

PATIENT FALLS DECREASE AS CONVERSATION DEEPENS

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ABSTRACT

A UK hospital reduced the rate of patient falls by 48% when a senior nurse worked alongside staff on 8 wards, reflecting in the specific local context if a patient fell over. In analysing what factors may have been significant, the authors reflected on the enabling and constraining interactions for falls at the hospital by using written narratives and theatre improvisation. Improvising situations with theatre methods enabled us identify the following aspects as important. The way the senior nurse and staff in the present moments worked with questions like ‘what did you expect to happen’ provoked a shift in perspective on behalf of those present. Over time the shift in the conversational themes between staff changed the norms of their practice, with a nurse noting that ‘falls are now more in the front of my mind’. The importance of a third party who was a skilled practitioner by whom others would wish to be recognised was key. Similarly the importance of conflict and shame in negotiating work ethics - features previously viewed as destructive - are now seen as also potentially generative in the interactions that lead to changing behaviour and attitudes towards preventing falls.

INTRODUCTION

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One in three people aged over 65, and half of those aged over 80 fall at least once a year. Falls are the commonest cause of death from injury in the over 65s; and many falls result in fractures and/ or injuries. Falls cost the UK NHS more than 2 billion per year (Tian, 2013). In hospitals, falls are the most frequently reported patient safety incident, frequently resulting in fractures and/or head injuries.

The Brighton and Sussex University Hospital (BSUH) Patient Safety Team, were tasked with reducing the number of patient falls using an approach common in the National Health Service (NHS). Steps included; a project launch; action plans and target setting. Falls reduced slightly over 3 months, but this proved unsustainable. There was no statistical reduction of falls after a year. An emergent approach (Suchman 2011) was adopted with board support, the Patient Safety Team focused instead on the social aspects of human behaviours at the bedside. A senior nurse worked with staff on the wards, reflecting with them on each fall partly drawing on an ‘After-Action Review’ technique. (Serrat 2010). Data collected over the 5 years of this project demonstrated a significant decline in the annual falls rate, from 6.22 to 3.26 falls per 1000 bed stay days. This equate to 695 fewer patient falls per annum; a reduction of 48% ($p < 0.001$).

The Patient Safety Team wanted to explain what caused this dramatic and unprecedented improvement which they had initiated. They could not explain this using classical organisational theory or mainstream behavioural change theories. They had a hunch that this was related to changes in nursing behaviours spreading through hospital wards after the Senior Nurse worked alongside staff in practice, hence our collaboration and the writing of this paper.

The five authors are connected in the following ways. Mark and Paula lead the Patient Safety Team in B.S.U.H. Mark shared the draft of a paper they were struggling to write about this work with his former Director of Nursing, Karen. Karen engaged Mark and Paula to run workshops on falls prevention in Gibraltar, where she was Chief Nursing Officer. Karen and Henry

met each other studying for a Doctorate at the University of Hertfordshire, where Karen now works for Chris, who contributed to our workshop and this paper. Karen engaged Henry to run workshops at BSUH and in Gibraltar. It is from the complex interweaving of these connections that this work evolved. In other words, none of us can say really when the project started, and how and we do not consider it finished. So, if we cannot explain our approach in the tidy way of a project plan and method - how are we understanding human interaction and the emergence of novelty in the falls work?

We draw on the theory of complex responsive processes of relating (Stacey et al. 2000). We understand communicative processes as potentially transformative. In line with George Herbert Mead's (1934) concept of communication as processes of gesturing and responding: *'The meaning of a gesture by one organism is found in the response of another organism to what would be the completion of the act of the first organism which that gesture initiates and indicates'* (Mead, 1934, p. 146). This presents an opportunity to renegotiate the meaning of the interaction as it unfolds in the present. In other words - the meaning of what we say unfolds as we experience how others respond to us. This is a radical challenge to the prevailing 'sender-receiver' model of communication (Shannon & Weaver 1949) in which any transformation is believed to take place within individual minds as a result of pre-reflected intentions of managers and leaving communication to only convey what is already thought.

In this paper we seek to understand the social processes of communicative interaction that might help explain the dramatic reduction in the number of falls. Whether we see the change at BSUH as a change in culture; a change in management structure; a change in the individual behaviour or a change in routines; we understand all of these as a consequence of a change in the communicative interactions; in the interdependencies of relating of those involved. This theoretical approach (unfortunately!) would be inconsistent with any suggestion that by simply copying what Mark and Paula have done - a drop in the falls rate can be guaranteed elsewhere. Neither (unfortunately!) are we suggesting it can persist in perpetuity in BSUH. Instead, we have sought to capture the local context and the enabling constraints, in all their 'messiness', as they unfolded at BSUH. We make the case for seeking *attention points*, particular themes we become aware of as pivotal, and ask what might be generalizable about the nature of the interactions we describe.

METHODS: AUTOETHNOGRAPHIC NARRATIVES; THEATRE IMPROVISATION AND REFLEXIVE CONVERSATIONS.

We have chosen to describe what happened as rich auto-ethnographic narratives (Holman-Jones et al. 2013). We believe that nuanced description of the unfolding process, with all the inherent complexity, is important for reflexivity. We do this to avoid making generalised and abstracted conclusions devoid of local context - as is consistent with our theory of action. Stacey and Grif-

fin (2005) are similarly arguing for a detailed reflection of experience:

"Given that one can only really understand an organization from within the local interaction in which global tendencies to act are taken up [. . .], the insights/ findings of the research must arise in the researcher's reflection on the micro detail of his or her own experience of interaction with others" (Stacey & Griffin, 2005, p. 9).

The authors have engaged in intense conversations about what happened, and how to understand the nature of leadership involved in this project. We used improvised theatre method (Larsen & Friis 2005) as an invitation to deepen our understanding of the conversational processes that give rise to these themes. By improvising situations that are similar to Paula and Mark's experiences, we recreated an opportunity to critically reflect together on the dynamics of the local interactions.

Working with theatre improvisation can be seen as an invitation to spontaneity among the participants (Larsen & Friis 2005). In these spontaneous interactions, the existing power relations are not static, but continuously negotiated (Larsen 2005). Although working with imaginary scenarios, participant's responses build on their own lived experience. They usually start to see themselves and each other differently as a consequence (Larsen 2005, 2011, Larsen & Friis, 2005).

We have enacted situations that Mark and Paula accept "could be real." We use skilled actors, experienced in this way of working (Friis 2005). Paula and Mark watched and commented on the plays. We point to how this prompted a different recognition of what was happening between those involved in the particular situation. This not only revealed what was believed to be already known, but also created new insights and understanding - which we argue has the opportunity to transform the sense of self in relation to others. This was developed further in the reflexive conversations that followed the theatre sessions. (Larsen 2005) . .

MARK'S STORY

THE PATIENT AND THE RELATIVES

This journey began with the fall of an elderly patient on a hospital ward. He had been in hospital for several weeks following an emergency admission and was making a slow recovery. One evening, he bent to pick up his slippers and fell. He told staff who attended him, that he had used his bedside table for support and, when this had moved, he had fallen face down on to the floor. The nursing staff hoisted Mr X back into bed. He had a lump on his forehead and neck pain. A subdural haemorrhage was later diagnosed, from which he died some days later.

This story of a catastrophic fall whilst in hospital is, regrettably, not unique. The response is well rehearsed: an investigation is undertaken, if this finds shortcomings in the level of care, a report is shared with the family and an action plan is developed to reduce the likelihood of a recurrence. We usually find the family and incident

investigator forge a trusting relationship and the family appreciate the candour of the report.

This family were very different. They struggled to accept the premise that *to err is human* (Kohn et al 2000). They were deeply unhappy that the patient's bed rails were down and strongly believed that if they had been in the correct position the fall would not have happened. The lead investigator had difficult discussions with the family about who should be held to account for the fall. They wanted to know who was accountable and wanted someone sacked for the error.

One of the hospitals Directors intervened as discussions were going around in circles. As a charismatic communicator, my assumption was that he would find a way of reconciling the family with the reports' recommendation and assure the family that we had learned valuable lessons as a result of their loss

I'm not that clear why, but this strategy failed. Instead, he told me after the meeting that he had given his assurance to the family that the Trust's falls rate would be reduced. I did not know much about falls at the time, (other than we had about 1500 per year.) But I did believe that falls were part of the pathway to frailty; something that happens to sick people. I told the Director that this was a "ridiculous promise as everyone knows falls can't be prevented". His retort was a typical "you know what needs to be done Mark".

In discussing this, we were struck by the fact that these kinds of explanations are rarely told. Usually the public transcript, (Scott 1990) would cover over such conflicts – and be presented as management setting a clear target as part of a pre conceived plan. However, we recognise the fact that what happened next was different to what had gone before. We drew attention to the fact, that all the 'nice' relatives did not create a similar impact. It seemed that the difference/ conflict was a key driver in shifting a cultural norm of what normally happens next.

APPROACHING FALLS WITH ACTION PLANS

In the absence of a better plan, I treated the project like any other large corporate initiative; a big launch with personal invites to all the ward managers and presentation from the national expert on falls. The Director gave an inspiring talk reconnecting staff with the values that made them want to nurse; a consultant talked about reducing unnecessary sedation; physiotherapists role played the falls hazards for elderly patients on a ward. Unusually for the NHS, we are data rich when it comes to falls. Loosely applying a comstat model (Weisburd et al. 2004), we encouraged ward managers to identify patterns and differences in their data and to develop action plans based on what they had heard and what they discovered in their data. The day went well, the engagement was good and the ward managers identified over 150 actions to reduce their falls rate.

The first month's performance was good, with a steep reduction in the falls rate. The second month seemed promising, but in the third month the rate moved upwards. For the rest of the year the rate went up some months and down the next, always exhibiting normal

variation. The ward managers met frequently to review the results. By the end of the first year, opinions were polarised into four camps: those who felt we had committed to the wrong actions, those who suspected the actions had not been properly implemented, those who believed progress was being made, but the focus on falls had led to more falls being reported and finally; those that held a position that falls are not preventable despite everyone's best efforts. I offered these four scenarios to the Director prior to his follow-up meeting with the family at the end of the first year. The final count for the year had identified that the number of falls had barely shifted from the 1500 in the previous year. The Director had an uneventful meeting with the family.

In our discussion on the 'failure' of the classic managerial approach, we noted how disappointing results are often rationalised within the existing theoretical paradigm. We see the number of interpretations created by the involved in this light, and although they all may be valid, they did not seem to invite reflection on any further change. We also notice how the assumption is that the theory has not been applied correctly, rather than challenging the theory itself.

THE STAKES BECOME HIGHER

The story may well have finished there; but for an incentivisation programme implemented by the commissioners of the hospital's services. The commissioners held back 1% of the hospital's funding in order to encourage the hospital to make quality improvements. They felt the falls work should be included.

Despite my protestations that only one UK paper had been able to evidence a reduction in falls, the negotiations progressed, with the Director's approval (my relationship with him was strained at this point). A reduction in falls rate of 18% was set as our target, the number taken from another hospital that had reported such a progress. A penalty of £600k was set if the target was not achieved. As the project was not going away, I gave up trying to stop it and renegotiated the original deal. The scope of the project was reduced to eight elderly care and acute medical wards with high falls rates; including the ward of the incident. I also wanted to try something different. Although we had debated the issue of behaviours and leadership over the past year, I wasn't as keen on the Directors emphasis on the leader and was increasingly interested in the idea of followership.

IMITATION AS A STRATEGY

I'd just finished reading Buchanan's book; *The Social Atom* (2007); and we were talking about Michael Wesch - *An anthropological introduction to YouTube*. (https://www.youtube.com/watch?v=TPAO-IZ4_hU) They made a strong case for the importance of imitation in our social lives. Nicholas Christakis was making a similar case in his paper; *The Spread of Obesity in a Large Social Network*. (Christakis and Fowler 2007). Additionally at the time the Arab Spring was also playing out, giving credence to the power of imitation and that a small act; Bouazizi's self-immolation, can have very unexpected consequences.

We reached a point where we had found a common ground for our different perspectives and agreed someone should role model a new approach to falls management (i.e. a leader). What was more important (from my perspective), was whether others would imitate and follow that leader.

An idea of imitation, backed by literature and impressive changes in other parts of the world was apparently influencing Mark in his negotiations with others at this point. We later reflected that in human processes of relating, responses are rarely pure imitation. The reaction will become a response to the gesture created by the 'role model', but pure imitation alone cannot explain emergence of novelty (Stacey et al. 2000).

A NEW ORGANISATIONAL STRUCTURE

At that time I also had an emotional driver. I'd been given a new line manager. Actually, the new line manager had recently been given my job! He was ex-military and brought in for his leadership skills and he was obsessed by action plans and strategy. His appointment and manner were a sense of deep personal irritation. I was becoming increasingly cynical about the value of action plans and how the completion of the action plan seemed to be increasingly the end in itself, rather than any actual change in practice. Suchman's (2011) paper on Emergent Design seemed like a wonderful intellectual antidote to this managerial mind-set.

My Director was persuaded by this paper. This freed me from action planning and effectively severed any need to report to my new line manager. For the first time in 20 years I effectively had no job in the hospital. I had a bag full of left-field incoherent ideas, a falls project with an unrealistic target and a £600k penalty if it wasn't delivered. And whilst I had autonomy, I had not managed to free myself from accountability, as I was expected to give a weekly report at the Thursday Executive Safety Briefing.

At this time it might be obvious to the reader, that thinking of what happened until now at BSUH as a "best practice" others should copy is not making sense. Still, the flow of events, from the unsatisfied relatives, to the new target and Mark being 'released' from his job against own will are important as contextual back-story to the project.

THE ROLE MODEL KNOWS NOTHING ABOUT FALLS

If the project was about role modelling fall safe behaviour and hoping it would go viral, I needed someone who could work with this idea. Although a millstone, the high financial price for failure also provided an opportunity to bring in a senior nurse to lead the project. The choice of nurse was an easy one. I'd known Paula for a couple of years. I cannot remember how Paula found me, but I'd been reading Weick (Weick and Sutcliffe 2007) and Paula seemed effortlessly to make the connection between his analogies of managing warships and the challenge of running a busy ward. I believed she wanted to come and work in the Safety Team, and I wanted her to lead this project. She initially refused, eventually settling for the same remuneration as me. Our flexible application of personnel processes included

adding the title 'nurse' to my old job description. Three people were now working to my old job description, although only one had the job!

Paula started and dropped the bombshell that she knew nothing about falls. I never saw this as an impediment, as we'd had the input of the national expert on falls in the first year, and yet falls remained static. We settled into a pattern of working that was different and refreshing. For the first time in both our careers we only had one project to work on. We immersed ourselves in the data, incident form narratives and daily stories of ward life.

Paula spent her time between the eight wards and the office. In the early days I'd wander to the wards with her. The casual visits always seemed to follow the same pattern, we'd arrive together and within minutes I would be left standing in the middle of the ward, Paula would quickly disappear behind a set of curtains for what seemed like an eternity. It was an alien environment, fascinating to watch, but always slightly awkward as the outsider. It always felt far more comfortable when we'd gone to the wards to talk to staff as it provided the context for understanding what I was seeing.

We established a pattern of working (that we jokingly called praxis). Paula would do all the work (practice) and I would spend my time listening to what she doing and theorise. After every fall, Paula would try and undertake an After Action Review – essentially a debrief. As we did more and more debriefs, we confirmed my prejudice that staff doing the job hold the answer to doing the job better, but all too frequently in the NHS we don't ask them, preferring the opinion of external experts.

In the conversations we have noticed the rich conversations between Mark and Paula apparently emerging from the difference combined with a having only on one task. Paula's skills as an experienced nurse seemed to play a significant role. So what was Paula doing behind those curtains?

PAULAS' STORY

When I walk on to a ward I immediately get involved, immersing myself in the environment. I scan the area; I'm looking, making an assessment. What is happening? Are the patients settled, where are the nursing staff? It looks busy, perhaps even chaotic, there is a lot going on. The curtains are pulled around a few of the bed spaces, whilst personal care is being carried out. This impacts on the visibility for the patients either side of this area. The nurses behind the curtains can't see what is happening outside. There are lots of people, doctors, physiotherapists, pharmacists, all wanting the nurses' attention. The phones are ringing, relatives are enquiring about their loved ones. The staff look harassed, not knowing what to do next, there are numerous interruptions for them. It must be difficult not knowing what to do first. Experience tells me when patients want or need something; I take notice of their non-verbal cues if they are restless, rushing, or distracted. They don't have to say

anything. Prioritizing comes with experience and confidence.

Standing here, I can see the potential risks. Some things make me anxious, beds pumped up to their highest height so that the housekeepers can clean underneath the bed frames. They don't realize the dangers! They are just doing their job, but the patient is asleep on the bed and is a high falls risk, blissfully unaware of what is happening.

I have choices. I can pretend I haven't noticed and walk by, but that wouldn't be right, would it? What if he suddenly woke up and tried to climb over the bedrails? I would feel uncomfortable, guilty, *that's* not caring or compassionate care. That could be my Mum or my Dad in that bed, and I would want the best for them. I want to make a difference. Experience tells me what is going to happen next if I don't intervene. I cannot avert my gaze, I have to do something. It's intuitive. I can see the problems ahead. A patient getting up unsupervised that might fall over; another looking agitated who will probably try and stand. There are nurses not reacting for whatever reason, some perhaps because they are not experienced enough yet to *see* the risk. Sadly, this is something that may only come with hindsight, perhaps when their patient falls. Others, because it's busy and they have to make decisions in the moment, like attending to the acutely unwell patient, a cardiac arrest, the need to change an intravenous infusion. They are constantly juggling the acute needs whilst also aware of the elderly agitated and confused patient who just wants to go home.

PATIENT INSIGHTS

Unfortunately I only get to see patients once they have fallen, so I talk to the patient, their families and the staff looking after them. My objective is to understand. I build a picture of what was happening on the ward at the time of the fall, as well as gaining insight into the patient as an individual and as a person. Today I meet James, who is 86, and has dementia. He has been admitted to hospital because he has deteriorated at home and his wife is finding him increasingly difficult to manage. I have been asked to see him because he fell in the early hours after returning from the bathroom. I have read his notes. James is described as having decreased mobility, and looks unkempt and smelling of urine. I speak with his wife. She tells me about her husband, what he was like and how he has been at home.

I learn he was a RAF pilot, a proud and highly respected man who is used to being in control and in charge. She explains that his mobility has deteriorated and that he finds it difficult to climb the stairs to bed. She also mentions that he has had several "accidents", but that James does not like to discuss his continence problems with her; he's embarrassed. She tells me she has been waiting for the continence nurse to visit her at home to undertake an assessment for over 8 weeks now. Meanwhile,

she has been managing this at home, buying continence pads from the local chemist. It's the night time, when James wets the bed that she can't cope with. She says that when her husband walks out to the toilet with his wash bag it usually means that he is "wet".

James's is distracted and he wants to go home. The fall he had was at night time and related to toileting. His nursing notes do not tell me what his sleeping is normally like, or his toileting pattern, but I do know that the night of his fall, he had a disturbed night with frequent trips to the toilet. A nurse has noted that he wanted to have a wash in the night and had his wash bag with him. She thought he was just confused, thinking it was daytime. (If only we had spoken to his wife). The frequent trips to the toilet make James's tired.

My expectation for anyone with continence problem is that a continence assessment a toileting chart needs to be completed. I am disappointed they haven't been. Understanding that James needs to maintain his independence, but perhaps more importantly his privacy and dignity, I undertake a continence assessment with the help of James's wife, implementing a toileting chart and providing suitable continence aids.

I discuss James with the nurses on duty and ask them "hand on heart" did they feel we had done everything to reduce James's risk of falling. They reply that they have. I start to challenge. I ask the question, 'What were your expectations?' This gets us thinking. Falls are impacted by so many other things. We talk about toileting, assessment, communication, patterns of behaviour, sleep and dementia. It comes to light that the nurse had left the bay momentarily to collect supplies leaving James and others unobserved.

We reflect, look at what our options may have been with the benefit of hindsight and then I ask the question again. "Do you think we have done everything we could have?" This time their answer is different. A new understanding has emerged from our conversation.

So this gives us a glimpse of what Paula might have been contributing. From the insight we now have we notice that being an experienced and respected nurse, she can immediately get an idea of the situation at the ward, that is impossible for an unskilled outsider to obtain in the same way, and she finds a way to stimulate staff to reconsider the specifics of their practice in a local context.

At this point in redrafting the paper- we note the impossibility of thinking of these narratives as purely our own, since each iteration provokes new insights and affects how we make sense of this work as we discuss them together. For coherence, we have indicated attention points we conclude as important in italics to aid the

reader. In this next section- Karen and Henry reflect more fully on the themes that have emerged from our work. Thus we point out the influence of how the theatre work affected how Mark and Paula are included below- rather than above.

KAREN – HOW I CAME INTO THIS

Mark sent me a draft paper he was struggling to get published for advice. This was strong on data supporting the statistically significant claims for their falls reduction - but provided much less information about what it was they actually were *doing* together in practice. Mark had laughed, and said that was because they didn't know! They had a hunch it was to do with some kind of mimicry of behaviours of nurses who worked alongside Paula in practice as a role model when she went to visit them after a patient had fallen over to find out what happened. What they found more difficult was to specify exactly *what* it was that she was doing and saying in these micro interventions that seemed to be making a difference.

I also had a hunch. Having participated in improvisational theatre techniques with University of Southern Denmark in the past, I had noticed how it seemed a particularly effective technique for provoking conversations that other qualitative research tools such as focus groups, interviews etc. failed to articulate. My hunch was that this may be a research method for helping them to identify more clearly what they were doing together - in order that we could then open this up for further discussion and theory making.

I had invited my Hertfordshire and Kingston colleagues into the conversation because I had an intuition that our joint knowledge and interest in the complexity sciences could bring something new to the discussion. Marks' hunch about why nurses may be changing their behaviours also looked to complexity sciences to seek explanations from a radically different perspective. I thought they were doing this because the systemic approaches to organisational change that dominate the NHS – and are based on a linear understanding where it is possible to correlate cause and effect – had not given them an adequate explanation for something that puzzled them.

This resonated with my own critique of such approaches based on my research of implanting an NHS risk management strategy with Mark as part of my Doctoral thesis (Norman, 2005). Such approaches make assumptions that are taken so much for granted that it seems they are seldom questioned. These assumptions are that i) it is possible for leaders to make plans for and direct the organisation understood as 'system' through using tools like strategic planning and policy implementation, ii) it is possible to 'cascade and implement' such plans and policies through careful top-down communication of the blueprint or plan by those who designed it, iii) it is possible to set goals and targets for the 'system', measure these, and take action to restore to equilibrium if measurements fall outside acceptable levels (an idea taken from homeostasis in the natural sciences), iv) it is possible for leaders to develop policies and procedures (forms of simple rules) that are followed by those lower

down the structure to produce a uniform output.v) 'Best practice' is therefore transferable to other 'systems' through identifying what this is, codifying it through education, guidance and training and 'implementation', vi) it is possible to create or change organisational 'culture' by senior leaders identifying the mission and values for an organisation and then implementing these, vii) it is possible to ensure that in the parts of the whole system, the staff understand such plans through managers conveying clear messages (the 'sender-receiver' model of communication).

In this way of thinking, as Mark and Paula discovered, if the desired outcomes are not achieved, it is often assumed that the problem must be either at an '**individual**' level and the person who wrote the plan got it wrong or that those responsible for executing the plan must not be doing it properly, (i.e. a 'performance' issue). An alternative explanation is often that it must be a '**systemic**' failure i.e. at some 'macro' level that is the cause of the problem.

A third explanation also cited by their colleagues was that it was the **culture** that was the problem. Notice how these latter two lose the paradox that we hold to, it is **us** as individuals who together form our systems and culture- as they also form us.

THE CONSEQUENCE OF NON LINEARITY

In the non linear world of complexity science – the link between cause and effect is effectively broken. Changes are understood to emerge as a consequence of sum of the interaction between *all* agents, thus what each agent is doing or not doing together with other local agents creates emergent patterns. There is a sensitive dependence in which a small change in one state can result in large differences in a later state; the *butterfly effect* (Lorenz 1963). From such a theoretical perspective- it can be seen that paying attention to the small interactions that occur from moment to moment becomes crucial, since it is from these that global patterns emerge. So whilst any long term prediction of such patterns are accepted as impossible (for example- as in the weather), techniques that enable us to recognise such patterns emerging over the shorter term might help us in developing more skilful ways of responding to them.. Perhaps this is the behavioural equivalent of knowing when it may be worth packing an umbrella?

This is what I think improvisational theatre techniques are good at doing. They help us spot how patterns in human relationships emerge through all of our participation – and help to provide a deeper insight into the perspectives of everyone involved in order that we can develop a more complex understanding of what is happening. So we will now describe how we work in this way.

HENRY – IMPROVISING WITH THEATRE

We worked with improvised theatre at our first meeting in the UK, hosted by Kingston University. Paula and Mark brought up some difficulties they had with a dementia ward. We met again in Denmark, where my students were presenting work they had done with falls. We

recorded this workshop on video and transcribed parts afterwards.

One of the students told a story from her visit to a Danish ward. An elderly woman with a recent hip replacement and Alzheimer's, was seen by a physiotherapist and left in a chair behind a closed door, without an alarm, after treatment. Mark and Paula previously discussed this with the student via Skype, and suggested we improvise the situation on stage. The intention in playing this scene was to come closer to understanding how Paula and Mark may influence behaviours in a situation like this and see if we could identify generalizable features that may explain how nurses changed their attitude towards falls.

The audience included students and other local stakeholders involved in a students projects about falls.

We had two actors on stage, one playing the nurse that found the patient in the chair and another taking the role of the physiotherapist. In an improvised conversation, the nurse was asked by Paula to challenge the physio as to why she had left the patient with no means of calling a nurse; knowing she could not summons help if needed - and behind a closed door. The nurse tried, (rather feebly the audience felt!) - but this didn't evoke much of a response from the physio. The improvisation illuminated how the first instinct of the nurse and physio was to politely dispute each other's version of events - both believing they knew what 'really' happened.

Mark commented: I don't think that there is any learning. You (the nurse) might become a bit more cross next time or maybe give up next time.

What the audience recognised was how realistic this felt. We get cross with colleagues - but find it hard to challenge them. And when we do - if this is not recognised as a legitimate challenge by the other person - it is hard to challenge again. So it is easy to walk away and console oneself that you 'mentioned it,' but at the same time realise it is still not resolved.

Ten years ago Karen and I were exploring poor hand washing amongst some staff at the hospital. We played a situation on stage in which a nurse bravely challenged a Doctor who hadn't washed his hands. Initially her nurse colleagues praised her. Later when she insisted on challenging him again as she felt he had not taken her seriously, the nursing audience commented was that she was 'too much'. She has made her point, and as colleagues that are dependent of each other, they needed to keep up good relations with the doctors.

Similarly, it became obvious that in a situation like this, that most probably nothing would change; as Karen said: |

Karen: I can imagine in future, where the patient falls, and the nurse says; 'Well, I told her twice!'

The immediate recognition of this situation became intensively discussed among us. In a social understanding of change-it is not possible to locate the emergence of risky falls behaviour solely with the physio. She assumed the nurse would come after she had gone. Unless something happens to change that belief, it is likely to

happen again. But challenging another's practice is difficult - because we care about what people think about us. Power is also important- it is more risky to challenge peers or seniors.



Fig 1. Karen playing the role of Paula in conversation with actors playing a nurse and a physiotherapist negotiating a situation that might have lead to a patient fall. Paula and Mark are directing Karen's action.

In improvised theatre, we mix professional actors with people from the audience. In setting up a fictitious situation on stage, people chip in their experience, so the situation on stage becomes what we call a fictitious reality (Larsen, 2005). I thought hard about how best to set up this scene. We needed to see what Paula and Mark would do in a situation like this. I had the idea of letting Paula direct someone playing her. We only had two professional actors available, already playing the nurse and the physiotherapist. I asked Karen to take the role of Paula. At that moment I had a hunch that it may work, only finding later why. From the direct work with this scene, and the reflections that followed not just immediately, but also after seeing the video the following attention points emerged.

PRESENCE OF A THIRD PERSON

Paula's first action when she started was to visit wards that have had falls incidents. By following the interaction on stage we noticed that bringing new voices to the conversation (e.g. the student or Paula) offers a potential to transform the conversational themes. Karen reflected on this after the theatre scene in her role as the third person;

Karen: I would expect a certain constraint because the third person is there, it constrains their behaviour and they know this in some way. They are worried about what I might think. There is something in there about not wanting to be seen to a third party, who may have some kind of power or you value their opinion. You don't want them to think that you have done something dangerous to a patient.

It might seem a banal observation, but we find it important to notice that the mere presence of an outsider will potentially change the conversation. Mead (1934) noted that as humans we are able to take the attitude of "the generalized other" to ourselves.. By this he means we can anticipate how others in our culture will perceive us

and our behaviour. When an outsider is present the conversation between the insiders cannot stay private, but will inevitably be influenced as a result of the physical presence of another “other”.

ASKING ‘WHAT DID YOU EXPECT TO HAPPEN?’

Karen went on stage, and asked what happened, directed by Paula and Mark.

Karen: What happened, what did you do? (looking at both)
Phys: We had an exercise, the normal one, where she walked from the bed, I walked with her, then we crossed the room to ...
The physiotherapist (and the nurse) seemed happy to explain what they did, and I expected this to go on for some time. However, Mark and Paula reacted immediately: Mark: I think we should stop here. You are now into a narrative over what’s happened, which I think is the natural way we often play out these conversations. I wonder, if we take it as a different approach, if Karen asks ‘So what are your expectations?’ Rather than you describing what happened. Say – ‘What did you expect to happen? When you left the room what did you expect to happen?’

This was a surprising moment. Apparently Paula and Mark were less interested in *what* happened, but would focus on the anticipation of what staff would expect to happen next. This was significantly different from just “talking things through with people”. From the look of Paula’s face, and next intervention, there is no doubt that this “What did you expect to happen” is obviously a part of their ‘method’. This technique of exploring intention and using the imagination of those involved, invites an immediate change of perspective.

Karen: So when you left the room, what did you expect to happen?
Phys: Well I expected that eh that the nurse would come and take .. the patient
Paula (directing Karen)– in a sharper tone: I would ask, so how she expected that to happen
Karen How did you expect that to happen
Phys: eh.. expect what
Karen: How did you expect that to happen
Phys: (hesitating again) .. eh .. expect what
Karen: The nurse to come. Did the nurse know they had to come or had they told you or..
Phys: Yeah – yeah that’s what we have negotiated (looks at the nurse)
Nurse: No I didn’t know she was taken out of bed and put in a chair

Watching the situation at stage it was obvious that the physiotherapist could not answer this question easily. The actor did what we agreed most of us would do. She knew what was being asked about, but she avoided responding. She had to question her beliefs and felt anxious. Paula persisted, without hesitating, with an even more challenging question; ‘How would you expect that to happen?’

Being asked about one’s professional imagination by a third person provokes shame if one cannot give a good response. This is in line with Aram (2001) who understands shame as produced by transgression against the rules of society others can see. Here the actor playing

the physiotherapist can feel the shame of not being able to respond to the question.

During the work, people from different wards reported that when Paula asked the nurses to account for what had changed, they replied: ‘Falls just seem to be more at the front of my mind’. This made Karen think about how she changed her own nursing practice? She suggested this might be connected with a sense of shame of doing something in a less than perfect way. After an initial defensive or resistant response- one might come to accept a new understanding that was more helpful than the one before. This involved an internal dialogue about her own beliefs on what is the right thing to do, which may call into question what we did before, evoking shame and guilt. She said; ‘As my understanding changed-so did my practice.’ This is a radically different way of understanding from one that posits we formulate a theory, which we then “*put in*” to practice.

With this perspective in mind, we now can see how questions like “what would you expect to happen” raised by an experienced third person may radically influence behavioural interaction.

In asking this question Paula and Mark are influenced by the method of ‘After Action Review’ (Serrat 2010). After Action Review originates from the military, but is now widely spread into the public sector, including hospitals as a form of group reflection; participants review what was intended, what actually happened, why it happened and what was learnt.. By reviewing what was intended, the literature advocates that participants divide the event into discrete activities, each of which had (or should have had) an identifiable objective and plan of action. They stipulate that ‘rank should be left at the door.’ The facilitator should ask ‘what actually happened?’ and state; ‘This means the team must understand and agree facts about what happened. Remember, though, that the aim is to identify a problem not a culprit.’

The thinking behind ‘After Action review has roots to the thinking of a Learning Organisation (Senge 1990; Garvin, 1993), in which the individual is seen as a part in the whole; the learning organisation. Stacey raises a critique of this in which he notices that only people can learn, and that learning cannot be understood as an individual activity, but only an activity of interdependent people (Stacey 2003).

We noticed how differently Paula and Mark are working with the After Action Review question. Their focus is on the interaction; it is not just what Paula says to them - but about how they respond – including their internal dialogue. This resonates with what we saw in the play and in the reaction from Paula and Mark, which problematised i) the notion of ‘leaving rank at the door’, ii) the notion that the team could reach consensus on what happened., iii) the notion that we can document ‘lessons learned’ and issue these as new protocols for best practice – as these are taken up in different ways depending on our previous experience.

So we conclude, that the way the question is asked is far beyond the idea in After Action review. The question is asked as an in-the-moment action, a critical question that in the present moment confronts the engaged professionals with their own practice- one that evoked feelings of guilt and shame and raised anxiety. This leads to our next attention point.

A PROVOCATION OR CONFLICT

Mark and Paula initially responded to questions about staff resistance by saying; 'There wasn't resistance from staff - because the suggestions for change came from them.' None of us initially challenged that assumption. However, in the play, the response to the question "What would you expect to happen," made us think more deeply about whether the suggestions really just 'came from them,' and whether the processes involved in emergence of new behaviours were always non confrontational. After our first event, the involved actor sent an email about another improvisation we all did together;

(I noticed) the apparent contradiction between Paula and Mark's comments that the staff..were quite open and positive in the conversation..- and the experience of the three of us playing the 3 staff of feeling criticized, attacked and resistant

Thus the theatre technique afforded an insight into what might be happening in other situations, e.g. when Paula asks the staff about whether 'hand on heart' they did all they could for James. When Preben, (the actor) said he *had* felt defensive when questioned in his role, Paula - she admitted she had felt upset about this - even to the point of checking back with the nurse in her original story whether this was the case. Our point is not whether the original interpretation was true or not- but why we are so resistant to the idea of being perceived to evoking resistance? Why is this seen in such a negative way? Is this because of an ideology around organisational change that privileges notions of consensus building and empowerment? ('Leave rank at the door?') And that Paula's sense of identity was also shaken when she felt mis-recognized. When we discussed this, we posed a different question. What if resistance, recognition and mis-recognition are essential pre conditions for understanding the behavioural changes in nursing practice that appeared to have led to the reduction in falls?

Furthermore, it can be argued that recognition is far more than an unconditional positive regard - of 'respecting everyone'. Maybe the critical questions are also felt as a deeper recognition of the work, of the core values and beliefs about what it means to be 'a good nurse,' leading to further reflection about professional identity? That we take our own- and others- experience seriously? The question that still remains is when, how and why such challenges are accepted by those involved, since we all agreed that not just any other person would do - our next attention point.

BEING RECOGNIZED AS A SKILLED PRACTICIONER

Reading Paula's narrative reveals her expertise. Over time, Paula and Mark have developed extensive knowl-

edge on falls, but we found what is at stake is much more fundamental; being recognised and recognising oneself as a skilled and competent practitioner. Late in the play the nurse and the Physiotherapist came to a point that some recognized as stuck. Mark said: "There has been some kind of movement, let's try and build on it", while Paula flatly rejected this as good enough: "they haven't come up with a clear plan".

In his work, Honneth (1997) notes that recognition is a physical act. Theatre interaction enables reflection about the impact of the physical interaction. When Karen, went on stage in the role of Paula, it worked well since they cannot *not* act as the experienced nurses they both are. In their reflection, the actors explained that this gave Karen a natural authority. So, it is not merely the presence of a third person engaging in the challenging conversation. We propose it has to be a person that other professionals want to be recognised by. This is important, because in today's performance culture, the NHS is replete with auditors whom clinicians often feel make judgements on aspects of their work they are unqualified to make. We agreed Karen's presence, as someone with nursing knowledge was important. The actors said it was because they felt she had credibility and that was important to how they responded - "rather than feeling like a kid being told off by the teacher." And Karen said she felt their respect-which influenced how she participated. Note again how this is a social process.

DISCUSSION

Our challenge has been to describe the emergent nature of our work together-in all its confusion and messiness-as a way to show how we developed a deeper understanding of how nursing behaviours/attitudes towards falls changed in BSUH. So how might we explain this now?

Mead defines 'attitude' as a 'generalised tendency to act.' Marks' initial hunch that we are somehow influenced by how others behave- and may copy them was a helpful starting point, but this work also showed us that mimicry alone could not explain how genuine novelty emerged. Similarly- the idea of a blueprint to learn lessons - cited in the After Action Review tool; ideas of splitting 'problem from culprit,' and suggestions that power is something that can be 'left at the door' are assumptions this work has challenged. Our research indicates that it's not just how sensitively or not someone poses problems - it is also about the internal dialogue we have with ourselves. We suggest values play a crucial part of that internal dialogue. Dewey (1934) describes values as a 'voluntary compulsion to act' and values therefore have a potential motivating and enabling call to action in our everyday life. They assist us in choosing from our desires what to do because we will be judging whether the intended outcome of our action is "good". In making this judgement, we take account of what Mead calls the "generalised other" - which is our capacity to take on the attitude of our social group and consider what they might think of such a choice. Norms are described as constraints, the "ought", which may constrain our choices of action because in our society or

culture certain ways of acting are not acceptable to others, or to ourselves (Stacey 2011). We believe from our research that this accounts for the how the paradoxically enabling/ constraining; conflictual /supportive conversations between Paula Mark and the staff reflect a negotiation of the values and norms around attitudes towards falls which provoke or restrain certain course of action. It is the process which quite literally enables us to change our mind- noticed by the nurse who said; 'It just seems (falls are) more at the forefront of my mind.' For her, this is a live question- a constant testing of values and norms of her practice. What would Paula and other think about what she is doing? How can she account for it?

We show how the theatre method is thus consistent with our theoretical and methodological emphasis on narrative and plot. This is why the question 'what did you expect to happen' is such a significant one. People are invited to understand themselves as someone with agency in an ensemble of players who have potential to influence the way that the play unfolds. We see a strong link between narrative method and the narrative-like quality of experience. Theatre is also narrative-like, giving people another change to re-experience, or to experience things differently. We argue that the systemic approaches BSUH used in the unsuccessful first year cover over agency, (i.e. what people are doing), because it recasts them as parts serving the whole.

Alasdair MacIntyre (1981) makes the case that we are constantly re-narrating our story in relation to others, and we come to accept that we figure, sometimes as minor players, in other people's narratives about themselves. We suggest that the theatrical method allows for this explicit re- narrativisation because it takes place publicly. It is a kind of open reflexivity which is bound to affect people's private conversation about themselves. The latter is consistent with Mead's definition of mind, (i.e. humankind's unique capacity to see oneself as an object and converse silently with oneself – 'thinking'.) Re-enacting and re-narrating allows for a change of mind about themselves for those involved, which holds the potential for transforming both the individual and the group both at the same time.

We now recognise from these improvisations that the behavioural changes to emerge do so as a result of the interdependency and micro interactions of *all* of those involved. It is not something located just 'in' Paula, the leader. She also changes her practices as role model. Thus this is not consistent with a sender – receiver model of an expert imparting knowledge to a subordinate. Together they are changing their understanding of the context and assumptions about why patients fall. We now question any notion of leadership being located within individuals, suggesting instead it is a social phenomenon, based on Stacey et al's understanding of change in human organisation emerging through human interdependency and the interweaving of conversational themes - in which patterns can either remain stuck or be transformed.

Linking this to our theme of conflict and resistance, we suggest that theatre allows for the conflictual negotia-

tion of different possibilities – things don't have to be the way they are, we have a chance to renegotiate a different future together in the present. We also suggest from this work that anxiety appears important for novelty to emerge. But we also propose that too little anxiety can lead to repetitive and stuck patterns of behaviour; too much anxiety and people become paralysed (as they might with targets and punitive sanctions). But anxiety which provokes the paradox of trust/mistrust (with no suggestion that this can be manipulated) might just create greater possibility new ways of acting to emerge.

Drawing on Mead, we argue that theatre may be a way of bringing alive the social object 'caring for patients' for nurses. So Mead argues that our ability to take part in social life depends upon our capacity to take in all aspects of the social object to ourselves. Paula, and Mark found theatre to be a useful way of making the social object, 'preventing falls' or 'good caring nursing', an accessible way to bring alive for them their own part in it – and one we would like to develop in future with more nurses involved in falls work.

Finally, we have to acknowledge serendipity, which Mark and Paula's stories seem to bring in again and again. But alongside chance, comes the capacity to recognize what the chance offers in the way of possibility. It is possible that what the re-enactment of play-lets allows for, is the potential of small differences of gestures amplifying up into something significant which the 'logic' of theatre allows for. In management terms, we could think of it as a kind of live scenario planning; a very different concept to Marks' dreaded action plans.

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