

## INSTITUTIONAL CURIOSITY FOR SAFER CARE:

### Curiosity for Detail—Analysing for Impact

*“...The goal is not data collection. Collecting reports and not doing anything with the information serves no useful purpose. Adequate resources and other support must be provided for analysis and response to critical issues.” (To Err is Human (1999))*

The quality and reliability of data fundamentally impacts on the quality and safety of care. Person-centred, safe healthcare requires data collection and analysis able to make sense of the experience at its heart.

The focus needs to shift from the extraordinarily tragic towards the painfully banal, establishing different, more sophisticated approaches to data analysis with a capacity to recognise emergence, patterns as they slowly gather storm under the guise of everyday normality. The data is there but we need to listen to hear and analyse to act.

We need to recognise the mastery of rescue:

- Developing new levels of intelligence, intelligence rooted in normality, in everyday experience.
- Strengthen organisational resilience in collaboration with patients and staff, not in spite of them.
- Build on our existing capacities instead of diverting resources into new layers of control.

When an organisation's core business is making people feel better, to relieve their suffering, understanding how people really feel and what they think of their care is not an optional extra. Identifying when and where attention is required and enabling and supporting professionals as they respond adequately is the safest most effective route for better care.

Applied Hermeneutics offers an intelligent approach to making sense of personal experience for the wider benefit of organisations. By analysing data through applied hermeneutics emergent patterns are recognised, facilitating a more responsive, forward thinking, safer health care provision.

*... deem me worthy of seeing  
in the sufferer who seeks my advice  
a person  
neither rich nor poor,  
friend nor foe,  
good nor evil.  
show me only the person.*

Moses Maimonides, 12<sup>th</sup> Century Physician

## The Mastery of Rescue:

### Better Care<sup>1</sup> through Reporting—Analysis—Rescue

*...you will take risks, and you will have failures. But it's what happens afterward that is defining. A failure often does not have to be a failure at all. However, you have to be ready for it—will you admit when things go wrong? Will you take steps to set them right?—because the difference between triumph and defeat, you'll find, isn't about willingness to take risks. IT'S ABOUT MASTERY OF RESCUE.*

Atul Gawande<sup>2</sup>

To err is human, but in medicine a failure to recognise and rescue errors can have devastating, fatal and expensive consequences<sup>3</sup>. Sir Robert Francis Inquiry Report into Mid Staffordshire Hospital Trust is a painful blow-by-blow account of the cost of persistent institutional failures to rescue, an account of how an organisation charged with ensuring high quality patient care failed to recognise and rescue fundamental failures in care. The Mid Staff Inquiry cost £13,034,300<sup>4</sup>; this is the economic cost of looking the other way. The human cost is immeasurable.

When your core business is to make people feel better, to relieve their suffering, understanding their experience (both as users and frontline staff) is not an optional extra. Identifying swiftly, reliably and efficiently when and where organisational attention is spent, supporting and enabling professionals to respond adequately is the safest most effective route for better care.

Caring organisations foster curiosity: they want to know more, deflect and disregard less, they learn from the insights of those using and delivering services, through such institutional intelligence they can mature into responsive providers of high quality care.

Overwhelmed and under-resourced health care providers respond to pressure by focusing on narrow performance criteria (money and activity), sometimes wanting to know less.

However the failure to know can be costly. It makes both clinical and financial sense for the health care industry to invest in 'the mastery to rescue', to allocate resources to recognise and respond to emergent patterns of failure in care.

Mid Stafford Hospital Trust lacked caring nurses but, even more fundamentally, it lacked an ambition to know, to reflect and to respond. It failed to master rescue.

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<sup>1</sup> The Oxford English Dictionary defines care as “**serious attention or consideration applied to doing something correctly or to avoid damage or risk**” to care is to pay attention, to listen, to understand, to respond and ultimately to avoid suffering. Consequently to care better is to understand more, recognise patterns earlier, and respond faster where and when it most matters. <http://oxforddictionaries.com/definition/english/care>

<sup>2</sup> <http://www.newyorker.com/online/blogs/newsdesk/2012/06/atul-gawande-failure-and-rescue.html>

<sup>3</sup> A trend illustrated by the rising cost of litigation: <http://www.hsj.co.uk/opinion/columnists/society-cannot-afford-rising-negligence-payouts/5051612.article>

<sup>4</sup> <http://www.midstaffspublicinquiry.com/inquiry-costs>

## Reporting for Better Care

The Institute of Medicine's 1999 report *To Err is Human* initiated a reassessment of modern medical practice. It identified the safety of care as a central challenge and re-established a strong direct correlation between quality of care and patient safety. Two years later with the publication of *Crossing the Quality Chasm* IoM went even further in endorsing the use of quality assurance and safety processes (e.g. checklists) developed in other high reliability industries for the health care service.

Undoubtedly, an effective understanding of work-as-done plays an important role in rescuing complex systems from drifting into catastrophic failure.

The success of risk management and quality assurance processes in high reliability industries relies on effective collaboration with frontline staff. Health care organisations by their very nature have an added responsibility to invest in strong models of engagement and facilitation. Safety reporting systems in health care are an opportunity for the organisation to benefit from such engagement by harnessing the wisdom and insight of 'thoughtfully passionate'<sup>5</sup> patients and staff to achieve a more responsive, forward thinking, safer health care system.

While most health service organisations have started to recognise the importance of listening to patients (PROMs) and staff (surveys), the evaluation and analysis of such data pose serious challenges.

Applied Hermeneutic Methodology (AHM) as used by the UK railway industry's Confidential Incident Reporting and Analysis System (CIRAS), is a viable and effective alternative to traditional qualitative data analysis approaches<sup>6</sup>. AHM is a dynamic data collection and analysis system, ensuring both theoretical and empirical validity. It is an outcome driven pragmatic approach which uses data to focus on and closely examine what is most relevant to those working on the frontline. It encourages an open mind and provides a well structured and managed framework for qualitative data analysis grounded in the reality of work-as-done.

Hermeneutic data analysis focuses resources where they have the greatest impact by making data meaningful and applicable. It asks what information is most useful on the ground, not what data is most easily available.

Its fundamental aim is to facilitate the recognition of emergent patterns within a highly diverse and rapidly changing environment. This recognition encourages effective learning and enables clinical leaders to work in partnership with frontline staff and patients. Hermeneutic analysis can help healthcare organisations to arrive at meaningful, actionable and relevant learning and support commissioners and management in their desire to facilitate effective learning and support.

A confidential, voluntary reporting system with facilitated hermeneutic analysis offers an effective new approach to qualitative data analysis, ensuring that the diversity of voices in the modern health care environment are reflected and respected to the benefit of the quality and safety of patient care<sup>7</sup>.

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<sup>6</sup> Although unfamiliar within health care, hermeneutic inquiry has been at the core of the western intellectual tradition for millennia, central to both Judeo-Christian theology and Aristotelian philosophy.

<sup>7</sup> Institute of Medicine: *To Err is Human* (1999: 8): *Voluntary reporting systems, which generally focus on a much broader set of errors and strive to detect system weaknesses before the occurrence of serious harm, can provide rich information to health care organizations in support of their quality improvement efforts....The goal is not data collection. Collecting reports and not*

## Diagnostic Assessment

Our health care system is caught in a paradigm of blame—the rapidly rising cost of litigation being merely one visible sign. Failures temporarily derail an otherwise regulated normality. We respond to catastrophic untoward events with increasingly elaborate and costly regulatory frameworks, and in turn are outraged by their inability to cope with a mounting backlog of cases.

During the past 60 years the pattern has changed little. We wait, and hope that all will be fine. When the inevitable disaster strikes we respond with outrage before the system is finally moved to take action. It is Catch-22: by the time we know it, almost always it is too late.

Anticipating and responding to financial trouble is more straightforward. We can see the figures and do the sums.

But the line between a small carelessness and a safety incident can seem blurred in a pressurised work environment, as long as nothing goes wrong. Knowing when an un-drunk cup of tea, an un-touched lunch, is not just a careless oversight but is an incident with an adverse outcome, is far more difficult. We can only react to what we know and recognising when normal business is no longer normal is complex.

According to aviation safety expert Sidney Dekker, normality in high risk industries lies somewhere within the continuous tension “between operating safely and operating at all”:

*In trade-offs between safety and efficiency there is a feedback imbalance. Information on whether a decision is cost-effective or efficient can be relatively easy to get. An early arrival time is measurable and has immediate, tangible benefits. How much is or was borrowed from safety in order to achieve that goal, however, is much more difficult to quantify and compare. If it was followed by a safe landing, apparently it must have been a safe decision.*

Patients suffer and tragedies like Mid Staff can happen when normal people are doing a normal day's work in normal organisations.

*The banality of accidents thesis says that the potential for having an accident grows as a normal by-product of doing normal business under normal pressures of resource scarcity and competition. No system is immune to the pressures of scarcity and competition (not even (or certainly not) regulators). The chief engine of drift hides somewhere in this conflict, in this tension between operating safely and operating at all<sup>8</sup>.*

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doing anything with the information serves no useful purpose. Adequate resources and other support must be provided for analysis and response to critical issues.

<sup>8</sup> Sidney W.A Dekker, “Why We need New Accident Models”, Technical Report 2005-02: 5,

[http://www.naturvetenskap.lu.se/upload/Trafikflyghogskolan/TR2005-02\\_NewAccidentModels.pdf](http://www.naturvetenskap.lu.se/upload/Trafikflyghogskolan/TR2005-02_NewAccidentModels.pdf)

## Current Treatment

Following the lead of other high reliability industries medicine has recognised the value of adverse incident reporting. Analysing what went wrong is now accepted as integral to knowing how to do it better in the future. But there is a danger in re-directing an organisation's energy and resources towards extraordinary failures. It can contribute to a disabling sense of shock, of operating under siege, which can inhibit learning, innovation and ultimately safety<sup>9</sup>.

Slow and cumbersome institutions are expected to react to patient demand with more and more all-encompassing collection of data. Against our better judgement, we hope that the pressure to collect, monitor and manage will implicitly result in better outcomes. We insist that more data is better data. While we amass figures we fail to create 'meaning', to make sense.

When we focus our resources on serious incidents and the wisdom of hindsight we disregard something fundamental. Adverse incidents do not occur in isolation. They are preceded by continuous and persistent efforts to keep things work. The normal by-products of doing normal business under normal pressure are patterns of 'drift,' in an effort to rescue.

While organisations and public institutions are increasingly proficient in retrospectively joining the dots, when it comes to the here and now, to the normal current of drift under pressure, they struggle to recognise an emerging pattern, to make sense of detail.

Maybe, it is time to question our underlying basic assumptions.

- Time to step back from mere incident reporting, customer service surveys, and consultation exercises—even if just for a moment.
- Time to aim for better analysis, and deeper understanding—to move beyond the blame game.
- Time to think in different terms about the most precious and valuable assets, the best resource - people.

The 'human factor,' the capacity to adapt and rescue even under adverse circumstances is not just the root cause of a 'wicked' problem, it is also a powerful resource, a solid basis for a sustainable solution. Humans, patients and clinicians alike share a unique capacity to learn and change through experience<sup>10</sup>. In resilient health care organisations individuals are supported to respond to their experiences, staff are encouraged to learn, gracefully and with ease. The organisation's focus is on work-as-done, rather than work-as-imagined.

Wanting to know is core business in health care,

*Organizational resilience is about finding means to invest in safety even under pressures of scarcity and competition, since that may be when such investments are needed most. Preventing drift into failure requires a different kind of organizational monitoring and learning. It means fixing on higher-order variables; adding a new level of **intelligence** and **analysis** to the incident reporting and error counting that is done today (Dekker, 2005: 13).*

Just as in aviation, such intelligence would suit us well in health care.

<sup>9</sup> The importance of motivation and mindset for effective learning is eloquently described in Matthew Syed *Bounce* 2010: 121.

<sup>10</sup> Institute of Medicine *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* 2001:64.

## Intelligent Cure: Applied Hermeneutics for Rescue

The focus needs to shift from the extraordinarily tragic towards the painfully banal, establishing different, more sophisticated approaches to data analysis with a capacity to recognise emergent patterns as they slowly gather storm under the guise of everyday normality.

The data is there but we need to listen to hear and analyse to act and master rescue:

- Develop new levels of intelligence, intelligence rooted in normality, in everyday experience.
- Strengthen organisational resilience in collaboration with patients and staff and not in spite of them.
- Build on our existing capacities instead of diverting resources into new layers of regulatory control.

In 1996 a team at the University of Strathclyde developed a confidential reporting system for the Scottish Railway industry with the aim of improving safety through analysing drift, called Applied Hermeneutic Methodology (AHM). Today, 21 years later, this work still forms the basis of the UK railway system's Confidential Incident Reporting and Analysis System (CIRAS).

Unlike other, on the surface seemingly similar qualitative data analysis methods, AHM does not 'reduce noise' to effectively 'operationalize' to arrive at a manageable model of reality but instead directs its focus to amplify what is most relevant to those operating on the ground. A pragmatic, workable taxonomy is developed through a transparent and collaborative process. Coders code all reports in line with these collaboratively agreed categories according to a continuously revalidated and tightly monitored protocol.

They combine technical coding expertise with profound negotiating skills and an ability to operate within an open, democratic and collaborative process. The shared aim of all involved is to develop a common understanding of what matters most to the service and those living with it. Looking for the opportunity to rescue failure. The search is for the pressing questions knowing that the answers are with the frontline. AHM offers a reliable methodological framework for embracing dynamic organisational realities. It builds on resource already within the healthcare system: committed staff, carers and patients<sup>11</sup>.

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<sup>11</sup> e.g., the economic value of the contribution made by carers in the UK is an estimated £119 billion more than the annual cost of all aspects of the NHS.

<http://www.carersuk.org/professionals/resources/research-library/item/2123-valuing-carers-2011>

## Validity, Unsolicited Complaints: Reports

There is a strong institutional bias against improving services in response to unsolicited reports. This is fuelled by the unsubstantiated but widely held assumption that questionnaires provide more reliable assessments of the quality of a service than unsolicited subjective expressions of patient dis-satisfaction<sup>12</sup>. Combined with the considerable methodological challenges of inputting potentially emotive, unstructured comments into an effective database management system this bias can lead to organisational inertia and the tendency to deflect complaints, reports, thus encouraging drift.

Too often only the imminent threat of legal action moves organisations to act. The history of Cure the NHS and their five year campaign to address the evidently unacceptable care at Stafford Hospital is a bleak demonstration of the devastating impact inertia and denial can have not only on the affected individuals but also on organisational resources. A system which requires commitment and campaigning skills on the scale of Cure the NHS to elicit a response and address such obvious wrong is socially and financially unsustainable.

Applied Hermeneutics offers a methodologically coherent and consistent approach to collating and responding to unsolicited comments by both 'passionately thoughtful' staff and dissatisfied patients. It offers a structured, trustworthy, efficient and effective way of systematically analysing findings to improve care. It builds on and nurtures the individual's innate learning capacity by strengthening existing structures of engagement rather than necessitating additional bureaucracy and management. Reports are gathered and analysed in real time, not ad hoc when things are getting tough; by then it is too late. Unlike other approaches, which also use patient narratives, AHM does not revert to generating overwhelming emotional responses to create an impact, but instead steadily builds a reliable picture of what is happening on the ground by facilitating a continuous and equitable feedback loop:

- Encouraging and supporting diverse groups of patients and clinicians to share their insights and experiences without fear of personal consequences.
- Finding efficient and effective ways of validating the shared data: through the application of judicial reasoning, the reliability of data is continuously re-validated.
- Developing eloquent and effective ways of filtering and analysing data to provide regular reports with relevant and actionable output.

In practice Applied Hermeneutics ensures a solid quality improvement framework within a high reliability environment. As used by CIRAS it offers a new and sustainable model of incident reporting and error counting. The more successfully AHM is applied, the fewer serious incidents there are to report<sup>13</sup>. AHM offers a realistic prospect of reducing litigation and an opportunity to direct more resources to directly benefit the service.

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<sup>12</sup> Gerald B Hickson and his team at Vanderbilt University have pioneered the study of unsolicited patient complaints. E.g. "Patient Complaint and Malpractice Risk" (JAMA 2002; 287 (22): 2951-2957 describes the positive association between physicians' complaint generation and risk management outcomes <http://jama.jamanetwork.com/article.aspx?articleid=195008>

November 2012 A. Darzi, L. Donaldson a.o published an project abstract demonstrating a reliable accuracy of the analysis of unsolicited, free-text information: "Machine learning and sentiment analysis of unstructured free-text information about patient experience on line".

[http://download.thelancet.com/flatcontentassets/pdfs/public-health/Public\\_Health\\_Abstacts\\_ALL\\_Part8.pdf](http://download.thelancet.com/flatcontentassets/pdfs/public-health/Public_Health_Abstacts_ALL_Part8.pdf)

<sup>13</sup> <http://cogprints.org/3092/1/hermeneutics.pdf>

### Some AHM basics:

- AHM uses easily available information supplied by individual practitioners and patients. It is confidential and easy to report to, encouraging staff and patients to share information without the threat of reprisal.
- It analyses the aggregate data, recognising emergent patterns. Findings are directly fed back to the relevant clinical teams and their management without diverting resources to an inspection regime.
- It harnesses the wisdom of individuals within an organisation while offering a methodology able to interpret the data within a larger sociological matrix.
- Taxonomies are developed through cooperation, in an open, democratic and focused process of negotiating a common understanding of what matters most to the service and to those using it.
- It encourages behavioural change by encouraging collaboration.
- It generates impact by anticipating problems through an effective feedback loop rather than by reacting to incidents.

## AHM in Health Care:

### An Insightful Reporting System for Better Care

With a fifteen year successful track record in the railway industry Applied Hermeneutics is an effective antidote to looking the other way. It is a manageable and cost effective alternative: a way to instil institutional curiosity, and operationalize reflective practice, offering an intelligent approach to recognising patterns, to making sense of personal experience for larger organisational benefit. It is an easy to implement and cost effective way of keeping institutional ears to the ground, to knowing more and overlooking less.

## The Mastery of Rescue for Better Care:

### Curiosity for Detail—Questioning for Impact

A confidential reporting system combined with a thorough hermeneutic analysis similar to CIRAS will enable us to take patient and staff engagement to its logical next level, helping us to gain a much more reliable picture of the everyday reality of care by closing the feedback loop. This in turn will ensure that both individual and organisational responses are timely and appropriate. Such an approach can help organisations to recognise drift as part of a subtle and complex continuum, rather than waiting for catastrophic and overwhelming errors to prompt action. Understood in this way, small incidents, rather than undermine, can contribute effectively to strengthening staff morale and will become the basis for better care and more intelligent cures.

## Project Framework: AHM in Practice

### Reporting: Accessible Data Gathering using Unsolicited Comments.

*What Report:* dis-identification can ensure confidentiality while discouraging vexatious or malicious reporting. Coders are able to verify and clarify reports in line with protocol.

*Who Reporters:* those connected with the service: patients, their friends and relatives and frontline staff.

*How Reporting:* through hotline and prominently displayed, easy to use report cards.

*Analysis:* Pattern Recognition through Hermeneutic Analysis.

### Step 1: Categorization

*What Categorization:* developed, and regularly validated in collaboration on the basis of random selection of original reports.

*Who Project Supervisory Team:* 5 to 10 core representatives, selected on the basis of their professional and personal insight into the service provision: balanced representation of frontline staff, patients, their friends and family, and senior manager with competence to address issues and implement changes.

*How Regular Meetings:* inviting wide range of views focused on finding valid and consistent categorization structure ensuring that the reasoning used is internally coherent and consistent.

Important: Reports concerning clinical safety and other legally (e.g. employment rights) contentious reports triaged into a first response category and responded to by the appropriate clinician, senior manager.

### Step 2: Coding

*What Verify and clarify* contentious points as appropriate by contacting reporter. Verified reports, dis-identification, removing names and any other revealing features before they are transcribed.

*Code and categorize* according to the protocol as developed and validated by project supervisory team.

*Identify* new and emerging patterns and recognise outliers.

*Who Coders* trained and validated through the project team.

*How In accordance* with protocols developed in collaboration by supervisory team.

**Important:**

Applied Hermeneutics for Better Care cannot, and does not aim to replace high quality clinical governance, rather it addresses the pressing issues of the culture of care: dignity, respect, compassion. Applied Hermeneutics for Better Care strengthens existing clinical governance structure by addressing non clinical issues in a clear and appropriate framework.

Feedback: Regular, Transparent, Meaningful and Actionable.

Crucial to the effective and efficient project outcome is a regular, reliable feedback process. Both reports and resulting action need to be publicly accessible (unless inappropriate in line with preset criteria: e.g. concerns of patient or staff confidentiality, potential legal disputes).

Complaint systems are frequently undermined by lack of transparency and follow up. A system which requires the voluntary cooperation of members of the public and frontline staff to report their personal experiences, relies heavily on trust and strong relationships to be effective. Outcomes from the reporting system need to be visible to prevent the system from being discredited as irrelevant and ineffective. Consequently the feed back process needs to be designed to be appropriate to the circumstances of the organisation.

All reports need to receive serious consideration no report will be dismissed (unless proven to be frivolous).

Action will be taken to address issues raised (even if the action is to explain why no action might be appropriate).

All reports available and accessible in overview and, when appropriate, in detail at regular supervisory team meetings: emergent patterns, negative outliers and relevant actions highlighted.

Feedback in line with protocol developed by project team.