Accountability and Patient Safety:

A Study of Mess and Multiplicities

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Abstract

Over the past decade, patient safety has emerged as a major issue in hospitals, arising from reports of unacceptable levels of harm to patients caused by the process of health care itself rather than any underlying disease. A growing research movement has developed around finding out why so much harm occurs, and what can be done to reduce it. The ever-increasing complexity of health care provision is consistently cited as an underlying factor, and alongside calls for more accountability and transparency, formal systems of accountability such as guidelines and incident reporting have emerged in response, designed to govern frontline activities and to manage complexity through standardisation. As popular as these approaches are however, they are also controversial, and a large subset of patient safety research is focused on identifying and overcoming local 'barriers' to their implementation.

In this thesis, I analyse the problematic implementation of this formal accountability and challenge its assumptions. I propose that we insufficiently understand how safety is currently practiced by clinicians, and likewise, how accountability is practiced. My thesis therefore focuses on exploring safety and accountability as *practices*. I describe accountability not only in formal terms, but also as informal and everyday talk and behaviour. Furthermore, I propose that the problems of implementation described above can be reframed instead as tensions *between accountabilities*. In this study therefore, I examine how clinicians negotiate multiple accountabilities in their practices of safety. With a multidisciplinary group of 72 clinicians in a children's hospital in New South Wales, Australia, I created ethnographic data through observations, field interviews and feedback sessions in two phases of field work, over ten months in total. Following each phase, data were iteratively coded and analysed using a grounded theory approach.

With these data, I show how clinicians are enacting safety through their practices of accountability, in contexts complicated by multiple accountabilities and multiple meanings of safety. I show how clinicians inevitably produce accounts that are partial and 'incomplete', at risk of becoming problematically disembedded from complexity. I also show how clinicians are re-embedding these partial accounts, by engaging in accountability practices that foreground multiplicity, diversity and reciprocity. I argue that if we wish for practices of accountability to reflect and support clinical practices that we see as complex and interconnected, then we need to embrace more complex and *interconnecting* practices of accountability. Rather than calling for more accountability, we need to practice more *accountabilities* instead, to increase the reciprocal and reflexive engagement of participants with one another in (and beyond) the health care system. In doing so, we would enable care that is 'safer' by enabling more people to participate more variously and directly in negotiating the complexity and shifting boundaries of health care delivery.

Glossary of abbreviations

ANT	Actor-Network Theory
CEC	Clinical Excellent Commission
CNC	Clinical Nurse Consultant
CNE	Clinical Nurse Educator
CNS	Clinical Nurse Specialist
EBM	Evidence-Based Medicine
HA	High Acuity
HD	High Dependency
ICU	Intensive Care Unit
IIMS	Incident Information and Management System
IOM	Institute of Medicine
M&M	Morbidity and Mortality
NSW	New South Wales
NSW Health	New South Wales Department of Health
NUM	Nurse Unit Manager
RCA	Root Cause Analysis
RCT	Randomised Controlled Trial
RN	Registered Nurse
SAC	Severity Assessment Code

Glossary of key terms

Accountability	A practical and on-going accomplishment, enacted through the creation, exchange and use of accounts that can be representative of practice, as well as explanations or justifications of practice. See below for Informal Accountability and Formal Accountability.
Articulation work	Work that is involved in coordinating action around formalised models of work, that deals with unanticipated contingencies, and is generally invisible in formalised models of work.
Combinability	Combinability allows for accounts to be *paired* and *compared* across distances and time, at the risk of estrangement from more local and complex understandings and interpretations.
Directionality / unidirectionality / multidirectionality	Directionality attunes us to consider for whom accounts are created, whose accounts are made visible, and the reciprocity of their exchange. Unidirectionality describes the exchange of accounts in only one direction, lacking reciprocity. Multidirectionality describes a multiplicity of reciprocal interactions between people.
Distance	Not necessarily geographical, it can also refer to hierarchical differences or differences in perceived power, for example.
Dis/embeddedness	The degree to which an enactment of accountability engages with, and adequately represents the complexity of contexts in which multiple meanings of safety may co-exist. Dis/embeddedness has implications for how practices of accountability connect and disconnect practices of safety.
Evidence-based medicine (EBM)	A movement that emphasises the use of scientific evidence in clinical decision making, particularly evidence that meets standards of objectivity and generalisability, epitomised by the randomised controlled trial (RCT).
Formal accountability	An approach designed to act ‘at a distance’ to control or impact upon local frontline activities, in what is imagined to be a unidirectional relationship.
High dependency / High acuity	High Dependency patients are those who are determined by doctors and/or nurses to require increased nursing care, for various reasons. High Acuity patients are a subset of HD

	patients, who are determined by doctors to be acutely unwell, and are to be seen by a medical team at least once every shift.
Informal accountability	Accountability that is not formal (see Formal accountability) or otherwise formally prescribed, usually initiated locally and contingently.
Intercontextuality	The re-creation of accounts and/or accountabilities across different contexts such as when past accounts are repeated or reproduced in subsequent account-exchanges, via the clinicians who are also situated within and across these contexts
Mobility	The ability of an account to travel between contexts and across distances.
Multiplicity	The claim that there is more than one way of describing or defining something, as opposed to singularity.
Reciprocity	A relationship describing the continual and mutual exchange of accounts between parties, as opposed to unidirectional accountability.
Resilience	The ability of actors to recover from unexpected change, or other adversity.
Stability	Can be thought to have two facets, namely the durability of the physical/tangible form of an account, and the reliability of its interpretation or meaning. These facets are inseparable, with the interpretation of an account emerging from the interaction between the form of the account and the context of its interpretation, rather than being somehow distinct and independent. Stability therefore is a contingent, relational effect, always in production. It is dependent on the relations generated between contexts by the accounts and accountabilities that flow between them.
Transparency	A relational effect, linked with stability, mobility and visibility, achieved by the interconnectedness of practices and people through the reciprocal flow of accountabilities.
Visibility	The degree to which an account (and the practices represented therein) is able to be ‘seen’ or otherwise attended to by others. Inextricably linked with the mobility and stability of the account.

Glossary of participant titles

Clinical Nurse Consultant (CNC)	An experienced nurse with expert skills and knowledge in one particular area. The CNC manages the overall care for their group of patients and helps the medical team with clinical decisions. They may also do procedures, provide education and support.
Clinical Nurse Educator (CNE)	An experienced qualified nurse who works with nursing staff to develop their nursing skills and knowledge and develops hospital-wide nursing education.
Clinical Nurse Specialist (CNS) / Specialist nurse	An experienced registered nurse with demonstrated competency in an area of specialisation.
Consultant	The most senior doctors in the team, who have finished their speciality training.
Dietician	An allied health professional who gives parents, nurses and doctors advice on nutrition. This includes assessing patients' needs and devising and managing nutritional care plans for patients.
Fellow	A doctor who is finishing their specialty training. They will usually become a consultant within a year or two. A fellow works under the supervision of a consultant, and is more experienced than a registrar.
Junior doctor	In this thesis, a junior doctor can refer to a fellow, a registrar, or a resident (see relevant entries in this glossary)
Nurse Unit Manager (NUM)	The nurse in charge of managing the ward. They are in charge of staffing, and coordinate admissions, discharges and transfers of patients. They do not care directly for patients.
Play Therapist	Play therapists use play to help children have a positive experience of hospital by encouraging normal appropriate play activities.
Nurse / Registered Nurse (RN)	A trained nurse who cares for patients in the wards.

Registrar	A doctor who is training in a particular medical specialty, such as paediatrics. They rotate placements about every three months. A registrar is more experienced than a resident.
Resident	The most junior doctor on the team, also known as a Resident Medical Officer (RMO). They rotate placements about every three months.
Senior doctor	A consultant (see glossary entry above).
Senior nurse	In this thesis, a senior nurse can refer to a CNC, CNE or CNS (see glossary entries above), or another experienced nurse, such as the shift team leader on the ward.
Social worker	An allied health professional who works with families and health professionals to help with practical and personal issues a child and family may be facing.
Speech therapist	An allied health professional trained to assess and treat people with a communication disability or a problem with eating or swallowing.

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