THC 72/378

PROJECT ON

COORDINATION OF SERVICES FOR MENTALLY HANDICAPPED

THE USE OF CRITICAL INCIDENTS AND THE GAPS THEY CAUSE AS A TEACHING & TRAINING DEVICE

SAB/SS

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FOREWORD

The project on Coordination of Services for the Mentally Handicapped was initiated by the King's Fund nearly three years ago, to test the thesis of Professor R.W. Revans, the Chairman of the Working Party, that real and meaningful improvement in the service could effectively be achieved through the involvement of the providers of the service in a systematic examination of it.

At all stages of the development of this project the providers of services, from seven local authorities and two hospitals, helped in the design of research, construction of 16 different questionnaires, completion of fieldwork and the analyses of data collected. The final report is now being revised to be presented to the King's Fund in September 1972 for publication.

In the course of this project the idea of collecting critical incidents was suggested by some of the participants to elicit gaps in coordination.

On the basis of these suggestions Diana Cortazzi, a senior clinical psychologist, and an active member of the Research Advisory Group supervising this project, developed a technique of using critical incidents as a teaching and training device. To begin with Diana Cortazzi used this approach in her own hospital, St. Lawrence, and found it extremely effective. Some illustrations from the community services were also received.

Considerable amount of time has been spent on discussing this technique with student nurses, nursing officers, training project officers, health visitors, social workers etc. As will be seen from the following pages more than the critical incident it is the personal involvement of those reviewing the incident that seems necessary before the gaps can be discovered and presented for discussion. In the words of Professor Revans "our task is to get those in contact with the patient to introduce into their compassion and into their professional responsibilities the structure of thinking and of doing that enables them to translate the here-and-now-and-me-and-the-patient into the future-and-somewhere-else-and-the-patient-without-me."

The technique described in this booklet can be used as a basis for teaching students or for refresher courses; by anyone involved in management and in creating a total care team; by senior managers concerned with discovering the basic causes of any critical incident which may threaten to disrupt a team, and with developing ways of preventing such occurences.

We hope to develop this technique further and to prepare it for wider use. We need from local authorities and hospitals, and indeed from other settings, comments

and criticisms, advice and suggestions to help us develop a meaningful teaching and training technique.

This booklet has been prepared in a draft form. We will welcome from you any ideas or illustrations on improved presentation.

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INTRODUCTION

WHAT IS THIS ABOUT?

i. Aims
ii. Definition of terms
iii. Specific objectives
iv. Plan of booklet

i. AIMS

The aim of this booklet is to develop a method of teaching and training which is guided by the students themselves. The tools are incidents in the work situation which demonstrate a serious gap in the service to a client.

It is the members of the group themselves who decide upon a critical incident to be discussed - an incident which must have been experienced by one of the group personally; the group then decides upon a method of analysis in order to discover the critical gaps in the service which caused the incident, and they themselves develop a form of diagram or pictogram to clarify it. The ideas on how the critical gaps might have been prevented and on how to project into the future to avoid similar occurrences, come also from the group. Teachers or tutors adopt the role of chairman, or conductor.

The basic belief underlying this method is involvement: since the topic is chosen by the group from their own world, interest and motivation are immediately aroused; since it is their world and not that of lecturer or tutor, the classroom becomes a practical workshop and is unlikely to be divorced from the realities of the job; since it is their world, the emotions involved are their own, first-hand experiences. For all these reasons, learning is likely to be highly effective.

As a method of training in team-building, the analysis of critical gaps which affect the efficiency or the service to a client has the same benefits; interest - because the experiences are personal; emotional involvement for the same reason; and practicality, since the incidents are real and (changing as they obviously do with each new group) continually up-to-date.

Finally, for all members of a team - whether professionals or not - to understand each others' roles and behaviour, it is essential that they learn to see things as the others in the team see them. In this way, individual responsibility for the group as well as group support for the individual become clear. This is again one way of learning which is constantly topical, changing and developing as the gaps are narrowed and closed.

ii. DEFINITION OF TERMS

A Critical Incident, for the purpose of this project, is an occurrence detrimental to the well-being of the client. It has a strong emotional content and has been experienced by the person who brings it for discussion. Something goes wrong, an action takes place (or is omitted) which causes the client to suffer in some way: there is a failure to provide him with the adequate and efficient service he needs.

Such an incident can affect the client directly, or indirectly through its effect on the staff concerned with his well-being.

The incident illustrates some kind of gap in the service to the client, whether this gap is in communication or in understanding of roles, in co-ordination or in leadership, in consultation, in clear objectives, in provision of services or in interest in the job to be done. There may well be other types of critical gap yet to be observed: it is hoped that those using this booklet will discover them.

There is a clear distinction between critical incidents and case histories: the objective here is not merely to describe, but to examine the causes of the incidents by studying the GAPS in the service. It is an analytic, and dissecting process, highlighting a moment in time when something might have been prevented, IF ... It is also a dynamic process, since it is essentially a forward looking technique. The study of critical gaps is not a series of post-mortems: it is an attempt to provide a constantly up-to-date means of improving the service given to the client.

The client is the term used throughout for simplicity to cover those to whom a service is given, whether it be to residents, to patients, to trainees, to clients, or just to people. If any better word is suggested, this term can be changed.

The staff is used similarly as a term embracing both professionals and non-professional, unqualified or ancilliary staff - again to avoid repetition of the different terms in use in the various services.

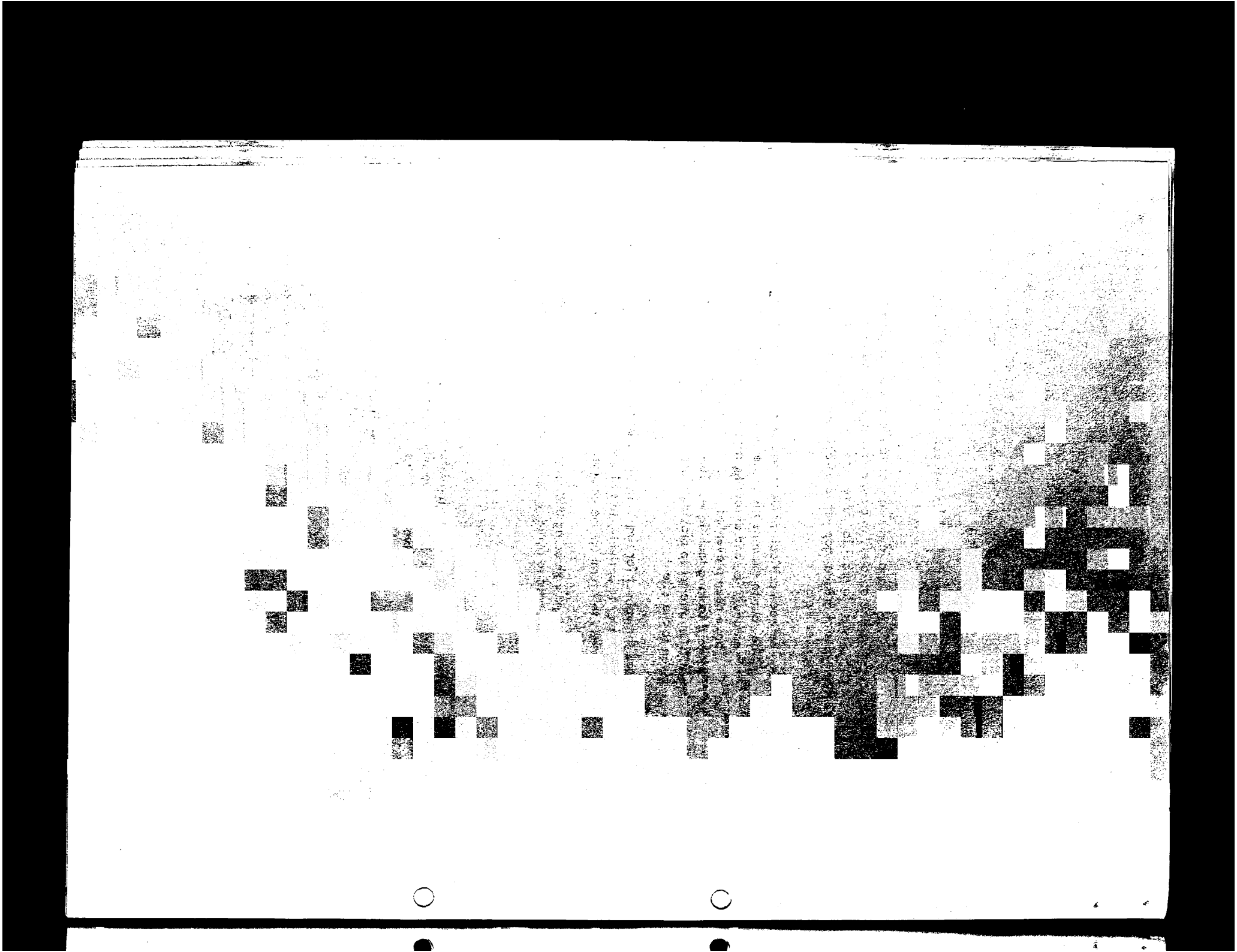
iii. SPECIFIC OBJECTIVES

It must be emphasised that the purpose of collecting information for the analysis of critical gaps in the service to a client is not to criticise adversely nor to condemn: it is of no interest to apportion blame - which is to live in the past.

The purpose is to provide a meaningful, active and creative situation which is highly constructive and positive, and is essentially forward-looking.

In such situations - personal, emotional and real - analysis of the gaps in the service may be scanned with a view to building bridges, and to developing an attitude of mind which considers the interests of the future rather than dwelling on the past. We need to consider the pettiness of today since a series of trifling incidents may lead to a serious occurrence; but the major consideration to focus on is the interest of the client and therefore of those who provide the services to him.

Involving those in the group by using incidents from their own experience as a basis for learning has the following specific objectives:



a) by examining WHY particular gaps occur, to learn to recognise danger signals well in advance and to take preventive action.

b) by taking incidents from the experience of a particular group in a particular sphere of service, to develop an active understanding of and support for, each other's roles - not only those roles in general, but as seen by each person in a specific situation.

c) by analysing a critical incident in this way and thus becoming aware of the moment when the gap might have been prevented, to focus away from the negative: WHO was responsible? to the positive: WHAT needs to be done? This becomes a creative learning situation, since it is seen that neither apportioning blame nor devising rules is likely to be as effective as developing a constructive attitude towards colleagues and keeping the client constantly at the centre of one's thinking.

iv. PLAN OF BOOKLET

Firstly, a short description of the mechanics: how the critical gaps are clarified in a group. This is followed by an indication of the advantages of developing diagrams, however simple.

Next, some examples of actual incidents are given. These are dramatic or humorous, serious or trivial, concerning all levels of staff and a variety of disciplines. The particular incidents quoted here happen to concern the mentally handicapped in a number of different hospitals: others analysed so far have come from the social services, from local government or local authority and from the world of education.

The examples are given only to suggest the scope of the method and are not intended to be set pieces inevitably to be discussed in class. In actual teaching or training sessions, it is basic to this method that the incidents to be analysed should come from the group itself. The process is essentially a dynamic one, and cannot be dependent upon the static lines of a text-book.

After this comes a brief outline of some problems that may be met in discussion.

The second chapter considers some constructive ideas and actions that have already begun to emerge: again, other staff in other areas may have different experiences to add. Both these chapters are merely sketched in to whet the appetite of those using this draft.

The third chapter demonstrates one actual session, for the benefit of tutors or teachers who like to have a concrete example in front of them before they start.

Lastly, a list of questions that have been posed is given with the object of finding the answers from a wide variety of people who have actually used this booklet. This will help in the planning of the final version for publication.

> To repeat: this is a rough draft only. Perhaps you, who are using it, have ideas for expanding it or modifying or re-designing it. In this, we need your help.

CHAPTER ONE

HOW DO WE START?

i. The mechanics

ii. The use of diagrams

iii. Some examples

iv. Possible problems

i. THE MECHANICS

a) An incident is experienced with a strong emotional reaction. It results in some sort of disservice to the patient and perhaps in problems for the staff.

b) The incident is described to those concerned with the project, usually by someone involved personally or who has witnessed it. The first report is often emotional, muddled and lacking in detail.

c) The incident is discussed by the group and attempts made to clarify its origins, with the emphasis on understanding the gaps rather than on finding a scapegoat.

d) When the story seems complete, the main characters are listed: at this stage, some characters are seen to be merely on the fringe and may be omitted. Next a diagram is constructed. This is not only a more compact way of conveying the essential ingredients of the episode, it is also more vivid. At this stage it frequently becomes apparent that not sufficient is known about the background and the people concerned to evolve an adequate diagram, and one has to return to the source.

e) There are times when the story as presented will not fit into a diagram. In searching for some way out of the impasse the incident may have to be looked at from a different angle, or the starting point be reconsidered, or the story streamlined and details which are then seen to be hindering clear thinking, omitted. The diagram itself then becomes an important part of the exercise in helping us to restructure our thinking.

f) The gaps in the incident may then be measured against the ideals and the satisfactions of those involved: why did they take up this work, why do they stay, what gives them a satisfying day? And how do these factors (if at all) relate to the gaps?

ii THE USE OF DIAGRAMS

The purpose of collecting these episodes is a positive one: at an early stage, however, it became apparent that the objective could be lost in the emotions aroused by the incidents and one reason why diagrams were developed was to reduce the temperature. Other reasons were:

i. Diagrams are a compact way of summarising an incident, a skeleton which makes an immediate and vivid impact. The first advantage is in clarifying one's thoughts, since the very act of drawing a line from A to B, or A to C, or B to K involves a very definite knowledge of the information one is trying to convey. Lines, unlike words, cannot hide woolly thinking.

ii. In constructing a diagram, the actual geography of the incident may become apparent for the first time. For instance, it was not until the idea of a second type of diagram for "Peter's Leg" took shape that the isolation of the OT Department became apparent.

iii. With the action of constructing such a diagram comes awareness of the 'beat' that each person involved should tread in order to ensure coordination. It is only when one has tried to make one's pencil follow an impossible path to link two or three persons, that one realises that these people may themselves find the link a difficult one to maintain. The actual route for the Social Worker from the doctor's office to the psychologist's and thence to the OT and the Voluntary Worker teaching road drill, would in fact have been quite long and time consuming in the case of "Peter's Leg".

iv. The diagram also usually makes it clear at what points positive action could have been taken to prevent the incident - a useful teaching point and one which is certainly not always clear in the verbal form of the story.

v. Diagrams do not always work on a straight forward time basis however, although it is a surprisingly difficult exercise to break away from the A-to-B or January-to-June rigidity of thinking: perhaps this in itself a contributory factor to poor co-ordination. In cases where it can be done, it certainly can throw a fresh light on the mechanics of the incident, and draw back a curtain to reveal new ways of dealing with such incidents, as happened in the case of "The Pink Daisies".

vi. Finally, diagrams can produce a short and simple formula which sticks in the memory as an aid to solving the problem of "the-future-and-somewhere-else-and-the-patient-without-me". Such a formula, for instance, as: "How to change red lines to black?" (red lines were used originally in the illustrations to denote poor coordination).

iii SOME EXAMPLES

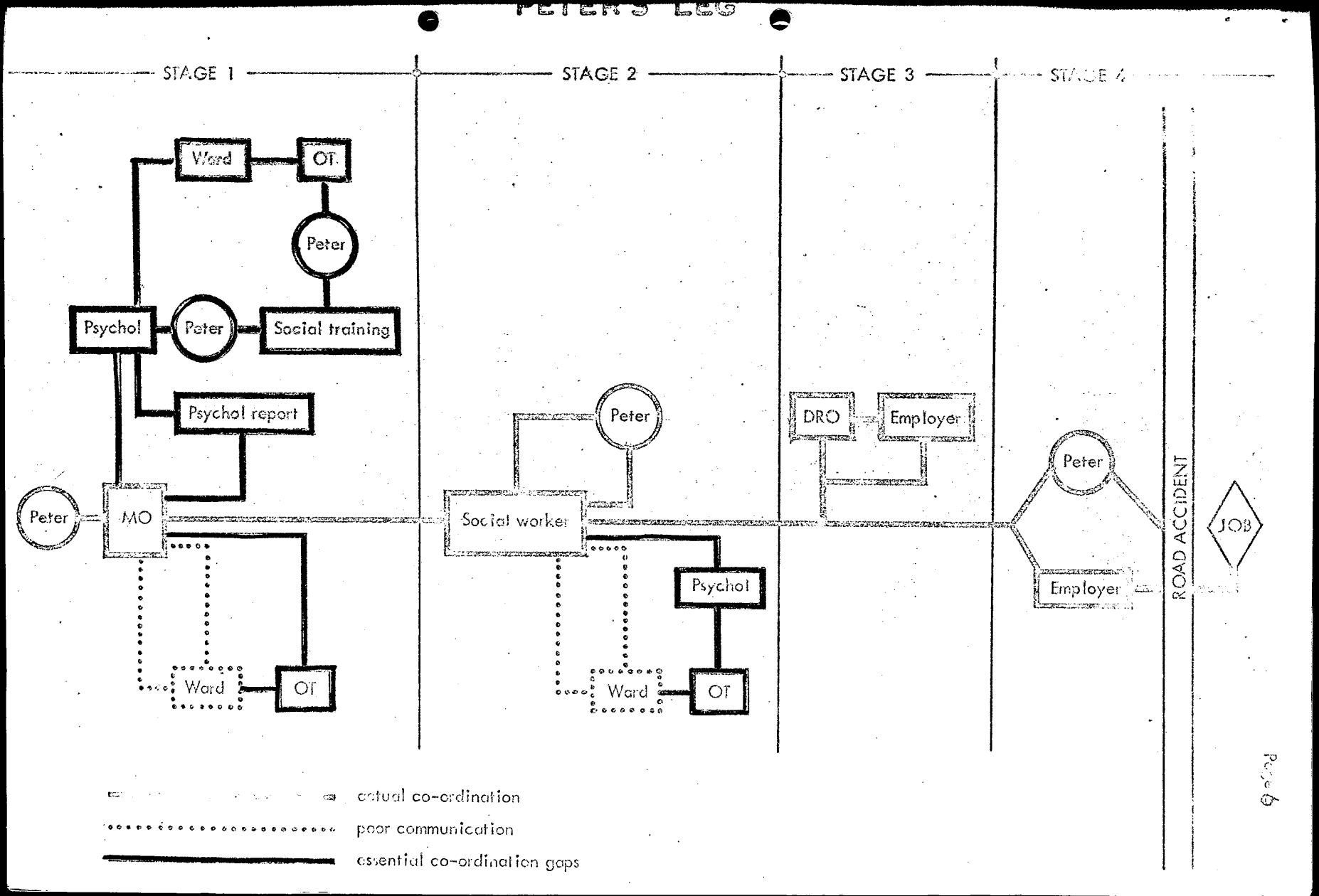
A. PETER'S LEG

a) The incident ...

Peter - a patient in hospital for the mentally handicapped - was knocked down while crossing the road on his way to his first outside job. His leg was crushed. A number of responsible people had known by word of mouth, or had suspected, that Peter was unaccustomed to crossing a busy road alone. No one spoke, no report was called for, no case conference was held. Peter was unable to work for six months.

b) Analysis ...

At first sight, this looks to be an obvious example of non-communication: nursing and occupation staff in several parts of the hospital, as well as the psychologist, knew that Peter never went out without two friends, crossing the main roads with one on either side. Peter's friends knew he could not cross alone: but no one asked them. Those who knew were not deliberately withholding information. They were not asked, or it was not their business, or "he'll be all right".


PETER'S LEG
STAGE 1
STAGE 2
STAGE 3
STAGE 4
Ward
OT
Peter
Psychol
Peter
Social training
Psychol report
Peter
MO
Ward
OT
Peter
Social worker
Psychol
Ward
OT
DRO
Employer
Peter
Employer
ROAD ACCIDENT
JOB
actual co-ordination
poor communication
essential co-ordination gaps

c) Diagrams ...

The first shows in a startling way the lack of communication. This type of diagram, however, offers no suggestion as to the critical periods in the story, nor can it pinpoint the exact meaning of the blanket term "communication", or suggest any remedy for the situation.

The second was developed to highlight in a positive way the points in time at which the incident might have been prevented, and in doing this, it became evident that it was not communication but ignorance of the roles of those concerned that was primarily the cause of the accident. The medical officer thought the psychologist was concerned only with intelligence tests, not realising that the assessment of social competence - including road drill - was also his province. Nor did he realise that the psychologist had close contact with the occupation unit in the capacity of advisor. The social worker was also ignorant of these facts. Both were also unaware (as were the ward staff) that one of the voluntary workers' roles was teaching road drill in that particular unit. The social worker might have seen his role as checking on Peter's ability in traffic, but in fact he stopped at the point of finding him a job. The psychologist was going through a phase of apathy.

d) Constructive thinking ...

This episode might have been prevented ...

IF ... i) The patient had been at the centre of each person's thinking

IF ... ii) The medical officer had known the role of the psychologist, of the OT, and of the voluntary workers.

IF ... iii) The social worker had been aware of these roles.

IF ... iv) The social worker had been alert to his own role.

IF ... v) A supportive type of case conference had been held.

IF ... vi) Individual responsibility had been developed.

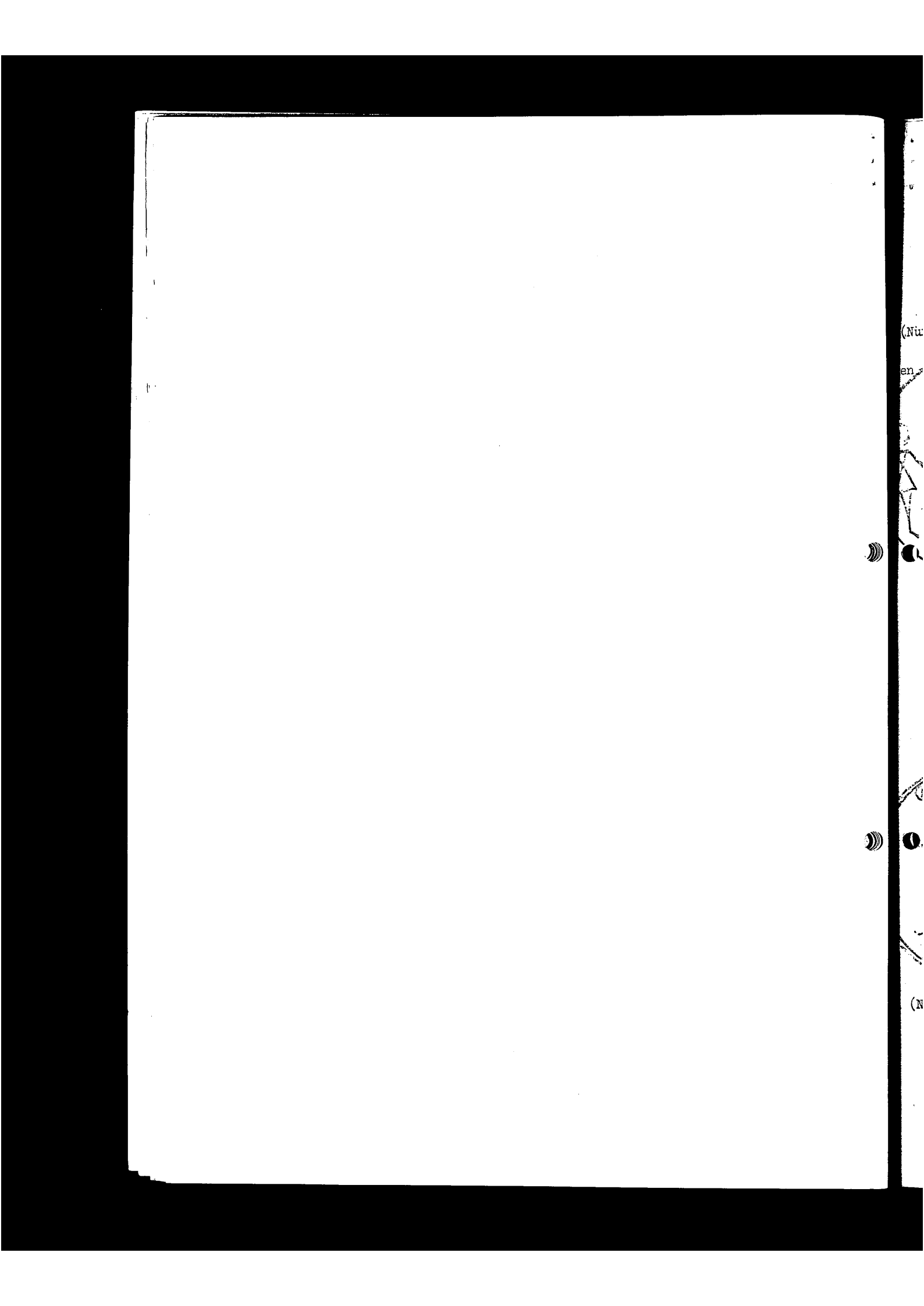
IF ... vii) Involvement had been intensive enough to combat apathy.

Peter's leg is primarily a story of ignorance of roles, though it has many other facets and is rich in teaching material.

B. THE PINK DAISIES

a) The incident ...

Nursing assistants in pink uniform were working in a special unit with incontinent adult patients, teaching simple educational skills. When the patients wet their pants, they were sent to the ward to be changed. The ward returned them to the unit, still wet, with the remark: "You're dressed up as nurses, you change them".



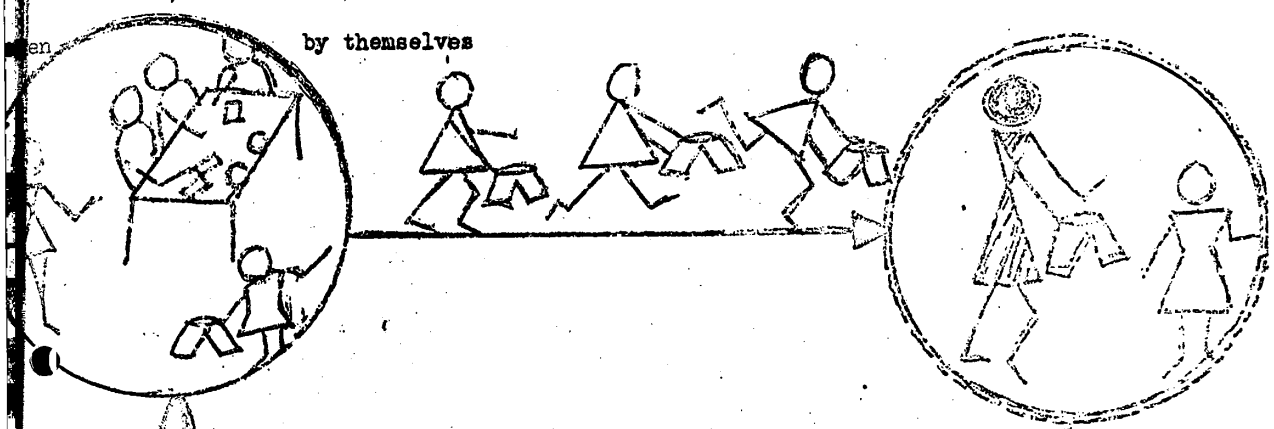
THE PINK DAISIES

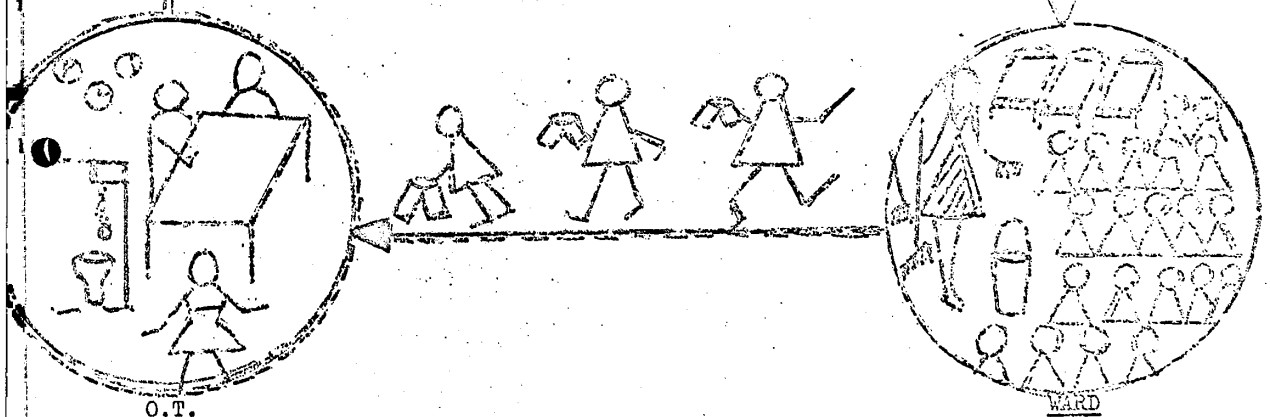
Misapprehension of Roles.

Poor Co-ordination

O.T. (Nursing Assistants) as seen by themselves

WARD as seen by O.T.





O.T. (Nursing Assistants) as seen by Ward

WARD as seen by itself

The patients were shuttled back and forth in this way for some months. At one stage, one side took the wet pants off, and the patients went bare, in winter.

The immediate controversy was ultimately solved, but the lack of communication and coordination between trained and untrained staff continued for a number of years.

b) Analysis ...

This episode, like other stories, has a wide application in various forms, and indeed was familiar in essence even to first year students in a different hospital.

On the surface it is an amusing anecdote, a beautiful example of 'tit-for-tattery'. But investigation of the episode reveals a number of deeper bayers.

Since those concerned in this incident have now retired, the story can be examined in greater detail, to show how an overtly trivial incident can have its roots a long way back, and can involve other elements than those apparent in the horror story as originally told.

The following is the sequence of events:

1. Consultant ASKS Psychologist to start a special unit.

2. Consultant then TELLS Senior Nursing Staff he has done so.

3. Senior Nursing Staff, displeased at not being consulted, INFORM the ward staff in such a way that they do not support the project.

4. Psychologist TELLS the ward; the atmosphere is in any case already negative and goodwill is missing.

5. Pink Daisies arrive on the scene: paid as Nursing Assistants they wear pink overalls - unlike other Nursing Assistants who were in uniform. Unlike them also, they work a five-day week.

6. Pink Daisies are put directly under the Psychologist by the Consultant, and so do not regard themselves as nurses. The ward staff, knowing their title and status, do regard them as nurses.

7. To add to the confusion the Pink Daisies can order any equipment they wish to have through the Psychologist, whilst the ward staff, ordering through a different channel, are very restricted and always short of play material.

8. The matter is never explained to either party by any of the senior staff concerned.

9. The horror story episode occurred many months later, and the effects in the misunderstanding between ward and occupation unit continued for a number of years.

c) Diagram ...

The ingredients of the Pink Daisies are common to numerous other incidents: lack of multi-disciplinary consultation; lack of professionalism in senior staff (who were also playing tit-for-tattery); not putting the patients at the centre of one's thinking.

But the Pink Daisies episode refused to conform to a diagram and took on a life of its own. It gradually became obvious, in discussions, that each side in the dispute over the wet pants was seeing itself in a mythical role and its rival in a false one.

The pictogram which resulted makes an immediate impact as a teaching device, and since similar incidents seem to be widely experienced, the Pink Daisies makes a good start to a discussion on Roles.

d) Constructive thinking ...

The long duration of the entire episode, which lasted several years, might have been prevented,

IF ... i.) The patients had been at the centre of each side's thinking: if their needs had been paramount.

IF ... ii.) Consultation, rather than an autocratic attitude had been in evidence during the formation of the special unit.

IF ... iii.) The tit-for-tattery had been regarded as a danger signal instead of a joke.

IF ... iv) A multi-disciplinary conference had been called, to include all levels of staff.

IF ... v.) Each side had discussed their roles with the other.

Apathy might have been prevented or forestalled:

IF ... 1.) The patient was at the centre of things, at all levels.

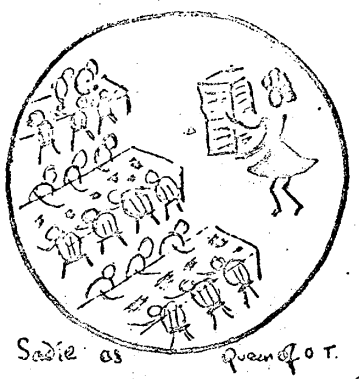
IF ... 2.) Teams were constructed in areas where job satisfaction is likely to be low, for mutual encouragement and support.

IF ... 3.) The enthusiasm of the juniors and their desire for team-work could be preserved when they become seniors.

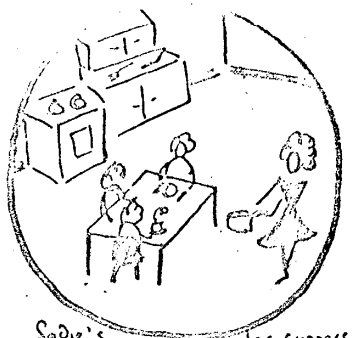
C. SADIE'S SUPPERS

a) The incident ...

Sadie was a patient in a unit where she was the best worker, responsible for checking the jobs before they were packed up for despatch. As a reward for her efficiency, she



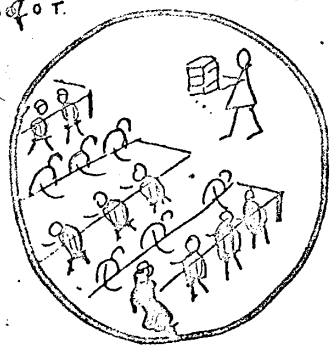
Sadie as Queen of O.T.



Sadie's reward... her suppers.

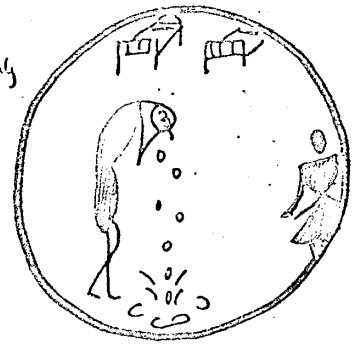
Social Worker gets Sadie a part-time job.

SADIE'S SUPPERS

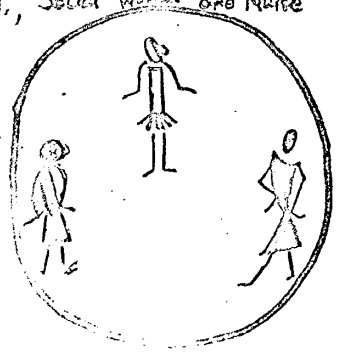


Sadie, in O.T. only part-time now, is no longer Queen.

Sadie goes to nurse.

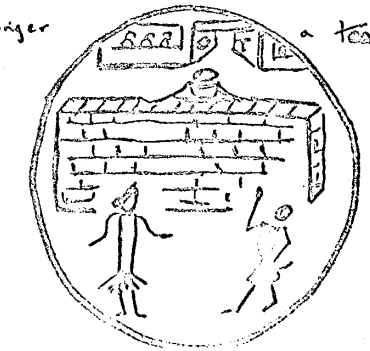


O.T., Social Worker and Nurse



Sadie is removed from O.T.

O.T., Social Worker and Nurse no longer a team.



was regularly allowed to stay behind in the unit for supper, cooked on the spot by a select group of patients.

When Sadie was found a part-time job for two days a week, outside the hospital, she came to the unit on the other days, to continue working as before. But another, less competent patient was placed in charge of the checking, and Sadie was put to work among the very handicapped patients in another part of the room. She was never again allowed to attend the special supper parties.

She became upset, subsequently spent her days on the ward, and neither Ward Sister, nurse in the unit nor social worker would discuss the problem.

b) Analysis ...

Since the only explanation offered for Sadie's demotion from Queen of the unit was anger at the Social Worker's action in removing Sadie and giving her an outside job, the story has to be taken as a very typical example of tit-for-tattery - leaving one's professional attitudes aside in order to indulge in personal rivalry or recriminations.
It could be argued that there was a lack of consultation, no case conference, no explanation of the roles of both parties with regard to this particular patient. Perhaps, therefore, tit-for-tattery should be seen as a symptom of deeper problems (as in the Pink Daisies, page) and a danger signal.

c) Diagram ...

Sadie defeated all attempts at an explanation in diagrammatic form, and the incident was shown as a pictogram - and it was only at this point that the role of the Ward Sister became clear, as protector of the innocent. It became clear, too, that the three staff concerned were at loggerheads for some long time after the incident, precluding the Social Worker from helping others in that unit. A trivial incident which affected a large number of patients.

d) Constructive thinking ...

The incident - and the long-term consequences - might have been prevented,

IF ... 1.) The patient's role of considerable responsibility had been compensated for.

IF ... 2.) Roles had been clearly discussed and agreed.

IF ... 3.) A case conference had been held, with all areas represented.

IF ... 4.) The patient had been at the centre of thinking.

IF ... 5.) All concerned had acted professionally.

D. IT'S NOT MY BUSINESS

a) The incident...

Nigel had a routine assessment by the Psychologist and a report strongly recommending that Nigel be sent to school as a matter of urgency was sent automatically to the Medical Officer. The report was initialled by the doctor and filed in Nigel's case notes without comment. It was found a year later by the Ward Sister who did nothing about it: "It's not my business to interfere", she said. Nigel never went to school.

b) Analysis ...

The gap here appears to be apathy: apathy in all concerned, collectively and individually. The report could have been followed up by psychologist and doctor, and by the ward staff who originally filed it. The individual responsibility for action is clear. So too is the responsibility for organising a case conference on Nigel.

Apathy, however, is an end-product. It probably arises from lack of job satisfaction over a long period. This in turn does not just happen. Job satisfaction may be a blanket term for a number of things such as having no confidence in one's superiors, or disagreement with their policy; not getting praise, recognition or promotion; working in unsuitable conditions; having high expectations which are never fulfilled or ideas which are never listened to.

Lack of job satisfaction comes when there are any such long lasting frustrations between a person's goal and his achievement, and it has probably been preceeded by long periods of fighting "Them" and of grumbling, possibly by threats of resignation, certainly by a number of unpleasant episodes.

c) Diagrams ...

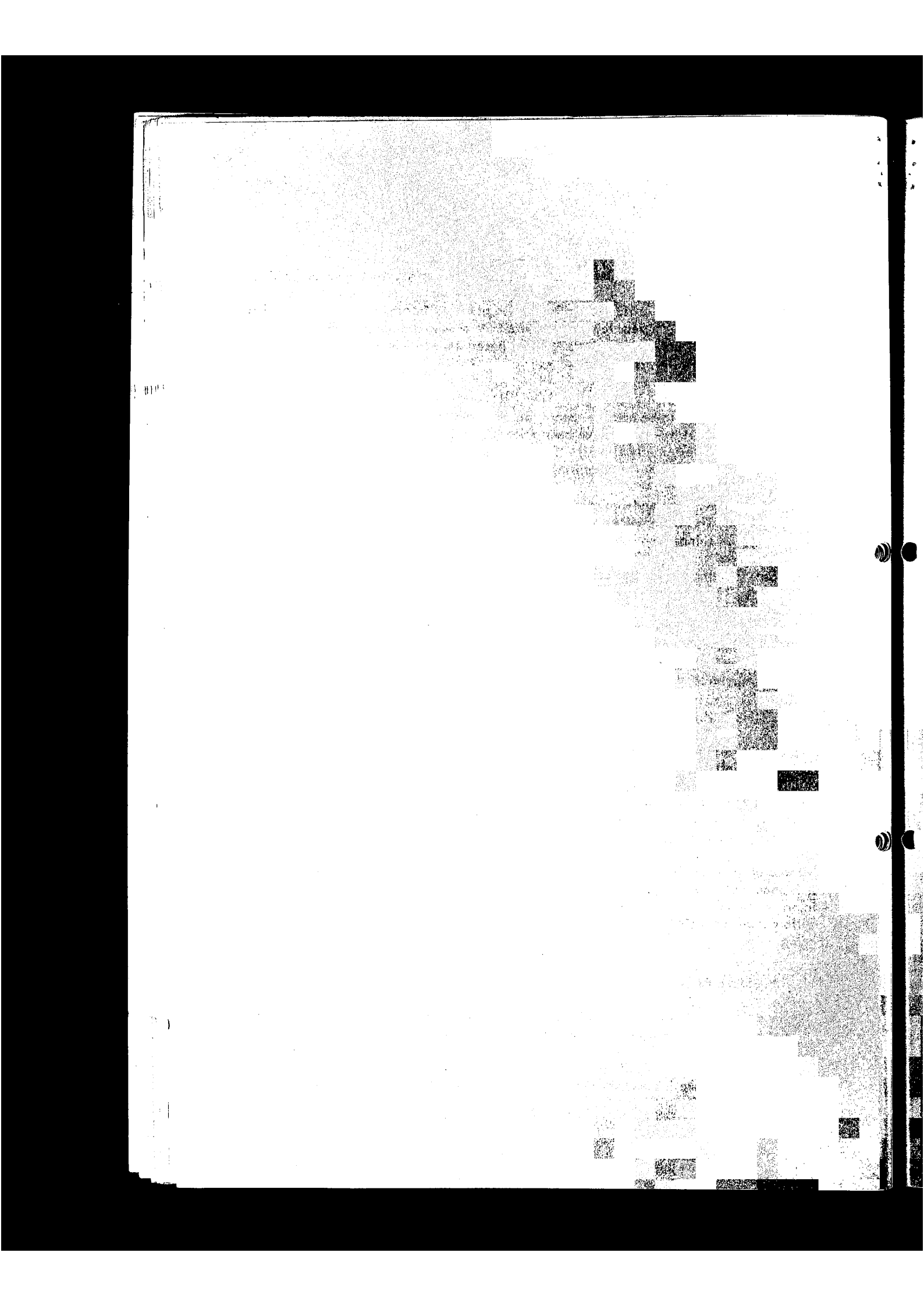
How can one pin apathy down in a diagram - or draw lines from a gap to a void? The verbal descriptions of those reporting these types of incident are vivid enough: "It's not being bothered, it's giving up bashing your head against a brick wall. It's avoiding unpleasantness - the easy way out. It's thumping the desk and saying 'That's my final decision, the conference is closed!' It's a 'what's the use?' feeling, it's just accepting your salary and waiting for the next pay-day. That's apathy."

Perhaps of all ingredients in a "horror story", apathy is fundamentally a personality factor. It is anger with the energy taken out; one way of reacting to the strain of exacting work in an emotionally demanding field, often without recognition or visible achievement. Different personalities might react in other ways. The danger of apathy is that it can be catching.

iv POSSIBLE PROBLEMS

Anyone starting such a search for critical gaps in the service may feel relief at knowing some of the problems that have been met by others so engaged.

One early difficulty may be in getting a story from the group which has enough personalities to make it a worthwhile study. Student nurses, for instance, may find it



difficult at first to find an incident which was not confined to the ward and to the Ward Sister. It also happens at the start that a person will bring along a story of which he only knows a part - and again, the gaps cannot be analysed. Until the basic ided is grasped, not all incidents will be suitable.

Another, occasional problem, is the negative 'blaming' attitude - again, a feature of the early days of using the method. It is well to make it quite clear that the interest is not in looking for a scapegoat, and that details of the place and the names of those featuring in the incident are not to be given under any circumstances.

A third problem may be the very natural and almost automatic response: "It couldn't happen here! " This, again, will only happen in the very early stages when one of the incidents quoted here is used as an illustration of the method. Since everyone has met, at some time or other, an incident which illustrates some sort of gap in the service to the client, it is fairly easy to divide the participants in the discussion into small groups and ask each to provide an incident for analysis. It is highly unlikely that every group will feel complacent.

Lastly, there may be problems in the early days with developing diagrams - often because the thought of a diagram (either drawing or interpreting it) arouses anxiety. The answer is partly to make sure that there is ample discussion within the group while the diagram is being constructed: it is often not the owner of the incident who can produce the clearest drawing. The owner may, in fact, be far too emotionally involved at this stage to think clearly. And as regards drawing the pictogram or devising a more conventional diagram, there is usually someone in each group who is willing to produce a schematic illustration or to cope with 'pin-men' drawings, and to derive great enjoyment from doing it.

SUMMARY

In this chapter the objectives were:

1. to describe the stages of discussing an incident and of finding the gaps.
2. to make clear the purpose of using a diagram.
3. to give a few examples of incidents to start such discussions, if this is felt to be necessary, and to show some examples of constructive thinking which came out of these particular incidents.
4. to illustrate some problems which can arise in the early stages so that the teacher or tutor may be prepared.

CHAPTER TWO

WHAT CAN WE GET OUT OF IT?

i. Typology of critical gaps

ii. Constructive discussion: roles
job satisfaction
forward thinking

iii. Constructive action: supportive conference

iv. Danger signals

v. Slogans

This chapter is concerned to make only sketchy suggestions, since it is felt that different disciplines and different areas may find the search for critical gaps leading them along very different paths. It is included at this stage again to whet the appetite.

i. TYPOLOGY OF CRITICAL GAPS

In analysing a large number of critical incidents in depth, certain types of gap in the service given to the client appear over and over again. The emphasis of course varies, and not all the types appear in each incident: it is a safe assumption, however, that every incident will illustrate more than one type.

The types are not given in any particular order in this draft. It is assumed that other reasons for gaps may appear and that constructive, creative thinking may also be applied to them.

TYPE A Needs of client not at the centre of the staff's thinking
TYPE B Lack of teamwork
TYPE C Ignorance of roles
TYPE D Apathy
TYPE E Lack of a mature attitude
TYPE F Lack of leadership
TYPE G Lack of specialised services for minority groups

It must be emphasised again that the purpose of collecting these stories is not to criticise adversely; there is no point in retrospectively apportioning blame.

The purpose is to learn in a positive way by analysing actual, current examples of gaps in the service, what may be done to close those gaps and provide a more effective form of help. It is also the hope, on a deeper level, to develop a constructive philosophy which will ensure a positive and dynamic attitude to the clients, to one's colleagues and to oneself.

ii CONSTRUCTIVE DISCUSSION: ROLES

So far, this has only been developed with student nurses and one or two social workers. It became obvious at the start that this was a vast area of ignorance and misunderstanding, and indeed, was confirmed when statistics from the study on Co-ordination of the Services began to appear. Ideas drawn from the students about their own roles and those of other disciplines were often stereotyped and vague, suggesting the urgent need for further exploration. It also became apparent that there was no such thing as - for example - THE role of the nurse: it was rather a question of which role did a given nurse see herself in at the time of the critical incident, and how did others see her at that moment?

Using this method of searching for critical gaps is both more lively and more realistic a means of discussing this topic than piecing together a lecture from expert dissertations - of which there are many - if only because the role of a doctor (for instance) will vary according to the hospital he is attached to. So too, will vary the roles of the nurse, and those of social worker, psychologist, supervisor and domestic.

JOB SATISFACTION

This is another area on which much has been written, but which again will bear richer fruit from this type of analysis. Most groups will naturally put money somewhere near the top of the list, but beyond that, priorities vary from group to group and from individual to individual. Since a lack of satisfaction in work, whether temporary or fairly permanent, may lie somewhere among the causes of gaps in the service - and may certainly be spotted by a number of 'danger signals' - this is another important area for development by those using this draft booklet.

FORWARD THINKING

An attitude which is not easy to promote, forward thinking is often clearly absent in a critical incident. Forward thinking is "the-patient-without-me" and puts him firmly at the centre of planning. It demands a broad knowledge of roles, or the capacity to think flexibly about them, in order to ensure that the right person has the right information necessary to the client's future welfare at the right moment. "Tit-for-tattery" is backward-looking, and so is another phrase heard around: "We're not speaking". Forward thinking is the art of using such negative energy as a positive drive. Again, it is an aspect which needs discussion by a variety of groups.

iii CONSTRUCTIVE ACTION

Only one example will be put forward here, since again, this needs to be discussed with groups using this booklet.

The example is of a team-building exercise which was termed a Supportive Conference. It arose as a direct result of the gaps revealed by the "Pink Daisies" episode, and of the various danger signals that pointed to Apathy ("We weren't asked, just told," and "What's this got to do with our hospital?").

Instead of the more usual Case Conference, this series was deliberately contrived as a discussion round the client of the roles, the attitudes and the needs of all the staff concerned with the particular case. It was envisaged as a "Spider's Web" type of support, each

member of the therapeutic team in contact with at least one other member for support and encouragement when therapy becomes too routine or difficult, and yet making his own individual contribution to the client at the centre. This is a dynamic concept since consideration of staff development with regard to an individual client is likely to lead to action.

iv. DANGER SIGNALS

In analysing the gaps in some depth, it seems likely that certain types of incident and certain phrases uttered in the course of such episodes, like the scream of a siren announdes the presence of danger. Sadie's Suppers, and the Pink Daisies for instance are not uncommon examples of what has been called "tit-for -tattery" - paying off some slight, real or imagined, by using the clients. The phrases: "Why should I?" and "What's it got to do with me?" and "Who does he think he is!" are refrains which suggest underlying tensions. So too, do the phrases: "It's not my business!" and "I'd rather not ask!" and the martyred: "Nobody told me!" and the stark alibi of: "They".

These are all common catch-phrases; they have all appeared, somewhere along the line in the history of an incident. If a collection of such types of episode and such phrases can be garnered from a wide variety of sources, we may find another key to the forward-looking, preventive action which could be taken the moment such a danger signal appeared.

v. SLOGANS

Accepting the fact that a snappy slogan is more likely to be remembered in a moment of crisis than solid theory or scientific fact, some have already been collected in group discussions. Others may well be devised in the relaxed atmosphere of such sessions. Examples are: tit-for-tattery, Tommy-without-me, changing red lines to black, Tommy-at-the-centre and How can a Senior stay Junior?

SUMMARY

In this chapter the objectives were:

1. to suggest some types of gap in service which already seem frequent.
2. to outline some constructive ideas which are beginning to emerge from this method of analysis
3. to stimulate further exploration

CHAPTER THREE

AN ACTUAL SESSION

i. SETTING THE SCENE

This had been done in the previous session, when the Pink Daisies had been analysed with the group of student nurses as an introduction to the method. There had been some destructive criticism of the staff concerned, which was discouraged and positive remedies were asked for. The students were asked to bring incidents of their own to the following session.

ii. THE INCIDENT

"Every day, an Occupational Therapy department took 30 patients, who went to and fro with a young, enthusiastic student nurse: twice there and twice back. The OT department wanted the young nurse to stay and help; the ward refused. The matter was referred to the Nursing Officers - the 'Men behind a desk in Burton Suits' - and they backed up the ward. The 30 patients did not get the benefit of an active programme with fresh ideas".

iii. CLARIFICATION

In its original form this, as many other incidents, was confusing for the rest of the class and for the lecturer. Considerable discussion was needed to bring it to its quoted form, mainly because the emotion of the student was muddling the sequence of events. It was decided to concentrate first on the staff involved.

iv. STRUCTURING

This is always an important stage since it is often extremely difficult for the owner of the incident to get away from the rigid, visual image of who was actually, physically present at the time, whether relevant to the incident or not.

In this case, it became clear that although several OT staff were prominent in the original story they need not be regarded as separate characters. That they were all elderly and semi-retired was of prime importance: the patients were young, lively male adults. It was some time before the significance of this point hit the group: up to that moment,

the emotion of the story-teller had seemed incomprehensible.

Next, the group clarified where the various characters were, and a simple two-way diagram was put on the board to show their movement (although in actual fact, only the student's movement were shown - a fact which escaped the group at that point).

Student	OT	
Student	Ward	
Student	OT	
Student	Ward	(for patients' lunch)

The whole process was repeated in the afternoon.

This now explained another facet of the student's emotion: what he considered to be a waste of time (10 minutes walk each way), and certainly not teaching him how to be a nurse, he thought.

Next, in structuring the incident, it was necessary to clarify what was actually happening: where were the gaps? In this case, it seemed simple at first: ill-feeling between Ward and OT staff was the cause, the only cause of the incident. (The 'incident' was defined by the student as a continuous process).

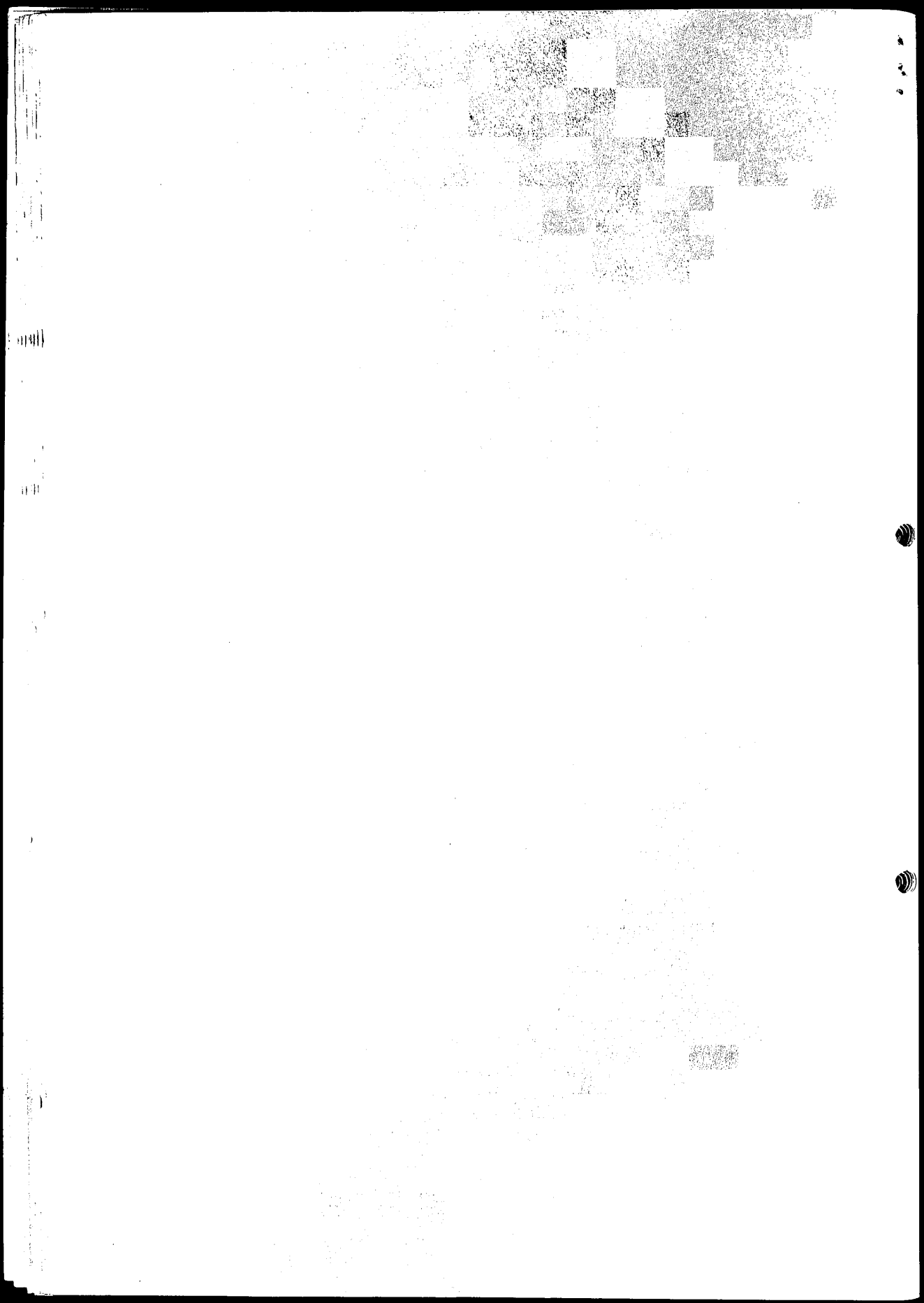
Throughout these stages of clarification and structuring, a problem had been clear communication - or rather, the lack of it.

v. DIAGRAM

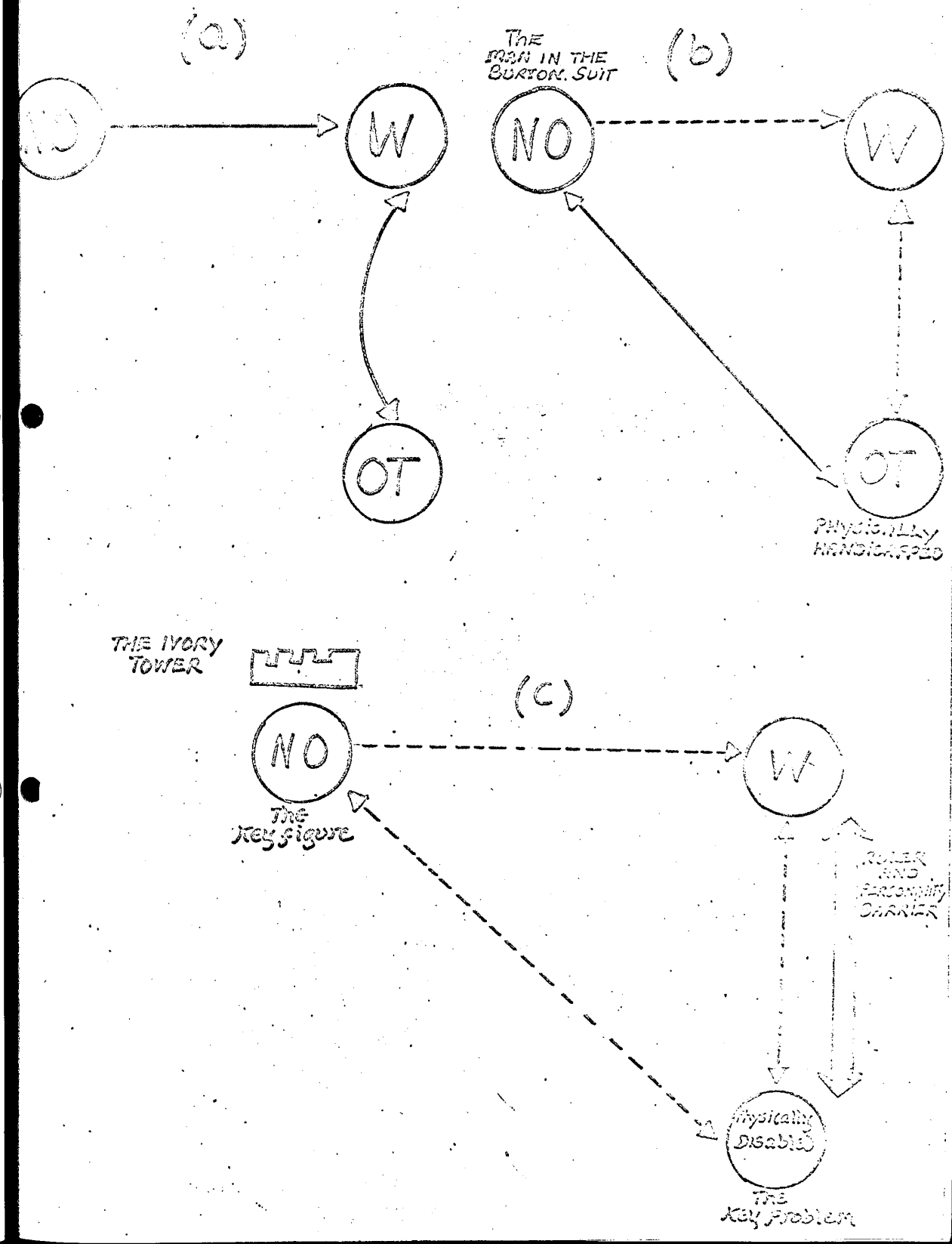
The first diagram (a), is not in fact particularly helpful in spotting the gaps, since it seems to imply that the Nursing Officer communicates adequately with the Ward, and that both Ward and OT are conferring. On eliciting the point about the elderly, semi-retired OT staff, the second diagram (b) was drawn with a dotted line to indicate poor communication, since the group felt that neither Ward nor OT had made their viewpoints clear to each other. At this stage, someone noticed that the Nursing Officer had not been shown as having a link with OT, so this was put in.

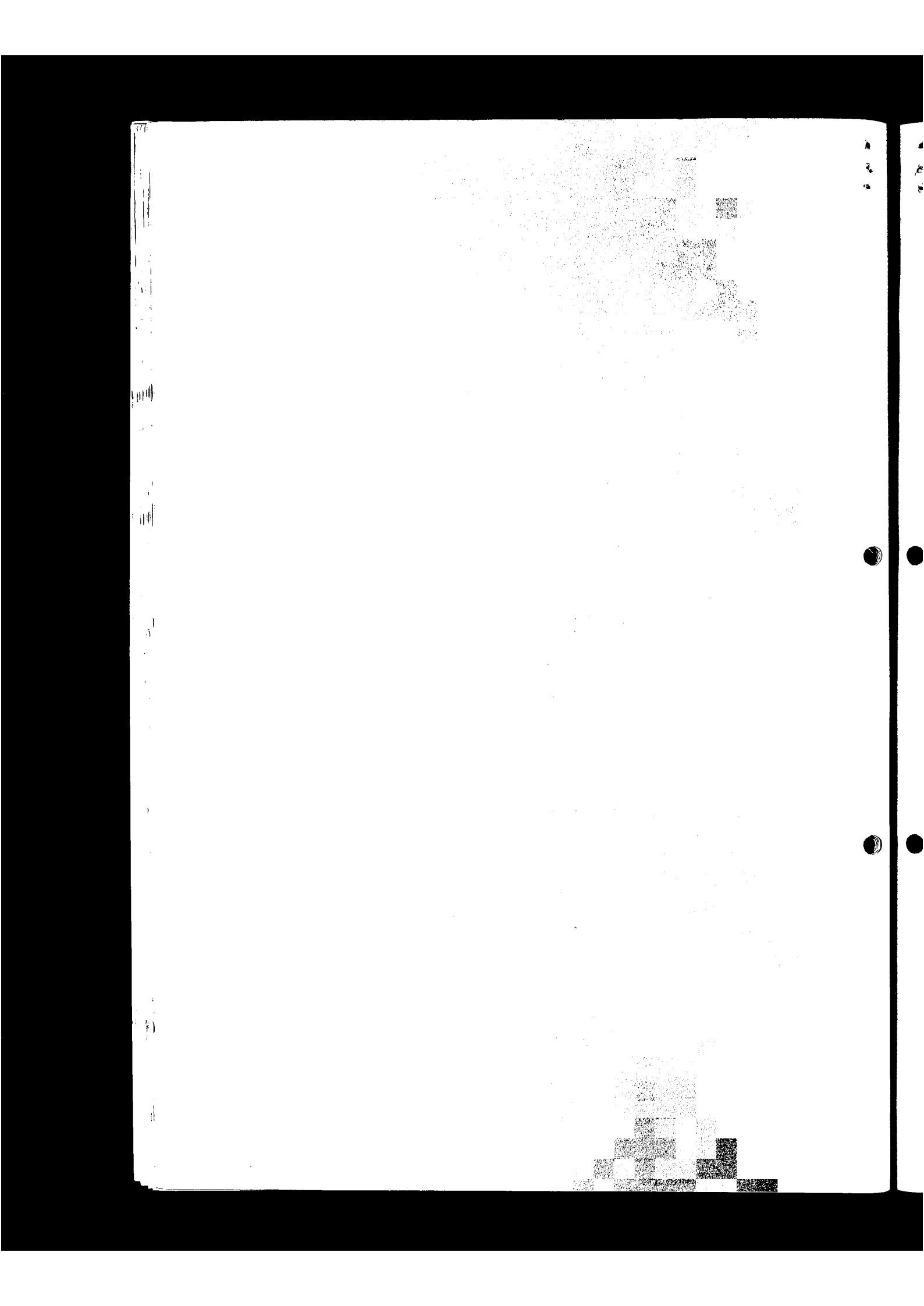
In considering the two diagrams and commenting further, the group probed deeper and discovered from the student that Ward and OT staff had a number of personality difficulties: the barrier was not merely non-communication. The student drew in a thick line to indicate incompatible personalities - diagram (c).

Meanwhile, the group, thinking back to an earlier point, realised that ALL the staff in the OT were both elderly AND physically handicapped: this had seemed so improbable that it had been overlooked. This, they decided was the key problem in a unit of young adults. It then followed, they thought, that the Nursing Officer must be the key figure, since his was the responsibility of allocating staff. They immediately christened the story 'The Ivory Tower', because they felt the Nursing Officer could not possibly realise the situation - or perhaps he did, but preferred to remain behild his desk.



THE IVORY TOWER





Finally, the group's questioning helped the student to realise that neither Ward nor OT had a clear idea of each other's roles, nor did they agree on the role of the student nurse. The Ward, left with only a few patients not at OT, looked on this as a good opportunity for extra training which the student should help with. The OT on the other hand, saw the Ward as 'idle', with only a few patients 'just sitting there', and thought the student could well help them to inject some youthful energy into their unit. The lines were all changed to indicate non-communication all round; the barrier of personalities remained.

vi. CONSTRUCTIVE THINKING

The group was too exhausted to produce any ideas at this point, although the lecturer for the first time realised the clear need to separate the role of the student nurse from that of the Ward Nurse, and this was done in all subsequent exercises.

At a much later date, the incident was discussed with the same student in another group who suggested a team conference to include a number of staff other than nurses - social worker, medical officer, psychologist, for instance. They also suggested a conference on a broad basis at which the role of the Nursing Officer could be worked out with those concerned with his services. This group then matched the characters in the Ivory Tower to their own lists of job satisfactions and work frustrations and again produced some constructive ideas on how to develop a sense of achievement in junior staff.

SUMMARY

In this chapter the objectives were:

i. to give an example of one framework of an actual session

ii. to indicate the interweaving of diagram and discussion

iii. to show how simple a diagram can be, and yet convey the necessary information.

HOW YOU CAN HELP

1. By trying out this method with different groups and noting comments.

2. By collecting critical incidents which have been analysed constructively and which (with names and places changed) could be used as illustrations or (if the incident might cause distress if used in this way) to provide further material for the typology section.

3. By suggesting additions, omissions, clarifications in the text.

4. It has been suggested that 2 or 3 incidents are sufficient to illustrate the method; it is also thought that an incident to illustrate each of the types of gap might be useful. What is your opinion?

5. Should we include examples of several different types of diagram that have already been used in analysis, or leave it to the ingenuity of those using the book?

6. Should there be one book describing the findings (typology, danger signals, roles, job satisfaction, etc.) and a separate booklet, a workbook, as brief, or even briefer than this one, to be used solely for teaching purposes?

7. Can YOU compose a snappy title for this book?

Please send us your comments and suggestions.