Taming uncertainty? Performance, personalisation and practices of patient safety in an Australian mental health service

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Taming uncertainty?

Performance, personalisation and practices of patient safety in an Australian mental health service

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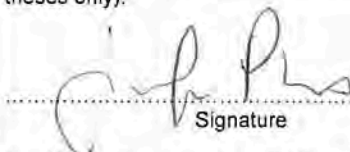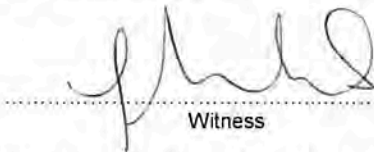
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The patients implied by the term 'patient safety' are most commonly lying on an operating table or in a hospital bed. They are cast as potential victims of harm resulting from their encounters with a health service, harm which is often attributed to malfunctioning systems or toxic cultures of care. Mental health patients and professionals, and the particularities of the illnesses and interventions which structure their encounters, have often been ignored in this discourse. This study is about what patient safety means from the perspective of professionals in a mental health context, where: risk type and severity are contested and unpredictable; patients are often viewed as a threat to their own safety; and the professional role in keeping patients safe extends to interest in their social and economic circumstances. Emphasis in patient safety research is often given to the causes and consequences of error and harm, but this research brings the day-to-day unfolding of professional work to the fore. This shift in perspective allows for a detailed examination of the strategies staff use to enact safety, and a concomitant exploration of the degree to which policies and rules penetrate practice. This has been accomplished through the ethnographically informed design of an inquiry into understandings and enactments of safe care among a multidisciplinary range of staff in a community mental health team and an acute inpatient psychiatric unit in New South Wales, Australia. In the course of daily work, these professionals are found to negotiate a tension between two versions of patient safety. In the fluidity of everyday practice, the 'safe patient' is only ever a transient, fragile phenomenon anchored to a particular time, place, and relationship between clinician and patient. However, the expectation of policymakers, Coroners, and members of the public is that the mental health service should act as guarantor of public safety. Theoretical frameworks of socio-material ontology are used to tease out the implications of these sometimes contradictory demands, and to explore the possibility of a patient safety which prioritises therapeutic impact on the patient rather than only the management of their risk.

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ORIGINALITY STATEMENT

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Signed ....

Date ....11/7/2013..

Table of Contents

Tables and figures

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Publications and presentations arising from this research

Refereed publications

1. Plumb, J., Travaglia, J., Nugus, P., Braithwaite, J. (2011). Professional conceptualisation and accomplishment of patient safety in mental health care: an ethnographic study. *BMC Health Services Research,* 11: 100.

2. Braithwaite, J., Clay-Williams, R., Nugus, P., Plumb, J. (forthcoming). Healthcare as a complex adaptive system, E. Hollnagel, J. Braithwaite, R. Wears (eds.) *Resilient Health Care,* Farnham: Ashgate.

International conference presentations

1. Plumb, J., Nugus, P., Travaglia, J., Braithwaite, J. (2012). Safe care as it happens: the production of patient safety in community mental health care. *Eighth International Organisation Behaviour in Healthcare Conference,* Dublin, Ireland, 17 April.

2. Plumb, J., Travaglia, J., Nugus, P., Braithwaite, J. (2011). Orchestrating patient safety in mental health care. *Australasian Association for Quality in Health Care: Great Healthcare Challenge,* Melbourne, Australia, 12 October.

National conference presentations

1. Plumb, J. and Debono, D. (2012). How does safe care happen? Using ethnography to study safety in real time. Invited presentation: *Australian Institute of Health Innovation Symposium: From systems research to improved healthcare*. Sydney, 27 November.

2. Plumb, J. (2011). The production of patient safety in mental health care. *University of New South Wales* (*UNSW*) *School of Public Health and Community Medicine Research Symposium,* Sydney, Australia, 5 August.

3. Plumb, J. (2010). Patient safety in mental health care: the contribution of ethnographic research. *UNSW School of Public Health and Community Medicine Research Student Conference,* Sydney, 22 October.

4. Plumb, J. (2010). Qualitative approaches to patient safety in mental health care. *Emerging Health Policy Research Conference*, University of Sydney, 11 August.

Other presentations

1. Plumb, J. (2012). Ethnography and patient safety. Invited presentation to Health Care Governance Group, Erasmus University Rotterdam, The Netherlands, 25 June.

2. Plumb, J. (2012). Patient safety in mental healthcare. Invited presentation to Patient Safety Research Group, Vrije Universiteit, Amsterdam, The Netherlands, 7 June.

Terminology

Note on use of the term 'patient'

There are multiple words used within mental health services to refer to those using the service. This is variable between countries, between types of service, and between individual professionals. For example, in the settings for this study, community-based staff were more likely to refer to their 'clients', and inpatient staff to 'consumers' or 'patients'. Psychiatrists were more likely than others to refer to 'patients'. Each term has associations and connotations, but as a discussion of these is not within the scope of this study, I have elected to use the term 'patient' throughout, except where direct quotes from professionals necessitate use of other terms. This is because I feel that this term offers the least ambiguity about who is being discussed. Where professionals are quoted directly, whichever word they employed in that instance to describe patients is used.

Note on use of the phrase 'patient safety movement'

The term 'patient safety movement' is used frequently throughout this thesis and, since the term is ubiquitously used in the patient safety research literature, it is important to define exactly what I mean by it. I use it specifically to denote the policy effort in developed countries across the globe to reduce rates of healthcare-associated harm. In this view, the 'social movement' connotations of the term are somewhat misleading, as it implies instead a suite of coordinated, programmatic, top-down interventions – usually at a national scale – in the conduct and structure of health care. It promotes a particular systems-based logic and conceptualisation of the health care organisation, where instances of harm can be traced back to its origin at a malfunctioning part or interaction of parts of the system. The starting point for this coordinated effort and diffusion of the system-based logic is commonly considered to be the publication of the Institute of Medicine's report *To Err is Human* (Kohn, Corrigan, & Donaldson, 1999).

Glossary

Acuphase: proprietary name for zuclopenthixol injection; long–acting major tranquiliser

Clozapine, chlorpromazine, haloperidol, olanzapine, paliperidone, risperidone: anti-psychotic medications

Consultant (psychiatrist): psychiatrist who has completed all specialist training

CTO: community treatment order; legally enforceable obligation on patient to receive certain treatment in a community setting. Patient may 'breach' the order by not complying with this regime.

Depot: generic term for regular injection of long-acting anti-psychotic medication

Iatrogenic harm: harm that is caused by health care professionals or processes

IIMS: computerised incident reporting system used in New South Wales

Midaz[olam]: fast-acting minor tranquiliser

NHS: National Health Service (England and Wales)

NSW: New South Wales, a State of Australia

OH&S: occupational health and safety

RCA: root cause analysis, a mandated investigation of severe untoward incidents

Registrar: doctor who (in this context) is enrolled in the Royal Australian and New Zealand College of Psychiatrists postgraduate training program

Schedule: involuntarily admit to inpatient care under the *Mental Health Act 2007*

Valium: proprietary name for diazepam, a minor tranquiliser

Zyprexa: proprietary name for olanzapine, an anti-psychotic medication

Chapter 1:   Introduction

This study deals with what patient safety means in a mental health service, from the perspective of the professionals responsible for maintaining it. Its focus is on the enactments of safe care which unfold at the intersection of people, policies and practices in the everyday work of two mental health teams. It is a study of safety-in-the-making rather than safety-as-a-state. As such, it acknowledges and investigates the non-linear and practical dynamics of safety production. In this thesis, I foreground the interdependencies between the nature of mental illness, uncertainties integral to the practice of psychiatry, the role the mental health service is expected to play in relation to risk, and the everyday safety- and risk-related practices of the study's participants.

Rather than exploring what should be done to reduce adverse events, this research offers an account of what is done day-to-day to keep the vast majority of patients safe, the vast majority of the time. There has been a tendency both in patient safety research and in the mental health literature to focus attention on the production of adverse events rather than of safety, indicating a preference for the unusual and spectacular above the everyday and the mundane (Dekker, 2005; Jerak-Zuiderent, 2012; Mesman, 2009). When 'things going wrong' comes to the fore, 'what goes right' (and what can be learnt from that) is left as an unexamined background presence. While this thesis does not ignore what goes wrong, the mundane tasks of safety creation are its focus.

For six months, I observed the work worlds inhabited by one group of professionals working in a community mental health team and by another group working on an acute inpatient psychiatric unit. The two teams were based in the same hospital in New South Wales, Australia. From the beginning, I wanted to explore two research questions. Firstly, I sought to understand how different professionals in these teams conceptualised safety (I did not predefine what 'sort' of safety I was interested in); and secondly I wanted to observe how they enacted what they considered to be safe care. Their safety work was coloured by a set of

contextual factors which are inextricably linked to the nature of mental illness and approved modalities of treatment, and which often distinguish it from physical health care. For example, many treatments are based on interaction between clinician and patient in the context of a therapeutic relationship – rather than on physical intervention; the principal threats to a patient's safety are often perceived to emanate not from badly conducted care but from within the patient themselves; patients may be unwilling recipients of enforced care or disputed diagnoses; and the idiosyncrasies of a person's history, personality, social circumstances, and interaction with clinicians can combine to threaten safety in unique and unpredictable ways. This study realises an account of how such characteristics of mental health care shape the teams' roles in relation to patients' safety.

Health care associated harm is often portrayed by patient safety researchers as originating in error-prone systems or staff (or a combination of the two). This is most clearly illustrated in the text which catalysed the patient safety movement more than any other, *To Err is Human* (Kohn, Corrigan, & Donaldson, 1999), which relied heavily on the work of two scholars. One of these scholars studied the Three Mile Island nuclear disaster to show how systems contribute to or protect against accidents (Perrow, 1984), while the other wrote about the 'human contribution' to such system failings (Reason, 1990).

Such approaches, along with many others published since, provide a somewhat abstract, standardised and static 'bird's eye' view of health care institutions as inherently error-prone systems. In contrast, the present study locates itself on the messy 'shop floor' of one such institution, among the often confusing flux of an ever-changing present – taking an 'ant's eye' perspective. From this angle, it becomes possible to see nuances and complexities that are obscured by the bird's eye view. We can see the contested and situated understandings of safety held by professionals, and the role of uncertainty, improvisation and persuasion in its 'good enough' enactment. Notions of system failure (with or without

contributory human factors) seem a long way from the rush and chatter of the nurses' station, while staff cast themselves and the service as protectors of patients rather than as potential sources of harm. On the whole, safe care of mental health patients – from the point of view of the professional participants – is a matter of weaving a strong 'safety net,' actively creating conditions to prevent a patient becoming the subject of a harm which they themselves precipitate. The role of professionals in iatrogenic harm, in this context, comes from failure to ensure the safety net is in place or to repair any holes before a patient can fall through.

The study developed out of an observation that there is a mutual blindness between the bodies of research knowledge related to, on the one hand, patient safety, and on the other, mental health services. Scholars of patient safety have thus far been preoccupied with surgical and acute medical settings. They have largely ignored the impact of the specificities of mental illness and its treatment context on conceptualisations and achievement of patient safety in that sector (Brickell & McLean, 2011; Nath & Marcus, 2006; Vincent, 2010). For their part, although mental health researchers recognise patient safety issues in terms of isolated and dramatic adverse events such as suicide and patient aggression, they frequently offer a mechanistic rather than holistic picture of what safe care entails in mental health services. (A full range of references for this type of study will be provided in Chapter 2, literature review). This literature is dominated by variations on a narrative of linear progression from discrete cause to adverse event to proposed solution and intervention.

How can we resist the lure of the spectacular and access instead the day-to-day emergence of safe care amidst the complexity of clinical worlds, in real times and real places? In Chapters 2 and 3, I examine strands of empirical and theoretical work which leave clues about how this might be done, and from which inspiration for the design and conduct of this study was drawn. This work is drawn from outside the 'mainstream' systems- and human factors-oriented

approaches to safety and has mainly been done by anthropologists and sociologists whose interest is focused on the everyday practices of professionals (for an overview of the sociology of patient safety, see Zuiderent-Jerak and Berg (2010)). I have drawn principally on four strands of research, some of which deal directly with patient safety concerns but most of which do not. The first is the empirical and primarily ethnographic project to explore the patterns and flux of social structure and life in mental health institutions, following in the footsteps of Caudill (1958), Strauss (1964), and Goffman (1961). The second is the wider effort across health care and other industries to expose the tacit knowledge and informal strategies used to ensure safety, including the notion of 'invisible work' notably articulated by Star and Strauss (1999). The third is work which critically explores the relationship of these practices to canonical accounts such as policy, in the tradition of Wittgenstein's (1968) practical account of rule-following. The final influence on the design and conduct of this study is the idea that it is the shifting interrelationships between people, things and ideas which facilitate an always-situated enactment of organisational life and its products. This follows sociologists of science and technology such as Latour (1987).

Among the conclusions that can be drawn from these combined strands of scholarship is that much inpatient psychiatric care in developed nations is structured around risk management priorities. The literature also points to specific types of risk uniquely concerning to mental health services, especially those perceived as originating in the patient such as suicide. In addition, a growing ethnographic tradition in patient safety research exposes the complexity of safety work and its situatedness (Dixon-Woods, 2010; Finn & Waring, 2006). Such studies have highlighted the non-technical, intuitive and interactive nature of informal work done by clinicians to prevent harm. Meanwhile, real-time observation of mental health wards has also uncovered less visible processes of iatrogenic harm, such as emotional trauma from experiencing admission to and life in these settings.

Overall, this body of work paints professionals as sources of resilience rather than only of error, and emphasises the importance of informal, non-codified strategies for the everyday operation of safe health services. Seeking to understand what is being done on an everyday basis by professionals to enact safe care is still a minority perspective on patient safety, but amidst disappointing progress using managerialist initiatives to effect safety improvement, prominent scholars in the field have called for its further elaboration and development (Øvretveit, 2009; Vincent, 2009).

I seek to frame the thesis theoretically in Chapter 3, drawing on sociologists of patient safety such as Zuiderent-Jerak, Waring and Dixon-Woods, practice theorists such as Gherardi and Nicolini, and those who have developed variations on actor-network approaches, such as Latour, Mol and Delanda. Using these scholars as inspiration provided a rationale for situating this study in the detail of everyday practice, and for paying attention to the multiple dimensions of this practice including the moral, temporal, spatial and material. Such ideas provided a scaffold throughout data collection and analysis for an articulation of how professionals understand and enact different versions of safe care.

Getting to know the dynamics of safe care in daily professional practice requires the researcher to be present alongside staff members for an extended period, to witness the unfolding enactment of safety in 'real-time'. The ethnographic research design I developed to achieve this is described in Chapter 4, and incorporates multiple modes of observation of the two teams as well as in-depth interviews and surveys. All phases of the research were conducted with participants drawn from the full range of professional backgrounds, including managers, doctors, nurses, allied health and ancillary staff. The research design has also been described in a previously published paper available at Appendix 1 (Plumb et al., 2011).

The patient safety understandings and enactments that emerge from the everyday clinical worlds of the two mental health teams are elaborated in the

findings Chapters 5, 6 and 7. They are fundamentally about how individuals and institutions cope with uncertainty. The level of uncertainty that pervades the practice of mental health care is apparent in the way professionals conceptualise safety in these services, which is the subject of Chapter 5. Patients' safety may be threatened by life events or circumstances, and so professionals perceive potential risk in a host of life domains including poor housing, lack of meaningful occupation, financial management, and toxic relationships, and may intervene in any of these to try to create safer conditions. However, clinicians are never sure whether to trust the patient's account in any of these domains; they mediate between this and accounts they receive or solicit from family or community members, written accounts, and other professionals. There can also be doubt and debate between colleagues about how to prioritise competing risks in any particular situation.

Chapters 6 and 7 show that there are two principal patient safeties being played out simultaneously in these services, each with its own logic, goals and accompanying material and intellectual technologies – and strategies for dealing with uncertainty. The first type of safety enactment involves professionals in performing according to outside expectations of what the services should be doing. Such expectations enter practice through the physical structure and layout of the mental health ward; through policies and documentation requirements; and through the threat of censure by Coroners, courts, media or regulators. These expectations, the subject of Chapter 6, have a performative effect on practice, engendering a wide array of activity designed to show the world that expectations are being met. However, such activity requires the bracketing out of the uncertainties that characterise everyday practice, so that the impression of an ordered service in which risk can be identified and managed is maintained.

Even as uncertainty is effaced to perform this first type of safe care (safe care in the eyes of external parties), professionals still have to work with it and get their job done despite it, an everyday effort which is explored in Chapter 7.

Observations of unfolding clinical practice reveal that the safety of a particular patient is fragile and momentary, and the strategies clinicians employ to create safe conditions for each patient are individually variable and highly situated. Everyday safety creation is a rolling process that is never completed; it is always emergent and requires considerable improvisation and coping with not-knowing. Intimate knowledge of the patient's past and present and the enrolment and maintenance of diverse support networks are essential to the safety effort, and the personalisation of the relationship between clinician and patient is a prerequisite for non-coercive safe care. Coercion enters the picture when the strategies of personalisation fail.

In Chapter 8, I integrate and further refine the findings with two recently developed frameworks of socio-material ontology which are developments of actor-network approaches, namely assemblage theory (Delanda, 2006; Latour, 2005) and multiple ontology (Mol, 2002). This enables the further exploration of the characteristics and dynamics of the two safeties outlined in Chapters 6 and 7, by reframing them as distinct safety ontologies which are simultaneously and continuously enacted. I tease out the moral, material, temporal and spatial dimensions of each ontology, and examine how the two depend on and interfere with each other in everyday practice. This exercise exposes the sometimes contradictory imperatives which challenge the achievement of therapeutic care.

The coexistence of multiple ontologies of safety highlights the political, values-based aspect of safety improvement. Such a theoretical framework makes it possible to conceive of choices that can be made about the type of safety to be promoted. By recognising that there are multiple logics of safety in play, perpetuated by the activities of staff but also embodied in the tools, infrastructure and intellectual technologies with which they work, there opens up an opportunity for stakeholders in mental health care to discuss what sort of safety they really want for patients, and the political, regulatory, infrastructural and workforce reform necessary to effect it.

This research is distinguished both empirically and conceptually from previous investigations of safety concerns in mental health care in three principal ways. Firstly, participants, through their words and actions, were allowed to define the scope of safety concerns as well as the nature of appropriate responses to such concerns. Avoiding pre-restriction of scope has resulted in a nuanced and detailed account of what 'counts' as patient safety in these settings and the practical ramifications of this. Such a move has opened up space to acknowledge and describe the often messy and improvised yet remarkably resilient character of safety maintenance efforts. Secondly, following staff and their activity over an extended period enabled a shift in focus from 'big' safety events such as suicide or violence, which have understandably always consumed much research time, towards the less dramatic improvised and ongoing efforts of clinicians to create conditions of safety around their patients. It is within this type of activity that productive clues about how to improve safety through harnessing the already successful strategies of staff can be found. Thirdly, this thesis makes a significant theoretical contribution towards a reconceptualisation of patient safety by articulating the practical coexistence of, and relationship between, multiple socio-material ontologies of safe care.

Chapter 2: Situating the study

If I am to make explicit how this text departs from the others around it, if I want to show how it both differs from them and is made possible by them, I will have to relate to the literature. But how to do this? (Mol, 2002, p. 2)

This is the point: generalisations about 'the literature' always draw together disparate writings that have different souls, different concerns of their own. (Mol, 2002, p. 6)

2.1.   Introduction

This study situates itself at the intersection of four lineages of empirical and theoretical scholarship. The first of these is research that explores the characteristics and concerns of safety and iatrogenic harm in mental health care by examining discrete kinds of harm (such as suicide) and ways to prevent or mitigate the consequences of that harm. The second is the tradition of ethnographic description of institutional life within mental health services, where safety concerns appear as integral parts of everyday practice. The third is the sociological and anthropological contribution to the study of patient safety, which exposes informal professional strategies of safety maintenance and offers a critical perspective on orthodox approaches to patient safety research and improvement. Finally, this study injects a fresh perspective to strengthen the latter effort by following the lead of science studies researchers to develop a process-based, socio-material ontology of safety. The first three domains of literature will be explored in the present chapter; and the last will be the subject of Chapter 3.

In this chapter, I aim to show how patient safety concerns in the mental health context differ in important (but not all) ways to those occupying the minds of clinicians working in the physical health field, and will outline some of the reasons proposed by others as to why this is the case. I will then argue that much prior scholarship concerning the safety of mental health patients has assumed a

conceptualisation of safety as a residual state that obtains when discrete acts of violence toward self or others are absent. Lastly, I will highlight examples of research that employs the theoretical and methodological tools of anthropology and sociology to reconceptualise safe care as (inter)actively accomplished in practice rather than existing by default as a state of absence.

These three aims imply a concern with exposing the knowledge gaps that this study was designed to help fill. Although there is a growing corpus of qualitative work examining the context for and practical achievement of safety, very little is set in a mental health context. That research which does describe life in mental health services exposes the central place of safety concerns in the day-to-day structure of mental health care, but the focus of such studies is the work and perspective of ward-based nurses. This has meant a relative neglect of how safety concerns figure in the daily practice of non-nursing professionals or community-based practitioners. To my knowledge, there is no existing ethnographic study of the multiple dimensions of safety work performed on an ongoing basis by entire multidisciplinary mental health teams in both community and inpatient settings.

In the early stages of the project, I was puzzled that 'patient safety' as a phrase seldom appeared in research related to mental health services. Similarly, searches of patient safety journals and books yielded little mention of mental health. However, when I turned to the grey literature (such as the products of think-tanks and government agencies) I began to discover a hazy topography of safety on the mental health map. It is, in many ways, a foreign landscape to any patient safety scholar raised on a diet of *To Err is Human* (Kohn, Corrigan, & Donaldson, 1999), hand-washing and Methicillin-resistant Staphylococcus aureus (MRSA).

Suicide and self harm, violence and aggression replace health care-acquired infections and wrong-site surgery in this new vista. These acts of violence against self and others appear as discrete events to be predicted and prevented in a clash of wills between protective staff and risky patients. The only unifying rubric seems to be that of risk: risk management, risk assessment, risk mitigation.

Harms and risks are certainly studied, in great detail and depth. By contrast, safety in this literature exists by implication only, as nothing more than the absence of harm and a state of no-risk.

To develop an articulation of what safety *is* rather than only what it *is not* in the context of these mental health services, it has been necessary to move beyond the discourse of the patient safety movement and to draw on texts possessing what Mol (2002) calls 'different souls, different concerns of their own.' Much of the conceptual apparatus for this research is derived from scholarship outside the mental health world. The first element of this apparatus is that work which involves critical examination of the assumptions underlying what has been termed the 'theoretical orthodoxy' of patient safety research (Waring et al., 2010), by unpacking how safety is understood and done in real times and places. The second – to be addressed in Chapter 3 – is derived from a body of thought that can be grouped under the term 'relational sociology' (Crossley, 2011; Emirbayer, 1997). In broad terms, this entails the theorisation of relations between formalised knowledge and everyday practice, and between material and human elements of that practice in the emergence of social phenomena. The theoretical and conceptual tools offered by these approaches suggest a novel way to study safety as a practice-grounded, socio-material, ever-emergent phenomenon.

2.2. Patient safety 'Cinderella'?

Mental health care is often colloquially referred to as a 'Cinderella service' because of a perceived lack of policy attention and consequent exclusion from the 'ball' at which resources are handed out to its richer medical cousins (Orr, 2013). When I began to search the patient safety literature for references to mental health care, it seemed that this part of the health sector, along with primary and aged care, has largely been excluded from the extensive political and research attention devoted to the problem of iatrogenic harm since the turn of this century.

The effort to reduce healthcare associated harm has been a defining feature of health policy in developed countries during this time. There are many reasons for this, but two stand out. Firstly, the notion that a social institution – whose ascribed role is to care and cure – can harm people at their most vulnerable is counter-intuitive. Since the extent of the harm became public knowledge and garnered media coverage at the turn of the century, the patient safety problem has provoked incredulity and emotion among the media and the general public, and has become a politically salient phenomenon which requires attention (and research funding) (Millenson, 2002). The second is that despite the effort, time and money going in to reducing rates of harm, improving safety nevertheless proves to be a 'wicked problem,' largely impervious to attempts to tackle it (Braithwaite, Runciman, & Merry, 2009; Rittel & Webber, 1973).

The quest to improve patient safety has over the last fifteen years become so central a story in the health care literature that it has become associated, through repetition, with its own creation myth and narrative arc. Even though concerns about iatrogenic harm have a much longer history (dating back to Hippocrates, making it as long as the history of medicine itself), most recent literature repeats a creation myth which dates from the 1999 publication by the Institute of Medicine of *To Err is Human: Towards a safer health system* (Kohn, Corrigan, & Donaldson, 1999). The title replaced the second half of Alexander Pope's (1711) line ('to forgive, divine') with a rather more prosaic, instrumental sentiment, but it was one which reflected the concerted push to make patient safety a policy and practical priority across health systems.

The title also reveals in embryonic form the logic of the patient safety movement which has persisted ever since: making things 'safer' is always inextricably linked with – and even equated to – reducing the tendency of people, things, and systems to 'err'. This book is ubiquitously quoted in the first paragraph of many journal articles tackling patient safety, having to date been cited almost 10,000 times; the rate of patient safety research articles published before and after its

release climbed from 59 to 164 articles per 100,000 papers indexed to *Medline* (Stelfox et al., 2006). It drew widespread media attention in multiple countries at the time of publication because of the revelation of the scale of health care associated harm (Dekker, 2011). It is perceived by many to have been a 'tipping point' (Grodzins, 1958) for public interest in the issue, and to have heralded the birth of the patient safety movement, despite increasing recognition of the problem of iatrogenic harm during the preceding decades (Elwyn & Corrigan, 2005; Weingart et al., 2000).

In 1998, the authors of a report from the National Patient Safety Foundation in the US were able to state that 'the phrase "patient safety" is, admittedly, only beginning to achieve currency in the health care community and is not yet widely used among the general public' (Cook, Woods, & Miller, 1998, p. i). However, in one volume, the authors of *To Err is Human* succeeded in marshalling previously distributed categories of iatrogenic harm under the umbrella category of 'patient safety', a move which enabled new realities to be enacted in the form of counting errors and investing in patient safety improvement initiatives. Hacking (1986) writes of a similar phenomenon in relation to the categories of multiple personality disorder and child abuse; prior to their invention, it was not as though the phenomena they describe did not exist – but the creation of the categories enabled classification of people and justified their management.

The patient safety narrative arc incorporates many elements of a morality play; there is a struggle between good and evil in which the expected resolution is the triumph of the former over the latter (Cuddon, 1977, p. 555). We observe researchers setting up an apparently insurmountable difficulty (some kind of iatrogenic harm), identifying the evil forces creating the difficulty (generally involving a search for causes of errors), heroes fighting on behalf of justice and good (managers and clinicians attempting improvement initiatives to eliminate the identified causes), and a logical progression to the vanquishing of evil (reducing the harm). Around this narrative (in an attempt to reach the

denouement) revolves a burgeoning popular and academic literature (with dedicated journals), national and international infrastructure to promote and fund improvement, public and private advisory bodies, and countless initiatives at country, region, hospital, ward and individual level to target and eliminate perceived sources of iatrogenic harm. A satisfying resolution to the story is still elusive however; progress is 'disappointing' (Wachter, 2010) and 'almost glacial' (Koppel & Gordon, 2012, p. 5).

Researchers have attempted many theoretical reconceptualisations of patient safety in an effort to overcome this. A review of these is beyond the scope of this chapter. However, following the headline recommendation in *To Err is Human* to reduce medical errors by fifty percent within five years, approaches which seek to identify numbers and causes of error have dominated the research picture in two ways. Firstly, despite efforts in the above report to advocate a 'no-blame' culture, attention has been given to the mistakes of individual clinicians at the 'sharp end' of care, and how tendency to err is related to factors like failure to follow guidelines, level of experience, and lack of sleep. This is manifested in the culture of litigation against clinicians which is long established in the US (Studdert et al., 2006) and increasingly common in Australia (Runciman, Merry, & Tito, 2003).

The second strand of error-based research is founded on the notion of 'latent' errors, in which some aspect(s) of the health care system are taken to increase individuals' susceptibility to make mistakes (Reason, 1990). Proposed remedies flow from each of these theoretical perspectives; for example, 'forcing functions' using technologies such as 'computerised physician order entry', and other human factors approaches were proposed to combat human tendency to err (Bates & Gawande, 2003), and system level interventions to repair, replace or streamline malfunctioning processes (Shortell & Singer, 2008). The concept of the 'high reliability organisation' was borrowed from other industries where failure could have catastrophic consequences, and also promoted a culture

'preoccupied with failure' where 'any lapse [is seen as] something wrong with the system' (Weick, Sutcliffe, & Obstfeld, 1999, p. 9).

Against this background, the identification and strengthening of factors that enable or foster safety (as opposed to increasing error) has subsequently gained traction (Borys, Else, & Leggett, 2010; Cook, 2005; Iedema, 2011). A defining characteristic of this approach is that rather than constructing staff as a safety liability, they are instead seen as an important protective resource *for* safety, especially in terms of their cognitive ability to adapt to the unpredictability of clinical practice (Nemeth et al., 2008). Their informal, tacit knowledge and 'sixth sense' ability to detect when things are unsafe, regardless of 'objective' observations, has also been noted (Smith & Arfanis, 2013). Key theoretical contributions in this vein have come from research into resilience (Braithwaite et al., forthcoming; Hollnagel, Woods, & Leveson, 2006; Jeffcott, Ibrahim, & Cameron, 2009). Overall, however, this type of safety-enhancing focus is a minority interest within the patient safety movement (Dekker, 2005), and there is a tendency to conflate system level analysis with group or team level functioning to the neglect of wider structural and cultural influences such as politics, inter-organisational relations, and professional cultures (Waring, McDonald, & Harrison, 2006). The present study seeks to extend patient safety research by describing the safety-creating dynamics at work within two mental health teams while attending to the wider institutional, political and ideological imperatives penetrating everyday practices of safe care.

Within all of this work, whether it aims at reducing error or creating safety, the patients implied by 'patient safety' are a very particular type of patient, and are not representative of 'patients' as a group. Mostly, they are patients in hospital rather than (the far more numerous) patients going to visit their primary care service (Gaal et al., 2011). Mostly, they are patients who suffer problems requiring acute medical or surgical intervention, rather than patients who access outpatient care or home care for management of their chronic illness (Gandhi &

Lee, 2010; Lang, Edwards, & Fleiszer, 2008). Mostly, they are patients on the operating table or in the intensive care unit, rather than those in the nursing home, prison or mental health ward (Nath & Marcus, 2006; Stern, Greifinger, & Mellow, 2010). They are victims of errors of commission, most commonly; errors of omission are far harder to detect and calculate.

It might be argued that all this is because the types of patients prioritised by the patient safety movement are those most likely to meet serious consequences or death as a result of harm. It might also be argued that voiceless or vulnerable populations receive less attention (Travaglia, 2009). In support of the latter argument and contradicting the former, suicide has ranked among the top five 'sentinel events' (serious adverse events) reported to the Joint Commission in the US since 1995 (The Joint Commission, 2010). From approximately one million contacts with specialist mental health services in England and Wales during the year to June 2011, 169,211 adverse incidents were reported (NHS England, 2012). Even acknowledging that such datasets represent only a small subset of incidents that occur (Panesar, Cleary, & Sheikh, 2009), it is therefore difficult to argue that the scale and seriousness of the problem is less significant in non-acute services.

When we look more closely at the literature surrounding the safety in health care of mental health patients, we discover that this group has indeed occupied a Cinderella role within the patient safety movement. This is despite the high numbers of adverse events impacting this population, and the relatively poorer safety outcomes in medical and surgical care for those experiencing serious mental illness (e.g. Khaykin et al., 2010). That there are patient safety concerns for this population is undeniable, but at first glance there appears to have been little attention to addressing them. Systematic literature searches substantiate this claim. When searches are undertaken for journal articles dealing with the intersection between mental health care and patient safety, it becomes clear that research focusing on mental health care. forms a tiny proportion of the total body of literature surrounding safety in health care. The discourse of risk is far more

widespread (Heyman, 2004). As a rough indication of this, the *Medline* database indexes 849 journal articles, published since 1946 and focused on mental health, which contain the word 'safety' in the abstract. In contrast, 8036 mental health-focused articles – almost ten times as many – contained the word 'risk' in the abstract (see Appendix 2 for search strategy).

Research into what patient safety entails in this context, in other words, appears to have 'hardly begun' (Vincent, 2010, p. xi), and 'good quality patient safety research focusing on mental health is scarce' (Brickell & McLean, 2011, p. 39). The intersection of mental health and patient safety literatures is small, and it is unclear whether this is because it is believed that the principles of safety can be applied equally to mental health as to medical and surgical sectors, or because it is so different as to warrant entirely separate treatment. Nath and Marcus (2006, p. 204) observe that the literature inspired by *To Err is Human* has 'consistently excluded patients with mental disorders; medical errors in psychiatry consequently demand closer attention.' Patient safety textbooks rarely mention mental health; *To Err is Human*, for one, contains no mention of mental health or illness, psychiatry or behavioural health.

2.3.   Different safeties for different patients

An apparent but under-examined question is why this should be the case. Some have argued that many mental health safety concerns do not easily map onto those of medical or surgical care. Partly, this is due to the greater individual variability and relative inaccessibility of a patient's mental condition when compared to their anatomy and physiology. For example, Mossman (2009, p. 26) remarks that 'procedures in anaesthesia and the mechanics of central line placement are united across all care sites by similarities in equipment and human anatomy' and asks 'are psychiatric units and the patients who occupy them similar enough to make generalisations about useful, error-saving processes?' This raises the possibility that the variable influence of personality, interpersonal, and other life circumstances on mental illness may make it harder to devise 'one

size fits all' approaches to patient safety in mental health care. The 'intensely private' nature of the one-to-one relationship between patient and provider in psychiatry also makes the traditional systems approach to error prevention 'largely beside the point or not readily applicable' in mental health care (Bates et al., 2003, p. 1600). Attributing causality for harm in mental health care is often less clear cut than in many other sectors of care. For example, it is difficult to definitively state that if a clinician or team had done something more or less or differently, a suicide would not have occurred. Contrast this with an error in surgery where the wrong dose of anaesthetic is given or the wrong site operated on; tracing the cause of such events seems more feasible (e.g. Dimidjian & Hollon, 2010).

Safety has a different relationship to the central purpose of a health service in mental health when compared to physical health care. Research cited below indicates that risk control is a principal – and sometimes the only – aim of inpatient mental health services. (That creating safety means more than just controlling risk is a separate question to be dealt with at different points in this thesis, particularly in Chapter 8 – but the two are commonly conflated (Wildavsky, 1988)). Ensuring the safety of a patient in this context is not simply a concern to prevent avoidable harm occurring as a by-product of the main business of treatment, but often appears to *be* the main business of treatment. This is particularly true in inpatient settings where the basic threshold for involuntary admission (at least in Australia and the United Kingdom (UK)) is the threat of a person harming themselves or others.

Indeed, some have argued that concerns with safety and risk come to structure the entire practice of inpatient care. For example: Sharfstein (2009, p. 395) writes that 'the components of the acute stay consist of interventions that focus primarily on safety'; Delaney and Johnson (2008, p. 386) remark that 'safety has become the organising thread of current inpatient guidelines'; and Lelliott and Quirk agree that 'ward staff are preoccupied with the management of dangerous

behaviours' (Lelliott & Quirk, 2004, p. 297). The notion of a person's physical safety being the main purpose of care, the risk sometimes presented to staff and public safety by patient behaviour, as well as the presence of a proportion of patients who are being kept safe against their will, all differentiate mental health from other types of care.

In hospital, mental health patients differ from other inpatients in several ways that affect the way safety is managed. While in hospital, they are not usually confined to bed, may not believe that being in hospital is necessary or of benefit, and apart from medication are not subject to many physical interventions on the body. The construction of the roles of patients and staff members in the mental health literature is distinctive. Those undergoing medical or surgical intervention tend to be portrayed as passive, immobile recipients of treatment, who may become potential unsuspecting victims of safety breaches originating in technical error or system failing. In contrast, mental health patients are often portrayed as the source of safety problems, always at risk of undermining attempts by health professionals to keep them safe. They may be seen either as violent, dangerous assailants or self-destructive victims (Quirk, Lelliott, & Seale, 2004, 2005). The active role in which mental health patients are cast is reinforced by the argument that, like many patients with chronic illness, they are often given responsibility for managing their own recovery and are at times 'actively involved in managing risks to themselves and risks they pose to others' (Brickell et al., 2009, p. 12). Unlike the patient on the operating table, the mental health patient (or their illness) is commonly seen as the agent of risk and focus of its management, and the patient can be reconceptualised as a 'risk object' (Barrett, 1996; Hilgartner, 1992; Warner, 2006) rather than a subjective person.

The role of the individual professional in relation to patient safety is traditionally portrayed as being potential agent of error (whether the 'fault' is attributed to the individual or to the system or culture surrounding them). However, in mental health care, professionals are cast as protectors of safety rather than potential

perpetrators of harm, even when this protection must override the patient's rights of privacy and freedom of movement (Maranagos-Frost & Wells, 2000). So, whilst agency in the production of adverse events in general health care lies with staff and institutions, in mental health care agency lies principally with patients with some, but less, emphasis on staff members (e.g. in terms of medication or diagnostic errors) and systems (e.g. requirement for rapid turnover of patients).

This is reflected in research which examines how staff can best protect themselves from patient violence and deal with the aftermath of physical and verbal violence (e.g. Bloom, 2011; Hollins, 2010; Padyab et al., 2012). There is comparatively more focus on staff being harmed by patients than staff *doing* harm to patients; despite the fact that entrenched physical abuse of patients by staff has been highlighted in several inquiries and investigations of poor care (e.g. Kennedy, 2006).The notion of the 'second victim' (Wu, 2000), where staff members in health care are adversely affected by errors they are involved in, therefore takes on a different connotation in mental health care. Rather than harm being a side effect of something the staff member has done, it is often a direct effect of something the patient has done.

The consequences of a decision, for example to discharge someone who later goes on to commit suicide or homicide, do not only fall back onto the clinician concerned and their organisation, but may also affect members of the public (Bursztajn, 2002; Glick & Applbaum, 2010). In the US, England and Canada (among others), the clinician's duty to protect members of the public (by warning them of potential danger from a mental health patient) is enshrined in law following the *Tarasoff* decisions of 1974 and 1976 (Felthous et al., 2008), and given to clinician discretion in Australia. Critics of the encroachment of risk management thinking on mental health care believe that 'governing risky individuals' (Rose, 1998) for the sake of public safety has come to override concern with potential harm to patients:

... mental health professionals have been given [the role] ... of the continuing and unending management of permanently problematic persons in the name of community safety ... As psychiatry is urged to prioritize community protection, it is increasingly difficult to articulate its reciprocal obligations – for example, the obligation to protect those with mental health problems from the actual and symbolic violence they face at the hands of 'the community' ... and the obligation to deny the logic that equates difference with danger. (Rose, 2002, p. 217)

The business of diagnosis and decisions regarding appropriate treatment in psychiatry rely to a much greater degree on the tacit knowledge and personal judgement of the clinician involved, in the absence (in most cases) of definitive and observable pathology (Mullen, Admiraal, & Trevena, 2008). The degree of uncertainty this introduces to the practice of mental health care, the potential consequences of a wrong decision for the clinician's safety as well as the safety of the patient, and the degree of agency ascribed to patients in the production of risk, are all factors pointing to a distinctive understanding of safety in the mental health context.

2.4.   Safety as a residual category

A residual category is defined by an absence, by *what it is not* rather than what it is (Star & Bowker, 2007). In the case of patient safety research, safety is often defined (or simply implied) as the absence of harm or error. Hence the logic that if we find and remove errors, we will be left with the residue of safety, with the consequence that safety remains a strangely silent background presence in much patient safety literature. Despite the distinctive character of the harms experienced in mental health care, we will see in this section that safety remains residual in the mental health literature in favour of a focus on particular types of harm, their prevention, prediction and management. Those types of harm which originate with the patient (such as suicide and aggression) figure much more prominently as a subject of study than does iatrogenic harm to patients as a

result of their interaction with services (such as experience of abuse by professionals and psychological trauma from experiences in the ward).

.An examination of the mental health policy literature supports the argument that safety in mental health settings is conceptualised differently to that in general hospitals. We have seen that few articles on patient safety take mental health care as their setting of focus. Similarly, a search for common terms in the patient safety discourse such as 'medical error' and 'adverse event' yields only a few studies relating principally to mental health (10 and 32 articles respectively in *Medline*) (see Appendix 2 for search strategy). However, policy and guidance documents from four countries (Australia, England, the US and Canada – see Table 1 for references), which set out each country's safety priorities for mental health care, reveal a distinctive but consistent set of concerns. Whilst some issues are familiar patient safety issues from medical and surgical settings (such as medication errors and falls), most are unique to mental health care.

Taking this grey literature as a guide and searching for some of these particular safety concerns in the peer-reviewed research literature provides a substantial set of results. The terms 'violence' and 'suicide', for example, were the focus of articles about psychiatry and mental health care 1576 and 1362 times respectively (see Appendix 2 for search strategy). The discourse associated with the patient safety movement appears, on this evidence, not to have permeated mental health care to any great extent, but its logic of identifying harms and researching ways of eliminating them is very much present.

Table 1: Four countries' patient safety priorities for mental health services

	Australia	**England**	**US**	**Canada**
Document	*National safety priorities in mental health* (National Mental Health Working Group, 2005)	*With safety in mind* (National Patient Safety Agency, 2006)	*SafeMD* (American Psychiatric Association, 2009)	*Patient safety in mental health*(Brickell et al., 2009)

	Australia	England	US	Canada
Priorities	Reducing suicide and deliberate self harm	Self harm and suicide	Suicide	Suicide and self harm
	Reducing adverse drug events	Medication error	Drug/ medication errors	Adverse medication events
		Disruptive or aggressive behaviour	Aggression	Violence and aggression
		Patient accidents	Falls	Falls and patient accidents
		Absconding and missing patients	Elopement	Absconding and missing patients
	Reducing and where possible eliminating restraint and seclusion			Seclusion and restraint
	Safe transport of people experiencing mental disorders	Sexual safety	Medical co-morbidity	Adverse diagnostic events
				Patient victimisation

As evidence of the extension of this logic into mental health care, there have been explicit attempts to classify harm and errors in psychiatry by extending existing taxonomies to add an extra mental health-specific component. For example, Holland (2007) added the category of 'abuse' to those of underuse, overuse and misuse to account for additional threats to safety encountered by psychiatric patients, partly because 'much can go wrong within professional relationships where significant power imbalance exists with vulnerable clientele' (p. 340).

Based on interviews with professionals, Cullen, Nath, and Marcus (2010) classified errors in inpatient settings into treatment errors, diagnostic errors, preventive errors and 'other', finding a degree of congruence with error taxonomies in other medical settings. However, they found some distinctive contextual factors felt by interviewees to be important in precipitating adverse incidents, including inadequate staff training in psychiatry, stigmatising staff beliefs about treating psychiatric disorders, patient 'lack of desire' for treatment, and co-occurring social problems for the patient. They asserted that 'many of the specific errors

and contextual factors manifest themselves differently [to those in medicine and surgery] and are shaped by the uniqueness of the inpatient psychiatric setting and patient population' (Cullen, Nath and Marcus, 2010, p. 197).

Concerned by a lack of existing definitions of 'basic patient safety concepts' in mental health to guide policy and practice, Brickell and McLean (2011) interviewed Canadian 'experts' in the field to elicit accounts of the key patient safety issues and priorities for safety improvement. They found 'little agreement' between experts, but common themes included a concern with adverse events, stigma, patient empowerment and overall quality of care, and an overall consensus about the shortage of research and information on this topic. In a more critical vein, Mullen, Admiraal, and Trevena (2008) exposed the impact of an error focus on professional conceptualisation of safety practices. They showed that a sample of New Zealand doctors and nurses believed 'defensive practice' – 'wherever a practitioner gives a higher priority to self-protection from blame than to the best interests of the patient' (p. 85) – to be widespread, ranging from delaying discharge from hospital to 'questioning patients about their safety' (p.85).

The focus on error continues in the documentation of rates of adverse incidents in inpatient mental health care by national reporting systems. Of incidents in England and Wales reported to the National Patient Safety Agency (2006) up until September 2005, the most common in mental health services were accidents and falls (35 percent of incidents), aggressive behaviour (23 percent), self-harm (17 percent) and absconding (9 percent). A more recent analysis of the same system (NHS England, 2012) shows that 20 percent of all recorded incidents in mental health services in the year to September 2011 were categorised as 'disruptive or aggressive behaviour.' A study by Benveniste, Hibbert, and Runciman (2005) of incident data from the Australian Incident Monitoring System between 2000 and 2002 found that in mental health units, 28 percent of incidents involved physical violence or 'violent verbal exchange' by patients.

Rates of medication error appear to be broadly similar to that in general health care settings, but 'little is known about the incidence of error in non-hospital settings or about the harm caused by it' (Maidment, Lelliott, & Paton, 2006, p. 409). Absconding rates are hard to determine but have been reported at a rate in England of about 6.1 per patient year (Bowers, Alexander, & Gaskell, 2003).

The search for ways to predict and prevent harmful incidents provides us with the first indication that safe care might mean more in mental health care than the elimination of errors. Examining the relationship between the organisation of nursing care and patient safety, Gerolamo (2006) found: that rather than staffing levels per se, the amount of attention received by patients was a better predictor of safe care; that a controlling intervention style by staff was associated with increased rates of aggression; and that prevention of incidents requires a good surveillance system. Bowers (2009) found that lower conflict and containment rates were strongly associated with the existence of an assertive community crisis team linked to the ward, as well as with clear rules and routines governing ward life. Staff ability to regulate their own emotions (Bowers, 2009) and the nature of their attitudes to patients and to psychiatric illness (Cullen, Nath, & Marcus, 2010) are also found to be important contributors to adverse events. In the latter study, professionals mentioned a 'perception that errors in psychiatry are not harmful' (p. 202) and stigma amongst both psychiatric and non-psychiatric staff as being detrimental to safety outcomes. Issues of vulnerability related to reduced capacity for self-advocacy or communication are also claimed to have important implications for efforts to preserve safety (Brickell et al., 2009). The influence of these non-technical, interpersonal factors on safety in the mental health setting indicate that the task of maintaining safety (at least in terms of preventing adverse incidents) diverges in some respects from other sectors of health care.

Given the range of types of harm identified in mental health care, it is noticeable that there is 'little formal concern about risks which patients face from the iatrogenic effects of treatment or from a hostile society in which they can easily

be victimised' (Godin, 2004, p. 356). Overall, far greater attention is given to events where patients are seen as having some degree of agency in the harm, such as suicide, self-harm, and aggression. The treatment of these types of harm in the literature will now be examined in more detail, in terms of research into their incidence, the difficulty in researching the effectiveness of existing prevention measures, and reports of attempts to introduce more humane and respectful interventions. This will be followed by an examination of iatrogenic harms which have been identified in the literature but about which there has been 'little formal concern', such as psychological harm from inpatient experiences, feeling unsafe on the ward, and incidents of professional abuse of patients.

2.4.1. Suicide and self-harm

Suicide of people who are in contact with mental health services, and particularly those who are inpatients at the time of their suicide, has received considerable research and policy attention (Luoma, Martin, & Pearson, 2002; Windfuhr & Kapur, 2011). In England and Wales, the suicide of inpatients using ligature points on the ward has been classified as a 'never event' (Department of Health, 2011), whilst in the US, the Joint Commission classifies inpatient suicides as 'sentinel events' (The Joint Commission, 2010). Inpatient suicides accounted for 16.3 percent of all sentinel events reported to The Joint Commission between 1995 and 2005 (Tishler & Reiss, 2009), while there were 13,000 suicides by mental health service patients in England and Wales during the years between 1997 and 2006, 14 percent of them by people who were inpatients at the time (Hunt et al., 2010). Although the causes of suicide are notoriously multi-faceted and difficult to attribute after the event (Shea, 2002), the classification of suicide as a sentinel event or never event imputes some level of cause to the action or inaction of professionals.

However, three particular difficulties with introducing or improving service-level interventions to decrease the rate of suicide among mental health patients

become apparent in the literature on suicide prevention. These illustrate the additional complexity introduced to the effort to maintain safety that is distinctive to mental health services. The first difficulty with intervening on a service level is that most of these suicides occur while the patient is not in direct contact with a clinician or service (following discharge from the ward, while being treated in the community, or while on leave from or absconding from the ward) (National Confidential Inquiry into Suicide and Homicide, 2012). It is ethically undesirable and financially impractical to solve that problem by increasing the level of contact services have with individuals (for example by treating more people as inpatients). The second difficulty is the unpredictability of suicide (Powell et al., 2000), and the poor predictive value of risk assessment tools (Large et al., 2011). The third is that even where services do directly intervene to prevent suicide, the techniques they have at their disposal are not readily testable for effectiveness. For example, there is little evidence that intermittent or constant observations of inpatients by staff members makes a difference to suicide or self harm rates (Stewart, Bowers, & Ross, 2012), and indeed some inpatient suicides take place when patients are under constant observation (Meehan et al., 2006). However, the assumption of effectiveness cannot be tested because of reluctance to have a 'control' group who are not observed (Manna, 2010).

Two large cross-sectional studies have recently been conducted on factors associated with the prevention of suicide in the English National Health Service (NHS). These attempt to overcome the difficulty in predicting suicide by looking at service and staff factors associated with prevented suicide, in contrast with the more conventional risk prediction tools which focus on the patient's characteristics and illness (Hatcher, 2010). Bowers et al. (2011) analysed all reports of attempted suicide by inpatients made to the English national incident reporting system during one year, with the intent of determining which staff actions are associated with prevented suicide, and promoting the spread of such interventions. Finding that suicides are often unpredictable even among

inpatients, Bowers and colleagues nevertheless assert that the 'nursing staff's thorough knowledge of the patient as a person, together with a constant and consistent attentiveness to their state of mind, whereabouts and safety' (p. 1464) is the key factor most associated with prevented suicide.

Another recent study examined the impact on rates of suicide across English psychiatric wards of taking up recommendations emerging from the UK's *National Confidential Inquiry into Suicide and Homicide* (While et al., 2012). These recommendations included such service changes as: removal of ligature points; introduction of community teams such as crisis intervention and assertive outreach; having a written policy on follow-up of patients within seven days of hospital discharge; staff training at least every three years on management of suicide risk; and having a written policy on multidisciplinary review and information sharing with families following a suicide. In this study, the greater the number of recommendations implemented by a service, the greater the decrease in number of suicides by patients in contact with the service. The 24-hour availability of a community-based crisis team was the initiative associated with the largest reduction in suicides. Both cross-sectional studies therefore emphasise the usefulness of general quality improvement strategies as opposed to specific error identification and reduction techniques. Such an emphasis allows for protection against errors of omission through provision of adequate levels of care.

Much research into managing suicide risk among mental health patients focuses on individual improvement initiatives at organisation or unit level, or takes the form of operational guidance about how prevention 'should' be done. Examples of such guidance include recommending detailed questioning of the patient about suicidal intent (Norris & Clark, 2012), 'safe and effective prescribing practices' on discharge (Fernandes & Flak, 2012), and use of standardised risk assessment tools (Linehan, Comtois, & Ward-Ciesielski, 2012). In terms of improving the care of potentially suicidal patients, there is a particular research

focus on the practice of formal observation among nurses as a tool for decreasing rates of suicide and self-harm among inpatients. As we have seen, there is little evidence for the effectiveness of these practices in prevention of suicide or self-harm, but there is difficulty in testing this. Instead, in recognition of the sometimes anti-therapeutic nature of such practices (Cardell & Pitula, 1999), increasing numbers of services are reporting their efforts to introduce alternatives to formal observation. These efforts primarily revolve around increasing staff engagement with patients and increasing the availability of therapeutic activity (Carr, 2012; Cox, Hayter, & Ruane, 2010; Ray, Perkins, & Meijer, 2011). Cutcliffe and Stevenson (2008, p. 950) reflect this type of approach in their assertion that 'caring for suicidal people must be an interpersonal endeavour ... one personified by talking and listening.'

2.4.2. Violence and aggression

Mirroring interest in the self-directed violence represented by suicide, the study of the incidence, antecedents, and impact on staff of violent or aggressive behaviour by patients towards others is common and reflects the prominence of this type of event in incident reporting. These types of incidents are thought to be increasingly prevalent (Drach-Zahavy et al., 2012; Duxbury & Whittington, 2005), partly attributable to the rising acuity of patient populations as inpatient beds continue to decrease in number (e.g. Lamb & Bachrach, 2001). The impact on psychiatric nursing staff, 50 percent of whom are estimated to be subject to physical assault per year (Royal College of Psychiatrists, 2007), and ways of managing this impact, have also been studied in detail (e.g. Collins, 1996; Inoue et al., 2006; Lawoko, Soares, & Nolan, 2004; Moylan & Cullinan, 2011). The prominence of this type of research, particularly in the nursing literature, might be attributed to an urgency arising from personal physical risk to staff members to an extent not seen in other sectors of care.

High profile cases of patient deaths whilst under restraint have attracted research attention to safe management of patient aggression. Gerolamo (2006) and others

describe a 1998 story from the *Hartford Courant* which reported 142 deaths resulting from restraint or seclusion episodes during the previous 10 years in the US. The public inquiry into the death of David Bennett (Blofeld et al., 2003) whilst being restrained in an English mental health unit resulted in considerable media, policy and research attention being directed to the issue (e.g. National Institute for Health and Clinical Excellence, 2005). Research into the benefits and risks of restraint have followed a similar pattern in relation to aggression to that of observation in relation to suicide. Like observation, there is little evidence for the benefits of manual restraint of patients to safety (Stewart et al., 2009), and researchers have focused on recommending ways to minimise the physical harm of restraint if it cannot be avoided (e.g. Benson et al., 2012; Hollins, 2010; Hollins & Stubbs, 2011).

Motivated by concerns about decreasing the perceived coerciveness of mental health care, preserving the dignity of patients and reducing physical risk to staff and patients, there has been a widespread effort across many developed countries to reduce the use of physical restraint and seclusion (Gaskin, Elsom, & Happell, 2007). The American Psychiatric Nurses' Association has focused its recent work on such an effort (Farley-Toombs, 2011) and the *Australian National Mental Health Strategy* (National Mental Health Working Group, 2005) has led to similar programs in mental health organisations in that country (Grigg, 2006). In the NHS, alternatives such as 'time out' in one's own room are now used more frequently than seclusion, particularly in managing verbal aggression (Bowers et al., 2012).

Most accounts of nationally or organisationally developed alternatives to restraint use focus on targeted interventions. However, there are emerging examples of safety-creating initiatives which have found restraint and seclusion use decreasing as a side-effect of these wider interventions. One five-year 'culture change' model oriented around 'patient-focused interventions' included adoption of a focus on recovery, introduction of multidisciplinary rounds three times a

day, and use of patient advocates. During the first two years of the model's implementation, there was a 48 percent decrease in staff injuries, and reduction in hours spent in seclusion or restraint of 75 percent (Goetz & Taylor-Trujillo, 2012). The attention paid to 'patient-centeredness' is a relatively unusual move, acknowledging the safety-enhancing effect of measures not exclusively aimed at predicting or preventing incidents. Similarly, a nationwide approach increasing emphasis on reducing patient boredom and increasing time staff spend with patients has had the effect of reducing aggression rates as a by-product of respectful and therapeutic ward interactions (Janner & Delaney, 2012).

Such work, which recognises a need to integrate aspects of safety with efforts to improve the overall quality of a patient's experience of care, is still isolated among the predominant dichotomous discourse where discrete incidents are identified and matched to discrete interventions to prevent or neutralise them. In this discourse, incidents are caused by patients, while interventions are carried out by staff. One manifestation of this discourse is the 'conflict and containment' model of safety (Bowers, 2006). Events that can potentially lead to patient or staff harm are labelled 'conflict', a concept which encompasses any behaviour which has the potential to cause harm to others or self, from violating ward rules (for example by 'refusing to get up' or consuming alcohol) to verbal and physical aggression, self harm and self neglect. Staff efforts to prevent conflict or their responses to conflict fall under the second conceptual category, 'containment'.

The focus in this section on research into suicide and aggression – their prediction, prevention and management – reflects the emphasis in the policy and research literature on these two aspects of safety in mental health care. Both issues have been researched in similar ways due to the difficulty of assessing the effectiveness of current commonly used interventions (observation and restraint). Both interventions are characterised by an 'emphasis on defensive and custodial practices' (Cutcliffe & Stevenson, 2008, p. 943) and an 'individualising discourse' (Paterson et al., 2010) which locates the source of the safety issue

within the individual 'deviant' patient rather than in the institution, staff or interaction between these.

However, there is evidence of a recent move towards interventions that involve greater therapeutic engagement with patients and take account of the impact of staff and organisational factors on harm. On the whole, though, the maintenance of safety is seen not as a constant flow of activity, but rather a background state perturbed by discrete events where 'patients as perpetrators' and 'staff as protectors' each act to undermine the purposes of the other. The overall effect is a reinforcement of the safety movement's focus on extraordinary incidents rather than everyday safety, a focus on events not processes, and on 'static things,' not 'dynamic unfolding relations' (Emirbayer, 1997).

2.4.3. *More than just absence of harm: safety as lived experience*

Research into less visible, particularly psychological, aspects of safety in mental health care gives us some additional insight into safety as more than simply the absence of violent events. Feeling 'misunderstood', 'bored', 'out of control', 'alone' and 'humiliated' are some of the harmful emotional and psychological experiences that can result from admission to a psychiatric ward (Hardcastle et al., 2007). Research into the patient's experience of ward practices aimed at protecting their safety reveals broadly negative perceptions. In one study, 45 percent of participants said they had 'been to a psychiatric facility they would never want to return to' (Grubaugh et al., 2007, p. 193). Other accounts have highlighted that admission and ward life in and of itself can be traumatic, creating what has been called 'sanctuary harm' (Frueh et al., 2005; Robins et al., 2005). Frueh and colleagues found that 63 percent of the 142 patients they questioned had witnessed 'traumatic events' whilst an inpatient, more than half had 'been around frightening or violent patients' (p. 1123), and many still experienced the aftermath of this trauma years later. Similarly, 'fear of physical violence and the arbitrary nature of the rules,' and 'depersonalisation, lack of fairness, and disrespect,' were expressed by patients in the Robins study (p. 1134).

Such psychological harm echoes findings that for women on mixed-gender wards, the experience was particularly troubling for women who had been abused in the past (Gallop et al., 1999; Waddell et al., 2006). Feeling understood and having regular contact with consistent nurses was important to addressing this. Loss of control and disempowerment on multiple levels is an element of patient experience which has also been vividly exposed in first-person accounts written by former inpatients (e.g. Goddard, 2011; Kivler, 2012). Wondering about the degree to which it is possible to behave sanely once given the role of psychiatric patient, given the surroundings of a psychiatric unit, Goddard (2011) reiterates a reflection from Rosenhan's (1973) study *On Being Sane in Insane Places*:

> *... how many patients might be 'sane' outside the psychiatric hospital but seem insane in it – not because craziness resides in them, as it were, but because they are responding to a bizarre setting?'* (Rosenhan, 1973, p. 257)

The iatrogenic harm potential of being admitted to mental health care, being called a psychiatric patient, and being responded to as such, is not one that falls in easily with the schematic notion of safety as avoidance of discrete acts of error or harm. It infers that safety is an active process defined by interpersonal attitudes and relations, not a passive state. Disproportionate levels of particular types of iatrogenic harm experienced by women and ethnic minorities have started to be highlighted using the terminology of 'sexual safety' and 'cultural safety'. Good (1997) highlights how the uncertainty surrounding psychiatric diagnosis can mean that there is an 'over-pathologising bias' towards some ethnic groups because of stereotypical perceptions of likelihood of violent behaviour. For example, African- American men are three times more likely to be diagnosed with schizophrenia than white American men (Eack et al., 2012), and British black men are four times as likely as British white men to be compulsorily detained under the UK *Mental Health Act* (Singh et al., 2007). The notion of 'cultural safety' originated in New Zealand from 'the experience of Maori pain and inequity' (Hughes & McKay, 2012, p. 28), and in part involves a shift from focus on the culture of the 'Other' towards examining the culture of the service being

provided, and how it can take account of understandings of mental illness which do not rely on notions of individual pathology (Josewski, 2012).

The sexual and physical abuse of mental health and learning disability patients by professionals and other patients has been exposed by multiple inquiries (Flynn, 2012; Kennedy, 2006), but remains an under-researched and hidden source of iatrogenic harm (Whitelock, 2009; Williams & Keating, 1999). The potential for institutional abuse is increased within psychiatric care because of the power differential between patients and staff and the isolated nature of some of the work (Carter, 2010). However, these kinds of iatrogenic harm have received little coverage and discussion in the academic literature when compared to suicide, self-harm, aggression and other patient-initiated acts, a phenomenon which is reflected in examples of institutional and professional blindness to abusive actions by colleagues (Margolin, 2012).

To sum up, then, this exploration of the place of mental health within the patient safety literature (and safety in the mental health literature) reveals a tension at the intersection of these two areas of scholarship. Safety remains a residual category, as attention in the mental health literature is focused on identification and prevention of acts of violence perpetrated by the patient against self and others. However, the focus on adverse incidents and staff efforts to target them obscures everyday processes of safety. These are exposed in accounts of hidden types of iatrogenic harm, which are accessible through the lived experience of insecurity by patients and staff. Because these types of harm do not obtain from dramatic events but rather from the mundane, everyday conduct of care, they give us our first clues that safety may usefully be reconceptualised not as a state which obtains in the absence of acts of violence, but as the presence of an ongoing, dynamic process.

To ascertain what the concept of 'safety' might mean in mental health settings (as opposed to concepts of harm), we need to now turn to research that examines

everyday life in mental health services for the professionals and patients populating them.

2.5.   Inside safety's 'black box'

Metaphorical use of the term 'black box' reflects the unexamined, taken for granted nature of the operation of some piece of technology or social concept. The inside of the black box is rendered unproblematic and certain, and the interest is focused elsewhere (Latour, 1987). Similarly, we often find the notion of 'safety' rendered unproblematic and certain in patient safety literature as the interest turns to errors. This section deals with research which, through detailed exploration of everyday practice in mental health settings, reveals much about how safety emerges from the flux and tensions characterising care work.

2.5.1. Ethnography and everyday life in psychiatric institutions

As Mol's (2002) words suggested at the beginning of this chapter, we may need to look to research with 'other concerns' at its heart to shed light inside the safety black box. Accounts of the everyday life and work of mental health professionals offer an understanding of safety that goes beyond errors and responses to them. Such accounts are often achieved using ethnographic methodology, which in its emphasis on researcher presence in the setting of interest to undertake lengthy periods of observation, has the advantage of capturing events in 'real time' as they unfold. The methodological rationale behind the use of ethnography for the present study will be explained in Chapter 4. For now, it is important to emphasise that this method has a unique role to play in offering insight into the interactive, practical, and informal aspects of everyday safety production which are bracketed out by other perspectives in the haste to detect patterns in, build models from, and impose order on, chaotic clinical realities.

Three ethnographic examinations of professional life in mental health services have been particularly important influences on the present study. This is because they attempt to gauge the impact of policy decisions and political ideology, which

often originate far away in time and space, on the unfolding experience of care for patients and staff. I have attempted to take a similar approach with regard to patient safety politics and policies in the two mental health teams I studied, something which is tackled in detail Chapter 6.

The prioritisation of rapid turnover of patients above therapeutic care in an American 'safety net' psychiatric intensive care unit was explored in the book *Emptying Beds* (Rhodes, 1991). Here, the focus was on how staff coped each day with the practical ramifications of the policy push towards de-institutionalisation. This issue had been explored a decade earlier by Estroff (1981) who examined the impact on patients trying to live in the community after having been long-stay patients. Luhrmann (2001) undertook four years of fieldwork with psychiatrists-in-training, in order to analyse how psychiatrists-to-be are shaped by the conflicts between biomedical and psychosocial models of mental illness, and how, through this newly constructed knowledge, they come to 'shape' their patients and their illnesses during the clinical encounter.

These three accounts expose the complexity of the relationship between externally imposed rationalities (such as financial constraints, deinstitutionalisation, and ideological battles over the origins of mental illness) and the locally enacted realities of psychiatric care. Such insight is only made possible by the researchers' direct observation of everyday life in the institutions they studied.

In more recent years, the nursing literature has proven the most fertile ground for studies of the role that safety and risk concerns play in mental health practice. Issues such as the boundary between the ward and the outside world (Quirk, Lelliott, & Seale, 2006), psychiatric nursing practices (Bray, 1999), the interactive construction of clinical knowledge (Buus, 2008), interdisciplinary collaboration (Fortune & Fitzgerald, 2009), staff-patient relationships (Johansson, Skärsäter, & Danielson, 2007), and stress and coping among nurses (Hummelvoll & Severinsson, 2001) have been the subject of such studies.

Research into life on the inside of mental health services is almost exclusively interested in a nursing perspective, and is further characterised by almost always being set in the context of an inpatient unit. Those researchers who do examine care in community settings tend to examine one aspect of the everyday work of community teams or clinics such as team meetings (Griffiths, 1998), labelling of patients by staff (Dobransky, 2009), or clinician-patient interaction (Davenport, 2000). Generalised inquiry into the rhythm of daily life is more often seen in studies of inpatient settings, such as Quirk et al. (2004), Buus (2008), Cleary (2004) and Johansson, Skärsäter, and Danielson (2006). The present study seeks to contribute a broader perspective, by expanding the field of observation to all professionals working in multidisciplinary teams, and to both community-based and inpatient services.

2.5.2. Safety in context

In this section, I will explore in more detail what observations of nurses' everyday work can tell us about safety as it emerges in particular contexts, and the relationship of safety maintenance to other aspects of a nurse's job. There is a set of nursing skills and practices that are commonly linked in this body of research to the nurse's ability to enact safe care. Many of these are presented as being usually hidden, involving tacit knowledge and use of judgement, and as largely ignored by task-oriented accounts of what nurses do. The overall conceptualisation of safety in mental health care that emerges from these accounts is one which appears to be produced by the (undervalued) efforts of nurses to use informal strategies hinging on their relationship with patients, including interpersonal skills and tacit 'knowing', in institutions whose policies, ideologies and power dynamics often act to stymie their efforts and desires to provide therapeutic nursing.

The psychiatric nurse is often presented as engaged in a perpetual inner struggle between what he or she perceives as proper or ideal therapeutic nursing work, and other demands that make achieving the ideal impossible (e.g. Hem &

Heggen, 2003). Often this is a source of frustration for staff who seek to carry out the idealised version of care in the context of strong therapeutic relationships, but who are constrained by institutional demands to prioritise 'keeping order' (Cleary, 2003a).

American nurses struggle particularly with the anti-therapeutic aspects of managed care models which make funding of treatment contingent on a narrowly defined criteria of 'progress' at odds with the complexities and unpredictability of care which is reliant on a therapeutic relationship (Lester, 2011). Dobransky (2009) shows that staff 'game' the funding system by deliberately misdiagnosing patients, in order to obtain what they consider appropriate funding for their care. Mulligan (2010) and Donald (2001) also challenge the neoliberal, actuarial assumptions behind managed care which, they assert, forces psychiatric professionals in the US into an algorithmically, not subjectively, driven model of care focused on performing tasks of quality measurement.

Emphasis on risk assessment and management is a significant barrier nurses perceive to achieving therapeutic care, sometimes to the extent that 'safety concerns determine the current model of acute inpatient care' (Cleary, 2003b, p. 143). The prioritisation of institutional order can be detrimental to the development of therapeutic relationships: 'the idea of "maintaining safety" in this study was related to keeping individuals quiet and limiting any extreme emotional responses' (Taua & Farrow, 2009, p. 280). One study of a multidisciplinary group of professionals found that 'images of danger and difficulty (e.g. risk, unpredictability, impulsivity, unreliability, non-compliance) predominated' their thinking (Hazelton, 1999, p. 226). The requirement for nurses to use 'coercive power' reduces their ability to use 'persuasive or normative power' which is required for therapeutic interaction (Porter, 1993), while the rhetoric of personalised treatment may not be reflected in a reality in which standardised socialisation is used to keep order (Egelund & Becker

Jakobsen, 2009). A conceptual dichotomy between 'keeping order' and 'being therapeutic' is set up in all these accounts.

However, there is a contrasting school of thought which holds that far from being at odds with risk-focused activities, therapeutic interaction in fact constitutes one of the most powerful tools for risk assessment and management. Such a perspective relies on the 'assumption that the nurse-client relationship is the primary vehicle of care' (Spiers & Wood, 2010, p. 374); the notion of the patient 'feeling cared for' and understood is felt to be an important element of safety maintenance (Cox, Hayter, & Ruane, 2010; Tzeng et al., 2010). Other techniques which facilitate therapeutic care as well as safety enactment include facilitating recovery through nursing 'presence' (being with the patient) (Engqvist, Ferszt, & Nilsson, 2010); engaging in 'soothing' interaction to avoid escalating risk of aggression (Salzmann-Erikson et al., 2011); and treating the patient with respect even when personal judgement makes this difficult (Rose et al., 2011). The advantage to safety of building a therapeutic relationship is also related to the fact that a nurse can build up tacit knowledge about the patient's particular needs and sensitivities (Dougherty, Sque, & Crouch, 2012; Kelly et al., 2011). By knowing the patient well, they can carry out regular informal risk assessment and surveillance activities (Hamilton & Manias, 2007) which are more acceptable to the patient than 'distancing' activities such as formal observations (Ray, Perkins, & Meijer, 2011; Reade & Nourse, 2012).

Implicit in much of this latter work is a challenge to the received wisdom that nurses do not do enough therapeutic work but act rather as coercive agents of social control (which in itself was originally a critical view perpetuated by the anti-psychiatry movement in the 1960s – e.g. Szasz (2007)). The importance of 'hidden work' (Star & Strauss, 1999) – unarticulated, informal work – to patient safety is increasingly being exposed through such studies. The improvised strategies and tacit knowledge used by clinicians are not generally recognised in normative, error-focussed accounts of safety: 'the way that medication work is

conceptualised is constraining and covers over much of what actually happens in everyday nursing practice' (Folkmann & Rankin, 2010, p. 3218).

Such hidden work, particularly in terms of the effort to build relationships with patients, can nevertheless be a source of safety and of system resilience. The maintenance of clinical networks, for example, has been attributed to this relational labour more than to any particular body of knowledge or expertise (Hunter & West, 2010). Harnessing this resilience is one potential avenue for safety improvement. Resilience has been claimed to emerge from the 'orienting frames' developed and shared by nurses who work together (Hazlehurst & McMullen, 2007) and also from nurses' 'skilful anticipation' entailing 'active accurate consideration of the potential embedded in clinical situations' (Lyndon, 2010, p. 2). Such skills may enable nurses to recover potential errors by identifying, interrupting and correcting them (Henneman et al., 2006).

Nurses' safety work is in turn based on tacit skills which are intuitive and embodied, and not readily trained or measured, such as 'anticipating problems and emergencies and being prepared; careful watching, surveillance, and vigilance' (MacKinnon, 2011, p. 119). The invisibility of such work in the safety discourse which valorises a system perspective on care frustrates some, who criticise the 'discursively limiting frameworks of biomedical science, law, management and safety' (Folkmann & Rankin, 2010, p. 3218). For others, though, exposing hidden work serves to highlight 'what patient safety discourse reveals and conceals' (MacKinnon, 2012, p. 266). This type of work, when exposed, is portrayed as being as skilful and patient-centred as it is undervalued and perceived non-technical and mundane: 'the nurses in [this] study were well aware that what they actually did at work was not as professionally valued as 'therapy', was not taught in the classroom, nor articulated in nursing texts' (Deacon & Fairhurst, 2008, p. 339). Such 'micro-therapeutic activity' (Cleary et al., 2011) comprises an ongoing effort to informally but pragmatically respond to patient needs, and encompasses skills which enrich the relational environment of the

service such as consistent, fair and reliable interaction with patients and a calming, persuasive use of language to encourage safe behaviours (Desjarlais, 1996, p. 883).

The value nurses place on informal, relationship-based approaches to safety is reflected in two forms of frustration with dominant models of mental health care. The first is the conflict between different disciplinary understandings of the aetiology and appropriate treatment of mental illness, especially between the nursing and medical paradigms (Fortune & Fitzgerald, 2009; Skorpen et al., 2009). This conflict can lead to clinicians deliberately working at cross purposes to justify the 'professional project' (Salhani & Coulter, 2009). The second source of frustration emerges in tension between intuition-based and epidemiologically based models of risk assessment. Nurses have been seen to resist actuarial models of risk assessment in favour of 'professional intuition' (Godin, 2004) because these were perceived by them as 'too mechanical, behaviourally reductive and dehumanising' (p. 352), and likely to make patients 'prisoners of their pasts' (p. 356).

The goals of risk management requirements and treatment models that emphasise patient empowerment and autonomy create other dilemmas for nurses. 'Positive risk taking' has been seen to be a key component of recovery but the risk management construction of each patient as inherently a potential risk to be averted contradicts this (Robertson & Collinson, 2011). Nurses may negotiate this using 'protective empowering,' emphasising empowering, autonomy-fostering interventions with the patient as they improve (Chiovitti, 2011). This is difficult when professionals' 'usual way of working' requires 'interfering in the lives of people who do not welcome it' (Broer, Nieboer, & Bal, 2010, p. 391), and some have argued that too much emphasis on empowerment might compromise staff safety (Moylan & Cullinan, 2011).

The tension-riddled nature of nursing work as exposed in these ethnographies exposes the complexity and centrality of safety maintenance in mental health

settings, as well as its production through practices that are neglected by system-level discourse about patient safety. In the previous section, a positive conceptualisation of safety was silenced by its relegation to residual category; in the current section we have seen that it is twice silenced by its positioning in the devaluing rhetoric of 'hidden' nursing work. While these ethnographies have given us a peek into the black box of 'safety' as complex, dynamic, effortful process (not just an absence of harms) in mental health care, our view remains obstructed. What safety means in relation to community services or to non-nurse professionals remains unclear.

2.6.   Patient safety and the sociologist's lens

The methodological and theoretical tools offered by the disciplines of sociology and anthropology are gaining prominence in the study of patient safety as the field searches for new perspectives in response to the often disappointing impact of conventional approaches to improvement (Øvretveit, 2009; Vincent, 2009; Zuiderent-Jerak & Berg, 2010). As demonstrated by the studies of nursing work, tools such as ethnography give us the chance to observe how health care professionals situate safety in the context of their everyday work. Rather than sticking to assumptions about what *should be* done, we can see what *is* done. In the process, we may start to gather clues as to why so many safety improvement initiatives fail, why professionals do not always follow rules, whether policies help or hinder clinicians, and how safety imperatives interact with other cultural, organisational, clinical and historical imperatives in the swirl and flux of everyday work (Finn & Waring, 2006). In short, by looking at what professionals say and do not only when things go wrong but also during the vast majority of the time when ward life is more mundane than dramatic, we may start to tackle Dixon-Woods' (2010) question 'why is patient safety so hard?'

One of the first scholars to bring a sociological lens to bear on the study of medical error (Bosk, 1979) has more recently noted that the patient safety movement has largely ignored the benefits of such an approach in its haste to

adopt a systems perspective (Bosk, 2005). He advises a reorientation towards an engagement with how professionals construct the meanings they associate with error, and with the complexity, uncertainty and flux surrounding the locally situated practice of patient safety. It is the link between such practice-based understandings of safety and the more commonly promoted instrumentalist approaches which is missing, and in recent years, prominent figures in the patient safety movement have called for increased recognition of the complementary contribution such perspectives can make to the understanding of the causes and consequences of patient safety incidents (Runciman, Merry, & Walton, 2007, p. 145). Vincent (2009, p. 1777) sees a clear gap for such research to fill: 'the lack of attention to wider social and inter-personal issues may ... go some way to explain the slow progress and the extremely variable impact of interventions.' Dixon-Woods (2010, p. 25) further emphasises the need to unravel the multiplicity of safety-in-context, through insight into how:

> *... alternative conceptions of what is 'safe' or 'good practice' may prevail, conditioned by coping with competing priorities, clinical uncertainties, organizational pressures, resource inadequacies and efforts at professional boundary maintenance. ... Efforts to improve safety need to be designed to take account of the realities of practice and based on an understanding of the logics people are using to inform their practice.*

The rationale behind this argument is that social theory and the methods of qualitative research can uniquely be used to examine the context-bound nature of safety. Rather than being ignored or controlled for, social scientists would argue, such contextual factors as organisational structure, professional relationships and cultures, and the mechanisms of their effect on safety, should be teased out and examined because they are likely to have determining impacts on whether efforts to improve safety succeed or fail. As Abbott (1997, p. 1152) writes, 'nothing that ever occurs in the social world occurs 'net of other variables.' All social facts are located in contexts. So why bother to pretend that they aren't?'

Sociological perspectives on safety using qualitative methodologies have been used to complement the findings of quantitative analysis, to better reflect the complexity or subtlety of safety-related phenomena. Such perspectives can help 'illuminate the processes underlying statistical correlations, inform the development of interventions, and show how interventions work to produce observed outcomes' (Forman et al., 2008, p. 764). In addition, the multiplicity of local factors potentially influencing outcomes of organisation- or system-wide safety improvement initiatives make them difficult to evaluate using quantitative methods alone. Multi-method approaches are useful in such circumstances (Braithwaite et al., 2007), given that 'improvement programs may succeed or fail due to a range of technical and non-technical issues associated with local implementation factors' and their interaction with program elements (Benn et al., 2009, p. 1773).

Recognition of the role of cultural meanings and interpersonal factors in the production of safety and error is not new, but as Bosk (2005) argued, such phenomena have been largely ignored by the patient safety movement. Between the 1960s and the 1980s, there was a rush of book-length ethnographic portrayals of hospital life for doctors (Becker, 1961; Bosk, 1979; Millman, 1977; Paget, 1988), some of which included descriptions of safety behaviours by clinicians and cultural factors affecting these. Bosk (1979), in his seminal work *Forgive and Remember*, sub-titled 'managing medical failure', found a culturally embedded categorisation of acceptable and unacceptable error amongst surgeons. Whilst technical errors were generally seen as liable to happen to anyone, and as part of the job, the errors which were considered as 'failures' by senior surgeons were those which violated their normative framework of what a 'good surgeon' should be and do, such as always knowing the status of their patients. The study showed how young surgeons are socialised into the value systems of their professional superiors and how professional cultures come to structure the way they conceptualise safe practice to the virtual exclusion of other structural influences.

It is possible to understand, on this account, why a managerially imposed initiative may not have great impact in such a context.

Descriptions of clinicians' everyday experience of safety issues provide valuable evidence of the impact of professional and organisational cultures and structures on the perception and practice of patient safety. Culturally mediated safety beliefs are perpetuated in hospital settings through socialisation into professional cultures. For example, Millman's *Unkindest Cut* (1977), in which conflict between different groups of doctors, combined with their 'neutralisation of medical mistakes' – ignoring errors of doctor colleagues and justifying their own – produced less than optimal safety outcomes for patients. Paget (1988), in *The Unity of Mistakes*, uses interview data viewed through a phenomenological lens to reveal the 'complex sorrow of clinical work' which characterises the interviewed doctors' internal experience of making mistakes. These mistakes, Paget contends, are an inevitable part of life as a doctor, and she seeks to discover 'what clinical work is like and what it is like to be a person who does this kind of work, a person who is mistaken' (1988, p. 10).

The general trend in patient safety research has been to prioritise the articulation and improvement of structural and formal dimensions over social and affective dimensions (Bosk, 2005; Iedema, 2009). However, during recent years, there has been a resurgence of interest in articulating the latter. A 2009 issue of the journal *Social Science and Medicine* was devoted entirely to the potential (and some actual) contributions of social science research to our understanding of patient safety and how it might be improved (Hewett et al., 2009; Kerr, 2009; Waring, 2009). Although 'the role of ethnographic and qualitative research has been insufficiently developed in the patient safety context' (Vincent, 2009, p. 1778), the volume of such studies being published is now rising. The penetration of these conceptual tools and techniques into the 'mainstream' patient safety literature is illustrated by the fact that *BMJ Quality and Safety* carried an issue in 2011 with a series of articles examining the epistemologies of improvement in health care.

One paper examined the value of qualitative comparative case study research as part of quality and safety improvement:

> *... such methods also offer the opportunity to enrich more traditional approaches to assessing interventions, helping to explain why some interventions are unsuccessful, or why they seem to work effectively in some contexts but not in others. Efforts to improve patient safety and quality of care need to take into account the complexities of the systems in which these improvements are being introduced. Case study methods provide a robust means to guide implementation of effective practices.* (Baker, 2011, p. i34)

Several large-scale evaluations of national patient safety programs in the English NHS have included substantial qualitative components (Dixon-Woods, 2010; McDonald et al., 2005); a Europe-wide study of patient safety practice is proposed to do the same (Robert et al., 2011). Overall, as we have seen in this section, qualitative methodologies which are informed by the social theories of anthropology and sociology are gaining importance in the study of safety-in-context.

2.7.   Conclusion

In conclusion, this study will draw together and extend four domains of literature: research delineating iatrogenic harms in the mental health context; that revealing hidden harms and professionals' informal techniques of safety as part of everyday institutional practice; that using qualitative methods to examine patient safety-in-context; and finally, that which uses theoretical perspectives from science studies to study safety and risk.

In so doing, the study will not restrict its conceptualisation of iatrogenic harm to incidents and risk originating in the patient, but will be open to recognising the more hidden types of harm emanating from the structure and operation of mental health services more generally. Treating safety as more than a residue remaining when harm does not occur means that there will be a focus on the

informal strategies for, and the dynamics and specific contexts of, the production of safe care in practice rather than solely on the genesis of harm. Such a focus presents a challenge to the underlying assumption that safety can be 'fixed' through system interventions which can be standardised across those systems (Jensen, 2008). To strengthen this challenge, I will in the next chapter introduce some theoretical tools that will help identify the contents and operation of the patient safety 'black box'.

Chapter 3: Relational sociologies and patient safety

3.1. Introduction

Theoretical approaches are used in this study as 'sensitising concepts' that 'suggest directions along which to look' in empirical work and give 'a general sense of reference and guidance in approaching empirical instances' (Blumer, 1969, p. 148). For this research, these have been drawn from four strands of social theory. These perspectives are introduced in the order in which they were examined in preparation for designing the study. They were 'discovered' in this order mainly because each represents a development of certain aspects of the preceding approach, forming a sort of theoretical family tree. At the top of the tree is the broad church of social constructionism, followed by the family of approaches called 'practice theories', actor-network theory, and lastly, multiple ontologies.

These four perspectives share a view of social realities and phenomena as emerging from different forms of interaction, thereby emphasising the dynamics and processes of becoming. Social constructionism as an epistemological position is as much maligned as it is over-cited, having become associated with the relativist position in the 'culture wars' and diluted to the point of meaninglessness (Hacking, 1999). It is, however, used in a specific sense here to denote the privileging of the socially interactive nature of meaning-making and learning. Practice theorists, meanwhile, assert that social phenomena (such as safety) are emergent products of intra- and inter-practice relationships (Schatzki, 2003). The actor-network approach proposes ontological parity for people, materials and ideas, and sees actors and phenomena like safety as fragile 'assemblages' of these three (e.g. Latour, 2005); and multiple ontologies express the multiple 'realities' (and connections between them) of phenomena like safety as they are enacted into being, for different reasons, in different contexts (Mol, 2002). Each approach incorporates epistemological and ontological orientations

that privilege the shifting and situated status of objects and phenomena whose meanings and enactments are always anchored in everyday practices.

My intention in this chapter is to show that these four are tools to study 'safety-in-the-making', thereby offering a conceptual alternative to conventional views of 'safety-as-a-state' or property. They represent a relational approach, defined in opposition to a substantialist approach where the interest lies in studying static 'things' and their essences (including individuals, systems, and structures) as the source of social action (Emirbayer, 1997). Each of the four approaches will be introduced through empirical applications to illustrate why they were chosen as sensitising concepts in this study of patient safety.

3.2.   Social theory and patient safety

Methodological approaches such as ethnography are often imported to the study of patient safety without explicit exploration of the epistemological and ontological assumptions underpinning their use. This is partly because of the popularity of 'grounded theory' in nursing research, in which both the use of formal theoretical ideas to help devise one's research problem and the framing of data using explicit theoretical assumptions are eschewed in favour of building one's own theory out of the data (Glaser & Strauss, 1967). The attraction of such an approach is that the data can speak first, without the researcher overtly shaping the result and simply finding what they were looking for. The disadvantage is that researchers' prior assumptions, experiences, and ways of looking at the world remain unexamined. Using such an approach would appear to sit uneasily with the intent behind ethnography to elucidate what is meaningful to participants themselves (Emerson, Fretz, & Shaw, 1995). This chapter is intended to explicitly outline the theoretical perspectives that informed the design and conduct of the present study.

Some patient safety researchers have been criticised for the misappropriation of sociological theory in the drive to conceptualise safety as a system property and

to connect the fixing of system parts to the reduction of error (Jensen, 2008). The 'translation' of the work of relatively few social scientists (such as Perrow, 1984; Reason, 1990) into the evidence base behind this view of safety has resulted in a 'theoretical orthodoxy' dominating patient safety discourse (Waring et al., 2010). This orthodoxy infers the preventability of error that was not present in the authors' original work, and corrals social scientists into a role consisting of identifying 'contextual' causes of errors, thus remaining stuck within the orthodox framework (Jensen, 2008).

Proposals are however emerging for alternative roles for the sociologist and anthropologist. Vincent (2009) called on social scientists to be 'contributors [to], not just critics' of patient safety improvement efforts. However, there is a difficult balance to be achieved by social scientists who may wish to question the assumptions underlying conventional approaches to safety improvement whilst at the same time wanting to acknowledge the normative value of improvement work of itself (Zuiderent-Jerak & Berg, 2010, p. 334). Not remaining 'straitjacketed by the conventional meanings that we have been taught to associate with the object' (Crotty, 1998, p. 51) of patient safety may be the key to this dilemma. Social scientists can thereby expose the interests and assumptions embedded within widely promoted solutions to safety problems through 'nuanced analyses' (Jensen, 2008, p. 310) of their operation in practice, to help determine why they may have limited impact when dropped into complex clinical worlds. Such analyses can also contribute by offering clues about more productive approaches to improvement, such as the harnessing of existing informal strategies of work.

The methodological and theoretical tools of anthropology and sociology enable us to 'complexify the taken-for-granted conceptualisations' about what counts as safe (Zuiderent-Jerak et al., 2009, p. 1713), and to 'unpack how patient safety is done and which possibilities and problems this produces' (p. 1720). Using some of these tools in the present study allows me to heed Vincent's call to contribute by offering a nuanced picture of how safety is understood and accomplished in the

context of care. It is difficult to know how to improve safety if we do not know what it entails for those responsible for maintaining it. This knowledge can help in the design of improvement initiatives that chime with, and capitalise on, this experience.

3.3. Locally constructed meanings for safety and risk

The first theoretical 'sensitising concept' is broadly 'social constructionism,' and more specifically, the notion that the meanings of safety and risk are locally negotiated and constructed in interaction between professionals, and between professionals and other stakeholders in health care. Lack of safety is often portrayed as a 'fixed', non-human property of the system (Zuiderent-Jerak & Berg 2010, p. 326). In contrast, the use of the social constructionist perspective:

> *... challenge[s] the conceptualisation of (workplace) safety as a disembodied, tangible, and easily quantifiable phenomenon; [instead] the meaning of safety is viewed as situated, negotiated, generated, and transplanted in the historical, socio-material, and cultural contexts in which interaction occurs.* (Turner & Gray, 2009, p. 1260)

In this view, it becomes problematic to roll out an improvement intervention across an entire health system (or even an entire hospital) because one intervention cannot suit all contexts (Brown et al., 2008). It is therefore a priority to examine how different contextually-bound factors interact, during the course of daily work, to produce particular understandings and enactments of safety.

Sociologists of safety argue that perceptions of behaviour or things as 'safe' or 'dangerous' are constructed through socially embedded interpretations, because we often cannot judge objective danger or safety from simple observation of our environment (Simpson, 1996). If we adopt a strong constructionist position, we could assert that there is no such thing as an objectively risky object, situation, action or person (Lupton, 1999). Indeed, we can go further to argue that not only risks, but also hazards are mediated by power relations, interests, and culturally

specific assumptions: 'what is counted as evidence to support the assessment is relative and culturally contingent' (Fox, 1999, p. 19). The reasons behind the identification of particular things as risky may be related to the perceived transgression of social norms (Douglas, 2002; Douglas & Wildavsky, 1983), and the implication is that within one organisation, multiple understandings of safe practice may coexist. For example, a dissonance between managerial and medical understandings of how safety breaches occur and how risk should best be managed, may mean that some managerially imposed safety improvement initiatives are simply 'lost in translation' (Currie et al., 2009; Waring & Currie, 2009).

Introducing automation or other technical and managerial 'improvements' without consideration of social and cultural factors can therefore have detrimental effects on the continuous and 'less explicitly observable' processes which drive the practical accomplishment of safety (Rochlin, 1999, p. 1556). Collective and individual agencies are implicated in these processes and may be ignored by initiatives that work with abstract system level ideas of safety. Understanding how to effectively improve safety entails studying these hidden agencies and processes of safety construction:

> *To the extent that regulators, system designers, and analysts continue to focus their attention on the avoidance of error and the control of risk, and to seek objective and positivistic indicators of performance, safety becomes marginalized as a residual property. This not only neglects the importance of expressed and perceived safety as a constitutive property of safe operation, but may actually interfere with the means and processes by which it is created and maintained.* (Rochlin, 1999, p. 1558)

We have seen in the previous chapter an example of selective construction of certain events and people as risky, where patient acts of violence are prioritised in terms of efforts at risk management above the iatrogenic potential of admission to the mental health ward (Busfield, 2004). The 'risk object' is the patient, not the system, environment or technology (Warner, 2006). Rationalities

of risk emerge from the intersection of pluralistic frames of reference, sociocultural context, local history and geography, resulting in a construction of certain things as worthy of risk management and others as not (Capelli, 2011).

Local constructions of risk and safety assume importance as the basis of strategies for coping with risk in situations where 'probabilities are fairly unknown' and where 'rational choice strategies have limited utility' (Boholm, 2003, p. 168). Such situations often obtain in mental health care, where there are multiple intersecting uncertainties related to aetiology, diagnosis, and effective treatment. In such cases, to be effective, safety strategies build on what is locally accepted as 'true, valid, customary and normal' as 'unprejudiced … assessments of decision alternatives' are impossible (Boholm, 2003, p. 168).

However, such strategies are not traditionally part of risk assessment activity, which has become ubiquitous amidst the 'moral outrage' surrounding incidents in the community involving mental health patients (Szmukler & Rose, 2013). This is premised on a realist conception of risk which holds that risk inheres to certain behaviours, objects, people or situations, and is amenable to objective measurement (Bradbury, 1989). A scientific 'linguistic imperialism' (Hayes, 1992) dominates, in which an impression of 'objective' probability emerges, dispensing with the need to consider other factors affecting risk construction. The causal relationship between risk and outcome is, in this discourse, assumed to be equally applicable across space and time.

> *Probability … now lies at the basis of all reasonable choice made by officials. No public decision, no risk analysis, no environmental impact, no military strategy can be conducted without decision theory couched in terms of probabilities. By covering opinion with a veneer of objectivity, we replace judgement by computation.* (Hacking, 1990, p. 4)

Such a move divorces safety from context. However, says Dekker (2011, p. 13), people (including health care workers) make decisions based on locally rational pragmatics: 'what matters for them is that the decision (mostly) works in their

situation. What matters is whether the situation still looks doable, that they are getting out of it what they want, and that their decisions are achieving their goals as far as they understand.' The notion of a locally legitimate conceptualisation of safety and risk emerges from work on social construction of safety, and this exposes some of the problems with standardised approaches to safety improvement.

3.3.1. *Professional socialisation into local notions of safety and risk*

To Err is Human promoted a 'no blame culture' in health care, but the ubiquity of the concept has led to concerns about where this leaves professional accountability (Walton, 2004). The notion of a 'just culture' where blameworthy acts are differentiated from blameless acts (Dekker, 2007; Wachter & Pronovost, 2009) has emerged in response to this dilemma. When safety is seen as a system property, and agency is pushed into the background, we risk losing sight of the informal mechanisms of accountability and blame that operate (regardless of exhortations for 'no-blame') at the local level (Hor, 2011).

Professional socialisation is one such local mechanism by which notions of safe practice are reproduced. Studies of how professionals deal with the uncertainties surrounding their practice show that they collectively devise frameworks which outline accepted relationships between risk taking, mistakes, and blame (Becker, 1961; Light, 1972; Millman, 1977; Paget, 1988). Such a framework is maintained by the selective attribution or evading of blame (Bosk, 1979), by assessing some rule violations as acceptable and some not (Smith et al., 2006), and by seeing some mistakes as worthy of censure and others as worthy of cover-up (Millman, 1977). This process is tied up with the need to protect the legitimacy of the profession's unique project. Blame is therefore hard to erase, and is integral to professionals' own accounting for and making sense of incidents (Benson et al., 2003). A no-blame culture, in this analysis, would require the disruption of historical patterns of professional socialisation and strategies for coping with uncertainty.

The quest to overcome what Paget (1988) has called the 'inevitability' of uncertainty and mistakes in medicine – notably acknowledged in the theory of 'normal accidents' (Perrow, 1984) – is also evident in the now routine practice of root cause analysis (RCA), which aims to identify a discrete cause for an adverse event. Such a move is symptomatic of the difficulty within regulatory systems of living with uncertainty: 'if there is no seed, if the bramble of cause, agency and procedure do not issue forth from a fault nucleus ... the world ... is a more disordered and dangerous place ... and we hold that nightmare at bay as best we can' (Galison (2000), in Pinkus (2001, p. 130)). Such attempts to overcome uncertainty could be seen as an extension of the culture of medical training in which trainees are encouraged not to display equivocation of judgement and 'learn to ignore the existence of uncertainty altogether' (Gabe, Bury, & Elston, 2004, p. 102). However, Paget's notion of the inevitability of uncertainty is upheld when the standardised root cause analysis RCA process is dropped into a local context and cannot overcome the complexity, politics, or desire for blame already circulating there:

> ... issues of blame still permeate these processes, with RCA being used as a technique to rationally and legitimately allocate responsibility to particular organizational groups ... RCAs are beleaguered by the cultural difference, inter-occupational politics and organizational pressures that often undermine forms of service improvement. (Nicolini, Waring, & Mengis, 2011, p. 39)

Social learning – the interactive construction of meanings with colleagues – is important in knowing how to do a job safely. Studies of social learning about safety in workplaces show that deciding how to act (in a safe way) is more about balancing individual and collective interests (in line with peer expectation) than about rational cost-benefit analysis (Baarts, 2009), and may be seen as part of 'cultural competence' in a particular setting (Gherardi & Nicolini, 2002). Learning how to be competent in safety is not a matter of book learning; it happens only through collective enactment and adjustment in practice:

... learning is no longer conceived of as an individual phenomenon, but as one that involves the whole community. It is not a separate activity as much as the way in which we take part in the power/knowledge games which constitute our social fabric. Learning is the primary way to engage with others in an ongoing practice and it also enables actors to modify their relations to others while contributing to the shared activity. (Gherardi & Nicolini, 2002, p. 195)

These authors link the particular version of safety into which newcomers to a building site are socialised to a contingent combination of circumstances (organisational and industry culture, laws, policies and regulations), history of that site, and individual factors. They argue that their findings about how safety is learnt go some way to explaining why traditional efforts to improve and regulate safety, such as awareness raising and inspections, flounder, because they 'fail to recognise the cultural and 'personal' nature of the safety competence' (p. 215).

That the meaning of safety is locally and collectively constructed is further borne out by work which highlights the importance of renegotiating the meaning of safe care in order reassert professional legitimacy and avoid culpability in the face of apparent failure. Light (1972) illustrates how 'professional talk' is used to this end by psychiatrists involved in investigating the suicide of a patient under their care. When the discussion turned to whether a mistake has been made, 'the clues are sufficiently obscure or ambiguous that the staff can assure itself that *no reasonable mistake was made'* (p. 827, original emphasis). Professional talk is used to 'recast the original stark event into professional standards and terms' (p. 826) usually based around a belief that 'suicide is ultimately impulsive and thus not usually within reach of the therapist ... [and yet] *the patient is responsible for his actions and life'* (pp. 828-829, original emphasis). In other words, no amount of safe practice could have prevented the suicide, and the official review becomes 'a ritual designed to reaffirm the profession's worth after a deviant act has cast doubt upon it' (p. 835).

In a similar example, senior psychiatric nurses were seen to establish their power and superiority in relation to their juniors by excluding the latter from discussions about safety. They also devalued or ignored up-to-date 'book learned' or 'evidence-based' information in favour of experience- and anecdote-based knowledge. This persisted despite some evidence of detrimental effects on patient safety (Buus, 2008).

The relationship of organisational culture(s) to safety is, then, rendered complex by the multiplicity of professional and other sub-cultures circulating within an organisation (and the power dynamics between these), which affect the ways in which different groups see safety and the appropriate ways to achieve it. Instrumental versions of culture are promoted by the patient safety movement, in the hope that fostering a 'safety culture' will lead to reduced incident rates (Silbey, 2009). This culture is generally viewed as a monolithic, consistent compound of attitudinal and behavioural 'norms' forming a backdrop for the main health care action (Gherardi, Nicolini, & Odella, 1998). Such a view of culture is implicitly challenged by the literature we have examined so far, and explicitly challenged by some critical sociologists who question in particular the elision of power dynamics and conflict in such accounts (Antonsen, 2009). Powerful individuals with vested interests can influence the development of others' understandings of risk and safety (Tierney, 1999). The role of medical power in particular in shaping the construction of patient safety in policy and improvement initiatives remains under-examined (Ocloo, 2010). Discourse surrounding safety culture as a mechanism for improvement, in short, ignores 'normative heterogeneity and conflict, inequalities in power and authority, and competing sets of legitimate interests within organisations' (Silbey, 2009, p. 241). It is a focus on everyday practices within these organisations that enables us to observe the coming together of such heterogeneities in the enactment of patient safety.

3.4. Safety in practice

The theoretical lens of social constructionism highlights the interactively produced, locally situated nature of conceptualisations of safety, risk, and legitimate blame. At the same time, this perspective helps expose weaknesses in some of the central tropes of the patient safety discourse, including safety as monolithic concept, safety as system property, and the non-reflexive use of safety culture (including no-blame culture) as a tool for improvement. In this section, I will explore other theories which can help us emphasise the relational, interactive nature of how what counts as safe care is enacted in practice.

The collection of approaches offered by theorists who have taken the turn towards a focus on everyday practice highlights the multiplicity of the construction and enactment of safe practice. Looking at patient safety using a practice framework enables us to question and find alternatives to existing approaches in several ways. Foremost among these is that this perspective allows us to foreground what is kept hidden when discrete adverse events are the focus: '... practice constitutes the unspoken and scarcely notable background of everyday life. Practices therefore always need to be drawn to the fore, made visible and turned into an epistemic object in order to enter discourse' (Nicolini, 2009, p. 1392). Secondly, the focus on practice allows us to escape the structure-agency dilemma. We are neither forced into privileging the impact of structures on safety (where, for example, professionals are left as passive cultural 'dopes' obediently following guidelines), nor the exercise of individual agency (which to greater or lesser degree deny the reality of outside influences on professional decisions and behaviour). In this view, it is only in practice that structures – such as social institutions and policies – are instantiated and observable (Giddens, 1984).

By observing practice over time, therefore, we can tease out the everyday interweaving of tacitly held and culturally acquired assumptions and formally sanctioned, codified policies and procedures; 'whether, how, and how much

official communities, official practices, and formal organisations in fact define the working nexus of living, culturally productive social practice' (Lave, 2008, p. 289). The discourse, activity and materiality of practice can reveal for us a nexus of influences, agencies and imperatives, which shine a light on the operations inside the safety black box. Practice approaches give purchase on 'micro-causal questions such as *why* – that is, through whose agency and enabled and constrained by which social structures – did the phenomenon in question emerge?' (Greenhalgh & Stones, 2010, p. 1288)

3.4.1. *The assumptions behind practice theories*

The theoretical turn to practice is reflected in several fields of study, including philosophy, sociology, and anthropology, amongst theorists active since the late 1970s and early 1980s (Ortner, 1984). Although the study of what people do and say in everyday life is nothing new, the practice turn is retrospectively seen as an attempt to theorise a response to a problem that has beset all three disciplines, namely the seeming contradiction between our idea (and lived sense) of free will or agency, and the arrangement of our society and culture into various groups which seem to limit individual desires and actions (Barnes, 2001, p. 342). At its heart, this so-called 'structure and agency' dilemma is a question about the nature of the relationship between humans and social institutions: do we make them, or do they make us?

Practice theorists seek to overcome the duality of this argument. Rather than oscillating between privileging the ways that humans shape society (e.g. rational choice theory in economics) and the ways that 'the social' shapes human behaviour (e.g. Durkheim's (1982) notion of the coercive force of 'social facts'), they argue that agencies and structures mutually constitute each other in ever-unfolding practice, which is therefore the always-emergent 'site of the social' (Giddens, 1984; Schatzki, 2003).

Wittgenstein's (1968)work on rule following was an early example of this move (Reckwitz, 2002; Rouse, 2006). He argued that rules in and of themselves cannot account for their application, and that the established ways of using rules are more important in governing behaviour. Prior to this work, the operation of rules was considered a classic case of theory (structures) determining practice, but Wittgenstein argued that rule following is really a participation in an institutional practice and that the continued existence of the rule is entirely dependent on its instantiation in practice (Bloor, 2001). Both Wittgenstein and Heidegger (1962) were novel in decentring mind and meaning created by mind in order to focus on the unfolding of practices in time (Nicolini, 2009). Prominent anthropologists and sociologists have since adopted a practice-focussed approach (one of Bourdieu's primary texts is the *Outline of the Theory of Practice* (1977)) although this was sometimes expressed in different terms such as structuration theory (Giddens, 1984) and ethnomethodology (Garfinkel, 1967). They were all, however, united by their reaction against both 'societist' approaches like structural-functionalism as well as methodological individualism (Schatzki, 2003).

Although many practice theorists eschew the idea of lumping their perspectives together as a 'grand narrative' since the complexity of practice would be effaced by such a move (Nicolini, 2009, p. 1413), some shared assumptions can be identified. First, empirical work is considered central and prior to theorising. It is oriented around articulating the dynamic processes of work (i.e. organising) rather than descriptions of abstract entities (i.e. organisations) (Czarniawska, 2004). Second, as mentioned, practice is seen as 'socially and historically constituted and as reconstituted by human agency and social action' (Kemmis & McTaggart, 2005, p. 576).

The third assumption is that practices are not just what people do, but are complex assemblages incorporating material, moral, and human dimensions which make up the social field (Schatzki, Knorr-Cetina, & Von Savigny, 2001, p. 3) and within which there are internal contradictions and tensions (Nicolini 2009,

p. 1393). Fourth, knowledge about 'how to go on' is unarticulated (Schatzki, Knorr-Cetina, & Von Savigny, 2001, p. 8) but embodied and created by interactions in practice. Fifth, since 'macro-social phenomena' (such as 'the economy' or 'safe care') only exist as they are instantiated in practice, they cannot be *sui generis* forms existing outside of practice (Reckwitz, 2002). It follows that all social phenomena are situated and context-bound to particular times and places.

3.4.2. *Applications of the practice approach*

Practice-based approaches have been used to shed light on the real-time operation of some of the social processes conventionally assumed to be important to patient safety, such as organisational learning and rule following. This work exposes a disjunction between the rules or beliefs according to which clinicians carry out their everyday work, and the rules, procedures and guidelines that policy makers and managers expect them to follow (Iedema et al., 2006). In response to this, some scholars recommend the fostering of 'bottom-up' mechanisms for change, such as naturally occurring groups and networks of professionals who, through their own initiative and a shared passion, get together to try to improve things:

> *Clinicians, like other professionals, work best when they … are empowered rather than directed, and nurtured and influenced by their peers rather than controlled by others. They are likely to become more involved in promoting safer and better care if invited rather than compelled, and should be encouraged to solve naturally occurring problems in voluntary collaborations with their fellow clinicians.* (Braithwaite, Runciman, & Merry, 2009, pp. 40-41)

Similarly, studies of how professionals learn through interaction illustrate why imposed 'organisational learning' initiatives may not have the desired effect. Such initiatives are often based on an assumption that if the information (about safe practice or learning from incidents) is collected and is accessible, and if there is active management of the process of learning, change will occur (Department of

Health, 2000, p. 74). Such active management is also the basis of incident reporting systems but it is at odds with the ways people learn and use knowledge in practice:

... future efforts at promoting learning and quality improvement should seriously reconsider ... the appropriateness of top-down managerial fixes and seek out 'alternative' methods of learning; reinforcing the significance of 'situated learning' ... [because] professional groups produce strong social and cognitive boundaries that provide a cultural and institutional framework within which clinical performance is interpreted and enacted at a local level. (Waring & Currie, 2009, p. 775)

When viewed in the context of practice, managerially imposed learning initiatives like incident reporting systems effect a translation of processes characterised by complexity and uncertainty into 'manage-able', bounded incidents.

Such initiatives may also fail as they engender a perception of attempted managerial encroachment on professional autonomy. For example, a study of surgeons at work found that they carry out their tasks and make decisions according to judgements tailored to each patient (and largely based on individual experience), making standardised guidelines seem irrelevant to their work (McDonald et al., 2005). Recommended safety practices such as the reporting of mistakes so that others can learn from them appear equally irrelevant as these surgeons saw many of their errors as consequences of factors particular to them, such as family concerns. Tacit socio-cultural norms, rather than explicit knowledge in the form of guidelines, appeared to be the dominant drivers of behaviour.

Reinforcing this point, the phenomenon of violations or workarounds (which may be practices going directly against formal rules) are analysed by some scholars as being essential to clinicians' ability to be agile in response to changing circumstances and to timely (and safe) care (Debono et al., 2012). A decision to commit a violation may emanate from perceived low risk of breaking the rule,

perception of own expertise and experience, resignation to 'inevitable risk', or simple desire to get the job done in the time available (Iszatt-White, 2007). Violations among anaesthetists are associated with factors to do with the rule itself (credibility, ownership, and medico-legal consequences of violating the rule); the anaesthetist (risk perception, experience, and desire to comply with the profession's notion of the 'competent anaesthetist') and organisational or situational factors (such as time and resources) (Phipps et al., 2010; Phipps et al., 2008).

All of this exposes difficulties in attempting to improve safety by implementing rules and guidelines, or ensuring that clinicians know all the rules and guidelines. The mess of everyday practice is often exposed during an inquiry into an incident or disaster, but is presented as an aberration; close study of practice reveals this messiness rather to be the normal state of things. There is a 'huge contradiction between the neat and tidy public image, and the messier reality which routinely confronts practitioners on the inside of the technological system' (Wynne, 1988, p. 150). Professionals in fact deal with a range of competing interests, ambiguities, uncertainties, and unforeseen circumstances which force them into ad-hoc rule-making as their activities unfold, leading them further away from formal rules which seem to have less and less to do with local needs. Such local rationalities echo Vaughan's findings of 'normalised deviance' inside NASA prior to the Challenger disaster (Vaughan, 1996).

The implication for patient safety is significant. Wynne (1988) argues that pressure to develop sets of rules promoting the myth of an internally ordered system is driven by public demand for a completely risk-free technology or service. As the myth is perpetuated, disjunction with everyday practice grows, and the possibility of acknowledging uncertainties inherent in the operation of the technology disappears from view. Also effaced is the potential to examine the nature and usefulness of workers' strategies for coping with uncertainty. There is a similar public pressure in relation to patient safety, and we can see parallels

with Wynne's work in the belief that implementation of more formal rules and guidelines will help improve safety. The production of local rules and ad-hoc improvisations during everyday practice thereby remain unexamined. As long as improvement initiatives attempt to create order, the opportunity to engage with and learn from professionals' encounters with disorder is lost.

3.5. Actor-networks and the socio-material achievement of patient safety

There are, however, emerging examples of the ethnographic use of practice theories which examine the usually hidden local productions of safe health care and expose both the inevitability of mess and uncertainty as well as how safety emerges in such difficult circumstances. In this section, some of this empirical work will be explored in detail, namely Jerak-Zuiderent (2012), Nicolini (2009), Mesman (2009), Brodwin (2010), and Mol (2002). Their interest is in how health care *works* on a daily basis, rather than on how it breaks down.

Observing general practitioners (GPs) at work, Jerak-Zuiderent (2012) challenges the idea that to understand patient safety we should focus on errors, and argues that such a move in fact produces danger if translated into practice. The GPs had devised a number of informal strategies to get their job done while allowing room in their practice for uncertainty, rather than attempting to eliminate it. For example, as they operate at the broad end of the diagnostic funnel, their most efficient option is to assume that the problems being presented are the most common ones, and then to be open to any subsequent information which they may hear, see, or sense. In a continuous stream of knowing and acting, links are made during and after interaction with the patient, to see if anything more serious emerges. A considerable amount of ongoing uncertainty is therefore involved, especially where a physically localisable cause cannot be detected. The GPs used a further heuristic for dealing with uncertainty when triaging out-of-hours phone calls. Although aware they might not identify some apparently less urgent patients who were actually dangerously ill, they also realised that if they

prioritised eliminating error above all else, they would not get to treating the cases they correctly recognised as urgent in a timely way. A focus on error would not have been safe or practical.

Jerak-Zuiderent (2012) argues that 'treating errors as a problem that needs to be eliminated is but one possible mode of ensuring patient safety' (p. 733), and not a very good one since it is impossible to ignore the uncertainty inherent in medical work. In addition, the improvised effort to maintain safety does not simply involve applying preformed 'knowledge' to 'action', but entails the constant interweaving of situated knowledge and action, each of which constitute and alter the other as practice unfolds. The role of uncertainty and situated knowledge in clinical realities is not acknowledged by the patient safety movement, says Jerak-Zuiderent, in which 'provision of safety [is] warranted by more certain knowledge and produced through actions adhering to safety norms and standards' (p. 746).

Nicolini (2009) and Mesman (2009), draw on an actor-network approach. Both privilege a relational perspective on 'good care', seeing it as an emergent product of contingent connections between things, people, and ideas. Actor-network theory (ANT) is an extension of practice-oriented relational sociology, and includes non-humans and concepts with people in the assortment of entities which, rather than possessing an unchanging 'essence', derive their (shifting) meaning and role from their relations with others. Primacy is given to:

> *... the enactment of materially and discursively heterogeneous relations that produce and reshuffle all kinds of actors including objects, subjects, human beings, machines, animals, 'nature,' ideas, organisations, inequalities, scale and sizes, and geographical arrangements.* (Law, 2009a, p. 141)

The advantage of this approach to safety research is its methodological insistence on doggedly following associations between these actors (Latour, 2005), allowing articulation of an anatomy of particular achievements of safety, in all their human, material and temporal multiplicity.

Nicolini (2009) traces associations between practices in the accomplishment of a cardiac telemonitoring service. He describes switching between theoretical approaches to study different aspects of practice, such as the discourse, materials, or objectives of the practice. Nicolini's ethnographic study of telemonitoring is described as 'zooming in and zooming out' with these lenses to understand both the 'conditions of the local accomplishment of practice and the ways in which practices are associated into broad textures to form the landscape of our daily (organisational) life' (p. 1392). Thus, intra- and inter-practice configurations are articulated, from the use of a telephone by an individual nurse, to the historically embedded policy imperatives which have driven national development of telemonitoring. Nicolini physically follows the practices from one location to another, seeing them as linked together in network-type formation (they 'extend rhizomatically') so that each practice is a nexus of other practices: 'practice is always a node, a knot and a conglomerate of many types of material and human agencies that have to be patiently untangled' (p. 1407). The interest is in how practices, through associations within and between them, produce phenomena such as 'safe care'. Patient untangling of practices, through observing their everyday conduct, becomes a way to get at how safety is first conceptualised and then accomplished. The 'safe service', in this view, 'boil[s] down to a complex texture of doings and sayings, places, and objects which can all be observed proximally' (p. 1411).

While Nicolini used ANT ideas to trace connections between practices which were often highly temporally and spatially distributed, Mesman (2009) instead explores in close detail one instance of the achievement of sterility in a neonatal intensive care unit. Like Jerak-Zuiderent (2012), she is in interested in the production of safety, not of error. She states that 'not only what is missing, the so-called gaps in the safety net, but also the fibre of the safety net itself, the elements that constitute the fabric of 'normal' practice, should be taken into consideration when we aim to strengthen what is already strong to preserve and improve patient safety' (p. 1706). In the practice of sterile cannula insertion,

safety both produces and is enabled by particular spatial ordering of people, equipment and cleaning materials in a ritualistic way, which in turn dictates the temporal ordering of clinicians' attention to different aspects of the procedure. While space creates sterility, sterility imperatives also create spaces, such as the air-lock at the entrance to the ward. Safety therefore emerges at the intersection of temporal, spatial, material and human orderings. We can see here the situated nature of safety, embedded in a flow of practice, never already there.

3.5.1. *Assemblages*

Medication adherence is considered important to patient safety in mental health care. Brodwin (2010) showed how its achievement is situated in a complex of socio-material practice, which he calls an 'assemblage'. Attending to the elements assembling together to enact this practice, he argued that to understand how adherence happens, it is necessary to examine both the 'front-line clinicians who literally hand pharmaceuticals to their clients as well as the distant regimes of power and knowledge that shape such observable negotiations' (p. 130). Like Nicolini, Brodwin's interest is in the way both local and more 'global' contingencies come together to enact a service.

One way in which this happens is through the 'medication cassette' (a box divided into days of the week, containing a patient's medications) which is analysed as a 'technology of compliance' (p. 137). It brings the 'global' ideology of biological psychiatry into local enactments of safety, because 'the call to comply … pre-exists and constrains any social interaction, and it operates through mundane artefacts' (p. 137). The cassette extends the psychiatrist's authority (and that of biological models of mental illness) into the work routines of non-specialist case managers and further into the patient's life.

The idea of assemblage has been elaborated as part of ANT (Latour, 2005), and also as part of the attempt by Delanda (2006) to develop a metaphysics of social life which takes account of its complexity and unpredictability. It represents a

distillation of several aspects of relational sociology, including attention to how social phenomena come together in a situated way through practice and through relations between people, things and ideas. I will make more use of the assemblage idea in Chapter 8 (Discussion) to unpack safety as it was enacted in my study sites, using it to denote a contingent and temporary constellation of interests, knowledge, actions, rationales, materials and bodies, which through their relationships enact safe care at a particular moment in a particular place. The advantages of seeing safety in these terms are that it allows us to foreground the embeddedness of every enactment of safe care in socio-material practices, and also allows for the possibility of multiple such enactments. In addition, it becomes possible to trace the connections between practices at 'macro' and 'micro' levels, as Brodwin discovered: 'the ethnographic analysis of compliance tacks back and forth between clinicians' point of view and a more distanced gaze on the broad landscape of psychiatric case management ...' (Brodwin, 2010, p. 133). These studies have been related in detail because they give important insight into how actor-network approaches can help us see inside our black box of safety, to view it while under construction.

The studies support the argument that staff members are a resource for safety creation because of their ability to introduce flexibility and improvisation in complex circumstances. This flexibility is required for safe care to continue even as objects break, environments are sub-optimal, and rules insensitive to context.

3.5.2. *Multiple ontologies*

One further theoretical tool, the idea of multiple ontologies, is the final theoretical inspiration for the current study. This is a development of the basic premises of ANT to take account of difference, contradiction and uncertainty in the practice of health care. The main thrust of this work is that any object, whether physical or abstract, is enacted into being within multiple practices. Because of the highly situated nature of each enactment, we cannot say that this is a singular object, but that it has multiple realities.

The most developed empirical example of these ideas is a book-length ethnography by Mol (2002) of the multiple enactments of the disease atherosclerosis (hardening of the arteries) within a single hospital. The different practices enacting the different atheroscleroses include laboratory examination of the disease as pathologic entity through a microscope, and discussions between doctor and patient in terms of the patient's inability to walk to the shop. These are not just different perspectives on the same phenomenon, argues Mol, but rather multiple enactments, pulling together different constellations of things, people and ideas, thereby producing *different realities* of atherosclerosis in which its different aspects are variously 'foregrounded or forgotten' (p. 31). For instance, the constellation still hangs together as atherosclerosis in the case of the pathologic entity on the slide when the patient is absent or even dead; however, a living, present patient is necessary for enactment of the second example of atherosclerosis.

In the discussion chapter, I will further develop the idea of multiple ontologies, and explore its implications in relation to my own findings. Before beginning fieldwork, these theoretical developments sensitised me to the possibility that multiple safeties are performed through and embedded in the everyday practices of mental health care. If we can tease out which safeties are privileged in which practices, and in which times and places, we will have gone a long way to understanding the meaning(s) of 'safe care' in the mental health service.

3.6.   Conclusion

If one examines any category, or any classification scheme, and looks at its genesis, it is clear that a category is something like a treaty or a cover of some sort that hides the messier version of what is inside. The old saying that one does not want to understand how either law or sausage comes to be made stands as well for categories. One implication is that the category is a desiccated form of a complex narrative. That is, it is a conclusion, wrapper, or label that points back to a long, contingent story. (Star & Bowker, 2007, p. 273)

Like sausages and laws, the genesis of the concept 'patient safety' – and its enactment in practice – has long been obscured by its own black box. Exposing the complex narratives surrounding safety, rather than bracketing them off in favour of examining error, or hiding them amongst the 'work that nurses do', is a prerequisite for understanding the dynamics of safety improvement. The present black boxing of patient safety enables construction of a 'master narrative' about how safety can be improved, but unfortunately:

> ... *master narratives cannot describe the struggles to live in and with "the sting of the miscellaneous and uncoordinated plurals" (Dewey). Often, these master narratives describe only those processes that are rational, male, European/North American, objective, and reducible to formulae. They have no tools for the wilderness of residual categories ... however ... locally coherent situations are also made invisible by the very postmodernism which criticises the master narrative – made invisible when it describes these processes of meaning-making as only irrational, fractured, without coherence.* (Star & Bowker, 2007, p. 278)

It is these multiple 'locally coherent situations', in which certain notions of safety (but not others) make sense and are rational in that time and that place, and in which contingent assemblages of people, things and ideas come together to enact safety-in-the-making, that this study seeks to articulate. Exposing the assemblages and multiplicity of safety is one way to engage with the messy and neglected realities dwelling within the patient safety black box.

Chapter 4: Ethnography design, conduct and analysis

4.1. Introduction

> *These are the traces of things we learn to seek through rational and 'academic'*
> *paths, but in fact they cannot be separated from chance, from fortuitous encounters,*
> *from a kind of knowing astonishment. (De Certeau (n.d.), cited in* (Terdiman, 2001,
> p. 400)

The purpose of this chapter is to tell the story of the study: the 'rational and academic paths' it set out to take, as well as the 'chance' events, 'fortuitous encounters,' and perhaps above all my own (often not so knowing) astonishment at what I was privileged to witness once I started down these paths. It contains some elements of what Van Maanen (2011) termed a 'confessional' genre in his classification of ways of relating 'tales of the field', in that it focuses on the 'explication of how fieldwork is accomplished' (p. 67). Mostly, however, it is an attempt to grapple with the idea that in this type of research, 'the specificity and individuality of the observer are ever present and must therefore be acknowledged, explored and put to creative use' (Okely, 1996, p. 28).

The chapter is structured into three sections, following the course of the 'natural history' of the project (Silverman, 2009, p. 334). The first section (4.2) begins in accord with the ethnographic tradition of the 'arrival story' (Davies, 1999, p. 216) and then moves back in time to an account (4.3) of the personal, professional, theoretical and methodological foundations of the study and the conceptual framework and research design which grew out of them. The third section (4.4) narrates the experience of choosing and gaining access to a field site; getting to know the participants and the patterns of life in the setting; some of the ethical and practical difficulties which emerged during fieldwork; and how the research design played out in practice. The chapter concludes (4.5) with an account of the reflexive process of 'making sense' out of the data, and how I arrived at a formal

analysis which combined the imposition of theoretically derived organising principles with an inductive, 'ground-up' logic.

The narrative approach I have taken to relate this natural history is intended to reflect my experience of fieldwork itself. It was a research apprenticeship apparently organised into a logical progression (thanks to flow charts and tables) but often punctuated by surprises, diversions, hasty adjustments, and unpredictability. The chapter forms a patchwork of perspectives, with the neat and tidy language of the research protocol interspersed with more informal accounts of my encounters with the improvisations, twists and turns of everyday ethnography.

4.2.   Arrival story

I spent a summer and an autumn trekking back and forth to the hospital to carry out my fieldwork. Three lemon scented gum trees stood by the back gate, along the path leading to the mental health unit. Stronger in the sun and more muted in the rain, their smell always soothed my rising nervousness as I prepared myself to be 'the researcher' for another day.

The first day, just before Christmas 2010, I approached the main entrance hot from the walk along the congested road from the train station. The buildings were faded but modern, built in the last twenty years, I supposed; I stopped to study a map of the site. Parts of the mental health service and the methadone clinic were on the edges of the main hospital buildings. The invisibility of mental health issues played out in spatial arrangements as usual, I thought, grumpily. 'It's always portacabins in car parks,' a former work colleague had said to me once, voicing a variation on the common characterisation of mental health as the 'Cinderella service'.

Entering the hospital, a light and bright atrium area was filled with tables and chairs servicing the two cafes facing onto it, with windows looking onto landscaped gardens on the opposite side. Happy at the thought that 'proper

coffee' must surely be available from at least one of the shops, I looked around for directions to the mental health service. I remembered Caitlin (not her real name), the operations manager, had said something on the phone about steps going down to it, but the only stairs I could see had no labelling attached. In the spirit of the intrepid ethnographer (already I was constructing my identity as such), I decided to go down there anyway, and came across a long corridor with the gardens on one side and a blank wall on the other. At last, a sign: medical records? No. Catering? No. Community mental health? These seemed like an unlikely assortment of neighbours (again my Cinderella anger surfaced – back office functions, and mental health?) but I headed down the corridor towards a waiting room on the right, which announced itself as the 'community mental health service.'

A woman behind a desk, which in its turn was behind a desk-to-ceiling glass panel, eyed me disinterestedly. I went up to the desk, feeling I needed to immediately make it clear who I had come to meet and that I wasn't a patient. (I was ashamed of this last reaction to arriving in the setting and it was something I would reflect on, behind my university ID badge, throughout my time there.) She looked at me through the narrow gap in the glass, listened, wrote my name down in a book on the desk, and told me to take a seat, waving vaguely at the chairs behind me. Two women were the room's sole occupants, and I chose a seat facing away from the reception desk, back towards the entrance.

As I sat down, I realised that this was the moment, if there *was* a single moment, that I first became an ethnographer. Remembering my 'how to do ethnography' reading (Davies, 1999; Emerson, Fretz, & Shaw, 1995; Hammersley & Atkinson, 2007) and the emphasis therein on scene-setting and not forgetting to document what you see as well as what you hear, I diligently took out my new notebook. First impressions are so important! You will never see this place with fresher eyes than today! You need to make the strange familiar *and* make the familiar strange (Garfinkel, 1967)! I paused. How should I write? What should I choose to write

about? What sort of ethnographer could I be? I sat for five minutes pondering these questions, staring intermittently at the blank page and up at the barely audible edition of *Oprah* playing out uselessly on a small screen suspended from the ceiling.

Finally I started, self-consciously, to make notes. Once I began, I was surprised by the ease with which I filled first one, then two, then three pages with jottings about the waiting room. This wasn't so bad, but I did wonder to myself who would ever want to read my intricate descriptions of the wilting pot plant (complete with ageing Christmas baubles) and the self-help leaflets which had been stuffed into a display stand (which, I earnestly noted, had clearly been designed for different sized publications). I supposed that thinking someone would read the results of my labours was presumptuous for a first-day ethnographer, so decided that in the interests of writing something, nothing was too boring to write down.

So it was that my freshly minted researcher's eyes noticed that at the entrance to the waiting room from the rest of the hospital, the hard, easy-to-clean flooring gave way to dark blue carpet; the clinical white of the walls transformed into pastel green; and the handrail – ubiquitous along hospital walls – disappeared altogether. This 'noticing things' and wondering about their import (was this environmental change an early indication of unique safety concerns in mental health care?) was proving very tiring, and I had only been doing it for ten minutes. How would I get through the three hundred hours of noticing and writing that I had planned for myself? I was relieved when a lady, I guessed in her fifties, wearing an extremely bright and flowery dress, bright shoes, and bright pink lipstick, bustled up to me, apologising for her lateness. She introduced herself as Caitlin, and led me to a door off the waiting room which she opened with a swipe card hanging, together with a mobile phone, from a lanyard round her neck.

We had come into an office area. Immediately, Caitlin was accosted by a staff member asking about some late pay. Another, a young woman, passed by and Caitlin asked her whether she would be attending the 'presentation' to be held now in the meeting room. Looking confused, this woman said she didn't know anything about it. I felt personally affronted. Silently, I tried to calm myself down. What?! How could she not know about it?! I was meant to present my research to all the staff here! Had it simply slipped someone's mind to tell people? I had been preparing for this moment for eighteen months! How could the place be so oblivious?

As we reached the meeting room, the community team was just finishing the weekly clinical meeting. Several people escaped through the door as we were coming in. To the rest, who were in the middle of extricating themselves from the tight gap between wall and table to make their exit, Caitlin said sharply 'we have a presentation, you have to stay!' Looking resigned to another half hour without lunch, they sank back into their chairs. My heart sank too. I wanted to run out and go home. Ethnographers obviously needed a thicker skin than I possessed. But Caitlin was busy introducing me, and I quickly took out the information sheets I had prepared. There were only five people left to listen, but as I started talking, some of them looked vaguely interested, and I gained the confidence to continue. I explained my broad topic of interest (safety and risk), my method (ethnography), and what my presence would mean for them. They laughed when I said that in the early years of ethnography, anthropologists had used the approach to study what they considered to be 'exotic' peoples in far-flung corners of the globe. Caitlin would repeat this to several people later in the day, and everyone who heard it made some comment about 'well that's us!'

The part of the presentation I had been most worried about was the explanation of what my observations would involve – listening in on their conversations and meetings, shadowing volunteers, and sitting in their team office. I was concerned that they would object to this invasion of their working lives. But this didn't seem

to occur to them. I wondered whether they simply felt they had to accept it because Caitlin (their ultimate boss) was sitting there. However, one of the nurses got straight down to practical matters: 'where are you going to sit?' mentioning a spare desk, and another laughingly asked 'can you take a case load?' Someone else mentioned that there is a 'business meeting that deals with OH&S [occupational health and safety] issues.' This wouldn't be the last time that my 'safety' topic was interpreted in this way, and I reminded myself to note down how people first reacted when I told them I was looking at 'risk and safety'.

My first day of fieldwork represented the first few in a long line of incidents that taught me two things about being a field researcher. Firstly, that this type of research can never be conducted exactly as planned. Life will always get in the way, and introduce unpredictable twists and turns. Secondly, that the importance of a researcher's work, at least in busy clinical settings, lies only slightly above keeping the waiting room pot plant watered: essentially peripheral to the politics and practice of seeing patients, keeping in with the boss, and getting everything written up by the end of the shift. The first day certainly had not been what I had imagined, and in many ways had been a bit of a mess. But I was, I told myself, on my way to becoming an ethnographer, and my notebook was no longer a blank reflection of my inexperience.

4.3.   Preparing for the field

4.3.1. *Personal and professional origins*

> *[When choosing a topic for research] ... determine what you care about independent of social science [...]. Such concerns can be born of current or remote biography ... without a foundation in personal sentiment all the rest easily becomes so much ritualistic, hollow cant.* (Lofland et al., 1984, pp. 7-8)

Mental health and illness had always fascinated and frustrated me, as had the responses of health services to it. Depression as a teenager led me to seek refuge in self-help books, academic psychology books, philosophy books, looking for the

source of this problem. Book after book piled up in the corner of my room, cast aside in frustration at the proliferation of theories but dearth of 'solutions.' My encounters with health services were sometimes helpful, sometimes not. I came to realise that the effectiveness of the help seemed to depend entirely on how well I got on with the person trying to help. I found mostly caring and wonderful professionals who helped lift me out of difficulty, but a couple made me feel humiliated, disempowered, and worse than before. Although I did not realise it at the time, in retrospect, feeling drawn to researching patient safety in mental health services came from a need to understand what lay behind these divergent experiences of care.

As an undergraduate, the study of Japanese understandings and treatments of mental illness challenged my previous assumptions about the universality of a biomedical model of mental illness. I began to see psychiatry as a peculiarly Western cultural construction, only possible because of the post-enlightenment valorisation of individualism and body/mind dualism. In Japan, unencumbered by Descartes' legacy, what we might label 'mental illness' was commonly expressed through somatic complaints.

Later, my Masters' degree was taught primarily by two men who were both psychiatrists and anthropologists, and their seminars and tutorials full of anecdotes about their clinical practice. In clinic, they discussed one patient's *jinn* with the same ease that they discussed another's hallucinations, operating expertly among these and many other culturally embedded registers of distress. At that time, cognitive behavioural therapy (CBT) was (and still is) the

psychological therapy of choice in the NHS, hailed by an economist as panacea to those expensive thousands with mild to moderate depression or anxiety[1].

With my newly culturally aware eyes, I examined CBT critically for evidence of Western cultural assumptions. On the basis of my knowledge of Japan at least, may render the therapy ineffective (or just irrelevant) for people of non-white-British backgrounds.

A subsequent job entailed visiting new or planned mental health units in order to set up a network, which brought architects, facilities managers, infrastructure planners, and NHS personnel together. Being shown around these shiny facilities, people always seemed keen to point out the 'anti-ligature door handles' and 'collapsible curtain rails'. They also instructed me in the relationship between brightly coloured furnishings and patient anger or violent behaviour, and the calming effect of pastel blue paint. The benefits of sensory gardens, availability of non-denominational spiritual space, and exercise equipment were all explained. The delicate balance between creating a homely, welcoming feel and 'not wanting them to stay too long' was discussed at length. A more general conflict between ensuring a therapeutic milieu for inpatients and managing risk emerged from this work.

I later worked with the England & Wales Department of Health on a workbook for service managers looking to invest in new facilities. It was all about designing and embedding a new model of care and patient-centred culture, before designing the facilities around this philosophy (National Institute for Mental Health in England & Care Services Improvement Partnership, 2008). Too often,

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[1] This came from a report written by Lord Richard Layard (London School of Economics, 2006) analysing the cost-benefit arguments for increasing access to treatment for those with mild-moderate depression and anxiety.

the Department felt, new buildings were expensive window dressing for old, unhealthy cultures. So, culture and mental health seemed to keep colliding in my life, and the impact of institutional cultures – as well as the hospital environment – on the quality and safety of care was something I wanted to explore further.

4.3.2. Arriving at research questions

My 'job description' as a new PhD student stated that I was meant to be studying communities of practice, and constructing a questionnaire for health care staff to form part of my research team's evaluation framework for the effectiveness of such mechanisms for improving health care. I was struck by how the notion of communities of practice had been appropriated as a management tool. The original concept, developed by Lave and Wenger (1991) and Wenger (1999), was derived principally from fieldwork undertaken by anthropologist Lave among various types of apprentices in developed and developing countries, and an ethnography of medical claims processors later conducted by Wenger. It was a term which encapsulated a complex of human tendencies to learn through doing together – situated learning. The community of practice, they argued, was a way to describe the social processes of learning that go on among groups of people who share a practice, whether they are members of a yoga class or work together in an office. This theory of learning was positioned against the formalised model of classroom-based book learning divorced from everyday practice.

However, nowadays, in the business and latterly the health care literature (Ranmuthugala et al., 2011), we find the notion of setting up and fostering 'a community of practice' within an organisation being promoted as a knowledge management tool, to help managers capture and harvest intellectual capital possessed by their workers. Wenger himself, it would seem, drove this trend by writing managerial self-help-style books and papers with titles like *Cultivating Communities of Practice* (Wenger, McDermott, & Snyder, 2002). The term no longer described an emergent process but signified an entity that could be put in place by managers to improve their organisation's bottom line. Whether they

were ever successful at doing this was part of the reason for my project team's existence (Braithwaite et al., 2009).

This conceptual about-face seemed symptomatic of the health service's efforts to improve quality and safety: implement a managerial 'initiative' – often borrowed from business (such as 'lean thinking' or 'organisational learning') – across multiple organisations, and wait for the benefits to accrue. Most often they didn't – principally because no one waited long enough before implementing another initiative (Braithwaite, Westbrook, & Iedema, 2005; Garside, 2004; Health Foundation, 2012). Much change fatigue among staff at the 'sharp end' of health care organisations appears to come from a lack of buy-in to top-down, imposed initiatives. In this context, Lave and Wenger's (1991) approach of studying a community of apprentice tailors as they went about their daily work, to develop an understanding of how it was they learnt their trade, is more appropriate. Such ground work would seem to be an essential starting point for anyone who saw it as necessary to in some way help the tailors become more efficient, or happier, or more innovative. Perhaps the tailors themselves might have some ideas about how this could be done.

So it was that my project morphed from questionnaire to ethnography, and from 'communities of practice' to just 'practice'. I was still interested in how people learnt appropriate versions of safety in a particular place, but also in how these notions of appropriate safety came about, how they changed and were negotiated, and how they were sustained through the practices which accomplished them. Early in my PhD, therefore, I was already moving away from looking at situated learning by itself to conceptualising it as one part of 'situated safety'.

4.3.3. *Conceptual framework and research questions*

A conceptual framework gradually emerged from this process, heavily informed by my reading on practice theory and acting as a basis for the design of my

fieldwork and research questions. I attached the hand-drawn diagram of the framework (Figure 1) to the wall above my desk, and it remained there as a reminder of the way I wanted to investigate patient safety – as it was enacted, encoded and embodied in the mental health setting and in the practices of its staff.

The items within the circles were ideas about the potential influences on how safety was conceptualised and achieved which I wanted to look out for during fieldwork. The concentric circles represented my interest in the relationship between the safety imperatives of the immediate clinical situation and imperatives emanating from decisions made and discourses forged far away in time and space. Using this model I hoped to be able to articulate what I thought of as an 'anatomy of patient safety' – the combination of people, ideas and ideologies, and material circumstances which coalesced to enable or inhibit the achievement of safe care. The diagram also contains the seeds of the eventual research design as I noted down ways I could try to capture the encoding, embodiment and enactment of safety.

All of this shaped the research questions which guided the study:

1. How are mental health professionals' concepts of safety and risk constructed?

    What is the nature of these understandings?
    How do clinicians legitimise and sustain them?

2. How do these professionals accomplish safe care through everyday practice?

    What different safety imperatives drive how care is delivered?

    What human, material, ideological, historical and institutional elements coalesce to produce safe care?

Figure 1: Initial conceptual framework
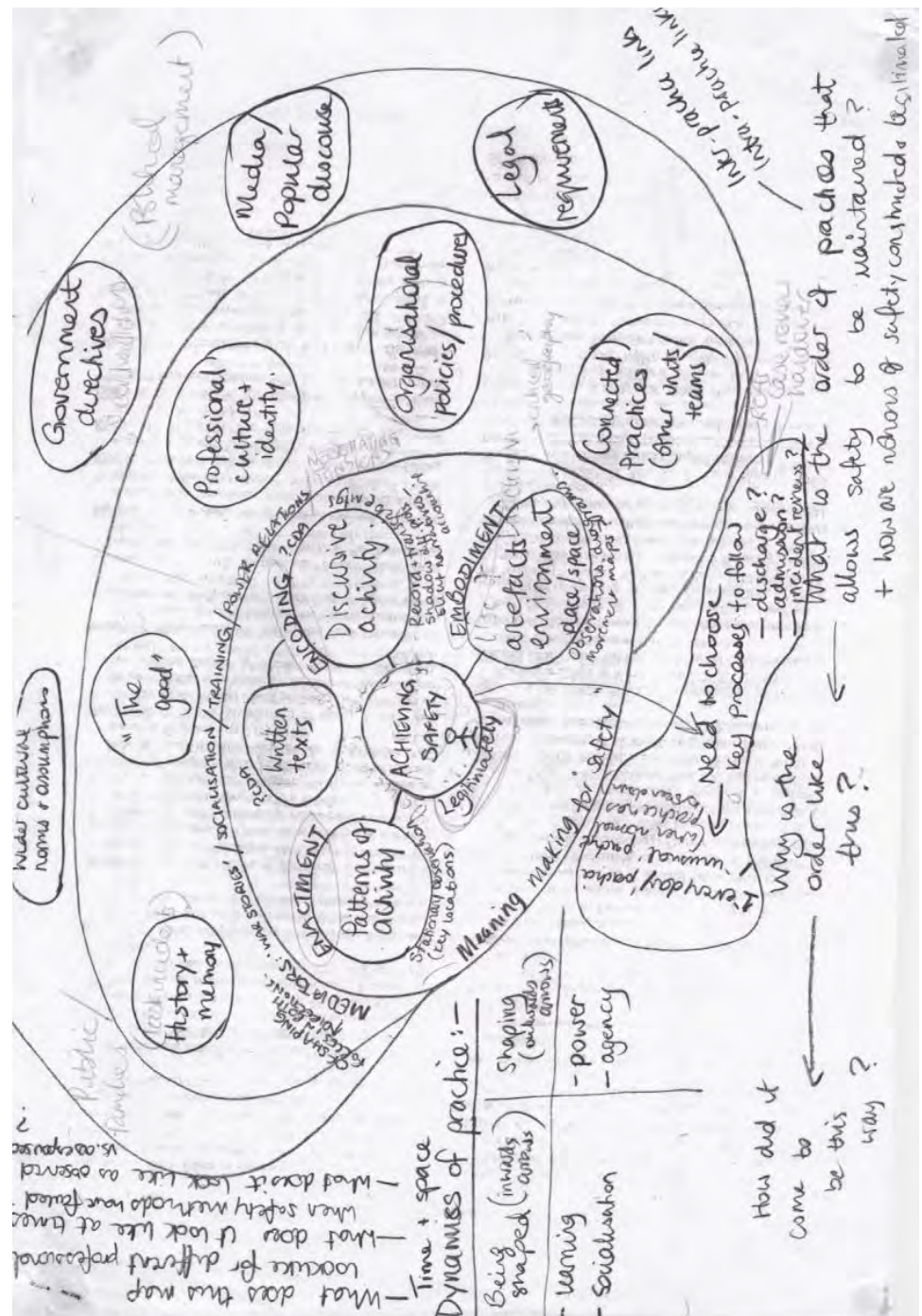
4.3.4. Designing the study

I knew what I wanted to investigate, something of the theoretical lens I wanted to use to do so, and that I wanted to use ethnography. How to 'use ethnography' though? As far as I could tell from much that I had read, traditionally,

ethnographers set out armed with their general question – often, like me, to describe some phenomenon as it operated in a social group – and a willingness to immerse themselves in the life of that group. As a result, research 'design' is supposed to evolve as the project progresses, informed by ongoing observations rather than being imposed on the world under study from the start (Fetterman, 1998; Hammersley & Atkinson, 2007).

However, in the world of health services research, at least, acquiring research funding and ethics approval requires provision of detail about how the research will be conducted before it can begin. For my study, a six-phase research design (Figure 2) was my response to these requirements, along with an associated fieldwork guide (Table 2). It was possible to retain some elements of flexibility, however, which will be explained in section 4.4 in relation to how the research design played out in practice.

The inspirations for this research design were drawn both from the empirical studies detailed in the previous chapter which used practice theories as the basis for ethnographic work, and also from writing about practice of ethnography itself. In terms of this latter body of work, the most memorable phrase I read, and one which would stay with me throughout the project, was that ethnographers could be 'data omnivores' (Lecompte & Schensul, 1999, p. 18), collecting a range of 'evidence' about their settings of interest using any appropriate method – decoupling 'ethnography' from its conventional exclusive association with 'participant observation'. I was also impressed by Atkinson, Delamont & Housley's (2008) call for ethnographers to pay systematic attention to multiple layers of cultural life in a setting, displaying a 'principled respect for the multiplicity of cultural forms ... rather than collapsing them into an undifferentiated plenum' (p. 824). These layers were narratives, visual representations, 'discourse and spoken action', 'material assemblages and technologies', and 'places and spaces'.

The research design was a conscious effort to include methods which would enable exposure of these different elements. This approach accorded with many of the previously detailed ethnographies based on practice and actor-network thinking. Nicolini (2009), for example, studied telemonitoring by following the people, artefacts and documents associated with a particular practice. He attended meetings on the subject, visited other sites of the practice, observed nurses telephoning patients to do the monitoring, and analysed the charts they used to keep track of the remote monitoring process. He was able to assess the micro-, meso- and macro-level factors influencing and being influenced by the practice of telemedicine. It struck me that this approach could be usefully employed with safety, rather than telemedicine, at its locus.

In a similar way, Czarniawska (2004) wrote about tracing connections between actions, not just between actors. In a book specifically on conducting ethnography in modern institutions, the same author (2007) emphasised the need for innovative ethnographic techniques to study organising as it happens. In particular, she recommended shadowing people as they go about their work, as well as shadowing key 'objects' as they circulate in an organisation. I wanted to design a study which allowed me to engage in some of these aspects of mobile organisational ethnography advocated by Nicolini and Czarniawska whilst taking account of Atkinson and Delamont's layered approach.

This resulted in a broad three stage approach to my study which I described in my notes at the time as follows:

> *Ethnographic design to gain a holistic picture of how safety is accomplished through discourse, activity, and use of tools and the environment ... should proceed through 1) exploratory investigation – observations 2) selective investigation of targeted topics – interviews and structured observation and 3) triangulation – seeing how widespread the observed assumptions/behaviours are through surveys or SNA [social network analysis].*

I developed these ideas into a framework (effectively a fieldwork guide) which would allow me to pay attention to the multiple forms of cultural life whilst not losing the imperative to follow people, things and practices through the everyday work of two mental health teams. The six phased study was the result, a design to be repeated in both settings. I will now explain the rationale behind each phase – and how each was to 'ideally' be conducted; how each phase actually turned out in practice will be explained in section 4.4 of this chapter.

Figure 2: Study process
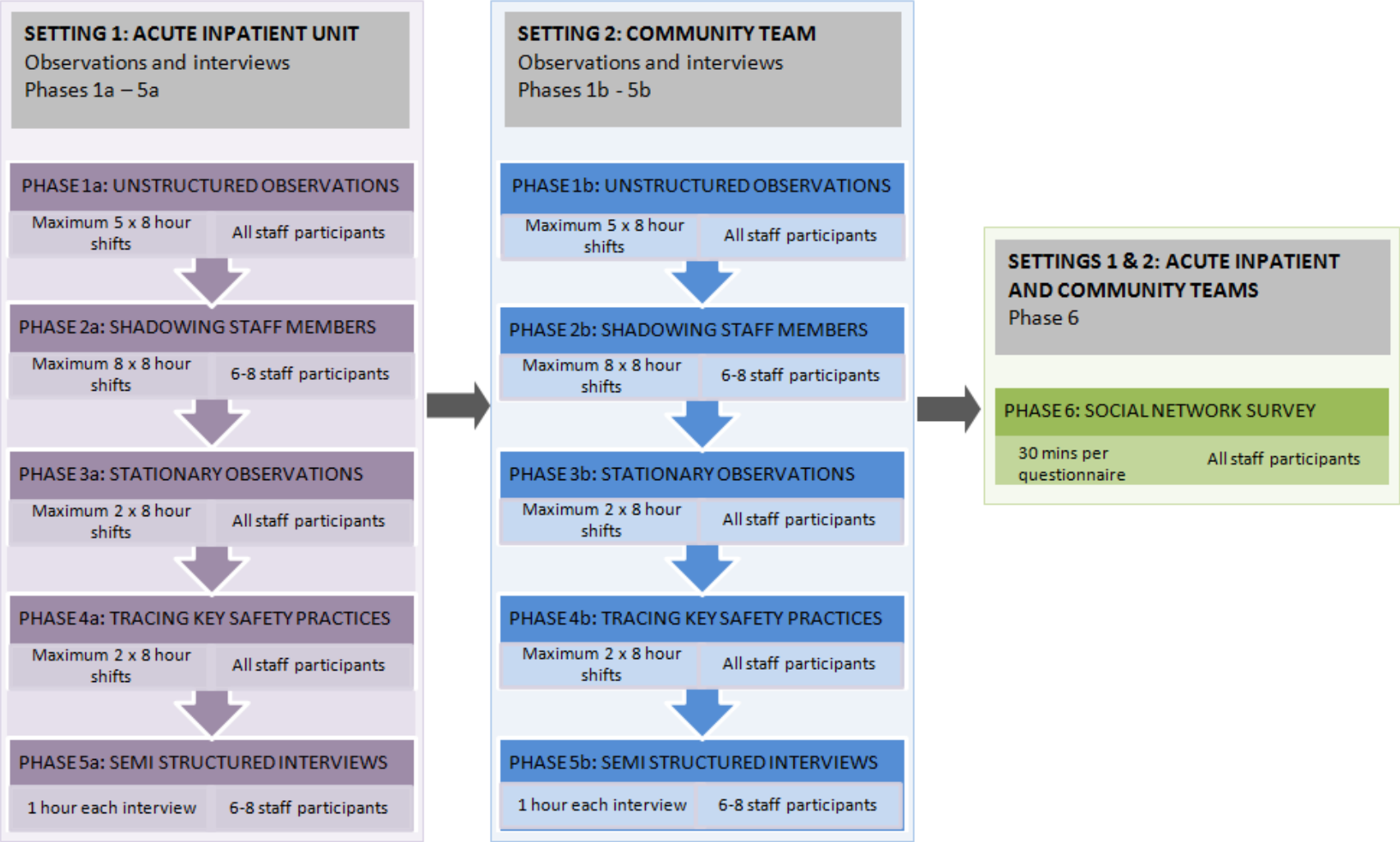
Table 2: Fieldwork guide

PHASE	ACTIVITY	PURPOSE	LOGISTICS	PARTICIPANTS	OUTPUTS
1. Max. 5 x 8 hour shifts	Initial unstructured observations	• Familiarisation with space and use of space • Familiarisation with timetable/ rhythm of setting • Starting to build relationships and trust • Determine who is amenable to shadowing • Identify key locations for stationary observations • Identify key policy/ guideline documents	• Background observation of activity (potentially accompanying key initial contact in the setting) • Introductions with staff members • 5 shifts on different days of the week (over 2 weeks) (=max 40 hours)	All staff	• Map of settings • Timetable of key regular events • List of 6-8 key informants • Collected documents for later analysis (e.g. policies, guidelines) • Fieldnotes
2. Max. 8 x 8 hour shifts	Shadowing staff members	• Observe mechanics of interactional construction of safe practice • Observe interactions newcomers/old-timers • Observe use of tools/artefacts/environment • Identifying key practices to follow in later stage	• Shadow each staff member for 1 shift/part shift • Audio recording of key meetings attended by staff member • Field notes re informal talk (corridor/staff room) • Field interviews	Ideally, 2 doctors 2 nurses 2 psychologist /OT/SW 2 managers	• Map of practices of each key informant – how they construe patient safety and how they go about trying to maintain it • Fieldnotes • Transcriptions of meetings
3. Max. 2 x 8 hour shifts	Stationary observations in key locations	• Observe role of key artefacts in constitution of safety (e.g. phone in nurse's station; filing cabinet etc). • Observe patterns of movement of staff	• 2 locations, 1 shift each (max. 16 hours)	All staff	• Fieldnote account of how artefacts play a role in the constitution of safety • Actor-artefact network map
4. Max. 4 x 8 hour shifts	Tracing key practices	• Observe the unfolding of specific practices previously identified as key to preservation of safety • Observe differences in activity when practice is in the course of the everyday (e.g. admission/ discharge) and, if appropriate, when it follows breakdown in order (e.g. incident review)	• 1 'everyday' practice over the course of 2 shifts (e.g. activity surrounding discharges) • If appropriate, 1 practice dealing with deviation from the normal (i.e. when safe practice has broken down in some way)	Staff involved in particular practices chosen.	• Map of 'practice nets' involved in practices key to preservation of safety • How practice nets change when normal order changes
5. Approx. 1 hr per interview	Interviews	• Elicit narrative accounts of safety preservation • Observe how the meaning of safety is constructed by different professionals – what 'rules and resources' do they draw on? • Test emerging findings / maps of practices	• 6-8 interviews – audio recordings	The 6-8 key informants from phase 2	• Transcripts for analysis
6. Approx. 30 mins per survey	Social network survey	• Provide triangulation of observation and interview data • Map overall patterns of communication about safety issues within and between the two settings under study	• Administer a social network questionnaire to all staff in the inpatient team and community team under study.	All staff	• Social network diagrams providing visual representation of patterns of safety communication

4.3.5. *Methods and their rationales*

Observation phases

Not being a clinician or covert researcher, my positioning as observer was always going to be as a non-participant, in a 'peripheral-member-researcher' role (Adler & Adler, 1987, p. 36). This role involved maintaining the identity of 'researcher' and conducting largely unobtrusive observations, but participating in interactions with professionals and helping with non-clinical tasks such as making coffee or setting up a room for an activity.

The main aim of ethnographic observations is to build up a picture of the cultural and social system under study through extended researcher exposure to a setting and the building of a relationship of trust with participants (Hammersley & Atkinson, 2007). Observation of what people actually do provides a useful comparison to data acquired through methods which only capture what people say they do (such as interviews). It does not rely on participants' memories, and goes some way to overcoming the problem of people describing their jobs in an abstract way that is 'expected' of them (Bryman, 2012, pp. 493-494).

Spradley (1979) described the process of ethnographic observation as a funnel, in that initial observations are relatively unfocussed, designed to 'get a feel for the setting' and to begin to build rapport with its members. So, the **unstructured observations of Phase 1** formed a period of reconnaissance, getting to know life in the setting so that people, places and practices could be selected for focus in later phases of observation. Documents would also be collected at this stage for later analysis.

Phase 2 was designed to enable the **shadowing** of participants, as suggested by Czarniawska (2007), with a variety of professional backgrounds and roles in the two teams – between six and eight people per team. This involves constantly watching an individual for a previously agreed period of time, following them around, listening to their conversations, and so on. It is an especially useful

technique to gain an insight into the everyday working lives of different professionals and how they interact with other professionals and with the environment to achieve their tasks over time. Depending on the role, seniority, and experience in the setting of the person being shadowed, this was also an opportunity to observe inter-professional communication, power dynamics and the socialisation of newcomers into the setting and its 'norms' of safe practice.

Because of ethics restrictions which will be explained in section 4.4.6, I planned to shadow the participants as they carried out their work with the exception of one-on-one treatment sessions. It was envisaged that each informant would be shadowed for a maximum of eight hours, whether one entire shift or spread over several shifts as circumstances allowed.

Phase 3, stationary observations, entailed observing two locations for a total of eight hours each. The purpose of stationary observations was to listen to informal conversations in places where staff gather together, to view patterns of staff movement, use of space, and the role of key artefacts. Such approaches can emphasise the 'interdependency of the human and the material' (Engeström & Blackler, 2005, p. 310).

Phase 4 was to focus on **following practices**. It was hoped that by this stage, earlier observations would have revealed the practices or activities which were perceived by the participants as most important to the achievement of safe care. Two practices specifically related to safety were to be followed for a maximum of one shift (eight hours) each. This would enable the mapping of factors contributing to, shaping, and being shaped by, the practices under study, providing a detailed picture of how safety is enacted. The artefacts, people, tasks and discourses employed in accomplishing the practice were to be noted.

Interviews

The interview is used in ethnography for two principal reasons: to gain information about the topic of interest, and to garner samples of participants'

discourse and narrative which can be used to study how people construe and construct their reality, how they order their experience and the resources they use to make meaning (Hammersley & Atkinson, 2007). In addition, the interview phase was intended to check participants' reactions to emerging findings from the observational phases. Such 'member checking' is a recognised way of validating findings but can also stimulate further discussion in an attempt to uncover more about how participants understand their world (Seale, 1999).

The term 'key informant' is used in ethnographic research to refer to those participants with whom the researcher interacts most and 'who have a disproportionate weight and role in the conduct and outcome of the research' (Bloor & Wood, 2006). In this study, the key informants were those who participated in the shadowing phase of observations, and the same people were also the interview subjects for Phase 5. The format and content of the interviews was to be determined by the observations made in earlier phases, in an effort to ensure firstly that that I employed the language and concepts used by participants rather than the concepts of social science (Spradley, 1979), and secondly to ensure in-depth exploration of participants' views on issues or events which had emerged as important during observations.

Social network analysis

To complement the observational fieldwork and interviews, I planned to conduct a social network analysis (SNA) of all participants in the two teams under study. SNA involves the mapping of ties or relationships between members of a selected group of people and the analysis of the structure of the network (Hawe, Webster, & Shiell, 2004). The idea of SNA is to show how social structure impacts on behaviour or other variables of interest. In the context of this study, SNA would be used partly as a triangulation device to help compensate for some of the limitations of observation techniques (where the researcher can only see and record a small sub-set of interactions) and enable an overall picture of relations on the ward or team to be built (Seale, 1999).

It was intended that mapping connections within and between different settings would help shed light on important safety issues which affect the quality of patient care, such as continuity of care between settings and discharge practice. I was also interested in how organisational and professional structures and cultures help or hinder learning and practice around patient safety. Close examination of interaction on issues of patient safety might reveal how structural factors can constrain or enable practitioners' efforts to avoid problems and incidents and learn from them when they do occur. At the design stage, it was intended that the questionnaire would ask staff members who they interact with on issues of safety, how frequently, and the nature of the interactions.

4.4.   Into the field

4.4.1. Gaining access

Six months prior to that first day at the hospital, my supervisor took me to see a psychiatrist he knew to help us find an 'in' to a research setting. It was the start of a repeated rhetorical effort at progressively lower rungs of the health service hierarchy to persuade and convince. First, we had to convince him that the study was worth doing it itself. We succeeded, and we were referred on to his colleague, the director of a mental health service. The next task was to persuade this director that doing the study in her service would not create any problems. My principal tactics were to bring along a copy of the research design (Figure 2 and Table 2), which brought some tangibility to the exercise; an assurance of the preservation of anonymity, for service and participants; and emphasis on the unobtrusive nature of the observations. She agreed to talk about the study to the managers and chief psychiatrist of one of the services in her area.

She justified her suggestion of one particular service by emphasising that it was 'well integrated' and a 'good' service. Having my research site not just chosen for me, but chosen by one of the powerful gatekeepers of that site, struck me as problematic (Seale, 2012, p. 252). However, I reasoned that accessing another site

may well take months of further ground work. In any case, the health system and the ethics approval process is structured such that these gatekeepers must always approve the site chosen, so the same problem may well occur in another place; I had read that ethnographers were more often beggars than choosers (Fine & Shulman, 2009, p. 179). A phone conference took place a month later with the same director, plus the director of the local mental health service she had suggested, and the chief psychiatrist. All seemed happy with the research design and unperturbed by my proposed presence observing the everyday work of the service.

4.4.2. Broad policy context

Mental illness is the leading cause of non-fatal burden of disease in Australia (Begg et al., 2007), and 45 percent of Australians are estimated to develop a mental illness during their lifetime (Australian Bureau of Statistics, 2008). Australian mental health care, like that in many other nations, has undergone a rapid de-institutionalisation process since the second half of the 20th century. Patients who previously would have been admitted as long-term patients in asylums now (in theory) live independently in the community, or in some cases in sheltered accommodation. The reality is that many of these patients live on a carousel where they are cared for as an outpatient, punctuated by short periods of repeated admission to a hospital unit. Of those diagnosed with a psychotic illness, 34.8 percent have had a hospital admission in the last year, with an average stay of 40 days (Morgan et al., 2011).

Mental health services in Australia have received significant national policy attention during the current political cycle, accompanied by increased investment and the establishment of a National Mental Health Commission which will annually report progress on improvement in mental health service provision and outcomes (National Mental Health Commission, 2012). In the fiscal year 2009/10, total spend on mental health services was AU$6.4bn, of which four percent came from private health insurers, the rest from public sources. This

represents an increase of 4.5 percent per head of population per year since 2005/6 (AIHW, 2011). In addition, the 2011/12 budget contained an extra AU$1.5bn of investment to support national mental health reform over the next five years, with specific initiatives to improve service coordination for those with severe illness and level of service provision for children and young people. There are currently 28,054 full time equivalent staff in public mental health services, with numbers increasing more rapidly in community than in inpatient settings. In 2009/10, there were 6.68 million patient contacts with community mental health services, and 6599 inpatient short-stay beds available in public mental health units (1800 in private hospitals) (AIHW, 2011).

At the time this study was conducted (having since been restructured), publicly funded health services in New South Wales were organised into 'Area Health Services', each of which delivered a full range of secondary care services to a population in a given geographical area. Inpatient mental health services are commonly based within, or in the grounds of, general hospitals, with community-based teams occupying scattered buildings throughout the area covered by the inpatient unit. It should be noted that 46 percent of Australians purchase private health insurance (Private Health Insurance Administration Council, 2012), and therefore it is the public system which picks up a high proportion of people with a more severe mental illness who qualify for disability benefits or do not work. Sixty-two percent of hospital separations from public specialised mental health services were for involuntary patients, against 0.3 percent of private hospital mental health separations (AIHW, 2012).

4.4.3. The teams

The setting for this study was a publicly funded non-teaching hospital in a suburban area of New South Wales, Australia, serving a population of roughly 200,000 people. The community teams for this area happened to be based within the hospital buildings, next to the two inpatient units. Each of the four community teams had a different functional role: crisis management, therapeutic

intervention, long-term care, and assessment of referred patients. The inpatient units were designed for acute and longer-term care.

The long-term care community team and the acute care inpatient unit were chosen as the two focal settings for the study. I felt that this combination was the best for the purposes of studying professional understanding and achievement of safe care because it offered: a contrast between community and inpatient care; a contrast between acute, crisis-based intervention and ongoing case management; and at the same time there would be some overlap in patient base. The contrasts were important to (in the time available) gain a picture of safety across a spectrum of types of mental health service, risk, and clinician expertise. The overlapping patient base offered an opportunity to investigate how similar (or the same) patients were dealt with by the two teams.

The community team consisted of 23 full and part-time staff members. Based in the team's office were psychologists (three), nurses (four, of which one part-time), social workers (two), diversional therapist (part-time), occupational therapists (two, of which one part-time), and a team manager. Peripatetic workers were four psychiatrists (two consultants and two registrars), three administration staff, a family therapist, rehabilitation worker, and an employment and education worker, all of whom worked across multiple teams including this one. All office-based and peripatetic staff participated in different phases of the observations.

The inpatient staff varied in number during the time I was there, particularly due to variable use of casual nursing staff. Non-casual staff numbered 55, and were: nurses (28), consultant psychiatrists (5), psychiatric registrars [doctors undergoing specialist training as psychiatrists] (5), health and security assistants (2), Nursing Unit Managers (2), Clinical Nurse Consultant, Clinical Nurse Educator, social workers (2), psychologist, occupational therapists (2), Resident Medical Officer, administrators (2), diversional therapist and consumer workers

(2). They were complemented by approximately 10 casual staff, who were all nurses.

4.4.4. *The patients*

At the time of the study, the community team's caseload numbered 172 patients of any age above 18. Of these, 150 had been patients of the service (including other community teams) for more than five years. The team took on those who had previously been managed by the therapeutic intervention team for two years, with little or no improvement. The four nurses, two social workers, and three psychologists operated as 'primary clinicians' for around 20 patients each, with the remainder being picked up between the team leader and an occupational therapist. This role varied according to the assessed needs of the patient. Some patients were seen or visited at home weekly, with other case management activities done on their behalf such as liaison with other agencies. Those patients considered more 'stable' may only be 'seen' by phone with irregular visits to the psychiatrist for review.

The primary clinicians did not seem to be matched to patients in any way apart from a patient's dislike of particular professionals or stated preferences for a particular gender or age of clinician. Apart from injections, which were performed by nurses, the work did not appear to vary according to the clinician's professional background. The majority of patients were diagnosed with schizophrenia or bipolar disorder, and it was explained to me on several occasions that patients only left the care of the team 'in a box' or if they moved out of area. This was beginning to change, however, as the service moved towards a 'recovery focussed' and 'strengths-based' treatment model (Weick et al., 1989) and away from traditional maintenance or case management. Of the caseload, 22 percent were subject to Community Treatment Orders, a legal obligation to attend for and receive treatment whilst living in the community, as determined by the case manager and psychiatrist and agreed by an external tribunal.

According to data presented to staff during my fieldwork by an official from the Health Department, patients of the inpatient unit stayed there for an average of around three weeks, a figure probably skewed by a small number of very long stayers (up to six months). Average age of the admissions was in the early forties, with the elderly housed on the same ward as younger patients. Many of the patients were termed 'frequent flyers' due to their periodic readmission to the unit. The principal diagnoses were psychotic disorders and mood disorders.

4.4.5. Sampling

The choice of setting was based on convenience, while the choice of what to observe within the setting was purposive, derived from the desire to paint as holistic a picture as possible of how safety is achieved and understood by professionals working in mental health care. Hammersley and Atkinson (2007) point out that within-case sampling should occur in ethnographic observations in terms of time, people and contexts.

I scheduled my observations so that I observed the working day of doctors and allied health workers (i.e. 9am to 5pm) on each day of the week. This enabled me to observe shift changeover for nurses at 1.30pm, and meant that I was able to cover the full range of times when all members of the multidisciplinary team were working together.

Effort was made to ensure that observations took in a wide variety of professional disciplinary backgrounds and levels of experience, settings of practice, and types of practices. An example of this can be found in the choice of participants for the shadowing and interview phases of the study (Table 3).

Table 3: Key informant characteristics

Job	Professional Group	Place of work	Hours shadowed	Interview length (mins)
Nurse (RN)	Nursing	Inpatient	4	58
Nurse (RN)	Nursing	Inpatient	4	58

Job	Professional Group	Place of work	Hours shadowed	Interview length (mins)
Nurse (RN)	Nursing	Community	8	85
CNC	Nursing	Inpatient	4	49
Service manager	Management	Community	8	84
Service manager	Management	Inpatient	5	52
Team leader	Management/ nursing	Inpatient	5	63
Team leader	Management/ nursing	Community	8.5	76
Diversional therapist	Allied health	Inpatient	8.5	63
Psychologist	Allied health	Community	7	76
Psychologist	Allied health	Community	7	73
Social worker	Allied health	Inpatient	8	64
Consultant psychiatrist	Doctors	Inpatient & community	7.25	76
Consultant psychiatrist*	Doctors	Inpatient & community	0	56
Psychiatric registrar	Doctors	Inpatient & community	12.5	69
Security assistant	Ancillary	Inpatient	7	48
			Total: 103.75	Total: 1050

*was interviewed but did not take part in shadowing phase

4.4.6. Ethics

Ethics approval was granted by the University of New South Wales Human Research Ethics Committee and by the equivalent committee at the health service where the study took place (copies of approval letters are at Appendix 3). Details of the consent, de-identification and data storage processes are given in Appendix 4. I will focus here on particular aspects of the ethical conduct of this study which derive from the combination of type of setting (mental health) and type of method chosen.

Ethical conduct in ethnographic research cannot simply be a case of filling out the ethics form correctly and filing it away in preparation for getting on with the research. Judgements have to constantly be made by the researcher, according to their situated sense of what is appropriate in that particular time and place (O'Reilly, 2005). This is all the more salient for the ethnographer because of their remit to follow the unpredictable twists and turns of everyday life for participants. So, for example, on occasion I withdrew from listening in on a conversation if it was clear from body language or facial expression that one or more participants was uncomfortable with my presence (they never told me this outright). On other occasions, despite spending a lot of time in the nurses' station which had windows looking out onto the ward, I tried to ensure that I did not sit staring out at patients, particularly if an incident was occurring or if a patient was distraught.

One ethical dilemma that emerged during the course of early fieldwork was a decision I had made to specifically exclude patients as participants in the study. Partly, the decision was driven by an increasing conviction through reading about the priorities of ethics committees that observation of mental health patients would result in immediate red flags being raised, and subsequent delays and compromises associated with studying 'vulnerable groups'. Also, my research institute did not conventionally study patients, and so this was an area of expertise not easily accessible. Lastly, I felt that the boundaries of the study had to be drawn somewhere, and that interactions between staff members would provide me with enough information about their conceptualisations of, and strategies for achieving, safe care.

However, I became caught up in the practical implications of this decision after fieldwork began. Although the study was designed with professional understandings and activities at its heart, I could not help but feel that not observing their encounters with patients was inviting production of a partial story of safety. Eventually, after fieldwork had begun and having already gained

approval for my patient-less research design, I submitted an amendment request to the leading committee.

During the early weeks of fieldwork, it had become increasingly apparent that 'shadowing' staff was difficult if I could not observe their interactions with patients; I had to 'sit out' some of their day's work. These staff encouraged me to put my amendment to the committee. This application was rejected, and would only be approved if I promised to get written consent from all patients observed (I had proposed that verbal consent would be obtained). I felt this to be impossible for two reasons: firstly, on ethical grounds, I (and the staff I consulted at the hospital) thought that interrupting every encounter a staff member had with a patient to shove a piece of paper in their face, give them enough information to ensure they were 'informed', and getting them to sign, would have a potentially distressing (or at the very least inappropriately demanding) impact on the patient; secondly, the staff I consulted also believed that such a task would not be practicable in the busy flow of clinical work. Similar concerns about the viability of written consent in the context of observing busy mental health care environments have been voiced by Allbutt and Masters (2010) and Øye, Bjelland, and Skorpen (2007).

The decision was therefore that I would not observe 'clinical' interactions with patients. In other words, I would not observe purposeful, one-to-one encounters of treatment or therapy. I did however observe some of their encounters in non-clinical situations, of which some examples may clarify the difference. When shadowing a diversional therapist, I accompanied her and a group of patients on a walk to a park. When shadowing a psychiatrist, he bumped into a patient in the corridor and had a brief conversation. When shadowing a psychologist, I observed him engaging in light-hearted banter in the common lounge area of the ward. Nurses, receptionists and security personnel chatted to patients in waiting rooms and in the ward. I observed a handful of ward round interactions where multiple staff members (at least three, sometimes up to eight) were present. On

all of these occasions, and similar ones where patients were present, I was careful not to note down anything that patients said, or even to write any notes when patients were present. The focus always remained how staff dealt with issues of safety and risk on a moment-by-moment basis. I found that these situated judgements allowed me sufficient flexibility not to have to sit out long stretches of a clinician's day, but at the same time ensured that I did not intrude on clinical practice in an ethically problematic way.

4.4.7. Entering the field and gaining trust

It was important that before I started observations, as many staff members as possible were aware of who I was and what I was doing in their workplace. After the abortive efforts to do this on my first day in the service, I did another presentation to a fuller complement of the community team, a presentation to a group of inpatient staff, two presentations to smaller groups of inpatient nurses, and a further presentation to the doctors (both consultants and registrars). I also made sure that all staff, including those who had not attended a presentation, received a participant information sheet (see Appendix 5). I emphasised in the talks, and on the information sheet, that participation was voluntary and that staff could opt out at any time by telling their manager, me, or my supervisor. Those 16 staff participating in the interview and shadowing phases signed written consent (form at Appendix 6), and all survey participants signed consent to do the survey. This context-sensitive approach to consent was felt to be a practical compromise between the need for informed consent by participants and the difficulty for the ethnographer who has 'limited control over who enters their field of observation' (Murphy & Dingwall, 2001, p. 342).

During the early days of my time with the community team, some members of the team studiously ignored me while others approached me frequently to invite me to 'observe' something they were doing. There was however development in all of these relationships during the course of the research. I maintained a friendly attitude towards everyone, trying both the tactic of engaging in small

talk and of asking people what they were doing to start to gain their acceptance. These early days recalled the feelings of starting at a new school – having to ask where to find everything, getting lost, and discovering the best source of food and drink. The feelings were exacerbated by a feeling of not really being 'one of them.' While some people were interested when I told them about my research, others were palpably suspicious and asked questions about whether I would tell their manager about what they were doing.

Increasingly, though, small talk became (at least with some staff members) talk about more significant issues. A few staff members were interested in research in general and talked to me about their own research projects and aspirations. At the same time, I sometimes became the butt of jokes around the community team office. The team leader was especially fond of telling everyone to 'behave because Jenny's writing it all down'; when someone asked where I was, he answered 'probably under the desk recording everything we say.' When I shadowed this team leader, he was so amused at the amount I was writing down as he worked at his computer that he ostentatiously got up and scratched his bottom, saying 'write that down then!' By the end of my stint in the community team, I felt I had managed to engage even those members who had initially avoided me. Throughout my time in the service, both with the community and inpatient teams, I was often amazed at how much people would say in front of me, particularly when talking about other members of staff. I hoped that this was an indication that they trusted I was not going around repeating what I had heard.

4.4.8. Observations in practice

As instructed by my observations framework, I began the community observations in an **unstructured** way, 'hanging around' the office and accompanying different staff members for trips to the inpatient unit, to clinical and administrative meetings, and to visit other agencies. During this time I discovered that the main hubs of staff interaction for community team members

were the community team office and reception desk area, and designated these as the locations for my stationary observations during Phase 3. I also began to recruit 'key informants' for the shadowing and interview phases of the study. Initially, I approached staff who had appeared interested in my study and who seemed most keen to talk about themselves and their work. As I gained confidence, and had completed a few days of shadowing observations, I recruited further 'shadowees' based on professional group rather than friendliness alone.

In the inpatient unit, I decided not to engage in unstructured observations at the start of my time there because of familiarity with the setting and many of its staff from my time with the community team. I began shadowing straight away, firstly with a nurse consultant and then a nurse manager. The nurse manager recommended I next shadow a security assistant due to what she considered his central role in the maintenance of safety on the ward. Participant selection then proceeded principally on the basis of professional group; I also tried to select a few staff who were either inexperienced in their profession or as an employee of this service.

The experience of **shadowing** proved to be a steep learning curve for both me and the participants. My first problem was that when I was arranging a day to do the shadowing with each person, many of them asked 'what sort of things do you want to see? On this day I've got this and this … .' I had to keep reiterating that I was interested in their everyday work, whatever that happened to be on a particular day, and that activities didn't have to be specifically aimed at safety issues as I wanted to see how safety emerged out of everyday practice. During shadowing, I frequently received apologies that certain work was 'boring' – leading to a mantra that I had to often use which went 'your boring is my interesting.' A few participants seemed concerned to explain why they weren't doing something in an approved way; one person, showing me her diary, explained that she should really write down the types of work she does every day and the time spent (ready for input to the activity database), and 'look, I *did* do it

yesterday!' I found it helpful at these times to insist that I was not there to judge or evaluate, merely to describe and understand their world.

On the whole I found the 'shadowees' not to be concerned about my presence (on more than one occasion a participant would forget I was shadowing them and go off to the toilet, only to have their over-enthusiastic follower trail them before realising where they were headed). My ability to ask naïve questions such as 'why are you doing that like that?' was helped by not having a clinical background. Even when I knew what something meant, I would ask what it meant or why it was done to enable the voicing of what would usually remain tacit. Asking such simple questions would often also lead to longer anecdotes about past patients or events.

Stationary observations were more challenging in terms of data gathering. Before starting, and inspired by Mintzberg (1970), I designed a form into which I could structure my observations and which would remind me to note down multiple aspects of what was going on – including who was there, their location, what type of activity they were engaged in, topic of conversations, objects used, and time spent on each activity (see Appendix 7). I chose vantage points for these observations which were very busy and this proved difficult in terms of deciding what to focus on at any given moment. The community team office was doubly tricky because an observer is only able to see part of the room at once (due to dividers surrounding each desk space), and because multiple phone and face-to-face conversations could be happening at the same time. The nurses' station in the inpatient unit was also difficult to monitor because there were three doors leading into it, and it functioned as a thoroughfare and stand-up conversation space as much as a sit-down-and-work space. At any one time, there could be a staff member talking to a patient at one door, two staff members talking on the phone, three sitting writing clinical notes, one using a computer to check blood results, two others having a conversation and making changes to details on the

patient whiteboard, another dealing with visitors at the window, and another fetching medications from a room adjoining the nurses' station.

Although I was hoping to monitor patterns of movement and time spent by different members of staff doing different activities (and particularly the amount of time spent by nurses with patients rather than in the nurses' station), this proved impossible for the reasons stated. It was also difficult in the nurses' station to be able to tell exactly what each staff member was doing without physically going around and asking each person, which would have meant that too many movements into or out of the space would have been missed. I began to wish for a video camera. Despite my structured observation template, I found that the most I was able to note down was (a) the time (but not often time spent), (b) the people involved, (c) a broad outline of the activity and (d) object used. For conversations or phone calls within my hearing, I wrote notes as close to verbatim as possible.

The stationary observations would have been helped by either a tighter focus on the types of information recorded (e.g. only record movement, or time spent by nurses in or out of the nurses' station) or by using two observers in tandem who could divide up the labour. I did attempt to make the nurses' station more manageable by only focussing on one half of it, but this did not substantially reduce the problem. In practice, I found I could best gather coherent data by focussing on writing down the conversation happening nearest to me.

The idea of **following practices** was also difficult to operationalise. I noted that in his cardiac telemonitoring study, Nicolini (2009) may have been observing connected practices, but in reality this meant he had to observe discrete activities happening in different settings located all over the country. It did not mean he literally had to follow, for example, a file of patient notes from desk to desk as they were written by various people. I realised that I would have to retrospectively make the connections between practices which I had observed during the first three phases of the study. There was a great deal of choice of

observed activities which were aimed in some way at risk management or patient safety because, as we will see in the findings, so much of these professionals' work is structured according to such goals. For example, the community team's weekly clinical meeting (of which I observed 12) mainly consisted of discussion of what to do about patients who were experiencing threats to their safety. Whether this is 'connected' (just by virtue of being aimed at patient safety) to the safety practice of inpatient staff, who met once a week to discuss which patients could most safely be discharged that week, is another question. In analysis of the data, I have made connections between an assemblage of practices which were aimed at projecting an image of a safe service to external audiences, and have contrasted this assemblage with another which had more to do with the day-to-day maintenance of patients' safety. This can be called following practices, but was a retrospective effort rather than a path I travelled during observation.

As the observations progressed, in both settings I did become more selective in my choice of activities to observe as I came to understand more about how safety was accomplished, and the types of situations in which understandings about safety and risk were most likely to be revealed, negotiated or even explicitly verbalised. This was the origin of my regular attendance at and recording of clinical team meetings, incident review, length-of-stay meetings, and clinical governance meetings. It also meant I opportunistically attended two days of a training course for nurses on how to manage aggression in the inpatient setting.

On one occasion, I was not observing on the day of an adverse incident where a patient had to be restrained; I made it a priority during subsequent days and during interviews to listen out for conversations about it, to find out more about how staff experienced and perceived that incident, and to observe how they made sense of it together. A nurse who had written a quality improvement project based on that event and feedback received about it from staff sent the document to me as further 'evidence' for my exploration of staff sense-making surrounding the incident, which I could add to the formal incident report I had also collected.

To some extent, the way I narrowed down my observations was guided by the participants themselves and their notion of what a researcher interested in safety would benefit from seeing or listening to. In both settings, once people knew who I was and what I was doing there, it was a frequent occurrence that they would come up to me and ask me to come with them to observe something they were doing. Others, particularly doctors, liked to talk more about their own philosophy of care or their views on the psychiatric enterprise in general.

Field interviews

Field interviews are conversations conducted by ethnographers during the process of observations to clarify something they have observed, to follow up on something a participant had previously said they were planning to do, or elicit more information or opinion from participants. Although they may appear to be informal conversations, the researcher is using them for these particular purposes (DeWalt & DeWalt, 2010, p. 139). In my study, these were often conducted with participants whilst walking down a corridor, over coffee, in their office, or immediately after a meeting once other team members had left the room. Often, these conversations would draw in others who were nearby or passing. The new person would back up the informant's account of events, agree or disagree with their opinion, add illustrative anecdotes from their own experience, or reminisce with the original participant about similar cases they had both encountered. The conversations therefore became rich resources of information about events I had not observed and the ways staff members collectively made sense of them.

These informal interviews were also a useful way to overcome the difficulties posed by not being able to observe one-on-one treatment sessions between staff and patients. For example, when a 'shadowee' returned to the car after a home visit, emerged from a therapy room after an appointment, or returned to the nurses' station after administering an injection, I would ask them to give me an account of what had happened. Some accounts were volunteered to me the next day, particularly for night time on-call shifts. Although these provided a

necessarily partial view of patient encounters, the accounts were germane to professionals' conceptualisation of safety.

Recording observations

The research design incorporated roughly two days per week to type up field notes taken during the other three days of the week. Short notes were taken whilst observing, unless this was impossible or inappropriate. These were expanded upon and typed up in narrative form as soon as possible after observations (mostly, the next day or the following weekend). The idea of doing this was to capture 'head notes' (Lecompte & Schensul, 1999) and the flow of events, and more detail was included in the typed up notes than was possible in the handwritten notes (see Appendix 8). Typing up time could also become thinking and reflection time, allowing for some concurrent analysis of emerging themes with which to structure more focussed observations as the research progressed (Glaser & Strauss, 1967). The weekly clinical meetings, incident review meetings, and 'length of stay' meetings were audio-recorded.

Table 4: Completed observations

Type of observation	Community team details	Hours	Inpatient unit details	Hours
Unstructured	Various locations	64.5	N/A	N/A
Shadowing	Nurses (1)	8	Nurses (3)	12
	Allied health (2)	14	Allied health (2)	16.5
	Managers (2)	16.5	Managers (2)	10
	Doctors (1)	12.5	Doctors (1)	7.25
			Ancillary (1)	7
Stationary	Team office	13	Nurses' station	18
	Reception desk	8		
Practices	Weekly team meetings	16.5	Restraint training	14
			Length of stay	
	Clinical governance meetings	8	meetings	3
			Doctors' meetings	3
			IIMS meetings	2
Total hours observed (community)		**161**	**Total hours observed (inpatient unit)**	**92.75**

Type of observation	Community team details	Hours	Inpatient unit details	Hours
			Total hours observed	253.75

4.4.9. *Interviews in practice*

Conducting the interviews

The original interview schedule was constructed during the community observations stage. It was designed to be semi-structured, that is, a series of questions was asked but not necessarily in the order they appeared on the schedule, depending on how the responses developed and the need to follow up unexpected leads (Kvale, 1996). The questions and the rationale behind each are shown at Appendix 9. Participants were told at the beginning that 'the questions are open-ended and this will enable you to expand on your responses so the interview becomes more like a conversation.' They were also told that I was particularly interested in examples and anecdotes to illustrate their points. I emphasised that the focus was on understanding (not evaluating) their perspectives about their work, and that there were therefore no right or wrong answers. All interviews were audio recorded and took place between 30 March and 11 August 2011, lasting between 48 minutes and 85 minutes (see Table 3). The interviews were all held in patient consultation rooms or in an office for more senior members of staff who had their own office.

The questions and how they changed

The first two interviews revealed a particular question to be confusing for participants to answer, and so an adjustment was made for subsequent interviews. The original question, inspired by an approach to interviewing called the 'interview to the double' (Nicolini 2009), had been:

Imagine you are going on long service leave for three months. I am the person who is going to take over your role, and I have similar experience and training to you but have never worked in this service before. What would you tell me now about your day tomorrow and what needs to get done?

The intention was to expose some taken-for-granted aspects of the everyday routines of work which would usually not be verbally articulated, thereby revealing how participants conceptualised the place of safety and risk issues in the context of everyday work. However, the first few answers I received to this question was essentially a list of tasks to do, rather than how they would be done or what I would need to know to be able to do them. The first participant also said that he shouldn't need to tell me much about how to do things if I had the 'same experience and training' as him anyway. When the second interviewee paraphrased the question as 'you mean a handover?', I decided to change the last part of this question to 'what would you consider the most important things to tell me as part of your handover, so that everything goes smoothly while you're away?'. It is possible, on reflection, that this change encouraged participants to focus more on the formal clinical and professional aspects of their work rather than on more informal cultural or relational aspects.

Reflecting experience with the interview schedules and knowledge of some of the differences between risk and safety issues in community and inpatient teams, some questions were modified or changed between use for the community team participants and for the inpatient team participants. In the schedule at Appendix 9, I indicate which teams were asked which question.

The main change made was the inclusion of more questions focussed specifically on safety and risk issues in the inpatient context. Therefore, for example, two questions (8 and 9) asked of the community team were intended to get them to differentiate between the management of acute/immediate and chronic risks (at the same time indicating the types of things they would place in these two categories), and also between patients they would consider low or high risk. In

the inpatient unit, this was considered inappropriate because most admissions were prompted by an acute, immediate risk or crisis situation. So, the emphasis for inpatient interviews was placed more on individual and collective strategies for maintaining safety on the ward, and the resources (including objects and documents) used to do so. The frequency of critical incidents on the ward was also much greater than in the community, and there had been one shortly before the interview period began. In response to that incident, a specific question was therefore included prompting description of a recent adverse event.

I had been interested in using visual tools during the interview, to enable participants to map their conceptual worlds surrounding safe care. I was inspired by Rhodes' (1991) ethnography of a psychiatric care unit where she asked staff to draw a diagram of how they thought the service functioned. However, I had difficulty designing an exercise which would involve a diagram because of the abstract nature of safety and risk. I therefore designed a visual prompt (see Figure 3) for the listing by the staff member of potential harms to patients until they exhausted their thinking. I then asked them to link one of the harms to factors they felt were likely to increase or decrease the likelihood of this harm occurring to a patient. This was intended to elicit a 'structure of [the] group's cognitive universe' (Coffey & Atkinson, 1996, p. 90) in relation to risk and harm and the variables they associated with increased or decreased likelihood of those eventuating. The intention was to see whether they voluntarily came up with any factors which did not place the agency for harm with the patient, as an emerging theme from ongoing observations and from the research literature was relative emphasis on types of harm caused by the patient rather than caused by a staff member or the service. If they did not, they were then prompted with another question about service factors they thought impacted on likelihood of harm occurring.

Figure 3: Harm potential question prompt
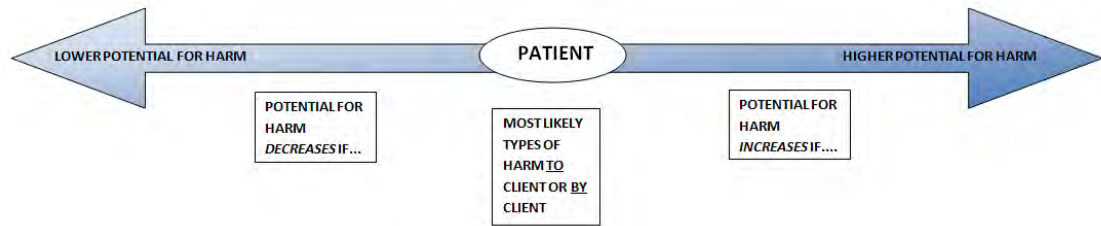
During the inpatient phase of interviews, I introduced a material prompt (a risk assessment form used in the service – question 12 in the schedule) to stimulate discussion about the impact such mandated, formalised tools were felt to have on the everyday achievement of patient safety. This form is shown in a later chapter, at Figure 8. It was introduced to test the prevalence of a view I had heard expressed during observations that risk was hard to predict, and that paperwork could sometimes prove harmful rather than helpful to the safety of patients.

Survey

After finishing the fieldwork and interview data collection, I designed a survey to elicit participants' perceived role and methods for maintaining patient safety (a copy is provided at Appendix 10). This was piloted with colleagues at the Australian Institute of Health Innovation who gave feedback on the question wording, formatting, and time taken to complete the survey.

A total of 65 participants were identified, which included all members of the community team and all inpatient staff members, with the exception of casual nurses and nurses not working a day shift during the week of survey administration. All managers, doctors, allied health, administration and ancillary staff (except cleaners) were given the survey. It was administered to 49 members of staff individually and filled out in the researcher's presence, taking them between 10 and 25 minutes to complete. The remaining surveys were left for staff to fill out; of these, nine were returned by post, leaving an overall response rate of 89 percent. Written consent was sought for the survey, whether or not the participant had taken part in earlier phases of the study.

Emerging findings and theorising out of the data already collected shaped the survey questions. The first part of the survey asked participants to nominate the three people, three things (including objects or documents), and three practices which they felt to be most helpful to them in their role maintaining the safety of patients in the service. This was intended to confirm or disconfirm findings from the other data collection.

Secondly, three social network questions asked participants to nominate (on a list of names of all people being administered the survey) which individuals they had never heard of; which individuals they had previously consulted about a patient risk or safety issue, and which had consulted them about the same; and lastly which individuals they had consulted during a particular recent deliberation about what to do for a patient in crisis. These questions were designed to elicit patterns of communication within and between disciplines and teams about patient safety issues.[2]

Thirdly, because of an emerging theme from fieldwork and interview data that a wide network of people and agencies appeared to be co-opted by mental health staff members into the effort to maintain safety for many individual patients, participants were asked whether they had consulted people from outside the community and inpatient teams when deciding what to do about the same crisis situation. If so, they were asked to indicate which individuals or agencies had been consulted, and whether any of these had been consulted before any members of the two teams involved in the study.

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[2] The results of the social network questions are not used in the findings chapters of this thesis due to space constraints.

4.5. Disciplining the data

The comprehensible representation of social worlds is ... produced via a kind of 'symbolic violence' (Bourdieu & Passeron, 1977). Understanding is always bought at the expense of fidelity to the phenomena. (Atkinson, 1992, p. 14)

4.5.1. The corpus of data

Having been typed up, the field notes comprised 510 pages of single-spaced text (258,481 words). The 16 interviews were transcribed verbatim and together amounted to 138,759 words. Added to this were 59 survey responses in hard copy, audio recordings of 12 community team clinical meetings (a total of 16 hours, 42 minutes), five incident review meetings, three inpatient length of stay meetings, and a recording of role plays undertaken by nurses during aggression management training.

I had also collected various types of documentation including leaflets about the service; blank forms which clinicians fill out to go into patient notes (including risk assessment forms, admission assessment forms and progress note templates); local, state and national policies relevant to the service; an aggression management training manual; and meeting agendas and minutes.

4.5.2. Reflexive analysis

Analysing this corpus of data did not only involve coding for themes. The analysis process was rendered more complex by a desire to engage in reflexive research practice (Davies, 1999) to avoid masquerading as a detached, disinterested observer conveying unmediated reports to readers. Such an approach has its roots in the 'crisis of representation' which began to paralyse anthropologist ethnographers from the middle of the last century, as the methodology became mired in a disciplinary guilt about perceived collusion with the Western colonialist enterprise (MacDonald, 2007, p. 67). The result of this was the emergence of various forms of reflexive practice, both in conducting research and

in constructing the ethnographic text. Sometimes, this meant the explicit foregrounding of the author's voice in ethnographic accounts and emphasis on the active role of the researcher, their actions, experiences and assumptions, in shaping and constructing the world that ended up being represented on paper. Some ethnographers elected instead to prioritise polyvocality in their representations, to allow participants better to represent themselves in the final account (Saukko, 2003).

In this study, I have tried to balance these two elements of reflexivity. This chapter, and particularly the sections on analysis which follow, does foreground my own voice as author in an effort to make it clear that my view of the mental health service I discuss is heavily mediated. In the findings chapters (5, 6 and 7) which follow, my voice is still present in the structures imposed on the data to make sense of it; however, it fades into the background in favour of allowing participants' own voices to be heard.

4.5.3. Selectivity and analysis

The movement from what we hope to represent to its representation in written form, from field to text, from observation to analysis, is full of tension and self-consciousness for the reflexive ethnographer as Atkinson's (1992) words at the head of section 4.5 indicate. Although it sometimes seems that the 'analysis phase' of the research project begins when we sit down with our pile of field notes and transcripts to devise a coding scheme, in reality we start our process of analysis from the moment the kernel of an idea for a study occurs to us (or is given to us). Part of analysis is a basic division of what we have seen and heard into that which is relevant for our purposes (whatever they are) and that which is not. By exposing elements of the field experience, we are forever obliterating others. 'Objective representation' – an account of *what really happened* – is seen as desirable by some who see researchers' bias as unscientific, exposed in the anthropologist's tendency to try to convince readers through naturalistic 'thick description' that they were 'really there' (Geertz, 1973). But we cannot create a

simulacrum of the social reality we have been a part of; even if we could, there would be little purpose in doing so (Atkinson, 1992, p. 7).

Our representations are therefore always and necessarily partial; a researcher's prior life experiences, academic background, personality and interests limit the scope of the possible projects they could or would want to undertake. The practical exigencies of where, with whom, and with what (and whose) funding further narrow the range of possible setting, scale, and focus. Further selectivity is displayed in the epistemological and ontological assumptions the researcher carries as they enter the field. What do they decide to write in their field notes? Perhaps they are a slow writer, or employ a structured template directing them what to look at, rather than an unstructured running commentary. Perhaps they cannot get around to typing up some of their notes until a week after they were taken, finding their memory for some details has failed them. Perhaps they run out of time to transcribe all of their interviews in full, electing instead to transcribe only parts they deem interesting. Selectivity is inescapable in the reporting of field-based research.

4.5.4. Seeing the field

Much researcher-imposed selectivity often remains unacknowledged in accounts of data analysis, where choices about what to represent begin to be made explicit. Throughout this chapter, and also during the theoretical explanations of the previous chapter, I have tried to expose many of the factors that have coloured, distorted or even partially covered the lens with which I have viewed the field setting and the data which emerged from it. These range from personal experience to theoretical interests to practical difficulties in executing planned methods. The categories and codes, which gradually and iteratively evolved into the representation of my field site, must be seen against this background.

Figure 4 is a diagrammatic depiction of how I saw the field, and the relationship of this gaze to the early stages of analysis which led to iterative development of

high-level concepts that would be applied later to the formalised analysis of my data. The central portion of the diagram depicts my own 'ethnographic gaze' and the filters that affected my view of the field. On the left are the formal research activities, in chronological order, while on the right I list elements of reflexive analysis which were not planned from the start but which, in retrospect, took place during each of those phases.

This is a simplification of a swirl of complex interactions between the tasks of the research project and reflection on these, a swirl which would drive the gradual evolution of a more formal analytic scheme. It does not capture the often recursive nature of these interactions, but does convey some sense that what I saw in the field, and later in my data, was a product of the tension between the need to create a formal account of and justification for my research, and the ongoing awareness of the partial, personal, and serendipitous influences on it.

Formal
research
process

Seeing the field

Reflexive
analysis

Enter PhD

Literature
review

Research
questions

Conceptual
framework

Research
design

Ethics
approval

Gaining
access

Field work

Me
Personal experience
Policy work

'The literature'
Theory reading
Others' research

Focus of data collection
Social negotiation of meaning of safety
Safety as produced through practice

Assumptions taken to the field
Existing safety improvement not working
Clinical realities are complex

**Reflections
on the field**

**Conversations
in the field**

Further focus data collection
Focus on safety-related spaces and practices (esp. meetings)
Focus on most important resources for safety maintenance
Focus on networks as mechanism for safe care
Focus on effectiveness of formal safety mechanisms

Reflect on impact
of own experience
on shape of study

Develop explicit theoretical
and empirical approach to
research interest

Develop awareness of how
your lenses may shape /
distort what you see

Write analytic memos
alongside field notes

Test early thoughts with
participants

Adjust focus of data
collection accordingly

Develop initial coding
scheme

4.5.5. A hybrid approach to analysis

Although this iterative cycle between field and theory may seem to resemble grounded theory (Glaser & Strauss, 1967), the degree to which my preconceptions and theoretical lenses influenced the research design and focus during observations and interviews meant that I took a hybrid approach to analysis. This entailed a mix of deductive and inductive approaches. Initially, while data collection was continuing, 'etic' (researcher-defined and imposed) high-level concepts were developed from elements of the theoretical frameworks described in Chapter 3 whose salience to the data was confirmed during observations and interviews. 'Emic' (locally relevant) categories were then inductively developed during close reading of the data, and nested within the 'etic' categories (Miles & Huberman, 1994, p. 61). Such an approach is recommended by Lofland et al. (1984, pp. 16-17) who see it as combining the advantages of both the 'Martian' (who 'stands outside the social ontological frame of his [sic] subjects') and 'convert' (who immerses himself or herself in the worldview of participants) perspectives. To explain how this worked, I will now turn to discussion of how both approaches evolved and interacted during ongoing analysis.

4.5.6. Evolution of analytic scheme

> *Reconstructed logic is nice and neat, but is it a faithful map of the actual actions and paths of empirical inquirers? More often than not, the actions of such inquirers are much less linear, less structured, and far less neat and orderly. They play hunches, or get inspired in the shower or in their dreams, or make guesses or take gambles.* (Shank, 2006, p. 24)

The development of analytic categories with which to make sense of the data very much followed a 'less neat and orderly' path. The following account of the iterative development of the coding scheme represents an audit trail of decisions made about how to make sense of the data, an exercise which is considered important to the dependability and confirmability of qualitative research (Lincoln & Guba, 1985).

As an overarching framework to help make sense of the corpus of data, I adopted Wolcott's (1994) three-phase conceptualisation of the process of 'transforming' textual data into a coherent, meaningful interpretation. He argues for the application of three strategies: description, analysis and interpretation. The first is 'description', which is where the account of the data should stay close to the way they were originally recorded. My original attempts at familiarising myself with and categorising the data were simply aimed at describing what was contained in the data rather than what it might mean (exemplified in the first and second iterations of coding described below). Secondly, Wolcott recommends 'analysis,' which is the careful, cautious and systematic search for themes and patterns within the descriptively defined categories. To facilitate this stage of sense-making, I integrated theoretical concepts with the more descriptive categories in order to develop the final coding scheme (see iterations three, four and five below). Finally, Wolcott moves to the 'interpretation' stage, which is where the researcher moves beyond the data to try to make sense of 'what is going on' and to set this new knowledge in the context of existing scholarship. This last task will be the subject of Chapter 8, the discussion.

First iteration: drowning in data

In a flurry of activity prompted by my attendance at a training course for data analysis software (NVIVO 9) during the early phases of fieldwork, I embarked on an elaborate coding experiment. I wanted to find relationships between age, gender, profession and what each staff member thought about patient safety. I coded one day of field notes, an operation that took nearly a week of coloured highlighting of text, dividing it up amongst the 121 categories I had developed. Now fearing that I would be 'drowned in waves of shapeless data' (Miles and Huberman, 1994, p. 155), I determined to formally employ theoretically driven 'high level concepts' which could act as organising principles for the analysis and under which themes could inductively be developed.

Second iteration: focussing my interest

The previous section offered a detailed account of how I narrowed observations and adjusted interview questions based on increasing knowledge of the field. This iterative development of the research design was mirrored in (and driven by) my attempts to get an early grip on emerging themes in the expanding dataset. I tried to do this by writing frequent asides in my field notes (bracketed off from the main text), which often consisted of questions I felt I should explore further in future data collection, comments linking different parts of the data together, or tentative interpretations. The sum of these was periodically written up into 'analytic memos' (containing reflections on emerging themes) for discussion with supervisors (Corbin, 2004).

This introspective work was supplemented by conversations I had in the field. Often I would see whether my interpretative fledglings could fly by making casual remarks during conversation to gauge reaction, enacting a type of 'member checking' during the course of fieldwork and interviews (Seale, 1999, p. 62). An example of this was my attempt to test an emerging theme of clinicians using a wide network of people outside the health service to help them manage a patient's safety:

> I say that I've noticed that families appear to be often employed by the clinicians in the management of risk. She [community psychologist] says 'sometimes' this is true. However, she says, the mother often exaggerates risk, and the client then underestimates risk. (Field notes, 28 January 2011)

Although this was partial vindication of my thinking, it also led to a further examination of how clinicians collect multiple accounts of a patient's condition before making a decision on the level of risk posed. I therefore, in this case, continued to look for evidence of my network idea, but also looked out for contention over the 'real' level of risk being negotiated by a clinician between members of that network.

My analytic thinking was perhaps most strongly influenced by chance comments that participants made to me or to each other. Two examples of this were particularly important. A psychiatrist on one occasion asked me 'you don't want a PC [politically correct] answer, you want the … real [answer]?' (interview 7), and on another emphasised the difference between 'official' and 'unofficial' versions of risk in the organisation (field notes, 21 January 2011). The difference between what people expect the mental health service to be doing in terms of risk and safety, and what they actually do in practice, was something which proved to be a productive distinction for analytic purposes. Having tested the idea of different versions of safety (for example, by eliciting comments on the risk assessment form during interviews with inpatient staff), I adopted this as a key organising principle for my data, and indeed two findings chapters (6 and 7) eventually emerged from it. I went through a similar process following a seminar given by a psychiatrist from outside the hospital at which he pointed out that risk assessment tools are not supported by evidence of having ever prevented harm (field notes, 26 May 2011), and a comment by another psychiatrist that it is impossible to predict suicide (field notes, 9 June 2011). This notion of the uncertainty and unpredictability of psychiatric practice and particularly surrounding risk management became a 'sensitising concept' during observations and interviews and, after more corroborating material was gathered, also became a prominent theme in my eventual findings.

These are some of the events I can positively identify as having influenced my eventual analytic framework. They were both influenced by, and drove forward, my ongoing reading in a mutually reinforcing cycle. As with all creative endeavour, though, it was often the case the ideas would coalesce when I least expected it and when not directly engaging with the research material.

Third iteration: from descriptive to thematic coding

As a result of this progress, I quickly gave up on the 121 codes. It was impossible to keep even just the highest level of the code hierarchy in mind whilst going

through the text, and each paragraph was multiply coded, sometimes with ten or more codes. I had to be more selective. In the original hierarchy there had been a high level category called 'theoretical codes', which were really themes developed out of a combination of my theory reading and experience in the field. I decided to concentrate on developing this category further, and the result of this work is shown in the research journal extract at Appendix 11, where the rationale for each code is noted. This iteration marked a shift in my thinking from Wolcott's (1994) 'description' phase to his 'analysis' phase, but the final two iterations (below) would see further refinement of the codes.

Fourth iteration: simplifying the coding approach

I puzzled over the seemingly irreconcilable distinction in the literature between a-priori imposition of categories on data, and grounded, inductive approaches. Neither fitted what I had started to do, and so it was with some relief that I read of the hybrid approach to analysis in Miles and Huberman (1994) and Lofland et al. (1984). I used this to develop a simplified coding scheme with conversations in the field was a condensing of the thematic codes into four principal high-level concepts:

1. **Key stories about the management of safety.** Rationale: this was to gather together the key 'stories' from the observation phases of the study which were central to that clinician's day and were relevant to how they manage safety day-to-day. Each 'story' should focus around the management of a single patient from the point of view of the clinician being shadowed – who did they interact with, what did they use, what practices were key, what knowledge did they try to marshal?

2. **Conceptualisations of safety.** Rationale: to highlight how different people viewed 'safe care', how any differences of understanding were negotiated, and how notions of safe care were learnt, perpetuated or and/or changed.

3. **Performed safety**. Rationale: to tease out the elements and characteristics of practice which were perceived by participants as being more to *show* that the service was safe than to actively maintain patients' safety.

4. **Everyday safety**. Rationale: to capture the strategies – whether informal or formal – which professionals employed on a day-to-day basis to manage the safety of patients experiencing different types of risk.

The high level concepts I would eventually turn into findings chapters therefore emerged in an iterative process involving an intermingling of my own personal interests and concerns, an identified gap in the empirical literature, the theoretical perspectives I had adopted, ongoing experiences of the field, and reflection on this experience.

Fifth iteration: thematic analysis and the final coding scheme

Having decided on the four high level concepts, I sat down with my printed out piles of interview transcripts and field notes and a blank Excel spreadsheet. I began with the interview data, sorting it using a process of what I called 'broad coding' which involved reading all the material and chunking it into the four categories defined above (some material was allocated more than one code). Each category was given its own column of the table (see Appendix 12), and each 'chunk' of data was paraphrased and given a time stamp to aid subsequent location of the chunk in the transcript. I added an 'other' column for any data which did not fit into any of the categories – designed to test their appropriateness and fit. Once all of the text was entered into the five columns, I started the inductive search within each category for themes to make up sub-categories (labelled as second level themes in Table 5). This constituted a thematic analysis, a technique which involves 'searching across a data set … to find repeated patterns of meaning' (Braun & Clarke, 2006, p.86).

This method worked well for interview transcripts, as the material was in some ways pre-structured by the interview questions and had been time-stamped during transcription, allowing for easy pinpointing and collation of extracts. Once sub-categories were identified, I transferred them onto mind maps to test the relationships between emergent sub-categories, as well as to gauge the amount of evidence I found to support each in the interview data. For each high level concept I constructed multiple iterations of these mind maps to clarify the sub-categories and to develop third level themes below these. These were based on a close second reading of the interviews; at this stage I had decided to use the key stories to illustrate, in detail, aspects of each of the three other high level concepts. An example of a hand-drawn map (for the 'everyday safety' concept), and an extract from a map drawn with mind-mapping software (for the 'conceptualisations of safety' concept), are seen at Appendix 13.

Having determined second and third level themes for each high-level concept, I developed a tentative structure for each of three findings chapters: conceptualisation of safety, performance of safety, and everyday accomplishment of safety. The 'stories' category I was able to incorporate as empirical examples of each of the three other major concepts, and those elements of the 'other' category which did not fit into any of the high level themes were included as negative instances to be explored in the context of the findings. Next to each proposed section of the three chapters, then, I listed supporting interview extracts to ensure a solid basis for each claim. This exercise of simultaneously working out second level themes and crafting them into a narrative structure that would flow as a chapter enabled me to establish relationships between themes. I decided that I would now test this coding and chapter structure on my field notes.

I had to find a different procedure for field notes, which, being less structured, and therefore much more time consuming to categorise even into the five broad categories, were not amenable to the Excel table method. Instead, I turned back to NVIVO, coded the field notes with the high-level concepts, then printed out

documents containing the data for each of the codes. I went through each document on paper, manually indicating sub-categories using the schema which had emerged from the interview transcripts, and adding additional supporting 'evidence' to my existing mind maps. This process highlighted missing codes and parts of the coding scheme which could be rearranged. The resulting conceptual structure (coding scheme) upon which the findings chapters were based is illustrated below.

Table 5: Final coding scheme

High level concept	Second level theme	Third level theme
Conceptualisations of safety	Typologies of risk and harm	Attitudes to risk and safety
		Definitions of safety
		How safety relates to risk
		Pervasiveness of risk concerns
		Types of harm – patients and staff
		Factors related to changes in risk
	Staff perceptions of their impact on patient safety	Limitations of impact
		Uncertainty and unpredictability
		Iatrogenic harm
	Dealing with multiple versions of safety	Compromises and 'least worst harm'
		Contested versions of risk
		Negotiating risk and safety definitions in practice
Safety as a performance	Nature and props of performance	External expectations
		Reasons for performance
		Nature of expectations
		Communication of the normative discourse to staff
	Compliance with performance demands	Documentation
		Benefits of complying
	Resistance to performance demands	Resistant attitudes to normative discourse (+ why)
		Resistant actions
Everyday safety	For 'settled' patients	Building and using rapport
		Knowing 'what's normal'
		Active safety maintenance
		Monitoring for deviation

High level concept	Second level theme	Third level theme
	For 'unwell' patients	Dealing with deviation
		Keeping safe on the ward
		Incidents and their management
		Incident aftermath/ analysis

4.6. Conclusion

The natural history of this project carries two parallel narratives. The characteristic progression from research design to data collection to analysis and write-up is one side of the story. This chapter has been an attempt to offer a transparent account of how my own interests (personal, professional, theoretical) imposed selectivity on each of these phases, including the data that was collected and the findings that were developed. These can only be a partial (in both meanings of the term) representation of my interaction with participants and setting.

The other story has been about the tensions I encountered during my time immersed in the ethnographic enterprise. Primary among these is that although the conventional version of the research process emphasises systematic thought, linearity, and traceability, I have found that to represent my own research process as such would be nothing more than an exercise in 'reconstructed logic.' I have therefore tried to reflect in these pages some of the difficulties and unpredictability which characterised the project, as well as how I sought to overcome them.

Three chapters of findings now follow. As the analysis progressed, symmetry emerged between this experience of the ethnographic process and a central tension negotiated by the study's participants in their work related to patient safety. Chapters 6 and 7 expose this tension between retrospectively constructed accounts that display an official version of events, and the negotiation of unpredictability moment-to-moment using strategies which are often

improvised. First, however, the professionals' conceptualisations of safety will be outlined in Chapter 5.

Chapter 5: Professional conceptualisations of safety

5.1. Introduction

This chapter presents findings related to the first research question. We enter the conceptual world of two teams of mental health professionals to see what, for them, counts as a 'safe' patient and 'safe' care. This acts as a foundation for the following two chapters which show how this conceptual world is enacted in everyday practice. The chapter is divided into three sections. The first section (5.2) articulates the basic contours of staff members' understandings of safety and risk: how safety is seen to be related to risk; the pervasive role of safety concerns in the perceived purpose of mental health work; the types of harm threatening the safety of patients; and factors thought to increase the likelihood of such harms occurring. The second (5.3) and third (5.4) sections highlight the multiplicity, situational variability and contestability of these notions of safety. In the second section, the focus turns to the way professionals perceive the impact of their own activities on the safety of patients as often limited, flawed and unpredictable, and the impact of the service as sometimes harmful. The last section is an examination of the multiple (sometimes conflicting) understandings of risk and how these are negotiated in practice.

5.2. How do staff conceptualise safety and risk?

5.2.1. Safety and its relationship to risk

Participants in this study were never asked directly what they thought 'patient safety' meant. The understandings of the concept presented here are derived from their use of terminology surrounding safety and risk both during interviews and as part of everyday work practices observed during fieldwork. In this first section, particular focus has been given to the use of the two concepts in relation to one another.

During fieldwork, staff members spoke less explicitly about the achievement of safety than about the identification, prevention, and management of risk. Within the field notes and interview transcripts, there were 892 instances of the words 'risk', 'riskiness', and 'risky' being used, against 263 mentions of 'safety', 'safe' or 'safely'.

Staff members' use of terms related to 'safety' was restricted firstly to management- or administration-related documentation and tasks, and secondly to refer to their own personal safety, that of colleagues and more widely of the community as a whole. The phrase 'patient safety' occurred principally in documentation and managerial talk. It appeared on a flyer for a safety seminar in the hospital, for example, and occasionally during meetings to discuss ratification of policies. Managerial emphasis on 'safety' as well as 'risk' was indicated by the hand-written labels on ring-binder files in managers' offices, which signalled their interest in 'safety assessments', 'safety surveys' and 'occupational health and safety'. Patient-related officially formatted documentation includes 'safety plans' and 'community safety checklists', and a training program for staff was called '*A Safer Place to Work*' (New South Wales Health, 2012).

The use of the term 'safety' in official contexts was reflected in the cynicism of some clinical staff towards the concept. The doctor quoted below associated 'safety' with pointless bureaucratic effort removed from the practicalities of frontline practice.

> He (doctor) says that his brother went to talk to a rail company about how to get their trains running on time, 'but all they wanted to talk about was safety.' The (brother) said 'the way to have no safety problems' is not to have any passengers. The doctor reflects on the *Yes Minister* [television comedy series] episode with the hospital which had managers but no patients ... 'that hospital won awards for cleanliness ... .' (Field notes, 30 June 2011)

Reinforcing the lack of currency of the term 'safety' in relation to patients, some staff (when told in an introductory presentation about the project that I was exploring 'safety in mental health services') seemed to think the research was primarily concerned with OH&S.

> I worried that I had emphasised 'safety and risk' too much in my talk, rather than trying to get an idea of their everyday life and how safety fits into that. At the end, they were suggesting things I might like to observe [...] one said 'well they discuss OH&S in that business meeting, don't they?' (Research journal, 13 December 2010)

In the conceptual world of these clinicians, the words 'safe' or 'safety' were rarely used in relation to individual patients. Instead, 'safety' was seen as a general state of things, services, actions and collectives, and was also used by staff members to refer to a state they desired for themselves. Safety (or 'unsafeness') was conceived of as a characteristic of physical environments and objects. The first field note extract below also shows the association of risk with patients, and safety with the physical environment of the hospital. The second illustrates the role professionals feel they have in protecting the safety of collective entities such as 'the community' against harm by particular patients.

> [Social worker] says that the physical safety of having mental health institutions is one thing, but 'how do we support people to minimise risk to themselves and others?' They suggest that 'if we can offer some compassion [...] to support families ... [there will be] better outcomes for families and us as a society.' (Field notes, 7 June 2011)
>
> Senior inpatient (IP) nurse: just making sure that in that period of their illness that they are in here and that the people in the community are safe from being harmed or ... threatened or ... physically or emotionally harmed by our patients. (Interview 10)

Professionals often referred to their own personal safety in terms of physical safety and also in terms of a feeling of security or being protected. An allied health staff member commented that 'it's not worth risking your own health and safety' (interview 11), while a nurse said 'it's important to feel safe at work' (field notes, 20 June 2011). Staff frequently acknowledged that their safety is their own responsibility, especially in terms of not behaving in ways that might inflame already risky situations.

> IP nurse: [The health and security assistants] are really good with the clients … they see things and you can feel supported with them if you're a bit nervous about your safety and stuff. (Interview 13)
>
> Senior IP nurse: In this setting, you actually have to use that as a background of well … ok what is high risk and what is more likely to inflame, and what are some things I need to do around my personal safety i.e. you know keeping a decent distance [from the patient]. (Interview 14)

Safety is seen as something the patient lacks, but which may be brought to them by others (especially staff). Many professionals believe they are achieving safety *for* patients and sometimes *despite* them. Indeed, patients and their behaviour were not observed in this study being described as 'safe'. Words to describe patients who staff thought presented a low risk include 'stable', 'settled', 'well' and their behaviour may be described as 'appropriate', but not 'safe'.

The principal characteristic of the conceptual relationship between safety and risk in this context, therefore, is that staff more often assign agency to themselves with regard to safety but are likely to see the patient as the agent of risk. The actions of patients may escalate risk while the actions of staff may maintain or produce safety, and there is a sense that the two are in constant tension. This ascription of agency is reflected in the active verbs used by clinicians to describe their own actions. That is, they 'ensure a patient is safe', 'keep people safe', 'provide safety', or 'maintain safety'. Agency may also be delegated to objects they give the patient such as medications.

> Senior IP nurse: The medications give them those chemicals back that they
> need and ... it's a chemical restraint in many ways as well for aggression, to
> maintain safety ... (Interview 10)

An exception to this pattern is when nurses ask patients on the ward whether they are able to 'guarantee' their safety. However, the opportunity patients are given to answer the question in the negative reinforces the perception by staff that they (staff) bear responsibility for safety even when the patient has forfeited their own.

> [A nurse] says to [the nurse-in-charge] 'I'm concerned about [patient] ... she's
> quite agitated ...' and adds that when she asked her [the patient] if she could
> 'guarantee her safety', she replied 'you can't help me' and that she can't
> guarantee her safety or the safety of anyone else. (Field notes, 15 June 2011)

Staff members have a broad definition of safety, and their role in maintaining safety is not restricted to clinical or technical definitions of safe care. As life events and circumstances can exacerbate mental illness or increase susceptibility to harm, the risk concerns of mental health services are extensive and ramified across a patient's whole life. A psychiatrist explicitly contrasts the relative predictability of physical health care (and therefore greater susceptibility to management by checklists and protocols) compared to psychiatry where exacerbation is as unpredictable as life itself. This extract casts the safety of care for a physical illness as easier to effect, because it exists in a *patient* in isolation from their *person*. The essence of the person is seen as intertwined with the course of mental illness by this doctor.

> Psychiatrist: With surgery, if you're dealing with cancer or appendicitis, I
> think you can be ... more concrete about protocols and checklists and you
> can be much more specific about when to intervene and when not to
> intervene. I mean the appendix doesn't know that a family member has
> died recently, whereas in psychiatry you're worried that this person has a

> schizophrenic illness and is at risk of relapse if there's a death in the family, so we absolutely need to take that into account. So I think a holistic picture is essential in psychiatry whereas, as one of my teachers said, a right lower lobe pneumonia is a right lower lobe pneumonia in anyone. Really we're just worried about that lung in that bed and really anything else that happens around that person is not going to make much of a difference to the pneumonia. (Interview 6)

Although concerns about safety extend to areas of a patient's life beyond the hospital, there is by no means an agreed definition of safe care in all situations and for all patients. A psychologist explains the difference in safety concerns between the inpatient and community teams (a distinction which incidentally was disputed by other staff during the course of observations):

> The inpatient side, [the psychologist] says, are mainly concerned with risk to life – if the patient is no longer a risk to self or others, they tend to discharge. But in the community, they view the patient's safety more widely, in terms of them having somewhere to go, and other social issues. (Field notes, 12 January 2011)
>
> In the inpatient context itself, there is acknowledgement that what constitutes safe care for one patient constitutes unsafe care for another. The following comment was made as part of a distinction this nurse was making between two patients. The first was a patient who was thinking of hanging himself, for whom the ward, in her opinion, would represent a safer environment than home. The second had previously had a traumatic experience on the ward and still harboured bad feeling towards the service, and admission would, she thought, reawaken bad memories and therefore do more harm than good.Senior IP nurse: So I guess we can decrease the harm by putting them in a safe place ... but we can also increase the potential for harm I suppose by putting them in here too. (Interview 10)

The safety and riskiness of a person or situation are often conceived of as being in an inverse relationship, such that an increase in one will result in a decrease in the other.

> Senior IP nurse: if everyone's at risk, [we] try and do something about it where we get extra staffing, extra security, extra medication ... not just say 'oh God!' and walk away, to try and do something to help increase the safety or decrease the risk. (Interview 10)

However, 'safety issues' and 'risk issues' are terms which are sometimes used interchangeably by nurses during the inpatient unit shift handovers, where commonly used phrases used to refer to patients include 'no safety-risk issues' and 'no safety or risk issues' (field notes, 15 June 2011). Overall, then, these professionals talk of risk and safety as two sides of the same coin. However, the ascription of responsibility for one to themselves, and the other to patients sometimes surfaced in an adversarial dynamic between the two. This was recognised by some participants as being detrimental to the quality of care they could provide, because giving patients a 'chance to fail' is seen as an integral part of the recovery process.

> Allied health worker: I think the service is really risk focussed and sometimes a bit too risk focussed maybe, cause we always talk about ... you've gotta let people, give people a chance to fail sometimes [...]. If you put cotton wool around someone, then they're not gonna get any better ... . (Interview 11)

The relationship between positive risk taking and recovery was reinforced by several observed conversations about equipment provided by this service to improve the quality of inpatients' spare time. There was a feeling that other services would not take such risks even at the expense of patients' recovery:

> Senior IP nurse: I think risk often goes against some recovery. The idea of risk and averting risk certainly gets services preoccupied – lots of [other]

> services are really bemused that we've got a basketball hoop, 'cause that
> poses great risk. (Interview 9)

5.2.2. *The pervasiveness of risk and safety concerns*

Maintaining safety is such a central concern for mental health professionals in these teams that they may perceive it as the central purpose of the whole service. Formal treatment interventions (aside from medication) can be a secondary consideration to be attempted if there is time. In other words, patients' safety is often the core aim of treatment, rather than a desirable characteristic *of* treatment.

> Psychologist: Safety and risk always has to come first, and then if you've got
> any time left over that's when you do your interventions. (Interview 2)

Professionals are continuously concerned about safety, many saying it is always in the back of their mind. This was attributed partly to safety breaches being unpredictable and the need to be alert to this.

> Allied health worker: I think the whole issue of safety … has to be just every
> time that we're engaging with people … we just don't know the ways in
> which it just could bubble up. But in terms of the overall safety, yeah I
> think people are fairly conscious of it, and it is just always in the back of
> your mind when you're kind of meeting with people. (Interview 12)

There is a tension to be negotiated by these professionals between the awareness that too much risk aversion can have counterproductive effects, and the knowledge that if something does go wrong they are likely to fall under the scrutiny of the Coroner.

> Psychiatrist: at any given time you're dealing with always the possibility of a
> death, y'know a death from suicide something like that. That's the most

> common sort of thing [...] that at any moment you're going to get a subpoena to a Coroner's [inquiry] ... . (Interview 16)

Risk aversion and defensiveness often trump giving people a 'chance to fail' as part of their recovery, and also that in the conceptual world of these clinicians, risk management activity and recovery-oriented activity can be seen as mutually exclusive.

5.2.3. A typology of risk

Each interviewed participant was asked at the end of their interview to write down a list of what they believed to be the 'most likely types of harm' to come to or be initiated by a patient of their service. This was a hypothetical exercise, and participants were not prompted in making their list, nor were they restricted in the number of answers they could provide. Fourteen participants (of 16 interviewed) answered this question. One prompt was used in three cases where respondents commented that they were giving the 'textbook' answers to the question and one said that the exercise reminded him of medical school. In these instances, the interviewer encouraged them to think about the harms they came across in their everyday practice. The responses were grouped into 16 categories, outlined in Table 6 below. The rightmost column shows the number of respondents who mentioned a risk of harm in this category. The terms in brackets show the types of responses that were grouped into the category.

Table 6: Professional typology of harms

Type of potential harm – 'risk of ...'	Respondents citing (N=14)
Patient is harmed	
Attributed to direct patient action or their illness	
Self-harm	13
Suicide	10
Drug and alcohol related harm (including illicit drug overdose and physical	7

Type of potential harm – 'risk of ... '	Respondents citing (N=14)
health problems)	
Financial problems (including overspending and gambling)	7
Misadventure (including absconding and impulsive behaviour)	5
Self-neglect	4
Physical health problems (including falls)	3
Deteriorating mental health (including distress and depression)	3
Sub-total (direct patient action)	**52**
Attributed to patient's illness-related behaviour	
Risk to reputation	6
Harm to or loss of important relationships (including loss of supports)	6
Loss of accommodation/ homelessness	5
Legal trouble or jail	2
Harm to career	1
Sub-total (illness behaviour)	**20**
Attributed to the actions of others	
Being sexually exploited or harmed	7
Being financially exploited	6
Being exploited (generic)	2
Victim of domestic abuse	1
Sub-total (actions of others)	**16**
Attributed to contact with mental health services	
Iatrogenic harm (physical restraint, stigma, sick role dependence, trauma of ward, alleged rape on ward, medication effects)	**6**
Total (patient is harmed)	**94**
Others are harmed by patient	
Aggression/ violence/ physical harm to others	10
Harm to families and children (including domestic violence, neglect, emotional distress)	6
Sexual harm to others (including assault and passing on sexually transmitted disease)	5
Harm to others (generic)	3
Emotional abuse of others	3
Verbal abuse of others (including staff and other patients on ward)	3
Homicide	2
Financially exploiting others	1
Total (others are harmed by patient)	**33**

Type of potential harm – 'risk of … '	Respondents citing (N=14)
Overall total	**127**

These responses constitute a typology of harms for which professionals believe their patients to be at risk. The most striking pattern to these responses, which confirms findings in the previous section, is the predominance of the attribution of agency to the patient and to attributes of their illness. In comparison, the risks of harm caused by others or by mental health services (iatrogenic harm) were infrequently mentioned. The different types of harm and professionals' understandings of them will now be further elaborated.

Risk attributed to a patient's action or to their illness

The risk of patients directly causing themselves harm or committing suicide accounted for 52 of 127 responses. Many of these types of harm, although directly caused by the patient, are seen as being mediated by their illness, especially by the severity of symptoms being experienced. Corroborating these responses, suicide and self-harm were also the most frequently discussed types of patient harm during the other sections of the interview and during observations. The patient is seen as the ultimate agent of their own suicide, often despite what clinicians see as their battle to prevent it.

> Senior IP nurse: I've had one guy … he's now dead … went on leave, and [got hold of] pethidine and Panadeine Forte. Had them in his underwear, and because there was no foil, the metal detector didn't go off. Shot up the whole box of pethidine, and took the whole box of Panadeine Forte. And we caught him and brought him back, and he hated us for it, and two days later he proceeded to go and put himself under a train – jumped over the wall and put himself under a train. (Interview 10)

The above quote represents another manifestation of the adversarial relationship between the agents of safety (staff) and the agents of risk (patients). The nurse in

the following extract attributes the suicide to the patient's illness, which is presented as having won the battle with the clinician.

> Senior community nurse: I presented him [patient] with the psychiatrist, and all the other psychiatrists said 'we don't think you can be doing anything different to what you're doing.' We put him in hospital ... he'd come out and the same pattern ... and he hung himself, there was nothing more we could do. The delusions had really ... we couldn't treat them, we couldn't get rid of those delusions. (Interview 1)

Risk attributed to illness-driven behaviour

Professionals consider risks such as homelessness, loss of important relationships, and loss of reputation to be a consequence of the behaviour associated with worsening symptoms of illness. These types of harm are usually not seen as being the patient's fault, but they often co-occur and compound each other, causing exacerbation of illness in a vicious cycle.

> Manager: the reputation stuff, again, can be illness related. So if you take your clothes off and you're running down the street naked, people will tend to notice that, but it can also be a bit because of the sort of stigma stuff – 'oh that's the mad person who lives up the road.' (Interview 5)
>
> [Informal discussion with community psychologist] He explains that the patient is at risk because if he keeps getting complaints [to the housing trust by his neighbours] he could be evicted, but that these complaints are mainly due to the girlfriend. He says that the patient's mental health will be even more at risk if he becomes homeless and goes into the sheltered accommodation system. (Field notes, 12 January 2011)

Risk attributed to the actions of others

Staff also see patients as vulnerable to being harmed by others, and try to act to protect them against this. Sexual and financial exploitation is directly related to

the status of being a mental health patient. Because of their illness, patients are seen as more vulnerable to their family taking advantage of them, or to being influenced by a 'bad' crowd. The patient in these cases is often described in a way that emphasises their helplessness against other people in the community.

> Manager: How to mitigate someone's risk of being exploited? [...] Things that we use here like guardianship to make sure that the finances are safe, making sure that where they're living is a safe environment, and if someone is around to look after them. If say they're at risk of predators using their place to live or predators using their finances, or predators using them sexually ... those sorts of things. Assessing their environment at home ... the lady we were talking about this morning, she may well be at risk from her neighbours because she upset her neighbours before coming in here, but now they might be a risk to her by harassing her and threatening her. So that's a huge risk to her, and she's quite vulnerable to that. (Interview 8)

This extract emphasises again the breadth of what staff feel to be their responsibility. The patient's wellbeing is not simply considered in clinical terms or in relation to their interactions with the health service, but also in terms of their personal circumstances and the people around them. It is the staff and not the patients who possess the ability and responsibility to prevent harm occurring.

5.2.4. *Factors contributing to the escalation of risk*

Professionals display different attitudes towards risk factors and how predictive they are of eventual harm. Some believe that level of risk is highly situation-specific, individual-specific, and constantly changing even for the same individual. It appears to them that any manner of otherwise routine life events could act as risk escalators in a highly unpredictable way, as described by the two psychiatrists quoted below.

> [During the weekly psychiatrists' meeting] a psychiatrist mentions that in the Coroners' cases he has been involved in, 'if you tracked what happened

> between when [the patient] came to the health centre and when they killed themselves' there are many gaps, and at any point there could have been a precipitating factor for their suicide. (Field notes, 26 May 2011)

> Anything in the universe can happen to increase the potential of harm... my dog shat on the carpet ... that could be the straw that broke the camel's back ... it's really difficult [...]. I had a guy, the first week of being a registrar, a guy who was drug-induced psychosis from smoking way too much cannabis. [...] he rang up [his] girlfriend from the ward, got [her] dad, the dad said 'you fucking crazy arsehole, go and fucking kill yourself' ... and this guy was agitated, depressed, psychotic, highly suggestible. And he did, he hung himself on the ward. So ... no-one kills themselves because cranky father in law says 'go and kill yourself!' This guy did, so you can't predict this stuff. (Interview 7)

Despite such uncertainty among many staff about which factors can contribute to the escalation of risk for an individual, a minority believe that identifying whether a person belongs to a 'high risk group' is important regardless of that person's individual circumstances or history.

> Senior community nurse: [Risk of] suicide can decrease if a clinician is aware of high-risk groups. I think that's important, because I think there's been a few suicides over the years ... and the clinician hasn't been aware that this person's been in a high risk group. (Interview 1)

Risk assessment heuristic

Aside from an acknowledgement that such an exercise is highly dependent on the individual, the type of risk being assessed, and on life events that cannot be predicted, clinicians employ a flexible heuristic for risk assessment decisions. This is especially true if the staff member is inexperienced or if the patient is not previously known to the service. Primary emphasis is however usually placed on the service's knowledge of the individual's history and prior 'red flags' for risk

escalation, a technique for risk assessment that will be explored in Chapter 7. The dimensions of the heuristic, and factors commonly mentioned by clinicians as being an indication of higher risk of harm are described in Table 7 below. These were responses to an interview question (Q16 in Appendix 9) about the factors increasing risk of harms they had identified.

Table 7: Staff identified indicators of high risk among patients

Dimension	Characteristic	High risk indicators
Patient characteristics	Age and gender	Middle aged male Elderly male
	'Insight' into illness	Low insight, does not accept illness
	Mood and behaviour	Hopeless or helpless No sense of purpose Not taking medication Concrete plan for suicide
Illness characteristics	Diagnosis	Agitated psychosis Melancholic depression Comorbid physical illness
	Symptoms	Worsening delusions or hallucinations Aural 'command' hallucinations present Worsening manic symptoms with poor impulse control
	Response to treatment	Little or no response to medication
Interaction with mental health service	Stage of treatment	Recent discharge from hospital Inpatient admission: lack of activities Inpatient admission: risky objects on ward
	Current relationship with service	Disengaged from services Prior negative experience of service
	Staff factors	Not taking notice of what patient says Falling into a rut with a patient Personality clash between patient and staff member Patient does not trust clinician
Life circumstances	Substance misuse	Abusing alcohol or drugs Lost significant supports
	Relatives and friends	No strong support network No children

Dimension	Characteristic	High risk indicators
	Living situation	No stable accommodation Access to means of harm Unemployed

A psychiatrist gave two accounts (below) that employ multiple elements of each dimension of the above heuristic. Her judgement was that the first patient can be considered 'high risk,' and the second 'low risk'.

> [Asked to describe a high risk patient] I have a young gentleman who is single, unemployed, living with his family. He continues to have active symptoms, which are perceptual abnormalities which he perceives as quite persecutory and derogatory, but there is also a lot of self stigma. He is ashamed and embarrassed by his psychotic experiences [...]. He's got a conflictual relationship with his parents and there has been an occasion in the past where he's tried to hang himself a few years ago. He keeps us at a distance, and I have a fragile rapport with him [...] I'm always worried about him, but there's really nothing I can do about it at this point [...] that's the best I believe is possible with him at this moment [...]. He continues to abuse cannabis [...] I'm worried that his illness will get the better of him and he gets tormented by to an extent that he feels this is about as much as I can take, I can't go on.
>
> [Asked to describe a low risk patient] There is a young lady I met yesterday in the clinic who's a bright young attractive lady who's had a really bad episode of psychosis ... admission a few years back, and she's not had an admission since then. She's well supported by her parents, she's compliant with medication recommendations, she's started attending a course [...]. She's in a steady relationship now, she's making plans to travel later this year, and she was completely symptom free. She was very insightful [...], so I would consider her low risk. But she's an exception rather than the rule. (Interview 6)

5.3. 'What can I do?' The limits of professional control

As in the extract above describing the 'high risk' patient reflects, a sense of futility and frustration often clouds these professionals' remarks about patient safety, couched in a constant awareness of the limits of their ability. This disempowerment stems from a conviction that guaranteeing or even improving the safety of some patients is impossible at times. One community nurse remarked to another when asked where her care plan document was for a patient:

> 'I never do one. You know what my care plan is for her? Keep her safe,'
> because she lives in a violent situation – 'what can I do? […] I try to keep
> her as well as I can ((resigned tone)).' (Field notes, 28 January 2011)

Such frustration is sometimes related to a feeling that despite the care of the service, the patient is not showing signs of improvement in their illness over time. Remarking on a patient who is frequently admitted to the inpatient unit, a psychiatrist said to a psychologist that the patient is 'not going to be super better' by the time he is discharged the following week, and the psychologist replies that he doesn't think he'll ever do any better on the ward (field notes, 4 February 2011). For patients whose illness does not seem to improve, it appears to be the best the service can do simply to stop them coming to physical harm by admitting them to hospital. One of the ward social workers remarked to me that 'being on the unit is about containing risk and we've done that for him (a patient)' and that really there is little further help they can give him with his problems (field notes, 1 June 2011). Such resigned pragmatism can conflict with the expectations of other agencies about what the service can do.

> [Psychologist] says that he has spoken to someone at [the] housing
> [department] who has received written complaints from a patient's
> neighbours. This person had said that since the complaints are in writing
> he will have to act on them […] [Psychologist] says that he told him 'we

> can't do any more with his mental state, this is how it's gonna be [...] we can't give him more meds to quieten him down.' (Field notes, 7 March 2011)

Such limitations are reinforced by a shared belief among staff about the circumstances when patients should take responsibility for their own safety. These are broadly defined as times when the risk presented is not related to mental illness, or when the clinician judges that they are not doing all that they can to help themselves, considering their ability. For example, risks stemming from what staff call 'personality' or 'behavioural' origins, from refusal to deal with drug or alcohol abuse, or from refusal to comply or engage with recommended treatment or interventions, are referred to as being beyond the service's control. A patient who kept going 'absent without leave' fell into this category, according to a community nurse: ' ... his mental health we can only control as much as we can medicate him and have him readily available to us ... I don't think we have responsibility for his drug and alcohol use, cause he won't address that, we have no control over that' (interview 1).

A community psychologist and a nurse were discussing whether they should attempt to chase up a patient who had not turned up to the clinic for her regular injection. They decided not to because they attributed her need for the drug as being due to behaviour driven by addiction, not mental illness:

Psychologist:	We're not really treating her for mental illness, just for chaotic behaviour ...
Nurse:	She just wants Valium from the doctor ...
Psychologist:	I can't say I've seen any mental illness ...
Nurse:	We can chase her but ...
Psychologist:	What's the clinical reason? ... not really sure what for.
Nurse:	There's no clear diagnosis there.
(Field notes, 15 February 2011)	

Despite feeling that these things should not be their responsibility, there were cases where the potential consequences of ignoring the risk were serious and therefore forced an action on the mental health service. A psychologist speaks of such an obligation due to fear of a 'witch hunt' during her night shift in the Emergency Department:

> ' ... he [patient] was convincing me that he was going to go and punch someone'... there would be a 'witch hunt' if she had 'let him out' [...] but he 'knew what he was saying.' A nurse comments that 'if it's not mental illness and it's behavioural, we can't stop somebody punching somebody' ... another nurse, listening in, agrees 'he's not unwell'. (Field notes, 3 March 2011)

For many of these professionals, therefore, the responsibility for protecting patients is broad, but should not extend beyond harm that can be related back to their role as a person with a mental illness. However, clinicians still have to act against this belief in situations where they project the potential future reaction of those outside the service (should something go wrong) as punitive.

The inpatient unit is felt to be impossible to keep risk free. Referring to an incident of sexual assault, which allegedly took place on the ward some time ago, a nurse remarked that even when patients are being checked every ten minutes, sexual safety is difficult to maintain. Patients may be in and out of one another's rooms and there are two staff nursing eight acutely ill patients (field notes, 10 January 2011). One psychiatrist told me that the inpatient unit is 'not the super safe haven' it is assumed to be (field notes, 21 January 2011), while nurses in a team meeting debated whether it was possible to remove all risky objects from the ward:

> After the senior nurse had said that iPod headphone cords should be allowed because they would not bear weight, another nurse points out that the prohibited list [list of items banned on the ward] says no cords at all. There

> are some smiles as if to say 'we'd ban everything', and a senior nurse says 'yeah I know, you can rip sheets up' [as if to say you can't remove every single risk]. (Field notes, 19 May 2011)

The lack of safety guarantees in the inpatient setting is reflected in an expectation voiced by some staff that patients will, when it comes to it, protect themselves from risk presented by other patients.

> Senior IP nurse: Ninety percent of the time if someone's going completely berko [beserk] there's not much you can do. [Other] patients just piss off to their rooms anyway and lock themselves in their rooms, they're not stupid.
> Interviewer: Self-preservation?
> Nurse: Yeah they do, it really kicks in with them. (Interview 10)

There is therefore a general acceptance that it is simply not possible for a mental health service to prevent, remove or mitigate all risks to patients. This can engender feelings of frustration or disempowerment in staff and a failure to meet the expectations of other agencies. However, many staff members assert that these limitations are defensible when it comes to risk that cannot be attributed to the patient's mental illness.

5.3.1. The unpredictability of risk

Unmasking the 'true' risk picture

The limitations to professionals' ability to keep patients safe partly stem from their perception of risk as often inherently unpredictable. There are multiple sources of uncertainty for mental health staff in predicting risk. The foremost of these is that they often feel that the 'real' degree of risk is being masked in some way. Often this masking is attributed to a personality disorder or manipulation of staff.

> [Discussion in nurses' station]: The psychiatrist says to the psychologist 'you can't accommodate the guy in hospital for the next five years because he says he'll kill himself. [...] I think you've gotta ignore this talk about suicide, it's manipulative. [He's] not demoralised or pessimistic, [he's] trying to put the frighteners on people. [...] somebody who intended to do what he says would keep it entirely to themselves.' (Field notes, 13 July 2011)

This notion that if someone 'really' wanted to commit suicide, they would not tell staff about it, adds an extra dimension of uncertainty to the attempt to determine a risk picture. Unlike clinicians in some other medical specialties who can detect a physical pathology and level of risk with their own tools (e.g. a blood test) or own eyes, mental health professionals feel they cannot trust the main window they have onto a patient's distress (what the patient says).

Such inability to trust the patient's account is also due to contention about which of their words reflect 'reality' and which emerge from their illness, such as the content of a delusion. Clinicians debate this among themselves because, as a psychologist put it, they are uncertain 'what's mental illness and what's eccentric' (field notes, 28 January 2011). During a nursing handover meeting, nurses discussed whether one patient's constant wearing of earplugs on the ward was an illness-related behaviour or whether it was justifiable. While some nurses attributed it to her illness, another argued 'it is pretty echoey in here though!' (field notes, 23 May 2011). On another occasion, two social workers discussed the veracity of a patient's story about her family. One of them is cynical, saying 'it could be true but it's hugely unlikely ... it's possible that she could have ... but on the balance of probabilities ... ' (field notes, 7 June 2011).

Corroborative accounts such as past clinical notes or verification by colleagues and a patient's family members make it more likely that the patient's account will be believed. A community psychologist believed part of a patient's story was 'real' because 'I found evidence of it in her file ... it's real', which is not characteristic of all her accounts: 'this is a woman who gets murdered every other day' (field

notes, 25 January 2011). Such mediation between different accounts is a key aspect of clinicians' decision-making around risk, a practice that will be examined in Chapter 7.

Clinicians sometimes doubt a patient's motives for presenting a certain account, which is another way patients are perceived as manipulating staff. One patient wanted to be allowed escorted leave home to pick up some belongings, which prompted a social worker to ask a colleague: '… is this just the reason he's using to get some freedom … just his way of getting out?' (Field notes, 7 June 2011). Cynicism is greatest when clinicians suspect that they are being deliberately manipulated; a nurse laments the way he dealt with a patient early in his career: 'I was so green then that she must have been playing games with me I suppose' (interview 1).

A final source of uncertainty when judging the veracity of a patient's account, particularly in relation to their safety, is that patients may present a lower or higher level of risk than the clinician judges to 'really' be the case. For example, community clinicians spoke about patients who had appeared well in the clinic, but whose homes were in a state of disorganisation suggesting (to them) a higher level of risk.

> A community nurse relates the story of how she picked up a client from another worker, and there was nothing in the handover to suggest that the client was doing badly. However, 'I just had that feel that she could give the spiel,' but when she visited her apartment there were 'tell tale' signs that she wasn't doing well – no sheets on the beds, not taking her medication – she was clearly deteriorating and was admitted to hospital. The nurse said she had 'held everything back' on interview. (Field notes, 4 February 2011)

Sometimes the appearance of high risk is dismissed because of a clinician's prior experience with the patient. In an interview, a psychologist described a patient who calls the service on a regular basis threatening to commit suicide:

> I know that a particular client will ring up, saying she's suicidal all the time. And that isn't based on history, that's based on the fact that she's easily redirectable. [Imitating patient] 'I wanna kill myself, I wanna take too much medication … .' But y'know ten minutes later she's future planning, she's not distressed, she's off having a cup of tea and has plans … and sometimes if their story's inconsistent it's hard. (Interview 2)

A receptionist in the community team told me that she had received a phone call from a patient who had said to her "if you can't get me somebody (to talk to) I'll take an overdose" but 'when I asked the case manager about it, I was told "oh their toaster was broken"' (field notes, 21 April 2011).

Diagnostic uncertainty and unpredictability of treatment effects

Difficulty trusting the accounts patients give is compounded for clinicians by the uncertainty surrounding diagnosis in psychiatry. The stories clinicians tell about patients are sometimes characterised by a catalogue of different diagnoses assigned at different times and by different doctors.

> On return to the office, the psychologist shows me a piece of paper on which she has typed out a list of about 10 diagnostic labels, including affective disorders, schizophrenia, eating disorders, substance abuse, and 'developmental delay'. She says he [a patient] has received all these diagnoses although he is in his twenties. When I ask her whether she thinks she really has all of these disorders or whether they are different clinicians' versions of his story, she seems to think they are valid, explaining different aspects or evidence for several of them. (Field notes, 10 January 2011)

Awareness of this issue is the subject of humorous banter. A psychiatrist told me 'our party line is that he's got it in him that he could be more capable than he has been. Not sure why he hasn't [been] except to say "it's psychiatric." It doesn't fit into any neat diagnostic category' (field notes, 23 June 2011). The same psychiatrist was later filling in a form regarding a patient and asked colleagues whether this patient has got 'schizoaffective disorder ... (or) more schizophrenia really?' and someone replies 'pick a label, any label!' During shift handovers on the inpatient unit, nurses commonly use the phrases 'patient is query (diagnosis)' or 'question mark (diagnosis)'. An autistic patient described by a psychiatrist had a 'question mark diagnosis of bipolar disorder'; this doctor said he always questions any diagnosis written in a patient's file unless he 'knows or trusts the clinician who made it. [...] personality disorders are real mimics of other disorders ... [I can] usually tell what their primary problem is by their demeanour and collateral history' (field notes, 21 January 2011). Diagnostic decision-making may however be rendered artificially clear-cut to justify some action such as sending the patient to a different service.

> Psychiatrist: It's usually not that simple. Distinctions like whether this is a personality disorder or a drug abuse problem or a psychotic disorder and therefore whether the person should be admitted or not admitted or treated in a certain way or not treated in a certain way ... sometimes those things are quite difficult to sort out and sometimes there's a lot of emotion and stuff hanging on those decisions and a lot of investment, and it sometimes may be simpler just to go 'nuh, it's drug abuse, nothing to do with us, get lost!' Simple ... but ((laughs))... it's never that simple.
> (Interview 16)

The effects that a treatment or intervention will have on an individual patient is frequently unpredictable. A therapist was asked by a patient on the ward whether patients could be supplied with information about how long recovery takes, replying that 'it's hard to know, it's like how long's a piece of string' (field notes, 9 June 2011). Uncertainty is particularly strong where medications are concerned,

and the development of a medication plan often incorporates trial and error. Two doctors were observed discussing this issue in relation to a major tranquiliser called chlorpromazine. One said 'I have a real beef with how medications are classified into anti-depressants, antipsychotics,' while the other agreed and (amused) said 'we just mix and match' (field notes, 14 February 2011). In the community office, two nurses debated the effects of an antipsychotic drug called clozapine. While one said that deaths had been linked to taking the drug, the other argued that the evidence of a link was not conclusive.

These multiple sources of uncertainty, stemming from the characteristics of psychiatry as a discipline and from the nature of the illnesses it attempts to treat, compound the difficulties staff have in trusting a patient's account of their risk. Indeed, there is frequently a sense among staff that some risk cannot possibly be predicted. In support of this view, several clinicians separately cited an incident where a patient had recently killed a staff member in another hospital despite having previously been assessed as low risk and being housed outside of a locked ward. The changeability of risk for an individual patient, even over the course of one day, is also used to illustrate risk unpredictability. In a management meeting, a discussion took place as to how long an admission assessment can be considered valid for an individual patient; one nurse manager laughed, commenting '24 hours they're valid for' (field notes, 1 June 2011). Two inpatient nurses discussed a particular patient's pattern of changeability:

> Inpatient nurse comes over to the bench on the acute side, and puts it [patient file] down saying 'I don't want to do this'... Senior nurse asks 'can I help you?' ... she replies 'it's just one of those emotionally difficult encounters.' One of the doctors had told a patient that they could have unescorted leave, but she [nurse] spoke to the doctor later and he changed his mind, so she had to tell the patient about it. Seeming surprised, senior nurse says '[he changed his mind] the same day?' Nurse explains that the patient 'presents well' in the morning but escalates in the afternoons, becoming agitated. (Field notes, 26 May 2011)

The unexpected events that punctuate everyday life can contribute to this changeability.

> Community nurse: ... you know the risk can change. I have people who do all sorts of odd things and get themselves in trouble with the police and what not. [...] it could be that somebody's up in court, or a relative may have died ... I mean it could be the whole gambit really of everyday things that can happen. Somebody could have had an accident ... that's the nature of people, you just don't know what's gonna happen. (Interview 4)

Professionals' responses to the unpredictability of risk

Professionals respond to such pervasive uncertainty in three principal ways. Some attempt to work with it without trying to control it, whilst others appear to deny or go to great lengths to tame it. A third group steers a course between the two.

Those staff seeking to work with uncertainty emphasise the importance of 'gut feeling' and 'vibe' when making judgements and decisions about risk. There is often a sense of 'just knowing' when something is not right with a patient, an intuition that detects what formal mechanisms like ticks on a risk assessment form cannot.

> Senior IP nurse: You always feel a little bit unsafe when there's aggression on the ward, cause they're quite unpredictable. The thing that I have always said to staff, and I always live by, is that sick feeling in your stomach. You have to trust it [...]. If your gut tells you it's not right, it's not and you leave, not to try and be a hero and save the world because you're not, you're gonna get yourself hurt. (Interview 10)

Some doubt the existence or importance of gut feeling, suspecting that the 'feeling' is actually the result of tacit knowledge and embodied skills gained from experience rather than an intuitive ability.

> Manager: [With some nurses] you'd hear them talk about 'my antenna was just telling me there was something wrong,' or 'I just had this gut feeling that something wasn't right.' You sort of get this view that there's this sort of weird nebulous thing called this gut feeling. These nurses had trouble articulating what it was, but [...] really what they were saying was that there was a whole lot of clinical experience that they had, dealing with people over a long period of time. They had a whole lot of skills around listening, observing, understanding what people's behaviours might mean. (Interview 5)

In contrast, a minority of staff appear to have faith in the ability of formal mechanisms to impose certainty on the risk assessment process. Such a belief may lead to the conclusion that problems with risk management are not to do with inherent unpredictability but rather with the absence of a suitably advanced formal risk assessment tool.

> Senior IP nurse: I think that we don't have a really good tool to assess risk. Other areas have got far more developed risk management tools ... like Justice Health ... have a couple of particular risk management tools that are really good. (Interview 9)

The majority of clinicians ply a 'middle way' between 'gut feeling' and risk assessment tools. They acknowledge the ultimate unpredictability of risk but at the same time go to great lengths to 'cover all the bases' in an attempt to tame it. Both extracts below illustrate the importance of consulting and informing as many people as possible about the potential risk; such distribution of knowledge among a network of stakeholders in the patient's wellbeing is felt to be the best way of dealing with unpredictable risks. These practices of safety management will be further elaborated in Chapter 7.

> Psychiatrist: When you're on call, one informal system is to just make a million phone calls. I used to be on call for the country hospital as a fly in,

so obviously I couldn't go in and see the patient. So my little way of getting around that was, and I used to use this phrase, I was like a little mini call centre. I'd take calls and I'd put calls out, so for every episode of a clinical decision, and it's very labour intensive, that's just my way of doing it, but to my mind it tends to rub off the edges … because then you can make sure everyone's informed cause otherwise, Murphy's law, the one person that really needs to know about it won't know about it, it will be a problem. (Interview 16)

Psychologist: I usually take the cautious approach I guess. If you're driving away from the hospital in the middle of the night still thinking 'oh but what if,' you probably haven't covered your bases. You should be able to leave … 99.9 percent sure that you have done all the appropriate things. You can never be a hundred percent because you can't exactly predict people but … it's have I considered this, have I consulted with this person, is there another support that I could get in contact with? (Interview 3)

During an interview, a psychiatrist drew a picture of a pinball machine that he felt reflected the nature of the service's impact on a patient's safety (see Figure 5). This drawing, and his explanation of it, sums up many of the findings presented in this chapter.

I kind of conceptualise it a bit like a pinball machine. So the patient's the ball, the ball gets fired up, bouncing around all over the place and stuff happening, and then you've got your paddles here. So your patient, it's all bad if your patient ends up in here ((indicating hole at the bottom of the machine)) right … so we're just madly trying whatever we can do. And these paddles are different places to try and keep this ball in play, that's kind of how I think about it. This ((a paddle)) might be the case manager, this might be the registrar, this might be the family … So the ball is this chaotic thing that is just 'bing bing' off anything right … and it hits this thing here. That increases the risk and it's now tumbling straight down the middle. If you manage to 'ping' deflect it off, and that's kind of what it's like … it's chaos … the ball's bouncing around like buggery and you're

> static. There's only a few things that you can do, and that's all you're doing.
> You try and take the chaos out of the system, and in theory let's say the
> pills slow the ball down a little bit, so you have a better chance of tapping it
> back into play maybe. (Interview 7)

The patient is represented as the ball which always threatens to tumble to the
hole at the bottom of the machine, being kept safe from that fate only by the

Figure 5: A psychiatrist's pinball machine
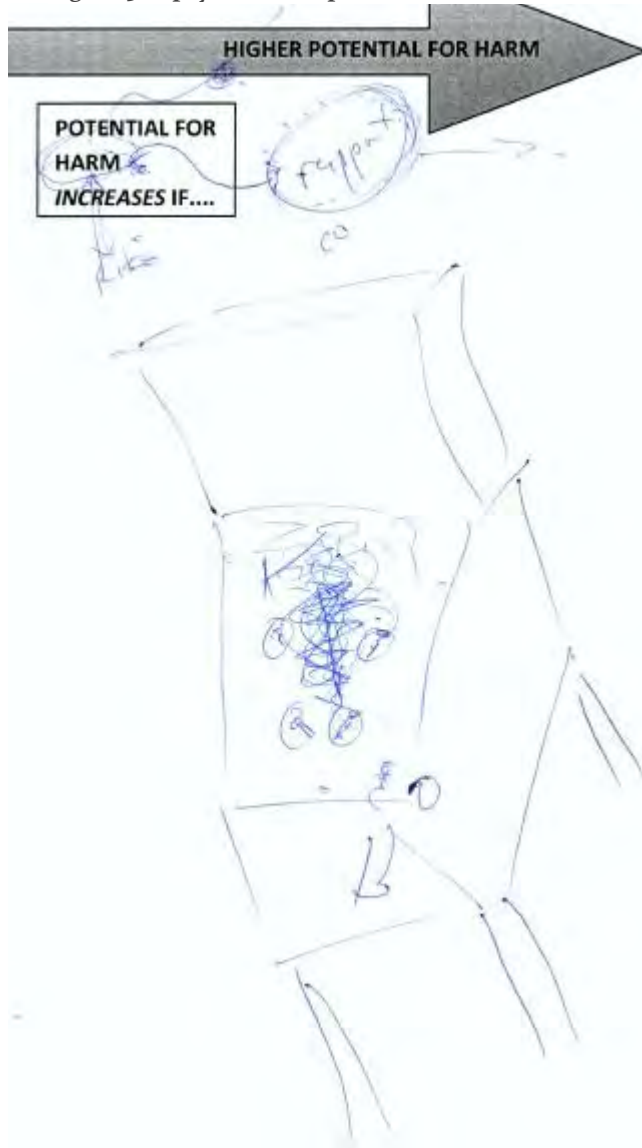
efforts of staff and family members who, as the paddles, continually push the ball back up the table. However, the ball's trajectory is chaotic, and the exact impact of the paddles on this trajectory is ultimately unpredictable. Such a picture of frenzied activity to keep a patient safe conveys something of the feeling of frustration and powerlessness participants often voiced. There is a sense here too that the activity of the paddles can never stop, because gravity and the slope of the table (and the circumstances of a patient's life and illness) pull the ball inexorably toward the hole.

5.3.2. Iatrogenic harm

The potential for a patient's interaction with mental health services and
treatment to result in psychological and physical harm is well recognised by

mental health professionals in this setting. However, rather than being attributed to mistakes made by clinicians themselves, this harm is most often seen as either an unavoidable result of protecting patients from a worse harm, or as a side-effect of using the available 'tools of the trade' in psychiatry. The three most commonly cited types of health care-related harm are attributed to physical interventions, medication, and the effect of admission to an inpatient ward itself.

Physical restraint of patients on the ward is thought by staff members to result in both physical and psychological harm. At the time of observation, several changes were being made to the staff training course on physical restraint techniques which constituted an acknowledgement of this. The first major change was to conduct floor restraint by holding the patient principally in the supine (on back) position rather than (as was previously the practice) in the prone (face down) position. The rationale behind this change was research evidence of respiratory compromise and death in patients restrained for too long in the prone position. Psychological harm was also acknowledged in the training manual, with considerable emphasis throughout placed on the importance of empathy when trying to understand the patient's behaviour, preference for verbal rather than physical de-escalation of aggression, and verbal debriefing with the patient concerned after the incident.

Medication error was not the main safety concern of staff when it comes to drugs. There was more discussion and concern about their side effects, which are often unpredictable for individuals. The harmful side effects of psychotropic medications were portrayed by several staff as a shameful aspect of psychiatry's history which continues in muted form in the present day. Disparaging mention was made of 'old' drugs (such as first generation antipsychotics), the effects of which were often irreversible and are evident in some older patients in the form of movement disorders and masked facial expression. Severity of side effects of newer medications in any individual is often uncertain, and many different combinations may be tried to minimise such effects. Even where a drug is

relatively well tolerated, there are still common side effects such as constipation, excessive salivation, sedation, and weight gain. Awareness of potential side effects, and of psychiatry's historical reputation for harmful drugs, were often part of conversations about medication.

> I overhear [social worker] ask [community nurse]: 'what is akathisia?' [The nurse] explains that it is one of the movement disorders, the worst of which is tardive dyskinesia. 'When you had them all in the bins [asylums] and they were loading them up on the largs [older antipsychotic drugs].' She adds 'it was terrible … .' (Field notes, 7 February 2011)

A third type of iatrogenic harm can result from the experience of being in an environment populated by those with acute mental illness. Many staff are aware that the fact of admission to the inpatient unit can be traumatic or place an individual at risk.

> [A nurse reports to the new shift on a patient]: '[We] haven't let her on sub-acute as she distressed another patient as she was in her face telling her long delusional stories. The other patient then started self-harming … Sub-acute is not a good place for her to be for the protection of the other patients.' (Field notes, 26 May 2011)
>
> A senior nurse comes into the handover room to update the shift on a new admission. He specifically requests they look out for her sexual safety: 'the new girl's [scared] … I would consider because she's [young] keeping an eye on her with the boys. I wouldn't underestimate [male patient] just cause she's so small and young.' (Field notes, 26 May 2011)

As these extracts imply, the mix of patients, in terms of age, diagnosis, gender and personality contributes to a dynamic on the ward which can be disturbing for some patients, particularly those who are not suffering active psychosis (such as people with depression), those who are old or frail, and those who are female. The traumatic experience of admission was cited by several staff as having led

directly to suicide in particular patients. On a more mundane level, the boredom experienced in the ward environment, as well as the removal of usual coping mechanisms (such as exercising and smoking) may also have a negative impact.

Dependency on mental health services and falling into a permanent sick role or learned helplessness is a form of iatrogenic harm recognised by staff. In the inpatient context, this may take the form of patients resisting discharge from the ward or returning as a 'frequent flyer'. In the community context it may mean an over-reliance on case managers to take on the everyday tasks of life. Some managers and clinicians are critical of case managers in the community who appear to foster this dependence and show reluctance to discharge them. Managers were trying to discourage this at the time of observation by promoting a strengths-focussed approach to care.

The stigmatising impact of being a mental health patient has a negative impact on the life of some patients. Sometimes this is due to self-stigma and shame, and sometimes due to discrimination by others. Related to this is the damage done to 'real life' during a long admission to hospital; examples were given of patients who had lost their homes, their jobs, and relationships due to being unable to maintain these while in hospital. Overall, iatrogenic harm in these settings is rarely related to the actions of staff members, but is often seen as an unfortunate but unavoidable side effect of the imperfect science and practice of psychiatry.

5.4.   The contestability of risk

To add to the complexity of managing safety, staff members commonly perceive multiple risks in a single situation which may be in conflict with each other and which must be weighed up. There can also be differences of opinion between the stakeholders involved about the degree and type of risk presented in the situation. These contested versions of riskiness must be negotiated between the parties involved, and a definition agreed upon, in order for a decision to be made or action taken to ensure a patient's safety. In many cases, there is no completely

risk-free solution and so staff members appear to aim at achieving the 'least worst harm' for all parties involved.

5.4.1. Balancing multiple safety imperatives

Clinicians are often confronted with the need for a compromise between multiple and conflicting risks to a patient or to others. Situations in which were observed to conflict included: when both the staff member's safety as well as the patient's safety are at risk; when there is concern for promoting patients' quality of life but at the same time preventing them being exposed to risky places, people, objects and situations; when there are no empty beds on the inpatient unit but no-one is really well enough to be discharged; when a patient is at risk in the community but historically does not respond well to inpatient admission; and when a patient needs to come into hospital for their own safety (or the safety of others) but to bring them in will cause them to stop trusting their clinician. There are potentially unsafe consequences to choosing either option, and a compromise is sought by weighing up the relative risk. Illustrating the difficulties of making such a decision, during a monthly meeting at which new local policies and procedures were discussed, managers debated the merits of changing the preferred physical restraint position. One used the debate over different positions to highlight the choice that has to be made between prioritising patient or staff safety.

> [A manager argues] '... we're waffling about this [time limit on prone restraint] and there are states [in the US] where it is banned'. He continues that the 'argument about restraint positions has always been about the safety of staff'. In the US and UK, he says, they finally thought they should consider the safety of patients. (Field notes, 1 June 2011)

Sometimes there is no optimal outcome and staff seek the 'least worst harm'. A manager remarked that when patients are discharged, 'rather than "they're better," it (discharge) means we think they're not likely to kill themselves or

someone else or less likely than somebody else who needs the bed ... it doesn't mean they're well' (field notes, 30 May 2011). A psychiatrist emphasised that in his view, some harms are preferable to others.

> [In a field interview with a psychiatrist] I talk a little bit about how I've noticed that [the community team] use Community Treatment Orders [CTOs, a legal mechanism for enforcing treatment in the community which, if not complied with, can also enforce an inpatient admission] a lot to manage risk, and the damage that this can cause to the primary clinician's relationship with the client. He says that in these situations it is also unsafe to leave the client at home and that they seek the 'least worst harm'. He adds that CTOs are good for keeping people out of hospital, inferring that if they didn't have them there would be more admissions. (Field notes, 21 January 2011)

The effort to balance the different risks may not always be successful. A psychologist related how she had gone on leave and whilst she was away one of her patients had physically assaulted another staff member. The psychologist felt that because of this, 'the client's needs just got dropped; everyone took a step back (and said) we're gonna provide all the support we can to the colleague, meanwhile [...] there was a token effort that somebody would look after this client, which they didn't' (interview 2). The balance in this case was shifted too far in favour of staff safety at the expense of the patient's care.

5.4.2. Contested definitions of risk

As well as balancing conflicting safety imperatives, clinicians were frequently observed disagreeing about the degree or nature of the risk presented in a certain situation. This took the form of different opinions between colleagues on the same team; colleagues on different teams; doctors and other clinicians; clinicians and managers; clinicians and patients or patients' families; and between clinicians and other agencies such as the police and housing department.

Conflicting views of risk management between policymakers and clinicians will be set aside here but discussed further in Chapter 6.

The differences of opinion between staff and patients about appropriate response to risk often meant the patient resisting what the staff member wanted them to do. Sometimes staff suggested that the patient did not feel their symptoms were a problem (which was not the opinion of the clinician). A community nurse disagreed with a patient on the phone about the appropriate treatment and framing of his illness: 'I suppose that's where we'll have to agree to differ. You think that getting better is through exorcism and praying to the gods, whereas we are treating you for psychosis. You're saying you're not ill' (field notes, 25 January 2011). During a case conference, a psychiatrist remarked that the patient is 'just focussed on his dreaming, not on things we think it's important for him to do [to get well]' (field notes, 14 February 2011).

Clinicians sometimes clashed with families about the treatment the patient should receive or about action to mitigate risk. A social worker spent an hour discussing with her manager how to proceed with a patient who refused to engage further with the service and whose mother blamed the social worker for not doing enough to help him. This breakdown in relationship had been precipitated by the social worker bringing the patient into hospital from his home with the aid of the police when the mother thought this unnecessary (field notes, 10 January 2011). On another occasion, a community psychologist complained that families did not understand the conditions under which patients could be involuntarily brought to the ward. She explained that a family often demand an admission when a patient is in a 'drug or alcohol induced stupor' but 'the best treatment may not be an admission, which is something the parents often struggle with – often it's not necessarily the illness that's playing up' (interview 2).

Colleagues within the same team often debated the risk presented by a patient who both parties were familiar with. A team leader was concerned about the risk

posed to one of his team members, whose caseload included a patient who was known to be a paedophile. As the team member lived close to the patient, and had children, the team leader wanted the patient to be given to another worker. However, the team member refused, saying that he had a good rapport with this person. Similarly, the conversation below, where clinician 1 wants clinician 2 to be involved in bringing a patient to hospital, reveals a different perception between the two about the severity and urgency of the risk presented by this patient.

> 1: I've got the family waiting and we're going to discuss bringing him in.
>
> 2: You won't get [registrar], he's out on a home visit assessment now.
>
> 1: This family are not gonna let this rest.
>
> 2: The family can call the cops …
>
> 1: Mum wanted to avoid involvement.
>
> 2: What they should have done is call the police when the assault happened – it depends how urgent it is, there is no recent [aggression/ violence]. What are the immediate risks today? It's an alleged assault at this stage. [He emphasises that his team does not have many staff on this evening]
>
> 1: How [do] we cover ourselves, if there are no staff? [later the same day, during another conversation]
>
> 2: We'll try and do it tonight but…
>
> 1: I'll bet you $100 that you'll hand it back in the morning.
>
> (Field notes, 7 March 2011)

Doctors and other clinicians (especially community case managers) frequently disagree about the risk presented by a patient, most commonly in terms of whether the patient should be admitted involuntarily to the ward. This can sometimes emanate from the case manager's long-term knowledge of the patient conflicting with the doctor's interest in the immediate picture.

> Psychiatrist: I think that the case manager almost had transference of the patient's experience of what happened last time in hospital and really wanted to avoid it. I think longitudinally she probably did have it right, but

> I had to go on the cross section of what I saw, and also advocate let's not
> keep him in for very long. I think this case manager has a good point ...
> you're always sort of trying to smooth things I guess. (Interview 7)

If there is a difference of opinion between doctor and other staff member about admission, it is the doctor's assessment of the risk that carries. For other staff, this can feel like obstruction of their attempts to keep the patient safe. A psychologist, asked what she saw as the main barriers to patient safety, replied 'a psychiatrist disagrees with you and therefore you can't get the outcome for the client that you wanted' (interview 2).

Multiple risks were explicitly negotiated between clinicians during the flow of practice in order to agree which to prioritise when making a decision. During an inpatient team meeting, a senior nurse asked what staff thought about proposed changes to the 'contraband policy' (items which are banned from the ward). The discussion revealed that different people perceived four separate risk priorities when thinking about which items to ban, and these were weighed up against each other. Firstly, a social worker emphasised the need for patients to retain a sense of normal life in the ward without too many of their routines being taken away, and that doing so constitutes a risk in itself: 'I can't imagine not having a hairdryer.' A junior nurse argued that there is not a realistic need for certain items during a stay on the ward. She was dubious about the need for hair straighteners, for example. The potential physical harm presented by the object was prioritised by a senior nurse who said 'I can see somebody using a hairdryer and someone coming up and throwing a cup of water over it or dumping it in the sink' (field notes, 19 May 2011). The last consideration was the time required of staff to supervise the use of risky objects. Even though the senior nurse who was responsible for the contraband policy acknowledged the validity of the quality of life arguments, she justified banning the hairdryer and other items because 'when you're working in an area of risk ... the line gets drawn a bit harder to protect us

and the patients' (field notes, 19 May 2011). Physical risk trumped quality of life considerations in this and many other risk negotiations I observed.

5.5.   Conclusion

Clinicians in these community and inpatient unit teams hold varied but nuanced and context-bound conceptualisations of 'safety,' which appears in many situations to equate to 'risk minimisation'. In general terms, they see their role in relation to the safety of patients as being that of protectors against a wide variety of risks which owe their origins to the patient's illness or circumstance. Nevertheless, this role and expectation can only be partially fulfilled, as professionals feel their impact to be limited by the unpredictable reaction of mental illness to life events and the uncertainties pervading the practice of psychiatry. Uncertainty and unpredictability surrounding risk involves clinicians in a constant balancing act to ensure their decisions result in what can sometimes be nothing better than 'least worst harm' for patients.

Chapter 6:   Enacting expectations of the 'safe' service

6.1.   Introduction

Two distinct forms of patient safety are accomplished by mental health professionals in these settings. Each has its own purpose, discourse and logic; its own intended audience and version of 'the good'. The first, the focus of this chapter, can be called performative, because it is the expectations of external audiences, distant both in time and space, which drive the form and function of this aspect of professional activity. Such a version of safety can be called performative because the technologies (such as buildings, policies and documentation) associated with it generate 'not only representations of reality, but also the realities those representations depict' (Law, 2009b, p. 239). Patients, risks, and the role of the service, in other words, are not just represented in particular ways by those technologies, but come to take on a particular reality whenever they operate. The main purpose of this version of safety enactment is to justify and defend the actions of clinicians and the mental health service, and to create an impression of an ordered world where risks, causes and effects can reliably be predicted and identified.

The second form of safety, the subject of Chapter 7, is accomplished moment to moment in response to the exigencies of the unfolding needs of the patient, and is primarily focussed on those immediately present including patients and colleagues. The maintenance of patient and staff safety on a day-to-day basis necessitates recognition of unpredictability, uncertainty and the situation-dependent nature of safety enactment. The activities related to these two logics of safety are sometimes carried out in isolation from one another, but are often intermingled (and interdependent) in the practice of care.

This chapter, dealing with performative safety, is structured in three parts. The first (6.2) examines the expectations of parties external to the mental health service regarding its social role and that of its employees in the maintenance of

patient and public safety. These expectations together form a normative discourse about how risk 'should' be managed and safety achieved. The second section (6.3) looks at the ways in which this discourse is remotely communicated to professionals by the ward environment, documentation, the objects of work and the 'war stories' of colleagues, all of which enable or constrain their activity in ways that reinforce the dominant discourse. The third section (6.4) is an exploration of the practical instantiation of these expectations in professionals' talk and work. The importance of showing the expectations to be met is acknowledged in emphasis on careful documentation practices with a view to avoiding personal censure, but a significant undercurrent of resistance to the prevailing discourse is present. Professionals exhibit neither an uncritical acceptance of external expectations nor a complete cynical dismissal of their usefulness. Rather, they weave the imperatives of formal requirements into their everyday practice.

6.1.1. The patient safety play

A theatrical analogy is useful to understand the dynamics of 'performative safety,' similar to Goffman's idea of the front-stage and backstage aspects of the 'presentation of self in everyday life' (Goffman, 1959). Here, we can substitute the 'presentation of safety' for 'presentation of self.' Professionals present their safe service on the public stage to a theatre full of critics – Coroners, policymakers, the public, journalists, patients' families, and regulators. The audience's unseen but omnipresent expectations drive the script, as well as design of the props (the objects of work), sets (the environment in which the action takes place), and stage directions (policies and guidelines). Significantly, patients do not appear front-stage. The staff performers often disappear backstage to interact with patients, returning to front-stage to relate a (selective) account of what they have done. It is these accounts which are judged by the audience, as it is all that they can see (as the only traces that remain after a day's work in the mental health service are various written accounts of what happened). Many of the performers

do not agree with the sentiments expressed in their play's script, and discard it when they leave the stage. Others carry the script with them, referring to selected parts to guide their off-stage activity. What unites their performances, however, is the constant effort to ensure that the audiences' expectations are fulfilled by the play, that reviews are positive, and that, above all, safety is seen to be done, no matter what the performers' opinions of the quality or usefulness of the script. If the play is panned, the performers may be sacked and the theatre may go out of business.

6.2. The normative discourse of safety

Professionals in these settings were observed to justify a substantial amount of their activity in terms of external expectations of what their service should deliver. It was seen as important to act to satisfy the expectations of external parties including: health authority management and policy makers (at regional, State and Federal levels); legal authorities, particularly the Coroner; patients' families; and 'the public' in general including the media. Together, these expectations form a normative discourse, a values-infused narrative indicating "'what is good or bad about what is' in light of "what one ought to do'" (Schmidt, 2008, p. 306).

6.2.1. Families and carers

Patients' families and carers are often heavily involved with the mental health service in terms of caring for the patient at home, advocating for them, and in some cases being patients of the service themselves. Support from families and a stable home environment are seen as essential to a patient's wellbeing and recovery. While family members are sometimes thought to hinder a patient's progress, clinicians nevertheless use them as sources of corroborative information about the patient or as an 'extra pair of eyes' to monitor patients' wellbeing.

However, families are felt to place a high level of demand on mental health professionals when it comes to mitigating the risk presented to or by their relative. Such demands emanate from an expectation that when the patient is under the care of services, it should be impossible for harm to befall them, and from a belief that the patient should be 'better' and present little risk when they are discharged from the ward. As the psychiatrist explains below, such assumptions are made explicit when things go wrong and families seek to attach blame to services and clinicians.

> Psychiatrist: [In this job] you must attend to and deal with families. The families are always there. My sense of it is the families, generally speaking, are reasonably entitled, can be quite demanding, and at times they can be quite unrealistic ... the bad combination is when you've got that sort of thing which somehow you didn't attend to, plus there's a death, usually of their family member and then you've got a hostile Coronial inquiry and Healthcare Complaints [Commission]. [...]
>
> [Then there are] hours and days and weeks of time spent needing to sort out that death, which you never really want to happen in the first place obviously ... you tried your best to avoid it [...]. I think you know they're ... they sort of have it good in [this area], the population's reasonably comfortable. They're maybe not that tuned in to the sort of possibilities of all these kind of bad things that can happen until it happens to them, and then there's a sense of wanting to blame someone for that. (Interview 16)

Local families, shocked by the 'bad things' which have intruded on their 'comfortable' lives, see the proper role of the service as protecting them from these things. This doctor's emphasis that staff 'obviously' don't want such events to happen and do their best to avoid them reflects a feeling that perhaps families perceive staff as uncaring or indifferent to whether patients come to harm or not. The use of words such as 'entitled', 'demanding', and 'hostile' infer that he believes the expectations to be unfair and unrealistic. He illustrates how the

expectations of families can coalesce with and be amplified by the expectations of authorities such as the Coroner and the Health Care Complaints Commission.

6.2.2. *The media and the public*

A general social trend towards risk aversion is blamed for what some professionals see as increasing public intolerance of risk presented by or to mental health patients.

> Manager: We seem now to have a society that's far more risk averse than has previously been the case, and mental health, we sit within society, so we sit within those same expectations. So what might have been considered acceptable levels of risk previously are often now seen as unacceptable, so then the expectation is around the individual clinician or the service being able to manage those. (Interview 5)

The responsibility of mental health services to protect public safety is keenly felt by staff and is strongly tied to the desire to protect the reputation of the service, particularly from media attention. Reflecting (or perhaps shaping) family expectations, public expectations – reinforced by the media – appear to be of a 'zero-risk' service which only lets patients into the community who present no risk to others or themselves.

> The psychiatrist explains that the 'official version' of risk management may well conform to the 'expectations from *A Current Affair'* [a tabloid TV news programme]. She says that there is zero tolerance in the community for risk and this is totally unrealistic, there are some very risky people out there. There is no 100 percent risk guarantee. (Field notes, 21 January 2011)

This doctor went on to give the example of the 'low risk' patient who recently killed a staff member in another hospital, a juxtaposition which has the effect of rendering these expectations unreasonable. The labelling of this 'version' of risk management as the 'official version' infers the importance placed by those in

authority on showing conformity with the zero-risk expectation, whether or not this is possible.

6.2.3. The legal system

The legal obligations imposed upon professionals by the *Mental Health Act 2007* structure many professional activities. The *Act* stipulates that people can only be involuntarily detained and treated if they are suffering from a mental illness or mental disorder *and* present a risk of serious harm to others or themselves. The treatment must be carried out in the 'least restrictive environment' possible and treatment may also be enforced in the community through Community Treatment Orders (CTOs). The stipulations of the *Act* carry primary importance for clinicians to the extent that they sometimes feel compelled to act against what they believe to be the best care for the patient, in order to comply with the letter of the law.

> While we sit at the bench in the nurses' station, [a consultant psychiatrist] comes in and says to the nurses that 'she [patient] wants to discharge herself ... I don't think I've got grounds to keep her.' Commenting on this, [a social worker] says to me that it's 'interesting how the *Mental Health Act* works' – explaining that even if 'we think it's in her best interests to be here ... unless she's a danger to herself or others due to a mental illness ... we can't keep her'. (Field notes, 7 June 2011)

Professionals frequently mention the threat of a Coroner's inquiry as influencing their activity and decisions concerning risk and safety. The main concern is to act in ways which will enable a professional to avoid personal censure during some hypothetical future inquiry. It is primarily through this threat that policy requirements influence practice. If these are shown in documentation to have been followed, professionals feel that they will be on safe ground. The Coronial expectation is that if a patient comes to harm, professionals must produce written evidence that they fulfilled their policy and legal obligations in the care

they gave this patient. If this evidence is missing, the clinician is exposed to potential censure.

> One of the managers from the other hospital says that under the *Civil Liabilities Act 2002*, policies can be 'taken up by the Crown' – a Coronial lawyer can ask 'did you read the policy?' (Field notes, 1 June 2011)

Emphasis on the documentation of compliance is connected to the difficulty in mental health care of proving that actions or omissions by clinicians directly led to harm (or avoidance of harm). This difficulty is related partly to the variety of factors which can lead unpredictably to harmful outcomes where, as described in the previous chapter, 'anything in the universe' might increase the risk to a patient in ways which are not under the clinician's control. Such uncertainty may mean that the act of having correctly filled in a form, being a tangible 'thing' in a world of intangibles, becomes the focus of attention in an inquiry as a physical trace of the day in question. There is a sense that if a form has been correctly filled in, the clinician is more likely to be 'off the hook' with the Coroner.

> Psychiatrist: Should anything go wrong, y'know it's [risk assessment sticker] an easy thing to look at, and the Coroner will say 'well, did you do a risk assessment?' 'Yeah I did there it's on the sticker … phew … I did it!' so at least you can say you did a risk assessment … and so therefore … next question. (Interview 16)

6.2.4. Health authorities

Managers in particular feel the pressure of expectation from local and State health authorities that they should keep their service operating within certain parameters. These are standardised requirements, codified in policy and regulatory guidelines, and are the subject of measurement and therefore audit by the authorities concerned. However, there are difficulties associated with the

most frequently discussed parameter, length of stay (LOS), in that it sometimes conflicts with achievement of a benchmark for readmission rates.

> She [senior manager] also mentions significant 'benchmark' pressure to discharge – such as LOS benchmarks which she describes as 'unrealistic' – LOS on the inpatient unit is supposed to be around 12 days but in reality it is more like 21 days. She says the benchmark is unrealistic because the patient only comes in when they have deteriorated so much that they cannot be managed outside of the unit. They also have [competing] pressures from the readmissions within 30 days of discharge benchmark. (Field notes, 12 January 2011)

6.2.5. Summary of expectations

These expectations of the mental health service in relation to safety and risk – and the normative discourse which they constitute – can be summarised as follows.

1. Risk of harm to patient or public can and should always be identified and mitigated by the mental health service, if necessary by removing the patient from the community.

2. Staff being aware of and following policy and legal requirements is a good way to ensure that harm does not occur.

3. If a person does come to harm, the service or individuals working in it can be blamed, especially if they cannot provide written evidence that they complied with relevant policy and law.

6.3. How expectations enter practice

Taken together, these expectations form a normative discourse about the nature of safety and risk in mental health services and how they 'should' be managed. These are elements of general social discourse, not specifically professional

discourse (Langan, 2010), and so it is likely that the professionals have already been socialised into these understandings before they start their career. However, once they start work in the mental health service itself, the normative discourse is further reinforced to them each day in their workplace. This reinforcement is not often done via direct communication to professionals by external parties. Rather, it happens through the rhetorical force of stories colleagues tell each other about the negative consequences of not meeting expectations, and through the embodiment of the discourse in the design and management of the physical environment and its encoding in policies and procedures.

In doing this reinforcement work, inanimate things – spaces, objects and buildings –become performative. That is, they enable certain understandings of risk and safety while restricting others, and they promote particular activities, decisions, and interactions whilst discouraging others. Some of the ways this process happens are elaborated below. Every professional's engagement with the materiality of their work reinforces parts of the prevailing discourse.

6.3.1. The physical environment

Liminal space

I used my own early reactions to and experiences of being in the hospital to reflect on how the physical environment gives certain messages about safety to newcomers. The extract below describes my first visit to the community team base. The service's location in the basement of the hospital next to 'back office' functions such as the medical records department already reflects isolation from the rest of the clinical spaces of the hospital. It also conveyed a sense of being separated from the outside world before I had crossed the threshold. On entering the community team offices, this feeling of separateness did not abate:

> None of these offices have any windows, and it feels generally a bit dark and 'surreal' under the fluorescent lighting, and a contrast to the bright and airy public areas of the hospital [...] [Later] [a senior manager] and I walk

> down another corridor (still behind the original swipe-card door) to an area which she says is rooms where patients are seen. [...] Still no windows anywhere. It is starting to feel like a twilight zone. (Field notes, 13 December 2010)

Although I later realised that some of the offices did have windows, I did not notice them at the time and was most struck by a feeling of the whole place being dark. The feeling of the environment as 'surreal' and in contrast with other areas of the hospital intensified when I entered the inpatient unit for the first time.

> [Inside the nurses' station], around three sides, there are shaded windows, it seems like the flight deck of a space ship, [...] with two TV screens mounted above the windows each with four CCTV views on them. From this area you can see into (on the left) the acute care unit and on the right and in front a larger sub-acute unit. In front of the nurses' station windows there is a large seating area, and beyond this area some windows with what looks like a courtyard with some rainbow/sky-type murals painted on the far wall. (Field notes, 13 December 2010)

I did not reflect on it then, but the use of the 'space ship' analogy represents a continuation of this otherworldly feeling. The courtyards, with their high walls carrying stylised depictions of local outdoor scenes, but with no view of a 'real' outdoors, heightened the sense of isolation from everyday life. The resulting impression to the newcomer was that of the mental health service as a liminal space, a perpetual limbo, neither part of the outside world nor entirely part of the hospital. Media and public expectation of managing mental health patients' risk by separating them from society was physically manifested here. However, the in-between nature of the place reflected the fact that patients and staff alike are caught 'betwixt and between' conflicting policy imperatives to protect the public as long as risk is present at the same time as limiting length of stay.

Controlling risk environmentally

Patients in a mental health ward are, most of the time, engaged in activities to pass the time such as watching television. Instead of the usual hospital clutter of machines, drip stands, and monitoring equipment interspersed with beds and visitors' chairs, there was an open and carpeted 'common area' populated by institutional-looking heavy furniture and little else. Despite these differences with 'conventional' hospital wards, curtained bed areas, whitewashed walls, beds on wheels, uniformed staff members and absence of colour marked the location.

As fieldwork progressed, it became clear that this modified hospital-style environment did not embody a concern with controlling infection risk (which is of prime concern in other wards). Rather, the environment worked to reduce opportunities for physical harm. A community worker's interaction with the materiality and space of the ward shows how the environment can communicate the nature and severity of risk posed by patients.

> The psychologist asks me several times whether I want to come onto the patient area of the ward with her. When I say I would like to, she explains [about the patient she is going to see] 'he has never threatened me' but infers that he does have a history of violence. She takes a duress alarm which she pins to her shirt, and we go on to the ward [...]. The patient's room is a double room and is dark, the door ajar. She gingerly knocks and when there is no answer, pushes the door more open and calls his name several times. [...] I see that there is a separate bathroom on this corridor, a wet room with a shower with no curtain or surround ... all the door handles are anti-ligature [hanging prevention] handles. The environment is very spartan and hospital like – no decorations or anything colourful. Patient beds seem to have plain white sheets on them. (Field notes, 10 January 2011)

These warnings about the patient, the donning of a duress alarm, and the reluctance to enter the patient's room all point to a belief in his risk to others. The modification of the environment through removal of objects such as

conventional door handles and shower curtains shows that the service must go further than simply using staff to directly watch patients. The building of permanent prevention measures into the fabric of the building conveys that the nature of suicide risk is that it can apply to any patient at any time. This, in addition to the removal or close supervision of any objects considered risky, emphasises to staff that patients are not to be trusted. If a patient cannot be observed by a staff member, the opportunities for self-harm must be removed from the environment. Objects that ordinarily constitute necessary or desirable aids to living are here perceived as infused with risk.

The doors and walls of the inpatient unit do safety 'work' which is different to that done by the doors and walls of a medical or surgical ward. This work is central to the service's ability to meet the expectation that patients cannot harm themselves or others while under its care. Walls and locked doors, in their immutability, enable extension and augmentation of staff ability to control patients and to physically contain the risk they are assumed to present.

Spatial instantiation of risk level

In the inpatient setting, different spaces are marked out as accessible only by patients considered 'safe' enough to be there. Staff exert control over risk partly by controlling patients' access to space. The patient's world is allowed to expand as their level of assessed risk decreases. This is illustrated in the following diagram (Figure 6) and explained further below.

Figure 6: Risk-mediated freedom of movement
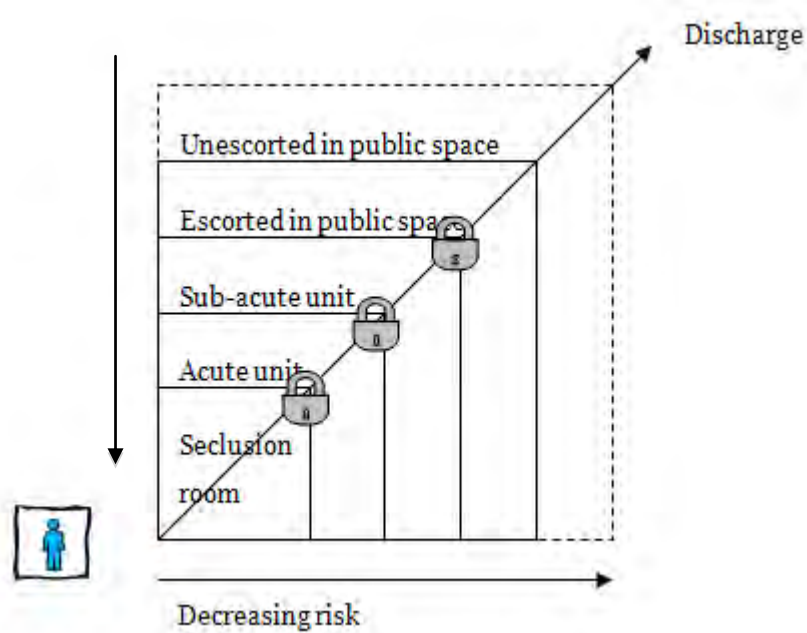
Although almost half of patients cared for on this unit were voluntary patients (are not compelled by law to be there), the ward doors were locked at all times. When patients first arrived on the ward, they were generally housed in the 'acute' side, separated from the sub-acute side by a locked door. When assessed as 'safe' enough, they were moved to the sub-acute side of the door. Before moving to a bed there, they were sometimes 'tested out' using short periods of time on the sub-acute side to see whether they were ready to move. Granting of periods of leave from the ward marks a further reduction in assessed risk. Gradations of leave are given; the length of time the patient is allowed out of the ward, and whether they are allowed to go only when escorted by a staff member or family member, is calibrated against assessed risk. In this way, passing over the threshold between areas of the ward or between the ward and the outside world is a physical marker of progression towards discharge and a token of staff trust. As these moves are made, safety shifts further away from being physically imposed towards being at least partly internalised by the patient.

Such spatial arrangements, where a degree less risk means that a patient can literally advance a step closer to contact with the public, embody the expectation

that 'risky' individuals should not be discharged to the community. Indeed, those considered most risky are two locked doors away from the outside world. The location of a patient's bedroom can also act as an index of their mental state:

> Senior IP nurse: When you're reviewing IIMS [electronic incident monitoring system] it kind of gets [asked] which side of the ward were they on ... you can kind of gauge unless we're bed blocking ... you can kind of pretty much gauge someone's mental state as to where they are ... . (Interview 10)

During acute episodes of aggression or agitation, a patient's world may be shrunk still more behind a further locked door in a seclusion room. The room is an extreme version of the rest of the unit in terms of having all objects except for a mattress removed from it. The environment has been modified over time to remove as much physical risk as possible and thereby externally impose safety to the greatest extent possible.

> [The nurse showing me around] points out the seclusion room. It is L-shaped, with a (locked) bathroom in one corner. She points out changes which have been made. They put vinyl all up the walls, because the 'gyprock' [wall] had been kicked in previously. She says that there used to be a 'kick board' along the base of the walls, which was also removed (I presume because it could be pulled off). There is a small window high up in the wall opposite the door, through which you can see the tops of some trees. It is about 20cm x 70cm. In one corner there is a round metal convex mirror (no glass) which is next to a CCTV camera. [The nurse] explains that this is so that anyone looking in through the window in the door can see the person if they are round the corner of the L-shaped room. There is a single mattress on the floor, which has a sheet and blanket on it. [...] Unlocking the bathroom, the nurse explains the lack of toilet seat – it had been destroyed too often so now they just don't replace it; they hardly ever use the bathroom anymore – patients are often only in the room for a few minutes or half an hour or so. She also points out the door which she says is a very heavy, metal door 'like in a bank'. (Field notes, 26 May 2011)

The inaccessibility of the bathroom is perhaps the most striking example of the priority given in this setting to prevent physical harm to the exclusion of any other consideration. Meeting the public expectation that risky individuals be removed from the community can often come at the cost of meeting patient expectations; the following extract illustrates how patients sometimes feel that rather than being hospital patients, they are really inmates, because of the locked and boring nature of the environment. These remarks were made during a training session for staff on physical restraint techniques; they were asked by the trainer to think about why patients might become aggressive on the ward.

> The NUM from the other hospital says 'I get lots of complaints' from consumers. 'They perceive they're in a bubble … they can't smoke, they can't [go out] … the design is atrocious for a therapeutic environment, so they're bored. Activities are limited, they see us as being punitive and they feel invisible. They just feel like they're in a prison sometimes.'
> Another nurse agrees: 'They [say] "what have I done wrong to deserve this?" Well, you haven't done anything wrong … .' (Field notes, 20 June 2011)

Nurses' station: extending the reach of the 'gaze'

The nurses' station is a prominent feature of the inpatient unit. It is locked, and has windows all along three sides, giving staff a view into the common areas and down the bedroom corridors on both sides of the ward. Long desks line the walls under the windows, containing three computers, folders with legal and other patient-related information, folders containing patient notes, staffing rosters and observations charts. A CCTV screen monitoring the seclusion room, and one extra computer which permanently monitors duress alarm locations and calls, also sit on the bench under the window. Above the windows, near the ceiling, two further monitors show four CCTV views each, including the courtyards, common rooms, and corridors. One inpatient staff member reflected as follows on the nurses' station in comparison to his former place of work.

> He mentioned that his other experience of an inpatient unit had been in the city where he used to work, which was light and a bigger environment, and the nurses' station was 'very tiny' ... he said he was struck [when he arrived here] that the nurses' station here is quite big. He relates this to Foucault's discussion of the panopticon, and says that one of the patients had said to him how they didn't like feeling they were being observed from the nurses' station all the time. (Field notes, 7 June 2011)

This ability to observe large areas of the ward from a central and secure vantage point was valued by staff. Importance was placed on not allowing obstruction of 'sight lines' across the ward – the location of vending machines was decided on this basis. The design of the nurses' station embodied particular messages about the nature of safety and risk and encouraged certain ways of working above others. The prominence of the windows onto the ward, and the fact that the room was closed in and locked, encouraged visual monitoring of patients rather than interaction with them. The locked doors also emphasised the power differential between patients and staff. Whilst patients had to knock on the door and wait for a staff member to attend to them, staff members could access patients at any time.

The separation of staff and patient worlds was reflected in the different objects and activities of the two areas. Parts of the nurses' station were used as storage for objects considered risky. The clutter and 'dangerous' objects such as medications, razors, 'contraband' confiscated from patients, and various signs of everyday life such as cakes or chocolates and thank you cards, provided stark contrast with the spartan patient spaces. While these were characterised by little movement and activities such as sleeping, watching TV or group discussions and therapies, the nurses' station was usually (during day shifts) characterised by constant chatter, staff coming and going, and paperwork. The two spaces demarcated the clinical and organisational work of staff members. The windows enabled them to carry out clinical work (observation) while doing organisational

(administrative) work at the same time. This encouraged staff to spend long periods of time inside the nurses' station, venturing out onto the ward for relatively short times to accomplish specific interactions with patients.

6.3.2. Objects

Objects as inherently risky

Everyday objects, on entering the ward environment, became potential sources of harm. Several procedures had to be carried out when any object crossed the threshold into the patient areas. Objects brought by visitors were checked against a the contraband policy before being allowed in. Patients returning from leave were frisked with a metal detecting 'wand', and courtyards searched for objects thrown over the walls for patients by relatives. Daily searches of patients' rooms and belongings were undertaken on the acute side of the ward.

> [Ancillary staff member] says he is going to go and do the room searches with [a nurse] and I ask if I can join them. He explains that they are looking for cigarettes. The search seems rather cursory to me – [ancillary staff member] looks inside a few jacket pockets, in wardrobes, in a wash bag, etc. Nothing gets confiscated except a 1.5 litre Coke bottle which is full of water – 'they can't have this, it's too big'. He empties the bottle out in the sink. From the same patient's room he has taken a reusable shopping bag, explaining to me that the 'handles are so strong' (and could be used for hanging). As they go through the rooms they talk about various hiding places – for example things can be stuck underneath furniture with chewing gum. A patient comes up and offers to show us another hiding place he's discovered. Firstly he infers that he will show them in return for reconsideration of his leave; however he then says he will show them anyway. He leads us to a bathroom and opens up the soap dispenser, which he thinks would be a good place to hide things. (Field notes, 17 June 2011)

The use of two objects introduced to the ward by the service in an effort to improve quality of life for patients were subject to intense supervision by staff. A fixed piece of sporting equipment and some beanbags were each assigned their own observations charts – the same charts used for patients – on which staff were supposed to note down every half hour of every day where the objects were and what use they were being put to. Awareness of the absurdity of such a requirement was illustrated by a mock notice circulating in the ward office which told staff to 'count all the beans in the beanbags' each time they were observed. These processes reflected the expectation of a zero-risk service, in the context of which every move to alleviate patient boredom or improve comfort had to be accompanied by extra staff labour. The joke notice reflected clinicians' beliefs that in reality such removal of all risk was impossible.

Objects as monitoring tools

The tools of the mental health professional's trade embody, just like the physical environment, messages about how safety and risk should be managed. While the riskiness of objects is the principal concern in patient areas, the use of objects to render aspects of a patient's current status visible to staff members across multiple shifts is characteristic of staff-only spaces. Two whiteboards in the nurses' station list patients according to the room they are occupying. Because blank rows indicate empty beds, the boards are a visual reminder of pressures to discharge, particularly when (as is usual) all the beds are full. Patients' names are listed in the left-most column of the table, and other columns display the same types of information about each patient. The boards represent the current pooled knowledge of staff, enabling them to communicate with each other about a patient even when they cannot talk face-to-face. However, this knowledge is only usable if it falls into a limited number of predefined categories as follows.

Category of information
Bed number
First name and surname initial
Age
Admission date
Shift nurse's first name
Care level
Legal status
Social worker's initial
Community worker's first name
Potential discharge date (or when their scheduling order is valid until)
Leave status

This choice of categories to characterise each patient signify to staff which dimensions of patient care they need to pay most attention to and keep updated. The inclusion of three staff members' names, as well as an indication (using pen colour) of which registrar and consultant psychiatrist are looking after the patient, indicate the importance of multidisciplinary input to the patient's care, and the need for different staff members to liaise regarding a patient. Care levels tell nursing staff how often they should be observing patients; legal status is either 'voluntary' or 'involuntary'; and leave status is a note regarding how long the patient can leave the ward, whether they need to be escorted, and whether their leave is only for specified activities. Excluded from the monitoring exercise are things such as diagnosis, medication(s), and therapeutic interventions. The emphasis on the restrictions placed upon a patient rather than upon their treatment or strengths serves to re-emphasise the expected function of the ward. It is a place for the containment of patients who are portrayed as passive subjects of risk-focussed parameters set down in policy and law, rather than as active participants in their own progress.

Monitoring of staff members' movements is accomplished by portable 'duress' alarms which are supposed to be worn when in patient areas. The alarms, if triggered, can pinpoint the location of a staff member on a screen in the nurses' station, so that help from colleagues can rapidly be given. The alarms, combined with CCTV cameras, do the work of observation without someone actually having to observe until something goes wrong. For community staff members going on home visits, a note is supposed to be made before leaving the base as to where they are going and at approximately what times. They also take a mobile phone with them with the emergency number on 'speed dial'.

Although most details of a patient's history and interaction with the service are recorded in paper records, each patient has a basic record in a computer database. The clinician is prompted by the database to check this record when they indicate, as part of their daily activity record, that they have had an interaction with a particular patient.

> He [psychologist] shows me how the [computer] program forces the user to check clinical details, including the client's diagnoses and legal status. On this tab there is also a button to 'view risk factor history' – under here he says you might put serious medical condition or history of violence. If something has been entered under risk history, there is a button under the 'clinical details' tab which says ALERT in bold red letters. If this is not checked, a warning pops up when the clinician tries to close the page. In the example page the psychologist is showing me, there are three listings from a single day nearly a decade ago – listing 'harm to others', 'damage to property', and 'absconding'. The psychologist says of this that the client 'gets very unwell' – I ask whether these alerts stay on the system forever, and he looks to see whether he can edit the page – he can't. (Field notes, 4 February 2011)

In forcing the clinician to review and be 'alerted' to the patient's 'risk history,' some of which may not be of current pertinence but which cannot be removed,

the program embodies a characterisation of the patient augmenting the emphasis on risk management.

6.3.3. Documentation: policies and forms

Staff members in both community and inpatient services spend a substantial amount of their time filling in documentation for patient files. The pre-formatted nature of the documentation indicates what tasks staff should be doing in relation to patients, and promotes particular ways of structuring them and carrying them out. The documentation is standardised and issued by the State health authority, which on its website directly links using standardised records for each patient with 'improving the quality of our mental health services' and enabling services 'to better understand and address the needs of our consumers and better plan their mental health care' (New South Wales Health, n.d.). This explicit link between documentation and improved practice infers that to be a good clinician is to use these documents as instructed.

As an example of how the format of this documentation conveys the normative discourse about risk and its management to clinicians, the 'risk assessment' section at Figure 7 features repeatedly in the same or similar format in multiple patient documentation modules, including triage, initial assessment, 13-week review, and discharge summary. There is also a longer two-page risk assessment form which is filled out on admission.

Figure 7: Short form of risk assessment

The recurrence of this short risk assessment in multiple documents, to be filled in at different stages of the patient's interaction with the service, indicates both the potential changeability of this risk (one assessment is not sufficient) and the centrality of this task in taking care of the patient. The absence of free text space on the form restricts clinicians to recording standardised and simplified information about each patient, while 'suicide' and 'violence' are considered the most important risks for clinicians to identify and assess – with limited scope to consider other risks.

In terms of working out whether a risk is significant or not, the form gives strong indications of the most important predictors to consider, namely knowing about past history of risk, recent thoughts and behaviours indicating risk, and the concerns of others. These factors are specific to type of risk (e.g. ticking 'yes' for 'significant past history of risk' for 'suicide' does not imply the answer will also be 'yes' for 'violence'). However, other predictors of current risk can apply equally to suicide and violence, including current substance misuse, the presence of major mental illness or disorder, and characteristics of current mental state. In addition, it appears to be enough to know that there has or has not been, for

example, 'significant past history of risk'; the nature, circumstances, and precursors of that risk are not important in comparison.

Implicit in all this is that considerable knowledge of the patient's history as well as information gathering from other sources is required to fill in the form, but cannot be reflected in it. The final demand made by the form is to force the clinician to classify overall risk into 'high', 'medium', or 'low', despite the earlier acknowledgement that assessed risk may be 'changeable' or subject to 'uncertainty'. Overall, then, the form encourages the clinician to present a highly selective account of the risk posed to or by the patient. The account will filter out complexity and uncertainty surrounding the assessment, and offers no guidance as to what the conclusions of the assessment might mean for practice and care of that patient. The only advice is to fill in a more detailed risk assessment form if certain boxes are ticked.

The importance of correctly filling in documentation is highlighted by the way the State health authority monitors service activity and performance through collecting a standard range of data about the service. At regional and hospital level, various audits are also run to monitor team and clinician performance and to demonstrate compliance with policies. A key feature of all these levels of audit is that they rely on written evidence that a particular activity has been carried out rather than direct observation of the activity itself. The importance of documenting activities and decisions in ways which present these in a favourable light is reinforced by the fact that negative consequences for the service or for individual clinicians – from the health department, managers, or the Coroner – can only accrue from what they have written rather than from what they have actually done.

During field observations, an official from the State health authority visited the inpatient unit and gave a presentation to clinicians intended to give feedback, through a series of tables and graphs, on the recent data collected about the unit. Each graph compared the unit to other, similar units. The types of data reported

on included: patient characteristics (average age, primary diagnosis and co-morbid substance abuse); activity of the unit (average patient length of stay, number of electroconvulsive therapy episodes, number of seclusions and readmission rates); and the rate of completion of certain documentation (for example, whether a Health of the Nation Outcomes Scale (HoNOS) (Wing et al., 1998) was completed on admission and discharge). All measures relied on what had been written down, and it is notable that whether an outcomes scale had been completed was mentioned, whilst the nature of those outcomes was not.

6.3.4. 'War stories'

Accounts of the consequences of things going wrong are an important source of information for staff about how they should be managing safety and risk and how they can avoid future censure. These accounts may be formalised in recommendations arising from a Coronial inquiry or RCA. They may equally be passed around among staff members as 'war stories' about personal experience of something going wrong and its aftermath. The discussion between senior nurses described in the first field note extract below shows that the claim of the first nurse that it is impossible in 'reality' to prevent all risky objects coming onto the ward is forcefully denied by another nurse, using the story of her own experience of a death on the ward as evidence of the danger of such a belief and the importance of following policy to the letter. The 'once you've had a death on the unit' argument trumps all other concerns for patient comfort, such as allowing patients to keep their trousers up with a belt or to listen to an iPod. The final emphasis on the staff members who 'had to go on the stand' reinforces the legitimacy of her desire to never let this happen again.

> [Senior nurse says that 'we probably allow some things on the unit that are on the [prohibited items list, but] we're talking reality.' The NUM from the other hospital disagrees – 'we had a successful hanging [with a cord from a hoodie and so now] no's no … the Coroner came to the site with [their] entourage of lawyers … .' Someone asks her what they do about belts if

> people can't keep their trousers up. She says 'it seems very harsh but once you've had a death on the unit … .' Another nurse from this hospital says that they don't allow shoelaces on the acute side of the unit, but that iPods are allowed but 'must be used in the common area' and have to be handed back in once used. The NUM from the other hospital says that they had somebody attempt self harm with iPod headphone cords, and they don't allow those either. With the hanging, they had 'four people who had to go on the stand … it was horrible. We're like Nazis over there about it [now]. When you have a twenty five year old man dead in a bathroom … that's not acceptable.' (Field notes, 20 June 2011)

The expectations of policy makers, patients' families, the Coroner and the public are embodied in the materiality of mental health work, encoded in documentation, and brought to life in the stories of others who have seen the consequences of not meeting these expectations. The environment's layout and contents promote an emphasis more on risk management than on quality or 'normality' of life for patients; more on monitoring patients from afar than engaging in therapeutic activity or interaction with them face-to-face; more on completing paperwork than on treatment; and more on staff and public safety than on patient dignity.

6.4.   Professional responses to expectations

In this third section of the chapter, the focus turns to how mental health staff members respond to these requirements. The aim here is to articulate the instantiation of external expectations in everyday practice. There is evidence of coexisting compliance and resistance to the assumptions underlying the expectations. Compliance is most evident in activities which deal with the possibility or actuality of something going wrong, such as in the documented recommendations of internal incident investigations and in the construction of written accounts of practice. Resistance is strong, however, to the core assumptions about the nature of risk and safety and to the suggested methods by

which safety is 'properly' attained. Clinicians are very far from allowing externally imposed demands to colonise their practice and beliefs surrounding safety and risk; they show compliance insofar as they will then be left alone to maintain safety as they see fit.

6.4.1. Expectations enacted: debating a line in a document

A conversation about the introduction of a new form to the service will be related in detail below, because it distils many of the characteristic ways in which staff members engage with external expectations during everyday practice. It lays bare the recognition amongst staff members that the act of *showing* safe care to have been done through documentation is different, and sometimes entirely divorced from, the act of delivering that safe care. This forms the crux of how the two logics of safety identified at the beginning of this chapter relate to one another.

The discussion took place during a monthly meeting of the local mental health service managers, Nursing Unit Managers (NUMs) and other team representatives to discuss the IIMS (adverse incident) reports submitted during the last month. Earlier in this meeting, there was some discussion about a recent trend for serious adverse events to happen while patients were on leave from the ward. Before this transcribed extract begins, attendees had been talking about the introduction of a new form which requires staff to write down that they have spoken to a patient's family about what to expect when they take their relative on leave from the ward.

A nurse expresses her doubts about whether the initiative will have any impact on the number of incidents taking place while a patient is on leave.

> Nurse: I mean it sounds great, but is that gonna prevent patients not coming back [from leave] or patients committing suicide? In practice ... is it gonna stop people doing exactly what they're doing now? [1]

A psychiatrist and a manager acknowledge that she has a point, but argue that she has misunderstood the real purpose of the form:

Psychiatrist:	If you did a research project you'd probably find it makes no difference.
Manager 1:	But it might make a difference in families feeling comfortable and understanding what's going on …
Psychiatrist:	Yeah it'd make a difference with families not taking it to Coroner's and suing us … because if you've had this discussion with them, and it's sort of understood, and then the patient goes under a train … well, you've had the discussion at least with the family, it's not a surprise so to speak. [2]

The psychiatrist is aware that under empirical examination, the form would probably not have the effect of reducing incidents, but emphasises instead the value to the service of recording the discussion with families to avoid being sued. He infers that if the family were told about the risk, they could not subsequently complain if they took this risk and things went wrong. The nurse tries again to argue that the discussion itself is more important than the documentation, but is again deemed to have missed the point of filling out the form. However, the manager also tries to point out the practice improvements that the documentation might stimulate.

> Manager 1: It's not *all* the paperwork … it's the signature, and leave explained, risk explained, [phone] numbers given … it's like da da da … sign, and it's not that much, and we're not doing that. And actually we're not having the discussions a lot of the time, which is kinda scary really. Like if I was a relative, I'd want to be talked to!' [4]

Entering the discussion for the first time, another manager reinforces the prevailing logic that improving patient safety is somewhat of a side issue to this

activity. In his case, documentation is primarily about demonstrating compliance with the Mental Health Act, whether this affects patient safety or not.

> Manager 2: And quite apart from whether in fact it prevents deaths or anything else ... it's actually a legal requirement. We're actually required to involve the primary carer under the [*Mental Health] Act* ... we need to do it, whether it makes a difference to the life or death of a patient is another question entirely.
>
> Manager 1: [sounding het up, cuts in] the data supports it does, that's why it's there!
>
> Manager 2: Sure. All I'm saying is whether that does or doesn't is one question, but in fact the *Act* requires us to do it and so we need to do it. **[5]**

The nurse interprets this (below) as meaning that the priority is to 'cover our backsides,' at which the Manager 1 points out that staff are only letting themselves in for trouble if they do not document properly, especially when they are doing the right thing in practice.

> Nurse: And so in practice we should be emphasising talking to the families instead of just ... I mean we've gotta cover our backsides ... legally we've gotta ...
>
> [...]
>
> Manager 1: We're doing a lot of the work already, and we've got great work happening with families. [But] we're not putting the sticker in ... we're not evidencing that. We're not actually even saying 'I spoke to this family member' ... and why not evidence your work when it's happening? And then an RCA comes along god forbid and it's like well I remember speaking to them but ... oh, I can't remember whether I covered this this and this point, and you're doing yourself a disservice.
>
> Manager 2: And that's what the Coroner's gonna ask you ... 'can you show me that you did?'... yes, I can. **[6]**
>
> (Meeting recorded 9 March 2011)

The debate over this particular piece of paperwork is a negotiation of the difference between the ostensive and the practical use of documentation. Ostensibly, the form will improve patient safety, but in practice, it will provide protection for the service and the clinicians from charges of not having acted properly. Clinicians see that they must show they are doing what the requirements tell them, but they do not always believe that the requirements to demonstrate risk management, if followed, will lead them towards safe care. Producing safe care is different, and additional, work.

6.4.2. Complying with expectations

Internalising the 'right' way to fix safety problems

An example external expectations instantiated in the everyday practice of senior professionals can be seen in the conduct and recommendations of internal incident investigations. When an adverse event occurs, different types of investigations are carried out according to the assessed severity of the incident. Severity is estimated using a calculation – using a 'risk matrix' – involving the seriousness of the incident's outcome and the likelihood of a repeat event occurring (New South Wales Health, 2005). When severity is of the highest level, usually involving a patient death, the incident and its antecedents will be subjected to an internal RCA investigation. Depending on the nature of the death, it may also go to a Coronial inquiry. In this service, incidents which were considered less severe were subject to another internal process called a Critical Incident Review (CIR). This was usually conducted by a senior psychiatrist and involved examination of relevant documentation and discussion with staff involved in the care of the patient concerned.

The three types of investigation, although conducted at different levels of detail and formality, aim to identify what went wrong and make recommendations for action to prevent similar events in future. The nature of the recommendations emerging from internally conducted investigations is strikingly similar to those

from Coronial inquiries. In both cases, the response to identified safety problems is to recommend the introduction of new formal mechanisms to the service such as new documentation or new guidelines, improving the use of current documentation or policy, or calling for audits of compliance.

As an example, the recommended actions arising from eight internal CIRs which were discussed during four regional health service clinical governance meetings in March, April, May and June 2011, were examined. Of 30 separate recommendations made, 16 involved improving the use of documentation, eight recommended improvements or changes in practice, two recommended improved liaison with other agencies, three recommended staff education on policies, and the last was a 'practice alert'.

This pattern is reflected in the recommendations arising from four Coronial Inquests held since 2004 pertaining to deaths of patients under the care of this hospital and its sister hospital. Of 41 separate recommendations made: 17 involved adjusting the form or use of existing documentation; another 17 involved adjusting mental health laws and policies or introducing new policies, guidelines or protocols; 11 asked for changes to be made to clinical or administrative practice; four for education of staff, and two for improved liaison with other agencies.

The recommendations from these investigations are heavily weighted towards prioritising changes in, or better use of, documentation and policy. Changes to practice receive comparatively minor attention. The similarities demonstrate the extent to which the importance of being able to *show* accountability and an acceptable audit trail has permeated the discourse and practice of safety in mental health care, all the way from Coroner's court to 'shop floor'. This was reflected in the understanding of the 'true' purpose of the documentation discussed in the conversation in section 6.4.1. The senior staff within the mental health service who conduct the internal inquiries have internalised Coronial expectations about appropriate ways to repair 'broken' parts of the service.

Recognising the benefits of documentation

Staff members by no means dismiss all formal requirements as irrelevant to the 'real' business of patient care. They sometimes see direct benefits to this care from activities to show compliance with policy, legal and other external expectations. At [4] in the conversation above, the manager argued that the requirement to document the family discussion would have the effect of improving practice by encouraging staff to have that discussion in the first place. A nurse points out that doing something to protect oneself doesn't automatically mean that the activity has no or adverse impact on the patient:

> IP nurse: You're covering yourself with your documentation but because you do have to document, it drives that accountability and your practice and having like high standard practices. (Interview 13)

Similarly, a community-based allied health worker spoke positively of the preformatted patient documentation, finding the risk assessment forms useful when trying to 'get to know' a patient he has never met before.

> [He says] that he always fills out the separate, two page risk assessment [form] even if the client is stable. I ask whether this is helpful. He says that it is mostly helpful as a quick summary when looking at someone else's client, for example if on call – even though risk status can change day by day. Also it's good if something happens to the case manager. (Field notes, 4th February 2011)

The same clinician supports the use of administering regular outcome measures (using the HoNOS) to bring trends over time to the clinician's attention; when they are regularly seeing the patient, they may not notice such a trend.

> If there is a change for the worse then [he] says he would discuss the client with the doctor and document the reasons. I ask whether these scores are useful when the clinician probably has a feel for how the client is doing

> anyway – he says he 'doesn't mind' HoNOS because sometimes things can
> 'creep up' without him noticing too much. (Field notes, 4th February 2011)
> He adds that being forced to fill in clinical reviews for patients every 13 weeks
> gives his work some momentum and a focus on progress.I think there's
> been a few things that have been brought in and all staff have kind of run
> with it, so maybe that's a good thing. You know, things like the reviews and
> just that idea of every three months, three or four times a year, you're
> actually sitting down and thinking … what am I doing with this client, what
> have I done … and what am I going to do – come up with some goals.
> (Interview 3)

In the inpatient context, filling out a short 'risk sticker' each day for each patient can provide an at-a-glance prompt for nurses to know the 'parameters' of the care they should deliver for that person on that day. These parameters are the level of risk (low, medium or high), regularity with which nurses have to document visual observations of the person ('care level'), their legal status, and leave allowance.

> Senior IP nurse: It alerts you to … if you see medium or high it alerts you, it
> alerts you to look more carefully in that domain in that client. And also
> the care level, it tells you what it is, so you know that if it's x, you need
> to do whatever, so if it's two you need to do ten minute checks etc. It
> also kind of gives you … a quick reference around what is their leave,
> and what are the conditions around their leave … so that that gets
> updated every day, so that you actually see … and it's really confirmed
> and you can't miss it. (Interview 14)

The senior nurse emphasises, by multiple use of the word 'alert', that the risk sticker is useful as a warning to the clinician to carefully watch particular types of risk with a particular patient.

While documenting correctly can improve practice, clinicians also cited examples of when *not* documenting 'properly' can directly and adversely affect the safety or

efficiency of care delivered to patients. In a medication committee meeting, a community team member brings up such a problem:

> She says that there is an ongoing issue with community teams not being aware of the drugs that their patients are on if they get the prescriptions through their GP. One of the psychiatrists says that surely the case manager should know and record on file what medications they're taking. The team member says that recently she had a case where the client had no record of their medications since 2008. The psychiatrist comments that 'this happens all the time ... I always get at least one call [per on call shift] from ED [emergency department] about a community client where no-one knows what medications they're on.' (Field notes, 24 May 2011)

Compliance as defence

The importance of careful documentation of actions and decisions is closely associated for clinicians with protecting themselves or the service from negative consequences if patient or public safety is compromised. Compliance with policy and legal requirements is sometimes seen as simply the 'right thing to do'. Some staff feel that if they work within these requirements, they can feel reassured that they are doing things in the right way. A security assistant remarked that 'those procedures do work so that's why they're in place, and if you follow them you know you should be ok ... cause they do work' (interview 15). However, such a belief that following official guidance provides a guarantee of 'correct' care was sometimes tempered by doubts about the legitimacy of the policies and the people who write them.

> Interviewer: What are the things the service can do to decrease the potential for harm?
>
> Allied health worker: Um, I guess if ... I mean it's a pretty cheesy answer but if staff ... follow policies then things ... possibly would work ... more by the book. But in saying that, sometimes people who write the policies are not the people who work in clinical areas or have been detached from clinical

> work for a long time so they may not know how things actually happen in
> reality. [...] So potentially policies I think are ... they're there for a reason ...
> as a guideline for people to follow ... so that things get done ... correctly but
> ... yeah ... . (Interview 11)

The doubtful way in which this remark trails off reflects her wish to believe that following a policy would mean things got done correctly and her ultimate regret that she cannot quite attain that faith. In contrast, the manager below has no such qualms, and assumes that abiding by these rules is of itself an indication of clinical correctness. His emphasis that documenting that one has adhered to these frameworks is what legitimises clinicians' actions and enables them to feel they are 'on solid ground'.

> Manager: As a clinician [...] if you're working within policies and guidelines,
> and within the ethical framework of your professional [body], then you're
> on pretty solid ground ... even if things go wrong, if you've done all of the
> right things, and that includes documenting. [...] cause you've got good
> evidence that you've done things ... clinically correctly. And so I think
> really our responsibility is to do our best by the clients that we work with,
> understanding that we work in a dynamic world ... and we can't always
> guarantee that bad things won't happen, but we ensure that we do all that
> we can, and all that's reasonably expected of us, to minimise the likelihood
> that that's an outcome. (Interview 5)

While the allied health worker questioned whether policies are actually representations of 'the right thing to do', it is more relevant to the manager that policies give clinicians the opportunity to show they acted according to the rules, regardless of whether the rules themselves are correct or not. The second half of the extract hints at the reason why being on 'solid ground' is so important; the world of the mental health clinician is here presented as an uncertain and 'dynamic' one where there are no guarantees against 'bad things' happening. The

lure of the 'solid ground' offered by evidence of adhering to policy is a way to tame such uncertainty.

In the conversation analysed at 6.4.1, the nurse initially implies that a reason for putting in place a new formal mechanism for discussing leave with families could be to improve the safety of patients. Her query as to whether this mechanism will in reality have that effect (at [1]) is dismissed by the others as beside the point. This dismissal is representative of a general awareness among staff in this service that being able to show compliance with policy, law, and professional standards has more to do with meeting external expectations and thereby protecting one's own reputation and career than with directly impacting on the quality and safety of care. One of the strongest indications of this is the way staff mention that they are conscious that their notes may become evidence at some future inquiry. They are constructed under the assumption that something will go wrong, written in the 'absent presence' of the Coroner.

> When he [psychologist] joined the organisation, he had some mandatory training on how to write clinical notes, and the trainer said that lots of quotes from clients should be used rather than writing something like 'seemed confused' [...] also to write everything as if it will be presented at a Coroner's inquiry … 'client said this' not 'client seemed'. (Field notes, 4 February 2011)

During observations of clinicians at work, the act of documenting was often accompanied by comments about needing to do this to 'cover your backside'. The logic of creating detailed accounts which fix actions as defensible for a hypothetical future audience in order to ensure self-protection is articulated by the nurse in the extract below.

> IP nurse: I've actually been in a criminal court twice. Both times, the things that saved me was my documentation in my notes, because a court inevitably happens two years after the event. You have no recollection

> whatsoever of the person or the event itself, and I've learnt from
> personal experience, so ... covering your backside legally, and good clear
> documentation so that [...] two years later when you're going to court
> you actually have really good recollection ... quite often if you haven't
> written it, it didn't occur [...] (Interview 13)

This link between 'good documentation' and the 'defensibility' is made again by a psychiatrist in the extract below; he explains that this is why he and colleagues continue to fill out risk documentation despite a view that it has little clinical utility.

> Interviewer: What makes something defensible ... in retrospect?
>
> Psychiatrist: Yeah well good question ... good question! Well, good
> documentation helps! ((chuckles)) [...]
>
> Psychiatrist: All of us I think ... the more we think about this [the risk
> assessment sticker] and the more we do this, we're so sort of sceptical
> about that, but we're still just going along doing it.
>
> Interviewer: Why?
>
> Psychiatrist: Why indeed! I think probably again it comes down to defence.
> You think well, should anything go wrong, it's an easy thing to look at, and
> the Coroner will say 'well, did you do a risk assessment?' ... 'Yeah I did
> there it's on the sticker ... phew ... I did it!' [...] Then they can question you
> about the validity of your assessment ... but then you can sort of talk about
> that till the cows come home and you can say 'well on that day ... I saw that
> patient smiling, happy, of course they were low risk!' And then another
> expert might say ... 'but doctor you know of course only the day before that
> patient wanted to kill himself; surely that's unlikely?' And you say 'no no I
> saw them that day.' But at least you've got something to go on, you've got a
> tick in the box. Whereas if you had no tick in the box, the obvious criticism
> would be 'aren't you supposed to do a risk assessment when you see a
> person?' [...] However, I think we do it relatively mindlessly. (Interview 16)

The validity of the assessment's contents can be debated 'until the cows come home' because of the subjective nature of the exercise. It is only the act of having done the assessment that can have any black and white certainty about it; it can therefore be presented as a 'trump card', proof that proper action has been taken. The act of having filled out the documentation is just as important as the nature of its contents.

6.4.3. Undercurrents of resistance

The 'risk sticker'

Staff members of all professional groups and all levels of seniority exhibited in their talk and practice various types of resistance to the prevailing safety and risk discourse promoted by external expectations and requirements and embodied in the environment around them. Although some expectations were seen by some staff as beneficial to their practice, the corpus of field notes and interview transcripts as a whole contained comparatively greater evidence of negative feeling, particularly against policy requirements.

Seven participants whose main role was clinical care in the inpatient unit were asked about the impact of the 'risk sticker' on their practice. This was a form with an adhesive back which had to be filled out each day for every inpatient and then inserted in the notes; a scan is provided at Figure 8. Of 40 separate statements made by the seven staff about the impact of the risk assessment part of the sticker (ringed in red), 28 reflected an unhelpful or negligible impact on practice and 12 a helpful impact on practice. The comments fell into the categories shown in Table 9 below.

Table 9: Perceived impact of risk sticker on practice

Impact	Times mentioned
Helpful **impact on practice**	
Indicates level of vigilance needed for particular risk domain with particular patient	4

Impact	Times mentioned
Indicates patient progress over time	3
Alerts clinician to intervene if assessed risk level has changed between shifts	2
Prompts questioning if risk level contradicts leave or care levels	2
Provides documentation of having done a risk assessment	1
Total (helpful impact):	**12**
No impact or *unhelpful* impact on practice	
Written risk assessments like this are largely unreliable guides to practice (subjective, guesswork, risk changeable, depends on clinician's relationship with patient, ability to assess risk poor, based on perception of what risk *should* be at this stage of care)	10
Pointless exercise ('tick box', 'extra chore', 'don't use', 'sceptical', 'done mindlessly')	8
Forms badly filled out (incomplete/ illegible/ copied from previous sticker)	6
Use other sources of risk information (face-to-face assessment, whiteboard)	3
Problem with form itself	1
Total (no or unhelpful impact):	**28**

Half of the positive impacts reported above came from one inpatient nurse, who qualified her enthusiasm with the assertion that, on the whole, she would not use information from forms filled out by others, but rather would fill out her own form based on face-to-face interaction with her patients. The form was more useful as a guide to her own activities than it was a reliable tool to communicate information between clinicians. The more negative comments about the sticker mostly reflected a belief that the act of ticking 'high', 'medium' or 'low' risk was not an exercise which enabled other staff to accurately know how their patient would be during their shift. This was due to the perceived changeable nature of risk amongst this patient group, as well as the impact of variables such as the clinician's relationship with the patient on assessed level of risk, and the 'subjective' nature of the exercise making it unsuitable for such attempts at categorisation. These comments reveal clinicians' resistance against the assumption that risk is predictable and quantifiable.

Figure 8: The 'risk sticker'

Keeping up appearances

At times it became clear that it was acceptable among groups of staff to explicitly voice a view that some policy requirements were misguided and that they only did them for appearances' sake. For example, the junior nurse expressed her opinion below that some documentation is done only to keep oneself and one's superiors out of trouble, while a manager remarked that he was only doing the required task to keep the 'minions' happy (in the second extract).

> [The junior nurse says to me] 'Writing out a care plan is great in theory, and if you don't write them on admission you'll get in trouble and your seniors will get in trouble with managers, but none of us look at them. I could count on one hand the times people read care plans and change their care of a patient as a result. The whole issue of patient safety comes down to Chinese whispers [passing information on from shift to shift] and your gut instinct.' [...] She then starts to ask her colleagues close by in the nurses' station 'when was the last time you read a care plan?' One nurse says 'today actually' and others say to her 'that's 'cause you're a good nurse!' She asks a senior nurse, and he gestures at her, as if to say 'I don't.' (Field notes, 3 March 2012)
>
> [In the managers' meeting] there is cynicism around the table about the consumer surveys which are supposed to form the basis of action plans [...]. One manager says 'are we just going to roll over every time some little minion tells us to do an action plan?' Others murmur 'no'. He says that he will do the action plan and put it up on the wall and 'make them happy.' (Field notes, 30 May 2011)

Awareness of the performance aspect of showing compliance with requirements is sometimes reflected upon through humour, such as a manager's emphasis on the circular nature of the act of compliance.

> Manager: Any complaint [about the service] that goes to the Minister for
>   Health or the local ministers, any complaint that goes to them by the
>   public – and the public aren't aware of this – will get sent to us to answer.
>   But not only do we have to answer and send back a dot point briefing
>   answering that complaint, we also have to write the Minister's letter ... I
>   have to write a letter back to you saying 'Dear [member of the public], I
>   have investigated this incident, signed Minister whatever.' And I've written
>   that for him. If the papers knew about that it would be ridiculous.
>   (Interview 8)

Unrealistic, ineffective, simplistic, misguided: doubting expectations

Clinicians often doubt that those who impose expectations upon the service from outside really understand the nature of their work and the way that risk plays out in everyday practice. In particular, the assumption that the service can and should be able to predict and mitigate all risk to patients and the public is often seen as unrealistic.

> I try to make conversation by mentioning the presentation from a few weeks
>   ago on risk assessment. The consultant says it's an ongoing issue; the
>   'dissonance between what we know we can do' and what the Coroners' and
>   public's expectations are. He says 'I've never met anyone in the field who
>   seriously thinks we can predict' suicide, when or to whom it will happen.
>   He says 'they're [Coroners, public] completely out of touch with the real
>   world.' (Field notes, 9 June 2011)

The disjunction between what is expected by external parties and what clinicians believe it is possible for the service to accomplish is highlighted by the manager quoted below, who states that 'the public will make you responsible for making sure that person is completely safe.' She believes also that in the eyes of the community, the mental health service is responsible not only for the safety of patients, but also for ensuring that they behave 'normally' when sent home from

hospital. She emphasises the error in the public imagination which conflates 'abnormal' behaviour with heightened risk. The breadth of the service's responsibility reflected in the complaints received from members of the public about patients who have been discharged reinforces the argument that patient safety in mental health care extends the professionals' responsibilities far beyond the walls of the hospital.

> Interviewer: Do you think the service can control everything like that? [She had just mentioned a patient being at risk from her neighbours on her return home from hospital]
>
> Manager: No we can't, but I think we have a responsibility to assess it, and put in place steps that at least help that person manage those risks. The [state health department] think totally different, and so will the public. The public will make you responsible for making sure that person is completely safe. [...] We've often got complaints about people being mad. 'Come and get them! [...] You've sent them home from hospital this way,' and they're complaining about the services sending them home. But they're stable. They've gone home and they're hearing voices and they're responding to them at night and they're yelling at their voices. But that's how they normally work with their voices ... and their risk hasn't increased to the community or themselves – they're just yelling at their voices. But yeah we've had several complaints. (Interview 8)

Policies do not always have their intended impact on practice. This can be due to initiative fatigue, where there are so many requirements that staff cannot keep up, or due to a cynical attitude towards policies which they see as irrelevant to practice.

> He [psychiatrist] says 'this psychological defence of adding more layers of complexity' [in terms of safety initiatives] is 'counterproductive'. He says although he's a senior member of staff, he's become cynical about the notion of 'mandatory compliance' with policies – mandatory has 'lost its meaning because everything is mandatory ... I need to decide what's super

> mandatory for me,' ... there's a limit to how much [can be handled]. (Field notes, 23 June 2011)

> Community nurse: It's an awful admission ... but I'm not sure that I know the policies here, because I suppose I've worked in mental health so many years ... the way you work with your clients is the same whether you work here or in [another service] ... because I think it doesn't really matter when I'm dealing with a client ... .(Interview 4)

Sometimes the tools given to staff to help them fulfil policy requirements are not suited to their purpose. For example, a preformatted 'wellness plan' is supposed to be given to each patient to involve them in choosing which types of treatment they would like to receive – but its format puts people off filling it in.

> [The consumer representative] says [to the manager] 'I'm struggling to get people to fill in the wellness plans' [...] The form is 'such a formal looking document'... The manager says 'it's something the State's decided and we don't have a choice in it'. She says they have to document in the notes that a wellness plan has been given. [...] They talk about how it's just for the consumer and that they don't have to show it to anyone if they don't want to, but the consumer rep reiterates 'it looks so official ... when I first saw it I just filed it away [thinking] ... later'. (Field notes, 1 June 2011)

Many clinicians see a contradiction between the nature of risk management as they experience it in practice, and the way they are supposed to show that they have managed or identified the risk. They may see ticking boxes to show level of risk as a simplistic and reductionist approach to a dynamic and nuanced issue.

> The inpatient nurse says that risk stickers and so on try to categorise risk in too concrete a way – and 'in mental health we're not concrete black and white kind of people. You can't put risk in little boxes. Trying to structure things too much never ever works. Structuring risk in a care plan is never gonna work ... risk is so changeable. Something written last night might

> not apply; nine times out of ten actually it doesn't. One day I'll be worried
> about someone's sexual safety risk, the next day that they'll punch me in
> the head. We go off our knowledge of what they've been like in the past. I
> worry if there are too many nurses on one shift who are new [since if you
> know what they were like last year when they were here, you can predict
> better...].' (Field notes, 3 March 2012)

Documentation cannot capture or guide the conduct of much safety work because such work is situation-dependent and dependent on the experience, intuition, tacit knowledge and behaviour of the clinician. The skill of not 'inflaming' a situation, for example, is improvised and not susceptible to prescription.

> Senior IP nurse: I think in reality what we find is that if you're operating in a
> safe way – i.e. you're not just going out there on your own and not
> activating alarms to a person who's swinging a chair around. If you do that,
> that's obviously high risk behaviour, from a staff's point of view. But if
> those really high end things are not happening, I think we do put a lot of
> weight on a clinician's ability to observe and assess and establish what is
> the best way to go about that, because our policies cannot be that directive
> ... human behaviour is too complex to be able to put in a policy. (Interview
> 14)

When compliance increases risk

The quest to show compliance with external expectations is sometimes felt by staff to cause iatrogenic harm, such as trauma from the experience of admission to the ward. This comes not only from being deprived of freedom but also from deprivation of dignity in a frightening environment. The implication is that risk aversion can be harmful in itself.

> [During a training session, the senior nurse says] 'the more risk managed we
> become the worse it is for the client.' The nurse manager replies 'a lot of

> them talk about their rights, but they don't have rights ... [because they are under the *Mental Health Act*] ... being out there [with patients on the ward] and communication [with them] is the biggest factor. A number of them feel unsafe, terrified, and want to leave. One man was too scared to leave his room – he was weeing in a cup.' (Field notes, 20 June 2011)

Community staff members complained that when they impose (or are required by a doctor to impose) a CTO on a patient, the patient may withdraw from them or mistrust them and the therapeutic rapport between patient and clinician is broken. A nurse reported how one patient was engaged when she talked to him but then became hostile when she attempted to enforce the requirements of the CTO.

> Community nurse: I used to have this terrible hostility [from him], cause he's on a CTO ... every time I rang up it was nicey nicey, and then I'd sort of get round to 'are you coming in for your injection?' and then we'd end up in all this abuse and then he wouldn't come and I'd end up having to sort of do the breach [when a patient does not abide by the terms of the CTO]. We didn't get down to the police but it was constantly the breaches and then ... he was hostile at the clinic, and I just thought surely there must be another way of engaging this man. (Interview 4)

Pressure on beds and the requirement to limit the length of stay on the inpatient unit can sometimes force early discharge and rapid readmission to the unit. Compared to many similar units, this unit had a longer average length of stay. This was partly due to an often-cited belief that complying with the length of stay target would ultimately be harmful to patients.

> IP nurse: I think that we try really hard not to just get them out on the street just to make another bed available. We do make sure that they have good follow up and they have good support and we do that as much as possible. [...] Yes the length of stay [requirement] is there but there is that real risk

> of readmission rates ... I look at the clients and I think that just must be awful. As much as they don't want to be here and they want to be discharged it must be just awful to go right back to the beginning again and to be readmitted three and four times in a year ... because they've been discharged too early. (Interview 13)

The structure of risk forms and of the stepped design of care on the ward can together have a performative effect on how staff rate risk levels and may mitigate against attempts to genuinely evaluate risk. The doctor below acknowledges that the requirement to justify discharge on the grounds of low risk can produce a misleading 'record' of a patient's progress towards discharge.

> Psychiatrist: I think because of the culture of the ward, we expect people to get better and we expect to move them on. We expect to move them on from the acute side to the sub acute side to leave to go home, and so we expect to see ... the ticks come down to the low risk. So I think we ... that box ... probably gets skewed ... too early towards low risk which is actually invalid. (Interview 16)

The principal way that documentation requirements may have a detrimental effect on patient safety is that the time taken to complete them can decrease the face-to-face contact with patients that staff members often see as more relevant to safety.

> Senior IP nurse: It does bug me, sitting there, your head in notes and there's people there banging on the door [of the nurses' station]. You're not here to be paid to read notes and write notes you're here to care for people. I don't care if you leave half an hour early ... if you've sat out there and had a really good interaction and that with a patient, that's your priority, not paperwork. And the amount of paperwork that we're having to do now is taking so much clinical time away from us it really pisses me off [...]. You've gotta fill in a leave form, and then you've gotta tick this box and sign that paper and ((sound of frustration)) admission

> checklist, discharge checklist ... dah di dah ... it's kind of like how do I
> get to discharge a patient if I don't actually get to do anything with
> them! (Interview 10)
>
> IP nurse: You can't look at and sit with patients every moment of every day.
> Probably the biggest barrier [to patient safety] is just time restraints. [...]
> On a Friday afternoon if I've got three discharges to do and ward round,
> [time for patient care] could drop as low as thirty percent. On a
> weekend, when my paperwork is just writing my clinical notes, that
> really kicks up to about eighty percent. [...] You initiate spending time
> with them and taking them on walks. Risk assessment obviously impacts
> on that, cause the more time you spend with your patients you get to
> know them and you can assess them better, so the more bogged down
> paperwork type stuff that you have to do, and other responsibilities ...
> checking drugs and all that sort of garbage – which is important as well
> – it just impacts on your ability to provide care. (Interview 13)

The second extract is illustrative of the perverse impact of the large amount of
risk documentation on patient safety; managing and recognising risk requires
spending time with patients, but this time is curtailed by the requirements to
document levels of risk. The time spent documenting activity means that the
amount of activity itself is substantially reduced.

6.4.4. The pragmatic interweaving of formal and informal practices

It would be misleading to claim that the activities of 'performed' safety and
'everyday' safety happen completely separately. In practice, the two are
interwoven in pragmatic ways which allow staff members to enact safe care. In
the following observation of nurses discussing a missing piece of information on
a medication chart, a conscious differentiation between 'clinically appropriate'
and legally mandated practice is made. In this case, the legally mandated practice
does not go far enough, as far as these nurses are concerned, and they do some
detective work to assess potential implications of the missing information. They

then act (informally, since only doctors are supposed to write on the chart) to modify the chart to make it more clinically appropriate.

> In the nurses' station at 19:38 (as evening medication rounds are being prepared), a junior nurse [Nurse 1] asks a more senior nurse [Nurse 2] about a patient's medication chart. She points out that there is no time written next to when the patient's meds are to be given. The nurse in charge [Nurse 3] joins in, saying 'it's not a valid script if it doesn't have the time' on it. They discuss how the chart was written after the morning dose which infers that the patient has not already had the dose today. Nurse 2 takes the chart and writes in the time herself, saying 'we know AM meds are given at 8am.' Someone suggests that he could have had it this morning, but Nurse 2 says that this patient was a 'new admission … also look at what the drug is …' (thiamine – not so significant, and Nurse 2 points out that the dose is sub-therapeutic anyway). Nurse 3 says that where he used to work [in another country] such a thing (not putting the time on the med chart) would be a reportable incident – 'do you not write 0800 on scripts and stuff?' […] Nurse 2 answers 'the legal answer is no, the clinically appropriate answer is yes.' (Field notes, 12 July 2011)

Finally, the need to use these kinds of informal strategies when formal mechanisms prove inadequate (or are not known about) is highlighted by a psychiatrist who emphasises the importance of 'corridor conversations', clinical judgement, and remembering 'the basics' over and above formal systems. He also states that blindly following rules may lead to complacency, and that in a difficult situation, using informal strategies is likely to be more effective than the formal 'systems'.

> Psychiatrist: The system would say that the policy is sent out to everyone and every worker understands and follows that policy exactly, and it just isn't that simple. People obviously still have to use some clinical judgement. People may or may not know about the policies so the informal system often involves people sort of talking to people in the corridor … this system

> [involves] constant reiteration of contact and communication. I find that, and again maybe it shouldn't be that way, but I think you've gotta use both. You've gotta try and get the formal system happening as best you can, but you must never forget the basics. I suppose what I'm saying is I think the formal system's good as far as it goes, but it can never capture all possibilities, and you shouldn't have a false sense of security that it's gonna cover all your bases. You've gotta do the basics too, and should anything else go wrong, you can forget the formal system and do the basics and you'll sort of be ok. (Interview 16)

The relative importance attributed by this doctor to informal and formal systems in the practical achievement of patient safety is mirrored in survey responses from staff of all professional backgrounds. All staff in both teams were invited to nominate three people, three physical things (objects, environment or documents), and three practices (things they do). Participants were not prompted, nor were they given responses to choose from. As a final exercise, they were asked to pick what they found to be the three most important out of these nine nominations. The number of mentions of each resource during this final exercise is given in Tables 10 and 11 below. Where a participant put two responses into one box, each was counted as 0.5 of a response.

Table 10: Perceived usefulness of formal safety mechanisms

Formal mechanisms		Number of responses
Following formalised procedures	Risk assessment	6.5
	Care levels	6.5
	Handover meeting	3
	Mental State Examination	3
	Medical reviews	3
	Vital observations	1
	Reporting	1
	Ward checks	1
	Team meeting	1
	Bed availability	1

Formal mechanisms		Number of responses
	Direct line to security	1
Sub-total (procedures)		28
Documentation (writing or accessing)	Generic	7
	Risk assessment documentation	5
	Patient notes and history	4
	Mental Health Act	2
	MIMS [drug formulary]	1
Sub-total (documentation)		19
Environment and tools	Medication	5
	Ward layout	3.5
	Duress alarms	2.5
	Locked reception window	2
	Contained/ safe environment	2
	Keys	1
	Metal detecting wand	1
Sub-total (things)		17
Total (formal mechanisms)		64

Table 11: Perceived usefulness of informal safety strategies

Informal factors		Number of responses
Interaction with patient and their family	Face-to-face talking, engagement, building therapeutic relationship with patient	8.5
	Assessing/ monitoring risk/ mental state/ physical health/ home environment	8.5
	Regular contact/ communication with patient	7.5
	Discussion with family and support network	5
	Give information/ educate patient	2.5
	Working with patient (respecting their goals)	2
	Counselling / psychotherapy	2
	Group program/ diversions	1
	Patient is not intoxicated	1
Sub-total (patient interaction)		38
Consulting others	Team	4
	Nurse(s)	15

Informal factors		Number of responses
	Doctor(s)	5
	Manager	4
	Security assistant	4
	Security staff	1
	Patient	1
	Case manager	1
	NGO and follow up	1
Sub-total (consultation)		**35**
Sharing or gathering information	Communicating with colleagues about patients	16.5
	Gather collateral information about patients	2
	Use the phone	1
Sub-total (info sharing)		**19.5**
Staff characteristics	Awareness of surroundings and risks	6
	Experience in dealing with patients and risk	3
	Staff morale, engagement and cohesiveness	2
	Working collaboratively	1.5
	Staff education	1
	Being present in patient area	1
	Police responding appropriately	1
	Crisis team responding appropriately	1
Sub-total (staff factors)		**16.5**
Total (informal factors)		**110**
GRAND TOTAL (formal and informal factors)		**174**

This exercise yielded a total of 174 nominated people, things and practices. Of these, just over one third (37 percent) were the formalised mechanisms which embody external expectations of the mental health service. When it comes to their role in maintaining patient safety, however, informal, improvised, face-to-face, interactive, non-standardised and non-codified elements of day-to-day work are more important resources for these professionals. It is these elements and practices which will be the subject of the next chapter.

6.5.   Conclusion

If the previous chapter highlighted the centrality of indeterminacy in professionals' understandings of risk and safety, the present chapter is a tale of their efforts to stage a performance of safe care in which uncertainty is rendered invisible. Scripts, props and sets embody a predictable version of risk and a standardised, context-independent approach to its management. Professionals knowingly grant their audiences a window on the world of the mental health service in which an ordered and defensible process of safety maintenance is fixed in written accounts. The view through this window is crafted on the assumption that it will be scrutinised only when something has gone wrong, and indeed the performance is put together based not on what is, but on what could (in the worst case) be. This logic of safety proves useful to professionals as far as it enables them to continue to do their jobs by avoiding blame if things go wrong and escaping the paralysis which would accompany surrender to uncertainty.

This is not to say that professionals engage in a cynical manipulation of their audiences' expectations to cover up a laissez-faire attitude to patient safety 'behind the scenes'. Rather, acquainted as they are with the constantly shifting sands upon which they must attempt to build a safe service, staff simultaneously employ an entirely different logic of safety during their everyday work. The everyday engagement with mess and indeterminacy is crucial to this 'other' patient safety, which is produced and reproduced on a moment-by-moment basis through clinician interactions with patients, colleagues, and people in the patient's world. In this case, safe care is never fixed once-and-for-all; it is a perpetually fragile achievement which may unravel at any moment. This safety is dynamic, an improvisation which may follow the vaguest of story lines but whose narrative detail must be worked out along the way. This improvisation will be examined in the next chapter.

Chapter 7:   Safety in-the-making

7.1.   Introduction

The findings so far have exposed a dissonance between the conceptualisations of risk and safety held by mental health clinicians and the assumptions upon which external expectations of their service's role are based. Such a narrative setup might conventionally dictate that the present chapter relate a resolution of the tension, a tale of initially stormy but finally blissful reconciliation of these differences. However, the 'other' logic of safety, that which characterises the moment-to-moment production of safe care in real times and real places, will not admit such neatness. Instead, the chapter is a story of the ways in which clinicians improvise their way to an emergent, incomplete version of safety which is never 'already there', and which is always in-the-making.

The chapter is divided into four sections. Each outlines a practice that stood out during observations and interviews as integral to the everyday maintenance of patient safety. Continued effort to maintain each practice is necessary, but not sufficient, to the continued emergence of safe care. Each interacts with and informs the others and none can be left to lapse. Because of the interactive and relationship-based nature of the work, the techniques of safe care are necessarily idiosyncratic. However, some 'golden threads' uniting the production of safety in these services can be detected and will be outlined below. They are: the building and cashing in of rapport between clinician and patient and the use of rhetoric to persuade (7.2); the marshalling of historically distributed knowledge about a patient (7.3); the real-time monitoring of the patient using an augmented 'gaze' (7.4); and escalation towards more physical and coercive interventions if risk has not been contained (7.5).

7.2.   Rapport as safety capital

The 'therapeutic relationship' and verbal communication are principal treatment mechanisms used by mental health clinicians. Indeed in many episodes of mental

health treatment – the 'talking therapies' – these are the only tools the clinician uses. Apart from its use in successful treatment, the ability to develop a strong rapport with each patient was felt by professionals working in these two teams to be a prerequisite for safe care. Part of the reason for this is that in the absence of conclusive tests to detect pathology, the patient's talk and their manner of relating to others are important clues to their mental state. If the patient cannot trust the clinician sufficiently to talk freely, it is a more difficult task to gauge the appropriate level of intervention necessary to maintain safety. Once rapport is built, it must be constantly maintained. In the manner of a savings account, rapport is built up when times are good (when the patient is 'stable'), to be 'cashed in' when times are bad and safety is threatened.

7.2.1. Building rapport

The importance of building rapport between clinician and patient was emphasised by staff members of all professional backgrounds and from both community and inpatient teams. This rapport is seen as a crucial tool in maintaining the safety of the patient because it can be used when the need arises to persuade the patient to comply with the clinician's version of safe behaviour. The existence of a positive, trusting relationship makes it possible to intervene in a more timely, preventive way, avoiding escalation to more forceful intervention such as admission. The centrality of this relationship to the achievement of safe care and the ability to have a therapeutic impact is emphasised below.

> [Asked the most important thing for a new member of staff to know]
>
> IP nurse: The most fundamental and most important thing is always listen to the clients, no matter how unwell they are, no matter how thought disordered they are. Actually listen to the clients and try and hear the sorts of things that are driving their symptoms, so if you try and help them with their immediate issues, you develop rapport and then you can actually do some therapeutic work with them. (Interview 13)

> Senior community nurse: The most important thing is engagement, and I feel like if you're working in this area if you can't engage a person, if you can't build a relationship … if you can't share a cup of coffee with somebody with an illness … you know sitting on an equal level at a table you probably shouldn't be in this game. (Interview 1)

Clinicians cite multiple ingredients in building such a positive relationship, including frequency of contact over time, development of trust, and the tailoring of a unique interpersonal dynamic which the patient responds to in the desired way. Frequency of contact with a patient is essential not only to enable the clinician to be fully aware of the patient's mental state, but also to enable them to remain fully involved in the circumstances and events of their life. Supplementary benefits of frequent contact include increased opportunity to reinforce the patient's belief that the clinician will always act in their best interest and can therefore be trusted in future.

> [Asked about the strategies staff use to maintain safety on a daily basis]
> Psychiatrist: Well I guess there's the sort of frequency of contact. So, let's say you've got a client in the community team, and the case manager sees that person. I mean if they just have no contact with them … they only see them very infrequently, obviously they're less able to make sure that everything is ok. (Interview 16)

Such contact intensifies in the inpatient environment. Clinicians, especially nurses, feel it is important to safety that they frequently spend time 'being with' and talking to patients so that they can tell how they are and how this compares to previous encounters. As senior nurse explains, this is the only way to know 'where they're at', and to spot changes between these regular encounters.

> Senior IP nurse: Understanding where that person's at, if you speak with people and you spend the time with them – and not five minutes – like a decent interaction with them, every shift, you'll understand where they're

> at … what are their concerns, what are they worried about, and what's their
> mental state like […]. When you spend time with them you know – when
> they're changing. (Interview 14)

Treating patients with respect is an important element of building rapport. This includes being honest, consistent, and not patronising them or 'fobbing them off'.

> [In the training session], someone returns to the issue of communication;
> 'being straight and honest and to the point, if you're actually honest telling
> them [what's happening] rather than saying "see what the doctor says,"
> [this] cools the situation down. At least [they know] you're a straight up
> person … .' Someone else continues this theme – 'if you say you'll do
> something and then don't, they'll remember however ill they are … they get
> really pissed off if the nurse says yes you can and then another says no you
> can't … .' (Field notes, 20 June 2011)

Many clinicians have known some patients over a period of years and they feel that rapport is strengthened as time passes. If the patient is known over a long period of time, the clinician learns how to gain and keep the patient's trust in ways that are always individually tailored and sometimes highly idiosyncratic. Such idiosyncrasies may include: not 'badgering' the patient; reacting to their behaviours in a no-nonsense way; and helping them to tackle their problems using creative methods.

> Psychologist: I guess the one [patient] I have to monitor most frequently … in
> order to have the rapport I have with him, I can't badger him. So if I ring
> up every day saying 'how are you feeling today,' he will get the shits
> something atrocious and not wanna have anything to do with me. So I
> need to be as careful to keep that rapport … so he doesn't feel like he's
> being badgered but at the same time I'm keeping a close enough eye on
> him, so if that means having a conversation with his support network as
> opposed to him … just so I'm not badgering him. (Interview 2)

Rapport is built not only by attending to the clinical needs of patients but also through small kindnesses and help with navigation through life's everyday tasks. In the community team, this type of help was frequently observed, and included such things as calling patients to remind them to attend for blood tests or other appointments, driving prescriptions to their house, arranging for money to be available for joining a soccer club or buying a birthday present, sorting out temporary housing, or going shopping with the person. The relationship may become so important to the patient that they regard the case manager as 'part of the family'; in discussions among community team members it is conventional to refer to patients' relatives as 'mum' or 'dad'.

> The community nurse brings up the issue of [a social worker] going on long service leave for 9 months and that the team seems to have capacity to absorb her clients. They joke about how some of her clients will be 'pining' for her and that often they become 'part of the family.' The nurse adds that clients are often passed from one person to another if someone says 'I can't work with this person.' (Field notes, 4 February 2011)

7.2.2. Cashing in rapport

Rapport is therefore an essentially safety-creating tool, as it is conceptualised in a preventive way in terms of keeping a patient 'well'. Rapport is treated by clinicians as a sort of capital to be stocked up on when times are relatively good, to be 'cashed in' if life events, circumstances or symptoms take a turn for the worse. Should the patient deteriorate and be admitted to the ward, such rapport is also used as an acute risk management tool by inpatient staff. In the two interview extracts below, a psychiatrist and then an ancillary staff member describe how they use rapport on the ward when there is an acute risk. Despite their different professional backgrounds, they both use basic techniques of face-to-face human contact, based on trust, to defuse situations where there is acute risk.

> Psychiatrist [asked what he does if he is called to an acute situation on the ward]: If it's not something obvious that needs to be done immediately, you need to do an assessment to see what the hell is the problem. So this is one of the things where it's really important to have rapport because this is where you can cash that in. If you've established a relationship with someone and they're a bit agitated, well you've got a relationship. People take different approaches, some go 'I'm doctor blah blah blah and you're blah blah blah' and if that works for them great – doesn't tend to work for me. I'm better off sort of going 'oh come on ... .' If I know them well [...] I can kind of talk with them. (Interview 7)
>
> Ancillary staff member: If you can get on with the patients, that's a big step [...], I can talk someone down rather than having to restrain someone ... so if you've got someone who can come in and speak to the patient on their level, then it will hopefully stop security intervention, you wouldn't have to restrain the patient. You need to have that bond with the patient, so if they are going off, and you do come to them, you come through the door – you can say 'hey ... calm down ... it's me, it's [his name] y'know ... relax.' (Interview 15)

In the inpatient context, rapport is also used to get the patient to 'drop their guard' and be more revealing of their 'true' mental state or potential risk of harm than would otherwise be possible, partially overcoming the difficulty many clinicians have in trusting the patient's account.

> [Asked what engaging patients has to do with risk]
>
> Senior IP nurse: Developing rapport, getting to know patients, allowing patients to drop their guard ... So when we can talk to them about risk we're able to get some pretty sound data ... that we can sort of consider. (Interview 9)
>
> IP nurse: There's certainly a huge amount of professional satisfaction to do a really accurate risk assessment on someone and be able to keep that patient safe, because to do that you have to have a fairly good rapport with

> them, you need them to disclose whether they've got ... auditory hallucinations that are telling them to self-harm and quite often people have paranoia and stuff like that ... so that rapport development to do a really accurate risk assessment. (Interview 13)

This nurse felt the level of rapport a clinician has with a patient to be so important to the mitigation of risk that she believed a nurse with good rapport would be likely to rate a particular patient's level of risk as lower than another nurse who does not have such a rapport (first extract below). Her inference was that this is not simply due to the nurse's perception, but rather to the patient actually behaving differently depending on their relationship with the nurse looking after them. The personality of the clinician is seen as important to their ability to enact safety in the second extract.

> IP nurse: I don't take these [risk assessment forms] as gospel, not at all. I find that these are really changed depending on who writes them. So if somebody has a really good relationship with a client, and deems them as low risk of harm to others ... but in actual fact, ninety percent of the nurses don't have a good relationship with the client, and he gets angry and aggressive. (Interview 15)
>
> He [community team leader] then talked about how some clients can be very angry or aggressive and that really it is down to the individual personality of the clinician as to how well this is handled and how quickly they calm down. (Field notes, 20 December 2010)

In the community setting, on a day-to-day basis, rapport is 'cashed in' as the clinician is allowed increased access to a patient's life. This enables regular monitoring of their activities and mental state. Community clinicians who have already established a relationship with a patient often use this familiarity and trust to help patients build a life and supports which create safety rather than simply head off risk.

> Psychiatrist: I guess the job of that service [the community team] is to keep people as well as is possible, keep them out of hospital, and work as a therapeutic team. I mean the case management model – some of the case managers are superb at keeping their patients well, and that's about experience, rapport, and that kind of stuff. (Interview 7)

7.2.3. Rapport in practice

The rhetoric of persuasion (1)

The extract below is from an observation of an occupational therapist's phone call to a patient and illustrates how clinicians use their rapport to monitor risk and encourage safety-creating activity. A number of rhetorical strategies are used by clinicians in their efforts to enact safe care. In his side of the conversation, the casual language this therapist uses, uses as well as the easy reference to recent and current events in the patient's life reflects the familiarity he has built up. Although the call's purpose appears to be to book a new appointment, he uses the conversation to monitor the patient's wellbeing ('how have you been?'), increase his knowledge about what she is doing ('getting your hair done?'), and to offer validation and reassurance about her efforts to complete tasks which are difficult for her ('that's the fantastic thing … you managed it'). His encouragement to 'work these things out for yourself' points to a desire to avoid dependence on him despite the closeness of the relationship. He finishes the call – and offers continuity in the relationship – by suggesting a practical strategy to work through ('write down reasons why you're doing it') for when they next meet.

> Hi it's [occupational therapist]. I hear [patient]'s got the flu at the moment?
> [Waits for patient to come to the phone]
> How are you feeling?
> [Listens]
> We need to book another appointment do we?

How have things been?

I can't do Tuesday Wednesday or Thursday next week. You're working
   Monday.

Getting your hair done are you? Looking forward to that? How does it make
   you feel? You like to look your best.

How about we say next Friday?

I'm gonna leave that to you … where do you think you need to be?

Have a good day at work.

Were you aware of which trains you could catch? … What was the drama? …
   How did you manage that? The stuff you tried must have worked … you
   worked through it so you stay on the platform and get on the train to work.

That's the fantastic thing … you managed it. I'm not gonna go into it with you
   now, cause you have to work these things out for yourself.

Can you do me a favour? Can you write down reasons why you're doing it and
   reasons why it's not a good idea?

(Field notes, 3 March 2011)

The rhetoric of persuasion (2)

The extended extract below from an evening observation of the ward nurses'
station shows the mobilisation of rapport to persuade a patient to take her
medications orally. In the first part, a discussion between two nurses about
gender reflects the need to individually tailor the relationship according to the
type of person and approach the patient is known to respond to. The
conversation continues between the same two nurses fifteen minutes later, with
Nurse 1 again using a previous encounter with the patient to substantiate her
concerns about her own ability to persuade.

1855: As Nurse 2 [nurse in charge] sits at the bench in the nurses' station
   filling in observations charts, a junior nurse [Nurse 1] asks him 'did [the
   patient] speak to you?' Nurse 1 mentions that she [patient] had said
   'conversations here are pointless …' and that when doing obs [visual
   observations] she had seen the patient doing the crossword and had said to

her 'so you're concentrating ok, I can write that ...' [in the patient notes] [...]. She reflects on the patient – 'it might be a girl thing, because she got on ok with Nurse 3 [a male nurse] ... she wouldn't take anything off me but she would off Nurse 3 ... .' Nurse 2 thinks 'she gives a certain level of abuse to see what tolerance [we have] ... .' Nurse 1 tells him 'if you've got good rapport you can medicate her ... .' He replies 'yeah that will be the test' [of rapport].

1912: Nurse 1 says to Nurse 2 'I don't have a good feeling about her taking her meds [this evening]'... she relates a previous conversation with the patient about her new meds [...]. Nurse 1 had gone out to give her an information booklet about the medication; she had read 'schizophrenia' on the indications and had said 'I haven't got schizophrenia.' Nurse 1 had reassured her that it was for bipolar as well – 'just have a read for me' 'but it says schizophrenia ... .'

Taking these concerns on board, Nurse 2 goes to talk to the patient, and on his return warns the security assistant that they may need to forcibly inject her. He then continues to prepare for an escalation of intervention by discussing the conduct of a potential restraint and seclusion with other nurses. Nurse 4 contributes her previous experience with injecting this patient, and also demonstrates awareness that her relationship with this particular patient has the effect of heightening risk, meaning that she would not play a part in the persuasion effort.

1918: Nurse 2 sits with the patient on sofa in common area of ward.

1938: Nurse 2 explains [to the security assistant] that the patient is 'very unlikely to take her meds, so we'll go down the IM [intramuscular injection] route. Hopefully she'll change her mind, but it doesn't look good ... .' [...] Nurse 2 continues 'I've got a good rapport [with her], she might respond to a male – but when it comes to the meds, she's still [unlikely].' The security assistant comments 'everybody put their cords in, she'll try and grab [them]' [referring to the cords on the duress alarms].

> 1946: Nurse 2 comes over to ask Nurse 4 'are you trained in control and restraint?' she says she is [...]. Nurse 4 says 'she really stresses out about men being present with her pants down' [when the injection is being given]. She says that the last time they had to inject her, they 'had security [guards] on standby' outside her room while the injection was being given; Nurse 4 says that she and another nurse 'had the arms' and 'they [security] completely destabilised the [other nurse's] lock. I asked the men to leave, I got the most full on serve' (from security about having only women present when the injection was given). Nurse 2 says 'I haven't made the call yet whether we need security,' Nurse 4 says 'I don't think we'll need them, she's not that strong.' She adds that last time 'we took her to her room ... once she got on the bed ... she lost all the fight out of her.' Nurse 2 suggests 'if she's really fighting and screaming, [we'll take her to] seclusion'. Nurse 4 says 'I suggest I stand back with the meds because I escalate her ... I'll stay out of the way while you're doing the negotiations.'

Despite his earlier concern that the patient was not going to take her medications voluntarily, Nurse 2 heads back out to the ward to attempt further persuasion. He is successful, and an escalation to forced injection is not required.

> 2006: Nurse 2 is in the lounge talking to the patient (sitting on the couch with her).
>
> 2008: Nurse 1 says 'Nurse 2 is an absolute demon at getting people to take their meds.' (Nurse 2 has gone back out into the ward with the meds and a cup of water). He returns to the nurses' station. Going to medication trolley, he says 'she wants to see me dispense it out of the packet, which is fair enough.' He asks 'where's the script?' another nurse reads '400 Solian' and Nurse 2 checks '400 yeah?' Nurse 1 checks the chart again and reads 'amisulpride 400 milligrams *nocte.*' Nurse 2 heads back out.
>
> 2010: Nurse 1 watches intently through the nurses' station window as Nurse 2 sits down again on the couch with the patient; she tells the security assistant 'you keep an eye ... [in case] anything terrible happens.' Nurse 2

> returns and says the patient took the medication but 'wants it documented that it was against her will.'
>
> 2024: Nurse 4 asks 'she took her medication?' Nurse 2 says she did; 'she knew what was coming.'

In situations where a patient is not known to the service but presents an acute risk to their own safety or that of staff or other patients, staff members were observed to rapidly develop rapport. Rhetorical techniques of a different kind are needed in such situations, rapport does not exist to be cashed in. These focus on communicating empathy and reassurance, as well as a non-threatening tone and manner. The following extract is taken from an observation of a training session in de-escalation and restraint, where nurses are acting out a role play to practice their verbal de-escalation techniques. After the role-play nurses assess the success of the de-escalation role-play, summing up the rhetorical strategies they see as valuable in such a situation.

> An RN volunteers to play the staff member de-escalating. One of the trainers plays the patient returning from leave. [...] The RN says 'we need to do a check -no lighters or anything sharp?' 'No.' 'In your pants there appear to be [some blades]?' 'Patient' says 'I need them to protect myself ... I need to have them!' [getting worked up]. RN says 'just look at me, focus on me. You realise you're here because you're not that well? You know you're safe in here ... is this person [threatening you] on the ward? Nobody on this unit [will hurt you] [...] If you're feeling insecure we can put you somewhere closer to the nurses' station ... .' Referring to the knives, the nurse says 'that's not safe, we'll put them in the locked area. If you hand [them] over now, you can put them on the counter, and we'll take you through ... .' The 'patient' then comes willingly and hands over the 'knives'.
>
> The role-play is finished [...]. One of the nurses watching points out that the nurse was 'finding out what the driver was, very non-threateningly. He used humour to show a friendly face, and developed rapport ... .'
>
> Continuing to analyse the nurse's performance – 'he was very positive

> about it all, kept reassuring the whole way ... it was good.' (Field notes, 27 June 2011)

7.2.4. *Working to maintain rapport*

The concern clinicians express about losing rapport reflects their experience of it as fragile and hard-won.

> Psychiatrist: Rapport ... that's really really valuable. It's so valuable, and you blow it by bringing someone into hospital, and you keep them there for so long and you've lost it. It's very hard to get it back, but if you can collaborate with someone on their treatment – even if their insight is only partial – they can see a little bit of benefit in what you're talking about. You can minimise their side effects, you can work with them, you can keep someone out of hospital, you can keep them well, you can keep them happy. But once you ... if you stick someone in a hospital and they don't really need to be there, they get really pissed off, you kill the therapeutic relationship and then they probably will need to come to hospital and it's all adversarial. (Interview 7)

These comments reflect the relationship between good rapport and safety creation, and between broken rapport and risk escalation. There is a vicious cycle between escalating levels of intervention, broken rapport, and escalating risk, which reinforces the view in Chapter 5 that iatrogenic harm can result from the use of the coercive mechanisms of risk management.

Rapport is also built and maintained with patients' families; the following comments show how important (and time consuming) this task is for a community psychologist.

> Psychologist [asked what she would advise the interviewer to do were she to take over her role for three months]:

> I would ask you to be pleasant to all of my clients' families ... as difficult as
> that might be ... because I've spent two years building rapports and if you
> turn around and broke them I'd be very upset. (Interview 2)

Staff members often voiced concerns about potential gaps in contact with the patient, underlining the importance of continuous effort in maintaining this fragile relationship. Such gaps may occur when a case manager goes on leave or is off sick; when a patient is discharged from the inpatient service without their community clinician being informed in a timely way; or even between nursing shifts on the inpatient unit. The service attempts to cover these gaps using mechanisms such as handover paperwork, post-discharge reviews, a 'duty officer' roster, and development of more robust discharge procedures. Inpatient staff frowned on community clinicians who did not 'keep up' with their patients by visiting them on the ward, while community clinicians complained that they were sometimes not told straight away about a patient being discharged from the ward.

Rapport is an important element of the asymmetric trust relationship that characterises the maintenance of patient safety in these mental health services. The relationship is asymmetric because the clinician attempts to ensure that the patient trusts them enough to comply with their efforts to maintain a safety net around them, but does not trust the patient's account of their own risk. This lack of trust in the patient necessitates the gathering of knowledge from other sources spread across time and space about the history and current circumstances of the patient.

7.3.   Marshalling historically distributed knowledge

The development of rapport is essential groundwork for the clinician to be able to persuasively interact with a patient at times of increasing risk without resorting to physical interventions. However, as we saw in Chapter 5, clinicians do not see direct interaction with the patient as always being enough to

determine their 'actual' level of risk. Sources of knowledge widely distributed in space and time are used to supplement this interaction.

7.3.1. Knowing what's 'normal for them'

Knowing detail about a patient's past, not only in terms of clinical history but also in terms of their developmental and social history, is considered by clinicians to be a necessary precondition for providing safe and effective care. A registrar attempted to emphasise this point to two medical students who were new to psychiatry.

Registrar:	It's not that different from any other area of medicine. [...] 80 percent of diagnosis is on history, the rest on examination. In psychiatry, it is 90-95 percent based on history. [...] In cardiology, we ask questions about their normal heart function for them. How do you gauge if a person is functioning normally [in psychiatry]?
Student:	Appearance?
	Big picture stuff – how do you define a 'normal functioning person'?
Students:	[no answer]
Registrar:	Relationships, who they live with, are they functioning at work. The social history gives you the context to work out what's normal for this person. So the history is just as important as it is in cardiology.
The registrar goes on to explain that 'normal in psychiatry is very wide' and is not easy to determine. (Field notes, 20 January 2011)	

A primary purpose for knowing about the patient's past history is to be better able to judge what is 'normal for them'. The point that 'normal in psychiatry is very wide' is the reason behind needing to know about each individual's past in detail, because 'normal' for one person may not be 'normal' for another. The logic is that if a person is in their 'normal' state, even if this might seem highly

'abnormal' in another person, they are more likely to be safe, and there is less reason to intervene. Below, a different psychiatrist points out that because a patient's case manager knows what the patient is usually like, they are in a good position to advise him about whether being 'mad as a meat axe' is cause for concern. In the second extract, the more senior receptionist uses her past experiences of the patient to reassure her junior about his behaviour. Level of safety is therefore frequently a judgement relative to an individual's history.

> Psychiatrist: It doesn't take a long time to get competent enough to realise that something is risky and needs something done about it urgently or if something doesn't matter, and this is where the case managers are really helpful. You might see someone who looks crazy to you – mad as a meat axe – you talk to the case manager [who says] 'oh yeah they've been like this for twenty years, this is actually good for him.' So all of a sudden it's like oh cool ... but if he's normally ... normal, kids, work, everything, if he's completely off ... even though he might not be as bad as the first one, you need to worry more about the second one. So I guess the thing is ... you need collateral history. (Interview 7)
>
> Later on, a client presents himself to reception repeating his sentences several times over. The noise level in the waiting room is rising steadily as more clients come in. Watching him warily, [admin assistant] asks [admin supervisor] 'is this guy getting cranky?' 'Yeah but ...' 'that's just him?'... '[Yes] ... he got like that last time. He's got developmental delay.' (Field notes, 21 April 2011)

7.3.2. Using the 'track record' to judge risk

A clear relationship exists between knowing the patient's 'baseline' or 'normal' state and being able to judge whether a patient is at risk in a particular situation or when they present a particular pattern of behaviour, words or mood. This is tied to a belief that past patterns of deterioration predict future escalation of risk. Knowledge about the severity of past harm is used by the psychiatrist below to

gauge the level of risk presented by current behaviour; similarly, the community psychologist describes how he uses his knowledge of a patient's 'track record' to try to prevent him spiralling into an admission, which from past experience he knows is not an effective intervention. Past patterns are seen as a reliable guide to the appropriate clinician response.

> Psychiatrist: [explaining how she decides if risk is likely to escalate or not] What's the worst he's done in the past? Oh look, he's actually castrated himself in a psychotic frenzy seven years back ... then we are a bit worried about where this is all going to. So each person you will find has a different story, has a different narrative to him. So it's about what works for this person. (Interview 6)
>
> Psychologist: If they are unwell, then again it's looking at their track record. I know he [this patient] unravels ... probably takes him a good two months to unravel. He also really really hates being admitted to hospital. He doesn't get a lot out of the admission. So, straight away I knew he was overdue for his depot [long-acting antipsychotic injection] so we went down and organised that with his pharmacy. [...] Then I'll just try and sort of have more frequent contact with him to try and prop him up, to try and stop that downward spiral, just to see if we can ... we've done it with him before and it's probably ... fifty-fifty that you're able to stop it, get him back on track. (Interview 3)

It is a long and difficult task to 'know' a patient well enough to be able to pick up on their warning signs. Asked what the monitoring of her patients would involve for a new person taking over her case load while she goes on leave, a psychologist says that this would be 'tricky' because she 'knows' them, but rather doubtfully says that she could tell the new person what to look out for. The notion of early warning signs is a common element of informal risk assessment in this service, signs which only emerge as significant with time and repetition.

> Interviewer: How do you tell that someone's becoming unwell?

> Senior community nurse: The particular clients that we look after are long
> term clients and you have a well documented history of their presentation,
> so you get a familiar pattern ... and you also start getting together some
> early warning signs that are the flags that there's something going wrong.
> (Interview 1)

Individual clinicians who have seen a patient over a number of years develop a great depth and breadth of knowledge about them. The following extract illustrates the nurse's knowledge about everything from the patient's family situation, past traumatic events, and his financial and substance misuse problems, to what he had for breakfast on this day, as well as the fact that she evidently cares not only about the patient but about his mother as well.

> [Talking to me about a client she has just been to visit] a community nurse
> says it is 'sad for his mum' because she and her husband had a business
> which went into receivership and they lost everything [...]. The client is 'on
> OPC' [his finances are managed by the public guardian] and his Mum gives
> him a Coles [supermarket] card to buy food. However, 'he's learnt you can
> get booze with it' and the nurse feels she should speak to the mother about
> this even though she doesn't want to 'add to her stress' [...]. The client told
> her today that he had had 2 drinks before she had arrived, and so she
> wonders how much he has during the rest of the day. She also wonders
> how much food he gets but he told her he had steak for breakfast and she
> could smell that there had been cooking going on. (Field notes, 15 February
> 2011)

7.3.3. A collectively engineered history

This depth and breadth of knowledge about an individual is often the result of the clinician benefiting from the pooled experiences of their colleagues as well as a network of people outside the mental health service who know the patient.

> Psychiatrist: the best investigation in psychiatry is getting collateral history. It's about calling the family, it's about speaking to the neighbours – are you worried – and then it's about making that judgement call. We know this person, and it's about understanding patterns of behaviour … how is he usually and what are his early warning signs … and the [community] team are pretty good at that, they know these people inside out, and I trust their opinion. (Interview 6)

Marshalling historically distributed knowledge is not simply a cumulative build up of information over time. It is also a dynamic process which plays out in situations where a decision needs to be made or a problem solved in order to ensure safe and effective care. Different sources of knowledge are often brought together when a decision needs to be made about a patient. Such marshalling of historically distributed knowledge happens in both formal and informal contexts and may be actively orchestrated or occur serendipitously. The latter may happen when, for example, a clinician bumps into a colleague's patient in a coffee shop, and the former when multiple clinicians have managed the same patient.

> Community nurse tells social worker about the call she has just had from a [private] doctor. He had said that the client felt he had not been getting any support from the service, but nurse said that she had seen the client in Gloria Jean's [coffee shop] and so he was evidently not just staying inside all the time. (Field notes, 25 January 2011)
>
> Psychologist: In the community team … we kind of know each others' clients to some degree or if you're not sure of such and such, you can ask someone. If they're not sure they'll be able to say oh look, so-and-so used to case manage them two years ago, go and ask them. So there's always lots of people around with lots of experience and knowledge. (Interview 3)

The need for clinicians to share their knowledge about patients was humorously highlighted in an exchange during handover when nurses realised a patient had been banking on their inability to do so.

> [An inpatient nurse is giving a shift handover to colleagues]
>
> Next is [patient] ...
>
> He refused a shower ... [this morning – saying he has his shower at night] so it must be tonight ... .'
>
> Another nurse cuts in that this patient had told her he has his shower in the morning; they discuss how they're going out there together to say 'are you gonna have a shower?' 'Cause he looks awful!'
>
> (Field notes, 15 June 2011)

7.3.4. *Using distributed knowledge in practice*

Finding out about an unknown patient's risk

The following series of extracts follow a community psychologist as she tried to deal with a request from a patient who is not known to her. She receives a call while she is doing her 'duty officer' slot, which is a service provided for patients whose community clinician is not available when they call. (All extracts in this section are from field notes, 28 January 2011).

> In the community team office, at 1307, the psychologist receives her first call as duty officer. After having the call passed through from reception, she says 'Hi, my name's [...]. How you going?'
>
> 'I can't write you a script but I can probably find a doctor who can'
>
> 'Zyprexa [olanzapine] 2.5mg, is that at night?'
>
> 'Look I can give you a script but I can't get you a box'
>
> 'I'll have to find a doctor'
>
> 'leave it with me'.

Putting the phone down, the psychologist sets about trying to verify the patient's claims. Firstly she checks the clinical notes for signs that the story about reducing the dose is true. When she initially cannot find the information, she immediately asks her colleagues in the office if they 'know' this patient.

> She walks out to the file compactus, [...] locates the file and takes it back to her desk. She says [to me] she has to double check and find evidence of the client having been prescribed this drug and that she had actually had the dose lowered (as she had said she had on the phone) before chasing it up. She reads the latest doctor's entry in the 'progress notes'. She finds no evidence that the doctor had lowered the dose, but the notes do say that the client had requested a lower dose.
>
> She asks the other people present in the office 'do you guys know [client name]? She's requested ... ah don't worry ...' (at this point she finds a note made by a psychiatrist at a previous team meeting saying that the dose has been lowered).

Having verified the patient's story, she goes to find the on call registrar to write the prescription. The registrar also checks in the notes for the veracity of the story, and finds some additional information which makes her concerned about an overdose. The psychologist says she will have to ask another clinician, who is 'familiar' with the patient, about this possibility. They also assess the likelihood that the patient really has not still got the prescription; her age is considered enough evidence to support her claim.

> As the registrar reads the file, she notices that the client had received a prescription two weeks ago. She asks the psychologist 'is she borderline?' – 'I don't know'. Registrar says 'I will write it but' the main concern is that she doesn't overdose. Psychologist says she will ask the patient's own psychiatrist about this as she's familiar with the client. She says it's possible that she's lost it but had said it was stolen. The registrar asks how old the patient is – '60' – this seems to satisfy her that she could indeed have lost it. [...] The registrar confirms with a colleague that the packs come in 28

> tablets and writes 56 on the prescription. She then writes that she has done this in the client notes.

Although the psychologist has been successful in getting the prescription, she has still been left with the doctor's doubts about risk of overdose. She undertakes a further scan of the notes for standard phrases indicating risk. She does not find any, and cannot get any information from the patient's own psychiatrist. In this state of uncertainty, she decides to further probe the patient about what happened to the previous prescription. Being told it was stolen, she decides to the patient they can pick up the prescription later that day.

Having made the decision, the psychologist persists in trying to clarify her patchy knowledge about this patient by asking a second colleague about her.

> Psychologist hangs up and asks community nurse 'do you know [patient]?' She replies that she doesn't. Psychologist says 'it sounds like she lost it but won't admit it'. The nurse says that another client of hers had a similar issue and she had told the chemist not to give her the script, just to keep it at the pharmacy.

This story illustrates the importance of marshalling collectively held knowledge when trying to make a decision about the risk posed to a patient not personally known to the clinician. In total, and in the space of half an hour, she consults the patient, two community colleagues, two registrars, multiple entries in the patient's progress notes, and attempts to consult the patient's psychiatrist. She is primarily trying to assess whether the patient's claims can be trusted. The active role of patient notes as arbiters of accurate historical information also emerges from this episode. In the absence of information from any person who knows the patient well, she is forced to make the decision in a state of considerable uncertainty. 'Safe care' in this case is fragile and cannot be guaranteed.

Collective decision making

The following conversation is taken from a community team meeting during January 2011. The clinicians are debating what to do about a patient who frequently becomes ill with bipolar disorder but will not take his medication as the team want him to. The conversation is essentially an attempt to work out whether it is worth trying to start this patient on a new long-acting antipsychotic injection. The hypothesis agreed on by the clinicians is that if there is evidence that he has done well on that sort of treatment in the past, and it has kept him 'well' for a longer period than six months, it is worth trying the same thing again. A total of seven team members, out of twelve present at the meeting, offer bits of evidence from their knowledge about this patient. This knowledge goes back, in some cases, for a period of years.

The conversation indicates firstly a close familiarity with the details of this patient's history among multiple members of the team not directly involved in his care, and the felt need to pool collective knowledge before making a joint decision about the next steps in treatment. Secondly, the importance of knowing the effects of past treatments on this individual for deciding on future treatments is evident. In the end, consultant (psychiatrist) 1 does not seem satisfied with the quality of evidence presented to her, and asks that the patient's history be examined in more detail with reference to his files.

Consultant 1:	What do we do now, [case manager]? I guess the key question is do we put him on a depot [long acting antipsychotic injection] or not?
Nurse 1:	Oh I think so
Case manager:	I was talking to [consultant 2] about it this morning, and even he was saying you know is there any point – do we just manage him and then ... because he bucks against it so hard, [...] whether we just say ok this is his manic episode for the season?
Team leader:	How long's he been well?

Consultant 1:	Six months.
Case manager:	Six months? Cause the last time was in winter [...].
Consultant 1:	Is half of this because of all the Valium [trade name for diazepam] and all the midaz [midazolam] he has been getting in the ward? The benzos [benzodiazepines] just disinhibit him and escalate and escalate.
Case manager:	They tend to [...] it's in the ward that he gets worse
Consultant 1:	He's got a manic episode but I'm just thinking that if we antagonise him it just escalates him further and the inpatient unit it probably aggravates [...]
Case manager:	And he just constantly stands at the nurses' station knocking on the door. It really just revs him up, being in there.
Consultant 3:	So is he compliant with his orals [orally administered medication]?
Consultant 1:	Mmm ... no.
Case manager:	No ...
Consultant 1:	He's not compliant with anything [...]
Consultant 1:	Has he been on reasonable periods of depot in the past?
Nurse 1:	Yeah he has
Team leader:	Yeah he has yeah
Case manager:	Six months?
Consultant 3:	We tend to put him on
Case manager:	Then he just gets it into his head, well since I've known him ...
Nurse 1:	Yeah but I think he's had longer than that.
Case manager:	Gets it into his head 'I don't want the jab any more it's slowing me down.'
Team leader:	He doesn't like that feeling of being normal – he likes the edge and the hypomania.
Consultant 1:	Can we just pull out all his old files and just go through them sorry and do a medication history? If he's ... I mean six

	months is not enough for us. Was he stable for six months this time anyway?
Case manager:	Mmm …
Consultant 1:	So if he's been longer than six months or a year or something without an admission on depot … then we'll just decide to put him back on the depot but otherwise … I don't know otherwise it's' just …
Case manager:	Has he been a year without a … ? Not since I've …
Psychologist:	I can't remember him being on it for that length of time
Case manager:	I thought six [months]
Consultant 3:	This was [consultant 4]'s patient wasn't it
Case manager:	No he's always been [consultant 2]'s
Consultant 3:	Always?
Case manager	Well, [consultant 2]'s had him for the last 3 or 4 years
Consultant 3:	Oh ok
Case manager:	[Consultant 2]'s said he's prepared to discharge him without a depot … depending on how he goes
Consultant 1:	I think he would really like him to be on a depot […]
Nurse 2:	What's his objection to the mood stabiliser? Cause he'd been on all of them?
Consultant 3:	Doesn't like being on them […]
Consultant 1:	Can we just pull all his files? We'll just spent maybe fifteen, twenty minutes just going through this.
Consultant 3:	Why not use Haldol [haloperidol] or the new Invega [paliperidone] depot?
Consultant 1:	Mmmm yes, that might be an option.

7.4. Real-time monitoring using the augmented gaze

The collective reconstruction of a patient's past using heterogeneous human and material sources is important in a world where, as we have seen, risk to an individual is considered not in absolute terms but as relative to their history. However, in order to know whether, at the present moment, a patient's safety is threatened, real-time information about them must be available which can be compared for deviation against the accepted picture of 'what is normal for this person'. In both community and inpatient contexts, the direct gaze of staff members can only accomplish part of this task. Their gaze is augmented using a spatially distributed network of people and things, enabling the distal monitoring of a patient's 'present'.

In the community, where a staff member's knowledge about a person is usually detailed but their ability to directly observe them limited, elaborate networks of 'informants' are recruited and maintained to ensure timely information is passed to the service about any potential escalation in the patient's risk. In the inpatient setting, the gaze on the patient becomes sharply focussed as doors, walls and environmental controls delimit the scope of their 'present'. In this setting, there is generally a more limited knowledge of a patient's version of 'normal'. As a result, a different kind of hyper-vigilance – which is embodied both in the person of the staff member and in the fabric of the ward – becomes necessary.

During field observations, clinicians repeatedly emphasised the importance of using monitoring in both community and inpatient settings to 'catch' any potential escalation in risk early, so that it could be prevented or at least curtailed. An inpatient nurse explained that timely interventions by community clinicians mean that the severity of illness of patients admitted to the ward is reduced and 'we kind of get people before they're florid' (interview 10). The importance of watching out for early signs of deterioration was also felt by a manager to be vital to preventing aggression in the ward environment.

> The manager says that the 'art of the skill is recognising somebody's escalating [or] more agitated than normal ... are they coming to the nurse's station over and over?' In terms of body language, staff can look for markers of increasing aggression and intervene early. They can then 'get them away from the situation' or reduce stimulation, give them medication or 'talk with them about what's happening.' (Field notes, 9 March 2011)

7.4.1. *Embodied hyper-vigilance*

In psychiatry, the clinical 'gaze' cannot be extended using technologies which can 'see' inside the body for signs of illness or deterioration. There are no machines whose alarms sound when a patient reaches a predetermined point of heightened risk to their health. The main 'gaze' in an inpatient psychiatric setting is just that, the use of the clinician's own eyes to look at the patient. Constantly being aware of patient location and behaviour in order to detect signs of deteriorating illness and escalating risk was a key organising principle of work on the inpatient unit. Such awareness was fundamentally embodied. For example, the need to 'keep an eye' on particular patients was a common phrase used during nursing handover and informal conversations in the nurses' station.

This type of observation goes beyond the requirements of formal 'visual observations' which are meant to be conducted at set intervals depending on the assessed risk of the patient.

> [In the nurses' station] the senior nurse sits down and looks through a folder which has a series of forms in it; they have been filled in with times and signatures. She says that this is the 'obs' [observations] folder [...] 'This guy is on level 2, so every ten minutes [his nurse must check] that he is present, breathing, a reasonable colour, conscious level ... .' Looking out into the lounge room where this patient is sitting, she says 'he's sitting up, I saw him moving a while ago ... generally ok physically, not self-harming, nothing kinda seriously wrong ... .' (Field notes, 26 May 2011)

Such episodic, formally recorded observation is qualitatively different to the constant state of watchful hyper-vigilance staff display towards patients on the ward. While the formal observations are concerned principally with signs that the patient is not in physical danger, clinicians use their senses – including eyes, ears, and 'gut' – to detect more subtle clues pointing to threats to safety. Clinicians were commonly observed looking together at a patient from the nurses' station and discussing their general demeanour and whether they were showing signs of escalation – sometimes described as 'brewing' or 'bubbling'.

Being actively aware of one's surroundings and monitoring the whereabouts of patients and colleagues is an important element of both patient and staff safety. However, many nurses and managers emphasise that simply being watchful through the glass of the nurses' station is not sufficient. Having a physical presence 'on the floor' (in the patient areas of the ward), exposing all the senses to what is happening, is thought to be better for safety in enabling a fuller awareness of ward dynamics.

> Inpatient nurse: I think that obviously the more present that nurses are on the unit [the better] because you see, you see what's going on. You see the men walking into the room – like into a woman's room, so the sexual safety risk is there [...]. Whereas if you're in the medication room or you're in the office, you don't see that stuff. You listen to the interactions between clients, the sorts of things they're saying to each other. Are they antagonising each other, are they at higher risk of like harm to each other because they're starting to bubble with each other and they're starting to bounce off each other? If you're on the floor watching TV with them, you hear all of that ... you're in the office you don't hear any of it. (Interview 13)

This sort of hyperawareness is not only directed out towards patients, but is also turned inward in a self-monitoring effort. Staff monitor themselves (and each other) for the impact their own bodily movement, position in relation to the patient, stance, voice and attitude are having on the safety of any situation. The

three extracts below highlight various aspects of this self-monitoring, including wearing appropriate clothing; ensuring a patient does not feel cornered; using a calm and respectful approach; and using non-threatening language and tone of voice.

> [During the aggression management training session, the trainer says] that it's not appropriate to come in [to the ward] with ripped shorts etc – 'some of the case managers too [are] way too slinky looking.' Another nurse points out that language on t-shirts needs to be watched for as well – 'they may think it's aimed at them ... bright colours even.' [...] The trainer continues that when in a room with a patient, position everyone 'so staff and consumers have equal access [to a door], so they don't feel cornered.' (Field notes, 20 June 2011)
>
> [The manager tells me that on the ward] it is important to be aware of your use of language, the words you use, your non-verbal communication, your tone of voice – these should be relaxed and non-threatening. [He continues] that you need an awareness of spatial issues – 'if there is potential for aggression do I get close enough [to be] within striking range, or do I stand back and stand so I get hit side on ... .' You need to understand yourself in the space. (Field notes, 9 March 2011)

The bodily movements of staff members are seen as potentially inflaming or calming a difficult situation. A senior nurse criticised the behaviour of some hospital security guards in escalating aggression with their elaborate preparations for what they evidently believed would be a violent situation – removing watches and pulling on rubber gloves in front of the patient (interview 1). Calming bodily signals were used to opposite effect by a security assistant who worked on the ward:

> I notice a loud bang around this time, and when the nurse-in-charge gets off the phone, the security assistant asks her if she can come to talk to a patient who has been slamming doors. We go down to the patient's room,

> and as the nurse talks to her about how it's not acceptable to slam doors in here, the security assistant is standing behind her in the doorway to the room making 'calm down' gestures to the patient. (Field notes, 17 June 2011)

7.4.2. *Focussing the gaze through environmental control*

The focussing of the staff member's gaze to the extent that such acute attention to patient behaviour is possible can only happen because of the nature of the ward environment. The 'work' done by walls, doors, and the type of objects allowed on the ward means that staff spend less time directly supervising patient interactions with the environment and (in theory) more time detecting the subtle signs of deteriorating mental state. Weaving risk reduction into the fabric of the building in this way severely restricts patient freedom, range of activity, and quality of life, but greatly facilitates the augmentation of staff gaze.

Although CCTV cameras are used on the ward, during field observations these played a minor role in the monitoring effort (usually being used only when something had already gone wrong) compared to other features of the environment that effectively rendered some types of direct monitoring unnecessary. The attempt to remove hanging points from the ward is an example of this. As another example, there is a beverage bay on both sides of the unit, with access to a tap that is supposed to provide 'boiling' water for patients to make their own hot drinks. Low risk is 'fixed' into this object, which therefore does not need to be supervised. In addition, adjusting the temperature of the tap so that it is hot enough to make drinks but not hot enough to scold is a physically instantiated calibration of the boundary between risk to quality of life and risk to physical safety – a further example of the negotiation between risks which was discussed in Chapter 5.

> Going into the lounge area he [ancillary staff member] says he is going to lock up the beverage bay now, it is only open for breakfast and morning tea because of the risk posed by the hot water. He tells me that they had set

> the new 'boiling' water tap at the coolest temperature possible (about 65
> degrees) but it had been too cool to make hot drinks, so now they have
> adjusted it to 72 degrees. (Field notes, 5 June 2011)

Control over people and things entering and leaving the unit further ensures that the monitoring work of the ward environment is not compromised. Some visitors are not allowed onto the unit: 'at the exit to the ward office I notice a whiteboard with 'visitor cautions' on it, and two warnings about people who are not allowed to visit certain patients' (field notes, 12 January 2011). In the following extract, a nurse had asked the ward manager to speak to a man who claimed he was a friend of a patient. The nurse had doubts about his suitability as a visitor, and the manager went to ask him questions before allowing him onto the ward.

> Coming back into the office, the NUM [nursing unit manager] says to me
> 'that's an example of safety' of the ward. 'You try and vet people at the
> door.' They make a judgement about whether to let someone in based on
> how they know people [on the ward] and have to check boxes [mentally] to
> risk assess whether to let them in or not. When I ask what this mental
> checklist consists of, he says 'how they present ... who they're asking for'
> (he explains that some people come and say random names). 'If you don't
> know their surname you're not coming in.' (Field notes, 15 June 2011)

Information coming onto and leaving the ward is also controlled, through the banning of Internet and mobile phones. To a certain extent, the patient group is also vetted. On several occasions managers were observed talking about doing 'deals' with other hospitals to either swap patients or deflecting an admission by offering to take an existing patient at another hospital (so that this hospital received the less risky patient) (field notes, 12 January and 14 February 2011). There were also instances of a patient considered to be too risky for the environment being discharged or sent to a higher acuity unit to ensure the protection of other patients. An allied health worker spoke about a patient who had been causing distress to other patients: 'eventually the guy was discharged,

'cause they said he's too big a risk to keep here, so they discharged him. They were like it's better to discharge one person than to compromise multiple people' (interview 11).

7.4.3. *Spatially distributed monitoring network*

When patients are living in the community, clinicians have relatively little direct contact with them. However, because of the expectation that they are able to contain a broad variety of risks to the patient, as described in previous chapters, clinicians have developed a way to maximise real-time monitoring of patients. This involves the recruitment and maintenance of a network of people who are distributed beyond the walls of the hospital. These 'informants' often give clinicians unsolicited information about patients, and are contacted by them when extra monitoring or specific information is required. This information is used by clinicians to identify whether there is a 'real' risk to their patient, and to determine whether they need to intervene.

> [Asked how he would know a patient was deteriorating]
>
> Psychologist: ... things have changed, their home's a little bit more disorganised; family or friends are contacting you, neighbours are contacting you, GP, chemist – we try and get good relationships with all those people. The chemist might ring and say such and such picked up their Consta [risperidone injection] today or they didn't ... or a neighbour [may say] the music's been a bit loud the last few days, and again you kind of know with that client that the volume starts to go up when they start to get a little bit disinhibited. Talking to them on the phone, seeing them, and even other clients are quite a good source – it's the sort of area everyone knows everyone else so [another client might say] 'jeez you know such and such was really off their head a couple of nights ago,' ok they were alright a week ago, I'd better give them a call. (Interview 3)

Such unsolicited information is frequently phoned in to a community clinician. While the majority is provided by a patient's family, other health professionals

such as GPs and pharmacists, as well as neighbours, friends, and other patients of the service also let case managers know the whereabouts and behaviours of patients. On one occasion, for example, a university counsellor told a patient's case manager that the patient had been exhibiting paranoid behaviour in class (field notes, 23 June 2011). The encouragement of members of the network to provide such information is illustrated in the following extract.

> At 1422, in the community team office, the psychologist makes a phone call to a relative of the patient she had just been talking to on the phone. She tells them that she has had several phone calls from his friends saying he's getting irritable and aggressive – 'just letting you know' and says she is concerned he is going downhill. 'Maybe just report back to me and let me know how he is.' (Field notes, 25 January 2011)

The mobilisation of the network is also a safety valve in terms of creating redundancy of monitoring and information flow. As one allied health worker put it, 'it's harder for something to get missed if there's lots of people involved. If it's just me I could get carried away with something and drop the ball, whereas six people aren't going to drop the ball' (interview 2).

What they term 'collateral' information is also actively solicited by clinicians from those close to the patient, in both community and inpatient settings. One registrar who worked across both settings emphasised the importance of this exercise: 'for Christ's sake, get collateral!' (Interview 7). In the community, this often takes the form of a practice which combines historical knowledge of a person's past patterns of deterioration with an appeal to the opinion of relatives and friends about their current state.

In the inpatient unit, where staff members may not be so familiar with the patient's history, such soliciting of collateral information is a common method by which they can rapidly plug gaps in their knowledge of the patient. The frequency of inpatient staff calls to family members, not just to inform them of

their relative's progress but to ask them questions about their recent and longer term past, shows that they do not feel their direct examination or observation of the patient presenting in front of them is enough to accurately assess what is 'going on' for this person.

> In the nurses' station, I notice that the registrar is on the phone. He seems to be mentioning it being documented that the patient has been verbally aggressive. He says 'what was he like before? When he was married etc? [...] A bit later he asks '[has he been] violent or aggressive towards anyone? Any family history of any medical conditions? Any genetic [conditions]?' Talking about some blood tests, he says 'I'm gonna speak to [his consultant psychiatrist] but it sounds like it will be a complicated process [finding out what's going on] ... your parents are really concerned about him. (Field notes, 24 May 2011)

7.4.4. Identifying the unsafe

The need to collect information beyond what the patient does or says has already been explored in the context of not trusting a patient's account. The practice of identifying whether something about the patient at the present time is a deviation from what is known about their 'baseline', and whether that deviation is a cause for concern, involves an integration of knowledge about their past and their present. However, on the inpatient unit, when staff are monitoring for signs of deterioration in a patient, they often do not have all this information to hand. In this case, staff members make substantial use of techniques which involve monitoring their own bodily sensations and instinctive reactions, as well as their patients' bodily movements.

> A senior nurse says it's important to 'understand what is happening with the dynamics of the environment' – sometimes when you walk into a setting, she says, 'you get this sense ... sometimes they are a bit heightened ... sometimes really chilled.' (Field notes, 20 June 2011)

> Manager: [Asked about what she meant by looking for 'non-verbal clues' to risk escalation] A change in facial expression to something that's not pleasant, someone that's clearly moving a lot more, feeling agitated, clenching muscles, being a bit more in your face ... trying to push into your personal space ... bit red, not looking around, looking a bit more distracted. [...] You and I on the street wouldn't be able to tell if someone's more agitated, but knowing if your patient's more agitated could be very slight, because you've seen them at that relaxed stage and then you've seen them at this stage. (Interview 8)

7.4.5. *The spatially distributed network in practice*

During a day's observations of a community team leader, information from a patient's mother about the deterioration of her daughter was passed to him by a colleague. Between meetings and attempting to complete timesheets so that his staff would be paid, he spent most of the rest of the day attempting to clarify the risks that this patient presented and then trying to arrange for her to be brought into hospital. This process illustrates the importance of the spatially distributed monitoring network (both within and beyond the service) in offering timely intervention when a patient or their family are thought to be unsafe.

> Around 9am, a member of the other community team (the 'duty officer') comes to the team leader's office. She says that a client's mother had called her during her duty officer slot since her usual case manager is away. The patient has assaulted her sister at the weekend, she says. 'How well is she?' asks the team leader. 'Not too well.' He asks her 'what's the risks?' She replies 'no risks to anybody except to her getting unwell.'
>
> Later, going back to discussing the risks, the 'big one' according to the team leader is that the patient assaulted her sister. At around 1030, the duty officer tells the team leader that according to the mother, there have now been complaints [to the police] that there has been noise coming from the client's unit through the night. He comments that this is risk number two – that she will lose her housing.

These discussions indicate the scramble to determine the seriousness and nature of the ongoing risk from and to this patient. In this task, the team leader combines his knowledge of the patient's history (augmented by information from the clinical notes) with 'collateral' real-time information from the mother. Having in the meantime consulted the crisis team about their availability to help bringing the patient to hospital (receiving a non-committal response), he next takes the problem to the weekly clinical team meeting at lunchtime. He is asking the consultant psychiatrist what he should do about this situation. Another nurse also chips in 'evidence' of the patient's current mental state.

> Team leader: [Psychiatrist] saw her about three weeks ago and she presented pretty much as I remember her, just wavering around. Over the last few days [community nurse] has seen her ...
>
> Nurse: Yeah I saw her Friday, gave her her depot, and she denied having hallucinations but was giggling and really inappropriate [...]
>
> Team leader: [Relates assault story]. Now what typically happens is that the family start escalating and saying she's psychotic she needs hospital, but given what's happened she probably now needs to be assessed and we need to work out whether we should bring her in or ... [he relates the family's past tendency not to want to call the police on their daughter, then continues] but the second call's come in from the uncle, and I haven't called him yet but he'll up the ante and then his brother will call and the whole family will get involved ... I'm not sure how urgent we need to ...
>
> Psychiatrist: No, she needs to be assessed today ... either with a registrar or an accredited person to see if she needs to be scheduled or detained.

Although the decision has been made by the psychiatrist, the team leader does not have the means of carrying it out, and in between other meetings and discussions with the crisis team, he makes another call at around 2.30pm to update the mother. He uses the opportunity to clarify what happened with the assault.

> 'Hi, it's [name], how are ya?'
>
> 'So with (client), I got handed it this morning … [Psychiatrist says] she may need to come in, so I've put a bed aside in case that happens …'
>
> … [listens]
>
> 'What did she do to [sister]?'
>
> 'Ok so I took it to [the crisis team] and he's getting down there with a view to bringing her in … '
>
> 'They're bringing the police because they won't do it without them […] when we've brought her in with the police before she's never actually gone off.'

At about 4pm, the team leader goes back to the crisis team office, to reinforce the urgency of the situation and his concerns about what might happen if the assessment does not happen today: 'I don't know what she's gonna present like … what happens if she does something [tonight]?' The crisis team member says she will get admitted via ED if that happens. The team leader continues 'just say she bashed somebody tonight, I'm covering my butt by handing it to you guys.'

At 4.30pm he calls the mother again, assuring her that efforts are being made to assess her daughter tonight but 'if you hear from her … or something untoward happens … you should call the police and they can bring her here.' […] He tells her that 'I'm going on your take on the situation … you've been a reliable source in the past' […] emphasising that 'there are two lots of risks [assault and housing loss] there which makes her a high priority.'

The team leader later calls the mother a third time to try to persuade her to come when they go to visit her daughter so that she can open the door herself.

> 'If they go out, they're not gonna take the key, we're not supposed to do it …'
>
> 'It's all about risk these days.'
>
> '… it's other people's property and we can't open doors…not even the police will do it.'
>
> 'If they don't do it tonight I will need you to do it tomorrow too … '
>
> He hangs up, saying to me 'oh fuck … every time I talk to her it gets bigger.'

Leaving the situation in the care of the crisis team, the team leader finishes by writing up what has happened in the patient's notes. The day's intensive efforts to coordinate a network of people had not yet resulted in a safe resolution, leaving him with considerable uncertainty which he attempts to assuage by carefully documenting that the issue is now the responsibility of the other team. The episode demonstrates that if parts of the distributed network are absent (the case manager) or do not play their parts as expected (the crisis team), considerable repair work is needed to strengthen other elements of the network (such as support from a psychiatrist and intensified contact with the mother and enlisting her practical help) in compensation. Even with such 'net-work', it may be impossible to completely close gaps in the safety net, patient safety can only be temporarily achieved, and risk may continue to escalate.

7.5.   Managing escalating risk

When monitoring efforts detect a deviation from 'normal', engagement with the patient intensifies and an escalation of intervention is put in place by clinicians to try to stop risk increasing. This escalation happens in a stepwise fashion so that if an attempt to contain risk is unsuccessful, interaction with the patient moves gradually (or rapidly, if the risk is acute) from the verbal to the physical and from the persuasive to the coercive. Clinicians emphasised that physical coercion is the last resort when all other methods have failed.

The circumstances in which intervention escalates reinforce the importance of preventive and early intervention work using the three strategies described in the first three sections of this chapter. As we have seen in the above account of the team leader's day, all three are contingent strategies and liable to break down under the weight of unpredictability, even given elaborate and repeated effort to maintain them. Rapport may be broken, history may be lacking, and elements of the spatially distributed monitoring and support network may not play their full part. Strands of the 'safety net' thus begin to unravel and the patient may start to fall through. Alternatively, if a person presents to the service for the first time in a

crisis, there may be no safety net in the first place. Its hasty (re)construction becomes necessary; it is these rapidly improvised efforts which are the subject of this section.

We have already seen that development of knowledge about a patient's past and the monitoring of their present rely on a collective effort, not just by clinicians but also by a distributed network of people and things which stretch far beyond the walls of the hospital. Similarly, when a clinician is alerted to some kind of risk to a patient, they do not keep it to themselves. It is seen as vital to maintain a collective awareness of the risk within the team. This reinforces the survey findings, reported in Tables 10 and 11 in the last chapter, that communication with colleagues was the single most helpful resource to staff in their endeavour to maintain patient safety. Handovers, where nurses tell the next shift what to look out for with particular patients, are an example of this activity.

> [Psychiatrist] says that personally he tries to 'over-communicate' so it [admission] runs smoothly and there are 'no surprises.' For example he will speak to the nurse, and the patient's community worker, and the family, and two more nurses (he goes on exaggerating his over-communication) so that 'they're ready' for the admission. (Field notes, 23 June 2011)
>
> [The nurse begins the handover of the patient to the next shift of nurses]:
> 'Bless her little soul
> Long history of abuse …
> Saying she doesn't deserve to live …
> I couldn't get her to calm down
> I said what are you worried about?
> She had 5mg of olanzapine
> Got the reg[istrar] to review her
> [She] managed to calm down.
> He said basically we've gotta support her …
> She couldn't guarantee her safety or the safety of others at that time …
> (She repeats this last statement)

7.5.1. Avoiding admission

When clinicians believe that a patient is unsafe in the community, they first attempt to mitigate the risk so that admission to hospital is not necessary. Although the risk in itself may not appear to necessitate admission, these clinicians often see a slippery slope of compounding risks if the first harm is not prevented. For example, a psychologist explained to me the importance of preventing a patient losing his housing because homelessness would then lead to deterioration in his mental state (field notes, 12 January 2011) and therefore potential admission. Sometimes staff want to protect a patient from admission because they believe their mental state will be further worsened by the dynamics of the ward (this is a particularly common belief about patients with borderline personality disorder; field notes, 21 January 2011). A frequent argument for placing a patient on a CTO is that this will stop a historical pattern of frequent admission to hospital (field notes, 20 January 2011).

7.5.2. Deciding to admit

If efforts to contain risk in the community seem to be failing, or if there is a sudden deterioration in the patient, the clinician goes through a process of either debating with others whether admission is necessary, or if they believe it is, trying to persuade others (especially doctors) of this. The following is an account of how a clinician would escalate his intervention, taken from an interview with a team leader (interview 1).

Hearing of a patient's deterioration, the first task would be to call the patient to determine if there was immediate risk to them or someone with them. If he thought there was high risk, for example 'they might be talking about killing themselves ... if I couldn't guarantee that this person in the next thirty minutes is

a safety to themselves, I need to escalate this to emergency services.' Alternatively, if there was a 'support person' with them or they were presenting a medium or low risk, he would go to their house or ask them to come to the clinic to see him. At this meeting, he would 'do a mental state assessment, a functional assessment, a risk assessment. If I was concerned from that point I'd discuss it with one of the medical staff.' The discussion with the doctor would then depend on whether the doctor already knows the patient or not. If not:

> ... a new doctor you would go through their age, their diagnosis, their living situation, their legal situation, their forensic; then you get into the history of their illness and then the recent history of their illness, and then into what their normal presentation is, and what their presentation is today. The thing they always wanna hear at the end is what are the risks today. Then the doctor would then either have to decide are we gonna manage this person in the community – and part of my handover to the doctor would be telling them what supports there are available; or if he's not happy and he thinks the risk is too great, he'll say we need to arrange an admission. (Interview 1)

In practice, the decision to admit a patient is again a collective one; although the doctor has the final say, they take the case manager's opinion into account.

> A case manager continues to explain to the registrar about the patient's recent deterioration. He's highly disorganised, and made a mess in a friend's house; also a friend called saying he was 'stalking' her. They then start debating admission. The registrar asks 'do you think he needs admission?' – case manager replies 'it's getting close'. She adds that he is 'good at holding his symptoms in' when he sees the doctor, and he's 'close but I don't think we'll admit him today'. The registrar questions 'but if he's already having manic symptoms?' [...] [Case manager] suggests that as he's not manic 'here and now' it would be hard to get him admitted. Registrar suggests that they make a plan with him today, and that the case manager will call him twice a week. (Field notes, 28 January 2011)

7.5.3. *After admission: managing escalation on the ward*

The pattern of escalated intervention continues once a patient is admitted to the ward. As the assessed risk level rises, the intensity of direct monitoring and interaction with the patient increases. During observations and interviews, the risk of aggression on the ward was the most common type of escalating risk requiring intensive intervention by staff. Analysis of incident reports supports this observation; of 228 incident reports submitted in the mental health wards at this hospital during the year to July 2011, 91 were classified as aggression – the most frequently cited category of incident.

Escalating intervention may entail more frequent observation, taking 'stimulus' out of the environment, offering increased 'talk time' or increased medication. Physically coercing the patient to be in the locked environment is also important to containing 'high risk'.

> The strategies they use in the acute inpatient units are for the worst of the worst and they're usually around making sure people are less agitated, are in a less stimulating environment, have them locked in a safe environment so they can't get out and hurt themselves or others ... and that they're not putting any other nursing staff or fellow patients at risk as well. (Interview 8)

In a situation of acute aggression risk, the preferred strategy was to use verbal persuasion and voluntary medication to 'de-escalate' the risk. In the following extract, a senior nurse reflects on how she managed such a situation. Her successful resolution of this patient's distress reinforces earlier findings about the centrality to the maintenance of patient safety of rhetorical strategies, showing empathy, and attempting to understand the reasons behind the behaviour. Such safety strategies are used both with patients who are considered 'stable' and with those who present an acute risk of aggression.

> It was Monday morning ... and there was this woman screaming blue murder
> ... and ... she had knitting needles in her hand, and I was like 'fuck, what
> the hell is she doing with knitting needles on acute ... aargh!' Anyway, I go
> out there and she's screaming 'get me out' she's kicking doors, she's got a
> bag she's got a knitting needle, and they [other nurses] had tried for a
> while to pacify this lady [...] It was going downhill fast ... and the needles
> were really concerning me cause she was getting quite aggressive. So that's
> when I stepped in and just started talking.
>
> Eventually she threw the knitting needles down the corridor. [...] Once I got
> her calmed down and said look you want out – I need [you] to [be] calm, I
> need you to speak to a doctor. [I] came back in [to the nurses' station] and
> said to the staff 'Don't know her, what's her big [problem]?' [They said]
> 'five litres a day she drinks ...' and I'm like 'has she been given any Valium?
> Is she in massive withdrawal out there?' She was not dosed enough. I said
> 'she's out there physically shaking, she's agitated.' I said ... 'Valium ... now.'
> So they went out and gave her ten more Valium ... down she came ... lovely.
> (Interview 10)

7.5.4. *Managing acute risk in practice*

The following extended extracts from an afternoon's observations illustrate how interventions become increasingly coercive and physical in nature, and involve more and more staff members, as each strategy fails. It is a long extract, but is included in its entirety because it acts as a summary of the multiple aspects of the enactment of everyday safety which have been highlighted in this chapter so far. So as not to interrupt the flow of the narrative, analysis will follow the extracts, which are taken from observations in the nurses' station during one afternoon in July 2011. (The numbers in bold and square brackets are for reference when reading the analysis which follows.)

> The first I noticed of the patient was the day previously when he was [...]
> singing and dancing in the lounge room. Today, the first indication for me
> that things had deteriorated is that very soon after I started my

observations of the acute side of the nurses' station, the nurse in charge [Nurse 1] talks to two doctors who have come in from another part of the hospital to see the patient (1247). She says 'seeing him today wouldn't be a good idea – he went out on leave and we're assuming he took some nice substances ... he's quite aggressive' **[11]**.

A short time later (1306), the patient knocks on the door to the nurses' station asking to know the details of a lawyer that can he can contact. [...] His nurse [Nurse 2] goes over to the admin assistant and speaks to her about legal aid. The assistant asks her 'is he voluntary?' She answers 'no, he's scheduled,' but on checking the whiteboard, 'oh hang on ... he's voluntary ... crap, I thought he was scheduled.' The admin assistant advises Nurse 2 to double check in the notes. [She talks to the patient, telling him he's voluntary and has the right to request discharge, but can only do so with the doctors] **[3]**. Half an hour later, a maintenance man comes in with a tool box to fix the sink on acute; Nurse 1 says to him 'can we not take the toolbox out there today?' **[11]** and explains about the patient. 'I'm hoping he'll be down by tomorrow.'

I go to lunch about 1350 and when I return at about 1430, there is mess (orange peel, rubbish) all over the floor in the acute lounge, and black scuff marks all down the corridor (visible on the CCTV camera). A consultant psychiatrist and registrar go out into the ward to attempt to talk to the patient **[16]**; they return quickly and Nurse 2 makes a call to security for them to come and be present during the interaction between the doctors and the patient – 'they're just not comfortable speaking to him without your presence' **[22]**. In the meantime, the two psychiatrists and Nurse 2 discuss the patient; the consultant psychiatrist asks 'is that his normal behaviour? Was he aggressive in the past?' **[7]** He muses 'what do we schedule him on is the thing ... (it's) going to be hard to discharge him without a case manager ... it's unlikely we're gonna be able to throw him out today.'

While this is going on, the patient is knocking continuously at the door and periodically yells through the gap in the door so that his voice sounds loudly in the nurses' station (he continues to do this through the next

couple of hours). After three security guards arrive, Nurse 2 and Nurse 3 (another nurse on shift) go with the two doctors out into the lounge room; as they leave, Nurse 1 asks the nurses 'are you two alright out there?' A manager also appears from his office and stands so he can watch what is going on from inside the nurses' station [16]. Nurse 1 tells him 'he's threatening he's got firearms, threatening Molotov cocktails.' He and Nurse 1, watching things unfold, critically discuss how the doctors have positioned themselves in relation to the patient; 'they've got him in the corner'… Nurse 1 says 'he's gonna tip the table'.

The two doctors have positioned themselves about two metres from the patient, sitting down (as the patient is) around two sides of a table in the far corner of the lounge; the patient is in the corner and behind the table. Two security guards are standing about two metres further away again, facing the encounter; the third guard sits at a table to the side of the room. They all wear plastic gloves. Nurse 3 stands near one of the standing security guards, and Nurse 2 sits at a table slightly further away. There are no other patients in the lounge room or courtyard. The manager points out to me that the patient really has very few options to escape the situation and will feel cornered. He says it's about 'being aware of how you position yourself [10] … I'd probably be at the other table' (pointing out another table that is not in a corner).

While the conversation in the lounge continues, a patient comes to the nurses' station door to return some razors; Nurse 1 answers the door and tells him to go back to his room. Similarly, as another patient approaches the lounge room from his bedroom, she quickly opens the door and in a loud whisper tells him to return to his room [11]. She answers the phone; it is the bed manager to whom she relates the situation and says 'so we have a show of force' [17]. The Resident Medical Officer comes through; looking out into the lounge, he comments 'it's like a *warzone* with all that debris!' About fifteen minutes after they went into the lounge, the security guards, nurses and doctors return to the nurses' station. Coming in first, Nurse 2 tells her colleagues 'they're frigging keeping him!' Someone comments 'he's scheduled so [now] we can do whatever necessary' [18].

One of the nurses asks the security guards whether they can come back out to the patient; 'can we get his boots off him while you're here?' They go back out to ask the patient, who removes his boots. I ask Nurse 4 (another nurse on shift) 'are they steel capped or something?' She says 'I dunno but I wouldn't want that to my head.' The boots are brought in and placed inside the nurses' station door [13]. Nurse 4 asks Nurse 2 'we gonna give him anything?' Meanwhile, the doctors sit at the bench continuing to write notes. The registrar writes in the medication chart [20], and the consultant tells her 'I'd put him on 5 *mane* [in the morning] and 10 *nocte* [at night] of this' (and lists several other drugs). [...]

At this stage the consultant is writing the schedule paperwork. Checking the patient's PRN [*pro re nata* – as needed] medication chart, Nurse 2 and Nurse 4 discuss how they can only give the patient 5mg more of olanzapine and 'we're up to the quota'. They ask the registrar's advice about this.

The registrar is still writing notes [20], and a nurse points out that the patient is staring through the glass at what she is writing. Unconcerned, she says 'he can't read it,' and adds 'no-one can read it!' [21] At 1516 the consultant leaves, saying 'no leave today and I will see him tomorrow.' At this point everyone gathers round for cake for a nurse's birthday. As we all stand around eating it, the patient is staring at us intently through the window [21]. Afterwards, as Nurse 2 sits and tries to catch up on notes [20], he keeps knocking on the door, and she answers him several times. Several of the nurses sit near Nurse 2, and Nurse 5 talks to her about the patient. One of them comments that they remember him (from previous admissions) as 'quite a nice guy ... leads me to believe that this is not him well.' [...] [1]

Meanwhile, the patient begins yelling through the door again and banging harder on it. Registrar says 'I have a feeling we're gonna be Acuphasing [zuclopenthixol, antipsychotic injection with several days of sedative effect] him ... he is nearly on the level now where he could destroy this door' [15].

Three other nurses join the conversation after the registrar leaves. They discuss how 'if you keep him here it's unfair on the other patients ... they're scared of him.' Nurse 2 comments 'I'd be scared of him if I was stuck out

there with him!' [4] One of them says 'if they're gonna do it [Acuphase], do it now before everyone leaves.' Continuing to discuss how the other patients would be finding it scary, Nurse 6 says that 'male and female should be separate' (areas of the ward) … 'he'd better not start throwing things around again!' About one particular patient, who they say looked really scared of this patient, Nurse 6 says 'tell her to spend time in her room tonight if she's worried' [4].

At 1615, Nurse 7 is on the phone to security; 'could you give us a hand with a patient, to give him an Acuphase? Yes, same (patient) as before … .' She tells the others she's called security; someone says 'he's threatening to trash the unit now' [22]. At this point, another nurse comes over and says that this patient's girlfriend's here to visit him. Nurse 4, coming out of the medication room (having prepared the injection) says that she (girlfriend) can't see him, he's not very well and 'is needing a bit of rest' [13]. She comes over to the registrar and asks her 'why no midaz [midazolam – quick acting sedative] with that?' (in the injection with the Acuphase). Registrar replies that 'he got a lot of olanzapine today, the last one was three o'clock.' Nurse 4 asks 'would it be better to wait till five,' (when they could also give the midazolam at the same time) because 'we'll stir him up' giving him the injection and it (Acuphase) won't kick in for a number of hours [8].

Initially the registrar agrees, saying 'yeah we can hold off.' Nurse 2 brings over a kidney dish with some plastic gloves and the filled syringe in it. Meanwhile, the security guards enter the nurses' station and stand close to where this discussion is taking place at the bench. There seems to be some indecisiveness about whether to hold off on the injection or not; Nurse 4 continues to say she's worried he'll 'arc up' when they give him this injection but he'll 'have nothing to hold him' until the medication kicks in, but the registrar continues 'this is a compromised patient, his processes are slower than usual … let's not risk it' [8]

The security guards stand there for about five minutes whilst this discussion is going on. It seems that the decision is taken to just give the Acuphase; Nurse 2 says to security 'so we've got an injection' to give to the patient. They (eight staff - three security guards, the manager and four nurses) go

into the lounge. Nurse 4 approaches the patient and he appears to agree to be taken to his room. He walks down the corridor with the manager beside him and the trail of seven other staff behind him [19]. Most of them go into his room, and emerge a few minutes later. The patient is soon back out again at the window.

While watching this going on, Nurse 8 says to me that he's being a bit 'naughty' and 'he knows better' [2] [6]. A therapist, sitting writing notes, agrees, saying that he seems to like the attention [2]. Nurse 4 takes a newspaper out to him and as she hands it to him at the door, has to use her bodyweight to push the door forcibly shut against him [5] as he becomes aggressive and appears to want to come forward into the nurses' station.

At other points throughout the afternoon when he had been yelling through the door and sounding aggressive, instead of opening the door his nurse (Nurse 2) would nod exaggeratedly at him as if to say she was hearing what he was saying. Through the afternoon he was yelling more bizarre things through the door. I noticed that the other nurses are vigilant when one nurse is at the door; for example, at one point Nurse 7 had the door half open talking to another patient, when the (agitated) patient started to approach; Nurse 6 called out 'watch the door!' [9] At another point, there is a loud noise as the phone is dropped during one of the times when the phone is passed out of the door to the patient – other nurses turn around and say 'are you ok?' The nurse with the phone emphasises immediately 'that was me!'

The registrar sits back at the desk writing notes [20], and the patient stands behind her outside the window aiming a mock weapon at her. She has her back to him. She says to me, amused, 'you're going to miss us aren't you?' and says that she doesn't need to watch movies, inferring that there's so much variety and action going on in here [21]. I decide to leave at this point (about 1640). Nurse 6 says 'you've had enough?' I realise that I'd found the situation quite stressful, especially feeling vulnerable when sitting opposite the door which was being bashed on by the patient [15].

The management of this patient illustrates the importance of the everyday strategies outlined in the previous three sections of this chapter, and demonstrates the argument of the present section that broken or missing parts of the 'safety net' are rapidly repaired or reinforced as risk escalates.

There appears to have been rapport between clinicians and this patient in the past (a nurse comments that he has been 'quite a nice guy') [1]. However, there is evidence that in the face of suspicions that his present behaviour may not be entirely illness-based, any rapport has broken down [2]. Nurse 2's attempt to help him with legal information and reassure him that he has the right to ask for discharge [3] does not improve the situation and relations become increasingly antagonistic during the afternoon. Towards the end of the observation, nurses are reflecting on how frightening it must be for the other patients to be in the ward with him [4], and the adversarial dynamic culminates in the patient pointing a mock weapon at the psychiatrist and a physical struggle by one nurse to prevent him entering the nurses' station [5].

The comparison of present with past behaviour the comment that 'he knows better' reflect a degree of familiarity with the patient's history of contact with the service [6]. The consultant psychiatrist's questions to the other staff about history of aggression show his attempts to ascertain this patient's 'normal' patterns against which to gauge the appropriate management of the current episode [7]. The discussion about which medications to give the patient is a negotiation between different risks to effect 'least worst harm', a theme of Chapter 5. While the nurse prioritises the calming of the patient in her wish to include a faster-acting tranquiliser with the longer-acting injection, the registrar prioritises the risk to the patient's physical health [8]

Many of the staff on shift that afternoon displayed an embodied hyper-vigilance towards this patient's movements, exemplified by Nurse 6's call out to Nurse 7 to 'watch the door!' [9] Staff not directly involved in the care of the patient, including the manager (who came from a different office to watch), the RMO,

therapist, and other nurses all offered comments about the management of the patient while watching through the glass of the nurses' station. Criticism of the way the doctors positioned themselves in relation to the patient is reflective of the hyper-vigilance turned towards staff behaviour as well as towards the patient [10].

The number of staff members, of multiple disciplines and levels of seniority, involved in the effort to deal with this patient, reflects the collective nature of the effort to manage patient safety in these teams. Such distributed monitoring, knowledge, and decision making was also a feature of the community team meeting conversation at the end of section 7.3.4.

Heightening of the senses among staff members was accompanied (and in many ways facilitated) by a tightening of environmental restrictions around the patient. Nurse 1's insistence at the beginning of the observation that both the maintenance man and the two doctors from outside the unit refrain from entering the ward [11], her later whispered instructions to two other patients to return to their rooms [12], and the refusal of Nurse 4 to allow a visit by the patient's girlfriend [13] minimised the number of people coming into contact with the patient. The removal of the patient's boots was a further attempt to control the environment and reduce physical risk to staff from aggression [14]. My own feeling of fear as I sat close to the locked and straining door of the nurses' station as the patient kicked it [15] made it clear to me that not only were the doors and walls of the ward working hard for the physical safety of staff safety as well as that of patients, but also that in this setting, the quest for 'patient safety' is unavoidably structured by staff members' concerns for self-protection.

Apart from this increased control of the immediate environment, staff interventions escalated in a variety of other ways as the patient's behaviour becomes more aggressive. The first escalation happens when senior clinicians become involved in interacting with the patient – the two psychiatrists, and later the manager who watches proceedings and takes the patient to have his injection

[16]. Secondly, the two doctors call for security staff to accompany them while they speak to the patient, so that seven staff members are present while the conversation occurs – called a 'show of force' by Nurse 1 [17]. Thirdly, the patient is scheduled and his legal status changed from voluntary to involuntary, enabling staff to 'do what's needed' [18]. Lastly, the summoning of the security guards (who do not say anything to the patient but provide physical force) [22] and the involuntary administration of medication with eight staff members present [19] completes the stepwise move away from verbal persuasion and voluntary treatment towards the physical and involuntary.

The previous chapter's findings about the amount of clinical time taken up by writing documentation are substantiated here; both psychiatrists as well as the patient's nurse spend significant parts of the afternoon writing clinical notes and paperwork [20], more time than was spent face-to-face with the patient. Finally, the habituation of these staff to an episode that to a member of the public (or a researcher) may seem unusual and at times even frightening is comically illustrated by the registrar's jokes and the juxtaposition of staff eating birthday cake as the patient watches on from behind the glass [21].

7.6.   Conclusion

Clinicians attempt to ensure the safety of their patients by the intertwining of four principal practices. Metaphorically, the continuous unfolding of safety across time – in both community and inpatient settings – is like the operation of a loom weaving an endless bolt of cloth. Rapport provides the quality and colour of the thread; its strength dictates the strength of the newly created safety material. Threads of historical knowledge run through the entire length of the cloth, and across these, fibres of real time information, contributed by the distributed network of informants, are added and added again as the loom continues its work. The safety cloth is fragile and can break at any time, and as time passes it must be continuously renewed. If any of the fibres, lengthwise or

crosswise, are missing or weak, and if the thread is not of strong quality, holes can appear which may tear the cloth if rapid repair work is not undertaken.

Chapter 8: Safety ontologies: interference and contradiction

8.1. Introduction

To my knowledge, this is the first study to foreground the multiplicity and situatedness of professional conceptualisations and enactments of patient safety, in the context of multidisciplinary mental health care. Its findings offer a detailed insight into the everyday dynamics of safety, and portray it as an actively accomplished phenomenon which is forever in-the-making. We have seen how externally developed safety imperatives penetrate (or do not penetrate) practice; how standardised safety requirements intersect (or do not intersect) with the immediate safety exigencies presented by provider-patient encounters; and how people and materials alike play a role in perpetuating ideas of what safety is and in making those ideas reality.

Ethnographic examination of the two teams at work revealed a world in which safety is a central driver of activity but at the same time, what counts as 'safe' is fluid. Safe care is differently expressed in clinical notes and documentation than it is in nursing station conversations; it is different for different patients and even for the same patient at different times; it can even have multiple forms in one situation according to prioritisation of different goals. The initial research questions about professionals' conceptualisations and practical accomplishments of patient safety therefore have both one and many answers, in that they are as mutable and multiple as the individual situations which give rise to them. Such multiplicity and fluidity could only be recognised and articulated because of the 'ant's eye view' (Latour, 2005) of everyday practice made possible by the ethnographic design of the study, an approach which does not necessitate the forced ordering or bracketing out of uncertainties or mess. There are, however, some patterns to all this multiplicity and fluidity, which will be discussed in

section 8.2 of this chapter with the help of the conceptual tool of the 'assemblage.'

The four domains of scholarship described in Chapters 2 and 3 inspired the design and focus of the study. In turn, its findings extend, confirm and challenge aspects of those domains. The research confirms prior claims that risk management activity (based on a rational-instrumental epistemology) structures much of the care provided to mental health patients. However, I have found that at the same time, a parallel sphere of activity – surrounding the improvised and personalised interaction between clinician and patient, and mediated by genuine care and rapport – is seen by staff as more important to the everyday maintenance of individual patients' safety, despite being absent from risk management and policy discourse. The findings also challenge the notion of safety as property of a system by grounding its production in unfolding practices which are anchored to particular times and particular places. There is no such thing as 'safety' existing prior to or above the socio-material enactments of health care. Further, there is no 'safety' which can be achieved once and for all. There is only an ongoing process of becoming more or less safe, and this process itself is highly situated.

In the present chapter, I will refine this practice-based perspective by proposing a theoretical framework integrating the study's findings with recent theoretical developments in socio-material ontology. This framework attempts to account for the coexistence of multiple safeties within the mental health service as well as the interdependence and contradiction characterising the relationships between them.

Towards the close of the chapter, I will propose some of the implications of this reconceptualisation of patient safety. Seeing safety in terms of two parallel enactments allows the teasing out of the contradictions between them, and it becomes possible to articulate how these contradictions can stand in the way of therapeutic care. Using such a framework also exposes the fundamentally

political aspect of standardised initiatives designed to effect safety improvement. The argument I will make in this chapter, namely that safeties operating according to different logics and different versions of a 'good outcome' can coexist in the work world of these professionals, has an important implication for safety improvement. That is, if we can articulate the socio-material arrangements which facilitate (or stymie) the enactment of each logic of safety, we can start to see that choices can be made about which safety stakeholders want to be prioritised – and how that safety might practically be realised.

8.1.1. *Disciplinary safety and personalised safety*

There are two broad patterns of safety conceptualisation and enactment in evidence in these services. The first was the subject of Chapter 6, with its emphasis on meeting external expectations through a complex of political, legal and physical technologies emphasising standardisation, categorisation, prediction and coercion. The focus in that particular logic of safety is on risk, its prevention and management – avoiding something bad happening. The second pattern – described in Chapter 7 – is represented by those improvised and interactive activities which engage with situatedness and uncertainty and which are aimed at creating safety in a person's life.

The first can be characterised as 'disciplinary safety' because its principal effects are to discipline staff and patients and to tame uncertainty. The second can be characterised as 'personalised safety' because its enactment relies on activities and interactions grounded in knowledge of individual tendencies, personalities and histories. These two enactments are not just different means to the same end ('safe care'). Rather, they produce *different safeties* which are often incompatible but which nevertheless have to coexist.

How might we better understand how these different safeties play out in practice, how they are sustained, and how they prove to be either benefits or barriers to effecting safe care? The theoretical framework presented here aims to answer

these questions, using two theories of socio-material ontology. These are the notion of the assemblage as developed by Latour (2005) and Delanda (2006), and the idea of multiple ontologies as elaborated by Mol (2002).

As a conceptual tool, the assemblage 'permits the researcher to speak of emergence, heterogeneity, the decentred and the ephemeral' (Marcus & Saka, 2006, p. 101), and is therefore useful to engage with the complexity of multiple safety enactments we have observed in this mental health service. Each assemblage is made up of a contingent constellation of 'elements' which are things, people and ideas coming together in a particular situation to enact some phenomenon – in this case, safety. For example, we saw in Chapter 3 that while Brodwin attended to the pattern of relations between moral, social and material elements of his compliance assemblage across multiple enactments, Mesman demonstrated the mutually constitutive relations between spatial, temporal and material dimensions of her sterility assemblage in one specific case. My goal in the first part of this chapter is, in a similar way, to expose the patterns in the moral, material, spatial and temporal dimensions characterising the elements of 'disciplinary' and 'personalised' safeties.

The key characteristics of the two safety assemblages along these four dimensions are given in diagrammatic form in Figure 9. Clinical practices (along the top of the diagram) sit along a spectrum, where their moral, temporal, spatial and material dimensions of their human, nonhuman and conceptual elements display more emphasis on either disciplinary or personalised safety work. At the bottom of the diagram, the spectrum of assessed risk shows how the emphasis on disciplinary safety enactment increases as assessed risk rises. However, the descriptions in the following section (8.2) of each type of safety in terms of its distinctive characteristics should not lead us to assume that the assemblages somehow exist as stable entities – they are dynamic and fluid. Many variations on each were observed in the study settings. Separating out the characteristics of each safety, however, does allow us to specifically identify the elements of

practice which sustain them. In capturing the pattern, we temporarily bracket the dynamic nature of safety in these settings. These dynamics will be the focus of the later section (8.3) dealing with multiple ontologies.

Figure 9: Disciplinary and personalised safety assemblages and their dimensions

Clinician activity	Building rapport	Marshalling distributed knowledge	Spatially distributed monitoring	CTO	Inpatient admission	Involuntary sedation	Seclusion

Dominant assemblage	Personalised		Disciplinary

Normative assumptions	Unpredictable, idiosyncratic	Nature of risk	Quantifiable, predictable
	Transient, emergent	Nature of safety	Static state to be achieved

Moral dimension	Patient wellbeing	Moral 'good'	Public safety
	Clinician and patient 'here and now'	Who defines good?	Absent authority
	Enacting good enough safety	Goal	Displaying a safe service

Temporal	Improvising in ever-unfolding present	Treatment of time	Fixing the present in episodic accounts

Material dimension	Human, interactive	Principal safety mechanisms	Material, depersonalised
	Individual's whole life	Subject of intervention	Generic patient's body

Spatial dimension	Expanding	Space of possible action	Shrinking
	Overflowing	Boundaries of possible action	Becoming more rigid

Risk	Lower		Higher

8.2. Moral, temporal, spatial and material dimensions of safety

8.2.1. Moral dimensions: what is 'the good'?

Practices always enact some version of what is considered to be 'good' (Wartofsky, 1979, p. 201). The 'good' is both an influence on and defined by arrangements in the assemblage. What versions of 'the good' distinguish our two safeties? We might at first assume that 'safe care' would be the object of both. However, we have seen that what counts as 'safe' varies; there are different 'logics of evaluation' characterising each (Thévenot, 2002). We might call the main 'good' enacted within the assemblage of disciplinary safety 'displaying safe care to the world', and that within the assemblage of personalised safety 'creating conditions for individual safety'; or – in terms of the psychiatrist's pinball machine metaphor (Figure 5) – 'pushing the ball back up the table.'

Public good and patient good

The conversation about getting families to sign a form before taking a patient on leave (at the beginning of Chapter 6) illustrated that much of the activity of disciplinary safety is driven by the need to be able to justify one's conduct in relation to the expectations of external parties. Flowing from this is the need of the clinician to protect themselves and the service from potential accusations of negligent or unsafe care, and this is associated with the idea that safe care entails the safety of the public. The safety of patients is only a secondary good enacted by this assemblage, and one in which the patient is enacted as a generic role rather than individual entity.

The uncertainties pervading the practices of mental health care mean that clinicians often see the enactment of patient safety as an achievement of 'least worst harm'. This type of 'good enough' safety is often infused with a personal and genuine concern for the patient (derived from intimate knowledge of their history, circumstances, and idiosyncrasies), and a desire to ensure they attain the best quality of life they can. The good here is principally the patient's good. It is

more about the wellbeing of a person, who is seen in the context of their history and life circumstances, than it is about their safety exclusively while in the role of patient.

Matters of fact and matters of concern

The relationship between elements in each assemblage can be distinguished by the degree to which their 'goods' are taken for granted. Disciplinary safety is characterised by relations between elements that effect a 'pre-disciplining of the imagination through the legacy of former expectations' (Borup et al., 2006, p. 293). The instruments of policy and law are expressions of historically derived concepts about how society deals with those considered 'deviant'; the physical characteristics (and existence) of the mental health ward are examples of this and are never seriously questioned. This type of safety is dominated by what Latour (2008) has called 'matters of fact', where the complexity and contingency behind the genesis of different technologies of governance (formal rules or documentation formats, for example) is invisible and their 'goods' are taken for granted as true.

Personalised safety expresses another, contrasting Latourian idea, 'matters of concern,' in which those complexities and contingencies are continuously exposed, negotiated and lived with: 'A matter of concern is what happens to a matter of fact when you add to it its whole scenography, much like you would do by shifting your attention from the stage to the whole machinery of a theatre' (Latour, 2008, p. 39). So, the enactment of personalised safety requires clinicians to take account of the uncertainties of psychiatric diagnosis, treatment effects, risk prediction, and so on, in their effort to ensure safety. Many elements of that assemblage are controversial and contested, as we saw in Chapter 5 in the negotiations about degree and type of risk and about situations where multiple risks compete for prioritisation. In such a world of flux, action is often accompanied by self-conscious reflection on what 'good' it is that a clinician wants to achieve with a patient at that moment. Disciplinary safety, however, is

enacted through elements which present these issues as uncontroversial and settled in a particular way, such as the implied predictability of risk in a form which requires placing a patient into a 'high', 'medium', or 'low' category.

8.2.2. Temporal dimensions

Fluid time and episodic time

The goods prioritised by each type of safety lead to contrasting time orientations between the two assemblages. Although talking about his theory of 'heterotopic' spaces, the differentiation made by Foucault (1967) between time orientations characterising certain places apply equally well here. He contrasted those places, like museums, which are linked to the accumulation of time with those, like fairgrounds, which are linked to 'time in its most flowing, transitory, precarious aspect ...'. The former places are 'oriented toward the eternal,' the latter toward the 'absolutely temporal.'

Disciplinary safety is 'oriented toward the eternal.' Its enactment entails a collapsing of past, present and future in the generation of written accounts. Clinical notes, for example, are consciously written for future audiences – whether colleagues on the next shift or the Coroner in some future hypothetical Inquest – whilst incorporating past events into the narrative. Similarly, the activity of risk management, in terms of filling out risk assessment forms, structures the prediction of future risk in terms of past behaviour, and the construction of RCA recommendations takes 'learning' from the past as the basis for recommendations for future change. All of these activities create a present which is eternally fixed, where the immediacy and currency generated in the writing is suspended for others to perceive (and judge) at any future time.

The temporal dynamics of personalised safety creation are more of the 'flowing', 'transitory' type. While formal safety activities fix the present for posterity, the defining temporal characteristic of this type of safety is its fluidity, generated by the requirement for continuous re-enactment, moment-by-moment. The 'safe

patient' can never be achieved once and for all, but is forever in-the-making, in *this* time and *this* place. The present situation, made up of a particular constellation of people and things, is the eternally shifting locus of personalised safety. In disciplinary safety, time is jerky and episodic, a series of carefully selected snapshots.

Safety as emergent process

The individual variability of the course of mental illness, and of the effect of interventions on the length and direction of this course, creates a climate of uncertainty throughout mental health care, with important implications for patient safety and staff accountability. We have seen that the final achievement of some state called 'safety' of an individual patient is forever out of reach, because life events or unexpected reactions to treatment can derail it at any time. There is therefore nothing that services can do, no conceivable protocol clinicians could follow, which would ensure a person's safety once and for all. Like the flow of a patient's everyday life with which it is intertwined, safety has to be constantly performed and re-performed. The active maintenance of rapport, the ability of the provider to marshal collective knowledge about the patient, and their mobilisation of networks of informants to keep this knowledge renewed in real time, are the practices necessary for this emergence to continue. The assemblage relations are liable to fall apart if the interactions are not maintained – hence the reality of safe care is always a fragile and transitory achievement. This means that consistent work is required by people and things for it to be enacted at any particular instant.

Such a process-focused reconceptualisation of safety is an additional way in which this study adds a new dimension to patient safety research. The shifting relations within the assemblage give the object (safety) its reality at that particular moment. Nothing is 'always already there'; everything is an effect of the relations between elements played out in practice. Safety is neither a static state, nor a property of a system or organisation that exists independently or

outside of practice. However, the technologies which have the effect of 'inscribing' disciplinary safety on the everyday practices of these professionals (Stoopendaal & Bal, 2013), including inspections and audits, reinforce a false impression of how safety is produced, because they are based on static written accounts rather than an observation of the uncertain flow of practice. A productive judgement about how staff deal with uncertainty within the reasonable bounds of their ability becomes impossible.

8.2.3. Material dimensions

Stability and durability of assemblage effects

Both Latour (2005) and Delanda (2006) write of assemblages as having varying degrees of stability and durability. Latour has argued that as particular relationships between elements of the assemblage are re-enacted in the same way, they are reinforced and the assemblage is rendered more stable and durable over time. To be rendered stable, any assemblage must be 'worked at'. An object such as safety does not just exist as an essence waiting to be perceived or used – it must be enacted, and re-enacted, in the context of the assemblage. Social or economic institutions, which endure for generations despite turnover of the human and material elements comprising them, are taken by Latour to be examples of highly stabilised assemblages. What endures over those generations is the repeated work carried out to define the identity, status, and function of the institution against others. Once the work stops, so does the assemblage. This is also performative work, in which the enactment of the institution in a particular way comes to stabilise the entity as a 'matter of fact' and part of what people perceive to be common sense.

> *Thus economists, for instance, are not simply describing some economic infrastructure which has always been there since the beginning of time. They are revealing calculative abilities in actors who did not know before they had them and making sure that some of these new competences are sunk into common sense*

through the many practical tools of bank accounts, property rights, cash register slips, and other plug-ins. (Latour, 2005, p. 257)

Latour suggests here that an assemblage can become stabilised as common sense if the proportion of material elements making it up increases. In an essay (Latour, 1992) about the work done by objects such as the automatic door closer and the seat belt, he argues that when a role (shutting a door and keeping it closed) or authority (of road safety law) is 'delegated' to a material object, this ensures the role is performed or authority exercised reliably and in the same way over time and across space. The key here is not only that the materials in this case force a human to behave in a certain way, but that the materials also prescribe appropriate and 'good' conduct (Akrich & Latour, 1992).

So when we think back to the bricks and mortar and layout of the mental health ward, or the wording of mental health legislation, we have elements of the safety assemblage that are fixed and prescribe certain actions as appropriate. The definition of appropriateness (which often originates far away) is carried, inscribed in material stuff, regardless of whether the other (human) elements of the assemblage change. The format of risk assessment forms and the specifications of guidelines mean that external expectations can be effective at a distance, and in many places at once. Latour (1992) makes the point that it is more efficient to replace the effort required to discipline an amorphous group of unreliable humans – only one of whom needs leave the door open for the discipline to need repeating – with a single reliable object.

The advantage is that you now have to discipline only one nonhuman and may safely leave the others (bellboys included) to their erratic behavior. No matter who they are and where they come from — polite or rude, quick or slow, friends or foes — the nonhuman groom will always take care of the door ... . (Latour, 1992, p. 157)

Whoever these humans are, whatever their individual characteristics, they are all treated the same by the automatic door closer. This is also the logic of the disciplinary assemblage, which goes some way to explain the predominance of its

material and standardised elements which act to depersonalise the relationship between service and patient. There are parallels here with Goody's (1977) commentary on Weber's analysis of the increasing bureaucratisation of the machinery of government. This process depersonalises relations between the governing and the governed, which are increasingly characterised by written communication. Those in positions of power can (in theory) control many 'secondary groups' (removed from them in time and space) via 'intellectual technologies' such as documents and policies. In former systems of government, where face-to-face communication with the proximal 'primary group' was the usual way to conduct business, there was no need for these technologies.

Materials and depersonalised safety

The heavy load of material and intellectual technologies associated with disciplinary safety contributes to a depersonalisation of relationships within that assemblage. These technologies (including administrative tools, documentation, categorisation of patients, building requirements, policies and so on) shut down the possibility of accommodating or responding to contextual or individual specificities. No matter what a patient's history, diagnosis or personal preference, the walls and doors of the unit hold them in the same way, and the forms in their patient file put them into the same group of categories as every other inpatient in the mental health system. In fact, far from being responsive to what is going on immediately around them, professionals performing disciplinary safety are engaging primarily in a lonely interaction between themselves and, via written accounts, unnamed and distant 'absent presences' such as the Coroner. They are 'physically present but absorbed in a technologically mediated world of elsewhere' (Gergen, 2002).

As with Weber's bureaucratised government, written communication is the single most important activity keeping disciplinary safety alive. Even when guidelines may not be read and policies not known about, it is the work of filling in forms, recording activity, and categorising patients by ticking boxes that

reproduces the clinician's (and the patient's) role in the disciplinary assemblage. This is a key way in which this assemblage disciplines – it restricts the range of normatively 'acceptable' actions by clinicians, who even if they disagree with the nature of the restrictions and resist in practice, must conform at least in their written accounts, because of the disciplinary (regulatory) machinery which enforces that version of safety. The regulatory and legal judgement of good or bad conduct is based entirely on the retrospective assessment of written communications rather than of ongoing activity.

Ironically for activity done in the name of patient safety, patients are largely absent from the disciplinary safety scenario. They appear only as cases (in the form of ever-accumulating piles of clinical notes) whose idiosyncrasies and vulnerabilities have been ironed out in the drive to fit them into the risk, diagnostic and behavioural categories provided. In contrast, the everyday effort to maintain safety that was described in Chapter 7 is conducted primarily as face-to-face contact between two people. Engaging with, and tailoring care according to, a patient's individuality is central to the way staff attempt to manage safety on an everyday basis.

Precariousness is a defining feature of the personalised safety assemblage. Unlike Latour's problem of a door being left open, the everyday preservation of a mental health patient's safety is, for clinicians, not a task that can be easily delegated to a nonhuman. Simply acting according to what the forms and policies say is not enough, and as we have seen, may in some situations be harmful where the relentless quest for risk mitigation goes too far. It is the ongoing and dynamic relationship between clinician and patient, and between patient and their significant others, which are the defining relations within this assemblage. Here, nonhumans mainly act to facilitate human relations – such as the use of the telephone by community mental health workers to check up on a patient's wellbeing.

Partly the personalised safety assemblage is precarious because of this. As Latour suggested, humans are unreliable and because they have their own minds, they may resist or simply forget the role they are expected to play. However, because everyday creation of safety relies extensively on human relationships, such fragility can never be entirely removed from clinical practice. Finding ways to work with the creative potential of this fragility would seem to have more therapeutic potential than attempting to erase it. The personalised safety assemblage is also fragile because it tolerates incorporation and coexistence of different versions of the 'good'. At present, the power of the disciplinary assemblage is such that when definitions of 'the good' held by patients and staff prove irreconcilable, clinicians invoke the mechanisms of disciplinary safety (and its depersonalising materials) to force the prioritisation of their own (and authority's) definition.

8.2.4. Spatial dimensions: boundaries and colonisation

Within the personalised safety assemblage there is a tendency for relations to multiply quickly, whereas disciplinary safety works to shut down such multiplication. For instance, when in the community a clinician perceives that a patient of theirs is 'becoming unwell' or showing signs of escalating risk, they recruit more people to help them in the task of monitoring and getting the 'real' story about that patient's behaviour and circumstances. Similarly, on the ward, a doctor deciding how to best treat a newly admitted patient whose diagnosis is ambiguous multiplies his or her contacts with colleagues, the patient's family, and documentary sources of historical information about the patient.

During face-to-face verbal or bodily communication with the patient, the exigencies of the immediate situation entail a rapid assimilation of many such multiplicities in order to enact personalised safety. As described in Chapter 5, there are often multiple risks perceived in any situation and even more when the views of others are added to the mix. Personalised safety, even from the viewpoint of a single staff member, shifts its character between patients, between

times, and between situations. Different people, different material resources, and different rhetorical strategies will be required to enact any single person's safety at any particular time.

Such multiplication leads to increasing heterogeneity of the personalised safety assemblage as risk increases: more and more elements become involved in enacting patient safety. Heterogeneity is also increased through a process of what Delanda, following Deleuze and Guattari (2004), called 'deterritorialisation'.

> *Processes of territorialisation are [those] that define or sharpen the spatial boundaries of actual territories ... and also refers to non-spatial processes ... such as the sorting processes which exclude a certain category of people from membership of an organization ... . A good example [of deterritorialisation] is communication technology ... which blurs the spatial boundaries of social entities by eliminating the need for co-presence ... .* (Delanda, 2006, p. 13)

These characterisations suit our two safeties rather well. Territorialising moves, in terms of sharpening the boundaries within which action can happen as risk increases, is a key feature of disciplinary safety, as is the categorisation of a patient's risk level to justify restriction of their range of movement and activity. Personalised safety overflows spatial and categorical boundaries; its enactment requires the participation of people far beyond the walls of the hospital, and as we have seen there is almost no limit to the aspects of a patient's life that may be subject to a clinician's intervention. It does not rely on broad categorisation of groups of patients but rather on perception of subtle differences in an individual's behaviour. If anything, rather than following in a linear way from absolute categorisation into risk and diagnostic categories, decision-making and action in personalised safety relies on *relative* notions of risk and on an understanding of a complex mix of a patient's life problems rather than whether they meet specific diagnostic criteria.

As risk increases, then, spatial and categorical boundaries become more porous and flexible during the enactment of personalised safety. As disciplinary regimes

are brought into play, however, they strengthen and become more rigid. At the same time, possibilities for action multiply in the former and decrease in the latter. Although I previously situated the increasing use of physical and coercive measures (in response to rising risk) as part of personalised safety (and therefore described it in Chapter 7), on reflection, it seems that this move is actually evidence of the creeping colonisation of personalised safety regimes by disciplinary regimes.

This colonisation affects more and more aspects of clinical practice as external expectations of a zero-risk service appear in greater danger of being breached. It entails a shrinking of the spatial parameters of the safety assemblage as the patient is admitted to the ward and subject to the more focussed gaze available therein. The realm of personalised safety shrinks in these circumstances, but still circulates in conversation between staff and patients, and in the constant hyper-vigilance and bodily awareness staff carry. It does not disappear until the patient's risk is considered so great that they must be chemically or physically restrained. At this point, the standardised techniques of medication dosages and pain-free holds are all that is left to throw a blanket over the flickering flames of uncertainty.

Disciplinary safety has its origins far away but often entails a rapid constriction of the spatial and technical management of escalating risk. By contrast, the imperatives driving the practice of personalised safety are usually characterised by proximal origins and spatially more expansive management. We have seen how assemblages of safety in this context are often hastily improvised and temporary, soon shifting to accommodate changing circumstances of an always-fluid present. We have also seen that this emergent type of safety is accomplished moment-to-moment. Using the notion of the assemblage, we can add that this accomplishment entails a shifting collection of widely distributed elements which facilitate the monitoring, intervention, and information gathering tasks of personalised safety. The sheer number of heterogeneous elements assembled

together means that redundancy comes as a built-in safety device. In contrast to the focussing manoeuvre of disciplinary safety, the personalised safety assemblage surrounding each patient expands as risk increases, and the network connections between case manager and supplementary sources of information and monitoring support greater volumes of traffic. The patient's everyday life becomes colonised by this safety assemblage.

8.2.5. *The socio-material situatedness of safety*

The above sections have highlighted the differences between the moral, temporal, spatial and material orientations of disciplinary safety and personalised safety. However, they are also similar in terms of the intertwining socio-material and practical situatedness of their enactments.

Both disciplinary and personalised safety enactments require the participation of elements of everyday practice which are heterogeneous. In other words, they are both rooted firmly in situated, socio-material practices, and it is impossible to imagine a version of safety which could exist apart from the context of its enactment. Even disciplinary safety, in which extensive material and policy instruments are enrolled in the effort to perpetuate the normative discourse, has to be enacted in particular times and places. This heterogeneity is an important characteristic to consider when attempting to improve safety:

> *Since the social structure of individual care systems is at least as heterogeneous as the biology of individual patients, it is rapidly becoming clear that anyone who works to change the performance of healthcare systems ignores that heterogeneity at their peril.* (Davidoff, 2011, p. i12)

 The emergence of safe care is inextricably tied to the particular site (a time and a place) of its enactment, and consequently to the material, social and moral configurations obtaining in that site. In these mental health settings, safe care was often said to be threatened by missing or malfunctioning elements of the configuration – but the effect of them being missing was situationally variable.

For example, a missing clinical file was considered a risk by a clinician when meeting an unknown patient in the middle of the night in an isolated room in the Emergency Department. In that situation, she had wanted to know whether this person had a history of aggression. The same clinician, however, did not feel the need to have clinical notes with her when she visited a patient at his home, as she had been seeing him for years and did not need the supplementary information provided by the file. A further example of the local nature of safety enactments is the feeling expressed by a number of participants that admitting patients with a diagnosis of borderline personality disorder to the ward would lead to a worsening of their symptoms, whereas admission for those with other diagnoses was habitually used as a way to bring distressing symptoms under control.

Viewing safety as a socio-material accomplishment helps in the development of a more integrated understanding of the genesis of safe care than that which predominates in the literature. We saw in the literature review that patient safety in mental health care has primarily been examined in patchwork and fragmentary fashion, in terms of particular risks (primarily suicide or violence), risk factors, and the effect of different interventions on risk. This fragmentation is further evident in the tendency for researchers to focus only on the perspectives of one professional group or one type of service (primarily nurses and acute inpatient care). By refusing to limit the investigation to any one aspect of practice or to one group of people involved in that practice, this study has been able to expose the fact that each and every successive enactment of safe care for a patient requires an intertwined complex of people, materials, and ideas of good care. The flow of everyday life carries safety requirements along with it in a continuous unfolding process of enactment rather than as a series of discrete episodes. Within this process, it is difficult (and misleading) to attempt to isolate particular elements from the relationships in which they are embedded and from the temporal and spatial dimensions of their enactment. Such a view also points to the importance for those who seek to improve the care and safety of patients to consider not only the relationships between staff or between different agencies in

the 'system' of health care, but to examine the interrelationships between the discourse, materiality and social dynamics of everyday practice obtaining in the setting of interest.

8.3.   Multiple ontologies of safety

The assemblage is a useful tool to open up the varying socio-material arrangements behind the enactments of different safeties. However, we require a further theoretical framework to better understand how different assemblages work with or against each other when they coexist in practice. The idea of the assemblage has been extended by Mol, most notably in her book *The Body Multiple* (2002), in which she developed the notion of multiple ontologies. She illustrated this idea in her ethnography of the enactment of an apparently singular disease object (atherosclerosis) in one hospital. The disease was, she argued, not a consistent entity seen from different perspectives, but rather was characterised by multiple realities depending on the particular assemblage enacting it. Our two safety assemblages, then, can equally be viewed as two ontologies of safety.

In Chapter 3 we saw how, for Mol, atheroscleroses are enacted differently in the pathologist's lab and in the surgeon's consulting room, dependent on the combinations of human, material, temporal and moral elements present in each context. These are not just different manifestations of an underlying pathology, argues Mol, but rather multiple atheroscleroses accompanied by assemblages enacting different versions of 'the good' via different socio-material constellations. Her key point is that these constellations neither directly clash nor completely ignore the others in practice; they take account of each other and intersect in various ways. They coexist and are interdependent but, at the same time, they can interfere with one another. This tension between interdependence and interference will now be explored in the following sections in the context of the disciplinary and personalised safety assemblages. It enables articulation of

the potential implications for stakeholders in mental health care of the orfen contradictory safety imperatives observed to be at work in this service.

8.3.1. Coexisting, interdependent ontologies

The description of the four dimensions along which the disciplinary and personalised safety assemblages can be said to differ was a simplification. It was used to illustrate generalities about the contrasting types of safety, but in practice, these safeties are interdependent. For example, public safety and patient safety imperatives are not mutually exclusive goals; one can occur as a result of a focus on the other. We might decide that focus on one goal rather than the other effects a greater common good – but this is a different question, to be tackled in the final section of the thesis considering the politics of patient safety.

Mol (2002) offers a framework to understand what happens in practice to allow multiple enactments of (for example) 'safe care' to be played out side by side. She proposes three moves that provide for the coexistence of different enactments which are simultaneously interfere with and depend on the other. These are *coordination, distribution* and *inclusion,* and in Mol's study, these allowed the perceived singularity of the notion of atherosclerosis to be maintained even amidst its manifestly different enactments through diverse practical assemblages.

Coordination

One type of coordination was achieved for different versions of atherosclerosis where, for example, one form of evidence for the severity of disease was dismissed as unimportant or somehow explained away. An example of such a move in this mental health service was seen in the conversation (at the beginning of Chapter 6) about the development of the new form for families to sign, where the two versions of safety came into direct conflict. The presence of the nurse, who questioned whether the form would have any *actual* effect on improving the safety of patients, meant that the assumptions of disciplinary safety were challenged. However, the nurse's concerns were dismissed as beside the point,

and with them any debate about effective ways of improving patient safety. That the recommendation for this form's introduction had emerged from an internal investigation into the death of a patient while on leave, presumably with the intent that such a move would help ensure a reduced likelihood of such an event recurring, was not emphasised in the conversation. Rather, the need for the organisation to protect itself from legal proceedings by families was the explicitly stated purpose of the document. In this situation, complexities associated with the everyday maintenance of a patient's safety were bracketed. The ontology of disciplinary safety had won out, in this case.

This hierarchy, where disciplinary safety concerns (to show safe care has been done according to expectation) trumped those of personalised safety (to improve the here-and-now safety of an individual), was a pervasive one during observations. The performativity of expectations, in which clinicians show that they are acting according to these even when they do not agree with them, was seen in the importance placed on activities where external judgement was most likely. It is only in cases of external judgement – against standards of law or policy – that there are negative consequences of non-compliance with expectation, and the only way external judges can 'get at' the reality of daily care is through written accounts (or, less commonly, CCTV recording). An example of such performativity is the feeling that compliance with the *Mental Health Act* must be enacted even where this conflicts with what clinicians might consider to be the best interests of the patient. Expectations act to discipline present action by promoting a desirable version of the future (Michael, 2000, p. 22) in which clinicians can avoid negative consequences, and by providing the tools needed to realise this future.

Other practices, in contrast, instantiated a prioritisation of personalised safety and a desire to keep the forces of disciplinary safety at bay. It was clear listening to and watching community clinicians at work that in many cases they tried almost anything to keep their patient from being admitted to hospital or from

being subject to compulsory community treatment. Their reluctance to engage with the disciplinary assemblage was reflected in the disappointment expressed by case managers when a doctor asked them to apply for a CTO.

Distribution

Distribution is, for Mol, the mode of coexistence in which differences between enactments of safety are not erased but rather lived with by separation of the enactments. It is an example of living with multiplicity and contradiction. The most striking example of this in terms of the two safety assemblages is the way they are distributed between physical locations. In general, the community team was able to work with a more personalised enactment of safe care, while the inpatient team members were required by the structure of the ward and legal imperatives to engage more with disciplinary regimes of care. In this way, the ethical contradictions between the personalised and disciplinary assemblages can be managed by distributing the disciplinary and depersonalised enactments of safety into a defined space, both in terms of physical space and acuity of risk. If the disciplinary regime is seen as restricted and clearly defined both temporally and spatially, its necessity even within the context of efforts at personalisation and patient empowerment can be justified more easily.

In Chapter 7 we saw that these mental health services operated according to a principle of distribution of information about and monitoring of patients that helped dissolve uncertainty by creating redundancy. Equally, in the case of crisis management by the team leader (7.4.5), the two safeties were simultaneously enacted by being distributed between activities. Phone calls to the family, the duty officer's account of events, decision making in the team meeting, and the absence of the boyfriend and baby, together and in their interaction produced a notion of 'not ideal but good enough for now' safety of *the patient and her family*. In contrast, the crisis team's short staffing, their low prioritisation of this patient, the careful documentation by the team leader, and threat of something going wrong and an inquiry resulting, interacted to produce a safety which was

achieved *for the team leader* but not necessarily for members of the crisis team nor for the patient or family.

Differences were noted in this study between the safety concerns of different professional groups, forming another distributive tactic. For example, doctors have a particular role in relation to disciplinary safety, in that they must approve involuntary admission; they are also required to sanction the seclusion of a patient and the administration of sedative medication. As is indicated by their job title, social workers in this study had comparatively little to do with these disciplinary activities but were more concerned with a patient's wider family and social circumstances; for example, during my observations, two social workers exhibited particular concern for a patient's need for reading glasses to make his stay on the ward less boring, and for another patient's concerns about her dog being held in the pound during her admission. The tasks of disciplinary safety, then, are distributed more to doctors than to social workers, enabling avoidance of explicit conflict over the version of safety being enacted under the rubric of the multidisciplinary team.

Inclusion

The third move or strategy for avoiding a direct clash of ontologies is the mutual dependence and inclusiveness of different enactments. To get anything done, to grapple with uncertainty, and to cope with instability and fragility, the enactments must include (flow into) one another. Just by co-existing, they each change the other in some way, especially when elements of each assemblage fail or don't play their part; are taken away or added; where new clinical tools or guidance are introduced, or political priorities change. This results in a constant state of tension which is nevertheless productive in medicine:

> *Incompatibilities between objects enacted are no obstacle to medicine's capabilities to intervene ... that the ontology enacted in medical practice is an amalgam of variants-in-tension is more likely to contribute to the rich adaptable and yet tenacious character of medical practice.* (Mol, 2002, p. 115)

An example of one safety assemblage partially connecting with the other (by adopting and changing elements of it) occurs in the activity of surveillance which, although a disciplinary technique embodied in the spatial relationship between nurses' station and patient areas, is adapted in the service of personalised safety as well. Particularly in community settings, where clinicians recruit informants to feed them real time information about a patient's behaviour and state of mind, surveillance has been personalised (as it requires the building of relationships with those closest to the patient) but still retains its disciplinary characteristics (if 'deviance' is noticed, this is cause for intervention).

The use of CTOs is also an instantiation of interdependent relations between disciplinary and personalised safeties. The clinician can effect a compromise between the two assemblages by invoking the persuasive force of potential legal sanction, but this offers them the space to offer personalised community-based intervention in the context of an already established relationship. The techniques and 'goods' of the two logics of safety are being simultaneously enacted.

In the extended field note extract describing nurses' attempts to persuade a patient to take her medication (at 7.5.4), a tentative construction process unfolds where nurses negotiate between disciplinary and personalised safety enactments. They ensure that they are prepared to administer either voluntary or involuntary medication depending on the shifting requirements of the situation and the part played by the patient. Both potential scenarios are thoroughly sociomateral: a combination of the nurse's words and the evidence of the medication's packaging (possibly combined with the threat of injection) convinced the patient to take the pills; in the other case, a combination of the nurses' bodies and the action of the needle against the patient's unwilling body would have accomplished a 'less safe' outcome. Both however would be considered more safe (at least by the staff) than the third option, the foregoing of the evening's medication altogether.

8.3.2. *Interfering ontologies as challenges to patient safety*

Although the two safety assemblages do coexist in practice, it is clear that trying to enact two realities of safety at the same time involves clinicians in the negotiation of contradictory imperatives. In this section, I will explore some of the resulting challenges to patient safety. Perhaps it is due to the effectiveness of the modes of coexistence in concealing controversy that these challenges have not been more widely recognised, but I would argue that they have significant implications for understanding of how 'safe care' can be achieved and improved. The challenges include the 'uncertainty paradox' and its implications for patient surveillance and management; the place of standardisation in relation to situated safety; the conflict between attributions of agency and of accountability; and the detrimental impact of physical risk mitigation strategies on the recognition of psychological harm.

The uncertainty paradox

The 'uncertainty paradox' refers to a situation in which 'it is recognised that science cannot provide decisive evidence on uncertain risks, while on the other hand policy-makers and authorities appeal to science for more certainty' (Van Asselt and Vos, 2006, p. 317), since this is required if action is not to be paralysed. Similarly, disciplinary safety logic is embedded in an expectation that clinicians act as though risk is calculable and predictable. In the meantime, however, the essential unpredictability of many risks associated with mental health patients and their care pervades these clinicians' decision-making on a day-to-day basis. Therefore they must act as though certain whilst knowing in many cases aware that there is no 'decisive evidence'.

This paradox has important implications for services, clinicians and patients. The logical extension of acting as though certain about the risk to a patient, whilst knowing that this risk is far from certain, would be the permanent seclusion of a person in a padded room with 24 hour surveillance as a precaution against future

harmful action. Indeed, the move in the UK to define 'Dangerous and Severe Personality Disorder' as a new diagnosis to justify preventive and potentially permanent incarceration of those considered prone to committing violent crimes has been something of a step in that direction (Manning, 2002). Although disciplinary technologies are useful for clinicians in terms of giving them a way of avoiding paralysis by uncertainty – in terms of tools to provide 'evidence' that they have complied with expectations of certainty – we might ask whether there is a better way of achieving this without resorting to excessively defensive practice.

One potential solution may be to investigate and clearly delineate the available information in terms of which types of risk are reasonably predictable by a trained professional, and which are not. In cases where risks are unpredictable, what constitutes a reasonable professional response to that uncertainty could be outlined. Van Asselt and Vos (2006) recommend a system-wide 'epistemological acceptance' about the limits of local and scientific knowledge, which is then codified in procedural approaches to professional accountability. If this was achieved, stakeholders in the system could then define what they considered normative preferences regarding risk, in light of which decisions under uncertainty could be made and the legitimacy of these decisions judged. What those 'normative preferences' might be, and who might define them, is another question, to be discussed in the concluding chapter.

Creating a 'virtual panopticon'?

As we recognise the extensive reach of the safety nets woven by community mental health professionals around each of their patients, we may ask whether the scale of involvement of mental health service in a person's life carries its own iatrogenic risks of dependency and learned helplessness. The level of surveillance of community patients may be recreating a 'virtual panopticon' to supplement the physical panopticon built into the fabric of the inpatient ward. Clinicians' explicit need to 'cover all the bases' is illustrative of the fear of some error of

omission, which is defended against by multiplying the number of people who know about the patient and who can feed information into the collective monitoring effort.

In turn, this activity is driven by a lack of trust in the patient and their ability to reflect a 'true' account of their mental state. Such a version of surveillance is explored in Scott's (2010, p. 220) argument that the 'total institution' (Goffman, 1961) is being replaced by what she calls 'reinventive institutions' which 'rely on a more dispersed, intangible authority built into relationships and practices,' and where 'the panoptical gaze is no longer tied to the physical structure of closed institutions but rather permeates the spaces of everyday life.' There is, again, considerable contradiction here between the empowering ideal of personalised community care and the reality of extensive intervention and mistrust of patient accounts.

Physical safety and psychological harm

In the light of findings from this study, in which disciplinary safety activities appear to rapidly colonise those of personalised safety in situations where risk is seen to be escalating, we may ask whether services are blind to the risk of excessive risk aversion. The focus in research and in policy on 'target risks' – such as those discrete acts of violence we saw dominating the literature – may obscure the wider 'countervailing risks' of iatrogenic harm. Emotional trauma and damage to quality of life are significant patient safety issues rarely tackled in research or policy, but were of significant concern to this study's clinicians. Both types of harm can result from the practices of disciplinary safety, which only tackle 'target risks' – mainly pertaining to physical harm to the patient or by the patient to another person. The psychological harm of the depersonalising coercive techniques of disciplinary safety requires further investigation. Due to the weight given within the regulatory system to compliance with disciplinary safety regimes, the balance between physical safety and psychological safety in the prioritisation of risk mitigation is at present weighted towards the physical.

What might be the mechanisms for and consequences of a greater prioritisation of psychological safety for mental health patients? Clinicians attempt to mitigate the negative consequences of disciplinary safety every day, and already possess many strategies for doing so. Trying to improve quality of life for patients occupied community clinicians' time and conversation, but numerous examples of disciplinary regimes hampering this effort were observed, such as the monitoring requirements surrounding the introduction of beanbags to the ward lounge. There are many examples from within Australia and overseas of services successfully providing therapeutic spaces (such as 'comfort rooms') without detriment to patient safety, but these are yet to become the environmental standard in existing facilities.

The centrality of the personalisation of interventions to the preservation of a patient's safety is indicated by the observation that risk of future harm is usually judged against a detailed knowledge of an individual's history and 'baseline'; that the use of persuasive rhetoric is based upon a stock of personal rapport and (asymmetric) trust; and that detection of deterioration in the inpatient unit is facilitated by an embodied hyper-vigilance to sense subtle changes in behaviour. The people, interventions (including medications) or life events that are detrimental to one person's mental health may be beneficial to another's. The use of personal judgement, based on an often close relationship with the patient, is the basis of a clinician's ability to attune themselves to an individual's changing needs or vulnerabilities in a particular situation and to adapt and improvise their interventions accordingly. It is knowledge of a patient *as an individual* with idiosyncrasies and a history, rather than as a vessel manifesting a disease, which is at the heart of safety maintenance in these settings.

Despite the importance of personalisation, the purpose of intervention as the patient's risk is assessed as increasing becomes more about the protection of the physical body of the patient and less about the wellbeing of the person. At this point, the reputation of the service and the clinician are prioritised above the

patient's whole-life safety. Effectively, the patient's individuality is stripped away as they are reduced to their depersonalised body (in the case of risk of self-harm or self-neglect) or to their ability to harm others. The interventions done as risk rises seek only to discipline this body or this ability, through the work of walls and locked doors, sedative medications, and – at the highest level of risk – physical restraint and seclusion. This depersonalising move has certain similarities to Agamben's (1998, 2005) characterisation of the imposition of a 'state of exception' by authorities in times of perceived social crisis, where citizens are effectively reduced to their 'bare life' – their existence as bodies.

As the role of personalisation and relationships between provider and patient are so important to whole-person safety, how might these strategies and lessons be applied to cases where physical risk is immediate and acute so as to avoid unnecessary psychological harm in the process? It seems counter-intuitive to remove the possibility of using these strategies at the very time when a patient is at their most unwell. The importance of staff 'presence' with inpatients has been highlighted in others' research (e.g. Engqvist et al., 2010) as important to the promotion of feelings of security, and sitting with patients was also emphasised in this study by nurses' accounts of the best way to build therapeutic rapport and detect the first signs of escalating risk.

The most obvious way to prioritise psychological safety would seem to be to structure services, wards and mandated tasks in ways that promote staff contact and interaction with patients. The expectations inscribed in such intellectual and organisational technologies, as well as in the materialities of working life, have been shown in this study to structure staff activity. Any attempt at sustainable service improvement, likewise, has been linked to careful consideration of the ways to render improvement ideas durable by inscribing 'values into texts, behaviour or materialities that steer action in a specific way' (Stoopendaal & Bal, 2013, p. 78). Promoting personalised care on the ward also points to finding ways to increase contact between community and inpatient staff, something which was

lacking during my observations – evidenced by the frustration of some ward staff about community workers not visiting their patients, and of community staff about not being given discharge information. Disciplinary safety requirements which emphasise documentation activity are major barriers to clinicians' ability to just 'be with' patients.

Psychological safety and its relationship to disciplinary regimes of psychiatric care is an under-recognised aspect of patient safety in mental health care. The findings from this study suggest that this is an aspect of iatrogenic harm in acute mental health services which is neglected in favour of a focus on physical risk management – and may even be exacerbated by this. There is a need to seek out (and embed) new models of care which can create a more personalised form of acute crisis management.

Agency and accountability

The relationship between agency and accountability for a patient's safety or harm is a vexed one in mental health care. Whilst the broad thrust of current health policy in general, and of recovery-based models of care in particular, is to empower the patient to take an active role in decisions about their care, the demands of disciplinary safety directly contradict this. A person behaving in a certain way due to their mental illness is dealt with in law and therefore by services as though they have diminished agency (in terms of capacity to make competent choices). The service takes over decision-making for that person, effectively acting as their agent in the name of preventing harm. This is the essence of involuntary detention and treatment where basic elements of agency, such as freedom to move around, to refuse treatment, and to be in a place of one's choice, are removed. Despite this, we have seen that clinicians in this service saw the ultimate agency of risk, particularly when it came to suicide, as remaining with the patient.

Considering the flux and fluidity of personalised safety enactments, and the uncertainties inherent in the practice of psychiatry as a whole, it seems reasonable to question how far one person can be held accountable for the actions of another. A recent court case in France saw a psychiatrist convicted of manslaughter because her patient had committed murder. The court found that she was negligent in not taking colleagues' advice to send the patient to a specialist hospital (Dyer, 2012). The decision was criticised by doctors' associations as promoting defensive practice. Leaving aside the particularities of this case, it does highlight that what counts as a professional mistake or error in psychiatric practice is often an omission rather than a commission. The limits to psychiatric accountability are also being tentatively discussed particularly in relation to 'the almost complete absence of empirical evidence showing that risk assessment has ever contributed to a reduction in harms associated with mental illness' (Large & Nielssen, 2012, p. 4). However, these remain minority voices.

Is it desirable or necessary to think about what sort of measures would help align the goals of the recovery-based patient empowerment ideal with the legal duty for a service to forcibly displace a person's agency? The notion of a psychiatric advance care directive is one way of doing this. This would allow for the development of a plan for how a patient would like to be treated if they should become acutely ill. The settings in this study employed what was termed a 'safety plan', which was filled out by a nurse with a patient at the time of their ward admission, detailing things that the patient considered helpful or detrimental to their mental state, and what they found helpful or exacerbating during a crisis. The advance directive would be based on a similar idea, but would be carefully thought out, agreed and personalised by a patient in collaboration with their community clinician at a time of wellness rather than on admission. It would also need to be adequately communicated to ward staff and would need to have some legal standing in the case of involuntary treatment. At present, mental health law overrides any advance care directive in place for an involuntary mental health patient (Australian Health Ministers' Advisory Council, 2011).

Situatedness and standardisation

One stark manifestation of contradiction between enactments of safety is that between the emphasis on standardisation in the disciplinary assemblage, and the emphasis on and need for individualised intervention, improvisation and situational awareness in the personalised assemblage. We have seen that viewed through the assemblage lens, 'doing' either type of safety is a situated, context-bound effort. Even disciplinary safety, which is stabilised to an extent by its material elements, only comes into being when other elements (a staff member filling in a form; a patient being physically restrained) respond to or resist them in particular places and times. However, it is in the face-to-face interaction between clinician and patient that rapport is built and cashed in, that understanding and trust grows, that signs of difficulty are first spotted, and that persuasion to 'do the safe thing' occurs.

The situatedness of personalised safety makes the role of instruments of standardisation problematic. How can guidelines be issued in the mental health context when what is proper for one patient may prove harmful for another? At present, policy for the management of escalating risk solves this problem by relying on the technique of increasing colonisation of everyday, personalised safety regimes with one-size-fits-all disciplinary regimes. Policy makers do need to set some kind of standard for services to meet, and this is not an argument for a laissez-faire approach. However, as personalisation has been identified in this study as such a key ingredient in patient safety, are there ways we can imagine to maintain this element of care even as a person becomes at greater risk of harm, to replace the blanket coercive measures currently in place?

There are few clues about how the clash of safety logics might be handled as standardised policy meets situated practice. One potential solution is offered by Wehrens and Bal (2012), who suggest the notion of the '(re)writing device' originally proposed by Callon (2002). This is a way of negotiating the tension between 'processes of "complexification" and "simplification"' (Wehrens & Bal,

2012, p. 281) which are terms which may equally apply to the rationalistic regimes of disciplinary safety and the improvised strategies of personalised safety. Documentation 'devices' such as practice manuals may prove a fruitful alternative to standardised protocols, but crucially only if they are collectively developed by those who will use them, and continuously revised (Wehrens & Bal, 2012).

Together, personalisation and socio-material situatedness point to the importance of particular interpersonal skills for these mental health professionals to possess. Being *attuned* to the patient, in terms of knowing what helps and hinders them and knowing how to elicit and detect signs of deterioration that may elude the casual observer, is vital in terms of being able to meaningfully respond to small situational changes. In addition, the material elements of the situation, from the state of a patient's home, to the layout of the ward, to the use of the phone to keep in touch with a patient also play their part in allowing safety to emerge.

8.4.   Research implications

There are several implications for research of the always-local enactment of a patient's safety. The first of these is that the material dimensions of this enactment cannot be considered separately to the interpersonal elements. The finding that the strict control and physical structure of the ward environment convey a particular normative discourse about how risk is appropriately handled is an example of this. Any effort to improve safety or to change the way it is achieved must therefore pay attention to the types of safety material arrangements promote or enable, and those they may prevent. In prior research, interpersonal and material aspects of safety have been examined separately (with the emphasis very much on the former), but the focus of the present study on their relationship in practice is a novel contribution to an emergent body of work using actor-network ideas.

The second implication of a focus on the socio-material configurations of safety enactments is that this enables us to move away from abstract, system-level accounts of safety, which are a step removed from the everyday situations in which safety happens or does not happen. Such accounts are necessarily depersonalised attempts at determining principles that apply across a wide range of situations, but here we have observed how important the elements of each individual situation are to each moment-by-moment enactment of safety. It is not just that it is not useful to generalise across them, but that it is the very unique, personal, and tailored nature of each interaction with a patient which appears to be the principal mechanism enabling safe care to happen. This calls for a research focus on the concrete interactions between humans and environments in particular times and particular places to study safety as it happens. This enables us to move beyond the debates over whether the origin of error lies in systems and cultures or in human fallibility. Oscillation between the two has been a key feature of the patient safety literature over the last ten years, and it would seem to be more productive to examine the intersection of individual clinicians' agency with various safety imperatives as this occurs in everyday practice.

The concept of the system as the site of safety or error production is an entrenched one, but given the socio-material interactions contributing to each safety enactment which have been exposed by this study, a new metaphor seems more apposite: that of the mangle. This is a metaphor used by Pickering (1994) who describes a dynamic of resistance and accommodation between material and human elements in practice. In the mangle, Pickering argued, we can see practice as 'an evolving field of human and material agencies reciprocally engaged in a play of resistance and accommodation in which the former seeks to capture the latter' (p. 23). With this metaphor (perhaps we could also call it a 'wrangle') we can re-envision the everyday practice of patient safety as a dialectic between the improvised, personalised interactions between particular clinicians and particular

patients and the 'stuff' of documentation, forms, walls and doors which embody and give agency to immutable and depersonalised safety imperatives.

Chapter 9:   Conclusion

9.1.   The politics of patient safety

In this final section, I will sum up with an argument that for disciplinary regimes to help rather than hinder efforts at safety creation for patients, there is a need for the physical and intellectual technologies of policy, infrastructure and documentation to take account of, rather than attempt to efface, uncertainty, and for a concomitant reorientation towards therapeutic care rather than risk management as the primary 'good' informing design of these technologies.

We have seen that the enactment of the disciplinary assemblage structures staff and patient activity in ways which ignore or attempt to remove the inevitable uncertainty of their daily interaction. Staff are disciplined at a distance via the threat of being called to court or before a Coronial inquiry, the writing and filling out of forms being their only route to portraying defensible action (as these tangible papers will be the sole remaining evidence of what they did on the day when something went wrong). Secondly, the uncertainty which is undoubtedly (as we have heard from participants) experienced during the practice of keeping patients safe moment to moment, is disciplined into a retrospective certainty through the written account and the completed form. However, clinicians cannot avoid mess and precariousness as they interact with the patients for whose safety they are accountable. The assemblage within which they do this work shifts constantly and in unpredictable ways. Having exposed these contradictions through examination of the intra- and inter-assemblage dynamics, we may ask whether the frantic attempt to create impressions of certainty is helpful to the effort to cope with it.

Disciplinary technologies are not sufficient to help ensure an individual patient's safety to be maintained within a service, and in fact they can sometimes be harmful to that endeavour. Further, they are only partially successful at disciplining staff, patients and uncertainty. Disciplinary technologies do,

however, enable services and individual clinicians to present to external audiences the version of safety that they expect and find acceptable. If we use the following analogy provided by Latour, the products of the disciplinary safety assemblage resemble the 'official' version of a film or skyscraper after it is released or unveiled for public consumption.

> *The 'making of' any enterprise – films, skyscrapers, facts, political meetings, initiation rituals, haute couture, cooking – offers a view that is sufficiently different from the official one … when you are guided to any construction site you are experiencing the troubling and exhilarating feeling that things could be different, or at least that they could still fail – a feeling never so deep when faced with the final product, no matter how beautiful or impressive it may be.* (Latour, 2005, p. 89)

This is at the heart of what this research has attempted to show: what the construction site of safety looks like in all its mess and uncertainty. However, in contrast to the making of a film or the construction of a building, there is never and can never be a finished product. The buildings stand on shifting sands and can only keep their current form temporarily. The logic of disciplinary safety dictates that a street-facing façade is maintained, painted on boards erected in front of the site, hiding all the precariousness and improvisation happening behind it. By looking behind the façade, we have seen how buildings are painstakingly constructed by clinicians, patients, families, and others, only to be hit by a sudden earthquake that monitoring systems cannot predict. Again they are built up, sometimes many times over the years, standing as testament to patching and mending, unconventional extensions, use of whatever materials are to hand, and usually in the knowledge that it may all need to be done again.

Building the facade and maintaining its appearance in many ways adds additional complexity to the everyday practice of a clinician, coping as they do with two logics of safety. The example of disciplinary logic embodied by decision support tools (such as risk assessment forms) has been described by Mol as follows:

While decision support tools claim to simplify practice, in fact they do not do so. They introduce, and thus add on, a further logic to those which are already there ... how ... to build tools that help to improve practice, without fantasising complexity away? (2002, p. 166)

Many patient safety improvement initiatives currently rely on stabilising such an additional complexity-free logic. They are presently disciplinary in character; they possess many of the characteristics we have seen in our disciplinary safety assemblage, but this could be otherwise. To strengthen and harness the techniques and improvisations used by clinicians each day in the face-to-face contact they have with patients, a different approach to improvement is needed which embraces rather than effaces uncertainty. Otherwise, improvement efforts simply serve to reinforce the normative discourse of safe care. This takes time away from personalised activities – including face-to-face contact – which staff in this study saw as the most important resource for the actual safety of patients.

The idea of imposing improvement techniques on services which rely on the disciplining of uncertainty effectively constitutes the application of 'normal science' (such as statistical probability) to try to solve problems that are inherently post-normal in character. What we have learnt about the pervasiveness of uncertainty in mental health care makes the following description particularly apt to the problem of improving the safety of patients under the care of mental health services.

[Post-normal problems are] the sorts of problems for which even the professionals' skills and commitment are insufficient; where deep uncertainty or even ignorance swamps our knowledge, and where the value-commitments of participants set incompatible frameworks for the policy issue in dispute. Resolving such issues requires new skills and attitudes. Dogmatic scientific demonstration gives way to open-ended dialogue. All participants learn to respect the others' approaches, so that there can be a creative process of resolution. None of this is easy, and success is far from guaranteed. But it is the only way forward, in the challenges we facing in coping

with the problems that our inherited socio-technical system has created. (Ravetz, 2004, p. 354)

What is to be done to approach such problems? What 'new skills and attitudes' are needed? It appears that part of this move is to accept that some aspects of psychiatry are fundamentally unpredictable, and to find ways to live with the 'radical uncertainties' riddling the practice of mental health care. Disciplinary safety assumes the calculability of risks, manifested in the technologies of risk assessment. A more realistic assessment of what constitutes reasonable accountability on the part of clinicians would be one manifestation of being able to live with uncertainty.

9.1.1. *Can we conceive of alternative safeties?*

If we can conceive of multiple ontologies, we can also conceive of ontological politics: 'if two objects that go under the same name clash, in practice one of them will be privileged over the other' (Mol 2002, p. 47). Analysing how this privileging happens, to whose interest and to what end, offers a potential route for change if stakeholders want a different reality to be privileged. In the case of safety, we can ask what sort of safety we want to be enacted, and what sort of effects we would like it to produce for patients, staff and other stakeholders. We have seen from this research that different safeties are simultaneously enacted in practice, which although both done in the name of 'patient safety' in fact engage different arrangements of moral commitments, people and things to the benefit of different parties. The positive side of analysing safety in this way is that it becomes possible for stakeholders to think about how they might like these arrangements to change, if at all.

Taking the notion of 'the good' as the starting point, this might result in a debate about whether it is more important to direct resources and efforts at reducing adverse incidents or at improving the quality of individual patients' lives, for example. If the chosen good is currently a 'weak reality', in Mol's terms, the

stakeholders can think about how to strengthen it through the different assemblage stabilisation devices this study has identified (such as inscribing it in spatial arrangements and architecture). This may involve accepting that both cannot be achieved at the same time, or if this is unacceptable to stakeholders, it may involve looking for safety assemblages enacting these two particular goods that can interact productively rather than wastefully. All such decisions are deeply political, ethical and value-bound.

The health policy climate has been shifting for some time towards promoting patient-provider coproduction of health care, often in the name of personalisation. This is partly a political move in response to investigative journalism and public inquiries that have found patient and family voices to be dismissed and ignored in the delivery of care, often with unsafe consequences. The time might be right politically to ask patient groups to develop models of their preferred version of safe care. What risks are acceptable for a service to take? What might help redress the balance between psychological and physical safety? What iatrogenic harms are not adequately protected against in the current service? How could acute risk be better managed without resort to coercion?

A starting point for services might be an exercise similar to the one undertaken in the previous chapter. If the moral and sociomaterial arrangements which sustain particular versions of safety are identified, elements of them which do not support the enactment of therapeutic interaction between service and patient can be unpacked, and ways to reorient them towards such a goal considered.

9.2. Risk reduction reframed as a by-product of therapeutic care

The recently published Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) into system-wide failures – over years – to detect a pattern of high mortality rates in Stafford Hospital in England has argued that blindness to the way poor care was harming patients resulted from a focus on financial and

target-based outcomes. The purpose of the health service – to care and cure – had been obscured by the complex of regulatory, structural and cultural drivers towards a different good. A similar sentiment has been expressed in relation to creation of therapeutic, rather than risk-focussed, mental health services:

> *In today's world of performance indicators and national standards, attention has been distracted from the patient's internal experience to an emphasis on ensuring patient safety, reducing risk to the organisation, enlivening through-put, and filling in ... forms. Mutuality of purpose and reciprocal respect between staff and patients seem to have been lost in this equation.*

> *An admission to hospital can become genuinely therapeutic, in the sense that it can become an opportunity for self-reflection, personal exploration and change. But it is often experienced as a traumatic event in one's life that should best be forgotten.* (Fagin, 2001, p. 118)

In these mental health services, we can see the seeds of the problem identified by Francis and Fagin in the elaborate technologies of compliance and the effort expended on displaying safe care to the outside world, sometimes at the expense of enacting it inside the service. It is important to ask which aspects of such a disciplinary regime are really contributing to patients feeling safe, secure and nurtured under the care of the service, and which interfere with such a possibility. I saw many instances of profound respect of patients' individuality as well as their physical and psychological needs by staff members in these mental health services. I also observed many genuinely felt attempts to inject a therapeutic aspect into contact with patients, and staff members going out of their way to try to prevent escalation of distress, help patients improve their quality of life, and to build trusting relationships with them. However, sometimes these efforts were frustrated or curtailed by defensive practices based on a fear of censure, and consequent prioritisation of risk management activities above therapeutic interaction and safety creation with patients.

From this research I would argue that mechanisms which interfere with the ability of staff to exercise their moment-to-moment judgement in attuning to the subtleties of a patient's needs are unhelpful aspects of the disciplinary safety logic. Similarly, the fact that increasing depersonalisation of the health care provider's interaction with an individual patient, as well as prioritisation of coercive management of physical safety, is structured into the conduct of risk management is potentially (and often actually) harmful to psychological safety. Rees (2012) is one of the few researchers to have recognised this relationship, in a rare example of the exploration of psychological safety in the context of paediatric care.

> *If external control supersedes personal judgement there can be a cost. Psychological safety depends on attention to individual detail, whereas practice is increasingly governed by the general, and by the measurable. Evidence obviously matters greatly, but for its interpretation and application, so do its broader context and limitations; psychological care is not readily amenable to objective assessment and is vulnerable in an evidence-governed culture.* (Rees, 2012, p. 440)

In Chapter 6 I explored how external expectations become performative because of their effects in enabling and constraining different enactments of safe care. Performativity can refer to the ability of a discourse (such as the normative discourse about the nature of risk and how safety should be achieved) to effect enactment of the processes or phenomena it purports to describe. In terms of policy designed to facilitate clinical governance, such as risk management regimes, a reality of purposive-rational action must be enacted by staff if they are not to face sanctions. Often, 'the resulting instrumental rationality of the system, lacking the consensus and consent of its subjects and devoid of norms is thus … deficient in terms of legitimacy and therefore unable to influence actors in more than the superficial, fictitious mode' (Brown, 2008, pp. 193-194). The phenomenon has been observed among teachers, where constant regulatory surveillance can mean that 'the whole school effort is directed away from education and towards passing inspection' (Perryman, 2006, p. 148).

The danger of such performative effects of regulation and inspection regimes operating in health care is that it breeds a culture of fear and mistrust. Just as clinicians cannot trust the accounts of patients, accountability and performance management regimes can normalise distrust of professionals, particularly if they are based on the threat of sanctions rather than reciprocity or consensus (Brown, 2008, p. 188). The focus in research on error and risk management is part of a similar mentality in which aiming for an absence (of risk) impoverishes the quest to find innovative and effective ways to achieve a presence (of safety).

This study has shown that a patient's safety is much more than simply a state which obtains in the absence of risk or harm. The desire for absence of risk is played out within the disciplinary assemblage, but it is in the personalised safety assemblage that we can see the potential of positive safety creation – a desire for presence of feelings of safety, security and sanctuary within each patient's interactions with the health service. A fundamental question arising from this research is whether a service can be envisaged which, in focussing on creating a holding – stable and secure – virtual or actual environment for those suffering more severe mental health problems, can meet public demands regarding risk management as a by-product of its activities rather than as a central driver of its relationship with the patient.

What would need to happen for such a service to become a reality? This has seldom been explored amidst drive to manage risk.

> We do not hold formal meetings to mark the positive developments that we may have helped to generate in vulnerable people (including perhaps reclaiming lives from the brink of suicide). In the same way, we do not create guidelines about the processes and conditions under which these life-affirming developments are nurtured. (Seager, 2006, p. 267)

I would suggest that this study, in its detailed characterisation of the dynamics of personalised safety, has provided some vital clues to the 'processes and conditions' under which safe care can be fostered as more than management of

risk. These clues suggest three potential ways in which a safety creating service could be nurtured. Firstly, there would need to be a greater consciousness of the effect of the ward environment and of policy and legal mechanisms in the perpetuation of a particular discourse about the mental health patient, the risk that they embody, and appropriate ways to manage that risk. Turning the normative discourse away from risk management towards therapeutic safety creation for each patient would require a parallel change in the materialities of mental health care. Secondly, care would need to be structured so that personal therapeutic interactions between patient and key staff members could be maximised and interventions to protect psychological safety prioritised. Finally, the development of already existing strategies to ensure personalised care would need to take on greater significance in policy and practice. In the context of the more formalised developments of the personalisation agenda in UK health and social care, Glasby (2011) also perceives the opportunity to achieve a safe - but also therapeutic and life-affirming - interaction between service and patient.

> *Although keeping people away from risk might seem like we are protecting [them] … ultimately we make people safer by connecting them to a wide range of other people, by making sure they are visible and present in local communities, and by building confidence and self-esteem.* (Glasby, 2011, p. 178)

One potentially powerful lever to promote such changes is a shift in emphasis within regulatory regimes to cast staff as agents of safety creation rather than as constantly vulnerable to tripping up, with the spectre of failure to prevent harm casting a shadow over every activity. This might be achieved in a move away from judging the proper conduct of a service based on written accounts of activity towards assessing the therapeutic effectiveness of a service by focussing on evidence of patients' feelings of security and improvements in their quality of life. An example of such a change would be a shift from current emphasis on verifying *that* an outcomes instrument has been completed in an patient's file, towards a more nuanced assessment of whether those outcomes indicate that the patient has benefited from the service they have received, not just in terms of symptom

relief but also in terms of quality of life. Such an assessment would need to rely not just on written accounts but also on assessors' access to everyday practice in a supportive rather than a punitive spirit:

> *... an ethos where the minds of professionals are not empathically linked to buffer the distress of service users, but are linked to a general 'surveillance' mentality ... deriving from risk-focussed ... policies and performance-driven managerial styles, provides a recipe for anxious, defensive and even 'paranoid' professional practice.* (Seager, 2006, p. 267)

The Francis Report expressed a similar sentiment in terms of how regulatory mechanisms might more effectively assess what is going on in services.

> *The investigation demonstrates how powerful the combination of direct observation of practice, contact with patients, families, frontline staff and examination of real cases is, as opposed to reliance on files of policies, committee minutes and overall figures. This is not to say that examination of systems is not important, but it is not and never will be sufficient.* (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013, p. 56)

Such a statement is confirmation of the need to reconceptualise safety as a locally situated, practice anchored, emergent phenomenon. This is a basic recasting from which changes to regulation, policy and public expectation could flow, away from a focus on risk elimination towards a demand for humane, therapeutic (and thereby risk-reducing) care.

9.2.1. A final thought: 18th Century lessons on safe care

The stories we tell ourselves and each other about the purpose of mental health care and about risky patients are important because stories are 'not just innocent descriptions. They may make a difference, introduce changes, or, alternatively, bring aid and comfort to the existing performances of ... reality *while it could be otherwise*' (Law & Singleton, 2000, p. 769). Can we change the stories in order to change the reality of mental health care?

A particular story told during the 18th century about what safety means in relation to mental health patients, and how this might be achieved, seems particularly relevant. A Quaker, William Tuke, who had no prior clinical experience, decided to set up an institution near York, England, specifically to care benignly for those afflicted by mental illness. He named it 'The Retreat', and it received its first admission in 1796 (Knight, 1946). Tuke carefully planned every detail of the buildings and grounds using an 'architecture of caring' (Edington, 2003, p. 107), promoting an atmosphere of tranquillity, in which 'the unhappy might obtain a refuge – a quiet haven in which the shattered bark might find the means of reparation or of safety' (Busfield, 1986, p. 212), quoting Tuke's son Samuel. Within the building a model of care developed emphasising 'wise kindliness' and respect, doing away with the spartan environments and manacles common in other asylums of the time, and fostering a homely environment in which patients occupied themselves in sewing, reading, or outside, in gardening, tending animals, and walks. Like the two assemblages we have explored, this too was a socio-material performance of safe care (the intent of the model of care was inscribed into the fabric of the buildings, for example), but one which emphasised creating feelings of welcome, comfort, refuge and security among patients.

Today, The Retreat still operates as a therapeutic community. In an information booklet for patients participating in a residential program for women suffering borderline personality disorder, the contemporary approach in this community to risk management is explained as follows.

> *This is not a suicide prevention programme; it is a programme designed to improve the quality of your life. This means that you will be in control of your life and be able to make decisions affecting your safety ... People who are on the programme have all put themselves repeatedly at risk ... While we will do all we can to support individuals and the whole group to maintain safety, the object of the programme is to help people learn to deal with their own impulses to self-harm: you will not do so if that*

responsibility is taken away by staff. We accept that this means we allow people to be at some risk of serious self-harm. (The Retreat, n.d.)

While public mental health services often deal with patients in crisis who do temporarily require responsibility for their wellbeing to be delegated to a service, this shift in responsibility can become pervasive as a result of the focus on defensive risk management. This is to the detriment of helping patients maintain control over their lives and improve their quality of life. The approach represented by The Retreat tells us a different story about patients and their needs: rather than primarily being seen as people likely to harm others or themselves, patients are recast as people capable of being responsible, making decisions, and living an enriched existence. It becomes the service's responsibility to nurture the latter type of person, rather than to simply restrict the former's capacity for action, because 'in an atmosphere of continuous fear, no therapeutic endeavours can take place' (Fagin, 2001).

The dominance of disciplinary and depersonalising activities particularly in situations where risk is deemed to be acute places too much emphasis on physical risk and not enough on psychological safety. In Mol's terms, there is an opportunity to choose a different ontology of safety in which nurturing, therapeutic, engaged aspects of care are prioritised and recognised in policy and where expectations of mental health services take account of the uncertainty and unpredictability of many of their tasks. In the personalised safety assemblage we can see that the foundations for a new focus on creating safety rather than managing risk are already there; we need to foster these abilities in staff. There is an opportunity to build on the existing strategies of clinicians which do not necessarily distinguish between the exercise of kind, therapeutic care and risk mitigation. The latter can emerge from a focus on the former.

9.3.   Study scope and limitations

The main limitation of any PhD thesis is that it represents what can be achieved in a three year cycle of full time research. The main objective here was to document a sufficiently in-depth ethnography while keeping to this time-scale.

This study could have been done in many different ways, even once its research questions and methodology had been decided. I chose to take a particular theoretical approach – outlined in Chapter 3 – which gave a set of lenses through which I then viewed the data. Actor-network inspired approaches have seldom been used in the study of patient safety or mental health practices, and have never been used to my knowledge to study the combination of the two. It was only through using such a novel approach that I could build the model of coexisting ontologies of safety given in this chapter.

However, the use of any social theory inevitably foregrounds particular aspects and dynamics of social phenomena whilst effectively concealing others. Choosing the insights of Latour, Delanda and Mol meant sacrificing the insights of others who have, for example, advanced critical perspectives on the use of disciplinary power in mental health services.

The design of the thesis, approved by the relevant ethics committees, in focusing on the work and conceptual worlds of professionals, excludes to a large extent the perspective of patients. A focus on patients' experienced ontologies of risk and safety is certainly necessary follow-up research, but was beyond the scope of the present work. Given that orthodox approaches to safety improvement are proving less successful than expected, it is more important than ever to understand the everyday safety work of the professionals who are or will be responsible for enacting such improvements.

9.4.   Conclusion

This study is at its core about uncertainty and how people and organisations try to cope with it. It is an account of individual and institutional reactions to fundamental uncertainties at the heart of psychiatry, revealed in ongoing debates about the aetiology, treatment and prognosis of mental illnesses. Institutional reactions often entail a move to discipline or efface these uncertainties by invoking the science of statistically-driven risk management technologies. Such moves perform to and validate expectations embedded in governance, regulatory and legal systems which presume the possibility of controlling uncertainty to the extent that risk can be predicted and mitigated. Whether as cause or effect of these expectations, members of the public and particularly patients' families prescribe a social role for the mental health service as protector of patients and the community against the apparently wayward will of those patients.

This black and white world contrasts with the greys characterising life at the 'sharp end' of mental health practice. Here, there is no way to remove complexity and uncertainty from everyday decision making, and it must be negotiated, tolerated and lived with. Clinicians cope with this firstly by leaving behind evidence, in the form of written accounts, that they have performed their 'proper' role as protectors according to expectations. Doing this means they can at least be reasonably certain of avoiding future censure. Removing other kinds of uncertainty is not so easy, and professionals employ a wide range of informal strategies to enable them to create patient safety. Such strategies are neither technical nor actuarial but deeply personal and rhetorical, tailored according to knowledge of each individual patient's circumstances and sensitivities. To do a good job of keeping a patient safe is to focus as much on psychological safety as physical safety, and to build rapport within the therapeutic relationship.

There is a certain inertia perpetuating this disjunction between the black-and-white world of institutional mechanisms for effacing uncertainty and the grey world of clinicians' efforts to do a safe enough job in a perpetual state of

'unknowing'. As powerful forces (of the law, government, and managers) align behind the black-and-white version of events, clinicians have no choice but to act as if this were the correct version of reality even when their experience often contradicts this. Such an imperative involves them in an array of activity and effort which has much more to do with showing the outside world that they are good protectors than it has to do with enacting safety-creating strategies on a face-to-face level with patients. It is the principal argument of this thesis that it is at this face-to-face level of personalised and therapeutic care that patient safety – as well as clinical improvement – can be most effectively ensured. Risk management can follow from a focus on truly therapeutic care; therapeutic care is, however, unlikely to follow from the present focus on risk management.

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Appendices

Appendix 1: Published study protocol

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STUDY PROTOCOL

Professional conceptualisation and accomplishment of patient safety in mental healthcare: an ethnographic approach

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Abstract

Background: This study seeks to broaden current understandings of what patient safety means in mental healthcare and how it is accomplished. We propose a qualitative observational study of how safety is produced or not produced in the complex context of everyday professional mental health practice. Such an approach intentionally contrasts with much patient safety research which assumes that safety is achieved and improved through top-down policy directives. We seek instead to understand and articulate the connections and dynamic interactions between people, materials, and organisational, legal, moral, professional and historical safety imperatives as they come together at particular times and places to perform safe or unsafe practice. As such we advocate an understanding of patient safety 'from the ground up'.

Methods/Design: The proposed project employs a six-phase data collection framework in two mental health settings: an inpatient unit and a community team. The first four phases comprise multiple modes of focussed, unobtrusive observation of professionals at work, to enable us to trace the conceptualisation and enactment of safety as revealed in dialogue and narrative, use of artefacts and space, bodily activity and patterns of movement, and in the accomplishment of specific work tasks. An interview phase and a social network analysis phase will subsequently be conducted to offer comparative perspectives on the observational data. This multi-modal and holistic approach to studying patient safety will complement existing research, which is dominated by instrumentalist approaches to discovering factors contributing to error, or developing interventions to prevent or manage adverse events.

Discussion: This ethnographic research framework, informed by the principles of practice theories and in particular actor-network ideas, provides a tool to aid the understanding of patient safety in mental healthcare. The approach is novel in that it seeks to articulate an 'anatomy of patient safety' as it actually occurs, in terms of the networks of elements coalescing to enable the conceptual and material performance of safety in mental health settings. By looking at *how* patient safety happens or does not happen, this study will enable us to better understand how we might in future productively tackle its improvement.

Background

Patient safety and mental healthcare

Despite the rapid expansion of the patient safety literature over the last ten years, work on patient safety in mental healthcare 'has hardly begun' [[1]: xi]. Key patient safety texts [e.g. [2,3]] routinely fail to mention psychiatric or mental healthcare. It is unclear whether this is because the principles of patient safety are assumed to be equally applicable to mental health as to hospital-based medical and surgical care, or whether mental health is considered so different an environment as to require separate treatment. Either way, for the safety agenda to move forward, research into what patient safety means and entails in the mental health context is a fundamental requirement. This is the principal aim of this project.

The apparent disregard for mental health in the patient safety literature is mirrored by a neglect of

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'patient safety' as a multi-dimensional concept in the mental health literature. Three distinct perspectives emerge from existing research into safety in mental health settings. The first, an operational perspective, is primarily focussed on description and guidance about discrete events and interventions, such as suicide prevention [e.g. [4]] and the anticipation and de-escalation of violent or aggressive behaviour [e.g. [5]]. The second, following Foucault [6], is a critical view of the role of mental health services as instruments of social control, preserving order (safety) in wider society by removing the 'disordered' (who are perceived as a risk or danger to the public).

Thirdly, there is a smaller body of work which examines safety in the context of everyday life and practice in mental health settings. These studies employ elements of the ethnographic tradition. Ethnographic methodology involves prolonged immersion of the researcher in the setting of interest in order to understand social phenomena from the 'inside' of the sites of their production. Many contemporary studies of this type [e.g. [7-9]] emphasise the central role of risk assessment and of 'keeping order' in structuring the conduct of mental healthcare, but generally do not focus on safety as their principal topic of interest. These studies also reveal that the patient is usually perceived as the principal locus of risk and its management, and that staff themselves, as well as the public at large, are considered to be 'at risk' if safety is not preserved. Such findings point to a distinctive conceptual framework surrounding risk and patient safety in mental health.

While each of the three perspectives contributes to our understanding of safety and mental health, they fall short of comprehensively articulating this conceptual framework and how it differs from prevailing notions of patient safety which are derived from the concerns of the medical and surgical sectors. This gap in knowledge is important if we are to avoid inappropriate safety interventions and improvement initiatives being implemented in the mental health context. There is also a lack of research illuminating what safe practice means to mental health professionals and how these meanings are enacted in everyday professional life. This is crucial in terms of the policy imperative to improve patient safety, because without such knowledge it is difficult to design improvement initiatives which chime with professionals' experience of trying to keep their services safe and the barriers they face to doing so. Intending to help fill this gap, the present project explores professional practice in mental healthcare as a nexus of social, historical, institutional and personal influences and tensions which come together in particular times and places to produce safe or unsafe practice.

Ethnography and its importance for patient safety research

Qualitative, and particularly ethnographic, research approaches are increasingly recognised by patient safety experts [e.g. [10,11]] as offering a valuable contribution to the understanding of patient safety. They provide access to the contextual and cultural factors that contribute to the production of safety and error. This is because 'ethnographic observations can explore how the norms and rituals of professional practice can have potentially latent consequences for safety' [[12]: 164]. This type of research gives us a way of unpacking why improvement efforts often fail [13]. It equally offers the opportunity to examine how staff manage to keep healthcare environments and interventions safe most of the time (it is generally argued that around ten per cent of admissions to hospital are harmed by the healthcare they receive [14]). The longitudinal nature of ethnographic research allows for the observation of events and human interactions unfolding in real time. It offers an alternative perspective to the 'theoretical orthodoxy' of patient safety research, dominated by ideas derived from the application of systems science and human factors engineering in other industries [15,16]. Although these latter approaches have led to valuable improvements in safety, they are based on assumptions about safety derived from humans acting on (largely predictable) machine systems rather than on or with (much more unpredictable) humans. They cannot account for the particularities of healthcare, where contextual (social, cultural, personal, and interactional) factors play a fundamental role in what, and how, things are done.

There is now a growing realisation amongst some leaders of the patient safety movement that, in spite of concerted political, policy and research attention over the past decade, progress in reducing rates of iatrogenic harm has been disappointingly slow [17,18]. There is therefore a strong argument to be made for a return to 'first principles' in patient safety research, where prior assumptions about what safe practice is and how it is best achieved are discarded. Ethnographic approaches can enable us to build a picture of how safety is accomplished and understood at the front line of care, unencumbered by the assumptions of previous research. They can free us to examine instead the assumptions about safety which are embedded in professional practice and in the actions, interactions, discourses and materials which comprise it. We can also avoid a monolithic conceptualisation of patient safety by teasing out the role of multiple safety imperatives - historical, social, moral, legal, and institutional - in the conduct of clinical practice.

In support of these arguments, Øvretveit [[19]: 1782] states that as social scientists we must find ways to

'ensure room for both the currently much-in-demand instrumentalist research that provides practical solutions to problems, and for research which is critical and problematises current ways of thinking and acting. There is also a need for researchers who take the more critical stance to show how their research ultimately may be more practically useful as it may probe the issues more deeply.' Ethnographic research offers the opportunity to achieve this.

Theoretical orientation

The theoretical and analytical framework shaping the project is derived from a body of social theory termed the 'practice approach' [20]. In the broadest terms this approach holds that social phenomena can be understood through examination of mundane, everyday human practices. The observation of everyday practices as they are carried out across time and in space offers rich opportunities for studying the social construction among professionals of concepts of safety and risk, as well as the actual accomplishment of safety, without resorting to attempts to 'get inside the minds' of participants. Notable empirical applications of this perspective using ethnographic methodology include examinations of the interactive production of safe practice on construction sites [21], and the practical accomplishment of cardiac telemonitoring [22].

Of particular interest to this study are those pragmatist theories which conceive of social phenomena as actively constituted, highly situated networks of practices, actions, ideas, artefacts and people. Such an approach is useful to our aim of returning to 'first principles' to articulate the building blocks of patient safety as they are revealed in professional practice. This approach is exemplified in actor-network theory (ANT) [e.g. [23]], later critical refinements of ANT [e.g. [24]], the notion of 'action nets' devised by Czarniawska [25] and the 'networks of practices' explored by Nicolini [22]. In a rare example of development of these ideas in relation to patient safety, Mesman [26] has described the accomplishment of sterility during central venous catheter insertion in a neonatal intensive care unit. She uses the notion of the 'safety net', attempting to articulate the 'fibres' of this net which, knotted together, enable sterility to be maintained. The fibres are the practices already in place, which usually recede into the background in research into safety - 'the elements that constitute the fabric of 'normal' practice' (1706). She emphasises the point that rather than focussing on missing parts of the net (when errors occur), it is vital to learn about the elements of the existing context and activity enabling the net to remain knotted together.

In this study the network metaphor will operate on multiple levels. Firstly it will be used conceptually, to enable us to articulate the networks of meanings contributing to different professionals' conceptualisations of safety. Secondly, the metaphor will be used as a methodological aid to help us trace the connections between people, artefacts, and organisational, legal, moral, professional and historical safety imperatives which come together to 'perform' safe or unsafe practice. Thirdly, the insights offered by identification and analysis of these networks of heterogeneous elements (humans, materials, ideas and practices) will be compared with the insights available through more conventional analyses of social networks or communities of practice (in which only humans are considered actors).

This study therefore seeks to use ethnographic methods, informed by the conceptual principles of actor-network and other practice-focussed theories, to illuminate what patient safety means in mental healthcare. Such an approach will enable us to articulate the concatenation of heterogeneous elements enabling its performance [[27]: 107].

Research questions

These concerns are encapsulated in the research questions guiding the study.

1. How are mental health professionals' concepts of safety and risk constructed?
    a. What is the nature of these understandings?
    b. How do clinicians legitimise and sustain them?
2. How do these professionals accomplish safe practice?
    a. Can we trace the network of connections between human, material, ideological, historical and institutional elements coalescing to produce safe or unsafe care?
    b. Is the analysis of the discourse, narrative, activity, space and objects used in the course of professional practice a useful method for doing this?
3. What implications do these findings have for patient safety research and policy?
    a. What do they infer for the way the patient safety movement defines safety problems and appropriate methods to tackle them?
    b. What alternative approaches to improvement can be recommended as a result of this work?

Methods/Design
Type of study

This is a qualitative study designed using an ethnographic methodological approach. An overview of the process is provided in Figure 1. Ethnography engages a variety of methods to build as detailed a picture as

SETTING 1: INPATIENT UNIT

Observations and interviews
Phases 1a – 5a

SETTING 2: COMMUNITY TEAM

Observations and interviews
Phases 1b – 5b

SETTINGS 1 & 2: INPATIENT AND COMMUNITY TEAMS

Phase 6

PHASE 1a: UNSTRUCTURED OBSERVATIONS

| Max. 5 x 8 hour shifts | All staff participants |

PHASE 1b: UNSTRUCTURED OBSERVATIONS

| Max. 5 x 8 hour shifts | All staff participants |

PHASE 6: SOCIAL NETWORK SURVEY

| 30 mins per survey | All staff participants |

PHASE 2a: SHADOWING STAFF MEMBERS

| Max. 8 x 8 hour shifts | 6-8 staff participants |

PHASE 2b: SHADOWING STAFF MEMBERS

| Max. 8 x 8 hour shifts | 6-8 staff participants |

PHASE 3a: STATIONARY OBSERVATIONS

| Max. 2 x 8 hour shifts | All staff participants |

PHASE 3b: STATIONARY OBSERVATIONS

| Max. 2 x 8 hour shifts | All staff participants |

PHASE 4a: TRACING KEY SAFETY PRACTICES

| Max. 2 x 8 hour shifts | All staff participants |

PHASE 4b: TRACING KEY SAFETY PRACTICES

| Max. 2 x 8 hour shifts | All staff participants |

PHASE 5a: SEMI STRUCTURED INTERVIEWS

| 1 hour each interview | 6-8 staff participants |

PHASE 5b: SEMI STRUCTURED INTERVIEWS

| 1 hour each interview | 6-8 staff participants |

Figure 1 Overview of study process.

possible of the setting(s) under study, in an attempt to understand more about what the people in that setting 'experience as meaningful and important' [[28]: 2]. Ethnographers are sometimes described as data 'omnivores' [[29]: 18] because they use any sources of information about and from the sites of study that will help them reach such an understanding. Broadly based on social constructionist ideas, this approach does not assume that there is a single objective reality 'out there' waiting to be discovered and described, but rather seeks to 'reveal the multiple truths apparent in others' lives' [[28]: 3] and the ways in which these realities are constructed.

Settings and participants

Two mental healthcare settings have been chosen for this study, and the six phases of data collection (see table 1 below) will be repeated in each. The first setting is an acute inpatient ward, and the second is a continuing care community service, both of which are located in the same hospital in New South Wales, Australia. The research participants are the approximately 50 mental health staff members working in these settings, comprising multi-disciplinary teams of doctors, nurses, psychologists, occupational therapists and social workers.

This particular combination of settings was chosen for several reasons. Firstly, the two services have an overlapping client group; as clients experience acute episodes of illness, they may be admitted to the inpatient unit, and on discharge may return to or enter the care of the community team. This overlap will facilitate the examination of safety issues arising when care is transferred from one team to another, when a client leaves or is admitted to hospital. Secondly, the co-location of the two services will enable analysis of the levels and types interaction between their staff members on issues of safety, especially during the shadowing (phase 2) and social network analysis (phase 6) phases.

Table 1 Ethnographic data collection framework

PHASE	ACTIVITY	PURPOSE	LOGISTICS	PARTICIPANTS	OUTPUTS
1. Max. 5 × 8 hour shifts	Initial unstructured observations	• Familiarisation with space and use of space • Familiarisation with rhythm of setting • Starting to build relationships and trust • Determine who is amenable to shadowing • Identify key locations for stationary observations • Identify key policy/guideline documents	• Background observation of activity (potentially accompanying key initial contact in the setting) • Introductions with staff members • 5 shifts on different days of the week (over 2 weeks) (= max 40 hours)	All staff	• Map of settings • Timetable of key regular events • List of 6-8 key informants • Collected documents for later analysis (e.g. policies, guidelines) • Fieldnotes
2. Max. 8 × 8 hour shifts	Shadowing staff members	• Observe mechanics of interactional construction of safe practice • Observe interactions newcomers/old-timers • Observe use of tools/artefacts/environment • Identifying key practices to follow in later stage	• Shadow each staff member for 1 shift/part shift • Audio recording of key meetings attended by staff member • Field notes of informal talk • Field interviews	2 doctors 2 nurses 2 allied health 2 managers	• Map of practices of each key informant - how they construe patient safety and how they go about trying to maintain it • Fieldnotes • Transcriptions of meetings
3. Max. 2 × 8 hour shifts	Stationary observations in key locations	• Observe role of key artefacts in constitution of safety (e.g. phone in nurse's station; filing cabinet etc). • Observe patterns of movement of staff	• 2 locations, 1 shift each (max. 16 hours)	All staff	• Fieldnote account of how artefacts and space play a role in the constitution of safety • Actor-artefact network map
4. Max. 4 × 8 hour shifts	Tracing key practices	• Observe the unfolding of specific practices previously identified as key to preservation of safety • Observe differences in activity when practice is in the course of the everyday (e.g. admission/discharge) and, if appropriate, when it follows breakdown in order (e.g. incident review)	• 1 'everyday' practice over the course of 2 shifts • 1 practice dealing with deviation from the normal (i.e. when safe practice has broken down in some way)	Staff involved in practices chosen	• Map of 'practice nets' involved in practices key to preservation of safety • How practice nets change when safety breaks down
5. Approx. 1 hr per interview	Interviews	• Elicit narrative accounts of safety preservation • Observe how the meaning of safety is constructed by different professionals - what 'rules and resources' do they draw on? • Test emerging findings/maps of practices	• 6-8 interviews - audio recordings	6-8 key informants from phase 2	• Transcripts for analysis
6. Approx. 30 mins per survey	•Social network survey	• Provide triangulation of observation and interview data • Map overall patterns of communication about safety issues within and between the two settings under study	• Administer a social network questionnaire to all staff in the inpatient team and community team under study.	All staff	• Social network diagrams providing visual representation of patterns of safety communication

Most patient safety research in mental health has focussed on inpatient settings, and so a comparison of safety concerns and strategies between inpatient and community settings will be a valuable and novel contribution to the knowledge base. The difference in client acuity and in the purpose of care between the two settings (stabilisation of crisis versus long term case management of chronic but stable problems) will also provide a point of comparison for professional conceptualisation and enactment of patient safety. Finally, the conceptualisation of patient safety and of how it is best preserved can be compared between the different

professional groups involved in the study (medical, nursing, and allied health staff). Much research in this area to date has focussed on the perceptions and practices of single occupational groups (especially nurses).

Data collection phases

Atkinson et al. [30] emphasise the importance in ethnography of systematic analysis of multiple cultural forms, including narratives, visual representations, discourse, material culture, and space. The data collection framework illustrated in Table 1 aims at enabling such a rounded analysis. The different observation modes proposed in phases 1-4 are also inspired by Strauss' methodological descriptions of his ethnographic study of psychiatric hospitals in the 1960s [31]. Czarniawska's more recent recommendations on innovative ethnography in modern societies have further influenced the framework; she argues that 'traditional ethnography is not enough anymore' [[32]: 7], because of the multiplicity of times, places and modes of communication in which contemporary professionals accomplish their work, and because of the more focussed interests of organisational ethnographers who wish to analyse the production of some phenomenon (such as patient safety) rather than the operations of an entire group or society. The methods of data collection will centre on structured and unstructured unobtrusive observations of staff and setting. These observations will be supplemented by field interviews (informal interviews during the course of observation) and by more formal interviews after the conclusion of the observation phases of the study. A final phase comprising a social network questionnaire will be undertaken in both settings.

The field researcher (JP) will spend a maximum of 16 hours per week, for 10 weeks, in each of the two settings. This is a maximum time limit because at each phase, observations will continue until thematic saturation has been reached and no new findings are emerging. This time includes the observational and interview phases of the study (phases 1-5). The social network questionnaire will be administered to staff in both settings after the observational and interview data collection phases have been completed.

Observation phases

The main aim of ethnography is to build up a picture of the cultural and social system under study through extended researcher exposure to the setting and the building of a relationship of trust with participants [33]. Observation of what people actually do provides a useful comparison to data acquired through methods which only capture what people *say* they do (such as interviews). It does not rely on participants' memories, and goes some way to overcoming the problem of people

describing their jobs in an abstract way that is 'expected' of them. The researcher can choose to play a particular role during observations, ranging from full participation and membership in the setting, to complete observer, having no interaction with participants [34].

In this study, the field researcher will employ what Adler and Adler term the 'peripheral-member-researcher' role, where the identity of the researcher is clearly maintained, where observations are largely unobtrusive, but where interaction with participants and participation in some non-clinical tasks (such as making coffee, helping to set up a room for an activity) is undertaken. Opportunistic field interviews will be used as needed to clarify understandings and elucidate more detail about individuals' viewpoints. This period will also be used to collect relevant documents for later analysis.

Field notes will be taken as soon as possible after (or if appropriate during) observations, with at least two days per week dedicated to writing them up in full. This will allow concurrent analysis of emerging themes which act to structure more focussed observations as the research progresses [35]. As wide a range of day time shifts as possible will be observed. Where consent is given, audio recordings will be made of interviews (phase 5), and of any staff meetings observed in phases 1-4.

Phase 1: Initial unstructured observations

Spradley [36] described the process of ethnographic observation as a funnel, in that initial observations are relatively unfocussed, designed to 'get a feel for the setting' and to begin to build rapport with its members. As time goes on and patterns or themes start to emerge from the data, observations become more focussed on particular people, events, and places. The initial (unstructured) phase will be used here for unobtrusive observations of patterns of activity, staff roles, layout of the settings, and to identify key informants and key locations and practices for phases 2, 3 and 4 of the study (see table 1 for details of the phases).

Phase 2: Shadowing key informants

Shadowing has been used as an observational technique by ethnographers interested in mapping how professional practice and organising are accomplished across time and space [32]. This is an especially useful technique to gain an insight into the everyday working lives of different professionals and how they interact with other professionals and with the environment to achieve their tasks. Depending on the role, seniority, and experience in the setting of the person being shadowed, this is also an opportunity to observe inter-professional communication, power dynamics and the socialisation of newcomers into the setting and its 'norms' of safe practice.

Between six and eight key informants will be shadowed in each setting. These informants will be chosen

to be representative of the professional groups employed at the setting. The researcher will accompany the key informant as they go about their work, and each informant will be shadowed for a maximum of eight hours, which may be one entire shift or be spread over several shifts as circumstances allow.

Phase 3: Stationary observations in key locations

The third phase will entail the researcher remaining *in situ* for a total period of 8 hours in each of 2 locations which have been identified in the previous phase, such as the staff office or nurses' station. The purpose of stationary observations is to listen to informal conversations in places where staff gather together, to view the patterns of their movement, use of space, and the role of key artefacts in the constitution of the phenomena of interest. The value of the observation of materiality and space in the revelation of aspects of the accomplishment of practice and meaning which are not revealed in text or talk is increasingly recognised by ethnographers using a practice approach [e.g. [37,38]]. Such approaches emphasise the 'interdependency of the human and the material' [[39]: 310].

Phase 4: Tracing key practices

Nicolini [22], a practice theorist, describes an innovative method of observation where, rather than shadowing people, he followed the conduct of particular practices which he had previously identified as key to the phenomenon he was studying (telemonitoring of cardiac patients). He does this by, for example, following the people, artefacts and documents associated with a particular practice, such as attending meetings on the subject, visiting other sites of the practice, observing nurses telephoning patients to do the monitoring, and analysing the charts they used to keep track of the remote monitoring process. By doing this he was able to assess the micro-, meso- and macro-level factors influencing and being influenced by the practice of telemedicine.

In the present study, two practices specifically related to safety preservation or to assessment of a near miss or incident will be followed for a maximum of one shift (eight hours) each. This will enable the mapping of factors contributing to, shaping, and being shaped by, the practices under study, providing a detailed picture of how safety is enacted. The artefacts, people, tasks and discourses employed in accomplishing the practice will be noted.

Interview phase

Phase 5: Interviewing key informants

The interview is used in ethnography for two principal reasons: to gain information about the topic of interest, and to garner samples of participants' discourse and narrative which can be used to study how people construe and construct their reality, how they order their experience, the resources they use to make meaning, and so on [33]. In addition, this research will use the interview phase to check participants' reactions to emerging findings from the observational phases. Such 'member checking' is a recognised way of validating findings but can also stimulate further discussion in an attempt to uncover more about how participants understand their world [40].

Between six and eight key informants will be interviewed in each of the two settings. These will be the same informants who participated in the shadowing phase (Phase 2). The types of questions asked will be determined by the earlier observation phases, because ethnographic interviewing employs the language and concepts used by participants rather than the concepts of social science [41]. Ethnographic interviewing uses open-ended questions, and the exact order and wording of questions is not pre-determined, although the interviewer goes in with a list of issues to be covered [33]. Questions proceed reflexively in response to the interviewee's answers, whilst steering the conversation back to the issues of interest.

Information collected during these interviews will depend to a large extent on findings during the earlier observation phases of the study, but in broad terms will comprise the following:

a. Information about how staff keep things running smoothly in their service, intended to get staff to reflect on and make explicit the usually taken-for-granted assumptions, norms and rules according to which they accomplish safe care.
b. Information about perceived barriers to and enablers of a smoothly-running service.
c. Information derived from participants' reflections on the researcher's emerging findings from the previous (observation) phases of the study.

Social network analysis phase

Phase 6: Safety communication network analysis

To complement the observational fieldwork and interviews, the settings under consideration will be studied using social network analysis (SNA). SNA involves the mapping of ties or relationships between members of a selected group of people and the analysis of the structure of the network [42]. The idea of SNA is to show how social structure impacts on behaviour or other variables of interest. In the context of this study, SNA will be used to help compensate for some of the limitations of observation techniques (where the researcher can only see and record a small sub-set of interactions) and enable an overall picture of relations on the ward or team to be built. This will also help determine how

typical of the setting observed interactions are. Being a highly structuralist approach to analysing human relations, the SNA will provide a useful methodological contrast to the 'bottom up' understandings garnered from the observation phases.

A social network questionnaire will be devised which will ask all members of the two study settings about with whom they interact on issues of safety and risk, and how often. In keeping with the emergent and exploratory nature of ethnographic research, the wording and structure of the questionnaire will be informed by the observation and interview phases of the study. Such a questionnaire can be used to map patterns of interaction, to reveal whether such interaction occurs mostly between members of the same professional group, same gender, level of experience, or other variable of interest. Interactions with staff outside of the two settings will also be taken into account. The nature of communications between clinical staff and clinical governance or risk management staff, for example, will provide valuable data, especially in the context of formal mechanisms for reporting and monitoring safety incidents. The contents of the questionnaire will be devised based on findings in earlier phases of the study, as its principal purpose is to provide a point of comparison or validation of the earlier findings.

Mapping connections between different settings may help shed light on important safety issues which affect the quality of patient care, such as continuity of care between settings and discharge practice. Analysis of the social networks present in the mental health settings under study might help to show whether organisational and professional structures and cultures help or hinder learning and practice around patient safety. Close examination of interaction on issues of patient safety might reveal how structural factors can constrain or enable practitioners' efforts to avoid problems and incidents and learn from them when they do occur.

The social network questionnaire will be designed so that it takes each staff member less than 30 minutes to complete. Its questions will ask staff members who they interact with on issues of safety, how frequently, and the nature of the interactions.

Data analysis

Ethnography is by its nature an inductive methodology. As findings emerge or phenomena of interest to the research questions emerge, methods of data collection and analysis may evolve or change [12,33].

In light of this, the process of analysis will be undertaken alongside data collection. Texts on qualitative data analysis generally recommend such an approach, where findings of ongoing analysis serve to help focus future data collection. Miles and Huberman [[43]: 50] encourage researchers to 'cycle back and forth between thinking about the existing data and generating strategies for collecting new, often better data.' To aid in the reflexive monitoring of progress and direction, a research journal will be kept in which emerging analytic ideas and hypotheses will be noted, developed, and fed back into the data collection process.

As data from multiple sources will be collected during the different stages of the study, multiple methods of analysis will be needed in order to understand what the data is saying about how staff understand safety and the implications these understandings have for practice. Although the overarching analytical approach will be theoretically informed by actor-network theory, a type of analytical 'toolbox', advocated by Nicolini [22], will be employed, where different practice approaches will be used in tandem as they best illuminate the data to be analysed. For example, use may be made of the empirical approaches employed by structuration theorists [following [44]], activity theorists [following [45]], nexus analysts [46], and ethnomethodologists [following [47]]. A detailed and integrated analytic framework informed by these practice theories will be developed once familiarity with the setting is obtained, and following ongoing engagement with these theories themselves.

As the research questions outlined above imply, this study will set out to analyse both *how* understandings of safety are developed and reproduced by mental health professionals (through interaction and learning), and *what* these understandings consist of for different people and in different contexts, as recommended by Silverman [48].

The data analysis process will employ the following techniques:

a. Iterative coding of the written data (from fieldnotes, interview and meeting transcripts, and existing documentation) in order to determine patterns of meaning using thematic, narrative and semiotic analysis.
b. Use of software aids such as NVivo to help with coding and organising textual data, and Leximancer, an automated data mining software, to obtain an overview of conceptual relationships present in the texts.
c. Validation of interpretations: methodological triangulation of findings across observation, interviews and social network analysis; member checking.

Ethics approval

Ethics approval has been granted by the relevant Area Health Service HREC and University of New South Wales HREC 10384.

Discussion

There are multiple theoretical, methodological, policy and practice contributions of this research. Theoretically, the use of practice theory and actor-network ideas as sensitising concepts for studying the conceptual and material constitution of patient safety is an innovative approach. It is an approach which contrasts with (and complements) the theoretical orthodoxy of much existing patient safety research by approaching safety not from the abstract and instrumentalist system level but from the level of professional practice. This enables a detailed examination of the respective roles of different safety imperatives (emanating from history or policy, for example) as well as the role of the social and material worlds in the constitution of safety as it unfolds.

Methodologically, the study of patient safety in the context of multidisciplinary care contrasts with much existing ethnographic work in mental healthcare, which tends to focus on the experiences of one professional group in isolation. The comparison of conceptualisations of safe care between professional groups, as well as between community and inpatient settings, is another unique contribution of the research, as much research into safety in mental healthcare takes place in the inpatient setting. The data collection framework will also enable comparison of findings derived from tracing how actor-networks are built by the actors themselves ('insider' view), against the more structuralist or 'outsider' approaches of traditional social network analysis [49].

In policy terms, this study is designed to demonstrate the importance of taking into account professionals' conceptualisations of safety and their strategies for accomplishing it when designing locally relevant safety improvement initiatives. It will be an opportunity for an assessment of the relative importance of formal policy as one of the many elements driving the safety agenda at the level of local services. It is also hoped that the findings will enable a re-examination of the theoretical orthodoxy of the patient safety movement. In terms of clinical practice, the findings of this study will provide an opportunity for stakeholders in mental health to reflect on the relative contribution of the patient, the nature of the mental health setting and care regimes in the preservation of safety. Uncovering the taken-for-granted assumptions which underlie professionals' decisions in relation to safety and risk is one way in which such reflection could guide local improvements in patient safety.

Conclusion

Two advocates of the ethnographic approach to patient safety research eloquently encapsulate the rationale behind the present study. Bosk [[16]: 1-2], a pioneer of the ethnographic approach to safety in healthcare, argues that we may be asking the wrong questions, or too narrow a set of questions, when it comes to patient safety research. Nearly thirty years after his seminal study of surgeons' conceptualisations of error [50], he finds that patient safety research is still almost exclusively asking 'How might adverse medical events be prevented?' He advocates that we turn to different questions, such as

> '...how do workers in a medical setting define what is an error? How do they understand what causes error? And how do they respond to errors? ... this second view...concentrates on the negotiation of the meaning of the term error on the 'shop floor'... [their] meanings are not fixed but are fluid and flexible, highly dependent on context.'

Interest in using qualitative approaches to understand uncertainty and mistakes in medicine waned after the heyday of Bosk [50], Millman [51] and Paget [52], with little work emerging in this vein until the latter half of the 2000s. This resurgence coincided with the abovementioned realisation that improvement efforts centred on human factors engineering and techniques imported from 'high reliability' industries such as aviation and nuclear power were having only modest impacts. The 'second wave' of interest in ethnographic approaches to understanding patient safety is concerned with better understanding the role of safety in the everyday world of clinicians. Dixon-Woods [[13]: 11-12] in an article entitled *'Why is patient safety so hard?'* further elaborates the potential contribution of this methodological approach:

> '[There is a]...need for solutions to be based on a sound understanding of the nature of the problems and what kinds of approaches are likely to be best suited to resolving them. Such an understanding requires insight into the complexities of the networks in which hospital workers are embedded, and of how alternative conceptions of what is 'safe' or 'good practice' may prevail, conditioned by coping with competing priorities, clinical uncertainties, organisational pressures, resource inadequacies, and efforts at professional boundary maintenance.'

It is this nuanced understanding of the complex of elements coalescing to enable or constrain the performance of safe care that we seek to further in this study. Its focus on tracing connections between the heterogeneous elements of mental health practice will enable the articulation of safety as an actively constituted, continuously emergent performance. This will involve turning away from the current focus on tracing the trajectories of adverse events, towards tracing the network of connections enabling safety to be maintained. Such an

approach heeds a recent call [11] for social scientists to contribute new ways of studying and improving patient safety rather than standing on the sidelines of the debate as critics.

Authors' contributions
JP is the primary author of this manuscript, and is responsible for the conceptual and methodological development of the described project which forms the basis of her PhD research. JB, JT and PN contributed to the conceptual and methodological refinement of the project; they also performed critical appraisal and editing of this manuscript. All authors read and approved the final manuscript.

Competing interests
This research is supported under the Australian Research Council's Discovery Projects funding scheme [project number DP0986493]. There are no financial or non-financial competing interests.

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Appendix 2: Search strategies

Medline **search strategy: overlap of patient safety and mental health literature**

Search parameters:

-articles published 1 January 1946 – 25 April 2013 and indexed to *Medline*

-research must relate to humans

Search strategy:

1. Ab= **safety**
    (Date and subject delimiters applied) (181109 results)

2. Subject heading (focussed) = [*Mental Disorders/ or *Hospitals, Psychiatric/ or *Mental Health Services/ or *Mental Health/ or *Mentally Ill Persons/]
    (Date and subject delimiters applied) (104407 results)

3. 1 and 2 (849 results)

4. Ab= **risk**
    (Date and subject delimiters applied) (915809 results)

5. Subject heading (focussed) = [*Mental Disorders/ or *Hospitals, Psychiatric/ or *Mental Health Services/ or *Mental Health/ or *Mentally Ill Persons/]
    (Date and subject delimiters applied) (104407 results)

6. 4 and 5 (8036 results)

Medline **search strategy: use of patient safety terminology in mental health literature**

Search parameters:

-articles published 1 January 1946 – 15 April 2013 and indexed to Medline

-research must relate to humans

Search strategy:

1. Subject heading (focussed) = ***medical error**/
    (Date and subject delimiters applied) (7557 results)

2. Subject heading (focussed) = [*Mental Disorders/ or *Hospitals, Psychiatric/ or *Mental Health Services/ or *Mental Health/ or *Mentally Ill Persons/]
    (Date and subject delimiters applied) (104407 results)

3. 1 and 2 (10 results)

4. Keyword = **adverse event.mp**

(Date and subject delimiters applied) (10359 results)

5. Subject heading (focussed) = [*Mental Disorders/ or *Hospitals, Psychiatric/ or *Mental Health Services/ or *Mental Health/ or *Mentally Ill Persons/] (Date and subject delimiters applied) (104407 results)

6. 4 and 5 (32 results)

Medline search strategy: use of terminology related to patient-originated harm in mental health literature

Search parameters:

-articles published 1 January 1946 – 15 April 2013 and indexed to Medline

-research must relate to humans

Search strategy:

1. Subject heading (focussed) = ***violence/** (Date and subject delimiters applied) (15474 results)

2. Subject heading (focussed) = [*Mental Disorders/ or *Hospitals, Psychiatric/ or *Mental Health Services/ or *Mental Health/ or *Mentally Ill Persons/] (Date and subject delimiters applied) (104407 results)

3. 1 and 2 (1576 results)

4. Subject heading (focussed) = ***suicide/** (Date and subject delimiters applied) (19316 results)

5. Subject heading (focussed) = [*Mental Disorders/ or *Hospitals, Psychiatric/ or *Mental Health Services/ or *Mental Health/ or *Mentally Ill Persons/] (Date and subject delimiters applied) (104407 results)

6. 4 and 5 (1362 results)

Appendix 3: Ethics committee approval letters

11 November 2010

Professor Jeffrey Braithwaite
Australian Institute of Health Innovation
Faculty of Medicine
Level 1, AGSM Building

Dear Professor Braithwaite

Professional conceptualisation and accomplishment of safety in mental health care
HREC 10384/

Thank you for the above application for ratification of the ethics clearance given by the
Area Health Service Human Research Ethics Committee to you dated 9 November
2010.

The Executive noted the above protocol at its meeting held on 9 November 2010, and is pleased to
advise it is satisfied that it meets the requirements as set out in the National Statement on Ethical
Conduct in Human Research*. The Deputy Vice-Chancellor (Research) accepted the ethics
Committee's recommendation.

Please note that the UNSW HREC period of approval for this project is valid for the duration of the
approval period given by the Primary Ethics Committee.

Yours sincerely,

Professor Andrew Metcalfe
Presiding Member
Human Research Ethics Committee

* http://www.nhmrc.gov.au

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ABN 57 195 873 179

Professor Jeffrey Braithwaite
Australian Institute of Health Innovation
Faculty of Medicine
Level 1, AGSM Building
University of New South Wales, Sydney 2052

Dear Professor Braithwaite

> **HREC reference number:** ▮▮▮▮▮▮▮▮
> **Project title**: Professional conceptualisation and accomplishment of patient safety in mental health care

I refer to correspondence of 2 November 2010 from Jennifer Plumb, PhD Candidate to the Human Research Ethics Committee for the ▮▮▮▮▮▮▮▮▮▮ (HREC), responding to a request for further information/modification to the above-noted study. This study was first considered by the HREC at their meeting held 12 October 2010.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* (2007), and the *CPMP/ICH Note for Guidance on Good Clinical Practice.*

The additional information Ms Plumb provided was reviewed at the meeting of the HREC Executive held on 8 November 2010.

I am pleased to advise that the HREC has granted ethical approval for the above project to be conducted at ▮▮▮▮▮▮▮▮▮▮▮▮▮▮.

The following documentation has been reviewed and approved by the HREC:

Document	Version	Date
NEAF (Submission Code ▮▮▮▮▮▮		15/09/2010
Research Project Information for Participants: Patient Safety in Mental Health Care	3	21/10/2010
Participant Information Statement and Consent Form: Mental health professionals' understandings of patient safety	3	10/09/2010
Study Process Overview	3	13/09/2010
Data Collection Framework	3	13/09/2010
Interview Schedule for Phase 5 of Study	2	10/09/2010
Research Protocol: Professional Conceptualisation and Accomplishment of Safety in Mental Health Care	5	02/11/2010
Correspondence from ▮▮▮▮▮▮▮▮▮▮▮▮, Area Director Mental Health Drug and Alcohol confirming support for the conduct of the project		13/10/2010

Please note the following conditions of approval:

1. The HREC requires that you provide annual reports on the study's progress on the anniversary of the date of ethics approval. The first annual progress report is due in November 2011.

2. The Principal Investigator will immediately report anything which might warrant review of the ethical approval of the project, including any serious or unexpected adverse events on participants, any unforeseen events which might affect the project's continued ethical acceptability, or any complaints made by study participants regarding the conduct of the study.

3. Proposed changes to the research protocol, conduct of the research, or length of the HREC approval will be provided to the HREC for review, in the specified format.

4. The HREC will be notified, giving reasons, if the project is discontinued before the expected date of completion.

5. The Principal Investigator will provide a final progress report at the completion of the study.

HREC approval for you to conduct this study at ███████████████████ ██████████████████████ is valid until **November 2012**. If your study is not completed by this date, you will need to apply for an extension of ethics approval along with your final progress report. Failure to do so may result in withdrawal of the HREC's approval for this study after this date.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project until you have submitted your Site Specific Assessment to the Research Governance Officer, ██████████████████, and have received a letter of authorisation from the General Manager. If you have any questions about the Site Specific Assessment, please contact the Research Governance Officer on ███████ ██.

Please refer to our website for the HREC Terms of Reference, Standard Operating Procedures, Membership and Standard Forms:
███████████████████████████████

Should you require any further information regarding your project, please do not hesitate to contact the Research Management Office on ████████. Please quote reference number ████████████ in all correspondence.

The HREC wishes you every success in your research.

Yours sincerely

███████████████

███████

Human Research Ethics Committee ████████████

Date: 9/11/10

cc ████████████████████████

19 November 2010

Prof Jeffrey Braithwaite
Australian Institute of Health Innovation
Level 1, AGSM Building
Faculty of Medicine
Sydney NSW 2052

Dear Prof Braithwaite

HREC reference number: ▮
SSA reference number: ▮
Project title: Professional conceptualisation and accomplishment of safety in mental health care
Collaborative Group: UNSW – Australian Institute of Health Innovation

Thank you for submitting a Site Specific Assessment for governance review of this project.

The following documents were submitted for consideration and entered into AURED:

Item Name	Date Checked In	Document Date	Received Date	Version	Reviewable?	Description
SSA Application	28 October 2010	06 October 2010	28 October 2010		Yes	▮
Ethics application	28 October 2010	15 September 2010	28 October 2010		Yes	
Protocol	28 October 2010	14 September 2010	28 October 2010	4.0	Yes	
Site Specific Consent Form	28 October 2010	13 September 2010	28 October 2010	2.0	Yes	
Site Specific Participant Information Sheet	28 October 2010	13 September 2010	28 October 2010	2.0	Yes	
CV of researchers	22 November 2010		28 October 2010		Yes	Braithwaite
HREC approval letter	22 November 2010	09 November 2010	09 November 2010		Yes	

I confirm that the Associate Investigators are: Jennifer Plumb, Dr Peter Nugus, and Dr Joanne Travaglia.

I am pleased to inform you that authorisation has been granted by the Chief Executive (or delegate) for this project to take place at the following site/s:

☐ ▮

You are reminded that ethical approval for this project expires in November 2012.

Please quote the above SSA reference number in all correspondence to the Research Governance Officer.

You are required to advise the Research Management Office of the following details (when applicable) at your earliest convenience:

1. Project commencement date
2. Registration of your trial with a recognised register to promote access to information, like: http://anzctr.org.au

Approval Letter: Final – September 2010

Appendix 4: Consent, de-identification, and data storage

The following are extracts from a research protocol document submitted to the ethics committees.

Recruitment and selection of participants

No prior relationships exist between any member of the research team and any staff member at the study site. Coercion to participate will be avoided by emphasising the voluntary nature of participation and the lack of consequences should participants decide not to participate or to withdraw during the study.

Identification of willing participants will proceed 3 stages:

a. Information sessions for staff will be conducted with acute inpatient unit staff and with community team staff, with an opportunity to volunteer or decline to participate. Staff will be left with information sheets and researchers' contact details to enable them to opt out of the study or to raise any questions or concerns.

b. During initial observations of these staff as they go about their work, between 6-8 key informants will be identified at each of the two settings. If they show interest in participating and sign informed consent documentation, these key informants will then be shadowed separately in Phase 2 of the study and then interviewed during Phase 5.

c. It is anticipated that the key informants, although primarily based in the two settings of focus (inpatient unit or community team), will during the course of their work move between teams and services based at X Hospital. If the key informant gives permission, the researcher will continue to shadow them, and will seek verbal consent from any staff involved in interacting with the key informant to have their interactions with the key informant observed. If the key informant is attending a meeting with staff members from other parts of the mental health service, verbal consent will also be sought from other meeting participants for the meeting to be recorded.

Informed consent

At all times, the researchers' priority will be to ensure that participants' interests and rights are protected. This will be done in the following ways

a. Staff will be told that their participation is entirely voluntary and that if they do decide to participate, they can withdraw at any time without fear of adverse consequence.

b. Staff who are primarily based in the settings under study will be encouraged to attend informal information sessions to be conducted before the commencement of the research by the primary field researcher (JP). These sessions will involve explanation of the purpose and nature of the study, the timescales, and what it will involve in practical terms for them.

c. Information sheets will also be made available for distribution to other staff not able to attend the information sessions.

d. Opportunity for questions to be asked and concerns to be raised will be given both at the information sessions and through provision of the research team's contact details.

e. Any staff member not wishing to be observed will be encouraged to contact the researcher or the site supervisor, either at the information session, by email, or by phone, to state that they do not wish to participate. They can also communicate this wish at any time during the research study.

Full written consent will be sought from the 6-8 key informants in each setting, who will be shadowed in Phase 2 and interviewed in Phase 5 of the study. Written consent to undertake audio recording of meetings and interviews will also be sought. All those undertaking the survey in Phase 6 will be given a consent form to sign.

At all times, the researcher will use guidance of staff members, the request of anyone present, and her own ethical judgement, to decide to withdraw from recording interactions or events.

Privacy and confidentiality

In order to ensure that participants cannot be identified individually, field notes and transcripts will use codes instead of participant names, and all identifying information will be removed prior to the writing up of the thesis and any other publications.

Data storage

Information will be stored in de-identified form in password protected encrypted files on a computer hard drive, with duplicate encrypted files on the field researcher's password protected flash memory drive. Handwritten notes and any printed transcripts or analysis from fieldwork will be stored in a locked cabinet at the Australian Institute for Health Innovation, to which only the researcher collecting data will have access. Data will be destroyed after seven years.

Appendix 5: Research information sheet

RESEARCH PROJECT INFORMATION FOR PARTICIPANTS
PATIENT SAFETY IN MENTAL HEALTH CARE

BACKGROUND

My name is Jenny Plumb and I am a PhD researcher at the University of New South Wales. I have worked in mental health policy for a number of years and am interested in finding out what patient safety means in mental health services.

WHAT IS THE STUDY ABOUT?

I am hoping to learn from the staff members at ███████████████████████ about two things:

1. How you understand the concept of 'safe practice'
2. Your individual and collective strategies for keeping things running smoothly and keeping everyone safe

WHY DO I WANT TO DO THIS?

1. Patient safety research has neglected mental health.
2. Most policy and guidance about patient safety is not based on what staff members of the 'front line' of mental health services think about safety.
3. There is little existing research about how mental health professionals accomplish safe care on an everyday basis.

WHAT WILL PARTICIPATION INVOLVE?

I am going to be conducting unobtrusive observations of how things work in the acute inpatient unit and ████████ team at ██████████ Hospital. To do this I will sometimes ask questions to clarify things I do not understand. Otherwise I will try my best not to interrupt the flow of your everyday work – I will basically be 'hanging around' trying to learn about safety from what you do and say. I will move around and listen in on interactions between staff, if they agree. I will also sometimes stay in one place for a number of hours to observe patterns of movement and interactions from a single vantage point.

After I have been getting used to the environment for a few sessions (and when you are used to me being around), I will be asking between 6 and 8 staff members from each of these teams whether they would be willing to have me shadow them during one working day, and to interview them about this afterwards. Finally, if I have enough time at the end of the study, I will be asking all team members (if they give their consent) to fill in a short questionnaire about who they interact with on safety issues.

I will be in your workplace for a maximum of 16 hours per week, for a maximum of 10 weeks.

CONFIDENTIALITY AND PRIVACY

Your participation in this research is entirely voluntary. If you do not wish to participate, or wish to withdraw your participation at any time, please let ██████████ or Jenny Plumb know.

Please note that I will not observe clinical treatment or therapy sessions between staff and patients. It may sometimes be helpful to observe informal interactions in common areas between staff and patients, but I will endeavour to ask permission from both staff and patients before observing, and will never identify patients.

If at any time you do not wish any event, conversation etc to be part of the data collected, let me know and I will remove it from my field notes or will not record it at all. All information will be de-identified and no individual identity will be disclosed to anyone outside of the research team at UNSW.

If you are privy to a complaint from a patient about the project, or have a complaint yourself, you should direct this EITHER to ███████████████████████████████████ OR to the Chief Investigator, Professor Jeffrey Braithwaite, ███████████████████████████ ██ All complaints will be dealt with in confidence.

If you have any questions, please feel free to contact me on ███████████████████████████████████.

Appendix 6: Participant information and consent form

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Mental health professionals' understandings of patient safety

You, _____, are invited to participate in a study of what patient safety means in mental health care. We (the UNSW research team: Ms Jenny Plumb, Prof Jeffrey Braithwaite, Dr Joanne Travaglia, Dr Peter Nugus) hope to learn how mental health professionals understand patient safety and how they accomplish it during everyday practice.   You were selected as a possible participant in this study because you are a mental health professional employed in the ███████████████████████ team.

If you decide to participate, we will accompany you for a maximum of 8 hours (this may be split over multiple days) to observe you going about your work and interacting with other professionals. At the conclusion of the observation period we would also like to interview you at a mutually agreeable time and location. The interview will take no longer than one hour.

If you agree, we would like to take field notes of our observational study and take audio recordings of any formal meetings with other staff, provided all participants agree. We also seek your consent to audio record the interview with you.

We understand that accompanying you may be inconvenient. You may need to interact with someone who has not given consent for this research. If so, we would like to ask them for their verbal consent. We will be as unobtrusive as possible and will not intervene in the flow of events, nor will we observe your private clinical interactions with patients.

We cannot and do not guarantee or promise that you will receive any benefits from this study, but we hope that the research will give you an opportunity to reflect on your experiences of mental health practice.

Please feel free at any time to contact us to discuss this research or any part of it that may be of benefit to you and the ███████████████████████ team. At the conclusion of the study, findings will be fed back to your team through a presentation by the primary field researcher.

All data collected as part of this study will be de-identified during the analysis. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, except as required by law. If you give us your permission by signing this document, we plan to publish the results in health and social science journals, at conferences and in a PhD thesis for which this study is designed. In any publication, information will be presented in such a way that you cannot be identified.

Complaints may be directed to the Research Management Office, ██████████████████████████
██ OR Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone 9385 4234, fax 9385 6648, email ethics.sec@unsw.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Your decision whether or not to participate will not prejudice your future relations with The University of New South Wales nor with ████████████████ If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you have any questions, please feel free to ask us. If you have any additional questions later, Jenny Plumb will be happy to answer them. You can contact her at ████████████████

You will be given a copy of this form to keep.

PARTICIPANT CONSENT FORM

Mental health professionals' understandings of patient safety

You are making a decision whether or not to participate in this study. Your signature indicates that, having read the Participant Information Statement, you have decided to take part in the study and to allow us to record the interview and meetings.

....
Signature of Research Participant

....
(Please PRINT name)

....
Date

....
Signature(s) of Investigator(s)

....
Please PRINT Name

....
Signature of Witness

....
(Please PRINT name)

....
Nature of Witness

REVOCATION OF CONSENT

Mental health professionals' understandings of patient safety

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with The University of New South Wales nor ███████████████

....
Signature

....
Please PRINT Name

....
Date

The section for Revocation of Consent should be forwarded to Research Management Office████████████████
███████████████████████████████, OR to the
Ethics Secretariat, The University of New South Wales, Sydney 2052 (phone 9385 4234, fax 9385 6648,
ethics.sec@unsw.edu.au).

Appendix 7: Sample of stationary observation field notes, June 2011

Time		Staff code	Location	Activity	Notes	Materials
0918		IAD2	Admin phone	Makes call	To CCON1 – 'we've got the police here because (patient)'s being discharged…	
0920		IDT1 IRN9		Patient discussion		
		ICNC1		Whiteboard	Looking at whiteboard	Whiteboard
		IRN11	S/A door	Safety admin	Filling in leave register for a patient to go out for a head CT	Leave register
		IRE5	S/A door	Leaves and enters	Carrying patient files	Pt notes
0923		CRE1	S/A desk	Notes	Writing in notes	Pt notes
		ICON3		Enters, patient safety discussion	ICON3 has come in past the police. Someone says 'just keep an eye out' (in case the patient kicks off when he is told about the police)…IRN9 (I think) explains to ICON3 that 'they're taking him into custody…' ICON3 comments 'a much better accommodation arrangement I think…they look like they mean business…' IAD2 chips in 'they've got undercovers as well…' Someone says 'I'll ring his girlfriend…' ICON3 continues 'I haven't seen that many capable looking coppers' (in one place before)..IRN5 says 'his reputation obviously precedes him…'	
		Multiple staff	S/A floor	Escorting patient to door	INUM1 and three or four others escort pt to ward door where the police receive him. The others watch from inside the nurses station [almost holding their breath, it seems to me]…after he is out the door, IRN9 says 'that went smoothly'.	Locked door
0927		ICON3 IRN9	S/A	Patient discussion	ICON3, looking out the window into the ward, says 'oh (patient's) back as well' (I think this is the pt who had been in HDU)… ICON3 asks about a patient 'is she eating and drinking…' IRN9 replies 'no she's not…' ICON3 'has she been worked up for ECT?' not yet…ICON3 says that 'I was hoping the wheels were already put in motion for it yesterday…' (paperwork for application for involuntary ECT at tribunal)	

Appendix 8: Sample of unstructured observation field notes

21.01.11, 1045, Community team office

I ask CPSY2 how her CTO hearing went this morning (earlier I had seen her preparing for it in CNUM2's office and she had said that when it is just one person she can do it in there). She said that she had been given the CTO but only for 6 months, not the 12 months she'd asked for – it seems this is mainly how these hearings go. She said that the relationship with the client had not been damaged this time, unlike the last hearing. She said it helped that she had at the start emphasised that the client had been complying with his CTO, turning up for his injections and so on. She said that there is usually an awkward time during these phone hearings when the tribunal members want to discuss the case between themselves, and so the case worker is left on the line with the client. She said she had got over the awkwardness by focussing on working out with him about future appointments he has, keeping it to that until they came back on the line.

I go to talk to CSW2 as I was aware she was having some difficulty with a client (probably from something I had overheard earlier). CPSY2 comes over and asks whether I'd like to come along to a family session later in the day with her. I say I can't observe actual therapy sessions...CSW1 suggests listening into their duty officer shifts that afternoon. All the community staff are allocated a two hour duty office shift per week. This means that they have to be next to their phone to take any calls which come through from known community clients whose case managers are not at the office at present. Sometimes this can involve dealing with crises, but they also mention one client of CRN2's who always rings through for help, for instance 'I don't know what to do this afternoon, I've got to do my shopping' etc...CSW2 says that usually this is just to validate plans that she has already made for herself...but seems to need someone to reinforce it – 'usually I'm not so direct with clients – choices and all that' says CSW2, but she tells her to 'go make a cup of tea' ..do the washing etc. CSW1 and CPSY2 have their shifts back to back, from 11-3 on a Friday.

CPSY1 says 'tell Jenny about your first ever duty officer shift'. CSW2 talks about how someone had rung on their way to a local bridge, saying they were going to jump off. Together they describe a system to me via a couple of vignettes about the need to communicate with other staff members when there is someone in crisis on the other end of the phone (to get them to call the ambulance or the police – the client needs to be kept on the line). To do this they signal to others in the office. She also cites an example of a well known client who called whilst taking an overdose – she could hear the blister

pack being popped and the sound of drinking. She described calling CCON2 on one of these occasions to confirm that there should be an ambulance sent round.

21.01.11, 1100, Hospital cafe

My phone rings and it is CRE3, apologetic for only just getting back to me. He suggests we meet right away in the hospital café. I decide to get a schnitzel roll but he just gets a coffee – I realise I should have paid for it (according to suggestions in the ethnography books!)...He starts off seeming a bit doubtful about the study but after I explain about the aims and methodology he seems to warm to me a bit … .

Appendix 9: Interview guide with question rationales

Q.	Team	Question and prompt(s)	Rationale
1	Both	**To start with, can you tell me briefly how you came to work in mental health?** *Prompt: Why were you attracted to mental health/ psychiatry in particular?*	Contextualise other responses, look at personal motivations for working in this setting, and break the ice.
2	Both	**What do you feel to be the overall purpose of your work here?** *Prompt: Give me a recent example of a time when you were successful achieving this.*	Reveal the extent to which safety and risk management concerns dominate practice/ perceived function, and to what extent therapeutic intervention, lifestyle management, social issues are felt to be important parts of the job.
3	Both	**What do you feel is the overall purpose of the community team/ inpatient unit?** *Prompt: Do you think the unit/team is successful in this on the whole?*	Reveal the extent to which safety and risk management concerns dominate practice/ perceived function, and to what extent therapeutic intervention, lifestyle management, social issues are felt to be important parts of the job.
4	Both	**For the next few questions, I want you to imagine that you are about to go on three months long service leave; I will take over your role from tomorrow; so that people do not know you are gone.** **Tell me what my day is likely to be like tomorrow // Can you give me a handover of the most important things I need to know to do your job, so that everything goes smoothly while you're away?** *Prompts: What are the most important things to get done? How would you advise me to get that done?* *Who will I need to talk to? What do I need to be aware of?*	This is deliberately vague. Answers will hopefully highlight the types of activity considered most important to keeping things ticking along as usual, thereby giving an impression of what they consider 'usual' in this context, and also what sorts of things they think have the potential to go wrong.
5	Both	**Are there any useful tips you could give me about fitting in, and working with the inpatient/community team staff?**	This question is designed to elicit some idea of appropriate/ acceptable behaviour in this team and organisation as well as some norms of practice. It may also elicit general comments about relationships between different teams and individual and possibly some idea of internal politics. Hopefully, the question will uncover informal/ 'profane' rules for conduct rather than official or normative versions.
6	Community	**If something is going to go wrong while you're away, what is it most likely to be? How should I deal with it?**	What do they classify as an adverse incident in mental health care? Do they conceptualise the primary potential cause as

Q.	Team	Question and prompt(s)	Rationale
			originating in a clinician's mistake/omission or in a patient's actions?
7	Both	**Just so I know what I'm letting myself in for, I'm interested to know whether there is anything about your job that keeps you awake at night?**	Elicit the most powerful (negative) imperatives structuring their practice. Are they most worried about threats to themselves/ their careers/ Or are they concerned they are delivering a safe/ effective service for patients? Or are they grappling with the uncertainty of their job/ unpredictability or feelings of powerlessness?
8	Community	**While you're away, if one of your clients starts to deteriorate rapidly:** *How will I hear about this?* *How will I tell they are deteriorating* *What should I do next? (take me through the steps) to ensure their immediate safety?* *What decisions will I have to make?*	This is intended to 'zoom in' on a particular practice of keeping a patient safe in a more acute situation, and to follow through the decision making process comprising a perceived 'appropriate response' to the situation. What 'deteriorating' means is an interesting question – will they answer in simply clinical/symptomatic terms?
9	Community	**I want you to think about one client who you'd consider high risk and one you'd consider a low risk client – what sorts of things should I be doing to ensure they stay safe on a day-to-day basis?** *Prompts: Why do you see them as high risk or low risk?* *Does this change?* *What resources can I draw on to help me?* *Are there aspects of safety it is not my responsibility to look after?* *What sorts of things might hinder my efforts?*	This is intended to 'zoom in' on the 'assemblage' of practices, people and things which are orchestrated to maintain a patient's safety on a day-to-day basis – where risk is not acute but chronic. It should also reveal the criteria they use among their patients to assess level of risk, the types of risk (and whether this is interpreted as 'is at risk of' or 'is a risk to') and the relation of this risk to 'safety' and 'wellness'.

Q.	Team	Question and prompt(s)	Rationale

10	Inpatient	**What advice can you give me about my role in helping to keep patients safe?**
		
		Prompts: If you want you can tell me about a recent time when you felt a patient to be at risk and you played a key role in keeping them safe.
		What do I need to do?
		    What do I need to be aware of?
		    Who do I need to talk to?
			Intended to elicit a narrative, to help in understanding their conceptualisation of what is risky, how they detect it, and what they consider an appropriate response to such identified threats to safety. Also intended to reveal something of their personal role in maintaining safety and the ways they feel they can achieve this, and who are the people they use or collaborate with to do so.

11	Inpatient	**What do you think are the main resources, tools and strategies which enable staff to maintain safety on the unit on a day-to-day basis?** *Prompt: What role do you think policies, procedures, risk assessments etc play in practically keeping people safe?*	In contrast to the last question, which was about their personal role in safe care, this is a general question to ask about their perceptions of the overall resources used by different team members. The idea of this question is to get at not just practices, but also material objects, documents and the environment, and also to ascertain the relative import of formalised and informal strategies.

12	Inpatient	**Take a look at this risk sticker which I have noticed staff filling out often.**
		 Prompts: Can you tell me first of all what you think it is for?
		    Can you tell me what you think of it?
		    What impact would you say this has on your everyday practice?
			As a specific example of a formal risk assessment tool used daily for each patient by staff, this was used as a prop to try to tease out staff opinions about the practical usefulness of such instruments in the practical achievement of safety.

13	Inpatient	**What are the main barriers to keeping patients safe that you've come across?**	
14	Inpatient	**Can you tell me about a time you've felt yourself to be at risk in your job?**	Another narrative elicitation question for the purpose of prompting discussion of their personal emotional relationship with the risk aspect of their own job, and the degree to which they feel safe in their job.
15	Inpatient	**Can you tell me about a recent critical incident on the ward – what went wrong, and how was it dealt with? Why do you think this went wrong?**	What constitutes a critical incident, what are the inferred causes, and how is the situation 'rescued' by staff action.
16	Both	**For the last question, I have a page for you to write on.**	To elicit a taxonomy of harms which professionals perceive as

Q.	Team	Question and prompt(s)	Rationale
		This diagram shows a continuum of the potential for harm. *The client is portrayed as moving along it.* a. Firstly, what sorts of harm have the potential to befall clients (in general terms?) *Please list these in the centre of the page.* b. Can you pick out one of these and list the things that might increase the potential for this harm to occur, and on the other side, the things that might decrease the potential? *Please circle the harm you have chosen and make this list under the appropriate box on the right and left hand sides of the page.* c. What role do you think the service plays in the movement of the client up and down this continuum?	potentially befalling their patients, and the protective or exacerbating factors associated with these. To elicit the relative importance of service-initiated and patient-related factors in determining the likelihood of a risk escalating or reducing.

Appendix 10: Survey questionnaire

Social Network Survey

INTRODUCTION

Thank you for taking part in this survey which is one component of a research study about patient safety in mental health care. It is being conducted by a team from the University of New South Wales, Faculty of Medicine (Jennifer Plumb, Dr Peter Nugus, Dr Joanne Travaglia, and Professor Jeffrey Braithwaite), and has been approved by ▮▮▮▮▮ and UNSW ethics committees (UNSW HREC ▮▮▮▮▮▮▮▮▮▮▮▮).

We are interested in who different staff communicate with when they have a concern, doubt or issue to do with the safety of patients. The purpose of the survey is to enable us to determine the patterns of staff communication within and between ▮▮▮▮▮ and ▮▮ teams in relation to safety.

In order for this survey to be effective, we need participation from as many people as possible from ▮▮▮▮▮▮▮ by 14 March 2012. It should take you approximately 15 minutes to complete the questions. Please note that it is important that you read the instructions and complete **all** the questions.

Your responses will be de-identified by the research team on analysis. Neither your name, nor the name of the service will be mentioned in any publications or presentations arising from the research.

We greatly appreciate your time and hope that you will find the results interesting when they are presented in aggregate form back to the teams following analysis. If you have any questions, or wish to withdraw your answers from the study, please contact Jenny Plumb: j.plumb@unsw.edu.au.

CONSENT

Please sign below to indicate you agree to participate in the survey.

SIGNATURE		PRINT NAME	

PRELIMINARY QUESTIONS

What is your job title?

How long have you held this
position?
year(s)   month(s)

How long have you been working in
███████████████ Service?
year(s)   month(s)

How long have you been working in
your current profession/ occupation?
year(s)   month(s)

QUESTION 1

This question relates to how you use other people and resources to help you maintain the safety of patients in ▮▮▮▮▮▮▮▮▮▮ **Service.**

a. Please name **three people** you feel are (in general terms) most helpful to you in your role in maintaining the safety of patients in the service:

1 [   ]   2 [   ]   3 [   ]

b. Please name **three physical things** (e.g. aspects of the physical environment, objects, tools, documents) which you feel are most helpful to you in your role in maintaining the safety of patients in the service:

1 [   ]   2 [   ]   3 [   ]

c. Please name **three practices** (things you do/ tasks you perform) which you feel are the most important to you in your role in maintaining the safety of patients in the service:

1 [   ]   2 [   ]   3 [   ]

d. Please nominate **ANY THREE of your responses above,** which you feel to be the *most important* to your role in maintaining the safety of patients in the service, in order of importance:

1 [   ]   2 [   ]   3 [   ]

QUESTION 2

Instructions:

1. On the following page, you will find a list of all staff in ███████████████ teams.

2. In the first (dark) column, please indicate with a TICK if you have **never** spoken directly (one-to-one) to this person.

3. Think about the <u>last ten days or ten shifts</u> you have worked at ████████████████████ Service.

Please indicate with a TICK in the appropriate columns <u>whether</u> during those ten days/shifts:

    a. **You have asked advice** from this person about a patient safety or risk issue

    b. **This person has asked advice from you** about a patient safety or risk issue

NB: 'asking or giving advice' means talking one-to-one, asking or giving an opinion or suggestion about what could or should be done.

COMMUNITY STAFF	Never spoken directly to this person	Have asked this person advice: (re. Patient safety/risk)	Have been asked advice by: (re. Patient safety/ risk)
OT			
OT			
DR			
DR			
DR			
DT			
REHAB			
PSY			
PSY			
PRA			
REHAB			
VETE			
RN			
RN			
RN			
RN			
RN			
WWF			
ADMIN			
ADMIN			
ADMIN			
MGR			
MGR			
MGR			

INPATIENT STAFF	Never spoken directly to this person	Have asked this person advice: (re. Patient safety/risk)	Have been asked advice by: (re. Patient safety/ risk)
DR			
DR			
DR			
DR			
DR			
DR			
DR			
DR			
DR			
DR			
RMO			
S/W			
S/W			
OT			
OT			
DT			
Psych			
HASA			
HASA			
Admin			
Admin			
C/W			
C/W			

INPATIENT NURSES	Never spoken directly to this person	Have asked this person advice: (re. Patient safety/risk)	Have been asked advice by: (re. Patient safety/ risk)
CNC			
NUM3			
NUM1			
RN			
RN			
RN			
RN			
RN			
RN			
CNE			
RN			
RN			
RN			
RN			
RN			
RN			
RN			
RN			
EN			

QUESTION 3

Instructions:

1. Think about a time in the last 2 months that you were concerned about the <u>immediate safety</u> of a client/patient (i.e. you were concerned that they would come to some form of harm if you did not act promptly).

2. Consider again the list of staff members of ███████████████ on the previous pages.

3. When you were thinking about what to do regarding the concerns you had about this patient, did you consult anyone from the ███████████ teams?

YES ☐   NO ☐

4. **If yes,** please indicate the people you discussed your concerns with, by placing a circle around their name(s) on the lists above.

If no, please go on to Question 4

QUESTION 4

Instructions:

1. When you were thinking about what to do regarding the concerns you had about this patient, did you consult anyone who is **NOT** ████████████ staff?

YES ☐   NO ☐

2. **If yes, please tick** on the list ON THE NEXT PAGE **all** those people you also consulted on that occasion (in the first column), and continue to the next part of the question.

If no, you have finished the survey - thank you.

3. In the second column, **please tick** if you consulted any of these people BEFORE ANY of the staff members of ████████████

	Consulted this person	Consulted BEFORE ███ or ███ staff
Patient/ client	☐	☐
Patient's spouse	☐	☐
Patient's parent(s)	☐	☐
Patient's child(ren)	☐	☐
Patient's sibling(s)	☐	☐
Patient's other family member(s)	☐	☐
Patient's friend(s)	☐	☐
Patient's neighbour(s)	☐	☐
Other patient of the service	☐	☐
Patient's accommodation provider	☐	☐
Centrelink	☐	☐
Patient's employer	☐	☐
Patient's education or training provider	☐	☐
Patient's GP	☐	☐
Patient's pharmacist	☐	☐
Staff of another mental health service	☐	☐
Staff of ███████ hospital (non-MH)	☐	☐
Other health professional (not at ███████ hospital)	☐	☐
Police	☐	☐
Ambulance service	☐	☐
Hospital security staff	☐	☐
Member(s) of ███████ team (please indicate role)	☐	☐
Member(s) of ███████ team (please indicate role)	☐	☐
Member(s) of ███████ team (please indicate role)	☐	☐
Member(s) of ███████ staff (please indicate role)	☐	☐

This is the end of the survey. Many thanks for your time.

Appendix 11: Research journal extract regarding rationale for codes

3/05/2011 11:55 AM

Developing the theoretical codes to apply to the data.

Tried to bring together my theoretical reading to develop codes which are relatively simple and which I already know (because I know the data pretty well and themes have been emerging all along) will be applicable to this data. The codes I have come up with so far (last Friday 29th) emerged from a narrative I tried to develop in the document 'attempts to develop codes'. I suppose I wrote the narrative to try to develop some schema within which the codes could be arranged which made sense as a story - a way to offer some coherence to the codes and to start thinking about the different conceptual levels of codes (e.g. descriptive vs analytical/interpretive).

1. Risk and safety as contested concepts. [this comes from the reading on the sociology and anthropology of risk (see theory draft), as well as my observation that the determination of a 'risky' situation or person depends a great deal on individual judgement in mental health and is highly variable]

2. Risk and safety as negotiated and coproduced (both conceptually and in enactment) at the informal level. [this comes from Gherardi et al's writing, as well as (to a certain extent) from the ideas of Wenger in his 1998 book. It is also derived from observations that stories clinicians tell each other play a large part in their calibration of what is risky, and some instances of negotiation/disagreement between clinicians about the 'real' risk a particular client presents (especially psychiatrists vs the rest)

3. Formal versions of safety and risk as they are inscribed (comes from Latour's idea of 'black boxing' - of patient safety, and also from Wynne's ideas about the formalised networks of how a system is supposed to work, while at ground level people are busy modifying different nodes with impacts for the whole network. Also brings in the idea of objects codifying certain versions of risk and safety - the impact, for example, of the risk assessment form or the structure of space on the inpatient ward on the clincian's conceptualisation of risk..and the seeming nonimpact of business rules and policies)

4. General rules about identifying riskiness (this is partly intended to form a taxonomy of risk in this context, and partly meant to catch the prevailing or dominant discourse about what riskiness is, both in the context of staff and

patient safety...also to capture the multiplicity of discourses from different professionals)

5. General rules about what sorts of things increase/ decrease risk (again, for the purposes of taxonomy building)

6. Spatially distributed safety net of people, things and knowledge (this develops fairly obviously from the ANT idea of the network, also from Mesman's 'safety net' work..also derived from the observation that clinicians use a range of people and things both within the boundaries of the hospital and well outside of it in order to monitor and intervene for the safety of their clients. Emphasis is on the effort required to ensure the 'safety net' works)

7. Temporally distributed safety net of people, things and knowledge (derived from the observation that some of the most important/ frequently cited and accessed elements making up the safety net embody historical knowledge of the patient - such as case files and past case managers.)

8. Types of uncertainty (observed that not much is predictable in mental health care. can think of several types of uncertainty (e.g. diagnostic, risk level) but want to see how much this sort of issue and the need to deal with it crops up. Is this a level of uncertainty that is distinctive to mental health? how does this impact on patient safety?

9. Taming uncertainty (the INFORMAL strategies used by clinicians to convert the uncertain into the certain, or to cope with the uncertain. Converting client interactions into documentation is one obvious example; the risk assessment form is another. Orchestrating the temporally and spatially distributed network could also be interpreted in this way).

10. Taming uncertainty/ risk management (the FORMAL/ OFFICIAL assumptions about risk management and how it should be done)

11. Nodes and relations in the network (what does the 'safety net' look like and how do its elements relate to one another)

12. Broken net (what does this look like, how does it happen...)

Appendix 12: Extract from Excel spreadsheet interview coding

Interviewee	Story		Formal		Everyday		Concept		Other
CNUM2	0000 - 0316	How he worked his way up in the service	1317-1343	juggling priorities - managerialist imperatives vs needs of clients	1230-1312	guiding staff whose clients are unwell and may need hospital		potential problems = team conflict; client becoming unwell; client being overdue for meds; can be solved by timely action; team communication	notio... clinic... perse... diffic... does... docu... being... chang...
	0333 - 0356; 0548 - 0639	What the purpose of his role is - client and team responsibilities - caring for clients	3300-3349	face to face assessment involves formal mental state assessment, functional assessment, risk assessment	1910-2101	sharing knowledge of potential problem "situation" with client is seen as vital - both within team and with senior management; keeping pts safe not an individual endeavour - but is this reflected in SMA? Making multiple parties aware is vital - is this distributed awareness a protection against unpredictability? This also highlights the agency of risk in mh services lying with the client - potential problems are never what staff might do wrong but what patients might do, and planning for or preventing that...is this different agency of risk the source of differences between mh and other sectors of healthcare? Is there a blame culture towards patients?	2659	seen as not safe for a staff member with kids to live near a paedophile client - team leader resolves to do something about it; it is balancing the risk of lost engagement with that client (the case manager's pov) with the risk of some harm coming to his kids	sourc... uncer... conte... riskin... rende... comp... patier... seen... too m...
	0645- 0823	"Pt transformation from "difficult"(drugs, crime) to successful : rescue story	3344	tells his staff 'to clear yourself if you're not happy with someone's presentation...you	2117 - 2212; 2338 - 2414	communication channels required of team leader when a situation arises. Preparedness and prediction of potential "unwellness" seen as very important to being a good clinician esp in eyes of senior mgt.	2843 - 3011	early warning signs that 'something's going wrong' can be detected through familiarity with the pattern of patient's prior presentations'- a good clinician will see what is out of the normal pattern just by chatting	lack o... high ri... espec... powe... mech...

Appendix 13: Extracts from mind mapping of field note codes

between client's story and collateral evidence
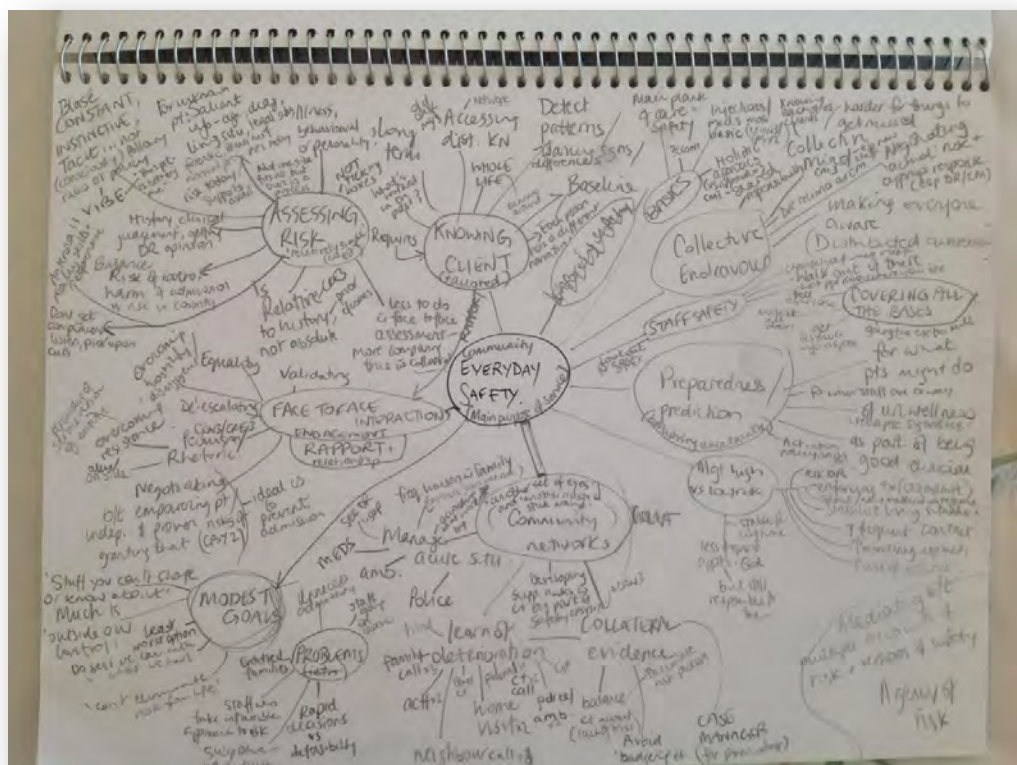
Contested notions of safety and risk

he says 'I found evidence of it in her file..it's real' and 'this is a woman who gets murdered every other day'. 25 jan r1 cont

disagreement between CRN3 and doctor over risk presented by lady who seemed better once she'd sobered up: doctor said she was playing down the problems which were more severe according to her notes.

COT1 points out that CTC do not do home visits; he says this means they miss out on detail. Someone may have great verbal skills but their flat may have boxes everywhere and cockroaches. However, because they assess people who are new to services, 'it's the unknown' – regarding the area where they live, who else might be in the home, and how they will respond to you. 4feb r3 cont

Ed staff sending pts down to ward before properly medically cleared. Nurses think pts with too many or acute medical problems should not be sent to the wb