Organizational Consequences of Patient Safety Work

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The Risk of Safety Technology

Overall thesis:

- Safety technologies/risk management creates new kinds of risks or problems

Contribution:

- Identification of four risk categories: *transparency risk, second order risk, standardization risk, responsibility risk*

Fieldwork:

- Observational studies and interviews in a large Danish university hospital and home care services and nursing homes in municipality

Transparancy risk

Argument:

- Patient safety technologies are dependent on the classification of errors or ’adverse events’
- Formalized and transparent areas (e.g. medication) are prioritized over less formalized and invisible areas (e.g. general care)

Consequence:

- Incidents of indeterminate status are often not included in the program

“Medication errors are measurable; it is described whether a citizen is to have two or three tablets. In wound care we may fluctuate, here it is ok to choose between different types of medical preparations. It is not the same, however, whether you choose to give two or three tablets.“ (Nurse)

Second order risk

Argument

- The introduction of safety technologies produce ‘second order’ safety work
- Safety comes to represent the processes and problems relating to the technologies

Consequence

- Possible tensions and trade-offs between safety as the workings of the technologies and safety as safe treatment of patients

> *“One of the greatest challenges for patient safety is that once we have prepared action plans in relation to root cause analyses, they are to be implemented. The next great challenge is to create more confidence in relation to reporting adverse events, so we get away from the anonymous reports”* (Riskmanager)

Standardization risk

Argument:

- Patient safety technologies are increasing standardization in a number of ways
  - Safety technologies are designed to produce standards
  - The patient safety discourse is endorsing standardization via ‘fail-safe systems’ rhetoric

Consequence:

- Standards become the preferred answer to safety questions

> *“It's all about finding out if the written standards are good enough, but just haven’t been implemented or whether you need to come up with a new guideline.”* (Quality coordinator)

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Responsibility risk

Argument:

- Safety procedures and devices are likely to redistribute roles and responsibilities
- This diffusion is further stimulated by ‘blame-free’ rhetoric

Consequences:

- Increased complexity of organization and diffusion of ties of responsibility

Reorganization of healthcare due to patient safety work

- Changed meaning of safety, learning etc.
- Redistributions of focus, time and responsibility
- Standardization as organizing principle

→ Traditional roles are challenged with potentially problematic consequences