reputation and stakeholders of an organisation. Henceforth this will be referred to as a smouldering crisis by the author of this thesis.

2.3 The Case of the Smouldering Crisis

The study of smouldering crises is central to this thesis' aim to develop the understanding of the management of organisational crises. Thus, the author

felt it was important to investigate and explore further literature concerning the nature and behaviour of crises as they evolved and their relative importance within the area of crisis management. This section will explore each area of these aspects in turn, providing case examples from the literature to support the discussion.

Smith (2005a, 2006b) explored the anatomy of crisis situations within the context of the organisational state advocating that generic complexity within organisations challenged management's capacity to maintain order and control and precipitated a chaotic and unstable environment which was reminiscent of incubatory crisis conditions. In short, crises smouldered, according to Smith, when problems that emerged within the organisation's systems were allowed by management, for a number of reasons, to progress unchecked. In so doing, Smith (2005a, 2006b) elaborated on the systemic origins of organisational crisis identified in the work of other writers (for example Hickman and Crandall 1997, Mitroff and Anagnos 2001, Mitroff and Harrington 1996, Mostafa et al 2004, Pauchant and Douville 1992, Pauchant and Mitroff 1992 Shrivastava et al 1988, Smith 1990, 1999, Turner 1994, Udwadia and Mitroff) by highlighting the contributory role of management failures during the evolution stage.

Smith's (2005a) forensic review of an evolving crisis was helpful to the author in specifically highlighting several points within the lifecycle of the smouldering crisis at which problems escalated and, drawing on Handy's (2002) terminology regarding transformational moments, he designated them 'points of inflection'. Smith (2005a) stressed the critical role played by operational management (as opposed to strategic management or crisis management teams) at these 'points of inflection' in shaping the destiny of a crisis as it developed since each successive inflection represented a moment when the nature of operational decision making and response had a significant bearing on whether the crisis was arrested or worsened (Smith 2005b, 2006c). The author feels that it would be helpful to the reader at this point to clarify what is referred to, throughout this thesis, as management. Aspects of this work refer to management and managers in a generic way, making little distinction between managers in different levels of an organisation's hierarchy. This is because these aspects

could be applied to management of all levels. However, there are points at which the nature of the discussion indicates a specific level of management, for example strategic management. When the term operational management is utilised, the author is referring to middle management, that is management which is concerned with the day to day control of the organisation's systems and processes. As the reader will see in Chapter 9, the contribution to knowledge and the management implications of this thesis have a pertinence to managers at all levels of an organisation.

Broadly speaking, where problems were anticipated by the organisation and were the subject of pre-planned contingency responses, management were, according to Smith (2005a), able to make informed decisions and effect appropriate task responses. The result was that the problem was dealt with, management fulfilled their responsibilities in effecting organisational control and the crisis was arrested. Whilst Pearson and Clair (1998) and Smith (1999) suggested that the evolving nature of smouldering crises led to ambiguity in identifying their root causes and impacts and, as a consequence, made resolution difficult, Smith (2005a) argued that early 'points of inflection' presented grassroots managers with the greatest opportunity to curtail a crisis since they were closer to the point of origin, a view with which James and Wootten (2005) concurred maintaining that emerging crises developing over time presented the organisations and particularly the managers within them with the best chance for containment and the restoration of control. This was an interesting argument for the author of this thesis as it indicated that there was validity in pursuing the perspective taken of developing the understanding of crisis management by studying the conditions in which crises smouldered.

However, according to Smith (2005a) and Smith and Toft (2005), unanticipated problems within the organisation's systems and some actions of management in expected problem situations held the capacity to worsen what was being experience within the organisation and elevated the situation beyond a 'point of inflection'. Smith and Toft's view (2005), shared by Smith (2006c), was that the emergence of systemic problems and the success of management's response were dependent upon several factors, some of which were focused on the issue

of management knowledge and information within the organisation (a view shared by Smith 2006b), whilst others were related to the efficacy of the organisation's management and defensive systems. What follows is a review of these factors, aspects of which Smith (2005a, 2005b) and Smith and Toft (2005) identified as being areas for further research. However, inevitably the discussions herein have a resonance with key aspects of the review of literature which appear later in this chapter. Some features of the discussion are, thus, truncated and appropriate signage is given in the narrative as to where the discussion is more fully developed. It is hoped that this facilitates a more clear, logical and cohesive discussion for the reader both here, regarding smouldering crises, and throughout the remainder of the chapter.

In the first instance, Smith (2005a), as did Fischbacher-Smith and Calman (2010), challenged the rational view of management literature (Augustine 1995, Hickman and Crandall 1997, Mitroff and Harrington 1996, Mitroff et al 1988, Pauchant and Mitroff 1992, Pearson and Misra 1997, Pearson and Rondinelli 1997) that managers would have, at their disposal, a complete portfolio of pre-planned responses to pre-identified problems which they could effect in order to restore order and control within the organisation and, thus, avert any smouldering crisis. The basis of his challenge was two-fold. Firstly, Smith (2005a) argued that the presence of 'bounded rationality' (Pauchant and Mitroff 1992) would restrict management's perceptions of problem potential and therefore influence what would and would not be part of a perceived crisis portfolio. The consequence of this was that management encountered problems which were not only unexpected but for which they had limited knowledge and resources to deal with effectively. Secondly, Smith and Toft (2005), as did Calman and Smith (2001), Fischbacher-Smith and Calman (2010) and Fischbacher-Smith et al (2010), broadened the above discussion stating that, being based on existing management knowledge and under the premiss of the precautionary principle, the management of risk and control within organisations was incomplete since the challenge of garnering complete knowledge concerning every potential management process and system's problem was difficult to realise. Moreover, it was proposed in aspects of the literature (Fischbacher-Smith and Calman 2010, Fischbacher-Smith et al 2010,

Smith 2006a, Smith and Fischbacher 2009 and Smith and Toft 2005), that, as a result of this and despite prevailing and historical risk assessment measures, the management of risk and control was socially constructed and therefore lacked objectivity. Yet Fischbacher-Smith and Calman (2010), recognised the merits of taking this approach stating that "By being more precautionary in the ways that we 'manage', we may go some way towards preventing future crises" (p209). Turner (1976, 1978) saw the implications of imperfect management knowledge as being the inherent difficulties that managers would have in attempting to deal with crises in this incubatory stage when unforeseen problems evolved, to a large extent, unobserved, because they were not sensitised to them. The limitations regarding perspective, knowledge and capabilities of management are also covered in the discussions regarding early warning systems, management denial and 'sensemaking' (Weick 1988) which can be found in Sections 2.5.1 and 2.5.2.

In the second instance, and crucially according to Calman and Smith (2001) and Fischbacher-Smith and Calman (2010), these knowledge and information difficulties resulted in a chasm between the organisation's processes and the smouldering crisis conditions that created in-built yet concealed weaknesses in which problems festered. Smith (2005a, 2006c), as did Smith and Fischbacher (2009), furthered the notion that despite some organisations and the managers within them creating crisis portfolio driven defences in their systems, these defences were vulnerable and could be breached as a smouldering crisis situation emerged. Referring to Reason's 'Swiss Cheese Model' (1987, 1997, 1998, 2000a, 2008), Smith attributed this to a combination of factors; gaps in defences, assumptions that defences, which had not been tested, were effective when in fact they were not and the promulgation of new defences over time which could impair the efficacy of existing defences. Reason and Smith's work regarding these crisis inducing 'latent conditions' is covered in more detail within the context of the review of human error as a causal factor in crises in Section 2.4 but was identified by Smith (2005a) as an area which was in need of further research.

In the third instance, the notion of management being able to avert not only smouldering crisis conditions but crises per se by adopting a probability-based approach to controlling expected problems through robust defences placated management into perceiving that all was in order according to Smith (2005a, 2005b). However, this perception of control and order was severely compromised when, inevitably, the unexpected occurred and managers were unable to make sense of what was happening leading to an escalation of events. Weick's concept of 'sensemaking' (1988), in which unexpected and problematic situations were exacerbated because of management's response, is covered in more detail in Section 2.5.2.

In the fourth instance, Smith (2005a) recognised the critical role that the dissemination of early problem warning information played in either averting or exacerbating a propagating crisis and attributed the efficacy or otherwise of the dissemination process to the proximity of critical players; the closer the informational relationship, the greater the chance for knowledge, formal or informal, to flow throughout the organisation and aid managers in arresting ensuing problems, a more remote informational relationship resulted in a converse situation. Within the context of the comments regarding management control outlined above, the author recognised that the power hierarchies which were an element of control structures within organisations also presented challenges in terms of the proximity of informational relationships, particularly those between grassroots individuals and operational and senior management. This area was identified as being in need of further research by Smith (2005a, 2005b) and Smith and Toft (2005) and the research study associated with this thesis has liberated the views of grassroots individuals in order to address identified informational limitations amongst managers. The nature and role of early warning signals is covered in more detail in Section 2.5.1.

Finally, Smith and Toft (2005), as did Smith (2006b), advocated that adverse events were a crucial yet challenging opportunity to create and exploit hindsight and learning as a means of arresting a smouldering crisis situation. However, Smith and Toft (2005), as were Elliott and Smith (2007) and Elliott et al (2001), were resolute in their assertions that organisations commonly did not take up

opportunities to learn from their mistakes or the mistakes of others. Learning in the aftermath of a crisis situation is covered further in Section 2.5.3.

Empirical evidence concerning the incidence of smouldering crises can be found in some of the most high profile and widely used cases to be found in the literature such as Chernobyl, Piper Alpha, Bhopal, Challenger and King's Cross (for example Heath 1998, Fink 2002, Mitroff 2004a, Mitroff and Anagnos 2001, Pauchant and Mitroff 1990, 1992, Reason 1997 2008, Shrivastava 1987, Vincent 2006).

The explosion at Chernobyl's nuclear plant in 1986 which released radioactive material over Europe was found to be caused by numerous and deliberate infringements of safety procedures within the plant that had been occurring over time (Vincent 2006). During a systems test, on what was a poorly designed reactor (World Nuclear Organisation 2011), the operators, who were both inexperienced and incompetent (Reason 2008), attempted to close down the unstable reactor but in so doing, caused a fire and the subsequent explosion.

The direct cause of the major explosion and fire on the Piper Alpha oil platform in the North Sea which killed 168 men was found to be poor maintenance procedures and a breakdown in communications between the day and night shifts (Miller 1991) and, whilst the events surrounding the fire and explosion took just 22 minutes to reach critical stage (Fire and Blast Information Group 2011), the Cullen Inquiry (The Public Inquiry into the Piper Alpha Disaster 1990) found that the build up to this had developed over time in a lack of attention to safety on the part of Occidental Petroleum (the owner of the platform) which pervaded the organisation's culture, structure and procedures (Vincent 2006).

In the case of Bhopal, against a background of poor management practice, a highly toxic gas was accidentally leaked by operatives into the atmosphere from the Union Carbide of India plant in Bhopal in 1984. In a densely populated area, this alone resulted in an accident with terrible human consequences, the like of which are still being recorded 25 years later (BBC News 2009). Competitive pressures in the marketplace had led the senior management of

United Carbide of India to decide to manufacture a product for which they lacked expertise. Furthermore, operationally there were human resource issues such as the high turnover of staff. The Indian Government was also found to be culpable in its reluctance to impose safety regulations on industry, the result of which was exposed by the accident, and also allowing a plant manufacturing highly toxic gases to be built within a densely populated area. (Shrivastava, 1987, Pauchant and Mitroff 1992).

The loss of the Space Shuttle Challenger in 1986 and those on board was attributed to a breach in the thermal protection system which allowed air to the Shuttle's insulation causing the structure to melt resulting in a loss of control and break-up of the craft (Vincent 2006). This happened despite early warnings from technicians on the programme of the potential for such an incident (Smith and Toft 2005). However, the root causes of the loss were recognised in the Columbia Accident Investigation Board's investigation to be embedded in the Space Shuttle programme's culture and history. For years the Shuttle programme had experienced resourcing and scheduling pressures, competing priorities and the engendering of practices within the organisation's culture that were contrary to safety including poor communications, inadequate learning and a lack of cohesion across the management of the programme (Reason 1997, Vincent 2006).

The Fennell Inquiry into the deaths of 31 people due to a fire at King's Cross Station in 1987 (Department of Transport 1988) concluded that the event was entirely foreseeable. There had been numerous fires at the station, although they had been extinguished before harm had been caused. The inquiry found that safety was prioritised in terms of the operation of underground trains but the profile of safety in stations was poor. Furthermore, as the event escalated, flaws in training, communications and co-ordination were exposed (Heath 1998).

Vincent (2006 p77) stated that "The accidents ... allude to poor training, problems with scheduling, conflicts between safety and profit, communications failures, failure to address known safety problems and to general sloppiness of

management and procedures." However, whilst these cases are shocking, their genesis was to be found in the events leading up to the catastrophic climax; inexperienced operatives and design flaws in the reactor at Chernobyl, a lack of safety culture, structure and procedures at Occidental Petroleum, poor management practice and lack of Government regulation in United Carbide India, a culture and history in the Space Shuttle Programme which ignored safety and safety concerns and finally, flaws in communications, training and co-ordination at London Underground. These are origins which provide support for the behavioural failings that Smith (2005a), and Smith and Toft (2005) (supported by the work of Reason 1987 1997 1998 2000a 2008, Turner 1976 1978 and Weick 1988), identified as being causally linked to the emergence of smouldering crises; the bounded rationality and denial state of managers at Chernobyl, Occidental Petroleum and Union Carbide which impinged management's ability to foresee the problems ahead, the defensive gaps in organisational processes exploited by the fire on the Piper Alpha platform, the escalation of events through inadequate 'sensemaking' at Chernobyl, the reluctance to accept attempts to provide early warning signals and learning by the Space Shuttle Programme and London Underground. The cases cited grew out of systemic management failures but evolved beyond the 'points of inflection' because of inadequacies in operational decision making and actions, they were smouldering crises.

In summary, Smith (2005a) foresaw that, within the context of an organisational crisis, it was possible for novel situations that were beyond management perception, knowledge and capabilities, pre-ordained contingency plans and organisational defences to escalate over time into the disastrous outcomes identified in Section 2.1 as being the characteristics of crises. Furthermore, Smith (2005a, 2005b) highlighted the research gap that existed in better identifying where the flaws in defences and knowledge might be. Thus, the author asserts that the study of smouldering crises is critical on two fronts; in the first instance, smouldering crises can breach 'points of inflection' and evolve into catastrophic organisational and societal events and, in the second instance, there is evidence that the research underpinning crisis management is limited in terms of developing the understanding of the incubatory phase. These

assertions have shaped the direction of the research study associated with this thesis and identified the author's positioning in terms of the contribution to knowledge.

Having explored how, through 'points of inflection', deficiencies in organisational defences and management perception, knowledge and decision making failures, smouldering crises develop, attention moves in the next section to the specifics of the causal routes to crises.

2.4 Root Causes of Organisational Crises

Perrow's work, '*Normal Accidents'* (1984), appeared particularly influential in management literature concerning the causal route to crisis conditions within organisations (for example Mostafa et al 2004, Pauchant and Douville 1992, Pearson and Clair 1998, Shrivastava et al 1988, Udwadia and Mitroff 1991).

Perrow (1984), as did Kouzmin (2008) and Pauchant and Douville (1992), believed that the business environment had become more hostile as a result of factors including industrialisation, globalisation, deregulation and the rise of the free market. According to Richardson (1995) and Shrivastava et al (1988) such circumstances propagated the conditions for organisational crises.

There was evidence from other aspects of the literature (Shrivastava 1988) that the underlying root causes of crises were multifaceted. Shrivastava et al (1988), as did Mitroff and Anagnos (2001) concurred proposing that although crises happened as a result of the cumulative and compounding impact of environmental conditions and the development and use of technology, they were also the result of organisational complexity and human factors (the latter two of which have already been introduced as part of the discussion so far). Mitroff (2004a) summarised this stating that crises were a result of the dysfunctionality of organisations, technology and people. The remainder of this section will explore the literature in the context of each of these aspects, namely organisational complexity, technology and human factors.

Perrow (1984) reasoned that as organisations grew in size and scale, their operations became more complex and less isolated. As a result, Perrow suggested, the process of conducting business was realised through a network of interdependent functions both within the organisation and outside. Mitroff and Anagnos (2001) and Smith (2005a) concurred suggesting a prevalence of diversity and fragmentation yet interactivity. According to Mitroff and Kilmann (1984) this situation was exacerbated by the ensuing impact of multiple stakeholders. Perrow identified that for some organisations this interconnectedness and "tight-coupling" (p97) was the source of reliability problems. His rationale was that greater interconnectedness created more interdependencies and a consequential larger number of opportunities for things to go wrong with less time and prospect of arresting any ensuing accidents. The author believes that Perrow's arguments concerning interconnectedness and coupling underlie the development of the systemic view of organisational crises discussed in Section 2.1. Perrow's research (1984) suggested that for some high-risk industries, such as nuclear power plants, systemic industrial accidents, possessing the characteristics of crises, were inevitable and therefore to be expected. However, some authors, for example Shrivastava (1987) and Smith (1990) whilst supporting the notion of the inevitability of crises did not restrict the observation to high-risk technologies and applied it more generally. This general acceptance of inevitability was evidenced in the work of others (for example Hwang and Lichtenthal 2000, James and Wootten 2005, Pearson and Misra 1997, Pearson and Rondinelli 1998, Watkins and Bazerman 2003).

In attempting to further understand the underlying causes of organisational accidents, Perrow (1984) identified the significant yet contradictory role played by technology, aspects of which are recognised in the views of others (Mitroff 2004a, Pearson and Clair 1998, Smith 1990). Pauchant and Douville (1992) asserted that there was evidence of a broad use of the term technology; whilst technology was deemed to embrace manufacturing processes it also applied to management processes, procedures, policies, practices and routines. Pearson and Clair (1998) observed the positive contribution that technology had made to business in suggesting that technology was responsible for great advances. A

view echoed in Mitroff's contemporary and more explicit perspective of technology (2004a) which expressed that technology had enabled organisations and the people within them to exceed physical, geographical, economic, cognitive and time limitations. However, according to Pearson and Clair (1998), Perrow (1984) and Smith (1990) some technology induced errors and caused serious destruction because it fuelled the dynamism and velocity that an organisation had to deal with.

The discussion so far in this section has considered the root causes of crises in terms of the hostility of the business environment, the complexity of organisations and the paradoxical nature of technology. Sections 2.1 and 2.2 have already remarked on the suggestion that organisational crises caused by humans were of particular concern in the management literature. Although Mitroff and Kilmann (1984) identified the case of Tylenol's product tampering as evidence that organisations were potential hostages to human mavericks, there was also recognition in the literature (Kouzmin 2008, Mitroff 2004a, Mitroff 2004b, Perrow 1984, Smith 1999, 2005a, Smith and Toft 2005, Weick 1988) that some crises had more humble human origins. The remainder of this section will explore the management literature concerning the causal nature of human error in organisational crises. However, as will be revealed, the author found that the depth of understanding concerning the nature of human error in a crisis context was limited and turned to other fields in order to seek further explanation.

Smith (1999) advocated that human error lay at the root of crises in many organisations, a view echoed by Erikson (1994) when he rationalised that human caused crises had increased "as we humans test the outer limits of our competence" (p142). Weick (1988), exploiting the concept of inevitability discussed in Section 2.1, proposed that this situation was to be expected suggesting that "human errors are fundamentally caused by human variability which cannot be designed away" (p308), a view which was consistent with Ackroyd and Thompson's concept of intrinsic 'misbehaviour' in organisations (1999) . Perrow (1984) emphasised the scale of this by claiming that 60-80% of accidents were attributed to "operator error" (p9). However, it was Mitroff

(2004a) who, with this in mind, elaborated on the underlying reasons for human error claiming that it was people, within the context of the environment, technologies and organisations, who enacted the errors within the organisation's system that led to crises. Perrow (1984) further defined the nature of human errors claiming that these could be accidental, caused by carelessness, ignorance or unawareness, or even all three since he believed that "man's reach has always exceeded his grasp" (p11). This was in keeping with Turner's view (1978) that during the crisis incubation period there were "a multiplicity of minor causes, misperceptions, misunderstandings and miscommunications" (p216).

Whilst Perrow's quantification of human error stated above was in harmony with Smith and Toft's research (2005), the origin of the human error was developed in their work to highlight that a "considerable proportion (of errors) are shaped by management's actions and inactions". This was an interesting finding for the author since, at first sight, the concept of 'operator error' appeared to place ownership for underlying problems at the feet of grassroots individuals, indeed Ackroyd and Thompson (1999) recognised a dominant tendency in management literature of identifying grassroots 'misbehaviour'. However, Smith (2005a, 2006b), as did Smith and Toft (2005)**,** was clear in distinguishing between the origins of the error and responsibility for it. Whilst the origins could be found in the actions of grassroots individuals, the responsibility for allowing the problems to arise lay with management for it was management who shaped the actions and behaviours of others through the systems and processes designed to instil order and control within organisations. In fact, Smith and Toft (2005) argued that even mechanisms designed to control behaviour within an organisation could prompt delinquency amongst employees as they went about their daily working lives.

As was outlined in Section 2.3, in terms of smouldering crises, failures of management underpinned the incubatory stage of a crisis and led to the escalation of problems beyond 'points of inflection' to the crisis itself and its aftermath. Firstly, crises smouldered as a consequence of limited existing knowledge of management which affected management's perspective

concerning problem and crisis potential. The result of this was an inefficacy of contingency plans, weakened early warning communications and a capacity to deny crisis potential. Secondly, within the context of control and order processes within the organisation, this inadequate knowledge and information led to gaps between the problems organisations encountered and the defensive processes established to deal with them. Moreover, imperfect defensive processes compromised control and order and when managers were faced with surprise events, they were unable to deal either physically or psychologically with them. Finally management failed to learn from experiences and thus, in so doing, contributed to the propensity for grassroots human error and management failure. For the author of this thesis, the assertions of Smith (2005a), and Smith and Toft (2005), reinforced the emphasis placed on systemically oriented management error as the root cause of organisational crisis which were discussed in Section 2.2.

Thus, within the literature, the author found that there was a strong feeling that unintentional human error, emanating both from grassroots individuals and managers, lay at the root of many organisational crises. However, the author of this thesis also felt that the depth of understanding was limited since although the literature had identified the significance and some characteristics of human error, particularly that of managers, the development of knowledge regarding the underlying reasons, particularly concerning grassroots error, was limited. This was felt to be an incomplete picture and certainly was insufficient to satisfy the author given that the emphasis of this thesis was on smouldering crises where the causes were human. Therefore, the author sought further understanding concerning the underlying reasons for human error per se and grassroots error in particular in the literature specifically concerned with human error. Given the fact that this thesis takes a healthcare contextual focus, the literature of Reason was particularly influential, although not exclusively so, in the development of the author's understanding.

Interestingly, the author found evidence (Reason 1990) that the large-scale socio-technical crises which underpinned the development of the management literature also stimulated the development of human error theory. Not

surprisingly, similar causal factors were identified, for example, Reason (1997, 2006) expressed that the rapid and dynamic development of technology had led to concerns about the level of reliability in organisations, the role of human error in incidents and systemic failures. Whilst aspects of human error literature (Rasmussen 1990, Sheridan 2003) demonstrated a shared intent to create a climate of preparedness (the management literature's perspective on this is explored later in Section 2.5.1), there was a heavy emphasis from writers such as Leape (1994) and Reason (1987, 1990, 1997, 2000a, 2008) on understanding the nature and characteristics of human error.
Reason's empirical work (1987, 1990, 1997, 2008) identified two modes of human error, the person approach and the systems approach, and whilst both of these modes considered human error from the perspective of the faulty behaviour of an individual somewhere within the organisation, Reason identified distinctive behaviours underlying each.

According to Reason (1987, 1990, 1997, 2008) the person approach to human error laid the blame for errors on individuals who made mistakes because they were forgetful, inattentive, careless or just plain reckless and, consistent with the dominant paradigm in management literature (Smith 2006b), advocated that the reliability of humans could be controlled through organisational procedures and processes or penal actions such as naming, blaming and shaming (2000a). Reason's later work (2000a, 2000b), which interestingly was presented in the healthcare context, was particularly critical of the person approach for a number of reasons. Firstly, he considered that adopting this approach resulted in an unhelpful and unproductive blame culture which suppressed opportunities to better understand the underlying reliability issues. Secondly, and associated with this, individualising the error, he believed, distanced the error from the organisation's system's context.

On the other hand, Reason (1987, 1990, 1997, 2008) was more positive about the systems approach which accepted that humans were fallible and, as a result, human errors were to be expected in all organisations. For the author of this thesis, this approach demonstrated some resonance with the notion of crisis inevitability promoted by Perrow (1984), Shrivastava (1987), Smith (1990

2005a, 2006b), Smith and Toft (2005) and Weick's (1988) perspectives on human error in organisational crises. Reason (2000b) suggested that 90% of errors fell into this category, with only 10% attributable to the person theory. Like Mitroff (2004a) and Perrow (1984), the systemic approach to human error suggested that incidents occurred where the organisation's technologies interacted with humans. The underlying root causes were, according to Reason (1987, 1990, 1997, 2008), to be found in error traps that were embedded in the organisation's procedures and processes, not at the hands of individuals, a view which was entirely consistent with the perspective in the management literature concerning the management failure causal route to crisis. Reason (1997) elaborated that the organisation's working environment created resourcing pressure and tension which, coupled with the fallibility of human nature, precipitated the conditions for "unsafe acts" (p16).

From Reason's perspective (1987, 1990, 1997, 1998, 2000a, 2008) almost all human errors that resulted in adverse events were a combination of two types of errors; 'active failures' and 'latent conditions'.

Reason believed that 'active failures' were unpredictable yet recurring errors that occurred at grassroots level within an organisation, in close proximity to the unsafe act (1987, 1990, 1997, 1998, 2000a, 2008) and could be classified as either slips and lapses or mistakes (1990, 1997). Reason (1990, 1997) stated that slips and lapses were due to inattention or forgetfulness. Mistakes were, Reason asserted (1990, 1997), higher order errors that happened because of inadequacies in the organisation's procedures or an individual's knowledge. 'Active failures', according to Reason (1990, 1997), could largely only be addressed by customised defence mechanisms as they arose.

In describing 'latent conditions', Reason (1987, 1990, 1997, 1998, 2000a, 2008) suggested that they were the 'resident pathogens' originated by the intentional or incidental decisions of top management or instigators of procedures and processes which were found in the preordained conditions of a workplace and gave examples including limitations in supervision and training, maintenance failures, unworkable procedures, inadequate equipment. According to Reason

(2000a), these ‘latent conditions’ cultivated a permanent or momentary climate where the potential for errors existed because of inadequacies in people, processes and procedures. The exposure of the organisation to error potential was encapsulated in Smith’s description of these occurrences as a ‘pathway to vulnerability’ (Smith 2000a, 2005a, 2006c, Smith and Fischbacher 2009, Smith and Toft 2005).

Reason (2000a) argued that although the risk of ‘latent conditions’ could be proactively identified and controlled by the management of an organisation, there were instances where they combined with ‘active failures’ to create error incidents. Reason presented this coming together of ’latent conditions’ and ‘active failures’ in his ‘Swiss Cheese Model’ (1987, 1997, 1998, 2000a, 2008). Reason (2000a) summarised the relationship between ‘active failures’ and ‘latent conditions’ by stating “we cannot change the human condition (active failure) but we can change the conditions under which humans work (latent conditions)” (p769). However, Reason (2000a, 2000b) warned that organisations and the managers within them needed to be aware of the challenges of controlling ‘latent conditions’ including increasing organisational complexity, the danger that ultimate human compliance with safety procedures brings, the replacement of one potential error area with another and the introduction of a complacent attitude towards safety due to the magnitude of defence mechanisms, themes upon which Smith (2005a, 2006b) built.

Reason’s research concerning human error was extended by Sasou and Reason (1999) who recognised that in the majority of organisations humans do not act alone but work within teams. Although stressing that this was perceived to promote increased efficiency and reciprocal support, Sasou and Reason (1999) suggested that it could also create opportunities for human error, either singularly or group wide, particularly in the planning and decision-making activities of the most apparently cohesive teams. Their findings concluded that teamworking environments produced problems that led to errors and that these problems centred on communication, trust, resourcing and hierarchical failures.

The author found that views in the management literature on organisational crises concerning the role played by environmental conditions, technology and organisational complexity, were consistent with assertions regarding the inevitability of organisational crises and the general nature of crises' systemic origins. There was also clear recognition regarding the predictability and integral role played by human error in both the prevalence and escalation of events that smouldered into crises. The author found that whilst there was some understanding of the behavioural contribution of managers indicating their complicit role played in smouldering crisis conditions was a product of poor perception, knowledge and capability, there was a limited understanding regarding the associated contribution of grassroots behaviour, a view also identified by Pauchant and Douville (1992).

The author sought further explanation in the literature specifically concerned with human error. There were strong environmental correlations concerning the origins of crises and human error theory leading to a co-emphasis on underlying systemic problems and human reliability issues. Given the emphasis on management responsibility for control and order in the literature, the two-way classification of errors was particularly useful in identifying errors where management had a propensity to influence the outcome ('latent conditions') and where it did not ('active failures'). The author found that this body of literature provided more insight into the nature of human error and, synonymous with the management literature on crises, placed ultimate causality and remedy in the hands of those who controlled the prevailing 'latent conditions' since this was where management both instigated the conditions in which promulgated error yet could best arrest it. The suggestion in the human error literature that managers within organisations could control the fallibility of humans by addressing issues in the working environment through management procedures was a significant finding for the author since it provided further guidance for the research study associated with this thesis and the ensuing positioning of the contribution to knowledge. Whilst grassroots error appeared to dominate the systemic problems underpinning smouldering crises, there was clear evidence in the human error literature that the causal route was management failures, particularly those of an operational nature. However, particularly in view of

Smith's (2005a) arguments regarding management's perspective, knowledge and capabilities, the author felt that without the benefit of a greater knowledge of the contributory role played by the working environment at grassroots level, understanding regarding the 'latent conditions' was partial.

In summary, Section 2.3 identified smouldering crises as the focus of this thesis and highlighted the dominant role played by systemic human error in the emerging nature of these crises. This section has further explored the root causes of crises. Although there was evidence that the environment, organisational complexity and technology contributed to organisational crises, human error remained a central issue. Through combining knowledge from the fields of management literature and human error theory, the author was able to develop some understanding regarding the nature of human error in systemic events. However, the literature was limited with regard to how grassroots behaviour in the prevailing working conditions contributed to smouldering situations. This thesis will address this gap in knowledge by exploring the behaviour of grassroots individuals within the thesis' healthcare context and investigating how this contributes to the role of management failures and systemic human error in smouldering crises.

2.5 The Management of Organisational Crises

The discussions preceding this section have largely been concerned with the significant issue of the context of crises in terms of crisis definitions and typologies, crises incubation and evolution and the causal roots of a crisis. This was important for the author since it prepared the groundwork for what was to follow in terms of the literature review but, more significantly, provided further validation and legitimisation for the need to develop the understanding of the management of crises, particularly those of a smouldering nature, because crises were a considerable organisational and managerial challenge. Therefore, with this in mind, the author felt it was then necessary to examine what the management literature suggested in terms of the management's handling of these damaging situations since without this the literature review

would be incomplete and it would also offer a further opportunity to isolate the area of contribution.

Smith (2005a) recognised that management control through organisational systems was a dominant paradigm, both in practice and in the literature. Drawing on the management literature on organisational control, Smith and Toft (2005), as did Smith (2005a), proposed that managers had the expertise to control the actions and behaviours of individuals, themselves included, within the organisation and were, thus, held accountable and responsible for this. The previous discussions have shown that adverse events such as smouldering crises breached organisational systems and jeopardised control and that it was widely recognised (Mitroff 2004a, 2004b, Mitroff and Harrington 1996, Pauchant and Douville 1992, Shrivastava et al 1988, Smith 1990 and 1999, Turner 1994 and Udwadia and Mitroff 1991) that, although the precipitation of adverse events was, in the main, dominated by grassroots behaviour, the underlying responsibility for these problems was to be found in management failures. However whilst Smith (2005a), and Smith and Toft (2005), argued that complete control in such an environment was challenging, possibly unachievable and in appropriate in complex and dynamic environments, Smith (2005a) maintained that management were often at fault in a crisis situation and remained responsible for crisis containment and the reinstatement of organisational control at what was a challenging time.

Consistent with Smith's emergence theme, several authors including Fink (1986), Pauchant and Mitroff (1992), Smith (1990) and Turner (1978) advocated that crises progressed through a series of phases, expressed by Shaluf et al (2003, p 26) as an "anatomy". Pauchant and Mitroff (1992), as did Jacques (2010), suggested that the management of crises was actually concerned with all of these phases since they were significant both in terms of the nurturing and the intensification of crises - "the failure to manage any one of these phases well may be responsible for the occurrence of a crisis in the first place and then for its escalation" (p135). Although less forensically detailed than Smith's model (2005a) which was outlined in Section 2.3, the phasal view of crises has influenced the author in two ways. Firstly, it provided useful direction for the

review of the literature on the management of crises. Secondly, as Sections 2.2 and 2.3 stated, smouldering crises that incubate in the time preceding a crisis are the focus of this thesis and so it was important to explore how the literature suggested crises were managed. Accordingly, the structure of this section is based on the major phases of a crisis (as shown below in Figure 2.1). It is also felt that organising the discussion on the management of crises along these lines will provide a logical progression through the section which will be of help to the reader.

This diagram has been removed for copyright reasons.

Figure 2.1 The Stages of a Crisis adapted from Pauchant and Mitroff (1992) and Smith (1990)

Therefore, this section will firstly explore how the management literature proposed that crises were handled before considering the underlying orientation suggested by the literature's approach. The author found that the managerial and systems orientation which had pervaded the contextual literature was also inherent in the literature on the management of crisis and shaped its content, direction and philosophy. This was a significant discovery in the literature journey and highly influential in the approach to the research methodology detailed in Chapter 4.

2.5.1 Stage 1 - Pre-Crisis Signal Detection, Preparation and Prevention

The evidence presented by the management literature was that crisis preparation was a necessity for organisations because organisational crises had catastrophic impacts yet were inescapable. Indeed, Smith and Toft (2005), citing Vincent and Reason (1999 p43) emphasised the need to address proactively the events which see the synthesis of 'active failures' and 'latent conditions'; "we cannot prevent the creation of latent failures, we can only make their adverse consequences visible before they combine with local triggers to breach the system's defences".

The catastrophic impacts and inevitability of crises have already been discussed in Sections 2.1, 2.3 and 2.4. However, Pearson and Misra in their 1997 paper suggested that organisations perceived that crisis management was only necessary when a crisis occurred and were, thus, neglectful of preparation in the pre-crisis period. Hickman and Crandall (1997) concurred, drawing attention to the fact that eight out of ten organisations lacking a crisis plan went out of business within two years of suffering a major crisis. However, Smith (2005a) was critical of the efficacy of such contingency plans noting that crises were allowed to smoulder and escalate because contingency plans or management's response to unknown crisis were insufficient; "Emergence is a key factor in the ways in which the task demands of a crisis exceed the planned contingency response that the organisation has in place" (2005a p4). Smith termed this a 'crisis of management' (1990, 2006b).

Nonetheless, there was a strong consensus in the literature for the need to prepare for crises (Lagadec 1993, Mitroff et al1996, Pauchant and Mitroff 1992). Smith (1990 and 1999) stated that organisations and the managers within them had a responsibility and necessity to manage the risk of inevitable crises through contingency planning. Kash and Darling (1998) stressed the validity of preparation in the pre-crisis period suggesting that "companies that prepare for crisis events are better able to handle them more efficiently and successfully" (p185). Mitroff and Anagnos (2001) also commended the virtue of preparation stating that "complete prevention (of crises) is impossible ....appropriate and

advanced planning and preparation, ... can limit substantially both the duration and the damage caused by (major) crises" (p 29), a view which was echoed by others (Augustine 1995, Mitroff and Harrington 1996). For Mitroff (1988) crisis preparation was a time critical activity and he suggested that the time to consider how to handle a crisis was not when the crisis occurred but beforehand, using tried and tested plans, concluding that "if it ain't broke, then now's the time to make sure it stays fixed" (p19). The emphasis on crisis preparation in the literature appeared to the author to provide the legitimacy for management research into crisis preparedness.

For some authors (Pauchant and Douville 1992) crisis preparation needed to be specifically concerned with addressing the triggers for crises such as organisational and technological complexity. For example, Pauchant and Mitroff (1992) espoused that "crisis prepared organisations attempt to buffer potential threats without substantially adding to the overall complexity of their operations" (p 120). However, Perrow (1984), as did Shrivastava et al (1988) and Weick (1988), identified that the challenge was to effect organisational design which emanated order and control, whilst at the same time nurturing flexibility and change receptivity particularly in an environment which was complex-inducing. In addition, Perrow (1984) advocated that crisis prone technologies were deselected in order to eliminate the threat, a view with which Weick (1988) concurred stating that "the general strategy in crisis management consists of decreasing the technological complexity of productive systems and of simultaneously allowing the complexity of human systems to emerge and to be effectively used" (p51).

Whilst aspects of the literature identified broader planning models (Heath 1998, Mitroff and Anagnos 2001, Mitroff et al 2003,), others focused on how to manage crises through the appointment of cross-functional crisis teams (Bland 1995, Heath 1998, Hickman and Crandall 1997, Mitroff 1988, Mitroff et al 1996). The virtue of designating specific responsibility for crises to a team was recognised by a number of authors (Andersen 2003, Kash and Darling 1998, Mitroff and Harrington 1996, Pearson and Misra 1997, Watkins and Bazerman

2003) who claimed that this would facilitate the spread of crisis management throughout the organisation.

However, whilst this was informative, the remainder of this section highlights the role played by early warning signals and culture in the preparedness of organisations. There are several reasons for this. Firstly, there appeared to be a common emphasis in the literature concerning early warning signals and culture. Secondly, although this was, in itself, an interesting finding for the author, it was also important to this thesis. In the first instance, and consistent with Smith's work (2005a) on emerging crises, smouldering crises which incubate in the organisation, giving off early warning signals as they develop, are the defined area of investigation in this thesis. In the second instance, this necessitates the author of this thesis understanding more about how the management literature suggested incubation was identified. In the third instance, the pervasive nature of culture would influence individual behaviour within an organisation which is a key research question for this thesis. In the fourth instance, critically examining the literature in terms of early warning signals and culture was influential in identifying further limitations of existing theory.

Considering the nature of management responsibility in the preparatory period, Smith (2005a) promoted the view that in pre-crisis conditions, as the crisis was emerging, it was the responsibility of management at grassroots level to deal with what was happening since the organisation did not, yet, view the events as a crisis and thus would have not effected a crisis management team. However, Smith (2000a) recognised the managerial problem posed, at this stage, by a complex, dynamic and escalating event, a view that also emerged in the work of Pauchant and Mitroff concerning crisis preparedness.

Building on Udwadia and Mitroff's earlier study concerning the genealogy of 60 organisations experiencing crises (1991), Pauchant and Mitroff (1992) conducted 500 interviews with professionals who were responsible for crisis management in order to determine the characteristics of crisis prepared and crisis prone organisations. Whilst it is not the intention to explore their findings

in totality, aspects of their work are explored here for two reasons. Firstly, their work appeared to be influential in other literature (for example Greening and Johnson 1996, Mitroff et al 2003, Pauchant and Douville 1992). Secondly, perhaps as a result of this, their work identifies a number of themes which were common and recurred across the literature.

Pauchant and Mitroff's (1992) findings suggested that crisis prone organisations were strategically reactive, paid little direct attention to crisis management and were psychologically defensive. Furthermore, these authors found that some organisations lacked preparation for crises because they refused to consider their potential, a view that was expressed by many others (Augustine 1995, Hickman and Crandall 1997, Mitroff 1988, Mitroff and Pauchant 1992, Mitroff et al 1994, Register and Larkin 2002, Richardson 1995, Smith 1999, 2005a, 2006b, Smith and Elliott 2000, Smith and Toft 2005, Turner 1978, 1994, Watkins and Bazerman 2003). Mitroff and Anagnos (2001) emphasised the danger of this denial as "the worst enemy of crisis management" (p8), a view with which Smith (1990) concurred suggesting that it was senior management and experts who needed to confront their reluctance to accept that crises are likely to occur.

In contrast, Mitroff and Pauchant (1992) found that crisis prepared organisations were strategically proactive and had effective crisis management units. Instrumental in their proactivity and efficacy was the capacity to detect threats through early warning signals, bolstered, argued Smith (2006b) through effective learning. Smith (2005a) stressed the importance of the transference of knowledge and information within the hierarchy and structures of an organisation in order to affect proactivity and, whilst identifying that this should cover formal and informal informational networks, acknowledged the complexity of realising this in practice through "nebulous" networks (p7) generally and, specifically, as a problem was escalating. Whilst this thesis does not directly consider informational and knowledge networks, the research methodology outlined as a result of the author's perceived limitations of existing literature and documented in Chapter 4 delivers a study which accesses a previously untapped network of information and knowledge, that of and from grassroots

individuals. The contribution to knowledge of this thesis will improve the perspective, knowledge and capabilities of managers where limitations have led to smouldering crisis situations.

The value of early warning systems in creating a state of awareness in the organisation was recognised in the work of others such as Coombs (1999), Fink (1986), Heath (1998), Laitinen and Chong (1999), Mitroff and Anagnos (2001), Pearson and Rondinelli (1998) and Quarantelli (1988) and was in harmony with Reason's (1987, 1990, 1997, 1998, 2000a, 2008) view concerning the significant role of early warning signals in addressing the crisis-inducing 'latent conditions' within an organisation. However, since the work of these authors acknowledged that crises came in different guises, Pauchant and Mitroff also advocated a portfolio approach to crises preparation, a suggestion to which there was common agreement (Augustine 1995, Hickman and Crandall 1997, Mitroff and Harrington 1996, Mitroff et al 1988, Pearson and Misra 1997, Pearson and Rondinelli 1997). Several authors (Coombs 1999, Heath 1998, Mitroff et al 1988, Mitroff et al 1996, Pearson and Misra 1997, Watkins and Bazerman 2003) rationalised the need for a portfolio approach because, different crises produced common early warning signals and required distinctive action plans.

Despite this general consensus in the literature towards early warning signal systems, Mitroff and Anagnos (2001) and Mitroff and Harrington (1996) issued a caution that their efficacy was limited if organisations did not provide appropriately receptive conditions. Mitroff and Anagnos (2001) articulated the problem by stating that "in complex organisations, separate individual signals, no matter how loud, may not be sufficient to connote a problem. If in effect the signals 'don't connect the dots', then we cannot and do not see a problem" (p111). The author of this thesis believed what seemed to be at issue here was management's capacity to heed early warning information regarding smouldering crises. Whilst Smith and Toft (2005) attributed the reasons for management's limitations to various factors including the complexity of organisations, the scale and scope of the problems faced by managers and the level of interconnectedness and dynamism, Smith (2002a, 2002b) postulated

that the limitations of existing management knowledge and the associated chasm between knowledge, contingency plans and organisational defensive processes challenged the efficacy of taking such a prescriptive, contingent approach. Smith (2005a) stated several contributory factors.

In the first instance, management did not have full knowledge in terms of the span of their control since the processes and subsequent interactions were difficult to define with any completeness. Smith and Toft (2005) elaborated stating that contingency plans were based on the perceptions of managers as to what could possibly happen and that this was often based on probability and had, as stated in Section 2.3, a 'bounded rationality' (Pauchant and Mitroff 1992). Thus, if there was little evidence that an adverse event would happen, then managers would have limited awareness of the potential and this would negate any reason to prepare contingency plans. Smith (2005a) intimated further that the separation of the knowledge between grassroots and management could distort management's perspective and erode organisational preparedness.

In the second instance, the plethora of processes and interactions rendered complete planning ineffective, managers simply could not plan for every eventuality that they were aware of. Smith and Toft (2005) were particularly critical that planning per se would not assist managers to better deal with adverse events, rather it was planning that was informed and well devised that was most effective. This was, perceived a number of authors (Smith 2005a, Reason 1990, 1997, 2004), exacerbated by the exposure created in contingency plans of unanticipated conditions.

Smith (2005a) stressed the importance of managers having the capacity to manage a crisis through effective knowledge based decision making stating that "under the conditions of crisis, managers need to ensure that they make sense of what is happening to help the organisation to deal with competing task demands within a potentially hostile and extremely dynamic environment. It is within this process that managers have to function, collect and act upon evidence and make decisions" (p2). However, Smith (2005a) argued that

management's limited perspective and knowledge created a gap between what were potential problems in the organisation's systems and processes and reality. Smith and Toft (2005) proposed that there was a need to investigate the incubation of a crisis further since this would provide additional information and knowledge that would elucidate the origins of the problems that caused breaches in the organisation's systems and processes which led to the promulgation of a crisis event. The methodology outlined in Chapter 4 was designed to provide such research and, in so doing, provide novel information and knowledge that, whilst not entirely eliminating these events, would further the understanding of smouldering crises.

In the third instance, given the magnitude of interactions within an organisation (some across organisational boundaries), monitoring the degree to which processes were adhered to and taking corrective action where necessary in the early stages of a crisis was difficult for managers to achieve. Furthermore, Smith (2005a) believed that early warning information was neither collected nor disseminated and that, as a result, the signals it raised were not brought to the attention of management so that appropriate action could be taken.

In the fourth instance, Smith (2005a) argued that organisations and thus the managers and individuals within them placed greater emphasis on efficiency at the expense of effectiveness. The result was competing and conflicting operational priorities which produced tensions within the organisation.

Within the context of creating receptive conditions for crisis preparation, some management theorists (Mitroff and Kilmann 1984, Quarantelli 1988, Smith 1990, Weick 1988, Weick et al 1999) contemplated the nature of organisational culture. In their consideration of organisational culture, Mitroff and Kilmann (1984) made the usual step of shifting attention from those who managed within the organisation to a more individualistic paradigm stating that "The likelihood that an organisation will anticipate and respond to an impending corporate tragedy is not just determined by personality and intellectual capacity of its leaders ... rather every organisation has ... a way of doing things ... this is where we will find the basis for an organisation's stance towards the unthinkable" (p

63). This view is echoed by Smith (1990, 1999, 2006b) who, whilst recognising that this was often a neglected area, believed a receptive culture held the key to inhibiting incubating crises. Furthermore, Smith (1990) explicitly proposed that this would be achieved by engendering bottom-up communication flows, a view echoed by Quarantelli (1988) and Weick (1988) and engendered in the research study underpinning this thesis. Building on this notion, Weick et al (1999) tendered the view that organisations that dealt well with unexpected events engendered a state of 'mindfulness' where collectively and culturally individuals within the organisation were vigilant and could anticipate, respond and recover from surprise events. However, whilst Richardson (1995) and Turner (1994) concurred with the possibility that an organisation may need to effect a cultural shift to become more receptive to crises, they also considered the challenges of realising this may be too great without the eradication of the potential for blame. Critically, though, Smith and Toft (2005) argued that culture was an imprecise concept which promoted a particular perspective rather than reality, a point Reason (1997) appeared to endorse when he argued that culture could promote working conditions which tolerated systemic error. Whilst it is evident from both this literature review and that which follows in Chapter 3 that author's have highlighted culture as a dominant issue in organisational crises, the research data underpinning this thesis and the intellectual development in Chapter 7, 8 and 9 identify organisational climate as being more critical. The feelings and beliefs that individuals hold about the internal environment of an organisation which is highly influential in their behaviour in the workplace was attributed to the organisational climate (Dawson et al 2008, Forehand and von Gilmer 1964, James et al 2008, Kaya et al 2010, Tagiuri and Litwinn 1968) and whereas culture reflected a system orientation which was 'owned' by the organisation, organisation climate was individually oriented and owned (James et al 2008). The author returns to this discussion to develop it further in Chapter 8 following the presentation of the research data.

Smith (1990, 1999), as was Jacques (2010), was critical of the effect the emphasis on preparation had on the attention that was given to preventing crises. Jacques (2010), supporting the concept of smouldering crises reflected that "most crises are not sudden events but follow a period of precognition and

red flags" which could be pre-empted through the proactive measures of "leaders and managers" (p10.). Using case-based evidence Smith's earlier work (1990) broadly concurred, although in identifying the cause of crises to be management failures believed they could be eradicated through a shift in managerial style and culture. However, the author found that the theme of prevention was not pursued in the literature to any great degree (Smith 2005b). In attempting to understand the reasons for this, the author concluded that the accentuation of the inevitability of organisational crises directed attention to preparedness at the expense of prevention. However, it seemed to the author that this added further credence to the need to develop the understanding of the management of smouldering crises as in so doing knowledge regarding the curbing of crises within their early stages would be extended.

The decision of the author of this thesis to focus on crises that smoulder within the organisation was explained at the conclusion of Section 2.2. Within the context of this decision, the author sees value in the notion of being sensitive towards occurrences in and around the organisation that could evolve into a crisis. However, in acknowledging the importance of early warning signals and the pervading influence of culture, it is surprising that despite some indication from Quarantelli (1988), Smith (1990) and Weick (1988) of the necessity to involve those at grassroots levels in crisis preparedness, the management literature on crises was not directed towards a better understanding of contributory role of grassroots individuals within the underlying systemic problems apparent in smouldering crises. The approach of this thesis in exploring the workplace behaviour of individuals will develop a greater appreciation of the role grassroots humans play in the signals that managers need to indicate that a smouldering crisis has commenced.

2.5.2 Stage 2 - Management of the Crisis

According to Pearson and Misra (1997) "Quantitative data collected across the Fortune 1000 shows that a company dedicates the bulk of its crisis management resources during this phase" (p 53). However, Heath (1998) stated that it is also a time of "crisis smog" (p209) typified by chaos in the

environment, overwhelming, incomplete or confusing information, distortions in communications and cognitive uncertainty amongst managers and executives, a view recognised by others including Lagadec (1993), Mitroff (2004a) and Shrivastava et al (1988). Roux Dufort and Metais (1999) summarised it as the "destructive phase" (p 115). This section will consider aspects of the above that were prominent in the literature, notably the effective implementation of crisis plans, communications, the characteristics of successful crisis leaders and enacted 'sensemaking' in crisis situations. However, this section will focus less on the finer detail concerning each of these aspects and more on the perspectives they illuminate, since this is what is important to this thesis. According to Mitroff et al (1996), and also Augustine (1995), a high level of resources was required within this phase, termed by Smith (2006b) as the 'operational crisis', because the crisis itself demanded swift and specific actions and decisions outside of normal business operations.

Prescriptively, Mitroff et al (1996) suggested that organisations needed to initiate the crisis management team, establish the nature of the crisis, communicate with stakeholders, contain the damage and recover. Practically, and quite exceptionally (since the work of others such as Fink (1986) and Smith (1990) offered more general advice), their work was supported by an action and decision blueprint for practioners sequencing what should happen and when. Smith and Toft (2005), within the human error causal route to organisational crises, were critical of solutions such as those discussed above which, they believed, were technical and process driven in nature.

Much was written in the literature about communications at times of crises by those who specialise in communications generally and public relations specifically (for example Barton 1993, Burnett 2002, Coombs 1999, Falkheimer and Heide 2006, Jacques 2009, Moore 2004, Murphy 1996, Ray 1999 Register and Larkin 2002). It was also considered by authors such as Fink (1986) who saw it as a part of the crisis management plan. In terms of substance, unsurprisingly, given the public profile of this stage, the literature addressed its content to those at the top of an organisation covering key issues concerning senior management such as dealing with media coverage (Mitroff et al 1996),

establishing credibility and trust (Augustine 1995, Mitroff and Anagnos 2001, Mitroff and Harrington 1996, Mitroff et al 1996, Pauchant and Douville 1992) and constructing effective communications' content (Augustine 1995, Kash and Darling 1998, Mitroff and Anagnos 2001, Mitroff et al 1996, Pauchant and Douville 1992, Pauchant and Mitroff 1992). In addition, several authors (Kash and Darling 1998, Mitroff and Anagnos 2001, Pauchant and Douville 1992,) warned that organisations whose messages were not effective at the outset could suffer from crisis creep which happened when "companies sometimes misclassify a problem, focusing on the technical aspects and ignoring the issues of perceptions but it's often the public perception that causes the crisis" (Augustine 1995 p51).

It was evident from Mitroff's empirically tested research (2004a) that those at the top of the organisation were perceived to play a significant role during the crisis itself, a view echoed by Pearson and Clair (1998). Whilst Pearson and Clair (1998) suggested that the actions of senior managers and their organisations were influenced by the thoughts and knowledge of senior decision makers during a crisis, Mitroff (2004a) utilised the theories of Jung and Myers-Briggs to identify the four languages of leaders but asserted that crisis leaders possessed an alliance of all four languages and were capable of thinking and nurturing of the highest order. Mitroff's suggestions were echoed by Richardson (1995) and James and Wooten (2005). However, Greening and Johnson (1996) considered the wider context of top management and, through their research and literature review, advocated that top management teams who were well educated, multi-disciplinary and possessed diversity in terms of age and tenure were more likely to be open-minded to crisis situations. This, they believed, was because they were more likely to engage in critical thinking, less influenced by groupthink and less entrenched in their attitudes and behaviour.

Weick (1988) developed the theme of the central role played by humans in crisis situations within the concept of 'enacted sensemaking'. According to Weick (1988), the undeniable fact was that humans engaged either intellectually, physically or intellectually and physically with a crisis since part of the impulse to make sense of a crisis came from intellectual or physical action.

Although Weick (1988) believed that adequate enactment in crisis situations came from those at grassroots level feeling empowered to act, he perceived that empowerment increased the potential for human variability and error-proneness. Furthermore, Weick (1988) advocated that an individual's reaction was specific to each crisis situation and the individual's own experience and heritage and stressed that pressures such as high staff turnover or understaffing could compromise the effectiveness of enactment. In addition, Weick (1988), as did Smith and Toft (2005) and Smith (2006b), believed that because crises challenged a human's ability to make sense of events, the under researched area (Smith and Toft 2005) of 'sensemaking' could be inadequate, causing, particularly from a management perspective, an intensification of the crisis. There was evidence of agreement to the notion that humans could exacerbate a crisis (Pauchant and Mitroff 1990, 1992, Pearson and Clair 1998, Smith 2005a, 2006c) since it was believed that humans, through their interactions, often exacerbated the impact of an error because they were not equipped to properly deal with it. Paradoxically, though, Weick (1988) claimed that, at times, enactment, though dangerous, could improve an individual's level of understanding and response to a crisis situation.

This section has been concerned with how the literature suggests that crises are managed. As was explained at the outset of the section, the author has chosen to highlight the key themes rather than explore the content of the literature in detail. This was a conscious decision since what the author found illuminating was the perspective that crises were incidents that could, largely, only be dealt with by those at the top of organisations. Whilst the author does not dispute the significant role played by those at the top of an organisation during a crisis, within the specific context of a smouldering crisis, the author questions this level of significance for several reasons. In the first instance, sections 2.1, 2.2, 2.3 and 2.4 have provided evidence that organisational crises are inevitable and predominantly arise out the acts of humans working within the organisation. Weick's concept of 'sensemaking' supports this notion. In the second instance, in the case of smouldering crises, crucially the evolving nature of a crisis suggested that it was the acts of humans at grassroots level and, in particular, in operational management positions that precipitated the triggers. In

the third instance, the literature regarding the management of crises has a tendency to focus on how managers should deal with sudden crisis events. The result is that not only was the literature partial in its understanding of the behaviours underlying human caused crises, but it did not directly address how managers might use this knowledge to better deal with the management of smouldering crises. Furthermore, the prescriptive, procedurally based approach, for example in the appointment of a crisis management team and provision of a blueprint for crisis management, also lacks the benefit of being informed by those who are closer to the crisis incubation point. The understanding of grassroots individual behaviour generated by this thesis will address these shortfalls, improve management perspective, knowledge and capabilities and thereby complement existing knowledge concerning how managers deal with smouldering crises.

2.5.3 Stage 3 - The Aftermath

Aspects of the management literature were concerned with the aftermath of a crisis, the so-called ‘crisis of legitimisation’ (Smith 2006b), and, although the level of academic writing is more limited than that concerned with the previous stages, it appeared to the author to centre principally on resolution and reflection (Heath 1998, Jacques 2010, Mitroff and Harrington 1996, Pearson and Misra 1997, Roux-Dufort and Metais 1999, Roux-Dufort 2000, 2007).

According to Shrivastava et al (1988), and also Heath (1998) and Hickman and Crandall (1997), crisis resolution and business continuity were affected by organisations mitigating the impact of the crisis with remedial action focusing on whatever impacts had been experienced, for example, financial recompense to victims for injuries sustained and process improvements for product and service faults. Considering business continuity in particular, Pearson and Misra (1997) advocated that organisations needed to be concerned with identifying the minimum that, both procedurally and in terms of the products or services that they offer, they would have to do in order for business to be resumed. Whilst the author acknowledges the literature concerned with business continuity in the management of the aftermath of crises (for example Elliott et al 2002), it is not

the intention of the author to explore this any further. The principal reason for this is that this thesis is concerned with the incubation of organisational crises through human error and, as has been outlined, the focus of business continuity is on resuming the normal business operations of the organisations and thus the contribution to the core theme of this thesis is limited.

There was some agreement in the literature (Jacques 2010, Pearson and Misra 1997, Roux-Dufort 2007, Smith and Elliott 2007, Smith et al 2000, Smith and Toft 2005) of a need for organisations to learn in the aftermath of a crisis since crises themselves were seen as moments of transformation. Mitroff and Anagnos (2001) rationalised the need to learn in the aftermath based on the observation that many organisations, having developed plans to deal with organisational crises, experienced frustration when implementing plans. According to Mitroff and Anagnos (2001) one of the main reasons for this was that the plans failed to take account of the fact that a crisis occurred not because one part of an organisation had failed but because there were systemic problems within the organisations. Smith and Toft (2005), as did Smith and Elliott (2007) and Smith et al (2001), highlighted the dangers of management within organisations negating learning opportunities since without effective learning, managers themselves were culpable in the evolution and persistence of smouldering crisis conditions.

With the exception of the triage system of Myer et al (2007) and Smith and Toft (2005), the author observed that ensuing suggestions were generally organisationally oriented and process driven, for example Mitroff and Harrington (1996) proposed a system for auditing in the aftermath of a crisis and Heath (1998) suggested that organisations construct their recovery around a strategy for planning, gathering information, managing core operations and resources and contingency plans for business recovery. Although Roux-Dufort (2000) was critical that few authors offered real practical advice regarding effecting organisational learning, Smith and Elliott (2007) explored learning in some detail.

Smith and Elliott (2007) distinguished between process driven and deeper learning, identifying two, quite distinctive levels of learning; first order learning, as exhibited by crisis prone organisations, focused purely on enacting learning through changes in organisational regulations, structures, practices and plans and second order learning which achieved a deeper learning and ”full cultural adjustment” (p522). It is interesting that whilst, the main thrust of literature saw learning as a process in the aftermath of a crisis situation, Smith and Elliott (2007) recognised that learning, of the first ‘hard’ and second ‘soft’ order, had a place in the pre-crisis stage and the most challenging second order learning occurred during and in the aftermath of a crisis, a view which is consistent with the transformational nature of crisis situations discussed in Section 2.1. Continuing the theme of second order learning, Smith and Toft (2005) proposed that in order to effectively learn from smouldering crises, organisations needed to review the way in which their problems were evaluated and assessed. Drawing on Weick’s (1988) notion of ‘sensemaking’, Smith and Toft (2005) considered that learning needed to focus on developing a better understanding of the role played by management behaviour in why and how problems emerged within the organisation. This contribution of this thesis will enhance understanding in terms of the emergence of smouldering crisis conditions and thus present a learning opportunity for academics, researchers, managers and, perhaps, policy makers.

Several authors (Carley and Harrod 1997, Heath 1998, Mitroff and Anagnos 2001, Roux-Dufort 2000, Smith 1999, Smith and Elliott 2000, Smith and Elliott 2007, Smith et al 2000 and Weick 1988) reasoned that barriers prevented organisational learning, identifying the recurring themes of management denial, a lack of ‘emotional intelligence’ and a focus on symptoms not causes as a means of scapegoating amongst them. Shrivastava, et al (1988) expressed similar concerns regarding scapegoating suggesting that “the focus on symptoms rather than causes leaves organisations vulnerable to similar crises that can deepen and extend the original problem” (p292). Smith et al (2000) recognised the relationship between scapegoating and a culture of blame, proposing that learning would not be achieved until a more trusting, blame-free culture was realised and commended the benefits this delivered in terms of

continuous, open communications and the free flow of information (even during the incubatory period).

Smith and Toft (2005) were particularly explicit regarding the underlying reasons why organisations and the managers within them had an inhibited approach to learning and thus were culpable in the evolution of smouldering crises. In the first instance, they asserted that management processes within the organisation did not always allow time or opportunity for discussion about how events incubate and escalate within organisations. In the second instance, and reiterating a recurring theme, Smith and Toft (2005) proposed that learning was not affected because smouldering crises were often nebulous. Smith and Elliott (2007) identified a series of specific learning barriers some of which have already been mentioned in the context of other discussions such as denial but also added that learning was adversely affected by management's inflated self belief and an inability and reluctance to learn from other organisation's experiences, near misses or non-events due to "rigid core beliefs and ineffective communications" (p527). Most importantly for this thesis, Smith and Elliott (2007) identified the significance of difficulties in accessing and handling information in forming barriers to learning and knowledge acquisition, advocating that "by focusing solely upon technical elements organisation may risk ignoring the human aspects of causality that are central to both crisis incubation and learning". A view with which Smith and Toft (2005) appeared to have some sympathy in arguing that the limitations in management knowledge could potentially entrench 'latent conditions' which give rise to error incidents in the organisation's processes. This thesis is aiming to develop the understanding of smouldering crisis management by exploring such human aspects from a novel and distinctive perspective and, in so doing, will contribute to learning and knowledge from both a practical and an academic perspective.

The author of this thesis believes that there is evidence of an intent to learn from crises throughout the management literature and specifically in the literature concerned with the aftermath of a crisis (although there is criticism concerning the efficacy of learning in practice). However, learning has, in the main, gravitated towards an organisational review of the processes associated

with the management of crises. Whilst the author concurs that there is a need for organisations to review the processes by which they deal with crises, to do this without exploring the learning that can be acquired by considering the behaviour of individuals within these processes results in a partial view.

Despite recognition of the aftermath stage being a period of transformation and a learning opportunity for organisations, the literature takes an organisational perspective; the crisis is resolved when the organisation has made recompense for the crisis and it has returned to its pre-crisis state, reflection has been effected when the processes for the management of crises have been reviewed and refined. The author does not oppose this approach, rather she considers it to be partial and believes that the learning opportunity presented by this thesis will provide a more rounded approach to the management of smouldering crises.

2.5.4 The Underlying Orientation of the Literature

Sections 2.5.1, 2.5.2 and 2.5.3 have discussed how the management literature addressed how organisations should deal with each phase of a crisis. However, the author's observations have not been restricted simply to the content of what was discovered in the literature. The author has also made observations about how the content implies an organisational orientation in the management literature concerned with organisational crises. This section is about those observations and is focused on three specific issues; the approach to the empirical research underlying the development of theory, the nature of the theoretical development and the audience to which theory is addressed. This final section of Chapter 2 will look at each of these issues in turn.

In the first instance, the author considered the approach to the empirical research underlying the development of theory. The management literature had grown through the empirical analysis of specific cases of organisational crises. However, to a large degree, the empirical base of the research had been centred on exploring and, sometimes measuring, the attitudes and behaviours of those at the top of the organisation who occupied executive and senior

managerial positions (Fink 2002, Mitroff, Pauchant and Shrivastava 1988, Mostafa et al 2004, Pauchant and Mitroff 1992, Pearson and Rondinelli 1998, Ray 1999, Register and Larkin 2002). Whilst the author is not suggesting that this is an inappropriate approach, the resultant theory, which has been founded on particular narratives, is partial and incomplete. In the case of smouldering crises, this is a significant observation and limitation as the dominant approach is neglectful of the narratives of those who are closer to the crisis incubation point. The research approach discussed in Chapter 4 and the resultant contribution of this thesis will address this imbalance since the crucial limitations in management perspective, knowledge and capabilities identified as being central to smouldering crises will be improved by the knowledge provided by the perspective of this thesis.

In the second instance, the author considered the nature of the theoretical development. Despite Smith (20002a, 2002b, 2005a, 2006b) and Smith and Toft's (2005) work which explored management behaviour in the smouldering crisis context in some detail, there is a strong orientation towards the organisational perspective within the development of management theory and, the consequence of this is a focus is on 'hard' knowledge. Indeed Pauchant and Mitroff (1988, 1992) proposed that in crisis-prone organisations change occurred only at superficial level (practices, structures and plans) rather than the deeper level of beliefs and assumptions**.** It is not the author's intention to repeat the detail of the preceding sections here but the discussion in Sections 2.5.1, 2.5.2 and 2.5.3 concerning the management of crises is suggestive that this organisational perspective is evidenced principally on three fronts. Firstly, the theory proposed that organisations have allowed crises to occur because management systems and processes within the organisations had failed. In addition, organisations had been neglectful in their cultivation of a culture that was sensitised to the possibility of crises occurring through changes in the business environment. Furthermore, organisations had been unsuccessful in the effective management of technology, people and organisational structure and design. Secondly, according to management theory, the best way of dealing with each type of crisis was through customised pre-planned, prescribed operational procedures. Moreover, crises achieved a more

successful outcome if they were led by an appointed leader who possessed the right skills and led from the front with the support of a dedicated crisis team. Finally, the management systems discussed in the previous two points should, from the perspective of the theory, be subjected to a systematic audit and review of processes and procedures following a crisis. Whilst aspects of the literature (for example Smith 2005a, 2006b, 2006c and Smith and Toft 2005) raised significant and informative 'soft' behavioural factors underpinning smouldering crises, the author of this thesis is suggesting that given the orientation of the research, management theory regarding organisational crises at this present time fails to fully exploit the knowledge that could be gained from considering the influence that the behavioural contribution of those at grassroots level might have in each of these broad areas of knowledge. This thesis will address the balance, particularly within the thesis' defined area of focus, that of smouldering crises.

In the third instance, the author considered the audience to which theory was addressed. Many authors (for example, Bland 1995, Burnett 2002, Fink 2002, Greening and Johnson, 1996, Heath 1998, Hitchcock 1998, Loosemore, 1998, , Mitroff 2004a, Mitroff 2004b, Mitroff and Anagnos 2001, Mitroff et al 1996, Parsons 1996, Preble 1997, Ray 1999, Register and Larkin 2002, Roux Dufort 2000) overtly addressed their work to executives and managers within organisations. Mitroff and Kilmann (1984), as did Pauchant and Mitroff (1992), expressed a common view in rationalising that this was borne out of an ethical responsibility and motivation to prepare organisations, and the managers within them, for crisis situations as these individuals were particularly influential in determining an organisation's reaction and outcome in crisis conditions. The author of this thesis appreciates the necessity for organisations and those within them to prepare and manage crisis situations but feels that this is better served by academics if the management literature takes a more holistic approach to understanding what happens in crisis situations and why. The research approach discussed in Chapter 4 and the resultant contribution of this thesis will address this imbalance.

2.6 Summary

This chapter has presented the author's analytical journey through the management literature concerned with organisational crises and has found the literature helpful to this study in a number of areas.

At the outset, the author, like others before her, found defining organisational crises challenging, predominantly due to the sheer diversity of the terms adopted throughout the literature. However, the author focused on examining the management literature concerning the characteristics and types of made-made organisational crises in order to arrive at a definition for this thesis which was appropriate within the context of the study. The discovery that whilst, throughout the management literature there was an emphasis on large-scale, high profile crises, crisis-like incidents could smoulder within an organisation, was significant both in terms of the author's area of interest and the direction of this work. Smouldering crises were of great interest to the author and, within the healthcare setting, bore all the hallmarks of an organisational crisis. Smith's work (2005a) was particularly illuminating regarding the nature of smouldering crises proposing that these occurred when problems that emerged within the organisation's systems were allowed by management, through negligent perception, knowledge and capabilities, to progress unchecked through 'points of inflection'. Thus, the author was able, for the purposes of this thesis, to define organisational crises as high impact occurrences with systemic origins which evolved over time and caused unexpected damage to the resources, reputation and stakeholders of an organisation.

The literature was also helpful in providing some explanation as to the root causes of crises. Whilst the impact that the environment, organisational complexity and technology had on the incidence of organisational crises was recognised, human error occupied a prominent position in the theory regarding root causes. There was some understanding concerning the behavioural role played by managers within smouldering crises, in particular the significant impact of failings in management's perspective, knowledge and capabilities. This was an important finding for the author and provided additional detail to a

prevailing theme within the management literature which placed both causality of and remedy throughout the stages of crisis situations at the feet of management. However, the author also identified a lack of knowledge within the management literature on crises concerning the contributory role of grassroots individuals and sought further explanation from literature in the field of human error. Whilst this literature helped to better define the nature of human error, the so-called 'person' approach to human error in which the causal route for error was the individual who was closest to the error point was not perceived to be an appropriate perspective. What appeared to dominate human error was a 'systems' approach and whilst the principles of this approach were consistent with the management literature, what was most illuminating was the identification of a clear distinction between the causal factors in error situation that management could influence (the 'latent conditions') through organisational systems and processes, compared to those it could not ('the active failures').

In terms of the management of crises, the author examined the management literature generally and, more specifically, in terms of smouldering crises. At a general level, there appeared to be a movement towards creating knowledge that would bring about an incremental reduction in the potential for the management failures associated with organisational crises. Specifically, knowledge development centred on better helping organisations and the managers within them prepare for, manage and learn from crises, although once again management's limited perspective, knowledge and capabilities were seen as damaging in each of these areas. This appeared to have happened at the expense of crisis prevention.

The author's final observations from her review of the literature were concerning the orientation of this body of work. The research was largely founded on the narratives of executives and senior managers and theoretical development exhibited a tendency to concentrate 'hard' knowledge. Whilst there were some aspects of the literature which notably took a more 'soft' behavioural approach, this tended to focus on knowledge about management behaviour rather than knowledge concerning those at grassroots level.

Therefore the author observed that there were limitations within existing knowledge concerning the management of smouldering crises, the defined area of study.

In the first instance, the prevailing theme within the management literature identified the dominant cause of crises as management failures within an organisation's systems and processes and that smouldering crises happened because managers had negated to build adequate defences. The specific underlying nature of these failures was articulated as being concerned with management's perspective, knowledge and capabilities. Managers had a 'bounded rationality' that prevented them from conceiving of the error potential within the organisation's systems and, at times, impinged 'sensemaking' in crisis situations. Furthermore, the complex nature of the organisation's operations challenged management capacity to create complete knowledge of error potential and, thus, appropriate defences. This was exacerbated by a poor approach to learning from experience. The result was that there was a chasm between management knowledge and the organisation's systems and processes and an incapacity to exploit early warning dissemination which created the 'latent conditions' in which errors occurred. Since it was argued that the prevailing 'latent conditions' were where management could best arrest smouldering crises, the author concluded that further exploration of these critical working conditions within organisations would contribute to an area where the shortfall in knowledge was engendering smouldering crisis potential.

In the second instance, the author also observed that the opportunity to inform the literature through the knowledge of those who were closest to the smouldering crisis incubation point had largely been neglected. The research underpinning the development of the literature was empirically based on the narratives of executives and managers and overlooked the relative contribution that those at grassroots level could make. This seemed a particularly critical observation given the contributory role of inadequate management knowledge in smouldering crisis situations outlined above. The author concluded that knowledge from the neglected perspective of grassroots individuals would be a

novel approach to take and would address inadequacies in management perspective, knowledge and capabilities.

These combined observations led the author to place the research methodology, which will be explained in Chapter 4, and the associated contribution in knowledge. The research methodology will focus on investigating and exploring the behaviour in the workplace of those at grassroots level where there is the potential to cause a smouldering crisis through human error. The analysis of the research will contribute additional knowledge from a novel perspective concerning the 'latent conditions' in which crises smoulder. This enhanced knowledge base will better help academics, researchers and the managers, who are responsible for the conditions in which crisis situations can smoulder, to curb smouldering crises as they emerge and at the 'points of inflection'. The contribution of this thesis will complement existing management theory by taking a more holistic and inclusive approach to understanding what happens in smouldering crisis situations and why. However, before the research methodology is outlined at Chapter 4, Chapter 3 will examine and critically review the literature concerned with patient safety.

Chapter 3 A Review of Existing Literature on Patient Safety

The overall aim of this thesis is to develop the understanding of the management of smouldering crises and patient safety. However, as the author explained in Chapter 1, the chosen context for the research study associated with this thesis is the healthcare sector. In this chapter the author will argue that the design of the research study will also facilitate positioning this work and the contribution to knowledge against identified limitations in the existing literature on patient safety. Patient safety was defined by Vincent (2006) as "the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare" (p14). Systemic human error in healthcare, which the author will assert is symptomatic of a smouldering crisis situation, is viewed by both academics and practioners as one which is concerned with the safety of patients. Thus, the chapter will concentrate on reviewing the subject of human error in healthcare from an applied literature perspective before proceeding to explore patient safety within the healthcare context. Whilst the chapter demonstrates the complexity of the subject, the seriousness with which the healthcare sector views human error in medicine and the associated intent of healthcare organisations to understand and learn from error incidents, there are areas which the author perceives are limited. These areas, together with the limitations identified in the previous chapter concerning existing crisis management literature, have influenced the design of the research study associated with this thesis outlined at Chapter 4. Moreover, the author will argue that, in addition to contributing to knowledge regarding the management of smouldering crises, the contribution of this thesis also has a particular resonance in patient safety.

3.1 The Healthcare Environment: A Climate for Human Error and Smouldering Crises?

Chapter 1 established the sectoral context of this study by presenting a brief situational analysis of healthcare in the UK and the NHS in particular. This chapter is focused on examining the subject of human error in healthcare and patient safety. Accordingly, this first section is concerned with looking more specifically at the healthcare sector as a sector in which human errors, which

are symptomatic of the smouldering crisis conditions that were discussed in Chapter 2, prevail.

Inevitably the author was faced with a wide ranging and comprehensive field of literature to review and therefore had to judge which aspects of the literature were significant for and helpful to this thesis. Thus, the author considered it was necessary to establish what the environment was like in healthcare and why this produced the conditions in which human errors occurred. In addition, the author felt it was important to synthesise these aspects (the environment and its affect on human error episodes) in order to demonstrate, and illustrate through case examples, the connections between what was happening in healthcare in the UK and the smouldering crisis events that were discussed in the previous chapter. These two lines of inquiry are adopted as the structure for this section.

In undertaking the literature review, the author found a significant level of cohesion between aspects of the discussion in the previous chapter, for example the anatomy of a smouldering crisis and human error theory, since this literature base has informed the development of knowledge in human error in healthcare and the agenda for improvements in patient safety. Whilst reference is made to the discussions in the previous chapter, this is performed on an applied basis in order to avoid extensive repetition of material. It should also be noted that for reasons of clarity and to aid the reader, this section will be principally concerned with human error in healthcare and the next section will be concerned with the agenda for improvements in patient safety. However, it will be evident in the discussion that there is overlap in the two areas since there is no such division in terms of either the concepts or the literature.

3.1.1 The Healthcare Environment and its Predisposition to Error

There is a plethora of studies concerning medical error. Some examine the concept of human error in medicine in specific contextual situations, for example there are studies which investigate error in nursing care (Thompson 2002) and operating theatres (Reason 2005). Others look at the broader issues

of human error in medicine, for example Mulcahy and Rosenthal (1999) and Vincent and Reason (1999). Some focus specifically on the fact that errors in medicine compromise patient safety (Vincent, 2006, Vincent and Knox 1997), review the mechanisms that healthcare organisations utilise in order to learn from incidents (Baba-Akbari Sari et al 2006, Saravanan et al 2007, Walsh and Anthony 2007) and aim to address systemic issues through analysis such as human reliability analysis and failure models and effects analysis (Lyons et al 2004). Whilst others have been commissioned by the Government either generally or as a result of public inquiries such as *Organisation with a Memory* (Department of Health 2000a) and the Clothier Report (Department of Health 1994).

It was generally accepted in the literature that, given the characteristics and complexity of healthcare, errors, instigated by humans, would happen which compromised patient safety (Leape 1994, Sheridan 2003). According to Smith (2002c), the situation was challenging to manage due to the time and spatial distance between the cause of patient safety incidents and their relative effects. In terms of further exploring the issue in healthcare, Sheridan's (2003) application of human error theory (Leape 1994, Rasmussen 1990, Reason 1987, 1990, 1997) to the healthcare sector was particularly useful to the author of this thesis, as it sought to consider the linkages between error propensity and the professional in the workplace which was a significant influence in this work. Sheridan (2003) highlighted the specific human error and patient safety challenges created by the nature of healthcare and healthcare professionals, the behaviour and well being of healthcare professionals and the efficacy of organisational learning through systemic reviews. These key perspectives of Sheridan provide the structure for the remainder of this section where they are explored further, with supporting commentary from other literature.

In terms of the nature of healthcare, Smith (2005a), as did Smith and Toft (2005), acknowledged the influence of non-linear organisational complexity, resourcing limitations and challenging communications and control on the propensity for error. Smith (2005a) elaborated, highlighting the diversity and number of organisations, services, cultures and management styles as being

key contributory factors in generating these complexity and control issues, a view with which others concurred (Leape and Berwick 2005, Reason 2008 and Walshe 1999). However, Smith (2005a) accentuated that it was the compounding effect of these issues within the context of the unstable and sometimes perilous nature of patients' conditions that created the germinating conditions for human errors, a view with which West (2006) acquiesced. Donaldson (1999 p218), as did Walshe (1999) expanded on this, proposing that errors were to be expected in healthcare and stating "given the volume and complexity of patient care provided by a modern healthcare organisation, some serious lapses in standards of care are inevitable". Chapter 2 has already identified that the dominant management paradigm was for order and control within organisations to be at the behest of managers and that the presence of human errors within the organisation's systems were seen as failures of management. However, as the review of literature in Chapter 2 showed, and consistent with Donaldson's view (1999), complete order and control, and thus zero error, was perceived to be unachievable principally due to the limitations of management perspective and knowledge, the chasm between knowledge and the organisation's defensive mechanisms and ineffective learning. Vincent (2006) illuminated further identifying that clinicians, either in managerial positions or on the frontline, demonstrated an intuitive propensity to deal with a patient's care but needed a greater perspective in order to achieve this safely within the organisation systems and processes, concluding, like Donaldson (1999) that as a result error free healthcare was probably unattainable.

Whilst the dominant view was that the responsibility for human error incidents lay with management, Sheridan (2003) attempted to distil the contributory behaviour of healthcare professionals in the workplace. Given that the individual in the workplace had been identified at Chapter 2 as the focus for the research study, Sheridan's work provided an interesting and informative contextual perspective for the author.

According to Sheridan (2003) the work undertaken by humans was a composite of the task goals and constraints, the resources available and the individual or group capabilities. However, whilst Smith (2005a) identified a need for

significant skills amongst those who were involved in a healthcare organisation's core activities, Sheridan (2003) believed that the work of healthcare professionals was subject to a continuous state of adaptation and learning and overwhelming tensions in terms of time, effort and unpredictability. As a consequence, Sheridan (2003) suggested that there was a need for healthcare professionals to simultaneously fulfil strategic criteria (such as organisational efficiency measures) and operational criteria (such as the tasks associated with getting the job done). The result, according to Sheridan (2003), was that from a task perspective, clinicians became orientated towards the satisfaction of job goals and, as long as the outcome did not result in a clinically instigated unsafe act, potential or minor errors were forgotten or even covered up, a view with which Leape (1994) and Reason (1997, 2000a) concurred. Leape (2000), as did Fischbacher-Smith and Fischbacher-Smith (2009) and Vincent et al (2000), in particular noted that such working conditions in healthcare could threaten patient safety as "safe performance cannot be expected from workers who are sleep deprived, who work double or triple shifts or whose job designs involve multiple competing urgent priorities" (p726). Smith and Toft (2005) and Smith (2002c), drawing on Reason's 'latent conditions' (1987, 1990, 1997, 1998, 2000a, 2008) and Smith's 'pathways to vulnerability' (2000a and 2005) and the influence of organisational culture, believed that the extent of professional interaction and relationships, the adequacy of training and support processes and overt self belief were particularly influential in creating the conditions in which human error failures could occur, a view with which Parker and Lawton (2006) concurred. As has already been indicated, the significance of working conditions identified in the literature had a particular resonance with the author's decisions made in Chapter 2 and further emphasised the need to examine in the research study the behaviour of grassroots individuals within the environment in which they worked.

Singer et al (2007) elaborated further regarding the working environment proposing that the degree to which a culture was safety oriented was a composition of organisational, unit and individual factors. Singer at al (2007) expanded stating that senior management's disposition towards patient safety,

the adequacy of resources and the overall emphasis on patient safety contributed to the organisational factors, whilst the unit factors were specifically concerned with the propensity within the immediate working environment to embrace patient safety and, finally, the orientation of the culture towards blame underpinned the third, individual, factor. Fischbacher-Smith and Fischbacher-Smith (2009), demonstrating a resonance with Smith (2005a) and Smith and Toft's(2005) work concerning management's error inducing limited knowledge and sensemaking covered in the previous chapter, took a more behaviouralist approach in proposing that it was both the extent and cognitive use of knowledge, sensemaking and communication that held the capacity to affect safety in clinical decision making. Furthermore, Fischbacher-Smith and Fischbacher-Smith (2009) refocused the debate on working conditions and highlighted particular factors within the 'latent conditions' within healthcare that exerted, they believed, a significant force on error propensity amongst healthcare professionals; the adequacy of the regulatory and training regime of healthcare professionals, the level of miscommunication between professionals, their patients and managers, the extent to which cultural changes resulted in shifts in rewards and task demands and the style of management.

However, it was Sheridan (2003) who recognised the personal consequences and associated tensions that were felt by healthcare professionals. Sheridan, (2003) believed that clinicians, in dealing with the physical and emotional needs of their patients, were conditioned in their education and practice to engender a personal responsibility for and a strong sense of duty towards their patients, a view with which Smith, R (1999) concurred, and stated that violations were divergent to such aims. Whilst the author's research findings, explored in Chapters 5 and 6, were consistent with Sheridan's views (2003), Vincent's arguments (2006) regarding the need for clinicians to balance patient care aspirations within the broader organisational perspective identified the difficulty of realising this in practice.

In judging the inevitable potential for 'active failures' at grassroots level and in the light of grassroots' limited opportunity to influence 'latent conditions', Reason (2008) appeared to build on the work of Vincent and Reason (1999)

and proposed an assessment for aiding healthcare professionals in establishing the level of risk in clinical situations. The 'Three Bucket' model, which was later utilised as a diagnostic tool for grassroots professionals in patient safety training (National Patient Safety Agency 2008), viewed the propensity for error to be a factor of the current state of the individual (or 'Self'), the context of the clinical situation (or 'Context') and the potential for error in the task (or 'Task'). In the healthcare context, 'Self' pertained to how a healthcare professional felt about their level of knowledge, skill, expertise, capacity to perform a task and general well being. In terms of 'Context' the individual considered the equipment, physical environment, workspace, the level of support and teamworking and organisation and management. Finally, in terms of 'Task' the individual reflected on their propensity for error in a task situation, the complexity and novelty of the task and the task process. Reason (2008) proposed that healthcare professionals were trained to utilise a simple mental numerical system of grading the probability of error in each 'bucket'(from 1 to 3, 3 being the highest probability), aggregating the scores to calculate the overall extent of the risk (with 9 being the highest risk and up to 5 being more routine). Reason's view (2008) was that the model would enable those who were closest to the error potential within a healthcare's system, yet not able to influence systemic changes, to almost intuitively better gauge and avoid error situations. Aspects of Reason's 'Three Bucket Model' (2008) were found by the author in developing the contribution to patient safety knowledge. However, as the author will explain in Chapter 9, the knowledge regarding the behaviour of grassroots health professionals derived from the research study associated with this thesis took a more holistic perspective of the individual within the workplace.

In terms of organisational learning, Sheridan (2003) proposed that when errors did occur, learning was often locally isolated so that systemic reviews were limited, a finding that has some cohesion with Elliott and Smith's review of experience in the UK soccer industry (2006). Fischbacher-Smith and Fischbacher-Smith were particularly critical of the lack of learning through early warning signals (2009) and against competing priorities but completely convinced that learning, generally, and particularly through early warning

signals, was essential for patient safety improvements. The discussion in the previous chapter is testimony to Smith's view (2005a), and that of Smith and Elliott (2007) and Smith and Toft (2005), that the inability to learn from incidents was widespread in organisations but he emphasised that in healthcare the organisational challenges were significant and three-fold. In the first instance the diversity and divisional nature of healthcare made the dissemination of learning difficult to successfully achieve. In the second instance, patient confidentiality could create a barrier to learning and, in the third instance, limited systematic reporting of incidents left learning incomplete (although as Section 3.2 will evidence, there has been some progress in this area in the UK).

At a more individual level, Toft and Reynolds (1994) suggested that individuals within organisations demonstrated a tendency to underestimate the probability and extent of injury related to adverse events and so were passive learners. Smith and Toft (2005) argued that an individual's ability to learn after an adverse incident was socially constructed and rooted in individual insight and 'sensemaking' (Weick 1988) and therefore had inherent limitations. Drawing on the concept of denial, which was discussed in the previous chapter (Augustine 1995, Hickman and Crandall 1997, Mitroff 1988, Mitroff and Anagnos 2001, Mitroff and Pauchant 1992, Mitroff et al 1994, Register and Larkin 2002, Richardson 1995, Smith 1990, 1999, Smith and Elliott 2000, Turner 1978, 1994, Watkins and Bazerman 2003), Smith and Toft (2005) proposed that it created a perception of invulnerability and approach that was psychologically defensive, both of which were impediments to effective learning. Furthermore, Smith and Toft (2005) proposed that management in particular suffered from a lack of contextual learning in that learning was replicated from elsewhere rather than being sensitised to local conditions.

Contextually, Smith and Toft (2005) identified learning as a particularly significant issue in healthcare due to the level of 'misbehaviour ' (Ackroyd and Thomspon 1999) and the pressures on individuals to cover mistakes, a view which was endorsed by Sheridan (2003). Although Smith and Toft (2005) were convinced that misbehaviour was widespread in healthcare, they considered that further research was needed in order to develop the understanding of the

relationship between misbehaviour and adverse events. Whilst the research associated with this thesis does not specifically focus on 'misbehaviour, it was designed to explore the behaviour that underpinned adverse events. In terms of the concealment of mistakes, Sheridan (2003), as did Fischbacher-Smith and Fischbacher-Smith (2009) and Leape (1994), stated that this in part occurred because when errors happened in healthcare there was a propensity to blame individuals and pursue them through negligence claims. In 2008, Reason was still claiming that, in healthcare, professionals perceived that error equated to personal incompetence. Several authors (Leape 1994, Sheridan 2003, Smith, R 1999) suggested that this affected the behaviour of healthcare professionals, for example, "medical students learn quickly that showing confidence is part of the culture of their education and practice" (Sheridan 2003 p385) and "... doctors, like pilots, tend to overestimate their ability to function flawlessly under adverse conditions such as under the pressures of time, fatigue or high anxiety" (Leape 2000 p 725). However, Sheridan (2003) also argued that working conditions such as the pressure of work, professional responsibility and lack of underlying support mechanisms could result in clinicians lacking the confidence or opportunity to reflect. Leape (2000), broadly concurred, arguing that systemic improvements must go hand in hand with improvements in the working conditions of healthcare professionals - "Creating a culture of safety requires attention not only to the design of our tasks and processes but to the conditions under which we work – hours, schedules and workloads; how we interact with one another; and perhaps most importantly, how we train every member of the healthcare team to participate in the quest for safer patient care." (Leape 2000 pp725-726). Leape was also a key proponent of the elimination of a blame culture (1994) as were Leape and Berwick (2005 and Finlayson (2002) who highlighted the dominance of blame in the NHS and identified that there should be a balance between establishing ownership for mistakes and a need to support those involved during the aftermath of an incident. The observations of Sheridan (2003) and Leape (2000) have a particular resonance with the findings of the study associated with this thesis as will be shown in Chapters 5, 6, 7 and 8. However, whilst Sheridan (2003) and Leape (2000) identify the conditions of work as being synonymous with a safety culture, the author will assert, in

Chapter 8, that what underpins effective patient safety is an effective organisational climate as outlined in the previous chapter.
As outlined at the outset of this section, this chapter is focused on examining both human error in healthcare and patient safety. The review so far has concentrated on looking more specifically at the literature concerned with human error in healthcare, identifying contributory factors as being the nature of healthcare and healthcare professionals, the behaviour of healthcare professionals and inadequacies in the approach to learning. The next section will explore the synthesis between human error in healthcare and smouldering crises.

3.1.2 The Synthesis with the Concept of Smouldering Crises

In the context of this thesis, Chapter 2 presented a definition of organisational crisis as being a high impact incident whose genesis lay in problems within the organisation's systems which progressed, unexpectedly, over time and caused damages to the resources, reputation and stakeholders of an organisation. The contributory factors in the precipitation of these incidents appeared to be organisational complexity and the organisation's systems and practices but predominantly human error. Chapter 2 also explored the anatomy of crisis situations and, utilising Smith's forensic examination of the incubatory progress of a crisis (2005a), showed how, at successive 'points of inflection' problems, which originated in the organisation's systems, escalated. Within the context of management's responsibility for order and control, Smith (2005a) emphasised the significant role that grassroots management played at these points since the quality of operational decision making and management's response would shape the destiny of a crisis by either arresting its development or exacerbating the situation. It was the view of Smith and Toft (2005) that the capacity to successfully stem systemic problems was a product of management's efficacy in terms of information and knowledge and the robustness of the organisation's defensive systems.

In the previous section, the author has discussed predisposition to error within healthcare in the UK. It has been shown that healthcare is a complex

environment and a number of factors have contributed to this. There was evidence that the service was disparate and delivered through a wide network of organisations each of which had its own distinctive management style and cultural underpinning which made management control and effective communications across the service challenging, resources were limited and, finally, patients were heterogeneous in both their nature and care issues and often arrived at the service in a perilous condition (Leape 1994, Leape and Berwick 2005, Reason 2008, Sheridan 2003, Smith 2002a 2002b, 2005, Smith and Toft 2005, Vincent 2006 and Walshe 1999). Within this complexity, healthcare professionals attempted to carry out their work in an error-free manner but there were indications of how this intent was compromised. In the first instance, in attempting to satisfy the strategic and operational demands of their role, healthcare professionals focused on the satisfaction of job goals and were less sensitised to error issues (Sheridan 2003). In the second instance, and within the demanding healthcare environment, it appeared that, at an individual level, complexity in relationships, inadequacies in training and the propensity for overt self belief amongst healthcare professionals were contributory factors in incubating error potential (Smith and Toft 2005). It appeared that the potential error risk was seen as being a composite of the status of the individual and the prospect of risk in any given clinical situation (Reason 2008). However, the situation regarding behaviour was exacerbated with what appeared to be a limited approach to learning from errors in the sector either through the pressure of work (Finlayson 2002, Leape 2000, Sheridan 2003), denial (Smith and Toft 2005, Toft and Reynolds 1994), an isolated approach to learning (Sheridan 2003), lack of systematic reporting (Smith 2005a, Smith and Elliott 2007, Smith and Toft 2005) and a concealment of errors due to the pervasive blame culture (Leape 1994, Reason 2008, R Smith 1999, Sheridan 2003). On this latter point, Rosenthal (1999), as did Esmail (2006), elucidated further that the factor of uncertainty, in terms of self knowledge and medical knowledge itself meant that a healthcare professional's work was a 'process of discovery' and that, as a result, this sat uncomfortably with error and blame. The consequences of this were that errors within the organisation's systems and practices occurred (Department of Health 2000a,

Fischbacher-Smith and Fischbacher-Smith 2009) and were to be expected (Donaldson 1999).

At one level, Smith and Toft (2005) believed that 'misbehaviour' (Ackroyd and Thompson 1999) was very significant because of the reverence and etiquette evident in the strong hierarchical relationships and there were some high profile, well publicised and damaging cases of this, for example, the cases of Nurse Beverley Allitt and GP Harold Shipman. However, more specifically for this thesis given the author's area of interest outlined in Chapter 1, some error incidents achieved a lower profile but were still damaging to those involved. Vincent (2006) used the 'Predictive Human Error Analysis' technique to classify them into three broad areas; errors of omission (forgetting to do things), errors of commission (doing the wrong thing) and extraneous errors (doing something that is unnecessary).

The Department of Health (2000a) provided some specific cases such as the administration of incorrect medicine dosage, for example, when a hospital patient was mistakenly administered antibiotic tablets incorrectly through an intravenous drip and when children received double the amount of medication prior to x-ray. Other incidents cited by the Department of Health (2000a) were connected with the technical procedures in the delivery of the service such as the cases of a number of women who, despite earlier sterilisations, became pregnant because a surgeon had placed the sterilisation clips incorrectly. There were also failures in terms of communications such as the case of a patient with a history of thrombosis, undergoing an exploratory operation, prior to which the details of the thrombosis were recorded on the admission form but not transferred to the operation form. The patient was discharged without the necessary anticoagulants and later developed a blood clot on his lungs. In each of these cases the patients survived and measures were taken locally to address the issues concerned (Department of Health 2000a).

Whilst these incidents appeared isolated, there was also evidence of recurring errors such as errors in the administration of spinal injections and negligent harm in obstetrics and gynaecology (Department of Health 2000a) and

examples of serious and extensive systemic error such as the cases of children's heart surgery provision at Bristol Royal Infirmary (Department of 2001b) and of emergency admissions at Mid Staffordshire NHS Foundation Trust (Healthcare Commission 2009).

The report of the public inquiry into children's heart surgery provision at the Bristol Royal Infirmary (Department of Health 2001b) identified that inadequate resources, poor structural organisation, flawed communications, ineffective leadership and teamworking were responsible for poor paediatric cardiac surgery and the ensuing high mortality rates. The report found that these circumstances had perpetuated because control of the care of these vulnerable patients lay in the hands of few. The Inquiry into the care of patients at the Mid Staffordshire NHS Foundation Trust, conducted by Robert Frances QC, has, so far, found that patients were routinely neglected by the organisation and those within it due to a preoccupation with cost cutting, targets and processes (The Mid Staffordshire NHS Foundation Trust Inquiry 2010). The report attributed compromises in patient safety to a chronic shortage of staff, which had existed for a long period of time, found that morale at the Trust was low and that staff either felt ignored when they raised concerns and issues or were prevented from speaking out for fear of bullying. The Inquiry judged that the Trust's board was disconnected from what was actually happening in the hospital. The cases of Bristol and Mid Staffordshire, which occurred a decade apart, serve to illustrate that despite the focus on patient safety both in academic and practical literature, recurring serious patient safety breaches which smoulder in the systems and processes of healthcare organisations in the UK remain a significant issue. Moreover, it further validates the need to be sensitised to and embrace the knowledge of grassroots professionals which underpins this thesis.

All of these incidents were unexpected and had originated over time from a coming together of 'active failures' and 'latent conditions' (Reason 1987, 1990, 1997, 1998, 2000a, 2008, Vincent and Reason 1999) to create a 'pathway to vulnerability' (Smith 2000a, 2005b) within the organisation's systems and had produced, through damage to the organisation's resources, reputation and stakeholders, a high impact.

The author's proposition is that incidents such as these meet the criteria for smouldering crises defined in Chapter 2 and are, thus, evidence of smouldering crises within healthcare, a view which is consistent with Smith's (2005a) and Smith and Toft's (2005) perspective. These emerging incidents, which compromise the safety of patients, are embedded within the systems and processes by which healthcare is delivered (West 2006) and are at the behest of management who are responsible for creating and controlling them (Donaldson 1999, Smith and Toft 2005).

From a position where the factors contributing to human error in healthcare had been reviewed through an examination of the literature concerned with the error in medicine, this section has explored the synthesis between human error in healthcare and smouldering crises. Utilising the principles that underpin knowledge regarding error in medicine and citing case examples from the healthcare sector, the author has shown that the errors that the healthcare professionals make in delivering patient care exhibited the characteristics of smouldering crisis situations, developed in the previous chapter, which are the focus of attention of this thesis. The next section will address how healthcare in the UK has attempted to better manage the risk of error in the delivery of patient care through the patient safety agenda.

3.2 The Rise of Patient Safety in UK Healthcare

"A well-led, well-managed healthcare organisation will seek to minimize (patient safety) incidents by preventing their occurrence and acting swiftly to limit their adverse consequences when they do occur" (Donaldson 1999 p219). This section will review the evolution of patient safety in UK healthcare. Since the beginning of this century there has been a general movement to address the issue of patient safety in the UK healthcare sector as a result there has been a plethora of papers and initiatives authored by public officials and under the auspices of patient safety research (House of Commons 2009). For the purposes of synergy with both the thesis and the previous chapter and focus, this section will concentrate on, what are for this thesis, the key aspects of the

patient safety literature, namely literature which considers adverse events where systemic failure appears to be the origins.

Whilst Smith (2002c) provided a useful summary of the early development of patient safety in the UK, a report by the House of Commons Parliamentary Health Committee on Patient Safety published in June 2009 presented a more contemporary audit (House of Commons 2009). Within the report a table, summarising what the Committee defined as the key patient safety documents and initiatives since 2000, is detailed and shown, with some minor adaptations, as Table 3.1 below.

2000	Chief Medical Officer's Expert Group, *An Organisation with a Memory*—sets a new direction for patient safety in the NHS
April 2001	Department of Health, *Building a Safer NHS for Patients: implementing An Organisation with a Memory*—makes the NHS the first healthcare system in the world with a patient safety strategy
July 2001	National Patient Safety Agency established
2004	Health Foundation establishes Safer Patients Initiative in four UK hospitals, including Luton and Dunstable in England
2005-6	Series of reports assessing progress: National Audit Office, *A Safer Place for Patients* Public Accounts Committee, *A Safer Place for Patients* Department of Health, *Safety First: A report for patients, clinicians and healthcare managers*
2008	Lord Darzi, *High quality care for all: NHS Next Stage Review Final Report*

Table 3.1 Summary of Key Patient Safety Documents and Initiatives Since 2000 (Adapted from The House of Commons Parliamentary Health Committee Report on Patient Safety June 2009, House of Commons 2009)

Organisation with a Memory (Department of Health 2000a) was the first focused review of patient safety in the UK healthcare sector although there were similar initiatives happening globally through bodies such as The Agency for Healthcare Research and Quality (US), The Institute for Healthcare Improvement (US), The Institute for Safe Medication Practices (US), The Joint Commission on the Accreditation of Healthcare Organisations (US) and The Australian Patient Safety Foundation (Australia).

Drawing on the work of noted academics and clinicians in the fields of risk and crisis management, human error and patient safety (for example Leape, Reason, Smith, Turner, Vincent, Weick), learning from other safety-critical fields such as civil aviation, within the context of an increasingly litigious society (Fischbacher and Fischbacher 2009) and reports of 400 deaths or serious injuries as a result of medical devices, 10,000 serious adverse reactions to drugs and a litigation bill of £400m, *Organisation with a Memory* acknowledged the fact that whilst there was evidence of 'active failures', there was also evidence of the contributory role of 'latent' failures' (Department of Health 2000a pix). As the previous chapter explained, what this meant was that patients were more likely to be harmed by failures in the organisations' systems rather than the actions of individuals. Consistent with the literature outlined in Section 3.1, the report, as did Fischbacher-Smith and Fischbacher-Smith (2009), advocated that there should be a move away from blaming and punishing individuals and a refocusing on aspects of the care system that created systemic errors. However, to achieve this outcome, organisations in healthcare needed to encourage openness in the reporting of incidents so that lessons could be better learned from systemic errors (Department of Health 2000a).

Whilst there were some adverse incident reporting mechanisms being used (for example the Yellow Card Scheme, reports to the Medical Devices Agency, the NHS complaints system, the National Confidential Inquiries line and litigation reviews), there was no formal and universal method of recording incidents and there was much concern that for every major injury there were a greater number of minor injuries (1:29) and an even greater number of near misses (1:300), the so-called Heinrich Ratio (Department of Health 2000a).

Organisation with a Memory (Department of Health 2000a) aimed to persuade the policy makers to introduce a mandatory reporting scheme for adverse events and specified near misses so that universal learning could be gained from systemic failures and, in so doing, patient safety would be improved. Specifically *Organisation with a Memory* reported the following ten recommendations for patient safety in the UK healthcare sector. In the first instance, a mandatory reporting scheme for adverse healthcare events and

specified near misses should be introduced. In the second instance, a scheme for confidential reporting by staff of adverse events and near misses should also be introduced. In the third instance, a reporting and questioning culture in the NHS was to be encouraged. In the fourth instance, a single overall system for the analysis and dissemination of learning from adverse events and near misses in healthcare should be introduced. In the fifth instance, existing sources of information regarding adverse events should be better exploited. In the sixth instance, the quality and relevance of adverse event investigations and inquiries should to be improved. In the seventh instance, a research programme into adverse events in healthcare should be instigated. In the eighth instance, the (new) NHS information systems were to be better exploited so that staff could access learning from adverse events and near misses. In the ninth instance, an action oriented approach was recommended so that learning from adverse events and near misses was implemented quickly and consistently across the sector. Finally, the specific categories of serious and recurring adverse events needed to be identified.

In 2001, and influenced by the findings of *Organisation with a Memory*, the US study *To Err is Human: Building a Safer Health System* (Kohn et al 1999) and the principles of clinical governance, the Department of Health published *Building a safer NHS for patients: Implementing 'An Organisation with a Memory' (*Department of Health 2001c) which set out how the recommendations within *Organisation with a Memory* (Department of Health 2000a) were to be implemented and specified patient safety targets.

In acknowledging the inevitability of patient safety incidents in a highly complex, risk-prone sector, the report (Department of Health 2001c) made key recommendations in two specific areas; to record and learn and to create the right culture. Accordingly, the key objective was to establish a universal reporting system so that learning from errors and adverse events could be achieved. This reporting system would see a rationalisation of the existing systems spread across the sector, be endorsed through an open and blame-free culture and focus on identifying the root causes of systemic error. It was also recommended that the learning that was envisaged from the reporting

system should be supported by a programme of patient safety research. The newly-established and independent National Patient Safety Agency (NPSA) would administer the reporting system within their remit of coordinating the effort throughout the country to report and more importantly to learn from mistakes and problems that affected patients (Williams and Osborne 2004). However, whilst the report identified the creation of a universal reporting and learning system as a key objective, there was evidence that the agenda for patient safety was broadening, for example, to embrace partnerships with outside agencies such as professional associations, suppliers and patients not initially specified by *Organisation with a Memory* (Department of Health 2001c).

Building a safer NHS for patients: Implementing 'An Organisation with a Memory' (Department of Health 2001c) also specified patient safety targets for what had been identified as common adverse events; by the end of 2001, zero deaths/paralysation by maladministered spinal injections, by 2002, zero hanging suicides by mental health patients and by 2005, the number of harm cases in obstetrics and gynaecology reduced by 25% and the number of serious errors in the use of prescribed drugs reduced by 25%. However, in 2005, the Department of Health reported these targets had not been met although some progress had been made (Department of Health 2005b)

By 2004, the Healthcare Foundation, an independent charity which works through research and collaboration at all levels within the sector to improve the quality of healthcare, had established the first phase of its *Safer Patients Initiative*. Under the banner of 'Identify, Innovate, Demonstrate, Encourage', the Foundations' *Safer Patients Initiative* was the first major improvement programme of healthcare interventions to address patient safety in the UK. Working locally with 4 hospitals during the 2004-2006 period and then a further 20 between 2006 and 2008, the Foundation had ambitions to bring about universal organisational systemic change through improving the reliability of specific processes within the delivery of healthcare including general ward care, critical care, perioperative care, pharmaceuticals management and leadership (Health Foundation 2011). Following a review of the two phases of the programme, the Foundation concluded that the initiative had succeeded in

raising awareness of and instigating action in patient safety and engaging senior managers in the drive to improve safety but had not delivered an impact at an organisational level. The report concluded that to achieve this overarching ambition would need a broader approach with the appropriate level of resources and time in order to instigate change at all levels of healthcare in the UK (Benning et al 2011a 2011b, The Health Foundation 2011).

The year of 2004 also saw the publication of the NPSA's *Seven steps to patient safety*. This report, building on recommendations from reports and the findings from studies in the UK, USA, Australia, New Zealand and Denmark, specified the actions that healthcare organisations, in particular the NHS, needed to take in order ensure patients' safety. With ambitions to help staff meet clinical governance, risk management and control assurance targets, *Seven steps to patient safety* was aimed primarily at staff, including senior leadership teams, with responsibilities for clinical governance and risk management although was advocated to be of use to staff in frontline positions. The *Seven steps to patient safety* were identified as; building a safety culture, leading and supporting staff, integrating risk management activity, promoting reporting, involving and communicating with patients and the public, learning and sharing safety lessons and implementing solutions to prevent harm (National Patient Safety Agency 2004). It is not the author's intention to explain or review every last aspect of each step, rather the approach will be to focus on critical aspects of the steps that are pertinent to this thesis.

Building on the work of Reason and Vincent outlined earlier in this chapter, *Seven steps to patient safety* (National Patient Safety Agency 2004) stressed the correlation between a safety aware, open and fair culture and improved levels of patient safety. One of the key benefits of this, according to the authors of *Seven steps to patient safety,* Woodward, Randall, Hoey and Bishop, was that with an aware, open and fair culture came a greater propensity for regular reporting which in turn created the opportunity to identify critical incident clusters and thus patient safety issue themes. Emphasising that culture was a difficult and time-consuming activity for leaders of organisations, *Seven steps to patient safety* offered practical advice regarding the promotion, measurement

and achievement of a safety culture and included a recommendation for the use of the now universally adopted 'Manchester Patient Safety Assessment Tool' for assessing the development of a safety culture through the exploration of the attitudes, values and behaviours evident in working practices (National Patient Safety Agency 2011).

Consistent with strategic literature (for example Doyle and Stern 2006, Lynch 2009) regarding the achievement of organisational goals and a united orientation, *Seven steps to patient safety* proposed that creating a safety culture and adopting an orientation to deliver improved patient safety required leaders to lead and command the respect and co-operation of those in the organisation. The report placed responsibility for the achievement of improved patient safety through the delivery of each of the 'Seven Steps' firmly at the feet of senior personnel within healthcare organisations and provided a tactical prescription of actions that would enable senior managers and executives to achieve (National Patient Safety Agency 2004).

Reason's concept of 'latent conditions' (1987, 1997, 1998, 2000a, 2008), that is recurring systemic issues within the organisation's environment which provoked patient safety incidents, was used in *Seven steps to patient safety* to emphasise the gains that could be achieved by systematically learning and proactively managing the risk of these conditions at an organisational level. The report advocated that risk be elevated to board level above a supporting and integrated network of risk staff, some of whom would be affiliated to the NPSA, and that widely recognised risk assessment infrastructure utilising models such as 'Failure Modes and Effects Analysis' be deployed in order to identify potential patient safety risks before they were enacted.

The main thrust of the move to promote reporting in *Seven steps to patient safety* was the National Reporting and Learning Service (NRLS), a recording and reporting system driven out of the initial recommendations of *Organisation with a Memory* and designed to provide an opportunity for universal learning from adverse events and near misses. Supporting the need to create an open and fair safety culture, reporting of incidents was anonymised and confidential,

as was the data emanating from the NRLS. In preparing the groundwork for the NRLS, the NPSA found a great diversity in the terms used to describe adverse events and near misses. The report, as did Donaldson (1999), set out a "lexicon" of terms that were used to describe such incidents and was critical of the suggestion of individual causality contained in some of the terms, for example error and mistake (National Patient Safety Agency 2004 p97). The report proposed that the term 'patient safety incident' replaced adverse incident or event, clinical incident or error, medical error or mistake and, most significantly, near miss since the NPSA was interested in learning from all incidents, potential or otherwise (National Patient Safety Agency 2004). Furthermore, a grading system was introduced, ranging from zero to catastrophic, to co-exist with the term 'patient safety incident' in order to indicate the seriousness of the incident. In 2009 the House of Commons' Health Committee Report on Patient Safety stated that the NPSA defined a patient safety incident as "any unintended or unexpected incident [due to medical management, rather than the natural course of the patient's original illness or condition] which could have [led] or did lead to harm for one or more patients receiving NHS-funded healthcare" (House of Commons 2009).

The reporting of all serious patient safety incidents to the Care Quality Commission via the NRLS became mandatory from 1 April 2010 and, since the NRLS was established, over four million incident reports have been submitted by healthcare staff (National Patient Safety Agency 2011). The NRLS has not been without its problems and although there was criticism when delivery of a fully operational system was delayed and exceeded its budget (Vincent 2007, Vincent et al 2008), there was an acknowledgement that enacting the system was more complex than the concept had originally suggested (House of Commons 2009).

Based on the need for Chief Executives of NHS organisations to comply with The Health and Social Care Act 2001 and, since it was recommended that patient involvement improved patient care and safety (Fischbacher-Smith and Fischbacher-Smith 2009, Department of Health 2001c), *Seven steps to patient*

safety proposed that patients were involved both at a strategic level and in terms of their own care, even when incidents occurred.

In recognising that the underlying reasons for patient safety incidents were predominantly systemic and therefore extended beyond the healthcare employee, *Seven steps to patient safety* advocated the use of Root Cause Analysis (RCA), pioneered by authors such as Rasmussen (1983) and Reason (2000a), to properly establish the causal route to the incident and enable learning to occur (although the report also advocated the use of the Incident Decision Tree (Reason 1997) in order to identify whether systems failure was the cause of the error). The benefits of universally adopting such a tool were argued as being that a consistent and uniform approach would be taken to each incident, that the focus would be on the systemic origins of the incident, that the process would engage staff and patients and that change would follow the identification of the causal factors. However, RCA was not advocated for all patient safety incidents rather the expectation was that it would be utilised in incidents concerning unexpected death or permanent injury, where acute care was needed as a result of the incident and those which triggered external investigations such as complaints, criminal investigations or the coroner's court. It was of interest to the author, although not surprising, that the methodology underlying RCA bore simiarlities to the Critical Incident Technique which was investigated as part of this thesis' research methodology considerations. Whilst the author did not fully consider RCA as a methodology for the research study associated with this thesis, as Chapter 4 will detail, the underlying rationale for the choice of methodology was a desire to establish the behaviours underlying workplace actions in healthcare in order to explore the notion of smouldering crises and their respective management.

The final step in the *Seven steps to patient safety* was centred on the need to learn from incidents and to translate this learning into universal and sustainable practices through a patient safety culture and the systems, processes and policies of healthcare in the UK. The NPSA performed a central role in this by identifying incident themes through the NRLS, forming partnerships with healthcare agencies and the Department of Health to create high level solutions

and establishing programmes of research including reports on medical error in 2005. By way of illustration, the NPSA published the first National Patient Safety Observatory Report in 2005, entitled *Building a Memory:Preventing Harm, Reducing Risks and Improving Patient Safety* (National Patient Safety Agency 2005) in which Vincent et al's work (1998) was used to identify nine factors which contributed to patient safety incidents; the patient, the task, the team and social, the work and environmental, communication, education and training, equipment and resource, medication and, finally, organisational and strategic. As it will be shown, these findings demonstrate a particular resonance within the findings of the research study undertaken for this thesis and presented in Chapters 5, 6 and 7.

However the path of the body responsible for patient safety in the UK, the National Patient Safety Agency, has not been smooth.

There have been structural issues; the Government's 2005 review of arm's-length bodies allocated additional responsibilities for the management of the National Clinical Assessment Authority, NHS Estates (hospital food, cleanliness and safe hospital design), National Confidential Enquiries and the National Research Ethics Service to the agency (Department of Health 2004) and the newly formed coalition Government's examination of quangos proposed that the responsibilities of the National Patient Safety Agency would pass to the new NHS Commissioning Board (The Official Site of the British Prime Minister's Office 2011).

More notably there have been issues regarding efficacy and substance. Precipitated by a lack of progress generally and specifically concerning the time and budgetary concerns regarding the NRLS, further reviews were undertaken by the National Audit Office, the Committee of Public Accounts and the Department of Health in 2005 and 2006 (Department of Health 2005b, House of Commons 2006, National Audit Office 2005,). The Department of Health's report (2005b) was particularly critical of the development of patient safety under the auspices of the NPSA, as were Baba-Akbari Sari et al (2006) and Kmietowicz (2007). The Department of Health (2005b) argued that patient

safety was not given the same priority as other major issues in healthcare such as waiting times and funding and the data collected via the NRLS was not being used effectively. The result was a change of leadership at the NPSA and a refocused agenda which included the need to scrutinise the NRLS in order to make reporting easier and ensure that learning was expedited across the NHS and outsourcing of the development of technical and organisational solutions for patient safety issues to other NHS organisations rather than handling them in-house (Guardian 2011).

Following Lord Darzi's NHS Next Stage Review (Department of Health 2008), the NPSA was recognised as the key body to drive forward patient safety in the UK and tasked with a number of key initiatives. In the first instance, the NPSA was to work with partners to develop a profile of Never Events, these were patient safety incidents which seriously harmed patients and were of significant concern to the NHS and the public yet were entirely preventable given the knowledge that was available. In the second instance, the NPSA was charged with driving safety improvement across the UK healthcare system by ensuring that successful safety initiatives were rolled out across the NHS (Department of Health 2008).

However, the House of Commons Health Committee's report into Patient Safety (House of Commons 2009) remained unconvinced by the progress that had been made regarding patient safety in the UK healthcare sector (a similar finding concerning progress in the UK was to be found in the Committee's Report in 2006 and in the US in Leape and Berwick's paper of 2005. The Committee, as were Boaden (2006) and Fischbacher-Smith and Fischbacher-Smith (2009), were critical of the adequacy of patient safety data, particularly on the grounds of the high level of underreporting, the persistency of a person centred 'blame culture' and, using examples such as the Mid Staffordshire NHS Foundation Trust case, stated that "there has been insufficient progress in making services safer .... there are sufficient deficiencies in current policy" (House of Commons 2009 p3). Whilst Baba-Akbari Sari et al (2006) and Walsh and Anthony (2007) were particularly vocal about the inefficacy and lack of discernable impacts regarding the NRLS data, the House of Commons Health

Committee's report drew particular attention to the need for the NPSA to gather qualitative data using models such as RCA through the NRLS, particularly in terms of extreme incidents where death or serious injury was present. Furthermore, where learning was available, the report asserted that it was not readily accepted by frontline staff because of the autocratic manner of communication and a cultural reluctance to accept that incidents in patient care were avoidable. The report, as did, Reason (2008), recommended greater involvement by frontline clinicians in the development of patient safety initiatives and more patient safety focused training which was interdisciplinary and was significantly critical of the adverse impact that inadequate staffing levels had on patient safety. Despite legislative direction and the NPSA's desire to engender patient safety into the leaders of healthcare organisations around the UK, the House of Commons Health Committee report (House of Commons 2009) reiterated the need to prioritise patient safety amongst managers and Boards, a view with which Fischbacher-Smith and Fischbacher-Smith (2009) concurred arguing that organisational learning needed to be better embraced in the very fabric of the healthcare organisations if patient safety improvements were to be realised. The report concluded by stating that "Government policy has too often given the impression that there are priorities, notably hitting targets (particularly waiting lists and Accident and Emergency waiting), achieving financial balance ..... which are more important than patient safety. All Government policy in respect of the NHS must be predicated on the principle that the first priority, always and without exception, is to ensure that patients do not suffer avoidable harm" (House of Commons2009 p7). However, whilst acknowledging the need for further improvement in terms of patient safety, the independent regulator for healthcare, the Quality Care Commission, argued that, consistent with Reason's 'Swiss Cheese Model', vigilance with regard to patient safety was not a transient issue for organisations and needed constant development (House of Commons 2009). Furthermore, although not underplaying the importance of serious patient safety incidents nor the need to fully explore them, advocated that, synonymous with smouldering crises, these were potentially signals for more significant failings in the organisation (House of Commons 2009).

This section has been concerned with how healthcare in the UK has attempted to better manage the risk of error in the delivery of patient care through the patient safety agenda. There is clear evidence that since the turn of the century there has been an intent to improve patient safety in the UK through policy and operational changes. However, the movement to improve patient safety, has encountered criticism, not least because progress towards the safer delivery of patient care in the UK has been limited. Whilst early criticism focused on the delay in the delivery and the budgetary overspend of the NRLS and the poor dissemination of patient safety information, more recently attention has centred on the inadequacies in NRLS, the lack of success in reducing errors in medicine and eradicating the blame culture and the priority with which patient safety is viewed. The errors in medicine which are reminiscent of smouldering crises are typified by adverse patient safety incidents in healthcare. This section has shown that despite a significant programme of policy and operational change, progress has been limited in curbing the nature and incidence of these events. Whilst these observations have been instrumental in further directing the research study associated with this thesis, the author will argue in Chapters 8 and 9 that this thesis' contribution to knowledge also has a particular resonance with regard to patient safety.

3.3 Summary

Chapter 1 outlined how Aneurin Bevan launched the NHS, what is today the largest publicly funded healthcare organisation, on July 5 1948 underpinned by a philosophy of delivering healthcare to all which was free at the point of delivery and based on clinical need, not the ability to pay. The philosophy remains and directs Government aspirations to achieve the highest standards of excellence and professionalism, reflect the needs and preference of patients, work across organisational boundaries in the interests of patients, provide value for money for the taxpayer and be accountable to those it serves. However, since its inception the perennial challenges of managing funding and resources has occupied successive Governments, the current Government included, which has vowed to focus on outcomes rather than processes and improve patient choice, experience and safety. This latter point of patient safety is a

critical issue within the context chosen for this thesis since systemic human error in healthcare is viewed by academics and practitioners as one which is concerned with the safety of patients.

The knowledge base for the development of patient safety in the healthcare sector has been heavily influenced by the paradigm that systemic management failures underpin the 'latent conditions' within organisations which create the incidence of smouldering crises. In this sense, the author recognised a correlation with the management literature concerning smouldering crises discussed in the previous chapter and a movement away from apportioning blame at individual level. However, there were also distinctive observations made in the literature concerning error in healthcare regarding the nature of healthcare and healthcare professionals, the behaviour and well being of healthcare professionals and the efficacy of organisational learning through systemic reviews. In the first instance, organisational complexity, resourcing limitations, communications and control challenges and the perilous conditions of patients precipitated the propensity for error in healthcare. In the second instance, whilst the work of healthcare professionals was driven by the task, resources and capabilities, their working environment was difficult. This, when combined with the operational and individual challenges, created the conditions in which errors smouldered, a patient safety culture was inhibited and compromised the dutiful ambitions of healthcare professionals. In the third instance, this situation was sustained due to the limited learning which was a result of a diverse and divisional structure and culture, an inadequate approach to learning which saw the persistence of denial and a blame culture and patient confidentiality.

Despite the challenges of combating error prone conditions and in spite of an acknowledgement that complete error-free healthcare was not an aspiration, the healthcare sector in the UK, headed by the NHS, has taken action to improve the safety of its patients. Pioneered in the Chief Medical Officer's report *Organisation with a Memory,* a programme aimed at reducing patient safety incidents has been embarked upon. Led by the National Patient Safety Agency and including pilot schemes to test patient safety initiatives, a range of technical

instruments and significantly, the first reporting mechanism for patient safety incidents, the programme has experienced some success. However, a series of appraisals by public bodies, academics and researchers has been critical of the level and nature of progress and believed that further developments, possibly with more involvement from frontline staff, were required. Criticism centred on several factors. In the first instance, early criticism focused on the delay in the delivery and the budgetary overspend of the NRLS and the poor dissemination of patient safety information. In the second instance, the adequacy of the data produced by the NRLS was questioned, specifically the continued level of underreporting and the lack of qualitative data. In the third instance, it was argued that despite a programme of patient safety, there had been an insufficient reduction in errors and the blame culture remained. In the fourth instance, patient safety was still perceived to be a lower priority than resourcing and funding issues in healthcare.

The review of error in medicine and patient safety led the author to identify three limitations in the patient safety in healthcare literature. In the first instance, although the principles of management literature on smouldering crises supported the development of patient safety in healthcare, the behavioural issues concerning the contributory role of management perspective, knowledge and capabilities had not been explicitly and widely acknowledged. Thus, there was a case for proposing that patient safety in healthcare could be better managed if those who managed the organisation's systems and processes had more information which was used effectively. In the second instance, the working environment of a healthcare professional appeared to play a significant role in the precipitation of errors in patient safety and, whilst there was some knowledge regarding the healthcare professional at work, there was a case for exploring this further. In the third instance, whilst the movement to improve patient safety embraced in the UK healthcare sector had made progress, key limitations concerning the nature and quality of the information underpinning its continued development had been identified. The direct criticism was in the over emphasis on quantitative information at the expense of qualitative information. It is within the context of these limitations that the author placed her work.

Accordingly, this led the author to consider further the research methodology and the associated contribution to knowledge. Chapter 2 has already reasoned that, in order to address the identified limitations of management literature concerning management failures in smouldering crises situations, the research methodology would focus on investigating and exploring the behaviour in the workplace of those at grassroots level where there was the potential to cause a smouldering crisis through systemic human error. Since the research context is healthcare, it was the workplace behaviour of healthcare professionals that would be the focus of the study. Within the context of the limitations in the patient safety in healthcare literature, exploring, from a qualitative perspective, the behaviour of professionals in healthcare would provide a further area of contribution. This thesis will contribute to patient safety knowledge by providing more in-depth information to those who manage the 'latent conditions' in the organisation's systems and processes which propagate patient safety incidents. Thus, this thesis will also contribute to the debate regarding patient safety and in so doing, will enhance management knowledge in the prevention of management failures that lead to patient led smouldering crises in healthcare.

Chapter 4 Research Methodology

This chapter details with the methodological approach taken in this thesis within the context of the epistemological and ontological alternatives available. It goes on to discuss the application of critical theory to the research study underpinning this thesis. The relative merits of quantitative and qualitative data collection methods are considered within the context of the aim of the thesis. The chapter concludes by detailing an account of the research choices made and the methods used to collect and analyse the data for this thesis. To aid the reader, the flow and sequence of decisions is signposted at the end of each section in diagrammatical form.

Instrumental in the consideration of the research methodology are the observations made about existing literature, that of crisis management in Chapter 2 and patient safety in Chapter 3. Specifically, the author has noted that crisis management theory has gravitated towards high profile crises and is founded on and centric to the views of those at the top of organisations. As a consequence, although some knowledge concerning the behaviour of management in the systemic failures that lead to smouldering crisis situations has been developed, knowledge is limited in terms of the contributory behaviour of those at grassroots who were closer to the crisis incubation point. Within the healthcare context of this thesis, the author has asserted that adverse patient safety incidents exhibited the characteristics of smouldering crises and, whilst knowledge in the areas of error in medicine and patient safety regarding the management of such events has informed policy and practice, tangible progress has been limited. The author has argued that knowledge has been developed in a partial manner focusing on ‘hard’ issues at the expense of the development of a more ‘soft’ behavioural approach and that research, policy and practice would be better informed if this was partiality was addressed.

Thus the aim of this thesis is to develop a deeper understanding of the management of smouldering crises and patient safety in healthcare by examining how the effect of grassroots behaviour can potentially cause smouldering crises conditions. Therefore the research study associated with

this thesis was focused on investigating and exploring how and why individuals at grassroots level behave in the way they do.

4.1 Research Philosophy

According to Wilson (2010), epistemological and ontological perspectives were central to any researcher's work. It is, stated Wilson (2010), the nature and combination of these concepts which dictated the philosophical position of a researcher since collectively they drive how a researcher views the world, the people within it and the nature of scientific discovery. As a consequence, a researcher's philosophical position would influence the methodology, research strategy, analysis and interpretation of data. Thus it was necessary for the author to consider alternative research philosophies in order to identify her philosophical position since this would be pivotal to the choice of research methodology and the design of the research plan which would facilitate the achievement of the aim of this thesis. It is not the intention of the author to present an evaluation of every research philosophy considered but to centre the discussion on the issues that were important to the author when identifying her philosophical position.

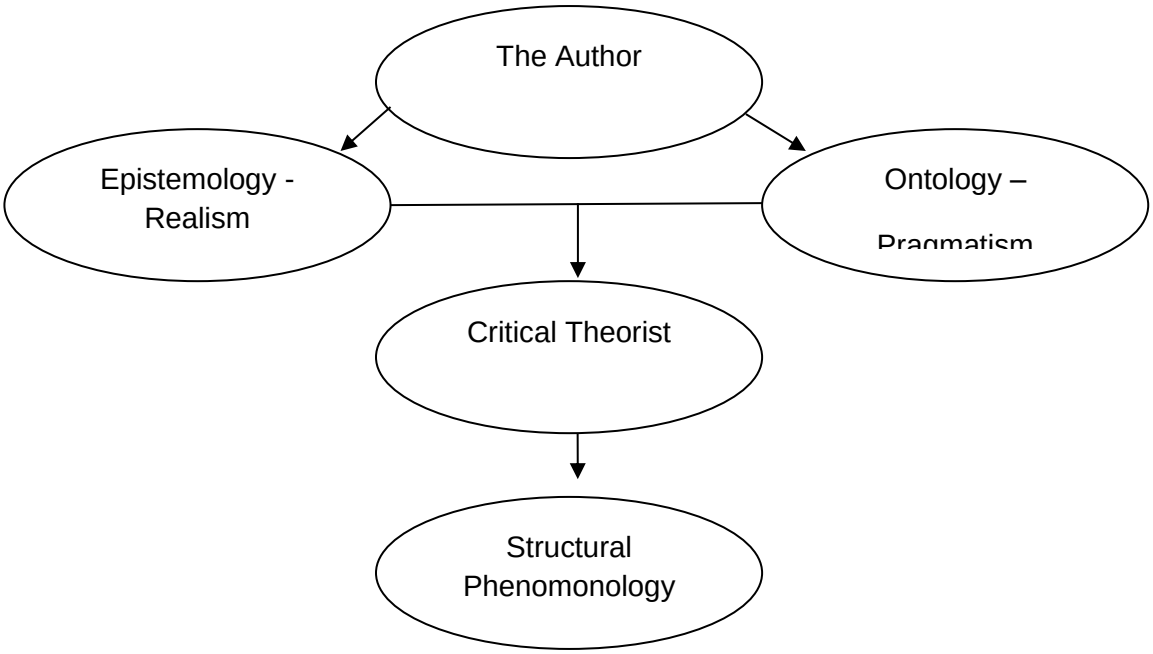
The author observed that a positivist philosophy advocated the notion that the research was able to be independent from what was being observed and, as a consequence, research could be undertaken objectively (Wilson 2010). According to Rorty (1979), the role of the research was to reflect what was being observed neutrally and without contamination. A researcher with a positivist orientation would approach studies concerning the social world in the same way that they would approach studies concerning the natural sciences (Johnson 2003) by, for example, focusing on facts, aiming to identify causality and formulating and testing hypotheses. According to Gill and Johnson (2002, 2010), a positivist philosophy would direct researchers to deductively prove theories by establishing cause and effect in a remote and value free manner. Wilson (2010) proposed that the research strategy of a positive researcher was likely to be quantitative as the research used measurement to validate testing and hypotheses. However, a positive philosophy was seen to take a limited

approach to matters such as human behaviour which could not be objectively observed and measured. The limited approach to acquiring behavioural knowledge was felt to be inhibiting by the author generally and specifically in the context of this study. The author was seeking to explore the behaviour of individuals in order to understand why potentially their actions may cause crises to smoulder within organisations. Consistent with the author's observations regarding the limitations of existing literature, the author believed that the aim of the research could not be achieved through measurement but required a deeper understanding of the reasons behind such action.

As the anti-thesis of positivism, a post modernist philosophy promoted the view that knowledge was socially constructed and highly subjective (Johnson 2003). According to Barry and Elmes (1997) and Kilduff and Mehra (1997) , it was impossible for a researcher to adopt a neutral observation of the world since by interpreting what was being observed the researcher was imposing meaning. A researcher with a post modernist philosophy would inductively develop theory by adopting methodologies which allowed the researcher to focus on meanings in order to develop an in-depth understanding of what was happening. The author felt that the emphasis on meaning and understanding within a post modernist philosophy overcame the main limitation of a positivist orientation and was more conducive to providing a successful foundation upon which to build the research strategy and design for this thesis. However, for some researchers with a post modernist orientation, such as interpretivists, investigations into issues concerned with the social world could only be explored if the research worked from within a setting. As the author felt that this was not an approach which was necessary in the context of this study, she sought to identify other philosophical views which addressed the issue of researcher involvement but retained the inductively based social constructivist approach of post modernism.

The author considered the philosophical position of critical theorism. Critical theorists maintained that the nature of science had twin dimensions, the empirical-analytical science of the noumenal world and historical-hermeneutical science of the apriori and phenomenal world and that reality involved an

understanding of both (Habermas 1974). Thus, the critical theorist's philosophy appeared to combine the ontological objectivism of positivism with the subjectivism of post modernism (Johnson 2003). Gill and Johnson (2010) highlighted that the aim of critical theorists was to explore contemporary pervading routines and their relative impact on the behaviours of the "disempowered" in organisational settings through structural phenomonology (p208). In Chapters 2 and 3, the author observed limitations in terms of the development of behavioural knowledge in both crisis management and patient safety literature. The author's intention in this thesis is to complement existing knowledge concerning the management of smouldering crises and patient safety by investigating and understanding the contribution of the behaviour of grassroots individuals. Furthermore, critical theorists believed that progression and the commitment to acquiring knowledge should be achieved through an inclusive, democratic process (Blaikie 1993). Gill and Johnson (2010) concurred, stressing the need to "emancipate people who are … disenfranchised in organisations …" (p208). As was evidenced in Chapter 2 and Chapter 3, knowledge regarding smouldering crises and patient safety has neglected to consider the views of grassroots individuals, developing as it has from an organisational perspective and, in terms of crisis management, through the empirical contributions of executives and senior managers within organisations. Thus, there appeared to be a cohesion between what the author aimed to achieve in this thesis and the mode of investigation of critical theorists. For these reasons, the author was orientated towards a critical theorist's philosophy and this would influence the research strategy and design.



4.2 Research Strategy

The previous section explained how the author arrived at the decision that her philosophical paradigm was that of a critical theorist and, in doing so, identified the emphasis on and value of taking a phenomological approach to the research strategy. Lee and Lings (2008) stated that a phenomological approach was justified when a research strategy aimed to study human experiences within the world in which those experiences were happening. Wilson (2010) suggested that an enquiry of a nature, which sought to elucidate meaning from narratives and stressed that reality was socially constructed, lent itself to qualitative research strategies. Thus, the author felt that a qualitatively designed phenomological strategy was entirely appropriate in view of the fact that the research aimed to explore the behaviour of grassroots individuals in their work setting in order to contribute to the level of understanding concerning the impact these behaviours had on smouldering crises and patient safety. However, in coming to this decision, quantitative strategies associated with deductive approaches to philosophy such as experiment and survey research were discounted due to their emphasis on measurement at the expense of generating insights into behaviour.

The author then reviewed a number of qualitative research strategies, all of which presented the opportunity of taking a phenomological approach to the research strategy, in order to identify the most relevant strategy for the research underpinning this thesis.

The author felt that the research aim did not require the collaborative approach of action research and participant observation strategies nor was there any benefit in taking the longitudinal and evolving nature of grounded theory. A case study strategy was, according to Yin (1994) though, more appropriate because case studies "investigate a contemporary phenomenon within its real-life context especially when the boundaries between phenomenon and context are not clearly evident" (p 13). Furthermore, Yin (1994) suggested that a case study strategy could be considered for critical, extreme or unique cases. The author considered whether the research aim could be achieved by building case studies around human error incidents in healthcare. However, the main reasons for rejecting this strategy were two-fold. Firstly, the author knew from previous research experience (which was outlined in Chapter 1), that gaining access to healthcare professionals involved in human error incidents was difficult and sometimes even prohibitive. Secondly, the gap in the literature identified in Chapters 2 and 3 was concerned with the incubation of smouldering crises. To focus specifically on human error incidents would inhibit the capacity to explore the broader impact of an individual's behaviour on incubating crises.

A critical incident technique (CIT) strategy also seemed, at the outset, appropriate. According to Flanagan (1954) CIT involved the exploration of a well defined and isolated critical incident from the reflections of those participating in it, in order to better understand the actions and motives of those involved. It was particularly helpful when understanding about an area was limited yet the study called for in-depth development of knowledge (Gremler 2004) because it facilitated the cognitive and behavioural understanding of the incident from the perspective of the individual (Chell 1998). There was evidence (for example Brant 1992, Kemppainen 2000, Kilroy 2006, Mallak etc al 2003) that CIT had been utilised as the research strategy in a number of healthcare studies.

Chell (1998) advocated that in order to identify critical incidents, it was necessary for a researcher to have a contextual understanding. Therefore, the author initiated secondary research in order to facilitate contextual knowledge and prepare the groundwork for subsequent primary research. In addition to Chell's specific comments regarding the operationalisation of CIT, the author felt that it was necessary to investigate the context of healthcare in the UK in order to formally familiarise herself with the setting of the research. Furthermore, as Chell suggested, this secondary data investigation and analysis was required to explore the nature and characteristics of human error incidents within healthcare in the UK as a precursor to identifying critical incidents. Aspects of the findings of the secondary data review have informed Chapters 1 and 3.

Although the author accessed a significant amount of secondary data in order to familiarise herself with the healthcare setting, The Department of Health's *Organisation with a Memory* (2000a) was a particularly helpful report since it collated secondary data from across healthcare in order to review the status of errors in the sector. The report identified a series of common errors which were maladministration of spinal injections, negligent harm in the field of obstetrics and gynaecology, errors in the use of prescribed drugs and negligent supervision of mental health patients. The Department of Health's subsequent document (*Building a Safer NHS: Implementing Organisation with a Memory* 2001c) outlined planned actions to address the incidence of errors generally and common errors in particular. In addition, the report also proposed a research programme, funded by the Department of Health and other major medical research funders. There was evidence that a major research programme was starting to address specific human error problems in healthcare.

Whilst this research programme validated and legitimised the subject of the thesis, it also caused the author to reflect on the research strategy underpinning this thesis. In the first instance, and notwithstanding the author's own reservations regarding the difficulties of approaching healthcare professionals involved in human error incidents, the Department of Health's research

programme might further hinder this study's access arrangements. In the second instance, the Department of Health's research would focus, to some degree, on the common error types that were identified in *Organisation with a Memory* (2000a). This was borne out in subsequent secondary research which identified research activity in these areas and caused the author to reconsider whether identifying common error incidents as critical incidents would be well received by the authorities who were responsible for granting access. Finally, and perhaps most importantly, the author reviewed all of this within the context of the gap in the literature identified in Chapters 2 and 3 and concluded that as the research underpinning this thesis was concerned with the incubation of smouldering crises in healthcare, focusing solely on human error incidents would inhibit the capacity to explore the broader impact of an individual's behaviour on incubating crises.

Thus, the author felt that it was not appropriate to utilise CIT in its purest sense, as in the work of Flanagan (1954). However, there was evidence in the work of Chell (1998) that the strategy had been adapted to specific research applications and the author remained convinced that whilst it did not seem appropriate to focus on critical incidents, broadening this strategy to a scenario based on working life worked well with the aim of the research underpinning this thesis. Thus, the literature on CIT as a strategy was helpful in providing more general guidance regarding the utilisation of a strategy which involved working life scenarios.

Determining the working life scenarios was challenging for the author. As outlined in Chapter 1, healthcare is a diverse and fragmented sector, yet it is necessary for distinctive and disparate elements to come together in order to care for patients. With the aim of the research being to explore how the behaviour of grassroots individuals created the potential to initiate a smouldering crisis, the author needed to consider which aspects of working life to focus upon. The literature suggested that a technique which utilised incidents worked best if the incident was well defined but the question was what and how to define. To specify an incident which focused on a particular element of healthcare would negate the opportunity to explore the behavioural

interactions between individuals in different elements of healthcare provision when caring for patients and this seemed from the review of literature in Chapter 3 to be an important issue. However, it was difficult to envisage being able to specify an incident that would provide the opportunity to explore the behavioural interactions between individuals across all elements of healthcare provision. So approaching the creation of incidents from an organisational perspective did not yield a decision regarding scenarios.

The author decided to take an alternative view and approach the creation of working life scenarios from the perspective of patient care. The author felt that, broadly speaking, patients needed the care of healthcare professionals in two ways. Patients needed acute care in emergency situations where there was some urgency in the provision or routine care in situations where provision could be planned. This appeared to be a better approach as it seemed to offer the author the opportunity to create scenarios which combined elements of healthcare but were specific to the scenarios healthcare professionals encountered in their working life.

The next decision was to decide how to articulate these two scenarios, one which expressed an acute care situation and one a routine situation. Within the context of the literature, the author considered how the scenarios were going to be used. In the first instance, the scenarios would be used to define the sample selection, since the sample selected would be based on those who would participate in a scenario. In the second instance, the scenario would be used to stimulate the reflections of these participants so that the behaviours in their daily working lives could be explored and evaluated. The author was concerned that if the specification of the scenarios was centred on particular acute or routine care needs, for example a patient is admitted by ambulance to hospital following a heart attack or a patient is referred by a GP to a consultant as a result of incessant pain in a shoulder joint, the discussion might focus only on the behaviours that happened as a result of these needs. Therefore, the author made a decision to base the scenarios on acute and routine care needs but not specify the precise nature of the need. Accordingly, the working life scenarios were expressed as:

Scenario 1

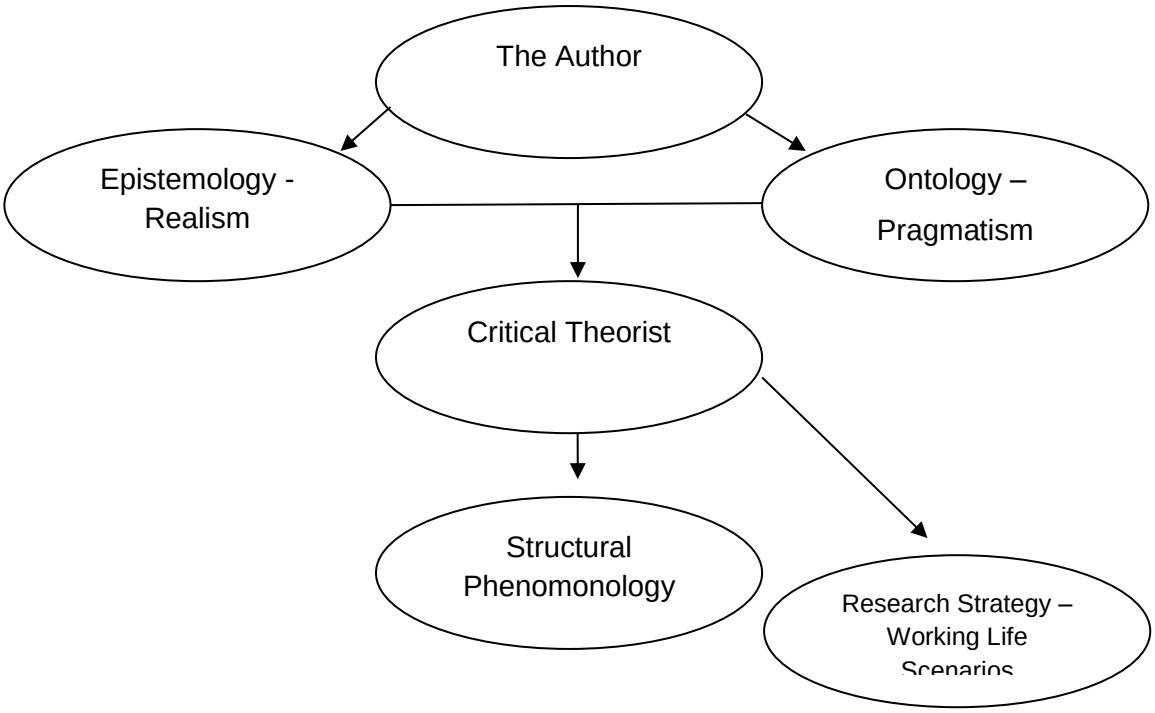
A patient is brought to Accident and Emergency via ambulance as an emergency and is later transferred to a general surgical ward

Scenario 2

A patient is referred by a GP to a Surgical Consultant who later arranges for a scheduled admission to hospital for a surgical procedure

These scenarios ensured that the research strategy could explore the behaviours of healthcare professionals across the sector, from general practioners, to ambulance personnel, to professionals in emergency and routine care provision in hospitals. They were felt to be specific enough to facilitate the reflections of these professionals in their working life yet offered a focused direction for implementation of the research strategy.

In conclusion, given the author's philosophical stance, working life scenarios were selected as the research strategy. The author believed that utilising narrative, phenomologically-based scenarios would aid individuals in discussing behaviours in their daily working lives. Furthermore, it would also assist the author in exploring and investigating meaning in these narratives (Davis 2006, Edvardsson and Roos 2001) which would explain how an individual's behaviour at work has the potential to contribute to smouldering crises and adverse patient safety incidents.



4.3 Primary Data Collection

4.3.1 Research Questions, Regulations and Boundaries

Before the data collection could take place, a number of issues had to be resolved. The first of these was to define the research questions in order to provide the focus for the collection and subsequent analysis of data (Saunders et al 2007). Secondly, decisions about the boundaries of the research had to be made since this would influence the recruitment of the sample. Whilst these are set out above as a sequence, in reality the author was dealing with each of the aspects concurrently as a decision in one area would affect what was happening in another. This section will explain the rationale for the decisions made in each of the above areas.

4.3.1.1 Research Questions

Chapter 2 defined smouldering crises as the area of research for this thesis. However, whilst the existing crisis management literature acknowledged the dominant role of human error as a root of these crises and knowledge concerning the contributory behaviour of management was developing,

understanding regarding the underlying reasons for grassroots behaviour was limited. Although Chapter 3 demonstrated that there were commonalities between crisis management and patient safety literature, the level of behavioural understanding was perceived, by critics, as inhibiting progress and for the author was identified as an area for development in this thesis. Therefore, central to the contribution of this thesis, and thus, the aim of the research, was to develop this understanding by exploring the nature of the behaviour of individuals at grassroots level.

In order to ensure that the research achieved this aim, it was critical to define clear research questions which were specific within the context of this study and the author's research philosophy (Saunders et al 2007). The focus of the research questions was to explore the behaviour of grassroots individuals in healthcare. However, this would be insufficient to achieve the aim of the study unless they were sensitised to the area of contribution.

Accordingly, the author rationalised the specific research questions as:

1. What influences grassroots healthcare professionals in the work setting?

2. How does this affect how they behave in their job roles?

These questions were necessary because the author wanted to explore the drivers for healthcare professionals in the work setting and how and where the behaviours of grassroots individuals in their daily working life created the potential to initiate a smouldering crisis.

3. What effect does the behaviour of grassroots individuals have on their peers?

This question was necessary because the literature concerning the systemic nature of smouldering crises suggested an inherent and cumulating progression towards a crisis situation. Within this context, the author wanted to explore the

consequential impact of one individual's behaviour on another in order to consider what part this played in a smouldering crisis.

4. What effect does the behaviour of grassroots healthcare professionals have on patient care and how might this behaviour in the workplace lead to patient safety errors which are symptomatic of smouldering crises?

This question sought to examine how behaviour impacted upon the care of patients since, as explained in Chapters 1 and 3, there were instances in healthcare organisations where the unintentional behaviour of individuals caused injury to those in their care. The author has argued in Chapter 3 that in organisations where the raison d'être was patient care, this behaviour was symptomatic of a smouldering crisis.

4.3.1.2 Research Boundaries

Given the scale and disparate nature of healthcare provision in the UK (examined in Chapters 1 and 3), the author felt that it was necessary to define the boundaries of the research underpinning this thesis.

In defining the boundaries of the research, the author considered a number of options.

In the first instance, with the incidence of human error in healthcare being central to the thesis, the author investigated whether she should conduct the research in a healthcare organisation where error incidents had been reported. Whilst these could be identified through secondary data such as broadsheet press commentary, Department of Health reports or public inquiries, the author felt that this would not be appropriate to the study on two counts. Firstly, organisations identified and examined via these methods might be reluctant to participate in any research. Secondly, domiciling the research in what might be viewed as error-prone organisations, would create a biased view of healthcare organisations.

In the second instance, the author considered using a number of healthcare organisations across the country. This option was discounted because it was felt that the qualitative nature of the research did not require a large sample nor the generalisability of the results of the research.

In the third instance, the author considered conducting the research in a healthcare organisation which would act as a proxy for healthcare organisations for the purposes of the study. Whilst several alternatives were considered, the author selected South Yorkshire Strategic Health Authority (SYSHA) as a proxy for a number of reasons. Firstly, the links between both Sheffield universities and the SYSHA is good and there was a particular desire to improve the links between Sheffield Hallam University, the sponsor of this research, and SYSHA. Secondly, and as a consequence, the author believed that this presented an opportunity to support the sponsoring organisation's move to improve links. Thirdly, the author felt that approaching an organisation with links to the University would expedite access arrangements. The author, though, was aware that this made the research locality based. However, Easterby-Smith et al (2008) did not identify locally based research as a particular problem for two reasons. The first reason being that any behaviour was contextually bound and therefore researchers would need to evaluate each context separately and avoid generalisation. Alpander (1982) concurred, believing that generic classification measures could be identified in such cases but their practical application regarding generalisability was limited. The second reason, according to Easterby et al (2002) was that generalisabilty often favoured the powerful and therefore it was more holistic to focus on what was happening in each locale.

4.3.1.3 Research Regulations

In terms of regulation, the research was subject to the ethical and scientific standards of both Sheffield Hallam University and SYSHA. Sheffield Hallam University (2006) stated that a research study should comply with a number of ethical principles; namely beneficence, non-malfeasance, informed consent, confidentiality and anonymity and intellectual property. In addition, National

Research Ethics Service stated that “The Research Governance Framework for health and social care defines the broad principles of good research governance and is key to ensure that health and social research is conducted to high scientific and ethical standards” (National Research Ethics Service 2011). The author felt that the procedures associated with satisfying these standards were beneficial as they provided additional guidance concerning the quality and integrity of the research process. The research was assessed as being compliant with the standards and therefore authorised by Sheffield Hallam University and relevant bodies in SYSHA. However, achieving approval from the relevant bodies in SYSHA to proceed was challenging.

In the first instance, the author had no prior knowledge of the regulatory process and found it difficult to establish what was required and by whom.

In the second instance, the time spent investigating what was required, together with the application and approvals process, impacted heavily upon the time frame of the study. This was important for the author since it required a modification of aspects of the research plans including the sampling method and the transcription process (see Section 4.3.2.2 and 4.4).

4.3.2 Collecting the Data

4.3.2.1 Implementation of the Method

The author decided to develop an understanding of an individual’s behaviour by exploring the daily working lives of healthcare professionals through the use of appropriate scenarios. This section is concerned with how the research strategy was implemented and the issues that the author felt it necessary to consider.

The author considered that within the context of the qualitative research strategy, there were two methods of implementing the scenarios: focus groups and personal interviews.

Lee and Lings (2008) advocated that focus groups were a good method of establishing people's attitudes and suggested that groups worked well when the researcher felt that it was necessary to explore the views of a specific group of people on a particular topic. Davis (2006) concurred, proposing that focus groups facilitated the explicit expression of implicit thoughts and feelings and allowed participants to describe the motivations for their actions. According to Lee and Lings (2008) one of the key benefits of utilising focus groups was that the researcher was able to observe how a group interacted. Initially, for these reasons the author felt that administering the scenarios through focus groups could be an appropriate method. It blended well with the aim of the research, the use of focused scenarios and the research questions, particularly question 3 regarding the interactions between professionals. However there were several reasons why focus groups were not utilised. In the first instance, the gap in knowledge and the contribution of this thesis was firmly placed at the individual level. Whilst the author wanted to explore the consequential impact of one individual's behaviour on another in order to consider what part this played in a smouldering crisis and adverse patient safety incidents, the unit of analysis was the individual healthcare professional. In the second instance, Lee and Lings (2008) warned that, logistically, focus groups were difficult to organise. The author investigated this further during a discussion with an experienced researcher in the proxy organisation who confirmed that this was particularly the case. For these reasons, focus groups were not considered to be an appropriate method.

Wilson (2010) suggested that interviews allowed a researcher to acquire an insight into the beliefs and attitudes of participants through verbal and non-verbal communication. Although interviews could be utilised in quantitative descriptive or explanatory research, they were also appropriate in qualitative exploratory researcher (Saunders et al 2007). Lee and Lings concurred (2008) stating that in-depth interviews were appropriate for sensitive issues or where "detailed individual experiences" were sought (p233). Qualitative interviews could be either unstructured, where the researcher used a few brief topics to direct the interview, or semi-structured, where the interview was directed through the use of a more detailed topic guide (Lee and Lings 2008).

Researchers would, according to Lee and Lings (2008) use the former when they did not wish to impose particular views on the participant but warned that this method at times did not generate useful data because it allowed the participant to talk about anything. On the other hand, Lee and Lings (2008) advocated that semi-structured interviews were appropriate where the review of literature had the potential to direct a focused topic guide. Lee and Lings (2008) advocated that interviewing was particularly useful because of its flexibility, in terms of content, style and timing, a view with which Wilson (2010) concurred, adding that an additional benefit was that interviews could be recorded. Operationally, therefore, interviews were considered by the author to be more straightforward to administer than focus groups yet would yield the same depth of reflection from participants, particularly if directed through a semi-structure topic guide that had been developed out of a researcher's review of research literature. For these reasons, the author concluded that the data would be collected through interviews.

The interviews utilised a semi-structured topic guide. The design and structure of the topic guide was informed by the advice of Lee and Lings (2008) and Saunders et al (2007) regarding good practice. In addition, aspects of the literature on critical incident technique (Chell 1998, Davis 2006 , Flanagan 1954, Gremler 2004, Mallek et al 2003) were applied. The topic guide can be found at Appendix 4.1.

The guide began by reviewing the information that had been provided to the sample beforehand in the information pack which can be found at Appendix 4.2 and then confirmed participant anonymity and confidentiality. Saunders et al (2007), as did Lee and Ling (2008), considered this to be good practice in semi-structured interviews. The remainder of the guide introduced the working life scenario then asked participants to discuss their respective roles and likely actions. Participants were also asked to identify and provide their own rationale for things 'going wrong' and 'right' within the scenario. There was an opportunity within the topic guide for the researcher to probe each aspect of the scenario. In addition, participants were asked to provide anonymised examples as the author thought this might help them to clarify and illustrate what they

were saying. Finally, participants were asked to identify specific areas where they provided patient care through the interaction with peers. For time management reasons, the author chose to utilise one scenario per interview, with the selection being based on the scenario's appropriateness to the sample. Where both scenarios were appropriate to the sample, the author rotated the scenarios.

4.3.2.2 Access Arrangements

Before the research method could be implemented, the author needed to negotiate access to participants in the proxy organisation. This section explains the process that the author encountered and the issues it raised for the thesis.

The author found that securing access to healthcare staff was a time consuming and lengthy process. The process was further complicated because the scenarios had been designed around the experiences that healthcare professionals encountered in their working life yet combined different elements of healthcare provision. The consequence was that, in order to fully explore the underlying behaviours of healthcare individuals within the scenarios, participants from several areas of the proxy organisation would need to be involved in the research. Specifically, a teaching hospital trust, a primary care trust and an ambulance trust. Each area had its own unique approach to ethics and scientific approval with no particular cross-liaison capability. Establishing the requirements of the process per se, and the distinctive processes within it, was demanding and, in the main, enormously frustrating for the author. More importantly for the author, this had implications for the timing of the research underpinning this thesis and required modifications to aspects of the implementation and analysis process.

Figure 4.1 at Appendix 4.3 shows a summary of the process as it happened, broken down into the constituent parts.

The research was subject to several ethical and scientific approvals. Specifically approval was needed from the sponsoring organisation, Sheffield

Hallam University and healthcare organisations where the research would be conducted. These were North Sheffield Local Research Ethics Committee (NSLREC) on behalf of Central Office for Research Ethics Committees (COREC), Sheffield Health and Social Research Consortium (SHSRC) and Yorkshire Ambulance Trust.

The author began the process by seeking ethical approval from the sponsoring organisation, firstly, at Faculty level and then through Sheffield Hallam University's Ethics Committee. These approvals were required by the author before Sheffield Hallam University could be documented as the research sponsor and provide indemnity insurance for the subsequent SHSRC and NSLREC applications.

The author was then required to seek an informal scientific approval from SHSRC in order to formally register the research as a live project. With registration complete, the author was able to make a formal approach for scientific approval from SHSRC. Registration and approval from SHSRC meant that the ethics application to NSLREC could be made and the award of a requisite National Health Service honorary contract formalised. The summation of the SNLREC application was an interview at Board level. The SNLREC application was a significant step for the research on a number of counts. In the first instance, achievement of ethical approval from SNLREC was the stimulus required to commence the access process into each specified area of the proxy organisation. In the second instance, the application process itself required a considerable level of detail about the research including a full explanation of the method and sample and the provision of detailed information and invitation packs, informed consent forms and the topic guide. Whilst this was a challenging and time consuming aspect of the access process, the author is clear about the benefits it delivered in terms of moving the thesis on and specifying the task of implementing the underlying research.

Once the author had received SNLREC approval, separate and discrete applications could be made to each distinctive aspect of the proxy organisation. The author found navigating this part of the access process demanding in terms

of time and effort as there was no uniformity in their respective approaches to and formalities of granting permission to access their staff. For example, whilst the Primary Care Trust was willing to take the approvals granted by SHSRC and SNLREC as proof of scientific and ethical governance, Yorkshire Ambulance Trust required a further briefing to, and an interview with, their Chief Executive. In addition, Sheffield Teaching Hospitals Trust sought security, data protection and occupational health clearance together with finance sign off for the research project.

It was only when this protracted process was completed that access was finally granted and the process of sample selection could begin. This caused an enormous strain on the time frame of the study. Sheffield Hallam University Faculty ethical approval was granted in October 2006, yet it was March 2008 before permission to gain access to NHS staff was finally achieved.

4.3.2.3 Sample Selection

The approach to the sample design was purposive. According to Saunders et al (2007) purposive sampling was a “non-probability sampling procedure in which the judgement of the researcher is used to select the cases that make up the sample.” (p608). This method, they proposed, allowed a researcher to select a sample of participants that would facilitate the achievement of the research aim yet were suitable for the research method. Wilson (2010) elaborated stating that in purposive sampling, the researcher used personal judgement to select participants because they were able to provide information that was important to the research which could not be provided by others. Saunders et al (2007) stated that purposive sampling was particularly common in qualitative research when a researcher was working with small samples and identified common uses of purposive sampling including extreme or critical cases or heterogeneous or homogenous cases. However, most notably for this research, according to Saunders et al (2007), purposive sampling could be used for typical cases when the researcher was using a typical case to create an “illustrative profile using a representative case” (p609). The author felt that this was very consistent with the scenario method that was to be used in the

research. Although the lack of generalisability was raised (Lee and Lings 2008, Wilson 2010), the author felt that this was not an issue for the research since this thesis aims to develop the understanding of the management of smouldering crises and patient safety by exploring the views of individuals at grassroots level within a healthcare organisation and does not intend to be definitive and generalised. Accordingly, a purposive approach to sampling was taken by the author.

The sample was designed around the health professionals who had information to impart in the context of the working life scenarios. Thus, it was drawn from grassroots health professionals in the SYSHA, specifically the Primary Care Trust and Sheffield Teaching Hospitals Trust, and Yorkshire Ambulance Trust areas. The composition of the initial sample selection is shown below in Table 4.1.

Location	Health Professional	Number	Applicable Working Life Scenario
Sheffield Teaching Hospitals Trust (Accident and Emergency)	Senior House Officer	1	Scenario 1
	Nurse	2	Scenario 1
	Receptionists	2	Scenario 1
Sheffield Teaching Hospitals Trust (General Surgical Ward)	Senior House Officer	1	Scenario 1 or 2
	Nurse	2	Scenario 1 or 2
	Ward Clerk	2	Scenario 1 or 2
Yorkshire Ambulance Trust	Ambulance Crew	6	Scenario 1
Primary Care Trust	General Practioner	3	Scenario 2
	Practice Manager	3	Scenario 2

Table 4.1 Initial Sample Selection

Before conducting the interviews the author sought further practical advice from an experienced researcher in the proxy organisation. The view was that securing the planned 22 interviews with healthcare professionals over the scheduled fieldwork period of 3 months was going to be a difficult task. However, given the impact on timings of the scientific and ethical approvals process, this schedule had to be adhered to. The author sought further guidance and suggestions from the research literature.

Highet (2003) had investigated previous research into a relatively novel combination of the focus group and the individual interview, a paired interview. A paired interview involved two participants, who had ties but no hierarchical relationship, being interviewed at the same time. Highet's (2003) subsequent evaluation of the implementation of this technique concurred with the research literature that suggested practical and data quality benefits. Highet found that arranging interviews was more straightforward as participants were more enthusiastic about taking part and participants were more relaxed as they were in familiar company, which helped the interviewer to develop rapport and trust more quickly. More significantly, within the context of her study, Highet (2003) identified that this led to better quality of data since participants were more ready to "elicit thoughtful, reflective accounts" (p108) which provided "the occasional glimpse into their private, emotional worlds" (p114) and shed new light on the research subject offering. With the benefit of this evaluation, the author of this thesis felt that paired interviews would expedite the collection of data without compromising the quality. On reflection, in some aspects of the sample, the author felt that paired interviews would be particularly beneficial to the quality of data collection. With the criterion of identifying participants with ties but no hierarchical relationship, the author returned to the sample selection in order to consider which interviews could be paired. The author felt that the Sheffield Teaching Hospital Trust interviews with nurses, receptionists and ward clerks would all satisfy the criterion as would the interviews with ambulance crew. However, the author felt that it would not be appropriate or logistically practical to pair the two interviews with senior house officers. Finally, whilst there was a hierarchical relationship between the general practioner and practice manager, the benefits of conducting a paired interview were felt to override the specific application of the criterion. Therefore, the final sample selection was as described in Table 4.2 below.

Location	Health Professional	Number	Paired Interview	Applicable Working Life Scenario
Sheffield Teaching Hospitals Trust (Accident and Emergency)	Senior House Officer	1		Scenario 1
	Nurse	2	Yes	Scenario 1
	Receptionists	2	Yes	Scenario 1
Sheffield Teaching Hospitals Trust (General Surgical Ward)	Senior House Officer	1		Scenario 1 or 2
	Nurse	2	Yes	Scenario 1 or 2
	Ward Clerk	2	Yes	Scenario 1 or 2
Yorkshire Ambulance Trust	Ambulance Crew	6	Yes (3 paired interviews)	Scenario 1
Primary Care Trust	General Practioner	3	Yes (3 paired interviews)	Scenario 2
	Practice Manager	3		

Table 4.2 Final Sample Selection

4.3.2.4 Final Sample Selection

At the outset, the author intended to identify and select the sample from information available in the public domain, for example, the annual Binley's Directory of National Health Staff. However, in progressing the access process explained above in Section 4.3.2.2, it became evident that line management approval would be required prior to identifying and selecting the sample. This might have been a further obstacle had it not been for Binley's Directory of National Health Staff, for whilst this source would not yield the details of the final sample, it was helpful in providing some line management contacts. Fortunately, for the author, the contacts made through the approvals process also yielded lucrative sources that were useful in identifying the final sample.

Accordingly, SHSRC via the Academic Unit for Primary Medical Care provided the names and contact details of 13 General Practioners and Practice Managers in their area. Yorkshire Ambulance Service provided the names and contact details of 6 ambulance crew in the Sheffield area. The Northern General Hospital, General Surgical Ward Firth 5 provided the names and contact details of 4 doctors, 2 nurses and 2 ward clerks. The Northern General Hospital, Accident and Emergency Department provided the names and contact details of 24 doctors, 2 nurses and 2 receptionists. This was not a large sample frame from which to achieve the desired sample and the author had to show

particular perseverance in the task of recruiting the sample. This was finally achieved as a result of a resolute determination and commitment to implementing the fieldwork.

Using the contact information offered by the parties above, individual potential participants were approached in writing at their work address. For convenience purposes and because the author was working with a relatively small sampling frame, an offer was made, and in most cases accepted, to conduct the fieldwork in a suitable area at the participants' workplaces. The author believed that this would overcome any logistical reservations potential participants had and improve the chances of recruiting to the study.

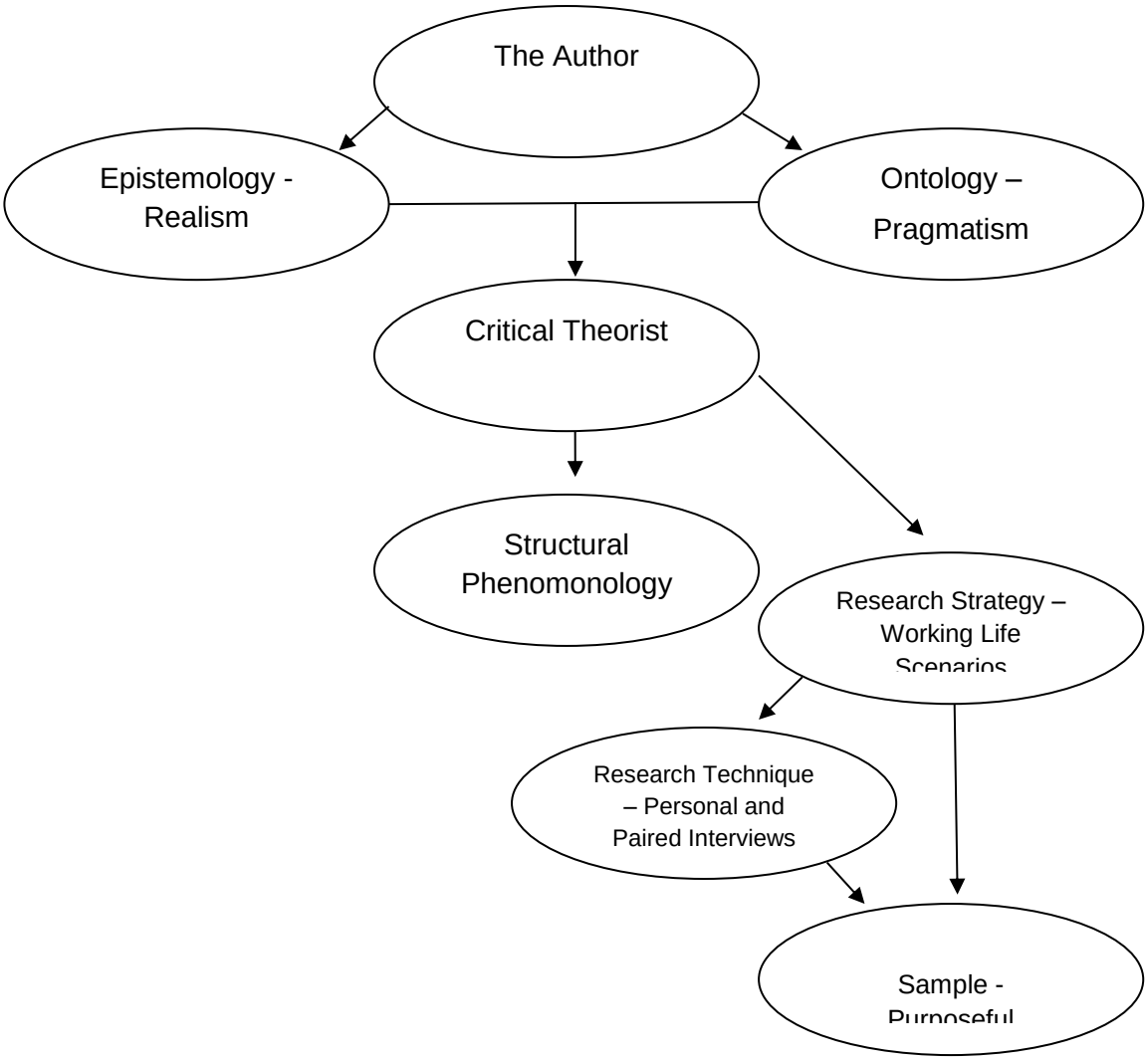
A full and detailed information pack accompanied the letter seeking participation, together with an informed consent pro forma. These are provided at Appendix 4.2. The invitation letter, information pack and informed consent pro forma carried full details regarding the purpose of this research and the role of participants within it and specific information about how the author would conduct the research. The pack was prepared in accordance with the requirements of the COREC scientific and ethical approvals process.

As was mentioned in Section 4.3.2.2 the requirements of the COREC were helpful in providing further guidance regarding the level and content of information supplied to potential participants. In the context of informed consent and data protection, the requirements of the COREC were particularly stringent. Therefore, within the information pack, participants in paired interviews were asked to consent to a discussion of the subject matter amongst their peers. In addition, any participants unwilling to take part were not pressurised into doing so and those who decided to take part were reassured that if the discussion became difficult, a follow up interview could be arranged. In the event, all participants felt able to complete the interviews (although eventually time prevented the two nurses on the General Surgical Ward from actually taking part) and, whilst some participants offered the author the opportunity to recontact them to discuss the findings, the author did not feel it necessary to take them up on their offer. Reassurances were also given by the author

regarding the security of the data collected and participants were advised that the intention was to use the data collected only for this study. Furthermore, during the interviews, the anonymity of participants was protected. Participants were assigned an identification code at the outset. The code was used by the author to 'label' the CDs carrying the interviews. Only the author had access to the information showing each participant's name and the associated identification code thereby protecting participants' anonymity during the transcription process.

The author had to demonstrate a great deal of tenacity in securing interviews with some participants. The process of approaching potential participants in writing, receiving completed informed consent forms and then contacting participants to arrange a mutually convenient time did not go according to plan. The letters were sent out over a period of time as the author secured line management approval and the contact details in a sporadic manner. However, the author received no completed informed consent forms by return. Accordingly, since time was a pressing issue, the author followed up the letters via telephone and email. In some cases, as soon as the author was able to discuss the study verbally with potential participants, some agreed to take part in the study. In other cases, and particularly in the case of Accident and Emergency Doctors, this was a protracted process. However, eventually verbal informed consent form was given and interviews were set up at a mutually convenient time. Formal documentary evidence of informed consent was given at the interview itself.

The author found the recruitment of the sample and the scheduling of the fieldwork to be a long and laborious process principally due to the difficulties of contacting potential participants, the pressure of work and the demands on their time. The fieldwork was eventually implemented as planned although, despite numerous attempts to secure a paired interview with nursing staff from a General Surgical Ward, this interview did not take place. Twenty interviews were completed, 9 on a paired basis and a further 2 on an individual basis.



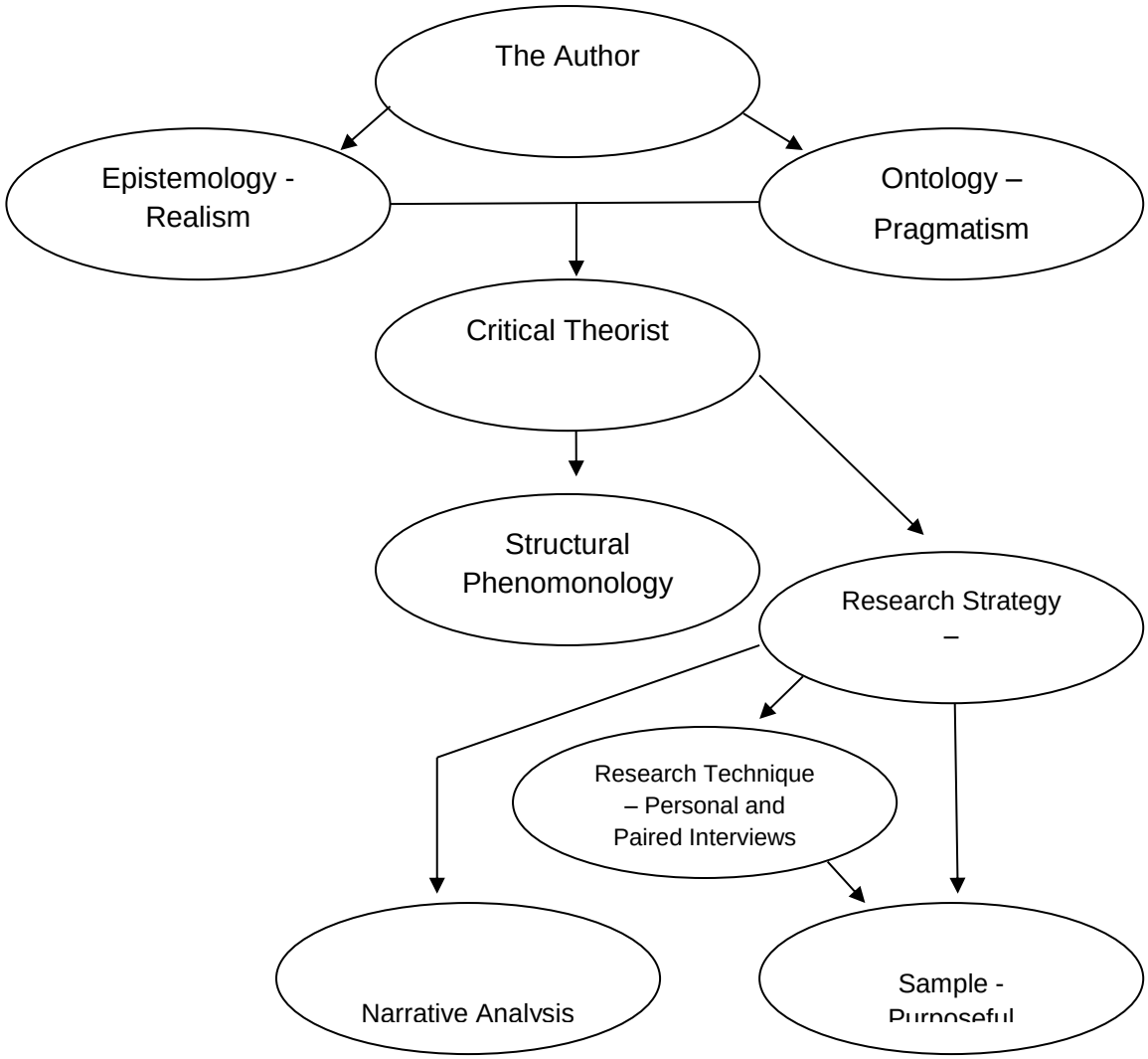
4.4 The Analysis Process

This section will explain how the overall approach to the analysis was informed by the aim of the thesis and the search for answers to the research questions posed. In so doing, this section will also later describe and rationalise the practical approach the author took within the context of the literature concerning qualitative analysis techniques.

The overall approach to the analysis needed to be coherent with the nature of the thesis' aim and the research questions posed (Wilson 2010). The aim of this thesis is to develop a deeper understanding of the management of smouldering crises and patient safety in healthcare by examining how the effect of grassroots behaviour can potentially cause smouldering crises conditions. In

order to do this the research focused on discovering what influenced grassroots individuals in healthcare during their daily working lives and how this affected their job role behaviour. In addition, the research investigated what effect this had on peers and patient care.

Wilson (2010) stated that an inductive approach to qualitative research, as proposed by the author of this thesis, developed an understanding of the data as it emerged. In the first instance, the author considered a grounded theory approach. Grounded theory offered the opportunity to take an open and inductive approach to the data as a means of generating theory (Wilson 2010). Within the context of the thesis' aim and the research questions, this seemed appropriate to the author of this thesis. However, the author was dissuaded from adopting this approach because in employing working life scenarios to direct the interviews, the author felt that this, to some degree, inhibited her ability to approach the data in a completely open manner. In the second instance, the author considered narrative analysis. The working life scenarios underpinning the research were narratively and phenomologically-based and focused on facilitating the exploration of behaviours within daily routines. According to Saunders et al (2007), narrative analysis was based on the accounts of individuals' experiences and the ways in which they explain these through their subjective interpretations and relate them to constructions of the social world in which they live" (p504). Lee and Ling (2008) considered narrative analysis as being particularly useful when participants were relating stories about the world in which they live. Through stories participants were able to make sense and understand particular contexts (Miles and Huberman 2002). In this sense, the author felt that narrative analysis was more consistent with the overall aim of the thesis, the research strategy and the research questions. However, whilst Saunders et al (2007) were guarded in stating that researchers should not seek to fragment the data, they suggested that fragmentation may be appropriate where narrative analysis was used to "explore linkages, relationships and socially constructed explanations that naturally occur within narrative accounts" (p 504).



Whilst Wilson (2010) recommended that although researchers should prepare a plan for the steps that were needed to undertake inductively based qualitative analysis, decisions regarding the narrative of the data were in the hands of the researcher. Broadly, Wilson (2010) advocated that the steps should involve the transcription of data, generation of categories, themes and patterns and interpretation and presentation. Miles and Huberman (1994) summarised these stages as data reduction, data display and conclusion drawing. A structured and planned process was adopted by the author to the analysis beginning with the transcription of the data. However, in order to remain sensitive to the overall aim of the thesis and research strategy, the author adopted a meta-approach to analysis. An overall approach of narrative analysis was combined with a more structured method of cross-case data reduction (Lee and Ling 2008) using a variable oriented strategy (Miles and Huberman 1994). The data

as a whole was reduced through descriptive coding before it was evaluated and interpreted through themes. The author's experience regarding data reduction was in line with Miles and Huberman's (1994) suggestion that the process was not a linear sequence but an iterative, cyclical process which reached a climax when the researcher reached conclusions. The remainder of this section will explain in more detail the process of analysis which was followed by the author and is summarised in Figure 4.2.

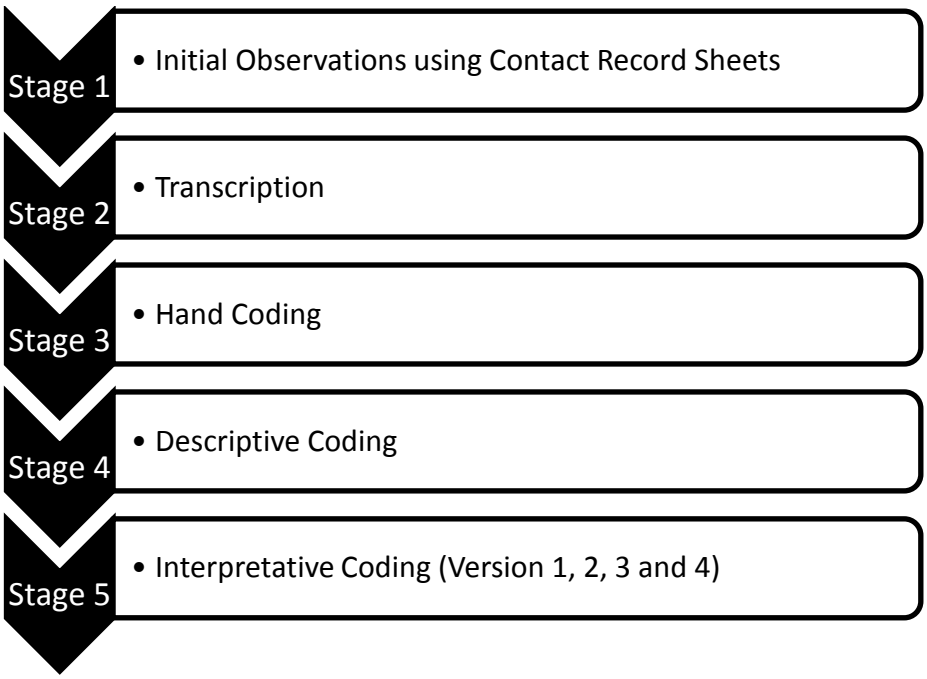


Figure 4.2 The Five Stages of Analysis

Stage 1

At the end of each interview, a contact record sheet, as advocated by Miles and Huberman (1994), was recorded as a preliminary part of the analysis. The objective here was an informal one and borne out of a desire to record the context in which the interviews had taken place as well as any observations regarding initial emerging themes.

Stage 2

Once the interviews had taken place, the data was transferred onto CDs ready for transcription. Initially the author was to transcribe the interviews, however, the fieldwork process had been protracted (see 4.3.2.2. and 4.3.2.3) and so for expediency purposes the possibility of making up some time by passing the transcription to a third party was considered. Wilson (2010) advocated that this was a common approach by research for two reasons. Firstly the researcher may not have the necessary skills of an experienced transcriber. Secondly, it was a time consuming process and transferring responsibility to another allowed the researcher to focus on other areas of the research. Accordingly, the author consulted the local COREC committee to seek their guidance and advice regarding sub-contracting the transcription process and was advised to select a third party with previous experience transcribing working for a healthcare organisation. The committee also advised that the appointed person must sign a confidentiality agreement prior to commencing her duties. The author observed both of these requirements in appointing a transcriber. The data was sent, bearing the participants' identification codes only, via post to the transcriber for transcription. The transcriber was requested to identify the participants by their identification codes and to blank any named references to other individuals. The transcription was prepared in word processing format and returned electronically to the author. The recorded data was securely electronically stored by the researcher and transcriber in password protected files and, once transcription had taken place, the transcriber was requested to destroy all copies in her possession. The original data remains securely stored at the author's home address.

Stage 3

All of the data, including contact record sheets, was hand coded in an open and category-free manner. Whilst this meant that the resulting analysis was at a micro level and produced a multiplicity of descriptive codes, this was necessary in order to begin the process of disaggregating the data (Saunders et al 2007). Physically handling the data in this way also had the added advantage of

allowing the author to begin the process of becoming familiar with the participants and their responses. The author chose to review this initial open coding using a structured, theme based, coding frame. The coding frame selected (Miles and Huberman 1994) was felt appropriate within the context of the study as it covered aspects such as how participants defined the situation, participants' perspectives about the setting and people and views about processes, activities and events. Although the coding frame was not useful in its entirety, the author found that it was helpful in beginning the process of managing the interpretation of the data.

Stage 4

Miles and Huberman (1994) suggested that coding gave access to meaning since codes were "tags and labels for assigning units of meaning to the descriptive or inferential information compiled during a study" (p56). They recommended the progressive, yet iterative approach to coding that was adopted for this analysis. According to Miles and Huberman (1994) formal coding involved an initial stage of descriptive coding in which aspects of text were assigned a classification before later interpretative coding in which more meaning was found by combining classifications into broader categories.

Before commencing this stage of the analysis, the author considered the support provided by qualitative computer software packages as a means of effecting this approach to analysis. Computer software packages provided a means of examining meaning in the data, exploring relationships and providing a sense-making framework (Miles and Huberman 1994). According to Bazeley (2007), the software package was not, in itself, an end to analysis, rather it was a toolkit which provided some of the means; "the use of the computer is not intended to supplant time-honoured ways of learning from data, but to increase the effectiveness and efficiency of such learning" (p 2). This view was one with which respected peer researchers concurred and, based on this recommendation and the pressures on time expressed in Section 4.3.2.2, Nvivo8 was selected to provide support for the analysis.

Concurrent with Miles and Huberman's approach (1994), Bazeley's (2007) practical advice regarding the utilisation of the Nvivo toolkit was followed. Once the data had been transcribed, it was loaded into Nvivo and the classification of the data into descriptive codes was undertaken. The author took a very fragmented approach to this, considering that classifications could be amalgamated rather than having to attempt to further disaggregate the data. This stage resulted in a total of 58 separate classifications of the data. These are shown at Appendix 4.4 as 'Descriptive Codes'.

Stage 5

As was discussed above, the author went through cycles of interpretative coding, each one realising a greater understanding of meaning over its predecessor before arriving at an interpretative coding frame which the author felt was valid since it represented the views of participants within the context of this thesis.

Initially, the author adopted a mind map approach to exploring the descriptive codes in Version 1 of the interpretative coding frame. Whilst this was useful for exploring some relationships between descriptive codes, the author felt that the data remained quite fragmented and the link with the thesis was rather weak.

In Version 2 of the interpretative coding frame, the author approached the aggregation of descriptive codes from the perspective of the individual in the sense of 'the working world as I see it'. This was felt to be much closer to the overall aim of the thesis, the research strategy and the research questions than Version 1. The author was aiming to contribute to the knowledge regarding the management of smouldering crises and patient safety through a better understanding of how the daily behaviours of healthcare professionals had the potential to incubate these incidents. The author felt that exploring how individuals, either personally or collectively, viewed their working world had the potential to reveal how individuals behaved. As participants made personal and collective observations, the author felt that it would also be appropriate to explore a shared view of the working world. Accordingly, descriptive codes

which were felt by the author to be consistent with the working world theme were selected and aggregated as shown in Table 4.3

What are my things that are set in my working life	What are the issues that I experience in my working life that are outside of my control	How do I deal with these issues	How we deal with these issues
Personal Limitations Responsibilities My Training My Education	Working Conditions Patient Care Transitions Ineffectiveness Inefficiency Training of Others Education of Others Individual Differences	Pragmatism Proactivity Risk Aversion Arrogance Esteem Humility	Tribes Territories Rumours Informal Communication

Table 4.3 Interpretative Coding, Version 2

Whilst this was another useful step in interpreting the data, the author felt that this approach would potentially explain how individuals behaved in the context of organisational controls, in terms of systems and processes, but not why. Furthermore, the author felt that the result was partial in that the approach to the interpretative coding was focused on exploring the behaviour of individuals within the context of organisational control. On reflection, interpreting the data within the context of perceived organisational control was not consistent with the aim of the thesis as it tended towards the organisational perspective that the author was so critical of in Chapters 2 and 3. For these reasons, the author believed that this approach to interpretation was not as closely aligned to the aim of the thesis as the author had originally thought.

A further attempt at interpretative coding, Version 3, shown in Table 4.4, was more successful in attributing descriptive codes to an interpretative coding frame which was based on how individuals felt about aspects of their working lives. The author observed that whilst some feelings were presented as being unique to the individual, others were common across participants. In addition, some feelings were focused specifically on the working environment.

Personal Feelings	Shared Feelings	Feelings Concerning the Work Environment
Working conditions Pragmatism Responsibilities Patient Care Transition Training of Others My Training Tribes Proactivity My Education Risk Aversion Territories Arrogance Changes – Implemented Changes – Pending Ineffectiveness Individual differences Esteem Personal Limitation Inequity Humility Education of Others Rumours Informal Communications	Inefficiencies Professionalisation and Experience Respect Frontline Employee Safety and Well Being Teamwork Reaction to efficiency Measures Patient Safety Local Context General Context Flexibility Collegiate Spirit Intra Communications Personal Stress Ineffectiveness Resentment Right – Intra NHS Right – Inter NHS Inflexibility Exposure Changes - Implemented Changes – Pending Resourcing Demoralised Autonomy Uncertainty Wrong – Intra NHS Wrong – Inter NHS Personal Relationships Patient Safety Incidents Inter Communications Complimentary Words Drama Deprofessionalisation	Local Context General Context The Process Time Changes – Implemented Changes - Pending

Table 4.4 Interpretative Coding, Version 3

Whilst an approach revealed individual and shared feelings was proving to be fruitful in the author's search for meaning, the author felt that this interpretation somehow lost sight of the research strategy and thus would be limited in helping the author achieve the aim of the thesis.

The author returned to the descriptive codes and reviewed them in the light of the aspects of previous versions of the interpretative coding frames that were consistent with the aim of the thesis. The notion of 'the working world as I see it' had some resonance for the author. The thesis was seeking to develop an understanding of smouldering crises by exploring how and why individuals

exhibited behaviours in their working lives that potentially could cause a smouldering crisis and adverse patient safety incidents. However, the author was also receptive to the fact that participants were narrating recounts of their working lives from both personal and shared perspectives. Thus the author attempted to investigate whether the narratives of participants identified in the descriptive codes could be combined into three interpretative categories. The first category would be how participants behaved in their working life. The second category would be why participants behaved in this way. The third category would be what participants drew from the shared perspective. The author found that the narratives of participants concerning their daily behaviour were centred on the affinity they had for the professional role that they occupied and their interactions with peers. However, whilst the behaviour of participants appeared to be role and peer driven, the underlying motivation was centred almost exclusively on patient care. This became Version 4 of the interpretative approach to coding and is shown in Table 4.5.

Individuals' Behaviour in Daily Working Life	Motivation for Behaviour	Influence of Peers
My Education Education of Others My Training Training of Others Individual Differences Inequity Professionalisation and Experience Responsibilities	Patient Safety Drama Complimentary Words Personal Limitations Pragmatism Professionalisation and Experience Responsibilities Respect	Collegiate Spirit Complimentary Words Informal communications Flexibility Humility Personal Relationships Teamwork Tribes

Table 4.5 Interpretative Coding, Version 4

These three categories and the descriptive codes within them were consistent with investigating how and why individuals behaved in the way that they did.

Before discussing how these codes were shaped into the themes that are presented in the next chapters, the author feels it necessary to point out several issues. Firstly, descriptive codes were selected for this version of the interpretative coding frame based on the contribution they could make to the themes identified. Accordingly, not all of the descriptive codes were selected. However, aspects of other codes which were not selected were represented in

those selected as some narratives were multiply coded. For example, a narrative which appeared in the code 'Respect' also appeared in the code 'Esteem', similarly a narrative that appeared in the code 'Personal Stress' also appeared in the code 'Reaction to Efficiency'. Furthermore, some codes that were selected appeared in more than one interpretative category, as with 'Professionalisation and Experience' where it appeared in 'Individuals' Behaviour in Daily Working Life' and Motivation for Behaviour'. This has only occurred where the author felt the descriptive code crossed categories.

Having reached a decision about which interpretative approach to adopt, the author then explored the narratives contained within the descriptive codes in each of the interpretative categories. When undertaking this, the author observed a further layer of recurring themes which crossed the interpretative categories.

Within some of the themes, the participants were observing and commenting upon organisational aspects of their working lives; the facets of their working lives through which the organisation structured and controlled what participants did (Targets, Boundaries and Resourcing) and the consequences of these aspects (Stress and Pressure). Other themes were more concerned with participants' views about themselves and their peers; their motivation for seeking and sustaining a career in healthcare (Patient Orientation), their feelings of belonging to a profession (Training) and the affiliations they had with their peers (Relationships and Respect and Value). These themes crossed descriptive coding categories, for example, in the code Professionalisation and Experience participants made comments that were attributed to Patient Orientation, Respect and Value, The Public, Boundaries, Resourcing and Stress and Pressure. The author deduced that the examination of the final version of interpretative categories yielded themes which offered a greater insight into what actually prevailed in terms of participants' behaviours. The author believed that this further layer of analysis, which created a depth of understanding beyond the interpretative coding, should form the basis of the presentation of data in Chapters 5 and 6. Chapter 5 will present the data

concerning participants' organisational perspectives whilst Chapter 6 will present the data concerning participants' individual perspectives.

4.5 Summary

This chapter has detailed the methodological approach taken by the author of this thesis. Since the author's research philosophy is oriented towards that of the critical theorist, the research strategy centred on taking a structural phenomological approach. Whilst a quantitative strategy was discounted by the author, several qualitative strategies were reviewed and the author rejected those of a collaborative nature such as action research. Whilst initially case study investigation seemed suitable, the author believed it would inhibit the research study and be practically difficult to implement. Critical incident technique, on the face of it, presented a more appropriate strategy. However, the findings of secondary research suggested that this would be a difficult strategy to adopt and would suffer from the same implementation issues as a case study strategy. Although the consequence of this was that the author felt it was not appropriate to implement a critical incident technique based strategy in its purest sense, there was an indication from the literature that the technique could be adapted. Accordingly, the author applied the concept of critical incident technique to the working life scenario and adopted this as the research strategy. Determining the working life scenarios was challenging but the author chose to take a patient oriented approach since this was influential in directing the work of healthcare professionals. Two scenarios were identified; one based on an acute patient care need and one based on a routine patient care need.

The overall aim of the primary research was to explore the behaviour of healthcare professionals in order to contribute to the understanding of the management of smouldering crises and patient safety. Thus the research questions were sensitised to this area of contribution. However, before the primary data collection could begin, the author had to define the boundaries of the research and navigate the lengthy and complex regulations concerning research, particularly research conducted in healthcare. Several qualitative research methods for data collection were considered. The author concluded

that observation would not provide the data required and, although focus groups were considered, the author was counselled against attempting them in a healthcare setting. Therefore, the author decided to implement personal and paired interviews using a semi-structured topic guide which was based on the working life scenarios. Although access and sampling was challenging, the author was fortunate enough to establish contacts within the regulatory process who were helpful in providing the contact details for a purposive sample. Given the pressure on time caused by the regulatory and access processes, the author decided to pair some of the personal interviews.

A narrative approach was taken to the analysis and the author developed the final analytical framework through a series of 5 stages involving the development of descriptive and interpretative coding. The final stage of interpretative coding blended the individual and shared perspectives that were found in participants' narratives. The author found that in recounting their working lives, participants' behaviour was centred on the affinity they had for their profession and peers whereas their underlying motivation was patient orientation. However upon further examination, the author identified themes which recurred across the interpretative categories. These themes had either an organisational or individual perspective and are the basis for the presentation of the data in Chapters 5 and 6 which follow.

Chapter 5 An Individual in the Workplace: Perspectives on the Organisation

The aim of the thesis is to develop the understanding of smouldering crisis management and patient safety by examining how an employee's behaviour can potentially cause smouldering crises conditions. Chapter 4 detailed the research methodology which, in the context of the thesis' aim and the limitations of existing literature identified in Chapters 2 and 3, focused on investigating and exploring how and why individuals at grassroots level behave in the workplace in the way they do.

It is not the intention to repeat the detail in Chapter 4 concerning the methodological approach to the research. However, in undertaking the final stage of the analysis, the author observed common themes that crossed the descriptive codes and interpretative categories. Whilst these themes shared the common bond of participants recounting aspects of their working life, the author observed that within the themes, participants were expressing their working life from two perspectives. The first perspective concerned participants' observations regarding aspects of their working life which were shaped by the organisation and influenced how they felt and behaved at work. Whereas the second perspective concerned participants' views about themselves and their peers and how these influenced how they felt and behaved in the work environment. The identification of these perspectives helped the author to make sense of the views of participants within the context of their behavior at work and it is upon this basis that the data from the research study is presented here. This chapter will focus on exploring and explaining the findings concerning the facets of participants' working lives which were organisationally oriented. Chapter 6 will focus on evaluating participants' feelings about themselves and their peers.

Participants' narratives concerning aspects of their life which originated through the organisation were centred on structural and control mechanisms and their relative impact on the individual at work. In exploring this perspective, the author identified five main themes which are used to structure this chapter. The themes were: the use and nature of targets, the delivery of patient care across

work boundaries, changes to the resourcing in healthcare, experiential training and the impact these initiatives had on the individual in terms of perceived inequities and stress. The chapter begins with a brief explanation concerning the presentation of the data which it is hoped will be helpful to the reader.

5.1 The Presentation of the Data

The data is presented at sample level unless there is specific evidence that particular participants or groups of participants within the sample held distinctive views. Several different techniques are utilised to present the data within the chapters. Direct quotations are utilised to explain particular findings but are also assembled into 'Illustrations' where it is important to present a sequence of quotations in order to support the discussion. Vignettes appear through each chapter when the comments of a participant summarise key aspects of the discussion. The data is presented in tabular form where participants have distinctive views on common aspects of the discussion. Finally, figures are also used selectively because they summarise in a presentational manner the observation that is being made.

In terms of sourcing the data, the data is referenced according to its Nvivo classification. The specific reference is constructed from the key theme identifier, followed by the sample identifier and the Nvivo coding reference. So the reference 'ID A&EN:1 N2' is taken from the Nvivo key theme entitled 'Individual Differences' or ID, the interview with the nurses from Accident and Emergency and Nvivo Reference 1.

5.2 The Use and Nature of Targets in Healthcare

The target culture and specific targets were a recurring theme in the interviews. Whilst there was the occasional mention of the difficulties in the pre-target era.(D A&EN:3 N1, N2), participants were particularly critical of the detrimental impact targets had on patient care.

There was anger from GPs (General Practioners) reacting to the introduction of extend opening hours.

"The people who are going to benefit from this are the people who have got a sore throat and turn up on a Saturday morning... The people who are going to come to harm are the little old lady who I saw down the road with diabetes who is living on her own and really struggling but she isn't going to get the level of input because I am spread so much thinner ... At the end of the day, what is happening is that trivia and patient demand is being prioritised... What has come about is it is all about patient choice and not about need. ... it isn't necessarily the people that shout loudest that need the most. You can probably feel the frustration which is unusual because I am normally quite positive." (RB GPPM1:24 GP1).

In discussing the 4-hour waiting time, Accident and Emergency nurses shared GPs' concerns for the shifting priorities associated with targets, seeing waiting time targets being responsible for directing what they did. Furthermore, they also recognised that in satisfying this deadline, the service had become more process oriented. These nurses took it very personally because it inhibited their aspirations to care for patients' humane needs [1]. For one nurse, the manner in which she described the process is particularly stark yet she reconciled her situation by considering the cost of failure [2].

[1] "... it does sometimes feel like a conveyor belt and that you are shifting patients and you are trying to push to get patients out ... sometimes they are not ready to go but you still just have to get rid of them." (PL A&EN:5 N1, N2)

[1] "My view, personally, is that it has got down not to what is happening with the patient but to how long it has taken, I don't think the patients are getting the care they should do because of that. Because it is only since that has been introduced that you have been getting people coming down saying why is this patient still here? ... they are just interested in getting that patient through the department and the nurses have to deal with the patient and why they are left in the department, it is more on targets, that is what it is run on now, targets. (PS A&EREC:6 R1)

[2] "... we've got all the names of the patients in the department on a board and as they are about to breach they turn red and you know you have got to sort that patient out because if you don't then the department loses money and if the department loses money then you lose nursing staff, you lose equipment, well you don't lose it but you don't get any more." (F A&EN:2 N2)

However, for Ambulance crew discussing response time targets (commonly know to them as the ORCON system), the feeling was one of almost

resignation. They were of the opinion that this quantified target was the only measure by which key internal and external stakeholders judged them. As a consequence, they believed that ORCON exclusively directed individual and organisational priorities. The explicit view from Ambulance crew was that this happened at the expense of the proactive management of other aspects of the service which were only dealt with when they became critical.

"... yes ORCON (the Ambulance Service's response target) is first because they get a bonus for meeting all their targets ... (ID AC1:9 AC1B)

"... there are many instances where people in cars have been left on scene a long, long time with a patient that really should not have been left on scene a long time but you just get the impression that CONS or the powers that be just think well they have got somebody with them, they have ticked that ORCON box, they have got somebody there and it is a paramedic, they are receiving all the treatment they can." (PS AC2:11 AC2B)

"... so what they are doing is they are activating us on just address alone, nothing else... we don't get more time, we get less ... they are taking all the details as they normally would but the clock is ticking ... and we are supposed to be on route so we can actually be there before we get any details other than address ..." (EM AC2:1 AC2A, AC2B)

"... I think in essence maybe it is because the government and general public judge the ambulance services performance on its ORCON, how fast we get from the call taken to the time we arrive at the door. That is quantifiable, that is easily recognisable, are the service achieving it or not, are they achieving their 75% or whatever the percentage is that they have to get now, yes or no, performing or underperforming and that is a shame because that is what the management seem to concentrate on and everything else falls out of the basket and is dealt with in a fire-fighting way only when it goes wrong." (D AC3:9 AC3A)

Finally, the opinion of other participants was a direct objection to the way in which some targets were used as the sole judgment of performance and disregarded the experience and knowledge of a professional. This was the case for the following GP who also questioned the ethics of how targets are administered (Vignette 1).

Vignette 1

"... the PCT tell me that I should be doing it through this new, hugely expensive, system that the government have put in place called Choose and Book and I can't choose the Consultant so you just see the surgeon with the nearest appointment ..." (PR GPPM2:1 GP2)

"... but if it is something like a bad knee or someone has had a knee replacement by somebody or other or had a bad experience with a different orthopaedic surgeon then sometimes I feel it is important to nominate the Consultant and I am not allowed to do that on this Choose and Book system so then I just have to send a letter in. But we have targets to send so many of our referrals through Choose and Book because the PCT get a bonus payment from the government if it is used." (PE GPPM2: 5 GP2)

"the secondary care trust of the hospital say we can't do that because GP's might just choose their favourites, as though somehow we're children."

(TR GPPM2:12 GP2)

5.3 The Delivery of Patient Care Across Work Boundaries

Evidence from the fieldwork suggested that whilst healthcare organisations were highly diverse and fragmented, employees relied on co-operation between different aspects of the organisation in order to effect successful patient care. Participants across the sample spoke about the difficulties of managing the treatment of patients across boundaries.

The concerns of some were focused on problems that occurred during critical points in the care service such as when a patient's care transferred from one aspect of the service to another.

"... taking a patient of another healthcare professional can be very frustrating ... I haven't had one for ages but we went through a run of some really uncomfortable jobs." (ID AC1:12 AC1B)

"I had another one where this baby had stopped breathing but would breathe if you stimulated it so you had to constantly stimulate it and that was off a nurse ...

but it's knowing which bit is my responsibility and which bit was hers and she wouldn't let go of the child, so she ended up sitting in an unsafe position in the vehicle with the child in her arms and then I was having to look after its airway and its breathing while she still had it in her hands ... she took hold of this baby and was so freaked out by it that she wouldn't let go, she knew that she was responsible at the time before we arrived but then wouldn't let go when we arrived ... (ID AC1:14 AC1B)

"Sometimes if they are in pain, they may have had some medication written up in A&E, on occasions when they haven't our staff have been informed to do an incident form ... " (TM GSWC1:1)

Furthermore, boundaries created barriers. These barriers impeded the ability to effectively care for patients because professionals became tribal and preoccupied with their own role. The result was that they failed to communicate and co-operate with others.

There was a great strength of feeling from one GP who argued that:

"There is this complete obsession with avoiding hospital admission but avoiding hospital admission is all about people communicating and people knowing what is going on and people working together and so what tends to happen is the situation deteriorates, it's almost supervised neglect in a way, the system creates supervised neglect, every individual is doing their own bit and they are all actually doing their own bit properly but the problem is that nobody is putting those bits together to realise that actually there is a global decline in this patient's condition. If they had been here with everyone with their own bits of knowledge and their own bits of skill and everything else, we'd have actually stopped that so then that patient wouldn't have ended up in hospital." (PR GPPM1:9 GP1)

As these situations escalated, there was evidence that, contrary to and in conflict with their patient oriented beliefs, professionals became insular and parochial.

"... it all gets very difficult and actually you then forget what you're there for which is the patient care and you then start fighting your corner ..." (RB GPPM1:20 GP1)

For some participants, boundary challenges struck at the very heart of their values and beliefs.

"... the very people who depend on us working together and spending time together are the people with serious illness.... (RB GPPM1:24 GP1)

The defined barriers created by boundaries in the workplace conspired to erode relationships and created an atmosphere that was toxic and unproductive, particularly in terms of patient care (Vignette 2).

As the following quotations show, participants were annoyed that this sometimes happened because professionals could not be trusted to fulfill their workplace responsibilities.

"... it really frustrates me when I am going through notes and things are in the wrong place. It surprises me that they just leave it because there are outpatient appointments, and yes the nurses can do it, ... everything just gets left ..." (TW GSWC2:5)

Vignette 2

"... we have a patient who goes to surgery at our branch surgery once a week who has very bad leg ulcers that have to be dressed every week ... He lives on his own, he is a rather eccentric individual and he is now of retirement age ... so every week he goes into our nurses, now district nurses see a lot of patients with similar problems to what he has ... they don't see our patient because he goes into the surgery because he is mobile ... ... he can walk there, he is not capable of getting on a bus, I think mentally he would struggle with that ... Now one particular week our nurse rang in sick and our second nurse, ... was on holiday so we didn't have a nurse. So I rang district nurse team and asked if they could go and see this patient at home to do the bandaging because I haven't got a nurse and the sister refused because he is mobile ... 'We only see patients who are housebound ' ... so I had a man here who we had already had to ring and say you can't go into the surgery this morning for your leg doing because our nurse is sick but don't you worry because we are sorting it ... he had already rung 4 times, 'when is somebody coming, you said somebody would be coming' and we're saying we are trying ... we put it through as a referral to the district nurse team so then it went in a different way but they still refused and so the poor man never got his leg done so he was totally out of it because he just couldn't cope. "

(F GPPM2:6, 7 GP2, PM2)

However, the issue of boundaries seemed much more prevalent amongst GPs and Practice Managers. There were examples, such as the following, where boundaries created an unwelcoming atmosphere between GPs and their peers.

"The relationship with the main district hospital up the other way used to be close but now there are so many Consultants around and now that it is a rather impersonal environment." (PE GPPM2:11 GP2)
The following GP concurred in suggesting that boundaries between professionals and their work were becoming too defined and rigid.

"I think the main problem in it all is that patients are beginning to fall through holes in the service because the boundaries are getting so defined. " (TW GP1PM1:10 GP1)

GPs and their Practice Managers were furious and outraged at how defined boundaries controlled patient care processes and provided several illustrations of this. In each case, their working relationship with the Primary Care Trust was both the source of the issues and the focus for their hostility.

In the first illustration, the demarcation lines between general practice and the Primary Care Trust is the subject of frustration for a GP and his Practice Manager. Their attempts to engage with the running of patient care in the area were disregarded and they felt snubbed and ignored. Their perception of the futility of this situation was apparent in their discussion.

Illustration 1

"... some of us in the 6 practices are trying very hard to help the health authority reduce their financial overspend but by remodelling and perhaps optimising services that won't cost any more but we have had no success in engaging with the health authority and saying actually we could give you some good ideas, why don't you do this, why don't you do that and then it will solve the service problem and also it will cost you less money and we have had 2 years of no listening ... they ask you the question and then never come back to listen to the answer do they? ... That's right ... and that is what you are up against, that they are coming out wanting you to help and then when you think of ways to help them, it is not what they want, they have thought of their own ways which may help them but it is not helping us, is it?" (RSP GPPM2:6 GP2, PM2)

The second illustration raised a recurring theme (see Vignette 3 and Illustration 3), that of the boundaries between general practice and district nurses.

Vignette 3

"Because everyone is being pushed into boundaries so they have drawn this up around themselves and they won't step outside it but there are a group of things that occur which don't actually fit into anybody's boundaries and it is those things which always fall through the net. And all it needed was that half hour cup of coffee talking about what was on tele last night and by the way have you seen Mrs Jones? And although you might have been talking about what was on TV last night, what was talked about in that half hour actually saved three hours work because it was what was talked about, you know, have you seen Mrs Jones's leg recently, it is actually looking a bit gammy, that would have triggered off a chain of events that would have actually solved the problem."

(TW GP1PM1:6 GP1)

Illustration 2

The GP began by providing some brief background information to the issue.

"... there are two ways of employing nurses in general practice or primary care, one is employed by the practice as a practice nurse and another group of nurses, the district nurses, are employed by the PCT and then at one time the district nurses were seconded or attached to the practices ..".

He then continued by explaining what they had observed in the working practices of the respective groups of nurses; Practice Nurses and District Nurses. To his mind, the resources of these two groups of professionals were not being used effectively or efficiently.

"... and we found that the nurses would be doing something at home with the patient then as soon as they came in here they would change and it always seemed that somehow people weren't using their skills and experience ..."

The result of this was that boundary responsibilities had not only created complexities in patient care but also conflict between individuals and a collapse in teamworking. The GPs first thought was to introduce a new supervisory role at Trust level to manage the situation.

" ... we almost had 2 groups of nurses kind of pushing work off on each other rather than working together and it did seem that the process was getting so complex that it needed a highly skilled but pretty well paid band 7 nurse to

manage the whole process from the community nursing group without any connection with us ...so we were saying, give us a district nurse, let her talk with our practice nurses for an hour about who is doing what, where and when and we could I'm sure deliver better nursing to the patients, cheaper. And all the other practices said fine, let's integrate it within our practices ..."

However, in attempting to address the boundaries he had observed, he encountered others similar to those cited at Illustration 1.

"...there was a substantial paper billed by a GP at one of the other practices and a district nurse and a community nurse which has been ignored by the PCT ... which would have improved care, saved money ..." (CS GPPM2:1 GP2)

The final illustration from General Practice also comes from the issues surrounding the boundaries between Practice and District Nurses.

Illustration 3

The discussion between this GP and his Practice Manager shows how entrenched attitudes became as boundaries were established. The professionals involved exhibited a vicious spiral of rigid and inflexible behaviour which at times verged on the ludicrous and combative. They were, though, resolute in apportioning blame at the door of the Primary Care Trust.

"... it becomes the only way that you feel you can fight back, if everyone else is watching their corner then your only defence is to start watching yours. ... so in a way you start getting dogmatic about it yourself and saying, this dressing is not actually our responsibility, it is the district nurses responsibility. ...You can get into a situation where if someone was to get in their car and go out and do a dressing, that could be a half hour job but you can spend three quarters of an hour having four conversations with four different people discussing whose job this actually is, almost until somebody breaks or someone picks up the ball that you've thrown them. ... none of this is the district nurses' fault, this is not district nurses saying I'm not going to do that or that is not in my remit, this is coming down on them from the PCT, their job descriptions changed, they were specifically told you can't do this, you can do that, they were given a whole set of guidelines that they had never followed before.' (RB GP1PM11:13-16 GP1, PM1)

"In actual fact we ask the nurses to do all the bloods in the future now and on the whole that works okay but it is a good example of the way the dogma within it made a system that should be potentially very straightforward, difficult ..." (TW GP1PM1:5 GP1)

However, whilst staff in General Practice seemed to experience the most damaging effects of boundaries, they were particularly expressive about how breaking down barriers between groups of health professionals had improved working relationships. This was, though, realised in a number of different ways. As the following illustration from a Practice Manager demonstrates, at times success was achieved through initiating casual contact at informal times such as when staff were having their lunch. This participant felt that the easy atmosphere created open conditions where communications could be shared and collegiatism was promoted through the establishment of trust.

" ... every day I have my lunch with them ... So we can talk on an informal basis ... I think that is why they feel they are part of everything because as soon as something is happening, they know of it, it is all in the open and they are always part of it." (CS GPPM2:5 PM2)

Other participants evidenced breaking down barriers in more formal ways. What follows is a dialogue between a GP and his Practice Manager about a situation they handled (CS GPPM1:2-5 GP1, PM1)

The GP and Practice Manager began by outlining what they had achieved. There was pride in the way in which they recounted the outcome of a holistic patient led service.

GP*: "... we were quite ground breaking some years back in that we actually established a proper integrated nursing team which had a mixture of district nurses, practice nurses, health visitors, all grades of people, all working together and they basically spread the workload, including the practice workload, and they did it all on the basis of who was the best qualified to do that particular task."*

PM1: *"The complication is, by and large, practice nurses are employed by the practice, health visitors and district nurses are employed by the PCT so the ground breaking bit was we had to break down barriers between people who were employed by different bodies ... the common denominator was they worked for the same group of patients ... "*

They then continued by explaining, using an illustration, how they effected the holistic service. Their methods were multi-layered.

First of all they established opportunities where staff could communicate. Secondly, they confronted hierarchical beliefs which shaped the demarcation lines between staff in terms of their responsibilities. Thirdly, they were prepared to be steadfast and determined in trying to overcome barriers that had formed.

GP1: *"It was quite complicated basically; there was an awful lot of sitting down together in teams, breaking down dogma actually. ... the health visitors didn't want to have anything to do with giving children vaccinations because they felt they were over-qualified to do it, they felt their expertise was very much about much more the child globally and we started off with lowly practice nurses should be given this because they are just technicians whereas we are something special. Well we got round that by saying actually nobody is anything special here and all of us, including doctors, will do whatever it is necessary to do within this common pathway. ... took all sorts of sessions and days and sitting down and writing down what had to be done and who was best to do it.*

There was clear evidence of negotiation in the calm and rational approach they took when the sense of what they were doing was challenged.

PM1: *" ... initially it was, well I'm paid by these and my team leader is, and who pays my petrol if I go out and do a practice visit because someone else pays my petrol, etc and once we'd got through all that and worked out that there was a balance here, that if a practice nurse did some district work then it balanced back so what we were doing was the same amount of work but it was fitting in better categories."*

GP1*: "The issue with that was, no matter how you wrote it down, the people who were spending most time with the children were the health visitors and they could be doing that while they were doing other things so they could be doing some of their assessment work while they were doing that, it wasn't difficult to do and in the end they did accept that and it worked incredibly well for a period of time."*

Most importantly, they articulated the significant benefits felt by the practice and its staff and patients.

"... they were all based around the practice as a unit and they met together, they met in their different groupings, they met with us and so the whole thing functioned very well and actually it did save an awful lot of time because things weren't duplicated, people with particular skills would go out and do stuff ..."

Their final reflections encapsulated and reinforced the patient oriented nature of healthcare professionals.

PM1: " ... we had to forget about organisational barriers ... it was forgetting about the organisation, forgetting about who paid you and what your job description said and basing it back on the patient and the patient being the centre of it."

These professionals had identified an issue, acted autonomously and used their initiative and skills. The result for them was better patient care delivered through the flexible collaboration of a group of individuals who understood and valued each others' perspective.

5.4 Changes to Resourcing in Healthcare

Participants were explicit in recognising the resource intensive nature of their occupation and readily described their working days.

"... just to run through my average day in general surgery, it would start at 7.30am and I would do probably an hour and a half ward round of all the patients and my job would involve documenting clearly what the Registrar had said, how the patient was that morning and any plans for the day. Then, once that ward round is finished my job while I go round, if I am on my own for example, usually there are 2 or 3 of us and we would kind of split a role, one writing notes, one would do the jobs that were requested and the other would keep a list of the jobs that were requested but if I was on my own I would have to do all three and then when the ward round is over I would have to go back and handle those patients and do the jobs that had been allocated by the seniors that morning, ..." (PE GSREG:33)

There was much commentary from participants across the sample about the impact of resourcing changes on their working conditions. Participants perceived that these changes distracted them from working with their peers to deliver the very best patient care possible and, thus, threatened their capacity to perform their duties. The result were feelings of discord. Furthermore, they argued that resourcing changes that were imposed on employees, by those at the top of the organistion rather than derived through consensus, were more likely to result in an unfavourable response from employees.

However, a significant amount of the discussion was context specific and so distinctive for each group within the sample. Although this meant that different groups of professionals were occupied by different issues, the outcome was the same. Participants perceived that these issues undermined their opportunity to

perform their professional duties. What follows is a presentation of the views expressed by firstly, hospital staff, secondly, those in general practice and finally, the ambulance service.

5.4.1 Resourcing Changes in Hospitals

Staff within hospitals felt that their roles were being extended, this seemed to create much anxiety particularly amongst administrative staff. This Ward Clerk felt particularly strongly that she was being asked to undertake duties for which she had no training and which, to her, seemed entirely inappropriate.

"... they are now asking the ward clerks to take more responsibility for outpatients ... they have said we don't want you to question a doctor's opinion but in a way they are asking us to question doctors... but how can we question a doctor? How do we know what this patient needs or things like that?" (PE GSWC2:5)

A member of the reception team in Accident and Emergency corroborated with this indicating that roles were being extended without any consultation with the staff involved. The futility of the situation appeared to add to this participant's sense of frustration.

"... I think everything has got to add to our tension because basically you are only employed to do one job and when lots of other jobs are thrown at you, whether you want to do them or not, you are expected to do them and you have to do them and so it is all adding to pressure and stress." (ID A&EREC:9 R1)

The working conditions created by the rotation system which underpinned the Foundation Programme for Doctors was identified by this doctor as a problem. This doctor's perception was that it held the potential to expose both experienced and inexperienced doctors.

" ... I had been doing surgery for 2 months when the others came into the job behind me ... as I said it is the busiest room in the hospital and you have a lot of very sick, very complicated patients and ... you went from having 3 people who knew everything inside out to 1 person who knew everything inside out and 2 people who have never done any surgery before which turned out to be 3 people who had never done any because of the F2 as well ..." (ID GSREG:27)

In spite of this, she was resolved to do her best for patients despite feeling isolated and alone with the responsibility.

"... you never know what emergency is coming in, you can have anything from a stabbing to a bottom abscess so you never know how long they are going to be in and how serious it is. That can be a bit difficult because there really is just one of you and one SHO and one Registrar and if they are not available then you are on your own ... So it ended up being me and 2 other house officers who kept this man alive for 4 hours before we could get the Registrar out of theatre ... and make theatre available for this gentleman and actually I pumped 10 units of blood into this chap and it resulted in me going over people's heads ... but this chap survived ... it is sometimes a battle with fire, you really do just need to get on with it .." (TM GSREG: 10, 13, 17)

In addition, the introduction of the Working Time Directive and its effect on the hours of junior doctors had, according to this doctor, escalated what was expected of doctors during the working day. Hypothetically this participant viewed the potential paradoxical effects on patient care.

"The reason it is busy is you have got the same number of medical staff that you had years ago and what you have done is you've just lowered the number of hours that they work so you are paying them less so you are doing the same amount of work in fewer hours, nothing has really changed in terms of the workload, the only thing that has changed is the amount of people doing it in lesser time. In terms of the effect that it has on patients, I guess mistakes are more likely in someone who is trying to sort a whole ward out by himself or who is busier; I guess you are more likely to make mistakes. On the other hand you can argue that if you are working less hours you are more alert so that kind of counters it." (TM A&ESHO:16)

As the following quotations testify, participants in hospitals believed that resourcing changes such as extended roles had created error incidences. Participants were open about errors, some were clearly concerned, yet all accepted the state of affairs. Disturbingly, this

Vignette 4

"... sometimes I have to decide whether to send people up to A&E and I'm not sure that they would get any better care up there because everybody is so rushed, they see doctors who are inexperienced and nurses who are under qualified for what they do and I get the impression that when people go through the front door of the hospital, the quickest solution is decided upon and they are sent back out and they sometimes have missed that they are dealing with a critical diagnosis."

(PE GPPM2:12 GP2)

situation was also readily recognised by other healthcare professionals as can be seen from the succinct summary of a GP (Vignette 4).

"... if you have not been back to look at someone that you know might become more ill then yes, you are taking a risk aren't you, you might go back and something has happened to them and you have not had chance to go and look ... it has happened in the department ...that people have deteriorated and you haven't been able to get back to them and then, when you have got back to them, they have been critically ill." (PL A&EN:12-13 N1,N2)

5.4.2 Resourcing Changes in General Practice

GPs and their Practice Managers felt that resourcing changes were destroying the very fabric of general practice (Vignette 5). The remainder of this section is concerned with the changes that they discussed.

Vignette 5

"... I think what is in danger of being lost in general practice is there is an awful lot of goodwill work done which can't be measured, which is not paid for and if we lose morale and motivation then that will go."

(CS GPPM1:9 PM1)

<u>Extended Hours</u>

The launch of extended hours for GP surgeries had just been announced when the interviews were taking place. As a result, it was a burning issue amongst this group, spontaneously mentioned by each GP and Practice Manager.

One particular GP and his Practice Manager summarised the situation beginning with their concerns about its impact on their collegiate locale.

"... if we are open from 7 in the morning until 7 at night, you can't expect everybody to be there at 11am and so as a result what happens is the whole thing gets spread thinner and thinner."

Furthermore, the extended hours were threatening to the GP because he felt that it stretched an already scarce resource and prevented him from engaging in what he felt were important training requirements.

"... it was about patents saying they wanted more appointments which was a big political thing ... the reality is will it actually work and will it actually meet the needs of the patient ... and the way we work ... We run educational meetings here and when I am stretched I am going to find it really difficult to run an educational meeting for 8 GPs, 3 of whom never meet the other 5 ... (EO GPPM1:4 GP1)

The GP and his Practice Manager then went on to explain the irrelevance of the scheme in their eyes. The clear concerns were that it focused attention and resources on the quantity of their patient care at the expense of recognising the quality.

"The only thing people are looking at is the number of appointment slots with patients at a particular time but seeing patients is probably the smallest part of our day or seeing patients in a face to face consultation. You spend a lot of time dealing with patient issues but somehow you can't measure that. ..."

This particular practice showed great concern for the finer details of patient care but felt that, as the emphasis changed, it would be impossible for them to continue to properly support patients.

" As we start to get stretched a little bit further and resources get stretched a little bit further, people are going to stop looking at those systems and they are going to stop doing those systems ... stuff just won't happen ever and that's the danger of where it's going at the moment." (CS GPPM1:7, 8 GP1, PM1)"

The threat to general practice presented by extended hours was also recognised by another practice team. However, they were pragmatic in their acceptance of the initiative, preferring to take an agreed view in terms of managing its introduction.

"The biggest threat we have had just lately has been that we have been asked to do extended hours which meant the staff would be working different hours to what they are contracted to work which is a big thing to ask your staff. ... I have talked to the staff from the minute it came up ... how did they think it would work and for us it wasn't looking like a problem at all ... (GPPM2:10, 11 PM2)

<u>Polyclinics</u>

The staff of General Practice were also extremely cynical about Poly Clinics and their likely impact on their practice.

"PM2 and I both sit on our local commission group and nobody is interested at all (about their concerns about Poly Clinics) and so there was a meeting with the local MP ... and the MP ... said that he was unaware that there was any privatisation agenda at all, that the dialysis centres and these new poly clinics are only going to be in London or in deprived areas, they are not going to come anywhere else at all, no no no there is no privatisation agenda so we could be reassured." (RSP GPPM2:4 GP2)

This participant went on to explain his fears for his practice and his patients, concerns which were shared by other GPs.

"Where it is moving is 60 doctors working shifts in a big centre which again is fine for a certain proportion of people but actually nobody is holding together the complicated bit. It's what is locked up in my head that is the problem, you know I know her son, I know who to contact if there is a problem, I know what level of crisis they can cope with as a family so I have got a pretty good idea of when it is falling apart and when they actually need some intervention. But all of that goes and all of that slides into an automated system ... " (PR GPPM1:5 GP11)

"... the problem that is going to arise is you don't know what you have got until you lose it and at the end of the day it is that load of stuff that you are going to lose, you can't do that when you haven't got the personal knowledge of people. (TW GP1PM1:8 GP1, PM11)

5.4.3 Resourcing Changes in the Ambulance Service

Of all those interviewed, the timing of the fieldwork coincided with great changes in the Ambulance Service. This element of the sample was enormously outspoken and critical about the impacts these changes had on their working life. Ambulance crew were particularly concerned about the negative impact of resource allocation on their ability to carry out their duties. As the four Illustrations below show, their concerns were context specific and centred on what they perceived as the ineffectiveness and inefficiency of resources.

Illustration 1

Over the recent past, the Ambulance Service has reorganised how it delivers its service to patients. Nowadays, patients might be cared for by a technician crew, who are mainly based in ambulances, or paramedics who drive the response cars.

Ambulance crew were disturbed by changes to the staffing regime. Synonymous with other services, the function and responsibilities of a member of ambulance crew is dictated by their role. So for example, technicians perform a more limited role than paramedics who have undergone specialist clinical training.

"... there is an ECP (emergency care practitioner) scheme so people started going to that but it was too expensive (band 7) so now we have PP Paramedic practitioners band 6) so they have less training ... they go on to cars so we kind of lose them from the main rota and some people go to Rapid Response vehicles which are single person." (PE AC1:27 AC1B)

There were also strong objections about the subsequent distribution of technicians and paramedics.

... it doesn't help when you know that you don't have 100% assurance in your own mind that control will respond the next available appropriately trained person to go to that job and assist you. (PS AC3:18 AC3A)

It was sometimes a case of the right people but the wrong transport or the wrong people but the right transport.

"... there are some technicians on cars still which to me is just silly ... so the car gets there and does all the assessment but often they are not backed up by an ambulance, so then, if they decide this patient is poorly, they have to phone and let comms know that they need an ambulance ...(TO AC2:4 AC2B)

"... you phone up and say, you do know we are a double tech crew, is there a paramedic running? ... We need to know if there is a paramedic running because depending on whether or not there is a paramedic determines what we do. ... (Interviewer: So you have all the equipment) Yes, on the unit, but not the person who can use it. ... can you imagine what it is like for a double tech crew to pitch up to somebody that needs, say adrenaline, or they could die then you know they need that but you can't give it. ... they know what needs doing but they can't do it. (TM AC2:8-9 AC2A)

The personal impact of resourcing was exhibited in crew's feelings of cynicism and dejection. They were sceptical about the underlying rationale for the changes and despairing about limited resources.

"... they want to increase the amount of cars and reduce the amount of ambulances, they want to increase the amount of urgent tier staff so they will send a car and they will hope that person can downgrade that job so that within

2 hours an urgent tier can get them and that bypasses the whole middle ambulance tier ....” (F AC1:8 AC1A, AC1B)

“... the problem we see is that fundamentally people need moving and there aren’t enough ambulances to move people … there are a lot of calls that need a 2-man ambulance and we have not got enough of them.” (F AC2:4 AC2A)

As the following examples testify, ambulance staff witnessed the patient suffering that resulted from the changes, namely technician crew being prohibited from administering life saving treatments [1] or paramedic staff being unable to transport patients to hospital [2]. In the eyes of these participants, the impact on patient care and the staff attempting to deliver it, was acute.

[1] “I was working on a job last night with another technician and I have done a paramedic diploma at Hallam university ... (I am) on the HPC register as a registered paramedic, I have done hospital placements so I can cannulate and insulate and all that ... So last night I go to a cardiac arrest, me and C who is a technician ... so patient is in cardiac arrest so what do you want to do, you want to cannulate and get some drugs in, they said a paramedic was coming and for 20 minutes we were doing CPR before the paramedic came. It is absolutely appalling because at the end of the day I could have cannulated that patient and got adrenaline in, intubated them, I could have done all that in 20 minutes, instead we were sat waiting for a paramedic to come.” (PL AC3:17 AC3B)

[1] “ (I feel) Frustrated more than anything, when you go to a job and you know what they need, what can be done for a patient, but you can’t do it. ... Well, God forbid, but if I was ever in that situation I think I would phone A&E to speak to a doctor and ask if they would authorise me to give adrenaline, how can you stand there and watch somebody die when you know what they need? ... you can’t just stand by and watch somebody die (PE AC2:8-10 AC2A)

[1] “I do think that having double technician crews puts patients at risk, without doubt ... (PS AC2:9 AC2B)

[2] “There are one or two people who have come off Car because they have had bad experiences where they have been left with people. It is a stressful enough job as it is but if you just imagine that you have a paramedic on scene with someone who has had a heart attack and they will also have the relatives asking where is the ambulance? They watch casualty, they know that they should be on an ambulance and should be going to A&E, ... the paramedic on scene is trying to do the best for the patient, trying to sort relatives out, ringing control and sometimes you just absolutely despair of the situation.” (D AC2:7 AC2B)

Ambulance crew recognised, though, the positive outcomes that occurred when resource allocation enabled technicians and paramedics to effectively work together.

"... it was a good job that car got there because they would have died but it is also a good job they sent that ambulance so that they got there within 5 minutes of the car getting there. So they do make a difference, they definitely can get there faster than us but they can only make a difference for a short while on a certain type of patient and if that ambulance doesn't back them up, they are stuck. It seems to happen to certain people, there is a guy here who came off the car because he constantly ended up at patients' houses where he was stuck without a back up and the patient was ill and there is a guy that moved to control for exactly the same reason' (ID AC1:10 AC1B)

Illustration 2

Ambulance crew are directed to patients by a communications team. Recently the local communications team was closed and a new regional communications team was established.

Ambulance crew appeared to demonstrate parochial tendencies and exhibited an attachment to pre-change conditions. Here, a member of crew described the first of the changes which was the relocation of Ambulance Control following the merger of two regional ambulance services.

"At the moment it is in Rotherham and it is quite small and works for the South Yorkshire area, it gathers calls and sends calls out to us in the South Yorkshire area whereas within the next month it is going through to Wakefield and then it will be the whole of the Yorkshire Ambulance Service which goes right up to the edge of Tees and is West Yorkshire all the way over to Hull and South Yorkshire. So, then that one control unit will supply the whole area with calls." (CW AC11:1 AC1B)

"... the move to Wakefield ... losing the relationship that we have actually got now with the people in cons unit in Rotherham ... teamwork ... because we do react together, their local knowledge about what we are doing and the fact that we do actually help personally..." (PR AC1:4 AC1A, AC1B)

Furthermore and without exception, ambulance crew participants then proceeded to highlight the problems that they either anticipated or had experienced as a result of the merger. Their criticism appeared two-fold. Firstly, a lack of local knowledge on the part of communications personnel produced an ineffective and inefficient use of ambulance crew as a resource. Secondly, at the very least this led to a disparity of workload but there was also evidence that it had seriously compromised patient care (Vignette 6).

Vignette 6

"We are now with a system where, with that fatality yesterday, a lone responder on a fast response vehicle was left on scene for a very long time and 2 other response vehicles heard on the radio that this person was asking for immediate assistance and they offered to go, they were close by and the call centre said that they were not needed, that it was not necessary and a crew was responding. In fact 2 crews were responding from out of Sheffield and one of the fast response vehicles was 4 minutes away and, bearing in mind we are dealing with a fatality on scene and a seriously ill 10 year old paediatric girl... that is the frustration because, first and foremost, if control phoned through and interrupted a meal break and said there was an emergency then anyone here would respond, no problem ..."

(PR AC3:5 AC3A, AC3B)

"... communications ... it has now moved to Wakefield whereas before it was here. That is not as good now, at least they were in Rotherham before and the staff there seemed to know the crews and the area, basically they knew who was closer to where, now it just seems like they haven't got a clue. Some crews are just hammered all day and other crews are sat on the station for 2 or 3 hours doing nothing ... They will say, what station are you from and we say so and so and they will say, where's that? (EO AC3:11-12 AC3A, AC3B)

"... the mind boggles sometimes when you are driving and you actually cross other crews and you think why are they not going to where they have just come from and why are we not going to where we have just come from and why are we passing like ships in the night? (EM AC2:3 AC2B)

"it was a lot better and there was all this promise that actually we don't need a local control centre that has a local knowledge and maybe a more intimate

knowledge of the crews and a local knowledge of where those crews were and who was best to respond." (PR AC3:11 AC3A)

Moreover, ambulance crew were disparaging about the quality of Ambulance Control staff.

"... they can be anybody, they could have worked in McDonalds last week and then have gone through the despatch training and then they are answering 999 calls and a few weeks later they are despatching ambulances with no clinical involvement." (PE AC2: 11 AC2A)

More importantly and as a direct consequence, it has also adversely affected their ability to deliver patient care.

" ... if I get an address in an area that I know is undesirable and I haven't got any details of what I am going to then I will quite happily admit that I will phone control and say unless I know what I am going to then I am not going any further. So then, yes, that is being detrimental to your patient because that patient might be a genuine chest pain patient who could be having a heart attack. So, in my eyes, they are delaying me going to the scene because they are not telling me what I am going to (PS AC2:4 AC2B)

Illustration 3

Deficiencies in the nature and quantity of supporting resources were also raised by ambulance crew. Crew were opinionated on the subject of the drugs that they carry. Whilst they had life saving improvements to suggest, their overwhelming perception was that decision makers were reluctant to listen because of resourcing priorities.

"My main issue (is that) ... our burns kit is a bottle of sterile water and a roll of cling film. The iconic picture of the bombings in London and the picture of a young woman with the burns mask on, why are we not carrying things like this? And when you ask, well they go out of date and are too expensive, well I know for a fact that if I pitched up at a house fire and it was some of my relatives then I would want them to have something more than a bottle of sterile water poured on them and piece of cling film draped over them." (PL AC2:14 AC2B)

"... it is the system that we use. We have one little material bag and in that bag there are various pockets, none of them are standard and so you pick one from one ambulance and another from a different ambulance and the layout will be completely different. We used to have Nubain which is an analgaesic and Narcam which is an opiate reversal and something we use for an overdose and you could give one against the other, when actually you could have an overdose and you wanted to give Narcam to combat the overdose and you

might have given Nubain which is an extra opiate because they both begin with a N and they are both in flimsy little cardboard boxes. One of the suggestions, moving on from something that happened, was let us have different coloured boxes because they are in the same size vial and they both begin with the same letter but they have completely different effects. ... there is a reluctance (to learn)..." (TM AC3:8 AC3A)

"... we carry a little grab bag of specific drugs, fatal given at the wrong time or at the wrong dose and clinical near-misses happen and we could have learned lessons from ones that have happened in the past but we don't seem to have and there is a reluctance to move forward with a whole raft of ideas that are cheap to implement but would really make things a lot easier ..." (D AC3:8 AC3A)

"... why can't we learn from these things and say okay we've got cheap measures that we could do to move one step on to try to avoid this happening again ... people are saying that sodium chloride has changed and it is not going to be long before someone mixes that up with Salbutamol, it might not be fatal or life threatening but ... another is sodium chloride in IV bags is the same size as glucose in IV bags and it might not be long before one of those is given in error." (D AC3:9-10 AC3A, AC3B)

In addition, there was some commentary about staffing changes following the merger of two ambulance services. It was the perception of participants that when the two services merged, staff who were employed locally to manage drug stocks were made redundant as part of efficiency measures. Staff were extremely frustrated that this had had a detrimental effect on the level of life-saving equipment available for them to use in care situations.

"Since we merged it is just an absolute nightmare, I mean over the bank holiday weekend up at A&E there has been no 100% oxygen masks, there has been no 40% adaptors for oxygen masks, we ran out of suction tubing, there were some drugs that some of the paramedics were saying they had run out of. ... there wasn't anything to stock up with (in Casualty), there was no stock at casualty and there was no stock here, where do we get it from?" (RB AC2:22-23 AC2A)

Illustration 4

Finally, participants explained the effects that changes to their pay and conditions had had on their goodwill and inclination to be flexible.

"... we used to be paid through our meal breaks so you could be on your break 5 minutes and the phone could ring and you would be off out again ... they don't pay us now. I think the reason for this is because they had to reduce our hours under Agenda for Change... but, if there is a cardiac arrest and we are 2 doors

down and on our meal break then they can't phone us. Now I know that I would want to go ... but they are not paying us so we don't respond now ..." (PR AC2:6 AC2B)

5.5 Experiential Training

Participants spoke extensively about training. Whilst there was some discussion about the broad processes that they were trained to perform, participants were more occupied with the dynamics of training. In the first instance, it was evident that participants possessed distinct attitudes towards training. Secondly, they distinguished between qualifications and training. Qualifications, they saw as defining their role, whereas the practioner-led training they received on the job was a crucial stage in gaining the experience they required to do the job well and progress within their profession. Thirdly, it was apparent that self-reflection co-existed with training to build the experienced professional. Finally, there was explicit commentary about the inadequacies of training. This section will present the findings of each of these aspects in turn.

5.5.1 Attitudes Towards Training

Participants had various attitudes to training ranging from being very appreciative to a more rational viewpoint.

As the following quotations show, one hospital doctor's attitude was influenced by several positive and constructive hands-off, on the job training experiences.

... when I started this job I thought I had the worst job in the world, I had a huge number of hugely complicated very sick patients ... and felt that I was learning nothing and just running around all the time doing just what the seniors had told me but by the time I finished, I realised I was probably the luckiest person there because I had a big period when I was completely unsupported and I just had to learn it in order to survive ... it is a brilliant way of learning ..." (TM GSREG:29)

"... if you have faith in your juniors ... then they are more willing to let you run free and make your decisions and stuff and just supervise from a distance. And I think that that's a very good way of learning because I think if you are hand held for most of our education then it is very easy to never learn anything really" (ID GSREG:20)

However, another hospital doctor demonstrated a more pragmatic opinion towards training.

"What we are there to do is see as much as we can, at the end of the day that is part of our training, you see as much as you can and you get confident and competent in dealing with all those different things" (EM A&ESHO:7)

5.5.2 An Evolving and Experiential Approach to Training

Across the sample, participants readily acknowledged the worth of training in terms of developing valuable experience, expertise and confidence.

"... I have always wanted to be in A&E, acute medicine, intensive care and trauma surgery so my objective in life is to expose myself to as much acute medicine and learn to cope with it without being frustrated ..."(ID GSREG:8)

"The Day Ward Clerk taught me, she has been here 20 years or something ... I have been here nearly 4 years now and I think you learn more and more ..."(TM GSWC1:4)

"... some things work really well, organising some ongoing or inter-department training with other units like the burns unit or A&E, on your float weeks ... people can now take opportunities to do day placements at maternity wards in Barnsley, an A&E placement at the Northern General, the same at the Childrens', the same with the chest pain nurses for cardiology experience ... (EO AC3:10 AC3A)

As the previous quotation indicates, this appeared to evolve over time. Consequently, participants perceived that growing experience and expertise would broadly run concurrent with status and tenure.

"I have been here for 2 years and I've just done cannulation and venapuncture and IV drugs so it is not something you do immediately it just kind of gets added on as you go through ..." (ID A&EN:13 N1)

" ... at the beginning I wouldn't have even ultra sounded a patient who needed an appendix out because I didn't know if that was the appropriate investigation." (TM GSREG:23)

"I mean the more experienced of us can decide that can wait but there are girls that are not as experienced" (ID A&EREC:9 R1)

The following member of ambulance crew explained how experience facilitated the intuitive practioner, able to judge the level of care a patient needed.

" ... there are patients that you go to and you think this is an ASHICE call, no doubt about it, and then you get other patients where you look at the ECG etc and you think well they are not critical at the moment ..." (TM AC1:5 AC1A)

As the participants below testify, the ultimate benefit of experience is that it can make a positive impact on the patient experience and patient care. This is borne out graphically by the story Vignette 7.

Vignette 7

"This lass was having a fit and the doctor was doing CPR and I got the bag and mask out to start and I looked down, the patient was only about 12, and I said "Doctor the patient is breathing" and they stopped. I mean she will have done that fit thing and they do stop breathing for an amount of time but then they just start again but the doctor assumed she was having a cardiac arrest. You don't get cardiac arrests that have come out of fitting unless they have been fitting for a long time."

(TM AC1:10 AC1B)

"... it makes more sense for someone with more experience to see them directly and makes the process a little quicker because SHO's are better equipped to make decisions about theatre or no theatre and know more about the kind of procedures people need whereas house officers don't have that knowledge." (EO GSREG:1)

"… I think what we are good at is, we have a good idea, we get a good history, we kind of package the patient up from being in a very messy state ... we get them bundled up into the ambulance, safe, hopefully feeling a little better …" (TO AC3:2 AC3A)

However, particularly when participants started to comment on the training of others, the converse was perceived to be true. Participants across the sample highlighted instances where their peers lacked the practical experience and knowledge to perform their duties.

"It is very difficult and very unusual, it is not a regular occurrence that the house officer has more experience than the F2 ... the way it worked was it just went on experience, he knew I knew more about the patients and the kinds of things we needed and took a step back and let me lead ward round and let me decide on things ... however, the other F1's who were coming in behind me who had 3 months with him are finding it very difficult, they look to me as the F2 rather than him which isn't appropriate but also goes along the lines that experience in medicine is valued as much as seniority ... "(IE GS REG:3)

In some cases, this appeared a transient situation that occurred when staff were new.

"... the majority of junior doctors when they move onto a ward, they acknowledge the fact that they don't have experience in that field ... (ID A&ESHO:12)

"... when we get new house officers on I would like to do and say these are the rules because they are in some ways just let loose ..." (TO GSWC2:1)

There were, though, more significant examples where the training regime limited practical experience and knowledge that ultimately compromise patient care.

"... there have been negative incidents that have happened, that people who were in AC3B's position or qualified and operating as a paramedic with little experience on the road have made some big mistakes" (EM AC3:7 AC3A)

As the following doctor reported, this variability in practical experience and knowledge became a source of conflict between professionals.

"We are trained in something different to what they are, the jobs are totally different but often doing a job for a few years, a nurse will become experienced in their field so they don't like junior staff coming there to learn that field within 4 months, for example, telling them or advising them or prescribing things because they are not allowed to do that whereas they are quite experienced in that field and they'll know what to do and they just can't be bothered to wait for it." (TO A&ESHO:5)

"... so being told not to do it that way sometimes there can be a rift ..." (ID A&ESHO:3)

Furthermore, participants appeared to harbour misgivings about the level of personal exposure inexperience brought.

"... not all house officers will see it that way, they will see it as a failure of the system and they should not have been put in that position on their own and they are very right ... it was difficult because as a first job you don't know where the boundaries are and it took the point where the nursing staff had to take someone aside and say this is not right, this is not fair on you, that you are doing the ward round, that they don't do any work ... leaving you alone on the ward." ID GSREG:10, 29)

"... there is also a box on the non-conveyance where we have to mark to say the patient is capable of making that decision ... and we've got no training for that ... we get sent to psychiatric cases as they will come up ...and we have minimal training for that ... you use anyone you can to witness it, we use police, we will take car numbers down ..." (TM AC1:11 AC1A AC1B)

One particular respondent described an incident which summarises the paradoxical nature of experiential training in healthcare. Incidents such as this are, on the one hand, a dramatic part of everyday working life when part of a person's professional training relies on learning on the job. However, for the staff involved they are also alarming and risky. It seems that they are, though, expected as a part of working life and, as long as the patient care outcome is positive, this particular healthcare professional felt validated by their actions and in fact, took some satisfaction from their achievement (Vignette 8)

Vignette 8

"... he was a gentleman who have been admitted from a medical speciality ... vomiting blood and passing blood from his back end and had been transferred across to us ... he had bled when I had been alone with him the day before and I had some senior support and we had managed to do some camera tests to see where it was coming from and what they thought was the cause had been treated and he had been put back on the ward and had been reasonably well. Then the following day, I didn't have any senior support at all, it was me and that was it and one of the other F1's who was stuck with another poorly patient on the other side, across the hospital ... this gentleman started to bleed profusely and uncontrollably and I had nobody, both of my SHO's were away, all of the Registrars bar one was away and he had been taken away to do a clinic at the Hallamshire and the on-call Registrar was stuck in theatre .. I did feel validated by the fact that I had done a good job and I have done everything I can and I have managed to do it. Probably the first time that I actually sat back and thought I have managed to save somebody's life today .. . "

(TM GSREG:12, 14)

5.5.3 Self Reflection and Organisational Learning

Within the context of developing their experience, some participants were open in their need for self-reflection as a mechanism for learning. The notion of self reflection was particularly significant for the doctors in the sample.

"We are mostly on the shop floor, seeing people, sorting them out and learning from it I guess." (ID A&ESHO:17)

"If you are willing to put yourself out there and say yes, the knowledge I have says this, this and this, I will double check it with somebody in a little while but my choice is to start this treatment and if it is wrong them I will have to learn from that decision ..." (TM GSREG:27)

One particular hospital doctor, who was humble enough in her reflections to recognise her limitations, condemned those who did not engage in self learning.

"I think knowing when the time has come to say, I really need help with this, could you do that and letting go a little bit is also very important ... (ID GSREG:24)

"... there are times when it is appropriate to look back on it and say, that was a good thing, that was a bad thing, that shouldn't have happened or maybe we could do something about it. But some people don't take it seriously, they don't reflect ..." (TM GSREG:19)

It was evident that learning through reflection was not restricted to an individual's self reflection. Participants commented upon the formal mechanisms within healthcare organisations which were used to prompt and gather self reflection as a means of generating organisational learning. The principal type of mechanism recalled by participants was the incident reporting schemes that record and report any so-called adverse events. However, participants remained unconvinced and challenged their efficacy on the grounds that they were cumbersome to complete, positioned defensively and thus, negated the capacity for organisational learning.

"... staff fill out incident forms if the patient has a little fall or anything like that, .. they would put everything on the incident form ... and then if something happens from a patient point of view and they look back at it and they have got a document of what staff have said at the time so it is protecting both sides really ... (EO GSWC1:1)

"I filled one in the other day and had someone helping me and I didn't think it was particularly an easy, friendly system to go through, it is just so long winded, I think there should be something a lot more simple ... because there are a lot of incidents that do happen and people don't report them because they know it is going to take a good hour or more to fill in ... and as AC2B says, she still hasn't heard anything back ..." (TM AC2:1-2 AC2A, AC2B)

"So in theory you could put an incident form in about it but what benefit would be gained by doing it I am not entirely sure." (PR GSREG:11-12)

5.5.4 Inadequacies in Training

So far this section has presented participants' opinions about training. These have, to a large extent, been positive with evidence of constructive attitudes towards the notion of training and experiential learning. However, there were indications that participants perceived inadequacies in the extent, quality, availability and content of training.

In the first instance, participants raised concerns that some staff received insufficient training to be able to perform their role well and this impacted upon others.

"... when the phone is going all the time, I find myself apologising and I have no need to but you just find yourself saying I am ever so sorry but she just wants to speak to you and you think maybe I should have better skills in putting them off ... (TM GSWC2:3)

"I think the way that doctors and nurses are trained ...., I don't think people see enough patients ..." (EO GPPM2:2 GP2)

In the second instance, this participant highlighted the dependency between the nature and quality of the training and the trainer, indicating a variable picture.

"What you do is you learn how to approach certain members by learning their character over the job ... some are more interested in some cases and not in others, some are very good at teaching you and helping you out with things, others aren't ..." (ID A&ESHO:7)

In the third instance, resourcing changes affected the availability of training. This seemed particularly acute amongst ambulance personnel who were anticipating new communications staff following the relocation of Ambulance Control. For them, the potential impacts were clear and detrimental to both ambulance crew and members of the public.

"... we haven't got hours given to us to even have meetings, our supervisor and management don't see all the girls all the time because of the different shifts and they don't even get chance to talk to half of the girls because of the different shifts that they do. So there could be meetings to try and but there is no money available ...and it's all down to funds because there is nothing available in the department for us to have ongoing training ..." (TM A&EREC:2 R1)

"... you've got this generation of Consultants who worked 120 hours a week when they were my age and my standard and so when you turn around and you say we need more support on the ward then they will go, what do you mean you need more support on the wards, I was on my own for 48 hours straight on a regular basis and nobody heard me complaining." (IE GSREG:6)

"... at the moment our Rotherham unit is closing and they are moving to Wakefield ... they don't have local knowledge like the control staff at Rotherham, they knew if you were being sent to a dodgy area and you got, be careful, watch yourself, it is a known area but staff in control now have no idea, they have no local knowledge (ID AC2:1 AC2A).

"You know if somebody phones 999 and says it's 100 yards past Tesco's near that church then someone in Rotherham will say I know where you mean and will send us, there will not be any of that when it goes to Wakefield so if members of the public don't know where they are then they have had it because there will be no local knowledge." (PS AC2:3 AC2A)

In the fourth instance, in a service where patient care is delivered across organisational boundaries, there were identified inadequacies in training to ensure cross-boundary empathy and understanding.

"We usually, these days, get a discharge summary ... which sometimes we can work out and sometimes we can't ... and that is the bug bear ... they will write on all sorts of things eg STEMI we used to get written on a discharge summary which we eventually translated which actually means, it is basically a heart attack when there isn't an ECG change to go along with it but again it was a piece of paper with just 5 letters on it." (EO GPPM1:1 GP1)

"... I actually get the choice of clinics which were written by surgeons and don't always make immediate sense to me, some of them do and some of them don't and sometimes it is straightforward and sometimes it's not." (EM GPPM1:1, 2 GP1)

"At one time, if they wanted to, they could come and spend a day with you but it is like everything else now in that there seems no leeway for people to do that ... (EO AC2:5 AC2A)

5.6 The Perceived Inequities of Organisationally Oriented Aspects of Working Life

Across the sample, participants spoke about the resource induced unfairness and inequity they experienced during their working life. These negative emotions created unconstructive conditions within which staff attempted to perform their roles and thus encroached upon their ability to perform their

duties. Whilst the notion of inequity affected how they felt as professionals, it also influenced their perceptions of other professionals. The inequity and unfairness was principally centred on responsibilities and reward.

Staff believed that there was an unfair approach towards the monetary rewards for working. In fact, as the following quotation testifies, some staff were resentful and bitter about the resource allocation arising from healthcare budgets and judged this in the light of the relative value of particular members of staff.

"I would say that everywhere in the health service or the hospital it is governed by money. And that is the annoying thing, we feel, as receptionists, that everything couldn't carry on without us but we are the ones that don't get paid a lot of money, we haven't got as many staff but there's always money for extra nurses and extra management that stand about ... and there is always money to bring locum doctors in, probably they are not going to do as much work ... So there is always enough money for medically trained ... but there is never enough money for the other jobs ... " (ID A&EREC:10 R1).

Some participants perceived that their role, when compared to others, had changed and as a consequence, now yielded a greater burden and level of responsibility which was not always recognised or appreciated by others. In some instances this resulted in feelings of professional exposure and compromised patient safety.

"I think there are situations where people don't always appreciate what another person's role is and what they need to get done because what is important to one person isn't to another. I think some of the nursing staff ... don't realise that after a weekend when you have been PI'n (admitting patient focus information), ... it is absolutely horrendous and I don't think they realise how important it is ..." (ID GSWC2:2).

"... it is difficult because of the way the system (the Foundation Programme for Doctors) works that you try as a junior, as a foundation year 1 or 2, to rotate through as many specialities as you can so you can decide what you want to do for your specialist training so you will inevitably ... end up with a senior as an F1 who knows less about your subject than you do. ... it can be quite difficult when somebody gets very unwell and you need somebody to call upon who you know will be there ... no matter how good ... you are, you can't manage on your own ... there are issues with safety" (IE GSREG:4, 7)

There was an awareness that the role, and burden, of particular members of staff were location and context specific. This seemed most acute amongst Accident and Emergency staff who indicated that they had greater responsibilities than those in other areas.

"... in A&E you are basically working by yourself, you have everyone around but you see the patient as your patient ... but it is not so much of a team between doctors compared to other disciplines ..." (TM A&ESHO: 13)

"... they are employing support workers who are advanced support workers ... support workers are like the old nurses that will actually feed patients and toilet patients and do all the basics and here all our support workers are being trained up on venapucture, cannulation, they do all ECG's, they all do extended roles that, in the hospitals, a lot of the nurses wouldn't do ... (TO A&EN:2).

Despite these observed inequalities, there was a egocentric underpinning evident in the comments of some participants who spoke about extended responsibilities. Some used extended responsibilities to elevate their role whilst others basked in the glory of self achievement.

"... more and more things are being expected that nurses get trained in but it is just where it differentiates them between a nurse and a doctor ..."(IE A&E N1N2:9 N1)

"... we didn't have a good relationship with our Registrar, so it really was correcting their mistakes for the best part of 3 months and meant we had a fantastic working relationship with the nursing staff because they knew how the ward worked, they knew what the Consultant wanted, they knew we usually do this, so it was brilliant. (IE GS REG:11)

5.7 The Stressful Impact of Organisationally Oriented Aspects of Working Life

The following quotation from a nurse encapsulates the physical and emotional demands she

Vignette 9

",,, sometimes you can be on a run of 10 shifts in a row and they are all different shifts so you don't do 10 lates or 10 earlies, you could finish at 9 o clock at night so you don't get home until 9.30pm, by the time you unwind when you get home it is 11, you get home, have something to eat, have a shower and go to bed, it is 11 and then you are up at 6am to be back on duty for 7am and you have done that for 10 days and you are really knackered. On day 1 and day 2 and day 3 you can probably cope with it and be alright but by day 10 you can sometimes cry ..."

(PL A&EN:4 N2)

encounters whilst fulfilling her daily duties. Implicit within her account are the resulting stresses and pressure (Vignette 9). Her views, whilst replicated across most of the sample, were particularly dominant in the interviews with hospital staff.

Some participants spoke about the impact this had on them, not only at work nor simply in terms of patient care. This was confirmed by the following nurse who argued that resource allocation was so challenged in some areas that staff were forced to compromise patient care (Vignette 10).

Vignette 10

"... when you have got to get somebody through in 4 hours and I have somebody with chest pain and I need to do an ECG then that will always take precedent over somebody needing the toilet and it sounds awful but it will and there have been times when I have been busy and I have knowingly left people incontinent in dirty sheets because they are not going to die from that and it is horrible and I feel horrible doing that but I think you need to go the other way and employ more people to do the basics."

(IE A&EN:10 N2)

The reflections about how the competing priorities within a role prevented participants from achieving job satisfaction were heartfelt, emotional and, for some, impinged on their home life.

"... we make a lot of mistakes, well we don't make them because we don't do it on purpose, it is just circumstances but the PFI that controls this system are completely aware of it, they try and blame us and say we are careless and we work too quickly but when you have got 6 or 7 ambulances to book in then you have to work quickly ...We average about 280 patients upwards a day, that's from the whole A&E including ambulances and people who walk in, so you can understand it, we are pulled from pillar to post. (PL A&EREC:3 R1, R2)

"I think the hard thing about this job is you never do a good job, there are always things that you could do better because, there are that many things to do, you always compromise what you are doing and the nice things like feeding them and giving them a cup of tea are the least of your priorities, they are way down on your scale of what you have got to do. They are the nice things, having a cup of tea and being clean but they are not going to kill you or make you really unwell so you never get to do those nice things and patients are never happy in A&E ... you personally feel awful; you get home and feel awful because you know there is more that you could have done really. "(PL A&EN:14-15 N2)

Throughout many of these interviews, participants spontaneously mentioned the stress and pressure that dominated their daily working, and at times spilled over into their home life, some of the common sources are shown below in Table 5.1.

Form of Pressure	Example
The Nature of Patients Needs	*"You get difficulties there when you can't get the full details from the patient for whatever reason and the doctors want to take bloods, they can't take bloods from the patient unless they have got this line up on the screen from admissions. So you have to phone up and tell them about him but all the details could be wrong and not checked, because the doctors will put you under pressure saying they want to take bloods and the patient has not been admitted yet, so you might just have to get a line up and go back in and change the details later but you just hope that they have got the proper details from the patient to put on the label for the bloods." (RB GSWC2:13)*
Relentless Workflow	*"...sometimes if there are no beds you can end up with about 15 people just waiting for a bed but it doesn't stop the other ones coming in the door as well." (PL A&EN:3 N1)* *"I think I can safely say that most people that work on that desk feel that you don't really acknowledge the person that you are talking to because you are just going through things, you want a lot of information from them and a lot of it is personal information that people don't always want to give, that is of no benefit to their visit to the department but it is because people in various areas of the hospital want the information for audits and figures and things and you are going through them at such a rate that you must appear to people as though you are not bothered, you are unconcerned and you are just treating them as though they are not a person. " (PL A&EREC:4 R2)*
Lack of Time	*"... it is really stressful in triage because they say you get on average 3 minutes to make that decision." (D A&EN:2 N2)* *"I feel quite stressed out of triage. Triage is quite nice if you've got time to do it but if you are really busy like, literally, they are booking in every 3 minutes, it's stressful to make them decisions quickly and safely and the most times I go home and worry is when I have been in triage, I worry about who I have put in the waiting room." (RB A&EN:30 N2)* *"I think, as a nurse, it (4 hour waiting time target)is probably more stressful because you feel you are constantly nagging at the doctors as well, what's happening, have you referred this patient on." (A&EN:1 N2)*
Letting Others Down	*"I mean our work piles up and piles up and that is stressful, I've got that to do and I've got this to do and still patients are streaming in, sometimes and you don't show it but you get knotted up, well I do because there is so much to do and we're never going to get it done before the next shift because you feel as though you are leaving your work for other people to carry on and that can be very stressful." (PE A&EREC:16 R2)*
Inadequate Human Resources	*"... sometimes they will just sit them with me to keep them quiet (slightly laughing) and I think, is that my job to baby-sit a dementia patient ... I can object but I would look a right git wouldn't I? I mean I've got my job to do as well. A lot of the time they are quite pleasant but there was one who attacked a support worker quite recently and got her by the throat and it took 3 people to get him off, he didn't know what he was doing, he couldn't be held accountable for what he did but you are sometimes quite fearful." (RB GSWC2:24-25)* *"... they are just so busy, one nurse has got ten patients and there is not always a nurse in charge that is floating between the bays, I mean it is a surgical ward so they are having operations and when they come back they are poorly so things get missed." (PL GSWC2:9)* *"...the thing when we phone admissions, we haven't had the notes up in time and they have been given something they are allergic to and the patient has been too out of it to convey, we have had that before and that is terrifying." (RB GSWC2:14)*
Continuous Change	*You get tired really; you get worn out don't you? ... you do ... changes have been happening forever ... (RSP GPPM2:8 GP2, PM2)*

Table 5.1 Sources of Stress and Pressure

Predictably some stresses occurred because of the urgent and incessant nature of patients' needs. However, they also arose because of the target-led processes for dealing with patients. At times, the tension participants felt was very personal. Whilst some participants were apologetic that their behaviour had not met their own personal standards, others were remorseful that in not fulfilling their duties they had let down their peers. For some, the anxiety of the working day encroached on their home life. Participants also spoke about how constraints in human resourcing within healthcare placed limitations on some staff and transferred the strain to others. Some participants were both unhappy and anxious about these situations yet felt powerless to do anything about them. Whereas others were open about the potential for human error as a result of inadequate resourcing. Finally, participants were disillusioned and exhausted by constant change in their working environment. Irrespective of the source of stress and pressure, being prevented from executing their duty elicited a range of emotions from participants and their peers as is shown in Figure 5.1 below.

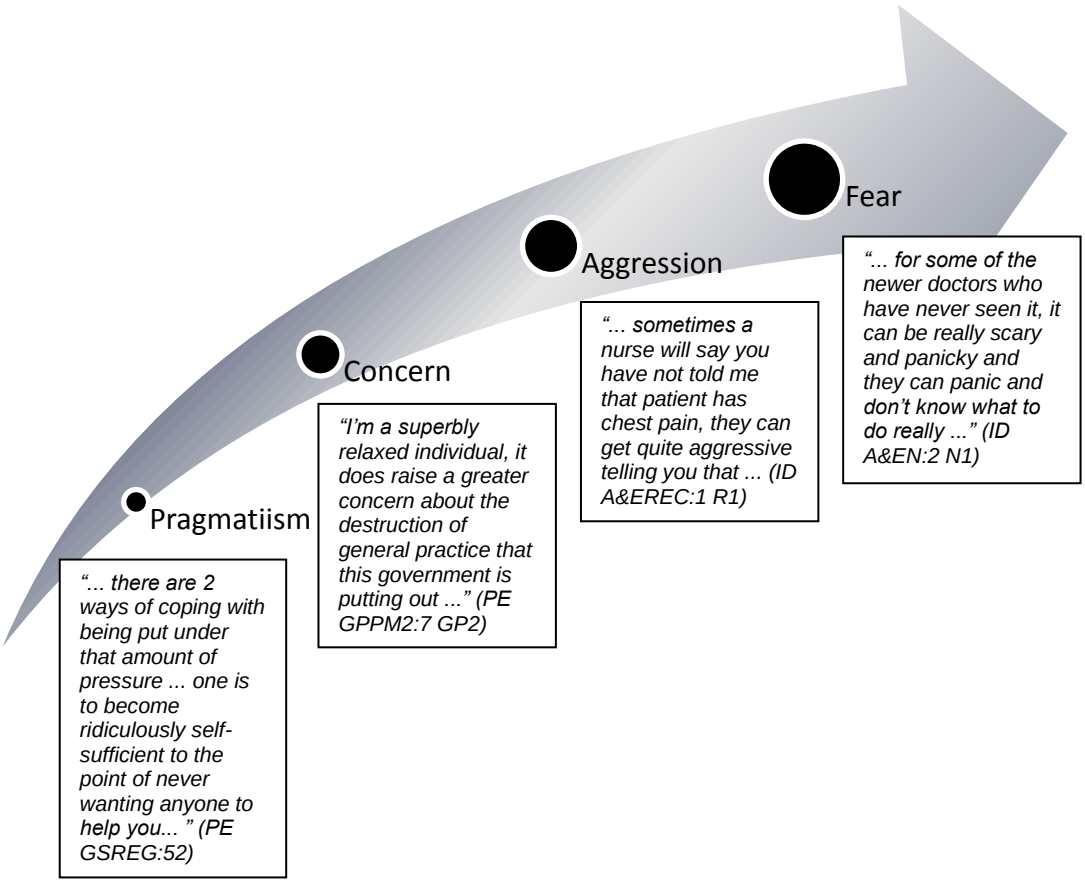


Figure 5.1 The Emotional Range of Participants

Some participants chose to face the pressure by developing a pragmatic attitude. For them, it was a case of simply getting on with things irrespective of the issues. Others exhibited a relatively considered response to matters but, in describing their reaction, they demonstrated their reluctance to accept a state of affairs. There was, though, evidence of more extreme behaviours and feelings when participants were observing their peers. Participants reported the aggressive behaviour by others when their sense of responsibility was challenged and, at its most extreme, there were others who had witnessed extreme fear, anxiety and helplessness on the part of their peers.

5.8 Summary

The aim of this thesis is to develop a deeper understanding of the management of smouldering crises and patient safety in healthcare by examining how an employee's behaviour can potentially cause smouldering crises conditions. This chapter has evaluated the narratives of participants regarding how organisationally imposed aspects of working life influenced the behaviour of healthcare professionals, why and how this impacted upon the individual.

Participants' views in this chapter centred on the mechanisms that the healthcare organisations utilised to enforce structure and control, namely targets, work boundaries, resourcing and training. Participants were critical of targets, believing them to be detrimental to patient care. Delivering good patient care across the boundaries that divided aspects of the healthcare service was felt to be challenging and, at times, divisive not least because of the resulting barriers that became erected between professionals. Furthermore, throughout the sample, resourcing changes were perceived to have resulted in ineffective and inefficient use of professionals and compromised patient care. Whilst participants were generally supportive of experiential training, there were concerns regarding the extent, quality, availability and content of training.

Although this chapter has shown that participants raised these organisationally led themes, their narratives were peppered with concerns regarding the relative impact on the individual. According to the views of participants, management

systems created pressure and stress in the working lives of healthcare professionals and fostered unconstructive conditions within which staff attempted to perform their duties. Their overriding concern was that, as a consequence, they were unable to properly perform their duties and patient care was compromised.

However, as outlined at the outset of this chapter, in undertaking the final stage of the analysis, the author also observed a second perspective concerning the working lives of healthcare professionals which concerned participants' views about themselves and their peers and how these influenced how they felt and behaved in the work environment. Chapter 6 will now focus on exploring and evaluating this second perspective.

Chapter 6 An Individual in the Workplace: Perspectives on the Individual

Chapter 4 explained how the analysis of the research found common themes within the interpretative coding which were expressions of participants' feelings concerning aspects of their working life. These feelings informed how and why individuals at grassroots level behave in the workplace in the way that they do. The author observed that the themes could be divided into two perspectives. Chapter 5 evaluated the first perspective and focused on how participants' working life was affected by organisational structure and control mechanisms. It was found that participants were critical of the impact that targets, boundaries, resourcing and aspects of training had on patient care. Furthermore, participants believed that ultimately this caused pressure, stress and unconstuctive working conditions for healthcare professionals. However, in the analysis of participants' narratives, the author also found evidence that this organisational perspective was not the sole influence of an individual's feelings and behaviour in the workplace. A second perspective, which was revealed in participants' views about themselves and their peers, influenced how they felt and behaved in the work environment.

Within this second perspective, the author identified three main themes which are used to structure this chapter. First and foremost, an individual's behaviour in healthcare is motivated by and directed towards patient care. Participants demonstrated a great sense of patient orientation. In addition, though, there was evidence that the behaviour of individuals was positively influenced by peer relationships. However, whilst both of these aspects had a beneficial impact on individuals in the work place, there was also evidence that aspects of peer relationships were destructive to the individual. Furthermore, participants exhibited strong negative feelings concerning the level of respect they perceived they were afforded by the organisation and their peers and this appeared to have a resounding effect on their self worth. Thus, the themes along which this chapter is structured and which formed the basis of the evaluation of the perspective of the individual are: patients and patient orientation, the paradoxical nature of peer relationships and their impact on working life and peer and organisational respect and value.

6.1 Patients and a Patient Orientation

This section explores the narratives of participants concerning the nature of patients and the profound orientation of healthcare professionals towards patients and patient care.

6.1.1 The Changing Nature of the Relationship with Patients

By the very nature of their work, healthcare staff interacted with the public on a day to day basis. As such they were subject to the impacts of changes in social trends which affected the nature of the patients they treated. Based on the views of participants, there were instances when staff felt ill-equipped to deal with some of these changes, finding their working lives challenged by the very people they were determined to serve, namely patients. Whilst this was mentioned across the sample, it seemed most acute for ambulance crew perhaps due to the frontline nature of their work. There were numerous reasons for their opinions and these are exemplified in the quotations from ambulance staff shown in Table 6.1

Firstly, crew were fearful of patients' propensity to take litigious action. In instances such as this, crew tended to err on the side of caution rather than use their professional judgement to assess a patient. Secondly, although their role responsibilities compelled them to attempt to treat patients, at times the offensive and dangerous behaviour of patients prevented them from doing so. Thirdly, changes in the characteristics of the population presented challenges in delivering patient care. Finally, crew were extremely frustrated by calls from time wasting patients as they perceived that this hindered the service they could offer to genuine cases.

Potential Litigation	*"I have not been on the service very long but basically I have just been taught to take the patient in, cover your own back and just take the patient in, it is not my decision to say they can't have an ambulance, just take them in ." (RB AC3:10 AC3B)* *"... the liability is a thing, it is always in the back of your mind, we will go to patients where you will think not a lot wrong here but, just in case, we are going to have to do this and this ... yes, take them to the hospital and then we are covered." (PE AC1:34 AC1A, AC1B)* *"... the thing is that the communications people know these regulars but they still have to send an ambulance out ... I think it is probably born out of a sheer terror of litigation, of being sued ..." (D AC3:2 AC3A)*
Abusive Patients	*"... the police were actually on scene at that one and this guy just grabbed my arm and started to twist my arm and wouldn't let go but the police jumped on him so that was not so much of a problem because the police were already there. So, even with police on the scene, you can still get assaulted. " (D AC2:4 AC2B)* *"We got a call the other day; somebody had collapsed in the street which is nothing new to us. We got this guy and he started being very aggressive, a young male on the scene said that he had phoned for the ambulance and he had told the staff on the phone that this man was known to be violent and aggressive particularly towards ambulance staff and he carries a knife .... It would be added to the statistics and we would get accurate abuse, verbal abuse, physical assault statistics ... it is underreported ...* (EO AC2:2- 3 AC2A, AC2B) *"… from our health and safety point of view, it is worse for us ... there are a lot of intimidating situations ..." (EM AC2:1 AC2A, AC2B)*
Population Changes	*"... we went to the Children's a couple of weeks ago with no information whatsoever even though there were 10 people in the room which we picked the baby up from, they did not speak any English whatsoever and they were trying to get a 3 year old to translate for us, they had only arrived in the country the day before ... it is unusual to have somebody with no English at all but sometimes you are dealing with a low amount of English and there are difficulties with understanding.* (TM AC1:6, 8 AC1A, AC1B) *"... we live in times now where there are lots of different nationalities here and we don't always know how to spell the names and so you can get things like that wrong and misunderstand what they mean and things like that. You might have to wait for interpreters, how can you wait for an interpreter when that patient is in pain, you have got to administer what you think. So there is a lot of onus to get things right, you might have to ask them if they were previously known as because some people could have been married several times and have 4 or 5 names and you go back, were you previously known as, were you previously known as, just to check it is that person." (RB GSWC2:16)*
Time Wasters	*"I think that is the frustration that those types of jobs, the genuine time-wasting jobs seem to be more than the genuine jobs." (PR AC3:3 AC3A)* *"... if they won't go but sometimes you can spend absolutely hours trying to persuade them to go and you try then I try and then you get a relative in to try or the police turn up and the two police try and you go round in circles." (PE AC1:35 AC1B)*

Table 6.1 How the Public Challenges Duty

In relation to the last point on time wasters, ambulance crew directed their strongest opinions towards management. Management, they believed, evaded their corporate responsibilities in not educating members of the public about usage of the service.

"I think there is a responsibility on a corporate level that there are better education programs set in place and a better PR system set in place" (EO AC3:4 AC3A)

"... there is no educational policy on a corporate level to educate the public as to what is an appropriate call and what isn't. And so I think the public are frustrated, ... they use us, rightly or wrongly ... the public has to learn how to use us appropriately ... (EO AC3:2, 6 & 8 AC3A, AC3B)

6.1.2 A Patient Orientation

Despite the difficulties healthcare professionals encountered when dealing with patients, there was evidence that participants were drawn to a career in healthcare. Although not entirely typical of the way in which other participants articulated their sense of duty as a vocation, Vignette 1 conveys how this doctor was irresistibly attracted to a career in healthcare.

Vignette 1

"... you get some people who have ... found their calling in life, love it every day and would be here all day every day if they were given a choice and sadly I might have to put myself in that bracket of wanting to be here all the time but there you go."

(PE GSREG:45)

Whilst there was also passion in the affection this participant exhibited towards her profession, this seemed to be tinged with what appeared to be a common appetite for the dramatic.

"... in my first year of medical school I completely fell in love with what I do and I fall a little bit deeper in love every single day that I work ... and my face still lights up when I talk about what I've seen." ." (MCC GSREG:1)

"... they said why don't you do medicine and I had seen ER and I thought oo yes that looks like fun, let's do that." (MCC GSREG:1)

Furthermore, this participant inferred that the desire for the more adventurous side of healthcare had directed her vocational ambitions.

"I am a rather unusual house officer in that I have always wanted to be in A&E, acute medicine, intensive care and trauma surgery so my objective in life is to expose myself to as much acute medicine ..." (PE GSREG:20)

In speaking further about their working life, it became apparent that participants' duty extended beyond an initial altruistic attraction to a career in healthcare. Participants exhibited an intense and overriding concern for serving and helping patients with the result that, almost without exception, patient orientation underpinned everything they did. However, within the responses of participants, the impetus for a patient orientation appeared to be multifaceted.

Firstly, participants positively reconciled serving patients with achieving job satisfaction.

"... that example I gave you was a time when I reflected on it and it is probably the first time I ever cried over a patient and I cried because they lived (laughing) not because they died, I cried from relief that I had done a good job ..." (CW GSREG:1)

:... a lot of the things we do, they work, and that is nice ..." (TM AC3:5 AC3A)

Secondly, there was a recognition and appreciation of the uniqueness of their interaction with patients. For some participants, this bestowed a privileged position on them and their role.

"I think what is unique for us is that quite a lot of the people we take in ... we have a unique opportunity of seeing them in their environment ..." (TR AC3:2 AC3A)

Thirdly, and to the last, participants believed that ultimately the patient was their responsibility and thus, as the following quotations show, their role was to ensure that everything possible was done in terms of patient care

"... if a patient came up to us and we thought that they were really ill or had got an abdo pain and we thought it was appendicitis then we would notify the nurse and ask them to see them next ..." (RB A&EREC:8 R1)

"... we are quite a good team and they help, the main point really is for the patient to get the best care and to treat the patient as best as we can really. So everybody has got the same goal and are working together." (TW GSWC1:11)

This sense of responsibility was, though, complex and not always an entirely positive experience for participants as is shown in Table 6.2 below.

Some participants recognised the importance of their responsibilities, indicating that the weight of responsibility correlated closely with the implications of what was at stake. For others, responsibility arose out of ultimate patient ownership. There was also evidence that participants were openly prepared to extend their obligations because of a pragmatic and genuine concern for patients. However, some participants' opinions regarding responsibility were more negative. Participants expressed feelings of passive resignation, fulfilling patient responsibilities in a compliant manner. There were others who appeared frustrated by the injustice which resulted from the association between responsibility and accountability.

High Stakes	*" We've got this big book of IV drugs and I look in it anyway even if I think I know just to check again, in fact I probably check the same drug every day even though I know, just to see it again." (PR A&EN:6 N1)* *"... if you make that judgement and you make the wrong judgement and you sit somebody out in the waiting room and they suddenly turn poorly, they have seen no doctor, it is all your responsibility. So if they had a cardiac arrest in the waiting room and died, you have got to answer to the family why you put that patient there (PS A&EN:7 N2)*
Ownership	*"... I don't think there is any clear cut thing of this is my job and this is your job, I think everything is our job and a few things are other people's jobs as well and if they are too busy then it becomes our job." (IE A&ESHO:3)*
Pragmatic Concern	*"... if nothing had happened I would have jumped in my car and done it myself ..." (D GPPM2:2 GP2)*
Passive Resignation	*"At the end of the day the patient needs that doing and if nobody else does it then we have to do it ... Everyone is busy, that is the problem, but if something needs doing I can see that it needs doing and if I can't get the message across to somebody else to either do it or prioritise it then I have to do it. (TM A&ESHO:6, 8)*
Accountability	*"At the end of the day it all comes down to us, it seems to be that we have all the responsibility for the patient so if something goes wrong it is our fault, if something goes right it is partly because we did our job right ... (TM A&ESHO:6)* *"... if a doctor prescribes a drug and I administer that drug because the doctors don't give drugs, I am accountable for that drug because I have administered it, not the person that has prescribed it ... so if the doctor prescribed penicillin and you didn't check the allergies and gave it to them then it would be your fault not theirs ... ultimately you are accountable for administering that drug (EM A&EN:5 N1 & N2)*

Table 6.2 Multi-Faceted Sense of Role Responsibility

Whilst the feelings of responsibility in Table 6.2 above were rooted in the function of a role, participants also demonstrated more sensitive and emotional connections with patient care. For hospital staff, this revealed itself in expressions of dedication and devotion to their work as is shown in Table 6.3 below.

Doctors	*"I am a little bit anal which is probably why I didn't leave until 5pm today because I realised there was something I hadn't done that I should have done in the day. I find people who don't take responsibility for their actions very difficult to cope with and I find people who consider themselves better than they are very difficult to cope with too. (RB GSREG:23- 24)* *"I am lucky if I spend less than 60 hours in this place at the moment and that is fine by me, I would gladly stay another 20 to have the experience." (PE GSREG:28)*
Nurses	*"... sometimes I know when I do triage that if I put somebody with a head injury who has lost consciousness into a team, if that team is really busy, they probably won't be able to reassess after an hour anyway and I might not be as busy in triage so I know that if I put that patient in the waiting room I can constantly see them out the window and I may be able to reassess them more easily. ... best for the patient." (PS A&EN:4- 5 N2)* *"... I often leave the doors and the curtains open just glancing at your patients as you go past ... you are looking at your patients all the time and making sure they are alright ... and there is always that thing where you might go and see somebody and their pulse and their blood sugar might be fine but you think I don't like the look of them and there is something going on ..." (TM A&EN:1, 7 N2)* *" ....you do think about things when you get home ..." (PR A&EN:1 N1)*
Ward Clerks	*"... staff should have gone home earlier but they are still there doing the writing, I know it shouldn't be like that but I think sometimes if they are experienced staff and they have had a particular shift where a patient has been unwell then they want to make sure, for their own peace of mind, that everything is okay before they go, it is not always the case that they feel they have to do that but I think people are dedicated." (PE GSWC1:5)* *"You just do the best that you can. I might be saying I need this information to put them on the computer and a nurse might say I'm not asking them now because they are in so much pain but then you worry that that bit of information is not going to be put on later if it gets left and I'll leave notes for the day ward clerk or try and leave a note on the notes, if they do go to a different ward I will leave a note for that ward clerk to say this patient has had a change of address and I haven't been able to input it on screen because I couldn't check it with them or whatever." (IE GSWC2:1).*

Table 6.3 The Dedication of Hospital Staff

The same can be said of ambulance personnel who exhibited a much stronger feeling of obligation and an almost compulsion to care (Vignette 2).

Vignette 2

"it is really hard to refuse an emergency call even if you are before your time and so we do go out." (RB AC1:2 AC1B)

"I will go to a job that I have very little information for and I will go to a job that someone has said standoff and I have to remind myself that I have the safety of my colleagues to consider and I have to remind myself not to put them into a situation that I am happy to walk into. ... some people are more proactive in finding out exactly what is wrong whereas I will go in, I'll take my oxygen and my resuscitator and I will work from what I find when I get there."

(ID AC1:3, 5 AC1B)

6.1.3 Protecting Patient Orientation

Despite the issues they faced in their daily working life, some of which were recounted in Chapter 5, many participants remained resolved to do what they could for patients and took a pragmatic approach to life in a healthcare organisation. The following General Practice team were accomplished in their ability to take a detached and pragmatic view.

"This is the NHS, if that is the rule that the NHS want me to play to this year then I will play to it, they will write a new set next year ... I think more and more changes are imposed by the department of health or ... the PCT ... I don't think I have got a choice. So yes we accept it and where we can, if we think it is necessary to maintain the stability of the organisation, we will try and work within it." (PR GPPM3:5 GP3, TR GPPM3:2, 3 GP3)

"... there are continuing problems because the secondary care providers will restrict booking in order to hit certain targets, they will restrict the availability of bookings in order that they hit their 18 week target from referral to being dealt with. And, in order to stop people being booked too far in advance, they will restrict the availability of appointments so there is a lot of sort of gaming goes on in order to meet these targets ... to the extent that the secretary/administrator of the practice comes in before 8 o'clock in the morning so she can access those appointments that are released on that day for that particular specialty because if you try and access them after 9 o'clock on that particular day there aren't any because the local provider only puts as many as it can put on to continue to meet its targets, but then like so many things in the NHS we are driven by competing targets." (PR GPPM3:8 GP3,PM3)

"... I think you have to step back from the concept that the GP is all things to all people all the time, I think we have a defined role and the defined role might be about comprehensive care of people in the community but we are not

completely responsible for everything that happens to anybody wherever they are whenever they are." (D GPPM3:6 GP3)

"Well you have to put a barrier around what I have concerns about and what I haven't got concerns about. I have got concerns about the quality of care we deliver that I am responsible for in this building but I can't lie awake all night worrying about what happens to people when they stroll into hospital in Bridlington. I mean there is a life (laughter) ..." (D GPPM3:7 GP3)

However, it was much more typical for participants to feel an emotional connection with protecting their desire to take care of patients.

"... there is quite a lot of pressure from the 4 hour that the government state to get people turned over and sometimes it is impossible, you know if, for whatever reason, you have got a really sick patient that you need to stay with then you can't always manage it (4 hour target)." (PL A&EN:2 N2)

For some participants, this was achieved by an unequivocal determination to do the right thing by patients.

"... the main point really is for the patient to get the best care and to treat the patient as best as we can really." (RB GSWC1:15)

Participants illustrated this further by evidencing their empathy towards patients. In addition, they went to great lengths to ensure that patients felt that they were important and were even prepared to be unpopular to achieve this (Vignette 3).

"I think the patient was comforted because I made a very big effort to reassure them and keep talking to them." (PE GSREG:41)

"... so I hope genuinely that people feel they have value and that, although when you try and manage anyone medically it is just impossible, I think generally that our patients like coming here and feel we are doing our best for them rather than not ..." (PE GPPM2:17 GP2)

Vignette 3

"... you have got a choice of being very hard nosed and saying you do this, you do this, you do that, I'll do this and any problems call me or sticking your head in the sand and just saying we'll all just do our best and see what happens. And I'm not really a head in the sand kind of person and it's difficult because you feel horrible about yourself for telling people that a) they are not doing something properly and b) bossing them around. But you kind of make a conscious choice I think of, do I want to get this done for the sake of my patients; well I think that is more important than feeling like a bit of a cow ..."

(PE GSREG:47)

For others, sustaining patient care was less altruistic and a more egocentric act as is exemplified in the quotations in Table 6.4. However, whilst for some participants it was about concentrating on the processes of their job, others were able to sustain their focus on patient care through the rewards it delivered to them in the form of an exciting and unpredictable environment in which to work, the sense of achievement they attained and, quite simply, the thanks they received.

Focus On Processes	*"... the nurse who has been caring, will say this patient needs follow-up and we've got a board that we've made and they write them on there and they sometimes forget but I always look because that is one of the things that worries me and I think it worries the day ward clerk as well because we are both similar in a lot of ways, we just don't want anybody to slip through the net. And I would rather someone be seen and alright than someone not be seen so I always check." (PE GSWC2:6)* *"I don't shout, I'm not angry but I will say things like, well obviously that is not right and I am very opinionated and I imagine in some respects that makes me quite difficult for seniors to work with because I will point out if I think they are doing something wrong." (PE GSREG:46)*
Exciting and Unpredictable Environment	*"... the adrenalin rush, one of the best things about this job is coming to work and not knowing what you are going to do, every job is different ... yes, so every chest pain job is different even though they are all the same." (MCC AC1:1 AC1A, AC1B)* *"... it is like any other job in that you have better days than others but your day goes so quick when it is fast paced and fast moving and sometimes I look and can't believe that is the time and I do like that fast pace and I've never really been sat there twiddling my thumbs, there is always something to do ... yes, you kind of thrive on it really I think." (D GSWC1:4)* *"... for me I think it is definitely both (the medicine of science and caring for patients) because it's problem solving, it's like a puzzle almost, what I do on a daily basis is solve riddles and puzzles, mysteries almost. I don't get to do it from scratch and I don't always get to the end and I won't know what the full answer is but I'll know somebody who does and I've been part of solving that puzzle and that is what I love, the little goals that come in between ..." (MCC GSREG:2)* *"Oh I do feel like that about this job (that every day is different) because you work with different people every day, you don't know who is going to be on the shift because it is different shifts and everyone is different. And obviously patients will be different so every day does bring its different challenges." (MCC GSWC1:1)*
Sense of Achievement	*"... if there is somebody that genuinely needs your help and you can get there then you can help them,... you can actually make a difference to that person. I mean, even as a technician, you can't do as many things as a paramedic can but you have got the training to walk in and know that this person needs to be loaded and we need to go with no messing about and you can get on and get that patient in and even though your skills aren't as extensive as a paramedic, you still feel you have made a difference." (CW AC2:1 AC2A)* *"... I suppose because there are so many difficult bits and stresses, I think you forget about the people you have helped and got through the department because you are probably dealing with something that is not going right and you forget that 5 people have just gone through fine and are onto the ward." (PL A&EN:17 N1)*
Gratitude	*"I like the feeling of and being thought well of." (PE GSREG:24)* *"... we've had some who have come back into reception, we had one who said thank you, you probably saved that man's life." (PE A&EREC:7 R2)* *"I have had many times patients ask me I would like to thank so and so and who can I write to do that ..." (CW A&ESHO:3)*

Table 6.4 Sustaining Duty for Reason of Ego

6.2 The Paradoxical Nature of Peer Relationships and their Impact on Working Life

Whilst patients, and particularly patient orientation, motivated the behaviour of participants, so did their relationships with peers. Although this section will show how peer relationships were a positive force for participants, there was also evidence of the destructive nature of relationships between professionals. This section will firstly look at the positive side of peer relationships before exploring the negative side.

6.2.1 Positive Peer Relationships

The cultivation of relationships across professional boundaries seemed to be apparent across the sample with participants extolling the positive benefits of peer relationships. There was particularly solid evidence amongst ambulance crew of the importance of peer relationships and an appreciation for the effect this had on their working day. Compared with the remainder of the sample, ambulance crew were uniquely aware of the kinship that was present in their workplace.

"... the beauty of this place at the moment is that you can come to work and no matter who you are working with you are going to have a good shift ... and that hasn't always been the case but it is really good at the moment and has been for a long while ..." (CW AC1:8 AC1A, AC1B)

"... we all have digs at different stations but they are communities within a community." (CS AC1:5 AC1A)

Furthermore, ambulance crew took pleasure and found great benefit in getting to know their fellow professionals, even showing a willingness to engage in social activities in order to do so.

"Sometimes you don't know what they look like but over the years, you sometimes get to pop in, or two of them recently came on a night out we had and you do get to put a face to the voice but you do get used to the voice and you know what voice goes with what name and how that person is and their personality. So even if you never see their face you do build up a relationship with them." (PR AC1:1 AC1B)

However, the narratives of most participants regarding positive peer relationships were purely restricted to the working environment and Vignette 4 exemplifies the positive personal outcomes that participants experienced.

There were several underlying reasons why peer relationships developed. Some peer relationships evolved quite naturally over time, whereas others grew out of mutual consideration and teamworking. There was also evidence that good peer relationships were fostered through the sense of responsibility one professional had for another and the rapport that existed between professionals. This section will now explore each of these reasons in more detail.

Vignette 4

'' the guy who delivered the stock you would speak to every morning so you would be able to say we are getting a bit low on such and such, is there any chance of getting any? And he would say I will see what I can do and the next day they would be there ... and just little things like, I am going to be working at such a place tomorrow, will you drop my kit off so I can cycle in? Of course I can and he would drop you your bag off, there is none of that now. I know that sounds like little trivial things but that is what creates a unit, an organised and functioning happy unit."

(CS AC2:4: AC2A&B)

6.2.1.1 Evolving Peer Relationships

In the first instance, some relationships had quite simply evolved over time.

"I think the relationship with the Registrars is better than what you get with the senior house officers because a lot of them, you might have worked with them when they were SHO's and they might have gone up to Registrar but because of their rotas they constantly work in A&E and I think they learn to appreciate the nurses more." (PR A&EN:5 N2)

6.2.1.2 Mutual Professional Consideration

In the second instance, peer relationships arose out of instances where one professional understood and was considerate of another.

There was evidence that professionals were aware of the needs of their peers and thus were considerate in their actions. Although some participants intimated this may not be an entirely altruistic act since a good deed could engender reciprocity or even facilitate quid pro quo arrangements.

"... if a crew is coming off and a crew is coming on then 90% of the time the vehicle has been re-equipped and ready to go and in that case you can almost be certain that if a job comes in you can go straight out." (CS AC1:3: AC11A)

"... if I've got a lot of notes then she will help me out as well so we help each other, we've got that support really from each other ." (TW GSWC11:16)

" ... our supervisor, when she is working, incorporates her hours so she is working on the reception desk to save the department money so that we can have extra hours for extra jobs that we have got because we do need the extra people and we just can't do it. " (F A&EREC:1 R1)

Ambulance crew enthusiastically reported that the concept of good working relationships was quite simply based on a professional's expertise in their role. It was suggested that this influenced their subsequent expectations and constructive dealings with others.

" I think on a day to day, person to person basis, I would like to think that we have a phenomenal and fantastic relationship with staff, very positive, very professional, from the secretaries to the doctors to the cleaners, really really good, really positive ... I think we all work really well together ... (CS AC3:5-6 AC3A&B)

"... then again that is that family teamwork sort of thing coming out again because we know we can do that with Northern General, Hallamshire." (TW AC1:7 AC1A)

The evidence of the sample was that their working lives were unpredictable and lacking in constancy. The consequences were that participants cited numerous examples of how they showed consideration for others in adopting a flexible approach to working life even within the formal processes of the healthcare service.

"I'll take a history, do an examination, order investigations or do the investigations, blood tests and things like that, x-rays and then prescribe the treatment that I think or some investigations involve the nurse doing them such as urine tests ... sometimes we have to do them depending on how busy it is or if there are enough staff ... " (TW A&ESHO:3)

"... you work in the same crew but you are a paramedic instead of a technician, the responsibility of each incident is ultimately the paramedics responsibility but we do swap job for job as to who attends ... we swap round, driver and attendant" (TW AC1:6 AC1A, AC1B)

"Depending on the ASHICE call, sometimes there is a doctor waiting for you and they will jump on board and have a quick look at what is happening and then you hand over to staff. Sometimes there can just be nursing staff and so you hand over to them ..." (TW AC2:2 AC2A)

Yet there were some excellent illustrations where acts of flexibility were informal but in keeping with fostering positive peer relationships. Some participants demonstrated this through a tolerance of thoughtlessness borne out of mutual understanding. For others, it rose out of hierarchical acknowledgement. Once more, though, there was evidence that staff were prepared to be flexible with their peers in the interests of a common mission for good patient care.

"... you do find vehicles and you've got to change this and you've got to change that or there isn't any of that and it will be because that crew was really busy during the shift and was late off, we are constantly late off ..."(TW AC1:3,4 AC1A, AC1B)

"... we do tend, with a lot of things, to work to how the nurse in charge on the day works, we know them, they know us and we work as to how they want us to work ..." (ID A&EREC:2 R2)

"It was all about flexibility but in the end it was actually about people saying what does the patient need and how best can we serve them rather than saying this is my job I only do this." (F GP1PM1:9 GP1)

However, within the sample, doctors in particular recognised that learning to handle themselves well produced dividends in a working environment where patient care was best achieved through co-operation with others. These doctors were honest and humble in their reflections and realised that they did not have complete knowledge, nor could they satisfy all of a patient's care requirements alone. The result was that they were more tolerant of others. Thus, when needing and seeking the help of others, principally nurses, to get through the working day, they did so in a self-effacing manner. They were critical of others who took a more superior tone.

"I think it is easy for me and the nursing staff because I don't consider myself senior to them because they have got more experience than me and I

appreciate that whereas some juniors don't do that, some juniors go well you are a nurse and I'm a doctor and therefore I know more than you and that's not how it works." (PR GSREG:9, 10)

This participant continued, illustrating and explaining how her approach was influenced by her past experiences, particularly those in healthcare. This doctor acknowledged and could understand and appreciate the perspectives of others in her working life.

"I worked my way through university, I worked as a dance teacher and I also worked as a health care assistant so I have worked both sides of the coin. So I have been the nurse on the phone saying 'this patient is ill, come now, please … he is going to die' and then they died and I have also been the house officer on the other end of the phone going 'I'm with someone else who is going to die right now, I'm really going to come as soon as I can, just try and do this' …" (H GSREG:5)

However, for some doctors, this was borne out of necessity to preserve their self image. The following doctor recounted a need to turn to nurses in preference to senior colleagues in order to conceal inexperience and a lack of confidence.

"... the majority of junior doctors when they move onto a ward … acknowledge the fact that they don't have experience in that field and the first point of help tends to be the nursing staff, I guess because you don't want your seniors to know that you are not very confident … (H A&ESHO:1)

6.2.1.3 Positive Peer Relationships Through Teamworking

In the third instance, the notion of peer relationships underpinning teamworking was endorsed by participants who, undeniably, recognised that they had to work as part of a team to deliver patient care. For some participants this was a very functional requirement within their immediate environment, particularly when novice staff were on duty (Vignette 5).

Vignette 5

"... staff pulling together and helping each other out. We have just had some new starters, nurses, so what will happen is if there is an experienced nurse then she might help one that is not experienced, the support workers are very good on the ward as well because they will do observations on patients and in the mornings they will get the patients washed and dressed. And with the doctors, the house officers changeover every 4 months, so when they come it may be their first post and the staff on here are usually quite good. I normally introduce myself and say if they can't find any stationery or they are unsure about putting something on the computer then they can ask me, it's just to help them find their feet and know their way around."

(TW GSWC1:10)

"I think you have to work in a team really and my role, as a ward clerk, is to support the administration of a group of healthcare professionals ... " (TW GSWC1: 9)

" ... generally, we work with them day in and day out , I can't think of anybody that doesn't work as a team and that is all it can be here." (TW A&EREC:8 R1)

Accident and Emergency staff in particular recognised the critical role of team working when faced with grave patient care situations.

"... we work in teams now ... if we assess someone and think they are really sick then we move them into resusc and hand them over to the resusc nurses." (A&EN:1 N2)

"I guess when the team becomes important, and it does happen, is in resusc situations where you have got a very sick patient coming into resusc and then everyone just goes there and assumes a role and does it and it works well." (TW A&ESHO:6)

Others, however, acknowledged the value and contribution made by professionals across the wider context of healthcare provision. There was evidence of a mutual respect and recognition that different groups of

professionals had distinctive skills and experience and that better patient care was achieved if this network of professionals collaborated and positive peer relationships ensued.

"Hospitals are very good in that they can investigate to a great degree what we will never be able to ... (ID AC3:1 AC3A)

" ...if we make an ASHICE call ... and we get in and we find out from the specialist nurses and doctors that it is not a heart attack but it is a deficiency of potassium which was exacerbated by a 4 day history of diarrhoea ... they are great, they always say don't worry, we would rather that you phoned it in, they don't look at you with daggers, you know you have just created extra work for us ... very professional ... (EM AC3:2 AC3A)

The sense of teamworking , though, resonated most strongly amongst ambulance crew. They demonstrated significant consideration for and connection with their peers as the following illustrations show.

"What you find, especially on nights, is you come in quarter of an hour earlier and there might be several night crews but only one crew is going off at 8, so one night crew takes that crew off, then they can go home and they know that in the last quarter of an hour they are not going to get a job so that night crew is very likely to go out before 8 especially here because we are very conducive to doing that. " (CS AC1:4 AC1B)

"... they might just go, they might see how strong you are and whether you need some help lifting the patient, they might see if you need someone to travel in the ambulance (if you have got a double tech crew then the car paramedic will be more highly trained and it might be best for them to travel with one of the tech crew in the ambulance)." (TW AC1:14 AC1B))

"... generally we are all pulling in the same direction." (CS AC1:6 AC1A)

" ...you get a chance to work with just about everybody and I think we are a good team here, everybody gets on well." (F AC2:6 AC2A)

Interestingly, there was a reasonable amount of reference made to the skills that good teams evidenced. Participants recognised that non-clinical based skills and experience also benefited teamworking.

" I think it is because we managed to attract a practice manager 4 or 5 years ago with a very strong HR background and she (referring to PM2) has very quietly and very effectively brought in a lot of the principles of good employment practice ... We have got an excellent team here and we have got a pretty stable

team here and they seem a happy and effective team because they are valued and that value comes from PM2 and their colleagues and I hope the doctors value them as well. (GPPM2:4 GP2)

"We got a huge number of staff from all walks of life which to me was fantastic for the service, we got a whole load of fresh blood in there and we were making headway with training." (TW AC2:9 AC2B)

6.2.1.4 Peer Responsibility and Defence

In the fourth instance, peer relationships were fostered out of a sense of responsibility one professional had for their peers and there was evidence that defending fellow professionals strengthened the bond between peers. The fact that fellow professionals were prepared to shield their peers in perceived unjust situations was very much appreciated [1]. For others, it offered important protection in dangerous situations [2].

[1] "We would have drowned in our first job without the nursing staff and I think there is an awful lot to be said for having the balls to stand up and say this isn't right ... you need to be taught how to do it properly, you are not a horrible person and we don't hate you but what you are doing is unfair and dangerous... " (CS GSREG:4)

[2] " ... there is a bit of a them and us but we mostly get on alright. You can ring them and they will try and help you out in a situation that you are in, you know that a lot of the time they will look out for your safety, you know that, a lot of the time, there may be someone in the control room who knows where you are going ..." (CW AC1:2-3 AC1B)

Some participants, who took on the role of defender, were motivated to do so because of injustices they perceived, as the following quotation from a Practice Manager speaking about her GP indicates.

"If you look at government statistics, it is all about counting how many appointments doctors have with patients, and there is no recognition of any workload following on from that." (TR GP1PM1:2 PM2) (a Practice Manager speaking about a GP)

It appeared that part of the rationale for defending peers was to be found in professionals' united front against the conditions in which participants were working. Participants spoke as if they were fighting a battle and had, through a collective mindset, achieved triumph in the face of adversity. This served to further strengthen the bonds of peer relationships.

"So you carry on with it (dealing with the Health Authority) for a year or two don't you and well we are still carrying on with it aren't we, I mean a lot would have packed up by now but we are carrying on because we do feel we are getting there at last and making some headway although it is very slow ..." (TR GPPM2:8 PM2)

" ... the pressures that it put on the ward and the ward staff ... meant we had a fantastic working relationship with the nursing staff because they knew how the ward worked, they knew what the Consultant wanted, they knew we usually do this, so it was brilliant ... we were forced into managing things that were far too complicated for our experience and just doing the best you could in a crisis ... " (CS GSREG:4)

"... nobody appreciates just how much responsibility we take, how we are two people dealing with something when almost anybody else, dealing with something in that much of an emergency, has many more than two people, have more people, have more training, have more knowledge or have at least somebody there above them that knows. There are two people but as soon as somebody is driving you become one person" (CS AC1:12 AC1B)

Vignette 6

"It's horrible sometimes, working on a ward, it really is quite horrible ... Yes and you see the pressure that people are under and you think they are under this amount of pressure and, in some instances, they are trying to save lives and keep people alive and it is difficult. Most people are really patient and there are not many rows that actually go off between staff, I think everybody just bottles it up and I think we work surprisingly well considering ..."

For the Ward Clerk in Vignette 6, the anguish and distress she felt for her peers seemed too much yet she spoke with such respect for what they accomplished.

6.2.1.5 Positive Peer Rapport

In the fifth instance, peer relationships developed out of the relaxed, non-authoritative approach of some senior professionals and the ensuing positive rapport they had with their subordinates.

"... we have a good relationship with the Consultants, they support us in what we say, they don't come down heavy on us at all, they just let us get on with it, they guide us as to how they want things doing but there is no, you will do this and you will do that, they are very good. ... they are not above themselves or anything like that and that is what makes it very nice and I think that is what makes them very nice to work with ... (PR A&EREC:1,3 R1, R2)

"I think it is just the manners ... they are important people but they are not self-important, they are just very down to earth people with us. That makes a big difference, when people can talk to you properly without talking down to you ..." (RSP A&EREC:8 R1)

"... I think the more senior the doctor,the better they treat you." (TO A&EN:1 N2)

As the following quotation demonstrates, when delivering patient care relies on co-operation between professionals, being able to communicate well is a significant benefit.

"it's like any job, if somebody speaks to you awfully, you are probably less inclined to help them and be agreeable to them, if someone speaks to you nicely and says please and thank you, you are much more open to helping them ... (ID A&EN:4 N2)

For the following participant, peer relationships had developed into friendships which were valued and preserved despite the hierarchy of daily life.

" I do consider myself friends with my Registrars and I have called them this week in fact for advice about problems I have at work as opposed to calling someone on the same level as me so I think your ability to be friends with people who are junior to you and still tell them what to do comes with experience. (PR GSREG:9, 10)

"... I think it is very difficult to get a balance between being friends with people and being senior to people. I think that sometimes has a big impact on team and I think I've just about managed it and I think it's hard because you want to be friends with the people that you work with but if you are senior to them or if you are in any way more experienced than them and need to tell them what to do or that they are doing something wrong occasionally, that makes it very difficult and I think that is something that comes with experience ..." (PR GSREG:8)

The importance of good communications in encouraging peer relationships was to be found in participants' specific comments about the relative merits of informal and formal communications. Their judgement fell on the side of informal communications.

This Practice Manager analysed the distinctions between formal and informal communications, concluding by praising the virtues of informal, bespoke communication.

"... capturing everything in IT just means you have screens and screens and screens full of information which ... So... we have a whiteboard in the coffee room so anything particularly pertinent is written on there so people glance at that while they are having their cup of coffee and they might say 'oh Mrs So an So what is happening there?' " (CS GPPM1:8 PM1)

By way of endorsement, her GP continued with his views on the value of informal communications. For him, informal communications help to create a more rounded view of a patient and their care.

"... what you can't put value on is conversations and I mean one thing we do now is at 11 o clock we all stop for coffee and we sit down and talk. We talk about all sorts of things. Yesterday we had a conversation about a chap who has quite severe psychiatric problems that we have all had a hand in but actually nobody had put the whole picture together until we sat down and said 'funny you should say that, I saw him on Monday when he was doing this and 'Well I saw him last week and actually he was fine' and 'I saw him with his mother the other day and there was something very odd going on' and suddenly you begin to get a picture. " (CS GPPM1:6 GP1).

This rounded view of patients can, according to this participant, be a particularly important asset when what has to be communicated is difficult. He concluded stating a belief in the efficacy of this method of mutual exchange, a view with which his Practice Management strongly concurred and fervently defended.

"... we had a very dissatisfied patient relative but the result of that is when I saw him yesterday I knew what had gone on, I knew what was happening and was able to handle it in a way that instead of the consultation being very angry, very aggressive and very difficult actually moved things on quite positively in a way that everybody was happy with. But you can't do that unless you spend the time... " (F GP1PM1:12 GP1)

"... this time is time that we have to protect ... that's our communication time, it's where we come together as a team and it's the time where district nurses and health visitors used to slot in as well. " (CS GPPM1:7 GP1).

Similar views were held by other groups of participants. The following quotation was taken from the interview with a member of ambulance crew. There was an interesting account here of how when one professional respects another enough to take the time to listen, understand and help, the respect is reciprocated.

"I have rung them and said I'm bringing in this patient and I'm just calling to let you know it could be this or it could be that, I am not sure but I thought I ought

to let you know in advance. And they are really supportive and say yes, fine, phone it in if you are not sure. And you ask them questions and they are quite happy to take time out and explain ..." (TW AC2:10 AC2A)

6.2.2 Negative Peer Relationships

The narratives of participants reveal that peer relationships were not always positive and this section is concerned with negative working relationships between professionals. Participants throughout the sample, argued that a breakdown in working relationships undermined their capacity to fulfil their professional obligations and sighted a number of contributory factors. These were the quality of interpersonal skills, power in relationships, practical clinical ability and mutual value and respect. This section will present the findings of each in turn.

6.2.2.1 Quality of Interpersonal Skills Amongst Peers

Whilst healthcare professionals received much formal and experiential training, some participants observed that their skill set was incomplete. Hospital staff were particularly critical of the lack of good interpersonal skills amongst their peers and recounted instances where this had a negative impact on relationships.

There was no common picture about the most prevalent offenders; doctors were critical of other doctors, administrative staff were critical of nurses but not doctors, nurses were complimentary about senior doctors yet disparaging about junior doctors. What was interesting, was what participants perceived to be the underlying reasons for particular communications and interpersonal skills, shown below in Table 6.5.

Lack of Manners	*"I think that when doctors qualify they think I'm a doctor and you're a nurse and it takes them a few years to realise that actually they need the nurses and if they speak to the nurses nicely then they get a lot more help." (TO A&EN:1 N2)* *"... arrogance because they are doctors ..." (IE A&EN:4-6 N1, N2)*
Stress	*"Yes but I would say the nurses get stressed because obviously they can go from being very laid back to stressed and shout at you without realising it ... on a busy day it can be a nightmare ..." (ID A&EREC:7 R1R2)*
Unwillingness	*"The problem in my first job was that they were both very rude and both unwilling to communicate properly and one was very junior, very, very senior ... and one was a very poor communicator ... and the other one, who was slightly more senior, had taken no responsibility to improve his communication ... (TO GSREG:14)*

Table 6.5 Reasons for Poor Communications Amongst Hospital Staff

Participants felt that some staff were simply impolite and amongst young doctors, it was felt that the novelty of their status got in the way of courtesy. Inevitably, there were examples where the stresses and strains of the job pushed staff to the edge and compromised the way in which they spoke to others. Disturbingly, there were also instances of discourtesy and contempt simply because it was perceived to be unimportant and irrelevant.

As this doctor recognised, at times, the communications issue was compounded by inadequacies on both sides which created tension within a relationship.

"Personally I think it can be both sides, it can be arrogance from the doctor or from the nurse point of view not wanting to follow something someone else said simply because of the way they said it or because they don't agree with it. ... it all comes back to being trained in communications skill ..." (TM A&ESHO:2,10)

"... occasionally the major problem with that is communications between staff, I think, especially between doctors and nurses, relationships can be difficult ... (ID A&ESHO:1)

However, participants were not always as complimentary about formal communications. This ambulance crew highlighted instances where respect was perceived to be missing from formal communications.

" ... I used to go to a lot of these meetings ... and things were moving and they were listening to road staff. And you could see it and you could actually go to

the meetings with the Directors and the Chief Executive, they were accessible to us, we could go and try and sort some things out ... Whereas, now, that has not happened because ... all we get back from the people we do have access to is no, you can't have that or somebody is looking into it, that is as far as you get and it is like banging your head against a brick wall. ... we have had it better than that before. (CS AC2:5 AC2B)

Participants expressed concerns in reconciling the quality of formal communications with delivering good patient care. Unequivocally, participants believed that this was compromised either because professionals had limited knowledge or were not always clear about what they were required to do. Irrespective of the reason, participants found poor quality communications very trying and were unsympathetic to their peers.

"And again it hasn't been a particularly well thought out communication ... because ... it would have been helpful to know why ... And that is the frustrating bit ... because you'll ring somebody who doesn't know and then they will have to ring somebody else to check and then this thing begins to snowball at that point. And all the time the patient who is a relatively innocent party in all this ... what is going to happen ..." (RSP GP1PM1:4 GP1)

"...we've asked the Registrars before to make clear statements in the notes, NO Follow-up, if there isn't because sometimes they just don't mention any follow-up... (TR GSWC2:2)

6.2.2.2 The Use of Power in Peer Relationships

Some of the observations made by participants were based on the notion that structure, hierarchy, experience and authority influenced the power in relationships between professionals. The consequences of this affected not only how people worked but how they worked together.

"... they go to performance meetings where they get shouted at like they are children over the fact that we haven't met ORCON as a whole and they are supposed to do something about that. So they find that frustrating, it is the god of ORCON, as we call it, and we are slaves to the god of ORCON and it doesn't mean anything. If a paramedic crew go to a job then they get ORCON and that's great, they have achieved the time ..." (ID AC1:8 AC1B)

The damaging effects of power within relationships seemed most acute between the doctors and nurses of Accident and Emergency and the no-win situation is epitomized by the quotations in Figure 6.1.

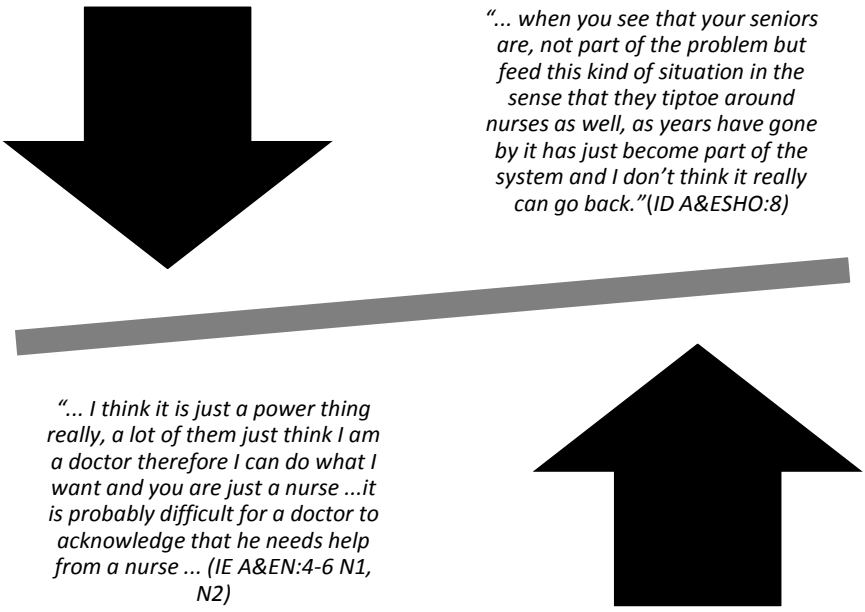


Figure 6.1 The Power Relationships Between Accident and Emergency Doctors and Nurses

There was, though, evidence from these professionals of an entrenched tolerance of the situation. Whilst for nurses this manifested itself in disdain for doctors, doctors demonstrated an almost pragmatic acceptance of the state of affairs.

"...Throughout med school you are just taught how to deal with problems and you just end up dealing with it, it just comes with the job I guess. ... I guess the nurses themselves decide, if you go to them and ask and they say I'm too busy then you just get on with it and do it, you just don't both arguing..." (IE A&E SHO:4-5)

"A lot of them are still public schoolboys that had a nice upbringing, not many of them went to comprehensives, they have had that middle class upbringing which is probably not what we have had as nurses ... it's probably difficult for a doctor to acknowledge that he needs help from a nurse maybe ..." (ID A&EN:9, 12 N1,N2)

Some participants sought to explain the root of power in their relationships with their peers. In the main, this was centred on peer evaluation and assessment. Doctors were vociferous in their objections to being assessed by nurses (Vignette 7). Nurses exhibited similar beliefs. At the very least whilst this nurtured barriers between staff, at its worst it had the capacity to foster a 'political' subservience.

"... the sisters have a sisters meeting once a month and none of the staff nurses are allowed to go and they will discuss us, how we are performing and things, so you get divides ..." (ID A&EN:3 N2)

6.2.2.3 Lack of Practical Clinical Ability

Participants readily recognised that professionals in healthcare were individuals and as such would have their own strengths. Some clinicians were very prepared to articulate their strengths.

"... I have lost very few patients that I have had to resuscitate pretty much on my own, in fact I haven't lost any patients I have had to resuscitate on my own ..."(IE GS REG:5)

Vignette 7

"... we, throughout training, were always taught to try and diffuse these situations, most people do it really well so it is just a case of ignoring it or letting it go by. The problem is we are always doing that and because we are always doing that things seem to be getting worse ... nursing staff are ... not employed by us, they have got their own hierarchy and they have got their own manager that they are answerable to and so whether they get good reviews or not doesn't depend on us, whereas our reviews do depend on nursing staff ...I don't think it is right that we don't get a say in how they do their everyday practice and I think that can affect relationships in that there is one person assessing you and you are not assessing them and they can do what they want and you can't really ..."

(IE A&ESHO:1-2)

There were some, though, who readily recognised the weaknesses of others which, whilst not preventing them from performing a role, influenced the way in which this was undertaken. Inevitably this affected peer relationships as it influenced the perceptions one professional had of another.

"... I have a few very good friends who are excellent academics ... but the clear difference between us, I think, ... his strength lies in the fact that he is a walking encyclopaedia and not the fact that he can resuscitate anybody ... (TO GSREG:7)

"... I have a friend who is 5 years older than me who is my Registrar who I have known all the way through medical school and is one year out of being a SHO and is very good but not very experienced, I also have another friend who is my other Registrar who is 4 weeks away from being a Consultant. So the experience you get in your Registrar is very variable ... so unfortunately not all Registrars and not all SHO's are created equal ...there is an understanding that experience doesn't always make you the best doctor, that just because you are

a year above me doesn't mean that you know more than I do ... (ID GSREG:3, 5, 7)

The observations of others went beyond simply perceptions of their peers, bordering on an intolerance of what they saw as blatant incompetence. This was most evident when participants were recounting instances where they felt that peers had not correctly performed their role.

"... if you do your job right and you have done all the right things, if you have done a good examination and a good history then it is pretty straightforward as to what it is and where the patient needs to go. The problem is some staff rush that sort of thing and they want the patient moving on from the department so when they make a call, if they have made a quick assessment and then made a call then the other person is a bit wary about it because you haven't told them all the information and they come down and see the patient and it is very different to what the story had been said ... the main problem I have is taking calls from people who haven't done their job properly ... (TM A&ESHO:11)

Disturbingly, this particular GP provided a most extreme example where ineffective care had become a case for complaint about negligent clinical practice (Vignette 8).

Vignette 8

"... a patient complained because cardiac failure was missed in a young person and one of the doctors here is being criticised for missing it but the person had been in hospital the previous day and had come back saying that all investigations had been normal and they thought it was X and just prescribe Y, which is exactly what he did. Unfortunately, when we look at some of the investigations, their interpretation was wrong and a few days later this man is in intensive care, I am not sure that the clinical quality is within the NHS..."

(EO GPPM2:1)

6.3 Peer and Organisational Respect and Value

Whilst the previous sections have shown how participants' views about patients and their peers influenced how they felt and behaved in the work environment , this was not a complete picture. The narratives of participants revealed that an individual's feeling of self worth was also a significant factor in their working life. This section will firstly explore the positive effects of the valued professional

before examining how a lack of respect, from both the organisation and peers, can have eroding consequences in terms of self worth.

6.3.1 The Valued Professional

Participants reported the positive effects of healthcare staff being involved in the running of their working environment. There appeared to be something in the closeness this fostered and a suggestion that this created, for staff, a greater affinity for their working domain. The following GP suggested that this was achieved by positive moves to encourage communication between staff. The result seemed to be that staff felt their situation and views were recognised and understood and they felt valued.

" ... we have a good team and I think some of it is because we are a small team ... and there is still that small feel about it where everybody is on one level kind of thing, there is no hierarchy... I think that everybody is listened to, everybody's consulted, they have a voice, they can speak up, if there is a change to be made then they are asked and I think they appreciate that, that they feel they are involved and are part of the practice." (CS GPPM2:3 GP2)

For some participants such as this ambulance crew, there was evidence that senior staff had addressed specific issues that were nagging at grassroots staff. In so doing, not only had they created more content personnel who felt that they had been listened to, they had also established aspirational goals for others.

"... I think there was a lot of hard work from the senior members that were here at the time ... to turn the situation around and make everybody feel part of the team again... certain ones got on to be technicians and then they were a lot happier, I think that is what changed ... and others then thought maybe I am not getting on because I am not good enough and tried harder." (CS AC1:9-10 AC1A&B)

"I think it was just a case of making everybody feel part of being here, making the station look a bit better, getting it tidied up and painted ... yes, really it was in such a bad state, no carpet on the floor and leaks in the roof ... " (TW AC1:13 AC1A, AC1B)

These hospital participants acknowledged the subtle yet effective way in which senior staff bestowed a sense of value on others.

"I think they do realise that we do do a very difficult job as opposed to any other receptionists in the hospital. ... I think you are appreciated not so much with what they have said but I think you feel it maybe." (TW A&EREC:7 R1, R2)

"I think any of the doctors, if you or I said to them everything looks alright but I don't like the look of them and I think something is going on, all of them would listen and they would go and see the patient quicker ... Because I do think that they appreciate that most of us have worked here for ages and it may be the first time the doctor has ever worked in A&E." (TW A&EREC:7 N1)

"...I make a conscious effort to say thanks for your help every single time because it used to annoy me that I had spent an hour and a half resuscitating this patient with a doctor who has then walked off and didn't even know my name." (PR GSREG:6)

6.3.2 Lack of Respect and Value from the Organisation

It was evident from the interviews that sometimes when a professional's sense of patient orientation was compromised, so was his sense of self worth. The grounds participants cited for this varied from general issues in the working day to much higher profile organisation-wide initiatives. Irrespective of the reason, participants perceived that the actions of others towards them indicated a lack of respect and value.

"I would expect that somebody would acknowledge that while I was doing my job that I was assaulted, perhaps for a manager to check, are you okay? Was there anything we could have done? Is there anything particular you were annoyed about that happened that day? Or just to basically acknowledge, we have got your report, we are looking into it, just to let you know that it is being addressed ... but nothing seems to be done." (TW AC2:5 AC2B)

However, as the following illustrations from General Practice demonstrate, participants exhibited much stronger feelings when they commented upon issues which they perceived had greater consequences for their feeling of self worth. By and large the majority of illustrations of this nature came from GPs, who appeared to explicitly vent their feelings on the actions of those at the top of the healthcare organisation and the actions they had taken. These participants were rather intense and emotional about the impact that these actions had on them and their working life and the tone of the discussion is passionate yet rather desperate in places.

Illustration 1

Illustration 1 concerns the Choose and Book system used by GPs to book hospital consultations. This GP was insulted by the way in which his skills and experience have been judged by those above as inconsequential.

"Perhaps after more than 20 years of practice in the area I suspect I know a little bit about the skills and attitudes of various specialists so ... if I was sending Mrs S to see somebody then I think the person she would get on best with and who also does a terrific job at this sort of problem would be Mrs X or Mr Y but I am now not allowed to use that experience, in fact it is suggested now that that experience is of no value ..." (PE GPPM2:6 GP2)

Illustration 2

In Illustration 2, the discussion centred on targets. In the first instance, this GP was resentful that targets were being used to exert control from the top of the organisation on those at grassroots level. In the second instance, he was disturbed that the targets were focused in aspects of patient care that could be quantified at the expense of what he perceived as the more vital, qualitative aspects of care. His response inferred that the nature of this control, in particular, took little account of his knowledge and expertise in terms of patient care.

"... the management of the health service has been littered by making the measurable important rather than measuring the important for ever, well certainly since the early 90's when the start of the top down attempt to manage, particularly the primary care, started." (D GPPM3:4 PM3)

Illustration 3

The themes in Illustration 3 have some sympathy with those in Illustration 2 in that the participant also recognised that their capacity to influence patient care in their working environment was limited by the control of those above. The feelings of this Practice Manager indicated that those above her were reluctant to recognise the contribution of those at grassroots level. However, this account was also about how staff felt when confronted by continuous change. This participant demonstrated feelings of frustration at the enduring nature of

change in healthcare and the effect this had on her ability to achieve in the workplace.

"... that is what you are up against, that they are coming out wanting you to help and then when you think of ways to help them, it is not what they want, they have thought of their own ways which may help them but it is not helping us, is it? ... it is just that the NHS move the goalposts every five minutes, you are on your way to something and then all of a sudden it is changed so you are back peddling because then you have got to start looking at it from a different angle because they have decided well that is what we asked you to do but now we want you to do this and so you never reach the goal." (PR GPPM2:6-7 PM2)

Illustration 4

Illustration 4 shows an account of a conversation between a GP and his Practice Manager. These participants shared others' sense of being controlled by those above them. Their expression of the situation epitomises a cynical and disillusioned disposition towards those who head healthcare in the UK. Sadly, it also highlights what they despondently view as a deteriorating state of affairs where control replaces independence and those at grassroots feel that they are not being heard.

GP: "I think that micromanagement from DOH down has spread down the whole system so every layer micromanages the layer below it and doesn't allow the flexibility. In the end DOH are only interested in whether you are in financial balance, they are not interested in anything else, ... and whether you hit their particular targets ... which aren't necessarily wrong but they don't actually look at patient care in the global sense of it. (PL GPPM1:2 GP1)

GP: "I think a lot of the civil servants that work within the Department of Health know that what they are doing is destroying something that is extremely valuable but again the gap sits with ministers and they only hear the bits that they want to hear. ... I think it is a shame and I think they have driven it beyond a point where it is going to be very hard for them to turn it round, some of the embittered views that have been established really. (RE GPPM1:12-13 GP1)

Their discussions then moved onto considering the specific effects that were felt in their practice. The challenges of keeping morale high, in spite of the working conditions, were evident. Whilst, this team never appeared to lose sight of their obligations, they were vocal about the damage that is being caused.

PM: " ... we have struggled this last 6 months, we have taken a nose dive haven't we? Yes and it is very hard to keep people motivated and keep people

going and doing the stuff. ... And you do it because actually, on the whole, the stuff that you do makes a difference ... (PE GPPM1:13 PM1)

PM: "... I think what is in danger of being lost in general practice is there is an awful lot of goodwill work done which can't be measured, which is not paid for and if we lose morale and motivation then that will go." (PR GPPM1:11 PM1)

For some, the feeling of lack of respect and worthlessness was intolerable and left them feeling embittered.

"I actually think that healthcare has deteriorated hugely in the past 3-4 years and I think the problem is you become bitter and angry about it all. There is a picture being presented which is very much a political picture which is not right and morale is at an all time low, it's about people are not being valued." (TR GP1PM1:3 GP1)

" If someone is in hospital and I want to know how they are getting on, I used to ring and say I'm the GP of so and so and I would speak to Sister and she would say, fine, hello Dr so and so, yes she is doing fine or whatever. Now, there was someone who rang me on my mobile at 10.30 at night saying I have taken my mum in because the Registrar wanted her admitted because she was confused and there is a possibility of dementia or some sort of cerebral stroke and so her daughter ... (said) my mum still hasn't been admitted, ... she is getting very upset ... and tired ... and I want to take her home. ... So I said okay, are you near the nurses' station then take your phone there and say you have your GP on the phone, let me just talk to the nurse and rearrange it. In my hearing on the mobile phone when this very reasonable woman tried to explain, the nurse said, Oh a GP, that will be no good anyway, I am too busy so nobody even had the courtesy to talk. ..." (CS GPPM2:2 GP2)

For some participants, paradoxically peer relationships were strengthened by perceptions of the 'underdog'. These feelings unified groups of professionals and created an almost tribal state of mind (Vignette 9). However, what underpinned the concept of 'underdog' was the notion that their contribution was not properly valued by others within the organisation.

Vignette 9

" ... I think maybe there is a shared feeling of we are all in a Cinderella department, we are not the only Cinderella within the NHS and maybe there is a bit of that which goes on ....

(T AC3:9 AC3A)

"... we make a lot of mistakes, well we don't make them because we don't do it on purpose, it is just circumstances but the PFI that controls this system ... try and blame us ... but when you have got 6 or 7 ambulances to book in then you have to work quickly ... We average about 280 patients upwards a day ... we are pulled from pillar to post." (TR A&EREC:2 R1, R2)

"... if they are going to add on these skills then they need to pay you for the skills as well ... they can't leave you on the same pay but expect you to be practically doing the doctor's job ..." (TR A&EN:12 N1)

These feelings were particularly acute amongst ambulance personnel who believed that their needs were considered to be less important than others (Vignette 10). For this group of staff, their neglect was felt to be on a number of fronts as the following illustrations show.

Vignette 10

"... we have just got a new fleet of ambulances but it is as if the transport manager or fleet manager from YAS has got a special deal from a dealership and they have just churned out any old sort of ambulance, there has been no interaction with crews of what works and what doesn't, what could be improved, we have taken a step back ... this is our office and they have just gone ahead and bought, as a guestimate, 100, 50, 60 of these and it is a terrible design. ... I think, in a nutshell, they just seem to blaze on ahead regardless of how staff on the road feel and what they think is good, there was no interaction or consultation ... "

(TR AC3:10, 11 AC3A)

Illustration 1 – Resource Needs

"... they are quite happy to spend millions on changing us from white to green when we became YAS but they can't buy decent burns kits ... I mean if somebody is in pain ... are they really bothered whether we all wear a green shirt, are they heck? All they want to know is that you are going to come and help them and get them sorted out." (RSP AC2:15 AC2A, AC2B)

Illustration 2 – Safety Needs

" ... we got the call to him in the street but we got his home address and we said would this be flagged? But they said they didn't know ... lo and behold, when we pitched up at A&E with him, the charge nurse knew straight away who he was and said I hope he has been checked because he carries a knife. So even staff up at A&E was aware about it but first on the scene, you and your mate, have got no idea." (CI AC2:1 AC2B)

Illustration 3 – Employment Needs

"... we were always stuck between being an emergency service and being NHS so I think we went more towards NHS with RS ... we got more perks of being NHS but then again we are an emergency service ... we don't get perks that the police get and the fire service in terms of pensions so we are just poor and stuck in the middle not knowing which side of the fence we are on so therefore we cop for all the crap from both sides." (RSP AC2:14 AC2B)

6.3.3 Lack of Respect and Value from Peers

There is much to be found in the comments of participants regarding why positive peer relationships were not achieved. The narratives centre around the boundaries that defined what professionals did and as a result how they were perceived by others. Following naturally on from this was the value of a professional. Participants decried the fact that the worth of professionals in their own right was not recognised nor were their capabilities and their capacity to act responsibly and appropriately in a professional setting. The result was that instead of acting collectively, professionals began to think and behave as individuals, thereby negating and eroding positive peer relationships.

There was evidence that the level of respect one professional had for another caused staff to question how valued they were and fostered destructive working relationships. The origins of these feelings appeared to be rooted in participants' perceptions about the nature of their role and its associated responsibilities.

Almost to the last, participants felt that they had the most difficult job in healthcare and, for some, this was linked to the notion that they felt they were at the frontline of patient care.

"We are mostly on the shop floor, seeing people, sorting them out ..." (ID A&ESHO:17)

However, the strength of reaction amongst participants appeared to be dependent upon the perceived magnitude and importance of the issue. Accordingly, where issues were perceived by participants to be relatively minor,

their reactions were more modest than instances which were seen as more significant and far reaching.

Particularly amongst administrative staff, there did not appear to be any correlation between understanding the challenges of a role and the level of respect they received from peers.

"I think ward clerks do deflect and protect staff a lot more than they appreciate, I will try and keep a lot of phone calls away from them if I can answer it myself or I will go and ask the patient if they are sat up in bed, 'how have you been today; am I okay to tell your auntie so and so'." (TW GSWC2:7)

"I think there are situations where people don't always appreciate what another person's role is and what they need to get done because what is important to one person isn't to another ... " (ID GSWC2:2)

"I had a patient the other day who had cut the end of their finger off ... because all the nurses were busy, they didn't want to see it and I had to make the managers aware, that patient still came back to me ... the finger was in the bag with cold water. So when you tell people something you hope that they will respect you and follow that through and they don't ... I think it is probably because we do overreact, we are not trained to do that " (D A&EREC:2-3 R1, R2)

However, some participants went further and there was evidence of much stronger feelings as the following illustrations show.

<u>Illustration 1 Nurses</u>

Nurses felt disgusted by the disrespect they perceived doctors showed to them.

" ... what annoys me is when a doctor is absolutely lovely to a patient and then speaks to me rudely because then I think they know how to be nice and they know how they should behave ... so why am I different because I am working here and I'm a nurse, why can you speak to me with no respect." (ID A&EN:6 N2)

Illustration 2 Ambulance Crew

At Vignette 11 is the telling account of a member of ambulance crew. These professionals possessed intense feelings of being on the frontline with a breadth and depth of responsibilities. However, they believed that there was little recognition of the fact, particularly from other professionals who were better resourced.

Vignette 11

"...and we will hand over at the hospital to a team of seven and you will have 4, 5, 6 doctors for the same patient ... with the nurses doing all the basic jobs that you have got to keep an eye on at the same time as doing the job that the doctor would be doing and you have got the relatives to deal with, you have got to negotiate that patient out of the house into the vehicle, you've got onlookers, you've got dogs, you've got mats and stairs ..."

(ID AC1:15 AC1A, AC1B)

Ambulance crews were also vocal about the fact that their qualifications and experience provided them with the skills and capability to assess patients. However, they felt that this was undervalued, ignored and, at times, undermined by others.

"We take a really decent history so we could basically say where that patient is going to end up, from our assessment, but the thing is we can't say eg it is a gallstone and the patient needs to go to a surgical ward, we have got to go through A&E ... (TO AC3:1 AC3B)

"... it is so busy in there ... there will invariably be some comment from somebody about that ASHICE call, that it wasn't good enough ... just casting aspersions on our ability to assess how ill the patient is ..." (TM AC1:4 AC1B)

"... so they can be writhing in pain when we get there but because of our intervention, when we get to hospital, sometimes the pain has gone completely and they disagree with your assessment ..." (TM AC3:6 AC3B)

"... they (the hospital) do seem to have a reluctance to appreciate that we can make an improvement in a case ..." (PE AC1:21 AC1B)

Their sensitivity to the issue of value was not helped by the lack of recognition from those outside of the service

"... my point is the press were quite positive and quite supportive of the fire service but we don't get that as a whole, there was very little mentioned of the work that we did on that job and we were called and we attended and we dealt with the two patients there but nothing was said ..".(EO AC3:5)

"... it would be nice to have a better coverage of the good things that we do rather than it always seems to be negative and shock headlines of when something has gone wrong rather than some of the good stuff that we do ..." (EO AC3:6)

Finally, ambulance crew believed that they had encountered the ultimate disparagement. This is encapsulated in their opinions in Vignette 12 of new ambulance vehicles which they felt had been commissioned without respecting the views of users.

Vignette 12

"… you try and find out who has input, some people went and looked at them and said this is not right, this will need to be moved, you need to put this here. So they did have some input from staff, fine, marvellous, did they take any notice? No. So we have now got vehicles with equipment positioned where you can't see it, you've got a stretcher that has to be moved out with a patient on and one person has to hold the stretcher while somebody deploys the ramp, the ramp is a very steep incline ... it puts a strain on your back trying to hold the stretcher from running away and the main issue is when you have a cardiac arrest because of how you have to deploy the ramp. With the old Renaults it was easy to get the ramp down and get the patient on and you were off. This new one is an absolute nightmare"

(RSP AC2:13 AC2A)

6.4 Summary

Chapter 5 evaluated how participants' working lives were affected by organisational structure and control mechanisms. However, in evaluating the analysis, the author felt that this was not a complete picture since there was also evidence that working life was influenced by participants' views about themselves and their peers.

This chapter has been concerned with evaluating the second perspective and has explored how an individual's behaviour in the workplace is also the outcome of an orientation towards patients, peer relationships and the notion of

self worth. Participants were driven in their work by a compelling sense of duty towards patients and exhibited a compulsion to care for patients. The unanimity of this orientation created a great strength of feeling towards patient care across peer groups so that collectively each individual, in pursuing a patient orientation, was aiding peers to do the same. The bond between professionals was furthered by the relationships fostered through mutual professional respect, teamworking and positive peer rapport. This appeared to create strong ties across peer groups and had a unifying effect between professionals so much so that participants felt a great sense of responsibility for their fellow professionals.

However, the picture was not completely positive and there was evidence in the narratives of participants that relationships could also be destructive and harmful to an individual's working life and, in some instances, patient care. Furthermore, whilst participants extolled the virtues of being valued in the workplace, they perceived that the actions of the organisation and colleagues eroded a professional's self worth and were detrimental to a patient focus and patient care.

The evaluation of the perspectives presented in Chapters 5 and 6 was helpful to the author in creating an image of a healthcare professional's working life. However, whilst the themes that contributed to the perspectives were useful, the author felt that the data remained fragmented to some degree. The author's consideration returned to the contribution that this thesis aims to make. Chapter 2 examined how the management literature on smouldering crises failed to take account of the behavioural influence of those at grassroots level in smouldering crisis situations and argued that this perspective would improve the limitations in management's perspective, knowledge and capabilities which were perceived in aspects of the literature to underpin these events. Chapter 3 proposed that policy regarding the management of adverse patient safety incidents, which exhibited the characteristics of smouldering crises, would be better informed if the established 'hard' knowledge was combined with a more 'soft' behavioural approach. The research associated with this thesis, described in Chapter 4, aimed to bridge these gaps by exploring the behaviour of healthcare professionals at grassroots level in order to understand how

potentially this could contribute to smouldering crisis situations. Therefore the unit of analysis was the healthcare professional. It was the author's view that the data in Chapters 5 and 6 were building blocks in developing this understanding but it was vital to centre the data around the dynamics of a healthcare professional in order to create a stronger insight into the individual and their behaviours in the workplace. This evaluation is presented in the next chapter, Chapter 7.

Chapter 7 Building on the Organisational and Individual Perspectives: An Individual's 'Faces of Self'

This chapter will evaluate the dynamics of a healthcare professional by building on the organisational and individual perspectives explored in previous chapters. In so doing, the author seeks to provide a greater insight into the individual and their behaviour in the workplace which is central to this thesis' aim of understanding why crises smoulder in organisations.

The narrative approach to the analysis found that working life behaviour in healthcare was centred on an individual's affinity with their profession and peers but grounded in an underlying need to care for patients. Whilst the associated themes identified were useful, the author felt that the data remained fragmented in terms of creating a picture of the healthcare professional. It was the author's view that these perspectives needed to be built upon so that a deeper understanding of the grassroots individual in their working life could be appreciated. In arriving at the perspectives explored in the previous chapters, narratives were identified which focused on how individuals behaved in their working life, why they behaved in the way that they did and what they gained from their dealings with peers. The author encapsulated these in the notion of 'the world as I see it', an identity which was more conducive to creating an understanding of the individual at work. A better understanding of frontline healthcare professionals and how they might contribute to smouldering crises was necessary to redress the imbalances that had been identified in existing literature, thereby providing a more inclusive and holistic approach to the management of crises and patient safety.

Thus, this chapter will build on previous chapters by exploring the viewpoint of 'the world as I see it' through the voices and contribution of individuals in order to develop an identity of the healthcare professional. Illustrations taken from the previous chapters and the data set are used to support the discussion.

7.1 An Introduction to the 'Faces of Self'

The approach of existing literature concerning the management of crises has been to view organisational crises as failures of management systems. However, whilst the dominant cause of these events has been identified as human error and there has been some development in understanding the role that management plays in smouldering systemic failures, theory has, largely, not been informed by knowledge concerning the contribution of grassroots behaviour. In the context of patient safety, adverse patient safety incidents exhibited the characteristics of smouldering crises and although knowledge has informed policy and practice, it was evident from existing literature that, firstly, tangible progress in curbing this classification of smouldering crises has been limited and secondly, this appeared to have happened in part because there had been a focus on 'hard' issues at the expense of the more 'soft' behavioural issues. With a critical theorist perspective, the author liberated the views of employees who were closer to the potential crisis incubation point in order to gain a better understanding of why healthcare professionals, with no intention to harm their patients, might make mistakes that adversely affect patients in their care. In so doing, the author deduced through the analysis that an individual's identity or 'sense of self' in the workplace was not simply the composite of the organisational and individual perspectives that had been identified. An individual's sense of 'self' was based on three separate yet distinctive features of their working life; their obligations to their patients, their affinity with their profession and their relationships with their peers. The author labelled these as 'Faces of Self' (shown below as Figure 7.1). Each 'Face' elicited an explanation of how and why health professionals behaved in the way that they did and why these behaviours might incubate error events which were symptomatic of smouldering crises.

The first 'Face of Self' was identified as the 'Duty Self'. Participants expressed sincere and strong obligations towards their responsibilities that were driven by a profound sense of duty towards patients.

"… it is probably the first time I ever cried over a patient and I cried because they lived not because they died, I cried from relief that I had done a good job …" (CW GSREG:1)

The second 'Face' was identified as the 'Professional Self'. Whilst the 'Duty Self' was motivated by patient orientation, having a strong affinity with their chosen profession was what underpinned the 'Professional Self'.

"… if I was sending Mrs S to see somebody then I think the person she would get on best with and who also does a terrific job at this sort of problem would be Mrs X or Mrs Y …" (PE GPPM2:6 GP2)

The third 'Face' was identified as the 'Collegiate Self' and was concerned with what participants drew from their relationships with peers. The author found that the narratives of participants concerning their daily lives were also grounded on the affinity they had for and the interactions with their peers. Participants demonstrated great empathy with their peers that arose out of a sense of belonging and this, in turn, generated benefits for themselves, their peers and patients.

"… especially on nights … you come in quarter of an hour earlier and there might be several crews but only 1 is going off at 8, so one night crew takes that crew off, then they can go home …" (CS AC1:4 AC1B)

Figure 7.1 Three 'Faces of Self'

In building the faces, a pattern emerged as the author identified that each 'Face' had distinctive origins, features and challenges. However, whilst the origins and features were what bound a 'Face', the challenges presented 'noise' which inhibited an individual's capacity to realise a 'Face'.

The 'Faces of Self' illuminated the motivations and behaviours of health professionals and provided explanations as to why these behaviours incubated error potential which was suggestive of smouldering crises. The remainder of

this chapter will explore the essence of each of the 'Faces of Self' beginning with the 'Duty Self' and then proceeding to examine the 'Professional Self' and finally the 'Collegiate Self'. In each case the discussion examines the origins, features and challenges of each 'Face' using selected extracts from the data and draws upon the literature within the field of individual and organisational behaviour in seeking explanations for the findings.

7.2 The 'Duty Self'

Central to the 'Duty Self' was a profound orientation towards patients which was also identified by Sheridan (2003) and Smith R (1999). Harris et al (2008) applied the concept of 'customer orientation' from the marketing literature in their study of the 'patient orientation' of UK frontline healthcare professionals. Harris et al (2008) stated that the fulfilment a health professional received from caring for patients was a significant driver in career choice.

Although not entirely typical of expressions in the data, the following quotation encapsulates how the sense of duty underpinned the vocational choice of healthcare professionals.

"... some people ... have ... found their calling in life, love it every day and would be here all day every day if they were given a choice and sadly I might have to put myself in that bracket " (PE GSREG:45)

However, according to Harris et al (2008) the desire to care for patients not only attracted health professionals to their career, it also played a crucial motivational role once in post which centred on two features. The first was the need to provide high quality patient care. The second was the enjoyment a professional received as a result of achieving this aim. There was evidence in the data analysis that the motivation of healthcare professionals was underpinned by a strong orientation towards patients and this influenced how professionals behaved. Moreover, as the following sections show, the compulsion to care and the satisfaction derived from it both emanated from the study and thus, featured in the identity of the 'Duty Self'.

7.2.1 A Need to Provide High Quality Patient Care

Harris et al (2008) found that healthcare professionals possessed an inherent desire to care for patients which was inextricably linked to their ability to be able to fulfil their duties. Moody and Pesut's (2006) study, also conducted amongst a group of frontline healthcare staff, found a similar expression with healthcare professionals expecting to be able to effectively care for patients once in post.

The author identified from the data that the behaviour of healthcare professionals arose from a strong affinity for patient orientation and that this orientation towards the patient was, in part, motivated by a sense of responsibility. The dynamics of a responsibility for patients were complex but included the critical nature of the work of healthcare professionals, a deep sense of ownership and genuine concern for patients. The essence of the following quotation bears strong resemblance with some of the facets that were used in the Harris et al (2008) study to measure the desire of a professional to attend to patients' needs, for example, "*I keep the best interests of my patients in mind" and "I achieve my own goals by satisfying my patients".*

"... sometimes I know when I do triage that if I put somebody with a head injury who has lost consciousness into a team, if that team is really busy, they probably won't be able to reassess after an hour anyway and I might not be as busy in triage so I know that if I put that patient in the waiting room I can constantly see them out the window and I may be able to reassess them more easily. ... best for the patient." (PS A&EN:4- 5 N2)

Drawing on the theory of behavioural state motivation, Moody and Pesut (2006) advocated that "self-efficacy" (p24) in terms of patient care facilitated a professional achieving a high performance in the workplace. However there were strong feelings emanating from the data that aspects of working life conspired to prevent professionals from achieving their patient orientation goal and thus, hindered performance.

As Table 7.1 shows there were a number of issues that challenged patient oriented obligations and thus, weakened the 'Duty Self'. Most of these issues resulted from influences imposed on the individual by the organisation and

included the impact of boundaries between professionals, a target oriented operational approach, resourcing constraints and changes to the social fabric of society, aspects of which have a resonance with the patient safety literature (for example Leape 2000, Fischbacher-Smith and Fischbacher-Smith 2009, Sheridan 2003, Smith and Toft 2005 and Vincent et al 2000).

Boundaries	*"... it all gets very difficult and actually you then forget what you're there for which is the patient care and you then start fighting your corner ..." (RB GPPM1:20 GP1)*
Targets	*"... it does sometimes feel like a conveyor belt and that you are shifting patients and you are trying to push to get patients out ... sometimes they are not ready to go but you still just have to get rid of them." (PL A&EN:5 N1, N2)*
Resourcing	*" (I feel) Frustrated more than anything, when you go to a job and you know what they need, what can be done for a patient, but you can't do it. ... Well, God forbid, but if I was ever in that situation I think I would phone A&E to speak to a doctor and ask if they would authorise me to give adrenaline, how can you stand there and watch somebody die when you know what they need? ... you can't just stand by and watch somebody die (PE AC2:8-10 AC2A)*
The Public	*"... the police were actually on scene at that one and this guy just grabbed my arm and started to twist my arm and wouldn't let go … So, even with police on the scene, you can still get assaulted. " (D AC2:4 AC2B)*

Table 7.1 Issues that Challenge the 'Duty Self'

Boundary disputes caused conflict which inhibited professionals from succeeding in their duty and delivering effective patient care, causing tensions between professionals. Targets shifted the emphasis from a patient oriented to a process approach to care so that professionals felt patient care and their associated workplace needs were threatened. Changes in the design and level of human resourcing prevented professionals from fulfilling their duties, creating workplace stress and compromising patient care with potentially disastrous human consequences. Finally, other issues, which originated in social changes outside the organisation, prevented professionals from carrying out their duties and had the capacity to erode the affinity healthcare professionals had with the people they wanted to serve.

Despite the issues faced in their working life, healthcare professionals remained resolved to do what they could for patients, in part because they felt an emotional connection with protecting their sense of duty and taking care of patients. This was consistent with Moody and Pesut's (2006) recognition that healthcare professionals were prepared to transcend organisational problems in order to serve and care for their patients.

"... there is quite a lot of pressure from the 4 hours that the government state to get people turned over and sometimes it is impossible, you know if, for whatever reason, you have got a really sick patient that you need to stay with then you can't always manage it (4 hour target)." (PL A&EN:2 N2)

Consistent with the findings of Harris et al (2008) and Moody and Pesut (2006), the author deduced from the data that healthcare professionals had an inherent desire to be patient orientated, this is what motivated their behaviour in the workplace and, thus, underpinned the 'Duty Self'. However, it is questionable whether aspects of the working conditions in healthcare played an enabling role in facilitating the achievement of a patient orientation approach and the 'Duty Self' since the evidence from this study is suggestive of the contrary.

7.2.2 The Satisfaction Derived from Caring for Patients

Professionals in the Harris et al study (2008) reported that caring for patients was the most satisfying aspect of their working life and felt that it was important to be able to empathise with patients in enjoyable encounters. Once again the essence of the following quotations from this study has a resonance with some of the facets that were used in the Harris et al (2008) study in order to measure the enjoyment professionals reaped from taking care of patients, for example, "*I really enjoy serving my patients" and "It comes naturally for me to have empathy for my patients".*

:... a lot of the things we do, they work, and that is nice ..." (TM AC3:5 AC3A)

"I think what is unique for us is that quite a lot of the people we take in ... we have a unique opportunity of seeing them in their environment ..." (TR AC3:2 AC3A)

Moody and Pesut (2006) viewed the satisfaction that healthcare professionals derived from caring for patients in the context of work motivation theory. Focusing on the application of the theories of Hertzberg (1968) and Hackman and Oldham (1980) in healthcare, Moody and Pesut (2006) explored how intrinsic and extrinsic rewards in the workplace provided the motivation and incentive to work. Although extrinsic rewards including tangible aspects of work such as salary, the role of working conditions and relationships was also

recognised, intrinsic rewards focused on delivering job satisfaction through an individual's perceived feelings of achievement, recognition, advancement and responsibility. Moody and Pesut (2006) noted that certain extrinsic factors, including a propensity to impact upon the lives of others, would heighten an individual's intrinsic motivation in the workplace. Georgellis and Tabvuma (2010) concurred, arguing that creating intrinsically motivated employees was a necessity in the public sector.

The author discovered that whilst health professionals attained satisfaction from fulfilling their patient orientated obligations, sustaining it on a day to day basis created difficult personal and patient impacts which were detrimental to a professional's well being.

In the first instance, and consistent with Moody and Pesut's findings (2006) regarding the emotional demands of the profession, there were many reported examples, such as the one below, of how stressful working life became particularly when professionals felt they were compromising patient care.

"I feel quite stressed out of triage. Triage is quite nice if you've got time to do it but if you are really busy like, literally, they are booking in every 3 minutes, it's stressful to make them decisions quickly and safely and the most times I go home and worry is when I have been in triage, I worry about who I have put in the waiting room." (RB A&EN:30 N2)

In the second instance, the data suggested that new working practices conspired to erode the opportunities for healthcare professionals to serve their patients in the way they felt was best for the patient. The result was that professionals felt devalued. Moody and Pesut (2006) proposed that there was evidence to suggest a correlation between poor self worth, "depersonalisation" (p25) and the presence of stress and pressure, although a study conducted by Roelen et al amongst healthcare professionals in the Netherlands (2008) appeared less convinced of these linkages.

"Perhaps after more than 20 years of practice in the area I suspect I know a little bit about the skills and attitudes of various specialists ... but I am now not allowed to use that experience, in fact it is suggested now that that experience is of no value ..." (PE GPPM2:6 GP2)

Finally, although healthcare professionals in this study demonstrated a single-minded resolve to care for patients, there was also evidence that competing priorities within the work environment precluded participants from this quest. As the following quotation illustrates the consequences of this can be acute both in terms of patient and professional well-being.

"... if you have not been back to look at someone that you know might become more ill then yes, you are taking a risk aren't you, you might go back and something has happened to them and you have not had chance to go and look ... it has happened in the department ...that people have deteriorated and you haven't been able to get back to them and then, when you have got back to them, they have been critically ill." (PL A&EN:12-13 N1,N2)

This study has found that healthcare professionals acquired great satisfaction from caring for patients and this strengthened the patient orientation which underpinned the 'Duty Self". Whilst an ambition to care for people was what motivated a professional's behaviour, the discharge of their duty was often threatened by the reality of a challenging organisational environment, a finding which was consistent with aspects of the patient safety literature (for example Smith and Toft 2005 and Vincent at al 2000). A study by Roelen et al (2008) stated that the nature of the working environment performed an important role in creating satisfaction amongst professionals. The findings of this study implied the contrary, suggesting that work satisfaction was adversely affected by difficult working conditions, specifically the complicit role played by the pressures of work, new working practices and competing priorities. As a consequence, the resolute determination of professionals to focus on duty was not always realised in practice, resulting in damaging personal effects which extended beyond individuals to their patients. The result was that professionals experienced a detrimental effect in their well-being in terms of stress and low self-value which damaged the 'Duty Self'. It is debatable, then, whether a healthcare professional can achieve a completely patient orientated underpinning to the 'Duty Self' without a working environment which is supportive and conducive to these aspirations.

7.2.3 A Summary of the 'Duty Self'

The author identified that the 'Duty Self' evolved out of a passion for patient orientation which led to healthcare professionals being undeniably drawn towards healthcare as a profession. The 'Duty Self' was then strengthened by the crucial motivational role played by a professional's need to provide high quality patient care which conferred a profound sense of responsibility on the professional and delivered job satisfaction when it was realised. However, a challenging working environment created disturbances which damaged the capacity of healthcare professionals to achieve a patient orientated approach and caused significant issues in terms of professional and patient well being. In so doing, the 'Duty Self' was weakened. This is summarised in Figure 7.2 below.

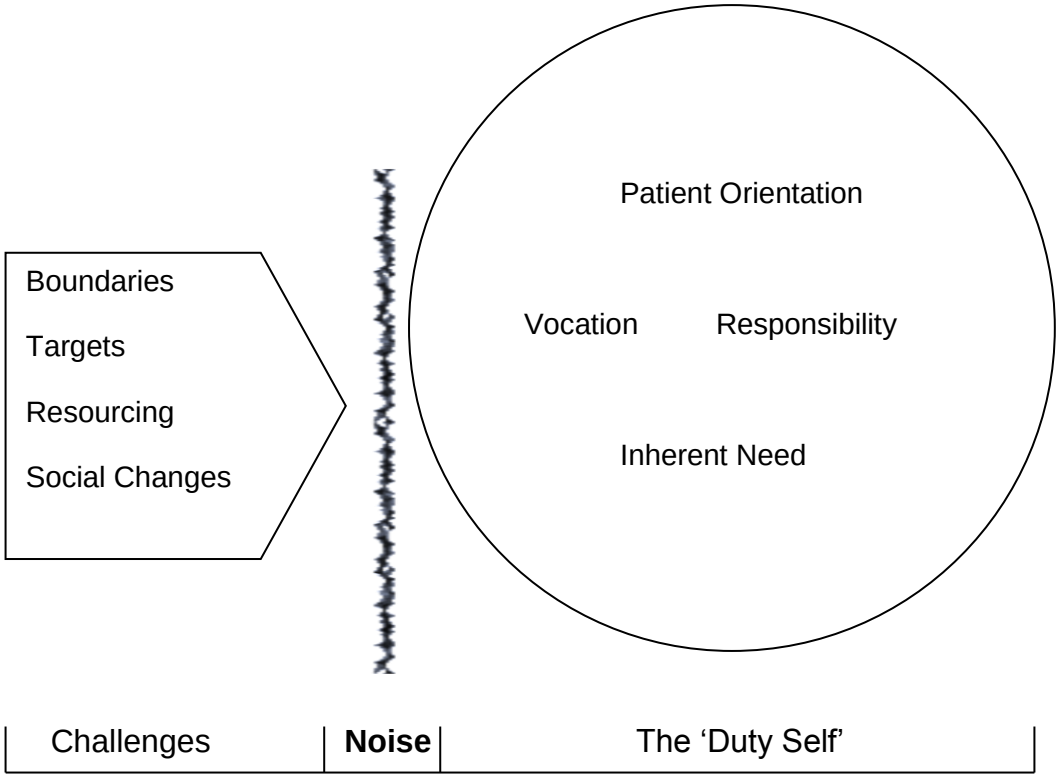


Figure 7.2 The 'Duty Self', Challenges and Noise

The picture of the 'Duty Self' deduced from the analysis has shown that healthcare professionals at grassroots level have something to add to the debate concerning smouldering crises and patient safety. Healthcare

professionals occasionally make mistakes which are symptomatic of smouldering crises. The existing literature views these errors as consequences of failures in management systems and would address them through procedural solutions. The author sees them as feature of a dysfunctional working environment which, if addressed by a management that was aware of them and their significance, would allow healthcare professionals to realise their strong desires to deliver effective and safe patient care.

To this end, Moody and Pesut (2006) advocated that the capacity to realise the motivation to care was influenced by effective environmental conditions which fostered a positive sense of self value and personal and professional well being. Harris et al (2008) concurred, stating that patient orientation was an important trait for healthcare professionals and an essential requisite for a successful healthcare career and, since healthcare professionals were the service, held the key to long term success for healthcare organisations, a view supported by Baptiste (2008).

The author proposes that in view of the crucial role played by patient orientation in both the performance of healthcare professionals and their organisations, it would be interesting to look further at the internal environmental issues that have been identified above and within the patient safety literature as impinging on realisation of this.

7.3 The 'Professional Self'

In exploring the working lives of healthcare employees through the data, one of the prevailing impressions was that first and foremost they saw themselves as professionals. Not only did their profession dictate what they did in their daily working life and how they did it but it also conferred upon them a certain identity and authority. Central to this impression of the professional was the nature and level of training, in fact so strong were the feelings emanating from the data that it was upon this platform that the author built the 'Professional Self'. Thus, in identifying the 'Professional Self' the author had constructed another account to explain the behaviour of individuals which would lead to a deeper understanding

of the working life at grassroots level and thus provide the opportunity to take a more holistic and insightful approach to the management of smouldering crises and patient safety than that found in the existing literature. However, whilst the 'Professional Self' was an expression of occupation and role, it was also the lens through which working life was observed. The author observed that within the data there was an apparent acute awareness of issues which challenged the 'Professional Self' on a daily basis. The author deduced from the data that these challenges not only affected how healthcare professionals felt about their profession but also how they viewed the attitudes and behaviour of peers. This was important to the author since the literature concerning the systemic nature of smouldering crises and adverse patient safety incidents suggested an inherent and cumulating progression towards a situation and the author had designed the research so that the consequential impact of one individual's behaviour on another could be explored in order to consider what part this played in the ensuing crisis conditions.

7.3.1 The Role and Nature of Training as a Platform for the 'Professional Self'

There was a strong support emanating from the data that training, and particularly experiential training that developed over time, was worthwhile in terms of developing valuable experience, expertise and confidence. The following quotation typifies the views of healthcare professionals.

"The Day Ward Clerk taught me, she has been here 20 years or something ... I think you learn more and more ..."(TM GSWC1:4)

Baptiste's (2008) study of 100 public sector employees, commended the virtue of public sector employers who, having recruited skilled employees, ensured that they continued to develop their professional expertise, knowledge and job capabilities through training. Moody and Pesut (2008) supported this position advocating that acquiring skills and knowledge enhanced individual behaviour in the workplace and was particularly effective when it was built up over time.

Furthermore, as exemplified by the following quotation, it was evident from this author's analysis that, consistent with the studies of Moody and Pesut (2008)

and Roelen et al (2008), acquiring new knowledge and expertise was seen within the context of career development.

"The way it works is you maybe did PTS then urgents then you get the technician course through A&E then you get the paramedic course." (EO AC1:1 AC1A)

Clarke (2005), in surveying attitudes towards training and development in palliative care organisations in the UK, found that a supportive training and development infrastructure which facilitated opportunities for reflection and informal learning were important for fostering an effective learning environment. Although the author derived from the data that learning in the form of self reflection was occurring, it was emanating from the motivation of individuals to learn from their patient care experiences and thus, driven from a patient orientation rather than being induced through formal organisational mechanisms.

"We are mostly on the shop floor, seeing people, sorting them out and learning from it I guess." (ID A&ESHO:17)

The study of Kuvaas and Dysvik (2009) into employee development and intrinsic motivation found that employees who were orientated towards helping others in their work and were able to realise this were intrinsically motivated and fulfilled in terms of their own goal achievement. This was consistent with what the author deduced as the data showed a strong connection between an individual's capacity to realise patient orientation expectations and the satisfaction that resulted from being intrinsically motivated as a result.

"it makes more sense for someone with more experience to see them (patients) directly and makes the process a little quicker because SHO's ... know more about the kind of procedures people need whereas house officers don't have that knowledge." (EO GSREG:1)

The author reasoned that some healthcare professionals in this study felt good about the fact that they had the necessary skills and were able to use them to make a difference to patients, particularly those with acute care needs. Baptiste's (2008) suggestion that training and the nature of the work that an individual performed influenced job related well being was supported by the findings of Morrison et al's study into job design, skill utilisation and intrinsic job

satisfaction (2005) . Morrison et al (2005) found a strong positive relationship between the degree to which an individual perceived that their skills were being utilised and developed and job-related well-being and intrinsic job satisfaction, this is illustrated by the following quotation taken from this study.

"... we kind of package the patient up from being in a very messy state or an awkward position or if they need some definitive pre-hospital care then we do that, we get them bundled up into the ambulance, safe, hopefully feeling a little better and get them to hospital." (RESPECT AC3:1 AC3A)

However, this was an area of contradiction in this study since some healthcare professionals felt that career progression and resourcing issues in the working environment inhibited their opportunities to fully utilise their skills. As a consequence, healthcare professionals who did not feel that their skills were being utilised, experienced job dissatisfaction and frustration.

"There is a group of us that were taken on, we applied to be trainee paramedics and we were taken on as trainee paramedics and we were told that in 3 years we would be paramedics. 4 years plus down the line, the majority of us are not paramedics and, no, we will not automatically become paramedics ... " (RCG AC2:14 AC2A)

Consistent with existing literature, this study found that healthcare professionals recognised the importance of professional expertise and the training that they undertook in order to develop this. As such the author reasoned that training underpinned the 'Professional Self'. The resulting value it bestowed on an individual in healthcare when a professional was able to utilise their expertise in order to help patients was a motivating factor.

7.3.2 The Challenges of Sustaining the 'Professional Self'

The preceding section focused on the author's understanding, deduced from the data, of the core element of the 'Professional Self', namely training. In analysing the recollections of healthcare professionals concerning their daily working life, the author postulated that the 'Professional Self' was a pervasive identity with which professionals had a great affinity and through which they viewed their working lives. As a consequence, the author became acutely aware of the resentment felt by professionals when they encountered issues

which affected their capacity to fulfil the roles for which they had been trained. These issues influenced a professional's self and peer perceptions. This section will focus on what the data inferred were the most prevalent of the issues, namely working conditions, perceptions of inequality and the relationships between professionals.

Moody and Pesut (2008) recognised that in order to foster positive working conditions it was necessary for healthcare professionals to have manageable levels of complexity in the work setting. The data in this study inferred that aspects of the working environment conspired to increase the level of complexity encountered by healthcare professionals in their working life and hindered the realisation of the 'Professional Self'.

In the first instance, changes in the social dynamics of the public inhibited a professional's ability to fulfil their role. The example below shows how this can result in professionals struggling to utilise their skills and care for patients.

"... we went to the Children's a couple of weeks ago with no information whatsoever even though there were 10 people in the room which we picked the baby up from, they did not speak any English whatsoever and they were trying to get a 3 year old to translate for us, they had only arrived in the country the day before ... it is unusual to have somebody with no English at all but sometimes you are dealing with a low amount of English and there are difficulties with understanding. (TM AC1:6, 8 AC1A, AC1B)

In the second instance, resourcing changes affected the development of employees because funding was scarce and training opportunities were restricted. However, and more seriously, the author also detected that resourcing changes were detrimental to safe patient care because professionals were unable to fulfil their professional duties in an effective manner, a view which was consistent with Smith (2002b) and Smith and Toft (2005).

".....and it's all down to funds because there is nothing available in the department for us to have ongoing training ..." (TM A&EREC:2 R1)

"At one time, if they wanted to, they could come and spend a day with you but it is like everything else now in that there seems no leeway for people to do that ... (EO AC2:5 AC2A)

"The reason it is busy is you have got the same number of medical staff that you had years ago and what you have done is you've just lowered the number of hours that they work ... so you are doing the same amount of work in fewer hours... In terms of the effect that it has on patients, I guess mistakes are more likely in someone who is trying to sort a whole ward out by himself or who is busier ..." (TM A&ESHO:16)

In the third instance, the data inferred a strong feeling of unfairness and inequity in professional life, particularly as a result of the approach to experiential training, role design and the use of targets to judge the efficacy of professionals. Contrary to what the data in this study inferred, Baptiste (2008) advocated that for individuals to perform well in an organisation, it was necessary to ensure that employees perceived the organisation to be supportive, trustworthy, fair and consistent in aspects of work including training and development. However, the data in this study was consistent with the findings of MacDonald's (2005) investigation into the effect of targets and directives in healthcare which showed that employees perceived them as control mechanisms which inhibited their professional working life.

A qualitative study of new workforce roles in healthcare in the UK conducted by Bridges et al (2007) suggested that there was evidence that roles had become extended and, as a result, more complex over time. Bridges et al (2007) attributed this extension and complexity to constant change and a distracting working environment. This was borne out by the data and was typified by the following quotation.

"They just keep extending the skills like nurses didn't used to take blood or put cannulas in but now they do and they just keep adding more and more things on so, if they keep on adding, where is going to be the difference between the nurse and the doctor other than taking the history which a nurse could do." (RB A&EN1N2:23 N1)

The findings of Hyde et al's (2005) study of role redesign in the UK health sector confirmed the extension and complexity of roles in the sector. Consistent with the author's observations in this study, Hyde et al (2005) identified that the roles of professionals working in healthcare in the UK had changed significantly and involved skill-mix changes, job widening and job deepening. Hyde et al (2005) identified that these changes had implications for the pay, management

and accountability and the education and training of healthcare professionals. Campion et al (2005) warned of the negative motivational effects of implementing job enlargement (increasing the number and variety of tasks within a job role) without delivering job enrichment (adding tasks which enhance the meaningfulness of work and the sense of responsibility) because employees perceived that they were being overloaded. The author of this study exposed a resulting undercurrent of dissatisfaction in the data as a consequence of these changes which is exemplified in the following quotations.

"... if they are going to add on these skills then they need to pay you for the skills as well don't they; they can't leave you on the same pay but expect you to be practically doing the doctors job but the doctor is on loads more than we're on ... I have been underpaid for 4 years ... because they changed the pay scale in 2004 but they have never given us the money yet so we are still on the old one... (IE A&EN1N2:11 N1,N2)

"At the end of the day the patient needs that doing and if nobody else does it then we have to do ..." (PE A&ESHO:5)

Consistent with the findings of Harris et al (2008), the negative emotions that the author sensed in the data created unconstructive conditions within which individuals attempted to perform their roles and thus encroached upon their ability to realise the 'Professional Self'. The author deduced that whilst the notion of inequity affected how they felt as professionals, it also influenced their perceptions of other professionals. The data exposed perceptions that role changes yielded a greater burden and level of responsibility which was not always fair nor was this recognised or appreciated by others. There were instances observed by the author where this resulted in feelings of professional exposure and compromised patient safety.

"... it is difficult because of the way the system (the Foundation Programme for Doctors) works that you try as a junior, as a foundation year 1 or 2, to rotate through as many specialties as you can so you can decide what you want to do for your specialist training so you will inevitably ... end up with a senior as an F1 who knows less about your subject than you do. ... it can be quite difficult when somebody gets very unwell and you need somebody to call upon who you know will be there ... no matter how good ... you are, you can't manage on your own ... there are issues with safety" (IE GSREG:4, 7)

In the fourth instance, the data inferred that when a patient's care crossed boundaries, professionals were defensive about their expertise to the extent

that working relationships between professionals became strained, as professionals felt their contribution was being devalued. This was consistent with McMurray (2006) and McMurray and Pullen (2008) who identified the discrete nature of health specialisms and the challenges of physical proximity as being responsible for boundaries between professionals. Loh et al (2009, 2010) supported the view stating that boundaries created an 'us' and 'them' mentality and caused individuals to be favourable towards those within their own boundary at the expense of those considered to be outsiders. Significantly, aspects of existing patient safety literature acknowledged (Leape 2005, Reason 2004, 2008, Smith 2005a and Walshe 1999) the role that boundaries played in incubating adverse patient safety incidents.

"... it is so busy in there ... there will invariably be some comment from somebody about that ASHICE call, that it wasn't good enough ... just casting aspersions on our ability to assess how ill the patient is ..." (TM AC1:4 AC1B)
(Ambulance crew discussing how they feel when they deliver patients to Accident and Emergency)

The discovery of the 'Professional Self' by the author was a further attempt to explain the behaviour of individuals in healthcare which was necessary if a deeper understanding of grassroots level was to be developed. However, once again, the author postulated that events within a professional's working environment endangered the realisation of the 'Professional Self'. Strong emotions were evoked by professionals who felt unable to fulfil their professional obligations since this was seen to attack their expertise and ultimately arrest their capacity to care for patients. The consequences weakened feelings of self worth, damaged peer relationships and created a climate in which human error incidents could occur.

7.3.3 A Summary of the 'Professional Self'

The author deduced from analysis of the data that the 'Professional Self' was an expression of expertise and role, built on a platform of training and experience. It was also the lens through which working life was observed. The value of experiential training and self reflection was widely recognised in the data, in its own right and within the context of patient care.

Kuvaas and Dysvik (2009) and Baptiste (2008) recognised the importance of developing employees' skills, knowledge and competencies for both the individual and the organisation. Utilising the concept of social exchange theory, Kuvaas and Dysvik (2009) proposed that when an organisation invested in its employees in this way, greater employee satisfaction ensued and the employee was more likely to reciprocate in positive ways. The data was suggestive that healthcare professionals aspired to develop their skills in order to better serve patients and, when this occurred, their well being was heightened.

However, the author identified from the data that a number of internal and external factors sought to erode the 'Professional Self' and the consequential care a professional could offer to patients. Whilst social changes impinged on an individual's capacity to fulfil their professional obligations, internal factors created the most disturbance. Changes in the working conditions of professionals had led to restrictions in training opportunities and fostered perceptions of unfairness and inequality amongst peers. Furthermore, professionals struggled to succeed in their aspirations to care for patients by utilising expertise when patient care was delivered across organisational boundaries and this created tensions in the relationships between professionals. This is summarised in the model of the 'Professional Self' at Figure 7.3.

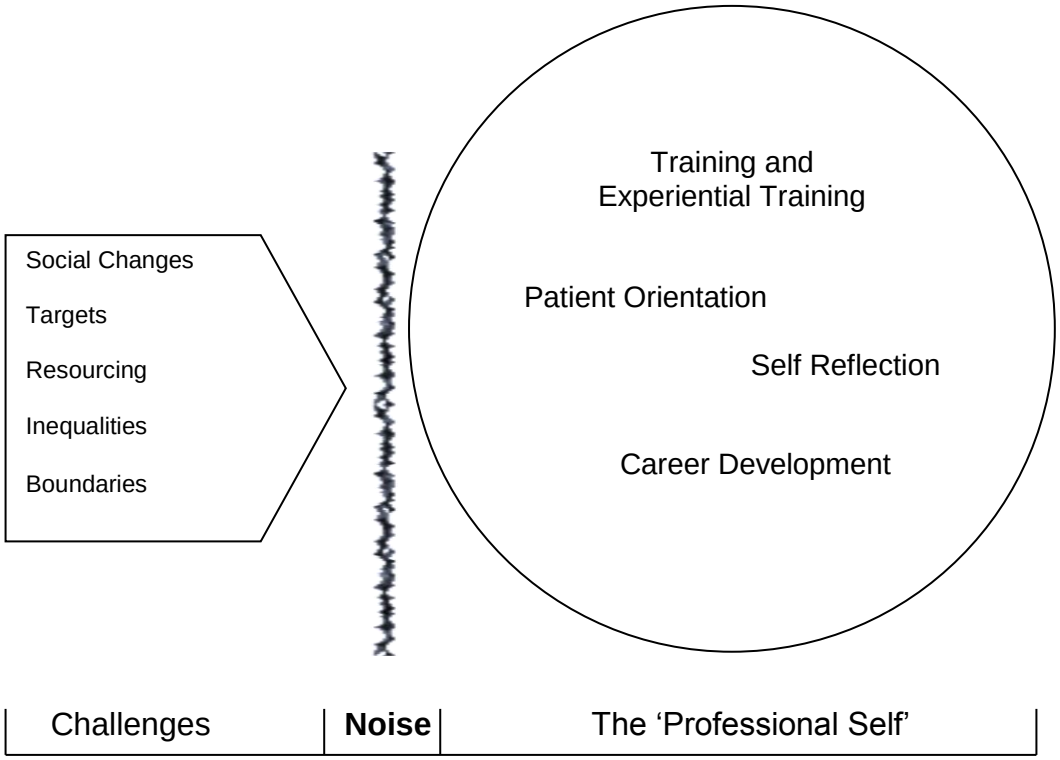


Figure 7.3 The 'Professional Self', Challenges and Noise

Clark (2005) proposed that an effective learning environment was achieved through a supportive training and development infrastructure which was realised through aspects such as the design of work, work environments and structures and policies. The author questions whether, given the analysis of the data, this has been achieved in the healthcare sector and to what degree this has impinged on the agenda for improving patient care and safety.

7.4 The 'Collegiate Self'

The author observed from the analysis of the data that whilst the 'Duty Self' and the 'Professional Self' were distinctly personal, what underpinned the 'Collegiate Self' was a feeling of belonging to a unified body of individuals, a collegiate in effect. This collegiate spirit influenced how people felt in the workplace but more significantly how they behaved, since it created an atmosphere of willingness and well being which was centred around the care of patients. In identifying the 'Collegiate Self' the author deduced that although the notion of

'Self' was very individualistic, a healthcare professional perceived that duty and professional aspirations could not be achieved without the contribution of peers. Thus, although in identifying this further aspect of the individual in the workplace the author had constructed a third account to explain behaviour, the discovery of the 'Collegiate Self' was important because it provided a root for the concept of 'Self' in the collective behaviours at grassroots level. This was important to the author since the research had been designed to expose what existing literature recognised as the cumulative progression of smouldering crises within the organisation's systems.

7.4.1 The Origins of the 'Collegiate Self'

The author constructed the following figure from analysis of the data which suggested that the 'Collegiate Self' was dependent upon several factors which appeared to evolve in a hierarchical fashion but commenced with how valued a professional felt. This is shown diagrammatically in Figure 7.4.

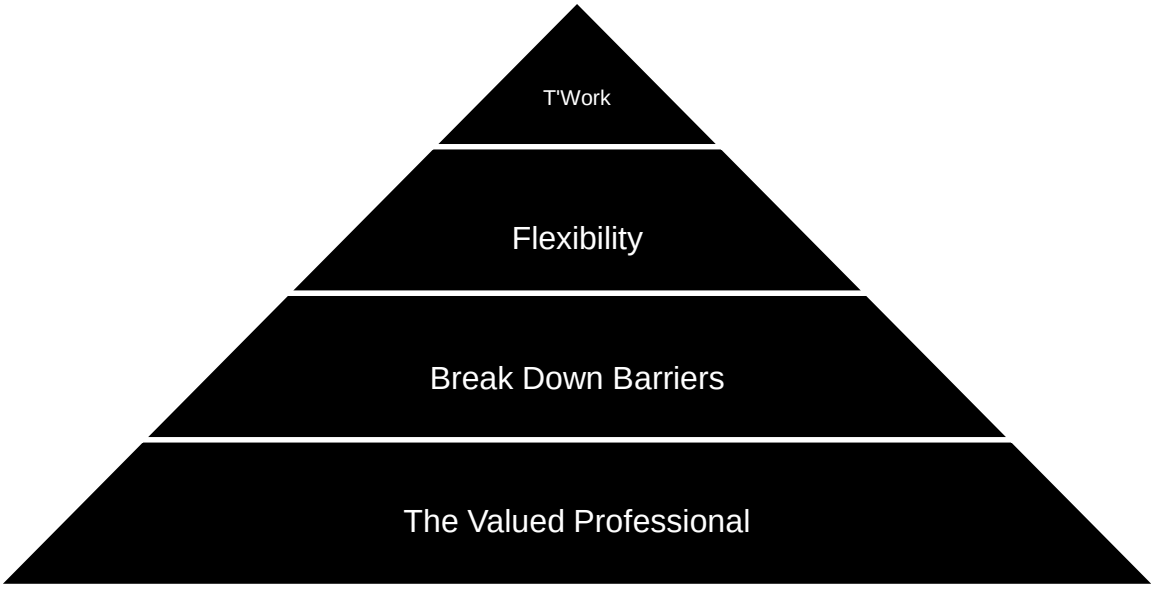


Figure 7.4 The Hierarchy of the 'Collegiate Self'

In the first instance, a professional who, through the attitudes and behaviours of peers and superiors, was content in the work environment and confident in their professional ability would, according to the views of participants, feel valued.

"I think it was just a case of making everybody feel part of being here, making the station look a bit better, getting it tidied up and painted ... yes, really it was in such a bad state, no carpet on the floor and leaks in the roof ... " (TW AC1:13 AC1A, AC1B)

"I think any of the doctors, if you or I said to them everything looks alright but I don't like the look of them and I think something is going on, all of them would listen and they would go and see the patient quicker ... Because I do think that they appreciate that most of us have worked here for ages and it may be the first time the doctor has ever worked in A&E." (TW A&EREC:7 N1)

In the second instance, valued professionals had a propensity to challenge the barriers and boundaries between professionals.

"...we actually established a proper integrated nursing team which had a mixture of district nurses, practice nurses, health visitors, all grades of people, all working together and they basically spread the workload, including the practice workload, and they did it all on the basis of who was the best qualified to do that particular task."

In the third instance, and as a result of the creation of a valued professional prepared to challenge boundaries, co-operation and flexibility were promoted and dutiful obligations to the patient were satisfied.

"It was all about flexibility but in the end it was actually about people saying what does the patient need and how best can we serve them rather than saying this is my job I only do this." (F GP1PM1:9 GP1)

In engaging with all of this, individuals felt appreciated, appreciated the role and perspective of others and therefore were better able to perform as a team.

"What you find, especially on nights, is you come in quarter of an hour earlier and there might be several night crews but only one crew is going off at 8, so one night crew takes that crew off, then they can go home and they know that in the last quarter of an hour they are not going to get a job so that night crew is very likely to go out before 8 especially here because we are very conducive to doing that. " (CS AC1:4 AC1B)

Interestingly, though, the data inferred that the 'Collegiate Self' went beyond teamworking and was not to be found in actions instigated by an organisation in the workplace. The author postulated that the essence of the 'Collegiate Self' was to be found in the relationships between professionals and the resulting consideration one professional had for another, particularly when faced with challenging situations in the workplace. This viewpoint was consistent with

Rosenthal (1999) who considered that collegiatism amongst professionals involved "closing ranks" (p152).

Healthcare professionals drew great satisfaction from positive peer relationships and there was a sense of responsibility and support evident between peers. This was consistent with Rosenthal (1999) and Martin's (2010) notion of productive peer support and coherent with the findings of Moody and Pesut (2006) who identified that conditions which fostered good relations and social support had a positive influence on work motivation. However, Roelen et al (2008) found that although peer relationships enhanced workplace satisfaction, the same strength of correlation was not found in the relationships that professionals had with their superiors. The author deduced that this confirmed that the notion of the 'Collegiate Self' lay in the relationships between peers and was not hierarchical. However, this observation reinforces the challenges explored in Chapter 2 regarding power and control in organisational hierarchies and the impact this had upon smouldering crisis situations (Smith 2005a).

"... the beauty of this place at the moment is that you can come to work and no matter who you are working with you are going to have a good shift ... and that hasn't always been the case but it is really good at the moment and has been for a long while ..." (CW AC1:8 AC1A, AC1B)

"... if I've got a lot of notes then she will help me out as well so we help each other, we've got that support really from each other ." (TW GSWC11:16)

However, the bonds between peers seemed, from the data, to be at their strongest when professionals were battling to provide patient care despite obstacles.

"... nobody appreciates just how much responsibility we take, how we are two people dealing with something when almost anybody else, dealing with something in that much of an emergency, has many more than two people, have more people, have more training, have more knowledge or have at least somebody there above them that knows. There are two people but as soon as somebody is driving you become one person" (CS AC1:12 AC1B)

Thus, consistent with the discussion concerning the 'Duty Self' and the 'Professional Self', the author concluded that, despite the 'Collegiate Self' being

a more collective expression of self, its roots remained in an orientation for the patient and a desire to deliver effective patient care.

7.4.2 The Factors that Harm Collegiatism

The essence of the 'Collegiate Self' lay in the sense of belonging that a professional garnered from being valued by and working with peers to effectively care for patients. The author construed, though, that there were also factors which could inhibit and destroy the sense of collegiateship amongst professionals. These issues, which centred on the impact of workplace resourcing changes and boundaries, broke down relationships and promoted conflict and ill feeling between healthcare professionals. More importantly, the results were that motivation and job satisfaction was eroded and patient care was compromised.

The author's analysis of the data inferred that resourcing changes, such as role redesign, prohibited peers from getting together to care for patients because of perceived role demarcation lines.

" ... we almost had 2 groups of nurses kind of pushing work off on each other rather than working together" (CS GPPM2:1 GP2)

Furthermore, as is illustrated by the following quotation, the author deduced that defined workplace boundaries created territorial tendencies amongst professionals which isolated individuals and had a detrimental effect on patient care.

"… everyone is being pushed into boundaries so they have drawn this up around themselves and they won't step outside it but there are a group of things that occur which don't actually fit into anybody's boundaries and it is those things which always fall through the net." (TW GP1PM1:6 GP1)

It was noted in the discussion concerning the 'Professional Self' that the studies of Loh et al (2009, 2010), McMurray (2006), McMurray and Pullen (2008) identified the discrete nature of health specialisms and the challenges of physical proximity as being responsible for creating an 'us' and 'them' situation

and erecting boundaries between professionals. Moody and Pesut (2006) concurred stating that frontline healthcare professionals perceived difficulties in patient care transitions between distinctive aspects of care due to collaboration problems. Penney and Spector (2005) also recognised that negative peer relations could adversely affect an individual's satisfaction and well being in the workplace and stated that this was counter productive to performance. Indicative of the author's analysis of the data, the research of Sasou and Reason (1999) indicated that teamworking environments produced problems that held the potential to lead to human errors. Furthermore, aspects of the patient safety literature (Leape 2005, Reason 2004, 2008, Smith 2005a and Walshe 1999) identify.

However, in addition to the detrimental impact on patient care, the analysis of the data in this study suggested that difficulties in the relationships across boundaries led professionals to question the respect their peers had for them and resulted in a lowering of self worth.

"In my hearing on the mobile phone when this very reasonable woman tried to explain, the nurse said, Oh a GP, that will be no good anyway, I am too busy so nobody even had the courtesy to talk. ..." (CS GPPM2:2 GP2)

7.4.3 A Summary of the 'Collegiate Self'

The author postulated that the 'Collegiate Self' was encouraged and sustained by the positive attitudes professionals held for each other and this, as a consequence affected their behaviour towards each other and had the capacity to enhance patient care. When a professional felt valued, they were more inclined to make the effort to break down barriers that existed between them and their peers. This resulted in improved communications, flexibility and teamworking. However, the author deduced that what distinguished the 'Collegiate Self' from teamworking lay in the feelings professionals had for each other. Professionals who were respected and valued by peers, reciprocated and the social cohesion of the collegiate grew. The author hypothesised that part of the reason for this was that professionals found strength in being united with others against the conditions they faced on a daily basis, in effect this

created a tribal mentality. However, the data inferred that these conditions, specifically the boundaries and resourcing changes in healthcare were, harmful to the prosperity of the 'Collegiate Self' because there was an associated breakdown in relationships as conflicts arose. The consequences were that professionals became demotivated and dissatisfied in the workplace and, disturbingly, patient care was compromised.

Effective patient care was best delivered through the combined efforts of professionals across organisational boundaries. The discovery of the 'Collegiate Self' demonstrated the potency of like-minded professionals working collectively for the common good. However, without conducive conditions at work, the strength of the collegiate was eroded and, consistent with the notion of smouldering crises, patient care suffered. Interestingly, the damaging theme of dysfunctional working conditions was, once more, surfacing from the data and the author felt that further exploration would be useful to the study. The 'Collegiate Self' is summarised at Figure 7.5.

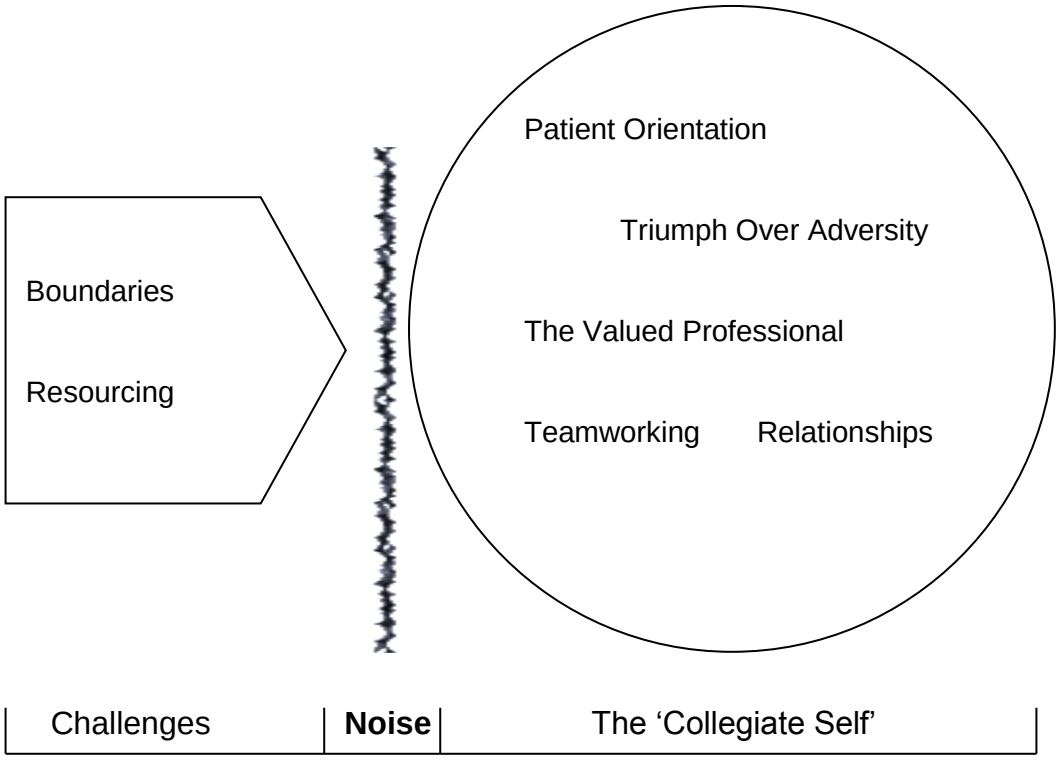


Figure 7.5 The 'Collegiate Self', Challenges and Noise

7.5 Summary

This chapter has built on previous chapters by exploring the viewpoint of 'the world as I see it' in order to develop a better insight into the role that grassroots' behaviour plays in smouldering crisis and adverse patient safety situations. The author saw this as necessary because existing literature concerning smouldering crises and patient safety viewed the causes of crises as human error within faulty management systems but exhibited a limited understanding of the contributory role of grassroots individuals.

The author deduced from the data that an individual's identity or 'sense of self' in the workplace was based on three separate yet distinctive features of their working life. The author classified these as the 'Faces of Self', with each 'Face' inferring a partial explanation of how and why health professionals behaved in the way that they did and why these behaviours might incubate error events which were symptomatic of smouldering crises. The 'Duty Self' was founded on participants' profound orientation for patients. The 'Professional Self' was created out of the affinity a professional had for their profession. The 'Collegiate Self' was an expression of what participants garnered from their relationships with peers. The orientation for effective care appeared to be a pervasive feature. Consistent with Harris et al (2008), the author found that when professionals were able to realise each 'Face' their intrinsic motivation was enhanced and their job satisfaction increased. However, in constructing each 'Face' and consistent with aspects of existing smouldering crisis and patient safety literature, the author found that common issues in the conditions in which professionals worked presented 'noise' which inhibited an individual's capacity to realise a 'Face' and caused detrimental impacts to professionals and patients alike. The author hypothesised that these issues appeared central to compromises in patient care which were symptomatic of human error induced smouldering crises and, thus, significant to this thesis and, therefore, worthy of further exploration. This is the subject of the next chapter.

Chapter 8 The Interrelationships between the 'Faces of Self' and the Contribution Value of the Thesis

This chapter will elucidate the theoretical development from this study through the synthesis of the discussion from the previous chapters and explain the contributory value of this thesis.

As outlined in previous chapters, notably Chapters 1, 2 and 3, the review of existing literature concerning crisis management, the management of smouldering crises, error in medicine and patient safety lead the author to identify limitations in existing knowledge regarding smouldering crises and patient safety. It was within the boundaries of these identified limitations that the author placed her work, specifically the design of the research methodology and the contribution to knowledge. Thus, the author will argue that the contributory value of this thesis has a dual perspective; the contribution to knowledge concerning patient safety and the contribution to knowledge concerning the management of smouldering crises.

The author advocated in the previous chapter that the motivation and behaviour of grassroots individuals was inspired by and gravitated towards a self doctrine based on an individual's relationships with patients, the profession and peers, identified and developed by the author into a model labelled the 'Faces of Self'. In exploring the dynamics of each 'Face', however, the author explained that in healthcare, where the raison d'être is 'first do no harm', the conditions in which professionals worked were precipitating errors and error potential in patient care which compromised patient safety and were suggestive of smouldering crises.

This chapter advances the discussions outlined in Chapters 5, 6 and 7 regarding healthcare professionals in the workplace. It will begin by exploring the relationships between the 'Faces' and how the interrelationships between all three 'Faces' played a crucial role in developing a healthcare professional who was more effective in the patient care setting and thus satisfied and intrinsically motivated. However, it will be argued that the conditions in which professionals worked had the capacity to create weaknesses in the interrelationships which inhibited a professional's ability to fulfil patient care obligations and held the

potential for human error which compromised patient safety. Thus, in the first part of this chapter, the author will propose that knowledge regarding patient safety will be developed if consideration is given to aspects of the working environment which damage a professional's opportunity to fulfil duty obligations and realise professionalism and collegiatism since the potential for adverse patient safety incidents are a consequence of such damage.

Given the significant influence of working conditions on the behaviour of individuals and the precipitation of error, the chapter will then explore the concept of organisational climate which is a pervasive perspective that individuals within an organisation hold regarding their working environment.

The chapter will conclude considering the contribution value of this thesis in terms of smouldering crises. The management literature on smouldering crises recognised the dominant impact of systemic human error, specifically in terms of management's limited perspective, knowledge and capabilities, on the precipitation of crisis conditions but the author of this thesis proposed that this was a partial view. The author will reveal how the literature on organisational climate can better explain the impact that working conditions have on the behaviour of grassroots individuals. Accordingly, this chapter concludes by proposing that the debate on the management of smouldering crises should embrace the organisational climate paradigm since it is the author's view that the limitations in management's perspective, knowledge and capabilities which are responsible for these situations will be improved if attention is given to the prevailing internal conditions of the organisation.

Finally, the reader will observe that the first part of the chapter is concerned with the author's arguments regarding the contribution value of this thesis in terms of patient safety with the latter part of the chapter being concerned with the contribution value of this thesis in terms of smouldering crises. However, it will also be clear that there is interplay between the factors influencing the author's discussion in both of these aspects. This is entirely intentional on the author's part and is a consequence of the author's holistic view of a healthcare professional which emanated in the discussions in Chapters 5, 6 and 7 and the

pivotal role played by the workplace conditions and the organisational climate therein.

8.1 Exploring the Relationships and Interrelationships between the 'Faces of Self' and the Contribution Value for Patient Safety

As the previous chapter has shown, each 'Face of Self' was distinctive, had been built up by the author from the narratives of grassroots and contributed to the understanding of the individual in their working life. Thus the 'Faces of Self', as deduced from the data, explained a professional's perspective of working life which was so crucial to this thesis in investigating why crises might smoulder in an organisation and why adverse patient safety incidents occurred. However, in developing an understanding for each 'Face', the author observed common themes. This observation was important because commonality between 'Faces' suggested that there was potential for further consolidation in order to present a more complete prospect of an individual's behaviour in the workplace and a strengthened concept of 'Self'. This consolidation facilitated the author's propositions in terms of the contributions to knowledge concerning patient safety, which is covered in this section, and smouldering crises, which is covered in Section 8.3.

8.1.1 The Interrelated 'Faces of Self'

The author considered that the relationships between the 'Faces' might be emergent in nature. Conceptually the author reasoned that the relationships might occur because a professional would be drawn to healthcare for vocational reasons, develop professional expertise and then have the confidence to grow within a collegiate of peers. As a consequence, the author contemplated whether the relationships might be sequential as is illustrated below in Figure 8.1

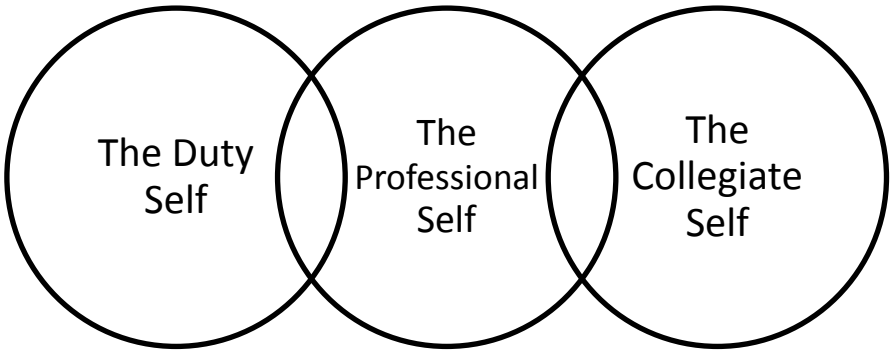


Figure 8.1 Sequential Relationships between the 'Faces of Self'

However, the author felt that this did not fully exploit the significance in the 'Faces' of the role of patient orientation and the ensuing impact on job satisfaction and intrinsic motivation which were so important to professionals in this study.

This led the author to consider the implications that the common features across the 'Faces' had in terms of the relationships between the 'Faces'.

Some aspects of commonality across the 'Faces' had a positive impact on the behaviour of individuals and strengthened the bonds between the 'Faces', others had the converse effect and eroded the bonds between 'Faces' and induced conditions in which errors could occur.

An orientation for patients and a desire to deliver safe and effective patient care underpinned each of the 'Faces'. The previous chapter revealed that the health professionals in this study demonstrated sincere and strong obligations towards caring for patients that were driven by a profound sense of duty and realised through personal professional expertise and working effectively with peers. Thus, the author construed that patient orientation had a positive effect on the motivation and behaviour of professionals and played a significant role in explaining the relationships between the 'Faces'. However, such was the pervading nature of patient orientation in a professional's working life, that the author envisioned the prospect of the 'Faces of Self' as being venn-like with patient orientation being the connecting relationship between one 'Face' and another. This is illustrated in the Figure 8.2 below.

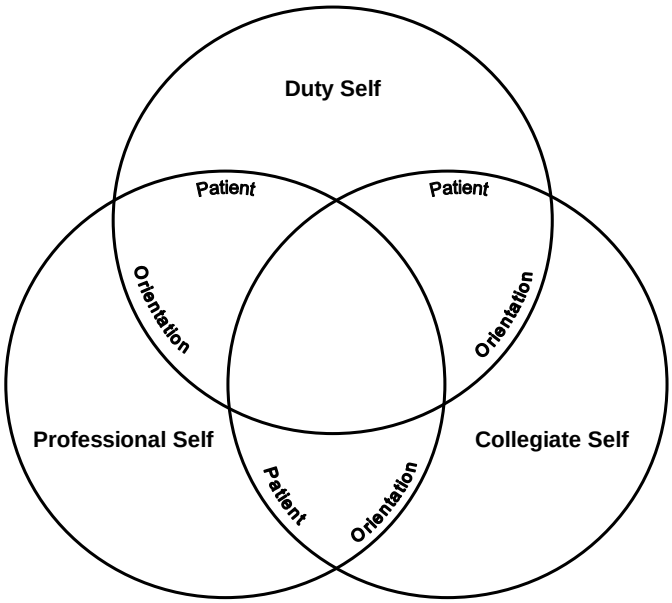


Figure 8.2 Patient Orientation and the ‘Faces of Self’

The previous chapter explained that when professionals were able to fulfil patient orientation aspirations, they derived job satisfaction and intrinsic motivation. Thus, the author contemplated the role that job satisfaction and intrinsic motivation played in the interrelationships between the ‘Faces’. The author postulated that job satisfaction and intrinsic motivation were the realisation of each ‘Face’ and thus strengthened not only the ‘Faces’ themselves but the common bond of patient orientation. This is illustrated in Figure 8.3 below where job satisfaction and intrinsic motivation are the resulting central core of the ‘Faces of Self’.

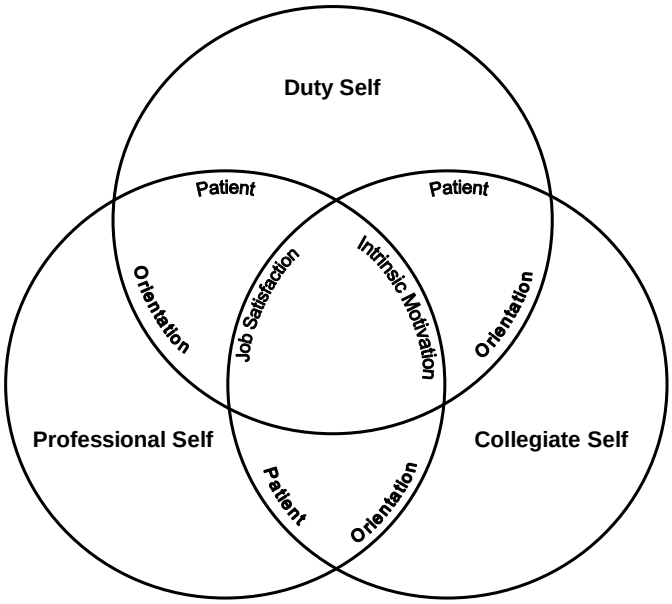


Figure 8.3 Fulfilment of Patient Orientation and the Central Core of the 'Faces of Self'

Whilst achievement of an orientation for patients created intrinsically motivated and satisfied professionals and resilient 'Self', the author deduced from the evidence in the previous chapter that there were areas common to each 'Face' that weakened the 'Faces of Self' and thus the performance of the professional in the workplace. More critically, in the context of the smouldering crises and patient safety, they were cited as the source of potential error incidents.

Similar to the observations of Fischbacher-Smith and Fischbacher-Smith (2009), Leape (2000) and Vincent, Stanhope and Taylor-Adams (2000), the inhibiting factors centred on the conditions in which professionals worked. The author identified that structural boundaries between professionals built barriers, created tensions and inhibited the delivery of effective patient care. Policies regarding the design of work and resourcing forced professionals to deal with the consequences of competing priorities and built resentment between peers. However, others were more concerned with the resulting personal damage to a professional's satisfaction and intrinsic motivation in the workplace. Professionals experienced unfulfilled ambitions, an erosion of self worth, a lack of mutual trust and feelings that they had been let down by their organisation. The consequence was that professionals felt embattled, were gravely concerned about patient care and resentful of the organisation which they

identified as being the instigator of the conditions. These inhibiting factors are shown in Figure 8.4 as creating a hole in the central point of the 'Faces of Self'.

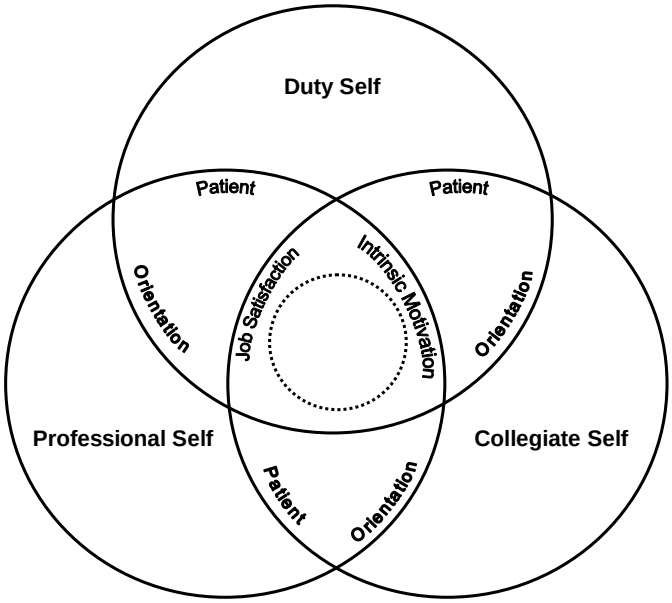


Figure 8.4 The 'Faces of Self'

The author, thus, deduced that the working conditions experienced by professionals within an organisation played a significant role in their behaviour and had the capacity to create weaknesses in an individual's performance which held the potential for the human error that was symptomatic of smouldering crises and adverse patient safety incidents.

8.1.2 The Contribution Value for Patient Safety

The normative theoretical corpus concerning patient safety proposed that 'latent' conditions in an organisation's systems and processes incubated adverse patient safety incidents. It was evident to the author that within the 'Faces of Self' model, behaviour was affected by the climate in which professionals worked and featured both the 'hard' management issues which were identified as influencing 'latent conditions' in the patient safety literature. However, aspects of the model also recognised the significant role played by the 'soft' behavioural issues which were often neglected in the literature. Furthermore, within the normative theoretical corpus, authors such as Reason (2004, 2008) and Vincent and Reason (1999) had also attempted to determine aspects of workplace behaviour in healthcare which exhibited a potential for the

creation of error. The author asserts that the 'Three Faces of Self', which had emanated from the author's approach to deriving meaning from the narratives of participants (Chapters 5, 6 and 7), was a more holistic and informative perspective of the healthcare professional than could be found in the existing literature since it explored both the 'latent conditions' which lead to errors and the 'soft' factors that could curb adverse patient safety incidents.

Thus, the first contributory value of this thesis is that improvements in the organisation's climate will address infringements on a professional's duty, professionalism and colleagiateship caused by deficiencies in the conditions in which healthcare professionals work and thereby address factors which can lead to adverse patient safety incidents and smouldering crises in healthcare. Healthcare professionals are duty-bound and demonstrate a responsibility towards those in their care as such they are strongly oriented not only to patient care but also to patient safety. Furthermore, these grassroots individuals perceive themselves to be, first and foremost, professionals and demonstrate a high degree of professional identification and integrity which, they feel, enhances their ability to deliver effective and safe care. Their duty and professionalism together is augmented by working with like-minded peers in delivering patient care. However, this orientation for the patient, professional identity and collegiatism is eroded by the factors within the working environment in which professionals work. Typically they feature the boundaries that exist between professionals which serve to build barriers and organisationally-led initiatives such as targets which produce competing priorities. Whilst at an individual level these conditions result in poor intrinsic motivation and job satisfaction, they are also reminiscent of the 'latent conditions' which are so corrosive for patient safety.

This section has explored the contribution value of this thesis in terms of patient safety. Given the significant influence of working conditions on the behaviour of individuals and the precipitation of error, the next section will explore the concept of organisational climate in more detail. The chapter will then move onto consider the contribution value of this thesis in terms of smouldering crises.

8.2 Working Conditions, the Organisational Climate and an Individual's Motivation and Behaviour

This study is based on the liberation of the views of those at grassroots level concerning their working life. The author deduced from the data that aspects of the internal organisational environment were inhibiting the performance of individuals. James et al (2008) stated that the feelings and beliefs that individuals held about the internal environment of an organisation influenced their behaviour in the workplace and was attributed to the notion of organisational climate. Thus, the author concluded that what was affecting the performance of individuals in this study and weakening the 'Faces of Self' paradigm was the organisational climate.

Tagiuri and Litwinn (1968), as did Forehand and von Gilmer (1964), saw the organisational climate as an enduring quality which distinguished one organisation from another but was based on the perceptions of employees and influenced their behaviour at work, a view with which other authors concurred (Dawson et al 2008, Kaya et al 2010). Kaya et al (2010) furthered the view stating that organisational climate was also an expression of the nature of an individual's relationships with others in the organisation. However, despite being based on the individual perspectives of those who worked in an organisation, the literature stated that the climate of an organisation was derived from the collective values of individuals (Dawson et al 2008, James et al 2008, Kaya et al 2010, McKay et al 2009 and Van de Voorde 2010). Within the literature, organisational climate was often associated with discussions on organisational culture. Explaining the distinction between the two concepts, James et al (2008) stated that climate was individually oriented and owned whereas culture reflected a "system-level" orientation and was owned by the organisation (p21). Momeni (2010) illustrated the distinction by suggesting that unlike organisational culture which exerted an invisible influence on the behaviour of the individual, the features of organisational climate were more visible. Whilst the review of literature in Chapters 2 and 3 highlighted the perceived importance of culture in either promulgating or inhibiting smouldering crisis conditions (Singer et al 2007, Smith 1990, 1999, 2002c, 2006b, Smith and

Toft 2005, Weick 1999), it was the author's view that what participants were identifying as inhibiting factors was the organisational climate and that this was was more influential in the behaviour of individuals in the workplace.

Aspects of the literature on organisational climate explored the dimensions of organisational life which contributed to an organisation's climate with the work of Jones and James (1979), James and James (1989), Kopelman et al (1990) being most widely recognised (for example in the work of Bellou and Andronikidis 2009, Griffith 2006, James et al 2008, McKay et al 2009 and Van de Voorde 2010). James and James (1989), as did Jones and James (1979), identified that the features of the organisational climate were based on workplace stress and disharmony, job challenge and autonomy, the facilitation and support for work and group cooperation and friendliness. The work of James et al (2008) extended these categories to include work attitudes in terms of job satisfaction, job involvement and commitment, psychological well-being and motivation. The dimensions were consolidated and expressed as work facilitation, goal emphasis, opportunities for growth and advancement and professional esprit de corps (Bellou and Andronikidis 2009). There was, to a large degree, synthesis between dimensions identified by James and James (1989) and Jones and James (1979) in the work of Kopelman et al (1990) who categorised the dimensions as goal emphasis, means emphasis, reward orientation, task support and socio-emotional support.

In order to facilitate a deeper understanding of the influence organisational climate had on the individuals within this study, the 'Faces of Self' and thus, the contributory value of this thesis in terms of smouldering crises and patient safety, the author explored aspects of these areas within the context of the data presented in this and the previous chapters.

8.2.1 Goal Emphasis

McKay (2009) expressed goal emphasis as "the goals that employees are expected to achieve" (p 769) and that an individual had a more positive disposition towards the organisation's climate if there was cohesion between

the aims of the organisation and the individual. In this connection, and consistent with the views of Dawson et al (2008), McKay (2009) proposed that positive climate conditions developed work behaviours that were relevant to the achievement of goals. Helpfully for the author of this thesis, Dawson et al (2008) and Gracia et al (2010) explored this in the service context. Gracia et al (2010) stated that "orientation should be more than an organisational premise; for it to be genuinely effective, employees have to perceive and share it." (p278). Dawson et al (2008) argued that individuals, who were more disposed to a service orientation, exhibited improved service behaviours if the climate was perceived to be positive.

The organisations that deliver healthcare in the UK aim to provide a safe, patient centred service (Department of Health 2000a). As the previous chapters explained, individuals in this study demonstrated a profound and genuine need and desire to take care of patients and exhibited this as a patient orientation. The author had determined that patient orientation underpinned each 'Face of Self'; in the 'Duty Self' it was found in the vocational choices made by individuals and exhibited in their sense of responsibility once in post, in the 'Professional Self' individuals aspired to develop their skills in order to better serve patients and in the 'Collegiate Self' individuals co-operated to overcome adversity so that effective patient care could be delivered across organisational boundaries. Despite there being an apparent coherence between the goal aspirations of the organisation and individuals within it, the author did not identify this perception in the narratives of individuals. The pressures of resourcing changes impeded patient care, patient centred targets forced individuals to compromise the quality of care in favour of quantity of care and boundaries created barriers that could not be overcome even in the interest of the patient. Consistent with the observations of Sheridan (2003) and Smith R (1999) individuals saw these organisationally-instigated climate conditions as being contrary to a patient orientated goal and disturbingly identified the impact on the incidence of human error.

8.2.2 Task Support and Means Emphasis

According to McKay (2009), and Martin (2010) and Van de Voorde (2010), in creating a climate where individuals perceived task support, employees within the organisation needed to feel that they were being supplied with all of the necessary requirements to be able to perform their duties. McKay (2009) furthered that task support was concerned with the quality of working life and job design. However, this was not the only gauge of organisational climate concerning the role that an individual performed. McKay (2009) stated that individuals also needed to feel that they knew what was expected of them in performing their duties through means emphasis. This was achieved by clear procedures and equitable and effective human resource policies and practices, such as training, rewards and career progression, a view with which Kaya et al (2010), Martin (2010) and Van de Voorde (2010) concurred. This, advocated Bellou and Andronikidis (2009), facilitated individuals perceiving that they were able to effectively perform their work.

Individuals in this study were complimentary about the value of the training they received and saw this and career progression contributing to the 'Professional Self'. However, perceptions of the organisational climate in this connection were damaged by perspectives on the quality and level of task support and inequities in means emphasis. As the author identified in this chapter and the previous, and consistent with viewpoints in the patient safety literature (Leape 2000, Fischbacher-Smith and Fischbacher-Smith 2009, Sheridan 2003, Smith and Toft 2005 and Vincent et al 2000), boundaries that existed between aspects of the organisation conspired to create difficulties for individuals attempting to perform their duties. This was exacerbated by what individuals perceived as a lack of commitment to supplying the adequate resources and training which individuals felt was required, a perspective also to be found in the patient safety literature (Smith 2002a and Smith and Toft 2005). Furthermore, changes to job design and the introduction of new working practices led individuals to assert that there were inequities in the organisation's treatment of one individual compared to another. Not only did individuals feel that they were inadequately prepared for the role they had to perform, but that the lack of training and

associated expertise as well as inadequate resources, resulted in the potential for human error.

8.2.3 Socio-emotional Support

McKay et al (2009) and Van de Voorde (2010) stated that individuals within an organisation needed to perceive that the organisation was considerate and protective of their personal well being through socio-emotional support. Kaya et al (2010) suggested that this arose out of mutual trust and support among different levels of the organisation, a view which was endorsed by Martin (2010) and Bellou and Adronikidis (2009) who proposed that this involved developing a communal spirit. Thus, the advocates of socio-emotional support within the context of organisational climate stated that individuals who perceived a positive organisational climate would feel that they could trust the people they worked for and gain affirmation and respect from peers (Momeni 2010).

In the previous chapters, the author identified from the narratives of individuals feelings of being undervalued to the extent that self-worth was questioned. The organisation was not perceived to be supportive in enabling the fulfilment of grassroots needs to effectively care for patients. Furthermore, individuals felt that the consequential personal stress that they experienced was ignored by those above in the organisation. Moreover, the tensions in attempting to deliver effective patient care across boundaries with overstretched and inadequately trained resources created an apparent lack of professional and personal respect between individuals.

In conclusion, there was recognition in the literature that organisations which had supportive climates were able to positively affect the intrinsic motivation of employees (Kaya et al 2010) because the organisation's climate influenced an individual's cognitive state, and thus their motivation at work, and affective state, and thus their job satisfaction (Chuang and Liao 2010, McKay 2009). Furthermore, this resulted in individuals who were more loyal and communal (McKay 2009). Moreover, according to the literature (Dawson et al 2008, Griffith 2006, James et al 2008, Kaya 2010, Kopelman 1990, McKay 2009),

organisational climates that were viewed positively and as more supportive, enhanced the attitudes and performance of individuals within them and effected a more favourable organisational outcome.

The author deduced from this study that the organisational climate was not fully supportive of individuals in their workplace. The result was that cognitive and affective states of individuals were diminished. In terms of the 'Faces of Self' which has been posited by the author as an expression of the individual in the workplace, the consequences were that the job satisfaction and intrinsic motivation which arose out of a patient orientation and strengthened the 'Faces of Self' was weakened. Within the context of the organisational climate literature and patient care, this resulted in a less favourable organisational performance.

8.3 Organisational Climate and The Contribution Value for Smouldering Crises

Whilst the formulation of the 'Faces of Self' in Chapters 5,6 and 7 led directly to the author articulating the contribution value for patient safety knowledge, the development of the model also had a resonance in terms of the contribution value for smouldering crisis knowledge. Referring back to elements of the previous chapters and this chapter so far, this section will further explore the notion that workplace conditions influence grassroots behaviour and assert that a better understanding of these conditions as the organisational climate will improve the limitations that have been identified in management's perspective, knowledge and capabilities which were identified as being instrumental in smouldering crisis situations (Smith 2005a, 2006b and Smith and Toft 2005).

This study has shown that individuals at grassroots level had a desire and intention to fulfil their duties in the workplace in an effective and error-free manner. Seemingly there would be no reason to perceive that grassroots individuals would commit patient care errors. However, whilst patient orientation underpinned a healthcare professional's duty, professionalism and collegiatism, there were factors which conspired to erode the realisation of each of these aspects and hindered an individual's patient care and safety

obligations. Exploration of the reasons why participants felt that they were unable to provide effective patient care centred on difficult working conditions. The discourse of the organisational climate paradigm, which was founded on the concept of an enduring and shared perspective based on how individuals in an organisation perceived the internal environment influenced their behaviour in the workplace, illuminated that the goal, mean and socio-emotional emphasis and task support dimensions of climate were inhibiting effective individual performance. Despite a public resolve to provide a safe, patient centred service, grassroots individuals did not perceive that an orientation for the patient was a shared goal. Furthermore, there was a belief that work facilitation was hindered by the quality and level of task support and by inequalities in means emphasis. Moreover, in the light of the above, individuals felt undervalued and stressed by the climate in which they worked, yet the organisation, and at times their peers, showed no consideration of these emotions.

The normative theoretical corpus concerning smouldering crises proposed that the roots of these crisis situations were to be found in the limited perspective, knowledge and capabilities of management (Smith 2005a, 2006c, Smith and Toft 2005). However, the author asserts that systemic human error, that is human error which occurs in the organisation's systems and processes, is reminiscent of the task support and means emphasis dimensions of organisational climate since it is concerned with how the organisation facilitates employees performing their duties. The contributory value of this study regarding systemic human error as a source of smouldering crises is that, by also considering the perspective of the task support and means emphasis dimensions of organisational climate, the debate is more holistic and inclusive since the knowledge gained from the shared perspectives of grassroots individuals will also be incorporated. However, the author also found that smouldering crises occurred because the goal emphasis dimension of the organisational climate was not realised. For a positive climate to be effected, it is a requirement that there is mutuality in the goals which direct organisational and individual behaviours. This was not the case currently in healthcare and the perceptions of individuals within the organisation were that whilst their behaviours were oriented towards those in their care, the same could not be

said of the organisation. The perceived effect was that care was compromised and, as a consequence, cognitive motivation and affective behaviour were impeded. Whilst the normative theoretical corpus recognised, even anticipated, that errors would occur within an organisation's systems and processes, there is little consideration of the benefits of common goal emphasis in stemming human error. Thus the author also asserts that if there is synthesis between the goals of the organisation and the individual and these are rooted in an orientation towards those who the organisation serves, grassroots individuals will be more effective and intrinsically motivated and the incidence and potential for smouldering error will be curbed.

8.4 Summary

This chapter has explicated the theoretical foundation of this thesis by synthesising the discussion from the previous chapters and stating the dual contributory value of the author's work. In terms of patient safety, the author asserts that improvements in the organisation's climate will address infringements on a professional's duty, professionalism and colleagiateship and address factors which lead to adverse patient safety incidents and smouldering crises in healthcare. The author also asserts that in order to develop the theoretical understanding of smouldering crises within organisations, it is necessary for the normative theoretical corpus on organisational crises to embrace the knowledge that is found within the discourse on organisational climate, specifically in terms of goal and means emphasis and task and socio-emotional support. These contributions will be formalised in the next chapter where the author will also chart the progression of this thesis, consider the management implications and limitations of this study, identify areas for further research and conclude with some personal and professional reflections.

Chapter 9 The Contribution to Knowledge

This chapter will synthesise the discussions from the previous chapters, propose the contribution to knowledge and reflect on the limitations of the study. In addition, the author will consider the practical implications for managers, reflect on the achievement of the thesis' objectives, identify areas for further research and conclude with some personal reflections.

9.1 The Progression of the Thesis

The aim of this thesis was to contribute to knowledge by developing the understanding of the management of smouldering crises and patient safety in healthcare.

In Chapter 1 the author explained her personal motivations for locating the research study associated with this thesis in the healthcare sector. The author had become intrigued by the notion that in organisations where the raison d'être was 'first do no harm', humans, through no apparent evil intention, were committing errors that were causing injury to those in their care. In addition, Chapter 1 also stated the aims and objectives of the thesis, documented defining moments in the journey, set out the business context of this work and concluded by presenting an overview of the research methodology and the structure of the thesis.

In Chapter 2 the author analysed the literature on crisis management in organisations. As a discipline, crisis management had evolved in an era of large-scale, socio-technological disasters such as Chernobyl, Three-Mile Island and Exxon Valdez. The author found that the dominant approach in the normative theoretical corpus was to consider crises from an organisational perspective, viewing them as management failures within an organisation's systems. The author felt that this was a limited perspective and cited a number of reasons for this.

In the first instance, the management literature on organisational crises had tended to focus on examining the reasons for large-scale, high profile sudden crisis events, seeing organisational crises as systemically originated transformational events which resulted in major damage to an organisation's resources, reputation and stakeholders. However, in adopting this approach, there was less attention given in the literature to an escalating incidence of relative minor crises that 'smouldered' within organisations which was first recognised by Turner (1976, 1978) and later adopted by a number of authors (Lagadec 1988, Smith 1990, 1999, 2005a, 2006b Parsons 1996, Heath 1998, Hwag and Lichtenthal 2000, James and Wootten, 2005, Kouzmin 2008). The empirical evidence that crises could smoulder within an organisation was highly significant for the author. The author felt that these incidents were reminiscent of the types of adverse events that were identified in Chapter 1 as an area of interest. Furthermore, the characteristics of crises were highly applicable to the healthcare context of this thesis in that they were indicative of systemic failure and wide ranging human, financial and reputational damage. Finally, the literature (James and Wootten 2005, Mitroff 2004 and Smith 2005a, 2006b) suggested that there existed a potential to contain what was seen as the dominant cause of organisational crises, namely human error and this had a particular resonance for the author, since it implied that there was a legitimacy in exploring the management of smouldering crises further.

In the second instance, systemic human error was widely recognised as a dominant cause of organisational crises. However, Smith (2005b, 2006b), as did Smith and Toft (2005), clearly distinguished between the origins of error and where responsibility was domiciled, for whilst the origins were often to be found in the interactions between grassroots individuals and the 'latent conditions' of the organisation's systems, the ultimate responsibility for failure lay with management. Smith (2005a) elaborated proposing that these failures of management, which were to be found in poor operational decision making and responses, began as the crisis emerged and allowed the crisis to escalate, passing through decisive 'points of inflection' as it progressed. Several authors (for example Smith 2005a, 2006b,

Smith and Toft 2005, Elliott and Smith 2007) exposed the behavioural limitations in management perspective, knowledge and capabilities as being the factors behind these management failures. Thus, the author concluded that the notion of systemic human error embraced both the behaviour of those closest to the crisis incubation point and those who were directly responsible for the systems within which they worked. The author sought further explanation in the literature specifically concerned with human error (Leape 1994 and Reason 1987, 1990, 1997, 2000a, 2000b, 2008) and found some insight into the nature of human error and strong agreement regarding underlying systemic problems and human reliability issues. However, whilst grassroots error dominated the systemic problems underpinning smouldering crises, consistent with the management literature on crises, the causal route was identified as management failures which were further illuminated by the identification of a clear distinction between the causal factors in error situations that could be influenced by management (the 'latent conditions') through an organisation's systems and processes, compared to those it could not ('the active failures'). Particularly in view of the management behavioural limitations in terms of perspective, knowledge and capabilities proposed by Elliott and Smith (2007), Smith (2005a, 2006b) and Smith and Toft (2005), the author felt that without the benefit of a greater knowledge of the contributory role played by the working environment at grassroots level, understanding regarding 'latent conditions' was partial. Furthermore, the author had identified through a review of patient safety literature the seriousness with which the healthcare sector viewed human error in medicine and the associated intent of healthcare organisations to understand and learn from error incidents. This further persuaded the author of the timeliness and legitimacy of addressing the limitations of management perspective, knowledge and capabilities by exploring the behaviour of those at grassroots level in healthcare as a means of developing an understanding of smouldering crises which incubated over time.

In the third instance, whilst theory was empirically based, this was founded on the narratives offered by those who occupied executive and managerial positions as

was evidenced in the work of several authors (for example Fink 2002, Mitroff et al 1988, Mostafa et al 2004, Pauchant and Mitroff 1992, Pearson and Rondinelli 1998, Ray 1999, Register and Larkin 2002). The author felt that although this was not an inappropriate approach, it was partial and incomplete since it was neglectful of the narratives of those at grassroots level who were potentially closer to the crisis incubation point. Furthermore, whilst elements of the normative paradigm (for example Smith 2005a, 2006b, 2006c and Smith and Toft 2005) raised, for the author, significant and informative 'soft' behavioural factors in the smouldering of a crisis, given the orientation of the research the author concluded that knowledge regarding organisational crises at this present time negated to exploit the learning that could be garnered from the behavioural contribution of those who were closer to the crisis incubation point. Finally, many authors (Bland 1995, Burnett 2002, Fink 2002, Greening and Johnson 1996, Heath 1998, Hitchcock 1998, Loosemore, 1998, Mitroff 2004, Mitroff and Anagnos 2001, Mitroff and Kilman 1984, Mitroff et al 1996, Parsons 1996, Pauchant and Mitroff 1992, Preble 1997, Ray 1999, Register and Larkin 2002, Roux Dufort 2000) in a movement to prepare organisations and the managers within them for crisis situations, overtly addressed their work to executives and managers within organisations. The author felt that although there was a necessity for organisations and those within them to prepare and manage crisis situations, this would be better served by academics if the management literature took a more holistic approach to understanding what happened in smouldering crisis situations, particularly in terms of the effect of identified limitations in management perspective, knowledge and capabilities, by acceding to seek the knowledge of those at grassroots level.

The author concluded that the identification of this limited perspective in crisis management literature led her to place her work in investigating and exploring the behaviour in the workplace of those at grassroots level where there was the potential to cause a smouldering crisis through human error. This would result in the contribution of additional knowledge, from a novel perspective, concerning the 'latent conditions' in which crises smouldered and, in so doing, effect a more

holistic and inclusive approach to the understanding of crisis management in smouldering crisis situations.

The discussion in Chapter 3 was based on the author's critical review of the literature concerned with patient safety. There appeared to be a strong correlation between the development of knowledge concerning patient safety in healthcare and the management literature concerning smouldering crises in that rather than apportioning blame to individuals, systemic management failures were perceived to underpin the 'latent conditions' within healthcare organisations which created the incidence of smouldering crises. There were also distinctive observations in the literature concerning a number of issues which appeared to precipitate error in healthcare (Donaldson 1999, Fischbacher-Smith and Fischbacher-Smith 2009, Reason 2004, 2008,Smith 1995, 2001, 2005a, Smith and Toft 2005, Walshe 1999, West 2006). Firstly, the recurring theme of organisational complexity was raised as was resourcing limitations, communications and control challenges and the nature of patients' conditions. Secondly, health professionals worked in an extremely difficult and challenging environment which, when combined with individual and operational challenges, not only created conditions in which errors occurred but also compromised the duty aspirations of professionals. Thirdly, the situation was exacerbated and sustained by an inadequate approach to learning.

In spite of these challenges, the NHS pioneered action to improve the safety of its patients. *Organisation with a Memory* (Department of Health 2000a), a programme aimed at reducing patient safety incidents and led by the National Patient Safety Agency, developed pilot schemes to test patient safety initiatives, a range of technical instruments and significantly, the first reporting mechanism for patient safety incidents. However, whilst the programme had experienced some success, a series of appraisals by public bodies, academics and researchers had been critical of the level and nature of progress (Boaden 2006, Fischbacher-Smith and Fischbacher-Smith 2009, House of Commons 2009). The criticism centred on several factors. Firstly, the delay in the delivery and the budgetary overspend of

the National Reporting and Learning Service (NRLS) and the poor dissemination of patient safety information. Secondly, the adequacy of the data produced by the NRLS was questioned, specifically the continued level of underreporting and the lack of qualitative data. Thirdly, there had been an insufficient reduction in errors and the blame culture remained. Fourthly, patient safety was still perceived to be a lower priority than resourcing and funding issues in healthcare.

Following the review of error in medicine and patient safety in Chapter 3 the author concluded that there were three limitations in the patient safety in healthcare literature. In the first instance, the behavioural issues concerning the contributory role of management perspectives, knowledge and capabilities developed in the management literature concerning crises was not widely recognised or regarded in this body of literature. The author proposed that patient safety in healthcare could be better managed if those who managed the organisation's systems and processes had more in depth information which was used effectively. In the second instance, given the prominence that the working environment of a healthcare professional appeared to play in the precipitation of errors in patient safety, there was a case for exploring this further. In the third instance, key limitations concerning the nature and quality of the information underpinning the movement to improve patient safety in healthcare had been identified, specifically the relatively low level of qualitative information. The author had, through these conclusions, identified a further area in which her work would be placed.

Chapter 2 reasoned that the identified limitations of management literature would be addressed by investigating and exploring the behaviour in the workplace of those at grassroots level where there was the potential to cause a smouldering crisis through systemic human error. The author had proposed that since the thesis context was healthcare, the focus of the study would be the workplace behaviour of healthcare professionals. Given the limitations that had been identified in the patient safety literature, creating a study which would explore, from a qualitative perspective, the behaviour of professionals in the healthcare

workplace would provide a further area of contribution in delivering greater knowledge for those who manage the 'latent conditions' in the healthcare systems and processes which propagated patient safety incidents.

In Chapter 4 the author explained that in order to examine the gaps in knowledge concerning the management of smouldering organisational crises and patient safety, the research methodology focused on investigating and exploring the behaviour in the workplace of those at grassroots level where there was the potential to cause a smouldering crisis through human error.

The research strategy centred on taking a structural phenomological approach. The author felt that the critical theorist's philosophy of combining ontological objectivism with epistemological subjectivism was consistent with her views. Furthermore, the author believed that the approach to research of the critical theorists, which explored contemporary pervading routines and their relative impact on the behaviours of the "disempowered" in organisational settings, was appropriate for the aim of the study. The author had observed the pervading organisational perspective of the management literature concerning the management of crises and the associated emphasis on management processes and it was her intention to complement existing knowledge concerning the management of smouldering crises by investigating and understanding the contributory behaviour of grassroots individuals. Thus, in line with perceived limitations in the behavioural perspective of both crisis management and patient safety knowledge, the research adopted a qualitative approach.

Several qualitative strategies were reviewed. The author rejected those of a collaborative nature such as action research and case study investigation since the author felt it would inhibit the research study and be practically difficult to implement. Furthermore, whilst critical incident technique presented a more appropriate strategy, the author's secondary research suggested that this would be a difficult strategy to adopt and would suffer from the same implementation issues

as a case study strategy. However, the author found evidence of ways in which critical incident technique could be adapted and so applied the principles of the strategy to working life scenarios and adopted this as the research strategy. In determining the working life scenarios, the author chose to take a patient oriented approach since this was highly influential in defining the work of healthcare professionals and two scenarios were identified; one based on an acute patient care need and one based on a routine patient care need. As the overall aim of the primary research was to explore the behaviour of healthcare professionals in order to contribute to the understanding of the management of smouldering crises, the research questions were sensitised to this area of contribution; specifically they were concerned with what drives grassroots individuals in healthcare during their daily working lives, how this affected their behaviour in the workplace and how the behaviour of grassroots individuals affected their peers and patient care.

The author discounted observation as a method for data collection on the grounds that it would not provide the data required and whilst focus groups were considered, the author was advised that organising such an approach would be extremely difficult in a healthcare setting due to the logistics of assembling a group of healthcare professionals. Therefore, the author collected the data by conducting a series of 20 interviews, from a planned 22, some of which were conducted on a paired basis as according to Highet (2003) this led to more thoughtful, reflective data, using a semi-structured topic guide which was based on the working life scenarios.

As the aim of the thesis was to develop the understanding of crisis management within the context of healthcare organisations by exploring the nature of the behaviour of individuals at grassroots level, a narrative approach was taken to the analysis. The author found that, in recounting their working lives, participants' motivation and behaviour was undoubtedly patient oriented and centred on the affinity they had for their profession and peers. Whilst exploring the narratives further, the author exposed a further layer of recurring themes. Within some of the

themes, participants were observing and commenting upon the facets of their working lives through which the organisation structured and controlled what participants did. However, other themes were more concerned with participants' views about their motivation for seeking and sustaining a career in healthcare, their feelings of belonging to a profession and the affiliations they had with their peers. The author felt that these themes offered a greater insight into what actually prevailed in terms of participants' behaviours and, thus, these themes formed the basis of the presentation of data in Chapters 5 and 6.

In Chapter 5 participants' views were focused on the mechanisms that healthcare organisations and the managers within them utilised to structure and control the behaviour of employees. Furthermore, in recounting narratives about the stress and pressure caused when their working lives interacted with management systems, participants highlighted incidences of potential and actual human error. However, the author identified that this was only a partial representation of the working lives of participants since the narratives were also concerned with their perspectives on themselves and their peers, how this influenced their feelings in the workplace and how they behaved.

In Chapter 6 the author evaluated the individual's perspective and found a profound feeling of patient orientation which, in the first instance, motivated healthcare professionals to care for patients and, in the second instance, drove their behaviour in the workplace and created a unifying force across peer groups. There was, though, also evidence that an individual's behaviour and focus on patient care was detrimentally affected by poor relationships between peers and an underlying lack of respect and value.

However, whilst the organisational and individual perspectives explained above provided a useful insight into the data, the author felt that the picture of individual behaviour remained fragmented. This was not helpful in achieving the aim of the thesis which was to develop the understanding of individual behaviour and its

contributory role in smouldering crises and patient safety. The author felt that the 'world as I see it' viewpoint was more conducive to understanding the identity, and ensuing behaviour, of an individual in the workplace. Thus, in Chapter 7, the author built on the findings of Chapters 5 and 6 by exploring the viewpoint of 'the world as I see it' through the voices and contribution of participants in order to develop the identity of the healthcare professional. The author developed an individual's identity, expressed as 'Self', based on three separate yet distinctive features of their working life; their obligations to their patients, their affinity with their profession and their relationships with their peers. The author asserted that these 'Faces' held the key to explaining how and why health professionals behaved in the way that they did and why sometimes errors which adversely affected patient care occurred. The first 'Face of Self' was identified as the 'Duty Self' and was distinguished by expressions of a sincere and profound sense of patient orientation, an attribute which was also identified by Sheridan (2003) and Smith, R (1999). The second 'Face' was identified as the 'Professional Self' and was distinguished by expressions of a strong professional affinity. The third 'Face' was identified as the 'Collegiate Self' and was distinguished by expressions of an allegiance to peer professionals. In exploring the dynamics of each 'Face', and consistent with the observations of Fischbacher-Smith and Fischbacher-Smith (2009), Leape (2000) and Vincent, Stanhope and Taylor-Adams (2000), the author found that conditions in the working environment were eroding the strength of each 'Face'. Furthermore, in healthcare, where the raison d'être is 'first do no harm', these same conditions were precipitating errors and error potential.

Consideration of the individual in Chapters 5, 6 and 7 had built a picture of the behaviour of individuals in healthcare and identified organisational and individual issues that held the potential for precipitating human error. However, in exploring the interrelationships between each 'Face of Self' in Chapter 8, the author identified that a profound desire to care for patients bound each 'Face' to the others and, when this was successfully achieved by healthcare professionals, resulted in a high level of job satisfaction and an intrinsically motivated employee.

However, whilst a patient orientation together with the resultant job satisfaction and intrinsic motivation explained the interrelationship between the ‘Faces’, the conditions in which professionals worked created a weakness in the central core of the model. The author concluded that what was affecting the performance of individuals and weakening the ‘Faces of Self’ was the organisational climate, an enduring quality which distinguished one organisation from another but was based on the perceptions of employees and influenced their behaviour at work (Tagiuri and Litwinn 1968 and Forehand and von Gilmer 1964). Grassroots individuals did not perceive that an orientation for the patient was a shared goal and believed that work facilitation was hindered by the quality and level of task support and by inequalities in means emphasis. This resulted in individuals feeling undervalued and neglected by peers and the organisation, experiencing workplace stress and incubating the propensity to commit errors.

9.2 The Contribution to Knowledge

The genesis of this thesis was in the recognition that organisational crises precipitated by human error were escalating and that the impact on organisations was significant, particularly in terms of the financial, human and reputational effects, and potentially fatal. Events like these are alarming and disruptive occurrences and never was this more so than in healthcare where the consequences of adverse events are so personally catastrophic for the individuals involved and organisationally destructive. There was, and still is, quite rightly, a compulsion, on the part of researchers and practioners, to understand why crisis events happened and to identify ways in which their progression can be halted. In the normative discourse specific attention was beginning to focus on the conditions that precipitated crisis evolution in the organisation’s systems and processes during the emergent, smouldering stages as a means of further curbing their development.

The review of the management literature, focusing specifically on these emergent conditions, led the author to conclude that the behavioural limitations in management's perspective, knowledge and capabilities that allowed crises to smoulder would be best addressed by extending knowledge concerning the contributory role of workplace behaviour amongst grassroots individuals where information was sparse. Furthermore, creating a qualitative study, exploring the workplace behaviours of healthcare professionals, would enhance knowledge concerning the 'latent conditions' which propagated the patient safety incidents that were typical of smouldering crises and provide a deeper understanding of the healthcare professional at work. In so doing, the author would be continuing the tradition of extending knowledge in order to identify ways in which the progress of smouldering crises could be limited.

This section will now present the author's specific contribution to knowledge in these areas; the management of smouldering crises and patient safety in healthcare.

9.2.1 The Contribution to Knowledge Concerning the Management of Smouldering Crises

The limitations of the normative discourse regarding organisational crises were identified and have been addressed through the design and execution of the research study associated with this thesis.

In the first instance, the focus of research had tended to be on large-scale, high profile cases. This had occurred at the expense of developing understanding of the rising concern in the literature regarding the evolutionary pathway of a smouldering crisis (Smith 2005b, 2006c). The research strategy associated with this thesis focused on the use of working life scenarios in order to explore daily working lives since this was where the potential for incidents and events, which were typical of smouldering crises, originated.

In the second instance, the normative discourse took a systemic causal viewpoint and resolved to inhibit crisis potential through procedural improvements in the organisation's systems (Smith and Toft 2005). The dominant cause of organisational crises was widely recognised as systemic human error. The emphasis had been on developing the understanding of why human errors occurred by taking an organisational perspective focusing on management failures (Vincent 2006, Pauchant and Douville 1992). However there was evidence of the complicit role played in these situations of limited management behaviour in terms of perspective, knowledge and capability (Smith 2005a, 2006c, Smith and Toft 2005, Elliott and Smith 2007). In addition, empirically based theory had been almost exclusively founded upon the narratives of executives and managers whilst the related and meaningful knowledge of grassroots individuals, who innocently and unwittingly precipitated the majority of these events, was largely ignored in the normative discourse. The consequence was that theory had been developed in a partial manner. This thesis has liberated the opinions of grassroots individuals and created a deeper and more insightful understanding of why their behaviour caused crises to smoulder within organisations. This perspective was novel and would improve the limitations observed in the literature concerning management's perspective, knowledge and capabilities. In so doing, knowledge regarding how organisations could better effect containment would be furthered.

However, in addressing these limitations, the significant contributory value of this thesis lies in the way in which the author has shifted the discourse regarding the understanding of smouldering crises to a position where it embraces the organisational climate paradigm. The normative discourse proposes that smouldering crises occur when limitations in management's perspective, knowledge and capabilities allow error incidents within the organisation's systems and processes to escalate through 'points of inflection'. This thesis proposes that aspects of these limitations can be addressed by management's more effective consideration of the organisational climate, specifically shared values, means emphasis and task support and socio-emotional support. The management

learning, delivered through the provision of this novel information, will influence aspects that are so critical in the incubation of smouldering crises, namely early warning knowledge, enlightened and more complete crisis contingency plans and systems and procedural developments and improved ‘latent conditions’. The consequence is that these aspects can be positively influenced by management so that these destructive and alarming error occurrences are curbed. The theoretical discussion regarding the movement of the debate to a position where it embraces the organisational climate paradigm is developed below, however, the specific management implications this new knowledge delivers in terms of early warning knowledge, enlightened crisis contingency plans and systems and procedural developments and the positive influence on ‘latent conditions’ is developed further in Section 9.3 The Management Implications of this Thesis.

Not all errors are inevitable primarily because grassroots individuals do not seek to be ineffective or error-prone in the workplace. Their aspirations are to seek a legitimacy in and acquiesce with the organisation’s ambitions, to see these ambitions imbued throughout the organisation, to be able to effectively perform their work and to perceive that they, as individuals, matter to the organisation. Hypothetically, organisations which realise a mutuality and operational underpinning in their goal ambitions, facilitate work performance and effect a considerate approach to grassroots level, will contain, although possible never eliminate, the instances of error. This is not the case in reality.

Despite an evident consensus in terms of goal philosophy, there is a disparity between intent and action on an organisation’s part which has a resounding and damaging impact on grassroots work performance and well being but more disturbingly creates the conditions for error potential which are reminiscent of smouldering crises. Organisations and the managers within them must be more considered in developing, communicating and implementing the strategic and operational attributes of the business based on an inclusive philosophy so that the mutuality of purpose is preserved and is capable of being enacted in the

workplace. Whilst this will result in better performing and more satisfied and motivated grassroots individuals, the most significant outcome is that the conditions propagating errors can be contained, as are the resultant damaging and disturbing impacts.

Thus, the first proposition of this thesis is that the limitations of management perspective, knowledge and capabilities which are responsible for the escalation of smouldering crises can be ameliorated if management are sensitive to and effective in the management of the organisation's climate. Specifically, through this enlightened perspective management within organisations can curb the human errors that underlie the incubation of smouldering crises if they effect an alignment of the organisational and individual goals and there is better consideration of how the organisation facilitates employee fulfilment of these goal aspirations. In so doing, the interplay between the organisation's systems and processes and individuals within the organisation is synchronised and focused on the same end. The benefits this creates in terms of employee cognitive and affective behaviours diminish the conditions in which errors incubate and are a source of strength in terms of a more effective individual, management and organisational performance. However, this can only be achieved if the management of an organisation engages with the dimensions of its climate. In so doing, management achieves improved perspective, knowledge and capabilities and the organisation will realise less crisis prone conditions which smoulder and are, ultimately, so damaging and destructive.

This aspect of the theoretical corpus of this thesis presents a complementary contribution to the normative debate on organisational crises as the resultant contributory discourse of organisational climate strengthens the normative paradigm making it less partial and more holistic. It is, thus, advocated that researchers and practioners pursuing the normative paradigm, engender the inclusive approach of this study in their work in order to harness the knowledge

that is contained in the narratives of grassroots level to provide better and more actionable information for management so that a more complete and deeper understanding of smouldering organisational crises than has been achieved to date is realised.

9.2.2 The Contribution to Knowledge Concerning the Quality and Safety of Patient Safety in Healthcare

Consistent with the approach taken regarding the limitations of the normative discourse on organisational crises, limitations in the patient safety literature were also identified and have been addressed through the design and execution of the research study associated with this thesis.

In the first instance, although there was commonality in that the principles of management literature on smouldering crises supported the development of patient safety in healthcare (for example Reason 1987, 1990, 1997, 1998, 2000a, 2008), the behavioural issues concerning the contributory role of management perspectives, knowledge and capabilities (2004, 2005a and Smith and Toft 2005), had not been explicitly and widely acknowledged. The research study associated with this thesis was designed explicitly to contribute to improved management knowledge and, in so doing, pre-empted research and knowledge requirements in the patient safety literature and practice regarding the emergent nature of smouldering crises.

In the second instance, the conditions in which healthcare professionals worked played a critical role in the promulgation of patient safety incidents (Sheridan 2003). Exploring the conditions at work of healthcare professionals through the utilisation of working life scenarios facilitated further exploration of this significant aspect underpinning smouldering crises.

Finally, key identified limitations in the UK's patient safety programme centred on the nature and quality of the information underpinning its development with direct criticism being levelled at the lack of qualitative understanding (House of Commons 2009, Boaden (2006) and Fischbacher-Smith and Fischbacher-Smith (2009). A qualitative approach to the research provided an opportunity to explore behaviour in the workplace within the context of patient safety in order to develop a deeper understanding of the issues involved.

In addressing these limitations, a second contributory value of this thesis was established. The author identified strong and unified themes emanating from the data which were utilised to encapsulate the behaviour in the workplace of healthcare professionals in an identity of 'Self'. Whilst author's such as Reason (2004, 2008) and Vincent and Reason (1999) had uncovered and articulated aspects of a professional's workplace behaviour that held the capacity to propagate error, this seemed to the author to be a partial approach. The author's formulation of the 'Three Faces of Self', which arose out of the process by which the author endowed meaning to the narratives contained in the research, has shifted the debate regarding the contributory role played by healthcare professionals in the workplace. In consolidating the perspective of the healthcare professional in the 'Faces of Self' the author has encapsulated the healthcare professional's 'world as I see it' in a more holistic perspective which, whilst exploring the fractures in behaviour that led to errors as has been done before, also considers factors that preserved patient safety. There was a further significant realisation concerning the factors that led to errors since whilst some were, as proposed in the normative discourse, systemically and process oriented and, as such, concerned with 'hard' management issues, there were others that were oriented towards the 'soft' management issues which the literature had recognised was neglected. The theoretical discussion regarding moving the debate to a position where it embraces a deeper understanding of the behavioural issues is developed below, however, the specific management implications that this new knowledge delivers in terms of structural boundaries and barriers between

professionals, policies regarding the design of work, resourcing and competing priorities and job satisfaction and intrinsic motivation in the workplace is developed further in Section 9.3 The Management Implications of this Thesis.

The intentions of healthcare professionals are entirely proper. Healthcare professionals have a profound responsibility and duty towards their patients which results in working lives that are underpinned by a strong patient orientation. This position is enhanced by their professional identification and integrity. Healthcare professionals are confident in their skills and expertise and are resolute in their desire to deliver safe and effective patient care. The environment of belonging and willingness fostered by effective peer relationships creates a positive work atmosphere which further contributes to better patient care. However, whilst patient orientation underpins a healthcare professional's duty, professionalism and collegiateship, there are also factors which conspire to erode each of these aspects. The boundaries that exist between professionals cause difficulties in the delivery of effective patient care and create tensions in the relationships between professionals. Organisationally-led initiatives such as targets and resourcing changes lead to competing priorities in the workplace and result in professionals feeling undervalued. For the individual, the result is poor intrinsic motivation and a compromise in the psychological contract between the professional and the healthcare organisation. However, through initiating changes to the organisation's climate, healthcare organisations can address the challenges which erode a professional's duty, professionalism and colleagiateship. In so doing, the conditions in which patient safety crises can smoulder within an organisation will be addressed.

Thus, the second proposition of this thesis is that action to address adverse patient safety incidents will only be as effective as the information and knowledge upon which it is based. The systemic and process elements of 'latent conditions' are only a partial causative view of incidents and must be complemented by an understanding, on the part of those who both instigate and manage the implementation of patient safety policy, of the contributory role of behavioural elements of 'latent conditions'. Specifically, these behavioural elements must consider the orientation of individuals to those they serve and work with and the means by which the service is delivered since ruptures in each of these areas underlie adverse patient safety incidents. Affective amelioration of both 'hard' and 'soft' 'latent conditions' by policy makers, leaders within organisations and management generally will create a more effective, motivated and satisfied healthcare professional in the patient care setting and negate the conditions in which the adverse patient safety incidents promulgate. In so doing, the smouldering crisis conditions, of which adverse patient safety incidents are typical, will be curbed and the patient safety programme in the UK will move forward on a more holistic platform.

This further aspect of the theoretical corpus of this thesis presents developmental contribution to the normative debate on patient safety in healthcare. The resultant contributory discourse enhances the knowledge and action that has been undertaken to date by harnessing the behavioural learning gained from grassroots healthcare professionals to present a more holistic perspective of the 'latent conditions' that promulgate adverse patient safety incidents, which are symptomatic of smouldering crises.

9.3 The Management Implications of the Thesis

In embarking on this thesis, the author had a desire to develop the understanding of smouldering crisis situations in organisations for two reasons; the first was a

wish to contribute to existing academic research and knowledge, the second was to practically support organisations and the managers within them who are tasked with dealing with smouldering crisis situations. The previous section has set out the two propositions of this thesis for academics and researchers. This section is concerned with the messages regarding the implications for senior and middle managers and policy makers within organisations and, although the research study associated with this thesis was implemented in the healthcare sector, some of the observations made by the author have a more generic application for managers. The author sees these implications operating on three levels; the first is concerned with messages for senior managers within organisations in terms of strategic level developments, the second is concerned with messages for middle managers within organisations in terms of operational development and the third is concerned with messages for policy makers regarding patient safety initiatives.

In the first instance, the senior management implications are drawn, by the author, from the way in which the key findings in Chapters 6 and 7 can ameliorate management's perspective, knowledge and capabilities. The previous section has already elucidated that in embracing the organisational climate, management's limited perspective, knowledge and capabilities which allow smouldering crisis conditions, would be improved, specifically in the areas of early warning knowledge, enlightened crisis contingency plans and systems and procedural developments and 'latent conditions'. The views of grassroots in the research study associated with this thesis detailed in Chapters 6 and 7 specified aspects of the 'latent conditions' in which they worked as precipitating smouldering crises. These aspects were centred on the nature and use of targets, boundaries across which the service was delivered, the design of resourcing, experiential training and the implications these had for professionals at work, aspects of which were entirely consistent with Reason's early specification of 'latent conditions (1997). For those at grassroots, there was difficulty in reconciling the need to meet targets with delivering an effective service. In addition, where effective delivery of the service required parts of the organisation coming together, there were often breakdowns in

critical points which impinged on the realisation of this. Furthermore, the manner and nature of resourcing changes, for example job design, and inadequacies in experiential training were felt to exacerbate prioritisation and service delivery issues. These novel views come from the frontline of an organisation, from those who are enacting the organisation's systems and processes in order to safely satisfy 'customer' needs and who testify that, despite initiatives to improve safe service delivery, the current decisions of senior managers regarding targets, boundaries, resourcing and training impinge on progress. The movement towards addressing smouldering crisis situations is a progressive one and senior managers now need to better move beyond service delivery measurement in order to better understand their qualitative context, since this will enhance management perspective, knowledge and capabilities by providing early information regarding situations in which crises are beginning to smoulder, better direct the organisation's systems, processes and contingency planning and thus, orient the focus on safe and effective service delivery thereby improving further the 'latent conditions' in which smouldering crises prosper.

In the second instance, at an operational level, there were numerous instances in the data where better receptivity and effective communication upwards by middle management of the views of grassroots concerning the orientation of systems and processes could have achieved much in exerting influence on aspects of the crisis smouldering 'latent conditions'. Centring targets on the quality and effectiveness of service delivery rather than the efficiency of service delivery would better ground targets in organisational and individual goals and would allow greater flexibility for service delivery across organisational boundaries. This could be enhanced by encouraging the development of informal intra service knowledge and appreciation. Resources would be more effectively and efficiently utilised if training and development achievements were formally and operationally recognised. Management bears ultimate responsibility for control and order in an organisation (Smith 2005a, 2006b, Smith and Toft 2005), however, the findings of this study are a testimony to balancing order and control with operational flexibility and

autonomy, for since without it the evidence of this study supports that of the 'misbehaviour' literature (Ackroyd and Thompson 1999) in finding that control processes can generate the motivation for grassroots individuals to embark on violations in order to fulfil their duties.

In the third instance, the implications for policy makers concerned with patient safety are three-fold. Firstly, the data from this study is evidence of the value that can be derived from qualitative data of the first person order in terms of patient safety (House of Commons 2009, Reason 2008). Despite various qualitative measures such as Root Cause Analysis and the Incident Decision Tree advocated by *Seven steps to patient safety* (National Patient Safety Agency 2004) the NRLS has focused on the learning that could be garnered from quantitative measurement. Secondly, the processes for reporting patient safety incidents are viewed with scepticism and, as a consequence, are perceived to have little significance or use. Thirdly, consistent with the findings of the House of Commons Health Committee's report into Patient Safety (House of Commons 2009), patient safety is judged by those at grassroots level to be a lesser priority than resourcing and funding and yet there is an inescapable link between resourcing, funding and the capacity to realise the safe delivery of patient care. Whilst, the National Patient Safety Agency (NPSA) is in the unenviable position of attempting to convince Government, policy makers, senior managers and leaders within healthcare organisations to focus on patient safety at a time of severe austerity and unrest, the present Government has vowed to focus on outcomes not processes and to improve patient experience and safety so the mandate to leverage action is evident (Department of Health 2010).

9.4 The Fulfilment of the Thesis' Objectives

At the outset, in Chapter 1, the author identified six objectives for this thesis. This section will examine the degree to which these objectives have been achieved.

The first objective was to explore what was understood about organisational crises and how far this explained the evolution of smouldering events which incubated over time in the behaviours at grassroots level. The literature review at Chapter 2 considered organisational crises in terms of their characteristics, typologies and then, in focusing on the defined area of this study, examined in detail the concept of the smouldering crisis. With particular emphasis on smouldering crises, Chapter 2 then proceeded to investigate the root causes of organisational crises. The conclusion of the review of literature was that management behavioural limitations were embedded within smouldering crises situations and, furthermore, there was evidence that this was an under researched area. This was thus where the author placed her work.

The second objective was to investigate how this knowledge was translated into meaningful advice concerning how smouldering crises could be best managed. The literature review in Chapter 2 also examined the management of organisational crises and identified that, consistent with the notion of the emerging crisis, these situations passed through a series of phases. Given the defined area of study being the smouldering crisis, the review adopted a focus on how the management behavioural limitations, identified as being significant to the propagation of these situations, impacted in the stages of a crisis. The evidence was that management's limited perspective was particularly influential in inhibiting early warnings, crisis contingency plans and systems and procedural developments and exacerbating 'latent conditions'. Furthermore, in reviewing the orientation of the literature concerning the management of organisational crises, a propensity to emanate empirical from the views of those in senior management positions was identified, at the expense of considering the views of those who were closer to the point at which a smouldering crisis incubated. This further refined the area where the author placed her work.

The third objective was to understand the contextual setting for this thesis as a means of establishing healthcare as a valid area of study of smouldering crises. A

brief situational analysis of the healthcare sector in the UK was given in Chapter 1 whilst Chapter 3 critically reviewed the literature concerning error in medicine. Commonalities were found between the literature concerning error in medicine and the literature on organisational crises in terms of root causes, a focus on systemic human error, the apportionment of responsibility on management failures and the tendency to view systemic and procedural improvements as the remedial solution for curbing error in medicine. However, whilst all the signs of smouldering crises were evident in healthcare, the arguments regarding the significant influence of 'soft' management behavioural issues occupied less prominence.

The fourth objective was to explore the knowledge regarding patient safety and investigate the extent to which this knowledge ameliorates adverse patient safety incidents in healthcare. Chapter 3 discussed the manifestation of error in a clinical situation as being that of patient safety. The literature evidenced that a critical review of patient safety initiatives had been undertaken and the conclusion was that, although progress had been made, there was a need for further research, particularly that of the exploratative qualitative nature. Both this and the limited prominence of 'soft' knowledge in healthcare was a significant finding which further influenced the author's placing of her work.

The fifth objective was to design and implement a research study that would facilitate improvements in management knowledge through the investigation and exploration of how and why individuals at grassroots level in healthcare behave, at times, in such a way that their actions lead to the errors which are indicative of smouldering crises. This objective came as a direct consequence of the limitations observed in both the literature review of organisational crises and patient safety; that there was increasing evidence that smouldering crisis situations arose due to limitations in the behavioural aspects of management's perspective, knowledge and capabilities and that understanding was particularly limited in healthcare, that aspects of these behavioural issues were identified as areas for further research and that, empirically, evidence regarding organisational crises ignored grassroots

perspectives. Accordingly, a qualitative research programme was designed to explore and investigate the behaviour of grassroots individuals in the workplace in order to better understand how smouldering crisis situations arose.

The sixth and final objective was to contribute to the normative debate regarding smouldering crises and safety in healthcare. This chapter has, at Section 9.2.1 and 9.2.2 set out the central propositions of this thesis. The core of the first proposition is centred on the proposal that the negative influence of management behaviour in smouldering crisis situations will be improved by embracing understanding the effect that the organisational climate has on grassroots individuals. The core of the second proposition is centred on the proposal that understanding of both adverse patient safety incidents and action to resolve them will be more effective if there is an appreciation of the impact that unfulfilled duty and inhibited professional and collegiate efficacy has on the capacity to exacerbate the 'latent conditions' that are causally connected to smouldering crises in healthcare.

9.5 Study Limitations

Inevitably the author has reflected on this study and has some observations regarding its limitations; some of which are concerned with the theoretical development of the contribution, some of which are concerned with practical implementation issues.

In the first instance, in terms of the proposed contribution to theory, the author is resolute that the knowledge developed in this thesis should complement existing management literature concerning the management of organisational crises. The contribution of this thesis has been developed solely around the limitations that the author observed in existing literature and is not intended to supplant existing knowledge.

Furthermore, the author is realistic in viewing this work as partial progress in developing ‘soft’ knowledge concerning the contributory role of management perspectives, knowledge and capabilities in smouldering crisis situations. Indeed this work could be viewed as an inaugural attempt to address the issues raised by others (Elliott and Smith 2007, Smith 2005a, 2006b and Smith and Toft 2005).

Finally, the review of literature could have explored other areas, most notably identity and healthcare management, to facilitate broader contribution to knowledge. However, whilst this could be viewed as a limitation, for two reasons, the author felt that this might diminish the strength of focus herein. In the first instance, the author’s area of interest is organisational crises, specifically smouldering crises particularly those in healthcare, to broaden this work would, in the view of the author, have moved outside this area of interest. In the second instance, the level of synthesis between knowledge concerning organisational and smouldering crises and error in medicine and patient safety was considerable. Whilst this has led to a wider contribution to knowledge in this work, there are equal synergistic benefits in so doing, both philosophically and practically. However, positioning this work in the body of knowledge concerning identity and healthcare management is identified in Section 9.6 as an area for further research.

In the second instance, this study is an exploratory one and the findings are based on the views of participants within Sheffield Strategic Health Authority. The author provided the reasoning for selecting this organisation as proxy in Chapter 4. In addition, the author makes no claims that the sample is entirely representative of the population of Sheffield Strategic Health Authority since it was selected on a purposive sampling basis. Furthermore, the final sample size of 20 interviews was relatively small. The unit of analysis was the individual. Accordingly, whilst the author exposed similarities and contradictions in aspects of the sample, the approach to the analysis was to build a picture of a healthcare professional, irrespective of their discipline. The author recognises that, as a consequence of these issues, the findings are conceptual rather than generalisable, a view with

which Smith and Toft (2005) endorse in their suggestion that issues raised are not readily transferable from one context to another.

Furthermore, whilst the research methodology was successful in eliciting and harnessing the views of grassroots level concerning workplace behaviours, there were challenges in establishing a valid and reliable study in the healthcare sector, principally in the area of access. Whilst the author attempted to navigate the process of access with expediency, this was not always achievable and had a significant effect on the study timeframe. Although the author adopted a contingent approach in ameliorating aspects of the research to overcome time issues, with improved prior knowledge of the process, some of these challenges could have been better anticipated and thus, better managed. This is a learning point for the author and anyone else attempting research in the healthcare sector.

Finally, in terms of the implementation issues, in adopting a working lives scenario strategy, the research did not aim to consider the role that personality characteristics had on behaviour. However, the author acknowledges the significance that personality can have on an individual's behaviour in their working life.

Notwithstanding the above, the author is confident that these findings are valid in the context of this thesis and that a rigorous approach to the research study was taken. As a consequence, the author feels that the findings are reliable and could be used as a basis for further research.

9.6 Further Research

Aspects of this study were grounded in the recognised need in literature for further research. The author has, in developing the contribution to knowledge, partially addressed these needs. However, and notwithstanding the research needs observed in the literature indentified at Chapters 2 and 3, in reflecting on this work

the author has recognised additional specific areas where further research would be appropriate.

In the first instance and in terms of the generic approach to research in the area of organisational crises, the author is an advocate of adopting the inclusive approach found in this study in empirical research in the normative discourse. This study has demonstrated the significant value of harnessing the views of grassroots level. This thesis is a testimony to the fact that there is much to be said for further research liberating the in-depth feelings of grassroots level to address the research issues identified above in order to develop a more holistic and deeper understanding of what is happening in the workplace and why.
However, this should not be at the expense of disregarding the views of those who enact strategic and operational decisions, since an optimal understanding of organisational crises comes from the knowledge garnered from all levels of the organisation.

In the second instance, it is argued that the nature of empirical investigation in the normative discourse in future research must embrace the dimensions of organisational climate that have been so notable in this study if knowledge concerning the containment of smouldering crises is to be realised. Mutuality of goals, facilitation of performance and consideration of individual well being influence the motivation and behaviour of individuals in the workplace because they influence the working environment. To negate to pursue these issues in future research, ignores aspects of an organisation which this study has identified as being significantly important in the incubation of smouldering crises.

In the third instance, and as identified in Section 9.5 above, this work is positioned within the research on organisational crises and patient safety. However, other areas particularly identity and healthcare management could have been considered. In Section 9.5 above, the author reasoned why this has not been done but it is identified here as an area for further research. The development of

knowledge in terms of identity and healthcare management through the concept of the ‘Three Faces of Self’ encapsulating professional identify seems to be a logical progression for this work.

In the fourth instance, as the author outlined in the limitations in Section 9.5 above, these findings are conceptual rather than generalisable. The author is confident that, in the context of the validity and reliability of this study, the research could be replicated using other Strategic Health Authorities. In addition, this study has been contextually located in the healthcare sector. Given the influence of organisational climate identified, the author feels that it would be worthwhile conducting research in other public sector organisations such as the fire service or more generally in the private sector.

In the fifth instance and reflecting more specifically about aspects of the findings of this study, the research associated with this thesis has explored behaviour within the healthcare setting at an individual level. Aspects of the analysis revealed stronger feelings from participants of some disciplines than others. Therefore the author feels that further research should focus on probing aspects of the findings which were raised amongst one discipline, amongst others.

Finally, in Chapters 1 and 3, the author identified an intent in the healthcare sector in the UK to better understand the incidence of human error. Consistent with the observations made in section 9.3 above regarding the management implications of this study there is a case for aligning these research findings with research currently being conducted in the UK and, since this is not solely a UK phenomenon, globally. However, and more specifically, this study raises significant operational issues in healthcare that inhibit the performance of professionals and are detrimental to patient care. Firstly, professionals feel ill-prepared to cope with changes in the social make up of the people that they serve. The sector and the managers within it need to investigate how it can address what is a training requirement and an operational issue. Secondly, despite accepting

that care has to be delivered across workplace boundaries, professionals feel that the divisions between peers are hindered by poor patient transition practices and the territorialism they engender. Further research is necessary to explore how territorialism can be best overcome and establish how transitions can be effected in a more cohesive manner. Thirdly, whilst professionals may be hostile to resourcing changes, what they are most critical of is the impact that these changes have on their capacity to deliver safe and effective care to patients. There is a strong case, particularly in view of the present political and economic climate, for taking a fresh look at resourcing. There are basic aspects of care which have to be absolutely right because they can become the source of dissatisfaction to professionals and patients alike. There are also, however, aspects of care which can make a significant difference to the way professionals and their patients feel (Hertzberg 1968). The distinctions between basic and other aspects of care will be different for particular groups of patients but exploring and investigating the dynamics of care will contribute to a better understanding of where resourcing can be efficient and where it must be effective.

9.7 Personal and Professional Reflections

Finally, this thesis has been an enormously challenging yet rewarding journey for me. Prior to becoming an academic, I was a commercial researcher and I have battled my intuitive impulses, particularly when designing and implementing the research. The doctoral journey has nurtured in me the rigour and discipline needed for academic research. Each stage of the journey has presented great learning opportunities, delivered magical moments and in the words of Pearson and Misra (1997) ‘hyper-extended’ me. I have, at times, had crises of my very own. However, the tenacity and strong work ethic instilled in me by my parents and the not insignificant growth I have witnessed in myself as a professional academic and researcher has seen me through the difficult times and allowed me to enjoy the ‘moments of magic’.

Bibliography

Ackroyd S and Thompson P (1999), Organisational Misbehaviour, Sage Publications, London

Ahmed PK, Cadenhead L (1998), Charting the developments in the NHS, Health Manpower Management, 24:6, 222-228

Alpander GG (1982), A pragmatic typology of hospitals based on their internal complexity dimension, Hospital and Health Service Administration,27:5,6-27

Andersen E (2003), Be Prepared for the Unforeseen, Journal of Contingencies and Crisis Management, 11:3, 129-131

Askill J and Sharpe M (1993), Angel of Death, Michael O'Mara Books Limited, London

Augustine N (1995), Managing the crisis you tried to prevent, Harvard Business Review, 73:6, 147-159

Baba-Akbari Sari A, Sheldon TA, Cracknell A and Turnbull A (2006), Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review, British Medical Journal, doi:1-.1138/bmj.39031.507153AE (published 15 December 2006)

Baptiste NR (2008), Tightening the link between employee wellbeing at work and performance, A new dimension for HRM, Management Decision, 46:2, 284-309

Barry D and Elmes M (1997), Strategy retold: Toward a narrative view of strategic discourse, Academy of Management Review, 22:2, 429-452

Barton L (1993), Crisis in organisations, managing and communicating in the heat of chaos, South and Western, Cincinnati

Bazeley P (2007), Qualitative Data Analysis with Nvivo, Sage, London

Bellou V and Andronikidis AI (2009), Examining organisational climate in Greek hotels from a service quality perspective, International Journal of Contemporary Hospitality Management, 21:3, 294-307

Benning A, Ghaleb M, Suokas A, Dixon-Woods M, DawsonJ, Barber N, Franklin BD, Girling A, Hemming K, Carmalt M, Rudge G, Naicker T, Nwulu U, Choudhury S, Lilford R (2011), Large scale organisational intervention to improve patient safety in four hospitals: mixed method evaluation, BMJ 2011;342:d195 [online] (cited 23 June 2011) Available from <URL http://www.ncbi.nlm.nih.gov/pubmed/21292719>

Benning A, Dixon-Woods M, Suokas A, Dixon-Woods, Ghaleb M, Dawson J, Barber N, Franklin BD, Girling A, Hemming K, Carmalt M, Rudge G, Naicker T, Nwulu U, Kotecha A, Derrington MC, Lilford R (2011), Multiple component patient safety intervention in English hospitals: controlled evaluation of second phase, BMJ 2011;342:d199 [online] (cited 23 June 2011) Available from <URL http://www.ncbi.nlm.nih.gov/pubmed/21292720>

Blaikie N (1993), Approaches to social enquiry, Polity Press, Cambridge

Bland M (1995), Training managers to handle a crisis, Industrial and Commercial Training, 27:2, 28-31

Boaden R (2006), The contribution of quality management to patient safety, Walshe K and Boaden R (eds), Patient Safety, Research into Practice, Open University Press, Maidenhead, pp41-65

Brant S (1992), Hearing the Patient's Story, International Journal of Health Care Quality Assurance, 5:6, 5-7

Bridges J, Fitzgerald L and Meyer J (2007), New workforce roles in health care, Exploring the longer-term journey of organisational innovations, Journal of Health Organisation and Management, 21:4/5, 381-392

Brown RB, McCartney S, Bell L, Scaggs S (1994), Who Is the NHS For?, Journal of Management in Medicine, 8:4, 62–70

Burnett J (2002), Managing Business Crises, From Anticipation to Implementation, Quorum Books, Connecticut

Calloway LJ and Keen PGW (1996), Organising for crisis response, Journal of Information Technology, 11, 13-26

Calman K and Smith D (2001) Works in theory but not in practice? The role of the precautionary principles in public health policy, Public Administration 79:1, 185-204

Campion MA, Mumford TV, Morgeson FP AND Nahrgang JD (2005), Work redesign: Eight obstacles and opportunities, Human Resource Management, 44:4, 367-390

Carley M and Harrod JR (1997), Organisational Learning under fire: Theory and Practice, American Behavioural Scientist, 40:3, 310-332

Chell E (1998), Critical Incident Technique, Symon G and Cassell C (eds) Qualitative Methods and Analysis in Organisational Research, A Practical Guide, Sage, London, pp51-72

Chuang C and Liao H (2010), Strategic human resource management in service context: Taking care of business by taking care of employees and customers, Personnel Psychology, 63, 153-196

Clarke N (2005), Workplace Learning Environment and its Relationship with Learning Outcomes in Healthcare Organisations, Human Resource Development International, 8:2, 185-205

Coombs WT (1999), Ongoing Crisis Communications, Planning Managing and Responding, Sage Publications, Thousand Oaks

Davies N (1993), Murder on Ward Four, Chatto and Windus, London

Davis P (2006), Critical incident technique: a learning intervention for organisational problem solving, Development and Learning in Organisations, 20:2, 13-15

Dawson JF, Gonzalez-Roma, Davis A and West MA (2008), Organisational climate and climate strength in UK hospitals, European Journal of Work and Organisational Psychology, 17:1, 89-111

Department of Health (1994), Independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital, HMSO, London

Department of Health (2000a), Organisation with a Memory, HMSO, London

Department of Health (2000b) Improving Working Lives Standard, Department of Health, London

Department of Health (2001a), Harold Shipman's clinical practice 1974-1998: a clinical audit commissioned by the Chief Medical Officer, HMSO, London

Department of Health (2001b), The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol, HMSO, London

Department of Health (2001c), Building a safer NHS for patients: Implementing 'An Organisation with a Memory', Department of Health, London

Department of Health (2004), Reconfiguring the Department of Health's Arm's' Length Bodies, Department of Health Publications Online, London

Department of Health (2005a), Creating a Patient-Led NHS, Delivering the NHS Improvement Plan, DH Publications Online, London

Department of Health (2005b), Safety First, A report for patients, clinicians and healthcare managers, DH Publications Online, London

Department of Health (2008), High Quality Care for All, NHS Next Stage Review Final Report, The Stationery Office, Norwich

Department of Health (2010), Equity and excellence: Liberating the NHS, The Stationery Office, London

Department of Transport (1988), Investigation into King's Cross Underground Fire, HMSO, London

Donaldson L (1999), Medical mishaps: a managerial perspective, Rosenthal M, Mulcahy L and Lloyd-Bostock S (eds), Medical Mishaps, Pieces of the Puzzle, Open University Press, Buckingham, pp210-220

Doyle P and Stern P (2006), Marketing Management and Strategy, Financial Times Prentice Hall, Harlow

Easterby-Smith M, Thorpe R and Jackson PR (2008), Management Research (3rd Edition), Sage, London

Edvardsson B and Roos I (2001), Critical incident techniques, Towards a framework for analysing the criticality of critical incidents, International Journal of Service Industry Management, 12:3, 251-268

Elliott D and Smith D (2006), Cultural Readjustments After Crisis: Regulation and Learning from Crisis Within the UK Soccer Industry, Journal of Management Studies, 43:2, 289-317

Elliott D and Smith D (2007), Voices from the terraces: from 'mock bureaucracy' to learning from crisis within the UK's football industry in Pearson C and Roux Dufot C (eds), International Handbook of Organisational Crisis Management, Sage, Los Angeles, pp271-295

Elliott D, Swartz E and Herbane B 2002, Business Continuity Management , A Crisis Management Approach, Routledge, London

Erikson K (1994), A new species of trouble: Explorations in disasters, trauma and community, Harvard University Press, Cambridge

Esmail A (2006), Clinical perspectives on patient safety in Patient Safety, Walshe K and Boaden R (eds), Patient Safety, Research into Practice, Open University Press, Maidenhead, pp9-18

Falkheimer J and Heide M (2006), Multicultural Crisis Communication: Towards a Social Constructionist Perspective, Journal of Contingencies and Crisis Management, 14:4, 180-189

Fink S (1986), Crisis Management, Planning for the Inevitable, American Management Association, New York

Fink S (2002), Crisis Management, Planning for the Inevitable, (2nd Edition), American Management Association, New York

Fink S, Beak J and Taddeo K (1971), Organisational crisis and change, Journal of Applied Behavioural Science, 7, 15-37

Finlayson, B (2002), Counting the Smiles, Kings Fund, London

Fischbacher-Smith D and Calman K (2010), A precautionary tale – the role of the precautionary principle in policy making for public health, Bennett P, Calman K, Curtis S and Fischbacher-Smith D (eds), Risk Communication and Public Health, Oxford University Press, Oxford, pp197-211

Fischbacher-Smith D, Irwin A and Fischbacher-Smith M (2010) Bringing light to the shadows and shadows to the light:risk, risk management and risk communication, Bennett P, Calman K, Curtis S and Fischbacher-Smith D (eds), Risk Communication and Public Health, Oxford University Press, pp23-38

Flanagan JC (1954), The Critical Incident Technique, Psychological Bulletin, 1, 327-358

Forehand GA and von Gilmer B (1964), Environmental variation in studies in organisational behaviour, Psychological Bulletin, 62, 361-382

Georgellis Y and Tabvuma V (2010), Does Public Service Motivation Adapt?, Kyklos, 63:2, 176-191

Gill J and Johnson P (2002), Research Methods for Managers (2nd Edition), Sage, London

Gill J and Johnson P (2010), Research Methods for Managers (3rd Edition), Sage, London

Goodwin N, Reinhold G and Valerie I (2006), Managing Health Services, Open University Press, Maidenhead

Gracia E, Cifre E and Grau R (2010), Service Quality: The Key Role of Service Climate and Service Behaviour of Boundary Employee Units, Group and Organisation Management, 35:3, 276-298

Greening DW and Johnson RA (1996), Do managers and strategies matter, A study in crisis, Journal of Management Studies, 33:1, 25-52
Gremler DD (2004), The Critical Incident Technique in Service Research, Journal of Service Research, 7:1, 65-89

Griffith J (2006), A Compositional Analysis of the Organisational Climate-Performance Relation: Public Schools as Organisations, Journal of Applied Social Psychology, 36:8, 1848-1880

Habermas J (1974), Theory and Practice, Heinemann, London

Hackman JR and Oldham G (1980), Work Redesign, Addison-Wesley, Reading

Handy C (2002), The Empty Raincoat:new thinking for a new world, Arrow Books, London

Harris EG, Dearth R and Shipra P (2007), Examining the Relationship Between Patient Orientation and Job Satisfaction in Health Care: Evidence from the Nursing Profession, Health Marketing Quarterly, 24:1, 1-14

Healthcare Commission (2009), Investigation into Mid Staffordshire NHS Foundation Trust March 2009, Healthcare Commission, London

Heath R (1998), Crisis management for managers and executives, Pearson Education, Harlow

Hertzberg F (1968), One more time how do you motivate employees?, Harvard Business Review, 46:1, 53-62

Hickman JR and Crandall WR (1997), Before Disaster Hits: A Multifaceted Approach to Crisis Management, Business Horizons, 40:2, 75-80

Highet G (2003), Cannabis and smoking research: interviewing young people in self-selected friendship pairs, Health Education Research, 18:1, 108-118

Hitchcock T (1998), Crisis management – an introduction, Credit Control, 19:7, 26-29

House of Commons (2006), House of Commons, Committee of Public Accounts, A safer place for patients: learning to improve patient safety, Fifty-first Report of Session 2005-06, The Stationery Office Limited, London

House of Commons, Health Committee, Sixth Report, Patient Safety (2009) [online] (14 June 2011) Available at <URL http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/15102.htm

Hwang P and Lichtenthal JD (2000), Anatomy of Organisational Crises, Journal of Contingencies and Crisis Management, 8:3, 129-140

Hyde P, McBride A, Young R and Walshe K (2005), Role redesign: new ways of working in the NHS, Personnel Review, 34:6, 697-712

Jacques T (2009), Issue and crisis management: Quicksand in the definitional landscape, Public Relations Review, 35, 280-286

Jacques T (2010), Reshaping crisis management: the challenge for organisational design, Organisational Development Journal, 28:1, 9-17

James EH and Wootten LP (2005), Leadership as (Un)usual: How to Display Competence in Times of Crisis, Organisational Dynamics, 34:2, 141-152

James LA and James LR (1989), Integrating Work Environment Perceptions: Exploration into the Measurement of Meaning, Journal of Applied Psychology, 74:5, 739-751

James LR, Choi CC, Ko CE, McNeil PK, Minton MK, Wright MA and Kim K (2008), Organisational and psychological climate: A review of theory and research, European Journal of Work and Organisational Psychology, 17:1, 5-32

Johnson P (2003). Philosophies of Business and Management Research, Sheffield Hallam University

Jones AP and James LR (1979), Psychological climate: dimensions and relationships of individual and aggregated work environment perceptions, Organisational Behaviour and Human Performance, 23, 201-250

Kash TJ and Darling JR (1998), Crisis management: prevention, diagnosis and intervention, Leadership & Organisation Development Journal, 19:4, 179-186

Kaya N, Koc and Topcu (2010), An exploratory analysis of the influence of human resource management activities and organisational climate on job satisfaction in Turkish banks, The International Journal of Human Resource Management, 21:11, 2031-2051

Kemppainen JK (2000), The critical incident technique and nursing care quality research, Journal of Advance Nursing, 32:5, 1264-1271

Keown-McMullan C (1997), Crisis: when does a molehill become a mountain?, Disaster Prevention and Management, 6:1, 4-10

Kilduff M and Mehra (1997), Postmodernism and Organisational Research, Academy of Management Review, 22:2, 453-481

Kilroy DA (2006), Clinical supervision in the emergency department: a critical incident study, Emergency Medical Journal, 23, 105-108

Kmietowicz Z (2007), Safety agency must simplify reporting of patient incidents, British Medical Journal, 334:7583, 12

Kohn KT, Corrigan JM and Donaldson MS (1999), To Err is Human: Building a Safer Health System, National Academy Press, Washington

Kopelman RE, Brief AP and Guzzo RA (1990), The role of climate and culture in productivity in Schneider B (eds), Organisational climate and culture, Jossey-Bass, San Fransisco, pp 282-318

Kouzmin A (2008), Crisis Management in Crisis?, Administrative Theory & Praxis, 30:2, 155-183

Kuvaas B and Dysvik A (2009), Perceived investment in employee development, intrinsic motivation and work performance, Human Resource Management Journal, 19:3, 217-236

Lagadec P (1993) Preventing chaos in a crisis: strategies for prevention, control and damage limitation, McGraw-Hill International (UK) Limited, London

Laitinen EK and Chong HG (1999), Early-warning system for crisis in SMEs: Preliminary evidence from Finland and the UK, Journal of Small Business and Enterprise Development, 6:1, 89-102

Laws E and Prideaux B (2006) Crisis Management: a suggested typology, Journal of Travel & Tourism Marketing, 19: 2-3, 1-8

Lawler, S (2008) Identity: Sociological Perspectives, Poility Press, Cambridge

Leape LL (1994), Error in medicine, The Journal of the American Medical Association, 272:23, 1851-1861

Leape LL (2000), Safe healthcare: are we up to it? We have to be, British Medical Journal, 320, 725-726

Leape LL and Berwick DM (2005), Five Years After to Err is Human, What Have We Learned, Journal of the American Medical Association, 293:19, 2384-2390

Lee N and Lings I (2008), Doing Business Research, A Guide to Theory and Practice, Sage, London

Lerbinger, O (1997), The Crisis Manager: Facing Risk and Responsibility, Routledge, New Jersey, US

Loh J, Restubog SLD, Gallois C (2009), The nature of workplace boundaries between Australians and Singaporeans in multinational organisations, a qualitative inquiry, Cross Cultural Management, An International Journal, 16:4, 367-385

Loh J, Restubog SLD, Gallois C (2010), Attitudinal outcomes of boundary permeability, A comparison of Australian and Singaporean employees, Cross Cultural Management, An International Journal, 17:2, 118-134

Loosemore M (1998), The three ironies of crisis management in constructions projects, International Journal of Project Management, 16:3, 139-144

Lynch RL (2009), Strategy Management, Financial Times Prentice Hall, Harlow

Lyons M, Woloshynowych M, Adams, S and Vincent C (2004), Error Reduction in Medicine, Final Report to the Nuffield Trust, Imperial College, London

MacDonald R (2005). Shifting the balance of power? Culture change and identity in an English health-care setting, Journal of Health Organisation and Management, 19:3, 189-203

MacIntosh J (2003) Reworking Nurses Professional Identity, Western Journal of Nursing Research, 25:6, 725-741

Mallak LA, Lyth DM, Olson SD, Ulshafer SM and Sardone FJ (2003), Diagnosing culture in health-care organisations using critical incidents, International Journal of Health Care Quality Assurance, 16:4, 180-190

Martin HJ (2010), Workplace Climate and Peer Support as Determinants of Training Transfer, Human Resource Development Quarterly, 21:1, 87-104

McKay PF, Avery DR and Morris MA (2009), A tale of two climates: Diversity climate from subordinates' and managers' perspectives and their role in store unit sales performance, Personnel Psychology, 62, 767-791

McMurray R (2006), From partition to partnership, Managing collaboration within a curative framework for NHS care, International Journal of Public Service Managdement, 19:3, 238-249

McMurray R and Pullen A (2008), Boundary Management, Interplexity and Nostalgia: Managing Marginal Identities in Public Health Working, International Journal of Public Administration, 31, 1058-1078

Melanie J and Mansour J (2005) Effective Healthcare Leadership, Blackwell Publishing, Oxford, UK

Miles MB and Huberman AM (1994), An Expanded Sourcebook, Qualitative Data Analysis (2nd Edition), Sage Publications, London

Miles MB and and Huberman AM (2002), The Qualitative Researcher's Companion, Sage, London

Miller K (1991), Piper Alpha, Industrial Law Journal 20:3, 176-187

Mitroff II (1988), Crisis Management: Cutting through the Confusion, Sloan Management Review, Winter 1988

Mitroff II (2004a), Crisis leadership, planning for the unthinkable, Wiley, New Jersey

Mitroff II (2004b), Think like a sociopath, act like a saint, Journal of Business Strategy, 25:5, 42-53

Mitroff II, Alpaslan MC and Murat C (2003), Preparing for Evil, Harvard Business Review, 81:4, 109-115

Mitroff II and Anagnos G (2001), Managing crises before they happen, What every executive and manager needs to know about crisis management, American Management Association, New York

Mitroff II and Harrington KL (1996), Thinking about the unthinkable, Across the Board, 33:8, 44-49

Mitroff II and Kilmann RH (1984), Corporate tragedies, product tampering, sabotage and other catastrophes, Praeger Publishers, New York

Mitroff II, Pauchant TC and Shrivastava P (1988), The Structure of Man-made Organisational Crises, Conceptual and Empirical Issues in the Development of a General Theory of Crisis Management, Technological Forecasting and Social Change, 33, 83-107

Mitroff II, Pearson CM and Harrington LK (1996), The Essential Guide to Managing Corporate Crises, Oxford University Press, New York

Momeni N (2010), The Relation Between Managers' Emotional Intelligence and the Organisational Climate They Create, Public Personnel Manager, 38:2, 35-48

Moody RC and Pesut DJ (2006), The motivation to care, Application and extension of motivation theory to professional nursing work, Journal of Health Organisation and Management, 20:1, 15-48

Moore S (2004), Disaster's future: The prospects for corporate crisis management and communication, Business Horizons, 47:1, 29-36
Morrison D, Cordery J, Girardi A and Payne R (2005), Job design, opportunities for skill utilisation and intrinsic job satisfaction (2005), European Journal of Work and Organisational Psychology, 14:1, 59-79

Mostafa MM, Sheaff R, Morris M and Ingham V (2004), Strategic preparation for crisis management in hospitals: empirical evidence from Egypt, Disaster Prevention and Management, 13:5, 399-408

Mulcahy L and Rosenthal M (1999), Beyond blaming and perfection: a multi-dimensional approach to medical mishaps, Rosenthal M, Mulcahy L and Lloyd-Bostock S (eds) Medical Mishaps, Pieces of the Puzzle, Open University Press, Buckingham, pp3-19

Murphy P (1996), Chaos Theory as a Model for Managing Issues and Crises, Public Relations Review, 22:2, 95-113

Myer RA, Conte C and Peterson SE (2007), Human impact issues for crisis management in organisations, Disaster Prevention and Management, 16:5, 761-770

National Audit Office (2005), Department of Health, A Safer Place for Patients: Learning to improve patient safety, National Audit Office, London

National Patient Safety Agency (2004), Seven steps to patient safety, National Patient Safety Agency, London

National Safety Patient Agency (2005), Building a Memory:Preventing Harm, Reducing Risks and Improving Patient Safety, The First Report of the National

Reporting and Learning System and the Patient Safety Observatory, National Patient Safety Agency, London

National Patient Safety Agency (2008), Foresight Training Resource Pack, National Patient Safety Agency, London

Parker D and Lawton R (2006), Psychological approaches to patient safety, Walshe K and Boaden R (eds), Patient Safety, Research into Practice, Open University Press, Maidenhead, pp31-40

Parsons W (1996), Crisis Management, Career Development International, 1:5, 26-28

Pask EJ (2005) Self-sacrifice, self-transcendence and nurses' professional self, Nursing philosophy: An International Journal for Healthcare Professionals, 6:4, 247–254

Pauchant TC and Douville R (1992), Recent research in crisis management: a study of 24 authors' publications from 1986 to1991, Industrial & Environmental Crisis Quarterly, 7:1, 43-66

Pauchant TC and Mitroff II (1990), Crisis Management: Managing Paradox in a Chaotic World, The Case of Bhopal, Ėcole des Hautes Commerciales de Montreal, Montreal

Pauchant TC and Mitroff II (1992), Transforming the crisis prone organisation – preventing individual, organisational and environmental tragedies, Jossey-Bass Inc, San Fransisco

Pearson CM and Clair JA (1998), Reframing crisis management, Academy of Management Review, 23:11, 59-76

Pearson CM and Misra SK (1997), Managing the Unthinkable, Organisational dynamics, 26:2, 51-65

Pearson CM and Rondinelli DA (1998), Crisis Management in Central European Firms, Business Horizons, 41:3, 50-61

Penney LM and Spector PE (2005), Job stress, incivility and counterproductive work behaviour (CWB): The moderating role of negative affectivity, Journal of Organisational Behaviour, 26, 777-796

Perrow C (1984), Normal Accidents, Living with high-risk Technologies, Basic Books, New York

Preble JF (1997), Integrating crisis management perspectives into the strategic management process, Journal of Management Studies, 34:5, 769-792

Quarantelli EL (1988), Disaster Crisis Management: A summary of research findings, Journal of Management Studies, 25, 373-385

Quarantelli EL (1998), What is a disaster? Perspectives on the Question, Routledge, London

Rasmussen J (1983), Skills, rules, knowledge, signals and symbols and other distinctions in human performance models, IEEE Transactions: Systems, Management and Cybernetics, 13:3, 257-267

Rasmussen J (1990), The role of error in organizing behaviour, Ergonomics , 32, 1185-1199

Ray S (1999), Strategic Communications in Crisis Management, Lessons from the Airline Industry, Quorum Books, Connecticut

Reason J (1987), Cognitive aids in process environments: prostheses or tools?, International Journal of Man-Machine Studies, 27, 463-470

Reason J (1990), Human Error, Cambridge University Press, Cambridge

Reason J (1997), Managing the Risks of Organisational Accidents, Ashgate, Farnham

Reason J (1998), Achieving a safe culture: theory and practice, Work and Stress, 12:3, 293-306

Reason J (2000a), Human error: models and management, British Medical Journal, 320, 768-770

Reason J (2000b), Safety paradoxes and safety culture, International Journal of Injury Control and Safety Promotion, 7:1, 3-14

Reason J (2005), Safety in the operating theatre – Part 2: Human error and organisational failure, Quality and Safety in Health Care, 14, 56-61

Reason J (2006), Human Factors: A Personal Perspective, Human Factors Seminar, Helsinki

Reason J (2008), The Human Contribution, Unsafe Acts, Accidents and Heroic Recoveries, Ashgate, Farnham

Register M and Larkin J (2002), Risk issues and crisis management: A casebook of best practice, 2nd Edition, Institute of Public Relations, London

Richardson W (1995), Paradox management for crisis avoidance, Management Decision, 33:1, 5-18

Roelen CAM, Koopmans PC and Groothoff JW (2008), Which work factors determine job satisfaction?, Work, 30, 433-439

Rorty R (1979), Philosophy and the Mirror of Nature, Princeton University Press, Princeton

Rosenthal M (1999), How doctors think about medical mishaps, Rosenthal M, Mulcahy L and Lloyd-Bostock S (eds), Medical Mishaps, Pieces of the Puzzle, Open University Press, Buckingham, pp141-153

Roux Dufort C (2000), Is Crisis Management (Only) a Management of Exceptions? Journal of Contingencies and Crisis Management, 15:2, 105-114

Roux Duxfort C and Metais E (1999), Building Core Competencies in Crisis Management Through Organisational Learning, the Case of the French Nuclear Power Producer, Technological Forecasting and Social Change, 113-127

Saravanan B, Ranganathan E and Jenkinson LR (2007), Lessons learnt from complaints by surgical patients, Clinical Governance: An International Journal, 12:3, 155-158

Sasou K and Reason J (1999), Team errors: definition and taxonomy, Reliability Engineering and System Safety, 65, 1-9

Saunders M, Lewis P and Thornhill A (2007), Research Methods for Business Students (4th Edition), FT Prentice Hall, Harlow

Shaluf IM, Admadun F and Said AM (2003), A review of disaster and crisis, Disaster Prevention and Management, 12:1, 24-32.

Sheridan TB (2003), Human Error, Quality and Safety in Health Care, 12, 377-383

Shrivastava P (1987), Bhopal: Anatomy of a Crisis, Ballinger, New York

Shrivastava P (1993), Crisis theory/practice: towards a sustainable future, Industrial & Environmental Crisis Quarterly, 7:1, 23-42

Shrivastava P, Mitroff II, Miller D and Miglani A (1988), Understanding Industrial Crises, Journal of Management Studies, 25:4, 285-303

Singer S, Meterko M, Baker L, Gaba D, Falwell A and Rosen A (2007), Workforce Perceptions of Hospital Safety Culture: Development and Validation of the Patient Safety Climate in Healthcare Organisations Survey, Health Services Research, October, 42:5, 1999-2021

Smith D (1990), Beyond contingency planning: towards a model of crisis management, Industrial Crisis Quarterly, 4, 263-275

Smith D (1999), Vicious Circles, Risk Management, 46:10 7-11

Smith D (2000a), On a wing and a prayer? Exploring the human components of technological failure, Systems Research and Behavioural Science, 17, 543-559

Smith D (2000b), Crisis management teams:issues in the management of operational crises, Risk Management: An International Journal 2:3, 61-78

Smith D (2002a), Management and medicine; strange bedfellows or partners in crime?, Clinician in Management, 11, 159-162

Smith D (2002b), Management and medicine – issues in quality, risk and culture, Clinician in Management, 11, 1-6

Smith D (2002c), Not by Error, But by Design – Harold Shipman and the Regulatory Crisis for Health Care, Public Policy and Administration, 17:4, 55-74

Smith D (2004), Performing as designed but not as intended? Managing cultural change in healthcare, Clinician in Management 12, 45-48

Smith D (2005a), Dancing around the mysterious forces of chaos:exploring issues of complexity, knowledge and the management of uncertainty, Clinician in Management 13, 1-9

Smith D (2005b), Business (not) as usual – crisis management, service interruption, and the vulnerability of organisations, Journal of Services Marketing 19:5, 309-320

Smith D (2006a), Crisis Managment – practice in search of a paradigm, Smith D and Elliott D (eds), Key Readings in Crisis Management, Systems and Structures for Prevention and Recovery, Routledge, London, pp1-12

Smith D (2006b), Modelling the crisis management process: Approaches and limitations, Smith D and Elliott D (eds), Key Readings in Crisis Management, Systems and Structures for Prevention and Recovery, Routledge, London, pp99-114

Smith D (2006c), The Crisis of management: Managing ahead of the curve, Smith D and Elliott D (eds), Key Readings in Crisis Management, Systems and Structures for Prevention and Recovery, Routledge, London, pp301-317

Smith D and Elliott D (2007), Exploring the Barriers to Learning from Crisis: Organisational Learning and Crisis, Management Learning, 38, 519-538

Smith D, Elliott D and McGuinness M (2000), Exploring the Failure to Learn: Crises and the Barriers to Learning, Review of Business 21:3/4, 17-25

Smith D and Fischbacher M (2009), The changing nature of risk and risk management: The challenge of borders, uncertainty and resilience, Risk Management, 11, 1-12

Smith D and Toft B (2005), Towards an organisation with a memory:exploring the organisational generation of adverse events in healthcare, Health Services Management Research 18, 124-140

Smith R (1999), Foreword in Rosenthal MM, Mulcahy L and Lloyd-Bostock S (eds), Medical Mishaps, Pieces of the Puzzle, Open University Press, Oxford, ppxvii-xix

Tagiuri R and Litwinn GH (1968), Organisational Climate, Graduate School of Business Administration, Harvard University, Harvard, US

The Health Foundation (2011), Learning report: Safer Patients Initiative, Lessons from the first major improvement programme addressing patient safety in the UK, The Health Foundation, London

The Mid Staffordshire NHS Foundation Trust Inquiry 2010, Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, 2005-2009, The Stationery Office, London

The Public Inquiry into the Piper Alpha Disaster (1990), HMSO, London

Thompson C (2002), Human error, bias, decision making and judgement in nursing – the need for a systematic approach in Thompson C and Dowding D (eds), Clinical Decision Making and Judgement in Nursing, Churchill Livingstone, London, pp21-46
Turner BA (1978), Man Made Disasters, Wykeham Publications Limited, London

Toft B and Reynolds S (1994), Learning from Disasters, Butterworth-Heinemann, London

Turner BA (1976), The organisational and interorganisational development of disasters, Administrative Science Quarterly, 21, 378-397

Turner BA (1978), Man-made Disasters, Wykeham, London

Turner BA (1994), Causes of Disaster: Sloppy Management, British Journal of Management, 5, 215-219

Udwadia FE and Mitroff II (1991), Crisis Management and the Organisational Mind, Multiple Models for Crisis Management from Field Data, Technological forecasting and Social Change, 40, 33-52

Van de Voorde K, Van Veldhoven M and Paauwe J (2010) Time precedence in the relationship between organisational climate and organisational performance: a cross-lagged study at the business unit level, The International Journal of Human Resource Management, 21:10, 1712-1732

Vincent C (2006), Patient Safety, Churchill Livingstone Elsevier, London

Vincent C (2007), Incident reporting and patient safety, British Medical Journal, 334:7584, 51[online] (cited 23 June 2011) Available from <URL http://www.bmj.com/content/334/7584/51>

Vincent C, Aylin P, Franklin BD, Holmes A, Iskander S, Jacklin A and Moorthy K (2008), Is health care getting safer?, BMJ2008;337:a2426 [online] (cited 23 June 2011) Available from <URL http://www.bmj.com/content/337/bmj.a2426>

Vincent C and Knox E (1997), Clinical Risk Modification, Quality and Patient Safety: Interrelationships, Problems and Future Potential, Best Practices and Benchmarking in Healthcare, 2:6, 221-226

Vincent C and Reason J, (1999), Human factors approaches in medicine in Rosenthal MM, Mulcahy L and Lloyd-Bostock S (eds), Medical Mishaps, Pieces of the Puzzle, Open University Press, Oxford, pp 39-56

Vincent C, Stanhope N and Taylor-Adams S (2000), Developing a systematic method of analysing serious accidents in mental health, Journal of Mental Health, 9:1, 89-103

Vincent C, Taylor-Adams S, and Stanhope N (1998) Framework for analysing risk and safety in clinical medicine, British Medical Journal, 316, 1154-1157

Walsh K and Anthony J (2007), Quality costs and electronic adverse incident recording and reporting system. Is there a missing link?, International Journal of Health Care Quality Assurance, 20:4, 307-319

Walshe K (1999), Medical accidents in the UK: a wasted opportunity for improvement?, Rosenthal M, Mulcahy L and Lloyd-Bostock S (eds), Medical Mishaps, Pieces of the Puzzle, Open University Press, Buckingham, pp59-73

Walshe K and Smith J (2006), Healthcare Management, Open University Press, Maidenhead

Watkins MD and Bazerman MH (2003), Predictable surprises: The Disasters You Should Have Seen Coming, Harvard Business Review, March 2003

Weick KE (1988), Enacted sensemaking in crisis situations, Journal of Management Studies, 25:4, 305-317

Weick KE, Sutcliffe KM and Obstfeld D (1999), Organising for High Reliability: Processes of Collective Mindfulness in Sutton RS and Staw BM (eds), Research in Organisaton Behaviour, 1, pp81-123

West , E (2006), Sociological contributions to patient safety, Walshe K and Boaden R (eds), Patient Safety Research into Practice, Open University Press, Maidenhead, pp19-30

Williams S and Osborne S (2004), National Patient Safety Agency: an introduction, Clinical Governance: An International Journal, 9:2, 130-131

Wilson J (2010), Essentials of Business Research, A Guide to Doing Your Research Project, Sage, London

Wooster P (1994), The Clothier Report, Modern Midwife, 4:11, 32

Yin R (1994), Case Study Research, Design and Methods, 2nd Edition, Sage, London

Websites

BBC News [online] (cited 3 December 2009) Available from <URL:http://news.bbc.co.uk/1/hi/world/south_asia/8390156.stm>

Department of Health [online] (cited 4 July 2005) Available from <URL http://www.dh.gov.uk/AboutUs>

Fire and Blast Information Group [online] (cited 23 June 2011) Available from <URL:http://www.fabig.com/Accidents/Piper+Alpha.htm>

Guardian.co.uk [online] (cited 15 June 2011) Available from <URL http://www.guardian.co.uk/society/2006/aug/05/health.frontpagenews>

NHS Choices [online] (cited 14 June 2011) Available from <URL http://www.nhs.uk/NHSEngland/thenhs/about>

National Patient Safety Agency [online] (cited 15 June 2011) Available from <URL http://www.nrls.npsa.nhs.uk/resources> < URL http://www.nrls.npsa.nhs.uk> and <URL http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents>

National Research Ethics Service [online] (cited 15 June 2011) Available from <URL http://www.nres.npsa.nhs.uk>

The Health Foundation [online] (cited 15 June 2011) Available from <URL http://www.health.org.uk/areas-of-work/programmes/safer-patients-initiative>

The Official Site of the British Prime Minister's Office [online] (cited 14 June 2011) Available from <URL http://www.number10.gov.uk/news/public-body-review-published>

The Telegraph a [online] (cited 14 June 2011) Available from <URL http://www.telegraph.co.uk/news/politics/david-cameron/8574086/David-Cameron-promises-major-concessions-on-NHS-reforms>

The Telegraph b [online] (cited as 14 June 2011) Available from <URL http://www.telegraph.co.uk/news/uknews/1551004/Doctors-call-for-an-independently-run-NHS>

World Nuclear Organisation [online] (cited 23 June 2011) Available from <URL:http://www.world-nuclear.org/info/chernobyl/inf07.html>

Appendix 4.1 Topic Guide

TOPIC GUIDE FOR PARTICIPANTS

Introduction

Introduce self and give thanks for attending

Refer to information sheet
- purpose of research and nature of output
- confidentiality and anonymity
- right to refuse to answer questions
- respect fellow contributors confidentiality (as appropriate)
- check for signed and returned informed consent
- check timeframe
- check whether people know each other/make introductions (as appropriate)
- check OK to proceed

As you know, I'm interested in trying to understand what happens in the NHS on day-to-day basis and why, particularly from the perspective of the individuals, like yourself, who work there.

What I want to do now is to show you a scenario and get you to talk about it:

I'm looking for you to specifically describe:

- your role in the scenario
- what you would do, when and why
- what things can go right, how and why
- what things can go wrong, how and why
- at what points you would interact with others, who they are and what form the interaction takes

So let's take each of these in turn now and you just take me through the scenario as you see it.

It might be helpful to you and me if you use anonymised examples from your recent working experiences.

Probe each area as required
THE PARTICIPANTS WILL BE SHOWN PATIENT JOURNEY SCENARIOUS AS OUTLINED IN THE FIELDWORK AND ANALYSIS PLAN.

Closure

Thanks for that. Before we finish, is there anything else anyone would like to either add to what they have said or check what they have said? OK. Well, thank you for your time.

Close

Appendix 4.2 Invitation and Information Pack, including Informed Consent Form

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Dear

Crisis Management in the NHS

My name is Debbie Hill. I am Senior Lecturer at Sheffield Hallam University. The above research is to be undertaken as part of my PhD and I am hoping that you will be prepared to participate in it.

Before you decide if you want to participate it's important to understand why the research is being done and what it will involve. So please read the attached information carefully and think about whether or not you would like to take part. If you would like to talk to me about the information contained in the pack before you make your decision, please do not hesitate to contact me on 0114 225 5054.

If you would prefer not to take part, then thank you for taking the time to read about and consider the study.

If, having read the information, you would like to take part then please do complete the attached consent form and return it in the SAE provided (I will provide you with a copy of your signed consent form for your records). It would be appreciated if you could post your reply back by <insert date>. I will then contact you to arrange a mutually convenient time when I can come along to your place of work to talk to you.

Yours sincerely

Debbie Hill
Senior Lecturer

CRISIS MANAGEMENT IN THE NHS

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please do not hesitate to contact me if there is anything that is not clear or if you would like more information – my details are given at the end of Part 1. Please also take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the study?

The study forms part of a PhD student research project. The origin of my work lies in the notion that organisations can incubate crises by not properly understanding what affects the behaviour of staff whilst they are working. Of particular concern to the study is what happens whilst a patient is undergoing treatment. Sometimes the underlying individual and organisational behaviour has an impact on the patient's experience. The research aims to explore this.

Why have I been chosen?

The study involves exploring the pathway of a number of patient treatment scenarios. You, and a small number of your colleagues, have been identified as having a role in some of these.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your role within the NHS.

What will happen to me if I take part and what will I have to do?

If you choose to take part in you will be asked to participate in either a paired in-depth interview (this is a joint interview with another participant) or a personal interview. The purpose of the interview will be to find out what you think about working in the NHS and more specifically your opinions on a treatment scenario. The researcher will ask you a series of open-ended questions and will record, in digital format, your response. Your discussions and interactions

with any other participants will also be recorded. The researcher is interested in discovering your opinions whatever they may be.

If you are asked to be involved in a paired in-depth interview and you feel you would like to participate in the research but would prefer not to do so in the presence of others, arrangements can be made for you to take part in a personal interview.

After the interview, what you said will be transcribed.

It is expected that the interviews will not last more than 1 and a half hours and will take place at a mutually convenient time before July 2008. It is anticipated that, in most cases, it will be more convenient for participants to do the interview in a quiet place within their work environment.

What are the other possible disadvantages and risks of taking part?

The subject matter is potentially sensitive and could be quite emotive. I hope the fact that I am a non-NHS research researcher will reassure you that I am only interested in your opinions in order to inform my research and for no other role-related reason. The detailed information on how this will be handled is given in Part 2.

What are the possible benefits of taking part?

This is an important, and so far largely neglected, area of study. Any help you can give by participating in the research and offering your opinion, will be used to inform the experiences of patients in the NHS and crisis management as a subject discipline.

What happens when the research study stops?

The research is primarily expected to take place during 2008. However, the researcher may contact you as a follow-up later on. The data collected in the research will form the fieldwork element of a PhD thesis due for examination in 2009.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

However, in the event of a complaint you should contact through STH NHS Foundation Trust Research Department (0114 271 3887).

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential (subject to NHS terms and conditions of employment). The details are included in Part 2.

Study Contact Details

Debbie Hill
Senior Lecturer
Faculty of Organisation and Management
Sheffield Hallam University
City Campus, Pond Street
Sheffield. S1 1WB
Telephone: 0114 225 5054 or 07870819465

This completes Part 1 of the Information Sheet.
If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time but the information collected up to the point of withdrawal may still be used in the research.

Complaints

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do her best to answer your questions (0114 225 5054). If you remain unhappy and wish to complain formally, you can do this through STH NHS Foundation Trust Research Department (0114 271 3887).

Harm

Sheffield Hallam University's standard public liability and professional indemnity cover will automatically apply.

Will my taking part in this study be kept confidential?

Recordings of interviews will be stored in a locked cabinet. The researcher alone will analyse the information and it will be stored in password protected files. You will be asked at the end of the interview if you wish to make changes to anything you have said.
Your anonymity will be protected unless an expression is made otherwise. You will be asked to maintain the confidentiality of the views of any other participants and you will be asked to consent to a discussion of the subject matter amongst your peers (in case of being asked to take part in a pair in-depth interview). However, anyone unwilling to take part will not be pressurised into doing so. In addition, should the discussion become difficult for you, a follow up interview will be offered by the researcher.

What will happen to the results of the research study?

It is the intention to use the data collected only for this study although top level findings will be made available to academic journals, the Department of Health, NHS and the National Patient Safety Agency. Your anonymity will be protected unless an expression is made otherwise. The study will remain the intellectual property of the author and Sheffield Hallam University. Any disclosures made by participants in the research will remain in the domain of the research (although the researcher and all participants are bound by NHS terms and conditions of employment).

Who is organising and funding the research?

The researcher, Debbie Hill, is the Chief Investigator and organiser of the study. The study is sponsored by Sheffield Hallam University.

Who has reviewed the study?

This study has been given a favourable scientific and ethical opinion for conduct in the NHS by Sheffield Hallam University, STH Research Department, Sheffield (North) REC, South Yorkshire Ambulance Trust and Sheffield Health and Social Research Consortium.
A copy of this Information sheet should be retained by participants. A copy of the signed consent form will also be provided to participants.

Finally thank you for considering taking part and taking time to read this sheet

Study Number: STH14602

CONSENT FORM

Title of Project: Crisis Management in the NHS

Name of Researcher: Debbie Hill

Please initial box

1. I confirm that I have read and understand the information sheet dated ..... (version 2.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my employment rights being affected. Although data gathered from me up to the time of withdrawal will be used in the study. ☐

3. I consent to discuss my opinions amongst my peers (paired interviews only). ☐

4. I will maintain the confidentiality of my peers (paired interviews only). ☐

5. I agree to the discussion being recorded. ☐

6. I agree to take part in the above study. ☐

_____ _____ _____

Name of Participant Date Signature

_____ Tel No. _____ EmailAddress

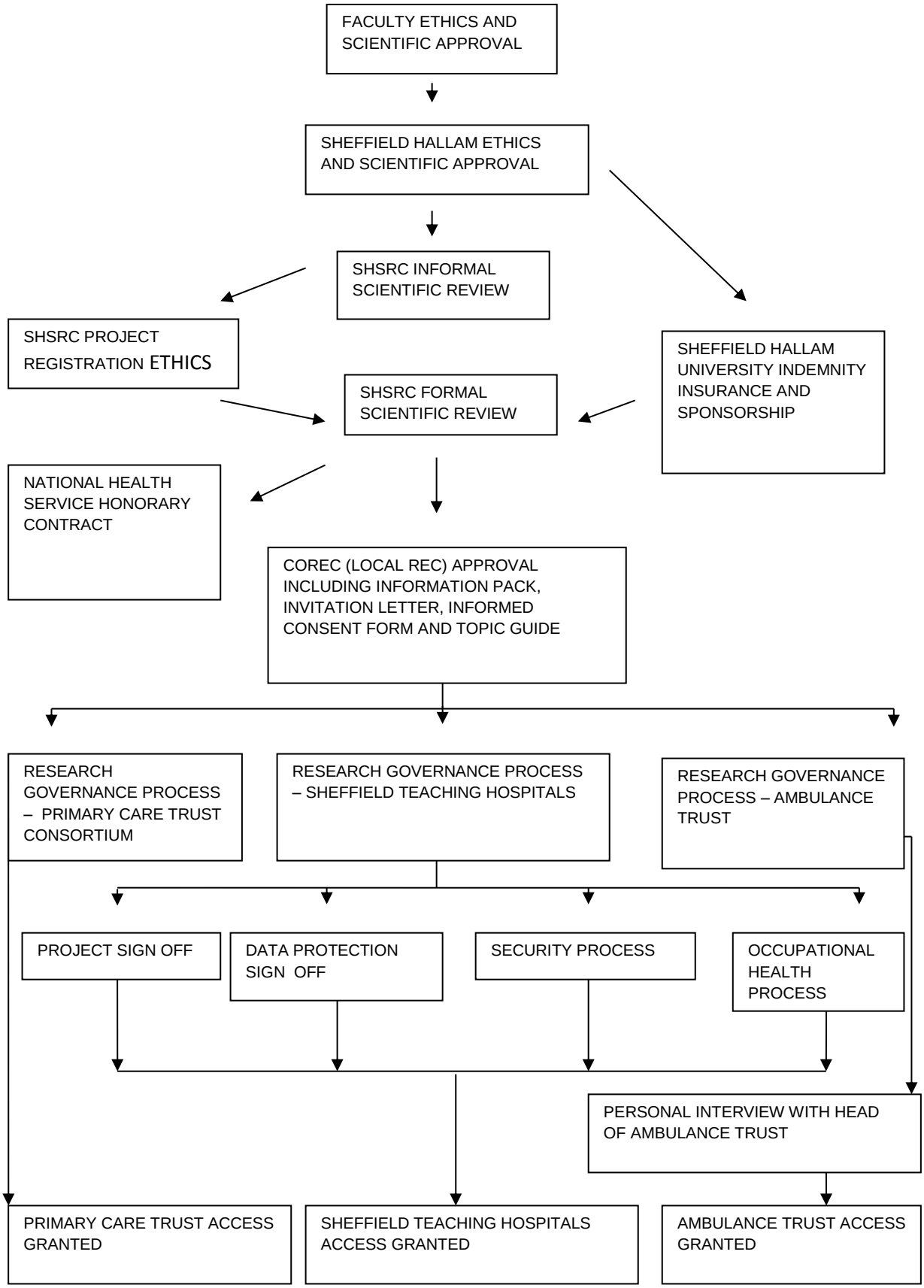
Please give an email address and telephone number should there be a need to contact you

_____ _____ _____

Researcher Date Signature

When you have completed this form, please return it to Debbie Hill in the enclosed SAE. Thank you.

Appendix 4.3 Figure 4.1 The Ethical and Scientific Approvals Process



Appendix 4.4 Descriptive Codes

Arrogance
Autonomy
Changes – Implemented
Changes – Pending
Collegiate Spirit
Communication – Inter
Communication – Intra
Communications – Informal
Complimentary Words
Contextual Setting – General
Contextual setting – Local
Demoralised
Deprofessionalisation
Drama
Education – Me
Education – Others
Efficiencies
Employee Safety
Esteem
Exposure
Flexibility
Frontline
Harsh Words
Humility
Individual Differences
Ineffectiveness
Inefficiencies
Inequity
Inflexibility
Patients
Patient Care Transitions
Patient Safety
Personal Limitations

Personal Relationships
Personal Stress
Pragmatism
Proactivity
Professionalisation and Experience
Resentment
Resourcing
Respect
Responsibility
Right – Inter NHS
Right – Intra NHS
Risk Aversion Rumours
Teamwork
Territories
The Process
Timeliness
Training – Me
Training – Others
Tribes
Trust
Uncertainty
Working Conditions
Wrong – Inter NHS
Wrong – Intra NHS