Social Science & Medicine 120 (2014) 233–242

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The habitus of 'rescue' and its significance for implementation of rapid response systems in acute health care

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A R T I C L E I N F O

Article history:
Received 28 January 2014
Received in revised form
12 September 2014
Accepted 18 September 2014
Available online 19 September 2014

Keywords:
Bourdieu
Ethnography
Patient safety
Acute care
Failure to rescue
Early warning systems
Division of labour
Interprofessional working

A B S T R A C T

The need to focus on patient safety and improve the quality and consistency of medical care in acute hospital settings has been highlighted in a number of UK and international reports. When patients on a hospital ward become acutely unwell there is often a window of opportunity for staff, patients and relatives to contribute to the 'rescue' process by intervening in the trajectory of clinical deterioration. This paper explores the social and institutional processes associated with the practice of rescue, and implications for the implementation and effectiveness of rapid response systems (RRSs) within acute health care. An ethnographic case study was conducted in 2009 in two UK hospitals (focussing on the medical directorates in each organisation). Data collection involved 180 h of observation, 35 staff interviews (doctors, nurses, health care assistants and managers) and documentary review. Analysis was informed by Bourdieu's logic of practice and his relational concept of the 'field' of the general medical ward. Three themes illustrated the nature of rescue work within the field and collective rules which guided associated occupational distinction practices: (1) the 'dirty work' of vital sign recording and its distinction from diagnostic (higher order) interpretive work; (2) the moral order of legitimacy claims for additional help; and (3) professional deference and the selective managerial control of rescue work. The discourse of rescue provided a means of exercising greater control over clinical uncertainty. The acquisition of 'rescue capital' enabled the social positioning of health care assistants, nurses and doctors, and shaped use of the RRS on the wards. Boundary work, professional legitimation and jurisdictional claims defined the social practice of rescue, as clinical staff had to balance safety, professional and organisational concerns within the field. This paper offers a nuanced understanding of patient safety on the front-line, challenging notions of the 'quick fix' safety solution.

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1. Policy background

A number of deaths that occur in hospitals are considered potentially predictable and preventable (Brennan et al., 1991; McGloin et al., 1999). The problem of 'failure to rescue' of patients who display signs of acute illness has attracted national and international policy attention (Australian Commission on Safety and Quality in Health Care 2008; HCC, 2009) and is regularly reported in the news media (BBC News, 2011; NBC News, 2008). Missed, misinterpreted or mismanaged changes in vital signs (such as heart rate, respiratory rate and blood pressure) can result in unanticipated admissions to the intensive care unit (ICU), increased length of hospital stay, cardiac arrest or death (McQuillan et al., 1998).

A structured, systems approach to management of acutely ill patients is now widely advocated (DeVita et al., 2006). While the majority of acute hospitals have implemented some form of rapid response system (RRS), research has shown considerable heterogeneity between the approaches adopted by different organisations. Critical care experts have suggested that a 'gold standard' RRS includes an early warning system (EWS), a rapid response team, and an evaluative process improvement and governance/administrative structure (DeVita et al., 2006). EWS are observation charts with predetermined 'calling criteria' (based on periodic recording of vital signs) as indicators of the need to escalate monitoring or call for assistance (Smith and Prytherch, 2011). A rapid response team, comprised of personnel with critical care competencies and diagnostic skills aims to provide support for ward staff, enable timely

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http://dx.doi.org/10.1016/j.socscimed.2014.09.033
0277-9536/© 2014 Published by Elsevier Ltd.

management of sick patients, and in some cases, avert the need for ICU admission. Some teams comprise critical care physicians as in the case of the Medical Emergency Team while others can be nurse led such as the Critical Care Outreach Team (CCOT).

The number of different systems in use, implementation strategies and contexts has made it difficult to interpret research findings related to the RRS. A recent systematic review concluded that there was moderate evidence that RRSs are associated with reduced rates of cardio-respiratory arrests outside of the intensive care unit and reduced mortality (Winters et al., 2013). RRSs have been assessed as one of the top Patient Safety Strategies ready for adoption (Shekelle et al., 2013). However, research has highlighted difficulties with implementation of the RRS, with poor completion of observation charts and early warning scores, and ward staff reluctance to ask for help from response teams (Buist, 2008). In 2012, the Royal College of Physicians endorsed a standardised UK EWS for acute care to aid familiarity and consistency (RCP, 2012).

In this paper, we explore the daily enactment of the RRS in the medical directorates of two UK NHS hospitals. Previous studies have tended to focus on RRS implementation within a technical framework. We shift the focus to the social practice of 'rescue' at micro level, and to the structural conditions that shape delivery of the RRS. We draw on Pierre Bourdieu's logic of practice (Bourdieu, 1977, 1984, 1990) to act as an interpretive aid. Application of Bourdieu's concepts to the social practice of rescue facilitates appreciation of the influence of health care's hierarchical and institutional structures, the ways in which staff negotiate these structures to implement the RRS, and the consequences of this for the care of acutely ill patients.

1.1. Bourdieu's habitus, field and capital

For Bourdieu, the 'field' provides a frame of analysis for the study of social life. The field represents a discrete social space, a network of objective historical relations between social positions anchored in certain forms of power (Bourdieu, 1977, 1990; Bourdieu and Wacquant, 1992). Each overlapping field constitutes an objective hierarchy, has its own values and regulative principles, and shapes and authorises particular discourses and activities (Webb et al., 2002). In this paper, our focus is on the field of general medicine within the acute hospital setting. Detection of and response to acute deterioration in patients' conditions offers us a lens into the nature of health care work on medical wards. Interpretation of the construct of deterioration, calls for help and response behaviour encompass the sociological themes of medical uncertainty and diagnostic labelling, the division of labour and technological influences, and the articulation of professional cultures and hierarchies. We focus on the doctors, nurses, health care assistants (HCAs) and managers that are 'players' within this field in order to make sense of how culture and power shapes rescue practice on medical wards.

Bourdieu notes that dominant norms characterise fields. He describes struggles and competition among individuals and groups because of their different stakes within the field (McDonald, 2009). He identifies four types of capital (goods or resources) that determine positions within the field, namely: economic capital (financial resources); cultural capital (legitimated knowledge, cultural credentials); social capital (a network of relationships); and symbolic capital (prestige and social honour). The four types are inextricably linked (Bourdieu, 1977). Capital is context specific but is influenced (valued, traded or ignored) by other fields. Thus the status and resource available to nurses and medical staff working within general medical wards is likely to contrast with their position in overlapping health care fields such as emergency and critical care.

In the UK setting, the hospital provides an example of a classic bureaucracy (Du Toit, 1995) due to the clustering of knowledge-based specialisation within its medical, surgical and critical care wards. HCAs, nurses and doctors have to negotiate hierarchical, occupational, temporal-spatial and bureaucratic boundaries (Gieryn, 1983; Bowker and Star, 1999) in order to promptly recognise and respond to patients whose conditions are deteriorating. While medical hegemony and the logic of managerialism dominate acute care (Finn et al., 2010), clinical staff also have scope to enact agency, change and recreate social relations within its structural constraints (Svensson, 1996). A plethora of national policy guidance provides resource for staff caring for acutely ill patients on hospital wards (NCEPOD, 2005; NICE, 2007; NPSA, 2007). Staff training programmes offer a systematic approach to the assessment and care of the severely ill, while the RRS with its rules and early warning systems potentially provides staff with the resource to negotiate occupational and hierarchical boundaries (Mackintosh and Sandall, 2010).

Bourdieu conceptualises social structures as both objective and subjective – objectively, capital can be quantified and described, while subjectively, the process of acquisition and distribution engenders individual sense-making and normalisation. The various groups of social agents, working in this case in medical directorates, each have their own 'habitus', or embodied, internalised history (Travaglia and Braithwaite, 2009). A person's (or occupation's or profession's) habitus is a system of 'durable, transposable dispositions, that are structured, inculcated and generative' (Bourdieu, 1977 p.53). These forms of knowledge are often partially recognised by those involved. The nature of this knowledge allows the dominant agents in the field to 'impose (or even inculcate) the arbitrary instruments of knowledge and expression (taxonomies) of social reality' (Bourdieu, 1991 p.168).

Existing structures, cultures and hierarchical working practices within acute care have emerged under the influence of professional, organisational, technical, economic and political constraints. In this paper we explore the rules of rescue within general medical wards to highlight collective norms and patterns of behaviour, and how these inter-relate with the RRS. Our analysis focuses on the processes of risk detection and diagnosis, asking for help, and response, drawing on ethnographic data collected over a two year period. It provides a nuanced understanding of inter-occupational interaction within medical wards and associated issues of legitimacy, power and conflict, offering theoretical insight into the social processes affecting RRS effectiveness.

2. Methods

2.1. Methodological approach

We adopted an 'ethnographic perspective' (Green and Bloome, 1997) to the study of the RRS. Ethnography is defined by a commitment to first-hand experience and exploration of a particular socio-cultural setting through participant observation (Atkinson et al., 2007). The researcher is the principal research tool (Allen, 2004). Observations are supplemented by conversations, interviews and textual material (Atkinson et al., 2007). Ethnographic inquiry offered the opportunity to add significantly to the existing evidence base regarding the RRS, which has come mainly from staff surveys and interviews (Rowan, 2007).

3. Participants and settings

Two tertiary UK NHS teaching hospitals were purposively selected on account of their different RRSs. The pseudonyms, Eastward and Westward, are used to maintain anonymity of sites. Each hospital's medical directorate admitted 15,000–20,000 patients per year.

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