“Emergent” Emergency Response

Lessons from COVID 19

David Slater

Outline – Main Points and Take-aways

1. Aim is to "Learn" not "blame" - No criticism implied of those professionals involved.

2. Emergencies "emerge" – there are both SAFETY I and SAFETY II responses

3. We Need to view actions from both sides' perspectives - not just sharp end or Top Down!

4. Are the "Rules of Engagement" constraining common sense / humanity?

5. So? - Organise appropriately – empowerment/support of teams?

"Normal" Emergency Response

Required -

Policies, Plans, Procedures and Professional "Standards".

By the Book – Train, train, train.

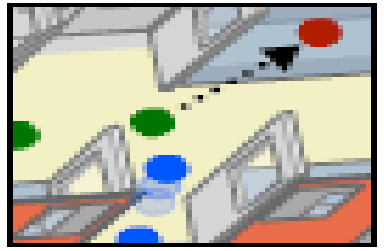
Avoid errors, mistakes! If in doubt don't!

Comply with relevant rules, PPE, etc.

Work as designed (Imagined) - based on "Expected" Emergencies

SAFETY? Health and SAFETY? By the book!

But - emergencies rarely "behave" as predicted – (Sun Tzu - Art of war?)



Still - seems to work most of the time?

– because they are attended by dedicated motivated professionals; no one is questioning the bravery and commitment shown in fighting fires, tackling armed criminals/terrorists and dealing with life threatening infectious diseases.

(I suspect that this is because most of the time these responders adapt and work round problems and through difficulties!)

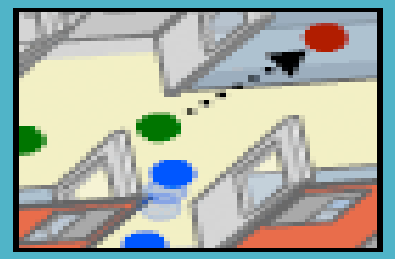
The problems arise when these instincts are overridden by "management" more interested in compliance and liability.

Consider the following examples:-

Police – Menezes, London Bridge

Healthcare – Manchester Arena, Westminster Bridge

Contrast with Fire –Grenfell, Manchester Arena



10.03 Doing the tube
10.04 must be challenged before getting down the tube
Stockwell Tube
No stop without 19

Dorset Road 3rd address
If good IDent
Can't let him down the tube

10.04 Stop him
CD
10.05 12 to do it
Going into tube

Stated 19
05 SO19 doing stop do not let surveillance intervene

1008 Subject has been shot
Ambulance asap – there
BTP already aware.

Jean Charles de Menezes

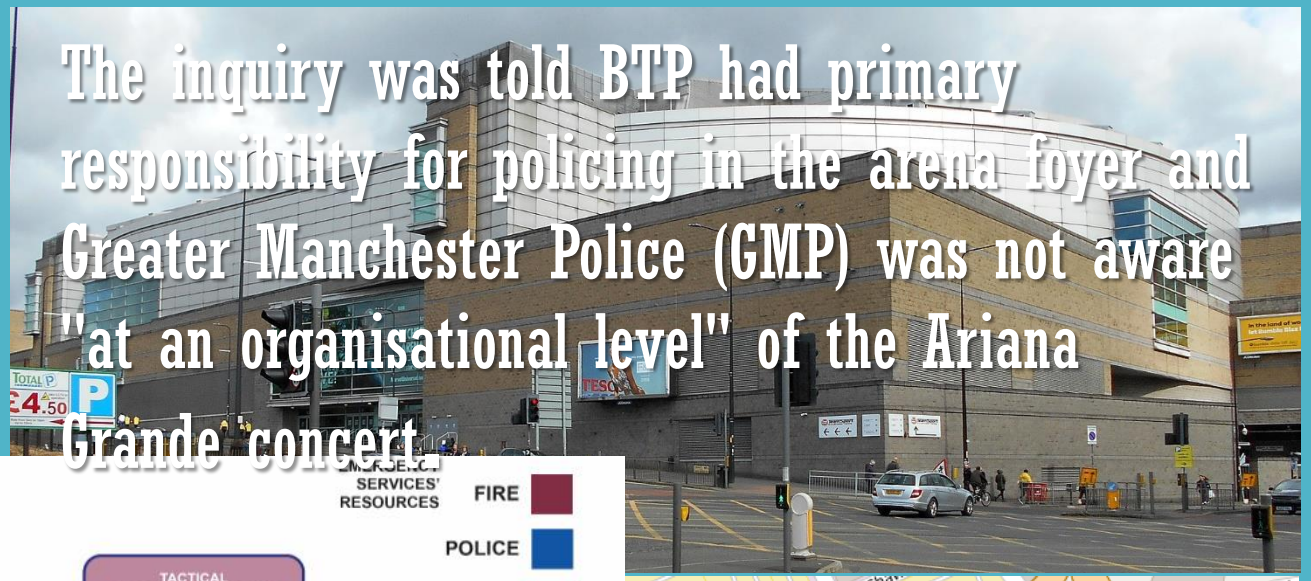
"This is an important decision in the light of what has happened," she wrote later that evening in the formal typed version of her decision log. "NOT appropriate for me to make it ... this has major implications potentially for the Metropolitan Police Service and London." Her superiors backed her and asked her to stay in charge of the operation room.

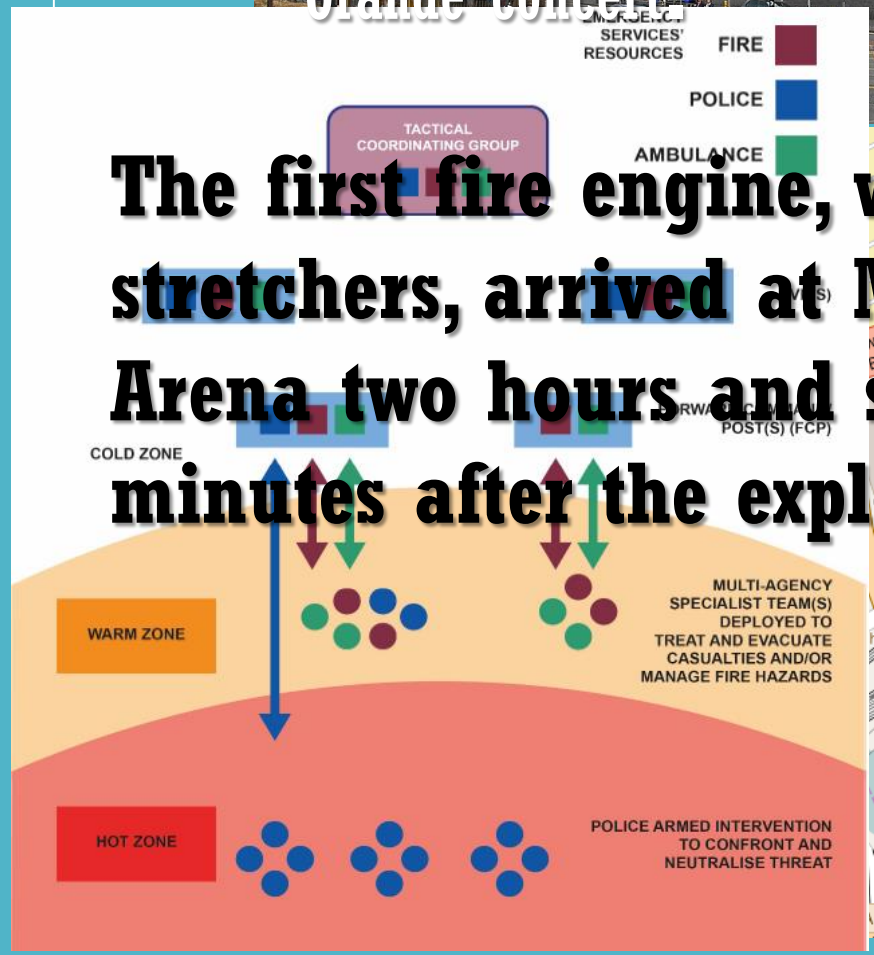
Cressida Dick – Decisions under Uncertainty

Manchester Arena

One paramedic at scene for 40 minutes after blast

The inquiry heard the BTP officer, who thought he was acting as operational commander, was in Blackpool when the bomb went off. He took a taxi to Manchester but "by the time he arrived the need for an immediate response had long since passed".



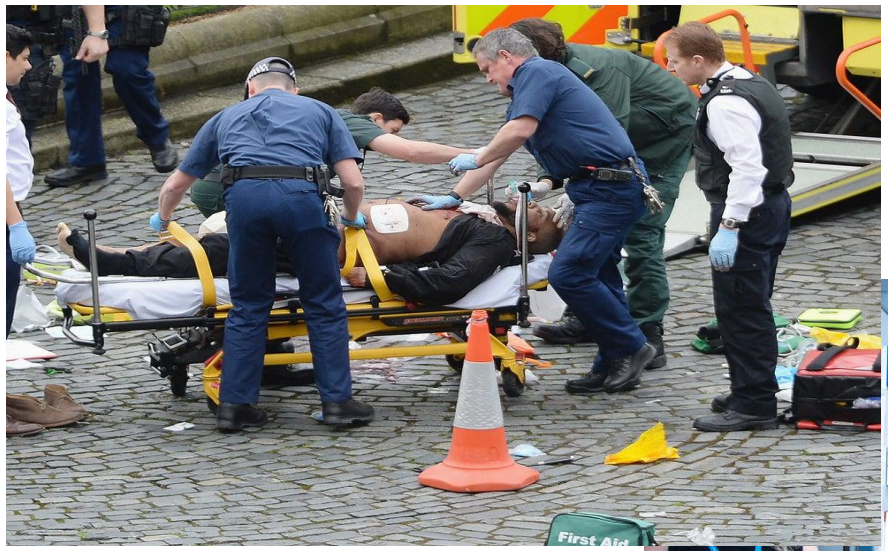


The first fire engine, which had stretchers, arrived at Manchester Arena two hours and six minutes after the explosion.

Healthcare – just do it?

London attack: Off-duty junior doctor 'ran to help' victims of Westminster terror incident after hearing screams

NHS doctors, nurses and emergency staff called 'heroes' for brave response to terror attack



At Manchester also,

NHS children's Hospital staff

Responded as needed –

not by the book!

Did what it took - ?

Why don't we learn the lessons?

"Want of foresight, unwillingness to act when action would be simple and effective, lack of clear thinking, confusion of counsel until the emergency comes, until self-preservation strikes its jarring gong – these are the features which constitute the endless repetition of history." – Sir Winston Churchill

There is a clear difference in the way the Fire Service and the police and medical teams responded.

There is no question of the bravery, integrity and professionalism of the different services at the "sharp end".

so the answer must lie deeper in the way the different organisations are managed and the "rules" of engagement.

https://www.bennettinstitute.cam.ac.uk/publications/policy-lessons-catastrophic-events/

https://www.linkedin.com/pulse/why-we-dont-need-covid-19-public-inquiry-david-slater/

"We have a duty to Protect our Workers"

Emergency Responders are Workers

Quite rightly protected by our exemplary Health and Safety Legislation

Was in a similar role as an enforcer of the E in HSE

Responsible employers have to take precautions to ensure "Safety" (I?)

Provide safe working environment, PPE, alarms, barriers, etc

Do "Risk" assessments – "if in doubt don't?"

"We have made a leviathan of the State, expanding and harnessing its power in order to reduce the risks that threaten our wellbeing. The 17th century may have abolished absolute monarchy but the 20th century created absolute democracy in its place". THE REITH LECTURES 2019: LAW AND THE DECLINE OF POLITICS Lecture 1: Law's Expanding Empire Jonathan Sumption

https://www.linkedin.com/pulse/health-safety-law-security-tyranny-quis-custodiet-david-slater/

Father hits out at safety rules that made fireman leave his son to drown in 3ft of water

Paramedic and police officer offered to jump in to save dying Simon Burgess but they were ordered not to

Coroner tells emergency services to improve their training after 41-year-old was left in the water

Fire chief thought man was already dead, so refused to let rescuers endanger their lives

Dead man's father David says everything possible should have been done to save his son

Prescription vs Reality

A Presentation at Malaga FRAMILY 2019 last year caused me to re appraise the basis of just compliance.

Risk Management for rock climbing?

This was a somewhat paradoxical example of a person deliberately putting themselves "at risk" and then looking to apply "safety" methodologies to improve his chances of survival, so they can take on even "riskier" challenges.

It highlighted the actions that are crucially needed to deal with emergent dangers and problems and still survive. Inaction (stop the world – I want to get off!) is definitely not an option at the top of "El Capitan".

In such unstable,"risky" environments, anticipation and compensating actions / interventions are essential to ensure and maintain recoverable situations.

Emergency responders are "Rock Climbers" not typists? (Resilience rules OK?).

So -Lessons from Fire Service Experience (David Wales)

The fire service training programme uses a scenario-based approach.(WAI)

Part of the rationale was to reduce the training/knowledge burden on part-time firefighters to tackle the disparity between them and career fire fighters. Possibly we are starting to see the unintended consequences of creating a level playing field.

Fire Services tend to be risk averse organisations and I suspect findings such as this will further entrench a 'follow the procedure' mindset, at a time when future incidents are likely to increasingly need more flexible and bold leadership.

For over 20 years national reviews have identified poor leadership in the fire service. Lessons learnt?? Not yet.

Grenfell too was following the right drill for the wrong type of fire.. (or building)- it was perhaps an even more remarkable case of 'plan A all the way' given personnel on the ground and visual cues that the assumed fire breaks were bypassed.

"Maybe we need to invent Imagination Theory – (SAFETY II?)

the thesis that 'what if' and 'what then' are the principal feedback

mechanisms that ensure successful adaptive/ agile response."

Lessons from Healthcare

The medical response culture seems to be more immediate, instinctive and adaptive – whatever it takes.

I have been fortunate to have been working with some very impressive committed people, looking at the way healthcare professionals have responded to the challenges of the COVID 19 crisis.

Here, as in Westminster and Manchester, the rule books were considered a bare minimum and the teams just got on with it and made it up as they went along.

I have been struggling to reconcile my experience of a can-do, responsibility driven, ethically committed reality, with the reports coming out from various long running, debilitating, inquiries into what went wrong and who was to blame for shocking tragedies at various Hospitals.

Lessons from COVID – 19 (Wave I)

Comments made in Steve Shorrock's blog are very revealing –

and I think get to the heart of the problem.

"A unique opportunity to do things differently"

My colleagues and I could adapt rapidly to these new conditions"

"We were finding solutions from the ground up"

"Frontline workers are the solution to most problems"

"You end up counting on good people to do everything they can"

"Looking back, local practice is not 'work-as-prescribed'"

(https://humanisticsystems.com/2020/09/17/learning-about-healthcare-work-in-a-pandemic/)

"I must admit I am feeling a bit frustrated at the moment as many imposed arbitrary rules, albeit well-meaning, are preventing us from preparing staff properly for wave two, such as applying the rule of six to teaching, even though we are exempt.

I believe many management decisions are being driven by a fear of blame of which the responsibility of following unachievable rules is being passed on to frontline staff! "

The WAI storm has returned"

Lessons from COVID – 19 (wave II)

"the loosening of the reins to adapt in March/ April has given way to procedural spaghetti and inertia".

"Team learning is needed"

"Let departments organise themselves"

Important lessons from this and other crises

We need to re-examine the way we organise and run our emergency services. (SAFETY II)

Centralisation of bureaucratic command and control has been disastrous in many of these examples and exemplified again in our "world beating" test, track and isolate program.

Why are the programs, procedures and rules designed and written by slick generalist and IT "consultants"? (WAI)

Another problem is that Trusts (mostly lay people),take their cues from the lawyers and their overriding concern is therefore, observing "ELF and Safety" laws and limiting liability.

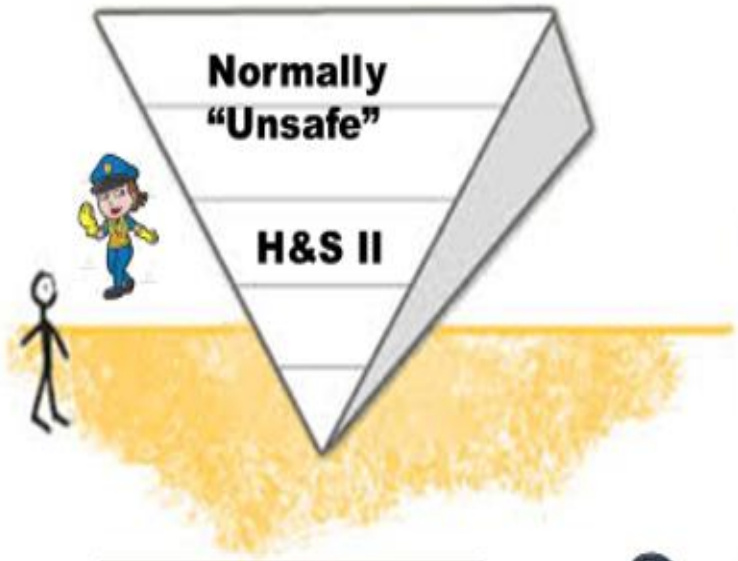
So isn't there a clear case for re-examining

how we should apply these HSE rules to emergency workers!

(H&S II for SAFETY II)

(https://www.linkedin.com/pulse/health-safety-ii-david-slater/)

Reality is a Risk – we evolved to deal with emergence and uncertainty! – it's the way we think!



No action is not an option

Outlaw the Ambulance chasing lawyers!

Good Samaritan law?

It happens
– its happening
- deal with it!

No, we can't wait for another Public Inquiry!
– we need to learn the lessons now!

https://www.linkedin.com/pulse/health-safety-ii-david-slater/

Thankyou!

– Questions?

Thanks to SIREN Colleagues for support and material

Supplementary Slides

"Self-managing teams"

"Self-managing teams have professional freedom with responsibility. A team of 12 work in a neighbourhood, taking care of people needing support as well managing the team's work.

A new team will find its own office in the neighbourhood, spend time introducing themselves to the local community and getting to know GPs and therapists and other professionals.

The team decide how they organise the work, share responsibilities and make decisions, through word of mouth and referrals the team build-up a caseload."

These are just immediate thoughts and suggestions, surely we need to raise these important insights at the highest level and talk to the politicians who seemingly are "reluctant to let a good crisis go to waste!".

Isn't it time to really learn some fundamental lessons from COVID 19?

https://www.buurtzorg.com/about-us/buurtzorgmodel/

"It is critical that 'work-as-prescribed' reflects 'work-as-done'"

Healthcare has a reputation for resistance to change, particularly top-down initiated change, with limited consultation with clinicians.

During the pandemic, many frontline clinicians experienced change done 'to' them, instituted by administrators, particularly rationing personal protective equipment.

Other organisations have initiated clinician-lead processes, resulting in durable models of care, but uncovering 'wicked problems'.

COVID-19 has taught me that engaging clinicians doing the work increases short-term complexity, but doing otherwise risks failure in the long term, losing trust on the way.

It is critical that 'work-as-prescribed' reflects 'work-as-done' to prevent depletion of the workforce through infection and exhaustion.

Kara Allen, Anaesthetist, Australia @ergopropterdoc

"Looking back, local practice is not 'work-as-prescribed'"

Despite 25 years in the specialty, the COVID19 pandemic was my first introduction to Personal Protective Equipment (PPE) and a FFP3 mask.

Fit testing achieved and training in PPE donning and doffing undertaken was great preparation to prevent catching a deadly viral disease.

However, this was no preparation for the daily challenges of working in PPE exacerbated by concerns around PPE availability and changes in doffing station practice.

The impact of heat, the need for good hydration, and the communication challenges became stressors – recognised and managed by great team working through adaptations in how we worked. Looking back, local practice is not 'work-as-prescribed'.

Alastair Williamson, Anaesthetist, UK @dr_alwilliamson

"Working in PPE is hot, tiring and difficult to both hear and see"

With the arrival of PPE – the sort you see on television – came the notion that it alone ensured staff and patient safety.

Thus the assumption evolved that the more PPE, the more safety, without considering the downsides.

Working in PPE is hot, tiring and difficult to both hear and see. Staff avoid drinking to reduce bathroom visits, all of which affects their ability to work.

Extra time is taken from patient care to put on and take off the PPE.

Thus the measures to reduce a single source of danger – Covid – indirectly affected patient safety in many other ways.

Pip Fabb, Consultant Anaesthetist, England @PipCassford

"We were finding solutions from the ground up"

During the start of the pandemic, the rules and guidance we had normally been following were gone.

Sometimes, rules set out by people that don't 'do the work' are not the way that the work happens.

These rules end up being a barrier to do the right thing. For example, filling a 35-page safety booklet about a newly admitted patient takes us away from practical tasks such as personal care or administering medication.

Now, no-one knew the best way to do things.

There was no evidence base to draw from, and no exemplars to follow.

This led to a more collaborative approach.

Everyone came up with ideas, and many more came from social media.

We openly learned from each other. We were finding solutions from the ground up and the senior leadership team listened.

Claire Cox, Former Critical Care Outreach Nurse, England @safetynurse999

"My colleagues and I could adapt rapidly to these new conditions"

Overnight, my job changed from in-person clinical care to online telemedicine.

Our telemedicine urgent care started seeing hundreds of COVID patients a day, a disease and volume that were totally new to us.

I learned that my colleagues and I could adapt rapidly to these new conditions.

The trade-offs between in person care and online care were challenging for everyone, as patients feared contracting COVID at the hospital.

Communicating clearly with one another and with our patients about uncertainty and risk were essential, as conditions changed rapidly.

Shannon McNamara, Emergency Physician, USA @ShannonOMac

"Let departments organise themselves"

Radiologists were split into two groups – one at home, one in department. Radiographers worked out their own rotas.

Radiographers and nursing staff worked on SOPs for imaging COVID positive patients.

No top down orders.

Homeworking was sorted in short time after years of dragging feet (helped by already having screens and laptops in hospital, but not set up).

We found that if IT sorted this out we could be appreciative and positive people, rather than grumpy and negative about IT

(we even nominated the IT staff who sorted this out for a 'GREATix' excellence report).

James, Radiologist, England (added 18/09/20)

“A unique opportunity to do things differently”

The rapid implementation of a new temporary critical care unit in response to the first surge meant that many aspects of standard WAI and WAP in critical care became irrelevant.

Bringing together an unknown, unestablished team released the cultural and silo-ed shackles we are so often bound by in healthcare and allowed us to learn as we did the work.

This allowed us to iteratively develop systems and processes that helped us adapt to the emergent situation.

This included delivering daily onsite 'just in time' training and bedside educational support to redeployed staff, implementing a coloured hat system to identify skills and improve escalation (airway and critical care) and develop new roles (bedside practitioner) and allocations that suited skills without causing excessive cognitive overload.

By breaking down previous social/professional boundaries and using some non-critical care junior doctors in a bedside practitioner role, we were able to have right people, in the right place, at the right time.

This nuanced way of doing things helped build collaboration, improved relationships and was seen by the majority of staff and professions as a positive intervention.

We have taken this learning and are trying to implement this again for wave two.“

“Frontline workers are the solution to most problems”

“

During COVID19 I learned that the need for change is the only thing we can reliably predict about the future.

Fortunately, frontline workers are the solution to most problems that will inevitably arise.

They are the most valuable resource in healthcare, both for delivering the care and for designing how to do it.

Locally, we have seen rapid, successful innovation of work practices through the marriage of simulation and human-centred design principles.

Sadly, though the safety of our workforce is paramount, it has been threatened worldwide.

We still haven’t learned how to put humans at the centre of healthcare.

Chris Nickson, Intensivist, Australia @precordialthump

"You end up counting on good people to do everything they can"

During the pandemic, I learned that no matter how well organised the healthcare system is, you end up counting on good people to do everything they can to overcome and minimise effects of hopefully rare but inevitable system flaws.

Filip Płużański, Orthopaedic Resident, Poland @filip_pluzanski

"The WAI storm has returned"

Five months on things don't feel as innovative as both national and local level government WAI rules, interpreted by Trusts into WAP around social distancing within education, workspaces and restrooms, often result in staff becoming more and more restricted in how well they can work.

Many rules are simply unachievable in a chronically under resourced healthcare system and have to be broken daily in order for staff to work, eat, rest, communicate and learn.

Therefore, as staff on the frontline are the ones 'breaking the rules' who will be blamed when there is a negative outcome???"

Lessons from COVID – 19 (unattributable!)

"I must admit I am feeling a bit frustrated at the moment as many imposed arbitrary rules, albeit well-meaning, are preventing us from preparing staff properly for wave two, such as applying the rule of six to teaching even though we are exempt.

I believe many management decisions are being driven by a fear of blame of which the responsibility of following unachievable rules is being passed on to frontline staff! "

– "the loosening of the reins to adapt in March/ April has given way to procedural spaghetti and inertia".

"Team learning is needed"

Individual adaptations are necessary to cope with goal conflicts, but team learning is needed to maximise the impact and ensure the safety of such adaptations.

In my GP practice, daily 'huddles' (short meetings) were used to discuss how we implemented rapidly changing guidance while coping with varying conditions (e.g., demand and capacity) and competing goals (e.g., reducing hospital admissions while maintaining patient safety).

Huddles encouraged sharing of innovative practice and increased understanding of why decisions were made and how decisions affected other parts of the system.

It also supported those making difficult decisions and ensured people did not drift into unsafe practices.

Duncan McNab, General Practitioner, Scotland @Duncansmcnab