LEARNING FROM EXPERIENCE IN A NATIONAL HEALTHCARE SYSTEM: ORGANISATIONAL DYNAMICS THAT ENABLE OR INHIBIT CHANGE PROCESSES

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DECLARATION OF AUTHENTICITY

Dedicated to all patients: past, present and future

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ABSTRACT

Healthcare organisations are seeking to advance safety and quality in a changing environment. They are also facing growing demands and obligations to identify and spread the use of best practices in the services that they provide. However, it has been shown that the dissemination and adoption of best practices can encounter several difficulties such as resistance to adjust to new clinical, organisational and interpersonal routines and the need to modify procedures to be context sensitive and applicable.

On the other hand, numerous examples abound in which individuals and teams in healthcare organisations were shown to exhibit creativity and leadership and consequently the capability to improve quality and engender organisational growth.

This study researched the organisational dynamics that either foster or inhibit the system change needed for the ongoing organisational development of the major acute general public hospital in Malta: Mater Dei Hospital (MDH). The researcher sought to elucidate whether and to what extent MDH is adopting and applying appropriate learning practices so that knowledge acquired and generated within the organisation is retained, disseminated, managed and applied. Malta is the main island of a small archipelago in the Mediterranean with a total population of just over 430,000.

This study utilized two major research methods: an action research arm and an in-depth interview approach. The former was achieved through the documentation and interpretation of a practitioner-researcher experience working within a multi-disciplinary hospital group. The **Pa**tient **S**afety and **Q**uality **I**mprovement **T**eam (PaSQIT) was set up to promote and implement projects that raise the profile of and increase the standards for patient safety and quality care at MDH.

Data collection and analysis were guided by the grounded theory paradigm to 'ground' the research process and product in the data. These processes were operated within a constructivist and informed grounded theory approach, wherein the researcher is allowed to be mindful and sensitive to the extant literature and to critically adopt pre-existing knowledge in the analysis judged in terms of relevance, fit, and utility. Another extensive literature review was conducted nearer to the end of the data collection and analysis processes to elicit existent knowledge that can challenge or corroborate the original findings of this research.

This research affirmed the high potential and capabilities of the hospital workforce. This potential is nonetheless susceptible to be affected and gradually transformed by identified organisational and external forces into a workforce that is highly territorial, cynical and showing lack of 'ownership' of the organisational vision and objectives. The results led to the generation of a theoretical framework that depicts a vicious circle that needs to be broken to allow the desired organisational development and learning. The report presents a number of recommendations to help counteract these forces and break the cycle.

The theoretical framework that was generated from the findings of this research is the key outcome of this study. This framework provides a visualization of the identified and inter-connected enabling and hindering factors and a practical schematic on which corrective activities can be designed, implemented and monitored. Although this framework has a specific relevance for MDH, this additional knowledge can be used and inspire other organisations operating within comparable conditions. Finally, this research can be a source for stimulation for future studies that compare and follow-up these findings over time at MDH or in organisations working in similar, different or contrasting situations.

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GLOSSARY OF ACRONYMS

A&E	Accident and Emergency
AR	Action Research
CG	Clinical Governance
CEO	Chief Executive Officer
CPD	Continued Professional Development
CPU	Clinical Performance Unit
DNS	Director Nursing Services, MDH
DoH	Department of Health
ESP	Employee Support Programme
EU	European Union
EWS	Early Warning Score
FEMA	Faculty of Economics, Management and Accountancy
FHS	Faculty of Health Sciences
HCP	Healthcare professional
HR	Human resources
HSE	Health and Safety Executive, UK
ICT	Information and Communication Technology
IOM	Institute of Medicine, US
IRC	Incident reporting committee
IRP	Incident reporting policy
IRS	Incident reporting system
JHMI	Johns Hopkins Medicine International
KPI	Key Performance Indicators
M&M	Mortality and morbidity meetings
MBA	Master in Business Administration
MCH	Mount Carmel Hospital
MDH	Mater Dei Hospital
MFH	Ministry for Health
MHEC	Ministry of Health, the Elderly and Community care
MUMN	Malta Union of Midwives and Nurses
PHC	Primary healthcare
PaSQIT	Patient Safety and Quality Improvement Team

Glossary of acronyms *(continued)*

PUPA	Pressure ulcers prevention activities
PS	Patient safety
QI	Quality improvement
RHKG	Rehabilitation Hospital Karen Grech
RPRB	'right patient right bed'
SALearn	Safety Alert system for Learning
SAMOC	Sir Anthony Mamo Oncology Centre
SET	Senior executive team, MDH
SLH	St. Luke's Hospital
TOR	Terms of reference
UK	United Kingdom
US	United States

CHAPTER 1: INTRODUCTION

1.1 Change in health systems and organisations

The only constant in healthcare is change: in some respects, the more things change in healthcare, the more they stay the same (Ginsburg and Lesser, 2006: 1). The importance of learning from and to avoid and repeat failures in a healthcare system cannot be over-emphasized. This importance stems from the fact that matters of life and death are at stake on a daily basis. In addition, there are increasing calls to continually stress on the need for health systems to be as efficient as possible so that they can be able to respond to escalating demands for health services. The present and future sustainability of health systems and organisations must be safeguarded so that they can deliver the access and quality of care that they are designed and financed to provide.

Healthcare organisations are seeking to advance safety and quality in a changing environment. Organisational learning practices can help to improve existing skills and knowledge and provide opportunities to discover better ways of how healthcare professionals and workers can work together (Carroll and Edmondson, 2002: 51). Several healthcare organisations and health authorities are facing growing demands and obligations to identify and spread the use of best practices in the healthcare procedures and pathways offered by the institution and by healthcare professionals working in their organisation (McGlynn et al., 2003: 2636). However, it has been shown that disseminating best practices in healthcare can create a complex, imprecise and moving target (Tucker, Nembhard and Edmondson, 2007: 896). Several difficulties can be met such as resistance encountered when adjusting to new clinical, organisational and inter-personal routines (Edmondson, Bohmer and Pisano, 2001: 707), and the need to modify practices to be context sensitive and applicable (Berta and Baker, 2004: 95).

There are many sources of resistance to change in healthcare. However, numerous examples abound in which individuals and organisations including healthcare organisations can be shown to exhibit creativity and leadership and consequently the

ability to improve quality and other outcomes by enhancing their capabilities including their capacity for organisational learning.

Organisational learning is a process of increasing the capacity for effective organisational action through knowledge and understanding. The learning 'process' is a cycle of action and reflection—that is, doing and thinking, performing and conversing (Argyris and Schön, 1996: 178). Learning from error and failure is complex and there are several factors which influence the ability of organisations to learn from failures when they do occur.

"Learning in organisations is inhibited by such factors as tradition, outdated procedures, values, structures, and tacit 'mental models' about how work gets done. On the other hand, effective organisational learning is supported by cultural values of openness and excellence; learning mechanisms that encourage information flow, challenge assumptions, and aid systems thinking and commitment of resources" (Carroll and Edmondson, 2002: 55).

Health systems are complex social systems. However, this obvious observation is often curiously absent in much of the current discourse about health systems and health sector reform (Blaauw et al., 2003: 5). To a certain extent, this oversight reflects the biomedical and economic biases of the field but is also influenced by a conception of health systems that focuses on the rather abstract macro level rather than engaging with the complex inner-workings of the system and the everyday organisational reality of health workers and managers. Because health systems are social systems, researchers and reformers in health systems need to give more attention to social theory as organisational and institutional theories are increasingly being indicated to provide useful insights for health system reform. Natural science methods of enquiry are inadequate and inappropriate for understanding social systems and literature is showing that health system researchers need to be much more active in using and contributing to the substantive body of work in the social sciences (Somekh et al., 2011: 3).

The national health system in Malta is publicly financed through taxation and healthcare is provided free at the point of use. The public healthcare system is a fully integrated model of healthcare delivery, organized and managed at the national level

and it offers a highly comprehensive basket of services, free at the point of use to all persons residing in Malta who are covered by the Maltese social security legislation. In addition, the healthcare system also provides all necessary care for special groups such as irregular immigrants or foreign workers who have valid work permits. EU citizens are also entitled to free emergency care through the European Health Insurance Card (EHIC) (National Health Systems Strategy for Malta, 2014).

1.2 Objectives of this research project

This study set out to research the organisational dynamics that either foster or inhibit the systems change needed to help the major healthcare facility (Mater Dei Hospital) within the public national health system in Malta to consolidate its scope, increase the quality of care it provides and its efficiency including the maximization of the use of its resources. This research centered on the quest of eliciting the factors that are contemporarily operating within the community of professionals working within Mater Dei Hospital (MDH) that can cultivate or hold back learning from successes and contrastingly from errors and failure. The main objective of this research is to elucidate whether and to what extent this hospital is adopting and practicing organisational development and learning practices so that knowledge acquired and generated by its component organisational members and structures is retained, disseminated, managed and applied.

This enquiry also sought to find functioning inter-connections between these factors. These findings were in turn analysed with a view of developing and illustrating a reasoned construct or theoretical framework that can explain the interactivity of the themes generated from the data collected and analysed during the fieldwork. The concluding two chapters of this report will present the generated theoretical framework and an attendant set of recommendations for action. The suggested measures are aimed at providing useful guides that can help the attainment of incremental and sustainable improvements and achievements by hospital management and staff in their incessant bid to pursue objectives and activities that will eventually lead to the successful realisation of the potential of the hospital to become a learning organisation.

The research conducted for this dissertation was designed to investigate, understand and find plausible answers and meanings grounded in the data that was collected through the chosen methodologies. The concomitant methods and techniques are explained in more detail in the Methodology Chapter. The qualitative paradigm was adopted for this research because it was understood that the whole phenomenon under study involves a complex system with multifaceted interdependencies and system dynamics that cannot be reduced in any meaningful way to linear, cause and effect relationships and/or a limited number of discrete variables (Anderson, 2010: 141).

This research employed two major research methodologies: an action research arm and an in-depth interview methodology approach. The qualitative findings, analysis and reflection on the outputs from these two distinct methodologies were fed into each other such that what was elicited through the latter was used to guide and inform the former action research methodology. Conversely, questions arising from the action research arm could be investigated further during the interview encounters.

The researcher gained entry into a hospital group that was set up in 2013 to promote and implement projects within MDH that raise the profile of and increase the standards for patient safety and quality care in the hospital and in a number of its component departments and units. This team is a multi-disciplinary group and is called the **Pa**tient **S**afety and **Q**uality **I**mprovement **T**eam (PaSQIT). Participating as a full member of this team has allowed the researcher to interact with, observe and analyse the mind-sets, behaviours and activities of different individual members, units or sub-groups within the organisation and a number of practices and structures operating at the organisational level. During the course of 30 months an action research diary was compiled with documentation generated by and for this group that includes several team and sub-teams meeting reports, terms of reference and progress reports.

The in-depth unstructured interviews were conducted with selected persons who were or are either members of the MDH workforce and the Department of Health (DoH) or experts from outside the organisation who have been engaged by MDH or DoH to mentor and assist in the continuous professional development of hospital professionals and teams.

Conducting qualitative enquiry necessitates both critical as well as creative thinking. Critical thinking requires methodical and disciplined intellectual work with meticulous and rigorous attention to detail and "a critical perspective in questioning emergent patterns even while bringing evidence to bear in support of them" (Patton, 2002: 513). Concurrently, critical thinking also requires the practice of and competence for creative thinking to assist the researcher in the discovery of new possibilities and creative connection-making. The data collection and analysis in this study sought to be guided by grounded theory methods to 'ground' the research process and product in the data. These approaches were operated within a constructivist and informed grounded theory approach as described by Thornberg (2012). From the 'informed grounded theory' viewpoint, the researcher is allowed to remain mindful and sensitive to the extant literature "in the substantive fields in a sensitive, creative, and flexible way". Pre-existing theories and research findings are "critically adopted in the analysis as they are judged in terms of their relevance, fit, and utility" (Thornberg, 2012: 255). Additionally, in line with both the classical (as originally promoted by Glaser and Strauss) and later modified and informed grounded theory approaches (Strauss and Corbin, Thornberg and others), another extensive literature search exercise was conducted nearer to the end of the data collection and analysis processes to elicit extant knowledge that can challenge and/ or corroborate the original findings of this research. For this main reason, the traditional sequence of presenting the literature review before the research findings is inverted and therefore the literature review is presented nearer to the end of this dissertation report and after the two chapters that demonstrate the findings of this research in detail.

Following the methodology report (Chapter 2) in which the theoretical underpinnings of the methodologies employed in the enquiry is presented and discussed, the dissertation report presents a detailed exposition of the context in which this study was conducted including the background of the practitioner-researcher and her relationship to and interests in the organisation and subject matter being investigated (Chapter 3). The data collection and analysis processes for the two research methodologies including the results of the different coding cycles are demonstrated in a step-by-step fashion in Chapter 4. The next chapter (Chapter 5) describes and

documents the consequent evolution process resulting in the emergence of the concluding twelve major categories. The data underlying each major category is presented in the following two chapters. Chapter 6 concentrates on the presentation of the data leading to the development of six major categories describing different inherent characteristics of the human resources at MDH while Chapter 7 exhibits the six major categories that demonstrate prevalent features of the organisational systems, external factors and major operational forces that act on and transform the human resource working in the hospital. Chapter 8 displays the theoretical framework that was developed to show and interpret the direction of plausible inter-connections between the major categories are then discusses the research findings within the framework of the extant literature related to the developed themes. The concluding chapter (Chapter 9) documents a number of recommendations that can help translate the knowledge resultant from this study into practical actions that can be applied, monitored and evaluated in practice to ensure onward progression of the hospital organisation in the quest of becoming more capable of organisational learning.

1.3 The Maltese Islands: the national context of this research project

The Maltese Islands form an archipelago of small islands located in the Mediterranean Sea approximately 93 km south of Sicily and 290 km north of Libya on the North African coast. The climate is characterized by long, hot and dry summers and short cool winters.

Only the two largest islands, Malta and Gozo are permanently inhabited. The total land area is 316 km^2 and the total population stood at 436,947 in 2016 (World Bank, 2017). Malta has the highest population density in Europe, with the population growing by over 7% in the last decade. However, it remains the smallest EU Member State by population. The Islands became an independent nation in 1964 and a Republic in 1974. They joined the European Union in 2004 and the Eurozone in 2008. Malta is also a member of international organisations including the United Nations, the World Trade Organisation, the Commonwealth and the NATO's Partnership for Peace.

The Maltese economy developed from one harnessed to the needs of the British colonial administration up to the mid-1960s, to a market-driven economy with an

emphasis on higher value-added economic activities in services, particularly financial services and tourism and more lately, information technology and remote gaming. Challenges to the Islands' economy are the relatively small internal market and their insularity. These are counteracted by a pleasant and attractive climate for tourism and the presence of an increasingly qualified and skilled labour force (National Statistics Office Malta, 2014: iii).

The Ministry for Health is responsible for the provision of health services, health services regulation and standards and the provision of occupational health and safety. The public healthcare system is the major provider of health services. The private sector supplements the provision of health services particularly in the area of primary healthcare. There are four public hospitals. Two of these are acute general hospitals (one in Malta and a smaller one in Gozo) and two are specialised hospitals (one for oncology and the other for rehabilitation services). Mater Dei Hospital (MDH) is a newly built modern hospital. It has been functioning since 2007 and is the major acute general hospital in Malta. It is also a teaching hospital, offers a full range of hospital services and employs almost half of all the public healthcare employees.

Over the past fifty years the Maltese health system has regularly registered remarkable progress and this is evidenced by the steadily rising and above EU average life expectancy and improvements in preventable and avoidable mortality. However, similar to health systems in other developed countries it is facing several challenges which include ensuring access to innovative expensive health technology and medicines while addressing the issue of financial sustainability associated with the ever-increasing longevity of the population (Azzopardi-Muscat et al., 2017: 125).

CHAPTER 2: METHODOLOGY

2.0 Introduction

Research is a systematic investigation of a problem. In the perspective of research in the arena of the social sciences, the aim is to increase the understanding of the specific situation and context of the identified problem or phenomenon. Researchers seek answers to questions that stress how social experience is created and given meaning. Qualitative researchers emphasize the socially constructed nature of reality, the close relationships between the researcher and what is studied, and the situational constraints that characterize the nature of the inquiry (Denzin and Lincoln, 2011: 8).

The qualitative paradigm was adopted for this research because it was understood that the whole phenomenon under study involves a complex system with multifaceted interdependencies and system dynamics that cannot be reduced in any meaningful way to linear, cause and effect relationships and/or a limited number of discrete variables (Anderson, 2010: 141). Qualitative research (or naturalistic inquiry) takes place in 'real-world' settings. The researcher does not attempt to influence or control the phenomenon of interest. The phenomenon of interest is observed and studied as it unfolds unconstrained (Guba, 1978: 14). In this approach manipulation by the investigator of the study setting and participants is minimized and there is no pre-determined course planned by and for the researcher such as would happen in the laboratory or any other controlled setting (Patton, 2002: 39).

Conducting qualitative enquiry necessitates both critical as well as creative thinking. Critical thinking requires methodical and disciplined intellectual work with meticulous and rigorous attention to detail and:

> … a critical perspective in questioning emergent patterns even while bringing evidence to bear in support of them… in qualitative research, critical thinking has to be combined with creative thinking to generate new possibilities and creative connection-making.
>
> (Patton, 2002: 513)

Through the employment of creative and associative ways of thinking, the researcher is enabled to progress beyond a descriptive cataloguing of data and into theorizing imaginatively (Thornberg, 2012: 253). This research that seeks to be guided by

grounded theory methods to ‘ground’ the research process and product in the data, can remain mindful and sensitive to the extant literature in the substantive field within a constructivist and informed grounded theory approach. Subscribing to an ‘informed grounded theory approach’ as promoted by Thornberg (2012: 255), the researcher is allowed to:

> … take advantage of pre-existing theories and research findings in the substantive field in a sensitive, creative, and flexible way. These are not uncritically adopted in the analysis but are judged in terms of their relevance, fit, and utility.

2.1 Data collection in the qualitative research paradigm

A general definition of qualitative research promoted by Strauss and Corbin (1990: 17) infers that this is "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification". Eisner (1990: 30-31) stated that all knowledge, gained either through qualitative or quantitative research, can be represented on a continuum from “true” fictional to the tightly controlled scientific experiment, and that there are many ways to represent our understanding of the world. Earlier work by Cronbach (1975: 124-126) stated that "the special task of the social scientist in each generation is to pin down the contemporary facts” and added that statistical research is incapable to take full account of the multi-dimensional interaction effects that take place in social settings. Logical positivism may discount effects that may be important, because they do not manage to demonstrate statistical significance, while naturalistic inquiry takes on the complex and dynamic quality of the social world.

The primary criteria for judging methodological quality is to deliberate on methodological appropriateness, design flexibility and situational responsiveness in the service of utility (Patton, 2002: 68). Seeking to decide on whether to adopt a primarily qualitative research methodology necessitates the consideration of a number of issues. Several writers have claimed that qualitative methods can be employed to get a better understanding of phenomena about which little is yet known. Qualitative research designs have also been advocated to add insight on perspectives on themes that may not have been already adequately explored, or to obtain information with a greater depth than that which can be provided through quantitative

study designs. Qualitative methods are considered appropriate in situations where the identification of unknown variables is the primary objective or where the researcher concludes that quantitative approaches are inadequate to demonstrate the required depth of or interpret the multiple inherent nuances of a situation (Hoepfl, 1997: 49).

The potential for a comprehensive description of a phenomenon has been described as a major strength of qualitative research reporting, from both the researcher's and reader's perspectives. Guba and Lincoln (1985: 120) asserted that "if you want people to understand better than they otherwise might, provide them information in the form in which they usually experience it" because this will in turn make it more meaningful and conceivable.

Qualitative research methods have several strengths. They generate abundant and exhaustive data that allow the participants' perspectives to remain intact and the availability of multiple contexts for understanding the phenomenon under study. Additionally, data based on primary and unstructured recordings of human experience that is obtained through qualitative methods is powerful and sometimes more compelling than quantitative data. Interaction with the research subjects in their own setting and on their own terms allows for the discovery of subtleties and complexities about them that would otherwise remain obscured. The flexibility of the research framework allows for revisions of the data collection, subsequent analysis, and interpretation of collected information as new information emerges (Anderson, 2010: 142).

On the other hand, several of the limitations of using techniques from the qualitative research paradigm tend to mirror the innate strengths of these methodologies. The quality of the research is heavily reliant on the researcher's abilities and they are more easily predisposed to her personal biases and idiosyncrasies. Furthermore, the volume of data generated can make analysis and interpretation laborious and time consuming and significant concerns may arise with regards to anonymity and confidentiality. These can present considerable challenges for the presentation of findings (Anderson, 2010: 142-143).

2.2 Methodologies applied for data collection in this study

2.2.1 Introduction

The design of this research was based on a purposeful selection of the cases for study. The sources needed to be arising from within the MDH organisation and seek to demonstrate the experiences of people and the cultures operating within the community of professionals in the hospital. The selected methodologies needed to be "information rich" and illuminative: having the capability to "manifest the phenomenon of interest". On the other hand, the sampling performed was targeted towards maximizing insight about the phenomenon (Patton, 2002: 40).

The collection of data was engineered to capture direct quotations about people's personal perspectives and lived experiences from unstructured interviews. Collection of data was also conducted to gather information from the researcher's personal experience and engagement through her direct contact and involvement with a team of healthcare professionals which was set up to spearhead activity within the hospital in the field of patient safety and quality improvement. The latter 'action research' methodology revolved on data collected by the researcher during the two and a half years' journey with this team. This data is closely connected with the researcher's personal experiences and insights as these are considered as a vital part of the inquiry and critical to understanding the phenomenon (Patton, 2002: 40).

The analysis of the collected data acknowledges that it is very context and temporal specific for the unique setting and situation at MDH within the time frame of this study: 2013-2015. An inductive analysis approach has been adopted and employed via the 'immersion' in the specifics and details of the data. Analysis was aimed at finding significant patterns, themes, and inter-relationships. The data is 'owned' by the researcher and the narrative portrays the researcher's perspective and reflexivity. The documentation of the researcher's reflections is meant to clearly portray her biases, presuppositions, and interpretations.

2.2.2 Selectively employing the qualitative paradigm of research

This dissertation is based exclusively on the qualitative paradigm of research. Hoepfl (1997: 49) synthesized a list of prominent considerations that had been identified by several earlier authors and that need to be explored when a research based on naturalistic inquiry is being planned and conducted. Patton (1990: 59) argues that these features are not "absolute characteristics of qualitative inquiry, but rather strategic ideals that provide a direction and a framework for developing specific designs and concrete data collection tactics". These attributes are analyzed and pegged with deliberations by the author of this dissertation. These considerations eventually led to the choice of the naturalistic paradigm as the foundation for this study and the specific strategy of choosing the two main methods for data collection: in-depth interviews and action research.

a. Qualitative research uses the natural setting as the source of data. The investigator seeks to observe, discern, depict and construe the research settings as they are. Patton (1990: 55) promotes the term "empathic neutrality" as a middle ground between becoming too involved (overly subjective), which can cloud judgment, and remaining too distant (overly objective), which can reduce understanding. The subjective versus objective terms are replaced by trustworthiness, authenticity, credibility and neutrality. The latter signifies the need that the investigator enters the research settings without a particular perspective or theory to prove or pre-determined results to support.

The researcher in this study sought to embrace and be mindful of all these qualities in her attitude towards her interactions experienced with all the research participants during the data collection encounters. This is also exemplified by the grounded approach taken in the data collection and analysis processes.

b. The researcher acts as the "human instrument" of data collection (Denzin and Lincoln, 2011: 115). In qualitative research, the researcher herself is considered as the "instrument" of data collection, meaning that the data are mediated through this human instrument rather than through other means such as records, surveys or equipment (Simon, 2011). Readers of the research dissertation need to get to know the instrument and therefore, the researcher

is required to communicate pertinent aspects of herself, including relevant biases, assumptions, expectations and experiences that make her eligible to conduct the reported study (Greenbank, 2003: 798). This is helped by a strong element of reflexivity wherein the investigator explains her personal reactions and reflections on the collected data. Furthermore, the researcher should declare her positioning on whether she is 'emic' – an insider or a full participant in the activity or initiative, or whether her role is more 'etic' – adopting a more outsider or observer stance.

In the data collection process, this researcher documented her reflexive insights in the various memos adjacent to a number of codes during the note taking, transcription and codification processes. Furthermore, this researcher took up an 'emic' role during the action research arm of her study as a member of Patient Safety and Quality Improvement Team (PaSQIT) and a more 'etic' role during the in-depth interviews.

c. Qualitative research reports are expressive and descriptive and present the "voice in the text" (Eisner, 1990: 36). An effective qualitative research report seeks to build a picture from the data, ideas and theories arising from the participants' perspectives. At the crux of qualitative research there needs to be the representation of the authentic voice of the informant and an illustration of the 'story' that reflects how the participants' perceive the situations studied (Klenke, 2008: 11). The study needs to have an interpretative character, designed at discovering the meaning proceedings have for the persons who experience them, and the construction of those implications by the researcher.

This research dissertation report is illustrating its findings and assertions with quotations and memos taken from and referencing to the action research journal including PaSQIT events and documentation, and detailed transcripts of the in-depth interviews.

d. Research embedded in the qualitative paradigm is required to draw on the distinctive data collected and to "pay attention to the idiosyncratic as well as the pervasive, seeking the uniqueness of each case" (Hoepfl, 1997: 49). Dey (2003: 18) mirrors this assertion by the counter-claim that "to recognise an

exception, we have to understand the rule…. recognising patterns of events". A distinguishing characteristic of the social world that qualitative research seeks to elucidate is that what underlies issues and events are often much more complicated than what they initially appear. When delving deeper into the groups of people collectively demonstrated for example in the statistics shown as results of quantitative studies, in all probability it will be found that individually they are much more differentiated in their views, opinions, interests and in terms of their ways of "navigating through the world", than what might be otherwise apparent in the positivistic reporting (Brown and Baker, 2007:45).

This dissertation acknowledges the wealth of distinct insights captured during its data collection activities and the thesis report will attempt to portray this richness from particular cases while at the same time seeking to find and expose the common threads that link them together.

e. It is important to underline the "emergent (as opposed to the pre-determined) design" (Hoepfl, 1997: 49) of qualitative research. Bazeley (1999: 279) describes the qualitative researcher as a "*bricoleur*, a practical person who works with whatever strategies, tools and materials are available to piece together an emergent solution to a puzzle or a problem". The analytic techniques used aim at reciting, decoding, rendering and subsequently come to terms with the meaning, not the frequency of certain naturally occurring phenomena in the social world (Gilmore and Carson, 1996: 23).

The researcher in this study endeavored to observe and interpret meanings in the context arising from the inquiries based on the research question. Data collection evolved taking into consideration what information will be most useful, and what data will have the most credibility. Flexibility in the research design was maintained throughout the conduction of this study to allow it to be responsive to emergent needs as the fieldwork unfolded and developed (Guba and Lincoln, 1985: 225). While the initial focus and plans for observations were documented, the naturalistic and inductive nature of this inquiry required that the design remained open-ended and receptive to evolving and unplanned new ideas and discoveries.

Brown and Baker (2007: 42) explained that judgements on the usefulness and credibility of a qualitative research report are left to the researcher and the reader to determine, often in the light of the ethical and political commitments and allegiances that the researcher declares in her detailed exposition.

2.2.3 The role of the researcher in qualitative inquiry

In preparation to conduct qualitative research, the researcher needs to become "attuned" to the characteristics of the naturalistic paradigm especially by homing in on the skills appropriate for data collection if she will assume the role of the "human instrument" (Hoepfl, 1997: 50). The term "theoretical sensitivity" initially introduced by Glaser and Strauss (1967) and then further expounded by Strauss and Corbin (1990) refers to,

> …. a personal quality of the researcher. It indicates an awareness of the subtleties of meaning of data. …[It] refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't.
>
> (Strauss and Corbin, 1990: 42)

Theoretical sensitivity is attributed to the researcher's skills and inclination to undertake a qualitative inquiry. These abilities are sourced from *inter alia* professional literature, and professional and personal experiences. Several characteristics have been identified that makes the choice of the "human instrument" as the instrument of choice for qualitative inquiry. These include the abilities to:

- be responsive to environmental cues;
- interact directly with the situation;
- concurrently collect information at several levels;
- perceive situations holistically;
- process data instantaneously as it is being collected, deliver immediate feedback and request clarifications and verifications as necessary, and
- search for atypical and unanticipated responses

(adapted from the seminal work of Guba and Lincoln, 1985: 193-194)

This is the second time that I have performed a research study guided by the approach of the naturalistic inquiry paradigm. The first instance involved the successful completion and presentation of my dissertation as a requirement for the Masters in Business Administration in 2005. I have also continued to use the skills I acquired in qualitative research during my professional work as a medical specialist in Public

Health Medicine mainly in the field of policy development. These abilities and experience have been brought forward, applied and further advanced during the course of conducting the data collection and analysis for this present study.

2.3 The qualitative methodologies employed for data collection

2.3.1 General considerations

Due to the nature of qualitative inquiry which sets down a premium on the strengths of the researcher rather than on standardization, Eisner (1990: 169) asserted that there is a "paucity of methodological prescriptions" that can be employed in qualitative research. Dey (1993: 1) opines that the need for a "plurality of perspectives" is also deemed reasonable due to the fact that "social science is a social and collaborative process (even at its most competitive), in which (for example) descriptive work in one project may inspire interpretive or explanatory work in another (and vice versa)". Tesch (2013: 58) identified and listed more than forty different approaches to qualitative research, but suggests that despite this remarkable spread there is still "a strong family resemblance between these different research orientations". This statement reinforces the importance that all these perspectives ascribe "to the meaningful character of social phenomena, and the need to take into account in describing, interpreting or explaining communication, culture or social action" (Tesch, 1991: 25).

Qualitative data is concerned with meanings and meanings are mediated through language and action (Dey, 1993: 10). On the subject of meaning, Dey further expands that:

> Meaning is essentially a matter of making distinctions…Meaning is bound up with the contrast between what is asserted and what is implied not to be the case…Meanings reside in social practice, and not just in the heads of individuals
>
> Dey, 1993: 11

Data dealing mainly with meanings may appear unreliable but they may also be highly illuminating and intriguing. Qualitative data encompass an immensely rich variety of cultural and social artefacts and concepts. Qualitative data is more linked to 'quality' which is a measure of relative value and which is in turn based on an assessment of the general character or inherent nature of what we are evaluating. Data related to

social phenomena is also described as “concept-dependent” or “polyvalent” as they are influenced by the meaning that we as “self-interpreting beings” ascribe to them (Sayer, 2010: 157). This is further supported by the understanding that it is seldom possible to reduce complex social behaviours into combinations of simple behaviours which are unalterable across contexts.

A method of data collection may produce different types of data. Dey (1993: 15) explains that ’collecting’ data constantly implicates the selection of data, and that the methods of data collection and transcription (through notes, recordings or other sources) will always have a bearing on what in the end constitutes ‘data’ for the objectives of research. Therefore, different methods may be appropriate to different situations and different research questions. In practice and in particular in qualitative research, a range of methods producing a variety of data are often employed. Dey (1993: 15) suggests that it is important and more valuable to focus on the data that has been produced rather than to concentrate on the rigid distinctions between different methods of data collection or research approaches.

In the course of the fieldwork for this dissertation, data was collected concurrently using two different methods or sources for data collection. The fieldwork for both methods, namely in-depth interviews and an action research project, were conducted more or less in parallel over a period of almost two years for the former and two and half years for the latter. Data was collected from:

1. A set of twenty-five (25) **unstructured and in-depth interviews** with people working within MDH or who have had connections with various sectors of the human resources at MDH, through for example, training and mentoring programmes. The selection of the interviewees was directed by the principles of “theoretical sampling” as utilized in research quests guided by the grounded theory approach. Coyne (1997: 629) claims that all sampling in qualitative research is “purposeful sampling” in that the sample is selected intentionally in accordance with the rationale of the study in question. Purposeful sampling allows selection of cases (e.g. people, organisations, events) that offer useful insights and manifestations of the phenomenon under study and is not aimed at empirical generalization from a sample to a population (Patton, 2002: 40).

Coyne (1997: 629) explains that the theoretical sampling technique is one type of purposeful sampling and is closely linked to constant comparative analysis and theoretical saturation. This route is most effectively used when the research focuses on theory and concept development. It is adept to research that has the explicit goal of developing theory and concepts that are grounded in, connected to or emergent from real-life events and situations.

2. An **action research** diary that documents sixty-eight (68) episodes of events and activity within the Patient Safety and Quality Improvement Team (PaSQIT) of MDH. This team started to be formed in March 2013. The author joined the team in May 2013 during the long weekend (2-6 May) during which Dr. Peter Lachman (Deputy Medical Director for Safety at Great Ormond Street Hospital) paid his first visit to the hospital. In 2013, Dr. Lachman was invited to MDH by the CEO of MDH at that time to help set up PaSQIT. The action research arm of the study starts with the reports of meetings held before the May 2013 visit and ends with another visit organised by PaSQIT in conjunction with the training coordinator of MDH for Dr. Lachman in November 2015 (13-16 November). Action research is a form of inquiry that permits practitioners to investigate and evaluate their work. Action researchers have been termed "insider researchers" because they are investigating a context in which they themselves are personally involved and participating (McNiff and Whitehead, 2011: 7-8). In action research, the process of 'observing – reflecting – acting – evaluating – modifying – progress to a new direction' is typically employed. This process often takes an ongoing cyclical or spiral trajectory and therefore it is frequently referred to as the 'action-reflection cycle' (McNiff, 2002: 57). Action research is about both improving practice as well as proposing explanations and descriptions ('generating theory') for what brought about the demonstrated practice improvements and changes by the practitioner's together with the other members of the action team involvement and actions (McNiff and Whitehead, 2011: 14).

2.3.1.1 Validation procedures

Research conducted within the qualitative domain seeks to provide powerful and comprehensive descriptions and interpretations about the phenomena under study and as they occur in their natural environment or setting (Sousa, 2014: 211). Hill and colleagues (1997: 518) emphasize that "the starting point is not a previously determined theory, but instead the conclusions are rather based on the data and are therefore, inductive". Qualitative data collection and analysis approaches are "exploratory rather than confirmatory, descriptive and comprehensive rather than explanatory, interpretative rather than nomothetic" (attempting to establish general laws and generalizations) (Rennie, 2002: 179).

Over the last two decades, several guidelines have been proposed for and their suitability extensively debated on the issue of validation in qualitative research. Sousa (2014: 213) describes how these procedures can be divided into two distinct clusters: extrinsic (arising from approaches used in quantitative research that are imported and adapted to qualitative methods) and intrinsic (exclusively based on the qualitative research context). An enduring notion is to supplant the three dominant concepts applied for the assessment of scientific knowledge particularly in the quantitative paradigm: validation, reliability and generalizability with the corresponding notions of trustworthiness of the method, coherence of results and transferability and application of results (Lincoln and Guba, 1985: 300; Hill et al., 1997: 556).

Several techniques have been documented as methodologies that promote and ensure the trustworthiness of the method/s used in a research project based on the qualitative approach and the related concepts of credibility, transferability, dependability and confirmability. These include the clear and meticulous description of all methodological steps employed in the data collection and analysis processes, the adequacy of the research question and participant sample to the thematic base of the enquiry, the use of triangulation and peer debriefing (Lincoln and Guba, 1985: 328; Morrow, 2005: 255). This research project report includes the detailed description of the methodologies applied for the data collection and analysis in this study in chapters 4 and 5. More than one method was employed and each arm informed the other and in particular the selection of subsequent interviewees. The selection of the two

methods employed in this study was based on the need to conduct an in-depth enquiry into a research question that is essentially exploring multifaceted phenomena in the complex social system of a hospital. Peer debriefing was conducted by sending the interview transcripts for the review of the interviewees and by submitting the meeting reports for the review of the PaSQIT members before the next meeting.

The reliability and coherence of results is another validation aspect of qualitative research. These criteria are also directly related to the trustworthiness of its interpretations and conclusions. Results are considered to be reliable, coherent and adequate "when they are internally consistent, effective and fecund, in other words, when there is consistency of meaning" (Sousa, 2014: 215). Practically all qualitative methods advocate the principle that interpretations should arise from the data and that the connections between the abstract constructions and conclusions and the context and content of the collected data are made clear and explicit (Morrow, 2005: 256). The data collection and analysis methods applied in this research were guided by the grounded theory approach with its mainstay of 'grounding' all research findings in the data generated by the enquiry. A detailed documentary of the analytical processes and the results of the different iterations of the data analysis through mainly the different coding cycles are described in chapter 5. Triangulation arising from the utilization of data collected from different sources and by different methods also reinforce coherence of results (Hill et al., 1997: 558; Sousa, 2014: 216). The use of the two distinctly different methods used in this study attest to this argument.

Finally, the consistency and plausibility between the data, its connections and its explanations should also be concerned with how the interpretations may add to and modify the knowledge about the subject matter under study and enable the elucidation of novel understanding and perspectives. Ascertaining and demarcating theories and conceptual structures that can be considered for application to other contexts is one of the aims of qualitative research. In naturalistic-inductive studies, advances to knowledge primarily follow a path from data to theory and "implies a continuous process of elaboration of new knowledge in systems of established meaning and an active accumulative process of representation" (Sousa, 2014: 217). This is directly related to the notion of applicability of results and external consistency.

The latter refers to the researcher's ability to demonstrate a consistent line between the resultant theory and concepts and their capacity to contribute to the generation of new knowledge. Therefore, while not always possible, the construction of new concepts and theory about specific phenomena of human experience may be found to be also useful and applicable to contexts, communities and, as in the case of this study, organisations beyond those from which the data that eventually leads to the generation of a theory was collected.

2.4 The methodologies applied for data analysis

2.4.1 Introduction

Qualitative analysis is a process of dissecting data into its component elements in order to reveal its distinctive constituents and structure. Analysis allows the creation of new and different views of the data collected. It can take the form of a circular process that involves the initial description, through the process of "breaking down" the data into small components, classification and categorization of these components and conceptualizing how they interconnect. The final aim is to derive a new account based on the re-conceptualization of the data (Dey, 1993: 30). This process can be depicted as a circular process as seen in Figure 1.

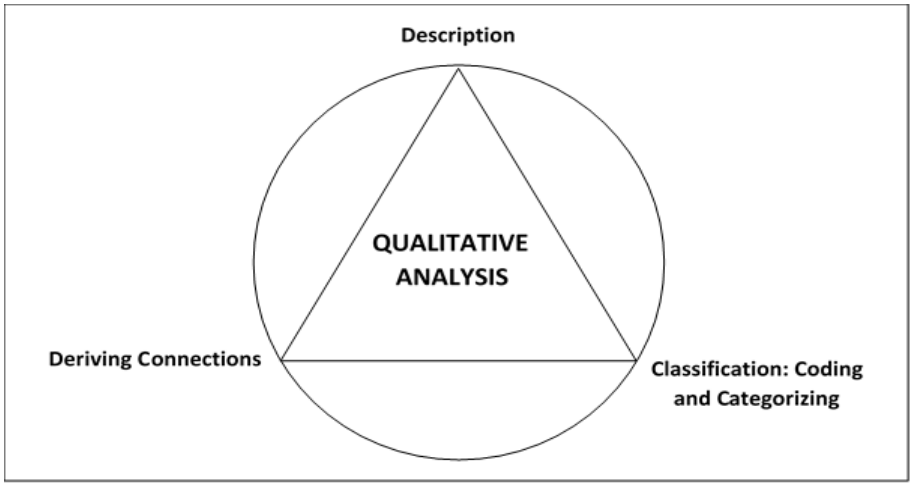


Figure 1. Illustration of the circular process in Qualitative Analysis incorporating the three main domains (Adapted from Dey 1993, Figure 3.1: 31)

The several processes or steps that take place during the analytic phase of qualitative data can be broadly divided into the three domains of:

A. Description
B. Classification: coding and categorizing
C. Deriving connections

2.4.2 Description

Description entails, the systematic and comprehensive description of the phenomenon under study. This is referred to as a "thick" description by Denzin (1978: 33) and needs to include 'the context of action, the intention of the actor and the process in which action is embedded' (Dey, 1993: 31).

i. Contexts: the context/s in which action/s are situated are very important and present a recurring theme in qualitative analysis. Contexts can be viewed as a "key to meaning", because only when the context is well explained and understood can the meaning be "'correctly' conveyed" (Dey, 1993: 32). Communication generally implicates the inference of meanings from the context in which it takes place (Sperber and Wilson, 1986: 15). Furthermore, observations of the same occurrence by different observers often differ and therefore, since meaning is dependent on context, the setting and hence the positions and perspectives of each observer or observation need also to be inclusively described.

ii. Intentions: how actors describe situations and developing explanations for the motivations that govern their actions is widely accepted as a major aim of qualitative analysis.

> The intentions and perceptions of subjects often enjoy a privileged position in qualitative research, because of the access they can give us to the meaning of action for particular observers.
>
> Dey, 1993: 36

The researcher also evaluates other sources of meanings invested in the social action apart from the description of the various perspectives on a particular phenomenon obtained from the different subjects involved in the research project. These can include relevant 'rules of the game', cultural significance, social organisation and any related psychological or economic rewards. However, the accounts of the research participants' intentions, and any

inferences from their behavior needs to be treated with the necessary caution. Due allowances need to be made for behaviors and attitudes that can result in communications provoked by for example, ignorance, self-deception, delusions and lies. Furthermore, the researcher needs to be mindful of the likelihood that these can be influenced or distorted by strong social forces such as on the one hand deferential attitudes towards power, pressures for conformity, fears of embarrassment or conflict, and on the other, politeness, civility and the desire to protect others (Dey, 1993: 36-37).

iii. Process: due to the probabilities of different contexts and intentions, the communication of meaning has been regarded as "negotiable" (Dey, 1993: 37). Additionally, meaning can also evolve and change over time and therefore a description of dynamic processes is considered as the third characteristic of the descriptive method of qualitative analysis. Data collection in qualitative research is frequently conducted over a period of time, and therefore, analysis can elucidate interactions, relationships and connections as they are revealed in the sequences of actions and events and eventually consequences in which the research participants are engaged. The importance of process in qualitative description is reinforced by the interactive methods that are often employed for data generation and collection. Analysis frequently ensues in tandem with data collection and the results are in turn contingent in character as they can in turn stimulate and be revised by the collection and examination of additional information.

In summary, the meticulous and detailed description of contexts, intentions and process are considered as essential in order to ensure that interpretation and explanation for social action are based on adequate foundations (Dey, 1993: 39). Well executed, description of the data will result in an integrated and reasoned account and will start to clearly demarcate the more central characteristics of the findings.

This research employs a range of techniques to accomplish this analytic phase. These include the summarization of events, the delineation of roles and personalities and the highlighting and portraying the chronological sequence of key events.

2.4.3 Classification

An essential and integral function of the analytic process is the classification or categorization of data. In the development of a meaningful report for the research project the researcher endeavors to interpret and explain (inferring meaning and accounting for actions and events not necessarily in agreement with the actors' explanations and intentions) actions and events. This necessitates the development of a conceptual framework through which the actions or events under study can be rendered understandable and can be clearly presented and communicated (Dey, 1993: 39-40). Additionally, Dey (1993: 44) asserts that classification is a 'conceptual process'. The process of classification is performed to achieve two main functions:

i. **Data is broken down 'into bits' through the process of coding.** In essence, coding is the process of defining what the data are all about. Saldaña (2013: 3-4) defines and explains that a code in qualitative inquiry is the:

> … word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual date.
> In qualitative data analysis, a code is a researcher-generated construct that symbolizes and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorization, theory building and other analytic processes.
> ...a code can sometimes *summarize*, *distill*, or *condense* data, and not simply *reduce* them.
>
> Saldaña, 2013: 3-4

Coding has also been described as the "critical link" connecting data collection with the elucidation of meaning and the formulation of an emergent theory to explain the collected data (Charmaz, 2001: 165). Coding is primarily an interpretative activity and in fact as Madden (2010: 10) notes such analytic activity does not diminish but actually "adds value" to the research story. The coding process involves the "combing" of the data for themes, ideas and categories which is then followed by the "marking" of similar passages of text with a code label. Code labelling will allow easier retrieval of related excerpts in the analytical exercises employed to identify patterns and make comparisons and connections between different parts of the data.

The coding process involves close reading of the text and codes. It can result in the derivation of themes or topics, can relate to ideas and concepts,

highlight specific terms and phrases or identify keywords. All texts that are judged by the researcher to be related to the same theme or concept are denoted by the same code. Codes will evolve and grow in number as more themes and concepts become apparent and the end result will be a list of codes that will identify different issues and topics contained or emerging from the research data set. Coding can start from *a priori* ideas such as from the literature review of previous research and pre-existing theories or can be allowed to emerge from the data collected as it is read by adopting a grounded approach, i.e. putting aside previously acquired knowledge and assumptions and focusing instead on finding new themes embedded in the data (Taylor and Gibbs, 2010: 1). The coding process in the grounded theory tradition entails creating and allowing codes to emerge as the data collected is studied and as a result the coding process may eventually take the study into unanticipated areas of interest and research inquiries. The researcher 'interacts' with the data and asks questions of them, such as:

> What is going on?
> What are people doing?
> What is the person saying?
> What do these actions and statements take for granted?
> How do structure and context serve to support, maintain, impede or change these actions and statements?
>
> Charmaz, 1996: 37

Some experts advise line-by-line coding. Advantages of this stance include the need to remain close to the data and to refrain from imputing the researcher's motives, fears or unresolved personal issues to the collected data. Furthermore, it is useful to ensure that the analysis is constructed from the ground up "without taking off on theoretical flights of fancy" (Charmaz, 1996: 37).

The coding processes adopted in this project were consistent with the practices used in the grounded approach and time-consuming line-by-line coding was performed to the texts accumulated from the in-depth interviews and action research diary and documents. The first cycle of coding generated 616 codes from the in-depth interviews and 203 codes from the action research diaries and documents.

ii. **Organizing codes into categories or classes**. The codes are brought together or organised and grouped into different categories and/or "families" of similarly coded data that share some characteristics, through a process described by Dey (1993: 40) as "practical reasoning". Categorization or classification use reasoning in addition to the researcher's tacit and intuitive senses to determine which data "look alike" and "feel alike" when grouping them together (Lincoln and Guba, 1985: 347). An apt metaphor for the development of categories and thence continuing the analysis to seek for connections between them was presented by Charmaz (2006: 45). She states that:

> … coding 'generates the bones to your analysis…[I]ntegration will assemble those bones into a working skeleton.
>
> Charmaz, 2006: 45

Qualitative inquiry calls for "meticulous attention to language and deep reflection on the emergent patterns and meanings of human experience" (Saldaña, 2013: 10). Following a first cycle coding process, second and consequent cycles of review of the data aim at refining the codes and categories and to proceed from the descriptive or representational to the more conceptual and abstract (analytical and sensitizing) codes and categories (Dey: 1999: 8). In these processes codes may need to be replaced, subsumed by other codes, re-labelled or removed altogether. Another apt metaphor for the subsequent reviews of codes and categories was created by Abbott (2004: 215) who likened these activities to:

> … decorating a room: you try it, step back, move a few things, step back again, try a serious re-organisation, and so on.
>
> Abbott, 2004: 215

In their seminal work that introduced Grounded Theory, Glaser and Strauss (1967) advocated a "constant comparative" method for generating and analyzing data. Initial stages involve the identification of categories and their properties. A "category" is expected to "stand by itself" as a conceptual constituent of the theory; whereas a property is a "conceptual aspect of a category" (Glaser and Strauss, 1967: 36). Categories are thus considered as "indicated" by the data rather than being only representative of the data and

they need to be analytic and lead to the conceptualization of some key features. Categories also need to be "sensitizing" in that they provide a "meaningful picture" that "helps the reader to see and hear vividly the people in the area under study" (Glaser and Strauss, 1967: 37-38). The researcher and analyst are advised to increase the levels of abstraction and integration through the process of "constant comparison" such that as the original concepts are compared and contrasted, more abstract and integrating concepts might emerge:

> …. different categories and their properties tend to become integrated through constant comparisons that force the analyst to make some related theoretical sense of each comparison.
>
> Glaser and Strauss, 1967: 109

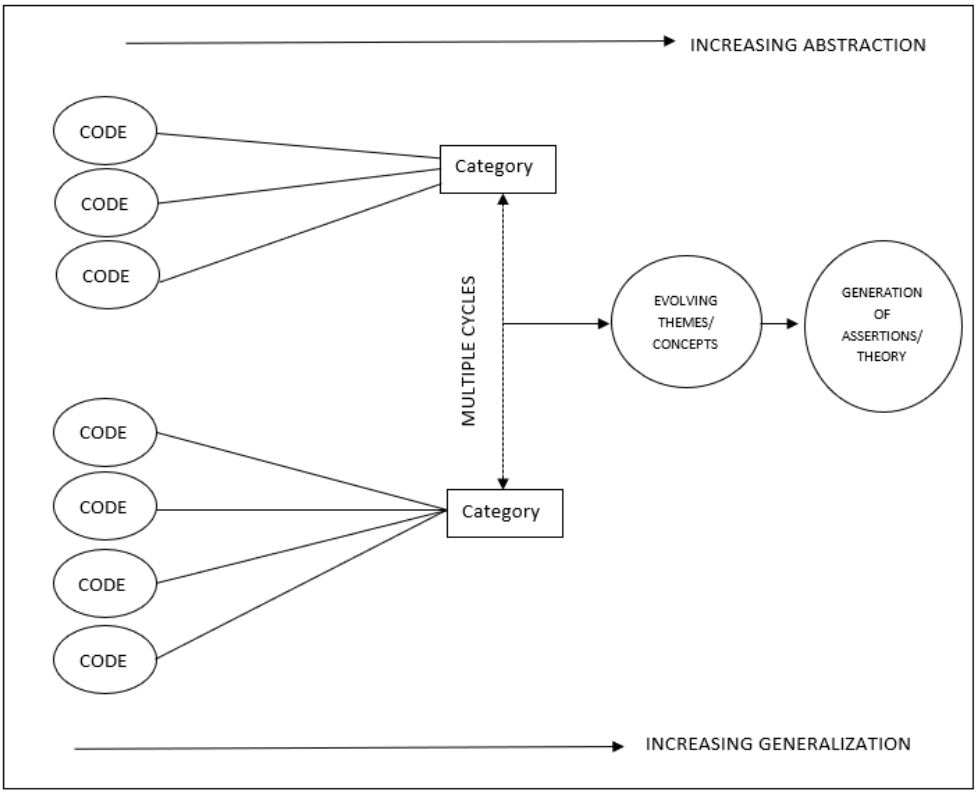


Figure 2. A streamlined codes-to-theory model for qualitative inquiry (adapted from Saldaña, 2013: 13, Figure 1.1)

The process of comparing categories with each other and the consequential re-organisation should eventually lead to "transcending the reality" of the data and towards the emergence of themes, concepts and theory (Saldaña, 2013: 12). In turn, Corbin and Strauss (2008: 55) opined that the systematic portrayal of the inter-relations of the emergent themes and concepts should lead to the development of theory. A simplified illustration of the codes-to-theory model that has served as an

inspiration for the expected direction and outcomes the data analysis conducted for this qualitative inquiry is shown in Figure 2 above (Saldaña, 2003: 13).

The codes generated during the first coding cycle from both the in-depth interviews and action research diaries and documents were separately re-visited a number of times. During each cycle codes were grouped (or classified) and sometimes re-grouped into rational and logical categories. In several instances, this involved the re-reading and re-analysing of the original source and attached analytic memos. All this work was aimed at re-organising and re-assembling the transformed data to achieve an increasingly better focus of the direction of the outcomes of my study. The 616 original codes generated from the data collected in the in-depth interviews were eventually incorporated into twelve (12) categories, while the 203 codes collated from the action research diaries and documents were in due course assembled into nineteen (19) categories. This work overlaps and alternates with the activities that are described in more detail below and entail the identification of substantive connections and associations between different variables (Dey, 1993: 47).

2.4.4 Deriving connections

The examination and search of the data for consistencies, patterns, deviations and peculiarities in the collated information and the identification of associations between the different variables lead to the postulation and derivation of connections. Description and classification and categorisation work aim at leading towards the elucidation of the concepts that are 'building' components of the data analysis. But the ultimate aim of all this work is the production of a coherent account of the data analysis and an apt metaphor promoted by Dey (1993: 47) illustrates "connecting concepts as the analytic equivalent of putting mortar to the building blocks". Through classification, substantive connections can be identified, and the further study of the emerging correlations between the different categories will help in the exposition of fresh perspectives and the depiction of a conceptualisation of the data which will be at the same time more complex but clearer than the picture concocted from first impressions of the collated information. In this analytical process, researchers "interrogate" their data and explore potential connections between categories. For

example, in the attempt to understand how events happened researchers may derive attributes about the inherent capabilities and liabilities of the social actors (be they individuals, teams or communities) of the study and how these interrelate together to result in the observed and particular effects and events. Information on the positions that the social actors occupy and interactions that they have within their specific social structures may also be relevant (Dey, 1993: 50). All these factors can influence the respective identities and roles of the actors and provide opportunities and constraints.

The main tasks of qualitative analysis are to develop conceptualisations, to evaluate the adequacy of the formulated concepts and themes in the light of the data and articulate hypotheses and indicators for the phenomena observed and documented. Furthermore, in social research, the dividing line between formulating and testing theories is often not highly discernible (Sayer, 2010: 204).

2.5 Adopting a grounded approach to data collection and analysis

Employing two initially unstructured and qualitative methods of data collection directed the methodology of subsequent data collection and analysis towards the choice of embracing a grounded approach in order to develop a continuous dialogue between the data gathering and the analysis processes. In due course, and through the use of this approach, the knowledge generated led to more selective and focussed data collection. This approach also surmises that theory develops from the data as it is collected and analysed. A "constant comparative" method is applied such that newly collected data is continuously compared with previously collected data from earlier study encounters, for instance with earlier interviews or diary inputs. This continuous and ongoing process permits concepts and themes to be gradually formulated, enriched, becoming more abstract, confirmed, or sometimes even discounted as a result of the new data that is collected, generated and emerging from the study. In line with the seminal work of Glaser and Strauss (1967), the constant comparative method is:

> … characterized as (1) generating and (2) integrating categories and their properties, before (3) delimiting them and then (4) writing the emerging theory"
>
> Dey, 1999: 7

Categories were generated as data was collected and coded. Subsequent cycles of coding and classification led to the development of categories that became more analytical or "indicated" by the data and "sensitising" by providing a "meaningful picture" rather than representational. Categories are considered to "stand by themselves" as conceptual elements; whereas properties are defined as "conceptual aspects or elements of a category" (Glaser and Strauss, 1967: 36-38). Following a number of iterations during which initial and subsequent emerging categories and concepts were compared and contrasted, a higher level of abstraction and integration was attained such that:

> …different categories and their properties tend to become integrated through constant comparisons that force the analyst to make some related theoretical sense of each comparison.
>
> Glaser and Strauss, 1967: 109

Research methodology guided by the grounded theory paradigm has become increasingly popular over the last two to three decades. In the process, different approaches to account for a range of ontological and epistemological underpinnings are evolving (Mills, Bonner and Francis, 2006: 8). Constructivist grounded theory is founded and established in relativism and an understanding of the multiple truths and realities of subjectivism. Constant reflexivity in qualitative research is considered as highly important by a majority of the grounded theorists especially post-2000 (Thornberg, 2012: 254).

> What is needed is for the researcher to recognize her or his own assumptions and beliefs, make them explicit, and use GT techniques to work beyond them throughout the analysis.
>
> Schreiber, 2001: 60

In qualitative research, the researcher applies herself as the principal instrument in data collection and analysis. Through the recognition of her preceding knowledge and theoretical understanding, the researcher acknowledges the necessity for constant reflexivity and in so doing she does not reject prior knowledge, perspectives and privileges, and does not pretend to be without preconceptions and theoretical influences. Mills, Bonner and Francis (2006:9) explain that the researcher has to reflect on and explicitly document her underlying assumptions and the analytical lenses through which she "gazes" at the data. This process is aided by creating and archiving personal thoughts, for example in memos or research diaries format and its application

allows the researcher to reflect on and become aware of how her own concepts are constructed. It can be used as a "self-monitoring tool" to test how the literature, preceding research and theoretical constructions are utilised. This is the basis of the informed grounded theory approach as promoted by Thornberg (2012: 255) through which the researcher

> takes the advantage of pre-existing theories and research findings in the substantive field in a sensitive, creative, and flexible way…critically adopted in the analysis but are judged in terms of their relevance, fit, and utility. The informed grounded theorists do not use the literature as forcing applications or deductions, but are guided by a set of data sensitizing principles.

The ultimate target of analysis is to produce an intelligible, coherent and valid account (Dey, 1993: 52). The process needs to be demonstrated as systematic and rigorous. Analysis can be portrayed as having an iterative and spiral course rather than a linear progression with distinct phases for description, classification and deriving connections. The qualitative researcher is intended to transcend simplistic views of the social world and to explain social action by critically evaluating the data collated in the research. During the analytic process, while steady focus is directed to methodically proceed from step to step, the researcher is allowed to from time to time obtain fresh vantage views of the path being followed and of the assembling picture. These new views are more than the sum of the sequence of steps that are taken during the analytic process. These viewpoints may lead to apparently non-sequential routes determined by the acquired new understandings of the findings, allows for the creative nature of the qualitative analysis to prevail and may be ultimately rewarded by unanticipated new revelations of the social actions and environments being studied.

2.6 Ethical considerations

Prior to the initiation of the fieldwork for this research in May 2013, the researcher with the expert assistance of her supervisor established contact with the Chair of the Research Ethics Committee of the Faculty of Economics, Management and Accountancy (FEMA). The nature of the research and planned methodologies were explained and the guidelines received were examined.

There were two main types of human interaction during the fieldwork for this research:

A. There were single one-to-one interactions between the researcher and each of the twenty-five interviewees during their individual interview sessions. The majority of these interviewees were professionals working at MDH. However, there was also a small number of interviewees who were not professionals working at the hospital during the time of the fieldwork or immediately before it. The latter small group of persons all had had or were still having close exchanges with different groups of the hospital workforce as experts in their fields, trainers and mentors in programmes and projects that had various aspects of human resources development as a key objective such as communications or management skills.
B. On the other hand, the action research methodology involved multiple contact sessions during PaSQIT meetings and activities both with the other team members as well as with the people that the team (as a whole or different sub-groups of it) came in contact and worked with. All the PaSQIT members were full-time healthcare professionals working at MDH. The vast majority of the people that the PaSQIT members worked with were also healthcare professionals working at MDH but there was also a small number of MDH members from other professional domains such as ICT (Information and Communication Technology), management and engineering.

Therefore, the research interactions were with participants in their own professional capacity. Furthermore, insights obtained both during the interviews as well as during the PaSQIT activities were obtained with the consent of the people involved. The interviewees were asked to read and sign a consent form which was based on the template supplied by the FEMA ethics committee. The consent form utilized is attached as Annex 1. Only an English version was prepared and used. The fact that the researcher's participation in PaSQIT was an integral part of her action research fieldwork was well known to the other team members. The researcher also took every available opportunity to inform people that were working with the team about her academic aims and her role as a participant-researcher. As advised by the supervisor, she also reported her progress in her research journey during a number of PaSQIT meetings.

Lastly, the data collected and analysed from the interviews was presented in an anonymized manner and every effort was taken to remove any possible identifiable information of all the respondents. The names of the members of PaSQIT as well as the names of a number of the top management people mentioned in this study are publicly well-known within the hospital environment. However, the data reported from the action research diary was also presented in anonymized manner within the dissertation report. The only notable exception was the naming of the expert invited by the hospital (Dr. Peter Lachman) to lead the two meetings (in May 2013 and November 2015) that were established as the start and end events respectively of the action research journal.

2.7 Conclusion

Recapitulating, this study adopted the qualitative enquiry paradigm as the basic underlying setting. Data collection and analysis focused on the documentation of and reflection on an action research process experienced by the researcher during her 30-month participant-researcher involvement with a group of professionals entrusted with promoting and implementing initiatives aimed at achieving quality improvement and patient safety within a major acute general hospital in Malta. The action research process was complemented with in-depth interviews conducted with individuals identified by using theoretical sampling techniques. Collection and analysis were also guided by a guided theory approach directed by the constructivist and informed grounded theory perspective, whereby pre-existing literature, research and theoretical knowledge are acknowledged and critically adopted in the analysis with the aim of positioning this study and its results and conclusions in the current knowledge base of the field and at the same time seeking to "also contribute to it by extending, challenging, refining, or revising it" (Thornberg, 2012: 255). Figure 3 illustrates the core epistemological approaches that were employed by the researcher and on which this research is based.

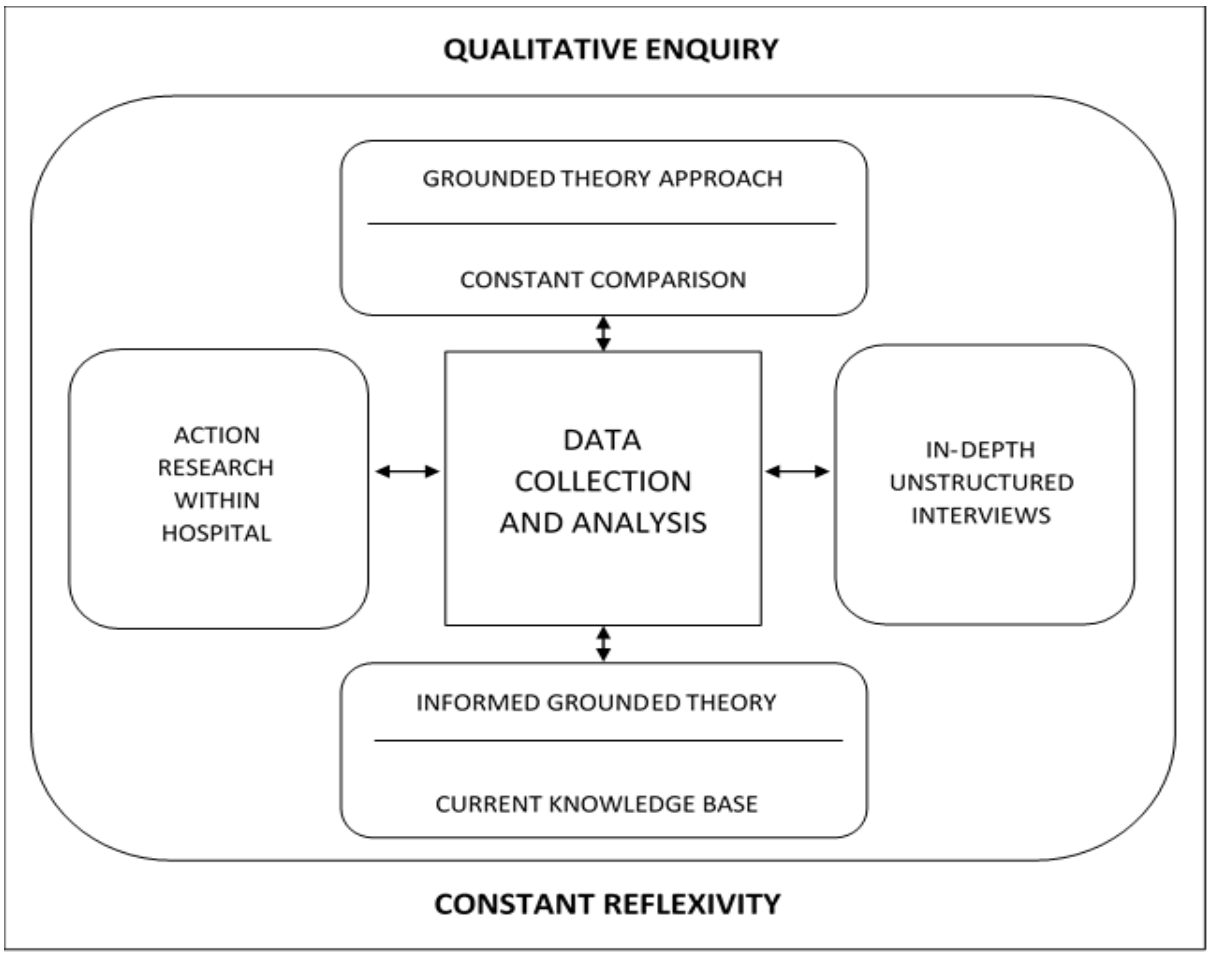


Figure 3: the core epistemological approaches that were employed by the researcher and on which this research is based

The next three chapters will report on and extensively demonstrate the data collected and analysed during this research. These chapters will be divided and structured around the three main domains that form the circular process in qualitative analysis as promoted by Dey (1993: 30-54) and presented in Figure 1 above. These three broad domains will articulate the:

A. Setting the scene (describing the setting and data collection)
B. Collecting and identifying the puzzle pieces (generating the data)
C. Bringing the puzzle pieces together (analysing the data)

CHAPTER 3: SETTING THE SCENE (Describing the Context)

3.0 The interest of the researcher in the questions underpinning this study

There is a growing body of literature that attempts to address research performed on institutions by practitioners. Several advocates for organisational learning and critical reflection including Chris Argyris and Donald Schön have noted the need for mechanisms that can be utilised to challenge and study the 'role expectations for legitimatization of *the status quo*' that are entrenched in most institutions. In other words, they recognized the value of problematizing the 'taken-for-granted' facets of organisations. There are several examples from a long tradition of studies on and theories concerned with "sources of distortion in social inquiry" (Harding: 1987: 9). They range from Plato's caves, to Freud's subconscious and Marx's false consciousness, through to Habermas's distorted communication, Lindblom's impairment of inquiry, and Argyris's theories-in-use (Herr and Anderson, 2015: 34).

Jürgens Habermas (1971) is a prominent promoter of the argument that there is no such thing as neutrality or disinterest in knowledge production. He asserted that interests are always in the background and provide substantial stimulus for the pursuance of a particular line of exploration. He also contended that within the public domain communications are always distorted through the relations of power embedded in the settings leading to the communicative acts. This contrasts with the stance taken by the vast majority of research traditions. Most research traditions are steered by sets of criteria that seek to determine the validity of the claims to the truth that are made and actually promote a disinterested standpoint towards the generation of knowledge.

Habermas (1971) asserted that human interest and knowledge generation were inseparable. A major development from his work are the arguments that counter the claims supported by objectivists that maintain the premise that only knowledge generated through the use of methodologies espousing empirical-analytical approaches are valid and hence legitimate. These methodologies emphasise the need for strict detachment between what is considered as the researcher bias and the subject matter being investigated. Instead, Habermas stresses that since knowledge is

created through the interest of the mind, then interest and knowledge are inseparably interrelated and cannot be disengaged. The illusions of the claim that "objectivism is the sole pathway to valid knowledge" are shattered by the processes of self-reflection. He consequently categorised the "interests" of the researcher in the quest for knowledge generation into three definite domains: technical, practical and emancipatory. Each individual "knowledge-constitutive interest" is rooted in human existence and expressed in a particular type of scientific or scholarly inquiry. Therefore, each is linked with a particular orientation and subsequently with different associated research methodologies (Habermas, 1971: 168).

Technical interest focusses on the human predilection (also termed "anthropologically deep-seated interest") to predict and control the natural and social environment. This orientation typically adopts a disinterested position toward the subject being investigated. Modes of inquiry and knowledge-production are prevalent in the "empirical-analytic" sciences: the natural sciences and types of social science that aim at testable general explanations (in contrast to the interpretive social sciences as the "normative-analytic" sciences which aim at achieving cultural understanding).

Practical interest refers to an orientation (which is equally deep-seated in the human psyche) concerned with gaining understanding through interpretation. The interpretative or cultural-hermeneutic sciences are employed in the quest to provide understanding of a given situation, in securing and expanding possibilities of mutual and self-understanding in the conduct of life and to inform and guide practical judgements (Bohman and Rehg, 2014). Human societies are dependent on such understanding, and the associated interpretive competencies, just as much as they are contingent on controlling the natural environment. Hermeneutical or interpretative methods such as textual, conversation and discourse analysis, ethnography and other qualitative approaches are affected by these interests.

The third cognitive interest according to Habermas is called ***emancipatory interest***. Emancipatory interest orientates the researcher towards the liberation of human potential and the inquiry of ideology and power within the organisation and society. Habermas drew from Freudian psychology and versions of Marxist social theory for the development of this cognitive interest. It is often expressed as a form of critical self-

reflection or a methodological reflection that aims to liberate science from the illusions created by the positivist paradigm. Carr and Kemmis (1988: 148) assert that the eventual target of this type of research is the:

> emancipation of participants from the dictates or compulsions of tradition, precedent, habit, coercion or self-deception.

The above attributes are thought to be subtly but deeply embedded into the belief structures of organisations. They can be retrieved and made apparent for examination through processes of critical self-reflection with the ultimate aim of inducing reform and transformation within the organisations. Kerr and Anderson (2015: 35) opine that while Habermas' knowledge interests have been heavily criticised especially when they have been appropriated to action research, the distinctions he expounded are useful and pragmatic. As a theory of rationality and knowledge, the theory of knowledge-constitutive interests is both pragmatic, in the consideration that human interests constitute knowledge, as well as pluralistic as it recognises that different forms of inquiry and knowledge emerge from different core interests. The idea of emancipatory knowledge interest points toward the potential for critical reflection and the problematization of current practices as well as one's unexamined assumptions (Tripp, 2011: 152). In essence, this notion emphasises the value of problem posing in conjunction or independently from problem solving. Table 1 summarises Habermas' cognitive interests.

Knowledge Interest	**Research Aims**
Technical (uses empirical analytic science and instrumental reason)	*Explanation* through empirical facts and generalizations
Practical/ Communicative (uses hermeneutical/ interpretative sciences)	Illumination and *understandings* of participants
Emancipatory (uses critical reflective/ action sciences)	*Critical reflection* – how understandings are constrained or distorted by power relations

Table 1: Continuum of Intentionality based on Habermas's Knowledge Interests
Source: Kerr and Anderson, Table 2.1: 36

This study was strongly motivated by my deep-seated and long-standing interest into the work dynamics of the people working within the major acute general hospital in Malta, namely Mater Dei Hospital (MDH). I have been close to the healthcare sector in

Malta throughout all my student and professional life. I wanted to be able to illustrate detailed examples of the complex and incessant interactions that take place between different professionals and between the professionals and the organisation and how these have an effect, both positive and negative, on the functioning (and outcomes) of the hospital. The functioning of the hospital is understood as meaning and including both the operational dimension particularly in the outputs of the organisation such as the number of patients admitted and treated, and more importantly the strategic dimension wherein outcomes take precedence such as the quality and safety of the care delivered.

I have both a personal and professional interest in seeking to learn and where possible influence (hopefully for the better) the functioning of MDH. To a certain degree, my personal interest stems from the fact that my relatives, friends and I are potential patients or carers of a patient. MDH is after all the only acute general hospital of its size and scope on the Maltese Islands and most secondary and tertiary care offered in Malta is either delivered completely or led by the professional teams working within this hospital. Professional interests are bound to my role as a health worker and especially to my specialisation and involvement into health policy-making which involves the planning, implementation, monitoring and evaluation of diverse health and healthcare services. Given the singularity and vital role of MDH in the Maltese context, working with and for this hospital acquires a special resonance to any developments and improvements that are envisaged and desired for health services delivery in Malta.

3.1 My 'Personal History' prior to my PhD journey

I have been immersed in the local health sector since my youth. The following few paragraphs seek to explain the trajectory of my working life from my late undergraduate student days to the present. The aim is to set the scene to how the interest in the subject chosen for my study has developed along the years and therefore to give a short portrayal of who I am and what influenced the interests and judgments that I had to make along the way. This narrative also aims towards showing how I gradually arrived into a position through which I could gain access within the

health system in Malta and in particular within MDH to areas that are usually restricted or allow only limited access even to most healthcare professionals by virtue of my professional positioning, roles and connections.

I am a female medical professional. My medical degree was obtained in May 1988 (aged 23 years) and I spent the first two years of my medical career doing my internship as a houseman (in today's terms as a Foundation Years doctor) at St. Luke's Hospital (SLH). During these two years I spent time working in the mandatory general areas of internal medicine and surgery and also covered specialist areas including paediatrics, oncology, gynaecology and obstetrics, and pathology.

In March 1990, I applied and was accepted as a Senior House Officer (in today's terms as a Basic Specialist Trainee) in Radiology. However, I just managed to spend four months in this new trainee post. In July 1990, I discovered that I was pregnant and the Clinical Chairperson for Radiology advised me to spend some time working outside the Radiology Department because of the inherent risks of radiation to early pregnancy. At that time, we were cognizant of the fact that the protective clothing for radiological work available did not provide sufficient and protective shielding to allay reasonable fears especially in early pregnancy. Consequently, I was transferred to work at the Department of Health Information. This department covers one of the several facets of Public Health Medicine through the conduction and coordination of descriptive and analytical epidemiology[1]. A few weeks after joining this department I was diagnosed to have had a 'missed abortion'. Following the end of the pregnancy I became rather obsessed with the notion of getting pregnant again and bringing the new pregnancy successfully to term. Therefore, it was not practical for me to return to my traineeship in Radiology and I started to be more and more involved in and committed to the medical discipline of Public Health Medicine.

[1] Epidemiology is the study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems. Various methods can be used to carry out epidemiological investigations: surveillance and descriptive studies can be used to study distribution; analytical studies are used to study determinants.
Source: World Health Organisation (2014) *Epidemiology*. Available at: http://www.who.int/topics/epidemiology/en/. (Accessed: November 2016).

I became immersed in the sub-discipline of Health Information and was assigned to focus on leading the development and establishment of population-based cancer registration in Malta. Subsequently, in 1995, I started reading for a Master's Degree in Public Health which was being offered for the first time by the University of Malta. I graduated in November 1997. In 2002, I started to read for a Master's Degree in Business Administration (Executive MBA) at the University of Malta and I was awarded the degree with distinction in November 2005.

In early 2007, I was nominated acting Head of the Directorate for Health Information. Later in the same year, in September 2007, I was appointed to the post of Director for Policy Development, EU and International Affairs at the Ministry responsible for Health. I occupied this position until August 2011. In 2009, I was promoted to the position of a consultant in Public Health Medicine. Following my retirement from the Director post (I did not re-apply for the post as I had aimed to start my PhD journey), I became attached as a Consultant assisting the Chief Medical Officer on Policy Development and International Public Health. I also assumed the role of principal location trainer for these two sectors for the medical specialist training program in Public Health Medicine. The consultant post and location trainer role are my major functions at my current work place within the Ministry for Health in Valletta.

My MBA dissertation was titled: Involving clinicians in hospital management roles - towards a functional integrative approach. This research was mostly concerned with how the "empowerment of those that deliver healthcare" will be achieved in the Maltese setting. It explored the challenges facing a small part of the healthcare providers involved, i.e. the medical clinicians working at the major acute general and teaching public hospital on the Maltese Islands. Sixteen unstructured in-depth interviews were conducted with a selection of eight clinicians (all medical professionals) and eight personnel working either at director level or above in the management of the hospital or in the topmost positions of the Health Division. The interviews were analysed using the grounded approach method. The study showed that presently medical doctors have almost complete autonomy on patient care and on all decisions related with the patients. However, they have almost no control whatsoever over the supply and use of resources; financial or human. All participants

acknowledged that more involvement of clinicians in the strategic, decision-making and resource allocation processes of hospital management is inevitable. The implications arising from the findings of this study related to clinical leadership were summarized into five main points. These include:

i. creating awareness among all participants of what the objectives are;
ii. ensuring that all the intended participants are involved as early as possible and at all stages of the process;
iii. recognizing that the level of commitment of those involved will be a major factor in achieving a successful outcome;
iv. ensuring that evaluation can take place on an ongoing basis as to what progress is being made against agreed time frames and objectives, and
v. acknowledging and coordinating the different influences that will present so that they complement rather than disrupt the process.

A synopsis of this dissertation was published as a research paper in the International Journal of Clinical Leadership (2012; Volume 17; pp: 139-145).

The above shows that I have been intimately involved with the health services and also with the hospital throughout all my professional as well as most of my academic life. A major personal interest and concern is to be able to, where possible, make an impact in and contribute to the development of the hospital mainly in terms of ensuring good quality and safe care. The commitment to this research and academic project is driven by the desire to ensure that the hospital functions at the maximum of its capacity and capabilities. An environment that fosters and supports organisational learning from failures is essential to achieve the aspiration for a healthcare organisation to identify, analyse, remove and control hazards that threaten or compromise quality care and patient safety (Edmondson, 2004: ii9). To this end I embarked on this journey in an attempt to study whether, how and what can be done for the hospital to move forward on the learning trajectory.

3.2 The positionality of the researcher in relation to the research setting and participants

Defining the positionality of the researcher is an important undertaking in all research. 'Positionality' was initially mentioned in the chorological work (study of the spatial

distribution of organisms – bio-geography) of the geographical sciences, closely followed by work on economics related to competition and choice, and later within the ambit of environmental planning. Merriam et al. (2011: 415) examines positionality and power in connection with where one stands in relation to "the other" and in regard to the politics of knowledge construction. The authors assert that bias continues to be an inherent and naturally occurring human characteristic. Therefore, positionality is frequently employed in the context of the inductive approach to social science inquiry as an exploration of the investigator's reflection on one's own placement within the many contexts, layers, power structures, identities, and subjectivities of the researcher's standpoint (England, 1994: 88). Positionality permits that a narrative placement for researcher objectivity and subjectivity is presented. By virtue of this presentation, the researcher is sited within the many aspects of perspective and positionality (Lave & Wenger, 1991: 33). The detailed documentation and evaluation of the researcher's positionality should assist to inform a research study rather than to undermine its validity or be considered as biased and tainted by personal perspectives and social or political viewpoints. In fact, Drake (2011: 17) opines that:

> … since new knowledge is not simply acquired or developed by the individual researcher in a vacuum, but that the researcher is positioned in a complex and stratified set of social complexities of power and status that enable him or her to make knowledge claims.

3.3 Outsider or Insider?

An important question that needs to be asked and thoughtfully answered in this regard is, 'Who am I in relation to the participants and the setting of this study?'. Embarking on any study involves a 'myriad of border crossings' (Herr and Anderson, 2015: 37). Examples include class, profession, race, gender and nationality. However, a principal and singular dilemma for action researchers is their relationship to the participants, setting and context of their study. One way of attempting to describe these relationships is by determining their position as outsiders or insiders. However, the implications and the notions of insider and outsider placements are alleged to be "multi-layered and fluid" and it is recognized that these positions can alter at different times during the course of the research journey (Thomson and Gunther, 2011: 27).

The rationale for the central concern in most action research studies focuses on the issues of the researcher's relationship with the research participants and setting (according to the dichotomy of insiders and outsiders). This is strongly influenced by the need for clarity required with respect of determining research validity, trustworthiness and research ethics.

Until a few years ago, the consultancy approach to action research was predominant and within this approach, action researchers are 'positioned' as 'outside change agents'. This research tends to be undertaken by an outsider on a contract basis and involves insiders in the enquiry to a greater extent than in more traditional research. Academic works directed by this style of action research are frequently performed by graduates in applied fields such as social work and health promotion in preparation for collaborative projects (Herr and Anderson, 2015: 38). However, due to the increasing prevalence of highly educated professionals with the appropriate research skills engaging in doctoral programmes, there is also the growing movement for action research dissertations that are primarily conducted by insiders (practitioner-researchers) within their organisation.

These practitioner researchers:

> … see research as a way to deepen their own reflection on practice toward problem solving and professional development, as well as a way to generate knowledge from the inside out.
>
> (Herr and Anderson, 2015: 38)

In the majority of these cases, the practitioner and the researcher are often the same person. Research performed by Anderson and Jones (2000) on dissertations in educational leadership indicated that practitioners (frequently occupying high level management positions in educational establishments) were inspired to study in and on their own setting in part because they would have a deep insider's level of tacit knowledge, but more importantly because they were motivated by their aspiration that through their research they could make a contribution to their setting and clients. Thus, a strong incentive for the generation and use of insider research is the inference that it represents a powerful instrument for personal, professional, and organisational transformation (Anderson and Jones, 2000: 457).

The issue of positionality is considered as being very important by Herr and Anderson (2015: 39-41) because they assert that the position that the researcher takes in her study ascertains how epistemological, methodological, and ethical issues can be presented and discussed in the dissertation report. They refer to the concept of a continuum of possible positionalities and that different implications apply for different stages within this continuum. However, it is acknowledged that defining one's position in her research is not an easy endeavour and that this is further complicated by the observation that one's positionality rarely falls 'neatly' into set categories. Furthermore, as mentioned above the researcher's positionality may even actually change a number of times during the course of the study. Table 2 reproduces the schematic presented by Herr and Anderson (2015: 40-41) to show the continuum and implications of positionality. The original version of this table was published in Anderson and Jones (2000: 441). The table presents a synthesis of a study on numerous action research projects in education. The information included has been however also expanded beyond the field of research in educational leadership to encompass an assessment of the potential implications of each defined position for the validity claims of action research studies.

Table 2: Continuum and Implications of Positionality

Reproduced from Herr and Anderson (2015: 40-41; Table 3.1)

Insider (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) Outsider			
Positionality of Researcher	**Validity Criteria**	**Contributes to:**	**Traditions**
1. Insider (researcher studies own self/practice)	Anderson & Herr (1999), Bullough & Pinnegar (2001), Connelly & Clandinin (1990) Heikkinen, Huttunen, & Syrjälä (2007)	Knowledge base, Improved/critiqued practice, Self/professional transformation	Practitioner research, Autobiography, Narrative research, Self-study
2. Insider in collaboration with other insiders	Gordon (2008), Heron (1996), Saavedra (1996)	Knowledge base, Improved/ critiqued practice, Professional/ organisational transformation	Feminist consciousness raising groups, Inquiry/Study groups, Teams
3. Insider(s) in collaboration with outsider(s)	Anderson & Herr (1999), Heron (1996), Saavedra (1996)	Knowledge base, Improved/ critiqued practice, Professional/ organisational transformation	Inquiry/Study groups
4. Reciprocal collaboration (insider-outside teams)	Anderson & Herr (1999), Bartunek & Louis (1996)	Knowledge base, Improved/ critiqued practice, Professional/ organisational transformation	Collaborative forms of participatory action research that achieve equitable power relations
5. Outsider(s) in collaboration with insider(s)	Anderson and Herr (1999), Bradbury and Reason (2001), Heron (1996)	Knowledge base, Improved/ critiqued practice, Organisational development/ transformation	Mainstream change agency, consultancies, industrial democracy. Organisational learning; Radical change: community empowerment (Paulo Freire)
6. Outsider(s) studies insider(s)	Campbell & Stanley (1963), Lincoln & Guba (1985)	Knowledge base	University-based, academic research on action research methods or action research projects.

3.4 Extent of collaboration, reciprocity and participation

In the deliberation of the positionality as the researcher in her study, it is pertinent that the researcher considers the subtle differences in the implications and potential consequences of how she positions herself with regard to her setting and participants especially within the context of the forces of power and politics that can be at work. The prevalence of studies sited at both the insider and outsider ends-points of the spectrum and within the continuum are becoming increasingly common in several fields outside the educational arena which up to a few years ago dominated the action research domain. Nowadays, several studies are available in a wide range of different settings and involving positionalities for the researchers across the whole continuum, including my special settings of interest, that is in hospitals, public health and organisational development.

Collaboration between an insider researcher and other insiders is perceived to have the possibility for a stronger generation of impact on the research setting. Moreover, it is alleged that it can be potentially more democratic than other situations (Herr and Anderson, 2015: 45). However, the subtleties of power relations need to be looked for and detected even when insiders are visibly being collaborative. In several organisations, insider collaborations are typically referred to as 'inquiry groups' and are often aimed at both using collaborative approaches to inquiry and also to influence changes in the organisational culture such as to help an organisation to become more supportive of communities for professional learning. Collaborative inquiry groups frequently originate as a result of formal institutional efforts that create site-based management teams that are tasked to engage in projects and initiatives for organisational change.

The insider researcher stance contrasts with several traditional research approaches in which the researcher joins the organisation temporarily and specifically for the purposes and duration of the research (Casey and Coghlan, 2001: 676). The outsider in collaboration with insider approach is the most widespread type of collaborative action research. Traditionally it took the form of outsiders (often with the status of consultants) initiating and conducting projects with an insider team. In several organisations, insiders are frequently perceived as being too busy to take up the roles

of full participants and furthermore, organisations rarely have incentive structures in place that encourage and reward research initiatives led by insiders (Herr and Anderson, 2015: 49). On the other hand, several authors described the defensiveness of insiders within an organisation to invited outsiders into their research projects and others have commented that substantial difficulty is usually encountered when outsiders and insiders negotiate for equal or comparable levels of commitment of such a project (Kelly et al., 2004: 206).

Positionality is not only relevant in terms of the researcher's position as an insider or an outsider to the setting being studied. Other positional distinctions also need to be meticulously described. These may include the researcher's location within the social and organisational hierarchy as well as positions of power in relation to other stakeholders acting from within or from outside the setting (Herr and Anderson, 2015: 52).

An important issue that needs to be carefully negotiated is the matter of **reciprocity** and this requires an understanding of the expectations of each stakeholder participating or contributing to the research project. Issues of reciprocity for collaborative research are very complex. Table 3 presents an intriguing illustration (related to a Johari Awareness Window or Model)[2] of the possible combinations of standpoints (perhaps extreme) that can be taken by insiders and outsiders in a collaborative research project. Outsiders entering a research study with a mindset placed in quadrant III are actually taking the stance of outside experts rather than collaborative researchers. A common reaction in such cases is for the insiders to opt for the viewpoint in quadrant II, thereby devaluing and suppressing their own professional and in-house (vernacular) knowledge (McLaughlin, 1996: 62). Collaborative research should aim at moving away from the tendencies to adopt the perspectives of quadrant II and III and align more with the desirable standpoints of quadrant I.

[2] The Johari Window model is a simple and useful tool used for illustrating and improving self-awareness, and mutual understanding between individuals within a group. The Johari Window model is also used to assess and improve a group's relationship with other groups. The Johari Window model was devised by American psychologists Joseph Luft and Harry Ingham in 1955, while researching group dynamics at the University of California Los Angeles. The model was first published in the Proceedings of the Western Training Laboratory in Group Development by UCLA Extension Office in 1955, and was later further expanded by Joseph Luft.

I We Know They know	**II** We don't know They know
III We know They don't know	**IV** We don't know They don't know

Table 3: The Four Squares of Knowledge (an adaptation of a Johari Awareness Window)
Reproduced from Herr and Anderson (2015: 50; Table 3.2)

Another interesting view was provided by Cornwall (1996: 96). She proposed a list of reasons for participation along a spectrum with **varying degrees of participation and collaboration** that can take place in a research project. This list shown in Table 4 presents a list of pronouns that helpfully imply the extent outsiders do research *on*, *for* and *with* insiders, or whether the study is being done solely *by* insiders.

Mode of Participation	**Involvement of Local People**	**Relationship of Research and Action to Local People**
Co-Option	Token; representatives are chosen, but no real input or power	*On*
Compliance	Tasks are assigned, with incentives; outsiders decide agenda	*For*
Consultation	Local options asked, outsiders analyse and decide on the course of action	*For/With*
Cooperation	Local people work together with outsiders to determine priorities; responsibility remains with outsiders for directing the process	*With*
Co-learning	Local people and outsiders share their knowledge to create new understanding and work together to form action plans, with outsider facilitation	*With/By*
Collective Action	Local people set their own agenda and mobilize to carry it out in the absence of outside initiators and facilitators	*By*

Table 4: Participatory Methods: Means to what end?
Reproduced from Herr and Anderson (2015: 51; Table 3.3)

In her work on the Black Feminist Thought, Collins (1986) coined the term "outsider-within". This term was elaborated to show that different vantage points and varying lenses of "reality" resulting as a consequence of the researcher's location within her community or organisation. Outsiders-within are people positioned in the periphery

and observing “the contradictions between the dominant group’s actions and ideologies” (Collins, 2000: 11). Collins asserted that outsiders-within can offer a unique “subjugated knowledge, a peculiar marginality, that provides a special standpoint on the self and society” (Collins, 2000: 11). Subjugated knowledge (as proposed by Foucault in 1980) can be put forward by persons who are sufficiently external to the mainstream of an organisation such as by women working in a male-dominated establishment who can become expert observers of the male culture as they circumnavigate their everyday exchanges with their co-workers. This specialised understanding can both stimulate and support organisational learning and also be viewed as threatening to the culture of the institution being evaluated.

Recapitulating, defining and clearly describing the often-complex relationships of the researcher’s connections to her setting and research participants necessitates careful consideration and a clear description. During the course of their studies researchers often find themselves occupying multiple positions that may intersect and transect each other. For example, a researcher may occupy an insider position wherein either simultaneously, in due course or in some dimensions be identified as an outsider. Dimensions such as the researcher’s gender, professional status and position in the organisational hierarchy can have an impact on the conceptualisations generated on the setting or the institution under study, in terms of cultural assumptions and political and ideological beliefs. All these factors can have a bearing on the construction of reality that is captured in the research.

3.5 Who am I in relation to the participants and the setting of this study?

3.5.1 My professional situation at the start of my project

My work base is at the Head Office of the Ministry for Health in Valletta and therefore it is both physically and functionally detached from the hospital setting. However, throughout the years and due to my medical education and several social interactions within the arena of the local health systems and communities (both at work-related and social levels), I have retained close contact and sustained personal relationships with several members of the administrative and clinical staff at MDH. This background and connections stood in good stead in my search for an ‘entry point’ into a MDH

structure or team that was created to address one or more of the major issues or objectives that MDH had identified in recent years and was working towards developing and addressing and that could have a bearing on the learning culture and capacity of the organisation.

My professional and medical background centres around my specialisation in Public Health Medicine. More specifically my general outlook is to a large extent informed by my professional work which in most instances entails working on and developing health policy on a nation-wide and population-based level. Public Health is a branch of medicine that focusses on population health in contrast with clinical medicine which most often focusses solely on the individual patient. The Public Health paradigm employs a spectrum of interventions aimed at the environment, human behaviour and lifestyle, and the health of populations whereas clinical medicine places predominant emphasis on medical care and specifically on disease diagnosis, treatment, and care for a single patient (Harvard School of Public Health, 2012). Health policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society through the health system. A health system is the sum total of all the organisations, institutions and resources whose primary purpose is to improve health (World Health Organisation, 2013).

3.5.2 How did my interest in Organisational Learning arise?

I initially became acquainted with the concepts of Organisational Learning and related perspectives in the social sciences and management during my research commitment for my MBA program. A more detailed description of the research conducted for my Master's dissertation can be viewed in Section 3.1 (pages 37-38) above. A vast amount of literature on the subject has been generated that encompasses several aspects relevant to living and developing in an organisation such as organisational strategy, culture, structure, absorptive capacity, problem-solving ability and employee participation (Wang and Ahmed, 2003: 8-17). Literature has also shown that several of these factors can determine whether, the extent and the model adopted for learning in a particular organisation. Gradually, I became more and more intrigued by an emerging notion and wish to search for and enquire about whether and to what extent

the health sector in Malta could be shown to have positive (enablers) and negative (barriers) factors that help or hinder it to function as an organisation that is open to and disposed towards learning from the analysis of different types of events and operating systems in order to ensure continuous quality and outcomes improvements of the services that it provides.

3.5.3 Choosing Mater Dei Hospital as the setting for my research

As I started delving deeper into the preparation and groundwork prior to selecting how and where to conduct the fieldwork for my research, I started to realize that tackling the whole of the health system in Malta as the setting for my study was going to result into an insurmountable and unmanageable task due to the vastness, diversity and complexity of the multiple players involved. Furthermore, as my research approach was moving towards adopting an action research methodology, it was becoming more evident that a more circumscribed organisation for the setting of my study was more advisable. The action research approach that I espoused for this study is well reflected in the definition promoted by Riel (2006: unpaged) which can be seen "as a systematic, reflective study of one's actions involving deep inquiry into one's professional practice, and the effects of these actions, in a workplace or organisational context". This approach is described in more detail in the methodology chapter and elsewhere in the dissertation report. Literature illustrating projects implementing the action research approach and discussing its methodology and philosophy have shown that while the design of action research may be instigated by an individual, the progression towards change is always social (ibid.). Over time, the action researcher often widens the arena of change to an extended group of stakeholders and therefore it would be more manageable to start from a more defined setting and then perhaps broaden through outreach to extra-organisational locations as the research progresses and when it becomes evident that this is necessary or appropriate.

The choice fell on the unique setting of Mater Dei Hospital (MDH) as the major healthcare facility in Malta. The public health system in Malta and Gozo employs the services of almost 8000 staff members and about half of these employees (just under 4000 workers) are engaged to work at MDH (Human Resources Department, Ministry

for Energy and Health, December 2014; personal communication). This makes MDH by far the single biggest organisation in the national public health system (and indeed in the whole country) as it engages more or less half of all the workers employed in the public health system. MDH can therefore, be viewed as a representative and a leader as it is the foremost player in the Maltese public health system.

3.5.4 Searching for operational themes or foci

During the time that I was searching for the appropriate organisational setting and during my reading into the topic of Organisational Learning and related subjects, I could identify three major and topical themes that could fit and present the potential opportunities that I was seeking. These were Patient Safety, Quality Improvement and Clinical Governance. These three issues are intimately inter-related and it is plausible to predict that progress or regression in one area will result in a similar and concurrent development and direction in the others. All these activities necessitate the creation of an organisational environment that creates, safeguards and encourages the dissemination of learning and counteracts the clinicians' natural tendency to protect their individual autonomy and reputation and the culture of blame and secrecy that so far has been pervasive in most of the healthcare industry (Huntington, 2000: 679).

In May 2011, a new Chief Executive Officer (CEO) for MDH was appointed and he replaced the CEO that had overseen the successful migration from St. Luke's Hospital (SLH) to MDH in 2007. He led the hospital until May 2014. He is a mechanical engineer by profession, has an extensive background in quality management and systems implementation and is an accredited auditor for quality and environment management systems. An Incident Reporting Policy (IRP) had been initiated a few years before the migration from SLH to MDH. The objectives of the IRP were to "identify and report incidents (clinical and non-clinical) that could or did lead to harm to a patient, staff member, visitor, contractor, building or equipment in order to identify areas where provision could be improved, limit damage whether physical, financial or to the reputation of the hospital or its staff, prevent recurrence by investigating the causes and addressing identified gaps/ deficits" (Draft Incident Reporting Policy, 2012, personal communication). The ultimate aim was to improve the quality of patient care

and service provision by monitoring and learning from incidents and the actions that are taken as a result of this policy.

Hospital top management started to give more prominence and promotion to this reporting system and the number of submitted incident reports started to gradually increase year on year. An Incident Management Committee (IMC) was created in mid-2011. The IMC met on a monthly basis and included members of the top management such as the CEO, Medical Administrator and the Directors for Nursing Services and Human Resources. During 2012, 614 reports were registered (approximate monthly average of 51 reports) which was the largest annual number of registered reports to date. However, the system started to run into serious trouble in April 2012 when the Malta Union of Midwives and Nurses (MUMN) caused an outcry when it reported that selected incident reports (originating both at MDH but also at other public hospitals) were ending up and exposed in the public media and consequently issued industrial directives for nurses and midwives to refrain from drawing up further reports (Times of Malta, April 2012)[3,4]. This resulted in a sharp drop of submitted reports. The total number of incident reports fell to 356 in 2013 (approximate monthly average of 30 reports) and by the beginning of 2014, only 10-15 reports were being submitted per month (Incident Reports Database, personal communication). The members of the nursing profession were the mainstay for the creation and submission of incident reports. The members of the medical and allied healthcare professional groups (healthcare professions distinct from nursing, medicine, dentistry and pharmacy) did not contribute to the system in any significant way. Therefore, when the MUMN issued its directives advising its members to refrain from issuing incident reports, the system had a substantial 'nose-dive'.

In 2011, the Maltese Government commissioned a report by the Johns Hopkins Medicine International (JHMI)[5] that was finalized in June 2012. This report has not

[3] Excerpt from Times of Malta 23rd April 2012: http://www.timesofmalta.com/articles/view/20120423/local/mumn-demands-investigation-of-leaks.416743. [Accessed: October 2016].

[4] Excerpt from Times of Malta 28th April 2012: http://www.timesofmalta.com/articles/view/20120428/local/nurses-directed-not-to-draw-up-incident-reports.417369 [Accessed: October 2016].

[5] Johns Hopkins Medicine International (JHMI) facilitates the global expansion of the Johns Hopkins Medicine mission: to improve the health of the community and the world by setting the standard of excellence in medical

been published to date. However, in March 2014, I was invited to review the final report that was generated by a working group that was asked to review the sections of the JHMI report relevant to Clinical Performance, Infection Control and Patient Safety. The assessment that was included in the original JHMI report had concluded that apart from the sector of infection control where there was the acknowledgement of significant steps to reach acceptable control in the levels of clinical quality and safety, there was evidence that formal systems and processes in the areas of patient safety and clinical performance were still significantly lacking and that there was an unexplainable and substantial variation in clinical practices throughout the hospital.

Consequently, at the start of 2013, MDH was in a situation where it had been determined (both by external and internal evaluators) that there was the need to re-think and re-start the processes and structures for the management and development of the critical areas for both patient safety and clinical performance. The measurement and monitoring of clinical performance and risk management have been listed as two of the major dimensions that constitute clinical governance. Other important dimensions mentioned include efficient use of resources and patients' satisfaction with the service provided (Scally and Donaldson, 1998: 62). To this effect, the assessment of the JHMI that deduced that MDH was very far away from having any sustainable and effective structures and processes for *inter alia* incident reporting to ascertain and monitor quality improvements or indeed deteriorations in the quality of the healthcare services offered and delivered. This report actually inferred that there was the existence of major deficiencies in the overall clinical governance of the hospital. This was the state of affairs at MDH vis-à-vis quality and safety improvement initiatives at the beginning of 2013, which is essentially when I was seeking for an 'entry point' to become involved and hence to start my research.

education, research and clinical care. Available from: http://www.hopkinsmedicine.org/international/about/. . [Accessed: October 2016].

3.5.5 Searching for an 'entry point' into activities aimed at promoting Patient Safety and Quality Improvement at MDH

MDH had engaged a Medical Director in July 2012. This was the first time that such a post had been issued in the public healthcare sector in Malta. The Annual Report of the Ministry for Health, the Elderly and Community Care (MHEC) for 2012 described the scope for the creation of this post:

> ….to consolidate and develop medical services through leadership of the medical profession, and work in consort with the other health, allied, and social professions, as part of hospital management.
>
> Annual Report 2012, MHEC, p.149

The Annual Report also included the definition and review of the performance measures proposed for the clinical chairpersons and medical consultants in their individual job plans for 2013, as one of the job objectives of the new Medical Director (ibid, 2012: 144). The newly engaged Medical Director was allowed to retain some clinical work but it was soon realised that "the demands by all for his presence at MDH are putting pressure on his role due to his time constraints" (ibid, 2012: 145).

I met with the Medical Director in late 2012 and made him aware of my research interests and that I was seeking 'entry' into MDH structures such as joining teams that have been or are set up to work in the development and progression of quality and safety improvement initiatives. He had felt that my medical and public health background, my academic interests and the fact that I could offer views that are both distinct from but at the same time can still be highly sensitive to and discerning of the sentiments of MDH clinicians (since I could be considered both a medical professional but also as a 'relative outsider') were a unique combination. He subsequently proposed that I request a lateral job move and offered me an opportunity to join and form part of the team that he was building to assist him in his duties at MDH.

Consequently, in late January 2013 with my agreement, together with the CEO of MDH he informally approached my superiors at the Ministry (the Permanent Secretary and the Chief Medical Officer) to request my release and transfer to MDH on a full-time basis and for a pre-defined time period to assist the Medical Director. Unfortunately, their request was summarily rejected claiming that they could not 'spare me', citing my different ongoing roles at the Ministry and that they felt that it would be very difficult to find an immediate and appropriate replacement. At that time (and the

situation still persists), I was the most senior public health specialist working within the Office of the Chief Medical Officer (CMO). In a way, I could fully foresee and understand their pre-occupations and I had even alerted the Medical Director that this was the most likely outcome from such an appeal. At the same time, I did feel disappointed because such a transfer and the possibility to assume duties directly related to the job specifications of the Medical Director would have been a perfect opportunity to establish an ideal access approach and as a consequence pursue my academic project with more intensity. However, on the other hand I could not but feel that my role within the Office of the CMO and the Ministry was highly recognized and appreciated. I had (and still do) have a long-standing mutually respectful working relationship with both my superiors at that time and they are also highly esteemed professional peers. Coincidentally, during the course of 2013, they were both replaced. A new Permanent Secretary was appointed in April 2013 and the post of Chief Medical Officer remaining vacant until August 2014 (after the contract of the incumbent was not renewed when it expired in late 2013).

Subsequent to this repudiation for my full-time transfer to MDH, I pursued my search for other possible access avenues. It became clear that I needed to seek opportunities that allowed my involvement on a part-time and/ or even over and above my full-time job hours and requirements.

In parallel with my personal experience described above, the CEO of MDH and the Medical Director were also working on the formation of a new team to promote the themes and stimulate practice conducive to increase patient safety and quality improvement at MDH. This group started meeting in March 2013 and consisted of a number of selected MDH professionals that had been hand-picked by the above MDH hospital leaders. Most of these candidates had shown previous special interest in pursuing activities related to patient safety and quality improvement. At the beginning the group included three medical professionals (a consultant anaesthetist, a consultant gynaecologist and obstetrician and a consultant cardiologist), a senior nursing manager (at that time the title was Departmental Nursing Manager or DNM), the Head of the Physiotherapy Department and a principal medical laboratory

scientist. The Medical Director and the Director for Nursing Services (DNS) were also members of the original group for a brief period (March to July 2013).

Prior to May 2013, this group was referred to by different titles including 'Patient Safety Committee' and 'Patient Safety and Quality Core Group'. Eventually the name of this group was established as the **Pa**tient **S**afety and **Q**uality **I**mprovement **T**eam (PaSQIT). The PaSQIT name was initially formulated after the meetings with Dr Lachman in May 2013, and it had become established by August 2013 when the first progress report was issued.

I was invited to join PaSQIT in early May 2013. The Permanent Secretary at the Ministry for Health had invited Dr Peter Lachman for a 5-day visit (2-6 May) to MDH to address senior hospital management on issues of patient safety and quality improvement. Dr Lachman was at that time the Deputy Medical Director for Safety at Great Ormond Street Hospital in London.

I was thrilled to be invited to attend these workshops and accordingly to form part of PaSQIT. The invitation came at a very short notice as I was informed by the Medical Director about the start of the workshops on the morning of the start date and I had to re-schedule a commitment that I already had for the same time. So perhaps, I had not been included in the planning phase for these sessions but the Medical Director may have recalled my interest on the subject at the eleventh hour. Nonetheless, this was a great opportunity that I could not miss. I managed to attend all the meetings open to PaSQIT members during this long weekend. All attended sessions were very instructive and I would eventually use Dr. Lachman's visit as the definitive starting point for the action research fieldwork of my project.

3.5.6 Joining PaSQIT in May 2013

The aims of Dr. Lachman's visit according to the report that he sent to the CEO after the visit (dated 19th May 2013) included the following:

- Assist in the development of the strategy for the quality improvement programme
- Advise on the process to be followed
- Work with the Core team to build a platform for future change (2 workshop sessions)

- Meet with key players in the process: Directors, Executive, Clinical Chairs, Clinical Performance Team
- Launch the programme with a keynote address to the Hospital

Brief Report on visit to Mater Dei, 2-6 May 2013, Peter Lachman

During his visit Dr. Lachman conducted two workshops with the PaSQIT group. The sessions were aimed at developing a common purpose for the group as well as a team building exercise. The workshops with Dr Lachman were meant to be "formative sessions". In his report, he stated that he saw the meetings with PaSQIT as the "central part" of his visit. His declared aims were to "develop a common purpose for the group, as well as team building". He summed up the team (he termed it the Core Group) as "consisting of leaders and innovators from different backgrounds that will work with hospital management and all Mater Dei employees to help deliver the mission of Mater Dei" (ibid.). On the final day of Dr. Lachman's visit the members of the PaSQIT were formally introduced by the CEO of MDH at a mid-day event that was organized to conclude Dr. Lachman's visit and to which all MDH staff were invited. I was part of the team that was publicly presented at this event. In fact, a senior midwife and I joined PaSQIT for the first time during these workshops.

3.5.7 The evolving composition of membership of PaSQIT

The complement of professionals that attended the different sessions during Dr. Lachman's first visit included the eight PaSQIT members (previous six members and two new recruits) at that time, the Medical Director, the Director Nursing Services (DNS) and the CEO of MDH. The latter attended the sessions for some of the time. Dr. Lachman reported that the PaSQIT brings together "a potentially powerful group of people for change" with "enthusiasm and a desire to change" but that the role of the group is not "entirely clear" while the "expectations are high" (ibid, 2013). He recommended that the group should continuously focus on matching expectations with clear desired outcomes. However, he concluded that the team necessitated ongoing mentoring and training in quality improvement and patient safety in order to deliver the outcomes required.

I was already well acquainted with some members of the team, in particular with the three other members of the medical profession. The Head of the Physiotherapy

Department was also a long-time colleague because I had already worked with her on other projects in the past. However, I had never met or worked with the representatives of the medical laboratory scientists, and the nursing and midwifery professions (one for each).

The number of members in the PaSQIT team continued to change and evolve over the next few months. Near to the end of 2013, the complement of members grew to a total of eleven members. Another medical professional had been added. This member has a special interest and is very active in infection control. Two members had to leave because they were unexpectedly re-assigned to duties outside MDH in late 2013. These replacements included the pharmacist who was added on the recommendation of Dr. Lachman at his visit in May. He had then noted the lack of representation from the pharmacists. In fact, the original pharmacist that joined the team shortly after the meetings with Dr. Lachman could only attend two meetings because he was transferred to a position outside MDH soon after. The other member that needed to be replaced because of a transfer to work at a facility outside MDH was the representative of the nursing profession. This person was eventually replaced by two senior nursing managers while the pharmacist was replaced by another senior pharmacist working at the MDH Pharmacy.

In the course of 2014, the team was joined by a new member that was sought to represent the Oncology Department. This new team member had assumed the newly created Ministry's Director post on Cancer Care Pathways in late 2013. The joining of this member was pursued in preparation for the migration of the oncological services to the new purpose-built Oncology Hospital. This clinical department which was previously housed in another healthcare facility in Floriana (Sir Paul Boffa Hospital) migrated to the new premises at Sir Anthony Mamo Oncology Hospital (SAMOC) in the summer of 2015 and is managed by the MDH management setup. SAMOC is situated on the MDH precincts.

During 2015, the team was joined by another four professionals which included a medical consultant who had started to follow a Master's program on Quality and Safety in Healthcare with the Imperial College in London in 2014. This program was sponsored by MDH. The other additions included two senior nurses. One of them

heads the Pressure Ulcers Prevention Activities (PUPA). This group's main objective is to monitor and support activities to prevent hospital acquired pressure ulcers in the patients of MDH. The other senior nurse was working in orthopaedics and had a special interest in the prevention of patients' falls. In June 2015, the senior hospital management assigned a senior pharmacist to coordinate the activity of the Safety Alerts for Learning program (SALearn)[6] that was launched in April 2015. The latter professional took up the role of a coordinator of PaSQIT during the summer of 2015 and was instrumental in the organisation of the second visit of Dr. Lachman. However, she left these two roles and was re-assigned to other functions within MDH soon after this visit was over at the end of November 2015. Finally, the Manager of the Physiotherapy Department that was a member of the original group in 2013 retired in the early months of 2015. She was replaced by a senior physiotherapist in June. Table 5 shows the teams' composition by major professional groupings and gender at the time of Dr. Lachman's second visit in November 2015.

Major professional groups	**Number (and gender) of representatives**
Medical	Six (1 female *[the researcher]* and 5 males)
Nursing and Midwifery	Five (3 females and 2 males)
Pharmacy	Two (1 female and 1 male)
Allied Healthcare	Three (2 females and 1 male)

Table 5: Representation of the professional groups in PaSQIT (as at November 2015)

Since its inception and throughout its ongoing existence, the team's composition remained highly skewed towards the medical profession (six out of sixteen – more than one third - as at November 2015). This representation is widely divergent from the proportions of the professions working at MDH where the medical profession as a whole constitutes around 20% of the whole healthcare workforce of the hospital. Historically, several multi-disciplinary teams within MDH (and other healthcare

[6] The Safety Alert System for Learning (SALearn) is the new system for incident reporting and management launched in April 2015. It is operated by PaSQIT. The overall purpose of the SALearn is to:

a. encourage **voluntary** information sharing between different Mater Dei Hospital (MDH) clinical and non-clinical teams on issues pertaining to patient safety;

b. be a **learning, educational and implementation resource for improvements** in patients' safety and quality of care at MDH.

c. create a system of "Reporting for Learning" on issues of patient safety that is confidential and anonymous for the purpose of improving patient safety and preventing avoidable patient harm.

facilities) tend to be constituted with an over-representation of the medical profession. Additionally, in most cases, leadership roles in these teams are most often assumed by or assigned to the representatives of the medical profession thus reinforcing its traditional dominant position within the overall hierarchy in healthcare organisations.

On the other hand, all the members of the PaSQIT held senior positions in their respective professional hierarchies and had been working in the healthcare sector for several years. All the medical professionals occupied consultant posts and two of the nursing professionals were Senior Nursing Managers (SNMs). A number of the members were included because they were already engaged in quality management processes to a varying degree within their respective departments and units. The age distribution of almost all members (except for two persons who were younger than 40 years of age) was skewed towards the age groups of people in their late forties or older. Finally, females made up 44% of the membership with a notable under-representation within the group of medical professionals.

3.5.8 The second visit by Dr. Lachman in November 2015

In November 2015, thirty (30) months after his first visit, Dr Lachman was invited again by the hospital management to re-visit Malta and MDH. This visit lasted for another long weekend from the 12th to the 16th November. During this visit, the whole PaSQIT group had a number of meetings with him with the aim of reviewing, discussing and advancing the team's objectives, activities and achievements. He gave us his expert feedback on these initiatives and supplemented his coaching with a number of interactive lectures. Some of these meetings were restricted to PaSQIT members only, while others were open to other groups of professionals within MDH such as medical consultants and senior nurse managers. All meetings were very well attended especially the ones where the medical consultants were invited. This was a positive development in comparison with the lukewarm attendance of this particular group of clinicians during his first visit.

The second visit of Dr. Lachman was effectively established as the closing date of the action research component of my study. I continued to be active within PaSQIT after this date but the collation and inclusion of reports, diary inputs and reflections on the

happenings of the team for the purpose of this dissertation stopped in November 2015.

3.5.9 Participating as a member of PaSQIT from May 2013 to November 2015

3.5.9.1 Involvement in and establishing my role in the first formative months of PaSQIT

An overview describing the reflections of Dr. Lachman in his report after his first visit in May 2013 reads as follows:

> The organisation is at a point where it is ready to build on the work done over the past few years. The foundations have been laid for an improvement programme to improve the flow of patients through the hospital, patient safety and patient experience. The WILL of the executive team to improve impressed me. This is a key factor as alignment of the aims of the executive with the Mission Statement is essential to improve. There is a body of leaders in the organisation who are ready to develop further in the improvement journey.
>
> Brief Report on visit to Mater Dei, 2-6 May 2013, Peter Lachman

I was privileged to form part of the team from such an early stage within its development. The energy and enthusiasm of the original group of members and the corresponding optimism of the senior management (especially the CEO, Medical Director and DNS) was "palpable". On the other hand, the objectives and areas for focus by the team were very wide and at the same time very elusive. At the end of his report, Dr. Lachman included a set of activities which he termed 'Early recommendations':

> **Early recommendations**
>
> - Develop an organisational **Strategy** for quality improvement and patient safety
> - Develop the **Structure** required to deliver the Strategy
> - Develop the **Processes** for change by the adoption of the Theory and Method for change such as the *Profound Knowledge (Deming*) and *Model for Improvement (API).*
> - Develop a **Measurement Process** with dashboards using Statistical Process Control (SPC).
> - Develop the **Core Team** and capacity for change.
> - Work in **Microsystems** and develop front leaders for change.
> - Build a **Risk Management System** with responsive processes to become a learning organisation
> - Move towards building a **Culture of Safety** over time.
>
> The above can be achieved in a comprehensive programme on quality improvement and patient safety.
>
> Brief Report on visit to Mater Dei, 2-6 May 2013, Peter Lachman

Following Dr. Lachman's visit the team together with the Medical Director and the DNS started to work on these recommendations in earnest. During the summer of 2013 (May to September), the team met six times and the first activity that was taken up concerned the drafting of a Terms of Reference. Being a medical professional trained in Public Health and having policy development as one my main roles, I tend to devote a substantial proportion of my working time to the composition of texts for a wide variety of purposes. Consequently, I was soon entrusted with the function of coordinating and finalising the text of this initial document. These skills were also earmarked by the other members of the team during the ensuing discussion on who would be best suited to take up the role of a secretary to the group. The choice was soon directed towards me. I accepted it willingly because I felt that this would give me more control on the recording of the team's activities especially because this documentation will be instrumental to the collection of data for my research.

An intriguing development at this early stage was the perception of and depiction by the other members of the team regarding my professional status and consequently the value of my role within PaSQIT. This portrayal was meaningfully illustrated in a slide (see Figure 4) that was designed by the person who from the beginning of the team adopted a leading role of the group and who after the first few meetings was unanimously chosen as the chair of the team. This slide was presented on several occasions especially during the introduction of the team whenever a new member joined PaSQIT or an invited guest or guests attended one of the group's meetings.

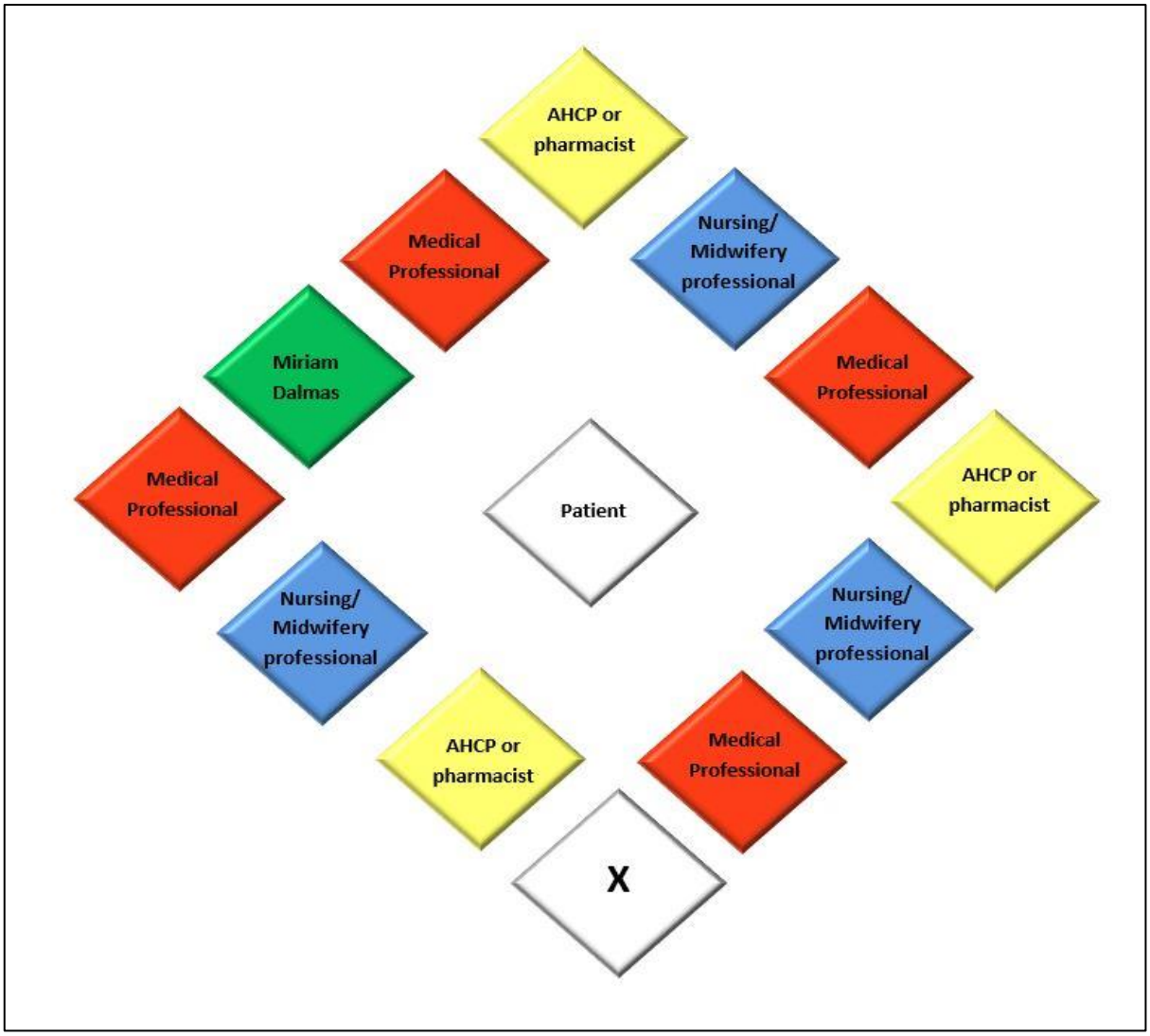


Figure 4: the broad professional groupings of the eleven members of the team by the end of 2013 (one diamond per member).

The diamonds were colour coded as follows:

a. Red for the medical professionals
b. Blue for the nursing and midwifery professionals
c. Yellow for the allied healthcare or pharmacy professionals.

A white empty box denoted with an 'X' was included to show that the team was foreseeing the eventual addition of new members, and the central diamond denoted as 'Patient' was included to infer at our central principle that whatever the team endeavoured to do was ultimately with the patient in mind and for the patients' benefit (patient-centeredness). Interestingly, I was given a different colour from the rest (green). My interpretation of this illustration was that on the one hand I was considered an integral member of the team, but on the other hand the image creator

found it difficult to classify me within the other broad categories. I was a medical professional but not a clinician (due to my specialisation in Public Health Medicine). Furthermore, I was a 'relative outsider' because I was not an employee at MDH.

In due course and over the following months, this rather compelling expression of my 'distinctiveness' became less and less apparent and palpable. I think that this was the result of three main developments. Firstly, I was proving myself to be an active and valued member of the group especially through my secretarial function and this engendered increasing dependence on my presence and involvement. Secondly, the expression of opinions that were often distinct from those of the other members because of my 'relative outsider' perspective, were being increasingly appreciated especially for their potential for 'objectivity'. Finally, I had managed to find a location within the hospital from where I could work for a day or two per week. In this way, I could benefit from a better position to absorb the feeling of and acclimatise to working at MDH and also increase my visibility and accessibility within the hospital premises.

3.5.9.2 Participating in PaSQIT meetings

Between May 2013 and November 2015, the PaSQIT team as a whole met for more than 50 times. There were also a number of other meetings especially between smaller sub-groups of members that concentrated on the planning and implementation of specific projects on which PaSQIT had embarked.

PaSQIT meetings usually lasted between 60 and 90 minutes (most frequently just over 60 minutes) and were held in the early afternoon in a boardroom in a central location within the hospital. It was usually very difficult to fix a date and time that was suitable for all members and it was very rare that all members were present at a particular meeting. This is because the meetings often coincided with other regular commitments of the members such as clinic or theatre sessions for the clinicians. Professionals that were more involved in management roles such as the nursing managers could be caught up in last minute crisis and others were more prone to get held up from attending at the last minute because of unplanned heavy work pressures. Up until late 2014, none of the members had managed to obtain approval for 'protected time' for work concerned with PaSQIT. The chair and one of the nursing

managers were eventually permitted a few hours per week of ‘protected time’ in late 2014. Therefore, for most of the time, all PaSQIT activities were performed over and above the members’ regular work commitments.

There were repeated efforts to organise the meetings so that the pre-set agenda will be more rigorously followed and the discussion more balanced and productive. However, most meetings ended up wasting a lot of time in the repetition of the same discourse or in fruitless discussions. For example, lengthy introductions and explanations were repeated several times in subsequent meetings of PaSQIT. Essentially, they were retold every time someone else joined the team for the first time or a guest attended for one of the group’s meetings. During the summer of 2013 this overlong section of the PaSQIT meetings took place practically during every session. In the end, it used to extend through the best part of the first 15-20 minutes of each meeting. Given that the interest and the ‘attention span’ of the members at the meeting usually started to ebb after the lapse of the first 30-45 minutes due to a number of reasons including other pressing commitments these repeated introductions used to have a considerable deleterious effect on the effective time available for constructive discussion. Particularly, discussions on the strategic decisions that needed to be taken and the evaluation of the progress on the work that was being conducted or orchestrated by the various team members tended to remain pending after every meeting because there was very little or inadequate time left for these important agenda items.

Additionally, some members were considerably more verbose than others and this characteristic for a tendency towards long-winded speeches by and also a related predisposition of a few of the members to assert a dominant role in every conversation remained a constant difficulty that the rest of the team members had to contend with. In my opinion, this feature was a main contributor towards the ill use of a substantial amount of the time spent at PaSQIT meetings and that would eventually result in the perceived relative ineffectiveness of the outcomes of the group especially when compared to the justifiable and/ or unjustifiable onerous expectations that were assigned to the team.

3.5.9.3 Changes in the senior management team of MDH after the inception of PaSQIT

Significant and unanticipated changes to the senior management team at MDH started to take place a few weeks after the inception of PaSQIT in early May 2013. The post of Medical Director was 'abolished' in July 2013[7]. This resulted in a substantial negative impact because he had been the major proponent of the group. When the news that his post will cease to exist started to circulate the team members scrambled to obtain a written nomination letter that certified their membership in PaSQIT signed by the CEO and the Medical Director before the latter left his post at MDH. Thereafter, he returned to his full-time clinical consultant job. He was not replaced but a new post of a Clinical Director at MDH (with more or less similar functions) was established in mid-2014. The DNS was also acrimoniously and suddenly transferred to a facility outside MDH in mid-May 2013[8,9,10]. Her eventual replacements (there were two replacements between 2013 and 2015) did not establish any contact with or show any special interest in the team. Lastly, the CEO of MDH at the inception of PaSQIT left his post in November 2014. He had already resigned in April 2014[11] but he had reversed his decision only to re-confirm his intention to leave MDH six months later[12].

These changes to the senior hospital management were also compounded by the parallel and frequent changes in the member composition of the group described in 2.3.7 above. These changes and repeated associated periods of instability had a considerable effect on the enthusiasm and motivation of the team as a whole and on a number of individual members. Enthusiasm and motivation tended to waiver and dip

[7] Excerpt from Malta Today 11th November 2012: http://www.maltatoday.com.mt/news/national/20261/health-minister-s-cousin-awarded-top-position-at-mater-dei-20120811#.WC9Ij9UrLIU. [Accessed October 2016].
[8] Excerpt from Times of Malta 15th June 2013: http://www.timesofmalta.com/articles/view/20130615/local/Nurse-wants-to-know-why-she-was-transferred.473928. [Accessed October 2016].
[9] Excerpt of The Malta Independent 16th August 2015: http://www.independent.com.mt/articles/2015-08-16/local-news/Former-minister-told-me-I-m-not-wanted-on-the-hospital-s-doorstep-former-nursing-director-6736140535. [Accessed October 2016].
[10] Excerpt from Times of Malta 21st May 2014: http://www.timesofmalta.com/articles/view/20140521/local/-Ex-Mater-Dei-nursing-head-was-humiliated-by-transfer-.519863. [Accessed October 2016].
[11] Excerpt of The Malta Independent 20th April 2014: http://www.independent.com.mt/articles/2014-04-20/news/mater-dei-ceo-cites-personal-reasons-for-resignation-4685135881/. [Accessed October 2016].
[12] Excerpt from Times of Malta on the 1st November 2014: http://www.timesofmalta.com/articles/view/20141101/local/Mater-Dei-CEO-quits.542114. [Accessed October 2016].

with each unexpected change. However, there were also multiple instances of resurgence of energy mostly resulting from the individual drive of the component members to make a difference in the hospital practices and performance outcomes. However, in the end, collectively these frequent alterations would ultimately have an accumulative and unsupportive impact on the effectiveness and progress on the group's objectives.

3.5.9.4 The researcher's participation in and contribution towards PaSQIT's objectives and activities

The researcher took up the roles of secretary for PaSQIT and was also frequently assigned the function of drafter and reviewer of text created by and for the team. These included terms of reference, progress reports, proposals and plans for the development and implementation of activities and projects and appraisal of reports drawn up by sub-groups of the members involved in other undertakings. One such example involved the review of the report drawn up by a working group that was tasked by the CEO of MDH in 2013 to draw up an implementation plan on the recommendations included in the JHMI (2012) report relevant to Clinical Performance, Infection Control and Patient Safety (described in section 3.5.4 above).

During PaSQIT meetings I would regularly spend time observing the various members' dynamics within the team and the different facets of the interactions between them. I made it explicit to the other team members that I was performing and documenting some of these observations and there were several instances where I was asked to relay my observations back to them. There was the pervasive feeling that though I was acknowledged as an active member and felt accepted as part of the team, I was still considered as a 'relative outsider'. For instance, this often meant that the other members felt the need to explain the MDH context to me in more detail than would have been expected for a 'MDH insider' so that I could better comprehend how 'things at MDH work'. Additionally, when there was a mention on some 'blunder' or misunderstanding that some people at the Ministry were involved or implicated in, I was approached to act as a conduit to their remonstrations. Sometimes, I was explicitly

asked for an 'outsider's' view on MDH in general or specific to particular circumstances or happenings.

The single most important aim for the CEO of MDH in 2013 to set up the PaSQIT group was to help him re-launch an incident reporting system. One of the objectives of this new system was to act as an instrument for organisational and team learning from the reported occurrences to enhance patient safety and for quality improvement of the hospital services. As previously described, an earlier incident reporting system had faltered during 2012. The absence of a well-functioning system was also highlighted as one of the major deficiencies in the JHMI (2012) report. This adamant demand was a source of repeated contention of the CEO of MDH with PaSQIT who often expressed his 'disappointment' with the lack of progress on this target. On the one hand, members felt that such a system could not function properly and be sustained if it was expected to rely only on and be operated by a 'loose' group of people without a more 'solid' structure in place for this purpose that included *inter alia* full-time personnel to receive and classify incoming reports and organise, follow-up, disseminate and implement the results of and the recommendations from the ensuing investigations. On the other hand, he repeatedly insisted that if PaSQIT does not succeed in launching and operating a new incident reporting system then he will consider the group as being a 'failure'. In fact, he actually recommended that PaSQIT should be dissolved in late 2014 (just before he left MDH).

In reality, work on the planning for the launch and implementation of a new incident reporting system did not start before the second quarter of 2014. During a PaSQIT meeting in April 2014 which was also attended by the ex-CEO, the researcher was chosen to lead a sub-group of PaSQIT in the preparations for the setting up and the launch of a new incident reporting system. Work revolved mainly around the drafting of four standard operating procedures to describe the main processes that will be undertaken by this new system and the delineation and acquisition of the resources required for the system to start functioning and to be sustainable. The system was eventually launched a year later, i.e. in April 2015. It was called Safety Alert for Learning (SALearn) and it would cater solely for the notification of clinical occurrences that have caused or could have caused harm to the patient or patients involved. The new system

had to actively avoid the words ‘report’ or ‘reporting’ to distinguish it from the earlier system that had run into trouble with the nurses’ trade union and was designed to allow notifications that are completely anonymised. The major reason for the considerable delay in the launch of the new system was the perennial inability by the team to acquire the basic resources requested, such as a small secure space or office, secure archiving facilities, dedicated telephone line and computer hardware and most importantly protected time for some of the members to work on this system. These resources only started to materialise in autumn 2014 when a new Clinical Director for MDH was appointed.

3.6 Insider, outsider or a mix of both?

This chapter sought to introduce and describe the theoretical underpinnings vis-à-vis the researcher’s interests, positionality and modes of collaboration and participation in the context of the chosen setting that included the organisation and the relationships with the individuals forming part of the group in which the study methodology is based and from which the research findings are extracted.

A detailed account of the unique circumstances of the researcher’s life journey before and immediately prior to the start of the study was intricately woven with the above. This was followed by a meticulous description of how the researcher achieved “entry” to the specific study setting and the ensuing developments and milestone events at the level of the organisation (particularly at the level of the senior management) and the PaSQIT team in which the researcher was included as a member. A series of events that happened immediately preceding and during the 30 months of the collection of research findings and action research activity were described. This chronological chain of events will form the framework on which the collected data will be categorised, analysed and conceptualised in the succeeding chapters.

The complex relationships of the researcher with the setting and the other actors in the team have been portrayed along the insider-outsider continuum of positionality. The researcher’s positionality during the course of the 30 months journey included in this study could be shown to have been multiple and variable in different situations. There was an underlying position of the researcher that can be best classified as an

"insider in collaboration with other insiders" because she was positioned as a medical and healthcare professional working within a group consisting of members from diverse healthcare professional groupings working towards the aim of engendering patient safety and quality improvements within the hospital. However, there were several superimposed instances where the researcher was perceived to be best visualised from the positionality stances of "reciprocal collaboration (insider-outsider teams)" and/or "outsider in collaboration with insiders" because of her medical specialisation in public health medicine and also because her main employment base was at the Department of Health, i.e. outside the hospital. Finally, the researcher could at times adopt an "outsider-within" viewpoint which as Collins opined (1986: S15) can provide a unique standpoint on self and community from the position of "peculiar marginality". This stance can be encountered when the researcher is on the one hand an integral member of a group but on the other hand being identified as somewhat different from the rest of the team on the basis of one or more different dimensions; in this case the fact that she worked in a predominantly non-clinical capacity.

Research wherein the researcher occupies multiple and intersecting positions may result in the extension of the worldview that she brings to the organisation, both in terms of political or ideological beliefs as well as in terms of cultural assumptions. All of these standpoints can be included in the construction of the reality that is captured in the study (Herr and Anderson, 2015: 55). Each of these positionalities and their inherent connections need to be investigated and the ensuing tensions experienced in the diversity of roles and statuses explicitly articulated. Herr and Anderson (ibid.) posit that in so doing there is the possibility of "crafting uniquely complex understandings of the research question".

In the ensuing account of the data collection and its analysis I will be attempting to do justice to the wealth of knowledge that has been generated through this research. The demonstration of and reflection on the knowledge gained from the different perspectives of my shifting positions within the research context should help me to add to the richness and trustworthiness of this report.

CHAPTER 4: COLLECTING AND IDENTIFYING THE PUZZLE PIECES (Generating the Data)

4.0 Managing, reading, annotating, coding, categorizing and linking data

Problems do not exist in isolation. They constitute part of, result from and are influenced by a complex network of events, activities, perception, beliefs, values, routines and rules. The overall regenerating outcomes and causes are part of the cultural system maintained throughout the life of the group, organisation or community. As more detail on the situation under study is revealed, the research focus and questions can be more clearly visualised and discerned features of organisational, community and professional/ individual import can start to be linked. During this process of disclosure, it will become more possible to move beyond the taken-for-granted perspectives and ultimately aspire to arrive at a more satisfying, sophisticated, meaningful and complete description and understanding of the situation (Stringer, 1999: 66).

The process of disclosure can be represented by the metaphor of assembling and completing a jigsaw puzzle that is made up of several and separate puzzle pieces. The finished puzzle represents the results of the research project which is made up of several identified facets of social action and constructs and their mutual inter-connections. Building and completing the puzzle involves several iterative processes and sequences. Puzzle pieces need to be assessed for their individual characteristics and thereby assigned to different categories such as the pieces pertaining to the sky or to a built feature in the puzzle or to the flat-edged frame of the picture. Connecting the pieces in each category and linking categories together will eventually lead to the construction of the whole puzzle image (Dey, 1993: 40).

4.1 Managing data

A pre-requisite for good analysis is efficient management of the data throughout the performance of data collection and analysis. The opportunities for errors are “various and infinite” and it pays to be meticulous throughout. Various functions are needed including accurate and exhaustive recording and documentation of the data in formats

that will facilitate analysis; employing an efficient filing system such as using a hierarchical system which allows the 'nesting' of files in separate folders and reducing the data such as by careful summarising and consideration for relevance while maintaining the possibility to reverting back to and retrieving the full original data as and when necessary. Management, recording, organisation and archiving of the data, documents, folders, codes and memos arising from this research was assisted with a software package which is a qualitative analysis tool by Researchware called HyperRESEARCH, version 3.7.3[13].

A full description of the data management systems employed in this research will be displayed in several of the sections within this chapter. A description of a number of points of justification for the choices made and employed in the conduction of the in-depth interviews and collection of the action research entry records has also been included. Furthermore, salient points and characteristics of each of the component documents amassed and analysed in this research project will be presented.

4.2 Reading and annotating

"To read without reflecting is like eating without digesting" (quote attributed to Edmund Burke; 1729-1797). 'Digestion' of the data is aided by reading and annotating. These are two components of the process needed to absorb the information and reflect on it. 'Reading' the situation is akin to exploring and interpreting the data for what it may mean (Sayer, 2010: 24). It implicates integration, or in other words relating various parts of the data to other parts or to the cumulative data as a whole and assimilation as in relating data to previous knowledge or pre-understanding. Sayer (ibid.) comments that this involves interpenetration and engagement of the 'frames of meaning' of the reader and the text as he asserts that text cannot be approached with an empty mind in the hope of understanding it in an unmediated fashion as the reader's frame of meaning is a vital tool for understanding.

Reading in qualitative analysis is not passive. It is an important function for comprehension but more importantly it has an essential role in the preparation for the

[13] HyperRESEARCH is copyright © 1988-2015 by ResearchWare, Inc. The software was bought by and is registered on the researcher's name. More information can be accessed from: http://www.researchware.com/.

analysis of the data. Several techniques are advocated to facilitate 'active' reading. These include the interrogative quintet (Who? What? When? Where? Why?) with the addition of 'So what?'; the substantive checklist made up of the fundamental issues with which the researcher is concerned (this is influenced by the researcher's disciplinary backgrounds); transposition of data (asking What if?) and reading by shifting focus (focussing on different 'outstanding' or 'key' points) or shifting sequence (reading through the data using a 'non-linear' approach) (Dey, 1993: 83-88). All these techniques can add value to the depth of the data analysis which needs to complement the richness of the research data obtained through the qualitative paradigm.

Annotation is closely connected with the reading of the data as it is a way of recording observations and ideas about the data and hence adding to its richness in the preparation of the ground for further analysis. Annotating can be viewed as making notes about the notes and is often referred to as making memos or 'memoing' (the act of recording reflective notes about what the researcher is learning from the data). "They may record pedantic points of information or brilliant leaps of imagination, …encompass a panoramic sweep of the data or pinpoint minutiae" (Dey, 1993: 89). This is an imaginative activity, the resultant memos should be explorative and suggestive but not necessarily conclusive and allows the researcher to record her personal critical comments, impressions and insights on the data and its quality. Annotating the data is an effective way to help 'opening up' the data prior to proceeding to a more methodical and in-depth analysis. This creative activity can be resorted to again and give 'added value' even later in the analytical process such as when categorising and linking data.

4.3 Coding and categorizing

The processes of reading and annotating were employed by this researcher concurrently and interactively with the coding and categorising activities in the initial phases of the data analysis for this research. Whilst reading on methodologies used in the data analysis of qualitative research, the terms coding and categorisation were often found and used interchangeably or by different authors to explain more or less similar processes. For example, Saldaña (2013) uses the terms 'codes/ coding', while Dey (1993) uses the terms 'categories/ categorizing' for essentially the same purpose.

For the rest of the report I will be using the term ‘code’ in line with the description of Saldaña (2013: 3): “A code in qualitative inquiry is most often a word or a short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data”, while the term ‘category’ will be used for collections or ‘families’ of codes that are clustered together according to defined characteristics or patterns in line with the explanation by Saldaña (2013: 8-9).

Coding is a conceptual tool used to classify and compare the important or essential features of the phenomena being studied. Charmaz (2006: 46) asserts that:

> Coding is the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you define what is happening in the data and begin to grapple with what it means.

Coding is first and foremost an interpretative activity and is not expected to be employed as a precise scientific tool. In different instances, it can be used to summarise, distil, condense or reduce the data under study. Madden (2010: 10) notes that coding as an analytic instrument should add value rather than diminish the worth of the research story.

Furthermore,

> A code is a researcher-generated construct that symbolizes and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorisation, theory building and other analytical processes.
>
> Saldaña (2013: 4)

Additionally, coding has been termed as a “judgement call” and is expected to bring to the fore the researcher’s subjectivity, personality, inclinations and idiosyncrasies (Sipe and Ghiso, 2004: 482-483). This is because it is accepted that since every person observes and construes social life from different points of view the analysis of qualitative research is bound and anticipated to present the existence of multiple realities.

Coding is a heuristic (an exploratory problem-solving methodology) and will lead the researcher to evocative analysis and interpretation of the data as it enables her “to link data to the idea, and from the idea to all the data pertaining to that idea” (Richards, Morse and Richards, 2007: 137). Coding acquires particular significance in the grounded theory approach to qualitative data analysis.

Coding methods aim at organising data in a systematic order. Categorisation methods aim at including data or codes in a system or classification through the alignment and assembly of similarly coded data using reasoning together with tacit and intuitive senses to determine which data "look alike" or "feel alike" (Lincoln and Guba, 1985: 347). Coding and categorisation are not one-off exercises. These activities necessitate careful attention to language and deep reflection so that emergent patterns and meanings of human experience can be identified and eventually understood (Saldaña, 2013: 10). In fact, consecutive cycles of coding may need to be performed as data is reviewed and codes are either recoded or grouped into categories.

A full explanation of the processes employed for the activities of reading and annotating, and coding and categorisation in the analysis of this research project and the results achieved will be illustrated in this chapter and in Chapter 5.

4.4 Linking data

Coding and categorising the data permits the comparison of observations in terms of their likenesses and dissimilarities. Another important complementing activity involves the linking of the data. Linking data involves the search for and recognition of substantive relationships between different 'bits' of data or data codes and categories. Substantive associations are concerned with how different parts of the data interrelate with each other (Dey, 1993: 152). For example, healthcare professionals and patients are two distinct social entities, but there is a substantive connection between these two social roles because one cannot exist (or does not have a reason for being) without the other. Sayer (2010: 61) distinguishes between 'internal' or 'necessary' relations and 'external' or 'contingent' linkages. The link between healthcare professional and patient is necessary because one social role presupposes the other. On the other hand, direct payment by the patient to the healthcare professional is a contingent relation as service provider can be paid by other means other than by payment at the point of service.

Comparing and linking codes and categories will eventually lead to the gradual appearance of themes and concepts with the ultimate aim that these will lead to the gradual development of assertions or a theoretical framework. Categorising leads us

to “get ‘up’ from the diversity of the data to the shapes of the data and what it represents. Concepts (and themes) lead us to get ‘up’ to the more general, higher-level, and more abstract constructs” (Richards, Morse and Richards, 2007: 157). The development and results of this final stage of the data analysis for this research will be documented and discussed in the next chapter.

4.5 Recording, documenting and organizing the data collected in this research

4.5.1 Un-structured and in-depth interviews

A set of twenty-five (25) unstructured and in-depth interviews with people working within MDH or who have had connections with various sectors of the human resources at MDH through for example training and mentoring programmes, were conducted over the course of 24 months (November 2013 – November 2015). The time spent on each interview varied from 45 to 75 minutes. The total time used to conduct the interviews totalled 1410 minutes (corresponding to 23 hours and 40 minutes).

4.5.2 Why interviews?

A variety of methods of data collection can be used in qualitative research, including observations, textual or visual analysis (e.g. from books or videos) and interviews (individual or group) (Silverman, 2013: 15). However, the most common methods used, particularly in healthcare research, are interviews and focus groups (Gill et al., 2008: 291).

Qualitative interviews may be employed either as the primary strategy for data collection, or in combination with other techniques including observation and document analysis. The rationale of the research interview is to delve into and explore the views, experiences, beliefs and/or motivations of individuals being interviewed on specific matters. Its central purpose is to listen attentively to what the interviewees have to say, in order to acquire more knowledge about the study topic. Kvale (2006: 481), explains that:

> In qualitative interviews, social scientists investigate varieties of human experience. They attempt to understand the world from the subjects' points of view and to unfold the meaning of their lived world. The interviews give voice to common people, allowing them to freely present their life situations in their own words, and open for a close personal interaction between the researchers and their subjects.

Qualitative interviewing frequently uses open-ended questions to allow for and encourage the interviewee's free expression and elicit individual variations (Hoepfl, 1997: 52). They are best carried out in places and under conditions that are comfortable for and familiar to the interviewee (Patton, 2002: 40). Establishing rapport with participants prior to the interview is also important as this can also have a positive effect on the subsequent development of the interview (Gill et al., 2008: 292). Another important consideration before the start of the interview process is on how to record interview data. Whether one relies on written notes or on tape recordings of the interview conversation or both together appears to be largely a matter of personal preference and literature has examples of arguments both for and against either method (Hoepfl, 1997: 52-53).

For this research, the use of informal, conversational interviews for one of the two methodologies employed in this project was selected. The choice of this approach was made in order to encourage interviewees to feel safe and expand at length on what they perceive as important aspects and understandings of the social phenomena at play on the subject matter under study. They were asked to impart detailed insights and sometimes controversial opinions on a number of topics. Some of these topics could be considered as being particularly sensitive matters within the specific context of a big organisation situated in a small country. Respondents needed to feel confident that what was said during the interview was dealt with sensitively both in the analysis and in the reporting of the data and that their anonymity was continuously and firmly secured. For this reason, the use of focus groups was considered as not appropriate for this enquiry as it could be forecasted that several participants may not wish to talk openly and candidly about such issues in a group environment. The choice to not use any recording equipment was also based on several of the above reasons. On the other hand, almost all interviewees knew the researcher well and for a long time

(professionally and personally). It was felt that the above tactical decisions made the interviewees feel more comfortable to willingly convey their personal insights.

4.5.3 Interviewing procedures

The request for an interview was initially communicated on a face-to-face basis. This was followed by an email correspondence that included a written summary of the objectives of the research and also of the methodologies being employed (see Annex 2) and the consent form (see Annex 1). The email correspondence was used to agree on a date, time and venue for the interview. In almost all cases the initially agreed date and time were not difficult to settle and in the majority of cases the interview took place in the interviewee's office. All persons invited for an interview accepted my invitation.

As a general rule, prior to starting the interview, I would reiterate a short overview of the aims of my research and the methodologies being employed. I would then invite the interviewee to introduce and expand on her/his views unimpeded with further direction so that the interviewees were free to decide on the course of the ensuing discussion. For the most part, my only interventions and questions were intended to clarify or ask for further elaboration and detail on what the interviewee was saying. Only, when it was apparent that the interviewee would have exhausted her/his self-identified issues on the subject, would I intervene to ask questions about their views on issues that had been discussed and recorded in the interviews that had already been conducted with previous interviewees.

No recording equipment was used. From my previous experience the absence of recording equipment can help the interviewee to feel freer and safer to be more forthright in her/his elucidation of views on the research enquiry than if such apparatus was present. As the interview progressed I jotted down several and copious notes on what was being said and then within 24 hours of the meeting, I transcribed these notes into a full report on the discussion that was held. This report was sent to the interviewee for her/his review and feedback. Almost all interviewees responding back within a few days either to confirm that the report was correct or else with a few suggestions for changes. There were a few instances where I needed to ask for some

clarifications or additional information in order to complete the interview report. In most cases these involved requests to confirm titles or the full text for acronyms that were used.

4.5.4 Characteristics of the interviewees and the interviews

Annex 3 shows the list of interviewees (in chronological order based on the temporal sequence of their interview) with a number of characteristics related to each person (at the time of the interview) and the month and year and the duration of the respective interview. The information given in this table has been construed and limited with the main aims of preserving the anonymity of the interviewees whilst allowing the reader to perceive relevant aspects of the context and backgrounds of the selected professionals.

The characteristics included took account of the following factors:

i. Senior position – this level was ascribed to people that have occupied or are still occupying senior headship posts and senior leadership roles such as Chief Executive Officers, Directors, Clinical Chairpersons, Medical consultants and Chief Nursing Managers. People at senior positions were further distinguished on whether they occupied senior clinical or senior non-clinical positions.

ii. Health versus non-health professional – health professionals include persons with a professional background in health and healthcare (medical, nursing, allied healthcare professionals).

iii. Leadership versus management roles: leadership roles were ascribed to people with various forms of headship positions. In all cases this was synonymous with a senior position. Management roles were ascribed to persons at more junior levels such as assistant directors or lower and/or healthcare professionals below the levels of medical consultant or chief nursing manager.

iv. Past versus present engagement (at the time of the interview)

v. External versus internal to the health sector: whether their main employment was within the health sector or otherwise. People ascribed as

'external' usually provide their service on the basis of specific assignments and contracted out projects.

The interviewees were almost equally divided by gender (12 females and 13 males). Their age had a higher preponderance for the older age groups. Only five of the interviewees were below the age of 50 years at the time of the interview. This is related to the fact that the majority of the interviewees were or had occupied senior positions.

4.5.5 Theoretical sampling of the interviewees

During conventional research methodologies, sampling is usually expected to precede data collection and analysis and is frequently directed by prevailing theory. In research which is guided by the grounded theory approach, this correlation is inverted and sampling cannot be determined *a priori* to the data collection.

> Beyond the decisions concerning initial collection of data, further collection cannot be planned in advance of the emerging theory.
>
> Glaser and Strauss, 1967: 47

Further data can only be collected when theoretical ideas start to emerge. The researcher will then establish what, where and how to seek additional data in order to explore and elaborate on these ideas. Glaser and Strauss (1967: 45) coined the term "theoretical sampling" to describe the flexible and dialectic process of determining data collection in the light of and jointly with coding and the emerging analysis. They argued that this offers an advantage over the inflexibility of traditional sampling strategies as it allows adjustment of the data collection process to take into consideration the ideas evolving from the ongoing research process. Sampling guided by "theoretical" significance is concerned with the contribution of new sources of data to the development of novel concepts. This is because the criteria for selection are chiefly concerned with "comparisons in terms of concepts being investigated (and their potential to illuminate key issues) – rather than selection of terms or other factors which might delimit populations or control the variables being studied" (Dey, 1999: 5). Using this methodology, selection of sources of data is governed by their comparisons on the grounds of theoretical value (in terms of codes and categories) instead of their value for representation or their usefulness for generalisations.

The sampling of interviewees was conducted based on the above-mentioned principles associated with theoretical sampling. An initial decision involved the selection of an interviewee with a broad experience of working for several years with numerous members and groups within the local health sector but was external to the health domain in that he has an employment background in various private and public non-health related ventures and a professional upbringing in an academic discipline which is unrelated to the health branch of learning. Consequent interviewees were identified following the analysis of the data collected at the first interview which led to the elucidation of initial potential lines of enquiry that merited further investigation. Each interview was analysed during and soon after it was transcribed. This analysis led to the identification of additional points of interest that were used by the researcher to guide the selection for the subsequent categories of interviewees to approach and with whom the discussion on these issues could be further discussed to seek new perspectives on the highlighted subject matters. There were often several potential contenders for each identified category of interviewees that could be approached. Most often, selection focussed on the availability of each candidate and the researcher's perception (arising from previous experience from the acquaintance with each person) of the extent to which individuals can be expected to open up and express her/his views candidly and in detail.

The first interview was conducted with a senior person who had been offering management advice and mentoring services to the health sector in Malta over several years and different administrations (national politics, ministry leadership and hospital management). This interviewee was involved and worked with different groups and levels of people in the health field, from people in headship positions within the Ministry to various individuals and groups of healthcare professionals. The professional background of this respondent was completely extraneous to the health domain. These characteristics were the reasons why I chose to select him for the first interview. I felt that this interviewee could introduce a wide range of issues that can then be further pursued with subsequent interviewees. The first interview was one of the longest (in terms of time spent) and a very wide spectrum of issues were covered.

The first interview was followed by meetings with two other persons who similarly had been engaged with advising and mentoring various groups and levels of people in the health field. These were followed with a series of interviews with people involved in the human resource management at both the Ministry and hospital levels. Different present and past occupiers of senior leadership positions (both non-clinical and clinical headships) were consequently approached. A number of interviewees were more representative of the grass-roots levels of healthcare workers while others were approached because they show distinctive potential to be tomorrow's leaders in their respective fields.

4.5.6 An action research diary of events and activity within the Patient Safety and Quality Improvement Team (PaSQIT) of MDH

This research arm was documented with the recording of sixty-eight (68) episodes of events and activity as a member within the PaSQIT of MDH. This team started to be formed in March 2013. The author joined the team in May 2013 during the long weekend (2-6 May) during which Dr. Peter Lachman paid his first visit to the hospital. The action research arm of the study starts with the reports of meetings held before the May 2013 visit and ends with another visit organised by PaSQIT in conjunction with the training coordinator of MDH for Dr. Lachman in November 2015 (13-16 November).

4.5.7 Why Action Research?

There are various views on what action research is meant to be and what the methodologies classified with this approach can be used for. Smith (2013) contends that the discussion in the literature veers towards two distinctive camps. There is the British tradition which is more inclined to assign action research to enquiries typically oriented towards the enhancement of direct practice, is most widely used in the field of education, is closely related to the realm of the self-reflective practitioner and the notion of reflective practice introduced by Donald Schön in 1983 and can be summed up with the following enduring definition by Carr and Kemmis (1988: 162):

> Action research is simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which the practices are carried out.

And there is the American tradition which is more adapt to the social welfare field and which can be broadly summed up by Bogdan and Biklen (1992: 223) as the "systematic collection of information that is designed to bring about social change". This tradition is more linked to citizens' action and community organising and is often used by its practitioners with the aim of assembling data and evidence that can lead to recommendations of actions for change such as on revealed discriminatory and socially or environmentally harmful practices.

Action research has a complex history because it is not a solitary academic discipline. It is an approach to research that has developed over time from proponents working in a broad range of fields. Its introduction has been attributed to the work of Kurt Lewin in the mid-1940s and to work performed through the Tavistock Institute for Human Relations. It is also strongly related to the work of John Dewey on the value of interaction, reflection and experience, interest in the community and democracy for development in the field of education. Action research has been promoted and has been related to the work of several pioneers leading diverse agendas. Examples include research on and involving an extensive variety of organisations, extending from private sector companies to public authorities such as the seminal work of Chris Argyris, Donald Schön, Reg Revans, William Torbert, Peter Reason and John Heron and work promoting action research approaches to oppression and institutional change carried out and publicised by social researchers including Paulo Freire, Budd Hall, Marja-Liisa Swantz, and Orlando Fals-Borda (Brydon-Miller, Greenwood and Maguire, 2003: 11).

Subsequently, more recent development in the field of action research activity has sought to draw and combine the two traditions such that it has gained a significant foothold both within the realm of community-based, and participatory action research and as a form of practitioner led and oriented improvements to practice (Smith, 2013). Reason and Bradbury (2001: 1) succinctly describe action research as:

> … a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.

Action research rejects the idea of an objective, value-free approach to knowledge generation in favour of an explicitly political, socially engaged, and democratic practice because "research into our ways of life cannot be conducted in the same, value-free way as in the natural sciences" (Shotter, 2003). Working collaboratively with others does not only give rise to community and organisational changes. There are likewise and frequently notable personal changes in the action researchers themselves as they reflect on their experiences and most acknowledge being profoundly changed by the new understandings attained through the research process (Brydon-Miller, Greenwood and Maguire, 2003: 14).

Werner Fricke (2002) opines that action research is:

> empathy and listening while meeting the other, it is a commitment to basic values like human creativity and democratic participation, it is based on the perception of social reality as a continuing process with individuals being subjects of their history and the social contexts they are dependent on... (we) cannot (and must not) avoid values and personal commitment.

Knowledge comes from doing and values require action (Brydon-Miller, Greenwood and Maguire, 2003: 14). The reason for choosing this research paradigm to be one of the two main research methodologies in this study is based on all the above. Above all it is based on the personal belief that through commitment, doing and acting individually and collectively within my research setting, the researcher could help to generate and document knowledge that can in turn be used to bring about change as an integral part of the research activity.

4.5.8 Documenting the action research journey

Soon after 'entry' as a new member of PaSQIT, the researcher started to assume secretarial duties for the team. Generally, clinicians in Malta are loathe to documentation of any sort. While most of them can appreciate the usefulness of clear and detailed documentation and bemoan the fact that this is scarce, some of them still resort to writing scanty and often unintelligible scribbles on patients' notes and dismiss any effort at standardising record-keeping as an unjustified administrative encumbrance that adds towards increasing their clinical burdens. The other members of the team soon started to seek the researcher to take the minutes (record) of

meetings, to review already existing draft documents of the team and to initiate the drafting of new documentation. After the first few meetings the researcher was nominated as the *de facto* secretary of the team by consensus.

This role was welcomed by the researcher as it helped ensure the upkeep of a standard level of quality and detail of the records for PaSQIT. The quality of these notes was useful both for the team's records as well as for the benefit of the researcher as they formed the main source and basis for the action research (AR) journal. In total, sixty-eight (68) major entries collected over thirty months were included in the AR journal. More than half of these records (41 records - 60%) were wholly created or included major input by the researcher. The rest (27 records - 40%) were documents created by another member of the team. This group of documents included the records of meetings that took place before the researcher joined the team and assumed secretarial functions (eight records - prior to July 2013) or when the researcher could not attend a meeting (six records - after May 2013) or the records created by an 'official coordinator' that was assigned to PaSQIT for four months from August to November 2015 (thirteen records). This coordinator took up the secretarial role during this period of attachment to PaSQIT.

All entries were coded and memos were added by the researcher to various codes and sites within the entries. These memos or annotations were intended to pose, record and elaborate on the researcher's ideas and reflections while reading through and coding the transcripts of these records.

Annex 4 lists the 68 entries in chronological order (either by the date of the recorded event or meeting or by date of the final or most finalised version of a document such as progress reports and terms of reference) in the AR journal.

4.5.9 Characteristics of the entries in the Action Research journal

Exactly three quarters (51 entries; 75%) of all entries were records of the meetings of the whole PaSQIT group. Two of these were records of half-day seminars and the rest were regular PaSQIT group meetings (47 entries) and the records of the two meetings of the initial group that took place in early 2013 before the first weekend organised

with the attendance of Dr. Lachman and the official launch of the PaSQIT on the 6th May 2013.

The dates of the half-day seminars were set weeks in advance, took place in a location outside MDH premises (in a training centre within another public hospital situated in Attard) and involved the engagement of a facilitator that was invited to lead and monitor the discussions on the day. Planning the agenda for these seminars was shared between members. Sessions at the seminar involved discussions on strategy setting for the group activities and team building exercises. They lasted between four to five hours (0900 to 1400) and on both occasions almost all members attended the whole seminar and the immediate aftermath was the emergence of a re-energised team. This enthusiasm lasted over the following few weeks but eventually "fizzled off" on both occasions.

On the other hand, regular PaSQIT meetings took place in the early afternoons and were convened initially in the boardroom of the Pathology Department and later (from the summer of 2015) in the boardroom of the Physiotherapy Department. Most of these meetings were attended by PaSQIT members only, but sometimes they were joined by different members of the senior management at MDH (most frequently the CEO and Medical Director of MDH at the start of the team's existence and the Clinical Director after mid-2014).

These meetings were presided over by the designated chair of the team when present. When the chair was not present, the meeting was either called off or was concluded within a shorter time than usual. One of the few rules that were regularly observed at these meetings involved delaying the 'official' start of the meeting up to 30 minutes from the set starting time until at least half of the team's members were present. Once these 30 minutes elapsed, the meeting started even if a quorum was not in place. Meetings lasted between 45 to 90 minutes but in most cases, they did not last for more than 60-75 minutes. It was very difficult to have all members present in any one meeting because of either other 'fixed' individual commitments such as clinical sessions or last minute and unanticipated incidents that required members to absent themselves to deal with an emergency or a crisis.

For a number of these meetings a tentative agenda was distributed by email a few days in advance of the meeting. However, discussions very rarely followed the agenda plan to any significant degree and a number of agenda items were repeatedly carried forward from one meeting to another.

From the summer of 2013, the minutes of the meetings were recorded onto an agreed template that included the decided activities, timeframes and members responsible for implementation after each identified action or point of discussion and subject matter. These reports were often sent to the other members for feedback a few days after the meeting but input was rarely received either before or even during the following meeting. The members attending the meetings did not participate equally in the debates. Discussions were often dominated by the same few particular members of the team and these members were repeatedly allowed to adopt an unchallenged 'dominant' position to the detriment of other members who were then not able to adequately express their views and suggestions for actions. The latter group of members often ended up voicing their frustrations about this repeated state of affairs especially when the domineering individuals were absent.

The remaining one-fourth of the entries in the AR journal (17 entries) included the six records of meetings of sub-groups of PaSQIT such as the sub-group that planned the launch of the Safety Alert system (SALearn). Another nine of these entries involved documents such as terms of reference, progress reports and concept papers (there were two documents of this type and both of them originated before the formal launch of PaSQIT group in early 2013). Progress reports were initially planned to be issued every six months but in the first 30 months of the team, only 3 reports were completed (August 2013, January 2014 and January 2015).

Finally, the remaining two entries were the reports for the various meetings that took place during the two visits of Dr. Lachman to MDH. Both these reports assembled all the proceedings of the meetings that took place over the four days of each long weekend; the first in early May 2013 and the second in mid-November 2015. These reports chronicled the discussions at each gathering with different groups of people as well as the different talks that Dr. Lachman gave to the PaSQIT group during their 'closed' meetings. The latter were mostly theoretical lectures on different aspects of

the themes concerned with patient safety and quality improvement. He termed these lectures as the imparting of "profound knowledge"[14] on these central subjects.

4.6 Reading and annotating, and coding and categorizing

The researcher often undertook the processes of reading and annotating concurrently and interactively with the coding and categorising activities in the initial phases of the data analysis for this research. Reading was carefully done during the transcription of the notes that were taken during the interviews and the PaSQIT events that were recorded. These reports were transcribed within 24 hours of the interviews or recorded meetings. The interview document was sent to the interviewee for her/his review while the record of meetings was sent to the team members prior to the next meeting and proposed for approval at the start of the successive event. Annotation (or memo writing) took place concurrently with re-reading of the completed transcript. In the case of the documents that the researcher did not write, the reading and annotation process were performed simultaneously.

Altogether, 208 memos were included within the collection of AR entries (average 3.1 per entry, mode: 3, median: 3, range: 0-9). The length of the memoranda varied from just one sentence to half a page. The scope of the memos also differed and could for example include an articulation of the researcher's observations on members' interactions, a connection between something said during the discussion with insight that the researcher would have obtained from previous experience and occurrences as well as a record for the expression of her own emotions such as satisfaction or frustration towards particular happenings, reports and or assertions.

Annotation was not used for the interview transcripts. This is because these records were written in more detail, were not restricted by a set format and the researcher included her interpretation and reflections within the interview reports as they were being drafted. The interview report was always bounced back with the interviewee and feedback was requested and sent when the interviewee disagreed with or wished to

[14] The terms 'profound knowledge' were interchangeably mentioned with Deming's System of Profound Knowledge. In fact, the four inter-related fields incorporated in Deming's seminal work on quality, management and leadership: appreciation of a system, knowledge of variation, theory of knowledge and psychology were introduced and frequently mentioned in Dr Lachman's lectures to the PaSQIT group.

amplify particular points further or alter the written account of what was said during her/his interview.

The data collected and analysed from the twenty-five interviews generated more than 600 different codes during the first coding cycle (see Annex 5). Some of the codes were re-applied a number of times to different excerpts either in the same interview or in different interviews. These codes were re-analysed in line with the "constant comparison" method described by Dey (1999: 9), collapsed and grouped into ninety-one (91) second cycle codes or categories as these were now starting to form "families" of codes that are clustered together according to characteristics and patterns that started to become more delineated and visible or evolving interpretation of meaning that could be aggregated. Another cycle of analysis collapsed these initial categories further with the resultant derivation of twelve (12) major categories. Annex 6 shows the first cycle codes grouped under the categories generated during the third and second cycle coding respectively. Annex 7 shows the second cycle categories generated from the analysis of the interviews with their corresponding third cycle encompassing categories.

A total of 203 codes were generated during the analysis of the different entries of the AR journal (see Annex 8). Several of these codes were applied to more than one selection of applicable text in the AR journal. Several excerpts of the text and codes were embellished with memos that were written by the researcher during the concurrent reading and coding processes. In most cases annotation took place simultaneously with or soon after the completion of the transcription process of the entry report. After the application of a second-cycle coding process, the number of codes were collapsed to a total of fifty-four (54) clusters of codes or categories (see Annex 10). A third cycle of analysis further assembled these categories into nineteen (19) major categories (see Table 8; pages 109-110).

4.7 Theoretical saturation

The main target of research guided by the grounded theory approach is to generate theory. As a consequence, the research can be concluded only when "adequate" theory has emerged from the analysis (Dey, 1999: 8). Glaser and Strauss assigned the term

"theoretical saturation" to the moment when it becomes apparent that no new properties, categories or relationships can emerge from additional data collection or analysis.

> After an analyst has coded incidents for the same category a number of times, he learns to see quickly whether or not the next applicable incident points to a new aspect. If yes, then the incident is coded and compared. If no, the incident is not coded, since it only adds bulk to the coded data and nothing to the theory.
>
> Glaser and Strauss, 1967: 111

Theoretical saturation can be recognized as achieved when no further conceptualisation from new data is required. It is concerned with conceptual variations and not data. Furthermore, Dey (1999: 8-9) claims that apart from concluding the research when the limits of particular conceptualisations are reached through theoretical saturation, research in its entirety can also be brought to a conclusion through increasing selectivity. He expands on the process of integrating categories and working towards the creation of a "core category" or what Glaser and Strauss called the main "story line" of the study. Finding this theoretical framework can either be used to conclude the study or else direct further data collection and analysis within a more defined and focussed agenda. The construction of "theory with a small set of higher level concepts" (Glaser and Strauss, 1967: 110), can be attained when the focus is relocated to the analysis of the major categories and their relationships, to the identification of underlying consistencies and the clarification of rational linkages.

A tentative assertion at "theoretical saturation" could be fielded at the end-stage of the second cycle of coding for the interviews because all new codes derived from the last few interviews could be classified into one of the already generated categories. A similar occurrence could be observed during the coding process of the AR entries recorded and coded during the summer and autumn of 2015. Constant comparison was applied between the codes generated from the analysis of the interviews and the analysis of the AR journal. Eventually, theoretical saturation could only be asserted when the data and corresponding codes and categories collected from both primary methodologies of this research were completely analysed and the emerging major categories from each research arm could be assimilated to start the building of a composite picture that could reflect, demonstrate and articulate the analysis from the findings observed and generated from the whole research project. At this stage, the

researcher could start to detect and delineate the appearance of the outline of a preliminary grounded theory resultant from this research.

4.8 Conclusion

This chapter described the processes followed in the data collection from the two main methodologies employed in this research project. The techniques used in the management, reading, storing, annotating and initial coding cycles of the data were described in detail. The points or events at which the main data collection was performed were also listed such as the interview dates and the different reports and other type of documentation extracted and/or created and included in the AR diary (see Annexes 3 and 4). Characteristics of each point or event were also identified such as descriptors of the individual interviewees and the duration of each interview and the information that describes each of the documents included in the action research account. The role and main features of the annotations added by the researcher during the reading and analysis of the data collected in the action research arm of the study were also documented.

The following chapter will demonstrate the processes and the results achieved during the different coding cycles employed in the analysis of the data generated by the two approaches used in this study. At the start of the chapter, the processes and results for each methodology are exhibited separately. Nearer to the end of the chapter, the processes employed for the merging of the results from the analysis of the two sources are described. Finally, the outcome of the merging activity is displayed through the presentation of the major categories that have been extricated as a result of the intense data collection and analysis activities undertaken.

CHAPTER 5: BRINGING THE PUZZLE PIECES TOGETHER (Analysing the Data)

5.0 Introduction: making connections

> Inquiry is rooted not in abstraction, deduction, and formalism but rather in the dynamics and demands of judgement, argument and lived conduct.
>
> Giarelli, 1988: 25

In qualitative analysis, the researcher repeatedly asks a number of questions to the data collected such as 'What happened?', 'What was said?' and 'What was meant?' (Dey, 1993: 220). Qualitative inquiry is often employed to provide direct evidence about the dynamics of what is happening. Dey (1993: 168) explains that one of the methods mostly used in qualitative analysis endeavours employs the following two main steps. The first major exercise is the analysis of the data resulting into the creation of codes and categories that are in turn used to capture the main elements of social action. The second step then is employed to unearth, explore, explain and document the interconnections identified as operating between the identified categories. This is the basic underlying methodology underpinning the elucidation of the dynamics of the social actions portrayed from the research settings and happenings documented in this research project.

Coding and categorisation are used to and result in the 'breaking up' of the data into smaller 'bits' each of which provides a series of discrete events, impressions or images. In the subsequent processes of linking data and identifying and documenting potential interconnections the separate pieces are re-drawn together to create an incrementally more inclusive and composite picture that will allow us to 'make sense' of all the gathered information. This process interplays the continuity between observation and inference. Frequently, inference follows observation but it important to also recognise that observation in itself often implicates elements of inference (ibid.: 169). Furthermore, judgments on potential connections also arise from comparisons between what was expected and what was actually observed as happening.

Making sense of connections is entrenched within the observation and understanding of the identified links (with the contribution of reasoning and experience) and how they correlate (Sayer, 2010: 17). The regularity with which certain events occur

together or follow as a consequence of each other also have a strong bearing on the likelihood that linkages can be identified. Sometimes, epistemologists make the distinction between 'associated events' and 'linked events'. Events are associated when they occur together while events are linked when there is an implication of an interaction such as when Event A is seen to lead to Event B. However, Dey (1993: 171) asserts that both these two forms of connections are mutually dependent as a basis of ascertaining connections between events and observations. This is because most often, establishing connections is influenced by and contingent with elements of both approaches.

5.1 Developing Theory using the Grounded Theory approach

As described earlier, Grounded Theory is generally considered as one of the major methodological approaches for qualitative inquiry. This process usually involves careful analytic consideration through the application of different types of codes to the collected data. This process is repeated a number of times resulting in a series of cumulative coding cycles with the ultimate aim of guiding towards the development of a theory – a theory "grounded" or embedded in the original data themselves. Figure 5 shows a simplified depiction of the different major steps employed in the development of the "classic" grounded theory.

Some of the coding methods, namely in vivo, process and open/ initial coding, are often collectively termed as First Cycle methods. These methods are used for the coding processes applied at the beginning of the analytic activity as the data collected is fractured into individually coded segments. Other methods including focused, axial and theoretical/ selective methods are consequently grouped as Second Cycle methods. These coding processes which are often applied in the more advanced stages of data analysis are meant to result in "both literally and metaphorically constantly compare, reorganise, or 'focus' the codes into categories, prioritise them to develop 'axis' categories around which others revolve, and synthesize them to formulate a central or core category that becomes the foundation for explication of a grounded theory" (Saldaña, 2013: 51-52).

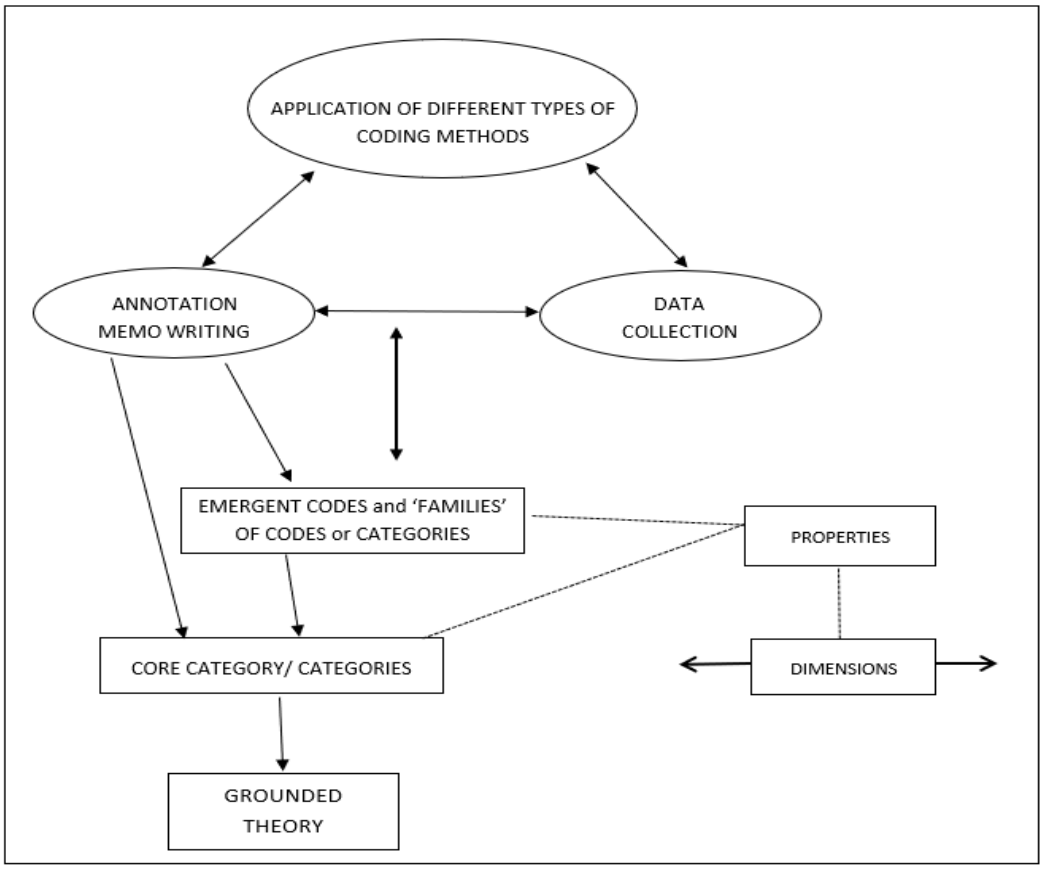


Figure 5. A simplified illustration of the different major steps employed in the development of the "classic" grounded theory (adapted from Saldaña, 2013: 53, Figure 2.2)

Glaser and Strauss (1967: 36) characterised categories as "conceptual elements of a theory". This implies that they are meant to be more than a name or a label. A name or a label may or may not have a conceptual import while "categories are always and inescapably conceptual" (Dey, 1999: 48-49). They are meant to be creative constructs that can convey "relations of similarity and difference but can also be connected theoretically through the identification of substantive (causal) connections between them" (ibid.: 63).

Methodological works explaining the intricacies of the grounded theory approach also include definitions and explanations on related terms called 'properties' and 'dimensions'. Over time, Barney Glaser and Anselm Strauss together, alone or with other authors (particularly Anselm Strauss with Juliet Corbin) published different explanations to differentiate between the three basic 'building blocks' of grounded theory: categories, properties and dimensions. Table 6 shows a collation of definitions and explanations that aim towards clarifying and demarcating the important differences between these three

terminologies: category, property and dimension. Extricating and differentiating between these different modes of analysis is useful in order to help steer a steadier path through the intricacies of a grounded theory methodology since this approach essentially aims at uniting different modes of inquiry (Dey, 1999: 63).

Grounded theory methodology can be firmly and without a doubt positioned as an interactionist research practice. Its orientation is chiefly directed towards elucidating how actions result and are connected with observed consequences, that is in the explanation of "basic social processes in dynamic terms". The main tool used to accomplish this goal is through the conduction of "constant comparison" across a range of settings in which actors are engaged in the basic social process under investigation (Dey, 1999: 68). Glaser and Strauss (1967: 68) contend that by comparing different views through constant comparison, "a proportioned view of evidence" can be attained since "biases of particular people and methods tend to reconcile themselves as the analyst discovers the underlying causes of variation". As a result, the researcher can muster "confidence in the data upon which he is basing his theory".

Grounded theory approaches claim to reconcile and amalgamate naturalistic inquiry with variable analysis. The former is typically concerned with the development of theory that can expose the complexity of social life. Resultant theories are usually "limited in scope, rich in detail and bounded by context". On the other hand, variable analysis is mostly aimed at the advancement of theory that can reduce and simplify complexity. In return, subsequent theoretical constructions tend to be broader in scope, less concerned with detail and less circumscribed with context (Dey, 1999: 39). In their original works, Glaser and Strauss attempted to reconcile these two widely divergent expectations of outputs through the development of the distinction between "substantive" and "formal" theory. They attested that both of these distinct types of theory can be generated through comparative analysis. Substantive theorising can be attained through comparative analysis "between or among groups within the same substantive area", while formal theory can emerge from comparative analysis conducted "among different kinds of substantive cases which fall within the formal area" (Glaser and Strauss, 1967: 33).

An example taken from the particular context of this study can illustrate the above as follows. If "territoriality" is taken as the "substantive" area; comparison across hospital teams or different health professional groups can provide the basis for generating

“substantive theory”. On the other hand, a comparison between different contexts such as the healthcare sector and the aviation industry can result and support the generation of a “formal theory”. In practice and through the accumulated experience of the researching community since the first treatise on Grounded Theory published by Glaser and Strauss, it has been recognized that maintaining this strict dichotomy was shown to encounter several difficulties. In particular, this recognition became evident because the major differences between these two distinct extremes are the degree of abstraction and whether the emphasis is more on capturing the complexities of specific cases or constructing generalities across a range of cases.

The level of abstraction required is more pronounced in the formal end of the spectrum but it is not totally absent in substantive theorising. Furthermore, at the formal extreme, the emphasis is concentrated on the target of exposing generalisations, while at the substantive end-point the focus is more on capturing individual complexity. Dey (1999: 41) concludes that generalisations can be useful when analysing the complexities of a specific case. Concurrently, generalisations also need to be applied within specific contexts. As a result, contemporary approach is more towards a dialectical conception of theory.

The ensuing sections of this chapter will portray in detail the findings of this research and the patterns and linkages that the researcher could elicit from the codes, categories and annotations that were developed during the data collection and analysis processes. These processes were guided by the principles described in earlier chapters and above.

Table 6: A collation of definitions and explanations that aim at clarifying and demarcating the important differences between categories, properties and dimensions in the context of Grounded Theory

	Glaser and Strauss, 1967	Strauss, 1987	Glaser, 1992	Dey, 1999
Category	Categories are concepts that "stand by themselves" as elements of a theory	Categories are the result of distinctions which are in turn the result of dimensionalizing	A type of concept. Usually used for a higher level of abstraction	Class, division, or any relatively fundamental concept. Categorising requires comparison. Categories can be created, but unlike properties or dimensions they cannot be discovered. Categories can be assigned through comparison and classification.
Property	Properties are aspects or elements of categories	The most concrete feature of something that can be conceptualised	A type of concept that is a conceptual characteristic of a category, thus it is at a lower level of abstraction than a category. A property is a concept of a concept	Owning, being owned; attribute, quality, characteristic; quality common to a whole class but not necessarily distinguishing it from others. Often refer to external relationships – how an entity acts on or interacts with its environment. Need not involve comparison. Properties can be attributed through analysing interaction.
Dimension	-	A basic operation of making distinctions	-	Measurable extent of any kind (e.g. length, breadth, intensity). Involves internal differentiation or characteristics. Need not involve comparison. Dimensions can be measured using a scale (not necessarily numerical).

5.2 Outcomes of the data collection and analysis of this research

Data generation for this research was the outcome of concurrently using two different methods for data collection. The following two sub-sections will exhibit and explain in detail the re-configuration of the data collected through the different cycles of coding and classification for these two arms of the fieldwork separately.

5.2.1 Outcomes of the data collection and analysis from the in-depth interviews

5.2.1.1 First cycle coding

The data collected and analysed from the twenty-five interviews generated 616 codes during the first coding cycle (see Annex 5). The number of first cycle codes generated per interview varied from a maximum of 39 codes from Interviewee W to a minimum of 15 codes from Interviewee J (average 24.6 per interview, median: 29, range: 15-39).

A small proportion of the codes (just over 10%) were re-applied a number of times to different excerpts either in the same interview or in different interviews. Coding was generated via line-by-line reading and re-reading of the interview transcripts. Some of the codes were derived as a summarisation of a small section of the transcript in order to clearly extract an identified point or points that the interviewee wanted to make. Other codes were constructed as a result of the researcher's reflection on what the interviewee has communicated and articulated. In several cases, the "descriptive" and "reflective" codes followed each other and emanated from the same section of text in the interview transcript. In actual fact, the "reflective" codes were used synonymously by this researcher as annotations to the data collected during this arm of the research fieldwork.

The content of the codes varied widely and are diametrically contrasting in several instances. Examples of different types include:

- statements on actual situations – for example: "barriers due to the smallness of Malta and insularity" (Interviewee N); "most wards at MDH (Mater Dei Hospital) were initially meant to be specialised wards" (Interviewee T).

- statements on perceived situations – for example: “10% of MDH employees are otherwise unemployable” (Interviewee E); “MDH not yet a 'learning organisation'” (Interviewee A).
- negative portrayal on different aspects and situations affecting MDH – for example: “managerial role of charge nurses is always submissive to clinical roles” (Interviewee C); “nursing specialisation still unrecognized” (Interviewee R).
- positive portrayal on different aspects and situations affecting MDH – for example: “many things work well in MDH against all odds and because most of the staff 'cares'” (Interviewee Q); “MDH invests a lot in staff development” (Interviewee K).
- what MDH can aspire to achieve or become – for example: “MDH should be the 'flag bearer' for other MT (Maltese) organisations with respect to learning and training” (Interviewee E); “nursing leaders to emphasise learning as a one of their central job tasks” (Interviewee L).
- what individuals or teams of members of MDH should do or be allowed to do – for example: “Incident Reporting Committee (IRC): CEO must 'walk the talk' to give it its due importance” (Interviewee I); “older staff should be allowed to concentrate on what they 'are best at'” (Interview Q).

5.2.1.2 Second and third cycle coding

In the second cycle phase of coding, the 616 codes generated from the first cycle were categorised into a number of “families” or clusters of codes. In total, all codes could be categorised or grouped into ninety-one (91) second cycle codes or categories. The process of “constant comparison” was employed during this categorisation and re-categorisation exercises. The categorisation of all the codes into distinct groupings could be derived at this data analysis stage as the researcher started to identify emerging characteristics and patterns in the codes extracted from the data. Annex 6 shows the first cycle codes grouped under the emergent categories generated during the second and third cycle coding processes.

During the second cycle coding exercise, a higher order of coding (more abstract than the first cycle codes) started to become more possible as the evolving interpretation

of meaning could start to be better delineated and more visible. Examples of second cycle categories that attained a higher level of abstraction and conceptual identity include categories VI (b) “high-quality role models engender and guarantee good/ positive practice” and VII (a) “national behaviour and characteristics are reflected in the MDH setting and community”. However, other emergent categories at this stage were still at a juncture where they could be best termed and considered as “umbrella” titles for groups of first cycle codes with similar origins and meanings. Examples of the latter include categories V (a) and (b): “Enabling features” and “Impeding features” respectively and II (a) and (b): “intra-departmental initiatives/ activities” and “inter-departmental activities” respectively.

Adhering to the explanation by Dey (1999) about the distinctions between conceptual categories, properties and dimensions in the context of Grounded Theory, summarised in Table 6 above, some of the first cycle codes included into each of the categories generated during the second cycle coding process, can be construed as representing properties and dimensions of the emergent category within which they are grouped. For example, the first cycle code “handover in 2011: actively discouraged by Ministry” can be viewed as a property of the category VIII (f): “dysfunctional systems and obstacles are entrenched in the organisation” because it reflects on the interaction of MDH with the Ministry which is an important external entity. On the other hand, the first cycle code “each initiative has a very limited 'line of sight'” can be regarded as a dimension of the category IX (b): “personal initiatives encounter several obstacles to progress” because it gives the notion of the extent of a particular internal attribute of personal initiatives by members of staff at MDH.

The second cycle categories were in turn aggregated and incorporated into twelve (12) more encompassing categories in the third cycle coding process. Annex 7 shows the second cycle categories with their corresponding third cycle encompassing categories. These third cycle categories were further reviewed and were eventually re-configured into ten (10) major categories. The re-configured third cycle categories into the conclusive ten major categories generated from the data collected during the in-depth interviews are shown in Table 7.

Table 7: The re-configured third cycle categories into the conclusive ten major categories generated from the data collected via the in-depth interviews

Third cycle categories		Major categories from the data analysis of the data collected from the in-depth Interviews	
I	Separation between and within the professions	AGGRESSIVE PROFESSIONAL TERRITORIALITY	1
II	Organised events for learning	WEAK STRATEGIC PLANNING	2
IV	Resources, structures, processes and developments for learning		
III	Organisational support for learning	UNRELIABLE ORGANISATIONAL SUPPORT	3
V	Enabling or impeding professional/ individual personal attributes	INDIVIDUAL AND TEAM DRIVE [IN SPITE OF]	4
IX	Self-propelled (self-driven) individual/ group initiatives		
VI	Taught practice vs performed practice	PERFORMANCE NOT AS EXPECTED	5
VII	External influence on the MDH organisation	INSEPARABLE NATIONAL SETTING	6
VIII	Dysfunctional organisational systems & communication channels	DYSFUNCTIONAL HOSPITAL SYSTEMS	7
X	Learning culture/ ethos at MDH	WIDE-RANGING WILLINGNESS FOR LEARNING	8
XI	Constraints for patient safety & quality improvement	OUTPUT OVERPOWERS QUALITY	9
XII	Outsiders views on the capacity of and future aspirations for MDH for learning	PLAYERS NEED TO 'OWN' HOSPITAL MORE	10

The resultant ten (10) major categories are now starting to illustrate more clearly emerging facilitators and inhibitors that are influencing the operations and aspirations of MDH as an organisation and in its organisational development including its progress towards becoming a learning organisation. These influencing factors can be traced internally through the qualities of its component members (such as individuals, multi-disciplinary teams and different professional groups; healthcare and management structures) and also to external factors. The latter can be seen to be mainly arising from MDH being a major organisation (both by size and function) within the unique national context of Malta. Category 6 (Inseparable national setting) represents and arises from data related to the effect external factors. Noticeable examples that can be recognized as

positive indicators or enablers at this stage included categories 4 (Individual and team drive [in spite of]) and 8 (Wide-ranging willingness for learning). On the other hand, a number of categories including 1 (Aggressive professional territoriality); 2 (Weak strategic planning); 3 (Unreliable organisational support); 7 (Dysfunctional hospital systems) and 9 (Output overpowers quality) can be effectively identified as emerging negative indicators or hindrances.

5.2.2 Reducing and focussing: deriving major or core categories

Since the seminal work of Glaser and Strauss in 1967, practitioners of Grounded Theory have been trying to reconcile the richness and complexity of qualitative studies with the scope and simplicity (parsimony) of quantitative analysis (Dey, 1999: 44) in the new approach that they were trying to evolve. Glaser and Strauss (1967: 41) describe that "a close correspondence of theory and data" needs to be achieved and maintained in order to satisfy the "two major requirements of theory", that is "parsimony in formulation and generality in scope". This tension comes about from the expectation to achieve maximum conceptual diversity of the generated categories and their interactions and properties through the employment of constant comparison and at the same time averting the threat of "conceptual overload". Glaser and Strauss propose a "delimiting" theory (1967: 110-111) that involves a reduction in the original list of categories for coding followed by an increasingly more selective and focussing of the coding and analysis of incidents as the theory gradually takes shape.

> Theoretical reduction allows the elimination of superfluous specificity in the construction of generalisations.
>
> Dey, 1999: 43

Theoretical reduction and focus can be attained through the simultaneous application of conceptual reduction and focussing and subsequently on the generation and development of a number of core categories. An ongoing debate is concerned by the persistent questions on whether the approach of conducting procedures for conceptual reduction and core categorisation are compatible or otherwise with the purported conceptual richness and diversity which is characteristic and expected from naturalistic inquiry (Dey, 1999: 44).

Both Glaser (1978) and later on Strauss and Corbin (1990) promoted the identification of core category or categories as a crucial route in the development of grounded theory. Glaser contended that "the generation of theory occurs around a core category" (Glaser, 1978: 93), Strauss and Corbin (1990: 116), deliberate the role of "selective coding" in the more advanced stages of data analysis:

> Selective coding: The process of selecting the core category, systematically relating it to other categories, validating these relationships, and filling in categories in that need further refinement and development.

Glaser (1978: 93) contends that since the main target is "to generate a theory that accounts for a pattern of behaviour which is relevant (workable) and problematic for those involved, researchers and practitioners require procedures that helps them to achieve 'conceptual delimitation'". The core category or categories (as small as possible number of core categories is usually recommended), should conceptualise the "basic social processes" or key issues that are eventually incorporated and explained by the theory generated from the research.

Glaser continues to explain that using core categories will help the researcher and analyst to optimise and amplify "parsimony and scope" while maintaining and safeguarding an emergent theory which is also "dense and saturated". Strauss and Corbin (1990: 116-117) reiterate that the identification of a core category arises from the study narrative as "the central phenomenon of the study" that in turn can explain the story-line. Ongoing debate among grounded theorists is concerned with whether core categories are "discovered" as they are indicated by the data and/or detected as an outcome of a heuristic necessity to set the limits for the emerging theory (Dey, 1999: 110-111).

In the end, the identification of the core category/ies underscores the "judgement role of the theorist" and is a test of the researcher's patience and prudence and "analyst's skills and abilities" to withhold any urges to hasten premature selection. The following is helpful advice developed and adapted by Dey (1999: 111) from Glaser's work on the characteristics that need to be sought in order to ensure that the identified core categories are effective and operative:

- It is *central* if it is related to many other categories and accounts for a large proportion of variation in the data.
- It is *stable* if it can be seen as a recurrent pattern in the data.It is *sufficiently complex* if it takes more time to saturate (identify its properties) than other categories.

- It is *incisive* if it has clear implications for more formal theory
- It is *powerful* if its explanatory power helps the analyst to "carry through" the analysis to a successful conclusion.
- It is highly *variable* if it is sensitive to variations in conditions in terms of degree, dimension and type.

Finally, Dey (1999) tends to render advice that the analyst should not limit herself to strictly one core category as this may result in the rejection and underestimation of the role of other important factors and alternative interpretations. In the end, the main foundation and justification for theoretical reduction including core categorisation and theoretical saturation (explored in Chapter 3), is to assist the researcher to set some boundaries to the analysis, to derive a resolution and to eventually enable a conclusion to the inquiry.

The ten major categories derived following the analysis of the data collected in the interviews were identified by the researcher during the data analysis informed by the principles of theoretical reduction explained above. These core categories were 'carried forward' to the section where they were analysed and discussed together with the major categories that were derived from the analysis of the data collected during the action research arm of this research.

5.2.3 Outcomes of the data collection and analysis from the action research diary

5.2.3.1 First cycle coding

During the 30 months that the researcher spent working as a member of PaSQIT, she recorded sixty-eight (68) episodes of events and activity in her action research diary. The data collected and analysed in these records generated 203 different codes during the first coding cycle (see Annex 8). Most of these codes (134; 66.3%) were used more than once, that is they were used as codes for different excerpts of text in the diary (sometimes also for different text in the report of a single event). In fact, the number of codes applied to all the data collected in the action research journal amounted to a total of 727 codes. The majority of codes were applied more than once included codes applied for two sites (36 codes; 17.8%), three times (25 codes; 12.4%) or four times (27 codes; 13.4%). The most frequently applied codes were the following:

"SALearn system started to take shape in May 2014": 19 times
"for about 6 months EMCS[15] projects take over PASQIT agenda ": 17 times
"re-introducing a centralised Clinical Risk Management (CRM) system central to PASQIT objectives": 17 times

The number of first cycle codes generated per diary entry varied. The maximum number of codes for a single diary entry totalled 37 codes. The median number of codes applied per entry equalled to ten (10). Eight diary entries (11.8% of all entries) were assigned more than 20 codes each while 32 reports (47.1% of all entries) were assigned more than 10 codes each. The number of codes per report tended to be smaller for the reports of events (especially regular PaSQIT meetings) occurring near to the end of the study period (August to November 2015). This was in part due to the fact that the reports for these meetings tended to be very short. They were recorded by the person who was assigned by the MDH management as PaSQIT coordinator during this time period. Furthermore, there were frequently very few new aspects on the group activity arising from the analysis of these late events.

Similar to the first cycle coding process employed in the analysis of the data collected from the interviews, codes were generated during line-by-line reading and re-reading of the action research diary reports. Furthermore, analogous coding techniques were utilised. Therefore, some of the codes were developed as a synopsis of a small section of the transcript in order to clearly express identified points that were discovered in the analysis of the text. Other codes were constructed as a result of the researcher's reflection on what the transcript was elucidating on the team's activities both during the reported proceedings of a meeting or from the reporting on activities carried out by different members of the group that were relevant to the team's objectives and ongoing projects.

Comparably, with the description of the codes generated in the analysis of the data collected for the interviews, the content of the codes varied widely and are diametrically contrasting in several instances. Examples of different types include:

[15] EMCS Consulting Ltd.: the flagship of a group founded in 1983 with the scope of providing economic research and business support services with a focus on strategy development (more information on the company is available from: http://www.emcs.com.mt/consulting). EMCS was contracted by the Department of Health to help small teams in different healthcare entities (including MDH) to develop and implement small projects focussing on quality improvement.

- statements on actual situations – for example: “chair was chosen almost automatically” (assigned to text in three different reports referring to the nomination of a chair for PaSQIT and a number of sub-committees); “Clinical Support managers: pilot started in 2015 with a few Clinical Directorates” (assigned to text in three different reports of PaSQIT meetings that took place in January 2014).
- statements on perceived situations – for example: “MDH is a micro-system of Malta” (assigned to text in the report of a PaSQIT meeting that took place in September 2015); “nobody has real 'executive powers'” (assigned to text in the report of a pre-PaSQIT meeting that took place in April 2013).
- negative portrayal on different aspects and situations resulting from the activity of individuals or teams at MDH – for example: “a lot of fine words were said and quoted but execution of actions faltered” (assigned to text in the report of a PaSQIT meeting that took place in August 2015 and to the first PaSQIT progress report of August 2013); “an observer imposed on group during one meeting by Clinical Director” (assigned to text in the report of a PaSQIT meeting that took place in September 2014).
- positive portrayal on different aspects and situations resulting from the activity of individuals or teams at MDH – for example: “objective outsiders’ views tend to be more positive than internal assessments” (assigned to text in the report of the second Lachman’s visit in November 2015); “well performing staff will only require intervention in 'exceptional' cases” (assigned to text in the report of a PaSQIT meeting that took place in May 2014 and to the report of a meeting that PaSQIT has with the Senior Executive Team of MDH in September 2013).
- observations on what PaSQIT and MDH can aspire to achieve or become – for example: “various attempts to be more organised and disciplined tried from time to time” (assigned to text in several reports of meetings of PaSQIT); “MDH needs more doers and not more philosophers” (assigned to text in the report of a PaSQIT meeting that took place in December 2013).
- recommendations on what individuals or teams of members of MDH should do or be allowed to do – for example: “PaSQIT members need training and mentoring”

(assigned to text in the report of a PaSQIT meeting that took place in December 2013); “identifying patient safety champions” (assigned to text in the report of the second Lachman’s visit in November 2015, in the revised Terms of Reference of PaSQIT in March 2014 and in two PaSQIT meeting reports that took place in the summer of 2015).

5.2.3.2 Annotations

On the other hand, a major difference from the coding process used for the analysis of the interviews, the process for the analysis of the action research journal resulted in the generation of a substantial number of annotations (memos) connected to different codes. These memos were generated in tandem with the generation of the codes during the analysis process. The aim of the memos was to document the researcher’s insight and reflection with the aim of giving a more detailed and nuanced interpretation on the meaning of the happenings that were reported mainly from the point of view of the researcher-practitioner. As described in Chapter 4, memoing or annotating was taken as an imaginative activity. The resultant memos were frequently explorative and suggestive. They gave the researcher the opportunity to chronicle personal critical comments, impressions and insights on the data and its quality at the time of the report writing and the initial coding process.

In total, 208 annotations were generated during the analysis of the whole action research diary (average 3.1 per entry, mode: 3, median: 3, range: 0-9). The length of the memoranda varied from just one sentence to half a page. A different memo was sometimes attached to the same code when it was assigned to separate excerpts in different entries and even in the same entry. They were created to help to ‘open up’ the data and to give ‘added value’ to the data analysis. Memos were often found to be very useful to further inform subsequent coding, in the collapsing of codes into categories in the consequent coding cycles and in the linking data and codes.

The following is an example of a memo that was created to document a personal critical comment:

> The ultimate target of 'right patient; right bed; right time' was soon identified after the outset. A lot of energy was spent lauding this lofty target. Achieving any success was

> soon felt to be unattainable as the realisation of the capabilities of the inadequately prepared, supported and resourced group became increasingly registered.

This memo was attached to the code "'right patient right bed' identified as the ultimate target' assigned to an excerpt from the first PaSQIT progress report of August 2013.

Giving a more detailed and nuanced interpretation of a coded excerpt in a diary entry can be illustrated by the following memo:

> This was the 'straw that could break the camel's back'. The SALearn (Safety Alerts for Learning) involved a lot of work to investigate the SAs received. Ultimately this was what was keeping most people back from proceeding - the fear of not being able to cope with and do merit to the received alerts.

This memo was attached to the code "a lot of work promised by individuals but undelivered" assigned to an excerpt from the report of a PaSQIT meeting that took place in September 2014.

5.2.3.3 Second and third cycle coding

In the second cycle phase of coding, the 203 codes generated from the first coding cycle of the data collected during the action research part of this study, were allocated to the secondary cycle codes that were being generated during the secondary cycle analysis procedures. In total, all codes could be categorised or grouped to fifty-four (54) second cycle codes or categories. The processes employed were different from those utilised in the analysis of the first cycle codes for the interview arm of this research. These processes entailed the review of each code following the collation together and re-reading of all the excerpts to which a particular code was assigned. The review also involved the re-reading of all the memos attached to this code during the same exercise. The outcome of this analysis involved the assignation of a number of secondary level codes or new emergent categories to each first cycle code studied. As a result, a single code could be classified to one or more of the secondary cycle categories. The full documentation of this work can be viewed in Annex 8. Annex 9 shows the secondary cycle codes allocated to each first cycle code generated from the data collected.

The composition and inclination of the second cycle codes is more abstract. The principal aim of second cycle coding:

> … is to develop a sense of categorical, thematic, conceptual, and/or theoretical organisation from your array of First Cycle codes…reorganised and reconfigured to

> eventually develop a smaller and more select list of broad categories, themes, concepts and/ or assertions.
>
> Saldaña, 2013: 207

Alternatively explained, the target of the second and any subsequent coding levels is to link "seemingly unrelated facts logically, of fitting categories one with another" (Morse, 1994: 25). Annex 9 shows that the majority of first cycle codes were allotted more than one second cycle code. This is because different concepts could be extracted from most first cycle codes. Furthermore, these concepts could be seen to be emerging from different original codes and hence from different excerpts of the original data collected in the action research diary. Hence, apart from articulating several facets for each first cycle code, this second analytic process also led to the development of a more "coherent metasynthesis of the data corpus" (Saldaña, 2013: 207). Only twelve (12) out of the 203 first cycle codes (6%) were only allotted one second cycle code. On the other hand, a maximum of eight (8) second cycle codes were allotted to a single first cycle code. Only two first cycle codes were allotted the highest number of second cycle codes. The average number of second cycle codes allotted to a first cycle code is 3.4 and the median is 3. Finally, towards the end of this data analysis process, it was becoming apparent that a sort of "saturation" was being achieved because there were no new second cycle codes emerging.

The process of "constant comparison" continued to be employed during the categorisation and re-categorisation exercises of a third cycle coding round. Table 8 shows the fifty-four (54) second cycle codes re-categorised and collapsed into nineteen (19) third cycle codes or categories. At this stage, the emergence of more distinct groupings which could be identified as clearly evolving concepts and themes was becoming increasingly apparent. The third cycle codes or categories are even more abstract than the component second cycle codes. Their title is in most cases not more than two words long. These categories chiefly aim at manifesting the essence of the component second cycle codes. Each third cycle code does not have more than five (5) second cycle codes assigned to it (average: 2.9; median: 3; mode: 2). Two second cycle codes were each assigned to two third cycle codes as they were visibly and inextricably a component of both emergent higher order categories.

The third cycle categories could be identified as having certain broad attributes. In some instances, these features are diametrically opposite:

- Categories 1 (Apprehension); 2 (Uncertainty) and 6 (Frustration) share the attribute of representing negative emotions or feelings, while category 12 (Enthusiasm for results) expresses positive feelings and emotions.
- Categories 4 (Attempting to manage); 8 (Work towards improvement); 17 (receptive to learning/ aspire to learn) and 18 (Resourcefulness) demonstrate concepts that show facilitating tactics, attitudes and capabilities while categories 10 (Competing priorities); 11 (Unforthcoming support) and 13 (Undependability) portray identified obstacles or obstructing attitudes.
- Categories 3 (Idealistic) and 7 (Deferring to authority) were identified as attitudes which could not be decidedly classified as either positive or negative as their effect will depend on circumstances and on the extent of which they are applied. For instance, an unchecked idealistic attitude which is over-ambitious can lead to unreachable goals and increased frustration and disappointment while exaggerated deferment to authority can supress creativity and lead to stifling submissiveness.
- Two categories: 5 (Inclusivity) and 19 (Patient orientation) included secondary cycle codes that were mostly descriptive of overarching principles such as patient-centeredness and the bottom-up approach to implementation of change.
- Another three categories: 14 (Personal characteristics); 15 (Organisational capability) and 16 (National mindset) brought together concepts at the individual person, overall organisational and national levels respectively while category 9 (Goings-on) enlisted specific events.

Table 8: The third cycle categories with their component second cycle codes emerging through the analysis processes of the data collected during the action research arm of this study. *The second cycle codes in italics are assigned to two third cycle categories*

Third cycle category	Category features	Component second cycle codes
Category 1: APPREHENSIVENESS	negative emotion/ feeling	1. UNEASY WITH STANDARDISATION 2. UNEASY WITH DOCUMENTATION 3. NEED DISPEL 'BLAME CULTURE'
Category 2: UNCERTAINTY	negative emotion/ feeling	1. LACK OF FOCUS 2. INDECISION
Category 3: IDEALISTIC (UNREACHABLE GOALS)	attitude	1. OVER-AMBITIOUS 2. FAR-REACHING VISION
Category 4: ATTEMPTING TO MANAGE	facilitating tactics	1. TENTATIVE DIVISION OF LABOUR 2. TENTATIVE DISCIPLINE 3. ACHIEVING VISIBILITY IS A PRIORITY
Category 5: INCLUSIVITY	principle	1. EVERYONE NEEDS TO BE ON BOARD 2. BOTTOM-UP APPROACH
Category 6: FRUSTRATION	negative emotion/ feeling	1. POWERLESSNESS 2. DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS 3. SHORT-LIVED / TRANSITORY PHASE 4. NON-DELIVERING
Category 7: DEFERRING TO AUTHORITY	attitude	1. SENIOR MANAGEMENT ENDORSEMENT 2. VALUED EXPERIENCE
Category 8: WORK TOWARDS IMPROVEMENT	facilitating tactics	1. SPECIALISATION 2. NEED FOR DETAILED PLANNING 3. NEED FOR CONTSTANT RE-EVALUATION *4. NEED FOR PREPARED LEADERS*
Category 9: GOINGS-ON	events	1. REPEATED ALERTS
Category 10: COMPETING PRIORITIES	obstacles	1. HEAVY WORKLOADS 2. ORGANISATION SWAMPED BY OPERATIONAL ISSUES 3. OUTCOMES ARE SIDELINED FOR THE SAKE OF OUTPUTS
Category 11: UNFORTHCOMING SUPPORT	obstacles	1. ABANDONMENT BY SENIOR MANAGEMENT 2. DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING *3. FAILURE TO EXECUTE* 4. LACK OF SUPPORTIVE NATIONAL FRAMEWORKS

Table 8 (continued)

Third cycle category	Category features	Component second cycle codes
Category 12: ENTHUSIASM FOR RESULTS	positive emotion/ feeling	1. APPRECIATION OF GOOD WORK 2. RARE TANGIBLE ACHIEVEMENTS 3. ENTHUSIASM FOR PROFESSIONALISM 4. WISH TO ADOPT POSITIVE APPROACHES
Category 13: UNDEPENDABILITY	obstructing attitude	1. NOT STICKING TO AGENDA *2. FAILURE TO EXECUTE*
Category 14: INDIVIDUAL ATTRIBUTES	personal characteristics	1. MONOPOLY SOUGHT AND GIVEN 2. OVERPOWERING PERSONALITIES 3. SELECTIVITY 4. PERSONAL AGENDAS 5. ISOLATION
Category 15: ORGANISATIONAL CAPABILITY	organisation's characteristics	1. NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT 2. 'REAL' AUTHORITY RESIDES OUTSIDE MDH 3. HEAVY BUREAUCRACY *4. NEED FOR PREPARED LEADERS* 5. LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES
Category 16: NATIONAL MINDSET	nationwide characteristics	1. NATIONAL CULTURE AND UNIQUE CONTEXT 2. INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM
Category 17: RECEPTIVE TO LEARNING/ ASPIRE TO LEARN	facilitating attitude	1. RECOGNITION OF NEED TO LEARN *2. SENSITIVITY & PERSERVERANCE FOR CHANGE* 3. NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION 4. RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE
Category 18: RESOURCEFULNESS	facilitating capabilities	1. MULTI-PRONGED ACTIVITY REQUIRED 2. ABUNDANCE OF IDEAS *3. SENSITIVITY & PERSERVERANCE FOR CHANGE*
Category 19: PATIENT ORIENTATION	principle	1. NEED FOR MORE PATIENT FOCUS

Another step in the analytic process of the data collected in the action research diary involved the re-organisation and subsequent assembly of the nineteen third cycle categories into eight (8) final categories. The results of this fourth cycle categorisation are shown in Table 9. At this stage, the third cycle category 9 (Events) was dropped from further analysis because no further consideration was indicated since its small number of contributing codes were just titles of specific events.

Table 9: The fourth cycle categories with their component third cycle categories emerging from the analysis processes of the data collected during the action research arm of this study

Third cycle category		*Category features*	Major categories from the data analysis of the data collected from the action research diary	
i	Apprehensiveness	*negative emotion/ feeling*	DISTRUST OF THE ORGANISATION	A
ii	Uncertainty	*negative emotion/ feeling*		
vi	Frustration	*negative emotion/ feeling*		
iii	Idealistic (unreachable goals)	*attitude*	LIABLE TO UNACHIEVABLE EXPECTATIONS	B
x	Competing priorities	*obstacles*		
vii	Deferring to authority	*attitude*	APPRECIATION OF LEADERSHIP AND MANAGEMENT SKILLS	C
viii	Work towards improvement	*facilitating tactics*		
xvii	Sensitivity for learning	*facilitating attitude*	RESPONSIVENESS TO OPPORTUNITY	D
xii	Enthusiasm for results	*positive emotion/ feeling*		
iv	Attempting to manage	*facilitating tactics*	ABUNDANCE OF INITIATIVE	E
xviii	Resourcefulness	*facilitating capabilities*		
v	Inclusivity	*principle*	PROFESS TO HIGH IDEALS	F
xix	Patient orientation	*principle*		
ix	Goings-on	*events*	-	
xi	Unforthcoming support	*obstacles*	FREQUENT RETRACTION FROM DECLARED COMMITMENT	G
xiii	Undependability	*obstructing attitude*		
xiv	Individual attributes	*personal characteristics*	INSEPARABLY PART OF THE WHOLE	H
xv	Organisational capability	*organisation's characteristics*		
xvi	National mindset	*nationwide characteristics*		

Similar to the equivalent stage in the analysis of the data collected from the interviews arm of this research, the resultant eight major categories arising from the action research arm are now starting to illustrate more clearly the emerging facilitators and inhibitors that are influencing the operations and aspirations of MDH as an organisation and its ongoing development. Correspondingly, the qualities of its component members (such as individuals, multi-disciplinary teams or professional groups; healthcare and management structures) and also the impact of factors that are strictly external to the hospital organisation and that are mainly linked to the unique national context of Malta are important contributors to the results achieved.

At this stage, categories C (Appreciation of leadership and management skills); D (Responsiveness to opportunity); E (Abundance of initiative) and F (Profess to high ideals) can be recognized as positive indicators or enablers, while categories A (Distrust of the organisation); B (Liable to unachievable expectations) and G (Frequent retraction from declared commitment) can be effectively identified as negative indicators or hindrances. Lastly, the external factors are primarily represented by category H (Inseparably part of the whole).

5.3 Bringing the analysis of the two research methodologies together

Table 10 shows the result of the exercise that was conducted to bring together the major categories generated from the intense but separate analysis of the interviews and action research methods. Some of the resultant major categories (six from each arm) can be demonstrated to be congruent and compatible as they can be shown to be representing similar findings and linked to comparable connotations. These matched categories are underlined and a new category title was generated to cover their combined meanings.

However, the remaining six categories (four from the interviews and two from the action research diary) could not be matched and have therefore been individually

retained. The titles of these categories were also amended to a smaller degree either to further condense the category name or to sharpen their focus.

Interestingly, the four unmatched major categories originating from the interviews method are all decidedly representing relatively more negative findings (mainly portraying barriers to effective organisational development and function). On the other hand, the two major categories resultant from the action research arm that could not be matched with the list arising from the interviews method were either unequivocally positive or moderately negative.

Table 10: Merging and further consolidation of Action Research (8) and Interviews (10) categories – 18 to 12 merged categories

Interviews		Action Research		Merged and/ or consolidated major categories	
1	AGGRESSIVE PROFESSIONAL TERRITORIALITY			**M1**	**TERRITORIALISM**
2	WEAK STRATEGIC PLANNING	C	APPRECIATION OF LEADERSHIP AND MANAGEMENT SKILLS	**M2**	**INADEQUATE LEADERSHIP/ GOVERNANCE**
		B	LIABLE TO UNACHIEVABLE EXPECTATIONS	**M3**	**UNREALISTIC (OVER-AMBITIOUS)**
3	UNRELIABLE ORGANISATIONAL SUPPORT	A	DISTRUST OF THE ORGANISATION	**M4**	**HIGHLY CYNICAL**
4	INDIVIDUAL AND TEAM DRIVE [IN SPITE OF]	E	ABUNDANCE OF INITIATIVE	**M5**	**HIGHLY MOTIVATED WORKFORCE**
5	PERFORMANCE NOT AS EXPECTED	G	FREQUENT RETRACTION FROM DECLARED COMMITMENT	**M6**	**FAILURE TO EXECUTE**
6	INSEPARABLE NATIONAL SETTING	H	INSEPARABLY PART OF THE WHOLE	**M7**	**EMBEDDED IN NATIONAL CONTEXT**
		F	PROFESS TO HIGH IDEALS	**M8**	**HIGH ASPIRATIONS**
7	DYSFUNCTIONAL HOSPITAL SYSTEMS			**M9**	**DYSFUNCTIONAL ORGANISATION**
8	WIDE-RANGING WILLINGNESS FOR LEARNING	D	RESPONSIVENESS TO OPPORTUNITY	**M10**	**GENERALLY RECEPTIVE**
9	OUTPUT OVERPOWERS QUALITY			**M11**	**DISTORTION OF/ MISGUIDED PRIORITIES**
10	PLAYERS NEED TO 'OWN' HOSPITAL MORE			**M12**	**MORE PERSONAL OWNERSHIP DESIRED**

The twelve major categories shown above are the final result of the data collection and analysis conducted during this research project. The data underlying and substantiating each major category will be demonstrated and examined in the next

two chapters. In these chapters, the research findings will be illustrated and substantiated by means of extracted quotations from the interviews and action research diary. Furthermore, the presented data will be assimilated with applicable references to relevant extant literature that has been found to either corroborate or dispute these findings and interpretations.

5.4 Dividing the emergent major categories according to the principal player/s involved in their formation

The twelve major categories displayed in Table 10 are constructs with different origins with regards to the main player or players they involve both from the aspects of their derivation and the location of foremost impact. Table 11 presents these categories with respect to these different derivations.

Table 11: The twelve major categories divided according to the principal player/s involved in their respective derivation and impact

Principal player/s involved in their respective derivation and impact	**Major category**
Human Resources (Input)	Highly motivated workforce (M5) High aspirations (M8) Generally receptive (M10)
Human Resources (Output)	Territorialism (M1) Highly cynical (M4) More personal ownership needed (M12)
Organisational Systems	Inadequate leadership and governance (M2) Dysfunctional organisation (M9)
External factors	Embedded in national context (M7) Distortion of/ misguided priorities (M11)
Resultant forces	Unrealistic expectations (over-ambitious) (M3) Failure to execute (M6)

Chapter 6 concentrates on the people or human resources dimension and presents the six major categories that provide information on and depict different distinctive characteristics of the human resources working in the hospital (the first two rows in

Table 11). Half of the categories represent the input that these human resources bring with them into the organisation (M5, M8 and M10). The other half epitomize the output or the transformation of these human resources after they are subjected to various forces and influences arising from within the hospital organisation and beyond through the effects of external factors including national characteristics, context and priorities (M1, M4 and M12).

Chapter 7 focuses on the remaining six major categories (the last three rows in Table 11). These major categories demonstrate the data collected and analysed that sheds light on and assists the understanding of the state of play of the organisational systems (M2 and M9) and the external factors (M7 and M11) impinging on the hospital function and strategic direction and the major consequential forces resulting from the influence of these two critical players (M3 and M6).

CHAPTER 6: EXPLICATING THE MAJOR COMPONENTS OF THE OVERALL PICTURE: THE HUMAN RESOURCES DIMENSION

6.0 Introduction

Reason (2000: 768) asserts that "two approaches to human fallibility exist: the person and the system approaches". He continued that "the persons approach focusses on the errors of individuals, blaming them for forgetfulness, inattention, poor motivation, negligence, recklessness and moral weakness" and "the systems approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects". He recommends that "understanding these differences has important practical implications for coping with the ever-present risk of mishaps in clinical practice".

A deep-rooted, widespread and frequent tendency observed in several health systems places the causes of unsafe activities on persons, especially the people working at the frontline such as doctors, nurses and pharmacists. Proponents of this approach are usually inclined to "treat errors as moral issues" and it has been related to what psychologists call the "just world hypothesis" (Lerner, 1970). Actions to counter this perceived major source of error are accordingly primarily aimed towards reducing "unwanted variability in human behaviour" and include "appealing to people's sense of fear, disciplinary measures, threat of litigation, retraining, naming, blaming and shaming" (Reason, 2000: 770).

Half of the major categories emergent from the analysis of the data collected in this research point towards a number of specific characteristics and attributes found in the human resources working within MDH. Interestingly, three of these categories mainly refer to the qualities that the human resources are endowed with or 'bring with them' to the organisation and include motivation, aspirations and willingness for learning and opportunity. These categories can be collectively grouped as the 'input' brought into the organisation by the people working in the hospital.

The other three major categories can be conversely grouped as the 'output' because they illustrate the outcomes that organisational and external influences have on the

human resources. These categories include the people traits of aggressive territorialism, cynicism and poor or reluctant 'ownership'. It has been observed that the 'output' attributes are more easily visible person features than the 'input' characteristics. This is possibly because the former group tends to overshadow the latter and also because negative traits are often more noticeable that positive ones.

This chapter demonstrates the major categories arising from the study of the human resources working in the hospital. The first three categories (M5, M8 and M10) constitute the 'input' group while the three consecutive categories (M1, M4 and M12) represent the 'output' cluster. Figure 6 is portraying the major categories illustrating the human dimension divided into these two distinct blocks.

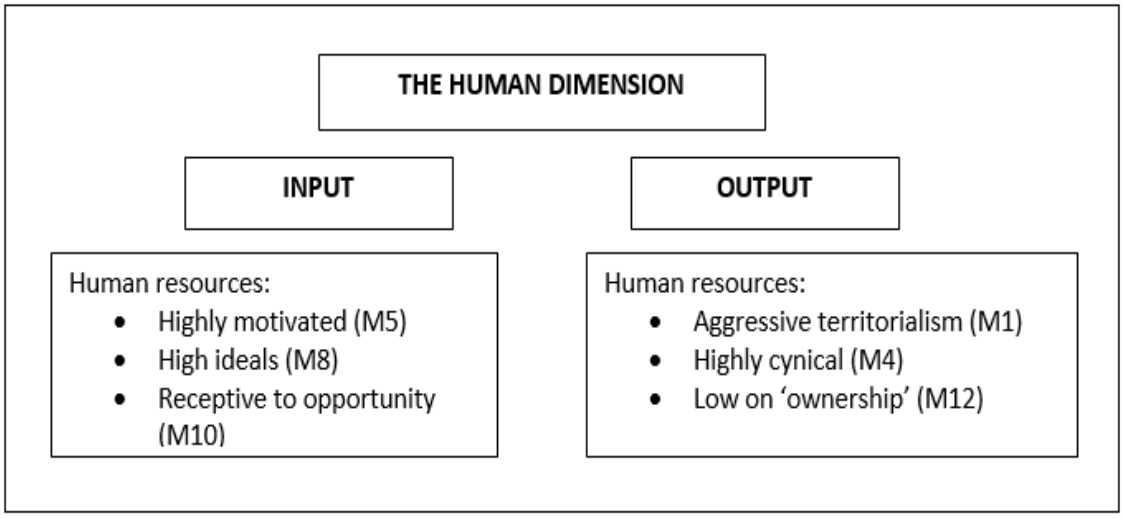


Figure 6: The two distinct blocks of the major categories representing the human dimension

6.1 Highly motivated workforce (M5)

The fifth major category was derived from the convergence of the concluding code 4: 'Individual and team drive [in spite of]' from the analysis of the data collected from the interviews and closing code E: 'Abundance of initiative' resulting from the exploration of the data gathered in the AR diary. Both the resultant major category and the contributing codes focus on the workforce of the hospital and are grounded in data that characteristically portrays predominantly positive features in different groups and levels of this labor force. Most of the data collected was referring to aspects that are specifically related to the healthcare professionals.

6.1.1 Individual and team drive [in spite of]

The codes contributing to this concluding code are ‘Enabling or impeding professional/ individual personal attributes’ and ‘Self-propelled (self-driven) individual/ group initiatives’. The majority of the interview respondents reported on several affirmative attributes (present or expected) of different groups of the hospital workforce. In their views, each of these aspects contributed profoundly to the “HR wealth” of MDH. Examples include:

- MDH has several 'very talented' nurses (Interviewee 11)
- younger members are less prone to be affected by territorialism and show more energy for change (Interviewees 3 and 16)
- performance, commitment and inter-personal camaraderie are often of a high level in MDH staff (Interviewee 17)
- MDH is filled with a lot of dedicated people that try to instill change with a lot of passion (Interviewees 20 and 21)
- HCPs will continue caring for patients whatever the turmoil (Interviewees 4 and 21).

A number of interviewees spoke very highly about the positive attributes of the members in their own team. Interviewee 18 reiterated:

> Surrounded by a strong team made up of a group of committed professionals. Most of them are of a very high technical calibre. Most members are very supportive, work very hard and will go the ‘extra mile to accommodate’ the frequent unplanned spikes in service requirements.

Interviewees also listed a number of professional HR assets that support and spur improvement. For instance, Interviewee 11 gave high prominence to enabling influence that “professional pride” has on responsibility and accountability of the HCPs, Interviewee 19 highlighted the capability to be flexible “to change own plans if 'a new and better idea is fielded'” and the “capability to acknowledge threats but be open and sensitive to opportunities” and Interviewee 21 stressed the importance that “HCPs are self-selected people that can be fulfilled by the 'caring' experience”. An intriguing point was made by Interviewee 19 with respect to the positive aspects of the female members of the workforce. This interviewee commented that especially in the case of female clinical leaders:

> Being female can help enrich position with attributes such as female intuition, a higher tendency to be non-confrontational coupled with the ability to ‘wait to find

> a good time' for a worthy confrontation and the lower inclination to do activities just 'for personal gain'.

Interviewees also fielded several opinions on organisational strategies that can be successful towards engendering positive attitudes in the workforce. Interviewee 15 mentioned that "a lot of personal contact with ward teams" was an effective approach that for instance has led to the successful rollout of the EWS, while Interviewee 16 emphasised the views that "achieving change increases if you target and work it out first with the younger people" and that "achieving change requires the seeking of 'win-win situations'". Another repeated theme was the need for senior hospital management to "lead by example" and "'walk the talk' to give it (whatever they are promoting) its due importance "(Interviewee 9).

Special qualities accorded to and desired from leaders at all levels were also pointed out. Interviewee 19 stressed the important qualities of "flexibility, endurance and perseverance", Interviewee 6 emphasised that "gaining trust requires constantly showing 'integrity of character'" while Interviewee 5 contributed by expressing the "need for a robust leadership that can see over and above the 'noise'". Interviewee 23 concluded that "leaders need to give good example because their attitude has a strong ripple effect".

On the other hand, a number of respondents described personal characteristics and misconceptions that need to be tackled (both at the leaders' and general staff levels) in order to improve the capability of and enable the workforce to be more receptive and sensitive to change and new ideas. At the leaders' level, examples include the observations by Interviewee 16 that "most clinical leaders have problems with delegating and they get 'bogged down' with operational issues as a result" and by Interviewee 19 who warned that several hospital leaders suffer from "delusions of grandeur". Interviewee 2 pointed out the very strong view on 'inhibiting' people within the hospital or at the Ministry who:

> intend to 'do good' but through their 'naivety' they tend to cause destruction and chaos. They are often manifested as 'harassed' persons and they tend to dismiss evidence, experience and internal structures. They end up 'planting chaos, discontinuity and insecurity'. They are usually highly egoistic, narcissist and individualistic people.

At the level of the general staff, Interviewee 5 commented on the misconception of efficiency of several members of the hospital staff by scathingly declaring that “MDH staff are less efficient than they think” and Interviewee 23 opined that “most MDH staff have a false sense of security (for their job) knowing that it is very difficult for them to be fired and also how difficult it is to find replacements if a vacancy is created”.

A very common characteristic of several initiatives started and conducted at MDH is that they are often too dependent on the motivation of most frequently a single person or at best a very small group of people. While the enthusiasm and passion of the involved individuals are often highly laudable, this feature is fraught with risks and is one of the most commonly attributed “reasons why several initiatives 'fizzle off'” (Interviewee 11). As Interviewee 5 explained “initiatives are often totally dependent on the people who try to 'pull them through'” and as such are reliant solely “'on own steam'” and furthermore are usually “limited by group boundaries”. Interviewee 11 also acknowledged that there are however “other multiple reasons and that these are also difficult to discern” and also indicated that:

> Some of these nurses (and other professionals) channel their energy and motivation towards creating and nurturing their pet projects (‘baby’). A few of these initiatives succeed and thrive and become established structures, e.g. renal unit, burns unit. Many others tend to fade away after a lot of energy is expended on them with the frequent result that its promoter and members of her/his team become very frustrated.

Interviewee 5 explained that personal initiatives encounter several obstacles to progress, including the facts that “each initiative (often) has a very limited 'line of sight'” and that frequently “initiatives fail because they do not 'cascade down' or filter down in a 'distorted' manner”. Additionally, this interviewee also acknowledged that “'innovators' become frustrated because MDH structures are typically non-supportive”. Another compounding issue is the typical absence of coordination at any level within MDH such that “there are usually a vast number of initiatives attempting to be developed and implemented in parallel” leading to “the risk of ‘fatigue’ with all this ‘heavy agenda’” (interviewee 12).

A few interviewees that presently occupy senior clinical positions commented that they feel they “can achieve much more desired change” since they got these leadership

positions. They stressed that “introducing something new needs persistence and dogged belief that adoption is required” and that they must be actively aware that they need to continuously plan and prepare for “'succession leadership' to minimize risk of a vacuum in leadership” and “practice formal delegation of duties to different people”. However, they also acknowledged that succession planning and the aptitude for delegation of duties were “uncommon qualities of several clinical leaders”.

Finally, the following excerpt from the transcript of the interview with Interviewee 17 sums up the deep-seated interpretation of the worth widely given to the remarkable impact of personal impetus and passion tendered by several members of the workforce at MDH:

> Many things work well at MDH against all the odds and the limitations. The latter are not reflected in the number of adverse events (far fewer than would otherwise be expected) or incidents that take place because the majority of the staff ‘cares’ and try to do the right thing.

6.1.2 Abundance of initiative

This category is the result of a combination of two advanced codes arising from the data collected and analysed through the action research method. These are ‘Attempting to manage’ and ‘Resourcefulness’. The former was derived from the aggregation of data illustrating strategies adopted by the PaSQIT team to allow it to progress towards its objectives and the latter shows the in-built resources of the team members that were considered helpful for the implementation of the team’s identified vision and mission.

There were several reported tentative attempts and different strategies were employed by the group to help improve its operations and organisational capacity. For example, the chair and secretary of the group were chosen almost automatically by May and August 2013 respectively; a fixed meeting venue was kept for the first 2 years of the group and then changed for another venue which was also repeatedly used and a format for the reporting on meetings (minute-taking) was also quickly decided upon and used more or less unwaveringly. In general, agreement on the team’s operational issues was easily achieved. Division of labour was also employed such as through the

assignment of identified members to lead the organisation of investigation and follow-up of different categories of incidents notified to SALearn, for example medication errors and patient falls.

However, most of these strategies tended to falter either from time to time or permanently after a few weeks of adherence. For example, the initial target of keeping well organised documentation and follow-ups was dependent on the person that assumed secretarial duties. When this person was not available meeting records were much less detailed and were often not completed before the following meeting. Memos attached to the report of a PaSQIT meeting held in January 2014 described how:

> Follow-up is always a problem as the initial momentum often dissipates due to over-burdened individuals, lack of support by organisation, emerging of priorities from other pressing issues (overwhelmed).

And,

> Any writing is done and reviewed by 1-3 members at best. It is the author's perception that most people barely read the covering emails let alone any attached draft documents that are sent for review.

A progress report was planned to be issued on a six-monthly basis, but only 3 reports were completed in 30 months. Additionally, the organisation of PaSQIT meetings was irregular with spurts of heightened activity followed by long lulls (sometimes of months) in which no meeting was organised.

The issues of 'visibility, communications and public relations' recurrently preoccupied members and also senior hospital management. For this reason, a sub-committee was created and entrusted to promote the visibility of PaSQIT in August 2014. The lead of this sub-committee was the promoter of the Early Warning System (EWS). However,

> This group met very infrequently. Objectives were initially very wide but eventually they 'narrowed' down to basically one item - more detailed transfer sheet to follow patient from one section of the hospital to another starting from A&E (Accident and Emergency Department).

Individuals and teams working in the fields of patient safety (PS) and quality improvement (QI) in healthcare recognise that they are multi-factorial. For instance, the report of the first half-day seminar in February 2014, included the following excerpt that describes this realisation by the team:

- PS needs to be viewed from the patient's perspective or point of view. The clinical perspective provides only part of the whole picture. QI is similarly differently perceived by the patients.
- QI includes PS and other elements such as the upkeep of the estate and hotel services
- PS centers on the avoidance of 'clinical harm'. It includes major sectors such as medication errors, pressure ulcers, infection control, falls, and communication issues. The Safety Alert System (SAS) is an important tool. On the other hand, issues like 'overcrowding' is a factor that can influence progress in the control of risks for PS.

Ideas for initiatives and projects that can be adopted by PaSQIT were never scarce. The imagination of most members was boundless. A memo attached to a meeting report dated November 2015 explains that:

> Team tends to expand an idea without any limits being adhered to the discussion. It is difficult to delineate what would be within team's remit or beyond it.

Even when clear direction was eventually achieved and agreed on, in most instances implementation proved to be "'too heavy to handle' with the resources (including the members themselves) available". However, there were notable successes such as the major boost in the influenza vaccination campaign for workers at MDH in autumn 2013 and 2014, the successful launch of the SALearn in April 2015 and the re-energizing of the work of the sub-committees working on pressure ulcers and patient falls. These successful stories were more often and more readily recognized and acclaimed by outsiders to the team and especially when these were also outsiders to the hospital. On the presentation of the work done and the progress registered by the team during Dr. Lachman's second visit in November 2015, he remarked and concluded that:

> The organisation is at a point where it is ready to build on the work done over the past few years. Since my last visit, the team has developed both as a team and within the organisation. I reviewed the annual reports and note the progress made. The foundation has been laid for the further development of an improvement program to enhance patient safety and patient experience.

PaSQIT members sometimes queried whether they are perhaps too downbeat about theirs and the hospital's achievement. In fact, whenever the group took stock of the work done as exemplified by a memo that was attached to a document compiled in December 2013 to show the activities and targets that were being carried over to 2014 revealed that there is:

> A lot to celebrate. Celebration is much rarer than denunciation when things go wrong. Sometimes being positive and giving visibility to what is being done can do a lot to allay general pessimism and the resultant pervasive apathy.

Human resources are vital to an effective healthcare system (Vujicic and Zurn, 2006: 101). In the workplace, motivation can be defined as an "individual's degree of willingness to exert and maintain an effort towards organisational goals" (Franco, Bennett and Kanfer, 2002: 1255). Motivation is closely linked to job satisfaction which in turn is related to the retention of workers at their jobs over time (IntraHealth International, 2006). Kidd (2009: 21) noted that healthcare "staff are not motivated to stay in employment solely by their rates of pay, although clearly it is an important factor". She affirms that motivation is also propagated by other factors that stimulate and satisfy the employees' needs to feel valued such as working in a culture which promotes participation in decision making, team working and opportunities for career development. On the other hand, poorly motivated health workers can have a negative influence on individual facilities and a whole health system (HRH Global Resource Centre, 2017).

The findings elaborated above show that on the whole the healthcare workforce at MDH are highly motivated and there are several instances where this motivation is channeled (sometimes misguidedly) to bring about improvements in hospital practices. Consequently, the organisation needs to better ascertain how to harness this positive energy so that this enthusiasm is not extinguished but is instead ignited and kept alight to amplify and sustain organisational strategies for the improvements of service processes and outcomes.

6.2 High aspirations (M8)

The eighth major category was generated using data collected only in the action research part of this study and labelled as concluding category F: 'Profess to high ideals'. There was no substantial corresponding data collected from the interview arm of this investigation. This category accumulated data that portrayed the ambitions of

the PaSQIT members and other HCPs which the researcher came in contact and interacted with during the recording of her involvement with the PaSQIT group.

6.2.1 'Profess to high ideals'

The data contributing to this category was earlier sub-divided into two main groups. One of these gathered data that demonstrated 'Inclusivity' which in turn covered aspects such as the recognition that 'Everyone needs to be on board' and the benefits accrued from a 'Bottom-up approach'. The other group represented data that focused on the professed principle and the need for the services to be more focused on the need of the patients (patient-centered).

The following excerpt from the original Terms of Reference (TOR) of PaSQIT drawn up in July 2013 shows that from its beginning the team was cognizant of the fact that achievements in patient safety and quality improvement at MDH requires that all healthcare professionals and hospital workers are on board:

> The overall aim of PaSQIT is to educate, motivate, empower and work with healthcare professionals and workers to bring about changes in practices and methods of care that will result in a safer patient environment leading to a higher quality of care, and a better patient experience.

By February 2014, an excerpt from the record of a PaSQIT meeting documented that involving everyone working within the hospital to accept the implementation of change initiatives will happen if "people can 'identify' with the change situation and get to believe that it will be a 'win-win' for them". Another realization was recorded in the second progress report issued in January 2014:

> Clinical Systems Improvement needs to be orchestrated at the micro-system level with the involvement of all the key stakeholders in a multidisciplinary environment.

Therefore, the understanding of the concept and desire for the implementation of inclusivity was strong. PaSQIT has a multi-disciplinary formation with all major healthcare professional groups represented. A comment recorded by Dr. Lachman during his first visit in May 2013 affirmed that PaSQIT is a:

> Very varied group with different skills and competencies and backgrounds. Scope of joining PaSQIT also varies between members. Enthusiasm is however universally evident but needs focus and strategic channeling.

Nevertheless, this team in particular and the hospital in general found it persistently very difficult to actualize the aspirations of inclusivity and multi-disciplinarity in practice. This is brought about by several factors. Some of these are also elucidated in other sections of this chapter and include the fact that team members and other involved individuals are already 'over-burdened' with other duties and responsibilities, the propensity for clashes between highly motivated, well-intentioned but dominant personalities and the perennial tensions between different professional groups. The latter is substantiated by a memo attached to the report of a PaSQIT meeting held in January 2015 that described how:

> Several meetings proposed but few actually happened. Suspicions and prejudices between different HCPs groups are very high.

Additionally, another memo that was attached to the report of the second half-day seminar of November 2015, corroborated by asserting that:

> Prejudice of different professional groups towards each other is very visible within the PaSQIT group itself.

Another observation that was repeatedly experienced concerned the reality that in general the patients' and relatives' involvement is still rather ineffectual and weak. This observation was recorded a number of times in the AR diary. In November 2013, an excerpt of a meeting record documented that:

> Patient involvement and empowerment: hospital staff needs to be more sensitive to and heed patients' wishes if flexibility is available and appropriate.

While another excerpt lifted from meeting notes written in February 2014 asserted that this deficiency is also an intrinsic feature of organisational culture in Malta and suggested that:

> The involvement of relatives to assist in the nursing care of in-patients needs to be seriously considered.

Adopting a 'bottom-up approach' was another high aspiration of several PaSQIT members. Over time, several suggestions were proposed by different members so that this ideal can be practiced. Examples include the following two models documented in the meeting notes dating August 2013:

- The setting up of "huddle groups" (informal team settings) as described in a recent publication by Peter Lachman to discuss and propose improvements to identified opportunities for QI (e.g. at the bedside)

- "Safety rounds" may also be considered. These would involve a lead doctor and a lead nurse conducting a round aimed at identifying and solving safety concerns and issues.

Furthermore, within the hospital there were a number of areas where outstanding progress could be registered on initiatives that fostered patient safety and quality improvements and there are also examples where hospital-wide initiatives were spearheaded by and succeeded on the merit of a single person or a very small team of individuals. Identified individual wards had systems for reporting, investigation and implementation of lessons generated from incident reports arising in the same ward, while a campaign that resulted in a remarkable increase in the uptake of the influenza vaccine by hospital workers in 2013 can be clearly attributed to the hard work and passion of a single healthcare professional who happened to also be a member of PaSQIT.

Lastly, another term frequently heralded by several persons within the hospital is 'patient-centered care'. In a document that was prepared by the Medical Director at the inception of PaSQIT specifically promoted this ideal as a central purpose for the new team:

> The committee should, in my opinion, concentrate and focus its main attention on patient centeredness: 'They give me exactly the help I need and want exactly when I need and want it' (Berwick, 2009: 558).

Discussion on proposed initiatives often also referred to this concept such as in the following excerpt from the report of the meeting with Senior Executive Team (SET) of MDH in September 2013:

> Whole project needs to emphasize patient-centeredness, if something is done, it needs to be ascertained because the patient needs it (rather than because e.g. the physician needs it).

However, as documented in a memo attached to the report of the same meeting with SET:

> 'patient-centeredness' has become a much-abused buzz word. We are all supposed to profess this concept. Most do in one way or another or most of the time. However, globally it is often not with the list of day-to-day priorities or 'theories in use'.

Examples of how this frequently stated principle is far from being applied across the hospital can be gleaned from the following excerpt taken from the report of a PaSQIT

meeting that took place in December 2013 and which shows that MDH does not truly function as a 24/7 hospital:

> Reported an incident that happened last weekend to demonstrate that 'bed blocking' is becoming more acute with time. It appears that a major crisis started to build in the day ward on Saturday but alerts were only initiated late on Sunday and remedial action only started on Monday morning.

There is a widespread awareness that the quality of care given after regular hours, during weekends and public holidays falls sharply when compared to the care given during the morning and afternoon hours of the regular working week (Mondays to Saturdays). An important premise for improvement is to upgrade the "agility of the HCPs to patients' changes in status'". This is the main objective of the EWS that was being rolled out gradually in all the wards during the time of this research and which was eventually incorporated and further supported by PaSQIT. The EWS and other systems need to be in place and operating so that as noted in the first half-day seminar in February 2014, "value can be added all along for the care system to be truly effective from the patient's perspective".

The data collected and assigned to this major category identified several high-level ideals such as the realisation that everyone needs to be 'on board' and that work should include professionals and workers from as wide and multi-disciplinary base as possible, the value of adopting bottom-up approaches to drive quality improvements and the centrality of the patient in healthcare and hence the importance of patient empowerment and patient centeredness.

All these aspirations have been mentioned in the literature promoting quality care over the past two decades. An influential publication issued by the Institute of Medicine (IOM) in the US: Crossing the Quality Chasm (2001) mentions most of these ideals as important approaches for healthcare organisations striving to change the way they deliver care. For example, it is recognized that "change needs to come from the bottom up as front-line healthcare teams recognize opportunities for redesigning care processes and acquire the skill to implement those new approaches successfully" (IOM, 2001: 119). This report also stresses the growing rationale for multi-disciplinary

team work to manage particularly patients with complex and multiple care needs such as cancer patients and the elderly (IOM, 2001: 131).

Finally, a central theme of the IOM report is patient-centeredness. This theme is regularly attached with "timeliness, efficiency and equity" (IOM, 2001: 19). However, it is repeatedly acknowledged that in most healthcare organisations realizing these ideals require new infrastructures that will challenge healthcare leaders (both clinical and management) and the commitment and involvement of all stakeholders including the patients and their families that are "united by the overarching purpose of reducing the burden of illness, injury, and disability in our nation" (IOM, 2001: 20).

6.3 Generally receptive to opportunity (M10)

The tenth major category is another theme which is made up from data that denotes several positive stances and perceptions interlaced with views on the obstacles that tend to deleteriously affect the affirmative positions presented. Data for this theme was collected from the whole spectrum of this research. The interviews section contributed data that was cumulatively gathered under the title of concluding category 8: 'Wide-ranging willingness for learning'. The action research section provided data that in the final stage of the analysis was included under the heading of concluding category D: 'Responsiveness to opportunity'.

6.3.1 'Wide-ranging willingness for learning'

The information provided by the interview participants and collated under this theme was in the main indicative of the prevailing learning culture and ethos at MDH. Several interviewees attested to the "professed sensitivity and will to learn" by individuals and teams working in the hospital. For example, Interviewee 22 highlighted that:

> The mindset that is sensitive towards issues of Patient Safety is more prevalent in the Dept. of Anaesthesia than in other clinical areas within MDH. This is probably because of the special ethos of the Anaesthesia specialty. Generally, anaesthesia is the forerunner or 'champion' of patient safety in most hospitals.

Other areas within MDH that have been highlighted by interviewees for above average disposition for learning are the neurosurgery and the pharmacy departments

(Interviewees 7 and 8). The overall disposition of people to learn was described by Interviewees 12 and 25. The former asserted that “people are actually 'prepared to learn'” while the latter attested that:

> The need for learning in all its aspects including for learning from failures is appreciated by most professionals working at MDH. However, the ‘how’ to promote learning from failures is basically still a big quandary.

Interviewee 5 opined that presently most HCPs undertake only “*ad hoc* and ‘on the job’” training but “ongoing training should be part and parcel of the mindset at the professional, personal and inter-personal (communication) levels”.

Positively, Interviewees 14 and 21 feel that “several enablers are present” or have been noted to have “increased over time to allow learning at MDH” and that there is an “increased general awareness and sensitivity to the principles of patient safety and quality improvement”.

However, the pervasive “‘blame culture’ and the attitude that 'if you fail then it's your fault'” transcends all levels of hospital workers (Interviewees 18, 22, 24 and 25). Interviewee 24 maintained that:

> Reporting for the purpose of learning from errors is still strongly perceived to lead to the ‘knock-off’ effect on the individuals involved instigating the blame culture and consequently ignoring the systems approach.

This is compounded by the big difficulties that are encountered when attempting to safeguard the confidentiality of information even when it is submitted anonymously due to a “well-developed and functioning gossip factory or grape-vine” (Interviewees 16 and 22), the palpable “fear of insecurity” arising from the situation of a single major hospital on a small island state (Interviewee 1) and the individual and collective memories of “earlier ‘let-downs’” (Interviewee 5). Interviewee 7 actually claimed that the ‘blame culture’ is less sensed in the local private hospital where from the interviewee’s personal experience a reporter of a medication error was more likely to be rewarded than reprimanded. An interesting point recounted by Interviewee 22 was concerned with observation that instead of investigating and learning from minor mistakes to improve the service, ‘minor’ transgressions get ‘ingrained’ in the way things are done:

> It depends on the type and severity of the adverse event. In the case of a minor mistake, sub-optimal practice or 'day-to-day omission', this tends to sometimes become 'ingrained' in the way things are done, e.g. short cuts.

Interviewees 20 and 22 described how the working environment of junior healthcare professionals (HCPs) was not conducive to increasing their receptivity for or their motivation to seek learning opportunities. They both attested to the long hours spent at MDH and how this aspect "sort of 'takes over your life'". People become more aware of "how much nicer life can be" when they spend some time working outside MDH. Generally, "junior doctors work on a 'conveyer belt' basis with negligible learning opportunities" and this is particularly evident during duties.

Concluding on a rather negative viewpoint, the hospital needs to face up to a considerable uphill struggle in its quest to motivate and support its workforce to adopt more receptive attitudes for learning and to better nurture a culture for learning at the organisational level. This assertion is supported by the claims of Interviewee 23: "general apathy and disinterest towards CPD and any learning by the nursing professionals" and Interviewee 25 who tellingly expressed that:

> The government is 'obsessed' with an overpowering direction towards increasing service provision ('at any cost'). The emphasis is fully on increasing the 'output'. Very little (if at all) attention is given to the 'outcome' – in terms of actual quality of care, achievement of desired patient outcomes and successful intervention/ reduced harm to patients (patient safety). Actually, outcome is perceived to be overlooked or sacrificed for the sake of increasing the output.

6.3.2 'Responsiveness to opportunity'

Two sets of data contributed to this concluding category from the AR diary: 'Receptive to learning/ aspire to learn' and 'Enthusiasm for results'. The data collated under these two headings was also characterized by generally positive observations documented or made by the researcher during the timeframe of this study.

The PaSQIT group was repeatedly reminded that the team needs to be continuously evolving. This pursuit for evolution can be seen through the revision of the TORs and also through the documentation of the team events and discussion. An insightful record was saved from the presentation of the moderator at the second half-day seminar in February 2015:

> We were reminded of the evolution cycle influenced by people and evidence. Sometimes this is a full circle, but more often it is a spiral, several circles on each other. The aim of the seminar was to re-evaluate the strategic purpose of the team – the reason why it exists and why/ how it should continue to exist and increase. This is 'reflection time'.

Furthermore, due to the considerable limitations experienced in acquiring and engaging the required resources, there needs to be more focus given on "continuously striving to build capacity and expertise" such as through "re-engineering people's time and job plans to increase efficiency and effectiveness" and match identified and emerging needs and gaps.

All members responded enthusiastically to learning opportunities especially when they were organised at the team level. The two visits by Dr. Lachman and the two half-day seminars were eagerly sought and attended by all members even when as in the case of Dr. Lachman's visits some of the sessions took place on Sundays. Members were very eager to learn more on the theoretical backgrounds of patient safety and quality improvements and there were several occasions in which team members shared literature on the subject that they have found informative and enlightening.

During the development of the SALearn system, there were frequent calls for the team to give more prominence to the objective of dissemination of learning points that will come out from the investigation of incidents. This was stressed in the following excerpt from the report of a PaSQIT meeting held in February 2015:

> The SOPs on Investigation and Dissemination are the most important and will require regular reviews.

Furthermore, there were also calls to nurture and improve the competence of 'reflection' of HCPs. An excerpt taken from the same report upholds:

> The 'reflection' that a system such as SALearn can foster is crucial. Members were urged to 'reflect' more on incidents to extract potential lessons that can be learnt and disseminated.

There were two concepts that were introduced during the formative meetings with Dr. Lachman that found notable resonance with the members and were frequently quoted in the team's discussions to help formulate the way forward. The concepts can be summarized as: "the development of the 'listening methodology' which needs to be exercised by the group members when working with stakeholders" and the fostering

of the “use of positive deviance and frontline ownership to effect change”. These ideas promote constructive outlooks by engendering a positive disposition on the one hand to learn from whoever wants to impart their views and suggestions and on the other to identify affirmative activity and learn about how success was achieved.

“Learning is possible when data is constantly and consistently collected”. This quotation was taken from the report of a PaSQIT meeting that took place in November 2013. Measurement of indicators that can show trends and change was recognized as a key function so that advances in patient safety and quality care are monitored and evaluated. These concepts are frequently mentioned in several meetings and locations within the hospital and several projects are started from time to time to measure different types of indicators, but initiatives are often not sustained. There are several possible reasons for these repeated breakdowns. These include the non-appreciation of the extent of the resources required (including time and expertise) to sustain data capture that can generate reliable and useful information and the fact that some people prefer to perpetuate their own “unfounded and inaccurate impressions” rather than risk having them disproven by objective data.

In 2013, the Clinical Performance Unit (CPU) at MDH started to issue a publication with six-monthly Key Performance Indicators (KPIs) that illustrated various clinical activities within the hospital. The reception of this information is “mixed” and although data is presented on an individual clinical firm basis, the firms involved are not identifiable. A memo attached to the meeting report dated August 2013 explains these ambiguous reactions:

> KPIs report have started to be issued by CPU regularly. They are welcomed and feared in equal measures. Sometimes they are also used by people with their own ‘warped agendas’ such as politicians. However, this is viewed by most people as a positive development including most clinicians who can view their own KPIs. KPI results are issued on an anonymous basis.

The notion that PaSQIT develops and adopts the role of a “knowledge hub for all safety initiatives” was given a lot of traction. Several members found this idea attractive but in the end sustaining such an initiative proved to be too much to cultivate and sustain using only the intrinsic resources of the team. There was rarely any appreciable direct and/ or material support from senior management as they are perennially taken up by

"micro-management" issues at the expense of neglecting their strategic and leadership functions.

The data that contributed to this major category disclosed several aspects and instances that showed that quite a few HCPs at MDH have appreciable sensitivity to and interest in learning and the dissemination of knowledge. On the other hand, on numerous occasions the data also revealed stances that counteract and often neutralize attitudes and behaviours that are 'open' to learning. Examples include the pervasive 'blame culture', the general lack of enthusiasm for documentation and collation of performance indicators and the heavy clinical workload that is often given as a justification for the unavailability of staff to do anything else apart from tending to their clinical burdens and tight schedules.

An interesting finding was the assertion of Interviewee 22 that indicated that the Department of Anaesthesia is more adept and sensitive to patient safety issues than other clinical departments. Lagasse (2002: 1617) had noted that some specialised sectors of medical practice such as in anaesthesia may have advanced more than others in making substantial contributions to patients' safety through concerted efforts by practitioners and equipment manufacturers to standardize processes.

Organisations need to be able to learn more than ever before because of "mounting forces such as intensifying competition, advances in technology, and shifts in customer preferences" (Garvin, Edmondson and Gino, 2008: 3). These authors have promoted the hypothesis that organisational research has disclosed that there are three broad elements that are crucial for organisational learning and adaptability. These include "a supportive learning environment, concrete learning processes and practices, and leadership behavior that provides reinforcement". These factors have been collectively labelled as the "building blocks of the learning organisation". Each of these blocks comprise a number of distinct but inter-related components. Most relevant for the data reviewed in this section are the characteristics that promote and safeguard a supportive learning environment (Garvin, Edmondson and Gino, 2008: 4). The components included within this "building block" such as "psychological safety" (staff can express dissenting views without fear of reprisals), time for reflection (time allowed

through a pause in the action to encourage thoughtful reviews of the organisation's processes), an appreciation of differences and openness to new ideas are all very pertinent to the expressed views and observations documented above.

6.4 Territorialism (M1)

The title of the major category for "Territorialism" was derived from the earlier category labels: "Aggressive professional territoriality" and "Separation between and within the professions". All 64 first cycle codes leading to the development of this theme originated from the Interviews arm of the study. Significantly, there was no similar development during the analysis of the data collected from the AR journey. A possible reason for this observation could be the actual nature of the PaSQIT group which was inherently multi-disciplinary through its membership. Tensions between the different professional groups during the interactions within the team were frequently observable but these were more often the result of inter-personal relations and there were several instances where active action to mitigate inter-professional conflict was attempted and where the worth of the different professional groups was acknowledged and appreciated.

6.4.1 'Aggressive professional territoriality'

The dominance of the medical profession at MDH was repeatedly recorded in the data collected during the in-depth interviews. This primacy and particularly the dominance of the medical consultants were demonstrated in several instances and in relation to other professional groupings and the hospital management. Interviewee 3 illustrated the prevalent relationship between the medical profession and the management of the hospital as follows:

> The centre of all decisions in most cases (even in non-clinical decisions) is the medical consultant. The clinicians strongly influence and have too much power over the administration of MDH…. They can manipulate set strategy and over-rule decisions taken at management level (even at CEO & superintendent levels) if they are not fully in agreement which is not a very rare occurrence. This is a major reason why this CEO has to date not succeeded in implementing effective change.

This interviewee further elaborated that the power of the medical profession extends beyond the confines of the hospital organisation and reaches the whole health system:

> Medical power influences all the health system.
> 'Who shouts loudest' matters and these are the medical consultants.

Interviewee 1 concurred and added:

> MDH has a strong 'silo' structure… It is also medics dominated. This tends to lower the role of other HCP groups and roles in management and leadership of the hospital. The confidence of the non-medical HCP is not high enough and needs to be elevated if they are to be able to impinge at all on the medical profession's dominance (hegemony).

Interviewee 2 whilst agreeing with the above took a more practical stance and emphasised the powerful cascading effect that can take place if change is instilled during the training of young doctors:

> The medical profession is singularly important. Influencing the development of new doctors will cascade into influencing the development of the other professions. This is due to the dominant influence of the medic al profession.

The medical profession has a long-standing history of dominance, monopoly and power in healthcare settings. A number of factors converged to support this strong position. These include university training for doctors (the only healthcare profession with a mandatory university education prior to the mid-1980s in Malta) and the early development of professional associations for and the medical licence (warrant) and regulation of medical practitioners provided a powerful political voice and lobbying ability for the profession. In addition, this dominant status allowed the medical profession to attain and maintain an important strategic position and this is exemplified by its strict ownership of powerful and innovative technologies such as anaesthesia, asepsis, and later, antibiotics (Nancarrow and Borthwick, 2005: 904).

The medical profession is perceived as being resolute in its attempts to maintain its distinctiveness. Interviewees 8 and 10 pointed out that the medical professionals do not participate in the organisational systems for incident reporting because they have their own distinct processes such as clinical case conferences which *inter alia* pursue the same purpose of evaluating and learning from adverse events. These meetings are predominantly organised for and attended by the medical professionals.

Finally, it was alleged that members of the medical profession still promote and maintain strict hierarchical positions within their profession. Interviewee 3 reiterated

that particularly medical consultants strive to protect their dominant position within the profession and their particular medical specialities. He explained that:

> Consultants do not think that they can learn anything from the junior staff. They end up hoarding knowledge and do not help their junior team members to advance. 'They keep them backwards'.

Another related and important issue that was repeatedly highlighted was the pervasive power struggle between the nurses and doctors. Interviewee 23 however commented that this is less marked in clinical areas such as in ITU where the different professions need to work closer and for longer periods of time together and in other specialised wards where the professional status of nurses is raised especially because of specialisation (Interviewee 20).

Healthcare is composed of a host of special interest and professional groups. In each of these groups, members have their own specialized, academic preparation, social system, and approach to the work they do. All these differences can lead to widespread mistrust, which can be dispelled only by the passage of time and working together to build relationships (Hajek, 2013: 46).

The different professional groups within MDH and even the different specialties are still very much entrenched in propagating the clinical and traditional 'silo' mentality at the expense of 'risk-quality-safety management' (ibid.). Different groups or silos persist in having a 'myopic viewpoint' focused on their own responsibilities and rights without due regard for the total system of care and the often-professed principles of patient-centered and integrated care systems. The perpetuation of these practices and also the challenges that need to be addressed in order to successfully breakdown these boundaries and the attendant fragmentation and incoordination was portrayed by Interviewee 22 who explained the transcendence of blame between different professional groups and also between different medical specialties:

> The blame culture transcends all levels.
> It is very common for different professional groups to blame each other for sub-optimal practice, e.g. nurses blaming doctors and vice versa. This tends to happen at all professional levels and between most professional groups (in so doing each professional group seeks to exonerate own group from the overall blame).
> Similarly, different medical specialties tend to blame each other and this often happens on the basis of stereotyping and is often the result of long-standing stigmatizing. These practices are also common in other hospitals abroad.

Additionally, Interviewee 3 maintained that the 'aggressiveness' that is sometimes attributed to the nursing profession is also related to the maintenance of the 'silo' mentality as a recognition of their power to disrupt hospital activity and hence to make their stance visible and voices heard:

> There is continuous struggle between doctors and nurses. Doctors depend on nurses and the most acute needs are for nurses and not for doctors. The lack of nurses can be the 'show stopper' and not the lack of doctors. Nurses can cause havoc if they strike and they have a 'higher power of redundancy'.
> The power of redundancy of doctors is much less.
> This can explain why nurses have become 'more aggressive'.

The most visible territorial tensions are between the two largest and most traditional groups: nurses and doctors and also within their respective professional groups as illustrated above. However, these 'hostile' perspectives are also compounded and repeated with as well as within and between the other healthcare professional groups such as the Allied Healthcare Professionals (AHCPs)[16] and pharmacists. Correspondingly, Interviewee 3 conceded that "tensions are visible between all professional groups" and Interviewee 8 informed that in the same way as the members of the medical profession, the AHCPs:

> …tend to tackle incidents internally through their internal setup. As a consequence, incident reports rarely reach the central system. Due to this they are not open to learn from what happens in other areas and lessons learnt in AHCP units are not disseminated to the rest of the hospital.

Molden, Brown and Griffith (2013: 3) assert that as "healthcare moves from an industry driven by volume to one focused on value", the prevalent multi-silo culture in hospitals needs to be dismantled and restructured to achieve integration of the facilities and the clinicians. However, they concede that "this culture will not go quietly into the night, and breaking the bonds of this traditional and hierarchical design will not be an easy task". Concurrently, they posit (backed by their experience at the Piedmont Healthcare in Altanta, US) that organisations that persevere and "keep pushing integration forward in a thoughtful way and continue to seek innovation, despite potential disruption, will be successful" (Molden, Brown and Griffith, 2013: 16).

[16] Allied HealthCare Professional groups (AHCPs) incorporate all healthcare professions apart from nursing, medicine, dentistry and pharmacy.

Several reports of the Institute of Medicine (IOM) in the US have repeatedly underscored that notwithstanding widespread attention to the importance of teamwork skills, healthcare professionals are not sufficiently equipped to employ these skills in practice (Balogh, Miller and Ball, 2015). The seminal IOM report of 2010: To Err is Human: Building a Safer Health System, indicated that difficulties with and concerns about the quality and safety of healthcare delivery continue to escalate, and that these weaknesses cannot be tackled by any health profession on its own (2010: 13). However, regardless of numerous reports that have been published since and citing the need for team-based education in health professions schools, meaningful preparation for collaborative practice has continued to trail behind changes in healthcare delivery. Consequently, the gap between the training of health professionals and actual practice needs has been described as growing wider (Schmitt et al., 2011).

The data collected from the in-depth interviews in this research corroborated with the assertions of the above literature and shows that collaboration between professional groups and specialties is still not happening as much as it would be expected and desired. A particular example was the Incident Reporting System (IRS) that was operated almost exclusively by the nurses. Because of this, the system practically stopped functioning after April 2012 following the issue of a directive by the nurses' trade union that instructed nurses to discontinue submitting reports to this system (Interviewees 8 and 10). Interviewee 5 succinctly explained and illustrated some of the issues detracting from inter-professional and cross-specialty collaboration as follows:

> In MDH the different groups or 'pockets' of employees (such as the people working in Pathology, people working in the Engineering Dept. etc.) each march to their own tune (walking on own steam). They do not necessarily march in parallel either. Each pocket can have about 200-300 people. They have distinct and different dynamics, structural hierarchy, training processes, professional mix and skills.

The same interviewee continued to reiterate that:

> These pockets are often shaped by the particularities (incl. drive) of the individuals who lead or led them in the past. Past leaders often leave a legacy/ imprint on their past 'pockets'… 'pockets' often have their own training programmes/ ongoing initiatives… completely at their own initiative (often a one-person level initiative or drive). No corporate planning whatsoever.

However, a number of interviewees reported systems and groups of healthcare professionals that are succeeding in establishing and propagating intra- and inter-professional collaboration. Interviewee 15 testified how the introduction of the Early Warning Score (EWS) system provided:

> ….an effective tool to improve communication at MDH (communication processes and communication skills are perceived as generally lacking at MDH) … (it has shown to) improve communication between nurses and medics and helps empower and strengthens the assertiveness of the former group. It also empowers the communication needed at the appropriate times. For example, when a FY doctor does not attend to an alert within 30 minutes, the nurse i/c is empowered to escalate alert to a higher level in the medical hierarchy.

Interviewee 15 attributed success to a number of factors which included:

> A strong feature was the 'bottom-up' approach. Success was best ascertained from the significant involvement of the people who will mostly operate the system (i.e. the nurses), the minimal involvement of the hospital authorities and the very careful and gradual roll-out.
>
> There was not an appreciable impact on the medical professionals. However, there was substantial enthusiasm from the 'middle tiers' of the medics and the nurses because it is known that this is a system operating in many other hospitals abroad and it can provide a positive upgrade to their individual CVs.

Additionally, Interviewee 21 described long-standing and effective cooperation being practiced between professions and specialties in the provision of care to children:

> Collaboration between the Paediatrics department and other clinical departments is effective and works well. This may be because paediatricians receive 'holistic' training (basic training in most clinical specialties) because when treating a child all aspects of her/his life are considered and not just the condition in question. Therefore, a good relationship with all clinical specialists and all disciplines is practiced and required.

On the other hand, and notwithstanding the above declaration, Interviewee 21 continued that some collaborative activities had to be discontinued:

> Inter-disciplinary meetings: some of these meeting groups have stopped happening over the last few months because of a number of reasons including the persistent lack of required resources and the paediatric day-care being taken up by adult medical patients.

and that the attempts to introduce and sustain 'transition' clinics that operate to ensure the appropriate handing-over of care from the paediatric to their adult team counterparts have been repeatedly unsuccessful:

> There are no functional 'transition clinics': to transfer a child that is approaching adulthood to the adult clinics. There were occasional attempts to set up such clinics but they have failed mainly because of the lack of required resources (mainly human resources and time).

Finally, several interviewees recognized and stressed the need for more cross-specialty and inter-professional interaction and a few of them suggested corrective and promoting actions such as the appointment of inter-departmental leads with the objective of identifying and addressing these differences and important sources of communications failures (Interviewee 16) and the need for the organisation to augment its efforts to foster the common interest of all its components and different professionals and the understanding that all have a role as "co-creators of the organisational knowledge" (Interviewees 1 and 2).

6.5 Highly cynical workforce (M4)

The fourth major theme was extricated through the combination of the concluding category 3: 'Unreliable organisational support' derived from the Interviews and the concluding category A: 'Distrust of the organisation' resulting from the analysis of the data collected in the AR diary. The category arising from the Interviews is presenting the result from the aspects of shortfalls or inadequacy of the organisational support for learning while the category generated from the analysis of the AR is bringing forth a number of feelings and emotions expressed by HCPs that in turn lead to the overarching frame of mind that can be characterized as a general distrust of the organisation.

6.5.1 'Unreliable organisational support'

This category resulted from the aggregation of several first and second cycle codes under the single heading dealing with an analysis of the data describing organisational support for learning.

A number of respondents stressed on the importance that all hospital structures and systems are well and explicitly supported by different members of the senior management. For example, Interviewee 10 emphasised that a new IRS must be openly championed by the new Clinical Director while Interviewee 11 underlined the requirement that senior nursing management "must be seen to really support ward

nursing managers". Interviewee 8 affirmed that the successful uptake of the first IRS started at St. Luke's hospital was to a significant extent the result of the visible backing of the CEO at that time "who put her full weight on this IRS". Interviewee 15 recounted that "the CEO was instrumental" for the successful roll-out of the EWS.

Different interviewees noted a number of deficiencies in and issues with the leadership of the hospital. Interviewee 11 gave examples that illustrate shortfalls in the organisational support accorded to the nursing profession such as the fact that too many wards are headed by deputy Nursing Officers instead of a fully appointed NO and also the persistent practice (until recently) whereby "a promotion for a nurse also meant a transfer from the area of expertise". On the other hand, Interviewee 3 insisted that "when a clinician takes up a managerial role s/he needs to detach from the clinical/medical practice".

Interviewee 14 asserted that progress is often hampered by "heavy bureaucratic procedures dependent on a few over-burdened individuals", while Interviewee 12 described the view that the "current 'heavy agenda' is due in part to newly created positions (all) struggling to establish their new roles".

Generally, several interviewees were in agreement (articulated by Interviewee 11) that "initiatives are launched in an uncoordinated way. They do not fall into an 'organisational plan' for development. Hence there is often 'piecemeal' implementation, fragmentation and duplication of effort". Reasons given for this assertion were highlighted in the following excerpt from the same interview transcript:

> Organisational support may be perceived to be 'weak'. Why is this so? It would be interesting to find out. Perhaps because the initiatives are not initiated by the centralized management of MDH? Or perhaps because management does not perceive them as aligned/ oriented with organisational needs/priorities? Funding is scarce and hence most initiatives encounter barriers when trying to access funds for new services.

Interviewee 13 wishes to see more clear direction and unceasing support from the top MDH management, while Interviewee 16 highlighted that an important reason for the perceived predominantly dysfunctional hospital support is the detachment between the Ministry/DoH and the hospital:

> The 'distance' between the Ministry and MDH is another persistent limitation. This persistent 'separation' or 'detachment' is not helpful for either party as it tends to result in uncoordinated and sometimes conflicting strategies being adopted.

The inadequate supply and scarcity of the required resources was a dominant reason fielded for the alleged generally poor or dysfunctional organisational support. This was summed up by Interviewee 16 as:

> The general and pervasive lack or scarcity of several resources including equipment (radiological, theatre), human resources, financial at all levels at MDH.

Interviewee 18 maintained that a major problem was the "persistent reluctance to recruit new staff even to replace retiring staff" and countered that in some areas of medical specialties (e.g. anaesthesia and pathology) this hesitancy contributes to the eventuality that "half the trainees eventually leave for abroad even though they are ensured a consultant's post" sometime in the future. He concluded that his "department is constantly understaffed and HR systems are inefficient and unhelpful".

The general scarcity of trained secretarial support was cited by several interviewees, and interviewee 11 focussed on the view that the available "supporting IT systems is still very inadequate for management monitoring and coordination". On the other hand, Interviewee 17 was concerned with the experience of:

> New practices relying more on IT applications have replaced 'old' tried and tested practices. Replacement took place without prior preparation for the transfer and they have been adopted without evaluation such that pitfalls that these new practices have generated have not been identified and/or corrected and in this way adverse events are not prevented.

On the contrary, during the interviews there were a number of instances where respondents earmarked and lauded examples of positive organisational support and coordination. Examples included the assertions by Interviewee 11 that MDH invests a lot in staff development, by Interviewee 14 that nowadays 'hoarding ' of items is much less possible and Interviewee 6 that the HR functions of nursing department were successfully bridged with mainstream HR functions.

Interviewees also expressed proposals for improved organisational support such as through heightened "promotion of hospital horizontal objectives including PS and QI" (Interviewee 13), better "coordination of new initiatives within a planned strategy" (Interviewee 12), augmentation of a recently adopted practice of "patient allocation to

a specific nurse" as this "should engender greater accountability" (Interviewee 14) and the "installation of business managers with clinical departments" (Interviewees 4 and 16).

Finally, the ubiquitous views of being generally surrounded by absent or dysfunctional hospitals support results in several expressions of negative feelings such as hopelessness and dejection. For example, with regards to the discontinued previous IRS, Interviewee 12 and 17 agreed that the "learned expectations" resulted because "people felt that 'nothing was happening - nothing came out of the system'". These feelings were heightened when interviewees compared MDH to foreign hospitals. For example, Interviewee 10 insisted that:

> Abroad incident reporting is taken more seriously. There is a fixed strategy of how to report safety alerts. This is complemented by a 'serious' hospital administration that takes the necessary measures to encourage and ensure compliance.

This commentary related to negative feelings expressed by interviewees is congruent to the first-hand documented observations and experiences of the researcher during the action research arm of this study. These records will be elaborated in the following sub-section.

6.5.2 'Distrust of the organisation'

This concluding category was generated from three groups of codes arising from the AR journal and titled: 'Apprehensiveness', 'Uncertainty' and 'Frustration'. The contributing data and underlying earlier codes was the result of the capture of several negative emotions and feelings observed in the members of the PaSQIT and experienced personally by the researcher during the 30 months of the AR diary that were recorded and analysed. The following is a detailed documentation of the data underpinning these emergent themes.

'Apprehensiveness' was derived from earlier codes that represent data showing prevalent hospital cultures that indicate 'uneasiness with standardisation', 'uneasiness

with documentation' and a widespread 'blame culture' and the need to work towards dispelling it.

The ultimate goal of standardization is to provide better and consistently good quality patient care. Standardisation generally refers to the process of making something conform to a standard (Zarzuela et al., 2013). In the specific context of this research it is meant to signify efforts towards reducing variation of procedures performed to patients with comparable indications and implementing, adhering and adopted healthcare procedures that are based on clinical consensus arising from and regularly updated by reputable scientific and medical evidence. In this sense, standardisation can help to improve the quality of the care given and consequently also patient safety. It can be achieved by various means that include observance and monitoring of the implementation of clinical guidelines. Standardisation, conformity with clinical guidelines and performance measurements are all professed aspirations of several PaSQIT members and also of other HCPs within MDH. However, when talking and working with different HCPs you get the distinct feeling that these aspirations are actually meant for "implementation at a distance" and most people quietly oppose the possibility that they are allowed to influence them in their personal activity.

An excerpt from the report of a meeting of the SALearn sub-group in June 2014 reads:

> The fear of documentation; all new documentation is viewed with suspicion and as another unjustified increase in the burden of work (apart from leaving a trail of evidence that can be followed).

Other text also entered in the same report narrates that "any new documentation including the design of the new safety alert notifications (the main source of information planned for the new SALearn) needed to be as simplified, versatile and generic as possible to enable all kinds of notifications to be submitted. We are interested in all notifications of events that are perceived as causing harm to a patient (real or potential)".

The fear of documentation is also one of the perceptible repercussions of the pervasive 'blame culture' at MDH. The following memo attached to the report of a PaSQIT meeting that was organised in December 2013 recounts a number of intriguing

illustrations of this guilt apportioning mentality and how it was a substantial factor in the procrastination for the launch of the SALearn (the new IRS launched by PaSQIT in April 2015):

> The re-introduction of a new IRS albeit under a different format was very divisive for the group. On the one hand, it was acknowledged as essential and central to the PaSQIT objective. On the other hand, it was viewed as impossible to implement given the MDH climate and prevalent 'blame culture'.
> There were concurrent feelings of wanting to embrace this task together with wanting to avoid it at all costs.
> Interestingly there was the duality of assertions between the nurses and the medics. The nurses sought the re-introduction of an IRS while the medics in general were wearier of this.

Two third cycle codes: 'Lack of focus' and 'Indecision' were combined in the derivation of the next level code: 'Uncertainty'. The lack of focus was evident on different occasions recorded within the AR diary. A major example is the PaSQIT group obsession with the 'right patient, right bed' ultimate objective during its first few months in existence. It took the team several months (up to the first half-day seminar in February 2014) to start to arrive at the point of realisation that this broad objective needs to be sub-divided into several more achievable goals and tackled through the planning, implementation and evaluation of several 'smaller' projects.

In the report of his first visit in May 2013, Dr. Lachman noted the following on the new PaSQIT group:

> My first impressions are:
> - This is a potentially powerful group for change
> - Their role was not entirely clear but now has more clarity
> - The expectations are high so need to be matched with clear desired outcomes
> - The work on the terms of reference have to allow for the development of the purpose

Lack of focus was also the result of difficulties to reach consensus on anything within the group. An excerpt for the report of a PaSQIT meeting held in December 2013 addressed this issue:

> We all have the same intentions and ultimate aim at heart but we are far from agreeing on how to get there.

This was in part the result of the unequal levels of 'dominance' in the different personalities of the members of the team. A personal observation illustrated in a memo attached to the reports of one of the earliest PaSQIT meetings in June 2013 describes how:

> … discussion often tended to follow an unordered form according mainly to the interest of the chair and some other 'dominant members'. Discipline in the conduction of a meeting was never a PaSQIT forte!!

The result in several instances was inertia, indecision and encapsulated in the code "a lot of fine words were said and quoted but execution of actions faltered".

'Frustration' was the last collective code included under the heading of the above concluding category. A number of third cycle codes contribute to it and include: 'Powerlessness', 'Disappointment following high expectations', 'Short-lived/ transitory phase' and 'Non-delivering'.

Over time, there were several moments when expressions of frustration were recorded. An example can be viewed in the following excerpt taken from the record of a meeting that took place in late 2013 and which was also attended by the CEO of MDH at that time:

> "too much talking and not enough action". TOR agreed in May was not being followed. CEO commented that what MDH misses or really needs are "more doers and not more philosophers". We all have the same intentions and ultimate aim at heart but we are far from agreeing on how to get there.

PaSQIT members also started to show concern "that PaSQIT is involved in 'too many things'". Concurrently this concern contributed to feelings of powerlessness and disappointment as articulated in the following excerpt recorded in the minutes of a PASQIT meeting in April 2015:

> This is impinging on the time each can afford for PaSQIT work as all are heavily burdened by their clinical duties.

The most notable example is the recurrent issue related to the inception of a new IRS. This was "a source of constant grief to the PaSQIT" group and a" source of constant squabbles between PaSQIT members and PaSQIT and CEO/ Medical Director. The exact role of PaSQIT re: risk assessment was never settled". In fact, by April 2014, the CEO at the start of PaSQIT had already resolved to disband the group since in his personal view his main objective for the setting up of PaSQIT had failed.

'Non-delivering' or 'failure to execute' was also resultant from the frequently transitory nature of several ideas and bouts of short-lived enthusiasm and activity. This theme will be picked up again in Chapter 6: section 6.6. As recorded in a memo attached to the third progress report issued in January 2015:

> Several teams are mentioned but few actually achieve targets or substantial progress. Members are often very busy with own regular work. A lot of enthusiasm but limited implementation is often the case.

By September 2013, it was noted that "enthusiasm fizzles away very fast when demands to members' time is made". Furthermore, although there were several tentative attempts for the group to operate in a more organised and disciplined fashion, such as by preparing a very long and detailed agenda with precisly timed time slots and list of presenters, "very little is actually ever heeded".

The above documentary reveals several adverse feelings on and assessments of the relationships between HCPs, the organisation and the Ministry/ DoH. Most of them are either the result of direct personal experiences which have led to a disappointment from unfulfilled expectations or from the presumption of poor expectations in the first place. It may be useful to ascribe all these indicators to the level of trust that workers have in the organisation. "Trust is a core relational construct, commonly conceptualized as a psychological state in which individuals make themselves vulnerable in a relationship based upon expectations, assumptions, or beliefs that another's future behaviors will be positive, beneficial, or favorable" (Carmeli, Tishler and Edmondson, 2012). Consequently, it is a manifestation of confidence by a party that they will not be exploited and that they will not be harmed by the behaviors or actions of the other party (Jones and George, 1998: 532).

At MDH, distrust seems to me more prevalent than trust and the result is widespread and entrenched cynicism. Organisational cynicism has been noted in the literature and an established explanation is the one contributed by Dean, Brandes and Dharwadkar (1998: 345) that describes it as a "negative attitude towards one's employing organisation leading to a tendency for disparaging and critical behaviour towards several aspects of the organisation consistent with a distrust of the organisation's integrity, fairness and sincerity towards its employees".

The 'blame culture' which is recurrently mentioned in the data collected for this study merits a special mention at this point. Reason (2000: 768) makes the strong statement that "blaming individuals is emotionally more satisfying than targeting institutions". The seminal IOM report - To Err is Human (Kohn, Corrigan and Donaldson, 2000: 157) states and recommends (emphasis in italics extracted as from the quoted report) that:

> *Safety is a characteristic of systems and not of their components. Safety is an emergent property of systems.* In order for this property to arise, healthcare organisations must develop a systems orientation to patient safety, rather than an orientation that finds and attaches blame to individuals.

The findings elucidated above and in other areas of this report shows that MDH has a long way to go before it can start to claim that the pervasive blame culture in the hospital is being counteracted. Specific strategies need to be carefully planned and meticulously implemented so that the blame culture is eventually replaced by a culture that inspires and urges learning from problems rather than defending against blame (Carroll and Edmondson, 2002: 54).

6.6 More personal ownership desired (M12)

The twelfth and final major category represents data collected from the interviews that focused on the views of persons who are outsiders to the MDH organisation and on proposed future aspirations for MDH on aspects such as learning, patient safety and quality care. Most of this data had mixed optimistic and pessimistic stances and it was presented as constructive advice for the hospital management and staff to ensure progressive improvements towards a state that was ultimately hoped for by all the interviewees that participated in this research. At this stage, it is appropriate to state that all interviewees wished to see the hospital attaining the aspired improvements because at the end of the day they genuinely had the hospital organisation and the care of its patients at heart.

6.6.1 'Players need to 'own' hospital more'

Several interviewees stressed that “inclusivity and interactivity is key” and that “everyone should be in this together”. Interviewee 1 elaborated that all components of the organisation are co-creators of organisational knowledge. In turn,

> The hospital organisation needs to be owned and open to all. It needs to be sensitive to the needs and aspirations of all players.

Frequently participants also fielded their opinions on how the hospital can cultivate its learning capacity through the empowerment of its workforce. Interviewee 4 claimed that “learning is fostered if people feel empowered to report” and how:

> Different individuals force majeure (inescapable/ unavoidably) need to work together and need to learn together.

Interviewee 1 got into detail to explain that “learning requires sharing of ideas” and Interviewee 3 suggested that “learning is more effective for both parties when trainers seek to learn from their trainees”. The same interviewee had observed that contrarily to the above, MDH consultants have a tendency of “thinking that they cannot learn anything from the junior staff”. Interviewee 1 also made the point that “learning needs to be based more on the study of evolving trends” and “learning something new often involves 'unlearning' old ideas and methods”. The same interviewee continued to specify that ‘Unlearning’ is considered to be a massive challenge due to the interconnected fear of failure and concluded that “MDH is not yet a 'learning organisation'”.

It may be interesting to note that both these interviewees (1 and 3 as well as Interviewee 2) were outsiders to the MDH organisation but that they had been individually engaged on a number of occasions to mentor different groups of hospital employees.

Most interviewees were keen to discuss their own outward looking viewpoints on how the ‘*status quo*’ can be challenged so that the outlook of the hospital becomes more progressive and amenable to change and learning. Interviewee 1 stressed the role of education as it aims to:

> Foster skills for adopting a critical approach; challenging the *status quo*. Challenging regulatory systems that are often anti-progressive. This is one of the features of the ‘learning society’.

Interviewee 3 referred to the success story of the training of family practitioners in primary healthcare and attributed this accomplishment to the fact that “it is based on best practice and aimed at getting the best result. It is also well monitored and the connection time between trainer and trainee is long”. Interviewee 4 also contributed substantial insight to this theme by suggesting that “MDH needs to learn in a vicarious (or indirect) way” and this can be achieved if documentation is really taken up and seeking to generate a substantial number of incident reports from which investigations reveal the systems failures that are the causes of most incidents.

A number of interviewees submitted their views on their hope that the hospital becomes “an evolving organisation in the 21st century” and gets unstuck “from the ‘old model’”. Interviewee 1 had a long list of wishes including a yearning for MDH to become “more strategic-oriented” and “more visibly 'caring'” and maintained that “learning is a manifestation of an evolving organisation”.

Interviewee 5 admitted that “MDH is a massive and complex organisation by Maltese standards” and heralded the interesting idea that:

> MDH should be a ‘flagship’ with regards to training for the whole public service in Malta. It has so much to offer with respect to training, practices and opportunities with which it can be ‘proud’ of itself. It is a massive organisation by Maltese standards and should be a beacon towards which other organisations look up to/ want to emulate.

On the issue of change implementation, Interviewee 9 maintained that “change needs to be consistent and incremental to be successful” but also warned that many people “expect change to occur with a 'magic wand'”, while the same interviewee insisted that “as much as possible change should be aimed at the system and not at the individual”.

The leaders of the organisation have a critical and highly influential impact on whether MDH can and will achieve all these aspirations. This point was stressed by Interviewee 2 as the:

> main stakeholders and influencers are the leaders of the organisation (with a combination from the clinical and managerial areas). In the case of MDH this group includes: senior managers of the Health system, namely the Permanent Secretary, DGs, CEOs, and Clinical Chairs.

Finally, as Interviewee 2 concluded, at an organisational level:

> Happy staff leads to rising profits. In the public sector and especially in the healthcare/hospital sector profits are supplanted by such things as satisfaction, motivation and outcomes.

In the end, the same interviewee stated that:

> Healthier and happier employees working in an environment that is structured appropriately with functioning systems and a strategy that reflects a robust policy which is reflective of competent and sufficient resources: leads to 'stronger organisations'. This is especially important for health-related organisation where staff is prone to anxiety promoting realities.

'Unlearning' is one of the challenging terms mentioned in the above documentary. The concept of unlearning has been related to the cognitive aspects by which old practices give way to the new that was promoted by Heldberg in 1981. Unlearning has been described as happening either at the individual level as a necessary step for the creation of new knowledge or at the collective level such as when organisations develop new routines. For organisational learning to occur, there must be unlearning in the sense of 'organisational forgetting' (Easterby-Smith et al., 2004: 373) or 'memory elimination' (Cegarra-Navarro, Wensley and Sánchez-Polo, 2010: 901). Some proponents have posited that assisting individuals to unlearn and let go of outdated practices is a primary preoccupation of organisations. However, it is acknowledged that this is an area that requires further intense research (Rigg, 2016: 200).

Garvin, Edmondson and Gino (2008) explain that an important building block of the Learning Organisation is constructed by the behaviour of the leaders in an organisation and how they either reinforce or impair learning. The importance and influence of leaders or role models at all levels in MDH to determine whether positive or negative attitudes and behaviours are propagated or reduced was stressed by both Interviewees 11 and 14. Particularly, in the case of new nurses Interviewee 11 remarked that:

> The crux of the ethos ('makes or breaks') of the nurses in a particular ward is the attitude and behaviour of the NO (charge nurse).

Garvin, Edmondson and Gino (2008: 6) conclude that organisational development is greatly affected by the behavior of its leaders. Leaders that actively question and listen to employees, thereby provoking and encouraging dialogue and debate consolidate the ethos that people in their institution feel encouraged and safe to

learn. To accomplish this “leaders need to signal the importance of spending time on problem identification, knowledge transfer, and reflective post-audits, these activities are likely to flourish. When people in power demonstrate through their own behavior a willingness to entertain alternative points of view, employees feel emboldened to offer new ideas and options”.

This chapter demonstrated a multitude of factors that are inherent to the human resources forming part of the hospital. Some of these factors refer to the qualities that the hospital workforce is endowed with. Most workers are usually more than willing to offer and use these abilities and talents during the performance of their duties towards the patients and the organisation. However, findings also showed other characteristics that are the result of transformations that happen to these human resources during the time that they spend working at MDH. The next chapter will delve into, demonstrate and discuss the organisational and external factors that were found to be associated with these changes.

Chapter 7: EXPLICATING THE MAJOR COMPONENTS OF THE OVERALL PICTURE: THE ORGANISATIONAL AND EXTERNAL FACTORS DIMENSIONS

This chapter will demonstrate and discuss the findings that influence organisational dynamics and development at MDH from the point of view of the organisational systems, factors that are external to the hospital and the forces that these generate between them. These factors were found to have an impact on the attitudes and behaviour of the hospital workforce towards their roles and commitment to the operation and advancement of this healthcare institution.

Figure 7 is portraying the six individual blocks that will be discussed in detail in this chapter. There are two blocks each for the organisational and external factors. An additional two blocks constitute the resultant forces that sustain the connections between these blocks.

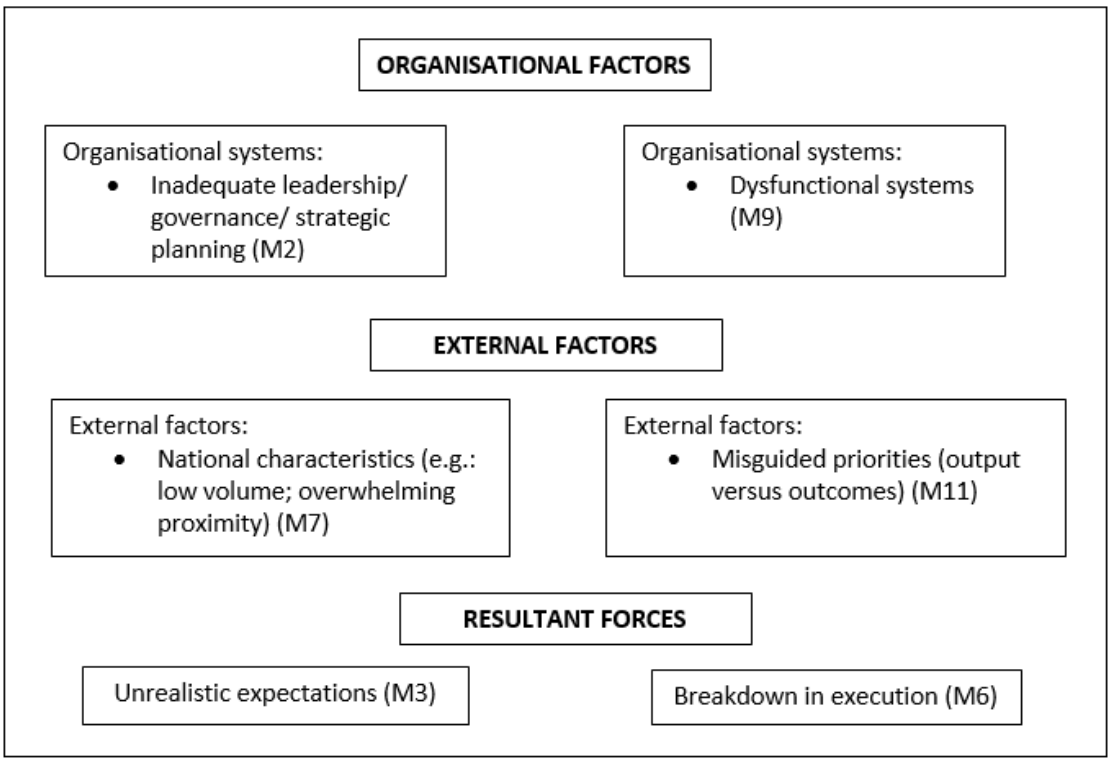


Figure 7: The six distinct blocks of the major categories representing the organisational and external factors and the forces sustaining the connections between them

7.1 Inadequate Leadership/Governance (M2)

The second major category or theme was derived through the combination of the concluding category 2: 'Weak strategic planning' derived from the Interviews and the concluding category C: 'Appreciation of leadership and management skills' resulting from the analysis of the data collected in the AR diary. These two concluding categories appear to be viewing the central issue articulated in the major category title 'Inadequate Leadership and Governance (M2) from different angles. The category arising from the Interviews is presenting the result of inadequate leadership and governance while the category generated from the analysis of the AR is bringing the general yearning of people working within and with PaSQIT for more leadership for and better management of MDH affairs.

7.1.1 'Weak strategic planning'

This category was derived from the merging of the two third cycle categories generated from the analysis of the in-depth interviews titled: 'Organised events for learning' and 'Resources, structures, processes and developments for learning'.

A number of intra- and inter-departmental meetings and events take place on a regular basis at MDH. Examples of intra-departmental meetings are the orthopaedics case conferences. These were described by Interviewee 10. He explained that:

> During these case conferences (also called pathology conferences) a case study is presented to discuss what went wrong and how it could be prevented. There is usually no formal recording of cases discussed. There are also no formal selection criteria of how cases are selected. The main purpose or learning objective centres on clinical improvements. It is very rare that there is an investigation to identify and correct systems errors.

He continued to amplify that at these case conferences:

> Presented events depend on the severity and the circumstances. Sometimes a clinician does not feel comfortable to present at the departmental meeting and prefers to discuss and inform the clinical chair on a one-to-one basis, especially if there are potential medico-legal implications. Clinicians may also be cautious because *"ma tafx min jogħbodok" (you never know who hates you).*

Other examples of intra-departmental events are the Mortality and Morbidity (M&M) meetings. The new Clinical Director started to strongly promote these meetings soon after his appointment in early 2015. Interviewee 16 explained that:

> M&M have re-started on the insistence and with the support of the Clinical Director and prior to this he sought to obtain a presumed 'legal protection' from any possible initiation of investigation/ prosecution/ disciplinary procedures outside the remit of the clinical domain from the Attorney General.

Several clinical departments regularly organised M&M meetings in the past. However, over time most of them had stopped organizing them or were running them only infrequently. One of the most cited reasons for stopping these meetings and the reluctance to organise them is the fear of disclosure of information presented at these events to others outside the meeting and even outside the hospital. These concerns and consequences were elucidated clearly by Interviewee 16:

> Re-started M&M meetings in the surgery department. There is a lot of reluctance for these meetings. Most of it stems from a bad experience from the past. On one occasion some years ago, disciplinary actions were started against implicated clinicians the day following a presentation of a report/ investigation at a M&M meeting due to presumed 'leaks'.

There are a number of inter-departmental meetings that are mostly organised in the form of multidisciplinary (MDT) events. The main purpose of these MDT meetings is to discuss and decide on the MDT management of individual patients. Interviewee 21 described the pre-discharge MDT meetings for paediatric patients. Interviewee 21 also described how other inter-departmental meetings that used to take place between paediatricians and clinicians of other clinical departments in the past had to be stopped because of persistent and unsolved limitations caused by issues of time and space.

Other organised events involve intra-professional programmes such as the induction training programmes organised by several professional groups. These include the induction programmes for newly engaged doctors and nurses. Interviewee 14 reported that the programme for nurses is undergoing substantial upgrading especially since a senior retired nurse has been engaged to oversee and further develop this initiative. Interviewee 14 asserted that:

> A potential enabler is the induction program for new nurses. This is being reinforced year on year and for the first time will be supplemented by a foundation year that will follow new nurses through the first year of their employment.

On the other hand, Interviewee 10 referred to the induction program for new doctors and asserted that the:

> Current meetings are not well planned and conducted and there is scope for more information.

Interviewee 12 claimed that there are several opportunities for and increasing awareness of the need for continuous learning and that a successful endeavour in the field of the nursing profession resulted from increasing the coordination of training for nurses with a centralised training coordinator structure which is part of the hospital HR Department). Formerly the training of nurses was coordinated by the nursing administration 'in isolation'. Interviewees 12 and 13 cited the example using the above structure of successful training programme that was organised as an update for nurses working in chemotherapy and radiotherapy. They concluded that recognition and accreditation of training provided (e.g. with MQRIC[17]) becomes more possible when adopting this route.

Interviewee 25 focused on the fact that "to date, 'protection for learning' is still not present either at the legal level or even in the overall organisational culture". This Interviewee continued to explain that:

> At the individual's level, there is the pervasive attitude to assign guilt and blame for adverse events to specific persons. Senior management also and still often operating within this '*forma mentis*'. Increasing risk of resorting to medico-legal practices as well as the lack for a very long time of cover for medical indemnity by the hospital (until a short time ago) did not help.

During the data collection from the in-depth interviews the researcher encountered several instances that documented the opinions and claims of different interviewees on the availability or otherwise of resources, structures and systems that are necessary for or can facilitate the learning capacity within the hospital organisation and community of healthcare workers. Interviewee 4 claimed that the "systems and structures for learning are still below critical mass" and elaborated that:

> Systems and structures available are still too little and need to show their visibility more clearly. Several initiatives were implemented. It is moving in the right direction and the inception of PaSQIT is a good example. The cadre of persons who understand the concept of the Learning Organisation (LO) has increased but needs to increase much further.

[17] Malta Qualifications Recognition Information Centre (MQRIC) is the competent body within the NCFHE (National Commission for Further and Higher Education) that recognizes qualifications against the Malta Qualifications Framework (MQF).

Interviewee 17 acknowledged that initiatives for learning such as the investigation of reported incidents frequently "take up a lot of time and effort before a significant cause can be clinched". Furthermore, Interviewee 12 added that even when investigations into reported incidents are done and completed, it is often very difficult to find:

> what happens to these reports and how recommendations are eventually implemented and evaluated (when this happens which is perceived to be a rare occurrence). Somehow and frequently 'the loop is not closed' and the general perception is that reports are often done more or less for 'the sake of doing a report'. The closing of the loop for 'learning purposes' is often missed.

Several inadequate or missing resources, structures and processes were earmarked by different interviewees. Interviewee 21 commented that resources required to increase the "potential of MDH to function as a learning organisation include better and faster availability of patient files and a comprehensive and enabling ICT system". Interviewees 8, 19 and 23 commented that the limitations and shortfalls in necessary human resources hamper the possibility for healthcare professionals to embark and spend the necessary time and effort on initiatives that support and pursue learning. These include secretarial staff, persons in middle management and professionals engaged in roles that have the scope for learning as one of their main terms of reference such as practice development nurses. Interviewee 5 commented that staff needs increases in the support services available for them including psychological support services.

It is very difficult for the hospital to manage its needs for resources because resourcing is too centralised and is almost exclusively dependent on decisions taken (sometimes without consulting hospital management) at the Ministry level (Interviewees 6 and 11).

Additionally, several interviewees expressed views that MDH experiences dysfunctional, counter-productive and even scaled-down organisational support and coordination activities and that these cumulatively contribute to hinder the development and advancement of organisational structures and systems that promote learning. Interviewees 6, 7 and 9 lamented the demise of the Incident Reporting System (IRS) that was initiated in 2006 prior to the migration of the hospital from St. Luke's to the new Mater Dei premises. Interviewee 7 declared that at its peak (2011-

2012) this IRS and especially its coordinating Incident Reporting Committee (IRC) were strong enablers and Interviewee 6 maintained that there used to be more than one board of inquiry set up every week and that "most of the time nominees accepted their nominations to sit" on these boards. However, interviewee 7 explained that:

> At MDH people feel that such a system presents a real threat. There was the ever-present debate on whether reporting should be anonymous. Hence commitment persisted to remain at a very superficial level.

Furthermore, Interviewee 7 expounded that the functionality of this IRS was severely hampered by several issues including the:

- IRC (incident reporting committee) was chaired by the person with the lowest grade on the team managing this programme
- tasks of the IRC team were not well shared. Many members lacked commitment. E.g. the drafted policy was not read or reviewed by several of the members. It was never a priority for most members.
- idea that reporting leads to lessons being captured and disseminated so that they are prevented from being repeated again or elsewhere was not well understood. No dissemination of knowledge generated was conducted except perhaps at specific departmental levels through departmental meetings (e.g. these used to happen in the Cardiac Dept.)

On the other hand, several interviewees proffered views that there are also several areas and instances in MDH where positive and gradually expanding organisational support and developments that can facilitate learning can be recognized. These include the:

- affirmation that certain aspects of people management (including rostering, attendance/ absenteeism, family friendly measures, performance measurement, wellness and safety) are fully decentralised and hence within the full control of the hospital management (Interviewees 6 and 8);
- massive improvement of the infrastructure at the new hospital premises which is "now equipped to handle patients much better than in the past", the availability of "several IT tools that are now also supporting the propagation of learning", and the success story of the Infection Control Unit (Interviewee 14);
- successful ongoing roll-out of the Early Warning Score (EWS) (Interviewee 15),
- training in leadership and management undertaken by several healthcare professionals (Interviewee 4);

- several ongoing health and well-being initiatives for hospital employees (Interviewee 6);
- gradually expanding role of the hospital training coordinator (Interviewee 13).

The original incident reporting system (IRS) created a number of sub-committees that were entrusted to focus their attention on specific areas for quality improvement such as the prevention and management of medication errors, pressure ulcers and patients' falls. These sub-committees also suffered a decline and lessened support after the IRS stopped functioning but their activity was re-energised when they were assimilated in PaSQIT (Interviewees 6 and 7).

Lastly, during the interviews a number of respondents proposed measures that in their views would boost the hospital's potential to improve its learning capabilities and culture. Interviewee 10 suggested that "each clinical team/department appoints a liaison officer/champion. These persons will liaise with management for safety alert notifications". Interviewee 4 added that the "clinical champions (already in place) in infection control can be replicated for PS and QI". Interviewee 7 extolled the benefits of "safety walk-a-rounds" that should focus on different themes including infection control and patient safety. This interviewee continued by insisting that the follow-up of complaints and suggestions submitted during these rounds need to be assured.

7.1.2 'Appreciation of leadership and management skills'

This category was derived from the merging of the two third cycle categories arising from the analysis of the data collected in the AR diary: 'Deferring to authority' and 'Work towards improvement'.

Some of the constituent codes refer to the importance given by individuals and teams at MDH to senior members in the hierarchy both in terms of authority (e.g. for endorsement, approval and support) and also expertise (both technical and managerial).

The second PaSQIT progress report recounts that team members repeatedly stressed that any planned initiatives to target the identified team's objectives necessitates the

direct involvement of senior hospital management in collaboration with the respective clinical chairs, lead clinicians and senior nurses. Furthermore, because ownership starts at the managerial and executive level, PaSQIT members expressed their concern that the team on its own can only propose ideas since members did not feel that they have the authority to bring about and enforce change: “we do not have the right buttons to press” and “we cannot make any effect on most of the buttons”. Consequently, the team constantly emphasized that success or otherwise is dependent on:

- Full support and ownership by the management of MDH
- Full support from other stakeholders (e.g. Ministry, Trade Unions, Media, etc.)

Early in the PaSQIT life course (first progress report) there was the clear realization that central coordination (ideally at senior level) of all initiatives being planned and implemented for quality improvement and patient safety is essential so that:

> it becomes possible to make use of success and improvements achieved in one area to other areas of the hospital, as well as avoiding duplication of well-meaning efforts by individuals and small groups working in isolation.

Enlisting the support of the hospital senior management was vital for the existence and survival of PaSQIT over time. However, it was becoming increasingly evident that the CEO had started to withdraw his backing (even as early as late 2013) because he was perceiving that his paramount objective for the creation of PaSQIT which was the re-launch of an incident reporting system for risk investigation and assessment (Risk Assessment Group – RAG) will not be met by the group. A memo attached to the report of a PaSQIT meeting organised in late 2013 explained that:

> The issue of the RAG was covertly exposed to PaSQIT members. It came up on an 'off and on' basis and CEO lost patience with the group when it 'failed' or 'disagreed' that this should be its main *raison d'être*.

One issue which constantly hampered the continued endorsement and support by senior management of MDH for PaSQIT was concerned with the visibility of the team’s achievements. This is a ‘failing’ of the whole health system and PaSQIT was no exception. In fact, during the second half-day seminar of the team held in November 2015, it was acknowledged that:

> DoH/ MDH neglect communications – something that the politicians do well – to show what we are doing.

Concurrently, one of the first (and frequently repeated messages) that the newly appointed Clinical Director in early 2015 conveyed to the team was to urge:

> PaSQIT to increase its visibility throughout MDH. He feels that PaSQIT should aim at becoming the 'talk of the hospital' and wants PaSQIT to 'deliver more' and expressed his 'disappointment' with the team's performance so far.

On a number of occasions, DoH contracted expertise (both of local and foreign individuals and companies) in various areas to assist in the training, mentoring and sometimes strategic planning of diverse teams of health professionals. The engaged experts are often highly esteemed by the recipient teams. Notable examples of these instances encountered during the term of this research include the visits of Dr. Lachman and the projects planned and implemented with the expert assistance of EMCS (a private company specializing in economic research and business support services with a focus on strategy development). EMCS also helped the team to organise its first half-day seminar in February 2014 and provided one of the two moderators at this event. Sessions with these experts were very enthusiastically supported by PaSQIT members and they were the very few occasions where everyone made a genuine effort to attend and to stay for the whole span of the meeting. Incidentally, both of these initiatives were at the outset organised by a person who occupied a very senior position at the DoH prior to April 2013 and PaSQIT members continued to express appreciation for this person's endeavours.

Another case in point is the work that was done on contract with Johns Hopkins International (JHMI). JHMI had conducted its investigative mission in 2012 and had issued a report with several recommendations for the attention of DoH and MDH leadership concerning both quality improvement and patient safety. A team of health professionals (which included several PaSQIT members) was tasked in late 2013 to design plans on how these recommendations can be implemented. The researcher was not part of this working group but was invited to review the report drafted by this team.

However, the implementation of recommendations received from these 'outsiders' although enthusiastically sought and received rarely materialise. A memo attached to the report of a PaSQIT meeting organised in March 2014 expressed these feelings:

> Changes need to be led by the 'people on the ground', i.e. experts working in the field under review. If the people involved are not engaged and are not leading change than the challenge of achieving change will be more difficult or even insurmountable. 'Outsiders' can only give ideas, mentor 'insiders' and monitor on behalf of the organisations.
> There is so much to do that lists appear daunting - we need to always 'keep feet on the ground' and operate within the well acknowledged limitations and known capacities.

Primarily, MDH is a general acute care hospital. This means that its main role is to provide general hospital (secondary) healthcare services. However, by necessity it also provides a number of more specialised (tertiary) services because of its unique situation as the only major hospital in an island country. Specialisation is related to the availability and/or concentration of expertise in one area of the hospital or within selected teams. Furthermore, healthcare professionals tend to view specialisation as an aspirational aim. It also has the potential to engender prestige. A memo attached to the report of the PaSQIT meeting held in November 2013 summed up some of these perceptions:

> Channeling patients with similar problems into one location has several benefits particularly in line with the creation of specialised wards and consequently more specialised care.

Specialisation was also incorporated within the objectives of PaSQIT through the creation and support of a number of sub-teams that focused on specific areas of interest. Some of these sub-groups were already existing (e.g. Pressure Ulcer Prevention Action group – PUPA, Falls working group) before the inception of PaSQIT and the team assimilated them. Eventually their leaders and main members were included as new members of the team. Others, such as the sub-group created to prepare for, launch and operate the Safety Alert system for Learning – SALearn) were conceived *de novo* by PaSQIT. This development started to become a main strategic aim of PaSQIT following the first half-day seminar in February 2014. This is explained in the following memo attached to the report of a PaSQIT meeting organised in March 2014:

> A number of sub-groups in which PaSQIT members collaborated or led were created and from thereafter a majority of the time in PaSQIT meetings started to be devoted to the follow-up of the activity of these groups.

A major and unsolved issue was the capacity of the resources available to implement initiatives. Due to the recognized lack of capacity repeated efforts to prioritize were discussed. On the other hand, it was recognized that capacity issues diminish when dedicated staff is deployed to work on the sector. This had happened in infection control and was attributed as a main success factor for this hospital function. Even when detailed planning is expended on a project as in the plans for the launch of the SALearn, initiatives take a very long time to take off. In fact, the 'soft' launch of SALearn did not happen before April 2015 even though preparations were started more than one year previously. The team was persistently aware that:

> There is a perennial quest to start small and focus and to be pragmatic to work where success is achievable.

However, as expressed in a memo created in early 2014, in the end:

> The inability to see things through is a constant feature of this team. In a way, it can also seem to represent a persistent trend in all of MDH.

Another related memo penned in late 2013 observed that:

> Unfortunately, attention was often distracted from this strategy by 'flighty' ideas and demands that arose all the time and lack of discipline on the part of members to 'keep on track'.

Consequently, the team had to constantly re-evaluate its priorities and modes of action and a memo attached to a report of a meeting in January 2014, concluded that:

> The goalposts keep changing. That is why we feel we never get there.
> This is a long journey. Need to recognise that only 2 years have passed.

And even when the direction seemed clear enough (as at the first half-day seminar in February 2014),

> in the end, it was 'too heavy to handle' with the resources (including the members themselves) available.

After the second visit Dr. Lachman expressed his view that meetings with a wide range of stakeholders but in particular with the medical consultants at MDH were well-attended. He noted this as:

> a marked change from the previous one two years ago. This reflects the growing interest in patient safety. There is a desire to know more and the interactions indicated that this is a group of leaders that will benefit from further training and development.

Dr. Lachman repeatedly stressed the need that PaSQIT members need training and mentoring so that they can individually and collectively adopt a role model status for

patient safety and quality improvement. Already present role models within the hospital were identified soon after the conception of the team. A notable example (also recognized in the JHMI report) is hospital infection control. The leader of this unit was invited to join the team by end 2013. In fact:

> Infection Control was considered as an important element in PS. This element is better developed than any other element at MDH with a history that dates back more than 10 years and an organised structure and dedicated resources. Results and successes in this field are demonstrable.
> Due to the above PaSQIT members view infection control as a 'role model' or something to aspire to. One of the key determinants for this achievement was the lead who is a very dedicated and determined medical specialist in the field.

Another repeatedly fielded proposed initiative was the identification of patient safety champions. A memo attached to the report of a PaSQIT meeting organised in the summer of 2015, elaborated:

> The issue of identifying patient safety champions creeps up repeatedly but it is never taken up seriously. Numerous suggestions have been fielded including approaching champions operating for other sectors such as infection control also taking over patient safety and quality improvement.

7.2 Dysfunctional organisation (M9)

The ninth major category aggregates the collected data that indicated and inferred that several systems within MDH had functional issues of different types and of various degrees. This category was generated exclusively from the in-depth interviews. It describes and analyses the input forwarded by most interviewees on how and why they view that several hospital systems are dysfunctional. A number of them concurrently also offered ideas and solutions to help rectify and facilitate onward development of a number of hospital systems.

7.2.1 'Dysfunctional hospital systems'

As can be expected in a big organisation such as MDH, there are a multitude of structures and systems that are operating either horizontally across the whole hospital or vertically in different and specific areas of the establishment. Most horizontal systems such an incident reporting system (IRS) are designed and intended at being

operated by all staff when and where applicable. However, from a number of interviews it transpired that different groups of HCPs in MDH were unaware that some of these hospital-wide systems actually existed. For instance, Interviewee 10 recounted that:

> … Did not know there was an Incident Reporting System before assuming a management role in 2013 (neither at MDH nor earlier at SLH).

Even when it was admitted that the knowledge of such systems was widely disseminated, interviewees reported that the uptake can be unacceptably or disappointingly low. Interviewee 21 reported that the adverse drug reaction reporting system which is coordinated by the Medicines Authority is "not used as much as it should", while Interviewee 6 explained how government-wide systems such as the Employee Support Program (ESP) operated by the Institute of Public Services achieved a particularly low turn-out by MDH staff. The ESP deals with mental health issues. A contributing factor for both reports is the perception that there will not be any direct or immediate benefit.

Another commonly reported observation is related to the opinions that frequently MDH systems are not applied on the basis of a sound strategy or plan. Interviewee 13 asserted that training initiatives are not awarded within an organisational plan and that:

> there is an element of 'who shouts loudest' succeeding more often to achieve her/his training aspirations. A common result was that the learning achieved would either have relevance only for the professional concerned or it would be retained solely by the individual involved.

Interviewee 18 focused on the systems that monitor and supply resources to meet the demand for services. This interviewee asserted that since MDH does not have peers in Malta, management needs to ensure that "the hospital can cater for peaks of activity" and added that in "quiet times we may appear over-manned, but even these resources may be inadequate for periods of high and extraordinary (but frequent) demand for services". This interviewee added that as a result of the "relentless high workload", several areas of the hospital (both clinical and non-clinical) are under constant "huge pressure on the available time and stretched resources". This in turn "often leaves little time and energy left to think (and strategize) and try to 'arrange/fix things'". Lack of

time for strategic thinking and implementation leads to further uncoordinated and inadequate supply and perpetuates the vicious cycle of insufficient and inappropriate support and provision.

Interviewees 6 and 8 affirmed that with regards to “Strategic HR management (SHRM): very little if at all happens at MDH”. For example, “succession planning is essentially non-existent”. Interviewees 8 and 25 reminded that on several occasions the hospital actually lost “corporate knowledge on the retirement or transfer” of persons who were not replaced in a timely manner that allowed for a proper handover. Incriminatingly, Interviewee 8 also posed the view that “some have an interest in the non-functioning of succession planning for their own dubious reasons”.

Interviewee 6 asserted that the lack of strategic implementation was intimately linked to the failure of some systems. One of the reasons why the committee that was established to oversee the original IRS dissolved was because the position of chair was assigned to the lowest ranking member of the group and another cause was attributed to the fact that the members “had little knowledge of the subject and no real executive powers”.

Another feature of dysfunctional systems is discontinuity. This aspect is prevalent at several levels of activity within the hospital. Interviewee 11 remarked on the “weak culture of handovers” at MDH and recalled how on the appointment to a Director position:

> No ‘over’ from the previous Director was received. Still trying to find way around and understand what was done by previous holders of the Director post. The process of handovers more often than not does not happen. This results in dis-continuities and a certain amount of wasted effort that would have been used better elsewhere.

Similar experiences were also recounted by other respondents. Problems with handover do not only arise from the direction of the predecessor towards the successor. Sometimes as recalled by Interviewee 9 the succeeding person refutes or does not take 'full advantage' from the handover given such that the giver was afraid that this will lead to a considerable loss of continuity and of the knowledge that had been gained. On the other hand, the same interviewee recalled how the changeover

between two CEOs was least dramatic in 2006 when the rest of the senior management team was not also replaced at the same time.

Interviewee 14 added that practices related to handovers and the associated practices of documentation are also generally weak at the clinical and ward level. The promotion and enforcement of these two practices is crucial to reinforce accountability and counteract attitudes described as 'skiving responsibility'. This interviewee also opined that the frequently quoted excuse for inadequate handovers and defaulting from documentation requirements is that 'there is never the time for it' and that this defence is unacceptable in the majority of cases.

Dysfunctionality is strongly evident in the frequent breakdown of communication channels. Interviewee 17 aptly expressed this reality by saying that "communications (lack of it or mis-communication) issues are a major source of 'grief'". It is not rare that members of staff are informed of important modifications in schedules at the eleventh hour and they are then "expected to be flexible and to 'accommodate' unplanned changes" (Interviewee 18). An interesting observation was recalled by Interviewee 17 on the "frequent need to resort to shenanigans (such as kicking up a fuss and shouting sprees) to get things done right. These episodes can detract clinicians from their core responsibilities and leads to frustration and exhaustion".

All the above tends to generate a general aura of negativity as expressed by Interviewee 18 who said that the organisation has "several barriers and some seem insurmountable" and "some barriers are long-standing and entrenched in the organisation". This was compounded by a "rigidity that is evident particularly at the organisational level and to a lesser extent on the individual level" (Interviewee 19). Interviewees 24 and 25 expressed the view that the "vulnerable system syndrome is a good descriptive model of MDH". The 'Vulnerable System Syndrome' (VSS) was described by Reason, Carthey and de Leval (2001: ii21) as follows:

> This syndrome has three interacting and self-perpetuating elements: blaming front line individuals, denying the existence of systemic error provoking weaknesses, and the blinkered pursuit of productive and financial indicators. VSS is present to some degree in all organisations, and the ability to recognize its symptoms is an essential skill in the progress towards improved patient safety.

Finally, Interviewee 22 complained that at the MDH level there are no readily available pathways to enable staff to forward ideas for improvement or observations on what is not right at the organisational level. Interviewee 21 concluded that:

> It is acknowledged that the organisation also strives to improve the situation but much more needs to be done with respect to better coordination and communication and with the realization and maintenance of the essential resources for the provision of safe and good quality care.

The accessible literature related to a wide variety of aspects associated with organisational change is extensive and includes inquiries on how members manage and achieve change and the impact of organisational structures and environment (Gustafson et al., 2003: 753). Studies have elicited several factors that were posited to positively or negatively affect the implementation of change in an organisation. Some of these factors were comparable to a number of the issues described in the above text and include:

- Leadership commitment, involvement, accountability and support. Aligning change efforts with the organisational goals has been found to be amongst the most effective ways to engage support (Hurley, 1992: 29). Successful implementation was positively correlated with clear objectives and explicitly identified, tangible, and measurable tasks. In this study, the unapparent tangible support of the hospital's senior management such as the difficulties encountered to obtain basic office resources is counter to this factor.
- Informal opinion leaders as innovators. Support of a proposed change by informal opinion leaders is essential for success. Opinion leaders are more likely to be innovative and to support a change if the organisation's norm is to adopt changes (Gustafson et al., 2003: 754). At MDH, the suggestion of identifying and promoting patient safety champions fits into this recommendation.
- Leaders and employees are more likely to support a project that they believe is in their own best interests (linked with 'win-win' scenarios). Change managers should understand employee needs and ensure that employees understand how the project will meet those needs (Hurley,

1992: 28). Another important key for success is the ability for change to meet customers' needs. This is an especially valuable point for healthcare as most professionals will be more amenable to accept change if they can be convinced that it will improve the patients' experience.

- Change agent prestige and commitment. Change agents are critical for the establishment of the right environment for the creation, implementation, and sustainability of change (Stjernberg and Philips, 1993: 1197). In healthcare, a change agent who is also a physician is often the most effective because of the traditional stature of the medical profession. Other researched features for the efficacy of a change agent include prestige, persistence, political influence and access to the required resources. The success of a project was also found to be heightened when innovators or consultants from outside the organisation are engaged (Gustafson et al., 2003: 755). The interest generated and sustained during and after the meetings with Dr. Lachman can attest to this factor in the findings of this research.
- Several researchers have found that successful change implementation is more likely when sufficient money, time, and personnel are allocated (Damanpour, 1991: 559). The availability of ample resources will *inter alia* allow the organisation to engage experts, purchase and bear the costs of instituting innovations and to plan contingencies for, learn from and absorb failures (Edmondson, 2011: 16). The scarcity of resources and the great difficulty encountered to attain even the most mundane of necessary supplies reinforces distrust in the hospital's management and systems. It also leads to several highly motivated people to become disenchanted and to gradually lose interest to pursue organisational goals or promote innovative approaches.
- Adopting a reasonable 'radicalness of design', well-defined tasks and reporting relationships, feasible schedules for change and controlling

> turbulence (such as sudden staff transfers) also increase the likelihood that implementation is achieved (Lorenzi and Riley, 2000: 118).

Most of these factors are either absent or persistently undersupplied in the MDH situation as attested in several instances by the different interviewees and/or observed and experienced during the researcher's participation in the PaSQIT group.

7.3 Embedded in the national context (M7)

The seventh major category represents data collected that shed a light on how and why the environment at MDH was inseparable from the wider national setting of Malta as a whole. This category was brought about by the convergence of category 6: 'Inseparable national setting' from the interviews arm of the study and category H: 'Inseparably part of the whole' from the action research journey contribution to this research.

7.3.1 'Inseparable national setting'

The data collected and classified under this heading portrayed input from the interviews that linked the impact of external influences of different kinds on various operations within the hospital and on the MDH organisation in general.

Several behaviours and characteristics identified as prevalent at the national level were described as "reflected in the MDH setting and community". For instance, Interviewee 13 stressed that the "'colonial mentality' prevailing and compounded by the insularity, smallness and high population density" of the country is reproduced within the hospital community. The 'colonial mentality' in this context refers to a lower perceived need by the individual to espouse accountability as the authorities are viewed as distant and therefore unable to truly recognise "who is responsible for what". This mentality is also sustained by an unclear and insufficient understanding that damage of property, wastage and inefficient procedures are actually financed by Maltese taxpayers' money. These features also manifest themselves in the "fear of mobility", that is feeling too comfortable in Malta and having no aspiration to go abroad or

interact with foreign peers (Interviewee 14). There is also what Interviewee 19 termed as the “one bone” mentality whereby everyone needs to fight to retain her/his small portion of the resources (and indeed of patients). This need fosters territoriality and protectionism (Interviewee 19) and the close proximity of extremes in several areas (Interviewee 24).

Some interviewees also indicated that improvements of particular attitudes and behaviours of hospital staff can only happen if changes are primarily or concurrently nurtured at the national level. Interviewee 11 declared that:

> The evidence and visibility of ‘civic responsibility’ and good ‘work ethics’ needs to increase. Both phenomena are low at a national level and perhaps this is reflected in the hospital environment as well.

Interviewee 24 added that “nationally there is a general poor safety culture” and Interviewee 17 expressed that “national and organisation culture do not favour reporting for learning”. Interviewee 2 encapsulated these assertions by the following bold statement:

> The most basic quality is **RESPECT**. Our culture is actually predominantly affected by the opposite or the absence of respect, i.e. the **LACK OF RESPECT** (disrespect, aggressiveness).
> Respect is engendered/ created/ promoted by such things as communication skills, self-respect and self-esteem and the ability to work in a team.

MDH is the “single acute general hospital on the Islands” and compounded by the above expositions renders MDH a unique institution and thence “non-comparable to other hospitals abroad” (Interviewees 1, 2 and 25).

On a more positive note, Interviewees 13 and 16 remarked that in their views the “closed mentality is less prevalent in the younger generations” and that “smallness and insularity issues are falling fast and nowadays are often only used as an excuse”. Encouragingly, Interviewee 17 expressed the opinion that “compared to other large national institutions MDH is perceived to perform 'pretty well'”.

The insular nature of Malta does not generally present “realistic opportunities for job mobility” to MDH healthcare professionals and this is considered as a characteristic that inhibits progress (Interviewee 5).

The “present medico-legal system discourages learning from errors”. Interviewees 24 and 25 added that the “prevalent 'tort' based system is a big obstacle to learning from errors”. Consequently, “'out of courts settlements'” are considered as a better option than litigation for all concerned (Interviewee 24) while Interviewee 17 recounted that frequently “people involved in an adverse event are advised not to testify” by their representing legal counsel and respective trade union.

Trade unions are also very strong and perceived as largely ‘militant’ within MDH. For example, unions that represent a specific professional class tend to have near to a 100% membership of their respective groups. A number of interviewees inferred that this signifies that unions have a lot of power and are a significant ‘alternative’ level of authority that constantly competes with MDH senior management and DoH leadership. Interviewee 7 stated that “QI is considerably hampered by trade unions activities”, Interviewee 11 opined that often union “activity towards upholding 'professional pride' is perceived as low on its agenda” and Interviewee 8 reminded that the initial IRS “suffered because of the actions of the nurses' union”. Finally, Interviewee 15 determined that the successful roll-out of the EWS was in part the result of “trying and managing to avoid trade unions”.

On several occasions interviewees commented on the perceived low support and actual palpable opposition received by MDH from healthcare providers working outside the hospital and DoH officials. Interviewee 12 referred to the frequently alleged lack of cooperation by professionals working in primary healthcare (PHC) and in the community: “MDH has to bypass deficiencies in PHC with own staff and volunteers and relatives of patients”. Comments related to the issues of unforthcoming requested resources included “professional staff are under severe and constant pressures to cater for increasing demand unmatched with increases in resources” (Interviewee 18) and “remuneration is not appropriately improved to match increasing activity demanded by QI” (Interviewee 21).

An interesting insight was presented by Interviewee 9 who recounted that the Ministry for Health “went out of its way to discard and discredit” the vast and valuable knowledge accrued by the hospital management at the time of the migration from St.

Luke's to MDH in 2007. Some people actually had to "resort to impart this knowledge *'bil-moħbi*'" (secretively) to personnel who replaced them in due course. On the other hand, it was pointed out that:

> This information was passed to foreigners and was greatly appreciated by them, e.g. HOPE[18], bilaterals with other countries. It is a case that complies with the Maltese adage that 'a prophet is not appreciated by own people'.

The 'lack of autonomy' of the MDH organisation was also described as a limitation imposed by external factors. This was affirmed by Interviewees 5 and 8 who stated that the fact that "MDH does not have any authority and possibility of 'hire and fire' adversely affects the scope of disciplinary procedures". On the one hand, there is "no clear distinction between senior MDH management and DoH at Head Office" and this is exemplified by the alleged "direct high-level interference and disproportionate micro-management" by DoH officials (Interviewee 18). On the other hand, Interviewees 3 and 22 stated that "DoH is perceived as 'very distant' and largely 'negative'".

The authority MDH leadership is further and substantially undermined by the "negative effect of Maltese politics" (Interviewee 1). Submissions related to this situation include the assertion that "health authorities and hospital administration are heavily influenced by the national 'political agenda'" (Interviewee 21) and the frequent occasions where "politicians overrule DoH when they deal directly with MDH" (Interviewee 3). Interviewee 5 made the outstanding remark that if there was no political interference "10% of MDH employees are otherwise unemployable" while Interviewees 1 and 23 begged that "politicians need to refrain from micro-managing health".

Additionally, MDH staff are observed as having the tendency of looking up to organisations and systems operating abroad (especially in the UK). Interviewee 17 stressed that "exposure to institutions abroad is an enabler and helps improve several deficiencies" and Interviewee 16 considers the above average "contact with centers abroad is a strong point of the Department of Surgery". Interviewee 15 described how

[18] HOPE = European Hospital and Healthcare Federation (http://www.hope.be/)

the fact that the EWS was designed on similar systems operating in UK hospitals helped its roll-out as “most medics were already acquainted with the systems through their experience or from training programs abroad”.

The attitudes and behavior of patients’ and the general public were also perceived as influencing developments and the direction of actions in the hospital. Especially following the migration to the new hospital, “everyone’s expectations have been immensely raised” and “patients' groups are becoming more significant” (Interviewee 25). The expectations of the public on how they will be treated at MDH was succinctly illustrated in the following excerpt from the interview with Interviewee 3:

> The public does not generally trust the system for appointments and organisational system of MDH. Migration to MDH has however increased the trust of the public in the medical services especially because of the introduction of new resources such as imaging equipment. However, people are still generally uncertain of getting consistently good quality care at MDH. The highest level of anxiety is encountered until a patient gains access to MDH (out-patients or A&E). Once inside then most people ‘put their minds at rest’.

Patients can have a very strong impact on the services delivery at the hospital by tending “to close the change cycle by starting to 'vote with their feet'” by for example influencing referral to the surgeons with the best reputation in a particular field (Interviewee 16). Importantly, Interviewee 2 concluded that “patients are super-sensitive to organisational dynamics” as they are:

> The weakest link: the effects of a malfunctioning organisation cascades down to the ‘weakest link’: the patients and their carers and especially the acute patients.

Finally, a few interviewees mentioned a number of observed positive factors and developments resulting from the input of agencies operating externally to MDH. For example, Interviewee 4 insisted that the DoH can be considered an enabler from the aspect of the substantial investment made available over the last few years for several leadership and management training initiatives. Generally, the European Union is also considered to be a positive external factor through its activities that promote and support the strengthening of the national regulatory infrastructure and the several programs and networks in which a number of MDH professionals enrolled and participated.

7.3.2 'Inseparably part of the whole'

The data contributing to this category demonstrates information generated during the AR journey and it describes characteristics of different levels of human interaction observed during the data collection phase that were considered to have an influence on the functioning and onward development of the hospital organisation. These characteristics have been sub-divided into three broad classes:

a. Individual attributes (personal characteristics)
b. Organisational capability (organisation's characteristics)
c. National mindset (nationwide characteristics)

7.3.2.1 Individual attributes

An excerpt from the report of a PaSQIT meeting organised in February 2014 noted that:

> The concept of teamwork needs strong support as it tends not to be an intrinsic feature of organisational culture in Malta.

The value given by PaSQIT members to 'teamwork' as a concept is very high. In fact, in an exercise conducted during the second half-day seminar in November 2015, 'teamwork' obtained the highest preference ranking from a set of several values presented to the group by the session's moderator. One of the reasons that could contribute to the difficulties of actually practicing teamwork effectively in real life is the presence of persons who seek to dominate a group and to have generally overpowering personalities. In the PaSQIT team there were a number of members that could fit within this description to varying degrees. These individuals could represent different professional groups and could be from either gender but the members with the highest predisposition for these characteristics were male and from the medical profession. In several instances, as noted in a memo attached to the report of a meeting held in September 2013, other members reinforced these tendencies by showing that they "seem more comfortable being 'armchair critics'". These tendencies resulted in other outcomes that included "monopolization of the discussion" during meetings such that any debate was dominated by only two to three of the members present, and also the propensity of assigning most PaSQIT activities to the same small sub-group of members.

Another notable highly professed value that was observed to be much less practiced in real life was the value of working within multi-disciplinary setups. To a certain extent this issue also ties in with the problem of working in teams but it adds the extra layer of working in harmony with other professional groups. An excerpt from the report of the second half-day seminar in November 2015 noted that:

> We need to also focus on how well the multi-disciplinarity of our team is working in reality. It is visible through the team dynamics that barriers are very visible and obstructive.

An adjoining memo commented that:

> Prejudice of different professional groups towards each other is very visible within the PaSQIT group itself.

Another value that was discussed at the second half-day seminar in November 2015 was the value of 'respect'. An excerpt from the report for this event documented that during the discussion it was declared that:

> The value of 'Respect' is central to 'Person-centeredness'. It does away with dominance because it sees the full person and all persons.

However, the preference rating for this value did not make it with the topmost chosen values as shown in the excerpt below:

> Preferences of topmost cards: Teamwork x9; Integrity x9; Competence x8; Communication x7; Dedication x6; Challenge x6; Respect x5. This is a reflection of our collective personality/ team identity. What is us? What do we crave most for? Do we walk the talk?

The following memo was attached to the seminar's report to articulate an interpretation of the exercise mentioned in the above text:

> The exercise at the half-day seminar generated a very insightful discussion. Several values especially those related to self-development and mastery/ achievement rated high on the collective level (competence, challenge/ dedication, integrity). This could infer high value given to the individualistic nature of several HCPs.
> Working in teams was given the highest score. However, this could also mean that it was chosen because of the aspiration to get there (its importance highlighted due to its relative absence in real life).
> Relational values such as 'respect' achieved relatively lower ranking. This value is relevant to both inter-member relationships as well to HCP-patient contacts.

7.3.2.2 Organisational capability

One of the characteristics that was noted whilst working within PaSQIT at MDH was that no one had a clear and overarching oversight on several matters such as on all the groups working towards specified goals at any point in time. One of the exercises that PaSQIT attempted to conduct at its inception was to collect a list of all the action teams functioning at MDH at that time. A memo attached to a PaSQIT meeting report in June 2013 commented that:

> Several committees listed but still list thought not to be exhaustive. Several were noted to be missing. TOR of PaSQIT overlaps with the role of other groups.

It soon transpired that there was no central repository that had all the related information. Consequently, there was no centralised understanding on what each group was doing and little knowledge on their respective terms of reference and achievements. It was also noted that several people are members of more than one committee. Furthermore, several of these groups tended to have a short lifespan or very long periods during which no meetings were organised or activity registered. Some of these teams are appointed by senior management but others form spontaneously out of the enthusiasm of the founding members. The former groups were inclined to be more multi-disciplinary.

Another notable organisational characteristic was that 'real' authority resides outside MDH. A favorite utterance of the CEO at MDH at the start of PaSQIT was that he conferred 'executive powers' to the team. However, none of the members ever managed to understand what these 'powers' actually entail and how and when they can be exercised. In actual fact, nobody (including the CEO) had any or a substantial amount of executive powers since power is highly centralised and is mainly exerted by the political class and to a lesser degree by the DoH. For example, the CEO has no power to recruit, fire or even discipline staff. Additionally, disciplinary action is recommended by CEO but needs approval by DoH before it is implemented.

An outside expert that was contracted and engaged by the senior management to help a number of hospital groups to plan and implement small projects aimed at addressing specific areas for quality improvement in late 2013 and early 2014 noted that "the lack

of well-functioning structures is negatively effecting the implementation and survival of ideas that are developed. Structures are needed to 'service' ideas and lead them to fruition". This expert was referring to structures and systems that were well and appropriately supported, had clear objectives, showed signs of sustained functioning by maintaining momentum over time and were sufficiently 'visible' to be recognized by a substantial proportion of the HCPs working in the hospital. As in the case of the original IRS, several structures and systems are started over time but very few (if any) could claim to fulfill all of these criteria.

7.3.2.3 National mindset

The 'uniqueness' of MDH was recognized by all PaSQIT members, senior management and most of the stakeholders that the team was in contact with during the 30 months covered in this research. An excerpt from the report of a PaSQIT meeting convened in November 2013 noted that:

> Comparisons of operations at MDH with other hospitals abroad is fraught with problems due to the very singular function of MDH for Malta. Useful comparisons for MDH can be performed over time.

Furthermore, MDH was described as a 'micro-system of Malta' in that several dynamics observed at the national level can be also detected within this organisation to a greater or lesser degree. Additionally, MDH does not function in isolation but is especially connected with and influenced by what happens and functions in other organisations within the country especially other healthcare facilities. A memo attached to a PaSQIT meeting report in September 2015 illustrates this point by explaining that:

> MDH presents a sub-set of patients, events and issues that are actually also relevant to the broader picture of healthcare institutions and at the national level.
> In reality, several of the patients seen and involved in MDH frequently move between healthcare facilities such as RHKG[19], MCH[20], etc.
> Therefore, what happens to them in the other facilities matters to MDH and vice versa.

Thus, for example, patient safety was frequently declared as being 'alien' to several MDH workers and indeed this is also applicable to workers in other healthcare and non-

[19] RHKG = Karen Grech Rehabilitation Hospital
[20] MCH = Mount Carmel Hospital (hospital for mental health illnesses)

healthcare institutions in Malta and consequently it was determined that “vigorous and frequent training is needed to establish awareness and sensitivity to safety issues”. As also noted during the meeting of PaSQIT representatives with the Senior Executive Team (SET) of MDH in September 2013, “several QI measures do not need to have additional funds injections but changes in culture and beliefs”. In the revised PaSQIT TORs issued in March 2014, the following point was included:

> The Team will help develop a culture of continuous clinical systems improvement including
> - Early response to serious untoward incidents
> - The awareness that culture and safety are the responsibility of each and every healthcare professional, requiring interventions from all.

During the first half-day seminar in February 2014, the programme included a detailed presentation from one of the team’s members who has a special academic interest in how cultural characteristics and differences affect behavioural change in individuals, organisations and populations. The following excerpt describes some of the points in the ensuing discussion that reflected the thoughts of several of the participants on the national context within which MDH operates:

> Learn from successful experiences elsewhere. Understand that our cultural values will never be those of a US, UK or Scandinavian hospital. Choose interventions that are compatible with our national (and organisational) culture, or adapt implementation methods so that they synchronize with - rather than go against - our local values. “Acknowledging the role of culture (should) not become an excuse for fatalism.”

All this knowledge needs to be applied in order to increase the likelihood that the motivation for change in all HCPs at MDH is nurtured and prospers. In a way, as described in the following excerpt from the seminar’s report:

> Change happens if either or both of the following are fulfilled:
> - Changing offers an advantage or benefit
> - *Status quo* offers a disadvantage or loss.

Consequently, it was determined that the team needs to learn and be vigilant to find and promote positive selling points and to maximise and disseminate the 'win-win' potential of change activities.

7.4 Distortion of/ misguided priorities (M11)

The data contributing to M11 can be mostly associated with negative stances and positions regarding the direction and general attitude of the hospital with respect to its priorities and amenability to change. The data was generated entirely from the in-depth interviews.

7.4.1 'Output overpowers quality'

Several interviewees maintained that MDH is generally resistant to change. For instance, Interviewees 7, 19 and 23 declared that there is a "general reluctance to change" and that this culture of resistance is in many respects "a reflection of and similar to the rest of Malta".

Interviewee 13 focused on the 'risk aversion' of staff members at MDH and commented that a high proportion of HCPs are scared of the "extra commitment" that will be needed when any activity that can be perceived as innovative or risk-taking is proposed for implementation.

> Staff are perceived to acquire a 'comfort zone' which is protected and from which they do not see the need to move out through innovations and initiatives that will seek to 'improve activities'.

On the other hand, Interviewees 6 and 15 opined that the resistance for change can be the result of problems associated with the comprehension of why and the expected results of change activities by the staff members that will most likely operationalize them. Both maintained that these problems are significant with the implementation of for example of the IRS and EWS. In the case of the EWS these problems were "in part due to the 'lack of understanding' of the significance of the different parameters such as the monitoring of the respiratory rate and temperature of patients". With respect to the original IRS,

> the value of reporting the incident to a central body was not well understood. The idea that reporting leads to lessons being captured and disseminated so that they are prevented from being repeated again or elsewhere is also not understood.

Similar to the views expressed with respect to other previously discussed themes, the high level of patient related activity at MDH was again associated with the excessive

focus on outputs at the expense of outcomes. These factors include high admission rates, high bed occupancy rates, patients of one firm spread in different wards across the whole hospital and the installation of 'temporary' or 'corridor' wards to deal with admission surges that became a permanent fixture for more than two years. These factors were blamed as leading to exceptionally "high pressures" on most HCPs (Interviewee 15), causing "clinicians' exhaustion'" (Interviewee 17) and drastically inhibiting professionals from establishing any appreciable rapport with the patients (Interviewee 14).

This theme was also linked by several respondents to challenges with the supply chain. Submissions on the supply of inadequate resources and their consequences on quality care included the "lack of permanent staff in one ward led to suspension of EWS" in that area (Interviewee 15), the "occupation of paediatric beds by adult patients is limiting the provision of good quality care to child patients" (Interviewee 21) and the absence "for a very long time of cover for medical indemnity by the hospital (until a short time ago) 'did not help'" (Interviewee 25). Other submissions concentrated on the supply of inappropriate resources such as the following example described by Interviewee 14:

> Systems failure in the supplies of items that are needed to ensure and enable practices for patient safety (e.g. items needed for infection control) are interminably not available where needed ('out-of-stock' items) or replaced by items of inferior quality or incongruent with specifications, resulting from a failure in the procurement/ supply chain.

Interviewees 7, 15, 21 and 25 claimed other relevant scarcities such as "several levels of expertise", "lack of recognition and scarcity of opportunities for career progression", non-appreciation of the "time required for good quality care" and "lack of continuous training and re-training initiatives".

Outcomes of care are the main objectives of most standards and guidelines and are the mainstay of clinical governance. Not sticking to standards and rules in general was attributed to "major problems with 'self-discipline'" (Interviewee 7), while Interviewee 22 stressed that the lack of adherence to quality standards of care was also reflective of "the non-holistic view in several clinical areas of the whole context of the patient:

medical, social, intellectual, etc..". This leads to an inadequate attention given towards the safety and the general well-being of patients.

A few interviewees referred to the apparently widespread "resistance to clinical governance and the application of standards and guidelines" at MDH. This statement was corroborated extensively by Interviewee 16 who added that:

> Observing clinical guidelines are still not a strong point of several clinicians at MDH. However, the younger generation again are more receptive. The 'win-win' basis that needs to be consistently stressed is that one of the main objectives for the use of guidelines is for the clinician's own protection.

Additionally, clinical governance should be led and 'championed' by the Clinical Director. Instead of focusing on this important principle and practice, Interviewee 16 explained that the present Clinical Director:

> is being overwhelmed and overtaken with operational and crises issues and tends to micro-manage them instead of delegating tasks to other competent people...The resultant is that he gets 'bogged down' with operational issues and lacks the time and energy to focus on strategic issues and development.

Apart from being frequently overwhelmed with crisis management, leadership at MDH is considered as being by and large inadequately equipped for clinical governance and to champion the advancement of patient safety and quality care principles. Interviewee 19 referred to the "'general scarcity of effective decision-makers'", while Interviewee 24 was particularly downbeat on the adequacy of PaSQIT to "championing" by asserting that:

> The present 'structure' (PaSQIT) is made up of informally engaged professionals (with possibility of offering part-time involvement or much less). This is clearly inadequate.

And concluded that:

> Having an established team led by a PS manager is a 'minimum requirement'. Such a PS manager should receive specific training and the team should include several nurses and other professionals who will assist the PS manager. The Incident Reporting System (IRS) should be an intrinsic part of this team's portfolio.

The above documentary demonstrated the findings leading to the generation of the major categories that represent the external factors found to influence both the human resources working in the hospital as well its organisational functions and structures. A number of key issues were elucidated. Examples include the national culture affected by the smallness, insularity and to a certain extent our colonial past

and the general and perennial scarcity of resources that apart from the difficulties associated with procurement are also related to the small and restricted manpower base and the limited patient pool because of the low population volume (Briguglio and Azzopardi Muscat, 2016).

Organisations do not operate in isolation. Management may be able to direct internal resources but several factors influencing organisations are beyond their internal control. In the literature, the external factors that impact on organisations are often collectively assembled under the PESTLE framework (Political, Economic, Social, Technological, Legal and Environment). The unique context of and high dependency of the country on MDH as the only major hospital in the Maltese Islands (which is also publicly funded) renders the effect of some of these external forces more powerful than would be perhaps observable in a bigger country with several other similar organisations. A number of these factors have been illuminated in the above discourse and the features that were most discernable was the effect of the national politicians' and workers' trade unions involvement and influence and consequently the persistent reluctance to accord more autonomy to the management of the hospital. Another related factor is the issue of constantly favouring quantity over quality. To an appreciable extent this is due to the dependency on this single hospital for all the secondary healthcare in Malta and Gozo resulting in the hospital being ever present on the national agenda.

Working well in a team came out as the highest-ranking aspiration of the group during an exercise conducted in November 2015. Yet as demonstrated in the findings of this research, achieving this objective was often very challenging for the members of PaSQIT. Schippers, Edmondson and West (2014: 732), described teams as information-processing systems that focus attention on the centrality of activities such as sharing, analyzing, storing, and using information in carrying out teamwork objectives. It has been opined that through members' cognitions and communication, teams process all kinds of information and this results in team outputs such as decisions, action plans and services delivered. However, since teams work with information the potential for misplaced emphases, distortion, or critical omissions can proliferate (Flores et al.,

2012: 652). PaSQIT group needs major and sustained mentoring to help it to grow and function better as a team and to become a role model for other teams working in MDH.

Clinical Governance (CG) is a term that was repeatedly mentioned by interviewees in the data accumulated within this major category. CG is a system through which healthcare “organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Scally and Donaldson, 1998: 61). Patient safety, quality improvement and clinical governance are intimately inter-related and it is plausible to predict that progress or regression in one area will result in a similar and concurrent development direction in the others. CG is becoming progressively more recognized as a major vehicle for continuously improving the quality of patient care and for a health system to develop the capability to sustain high performance standards (Huntington, Gillam and Rosen, 2000: 681).

However, organisation-wide transformation, clinical leadership and positive organisational cultures in which excellence in clinical care will thrive are essential for the successful adoption of clinical governance (Scally and Donaldson, 1998: 61). An assessment performed by a team from Johns Hopkins Medicine International (JHMI) in 2012 on the level of implementation of clinical performance, infection control and patient safety at MDH concluded that apart from the sector of infection control where it is widely acknowledged that significant steps to reach acceptable control in the levels of clinical quality and safety, there is no evidence of any significant progress on the establishment and operation of formal systems and processes in the areas of patient safety and clinical performance in the hospital. This report also ascertained that there are unexplainable and substantial variations in clinical practices throughout the hospital. These conclusions were still relevant during the timespan of this study (2013-2015) as attested by the findings documented in the above commentary.

7.5 Unrealistic (over-ambitious) (M3)

The third major category resulted completely from the data analysis of the data collected in the AR diary. There was no correspondingly significant and comparable

input from the data collected from the interviews. This major category emerged from the merging of two concluding codes: 'Idealistic (unreachable goals)' and 'Competing priorities'. In turn, there were two third cycle codes contributing to the former: 'Over-ambitious' and 'Far-reaching vision', while the later was the result of a combination of three third cycle codes: 'Heavy workloads', 'Organisation swamped by operational issues' and 'Outcomes are sidelined for the sake of outputs'. The following commentary will illustrate and discuss the data underpinning this major category and its contributory codes.

7.5.1 'Idealistic (unreachable goals)'

During the summer of 2013, PaSQIT identified an overarching objective which was summarized in the label 'right patient right bed' (RPRB). In the first PaSQIT progress report issued in summer 2013 this ultimate target was described as follows:

> "Right Patient; Right Bed" was selected as the topmost priority and overarching target for MDH. All the other targets and issues to be tackled should contribute towards achieving this ultimate aim. Patients should be cared for in an appropriate ward/unit and in a timely way – hence we also developed the idea of "right patient in the right bed at the right time". This will increase patient safety since one can then allocate dedicated and experienced staff as well as appropriate resources to the particular cohort of patients, will also increase staff satisfaction and increase the efficiency particularly of the medical/surgical teams because their patients will be aggregated in one particular area.

This overarching objective continued to dominate as the main professed priority of PaSQIT for almost all of its first year of existence. However, there was a gradual realisation that this target was "too big to handle" and it was instead becoming a source of frustration and had a recurrent disheartening effect on several PaSQIT members. A memo that was attached to the report of a PaSQIT meeting in December 2013 summed up a number of these feelings:

> Several objectives and proposals for projects needed to address the overall 'right patient in the right bed' theme listed. Each required major organisational change and involvement. Each has been attempted by different people at different times. Most are entrenched and long-standing problems. Most are also heavily influenced by factors external to MDH such as the lack of community support rendering patients to seek hospital care faster and more frequently.

> Feeling of helplessness from the enormity of the objective and also feeling of disempowerment contrary to the repeated assertions of the CEO who maintains that he is giving 'executive powers' to PaSQIT.

A recurring theme that was codified into “a lot of fine words were said and quoted but execution of actions faltered” was generated to describe the high level of posturing which in turn did not translate into action. A memo attached to the first PaSQIT progress report elaborated some of the elucidated reasons that can explain why this was happening:

> A lot of fine words were said and quoted in reports and during meetings. However, execution of actions and commitments often faltered. Several factors could be in action including inertia; unwillingness to take up more responsibility over and above formal and onerous full-time duties; unexpressed differences between 'espoused theory' and 'theory-in-use'; feelings of helplessness when confronted with unrealistic expectations and unrequited demands for support and resources.

There were regular recordings of protestations made by different PaSQIT members about the limitations that they perceive as hampering them from progressing towards the team’s objectives. In most instances, these could be summed under the label “dedicated time and executive powers”. The CEO that established PaSQIT in 2013 repeatedly insisted that both dedicated time and executive powers have been assigned to the team at its inception. However, members continued to doubt the meaning of the “executive powers” as portrayed by the ex-CEO. This is exemplified by the following excerpt from the report of a PaSQIT meeting held in August 2014:

> A number of PaSQIT members expressed the concern that they still find difficulty to understand the true meaning and authority of the ‘executive powers’ which is accorded to them by the CEO. It is apparent that the members are still not feeling as empowered and are not as yet as convinced of their importance up to the level of the CEOs expectations.

With regards to the issue of “dedicated time”, only two PaSQIT members have at some point been assigned and took up protected time for PaSQIT related work. This only became a reality in late 2014 and early 2015, when these two members started to dedicate a day from their working week to support and operate the SALearn system.

It was also becoming apparent that the scope for and the expectations from the team activities were too vast and members often expressed the feeling of being overwhelmed. There were instances that either people in management or even members themselves expressed the perception that this team was meant to be the

“solutions for all the troubles of the hospital”. As expressed and anticipated in a document prepared at the start of PaSQIT in May 2013:

> Over the years several issues have been neglected and they have now accumulated or become critical but there is not the strength of will or conviction to work hard on them. Creation of a committee is falsely meant to be the 'healer' of all ills.

For example, apart from the objectives to promote and implement measures that lead to improved patient safety (PS) and quality improvement (QI), there were also instances where the objective of clinical governance (CG) was also being directed towards the team. This created a long and intense debate within PaSQIT and an excerpt from the report of a meeting held in March 2014 recounted that:

> Most members felt that CG was an important determinant for PS and QI at MDH. However, it was widely felt that this is not an area that can be led by PaSQIT. Instead, most members were of the opinion that CG needs to be managed separately and that it should best be led and ‘championed’ by the new Clinical Director and Clinical Chairs.

In due course, PaSQIT ‘adapted’ to all these challenges by gradually streamlining its method for action by increasingly focusing on scaled-down and achievable objectives outlined into more clearly defined projects and activities and by supporting and working through sub-groups (already existing or newly created). This was reinforced by the analysis of and advice given on the team’s achievements presented to Dr. Lachman during his second visit in November 2015. A memo attached to the report of this visit explained this gradual change: “there is a perennial quest to start small and focus and to be pragmatic to work where success is achievable”.

7.5.2 ‘Competing priorities’

All the members of PaSQIT are healthcare professionals with a senior position within their respective professional class and with a full-time commitment to their corresponding roles and responsibilities. In his second visit in November 2015, Dr. Lachman expressed that:

> It is commendable that most members of PaSQIT donate their time and develop their programmes with limited resources. There are advantages for the desire for change to emanate from the frontline.

However, each member's onerous commitments also resulted in recurrent difficulties for them to adhere to their promises and deadlines to deliver. An excerpt from the report of a PaSQIT meeting held in January 2014 articulated this concern as follows:

> The inability to see things through is a constant feature of this team. In a way, it can also seem to represent a persistent trend in all of MDH.

Sometimes, even trying to schedule a PaSQIT meeting where most members can be present was very problematic. In fact, while PaSQIT meetings were frequent and quite regular in the first 18 months with two to three meetings taking place every month, the occurrence of these meetings dropped to once a month or less by early 2015. There was a gap in the convening of meetings of about 11 weeks between October 2014 and mid-January 2015 and almost four months between April and August 2015. Meetings started to be very frequent again from August to November 2015 (almost weekly) when a healthcare professional was transferred by the Clinical Director to work with and organize PaSQIT matters (on an almost full-time basis). This trend continued until the second visit of Dr. Lachman in November 2015. When this professional left this role soon after this meeting with Dr. Lachman, PaSQIT meetings took another 'nose-dive' from which they have not recuperated to date.

The competing priorities arising from the members' inherent responsibilities, are compounded by the list of priorities that was drawn up by the team together with senior hospital management during the first few meetings of the new team from May to July 2013. A memo attached to the report of a PaSQIT meeting organised at the end of May 2013 described the researcher's perception that:

> The list of priorities looked more like a 'wish list' of issues to be addressed. It included wide-ranging problems from admission policies and discharge planning to falls and consent…. Most were deemed unattainable as they required more senior level engagement and push for change. The most PaSQIT could do was to be another 'advisory' group on most issues.

Additionally, the lack or absence of functional hospital structures and systems such as sustained hospital reporting systems and intra-/ inter-departmental events, were considered as "negatively effecting the implementation and survival of ideas that are developed. Structures are needed to 'service' ideas and lead them to fruition" (excerpt from a PaSQIT meeting report held in December 2013).

Lastly, a prevailing operational reality at MDH which is reinforced by the Ministry through its insistence on the publication of output figures (without corresponding outcomes e.g. complications, re-admission and/or mortality rates) such as the number of surgeries performed leads to the perception that "quality has been generally subservient to other perceived 'priorities'", namely quantity. Two excerpts from the report of the second half-day seminar organised in November 2015 illustrate this view:

> Quality is always neglected and downgraded in the face of perceived 'priorities' such as waiting lists, push to increase outputs, needs of the HCPs even if these negatively affect quality care and patient safety.
>
> Quality has been ignored for many years. We are now paying a high price for unwittingly neglecting several 'things' including quality, inter-disciplinarity, breaking silos, investing in own people, mindfulness, joy and meaning in work.

7.6 Failure to execute (M6)

The sixth major category was derived from the assimilation of the concluding code 5: 'Performance not as expected' from the analysis of the data collected from the interviews and closing code G: 'Frequent retraction from declared commitment' resulting from the exploration of the data gathered in the AR diary. The discussion on this major category presents the differences between the expected and the actual performed practice and documents episodes that illustrates retraction from declared commitment.

7.6.1 'Performance not as expected'

The title of this code is a re-labeling of a collection of earlier codes under the heading 'Taught practice versus performed practice'. A number of interviewees commented on the big and 'unexplainable' differences that they observe in the practice especially of newly engaged healthcare professionals just a few months after they start to work following their graduation and employment. This point was very clearly made by Interviewee 11 who explained how the interviewee:

> feels 'let down' when visiting wards and seeing some of her ex-students behaving unprofessionally and showing 'negative attitudes' which are not in line with what is so emphatically stressed by her and her colleagues at FHS[21]. Students are viewed as 'not living what they had said' in class.
> Reasons for these developments can be multiple. One of them is the 'peer' influence of other nurses working with them ('to comply with group norms'; '*ikunu bħalhom'*).

Interviewee 14 reiterated that:

> New nurses are strongly influenced by the ethos/ practice of the ward 'leader/s'. When the attitude of the ward manager is predominantly negative this can often spell the 'beginning of the end' for new recruits. The 'ward leader' (ward manager) controls what goes on in the ward. S/he is a strong 'role model' for the ward team and can therefore 'attract or detract' good ward teams.

Interviewee 13 stressed that supporting new recruits to retain the high ideals and aspiration for good practices attained in their training requires more effort to prolong guidance and supervision over the "critical period being after graduation and during the first few months and years of their employment" and provide them with "high-quality role models". This is already being successfully done in the Foundation Years for new medical doctors and plans for this programme to be emulated for the nursing and allied healthcare professions at MDH are being actively pursued by their respective professional leadership structures.

Engendering and guaranteeing unrelenting good practice can be advanced by *inter alia* the "need for emphasis on 'back to basic nursing and medical care'" (Interviewees 11 and 17); professional leaders that must "be urged to be more 'on the ground' and be very observant" and to "emphasize learning as a one of their central job tasks" (Interviewee 12) and by working towards achieving "major changes in practice that necessitate the establishment and enforcement of 'standard practice'" (interviewee 19). Another interesting proposal that was fielded to promote better quality practice was the encouragement of healthcare professionals to seek and attain specialisation and special interests (Interviewees 19 and 23). Finally, as succinctly expressed by Interviewee 14: "good practice is applied by staff members either because it is a belief or because they are afraid of the consequences if they default".

[21] FHS = Faculty of Health Sciences, University of Malta

Concurrently, a number of interviewees underlined some attitudes and vulnerabilities that they think inhibit and compromise good and progressive practice. Interviewee 12 suggested that a commonly observed attitude described as “everyone assumes that another person will do it” is indicative of poor ownership and accountability while Interviewee 3 exemplified worrying attitudes in the nursing profession by reiterating that “some nurses are there only for the job and do not have the ‘nursing vocation’”. Lastly, consistent with the emphasised need to establish and enforce ‘standard practice’, Interviewee 19 concluded that:

> Unless this is achieved the hospital will remain beleaguered with its current and perennial problems of bed shortages and in-hospital quality of care that often leaves much to be desired. A good part of the ‘bed problem’ is ‘artificially induced’.

7.6.2 ‘Frequent retraction from declared commitment’

Data that led to the generation of this code was mainly concerned with the observations made and documented during the AR journey concerning differences between expected or pledged support and the actual backing received by PaSQIT to help the team to progress in its endeavors.

From its inception, PaSQIT made a number of demands for resources (including material resources) from hospital management to help it to pursue and perform its mission. Examples included basic requests such as office space and administrative and technical support. However, despite a number of declarations by different individuals in senior management about the importance they initially accorded to this team, none of these resources were forthcoming before the advent of the new Clinical Director in 2014. Requesting ‘more ambitious’ resources such as monitors for the presentation of ‘changeable’ patient safety messages in different locations within the hospital (although initially enthusiastically received) in the summer of 2014, proved to be just:

> 'wishful thinking'. In the end, such ideas were curtailed by a 'slap in the face' either by MDH management or else by the provider that was earmarked as a potential supplier.

In the end, as noted in a memo attached to the report of a PaSQIT meeting in September 2014, the team:

> Often had to resort to doing things that can be done without the availability of requested equipment.

Sometimes, the team was given resources that were inferior to the level of its demand. A notable example was the assignment of a young clerk to provide part-time administrative support to the group. The following memo drafted in January 2015 recalls how:

> It was soon realized that someone with a clinical/ medical background was more appropriate. Hence loss of clerk (he was re-deployed after a few weeks) was not considered as a catastrophe. The acquisition of HR at the appropriate level is often very difficult. Usually when one requests new HR someone much below the necessary level is given to *'jagħlqulek ħalqek*' (to falsely appease you). This addition often ends up being a burden more than a help.

PaSQIT Members had to leave the team when they were transferred to a post outside MDH. Often this happened suddenly without prior warning even of the involved individuals. Several of these transfers took place in late 2013 and early 2014. As noted in a memo attached to a meeting report in October 2013:

> This led to dis-continuity because the involvement of the transferred member is ended suddenly and a new replacement needed to be found. Absorbing a new replacement was viewed negatively. Replacements were requested and nominated by senior MDH administration. Reasons included apprehension to find someone suitable that could share views with the rest of the team, reluctance with change of any kind, challenge of re-establishing a new rapport. The imposition of a new nomination could also have been a factor.

During his first visit, Dr. Lachman had clearly recommended that team members "will require ongoing mentoring and training in QI and PS in order to deliver the outcomes required". The scarcity of expertise in both areas available in Malta led him to also recommend frequent contact and exposure with relevant institutions and groups abroad. However, even when opportunities arose, this rarely materialised because few members were 'free enough' to attend events abroad if they were not directly connected to their specific professional roles. On the other hand, the hospital issued a call, selected and sponsored a clinician to attend formal training (Masters in Quality and Safety in Healthcare) in 2014.

Another aspect of perceived 'undelivered support' involved the supply of legal guidance, assistance and protection. Members and senior management always maintained that legal backing to the work of PaSQIT especially concerning the planned

new incident reporting system (IRS), the SALearn was highly important. However, it was generally acknowledged that:

> Legal support is always under-resourced all over the health system. This is the result of on the one hand failure to fully acknowledge the significance and role of the legal output (leading to seeking legal support that is usually not well matched with the real needs) and the other hand the perennial loss or high turnover of whatever legal support we may have (due to the related cycles of under-resourcing and unattractive work conditions for recruitment and retention).

Legal guidance and protection was acutely needed to prevent and safeguard data collection meant for learning and improvement from being used as evidence against healthcare workers in medico-legal cases. This shortcoming was deemed to be a major cause of the demise of the original IRS and it was not resolved before or after the launch of SALearn. To counteract this risk, the provision of notification routes that could be used anonymously was introduced in the new system. In January 2015, it was reported that the Clinical Director was seeking to "increase efforts to seek 'legal backup' for protection of knowledge attained by or through the SALearn system". However, to date no known significant progress has been registered in this quest.

7.7 Conclusion

Chapters 6 and 7 documented and discussed the voluminous data collected and analysed in this research. The data analysis resulted in the elucidation of twelve major categories that can now be used as building blocks to construct a composite picture or theoretical framework. This picture will be exhibited in the next chapter. The visualisation of this framework was brought about through the interpretation of the emerging linkages extricated from the careful examination of all the categories brought together.

CHAPTER 8: CONNECTING THE PUZZLE PIECES TO CONSTRUCT THE WHOLE PICTURE (Presenting and Discussing a Theoretical Framework)

8.0 Introduction

Social theories have been described as analytical frameworks and paradigms that can be applied to scrutinize, understand and devise solutions to address identified social problems. Saldaña (2013: 250), explains that there are three leading features in the conventional formation of a social science theory. These include the prediction and control of actions through an 'if-then logic'; the explanation of how and/ or why something happens by the identification and documentation of its causes and the provision of insights and guidance for the improvement of the social situation under study.

Glaser and Strauss (1967: 3) rationalize that in grounded theory the aims of theorizing should generally subscribe to the following:

- To enable prediction and explanation of behaviour
- To contribute to theoretical advances in sociology
- To produce practical applications – prediction and explanation should be able to give the practitioner understanding and some control over situations
- To provide a perspective on behaviour - a stance to be taken towards data
- To guide and provide a style of research on a particular area of behaviour.

They continue to explain that theory should additionally meet two criteria: that the "theory can be verified in present and future research" and that it "must be readily understandable". Therefore, they surmise that the emergent theory must "fit the situation being researched, and work when put in use":

> By 'fit' we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by 'work' we mean that they must be meaningfully relevant to and be able to explain the behaviour under study.
>
> Glaser and Strauss, 1967: 3

Furthermore, Strauss and Corbin (1994: 278) propose that theories are subject to continuous elaboration and qualification and therefore they need to be continually viewed as provisional and as bounded by time considerations. This is because conditions are constantly changing. As a result, this dynamic state inevitably affects the relationship of theory to contemporary reality. According to this perspective,

predictability can only be attained by the "production of theory that is conceptually 'dense' and therefore sensitive to the range of (changing) conditions under which it can be applied" (Dey, 1999: 233). Strauss and Corbin corroborate by explaining that:

> if elsewhere approximately similar conditions obtain, then approximately similar consequences should occur.
>
> Strauss and Corbin (1995: 278)

The ultimate aim of theory in this context is then not so much in establishing the overall truth but more in its ability for application in the real-world of specific situations (Glaser and Strauss, 1967: 244). Consequently, the emphasis of the grounded theory approach in the development of theory is placed higher on the comprehensibility and usability for practitioners and lower (or not solely) for the understanding of researchers. Dey (1999: 233) concludes that:

> Theory allows prediction and offers control by illuminating the connections between conditions, interactions, and consequences – but only in particular contexts.

Establishing the applicable relevant contexts is consigned to whoever wants to apply the theory as they "make the necessary corrections, adjustments, invalidations and in-applications when thinking about or using the theory" (Glaser and Strauss, 1967: 232). In conclusion, theory derived using methodologies guided by the grounded theory approach is expected to be repeatedly adjusted when application is being considered, but on the other hand, it is also required to maintain adequate "generality" to be applicable across a range of contexts and provide a "sufficiently holistic view to convey the total picture" (Glaser and Strauss, 1967: 243).

8.1 Connecting the building blocks to form the picture

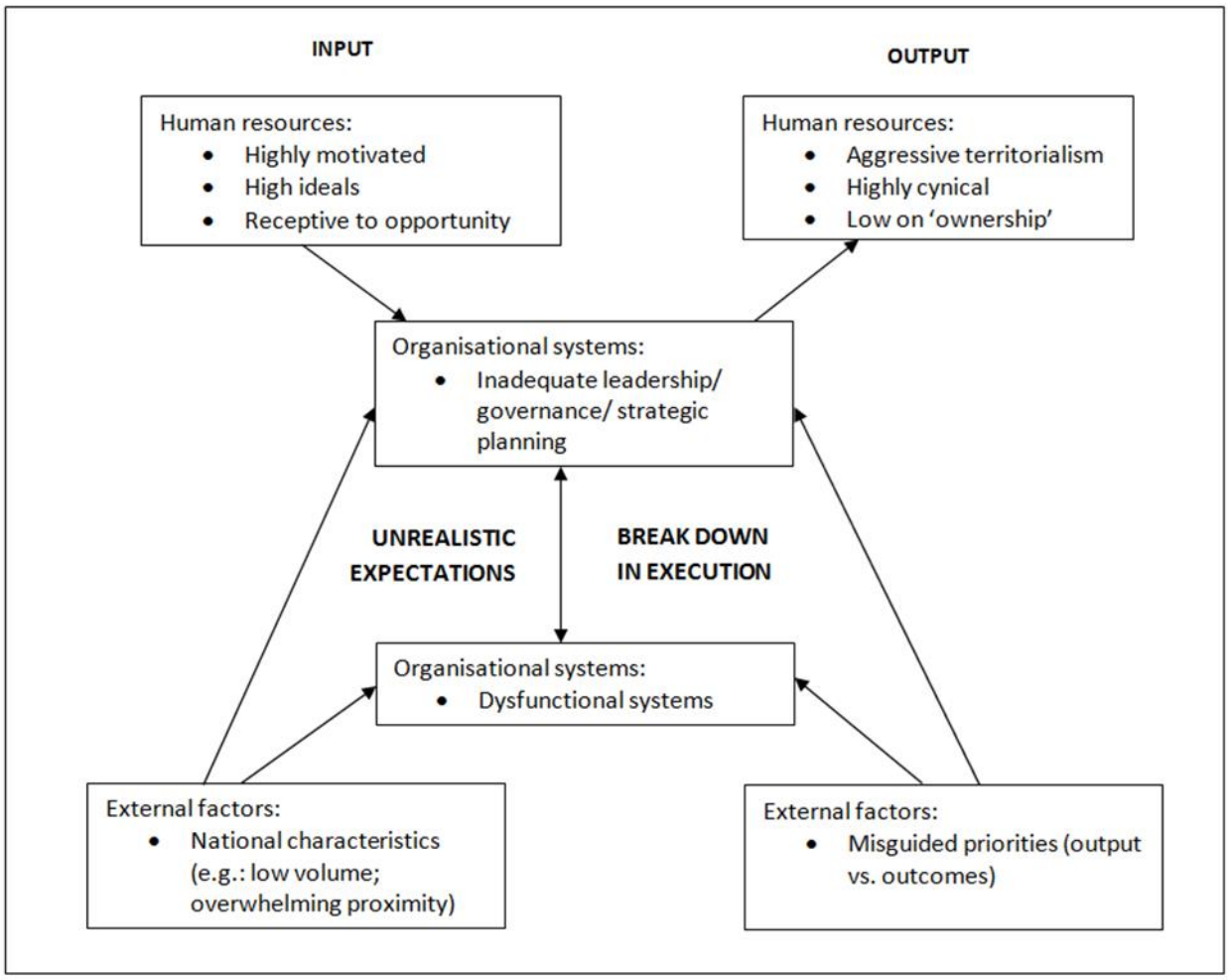
In the previous two chapters, each of the twelve building blocks (major categories) that emerged following the independent and combined analysis of the data collected from the in-depth interviews and action research (AR) experience of this research project were illustrated in detail with the data that led to their elucidation. In this chapter, the researcher will be presenting a framework to show how these puzzle pieces can be connected. The derivation of this theoretical proposition will be substantiated and challenged with relevant literature applicable to several aspects of organisational

development especially those most pertinent to the healthcare domain. In the course of this commentary the researcher will argue how this framework can be shown to "fit" the context, and consequently also shown to how it can "work" within the particular setting that was researched.

As described earlier, out of the twelve consolidated major categories, six of them could be grouped as characterising the human resources engaged in the organisation. Three of these can be assigned as inputs and the other three as outputs. The latter result as the human resources are transformed and affected by the dynamics related to the characteristics identified as pertaining to the organisational systems and the external influencing factors. Both of these latter two domains are represented by two major categories each. The remaining two major categories are mostly demonstrative of both cause and effect of the categories characterising the organisational systems. This is because while they are the result of the difficulties arising from the inadequacy of organisational structures and dysfunctional systems they in turn lead to the continued aggravation of these obstacles and thence increase the challenges for initiatives planned and implemented in an attempt to address these shortcomings.

Figure 8 illustrates the twelve major categories and the potential inter-relationships that can be construed between them. This figure portrays the picture built by the researcher following the analysis of the data collected during her studies. It was brought about through the data collection and analysis processes guided by the qualitative paradigm and in particular the underlying principles of research conducted within the framework of the practitioner-researcher in action research and analysis performed using the tenets of the grounded theory approach. Figure 8 represents the theoretical framework that was generated as a result of this study and that can explain the dynamics of all the actors involved and thence presented as the overall picture.

Figure 8: The merged and consolidated major categories and the inter-relationships that can be at play between them



8.2 Interpreting the picture

The findings of this research point out in a definitive way to the high potential and wealth of capabilities of by far the majority of the healthcare workforce at MDH. It showed that the members of this workforce (especially the professionals: both healthcare and non-healthcare) are of a very high caliber and most are eager to actively contribute to the organisational development of the hospital. Results show that they are intrinsically exceedingly motivated and that they have in-built high ideals especially concerning their desires to improve the patients' experience. They are by and large sensitive to the need to pursue opportunities and change that can individually and collectively help towards service improvement and learning. However, it has been

repeatedly shown that they need to be persuaded that change is essential and that it can impart 'win-win' situations for all parties involved. They also need to be appropriately and convincingly supported. Mostly, this is in part due to the incontrovertible reality that in most cases they are carrying heavy workloads (both as clinical and/or managerial burdens).

The above-mentioned potential presented by the 'input' is nevertheless for better and for worse prone to be substantially affected by the environment in which it is operates. The organisational culture, structures and systems and leadership have been earmarked as particularly important aspects for organisational development (Huntington, 2000: 679). The findings of this research elicited the significance of all these aspects. The organisational structures, systems and leadership were frequently not found to be a constructive influence as they were recurrently characterized as inadequate or dysfunctional while the organisational culture was found to be strongly influenced by external factors that were frequently rooted at the national level. Other important external factors extracted from the results of this inquiry were grouped as resulting from the demands that are made on the hospital in its unique and solitary situation as the major acute general hospital for Malta and Gozo. All these dynamics result in the continuous reinforcement of forces that have been grouped under the two main titles of 'unrealistic expectations' and 'breakdown in execution'. These forces are sustained by the organisational and external factors and it is the researcher's views that progress can only be registered if and when this vicious circle is broken.

The final element of this framework is concerned with the consequential features of the human resources that have been subjected to this long-standing organisational environment and which is being termed as the 'output'. This research has shown that the transformation of the human resources is often exhibited in overt manifestations that include territorialism, cynicism and a lack of 'ownership' of the organisational vision and objectives.

8.3 Corroborating the findings with the literature

> A dwarf standing on the shoulders of a giant may see further than the giant himself.
> Burton, 2007: 27

In accordance with the 'informed grounded theory approach', the researcher was aware of the wide breadth of the extant literature in the substantive field through comprehensive reading of the literature on various subjects that impinge on the areas relevant to this study prior to the start of the fieldwork. Searches were conducted in different fields that included organisational learning, patient safety and quality improvement in healthcare services, adverse events and medical errors and the human factor in organisations. This reading made the researcher aware of the main issues and current lines of the debate in these areas of interest and hence "to situate the study and its product in the current knowledge base of the field" (Thornberg, 2012: 255).

The preceding literature search also helped the researcher to thoughtfully, creatively and flexibly use this knowledge to direct the field of enquiry. In this way, the researcher was enabled to critically assess the accumulating data in terms of relevance, application, fit and usefulness. The following exposition of selected literature was compiled after the data collection and analysis was completed including the assembly of the theoretical framework which is depicted in Figure 8 and explained in section 8.2 above. Consequently, whilst capturing the benefits of the knowledge imparted by "pre-existing research and theories to enhance theoretical sensitivity, the researcher sought to remain free, open and data sensitive, and to avoid forcing pre-existing theories, concepts or assumptions as 'pet codes' or non-fitting irrelevant codes into their analysis" (ibid.)

8.3.1 Calls for systems review and organisational development

Hospitals have traditionally depended on a dedicated and highly skilled professional workforce to compensate and counteract for any operational failures that might occur during the delivery of care services to patients (Tucker and Edmondson, 2003: 55). Up until a few years ago, the means to ensuring the provision of acceptable quality care to patients were largely reliant on employing good doctors and nurses and much less

contingent on having a great organisation and management. However, since the mid-1990s, increasing public awareness of deficiencies in healthcare delivery has resulted in the inception of movements in the healthcare community that started to call for systematic reviews and organisational improvements to safeguard and improve patient safety. Focus has therefore been shifting to give heightened attention to hospital culture, structures and systems, and reporting processes. This shift is clearly visible at MDH and the findings of this research have shown that it is still gaining momentum. Similar to other contemporary reforms, Malta tends to lag to a lesser or greater degree behind comparable developments in other bigger and mainland connected countries.

Organisational development is a field of applied behavioural science that seeks to develop the principles and practice of managing change and improving effectiveness in organisations (Huntington, 2000: 680). Adverse events and systems failures in healthcare establishments can lead to death and temporary or permanent disabilities. Simultaneous with the predisposition of clinicians to protect their individual autonomy and reputation, this can lead to the unchecked promotion of the culture of blame and secrecy that inhibits the organisation from learning and thus from preventing such incidents in the future (Huntington, 2000: 679).

A key message of the presently acclaimed theories on quality improvement is the maxim that the imperfect functioning of individuals within organisations is frequently reflective of either underlying systems failures or deficient and dysfunctional organisation-wide systems for quality assurance (Berwick, 1989: 54). Berwick asserts and upholds the superiority of the theories of continuous improvement (initially promoted by W. Edwards Deming and Joseph M. Juran in Japanese manufacturing industries) as they focus on the average producer and not on the outlier, on learning and not on defense over what he termed the “theory of bad apples”. The latter theory is based on the premise that problems of quality are caused by poor intentions and that the cause of trouble is people through their intrinsic venality, incompetence and insufficient caution (ibid.). This idea has nowadays been largely discarded as several studies and experiences have shown that the root cause of most failures in

organisations is a combination of “poor job design, failure of leadership or unclear purpose” (ibid.).

8.3.2 Types of process or systems failures

In their research published in 2003 on the care delivered by hospital nurses, Tucker and Edmondson (2003: 56-57) identified two distinct types of process or systems failures. They termed these two types as ‘errors’ and ‘problems’. An *error* was described as the performance of an assignment that is either unnecessary or is executed incorrectly. An error can be avoided with the suitable distribution of pre-existent information such as when a patient is taken for surgery whilst it can be ascertained that s/he is not adequately prepared pre-operatively. A vast majority of errors are apprehended and rectified before patients are ever harmed. Nevertheless, lack of attention to process errors can result in the occurrence of more visible, consequential failures and this in turn may restrict or refute opportunities for organisational learning.

On the other hand, failures termed as *problems* were identified as disruptions in workers’ capability to complete a given job. This can occur because the resources needed to accomplish the designated operation are not available when, where, in the quantity and up to the design specifications required thus precluding the execution of the task as planned. Alternatively, it can be the result of the presence of something when it should not be there such as mislabeled or erroneous medications.

Staff members are usually fully cognizant of the problems that they meet in the course of their work but are frequently unaware of their own errors as they make them. In fact, according to these researchers the majority of failures detected by front-line workers are problems rather than errors. They conclude that both types of failures necessitate attention and action in order for patient care to be safe and proceed uninterruptedly. However, they stressed that while healthcare workers can in most cases take appropriate action to solve problems since they are often acutely aware of them, management involvement and oversight is essential for the prevention of errors and to reduce the likelihood that they occur through appropriate reporting systems

and consequent modifications of work systems and structures. The above-mentioned literature stresses the essential role that leadership and management in healthcare needs to have to steer the necessary agenda for change and for learning. This corroborates with the findings of this research that on the one hand showed the recognized need and yearning at most levels for strong headship and on the other hand highlighted the effect that the relative absence, dysfunctional or obstructed health and hospital leadership are having on the development of MDH as an organisation.

8.3.3 Fear and psychological safety

The potential for individual members to speak up about important issues is valued in most modern organisations. However, research is increasingly implying that staff members frequently opt to stay silent instead and this is most often related to a fear of adverse personal and professional consequences. “Fear is a powerful emotion that shapes many aspects of our lives” (Kish-Gephart et al., 2009: 164). Fear has been shown to be a highly relevant factor in organisational life, particularly because of its role in employees’ silence.

Organisations are becoming increasingly more dependent on employees at all levels to weigh in with their ideas and observations (in addition to their time and physical energy) in order to develop and sustain the well-being of the collective establishment. However, a frequent finding is that employees often remain silent even when they are specifically invited to interject about matters such as “employee treatment, managerial behaviour, patient care, organisational functioning and performance, or the outbreak and spread of corporate scandal” (Kish-Gephart et al., 2009: 165). Correspondingly, research has associated lower levels of psychological safety with silence and higher levels of psychological safety with “voice” implying at the central role of fear as a determinant on whether employees feel safe to risk deeper involvement to assist organisational development or not (Edmondson, 2003: 1441; Detert and Burris, 2007: 881).

> Psychological safety plays a vital role in helping people overcome barriers to learning and change in interpersonally challenging work environments
>
> Edmondson et al., 2016: 65

In this recent research, investigators sought to inspect and theorize differences in psychological safety based on the type of work carried out, hierarchical status, and the effectiveness of leadership through the comparison of organisations that were termed as having “high-stakes and challenging contexts” but operating in different domains, namely in the healthcare and educational fields. Psychological safety is defined as the extent by which people perceive the environment in which they work as favourable to interpersonally risky behaviours such as speaking up and speaking one’s mind or requesting help. It is considered as a prominent variable in organisational climates where learning happens and is acknowledged that it makes a difference (Edmondson and Lei, 2014: 42).

This inquiry by Edmondson and colleagues, focused on psychological safety, learning and human development and the approach adopted was concerned with the environment in which persons work as an influence on how a person reacts and adjusts (Lerner, 2015: 170; Edmondson et al., 2016: 66). The following table (Table 12), extracted and adapted from Edmondson et al. of 2016, synthesizes various characteristics and constructs taken from prevalent research. In the researcher’s view, these features conform well to several of the findings of this research such as the effect of hierarchical and professional statuses and how leadership effectiveness is assessed. Issues with fear of speaking up, reporting and suggesting improvements were also predominant in the findings of this research and they could be used as indicators to measure any future initiatives implemented to address these shortcomings.

Table 12: Selected characteristics and constructs of healthcare organisations.
(Examples of applicable findings and context from this research project are included in the last column)

Characteristic	Additional points	**Applicable findings and MDH context (extracts from this research project)**
Challenging high-stakes work	The work affects patient health, sometimes in life or death circumstances	MDH is the "single acute general hospital on the Islands" (Interviewee 1, 2 and 25).
Crucial role of front line professionals	Physicians, nurses and other clinical roles	The inclusivity of all major professional groups in PaSQIT was recognized as an asset for success by the senior hospital management, Dr. Lachman and documented in each PaSQIT progress report
Nested organisational structures	Groups of clinicians within clinical units within hospitals or integrated delivery systems	MDH is a complex organisation with multiple and varied component departments, units, multi-disciplinary teams, professional groups and healthcare and management structures
Salient hierarchical structure	Professional status hierarchy (within disciplines: subspecialists, specialists, generalists; among disciplines: physicians, nurses, paraprofessionals)	A number of codes generated refer to the importance given by individuals and teams at MDH to senior members in the hierarchy both in terms of authority (e.g. for endorsement, approval and support) and also expertise (both technical and managerial).
Powerful professional norms	Value autonomy Respect status and expertise	A repeatedly highlighted issue was the pervasive power struggle between the nurses and doctors. Interviewee 23 however commented that this is less marked where the different professions need to work closer and for longer periods of time together and in other specialised wards where the professional status of nurses is raised especially because of specialisation (Interviewee 20).

Table 12 ***(continued)***

Construct	***Definition***	Additional points	**Applicable findings and MDH context (extracts from this research project)**
Psychological safety	*The degree to which people view the environment as conducive to interpersonally risky behaviours like speaking up or asking for help*	Implications for clinician willingness to ask for help or report mistakes—and thus for patient safety and quality of care	The pervasive "'blame culture' and the attitude that 'if you fail then it's your fault'" transcends all levels of hospital workers (Interviewees 18, 22, 24 and 25). The re-introduction of a new incident reporting system albeit under a different format was very divisive for the group. On the one hand, it was acknowledged as essential and central to the PaSQIT objective. On the other hand, it was viewed as impossible to implement given the MDH climate and prevalent 'blame culture' (Memo attached to report of a PaSQIT meeting that took place in December 2013).
Work type	*Salient differences in the categories of work within the industry context*	e.g., cardiac surgery, oncology, paediatrics, emergency care, etc.	Safety is more prevalent in the Dept. of Anaesthesia than in other clinical areas within MDH (Interviewee 22). No dissemination of knowledge generated was conducted except perhaps at specific departmental levels through departmental meetings (meetings more frequently held in the Surgery, Orthopaedics, Cardiac Departments) (Interviewee 7).
Hierarchical status	*The degree of authority and respect afforded to individuals based on their position in a social system*	Status is highest for subspecialists, then specialists, then generalists; Status is highest for physicians, then nurses, then ancillary care providers	Healthcare professionals tend to view specialisation as an aspirational aim (PaSQIT meeting report November 2013). The PaSQIT members composition remained highly skewed towards the medical profession throughout. The confidence of the non-medical professionals is not high enough and needs to be elevated if they are to be able to impinge at all on the medical profession's dominance (hegemony) (Interviewee 1).
Leadership effectiveness	*The degree to which people respect and value their leaders in a social system*	Ratings of the effectiveness of the clinical leaders of various patient care units	Most clinical leaders have problems with delegating and they get 'bogged down' with operational issues as a result (Interviewee 16). Hospital leaders are "overwhelmed and overtaken with operational and crises issues and tends to micro-manage them … get 'bogged down' with operational issues and lack the time and energy to focus on strategic issues and development (Memo attached to PaSQIT meeting report January 2015).

Adapted from Table 1 and Table 2 of Edmondson et al., 2016 (pp. 67 and 71)

8.3.4 The effect of leadership on involvement in teams

Comprehending the conditions that empower employees in healthcare organisations to circumnavigate the "intense, varied, and complex needs of their organisations and constituencies is critical to their own career success and to the well-being of those they serve" (Edmondson et al., 2016: 80). Nowadays, healthcare professionals need to deal with a constant high rate of change in medical knowledge. Nembhard and Edmondson (2006: 942), surmise that this is mainly the result of three forces, namely increasing knowledge, specialisation and interdependence. Individuals cannot singlehandedly capture all of the emerging knowledge in a timely manner and patients are simultaneously increasingly managed by different healthcare professionals and specialists requiring the development of patient care plans decided at the multi-disciplinary level.

Despite all of the above reasons, team-based quality improvement efforts are often hindered by factors that include the fact that healthcare operates within a high stress environment where stakes are indisputably high and risk taking is correspondingly inhibited, assimilating expertise and knowledge from different professional backgrounds is always very challenging, and hierarchy positions are deeply ingrained making critical communication within and across professional boundaries a difficult prospect to surpass (Nembhard and Edmondson, 2006: 943). All these issues support the findings in this study related to territorialism, intra- and inter-professional boundaries and the challenges faced in the functioning of multi-disciplinary teams including the PaSQIT itself.

The attitudes and behaviours of team leaders have been indicated as an important influence on the internal dynamics of a team which are in turn affected by team climate and learning orientation (Edmondson, 1999: 356). Most members in a team will be highly attuned to the behaviour of their team leaders. They will be well attuned to the leader's actions and correspondingly to what can be expected and acceptable in team interactions. Leaders that espouse authoritarian, unsupportive, or defensive stances engender an environment where team members are more likely to feel that speaking up in the team is risky.

Conversely, leaders that adopt more democratic and supportive positions and encourage a balanced debate increase the likelihood that team members experience greater psychological safety both with the team as a whole and also in the exchanges with different members (Nembhard and Edmondson, 2006: 947). These authors devised the term “leader inclusiveness” which was defined as “words and deeds by a leader or leaders that indicate an ‘invitation’ and ‘appreciation’ for others' contributions”. This construct encapsulates a leader’s efforts to include all members in the team deliberations and decisions especially when the opinions of some of the members may otherwise be un-captured and refers to both a leader’s coaching behaviour as well as the adoption of participative leadership characterized by consultation, shared decision-making and delegation of authority to peers and subordinates (ibid.).

Team leaders interviewed, interacted with and observed in this study conformed to the definition of leader inclusiveness to varying degrees but it is evident that a number of them find the tenets of participative leadership challenging in practice. Nembhard and Edmondson (2006: 958-959) concluded that higher leader inclusiveness can assist to overcome the inhibitive effects of hierarchical status in healthcare organisations and teams. Consequently, they recommend that in addition to providing training and opportunities for staff to speak up, organisations need also to concentrate on providing training for team leaders to help them adopt higher leader inclusiveness behaviours.

8.3.5 Job burn-out and other human factors

A recurrent feature in the findings of this research project was concerned with the reported and witnessed heavy work burdens of several of the actors that the researcher interacted with during the fieldwork. Chronic exhaustion, cynicism, and inefficacy (collectively grouped as features of ‘job burn-out’) have been shown to cause enduring distress to employees and undermine organisational performance. In particular, “cynical attitudes toward work have been found to discourage employees from investing their energy in the enterprise or to be inspired by their experiences at work” (Leiter et al., 2013: 959).

Lowering the capacity of staff members to be energetically involved within the organisation can result in huge costs on personal self-actualization and organisational output and quality of services (ibid.). A number of initiatives have been examined and found to be effective to enhance the quality of work life and to reduce the risk of job burn-out. These included options to improve the flow of coordinated and relevant information, skills discretion, stability and predictability, adequate resourcing for the various tasks in hand and initiatives that improve collegiality (Leiter et al., 2013: 970). The options presented above can all be considered as viable lines of action that can be taken to counteract the various and frequent symptoms that indicate the risk of job burn-out found within the MDH environment.

A 'how to guide' published by the Health and Safety Executive (HSE) of the UK recognized that work stress is a significant contributor in several adverse events that occur in healthcare. People have been shown to perform differently in circumstances compounded by high pressure levels. During such times, sensitivity to unfavourable human factors is intensified, particularly those that are most likely to modify perception and cognitive functions. The HSE report registered a number of common human factors that can increase these risks. These include mental workload, distractions, the physical environment, physical demands, device/product design, teamwork and process design (HSE, 2009: 5).

A well-known human factors model is the Swiss Cheese hypothesis promoted by James Reason (Reason, 2000: 769). This model posits that in any system there are several levels of defences. However, there are also 'holes' (latent conditions) in each level. These gaps may be caused by such factors as poor design, limited or lack of resources, lack of training and senior management decision-making procedures. A window of opportunity for a patient safety incident appears when latent conditions become aligned and compounded by 'active errors' (staff not doing the right thing even when they know what the right thing is).

The HSE report of 2009 mentions two main lines of evidence that explain why staff may deliberately contravene the rules: when there is a perceived benefit such as saving time and when potential consequences are assumed to be absent or minimal. The larger the

benefits and lesser the probable consequences, the more frequent it is “for people to ‘migrate’ towards working in ways that they know to be wrong or that break the rules. Over time these ways become normalised and are integrated into the culture – ‘This is how we do it here’” (HSE, 2009: 7-8). This is in line with a statement made by Interviewee 22 in this research who said that “in the case of a minor mistake, sub-optimal practice or ‘day-to-day omission’, this tends to sometimes become ‘ingrained’ in the way things are done, for example through short cuts”.

8.3.6 Organisational culture and ‘safety culture’

Culture can be described in vernacular terms as "the way we do things around here". Culture creates the setting within which people assess the suitability of their behaviour. Correspondingly, organisational culture is a strong influence on the behaviour and performance at work of its human members. The Health and Safety Executive (HSE) of the UK contends that the “'Safety culture' is a subset of the overall organisational or company culture” and that an organisation's culture can have as big an influence on safety outcomes as the safety management systems in place within an enterprise.

The HSE also argues that although the inclination of employees to comply with rules or act safely or unsafely is recognized as a relevant component of the safety culture, an even more significant determinant is the culture and style of management adopted by the organisational leaders. Examples mentioned include a natural and unconscious bias for production over safety and quantity over quality, a tendency to focus on the short-term and being highly reactive at the expense of proactive and strategic implementation. Ultimately, a successful safety culture is the result of a combination of “good leadership, good worker involvement and good communications” (Hse.gov.uk, 2017) and a list of the largest influencers of a safety culture within an organisation includes:

- management commitment and style;
- employee involvement;
- training and competence;
- communication;
- compliance with procedures; and
- organisational learning (ibid.).

All these factors have been repeatedly highlighted in the data collection and analysis conducted for this research as facilitators or deterrents to the development of positive organisational dynamics in the MDH setting. In most cases, there are both facilitating and deterring forces at work concurrently and often counter-productively. For example, while the inception of PaSQIT was a strong sign of the hospital's management commitment and drive to promote quality improvement and patient safety, the persistent shortfalls in the 'promised' support, unrealistically high expectations and on one occasion the rapidity by which the team was temporarily and unilaterally dissolved in the summer of 2014, by the CEO at that time, were deleterious to the PaSQIT's progress (both from the point of view of its members as well as of other persons working in the hospital and at the Ministry for Health/DoH). Another example of the organisational culture which is counterproductive is the frequent practice of taking action outside a set strategy such as in the area of the training opportunities offered by the hospital. This is illustrated by the submission of Interviewee 13 who said that training initiatives are not awarded within an organisational plan and instead there is an element of 'who shouts loudest' succeeding more often to achieve her/his training aspirations with the result that the learning achieved would either have relevance only for the professional concerned or it would be retained solely by the individual involved.

In conclusion, the degree of facilitation or deterrence of each of these factors is impacted by whether and to what degree they are present or absent. Moreover, these factors are inter-dependent on each other such that an improvement or otherwise on one of them will affect a similar change in the others.

8.3.7 External factors influencing healthcare organisations

An organisation can be the recipient of and affected by several cultural influences from outside the institution and the socio-political context in which it operates (Fleuren, Wiefferrink and Paulussen, 2004: 108). The direction of these factors may be congruent to or at odds with the internal organisational culture (Davies, Nutley and Mannion, 2000: 114). Literature documents quite a few notable environmental or external elements that have been found to have an impact on healthcare organisations (Davies,

Nutley and Mannion, 2000: 112). Fennell and colleagues (2010: 76) posit that these factors can be grouped into two broad categories of environmental constraints: technical and institutional.

Technical factors include such features as the economic health of the environments in which they operate, the demographic properties of population they serve, the geographic setting of the institution (such as urban versus rural; regional versus national). They also comprise technological issues such as the infrastructure and treatment facilities available and the volume and quality of the human resources employed by the facility (Fennell and Alexander, 1993: 101).

On the other hand, institutional features encompass the social and political structures to which organisations must conform. These consist of the opinion of the public, legal support and structures, the expectations and ideologies of the component professionals and the various regulatory structures that impinge on the organisation, as well as funding and entitlement principles and mechanisms (Fennell and Campbell, 2007: 7) and structures that control access to resources. Input from these factors may be explicit as in the issuance of a license from a regulatory body or normative (for example comparative benchmarks between hospitals). These factors have been found to be at least indirectly related to an organisation's performance (Fennell et al., 2010: 76).

Additionally, Greenhalgh et al. (2004: 608-610) discuss the influence of a number of external issues that have an impact on the decision-making of organisations to adopt, implement and maintain innovations. They include factors such as informal inter-organisational networks (on how other comparable organisations deal with an innovation) and international spread initiatives (the effect of formal networking initiatives such as on quality improvement at the EU level). They also mention 'political directives' as in politically mandated 'must-dos' that increase the likelihood for action by the organisation but not necessarily its capacity. They conclude that such directives (or the fear of them) may actually result in the diversion of activity away from change, improvement and innovations as "organisations second-guess what they will be required to do next rather than focus on locally generated ideas and priorities".

Almost all of external factors mentioned in the above commentary are consistent with the findings of this research. A notable exception is the informal inter-organisational network because of the unique peerless situation of MDH in Malta. However, it needs to be recognized that MDH is affected by the strategies implemented in the other healthcare facilities in Malta particularly the primary healthcare (PHC) services. Patient management and human resources practices in the latter have a substantial impact on patient and professional mobility between the two sectors. One of the frequently cited reasons for the high patient referral to hospital is the persistent under-capacity of PHC. Additionally, while it has been noted that professionals tend to leave MDH for PHC and not vice versa (Interviewee 12).

8.3.8 The wisdom of learning from failure

> Complex, well defended, high technology systems are subject to rare but usually catastrophic organisational accidents in which a variety of contributing factors combine to breach the many barriers and safeguards. To the extent that healthcare institutions share these properties, they too are subject to organisational accidents.
> (Reason, 2004: ii28)

Edmondson (2011) stated that even though the "wisdom of learning from failure is incontrovertible", the organisations who actually do it well are "extraordinarily rare". Edmondson asserts that this is a result of two prevalent misconceptions, namely that failures are always bad and that learning from failures is uncomplicated and straightforward. She continues that failures are "sometimes bad, sometimes inevitable and sometimes even good" and that "learning from organisational failures is anything but straightforward".

In most cultures, organisations' and even households' failure and fault are practically indivisible. Young children soon learn that confessing to a failure generally results in also getting the blame. This early lesson is ingrained in most people and is reflected in the small number of organisations that have successfully embraced a culture of psychological safety where the benefits of learning from failure are truly recognized and actuated.

Edmondson (2011) posits a “spectrum of reasons for failure” whereby at one end there are the truly blameworthy actions such as deliberate deviance and at the other extreme there are the actually highly praiseworthy malfunctions such as a failure which is a result of thoughtful experimentation. Between these two extremes there are failures such as those resulting from inattention, lack of ability, process complexity and uncertainty. When analyzing the causes for such failures the result may indicate that the manager may be more at fault than the employees or subordinates. She concludes that leaders alone can create and reinforce a work environment that offsets the blame culture, making employees feel both at ease with and accountable for coming out with and learning from failures. They need to recognise the “inevitability of failure in today’s complex work organisations” and make the paradigm shift to counteract the deceptive contradiction of wanting to “neither discourage the reporting of problems nor to create an environment in which anything goes”.

In many ways, the hypothesis promoted by Edmondson is also visibly at work within the MDH environment as discovered during the course of this research. This is most notable from the aspect of the wish professed by many for the hospital to be able to learn from reported adverse events and mishaps and which is at the same time seriously countered by the pervasive culture of fear and blame. The reality that the hospital needs to seek lessons from the investigation of safety alerts is widely acknowledged but the ‘tort’ culture provides a big obstacle to any progress in this regard (Interviewees 24 and 25). Organisational and external factors can be both highly instrumental as they can be directed to affect change such as in the promotion of a safety culture and the suppression of the blame mentality. For example, the institution of the required changes in the national legislation to protect investigations performed for learning purposes from medico-legal processes and the support of hospital leaders (such as clinical chairpersons in the case of Mortality and Morbidity meetings) with the provision of dedicated time and administrative support by the hospital organisation will help immeasurably towards achieving the desired developments.

Reason (2004: ii28) registers three distinctive features of healthcare organisations in comparison with other high technology, complex and highly hazardous enterprises such

as nuclear power generation and transport systems. Firstly, there is a major scarcity of in-depth reporting and investigation of incidents and this poses a significant challenge for any external or internal review to identify organisational causes and deficiencies. Secondly, healthcare is distinctly characterized by some unique features such as the "enormous diversity of its operations and equipment, the frequency of emergencies, the degree of uncertainty, and the vulnerability of patients". Lastly, whereas in other industries, a few individuals serve a large number of end users, in healthcare, services are provided on a one to one or a few to one basis.

He concludes that because of the frequent unexpected, solitary, and very personal transactions in healthcare provision, both the correction of the defective barriers and regular audits of all the system's defences, as well as "instilling informed vigilance and intelligent wariness" in those at the front-line of service provision and building an organisational culture that is demonstrably receptive and responsive to unsafe conditions are essential. Only when both paradigms are working together and in synergy in healthcare organisations can this "error wisdom be cultivated" (Reason, 2004: ii32).

This research has shown that a substantial proportion of clinical and management leaders and professionals are aware of what needs to be done so that the knowledge that can be accrued from the investigation of reported and identified hospital failures is channeled into informing strategies for patient safety and quality improvement. Initiatives and goodwill abound but execution frequently falters due to several reasons that include the heavy work burdens of most professionals within the hospital. These factors are further compounded by the externally imposed pressures to continuously increase output (such as number of surgical operations and reductions in the waiting lists for out-patient clinics) because MDH is the only hospital of its size and wide scope on the Islands. One solution which is often promoted but still awaits substantial implementation effort is the devolution of hospital services (where applicable and safe to do so) to the primary and community healthcare services. This off-loading may eventually allow the hospital to streamline, manage and plan services which truly require hospital care and consequently permit hospital professionals and management

to focus more on strategy, clinical governance, organisational learning and development.

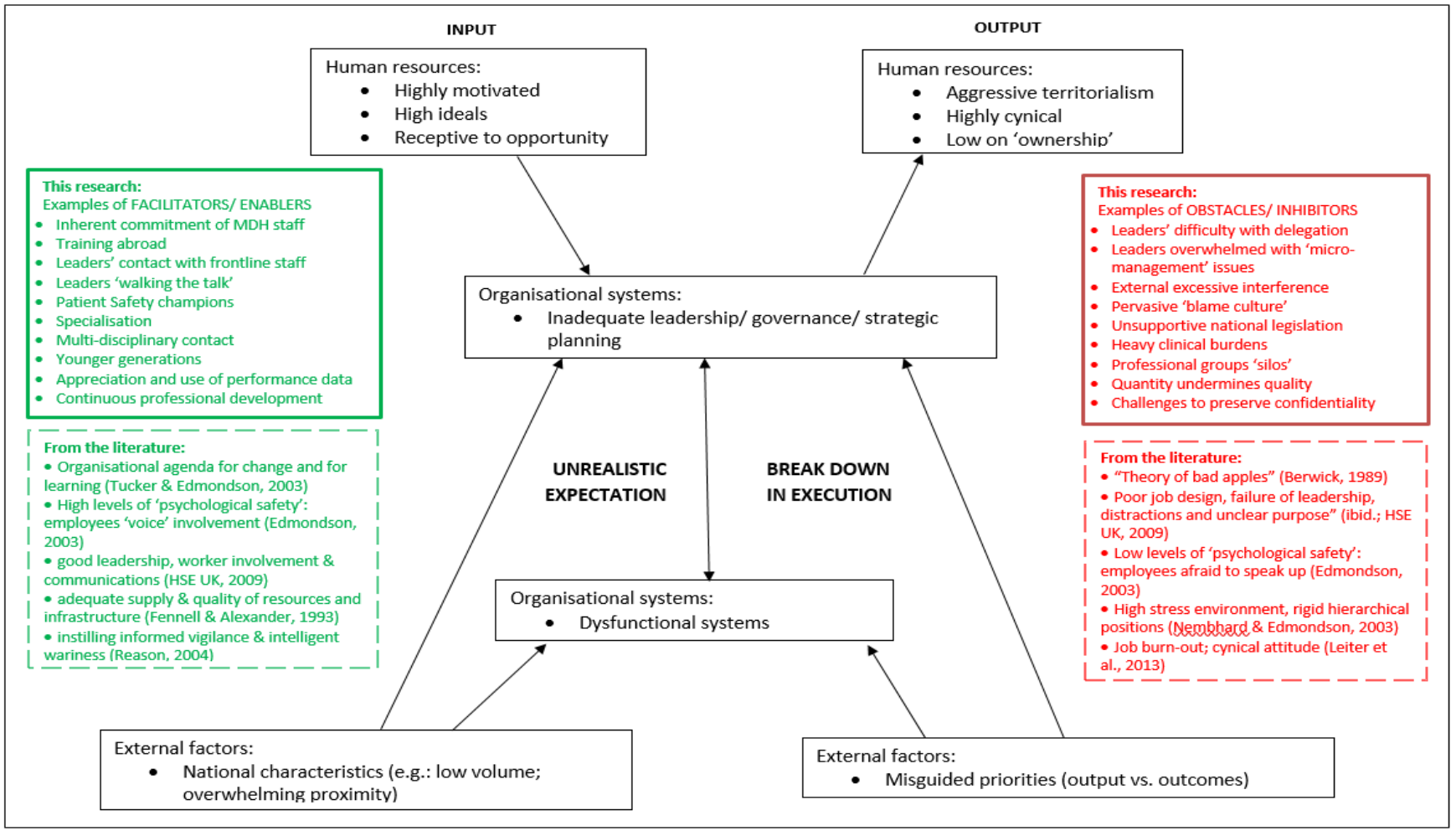
8.4 Conclusion

In this chapter, a theoretical framework generated from the data collection and analysis of this research was introduced and discussed. This framework presents the twelve major categories that emerged from the data by grouping them into five different groups and devising connections between these clusters. A process could be discerned whereby different characteristics of the human resources at MDH were transformed as they were subjected to and experienced working within an organisation that has a number of inherent challenges and is also affected by identified external factors. This process was noted as forming a vicious cycle and is self-perpetuating unless well led and supported efforts are made to break it at several points simultaneously.

A literature search was conducted following the derivation of the theoretical framework. In the main the current literature that is concerned with different aspects studied in this enquiry corroborated the findings emerging from the data collected and analysed in this research. Several salient sections of this literature review were presented and discussed in this chapter. Figure 9 (on page 218) shows the theoretical framework presented at that start of this chapter (Figure 8 on page 199) with additions of notable examples of the themes in practice generated by this research and corroborated by the literature presented in this report.

The following chapter will be drawing a number of conclusions on this study and will be introducing and discussing recommendations that can lead to the desired organisational growth at MDH guided by its unique situation and identified specific features as well as relevant and corroborating published experiences and literature from proponents of best practices in the fields of organisational learning and development.

Figure 9: Theoretical framework with additions of notable examples of the themes in practice extracted from the findings of this research and the literature presented in this report



CHAPTER 9: CONCLUSIONS AND CONTRIBUTIONS TO KNOWLEDGE

9.0 Conclusions

Effective healthcare organisations depend on a trained and motivated workforce to carry out their functions and to stimulate and sustain ongoing development and achieve their goals and continuously improve the quality and safety of the services they provide.

Continuous improvement necessitates a sustained commitment to learning. Real improvements can only happen when an organisation is predisposed to learn new lessons and act on them. Resolving a problematic issue, initiating a new service, and reforming procedures all entail envisaging the world from different perspectives and proceeding accordingly. Without learning, organisations and individuals will simply continue to repeat old and flawed practices and any apparent "change remains superficial and cosmetic and consequently developments are either fortuitous or short-lived" (Garvin, 1993: 78).

This enquiry has studied several aspects of the MDH organisation over a period of almost three years. The overall aim was to elucidate salient factors that are working towards either supporting or inhibiting change and learning through close contact with several members of the hospital's workforce. Change was viewed from the predominant aspect of continuous improvement especially with regards to the quality of the services provided and patient safety.

Applying meticulous procedures guided by grounded theory approaches to data collection and analysis for both arms of the research fieldwork, the initial more than 800 first cycle codes that were generated were gradually collapsed during a number of subsequent coding cycles into twelve major categories. These categories were in turn configured with plausible connections to form the theoretical framework that was presented in Figure 8 (page 199) and Figure 9 (page 218).

In continuation with earlier positions on the use of grounded theory approaches for data collection and analysis, Dey (1999: 9) recommends that during the phase of concluding a research project, the process of integrating categories and the formation of a central

theoretical framework "could crystallize around a 'core' category – otherwise described by Glaser and Strauss as the main 'story line'".

Further reduction and focus as advised by Dey (1999: 42-44) on the basis of the theoretical framework was completed with the resultant identification of two inter-twined core categories:

A. Supply of highly talented human resources
B. Transformation of human capital by organisational and external factors

Reflecting on the findings and analysis of this project led to the development of a number of recommendations for action to direct and assist the hospital towards registering discernable and incremental progress in the achievement of its enduring objectives for continuous improvement.

9.1 Recommendations for action

Learning in organisations is frequently viewed as a process that unfolds over time and that it is related to knowledge acquisition and improved performance. An organisation that aspires to become a learning organisation needs to attain the skills for generating, acquiring and disseminating knowledge and for altering its collective and individual members' behaviour to reflect new knowledge and understandings (Garvin, 1993: 79).

Garvin (1993) and later together with other colleagues such as Edmondson and Gino (2008) studied several organisations that were considered successful in terms of meriting the claim that they have achieved the status of a learning organisation by showing that they have become capable at converting new intelligence into new ways of performing. These studies resulted in the extraction of a number of distinctive policies and practices that were found to be responsible for this accomplishment.

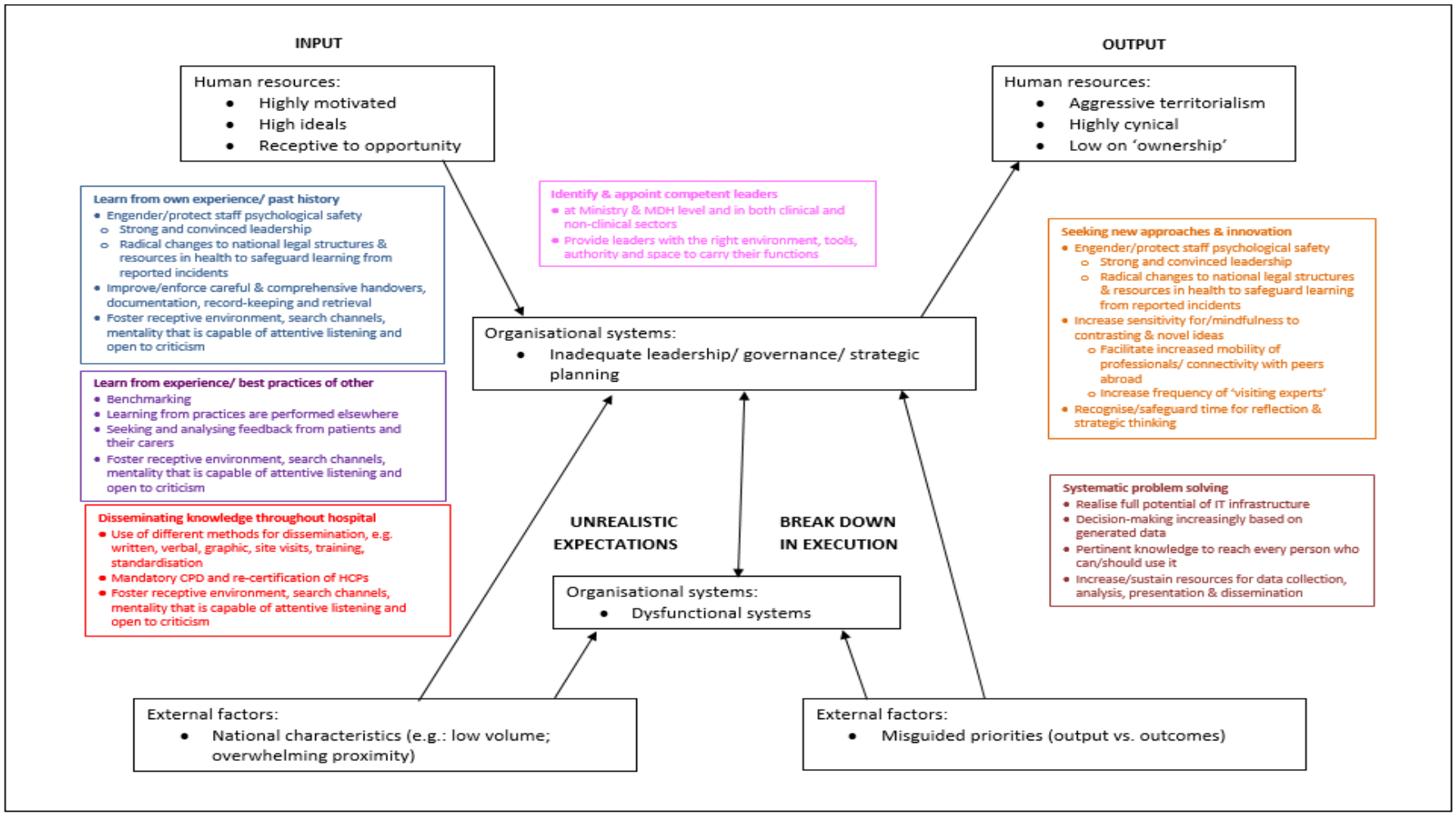
These characteristics that were termed the "building blocks of learning organisations" include:

1. Systematic problem solving
2. Experimentation with new approaches and innovation
3. Learning from own experience and past history

4. Learning from the experience and best practices of others
5. Disseminating knowledge quickly and efficiently throughout the organisation (ibid.)

Each of these themes require the attainment of changes in the mindsets, tools and appropriate behaviour patterns and need to be incorporated in the day-to-day performance of the organisation and not only applied on one-off situations. Furthermore, examination of an organisation through the perspective of each of these 'blocks' can be used to elicit facilitators and inhibitors present in the organisation's dynamics that can either assist or impede progress towards the organisational capability to achieve them. This research has sought to accomplish this main objective with respect to Mater Dei Hospital. The following recommendations were developed from the interpretation of the findings and analysis of this research and will be presented on the basis of the framework provided by the above 'building blocks'. Figure 10 shows the theoretical framework presented and discussed in Chapter 8 with the superimposition of each of these five building blocks and another separate theme dedicated to the identification and appointment of leaders with examples of the different measures elaborated in the following sub-sections 9.1.1 to 9.1.5.

Figure 10: Theoretical framework with additions of recommendations for actions arising from the interpretation of the findings and analysis of this research



9.1.1 Systematic problem solving

Activities undertaken for problem solving are integral to the philosophy, approaches and methods of the quality movement initially promoted in the 1950s by William E. Deming and others. Problem solving in this paradigm necessitates that decision-making is made on the basis of data and not intuition or assumptions. The process entails correctly identifying the problem, planning and implementing action, assessing change and restarting the cycle. The required tools and processes may be in place but what is frequently the missing link is the acquisition of the essential conviction for the need of regular adoption of the necessary disciplined thinking and attention to detail. This mindset is essential for the practice to become ingrained in the psyche of the hospital management and workforce.

To facilitate the adoption of systematic problem-solving activity and mentality, the data generated by this research indicates the emergence of the following proposals:

a. The review and a more complete and expedited implementation of the IT strategy for the hospital. The basic infrastructure is evidently in place but its full potential is still not being utilized and it needs to substantially cascade to increase use and application by all levels and particularly by the frontline staff.
b. Decision-making needs to be more frequently undertaken based on this paradigm with a view of eventually using it for all strategic decisions. Currently, as documented in several instances both in the interviews as well as in the AR diary, a significant number of strategic decisions are still taken based primarily on intuition and unfounded assumptions. Unless this is taken up "the organisation will remain a prisoner of 'gut facts' and sloppy reasoning, and learning will be stifled" (Garvin, 1998: 80).
c. Resources for data collection, analysis, presentation and dissemination need to be increased, better supported and safeguarded. The appreciation of the effort required to collect and present accurate and detailed data and information is still too low at all levels (leadership, management and clinical) both at the DoH and MDH.

9.1.2 Experimentation with new approaches and innovation

This activity entails regular scanning for, investigating and testing of new knowledge and practices. A methodology similar to systematic problem solving is most frequently recommended. However, this activity is typically more driven by opportunity and expanding horizons than by identified difficulties and problems.

Together with learning from own past experience this activity requires an environment that is both inductive and supportive of learning. Concurrently, this activity together with learning from the best practices and experience of others requires increased contact with and exposure to peers both at the national and international levels.

The following recommendations will help towards making MDH more susceptible to seeking, implementing and evaluating innovation and change.

a. Engender and protect the psychological safety required for staff members to feel unthreatened, comfortable and protected to speak up and forward their suggestions for improvements and change. A notable proportion of the interviews and observations documented by the researcher in the AR journal indicated that psychological safety levels are rather low in the general MDH environment and indeed at the national level, where the opposite notion of the blame culture is still visibly highly pervasive and dominant. Strong and convinced leadership both at the DoH and MDH levels as well as at the political level to allow and support a gradual change process in this regard are critical (Edmondson, 2011). It also requires radical changes to the legal system to include provisions that support and protect reporters that notify observed and experienced mishaps and adverse events as in the SALearn system introduced in 2015. Supporting the growth of psychological safety in healthcare in Malta is one of the areas in which learning from the experiences of other hospitals and countries abroad can yield considerable benefits.
b. Learning is not only about correcting errors and resolving problems. Learning is also positively propagated when people can become sensitive to and mindful of opposing and novel ideas. “Recognizing the value of competing functional outlooks and alternative worldviews increases energy and motivation, sparks fresh thinking, and prevents lethargy and drift” (Garvin, Edmondson and Gino,

2008: 112). To a large extent, engendering psychological safety goes a long way towards facilitating these activities as well. Another imperative set of actions involves the facilitation of mobility of professionals to meet, connect more freely and frequently and communicate with peers and experts working in other institutions locally and abroad. This mobility is perhaps more important for Malta because of its small size and insularity. Mobility can take place either physically or through virtual means by supporting employees to attend and participate in for example conferences, training programmes and attachments and research collaborations.

c. Time for reflection. All too often, workers especially managers and professionals are judged by the absolute number of hours that they spend at work and the tasks that they complete. However, as Garvin, Edmondson and Gino (2008: 113) point out, "when people are too busy or overstressed by deadlines and scheduling pressures, their ability to think analytically and creatively is compromised". Heavy workloads and overwhelming work burdens were noted as recurrent characteristics of a high proportion of both managers and professionals working at MDH. On the other hand, it has been also frequently demonstrated that several individuals do their utmost to get involved in initiatives that requires them to perform functions over and above their regular call of duty. However, in several cases the end result of these persons performance in these projects is below (realistic or unrealistic) expectations leading to all round frustration and disillusionment. Time for reflection and strategic thinking needs to be recognized as essential for organisational development and quality improvement and dedicated or 'protected' time for these purposes that may involve re-organisation of duties applied accordingly.

9.1.3 Learning from own experience and past history

A frequent quotation from the works of a famous early 20th century philosopher, George Santayana (1863-1952) says: "Those who cannot remember the past are condemned to repeat it". Organisations pursuing development and improvement must regularly and systematically assess their successes and failures, document lessons learnt and

disseminate them in a format that is understandable and accessible to their employees (Garvin, 1993: 83). “The knowledge gained from failures [is] often instrumental in achieving subsequent successes… In the simplest terms, failure is the ultimate teacher” (Maidique and Zirger, 1985: 299). Garvin (1993: 83) attests that learning from the past requires a specific mindset that allows an organisation to “to recognize the value of productive failure as contrasted with unproductive success. A productive failure is one that leads to insight, understanding, and thus an addition to the commonly held wisdom of the organisation. An unproductive success occurs when something goes well, but nobody knows how or why”.

The actions described for 9.1.2 are also relevant and useful for the achievement of progress in this area. An additional recommendation that can be construed as more specific to increasing the organisational capability to learn from its past is the issues of documentation, record-keeping and retrieval and handovers. Learning from previous experiences must not only rely on individual and collective memory that can be passed verbally from one person to the next. The cornerstone is to keep comprehensive and retrievable records that document events, investigations, lessons learnt, action taken and subsequent evaluations of any changes implemented. Unfortunately, practices requiring documentation and handovers are not a strong point of several aspects of the hospital’s organisational structures as demonstrated in several instances throughout the findings of this study. A strong direction towards increasing, assisting and even mandating these practices, understanding their value and providing repositories that allow facilitated recovery of the necessary records when required needs to be promoted especially at the different levels of senior hospital management; both clinical and non-clinical.

9.1.4 Learning from the experience and best practices of others

Apart from self-reflection and self-analysis, valuable learning can also be acquired and assimilated when organisations and their component members gain new understandings by searching for information and experiences outside the confines of their institution. Lessons can be gleaned from both organisations within the same as well as from organisations beyond their industry’s domain. Benchmarking is a

commonly cited tool used for this purpose and can be defined as “an ongoing investigation and learning experience that ensures that best industry practices are uncovered, analysed, adopted, and implemented” (Garvin, 1993: 83). Organisations mainly benefit from learning how practices are performed elsewhere and not from the actual results or outcomes. It is particularly important to bear this in mind especially when considering benchmarking comparisons of MDH with other hospitals abroad because of the former unique national context.

Another important source of information is clients’ feedback; patients’ responses in the case of a hospital such as on their experience and satisfaction with healthcare services provided and received. Customer care services at MDH have undergone substantial development over the past few years but have generally remained rather solely reactive as the receiving outlet for customers’ complaints. A more proactive stance needs to be promoted such as through the application of frequent and regular patient satisfaction surveys and outreach initiatives to learn from patients, their relatives and the general public.

9.1.5 Disseminating knowledge quickly and efficiently throughout the organisation

The impact of lessons learnt and new acquired knowledge can be maximized when they are widely distributed and not when they are retained by a restricted group of people. Literature demonstrates a wide assortment of methods that can be used to stimulate and hasten dissemination processes. These can include written, verbal and graphic presentations and reports, site visits and personnel rotation programmes, training and standardization procedures.

As described in some of the interviews particularly by Interviewee 23, staff at MDH while on the one hand professing a need for continued professional development (CPD) has been observed to frequently refrain from participating in such events and attendance is limited to smaller numbers than would be expected and desired. Another observation emerging from the findings of this research shows that dissemination activities (similar to other activities such as documentation) are often and consistently placed low on the priority list of duties. For example, even when visibility of PaSQIT activities was considered of utmost importance to ensure the group’s viability, the dissemination of

relevant information tended to falter because of challenging time and resources constraints.

Mandatory CPD and re-certification of professionals at regular time intervals are being introduced in several European jurisdictions and should be seriously considered for introduction in Malta. Appropriate and adequate time and resources required to enable and ensure gradually increasing dissemination initiatives need to be authorized and supplied with the visible and full backing of the hospital leadership.

Finally, numerous examples of effective leadership were documented, experienced and observed during the course of this research. Other instances showed the effect of ineffectual leadership and leadership attempts that were impeded by a number of factors. These include external factors such as the non-autonomous status of MDH and the reality that like most other people within the organisation senior management is frequently bogged down by micro-management issues at the expense of spending adequate time and energy to strategic planning and implementation. Identifying and appointing promising and competent leaders at the topmost levels of the Ministry and the hospital and also at several different levels in both the clinical and non-clinical sectors needs to be complemented with an increased momentum at providing them with the right environment, tools, authority and space to allow them to truly implement their important functions. One of their more important roles should be to lead the hospital to foster a climate that supports “open-minded questioning, thoughtful listening, consideration of multiple options and acceptance of multiple points of view” (Garvin, Edmondson and Gino, 2008: 116).

9.2 Contributions to knowledge

In the preparatory phase prior to the elucidation of the main objective for this research project, the researcher conducted an extensive literature review in different academic domains that included organisational learning, patient safety and quality improvement in healthcare services, adverse events, medical errors and the human factor in organisations. The exploration for the objectives of this study also assisted in the preliminary formulation of what would be the possible value of the added knowledge

that this enquiry could help to generate and consequently contribute to these academic fields separately or together.

Following the completion of the data collection and analysis the researcher conducted another literature search to connect with extant academic knowledge that corroborated or challenged the main findings of this enquiry. The latter search process also helped to consolidate and demonstrate the additional knowledge gained from this original research project particularly through the application of existent knowledge to a specific situation characterized by the unique setting of a major healthcare organisation in a small island nation and the new knowledge gleaned from the presentation of different hitherto undiscerned perspectives.

The notions of Organisational Learning and Learning Organisations have become very prominent and have flourished over the past three to four decades (Wang and Ahmed, 2002: 8). They both evolved from the concept of learning in individuals and the main distinction between them is that the former is more predominantly used by academics and the latter is the preferred term for practitioners (Easterby-Smith, 1997: 1107). Organisational learning is viewed as a powerful tool to use in activities aimed at ameliorating the performance of an organisation. Both academics as well as practitioners are interested in this phenomenon because of its potential and relevance for inclusion in the strategy and operations of organisations of different types and scope. Over time a substantial volume of literature that debates key ideas and differences of opinion has been steadily accumulating (Easterby-Smith, Crossan and Nicolini, 2000: 783).

Some of these ideas are well established such as the respective values of single- and double-loop learning, the contrasting concepts of theories-in-use and espoused theories and the corresponding Models I and II of organisational learning (introduced by Chris Argyris and David Schön in the 1970s). Others are the basis for ongoing debates such as the territorial boundaries between competing concepts exemplified by the tension between the ideas of organisational learning and knowledge management and the growing recognition of the role of power and politics in learning within organisations (Easterby-Smith, Crossan and Nicolini, 2000: 788).

The debate surrounding levels or units of analysis was mainly concerned on whether organisational learning is merely the sum of what individuals learn within organisations or on whether it amounted to more than an additive result. Fiol and Lyles (1985: 811) advanced the suggestion that the procedures, structures and systems in an organisation have an effect on individual learning and Hedberg (1981: 6) suggested that learning is stored in the procedures, structures and systems of the organisation. Other proponents tend to concentrate on the role of the group level, such that the levels of analysis have been extended to research learning between organisations and communities (Lucas and Oglivie, 1999: 611). These arguments are supported by the social constructionist perspective that suggests that learning occurs and subsequently knowledge is created mainly through conversations and social interactions between people (Nicolini and Meznar, 1995: 743). A noteworthy result of these developments is the appearance of new terms for new levels of analysis such as the 'communities of practice', 'activity systems' and 'ecologies of knowledge' (Easterby-Smith et al., 2000: 788).

The data collected and analysed in this research project can be visibly linked to the above-mentioned concepts of Organisational Learning and the ensuing debates in this arena. The value of the 'grounded data' of this research can be compellingly ascribed to the demonstration of the consequence of the organisational structures and systems that can determine the effectiveness of individual and group/community learning in the particular setting from which they were generated. This data showed that the organisation will not benefit from the maximum possible potential supplied by the capabilities and motivations inherent in the human resource available when the organisation operates through dysfunctional systems, does not uphold adequate governance and leadership and is embedded within an external context that frequently overrides its choices of strategies for development and operational priorities. The theoretical framework that was developed by the researcher from this data can be used to explain how these different actors can be interconnected and indicate sites that can be targeted to break the vicious cycle. The recommendations presented in sub-section 9.1 above are meant to propose practical examples of actions that are specific to the MDH context and that can help realize the target of optimizing the use of the capacity of the organisation's dedicated and talented human capital.

Another important issue for debate in the field of organisational learning is concerned with the dilemma of whether to use positivist or interpretive methods in the studies on organisational learning. This discussion seems to resonate with the deliberations on the distinction between cognitive and social constructionist theories. A need to provide accurate descriptions of organisational learning tends to favour the positivist approach through the development of valid and reliable measurement instruments. These studies are more adapted to take a 'macro' perspective and tend to regard the organisation or its component major sub-divisions as the primary level of analysis (Easterby-Smith et al., 2000: 788). Conversely, the study of phenomena such as the 'communities of practice' has led to proponents strongly arguing in favour of the use of qualitative methods such as participant observations and unstructured interviews. Studies employing this approach usually set the individual as the unit of analysis and the main objective is often to make sense of organisational events and phenomena (Boje, Luhman and Baack, 2000: 358).

In addition, there has been an accumulation of studies that use a combination of methodologies taken from both the macro/positivist and the micro/interpretative approaches. They typically focus on case studies and in so doing they follow the interpretative tradition to the extent that researchers collect data mainly from interviews and observation/participation. However, they also tend to focus on the complete organisation or on comparisons between similar cases or organisations. They can also include longitudinal designs, and accumulate data over a period of time and repetitively from the same participants. Finally, Easterby-Smith et al. (2000: 789) noted the divergent preferences for different approaches between European and North American researchers: the former tend to prefer the interpretative methods while the latter are more likely to employ quantitative methods. These authors however argue in favour of the adoption of a more pragmatic approach in that the choice of the appropriate methods should be more sensitive to the research problem at hand than to traditional backgrounds.

This research employed two distinct methodologies that are based mostly on the naturalistic and interpretative research paradigms. The qualitative paradigm was adopted for this research because it was understood that the whole phenomenon under

study involves a complex organisation with multifaceted interdependencies and system dynamics that cannot be reduced in any meaningful way to linear, cause and effect relationships and/or a limited number of discrete variables (Anderson, 2010: 141). The choice of methods and meticulous data collection and analysis employed by this enquiry add to the contribution to knowledge by providing authentic, in-depth and dialectical evidence generated from data 'grounded' and arising directly from the setting and assimilated longitudinally over the 30 months of fieldwork for this project.

Emblematic goals of healthcare organisations include improving patient well-being, handling larger case-loads with lower costs, attracting and retaining top quality staff, and training and retraining healthcare professionals. These objectives are reached through various activities such as patient admissions, delivery of care, recruiting and training human resources, buying and maintaining equipment, buildings maintenance, and the creation and implementation of a mission and strategic plan. The knowledge required to carry out these activities may be stored and disseminated in several different forms and locations, including IT systems, procedure manuals, in individual minds and collective memory.

Carroll and Edmondson (2002: 51) assert that healthcare organisations can improve quality and other outcomes by enhancing their capabilities for organisational learning. Organisations learn by creating opportunities for the flow of information and the creation of knowledge by means of a wide range of learning mechanisms including system and action reviews, problem investigations, performance appraisals and benchmarking (Popper and Lipshitz, 1998: 169).

The value and importance of research in organisational learning in healthcare organisations is to explore and offer frameworks that can assist complex interconnected and dynamic systems where all operational units are enabled to learn and perform their assigned roles in order to collectively advance safe patient care and consequently to inform the development and implementation of policies and procedures that can lead to sustained reductions in the incidence of adverse events and medical errors (Ratnapalan and Uleryk, 2014: 26).

This research managed to provide such a structure. The theoretical framework that was derived from the data collection and analysis of this study specifically depicts the

organisational strengths and weaknesses at MDH and how these are interconnected and interdependent. It can be used to design, implement and monitor actions aimed at counteracting the organisational and external factors that negatively impinge on the resourcefulness its human capital and learning capabilities. Furthermore, as explained by Dey (1999: 233) and Strauss and Corbin (1995: 278), the findings of this research may be also helpful and useful in other 'similar' organisations because "conceptually 'dense' theory can be sensitive to the range of (changing) conditions under which it can be applied" and "if elsewhere approximately similar conditions obtain, then approximately similar consequences should occur".

In conclusion, the main contributions of this research to extant knowledge are mainly concentrated on organisational management and particularly on the different aspects of what enables and hinders organisational learning in the unique setting of a major hospital operating in a small island nation. The key outcome is the formulation of a theoretical framework that was generated from collected, analysed and merged 'grounded' data arising from the in-depth unstructured interviews and documented practitioner-researcher experience using an action research approach. This framework provides a usable visualization of the elucidated enabling and hindering factors and how they influence each other and a practical schematic on which corrective activities can be designed, implemented and monitored. It can be realistically inferred that although this framework is aimed to have a specific impact when used for the organisational advancement of Mater Dei Hospital in Malta, this new additional knowledge can also be usable and inspirational to other organisations operating within comparable conditions. Finally, this research can be a source for stimulation for future studies that compare and follow-up these findings either over time at Mater Dei Hospital or in organisations working in similar, different or contrasting situations.

9.3 Final remarks

This research journey provided an invaluable experience and privilege for the researcher to meet with, discuss and interact with a sizeable number and diversity of professional members of the MDH workforce. In the process, the researcher also had the opportunity of exchanging ideas and eliciting insights from a small number of people who although not an integral part of the hospital, had repeated experience working with groups of the organisation's employees and could therefore provide the priceless perspectives of relative outsiders.

The researcher herself brought particular perspectives to the research findings and analysis through her unique position of being concurrently an outsider in some respects and an insider in others. She can attest to the reality that this was an enriching experience which will leave an indelible mark in her life experience and rich new understandings of work dynamics in this singular organisation in Malta. She hopes that the knowledge unearthed by this study will eventually be used to help the hospital in its continuous endeavours to regenerate and develop in order to achieve objectives that will render and allow it to truly claim that it is an organisation of the 21st century.

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ANNEX 1

University of Malta
Faculty of Economics, Management and Accountancy

RESEARCH CONSENT FORM

Name of Researcher	**MIRIAM DALMAS**
Address	**16, Triq il-Familja Cumbo, Mosta**
Telephone Number	99824521

Purpose of the Study

This research project is seeking to study the organizational dynamics of a major setting in the national health system of Malta to elicit the factors that are fostering or inhibiting learning from successes and contrastingly from errors and failure. The findings will consequently be analyzed and used to support and stimulate the instilling of change that is identified as needed to avoid further failures, lessen the consequences of the errors or avoid future repetitions of the same pitfalls. The setting chosen for this research is Mater Dei Hospital due to its important role as the major acute general public and teaching hospital for the Maltese Islands.

Methods of Data Collection

This study will be employing a number of different methodologies. A qualitative research methodology will be utilized through a number of interviews that will be conducted with stakeholders (both internal and external to the organization). The conduction of unstructured or minimally structured interviews and the content analysis of the interviews will follow the grounded theory approach. Furthermore, the sampling process for interviewees will involve an ongoing sampling strategy that will be directed by the data collected as the research progresses.

Use made of the Information

Grounded theory is a theory generating research methodology and the researcher should refrain from having a pre-defined theoretical framework. Through the interviews and the analysis of the findings, I aim at generating a workable theory and a theoretical framework that will allow me to proceed in a more informed and critical fashion with the action research arm of the study.

Guarantees:

I will abide by the following conditions:

1. Your real name will not be used in the study.
2. Only the supervisor and examiners will have access to the data.
3. You will remain free to quit the study at any point and for whatever reason. In the case that you withdraw, all the records and information collected will be destroyed.
4. No deception in the data collection will be used.

I agree to the conditions.

Name of participant: _____

Signature: _____ Date: _____

I agree to the conditions.

Researcher: Miriam Dalmas

Signature: _____ Date: _____

ANNEX 2

UNIVERSITY OF MALTA

Faculty of Economics, Management and Accountancy

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Summary of research project – background for interviewees

LEARNING FROM EXPERIENCE IN A NATIONAL HEALTHCARE SYSTEM: ORGANIZATIONAL DYNAMICS THAT ENABLE OR INHIBIT CHANGE PROCESSES

The importance of learning from and to avoid and repeat failures in a healthcare system cannot be over-emphasized. Not only are matters of life and death at stake on a daily basis; it is also becoming paramount to continually stress on the efficiency of the system in order to ensure the ability to provide the access and quality of care that it is designed and financed to give and most importantly to ensure its present and future sustainability.

This research project is seeking to study the organizational dynamics of a major setting in the national health system of Malta to elicit the factors that are fostering or inhibiting learning from successes and contrastingly from errors and failure. The findings will consequently be analysed and used to support and stimulate the instilling of change that is identified as needed to avoid further failures, lessen the consequences of the errors or avoid future repetitions of the same pitfalls. The setting chosen for this research is Mater Dei Hospital due to its important role as the major acute general public and teaching hospital for the Maltese Islands.

This study will be employing two main research methodologies:

1. A qualitative research methodology will be carried out through a number of **interviews** that will be conducted with stakeholders (both internal and external to the organization). The conduction of unstructured or minimally structured interviews and the content analysis of the interviews will follow the grounded theory approach. Grounded theory is a theory generating research methodology and studies using this research paradigm do not need to start with a pre-defined theoretical framework since the aim of the research is to generate theory and the theoretical framework. Furthermore, the sampling process for interviewees will involve an ongoing sampling strategy that will be directed by the data collected as the research progresses.

ANNEX 2 ***(continued)***

2. The other methodology will be based on the **Action Research** paradigm. Action research is an increasingly known application of participatory methodologies. The main intent of action research is to find explanations and/or propose improvements to practical problems. This will be through the researcher's participation as a practitioner-researcher in activities that will be taking place during the course of the study in the organisation that aim at promoting the theoretical concepts of the organisational learning. The researcher has gained entry and established herself as an active participant in the Patient Safety and Quality Improvement Team of MDH. The action research arm of this study will be carried out using this setting and its related activities as the focus from where she can participate in and observe the organisational dynamics to generate and retain knowledge and to instil change in organisational culture and practices.

ANNEX 3

List of interviewees (in chronological order based on the temporal sequence of the interview) with a number of characteristics related to each person and the month and year and the duration of the respective interview

Interviewee No.	Salient characteristics	Month and year of the interview	Duration of interview (minutes)
1.	• Senior non-health professional • External to health domain • Engaged on various occasion to advise and mentor groups in the health sector	November 2013	75 minutes
2.	• Senior health professional • Internal to health domain • Engaged on various occasion to advise and mentor groups in the health sector	January 2014	60 minutes
3.	• Senior non-health professional • External to health domain • Engaged on various occasion to advise and mentor groups in the health sector	January 2014	60 minutes
4.	• Senior health professional • Internal to health domain • Had been engaged at senior leadership level in the health sector	January 2014	60 minutes
5.	• Senior non-health professional • Internal to health domain • Engaged at senior leadership level in the health sector	April 2014	60 minutes
6.	• Non-health professional • Internal to health domain • Engaged at management level in the health sector	May 2014	60 minutes
7.	• Senior health professional • Internal to health domain • Engaged at management level in the health sector	May 2014	60 minutes
8.	• Senior non-health professional • Internal to health domain • Engaged at senior leadership level in the health sector	June 2014	60 minutes
9.	• Senior health professional • Internal to health domain • Had been engaged at senior leadership level in the health sector	June 2014	45 minutes

ANNEX 3 ***(continued)***

Interviewee No.	Salient characteristics	Month and year of the interview	Duration of interview (minutes)
10.	• Senior health professional • Internal to health domain • Had been engaged at senior leadership level in the health sector	June 2014	45 minutes
11.	• Senior health professional • Internal to health domain • Engaged at senior leadership level in the health sector	September 2014	75 minutes
12.	• Senior health professional • Internal to health domain • Engaged at senior leadership level in the health sector	October 2014	45 minutes
13.	• Health professional • Internal to health domain • Engaged at a management level in the health sector	October 2014	60 minutes
14.	• Senior health professional • Internal to health domain • Had been engaged at senior leadership level in the health sector	November 2014	60 minutes
15.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	December 2014	60 minutes
16.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	January 2015	45 minutes
17.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	January 2015	75 minutes
18.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	February 2015	45 minutes
19.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	February 2015	45 minutes

ANNEX 3 ***(continued)***

Interviewee No.	Salient characteristics	Month and year of the interview	Duration of interview (minutes)
20.	• Health professional • Internal to health domain • Engaged at clinical and management level in the health sector	March 2015	60 minutes
21.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	April 2015	45 minutes
22.	• Health professional • Internal to health domain • Engaged at clinical and management level in the health sector	May 2015	75 minutes
23.	• Health professional • Internal to health domain • Engaged at clinical and management level in the health sector	June 2015	45 minutes
24.	• Senior health professional • Internal to health domain • Engaged at senior clinical leadership level in the health sector	October 2015	45 minutes
25.	• Senior health professional • Internal to health domain • Engaged at senior leadership level in the health sector	November 2015	45 minutes

ANNEX 4

List of the 68 entries in the AR journal in chronological order (either by the date of the recorded event or meeting or by date of the final or most finalised version of a document such as progress reports and terms of reference)

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
1.	Medical director views for a Patient Safety (PS) committee	8 March 2013	Concept document	Medical Director	Medical Director's views re: the setting-up of the PS Committee
2.	Pre-PASQIT Implementing changes in clinical care	27 March 2013	Concept document	Member of initial team prior to May 2013	Initial ideas on the role and objectives of a team that advances and implements activities to improve quality care and patient safety at MDH
3.	Actions following April 2013 meetings	5 and 8 April 2013	Record of the meeting	Not known	Record of invitees and attendees to the two meeting. Notes on the discussion are very scanty
4.	PaSQIT meeting minutes 080413	8 April 2013	Record of the meeting	Not known	Detailed record of the meeting
5.	Lachman's visit May 2013	2 to 6 May 2013	Record of and reflections on this series of meetings	Peter Lachman Researcher	Brief report with reflections of Dr Lachman on the progress of the meetings with additions from the researcher arising from her experience of these meetings
6.	PaSQIT meeting minutes 270513	27 May 2013	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
7.	PaSQIT meeting minutes 100613	10 June 2013	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting

ANNEX 4 ***(continued)***

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
8.	PaSQIT meeting minutes 140613	14 June 2013	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
9.	PaSQIT - Terms of Reference July 2013	July 2013	Terms of Reference	Major input and review by researcher	Initiated by the member designated as the Chair of PaSQIT
10.	PaSQIT meeting minutes 160813	16 August 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
11.	PaSQIT – 1st progress report August 2013	August 2013	Progress report	Major input and review by researcher	Initiated by the members of the initial team prior to May 2013
12.	Meeting with Senior Executive Team (SET) of MDH 020913	2 September 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
13.	PaSQIT meeting minutes 130913	13 September 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
14.	PaSQIT meeting minutes 270913	27 September 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
15.	PaSQIT meeting minutes 071013	7 October 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
16.	PaSQIT meeting minutes 081113	8 November 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
17.	PaSQIT meeting minutes 151113	15 November 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
18.	PaSQIT meeting minutes 061213	6 December 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting

ANNEX 4 ***(continued)***

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
19.	PaSQIT meeting minutes 201213	20 December 2013	Record of the meeting	Drafted by researcher	Detailed record of the meeting
20.	PaSQIT meeting minutes 030114	3 January 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
21.	PaSQIT meeting minutes 100114	10 January 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
22.	PaSQIT meeting minutes 170114	17 January 2014	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
23.	PaSQIT meeting minutes 270114	27 January 2014	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
24.	PaSQIT – 2nd progress report January 2014	January 2014	Progress report	Major input and review by researcher	Initiated by the member designated as the Chair of PaSQIT
25.	Items on the agenda of PaSQIT carried forward from 2013 to 2014	January 2014	List of pending activities	Created by researcher and Chair of PaSQIT	Attempt at organisation of team's ongoing activities and unresolved issues
26.	PaSQIT meeting minutes 070214	7 February 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
27.	Half-day Seminar 280214	28 February 2014	Record of the seminar	Drafted by researcher	Detailed record of the seminar
28.	Safety Alert for Learning (SA Learn) working group - Terms of Reference February 2014	February 2014	Terms of Reference	Drafted by researcher	Initiated by the researcher as the Chair of the SA Learn WG
29.	PaSQIT meeting minutes 070314	7 March 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting

ANNEX 4 ***(continued)***

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
30.	PaSQIT meeting minutes 280314	28 March 2014	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
31.	PaSQIT - Terms of Reference (TOR) March 2014 (revision of initial TOR of July 2013)	March 2014	Terms of Reference	Major input and review by researcher	Initiated co-jointly by the member designated as the Chair of PaSQIT and the researcher
32.	PaSQIT meeting minutes 040414	4 April 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
33.	SA Learn working group meeting minutes 160414	16 April 2014	Record of the meeting	Drafted by researcher	Meeting chaired by researcher Detailed record of the meeting
34.	PaSQIT meeting minutes 160514	16 May 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
35.	Pressure Ulcer working group (PU WG) meeting minutes200514	20 May 2014	Record of the meeting	Drafted by another member of PaSQIT – Chair of PU WG (not the researcher)	Detailed record of the meeting
36.	PaSQIT meeting minutes 060614	6 June 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
37.	PaSQIT meeting minutes 200614	20 June 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
38.	SA Learn working group meeting minutes 210614	21 June 2014	Record of the meeting	Drafted by researcher	Meeting chaired by researcher Detailed record of the meeting
39.	PaSQIT meeting minutes 270614	27 June 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
40.	PaSQIT meeting minutes 060814	6 August 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting New Clinical Director introduced
41.	PaSQIT meeting minutes 080814	8 August 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting

ANNEX 4 ***(continued)***

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
42.	PaSQIT meeting minutes 290814	29 August 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
43.	PaSQIT meeting minutes 050914	5 September 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
44.	PaSQIT meeting minutes 300914	30 September 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
45.	Systems & Communications committee (SCC) 1st meeting 031014	3 October 2014	Record of the meeting	Drafted by another member of PaSQIT – Chair of SCC (not the researcher)	Detailed record of the meeting
46.	PaSQIT meeting minutes 171014	17 October 2014	Record of the meeting	Drafted by researcher	Detailed record of the meeting
47.	PaSQIT meeting minutes 311014	31 October 2014	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
48.	SA Learn working group meeting minutes 111114	11 November 2014	Record of the meeting	Drafted by researcher	Meeting chaired by researcher Detailed record of the meeting
49.	PaSQIT meeting minutes 160115	16 January 2015	Record of the meeting	Drafted by researcher	Meeting chaired by researcher Detailed record of the meeting
50.	PaSQIT meeting minutes 300115	30 January 2015	Record of the meeting	Drafted by another member of PaSQIT (not the researcher)	Detailed record of the meeting
51.	PaSQIT – 3rd progress report January 2015	January 2015	Progress report	Input by researcher	Initiated by the member designated as the Chair of PaSQIT
52.	PaSQIT meeting minutes 030215	3 February 2015	Record of the meeting	Drafted by researcher	Detailed record of the meeting
53.	PaSQIT meeting minutes 280415	28 April 2015	Record of the meeting	Drafted by researcher	Detailed record of the meeting

ANNEX 4 ***(continued)***

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
54.	PaSQIT meeting minutes 180815	18 August 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
55.	PaSQIT meeting minutes 210815	21 August 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
56.	PaSQIT meeting minutes 250815	25 August 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
57.	PaSQIT meeting minutes 010915	1 September 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
58.	PaSQIT meeting minutes 110915	11 September 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
59.	PaSQIT meeting minutes 150915	15 September 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
60.	PaSQIT meeting minutes 220915	22 September 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
61.	PaSQIT meeting minutes 290915	29 September 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
62.	PaSQIT meeting minutes 061015	6 October 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting

ANNEX 4 ***(continued)***

No.	Title of the entry	Date/s of entry	Type of entry	Author (input by researcher)	Remarks
63.	PaSQIT meeting minutes 161015	16 October 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
64.	PaSQIT meeting minutes 231015	23 October 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
65.	PaSQIT meeting minutes 271015	27 October 2015	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
66.	PaSQIT meeting minutes 061115	6 November 2915	Record of the meeting	Drafted by the assigned PaSQIT coordinator	Detailed record of the meeting
67.	Half-day Seminar 101115	10 November 2015	Record of the meeting	Drafted by researcher	Detailed record of the meeting
68.	Lachman's visit November 2015	12 to 16 November 2015	Record of and reflections on this series of meetings	Peter Lachman Researcher Additions by researcher and other members of PaSQIT	Report with reflections of Dr Lachman on the progress of the meetings with additions from the researcher and other members of PaSQIT arising from their experience of these meetings

ANNEX 5

List of first cycle codes generated from the interviews (616 codes)

1. 'blame culture' and attitude that 'if you fail then it's your fault' are pervasive
2. 'champions' are key for success
3. 'colonial mentality' prevailing and compounded by insular & smallness & high population density
4. 'everyone knows everyone else' with high risk of leaks
5. 'hoarding ' of items is much less possible now
6. 'innovators' become frustrated because MDH structures are typically non-supportive
7. 'minor' transgressions get 'ingrained' in the way things are done
8. 'mis-communication is a source of substantial 'grief'
9. 'no handover whatsoever' from predecessor on assuming new post of Clinical Chair
10. 'out of courts settlements' better option than litigation for all concerned
11. 'over-reliance' on and 'false security' from computers leads to mistakes such as mis-labelling
12. 'silo' structure of MDH
13. 10% of MDH employees are otherwise unemployable
14. a big barrier in Malta is the 'fear of mobility'
15. a good part of the 'bed problem' is 'artificially induced'
16. a notable success story has been infection control
17. a number of improvements took place over the past 1 year
18. a system of informal & verbal reporting to senior people in own department works well in some units
19. A&E dept. needs to focus more on its core responsibility of primary mngt & investigation of emergency & stabilisation of patient
20. accreditation of training is necessary but requires a lot of effort
21. accreditation of training is necessary to justify MDHs title as a 'teaching hospital'
22. achieving change increases if you target and work it out first with the younger people
23. achieving change requires the seeking 'win-win situations'
24. action in anaesthesia is fast not so in most other clinical departments
25. adequate amounts of the new treatment charts are not always available
26. adverse drug reaction reporting system 'not used as much as it should'
27. AHPs are not interested in the central IRS system
28. AHPs tend to deal with incidents with internal departmental actions
29. aiming to introduce EWS for several years
30. aims at leaving 'a legacy of change'
31. all components of the org. are co-creators of organisational knowledge
32. all medics and higher nursing levels are expected to be 'perfect'
33. all priority is given to the elderly population at the expense of paediatric patients
34. an effective promoting factor is by 'word of mouth' through MDHs 'gossip factory'
35. anaesthesia is often the 'champion' for PS in most hospitals
36. anaesthetists are often informed of changes on the 11th hour
37. anonymity & confidentiality are very difficult to maintain
38. applications for training will seek justification & alignment with hospital training objectives
39. aspire for MDH to become more strategic-oriented
40. aspire for MDH to become more visibly 'caring'
41. at application for training to show how improvements will be measured

42. at MDH level there are no readily available channels for staff to forward ideas & concerns
43. at MDH there are no readily available channels for staff to forward ideas & concerns
44. at peak of IRS there was more than 1 BOI started per week. Most nominees accepted
45. audits and other studies are required for FY program and merit award schemes
46. audits need to be encouraged and performed on an ongoing basis as a form of CPD
47. availability and incentives for learning increasingly available
48. availability of knowledge increasing at a fast pace
49. barrier: difficulty to sustain support for initiatives
50. barrier: general reluctance to change
51. barrier: lack of continuous training and re-training
52. barrier: major problems with 'self-discipline'
53. barrier: no culture to review SOPs
54. barrier: pervasive culture of persons finding difficulty to admit that they erred
55. barriers due to the smallness of Malta and insularity
56. bed management is negatively influenced by the high bed occupancy rate
57. being female can be helpful with 'female intuition' & lower confrontational tendency & lower inclination 'to do things for personal gain'
58. benefits of walk-a-rounds. Need to be led by high level personnel
59. best growth and improvement in medication safety and infection control
60. better structured wards at MDH is counterpointed by the 'improvised wards'
61. beware 'delusions of grandeur'
62. big difference - one reason is compliance with ward group norms
63. big difference btw what is taught and what is practiced
64. biggest reluctance for change comes from the Medical Dept. and the nursing profession
65. blame attribution is influenced by long-standing stereotypes
66. blame culture transcends all levels
67. BoI issue recommendations requiring more stringent evaluation of implementation
68. calls for clinical service managers CSMs
69. capture level of currently accepted/ available knowledge
70. Capua has better 'no blame culture' reported medication error and was acknowledged instead of reprimanded
71. case conferences need to take place regularly by each clinical dept.
72. cases presented at case conference depend on severity and on whether consultant feels safe vs medico-legal risk
73. central training coordination role to be further developed and better equipped
74. CEO becomes ineffective and defensive
75. CEO must 'lead by example'
76. chair continues to carry full clinical load with no allowance for new duties
77. Chair is an enabling person & reports are heeded and acted upon
78. change achieved through the trigger of the 'envy cycle'
79. change needs to be consistent and incremental to be successful
80. change should be aimed at the system and not at the individual
81. changes in appointments in paediatrics are resisted because it affects patient and her whole family
82. clinical champions in infection control can be replicated for PS and QI
83. clinical depts. tend to function as 'silos' and independent of each other
84. Clinical Dir seeking 'legal protection' from AG for intra-hospital investigations for learning
85. clinical governance is weak and should be the main priority of the Clinical Director

86. clinical risk management and PS are now merging
87. clinicians and management do not understand or back each other
88. clinicians taking up managerial role need to release clinical roles
89. clinicians' exhaustion is caused by the widespread location of firm's patients across all MDH
90. closed mentality is less prevalent in the younger generations
91. communication between MDH and DoH very poor territorial defence
92. compared to other large national institutions MDH is perceived to perform 'pretty well'
93. constant need to strike right balance between professional & employment & personal duties
94. constant tension between strategy vs operations - often strategy gets neglected
95. consultants do not think they can learn anything from junior staff
96. consultants tend to 'hoard knowledge' & keep juniors from advancing
97. contact with centers abroad is a strong point of the Dept. of Surgery
98. contact with nurses varies on type of ward and is higher in the more specialised wards
99. continuation of education & assessment - more programs need to become mandatory
100. continuous struggle between doctors and nurses
101. continuous systems improvement: functional system for action present
102. continuously planning for 'succession leadership' to minimise risk of a vacuum in leadership
103. corporate knowledge: loss accentuated by increase in email and decrease in paper records
104. CPD is essential for MDT setting and for integration of nurses with other HCPs
105. CPD is still performed on a voluntary basis
106. CPD needs monitoring both a national regulatory & hospital level
107. CPD: several opportunities and increasing awareness
108. creation of specialist nurses is positive development
109. CRM succeeded in creating a number of WGs that are still functioning
110. crux of ward ethos is the attitude & behaviour of the NO
111. culture: national 'Malta' context
112. current 'heavy agenda' is due in part to new positions struggling to establish their new roles
113. current 'heavy agenda' of changes risks staff fatigue
114. decisions are often taken by individuals then blocked
115. decisions are often taken on the basis of 'quantity and not quality'
116. defensive medicine in response to litigation for clinical mishaps
117. delegating is an uncommon capability of most medical leaders
118. delegation of departmental duties possible because of a strong team
119. demographics of children with respect to ethnicity and prevalence of rare & complex conditions changing
120. demoralising situations such as lack of recognition and scarcity of opportunities for career progression
121. department is constantly understaffed and HR systems are inefficient and unhelpful
122. dependency on nurses have made them 'more aggressive'
123. development & promotion of quality care is less than desired
124. different groups at MDH 'march to their own tune'
125. different groups at MDH influenced by particularities of who leads them
126. different groups have own learning and training programmes & structures

127. direct high-level interference and disproportionate micro-management
128. Director or unit manager were informed of IRS usually they would be already in the know
129. dis-respectful attitude by juniors to everyone in general_need for more 'decency based' behaviour
130. discipline needs to be graded
131. doctors tend to develop 'confidence in own group' and to try to protect own team members
132. DoH invested a lot in mngt and leadership training in past 5 yrs.
133. DoH is perceived as 'very distant' and largely 'negative'
134. due to relentlessly high workload it is difficult to find time to strategize and reflect
135. duplication of work done at MDH by MoH
136. each initiative has a very limited 'line of sight'
137. each professional group attempts at exonerating own members from blame
138. education to challenge the status quo/ anti-progressive systems
139. effective way to start something new is to start practicing it yourself
140. empower to try and resolve problem before referring higher
141. enablers: DoH_ CEO_EU
142. enablers: people capable of acknowledging and fostering respect
143. enforcing & raising standards of practice will reduce adverse events 'prophylaxis'
144. entry into HC faculties should be more influenced by presence of 'vocational aptitude'
145. ESP had poor turnout possibly because staff do not perceive there will be direct or immediate benefit
146. everyone expectations have been immensely raised
147. evolving organisation in the 21st century
148. EWS designed on the 2011 NEWS UK system
149. EWS does not have support staff precluding evaluation and audit
150. EWS during a ward roll-out a lot of personal contact is required
151. EWS ex-CEO was instrumental
152. EWS excluded patients 'not for CPR' & paediatrics and obstetrics
153. EWS found to be an effective tool to improve communication
154. EWS garnered massive support and enthusiasm by several people
155. EWS gradual addition of new wards for roll out_All wards to be included 2 years from launch
156. EWS implementation led in many ways by the nurses
157. EWS implementation performed in a very 'flexible' fashion
158. EWS improves assertiveness of nurses
159. EWS lack of permanent staff in one ward led to suspension of EWS
160. EWS launched in 3 pre-selected wards for different reasons
161. EWS most medics acquainted with system through experience abroad or training programs
162. EWS not coordinated by a fixed or formal group
163. EWS prior to launch extensive & long discussions with nursing leaders and ward managers
164. EWS prior to launch meeting with clinical chairs was held
165. EWS problems with implementation included lack of understanding by operating staff
166. EWS required extensive effort by leads risking fatigue of people involved
167. EWS strong feature is bottom up approach with minimal involvement of hospital authorities

168. EWS training to FY doctors
169. EWS tried and managed to avoid trade unions
170. EWS trigger cardiac surgeon promotion at MMSC 2012
171. EWS trigger observing closely monitored patients due to co-morbidities were benefitting with earlier detection of problems
172. EWS used as justification for requesting new or more resources
173. EWS very small and dynamic core group
174. existence of a distinct MDH modus operandi. HCPs working in private_public lead double lives
175. expectations that 'nothing will come out of a report'
176. exposure to institutions abroad is an enabler and helps improve several deficiencies
177. finding time for chair administrative duties requires engagement of junior staff as replacements
178. focussed development on under-grads and new doctors
179. following completion of induction program nurses do not have any further performance assessments
180. frequent need to resort to shenanigans detract clinician from core responsibilities and leads to frustration & exhaustion
181. funding for new initiatives is difficult
182. funds too centrally managed - director has no direct access to funds
183. gaining trust requires constantly showing 'integrity of character'
184. gender and age are not felt to be detractors from leadership positions
185. general apathy and disinterest towards CPD by the nursing professionals
186. general culture in MDH is resistant to change and in many respects, this is similar to the rest of Malta
187. general lack of enthusiasm to report someone else
188. general lack of number and of the appropriately trained and qualified secretarial support
189. general lack of the appropriately trained and qualified secretarial support
190. getting consistently good quality care perceived as not guaranteed by public
191. give more meaning to work
192. good 'ward leaders' view nurses holistically
193. good nursing practice is best solidified in the general medical & surgical wards
194. good practice is applied either because it is a belief or because afraid of consequences
195. GP training programme is effective for learning
196. half the trainees eventually leave for abroad even though they are ensured a consultant's post
197. handover & documentation are imperative for accountability & recognition of specialisation
198. handover 2011: giver feels that it was unappreciated by new CEO
199. handover in 2011: actively discouraged by ministry
200. handover in 2011: had to resort to written handover
201. handover of 2011: since it was not well received fears for continuity & retention of knowledge gained
202. handover: best given personally by person being replaced
203. handover: full handover offered in the CEO change in 2011
204. handover: little overlap when there are changes in top positions
205. handover: more effective at lower levels & often 'hand holding'
206. handover: new CEO did not take 'full advantage' and did not appreciate it appropriately

207. handover: several negative effects when this does not happen
208. has view from an entity to a ministry
209. HC outcomes: satisfaction & motivation & clinical
210. HCPs self-selected people fulfilled with 'caring' experience
211. HCPs to be better prepared to listen esp. to patients' experiences
212. HCPs will continue caring for patients whatever the turmoil
213. Heads of entities are FMS employees & cannot take decision on discipline on public service staff
214. Heads of entities are perceived to have low authority: cannot discipline & low IRS activity
215. health & wellbeing initiative at MDH
216. health authorities and hospital administration heavily influenced by 'political agenda'
217. heavy bureaucratic procedures dependent on a few over-burdened individuals
218. heightened HC staff awareness & expectations for better work-life balance
219. high bed occupancy can lead to forego pre-operative assessments
220. high proportion of MDH are 'risk averse' and scared of 'extra commitment'
221. hospital need to be 'owned' by all players
222. hospital needs to be sensitive to needs & aspirations of all players
223. HR at several levels of expertise is scarce
224. HR databases is not inter-operable across all MEH entities
225. HR functions of Nursing dept. were successfully bridged with mainstream HR functions
226. huge development and sophistication changed medicine beyond recognition
227. identification of specialised nurses such as in infection control has been successful
228. if at all learning is limited to within prof. groups
229. imp staff like clinical pharmacist are not adequately available
230. important for all consultants of a clinical department to share same vision
231. improvements in capacity of MDH as a LO need better medical file retrieval & enabling ICT systems
232. in several specialities, the person is not viewed holistically including all of her medical & social context
233. in some clinical department channels to forward ideas & concerns are more readily available
234. increase and maintain employee well-being
235. increased general awareness and sensitivity for PS & QI
236. individuals learn together because it is unavoidable
237. individuals: knowledge & capacity & competence
238. induction meetings for house officers are poor and not well conducted
239. induction program and supervision of new nurses at ITU by PDN
240. induction program for new nurses is a great enabler
241. induction program for new nurses will now be further complemented by on the job training during 1st year
242. induction training for nurses: well structured & very important
243. info on events travel fast 'through the grapevine'
244. inhibitors: good intention but cause destruction & chaos
245. initiatives fail because they do not 'cascade down' or filter down 'distorted'
246. initiatives launched in an uncoordinated way and do not fall into an 'organisational plan' for development
247. initiatives often totally dependent on the people who try to 'pull them through'
248. initiatives taken up continue or fail if 'champion' becomes disheartened
249. inspirational leaders: watch_teach_understand

250. instead of focussing on clinical governance clinical director is overwhelmed with micro-management
251. inter-disciplinary collaboration between paediatrics and other clinical depts. is good
252. inter-disciplinary meetings stopped due to lack of resources and the occupation of paediatric beds by adult cases
253. interaction leads to the growth of the creator individual
254. introducing something new need persistence and dogged belief that adoption is required
255. investigation of reported incidents is vital
256. investigations take up a lot of time and effort
257. IRC established a no. of WGs: still sluggishly active
258. IRC was a strong enabler
259. IRC: CEO must 'walk the talk' to give it its due importance
260. IRC: CEO must give it her full weight if it is to be taken seriously
261. IRC: characteristics of IRC as established and worked under 1st CEO
262. IRS and dissemination of lessons is more practiced at departmental level than at hospital-wide level
263. IRS and low blame culture are best taken up Pharmacy Dept.
264. IRS at SLH & MDH for a long time but never well established
265. IRS considered by many as a real threat
266. IRS in foreign hospital is seriously supported by top mngt
267. IRS is beleaguered by under-reporting & strong blame culture
268. IRS is mostly used by nurses & poorly used by doctors
269. IRS lead had little knowledge of subject and no real executive powers
270. IRS led by lowest ranking person in WG
271. IRS met with tepid success and enthusiasm in the wards
272. IRS suffers because of the actions of the nurses' union
273. IRS team members did not share work & lacked commitment
274. IRS: 1st CEO put her full weight on the IRS
275. IRS: consultant did not know it existed before joining mngt in 2013
276. IRS: did not have adequate resources required to function properly
277. IRS: each clinical team & department needs a liaison officer or champion
278. IRS: medico-legal implications are barriers especially in a small country
279. IRS: medics seek to learn from incidents using other means e.g. weekly case conferences in orthopaedics
280. IRS: more medics need to be aware of it
281. IRS: need to be supported by the newly appointed Clinical Director
282. IRS: needed for hospital to implement continuous quality improvements
283. IRS: needs to be fully supported by a 'no blame philosophy'
284. IRS: operated by HCPs other than medics
285. IRS: started at SLH even before 2006
286. IRS: stopped because people felt that 'nothing came out of the system'
287. IRS: take up in a ward is heavily dependent on the views of the NO & DNO
288. issue of PDN posts without specialisation requirement is a regressive development
289. it is difficult to postpone or reschedule surgery even when there is clinical justification
290. ITU MDT meetings main role is to identify and implement QI initiatives
291. junior doctors work on a 'conveyer belt' basis with negligible learning opportunities esp. during duties
292. key word to ensure changes happens is perseverance
293. knowledge on migration: a lot was recorded

294. knowledge on migration: ministry went out of its way to discard & discredit it
295. knowledge on migration: passed on to foreigners and greatly appreciated
296. knowledge on migration: some people resort to it *'bil-mohbi'*
297. knowledge sharing from local to global levels
298. lack of adequate space is a major obstacle to the provision of good quality care
299. lack of medical indemnity cover 'did not help'
300. leaders need to give good example because their attitude has a strong ripple effect
301. learning fostered if big no. of incident reports is generated
302. learning from training achieved has relevance for and retained solely by individual beneficiary
303. learning is a manifestation of an evolving organisation
304. learning is fostered if documentation is really taken up
305. learning is fostered if people feel empowered to report
306. learning is fostered if systems failures are the most often cause of incidents
307. learning is not generally encouraged at the organisational level
308. learning more effective if trainers seek to learn from trainees
309. learning needs to be based more on the study of evolving trends
310. learning occurs 'ad hoc' & 'on the job'
311. learning opportunities initially directed towards who showed most motivation
312. learning requires sharing of ideas
313. learning something new often involves 'unlearning' old ideas and methods
314. legal 'protection for learning' still not present
315. line of command is usually strictly adhered to
316. LO encourage individuals to institutionalise their learning
317. long hours spent at MDH and this sort of 'takes over your life'
318. M&M meetings started on insistence of Clinical Director
319. M&M meetings suffer from a general lack of ownership and on who should report adverse events
320. main functions of PDN is to foster MDT work & enhancement of training
321. major changes in practice necessitate establishment & enforcement of 'standard practice'
322. Malta is a country of extremes
323. managerial role of charge nurses is always submissive to clinical roles
324. many things work well in MDH against all odds and because most of the staff cares
325. massive challenge is to 'unlearn' the fear of failure
326. massive changes in medical practice from 'care' to 'cure'
327. MDH are structurally designed to host a definite number of patients_better planning & monitoring
328. MDH corporate training structure is severely under-staffed & underfunded
329. MDH has several 'very talented' nurses
330. MDH has to be a LO
331. MDH has to bypass deficiencies in PHC with own staff & volunteers & relatives of patients
332. MDH invests a lot in staff development
333. MDH is a massive and complex organisation by MT standards
334. MDH is filled with a lot of dedicated people that try to instil change with a lot of passion
335. MDH is negatively affected by lax disciplinary activity
336. MDH is non-comparable to other hospital abroad
337. MDH is still lagging far behind in infrastructure for PS
338. MDH is stuck in an 'old model'

339. MDH is very sceptical on initiatives because of several earlier 'let-downs'
340. MDH mngt does not have hire & fire authority affecting scope for disciplinary activity
341. MDH needs to learn in a vicarious/ indirect way
342. MDH not yet a 'learning organisation'
343. MDH should be the 'flag bearer' for other MT organisations wrt learning & training
344. MDH sluggish efforts for learning accentuated by smallness of Malta & sole major hospitals
345. MDH staff are less efficient than they think
346. MDH without effective systems for the generation and dissemination of learning
347. medical class needs to open up
348. medical consultants are the centre of most decisions
349. medical power influences all the health system
350. medics have too much power on MDH administration
351. medics manipulate admin and prevent initiatives from implementation
352. medics needs to release its hold on power
353. medics oriented: lowering roles everyone else incl. mngt.
354. micro-management is the remit of the professionals/ technical
355. migration process was accepted by everyone as a success
356. migration success: close working team & each had clear specific roles
357. minimise unnecessary experimentation in patient care
358. minimum level to apply for PDN post recently established at Masters level
359. mis-management and mis-matching of staff esp. nurses is wasteful
360. more psychological support services are needed
361. more serious events are directly reported to the Chair
362. most clinical leaders have problems with delegating and they get 'bogged down' with operational issues as a result
363. most clinicians do not as yet appreciate specialisation in PS
364. most HCPs are under constant high pressure
365. most MDH has a false sense of security for their job
366. most MDH professionals esp. high levels do not have realistic opportunities for job mobility
367. most susceptible nurses are those within 3-6 years from graduation
368. most wards at MDH were initially meant to be specialised wards
369. move away from arbitrary executions of 'wish lists' towards decisions based on an agreed strategy
370. much more needs to be done for better communication & coordination and maintenance of essential resources
371. MUMN activity towards upholding 'professional pride' is perceived a low on its agenda
372. MUMN almost 100% membership signifying a lot of power
373. MUMN draws on the disillusionment of some nurses
374. MUMN leads MDH nurses from the 'outside'
375. national & organisation culture do not favour reporting for learning
376. national limitations include smallness & insularity & 'one bone' characteristic leading to protectionism
377. nationally there is a general poor safety culture
378. need a flatter approach which is more patient-centred
379. need capability to acknowledge threats but be open and sensitive to opportunities
380. need for a robust leadership that can see over and above the 'noise'
381. need for capacity to work in teams
382. need for continuous CPD for nurses

383. need for coordination of new initiatives within a planned strategy
384. need for emphasis on 'back to basic nursing & medical care'
385. need for learning is appreciated by most HCPs at MDH
386. need for more and higher level secretarial support
387. need for more widespread availability of 'good role models'
388. need more evidence and visibility of 'civic responsibility' and good 'work ethics' starting at national level
389. need new emphasis in achieving 'good medical practice'
390. need to actively strive to be a 'constant learner'
391. need to be able to change own plans if 'a new and better idea is fielded'
392. need to cater for peaks of activity
393. need to stress that observing clinical guidelines protect clinicians
394. needs of the professionals are leading the agenda
395. needs to cater for all demands and exigencies and leaves little room to manoeuvre
396. negative effect of Maltese politics
397. new chair feels he can achieve much more desired change since he got this position
398. new development: extended induction and new 1year foundation program for new nurses
399. new nurses are heavily influenced by older 'role models' on the wards
400. new nurses are strongly influenced by attitudes of 'ward leaders'
401. new techniques are acquired by sending young professionals for training abroad
402. no fault medical compensation_legal shield_is a facilitator
403. no handover results in discontinuities and wasted effort
404. no handover took place - culture of handovers is not strong
405. no overlap between CEOs counteracted by the unchanged senior managers in 2006
406. no succession planning: corporate knowledge is lost on retirement & transfer
407. not enough learning takes place
408. not having a plan B will affect your credibility
409. now better equipped to handle patients than in the past
410. NRLS has low reporting_best for rare incidents
411. NSU earned title of 'elite ward' patients constantly informed
412. NSU gave optimal personalised patient care
413. NSU positive feature 'celebrated success'
414. nurses can be unfortunately labelled as the 'lost profession'
415. nurses do not project themselves very professionally and are prone to be 'played up by the media'
416. nurses have habitually ingrained insecurity issues and are often unable to accept internal authority structures
417. nurses have the highest 'power of redundancy'
418. nurses in specialised wards tend to be more 'respected' and sought for their experience
419. nurses should have the option for promotion but remain working in their area of expertise
420. nurses' specialisation needs careful consideration of minimum qualifications & experience
421. nurses: circular mobility private_public no return when transferred out of MDH
422. nursing & AHP admin at DoH are detached from MDH situations
423. nursing leaders are being urged to be more 'on the ground' and be very observant
424. nursing leaders to emphasise learning as a one of their central job tasks
425. nursing specialisation still unrecognised
426. nursing specialisation will allay 'fears of being moved around'

427. nursing standards have greatly improved since the inception of the graduate nurses
428. nursing training is increasingly being coordinated by & with central MDH training coordination structure
429. observing clinical guidelines is still a weak point of several clinicians at MDH
430. occupation of paediatric beds by adult patients is limiting the provision of good quality care to child patients
431. often the 'loop is not closed' at investigations - missed learning & implementation of recommendations
432. often very difficult to identify agendas behind the initiatives & ideas
433. old practices replaced by new IT processes without evaluation to identify & rectify pitfalls
434. older members may consider changes when they start to take hold for fear of becoming 'left out'
435. older staff should be allowed to concentrate on what they 'are best at'
436. ongoing training should be in everyone's mindset
437. only one PDN at ITU with over 90 nurses
438. opt-out from Working Time Directive is not the exception but the role in MDH
439. organisation needs to foster common interests of all its components
440. organisational dynamics: influenced by the leaders in an org.
441. organisational dynamics: psychology & management
442. organisational dysfunctional system as in the transfer of patients to and from OT
443. organisational dysfunctional system leading to misuse of resources and poor patient experience
444. organisational support for new initiatives is perceived as 'weak' Why?
445. organisations need to address issue of generating value
446. orthopaedic case conferences: aim is clinical improvement & investigations are rare
447. output overpowers considerations for outcomes and quality
448. PaSQIT is made up of informally engaged individuals_inadequate for purpose
449. patient allocation to a specific nurse should engender greater accountability - needs auditing
450. patients form stronger 'emotional bonds' with nurses
451. patients super-sensitive to organisational dynamics
452. patients tend to close the change cycle by starting to 'vote with their feet'
453. patients' groups becoming more significant
454. PDN role not well refined & and there is no performance appraisal system
455. people are actually 'prepared to learn'
456. people expect change to occur with a 'magic wand'
457. people in healthcare tend to be self-selected
458. people involved in an adverse event are advised not to testify
459. people management is fully decentralised on MDH & entities
460. people mngt at HO is less developed than at MDH
461. people mngt includes:
462. people mngt: lack of middle managers at MDH leading to halted development
463. people mngt: several HR roles minus recruitment & training
464. performance & commitment & inter-personal camaraderie are often of a high level in MDH staff
465. persistent reluctance to recruit new staff even to replace retiring staff
466. politicians need to refrain from micro-managing health
467. politicians overrule DoH when they deal directly with MDH
468. poor accountability as in 'everyone assumes that someone else will do it'
469. post of chair was not wanted by anyone else

470. power struggle between nurses & doctors is less in ITU
471. practice nurses: key role is QI
472. practices 'formal delegation of duties to different people' to help smoothen succession when this will happen
473. pre-discharge MDT meetings take place regularly
474. preference for one-to-one communications and re-direction *'bil-kelma t-tajba'*
475. present medico-legal system discourages learning from errors
476. prevalent 'fear of insecurity'
477. prevalent 'tort' based system is a big obstacle to learning from errors
478. primary aim of bed management is to find a bed for an admission and not patient's comfort and safety
479. prior to specialisation new nurses need work experience in general medical & surgical wards
480. priorities & initiatives complemented by time-framed action plan incl. budgetary & accountability considerations
481. proactive meetings sought to involve all depts. and not allow e.g. AHCPs to function separately
482. proactive meetings with different depts. during term of 1st CEO of MDH
483. problems are often solved on an individual's initiative
484. prof staff are under severe and constant pressures to cater for increasing demand unmatched with increases in resources
485. professional pride imp impact on responsibility & accountability
486. promotion of hospital horizontal objectives incl. PS & QI
487. PS is greatly compromised in the 'improvised wards' for several reasons_more recent admissions & difficult to establish rapport with patients
488. PS needs a multi-disciplinary team led by a trained manager_IRS in its portfolio
489. public educated by professionals who need to embrace 'change' first
490. public has increased trust in medical services at MDH
491. public has poor trust in appointment & organisational system
492. QI initiatives require consensus building
493. QI is considerably hampered by trade unions activities
494. quality improvements require clinicians to spend more time at MDH_appropriate rise in remuneration
495. rapport with nurses is negatively influenced by the spread of patients of own firm throughout hospital
496. rate of return from PHCD is still very low - outreach needs to be supplanted by MDH staff
497. reasons why several initiatives 'fizzle off' are probably multiple and difficult to discern
498. recriminations towards new leaders
499. recruitment and business planning are done at MDH
500. reduction of paperwork and inclusion of more computerised prescribing
501. regular MDT meetings at ITU steered by PDN & and lead consultant
502. relatively few opportunities for career development
503. relies on the indispensable support of the clerk that does secretarial duties for clinical dept.
504. resistance for introduction of ODAs to 'retaining territory' by nurses
505. resourcing is almost exclusively dependent on MoH: too centralised
506. resourcing is almost exclusively dependent on MoH: too centralised
507. respect/ dis-respect: a central theme in the population

508. rigidity id evident particularly at the organisational level and to a lesser extent on the individual level
509. role of practice nurses in continuous learning challenged by low staff complements
510. senior administration needs to be more 'visible' at the patient 'frontlines'
511. senior and older members stay longer hours while younger members opt-out
512. senior nursing - SNMs and CNMs - need to support NOs
513. seniority can trump motivation in selection for learning opportunities
514. several barriers and some seem insurmountable
515. several enablers are present to allow learning at MDH
516. several factors are hindering developments to increase quality care
517. several HCPs are being trained in leadership & management
518. several HCPs lacks a desired level of 'professional pride'
519. several IT tools have also supported propagation of learning
520. several modalities for learning are available
521. shortened exposure time of FY spent with firm is leading to problems
522. single acute general hospital on the Islands
523. situation has gradually and generally improved over the years
524. SLH to MDH migration: generated a lot of knowledge
525. smallness and insularity issues are falling fast and nowadays are often used as an excuse
526. SNMs are encouraged to identify document and investigate a problem_system review
527. SNMs have an important role model function
528. SNMs to start elaborating on a personal project that will be included in their performance plan
529. some barriers are long-standing and entrenched in the organisation
530. some nurses do not have a 'nursing vocation'
531. some of these 'pet projects' thrive while other flounder with resultant frustration
532. some past good practice discontinued when lead retired or replaced
533. some people channel their energy into developing 'pet' projects
534. sought personal characteristics to be a positive role model
535. specialist training abroad is encouraged and dept. has agreements with a number of hospitals abroad to facilitate attachments
536. staff are expected to be flexible and to 'accommodate' unplanned changes
537. staff seek to maintain 'comfort zone' avoiding innovation & resisting new initiatives
538. strong organisation: competent & sufficient resources
539. strong team made up of committed and technically high-level members
540. strong tradition of weekly academic meetings
541. sub-specialities and special interest should be encouraged
542. succession planning: essentially non-existent
543. succession planning: some have interest in it non-functioning for their own dubious reasons
544. supply chain problems with the supply of items needed to maintain PS
545. supporting IT systems is still very inadequate for management monitoring and coordination
546. systems & structures for learning are still below critical mass
547. TC aims to design & coordinate & implement & monitor a pan-MDH training strategy
548. TC needs clear direction & constant support from top MDH management
549. TC needs more access to performance data & IT support
550. TC: earliest role was for training abroad purposes

551. TC: needs more collaboration such as by being more timely informed by directorates at Ministry level
552. TC: new SOP to aide planning - approvals at high central level
553. TC: role is gradually expanding and now includes all professional groups
554. TC: seeks to embed training within collective improvement strategy of MDH as an organisation
555. TC: units & departments requested to submit an annual training plan
556. team members of a clinical dept. need to have high levels of flexibility & endurance & perseverance
557. teamwork is more evident at lower staff levels
558. tensions are visible between all professional groups
559. tensions in strategy vs operation should not be an excuse for never finding the time for the former
560. territoriality is significant both in inter- and intra-professional spheres
561. the 'camaraderie' that forms between colleagues is a positive result of the long hours spent at MDH
562. the 'temporary' wards in corridors are a 'nightmare' for several aspects of patient safety
563. the effect of increases in the intake of 'mature' medical students is worth studying
564. the how to promote learning is still uncertain
565. the installation of business manager with clinical depts. is a welcome measure
566. the non-holistic view in several clinical areas may explain inattention towards OS & general well-being of patients
567. the persistent perceived detachment of Ministry and MDH is unhelpful
568. the present IT system for patients' result has several loopholes that can allow results to go unchecked
569. the probability of being on duty with senior members of your firm is only random
570. the reception of an admitted mistake varies by personality of the receiving senior
571. there are no functional transition clinics to transfer paediatric patients to the adult services
572. there is a 'general scarcity of effective decision-makers'
573. there is a difference between 'learned knowledge' and actual practice
574. there is a need for cross-speciality interaction e.g. appointment of interdepartmental leads
575. there is a pervasive lack or scarcity of resources incl. HR and equipment
576. there is a pervasive power struggle between nurses & doctors
577. there is no clear distinction between senior MDH mngt. and DoH at Head Office
578. threats to initiatives: uncoordinated & dependent 'on own steam' & limited by group boundaries
579. through the time perspective it is possible to see that several enablers have increased over time
580. time excuses for inadequate handover and documentation are not acceptable
581. time required for good quality care is not recognised
582. too many wards are headed by deputy NO instead of a fully appointed NO
583. top consultants need intensive training in leadership
584. trainee feels well supported during training
585. training applied on won initiative not within org. plan and there is an element of 'who shouts most'
586. training in 'core soft skills' only available at trainee level
587. training initiatives need to identify & demonstrate 'return on investment'
588. training needs for CPD need to be well analysed

589. training objectives clearly stated in application showing potential organisational gains
590. training successful if supported by an effective team
591. transfer of nurses including for promotion creates great losses of expertise
592. tries to 'accommodate' all requests by staff for training which can be problematic due to staff shortages
593. trusted with conduction of a project which is then shelved
594. tying waiting lists minimising efforts with performance appraisal is not a good idea
595. unit leaders have no say whatsoever on who is sent to work in their unit
596. units and departments requested to draw up annual training business plans
597. until recently a promotion for a nurse meant transfer from area of expertise
598. upon realising that a mistake has been done reporting usually takes place to the immediate superior
599. usually vast numbers of initiatives are being developed & implemented in parallel
600. value of IRS to well understood
601. very busy schedules with learning aspect from incidents not given due importance
602. very difficult to safeguard confidentiality
603. very little SHRM takes place at MDH
604. visible detachment between DoH and MDH
605. voluntary CPD results in poor participation
606. vulnerable system syndrome is a good descriptive model of MDH
607. walk-a-rounds: need to ensure follow-up of complaints & suggestions
608. walk-a-rounds: reception mixed but overall positive
609. walk-a-rounds: themes include infection control & patient safety & IRS
610. ward leader needs to 'reach the patient through the nurse'
611. weakest link is the organisation input
612. weakest link: patients and their carers esp. acute patients
613. working outside MDH esp. A&E makes you realise 'how much nicer life can be'
614. younger members are less prone to be affected by territorialism
615. younger members fear being perceived as different from the norm
616. younger staff has more energy for change

ANNEX 6

The first cycle codes generated from the analysis of the interviews grouped under the categories generated during the third and second cycle coding respectively
(Numbers in brackets denote Interview number)

- **Second cycle codes in bold lower case – numbering format a., b., c., d., ….**
- **THIRD CYCLE CODES IN BOLD UPPER CASE – numbering format I., II., III., IV., ….**

I. SEPARATION BETWEEN AND WITHIN THE PROFESSIONS

a. Medics vs. other HCPs/ MDH workforce

- IRS: operated by HCPs other than medics (10)
- IRS: medics seek to learn from incidents using other means e.g. weekly case conferences in orthopaedics (10)
- EWS prior to launch meeting with clinical chairs was held (15)
- medics oriented: lowering roles everyone else incl. mngt. (1, 2)
- medical class needs to open up (3)
- medics needs to release its hold on power (3)
- medical consultants are the centre of most decisions (3)
- medics have too much power on MDH administration (3)
- medics manipulate admin and prevent initiatives from implementation (3)
- medical power influences all the health system (3)
- continuous struggle between doctors and nurses (3)
- clinicians and management do not understand or back each other (3)
- IRS is mostly used by nurses & poorly used by doctors (8)
- there is a pervasive power struggle between nurses & doctors (23)
- power struggle between nurses & doctors is less in ITU (23)

b. Aggressiveness of individual HCPs groups

- IRS suffers because of the actions of the nurses' union (10)
- resistance for introduction of ODAs to 'retaining territory' by nurses (18)
- nurses have the highest 'power of redundancy' – *disturbance by nurses causes most problems (more than by medics)* (3)
- dependency on nurses have made them 'more aggressive' (3)
- medics manipulate admin and prevent initiatives from implementation (3)

c. Territoriality/ Isolationist/ Protectionism

- territoriality is significant both in inter- and intra-professional spheres (11)
- clinical depts. tend to function as 'silos' and independent of each other (16)
- 'silo' structure of MDH (1, 18)
- resistance for introduction of ODAs to 'retaining territory' by nurses (18)
- each professional group attempts at exonerating own members from blame (22)
- consultants do not think they can learn anything from junior staff (3)
- consultants tend to 'hoard knowledge' and keep juniors from advancing (3)
- different groups have own learning and training programmes & structures (5, 25)
- AHPs tend to deal with incidents with internal departmental actions (8)
- AHPs are not interested in the central IRS system (8)

d. Activities led by specific HCPs groups

- EWS implementation led in many ways by the nurses (15)
- patients form stronger 'emotional bonds' with nurses (21)
- practice nurses: key role is QI (7)
- main functions of PDN is to foster MDT work & enhancement of training (23)

e. Recognised need for more cross-speciality interaction/ distrust and uncooperative stances

- there is a need for cross-speciality interaction e.g. appointment of interdepartmental leads (16)
- if at all learning is limited to within prof. groups (1)
- organisation needs to foster common interests of all its components (1, 2)
- inter-disciplinary collaboration between paediatrics and other clinical depts. is good (21)
- there are no functional transition clinics to transfer paediatric patients to the adult services (21)
- tensions are visible between all professional groups (3)

- different groups at MDH 'march to their own tune' (5)

ANNEX 6 ***(continued)***

- different groups at MDH influenced by particularities of who leads them (5)
- different groups have own learning and training programmes & structures (5, 25)

f. Need to improve on professional standing (esp. of the nursing profession)

- nursing specialisation still unrecognised (18)
- nursing specialisation will allay 'fears of being moved around' (18)
- nurses can be unfortunately labelled as the 'lost profession' (19)
- nurses do not project themselves very professionally and are prone to be 'played up by the media' (19)
- nurses have habitually ingrained insecurity issues and are often unable to accept internal authority structures (19)
- contact with nurses varies on type of ward and is higher in the more specialised wards (20)
- nurses in specialised wards tend to be more 'respected' and sought for their experience (20)
- managerial role of charge nurses is always submissive to clinical roles (3)
- need for continuous CPD for nurses (23)
- CPD is essential for MDT setting and for integration of nurses with other HCPs (23)
- creation of specialist nurses is positive development (23)
- nurses' specialisation needs careful consideration of minimum qualifications & experience (23)
- minimum level to apply for PDN post recently established at Masters level (23)
- PDN role not well defined & and there is no performance appraisal system (23)
- issue of PDN posts without specialisation requirement is a regressive development (23)
- nurses do not project themselves very professionally and are prone to be 'played up by the media' (23)

g. external imposition

- transfer of nurses including for promotion creates great losses of expertise (18)
- nursing & AHP admin at DoH are detached from MDH situations (5)

h. resistance to change/ 'fixed' mind-sets

- biggest reluctance for change comes from the Medical Dept. and the nursing profession (19)
- blame attribution is influenced by long-standing stereotypes (22)
- medics manipulate admin and prevent initiatives from implementation (3)

i. organisational issues

- rapport with nurses is negatively influenced by the spread of patients of own firm throughout hospital (20)
- there are no functional transition clinics to transfer paediatric patients to the adult services (21)
- nurses: circular mobility private_public no return when transferred out of MDH (5)

II. ORGANISED EVENTS FOR LEARNING

a. intra-departmental initiatives/ activities

- orthopaedic case conferences: aim is clinical improvement & investigations are rare (10)
- case conferences need to take place regularly by each clinical dept. (10)
- M&M meetings started on insistence of Clinical Director (16)
- M&M meetings suffer from a general lack of ownership and on who should report adverse events (20)
- strong tradition of weekly academic meetings in paediatrics (21)
- regular MDT meetings at ITU steered by PDN & and lead consultant (23)
- ITU MDT meetings main role is to identify and implement QI initiatives (23)
- induction program and supervision of new nurses at ITU by PDN (23)
- specialist training abroad is encouraged and dept. has agreements with a number of hospitals abroad to facilitate attachments (22)
- trainee feels well supported during training (22)

b. inter-departmental activities

- pre-discharge MDT meetings take place regularly (21)
- inter-disciplinary meetings stopped due to lack of resources and the occupation of paediatric beds by adult cases (21)
- proactive meetings sought to involve all depts. and not allow e.g. AHCPs to function separately (8)

c. fear of medico-legal risk/ exposure

- cases presented at case conference depend on severity and on whether consultant feels safe vs medico-legal risk (10)
- legal 'protection for learning' still not present (25)

ANNEX 6 ***(continued)***

d. induction meetings/ supervision for new recruits & junior staff

- induction meetings for house officers are poor and not well conducted (10)
- induction program for new nurses is a great enabler (14)
- induction program for new nurses will now be further complemented by on the job training during 1st year (14)
- focussed development on under-grads and new doctors (2)
- induction program and supervision of new nurses at ITU by PDN (23)

e. opportunities for learning events

- CPD: several opportunities and increasing awareness (12)
- several modalities for learning are available (12)

f. support for training initiatives (incl. organisational support)

- nursing training is increasingly being coordinated by & with central MDH training coordination structure (12)
- training successful if supported by an effective team (13)

g. requests to increase standards of training

- accreditation of training is necessary but requires a lot of effort (13)

III. ORGANISATIONAL SUPPORT FOR LEARNING

a. happening abroad but not occurring in Malta/ aspiration to make it happen in Malta

- IRS in foreign hospital is seriously supported by top mngt (10)
- accreditation of training is necessary to justify MDHs title as a 'teaching hospital' (13)

b. fear of medico-legal risk/ exposure

- IRS: medico-legal implications are barriers esp. in a small country (10)
- IRS: needs to be fully supported by a 'no blame philosophy' (10)
- Clinical Dir seeking 'legal protection' from AG for intra-hospital investigations for learning (16)

c. endorsement by senior MDH management

- IRS: need to be supported by the newly appointed Clinical Director (10)
- senior nursing - SNMs and CNMs - need to support NOs (11)
- funding for new initiatives is difficult (11)
- EWS ex-CEO was instrumental (15)
- IRS: 1st CEO put her full weight on the IRS (8)
- proactive meetings with different depts. during term of 1st CEO of MDH (8)

d. deficiencies in and issues with leadership/ senior positions

- too many wards are headed by deputy NO instead of a fully appointed NO (11)
- nurses should have the option for promotion but remain working in their area of expertise (11)
- until recently a promotion for a nurse meant transfer from area of expertise (11)
- relatively few opportunities for career development (11)
- current 'heavy agenda' is due in part to new positions struggling to establish their new roles (12)
- heavy bureaucratic procedures dependent on a few over-burdened individuals (14)

e. perceptions of lack of or inappropriate organisational support/ coordination

- organisational support for new initiatives is perceived as 'weak' Why? (11)
- initiatives launched in an uncoordinated way and do not fall into an 'organisational plan' for development (11)
- need for more and higher level secretarial support (11)
- TC needs more access to performance data & IT support (13)
- TC needs clear direction & constant support from top MDH management (13)
- EWS not coordinated by a fixed or formal group (15)
- the persistent perceived detachment of Ministry and MDH is unhelpful (16)
- tying waiting lists minimisation efforts with performance appraisal is not a good idea (16)

- all priority is given to the elderly population at the expense of paediatric patients (21)
- decisions are often taken on the basis of 'quantity and not quality' (21)

f. inadequate supply of required resources

- funding for new initiatives is difficult (11)
- supporting IT systems is still very inadequate for management monitoring and coordination (11)
- better structured wards at MDH is counterpointed by the 'improvised wards' (14)
- IRS: did not have adequate resources required to function properly (17)
- persistent reluctance to recruit new staff even to replace retiring staff (18)
- half the trainees eventually leave for abroad even though they are ensured a consultant's post (18)
- old practices replaced by new IT processes without evaluation to identify & rectify pitfalls (17)
- general lack of number and of the appropriately trained and qualified secretarial support (16)
- there is a pervasive lack or scarcity of resources incl. HR and equipment (16)
- department is constantly understaffed and HR systems are inefficient and unhelpful (18)
- adequate amount of the new treatment charts are not always available (21)
- imp staff like clinical pharmacist are not adequately available (21)
- clinicians taking up managerial role need to release clinical roles (3)
- MDH corporate training structure is severely under-staffed & underfunded (5)
- training in 'core soft skills' only available at trainee level (25)

g. organisational support/ coordination already provided

- MDH invests a lot in staff development (11)
- nursing training is increasingly being coordinated by & with central MDH training coordination structure (12)
- priorities & initiatives complemented by time-framed action plan incl. budgetary & accountability considerations (13)
- 'hoarding ' of items is much less possible now (14)
- EWS used as justification for requesting new or more resources (15)
- HR functions of Nursing dept. were successfully bridged with mainstream HR functions (6)

h. organisational support/ coordination planned or desired

- need for coordination of new initiatives within a planned strategy (12)
- central training coordination role to be further developed and better equipped (12)
- TC aims to design & coordinate & implement & monitor a pan-MDH training strategy (13)
- applications for training will seek justification & alignment with hospital training objectives (13)
- promotion of hospital horizontal objectives incl. PS & QI (13)
- training initiatives need to identify & demonstrate 'return on investment' (13)
- move away from arbitrary executions of 'wish lists' towards decisions based on an agreed strategy (13)
- patient allocation to a specific nurse should engender greater accountability - needs auditing (14)
- MDH was structurally designed to host a definite number of patients_better planning & monitoring (14)
- the installation of business manager with clinical depts. will be a welcome measure (4, 16)
- audits need to be encouraged and performed on an ongoing basis as a form of CPD (16)
- sub-specialities and special interest should be encouraged (17)
- practice nurses: key role is QI (21)
- CPD needs monitoring both a national regulatory & hospital level (23, 25)

i. competing priorities vs. activities for learning/ improvements

- very busy schedules with learning aspect from incidents not given due importance (12)
- constant tension between strategy vs operations - often strategy gets neglected (13)
- tensions in strategy vs operation should not be an excuse for never finding the time for the former (14)
- chair continues to carry full clinical load with no allowance for new duties (16)
- finding time for chair administrative duties requires engagement of junior staff as replacements (16)
- due to relentlessly high workload it is difficult to find time to strategize and reflect (18)

j. feelings of hopelessness/ dejection

- IRS: stopped because people felt that 'nothing came out of the system' (12)
- current 'heavy agenda' of changes risks staff fatigue (12)
- current 'heavy agenda' is due in part to new positions struggling to establish their new roles (12)
- expectations that 'nothing will come out of a report' (17)

IV. RESOURCES, STRUCTURES, PROCESSES AND DEVELOPMENTS FOR LEARNING

a. perceptions of inadequate supply of required resources (and lacking organisational support/ coordination)

- often the 'loop is not closed' at investigations - missed learning & implementation of recommendations (12)
- investigations take up a lot of time and effort (17)
- HR databases is not inter-operable across all MEH entities (8)
- relies on the indispensable support of the clerk that does secretarial duties for clinical dept. (19)
- improvements in capacity of MDH as a Learning Organisation need better medical file retrieval & enabling ICT systems (21)
- systems & structures for learning are still below critical mass (4)
- more psychological support services are needed (5)
- people mngt: lack of middle managers at MDH leading to halted development (8)
- only one PDN at ITU with over 90 nurses (23)

b. perceptions of dysfunctional, counter-productive or scaled-down organisational support/ coordination

- funds too centrally managed - director has no direct access to funds (11)
- resourcing is almost exclusively dependent on MoH: too centralised (6)
- tries to 'accommodate' all requests by staff for training which can be problematic due to staff shortages (18)
- IRC was a strong enabler (7)
- IRC established a no. of WGs: still sluggishly active (7)
- Director or unit manager were informed of IRS usually they would be already in the know (6)
- at peak of IRS there was more than 1 BOI started per week. Most nominees accepted (6)
- IRS: started at SLH even before 2006 (9)
- IRC: characteristics of IRC as established and worked under 1st CEO (9)
- SLH to MDH migration: generated a lot of knowledge (9)
- knowledge on migration: a lot was recorded (9)
- people mngt: several HR roles minus recruitment & training (8)
- people mngt at HO is less developed than at MDH (8)

c. positive and expanding organisational support/ coordination provided

c1. Positive and effective organisational support/ coordination provided

- people management is fully decentralised on MDH & entities (6, 8)
- now better equipped to handle patients than in the past (14)
- identification of specialised nurses such as in infection control has been successful (14)
- several IT tools have also supported propagation of learning (14)
- EWS trigger observing closely monitored patients due to co-morbidities were benefitting with earlier detection of problems (15)
- EWS prior to launch extensive & long discussions with nursing leaders and ward managers (15)
- EWS launched in 3 pre-selected wards for different reasons (15)
- EWS strong feature is bottom up approach with minimal involvement of hospital authorities (15)
- EWS implementation performed in a very 'flexible' fashion (15)
- EWS excluded patients 'not for CPR' & paediatrics and obstetrics (15)
- EWS training to FY doctors (15)
- new techniques are acquired by sending young professionals for training abroad (18)
- audits and other studies are required for FY program and merit award schemes (20)
- 'champions' are key for success (21)
- several HCPs are being trained in leadership & management (4)
- health & wellbeing initiative at MDH (6)
- recruitment and business planning are done at MDH (6)
- CRM succeeded in creating a number of WGs that are still functioning (6)

c2. Evolving and expanding organisational support/ coordination provided

- TC: role is gradually expanding and now includes all professional groups (13)
- TC: earliest role was for training abroad purposes (13)
- TC: seeks to embed training within collective improvement strategy of MDH as an organisation (13)
- training objectives clearly stated in application showing potential organisational gains (13)
- at application for training to show how improvements will be measured (13)
- TC: new SOP to aide planning - approvals at high central level (13)
- TC: units & departments requested to submit an annual training plan (13)

- new development: extended induction and new 1year foundation program for new nurses (13)
- availability and incentives for learning increasingly available (14)
- best growth and improvement in medication safety and infection control (14)
- SNMs are encouraged to identify, document and investigate a problem_system review (14)
- EWS gradual addition of new wards for roll out_All wards to be included 2 years from launch (15)
- A&E dept. needs to focus more on its core responsibility of primary mngt & investigation of emergency & stabilisation of patient (19)
- empower to try and resolve problem before referring higher (6)

d. organisational support/ coordination planned, desired

- IRS: each clinical team & department needs a liaison officer or champion (10)
- IRS: needed for hospital to implement continuous quality improvements (10)
- SNMs to start elaborating on a personal project that will be included in their performance plan (11)
- clinical champions in infection control can be replicated for PS and QI (4)
- benefits of walk-a-rounds. Need to be led by high level personnel (7)
- walk-a-rounds: reception mixed but overall positive (7)
- walk-a-rounds: need to ensure follow-up of complaints & suggestions (7)
- walk-a-rounds: themes include infection control & patient safety & IRS (7)
- training needs for CPD need to be well analysed (25)

V. ENABLING or IMPEDING PROFESSIONAL/ INDIVIDUAL PERSONAL ATTRIBUTES

a. Enabling features

a1. Organisational HR wealth

- MDH has several 'very talented' nurses (11)
- EWS very small and dynamic core group (15)
- younger members are less prone to be affected by territorialism (16)
- younger staff has more energy for change (3, 16)
- performance & commitment & inter-personal camaraderie are often of a high level in MDH staff (17)
- strong team made up of committed and technically high-level members (18)
- MDH is filled with a lot of dedicated people that try to instil change with a lot of passion (20, 21)
- HCPs will continue caring for patients whatever the turmoil (4, 21)

a2. Individual professional HR assets that support and spur improvement

- professional pride imp impact on responsibility & accountability (11)
- good 'ward leaders' view nurses holistically (14)
- EWS garnered massive support and enthusiasm by several people (15)
- many things work well in MDH against all odds and because most of the staff 'cares' (17)
- nursing standards have greatly improved since the inception of the graduate nurses (14)
- people in healthcare tend to be self-selected (17)
- strong team made up of committed and technically high-level members (18)
- delegation of departmental duties possible because of a strong team (18)
- gender and age are not felt to be detractors from leadership positions (19)
- being female can be helpful with 'female intuition' & lower confrontational tendency & lower inclination to do things for personal gain' (19)
- aims at leaving 'a legacy of change' (19)
- need to actively strive to be a 'constant learner' (19)
- sought personal characteristics to be a positive role model (19)
- need to be able to change own plans if 'a new and better idea is fielded' (19)
- need capability to acknowledge threats but be open and sensitive to opportunities (19)
- problems are often solved on an individual's initiative (20)
- changes in appointments in paediatrics are resisted because it affects patient and her whole family (21)
- HCPs self-selected people fulfilled with 'caring' experience (21)
- Chair is an enabling person & reports are heeded and acted upon (22)
- individuals: knowledge & capacity & competence (2)
- enablers: people capable of acknowledging and fostering respect (2)

a3. Organisational HR approaches that are needed and used to promote momentum for improvement

- ward leader needs to 'reach the patient through the nurse' (14)
- SNMs have an important role model function (14)
- EWS during a ward roll-out a lot of personal contact is required (15)
- entry into HC faculties should be more influenced by presence of 'vocational aptitude' (15)

- EWS required extensive effort by leads risking fatigue of people involved (15)
- achieving change increases if you target and work it out first with the younger people (16)
- older members may consider changes when they start to take hold for fear of becoming 'left out' (16)
- achieving change requires the seeking of 'win-win situations' (16)
- preference for one-to-one communications and re-direction *'bil-kelma t-tajba'* (16)
- older staff should be allowed to concentrate on what they 'are best at' (17)
- senior and older members stay longer hours while younger members opt-out (18)
- important for all consultants of a clinical department to share same vision (19)
- team members of a clinical dept. need to have high levels of flexibility & endurance & perseverance (19)
- key word to ensure changes happens is 'perseverance' (19)
- give more meaning to work (1)
- HCPs to be better prepared to listen esp. to patients' experiences (1)
- top consultants need intensive training in leadership (3)
- inspirational leaders: watch_teach_understand (4)
- need for a robust leadership that can see over and above the 'noise' (5)
- gaining trust requires constantly showing 'integrity of character' (6)
- IRC: CEO must give it her full weight if it is to be taken seriously (9)
- CEO must 'lead by example' (9)
- migration success: close working team & each had clear specific roles (9)
- QI initiatives require consensus building (23)
- learning opportunities initially directed towards who showed most motivation (23)
- IRC: CEO must 'walk the talk' to give it its due importance (9)
- leaders need to give good example because their attitude has a strong ripple effect (23)

b. Impeding features

b1. Individual professional HR shortcomings that oppose and deter improvement

- delegating is an uncommon capability of most medical leaders (16)
- recriminations towards new leaders (16)
- most clinical leaders have problems with delegating and they get 'bogged down' with operational issues as a result (16)
- dis-respectful attitude by juniors to everyone in general_need for more 'decency based' behaviour (17)
- general lack of enthusiasm to report someone else (17)
- senior and older members stay longer hours while younger members opt-out (18)
- post of chair was not wanted by anyone else (19)
- beware 'delusions of grandeur' (19)
- not having a plan B will affect your credibility (19)
- needs of the professionals are leading the agenda (1)
- inhibitors: good intention but cause destruction & chaos (2)
- existence of a distinct MDH modus operandi. HCPs working in private_public lead double lives (5)
- need for a robust leadership that can see over and above the 'noise' (5)
- MDH staff are less efficient than they think (5)
- most MDH staff have a false sense of security for their job (23)

b2. Organisational practices and characteristics that need to be dis-used or curtailed as they decelerate momentum for and impede improvement

- initiatives taken up are dis-continued or fail if 'champion' becomes disheartened (7)
- IRS: take up in a ward is heavily dependent on the views of the NO & DNO (8)
- seniority can trump motivation in selection for learning opportunities (23)
- most MDH staff have a false sense of security for their job (23)

VI. TAUGHT PRACTICE VS PERFORMED PRACTICE

a. differences between taught and performed practice exist

- big difference btw what is taught and what is practiced (11)
- big difference - one reason is compliance with ward group norms (11)
- there is a difference between 'learned knowledge' and actual practice (14)

b. high-quality role models engender and guarantee good/ positive practice

- crux of ward ethos is the attitude & behaviour of the NO (11)
- need for more widespread availability of 'good role models' (11)
- new nurses are heavily influenced by older 'role models' on the wards (13)
- new nurses are strongly influenced by attitudes of 'ward leaders' (14)

c. principles and activities that engender and guarantee good/ positive practice

- need for emphasis on 'back to basic nursing & medical care' (11)
- continuation of education & assessment - more programs need to become mandatory (11)
- nursing leaders are being urged to be more 'on the ground' and be very observant (12)
- nursing leaders to emphasise learning as a one of their central job tasks (12)
- good practice is applied either because it is a belief or because afraid of consequences (14)
- good nursing practice is best solidified in the general medical & surgical wards (14)
- need new emphasis in achieving 'good medical practice' (17)
- sub-specialities and special interest should be encouraged (19)
- major changes in practice necessitate establishment & enforcement of 'standard practice' (19)
- induction training for nurses: well structured & very important (7)
- prior to specialisation new nurses need work experience in general medical & surgical wards (23)
- clinical risk management and PS are now merging (24)

d. attitudes and vulnerabilities that inhibit and compromise good/ positive practice

- poor accountability as in 'everyone assumes that someone else will do it' (12)
- MUMN draws on the disillusionment of some nurses (12)
- most susceptible nurses are those within 3-6 years from graduation (12)
- a good part of the 'bed problem' is 'artificially induced' (19)
- some nurses do not have a 'nursing vocation' (3)

VII. EXTERNAL INFLUENCE ON THE MDH ORGNISATION

a. national behaviour and characteristics are reflected in the MDH setting and community

- need more evidence and visibility of 'civic responsibility' and good 'work ethics' starting at national level (11)
- 'colonial mentality' prevailing and compounded by insular & smallness & high population density (13)
- closed mentality is less prevalent in the younger generations (13)
- a big barrier in Malta is the 'fear of mobility' (14)
- barriers are the smallness of Malta and insularity (14)
- smallness and insularity issues are falling fast and nowadays are often used as an excuse (16)
- national & organisation culture does not favour reporting for learning (17)
- compared to other large national institutions MDH is perceived to perform 'pretty well' (17)
- national limitations include smallness & insularity & 'one bone' characteristic leading to protectionism (19)
- single acute general hospital on the Islands (1, 2, 25)
- demographics of children wrt ethnicity and prevalence of rare & complex conditions changing (21)
- culture: national 'Malta' context (2)
- respect/ dis-respect: a central theme in the population (2)
- Malta is a country of extremes (24)
- nationally there is a general poor safety culture (24)
- MDH is non-comparable to other hospital abroad (25)

b. prevalent methodologies that inhibit progress

- most MDH professionals esp. high levels do not have realistic opportunities for job mobility (5)
- present medico-legal system discourages learning from errors (24, 25)
- people involved in an adverse event are advised not to testify (17)
- prevalent 'tort' based system is a big obstacle to learning from errors (24)
- 'out of courts settlements' better option than litigation for all concerned (24)

c. militant unions uphold members' position and perceived rights above all else/ unions dealt with caution

- MUMN leads MDH nurses from the 'outside' (11)
- MUMN almost 100% membership signifying a lot of power (11)
- MUMN activity towards upholding 'professional pride' is perceived a low on its agenda (11)
- EWS tried and managed to avoid trade unions (15)
- QI is considerably hampered by trade unions activities (7)
- IRS suffers because of the actions of the nurses' union (8)

d. perceived low support and opposition from healthcare providers outside MDH and DoH

- rate of return from PHCD is still very low - outreach needs to be supplanted by MDH staff (12)
- MDH has to bypass deficiencies in PHC with own staff & volunteers & relatives of patients (12)
- professional staff are under severe and constant pressures to cater for increasing demand unmatched with increases in resources (18)

- quality improvements require clinicians to spend more time at MDH_appropriate rise in remuneration (21)
- defensive medicine in response to litigation for clinical mishaps (3)
- knowledge on migration: ministry went out of its way to discard & discredit it (9)
- knowledge on migration: some people resort to it *'bil-moħbi*' (9)
- knowledge on migration: passed on to foreigners and greatly appreciated (9)

e. limitations arise from lack of autonomy

- MDH mngt does not have hire & fire authority affecting scope for disciplinary activity (5)
- direct high-level interference and disproportionate micro-management (18)
- there is no clear distinction between senior MDH mngt. and DoH at Head Office (18)

f. unwarranted interference from external players

- micro-management is the remit of the professionals/ technical (1)
- negative effect of Maltese politics (1)
- politicians need to refrain from micro-managing health (1)
- politicians overrule DoH when they deal directly with MDH (3)
- 10% of MDH employees are otherwise unemployable (5)
- politicians need to refrain from micro-managing health (23)
- health authorities and hospital administration heavily influenced by 'political agenda' (21)

g. communication between public healthcare institutions considered sub-optimal

- TC: needs more collaboration such as by being more timely informed by directorates at Ministry level (13)
- DoH is perceived as 'very distant' and largely 'negative' (22)
- visible detachment between DoH and MDH (3)
- communication between MDH and DoH very poor territorial defence (5)

h. experience of training/ working abroad should foster inclination to more outward looking attitudes

- EWS most medics acquainted with system through experience abroad or training programs (15)
- no fault medical compensation_legal shield_is a facilitator (24)

i. tendency to look up and refer to systems operating abroad (especially in the UK)

- EWS designed on the 2011 NEWS UK system (15)
- contact with centers abroad is a strong point of the Dept. of Surgery (16)
- exposure to institutions abroad is an enabler and helps improve several deficiencies (17)
- NRLS in the UK has low reporting_best for rare incidents (24)

j. patients' behaviour and perceptions influence choice and direction of action in hospital

- patients tend to close the change cycle by starting to 'vote with their feet' (16)
- patients super-sensitive to organisational dynamics (2)
- weakest link: patients and their carers esp. acute patients (2)
- public has poor trust in appointment & organisational system (3)
- patients' groups becoming more significant (25)
- everyone expectations have been immensely raised (25)

k. observed positive factors and developments

- public has increased trust in medical services at MDH (3)
- DoH invested a lot in mngt and leadership training in past 5 yrs. (4)
- enablers: DoH_ CEO_EU (4)
- compared to other large national institutions MDH is perceived to perform 'pretty well' (17)
- massive changes in medical practice from 'care' to 'cure' (25)
- huge development and sophistication changed medicine beyond recognition (25)

VIII. DYSFUNCTIONAL ORGANISATIONAL SYSTEMS & COMMUNICATION CHANNELS

a. incomplete uptake of information on MDH systems/ initiatives by different groups

- IRS: consultant did not know it existed before joining mngt in 2013 (10)
- IRS: more medics need to be aware of it (10)
- EWS found to be an effective tool to improve communication (15)
- EWS improves assertiveness of nurses (15)
- adverse drug reaction reporting system 'not used as much as it should' (21)
- ESP had poor turnout possibly because staff do not perceive there will be direct or immediate benefit (6)

b. MDH systems are not applied through a sound strategy/ plan

- training applied on own initiative not within org. plan and there is an element of 'who shouts most' (13)
- mis-management and mis-matching of staff esp. nurses is wasteful (17)
- primary aim of bed management is to find a bed for an admission and not patient's comfort and safety (17)
- it is difficult to postpone or reschedule surgery even when there is clinical justification (18)
- needs to cater for all demands and exigencies and leaves little room to manoeuvre (18)
- need to cater for peaks of activity (18)
- very little SHRM takes place at MDH (6)
- IRS led by lowest ranking person in WG (6)
- IRS lead had little knowledge of subject and no real executive powers (6)
- learning from training achieved has relevance for and retained solely by individual beneficiary (13)

c. continuity suffers

- no handover took place - culture of handovers is not strong (11)
- no handover results in discontinuities and wasted effort (11)
- time excuses for inadequate handover and documentation are not acceptable (14)
- handover & documentation are imperative for accountability & recognition of specialisation (14)
- 'no handover whatsoever' from predecessor on assuming new post of Clinical Chair (19)
- BoI issue recommendations requiring more stringent evaluation of implementation (6)
- succession planning: essentially non-existent (8)
- no succession planning: corporate knowledge is lost on retirement & transfer (8, 25)
- succession planning: some have interest in it non-functioning for their own dubious reasons (8)
- handover: little overlap when there are changes in top positions (9)
- handover: more effective at lower levels & often 'hand holding' (9)
- handover: new CEO did not take 'full advantage' and did not appreciate it appropriately (9)
- handover in 2011: had to resort to written handover (9)
- handover 2011: giver feels that it was unappreciated by new CEO (9)
- handover of 2011: since it was not well received fears for continuity & retention of knowledge gained (9)

d. common dysfunctional or un-functional systems of communication

- organisational dysfunctional system as in the transfer of patients to and from OT (17)
- organisational dysfunctional system leading to misuse of resources and poor patient experience (17)
- staff are expected to be flexible and to 'accommodate' unplanned changes (18)
- 'mis-communication is a source of substantial 'grief' (17)
- anaesthetists are often informed of changes on the 11th hour (18)
- 'no handover whatsoever' from predecessor on assuming new post of Clinical Chair (19)
- much more needs to be done for better communication & coordination and maintenance of essential resources (21)
- at MDH level there are no readily available channels for staff to forward ideas & concerns (22)
- IRS team members did not share work & lacked commitment (6)
- corporate knowledge: loss accentuated by increase in email and decrease in paper records (8)
- handover: several negative effects when this does not happen (9)

e. resort to commotions (scenes) and defensive stances by some senior members of MDH

- frequent need to resort to shenanigans detract clinician from core responsibilities and leads to frustration & exhaustion (17)
- CEO becomes ineffective and defensive (3)

f. dysfunctional systems and obstacles are entrenched in the organisation

- several barriers and some seem insurmountable (18)
- some barriers are long-standing and entrenched in the organisation (18)
- rigidity is evident particularly at the organisational level and to a lesser extent on the individual level (19)
- duplication of work done at MDH by DoH (6)
- handover in 2011: actively discouraged by ministry (9)
- MDH is negatively affected by lax disciplinary activity (23)
- vulnerable system syndrome is a good descriptive model of MDH (24, 25)
- high bed occupancy can lead to forego pre-operative assessments (18)
- learning is not generally encouraged at the organisational level (22)
- Heads of entities are FMS employees & cannot take decision on discipline on public service staff (8)
- Heads of entities are perceived to have low authority: cannot discipline & low IRS activity (8)

g. solutions to improve effectiveness of organisational systems/ functions

- reduction of paperwork and inclusion of more computerised prescribing (21)

- In some clinical department channels to forward ideas & concerns are more readily available (22)
- BoI issue recommendations requiring more stringent evaluation of implementation (6)
- no overlap between CEOs counteracted by the unchanged senior managers in 2006 (9)
- handover: best given personally by person being replaced (9)
- handover: full handover offered in the CEO change in 2011 (9)
- a system of informal & verbal reporting to senior people in own department works well in some units (23)

IX. SELF-PROPELLED (SELF-DRIVEN) INDIVIDUAL/ GROUP INITIATIVES

a. 'pet projects' abound but they often 'fizzle out'

- some people channel their energy into developing 'pet' projects (11)
- some of these 'pet projects' thrive while other flounder with resultant frustration (11)
- reasons why several initiatives 'fizzle off' are probably multiple and difficult to discern (11)
- decisions are often taken by individuals then blocked (3)
- initiatives often totally dependent on the people who try to 'pull them through' (5)
- trusted with conduction of a project which is then shelved (6)

b. personal initiatives encounter several obstacles to progress

- usually a vast no. of initiatives are being developed & implemented in parallel (5)
- each initiative has a very limited 'line of sight' (5)
- often very difficult to identify agendas behind the initiatives & ideas (5)
- initiatives fail because they do not 'cascade down' or filter down 'distorted' (5)
- 'innovators' become frustrated because MDH structures are typically non-supportive (5)
- threats to initiatives: uncoordinated & dependent 'on own steam' & limited by group boundaries (5)

c. individual initiatives often require a long course

- aiming to introduce EWS for several years (15)
- EWS trigger cardiac surgeon promotion at MMSC 2012 (15)
- introducing something new needs persistence and dogged belief that adoption is required (16)

d. higher hierarchical position brings feeling of increased empowerment

- new chair feels he can achieve much more desired change since he got this position (16)
- continuously planning for 'succession leadership' to minimise risk of a vacuum in leadership (19)
- practices 'formal delegation of duties to different people' to help smoothen succession when this will happen (19)

e. teamwork perceived to function better at lower levels

- teamwork is more evident at lower staff levels (3)

X. LEARNING CULTURE/ ETHOS AT MDH

a. there a professed sensitivity and will to learn

- people are actually 'prepared to learn' (12)
- increased general awareness and sensitivity for PS & QI (14)
- anaesthesia is often the 'champion' for PS in most hospitals (22)
- action in anaesthesia is fast not so in most other clinical departments (22)
- learning occurs 'ad hoc' & 'on the job' (5)
- ongoing training should be in everyone's mind-set (5)
- need for learning is appreciated by most HCPs at MDH (25)

b. MDH enablers for learning/ dissemination of information

- several enablers are present to allow learning at MDH (14)
- through a temporal perspective it is possible to see that several enablers have increased over time (14)
- NSU earned title of 'elite ward' patients constantly informed (7)
- NSU positive feature 'celebrated success' (7)
- IRS and low blame culture are best taken up Pharmacy Dept. (8)

c. situation improving/ availability of knowledge increasing

- availability of knowledge increasing at a fast pace (14)
- situation has gradually and generally improved over the years (21)
- a number of improvements took place over the past 1 year (21)
- heightened HC staff awareness & expectations for better work-life balance (25)

d. pervasive 'blame culture'

- 'blame culture' and attitude that 'if you fail then it's your fault' are pervasive (18, 24, 25)
- prevalent 'fear of insecurity' (1)
- very difficult to safeguard confidentiality (22)
- 'blame culture' transcends all levels (22)
- MDH is very sceptical on initiatives because of several earlier 'let-downs' (5)
- IRS is beleaguered by under-reporting & strong blame culture (23)

e. protectionism of own professional group/ colleagues

- doctors tend to develop 'confidence in own group' and to try to protect own team members (20)
- upon realising that a mistake has been done reporting usually takes place to the immediate superior (20)
- line of command is usually strictly adhered to (20)
- the reception of an admitted mistake varies by personality of the receiving senior (20)
- all medics and higher nursing levels are expected to be 'perfect' (3)
- the 'camaraderie' that forms between colleagues is a positive result of the long hours spent at MDH (20)

f. system 'absorbs' small transgressions and makes them the 'accepted norm'

- 'minor' transgressions get 'ingrained' in the way things are done (22)
- younger members fear being perceived as different from the norm (3)

g. reports tend to travel through known un/semi-official channels

- more serious events are directly reported to the Chair (22)
- an effective promoting factor is by 'word of mouth' through MDHs 'gossip factory' (16)
- info on events travel fast 'through the grapevine' (22)

h. negative assessment of learning capacity at MDH

- not enough learning takes place (5)
- Capua has better 'no blame culture' reported medication error and was acknowledged instead of reprimanded (7)
- IRS met with tepid success and enthusiasm in the wards (8)
- general apathy and disinterest towards CPD by the nursing professionals (23)
- most clinicians do not as yet appreciate specialisation in PS (24)

i. reasons for low learning capacity at MDH

- MDH is very sceptical on initiatives because of several earlier 'let-downs' (5)
- the probability of being on duty with senior members of your firm is only random (20)
- constant need to strike right balance between professional & employment & personal duties (23)
- opt-out from Working Time Directive is not the exception but the rule in MDH (20)
- long hours spent at MDH and this sort of 'takes over your life' (20)
- working outside MDH esp. A&E makes you realise 'how much nicer life can be' (20)
- junior doctors work on a 'conveyer belt' basis with negligible learning opportunities esp. during duties (20)
- CPD is still performed on a voluntary basis (23)
- MDH is still lagging far behind in infrastructure for PS (24)
- several factors are hindering developments to increase quality care (25)
- output overpowers considerations of outcomes and quality (25)
- voluntary CPD results in poor participation (23, 25)

XI. CONSTRAINTS FOR PATIENT SAFETY & QUALITY IMPROVEMENT

a. resistance to/ lack of understanding for change and new ideas

- high proportion of MDH are 'risk averse' and scared of 'extra commitment' (13)
- staff seek to maintain 'comfort zone' avoiding innovation & resisting new initiatives (13)
- EWS does not have support staff precluding evaluation and audit
- EWS problems with implementation included lack of understanding by operating staff (15)
- several HCPs lacks a desired level of 'professional pride' (15)
- general culture in MDH is resistant to change and in many respects, this is similar to the rest of Malta (19)
- value of IRS not well understood (6)
- barrier: general reluctance to change (7)
- MDH sluggish efforts for learning accentuated by smallness of Malta & sole major hospital (23)

b. high level of patient activity

- PS is greatly compromised in the 'improvised wards' for several reasons_more recent admissions & difficult to establish rapport with patients (14)

- most HCPs are under constant high pressure (15)
- clinicians' exhaustion is caused by the widespread location of firm's patients across all MDH (17)
- bed management is negatively influenced by the high bed occupancy rate
- most wards at MDH were initially meant to be specialised wards (20)
- the 'temporary' wards in corridors are a 'nightmare' for several aspects of patient safety (20)

c. supply chain challenges (tangible and non-tangible)

- supply chain problems with the supply of items needed to maintain PS (14)
- EWS lack of permanent staff in one ward led to suspension of EWS (15)
- HR at several levels of expertise is scarce (15)
- demoralising situations such as lack of recognition and scarcity of opportunities for career progression (15)
- lack of adequate space is a major obstacle to the provision of good quality care (21)
- occupation of paediatric beds by adult patients is limiting the provision of good quality care to child patients (21)
- time required for good quality care is not recognised (21)
- role of practice nurses in continuous learning challenged by low staff complements (3)
- following completion of induction program nurses do not have any further performance assessments (23)
- barrier: lack of continuous training and re-training (7, 25)
- lack of medical indemnity cover 'did not help' (25)
- legal 'protection for learning' still not present (25)

d. resistance to clinical governance and the application of standards and guidelines

- observing clinical guidelines is still a weak point of several clinicians at MDH (16)
- need to stress that observing clinical guidelines protect clinicians (16)
- clinical governance is weak and should be the main priority of the Clinical Director (16)
- in several specialities, the person is not viewed holistically including all of her medical & social context (22)
- the non-holistic view in several clinical areas may explain inattention towards PS & general well-being of patients (22)
- getting consistently good quality care perceived as not guaranteed by public (3)
- barrier: major problems with 'self-discipline' (7)
- barrier: no culture to review SOPs (7)

e. leadership not well equipped and overwhelmed with micro-management

- instead of focussing on clinical governance clinical director is overwhelmed with micro-management (16)
- there is a 'general scarcity of effective decision-makers' (19)
- unit leaders have no say whatsoever on who is sent to work in their unit (23)
- PS needs a multi-disciplinary team led by a trained manager_IRS in its portfolio (24)
- PaSQIT is made up of informally engaged individuals_inadequate for purpose (24)

f. ‘over reliance’ on non-comprehensive ICT systems

- 'over-reliance' on and 'false security' from computers leads to mistakes such as mis-labelling (17)
- the present IT system for patients' result has several loopholes that can allow results to go unchecked (20)

g. changes in exposure and characteristics of junior staff

- shortened exposure time of FY spent with firm is leading to problems (17)
- the effect of increases in the intake of 'mature' medical students is worth studying (17)

h. difficulties to retain confidentiality

- 'everyone knows everyone else' with high risk of leaks (17)
- IRS considered by many as a real threat (6)
- anonymity & confidentiality are very difficult to maintain (23, 25)

i. multi-faceted problems for the implementation of IRS

- IRS and dissemination of lessons is more practiced at departmental level than at hospital-wide level (6)
- IRS at SLH & MDH for a long time but never well established (7)
- barrier: pervasive culture of persons finding difficulty to admit that they erred (7)
- barrier: difficulty to sustain support for initiatives (7)
- MDH without effective systems for the generation and dissemination of learning (23)
- investigation of reported incidents is vital (24)
- several factors are hindering developments to increase quality care (25)
- the how to promote learning is still uncertain (25)
- need for learning is appreciated by most HCPs at MDH (25)

XII. OUTSIDERS VIEWS ON THE CAPACITY OF AND FUTURE ASPIRATIONS FOR MDH FOR LEARNING

a. inclusivity and interactivity is key/ everyone should be in this together

- all components of the org. are co-creators of organisational knowledge (1)
- hospital need to be 'owned' by all players (1)
- hospital needs to be sensitive to needs & aspirations of all players (1)
- interaction leads to the growth of the creator individual (1)
- learning requires sharing of ideas (1)
- learning more effective if trainers seek to learn from trainees (3)
- individuals learn together because it is unavoidable (4)
- learning is fostered if people feel empowered to report (4)
- change needs to be consistent and incremental to be successful (9)
- leaders need to have view from an entity to a ministry (8)

b. several aspirations for MDH to become better

- aspire for MDH to become more strategic-oriented (1)
- aspire for MDH to become more visibly 'caring' (1)
- need to improve capture level of currently accepted/ available knowledge (1)
- aspire to be an evolving organisation in the 21st century (1)
- learning is a manifestation of an evolving organisation (1)
- increase and maintain employee well-being (2)
- MDH has to be a LO (4)
- MDH needs to learn in a vicarious/ indirect way (4)
- MDH should be 'flag bearer' for other MT organisations wrt learning & training (5)

c. promotion of outward looking views to challenge status quo

- education to challenge the status quo/ anti-progressive systems (1)
- knowledge sharing from local to global levels (1)
- LO encourage individuals to institutionalise their learning (1)
- GP training programme is effective for learning (3)
- public educated by professionals who need to embrace 'change' first (3)
- learning fostered if big numbers of incident reports are generated (4)
- learning is fostered if systems failures are the most often cause of incidents (4)
- learning is fostered if documentation is really taken up (4)

d. consequences of learning

- learning is a manifestation of an evolving organisation (1)
- learning needs to be based more on the study of evolving trends (1)
- learning requires sharing of ideas (1)
- learning something new often involves 'unlearning' old ideas and methods (1)

e. negative assessments and detractors to progress at MDH

- massive challenge is to 'unlearn' due to the fear of failure (1)
- MDH not yet a 'learning organisation' (1)
- MDH is stuck in an 'old model' (3)
- MDH is a massive and complex organisation by MT standards (5)
- people expect change to occur with a 'magic wand' (9)

f. advice that needs to be heeded before progress can be achieved at MDH

- minimise unnecessary experimentation in patient care (1)
- need a flatter approach which is more patient-centred (1)
- organisations need to address issue of generating value (1)
- organisational dynamics: influenced by the leaders in an org. (2)
- need for capacity to work in teams (2)
- change should be aimed at the system and not at the individual (3)
- discipline needs to be graded (3)
- MDH needs to learn in a vicarious/ indirect way (4)
- continuous systems improvement: functional system for action present (4)

g. theoretical statements

- HC outcomes: satisfaction & motivation & clinical (2)
- organisational dynamics: psychology & management (2)
- strong organisation: competent & sufficient resources (2)

ANNEX 7

The second cycle categories with their corresponding third cycle encompassing categories

Third cycle category		Second cycle categories
I.	SEPARATION BETWEEN AND WITHIN THE PROFESSIONS	a. medics versus other Health Care Professionals (HCPs)/ MDH workforce b. aggressiveness of individual HCPs groups c. territoriality/ Isolationist/ Protectionism d. activities led by specific HCPs groups e. recognised need for more cross-speciality interaction/ distrust and uncooperative stances f. need to improve on professional standing (especially of the nursing profession) g. external imposition h. resistance to change/ 'fixed' mind-sets i. organisational issues
II.	ORGANISED EVENTS FOR LEARNING	a. intra-departmental initiatives/ activities b. inter-departmental activities c. fear of medico-legal risk/ exposure d. induction meetings/ supervision for new recruits and junior staff e. opportunities for learning events f. support for training initiatives (including organisational support) g. requests to increase standards of training
III.	ORGANISATIONAL SUPPORT FOR LEARNING	a. happening abroad but not occurring in Malta/ aspiration to make it happen in Malta b. fear of medico-legal risk/ exposure c. endorsement by senior MDH management d. deficiencies in and issues with leadership/ senior positions e. perceptions of lack of or inappropriate organisational support/ coordination f. inadequate supply of required resources g. organisational support/ coordination already provided h. organisational support/ coordination planned or desired i. competing priorities vs. activities for learning/ improvements j. feelings of hopelessness/ dejection
IV.	RESOURCES, STRUCTURES, PROCESSES AND DEVELOPMENTS FOR LEARNING	a. perceptions of inadequate supply of required resources (and lacking organisational support/ coordination) b. perceptions of dysfunctional, counter-productive or scaled-down organisational support/ coordination c. positive and expanding organisational support/ coordination provided c1. Positive and effective organisational support/ coordination provided c2. Evolving and expanding organisational support/ coordination provided d. organisational support/ coordination planned and desired

ANNEX 7 *(continued)*

Third cycle category		Second cycle categories
V.	ENABLING OR RESTRICTING PROFESSIONAL/ INDIVIDUAL PERSONAL ATTRIBUTES	a. Enabling features a1. organisational Human Resources (HR) wealth a2. individual professional HR assets that support and spur improvement a3. organisational HR approaches that are needed and used to promote momentum for improvement b. Impeding features b1. individual professional HR shortcomings that oppose and deter improvement b2. organisational practices and characteristics that need to be dis-used or curtailed as they decelerate momentum for and impede improvement
VI.	TAUGHT PRACTICE VERSUS PERFORMED PRACTICE	a. differences between taught and performed practice exist b. high-quality role models engender and guarantee good/ positive practice c. principles and activities that engender and guarantee good/ positive practice d. attitudes and vulnerabilities that inhibit and compromise good/ positive practice
VII.	EXTERNAL INFLUENCE ON THE MDH ORGNISATION	a. national behaviour and characteristics are reflected in the MDH setting and community b. prevalent methodologies that inhibit progress c. militant unions uphold members' position and perceived rights above all else/ unions dealt with caution d. perceived low support and opposition from healthcare providers outside MDH and Department of Health (DoH) e. limitations arise from lack of autonomy f. unwarranted interference from external players g. communication between public healthcare institutions considered sub-optimal h. experience of training/ working abroad should foster inclination to more outward looking attitudes i. tendency to look up and refer to systems operating abroad (especially in the UK) j. patients' behaviour and perceptions influence choice and direction of action in hospital e. observed positive factors and developments
VIII.	DYSFUNCTIONAL ORGANISATIONAL SYSTEMS AND COMMUNICATION CHANNELS	a. incomplete uptake of information on MDH systems/ initiatives by different groups b. MDH systems are not applied through a sound strategy/ plan c. continuity suffers d. common dysfunctional or un-functional systems of communication e. resort to commotions (scenes) and defensive stances by some senior members of MDH f. dysfunctional systems and obstacles are entrenched in the organisation k. solutions to improve effectiveness of organisational systems/ functions

ANNEX 7 *(continued)*

Third cycle category		Second cycle categories
IX.	SELF-PROPELLED (SELF-DRIVEN) INDIVIDUAL/ GROUP INITIATIVES	a. 'pet projects' abound but they often 'fizzle out' b. personal initiatives encounter several obstacles to progress c. individual initiatives often require a long course d. higher hierarchical position brings feeling of increased empowerment e. teamwork perceived to function better at lower levels
X.	LEARNING CULTURE/ ETHOS AT MDH	a. there a professed sensitivity and will to learn b. MDH enablers for learning/ dissemination of information c. situation improving/ availability of knowledge increasing d. pervasive 'blame culture' e. protectionism of own professional group/ colleagues f. system 'absorbs' small transgressions and makes them the 'accepted norm' g. reports tend to travel through known un/semi-official channels h. negative assessment of learning capacity at MDH i. reasons for low learning capacity at MDH
XI.	CONSTRAINTS FOR PATIENT SAFETY AND QUALITY IMPROVEMENT	a. resistance to/ lack of understanding for change and new ideas b. high level of patient activity c. supply chain challenges (tangible and non-tangible) d. resistance to clinical governance and the application of standards and guidelines e. leadership not well equipped and overwhelmed with micro-management f. 'over reliance' on non-comprehensive ICT systems g. changes in exposure and characteristics of junior staff h. difficulties to retain confidentiality i. multi-faceted problems for the implementation of IRS
XII.	OUTSIDERS VIEWS ON THE CAPACITY OF AND FUTURE ASPIRATIONS FOR MDH FOR LEARNING	a. inclusivity and interactivity is key/ everyone should be in this together b. several aspirations for MDH to become better c. promotion of outward looking views to challenge status quo d. consequences of learning e. negative assessments and detractors to progress at MDH f. advice that needs to be heeded before progress can be achieved at MDH g. theoretical statements

ANNEX 8

List of first cycle codes generated from the the entries in the action research journal (203 codes)

3. 'non-conformity' can be the result of not doing things well or lack of standardisation
4. 'right patient in right bed' still at it without clear objectives after 5 months
5. 'right patient right bed' identified as the ultimate target
6. 'right patient right bed' PaSQIT priority for almost all of its 1st year in existence
7. 'right patient right bed' target is multi-factorial and required support of everyone at MDH
8. 'specialty wards' surface in discussions from time to time
9. 'wrong blood in bottle' identified as a serious_potentially dangerous repeated alert
10. a lot of fine words were said and quoted but execution of actions faltered
11. a lot of work promised by individuals but undelivered
12. a lot of work started but not finalised_launched_concluded
13. a medic was eventually selected and sent for training on PS
14. a number of people seeking new objectives for employment
15. a separate reporting system at ITU level was developing in parallel
16. agenda item not discussed
17. agenda setting is often left to chair
18. agreement on best day and time for meeting achieved with some difficulty
19. agreement on organisational issues easily achieved
20. aim to do several things but fail to ever do them
21. an observer imposed on group during one meeting by Clinical Director
22. aware of several committees working at MDH
23. awareness of the need for learning needs to be increased
24. basis for new CRM agreed several months before it was actually launched
25. bureaucracy and administrative obstacles esp to obtain required resources
26. careful design of projects highlighted
27. careful selection of new recruits for aptitude is an important issue
28. celebration of success stories
29. CEO & Clinical Director often expressed 'disappointment with the team's achievements
30. CEO appeared initially 'generous' with powers given to PASQIT
31. CEO often requests MDH to emulate industry
32. CEO_ team members should have protected time & executive powers
33. Chair organises and attends meetings with third parties often on his own
34. chair was chosen almost automatically
35. change requires the understanding of organisational culture and philosophy
36. change will happen if people involved perceive benefit
37. channelling patients with similar conditions into one ward or location
38. clinical governance_role of PaSQIT disputed by members vs. CEO
39. Clinical Support managers_pilot started in 2015 with a few Clinical Directorates
40. clinicians need to assume higher 'ownership' of patient
41. common folder to include all PASQIT docs and communication set up
42. comparisons with hospitals abroad is a problem because of unique context of MDH
43. completed membership medics & nurses & AHCP & pharmacy & midwife
44. confidentiality issues are a major threat to CRM
45. contact points had problems reconciling IRC work and own personal duties
46. contact points supposedly given 'dedicated time' to function

ANNEX 8 ***(continued)***

47. contractor resource to develop QI projects
48. convening meetings of several busy people is daunting
49. definition of PASQIT role needs to be revised
50. demonstrable change in a health care setting can take up to 8 years
51. desire to know more about PS evidently on the rise
52. different professional groups tend to seek to work on their own
53. documentation for SA Learn at ITU developed apace with strong leadership & eager members
54. each category of incident had one lead contact person
55. effort at decentralization by lowering threshold for approval of SOPs
56. efforts to revamp existing WG
57. element of naivety visible
58. eliciting standards and processes used elsewhere
59. enlisting new Clinical Director as a new ally
60. eventually the need to select more circumscribed themes for activities recognised
61. exposure and contact with abroad infrequent
62. extending visitors' hours at MDH
63. falls WG presumably making progress which is poorly visible
64. feedback requested on drafted documents is rarely received
65. first addition of HCP member who is working full-time on PS & QI projects
66. fixed meeting venue organised for the first 12 to 18 months of PASQIT
67. for about 6 months EMCS projects take over PASQIT agenda
68. full-time focal point for CRM & PASQIT eventually materialised in June 2015
69. group expected to lead and promote change and change mentality
70. group needs to sets direction through defining mission & vision & strategy
71. identifying patient safety champions
72. implementation of change is very complex and needs to be truly supported
73. importance of area-specific & topic-specific MDTs
74. improvements in quality and patient safety can be achieved when working with clinical micro-systems
75. inefficient systems lead to considerable wastage
76. infection control had 'role model' status within PaSQIT
77. influenza vaccination campaign became prominent in 2013 and again in 2015
78. initial expert advice was that reporting system and PS & QI group should be separate but closely communicating
79. initially well organised documentation and follow-up plans
80. insurance issues have to date been neglected
81. intense and diverse methodology to work towards and achieve change
82. IRC_priority given to medication errors
83. ITU designed CRM seen as a precursor or component of a centralised system
84. JHI report earmarked several actions incl. PS
85. KPI reports started to be done by CPU on a regular basis
86. Lachman to re-visit after 2 and a half years_1st visit in May 2013
87. lack of structures negatively affects implementation & survival of ideas
88. learning requires constant data input & analysis
89. legal backing is a perennial sore point
90. long list of priority or 'wish list' of issues to address drawn up
91. long list of requested resources started to seep in after 1 year of PaSQIT

ANNEX 8 ***(continued)***

92. major problem with MDTs is often tensions between different groups of HCPs
93. mandatory continuous CPD 'the elephant in the room'
94. MDH culture comprises of several sub-cultures dependent on unit or team
95. MDH does not truly function as a 24/7 hospital
96. MDH is a micro-system of Malta
97. MDH needs more doers and not more philosophers
98. MDH_existence of a pervasive fear of documentation exists in several quarters
99. measurements and indicators also occasionally highlighted
100. medication errors identified as a special class
101. meetings initially very frequent
102. members are full-time HCPs with heavy personal work loads
103. members made to leave PASQIT when they are transferred outside MDH
104. members of sub-WG becoming central members of PaSQIT.
105. Mortality & Morbidity meetings launched as another arm for learning in PS
106. need for separate advisory committee and executive structures
107. need to be aware of evolution of the team and to continuously re-assess strategy
108. need to continuously strive to build capacity and expertise
109. need to identify pockets of 'good practice' for evaluation
110. need to increase agility of HCPs to patients' change of status
111. new format for minute reporting by researcher
112. new group designed to work with & coordinate work of other hospital committees
113. new group with very broad and undefined objectives formed in 2013
114. new members added to replace leaving or retiring ones
115. new team seen as the one solution for anything that has not been achieved to date
116. new WGs keep cropping up from time to time
117. no legal backup a constant problem and threat
118. nobody has real 'executive powers'
119. non-punitive objective of SA Learn needs to be stressed repeatedly
120. nursing & ward practices require reform
121. objective of PaSQIT as a knowledge hub for PS
122. objective outsiders' views tend to be more positive than internal assessments
123. of the several objectives identified in 2013 only one materialised in April 2015
124. official & formal letter of appointment was requested by members
125. oncology hospital is being included with MDH governance
126. optimizing bed occupancy at MDH_several small projects_cumulative effect
127. parallel reporting systems still in operation_informal agreement to channel PS alerts to SA Learn
128. PaSQIT conceived to replace wound up IRC
129. PASQIT effected by loss of members when they are transferred outside MDH
130. PaSQIT initially committed to a six-monthly progress report
131. PaSQIT meetings held regularly in spurts to be followed by long lulls
132. PaSQIT members feel 'overpowered' by the demands to work that PASQIT role demands
133. PASQIT members need training and mentoring
134. PaSQIT members' role bolstered by persuasion skills
135. PASQIT strategy well defined
136. PaSQIT supposedly led and supported by Clinical Director
137. PASQIT team building sessions_did not take place really except for half day seminar in Feb 14

ANNEX 8 ***(continued)***

138. PaSQIT was invited to contribute to other projects ongoing at MDH at time of inception
139. patient safety is professed to be the ultimate priority
140. patient safety was declared as being 'alien' to several MDH workers
141. patients' and relatives' involvement still rather weak
142. politicians take over when HCPs fail to engage
143. post-meeting & event reflection
144. pre-requisites for patient centred care
145. pre-requisites to achieve are well known but realisation falters
146. presentation of PhD progress report to members
147. pressure ulcers gradually rose in prominence as another major objective
148. progress report shows lacking enthusiasm on a number of actions
149. projects dropped because of lack of promised enthusiasm
150. PS is multi-factorial
151. QI projects require in-depth investigation of the root causes
152. quality has been generally subservient to other perceived 'priorities'
153. quality improvements best achieved through changes in culture and beliefs
154. quality of care given after regular hours & during weekends & public holidays falls sharply
155. re-introducing a centralised CRM system central to PASQIT objectives
156. recognised need to educate_motivate_empower MDH HCPs
157. recognition or acknowledgement of work done and done well should be internalized in MDH operations
158. replacement of members who retired_Head replaced with less senior representative
159. reporting to SA Learn to be made easy and versatile
160. risk assessment committee_real underlying reason for CEO & Medical Director bid to form PASQIT
161. risk of leaving medications by the patient's bedside
162. RPRB requires upgrades in bed management & planning practices esp. through proactive discharge planning
163. SA Learn should aim at improving the competence of 'reflection' of HCPs
164. SA Learn system started to take shape in May 2014
165. SA Learn to be promoted as another tool to make MDH work better
166. SA Learn_dissemination of learning is most important function
167. same aims and intentions but finding great difficulty in agreeing on how to get there
168. secretarial duties assumed by one member_no effective rotation materializes
169. several demands laid down to help group become effective
170. several ideas for new activities to boost QI all needing motivated clinicians
171. severity assessment matrices
172. significant work done however sustainability problematic due to lack of resources
173. solutions and activities need to be led by experts in the area concerned
174. some members can be individually overpowering over the rest of the team members
175. some ward items such as temperature monitoring equipment is beyond the remit of HCPs
176. standardised care pathways started to be occasionally mentioned
177. sub-groups created and followed-up from 2014
178. surgery as reflected in waiting time lists is very powerful
179. team was always cognizant that it cannot manage IRS on its own
180. teamwork concept tends not to be strong in the Maltese context
181. the capacity to investigate SAs remains a persistent problem

ANNEX 8 ***(continued)***

182. the chasing & investigation of incident report to be done by PASQIT members
183. the concept of 'patient-centeredness' is often flaunted
184. the development of the 'listening methodology' stressed by expert in the formative sessions
185. the idea of measurement for achievement and accountability present from the beginning
186. the main aim of the CEO to create PaSQIT to substitute for faltering IRS
187. the need for communication and PR is occasionally highlighted
188. the new concept of positive deviance introduced
189. the problem of re-establishing a CRM was avoided for a few weeks
190. the RAG theme was a source of constant grief to PASQIT
191. the value of 'respect' is notable by its low collective ranking
192. the WILL to improve and bring about change is evident
193. too much detail on the educational programs
194. TORs to be developed by PASQIT members
195. two new senior nurses joined
196. value chain approach and analysis suggested as a tool
197. values of team members extracted and prioritized
198. various attempts to be more organised and disciplined tried from time to time
199. visibility is always an issue_several suggestions to boost visibility frequently fielded
200. well performing staff will only require intervention in 'exceptional' cases
201. when one person is motivated enough things will be performed
202. wide range of areas and topics require attention
203. wide range of solutions to be explored & activities to be performed
204. work on SA Learn started to pick-up when EM joined
205. written work is almost exclusively done by only 2 members

ANNEX 9

The secondary cycle codes allocated to each first cycle code generated from the data collected during the action research arm of this study.
(First cycle codes represented in alphabetical order)

Code No.	First cycle code	Assigned secondary cycle code
1	'non-conformity' can be the result of not doing things well or lack of standardisation	• UNEASY WITH STANDARDISATION
2	'right patient in right bed' still at it without clear objectives after 5 months	• LACK OF FOCUS • INDECISION • OVER-AMBITIOUS
3	'right patient right bed' identified as the ultimate target	• OVER-AMBITIOUS • FAR-REACHING VISION
4	'right patient right bed' PaSQIT priority for almost all of its 1st year in existence	• LACK OF FOCUS • AMBITIOUS • FAR-REACHING VISION
5	'right patient right bed' target is multi-factorial and required support of everyone at MDH	• TENTATIVE DIVISION OF LABOUR • EVERYONE NEEDS TO BE ON BOARD • POWERLESSNESS • SENIOR MANAGEMENT ENDORSEMENT
6	'specialty wards' surface in discussions from time to time	• SPECIALISATION • SHORT-LIVED / TRANSITORY CRAZE
7	'wrong blood in bottle' identified as a serious/ potentially dangerous repeated alert	• REPEATED ALERTS • HEAVY WORKLOADS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
8	a lot of fine words were said and quoted but execution of actions faltered	• OVER-AMBITIOUS • NON-DELIVERING • SHORT-LIVED / TRANSITORY CRAZE
9	a lot of work promised by individuals but undelivered	• OVER-AMBITIOUS • NON-DELIVERING • HEAVY WORKLOADS
10	a lot of work started but not finalised/ launched/ concluded	• OVER-AMBITIOUS • NEED FOR DETAILED PLANNING • SENIOR MANAGEMENT ENDORSEMENT • POWERLESSNESS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • APPRECIATION OF GOOD WORK

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
11	a medic was eventually selected and sent for training on patient safety (PS)	• SENIOR MANAGEMENT ENDORSEMENT • APPRECIATION OF GOOD WORK • RARE TANGIBLE ACHIEVEMENTS
12	a number of people seeking new objectives for employment	• EVERYONE NEEDS TO BE ON BOARD • VALUED EXPERIENCE • APPRECIATION OF GOOD WORK (achievers sought)
13	a separate reporting system at Intensive Therapy Unit (ITU) level was developing in parallel	• APPRECIATION OF GOOD WORK • POWERLESSNESS
14	agenda item not discussed	• NON-DELIVERING • NOT STICKING TO AGENDA
15	agenda setting is often left to chair	• MONOPOLY SOUGHT AND GIVEN
16	agreement on best day and time for meeting achieved with some difficulty	• HEAVY WORKLOADS • NON-DELIVERING
17	agreement on organisational issues easily achieved	• NON-DELIVERING • NOT STICKING TO AGENDA • TENTATIVE DISCIPLINE • MONOPOLY SOUGHT AND GIVEN
18	aim to do several things but fail to ever do them	• NON-DELIVERING • OVER-AMBITIOUS • LACK OF FOCUS
19	an observer imposed on group during one meeting by CD	• POWERLESSNESS
20	aware of several committees working at MDH	• NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT • LACK OF FOCUS
21	awareness of the need for learning needs to be increased	• EVERYONE NEEDS TO BE ON BOARD • RECOGNITION OF NEED TO LEARN
22	basis for new CRM agreed several months before it was actually launched	• RECOGNITION OF NEED TO LEARN • NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT
23	bureaucracy and administrative obstacles esp. to obtain required resources	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • ABANDONMENT BY SENIOR MANAGEMENT • HEAVY BUREAUCRACY • HEAVY WORKLOADS
24	careful design of projects highlighted	• NEED FOR DETAILED PLANNING • MULTI-PRONGED ACTIVITY REQUIRED
25	careful selection of new recruits for aptitude is an important issue	• SELECTIVITY

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
26	celebration of success stories	• APPRECIATION OF GOOD WORK • SENIOR MANAGEMENT ENDORSEMENT
27	CEO & CD often expressed 'disappointment with the team's achievements	• ABANDONMENT BY SENIOR MANAGEMENT • NON-DELIVERING • ACHIEVING VISIBILITY IS A PRIORITY • TENTATIVE DISCIPLINE
28	CEO appeared initially 'generous' with powers given to PaSQIT	• SENIOR MANAGEMENT ENDORSEMENT • SHORT-LIVED / TRANSITORY PHASE • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS
29	CEO often requests MDH to emulate industry	• DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS
30	CEO_ team members should have protected time & executive powers	• SENIOR MANAGEMENT ENDORSEMENT • OVER-AMBITIOUS • HEAVY WORKLOADS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
31	Chair organises and attends meetings with third parties often on his own	• PERSONAL AGENDAS • ACHIEVING VISIBILITY IS A PRIORITY • HEAVY WORKLOADS
32	chair was chosen almost automatically	• PERSONAL AGENDAS • TENTATIVE DIVISION OF LABOUR • SELECTIVITY
33	change requires the understanding of organisational culture and philosophy	• NATIONAL CULTURE • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • NEED FOR DETAILED PLANNING • FAR-REACHING VISION
34	change will happen if people involved perceive benefit	• EVERYONE NEEDS TO BE ON BOARD • NATIONAL CULTURE • PERSONAL AGENDAS • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • NEED TO DISPEL 'BLAME CULTURE' • ENTHUSIASM FOR PROFESSIONALISM
35	channelling patients with similar conditions into one ward or location	• SPECIALISATION • SHORT-LIVED / TRANSITORY PHASE • VALUED EXPERIENCE • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM
36	clinical governance_role of PaSQIT disputed by members vs. CEO	• OVER-AMBITIOUS • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • SHORT-LIVED / TRANSITORY PHASE

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
37	Clinical Support managers_pilot to start in 2015 with a few Clinical Directorates	• SHORT-LIVED / TRANSITORY PHASE • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • NON-DELIVERING
38	clinicians need to assume higher 'ownership' of patient	• ABUNDANCE OF IDEAS • TENTATIVE DISCIPLINE
39	common folder to include all PaSQIT docs and communication set up	• ABUNDANCE OF IDEAS • TENTATIVE DISCIPLINE • HEAVY WORKLOADS
40	comparisons with hospitals abroad is a problem because of unique context of MDH	• NATIONAL CULTURE AND UNIQUE CONTEXT
41	completed membership medics & nurses & allied healthcare professionals (AHCP) & pharmacy & midwife	• ABUNDANCE OF IDEAS • EVERYONE NEEDS TO BE ON BOARD • FAR-REACHING VISION
42	confidentiality issues are a major threat to Clinical Risk Management (CRM)	• NEED TO DISPEL 'BLAME CULTURE' • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
43	contact points had problems reconciling Incident Reporting Committee (IRC) work and own personal duties	• HEAVY WORKLOADS • SHORT-LIVED / TRANSITORY PHASE • NON-DELIVERING • RECOGNITION OF NEED TO LEARN • ABUNDANCE OF IDEAS
44	contact points supposedly given 'dedicated time' to function	• HEAVY WORKLOADS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
45	contractor resource to develop Quality Improvement (QI) projects	• TENTATIVE DIVISION OF LABOUR • OVER-AMBITIOUS • SENIOR MANAGEMENT ENDORSEMENT • NON-DELIVERING • ABUNDANCE OF IDEAS • NEED FOR PREPARED LEADERS
46	convening meetings of several busy people is daunting	• TENTATIVE DIVISION OF LABOUR • HEAVY WORKLOADS • EVERYONE NEEDS TO BE ON BOARD
47	definition of PaSQIT role needs to be revised	• INDECISION • LACK OF FOCUS • RECOGNITION OF NEED TO LEARN
48	demonstrable change in a health care setting can take up to 8 years	• SENSITIVITY & PERSERVERANCE FOR CHANGE
49	desire to know more about PS evidently on the rise	• NEED FOR PREPARED LEADERS • RECOGNITION OF NEED TO LEARN • SENSITIVITY & PERSERVERANCE FOR CHANGE

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
50	different professional groups tend to seek to work on their own	• SELECTIVITY • EVERYONE NEEDS TO BE ON BOARD • UNEASY WITH STANDARDISATION • MONOPOLY SOUGHT AND GIVEN • ACHIEVING VISIBILITY IS A PRIORITY
51	documentation for SA Learn at ITU developed apace with strong leadership & eager members	• ABUNDANCE OF IDEAS • NEED FOR PREPARED LEADERS • RARE TANGIBLE ACHIEVEMENTS
52	each category of incident had one lead contact person	• TENTATIVE DIVISION OF LABOUR • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS
53	effort at decentralization by lowering threshold for approval of Standard Operating Procedure (SOPs)	• TENTATIVE DISCIPLINE • POWERLESSNESS • RARE TANGIBLE ACHIEVEMENTS
54	efforts to revamp existing Working Group (WGs)	• TENTATIVE DIVISION OF LABOUR • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS • EVERYONE NEEDS TO BE ON BOARD
55	element of naivety visible	• EVERYONE NEEDS TO BE ON BOARD • NEED TO DISPEL 'BLAME CULTURE'
56	eliciting standards and processes used elsewhere	• RECOGNITION OF NEED TO LEARN
57	enlisting new Clinical Director as a new ally	• SENIOR MANAGEMENT ENDORSEMENT
58	eventually the need to select more circumscribed themes for activities recognised	• FAR-REACHING VISION • APPRECIATION OF GOOD WORK • RECOGNITION OF NEED TO LEARN • FAILURE TO EXECUTE
59	exposure and contact with abroad infrequent	• ISOLATION • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • HEAVY WORKLOADS
60	extending visitors' hours at MDH	• RARE TANGIBLE ACHIEVEMENTS • ABUNDANCE OF IDEAS
61	falls WG presumably making progress which is poorly visible	• ACHIEVING VISIBILITY IS A PRIORITY • HEAVY WORKLOADS • MULTI-PRONGED ACTIVITY REQUIRED • SPECIALISATION
62	feedback requested on drafted documents is rarely received	• NON-DELIVERING

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
63	first addition of healthcare professional (HCP) member who is working full-time on PS & QI projects	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • RARE TANGIBLE ACHIEVEMENTS • SENIOR MANAGEMENT ENDORSEMENT
64	fixed meeting venue organised for the first 12 to 18 months of PaSQIT	• TENTATIVE DIVISION OF LABOUR • TENTATIVE DISCIPLINE
65	for about 6 months EMCS projects take over PASQIT agenda	• NOT STICKING TO AGENDA • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS • LACK OF FOCUS • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS
66	full-time focal point for CRM & PaSQIT eventually materialised in June 2015	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • RARE TANGIBLE ACHIEVEMENTS
67	group expected to lead and promote change and change mentality	• OVER-AMBITIOUS • FAR-REACHING VISION
68	group needs to set direction through defining mission & vision & strategy	• OVER-AMBITIOUS • FAR-REACHING VISION
69	identifying patient safety champions	• NEED FOR PREPARED LEADERS • FAILURE TO EXECUTE
70	implementation of change is very complex and needs to be truly supported	• SENSITIVITY & PERSERVERANCE FOR CHANGE • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • NEED FOR DETAILED PLANNING • RECOGNITION OF NEED TO LEARN
71	importance of area-specific & topic-specific Multi-Disciplinary Teams (MDT)	• EVERYONE NEEDS TO BE ON BOARD • NEED FOR PATIENT FOCUS • WISH TO ADOPT POSITIVE APPROACHES
72	improvements in quality and patient safety can be achieved when working with clinical micro-systems	• EVERYONE NEEDS TO BE ON BOARD • BOTTOM-UP APPROACH • APPRECIATION OF GOOD WORK • NEED FOR PREPARED LEADERS
73	inefficient systems lead to considerable wastage	• UNEASY WITH STANDARDISATION • RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE
74	infection control had 'role model' status within PaSQIT	• NEED FOR PREPARED LEADERS • ENTHUSIASM FOR PROFESSIONALISM • APPRECIATION OF GOOD WORK • VALUED EXPERIENCE

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
75	influenza vaccination campaign became prominent in 2013 and again in 2015	• EVERYONE NEEDS TO BE ON BOARD • LACK OF FOCUS • ABUNDANCE OF IDEAS
76	initial expert advice was that reporting system and PS & QI group should be separate but closely communicating	• OVER-AMBITIOUS • TENTATIVE DIVISION OF LABOUR
77	initially well organised documentation and follow-up plans	• OVER-AMBITIOUS • TENTATIVE DIVISION OF LABOUR • TENTATIVE DISCIPLINE • ABUNDANCE OF IDEAS
78	insurance issues have to date been neglected	• HEAVY WORKLOADS • ORGANISATION SWAMPED BY OPERATIONAL ISSUES
79	intense and diverse methodology to work towards and achieve change	• FAR-REACHING VISION • OVER-AMBITIOUS
80	IRC_priority given to medication errors	• SPECIALISATION • REPEATED ALERTS • NON-DELIVERING • VALUED EXPERIENCE • NEED FOR PREPARED LEADERS
81	ITU designed CRM seen as a precursor or component of a centralised system	• BOTTOM-UP APPROACH • NEED FOR DETAILED PLANNING • APPRECIATION OF GOOD WORK
82	Johns Hopkins Medical International (JHMI) report earmarked several actions incl. patient safety	• VALUED EXPERIENCE • MULTI-PRONGED ACTIVITY REQUIRED • NEED FOR MORE PATIENT FOCUS • FAILURE TO EXECUTE
83	Key Performance Indicators (KPI) reports started to be done by Clinical Performance Unit (CPU) on a regular basis	• NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION
84	Lachman to re-visit after 2 and a half years_1st visit in May 2013	• VALUED EXPERIENCE • RECOGNITION OF NEED TO LEARN
85	lack of structures negatively affects implementation & survival of ideas	• ORGANISATION SWAMPED BY OPERATIONAL ISSUES • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES
86	learning requires constant data input & analysis	• RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION • RECOGNITION OF NEED TO LEARN • NEED FOR PREPARED LEADERS • SENIOR MANAGEMENT ENDORSEMENT

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
87	legal backing is a perennial sore point	• LACK OF SUPPORTIVE NATIONAL FRAMEWORKS • NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
88	long list of priority or 'wish list' of issues to address drawn up	• LACK OF FOCUS • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • ORGANISATION SWAMPED BY OPERATIONAL ISSUES
89	long list of requested resources started to seep in after 1 year of PaSQIT	• DESIRED BUT UNFORTHCOMING INVESTMENT • NON-DELIVERING • ABANDONMENT BY SENIOR MANAGEMENT
90	major problem with MDTs is often tensions between different groups of HCPs	• EVERYONE NEEDS TO BE ON BOARD • HEAVY WORKLOADS • SELECTIVITY • NEED FOR PREPARED LEADERS • NEED FOR MORE PATIENT FOCUS • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS
91	mandatory continuous Continued Professional Development (CPD) 'the elephant in the room'	• RECOGNITION OF NEED TO LEARN • TENTATIVE DISCIPLINE • EVERYONE NEEDS TO BE ON BOARD • WISH TO ADOPT POSITIVE APPROACHES • BOTTOM-UP APPROACH
92	MDH culture comprises of several sub-cultures dependent on unit or team	• ORGANISATION SWAMPED BY OPERATIONAL ISSUES • BOTTOM-UP APPROACH • MULTI-PRONGED ACTIVITY REQUIRED
93	MDH does not truly function as a 24/7 hospital	• FAILURE TO EXECUTE • RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE • NEED FOR MORE PATIENT FOCUS
94	MDH is a micro-system of Malta	• NATIONAL CULTURE AND UNIQUE CONTEXT
95	MDH needs more doers and not more philosophers	• DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • POWERLESSNESS • NON-DELIVERING • FAILURE TO EXECUTE
96	MDH_existence of a pervasive fear of documentation exists in several quarters	• UNEASY WITH DOCUMENTATION • UNEASY WITH STANDARDISATION • TENTATIVE DISCIPLINE • NEED DISPEL 'BLAME CULTURE' • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
97	measurements and indicators also occasionally highlighted	• RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION • BOTTOM-UP APPROACH • MULTI-PRONGED ACTIVITY REQUIRED • UNEASY WITH DOCUMENTATION
98	medication errors identified as a special class	• SPECIALISATION • SHORT-LIVED / TRANSITORY PHASE • HEAVY WORKLOADS • NON-DELIVERING
99	meetings initially very frequent	• OVER-AMBITIOUS • TENTATIVE DISCIPLINE • SHORT-LIVED / TRANSITORY PHASE • NOT STICKING TO AGENDA • ENTHUSIASM FOR PROFESSIONALISM
100	members are full-time HCPs with heavy personal work loads	• OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS • FAILURE TO EXECUTE • HEAVY WORKLOADS • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS
101	members made to leave PaSQIT when they are transferred outside MDH	• POWERLESSNESS • ABANDONMENT BY SENIOR MANAGEMENT • 'REAL' AUTHORITY RESIDES OUTSIDE MDH
102	members of sub-WG becoming central members of PaSQIT	• TENTATIVE DIVISION OF LABOUR • EVERYONE NEEDS TO BE ON BOARD • SPECIALISATION • APPRECIATION OF GOOD WORK • MULTI-PRONGED ACTIVITY REQUIRED
103	Mortality & Morbidity meetings launched as another arm for learning in PS	• MULTI-PRONGED ACTIVITY REQUIRED • EVERYONE NEEDS TO BE ON BOARD • TENTATIVE DISCIPLINE • RECOGNITION OF NEED TO LEARN
104	need for separate advisory committee and executive structures	• FAR-REACHING VISION • TENTATIVE DIVISION OF LABOUR • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES
105	need to be aware of evolution of the team and to continuously re-assess strategy	• DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • NEED FOR DETAILED PLANNING • RECOGNITION OF NEED TO LEARN • ABUNDANCE OF IDEAS

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
106	need to continuously strive to build capacity and expertise	• TENTATIVE DIVISION OF LABOUR • SPECIALISATION • RECOGNITION OF NEED TO LEARN • NEED FOR PREPARED LEADERS • VALUED EXPERIENCE
107	need to identify pockets of 'good practice' for evaluation	• SHORT-LIVED / TRANSITORY PHASE • RARE TANGIBLE ACHIEVEMENTS • WISH TO ADOPT POSITIVE APPROACHES
108	need to increase agility of HCPs to patients' change of status	• NEED FOR MORE PATIENT FOCUS • BOTTOM-UP APPROACH • UNEASY WITH STANDARDISATION • EVERYONE NEEDS TO BE ON BOARD
109	new format for minute reporting by researcher	• TENTATIVE DIVISION OF LABOUR • TENTATIVE DISCIPLINE • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION
110	new group designed to work with & coordinate work of other hospital committees	• NEED FOR PREPARED LEADERS • NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT • EVERYONE NEEDS TO BE ON BOARD • SENIOR MANAGEMENT ENDORSEMENT
111	new group with very broad and undefined objectives formed in 2013	• LACK OF FOCUS • OVER-AMBITIOUS • FAR-REACHING VISION • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES
112	new members added to replace leaving or retiring ones	• NEED FOR PREPARED LEADERS • EVERYONE NEEDS TO BE ON BOARD • APPRECIATION OF GOOD WORK
113	new team seen as the one solution for anything that has not been achieved to date	• OVER-AMBITIOUS • FAR-REACHING VISION • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS
114	new WGs keep cropping up from time to time	• ABUNDANCE OF IDEAS • EVERYONE NEEDS TO BE ON BOARD • SPECIALISATION • APPRECIATION OF GOOD WORK • MULTI-PRONGED ACTIVITY REQUIRED
115	no legal backup a constant problem and threat	• LACK OF SUPPORTIVE NATIONAL FRAMEWORKS • 'REAL' AUTHORITY RESIDES OUTSIDE MDH

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
116	nobody has real 'executive powers'	• LACK OF SUPPORTIVE NATIONAL FRAMEWORKS • 'REAL' AUTHORITY RESIDES OUTSIDE MDH • ABANDONMENT BY SENIOR MANAGEMENT
117	non-punitive objective of SA Learn needs to be stressed repeatedly	• RECOGNITION OF NEED TO LEARN • NEED DISPEL 'BLAME CULTURE' • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
118	nursing & ward practices require reform	• NEED FOR PREPARED LEADERS • EVERYONE NEEDS TO BE ON BOARD • APPRECIATION OF GOOD WORK • REPEATED ALERTS • SENSITIVITY & PERSERVERANCE FOR CHANGE
119	objective of PaSQIT as a knowledge hub for PS	• FAR-REACHING VISION • SHORT-LIVED / TRANSITORY PHASE • RECOGNITION OF NEED TO LEARN • ACHIEVING VISIBILITY IS A PRIORITY • RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE
120	objective outsiders' views tend to be more positive than internal assessments	• NEED FOR PREPARED LEADERS • SENSITIVITY & PERSERVERANCE FOR CHANGE • VALUED EXPERIENCE
121	of the several objectives identified in 2013 only one materialised in April 2015	• OVER-AMBITIOUS • FAILURE TO EXECUTE • RARE TANGIBLE ACHIEVEMENTS
122	official & formal letter of appointment was requested by members	• SENIOR MANAGEMENT ENDORSEMENT • NON-DELIVERING • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS • ORGANISATION SWAMPED BY OPERATIONAL ISSUES
123	oncology hospital is being included with MDH governance	• EVERYONE NEEDS TO BE ON BOARD • LACK OF FOCUS • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES
124	optimizing bed occupancy at MDH_several small projects_cumulative effect	• SHORT-LIVED / TRANSITORY PHASE • NEED FOR DETAILED PLANNING • MULTI-PRONGED ACTIVITY REQUIRED • TENTATIVE DIVISION OF LABOUR • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION
125	parallel reporting systems still in operation_informal agreement to channel PS	• NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT • TENTATIVE DIVISION OF LABOUR

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
126	PaSQIT conceived to replace wound up IRC	• SENIOR MANAGEMENT ENDORSEMENT • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • ABANDONMENT BY SENIOR MANAGEMENT • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING
127	PaSQIT effected by loss of members when they are transferred outside MDH	• DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • HEAVY WORKLOADS • NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT • 'REAL' AUTHORITY RESIDES OUTSIDE MDH
128	PaSQIT initially committed to a six-monthly progress report	• TENTATIVE DISCIPLINE • NON-DELIVERING • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS
129	PaSQIT meetings held regularly in spurts to be followed by long lulls	• TENTATIVE DISCIPLINE • NON-DELIVERING • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS
130	PaSQIT members' role bolstered by persuasion skills	• NEED FOR PREPARED LEADERS • SENSITIVITY & PERSERVERANCE FOR CHANGE • ENTHUSIASM FOR PROFESSIONALISM
131	PaSQIT members feel 'overpowered' by the demands to work that PaSQIT role demands	• POWERLESSNESS • ABANDONMENT BY SENIOR MANAGEMENT • HEAVY WORKLOADS • FAILURE TO EXECUTE
132	PaSQIT members need training and mentoring	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • VALUED EXPERIENCE • RECOGNITION OF NEED TO LEARN • ENTHUSIASM FOR PROFESSIONALISM • NEED FOR PREPARED LEADERS
133	PaSQIT strategy well defined	• FAR-REACHING VISION • SPECIALISATION • NEED FOR DETAILED PLANNING • WISH TO ADOPT POSITIVE APPROACHES • NEED FOR CONTSTANT RE-EVALUATION
134	PaSQIT supposedly led and supported by Clinical Director	• SENIOR MANAGEMENT ENDORSEMENT • ABANDONMENT BY SENIOR MANAGEMENT • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • NON-DELIVERING • NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
135	PaSQIT team building sessions_did not take place really except for half-day seminar in Feb 14	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • RECOGNITION OF NEED TO LEARN • VALUED EXPERIENCE • SELECTIVITY
136	PaSQIT was invited to contribute to other projects ongoing at MDH at time of inception	• TENTATIVE DIVISION OF LABOUR • EVERYONE NEEDS TO BE ON BOARD • SPECIALISATION • MULTI-PRONGED ACTIVITY REQUIRED
137	patient safety is professed to be the ultimate priority	• TENTATIVE DISCIPLINE • NEED FOR DETAILED PLANNING • NEED FOR CONTSTANT RE-EVALUATION
138	patient safety was declared as being 'alien' to several MDH workers	• UNEASY WITH STANDARDISATION • UNEASY WITH DOCUMENTATION • RECOGNITION OF NEED TO LEARN • NATIONAL CULTURE AND UNIQUE CONTEXT • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • SENSITIVITY & PERSERVERANCE FOR CHANGE
139	patients' and relatives' involvement still rather weak	• TENTATIVE DIVISION OF LABOUR • EVERYONE NEEDS TO BE ON BOARD • MULTI-PRONGED ACTIVITY REQUIRED • NEED FOR MORE PATIENT FOCUS
140	politicians take over when HCPs fail to engage	• 'REAL' AUTHORITY RESIDES OUTSIDE MDH • NATIONAL CULTURE AND UNIQUE CONTEXT • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES • LACK OF SUPPORTIVE NATIONAL FRAMEWORKS
141	post-meeting & event reflection	• NEED FOR CONTSTANT RE-EVALUATION • RECOGNITION OF NEED TO LEARN
142	pre-requisites for patient-centered care	• NEED FOR MORE PATIENT FOCUS • ABUNDANCE OF IDEAS • EVERYONE NEEDS TO BE ON BOARD
143	pre-requisites to achieve are well known but realisation falters	• SHORT-LIVED / TRANSITORY PHASE • NON-DELIVERING • FAILURE TO EXECUTE
144	presentation of PhD progress report to members	• ACHIEVING VISIBILITY IS A PRIORITY • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
145	pressure ulcers gradually rose in prominence as another major objective	• NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION • NEED FOR PREPARED LEADERS • ABUNDANCE OF IDEAS • ENTHUSIASM FOR PROFESSIONALISM • SPECIALISATION • APPRECIATION OF GOOD WORK
146	progress report shows lacking enthusiasm on a number of actions	• SHORT-LIVED / TRANSITORY PHASE • NON-DELIVERING • FAILURE TO EXECUTE
147	projects dropped because of lack of promised enthusiasm	• SHORT-LIVED / TRANSITORY PHASE • NON-DELIVERING • FAILURE TO EXECUTE • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS
148	PS is multi-factorial	• EVERYONE NEEDS TO BE ON BOARD • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS
149	QI projects require in-depth investigation of the root causes	• RECOGNITION OF NEED TO LEARN • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION
150	quality has been generally subservient to other perceived 'priorities'	• UNEASY WITH STANDARDISATION • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS • ORGANISATION SWAMPED BY OPERATIONAL ISSUES • OUTCOMES ARE SIDELINED FOR THE SAKE OF OUTPUTS
151	quality improvements best achieved through changes in culture and beliefs	• SENSITIVITY & PERSERVERANCE FOR CHANGE • NATIONAL CULTURE AND UNIQUE CONTEXT • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • EVERYONE NEEDS TO BE ON BOARD
152	quality of care given after regular hours & during weekends & public holidays falls sharply	• UNEASY WITH STANDARDISATION • SHORT-LIVED / TRANSITORY PHASE • REPEATED ALERTS • MULTI-PRONGED ACTIVITY REQUIRED • NEED FOR MORE PATIENT FOCUS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • ORGANISATION SWAMPED BY OPERATIONAL ISSUES
153	re-introducing a centralised CRM system central to PaSQIT objectives	• FAR-REACHING VISION • INDECISION • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • ABANDONMENT BY SENIOR MANAGEMENT • FAILURE TO EXECUTE

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
154	recognised need to educate_motivate_empower MDH HCPs	• EVERYONE NEEDS TO BE ON BOARD • MULTI-PRONGED ACTIVITY REQUIRED • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION
155	recognition or acknowledgement of work done and done well should be internalized in MDH operations	• WISH TO ADOPT POSITIVE APPROACHES • NEED FOR PREPARED LEADERS • APPRECIATION OF GOOD WORK
156	replacement of members who retired_Head replaced with less senior representative	• NEED FOR CONTSTANT RE-EVALUATION • NEED FOR PREPARED LEADERS
157	reporting to SA Learn to be made easy and versatile	• UNEASY WITH DOCUMENTATION • EVERYONE NEEDS TO BE ON BOARD • NEED FOR DETAILED PLANNING • NEED DISPEL 'BLAME CULTURE' • SENSITIVITY & PERSERVERANCE FOR CHANGE • WISH TO ADOPT POSITIVE APPROACHES
158	risk assessment committee_real underlying reason for CEO & Medical Director bid to form PaSQIT	• FAR-REACHING VISION • SENIOR MANAGEMENT ENDORSEMENT • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • ABANDONMENT BY SENIOR MANAGEMENT
159	risk of leaving medications by the patient's bedside	• VALUED EXPERIENCE • NEED FOR PREPARED LEADERS • REPEATED ALERTS
160	'Right Patient Right Bed' (RPRB) requires upgrades in bed management & planning practices esp. through proactive discharge planning	• BOTTOM-UP APPROACH • ORGANISATION SWAMPED BY OPERATIONAL ISSUES • WISH TO ADOPT POSITIVE APPROACHES • MULTI-PRONGED ACTIVITY REQUIRED
161	SA Learn should aim at improving the competence of 'reflection' of HCPs	• NEED FOR CONTSTANT RE-EVALUATION • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • RECOGNITION OF NEED TO LEARN
162	SA Learn system started to take shape in May 2014	• DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • POWERLESSNESS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • NEED FOR DETAILED PLANNING • SENSITIVITY & PERSERVERANCE FOR CHANGE • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES • LACK OF SUPPORTIVE NATIONAL FRAMEWORKS

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
163	SA Learn to be promoted as another tool to make MDH work better	• FAR-REACHING VISION • EVERYONE NEEDS TO BE ON BOARD • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS
164	SA Learn_dissemination of learning is most important function	• WISH TO ADOPT POSITIVE APPROACHES • ACHIEVING VISIBILITY IS A PRIORITY • RECOGNITION OF NEED TO LEARN
165	same aims and intentions but finding great difficulty in agreeing on how to get there	• LACK OF FOCUS • INDECISION • NOT STICKING TO AGENDA • OVERPOWERING PERSONALITIES • SELECTIVITY
166	secretarial duties assumed by one member_no effective rotation materialises	• TENTATIVE DIVISION OF LABOUR • TENTATIVE DISCIPLINE • NON-DELIVERING • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS
167	several demands laid down to help group become effective	• SENIOR MANAGEMENT ENDORSEMENT • NEED FOR CONTSTANT RE-EVALUATION • NEED FOR PREPARED LEADERS • SENSITIVITY & PERSERVERANCE FOR CHANGE
168	several ideas for new activities to boost QI all needing motivated clinicians	• BOTTOM-UP APPROACH • NEED FOR PREPARED LEADERS • ABUNDANCE OF IDEAS • INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM • MULTI-PRONGED ACTIVITY REQUIRED
169	severity assessment matrices	• NEED FOR DETAILED PLANNING • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION
170	significant work done however sustainability problematic due to lack of resources	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • APPRECIATION OF GOOD WORK • RARE TANGIBLE ACHIEVEMENTS • VALUED EXPERIENCE
171	solutions and activities need to be led by experts in the area concerned	• EVERYONE NEEDS TO BE ON BOARD • SPECIALISATION • VALUED EXPERIENCE • NEED FOR DETAILED PLANNING
172	some members can be individually overpowering over the rest of the team	• OVERPOWERING PERSONALITIES • SELECTIVITY

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
173	some ward items such as temperature monitoring equipment is beyond the remit of HCPs	• POWERLESSNESS • NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT • ORGANISATION SWAMPED BY OPERATIONAL ISSUES • LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES
174	standardised care pathways started to be occasionally mentioned	• UNEASY WITH STANDARDISATION • TENTATIVE DISCIPLINE • APPRECIATION OF GOOD WORK • RARE TANGIBLE ACHIEVEMENTS • ENTHUSIASM FOR PROFESSIONALISM • RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE
175	sub-groups created and followed-up from 2014	• TENTATIVE DIVISION OF LABOUR • EVERYONE NEEDS TO BE ON BOARD • SPECIALISATION • MULTI-PRONGED ACTIVITY REQUIRED
176	surgery as reflected in waiting time lists is very powerful	• OUTCOMES ARE SIDELINED FOR THE SAKE OF OUTPUTS • ORGANISATION SWAMPED BY OPERATIONAL ISSUES • 'REAL' AUTHORITY RESIDES OUTSIDE MDH
177	team was always cognizant that it cannot manage an Incident Reporting System (IRS) on its own	• POWERLESSNESS • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • NEED FOR CONTSTANT RE-EVALUATION • SENSITIVITY & PERSERVERANCE FOR CHANGE
178	teamwork concept tends not to be strong in the Maltese context	• ISOLATION • NATIONAL CULTURE AND UNIQUE CONTEXT • PERSONAL AGENDAS • MONOPOLY SOUGHT AND GIVEN • OVERPOWERING PERSONALITIES
179	the capacity to investigate SAs remains a persistent problem	• LACK OF FOCUS • POWERLESSNESS • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • NON-DELIVERING • NEED FOR DETAILED PLANNING
180	the chasing & investigation of incident report to be done by PaSQIT members	• OVER-AMBITIOUS • FAR-REACHING VISION • SENIOR MANAGEMENT ENDORSEMENT • FAILURE TO EXECUTE

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
181	the concept of 'patient-centeredness' is often flaunted	• NEED FOR MORE PATIENT FOCUS • ABUNDANCE OF IDEAS • FAR-REACHING VISION
182	the development of the 'listening methodology' stressed by expert in the formative sessions	• VALUED EXPERIENCE • RECOGNITION OF NEED TO LEARN • SENSITIVITY & PERSERVERANCE FOR CHANGE
183	the idea of measurement for achievement and accountability present from the beginning	• UNEASY WITH DOCUMENTATION • TENTATIVE DISCIPLINE • ACHIEVING VISIBILITY IS A PRIORITY • NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION • RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE • OUTCOMES ARE SIDELINED FOR THE SAKE OF OUTPUTS
184	the main aim of the CEO was to create PaSQIT to substitute for faltering IRS	• FAR-REACHING VISION • SENIOR MANAGEMENT ENDORSEMENT • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • NEED FOR CONTSTANT RE-EVALUATION • FAILURE TO EXECUTE
185	the need for communication and Public Relations (PR) is occasionally highlighted	• SHORT-LIVED / TRANSITORY PHASE • ACHIEVING VISIBILITY IS A PRIORITY • WISH TO ADOPT POSITIVE APPROACHES • NON-DELIVERING
186	the new concept of positive deviance introduced	• NEED FOR CONTSTANT RE-EVALUATION • APPRECIATION OF GOOD WORK • VALUED EXPERIENCE • RECOGNITION OF NEED TO LEARN • WISH TO ADOPT POSITIVE APPROACHES
187	the problem of re-establishing a CRM was avoided for a few weeks	• INDECISION • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • NEED FOR CONTSTANT RE-EVALUATION • FAILURE TO EXECUTE
188	the Risk Assessment theme was a source of constant grief to PaSQIT	• INDECISION • DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS • NEED FOR CONTSTANT RE-EVALUATION • FAILURE TO EXECUTE
189	the value of 'respect' is notable by its low collective ranking	• OVERPOWERING PERSONALITIES • SELECTIVITY • PERSONAL AGENDAS • ISOLATION

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
190	the WILL to improve and bring about change is evident	• APPRECIATION OF GOOD WORK • VALUED EXPERIENCE • ENTHUSIASM FOR PROFESSIONALISM • NEED FOR PREPARED LEADERS
191	too much detail on the educational programs	• EVERYONE NEEDS TO BE ON BOARD • SHORT-LIVED / TRANSITORY PHASE • NON-DELIVERING • NOT STICKING TO AGENDA • MULTI-PRONGED ACTIVITY REQUIRED • WISH TO ADOPT POSITIVE APPROACHES • BOTTOM-UP APPROACH
192	TORs to be developed by PaSQIT members	• FAR-REACHING VISION • TENTATIVE DIVISION OF LABOUR • NEED FOR DETAILED PLANNING • NEED FOR CONTSTANT RE-EVALUATION • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS
193	two new senior nurses joined	• EVERYONE NEEDS TO BE ON BOARD • SPECIALISATION • ENTHUSIASM FOR PROFESSIONALISM
194	value chain approach and analysis suggested as a tool	• VALUED EXPERIENCE • NEED FOR CONTSTANT RE-EVALUATION • RECOGNITION OF NEED TO LEARN • NEED FOR PREPARED LEADERS • NEED FOR MORE PATIENT FOCUS
195	values of team members extracted and prioritized	• NEED FOR CONTSTANT RE-EVALUATION • VALUED EXPERIENCE • NEED FOR PREPARED LEADERS
196	various attempts to be more organised and disciplined tried from time to time	• TENTATIVE DIVISION OF LABOUR • TENTATIVE DISCIPLINE • HEAVY WORKLOADS • NON-DELIVERING • NOT STICKING TO AGENDA • OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS

ANNEX 9 *(continued)*

Code No.	First cycle code	Assigned secondary cycle code
197	visibility is always an issue_several suggestions to boost visibility frequently fielded	• EVERYONE NEEDS TO BE ON BOARD • SHORT-LIVED / TRANSITORY PHASE • NEED FOR CONTSTANT RE-EVALUATION • ACHIEVING VISIBILITY IS A PRIORITY • ABUNDANCE OF IDEAS • SENSITIVITY & PERSERVERANCE FOR CHANGE
198	well performing staff will only require intervention in 'exceptional' cases	• APPRECIATION OF GOOD WORK • ENTHUSIASM FOR PROFESSIONALISM • WISH TO ADOPT POSITIVE APPROACHES • BOTTOM-UP APPROACH
199	when one person is motivated enough things will be performed	• ENTHUSIASM FOR PROFESSIONALISM • WISH TO ADOPT POSITIVE APPROACHES • BOTTOM-UP APPROACH
200	wide range of areas and topics require attention	• OVER-AMBITIOUS • FAR-REACHING VISION • SPECIALISATION • NEED FOR CONTSTANT RE-EVALUATION • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS • SENSITIVITY & PERSERVERANCE FOR CHANGE • ORGANISATION SWAMPED BY OPERATIONAL ISSUES
201	wide range of solutions to be explored & activities to be performed	• OVER-AMBITIOUS • FAR-REACHING VISION • SPECIALISATION • NEED FOR CONTSTANT RE-EVALUATION • MULTI-PRONGED ACTIVITY REQUIRED • ABUNDANCE OF IDEAS • SENSITIVITY & PERSERVERANCE FOR CHANGE • ORGANISATION SWAMPED BY OPERATIONAL ISSUES
202	work on SA Learn started to pick-up when the assigned PaSQIT coordinator joined	• DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING • RARE TANGIBLE ACHIEVEMENTS • OVERPOWERING PERSONALITIES • SELECTIVITY • PERSONAL AGENDAS
203	written work is almost exclusively done by only 2 members	• TENTATIVE DIVISION OF LABOUR • TENTATIVE DISCIPLINE • NON-DELIVERING • NOT STICKING TO AGENDA

ANNEX 10

SECONDARY CODES for AR files

i. UNEASY WITH STANDARDISATION (resulting in widespread 'non-conformity', variation, inefficiencies and wastage; unguaranteed quality irrespective of time of day or week, location or healthcare deliverer)

ii. UNEASY WITH DOCUMENTATION (fear of leaving a trail; blamed as a cause for increase in administrative burden, related to [i.] above; the idea of performance assessment is desired but at the same time dreaded – one reason for the latter is the suspicion that it may be misused by the management and authorities)

iii. LACK OF FOCUS (wide-ranging, all-encompassing and unachievable objectives; role and operating methods of PaSQIT frequently needs revision or constant re-alignment; ambivalence between advisory and executive role)

iv. INDECISION (procrastination to take decisions and move effectively forward; different apparently irreconcilable ideas and points of view; indecision through dis-agreements – similar aim but different strong views)

v. OVER-AMBITIOUS (wide-ranging and unachievable objectives; unrealistic; lofty aims; idealistic)

vi. FAR-REACHING VISION (clear overarching and encompassing end-objective; very long and never-ending agenda; 'objective' in the mind of senior management set very early on but 'veiled')

vii. TENTATIVE DIVISION OF LABOUR (attempts to divide overall objective into smaller more manageable and focussed chunks but ensuring constant and effective communication; better definition of expertise and skills required, roles and deliverables)

viii. TENTATIVE DISCIPLINE (attempts at being disciplined, ordered and structured are tried repeatedly but are frequently short-lived and transitory especially because of non-participation; attempts at reducing variation and establish good practice procedures)

ix. EVERYONE NEEDS TO BE ON BOARD (multi-disciplinarity/ inclusivity required; everyone needs to be committed; all stakeholders within and beyond MDH including patients and their caregivers and the general p; multiple skills required; decrease conflict and prejudice between the professions and increase cooperation and understanding)

x. POWERLESSNESS (feelings/ perceived lack of authority and 'executive power'; inability to implement; not empowered to rebut 'unappreciated' impositions from senior management; frustrated with senior management mis-matched support in proportion to the demands communicated)

xi. SENIOR MANAGEMENT ENDORSEMENT (any semblance of authority and executive power resides only with the most senior management; close liaison with hospital management structures; maintenance of endorsement is dependent on visibility of results)

xii. DISAPPOINTMENT FOLLOWING HIGH EXPECTATIONS (disillusionment; unrealistic expectations unmet with promised support)

xiii. ABANDONMENT BY SENIOR MANAGEMENT (perceived lack of real support or only reluctant support evident from the SET; initial enthusiasm by SET fizzled off after a few months and replaced by allegations that team is weak and lethargic; conflicting expectations)

xiv. SPECIALISATION (acquire more expert sub-divisions/ structures/ groups; special focus given to special areas e.g. medication errors, fall, pressure ulcers)

xv. SHORT-LIVED / TRANSITORY PHASE (trends that 'come and go'; the 'in thing' for a short while but then forgotten; transitory 'buzz words')

xvi. REPEATED ALERTS (arising from SA Learn activity; feared to be the 'tip of the iceberg'; several recounted stories of unacceptable practices)

xvii. HEAVY WORKLOADS (doctor/ nurse to patient ratios below desired levels; fatigue and confusion ensue; added workload onto regular full-time commitments; competing priorities; excuse for non-compliance)

xviii. DESIRED BUT UNFORTHCOMING INVESTMENT/ RESOURCING (system improvements requiring expenditure take a long time to materialize if ever; tardiness by which required resources are supplied incl. work time lead to repeated delays and postponements)

xix. NON-DELIVERING (a lot of promises but no commitment to delivery; team work not prioritised; sign of low enthusiasm and not 'walk the talk'; could be a sign of non-commitment or of being swamped by so many duties)

xx. NEED FOR DETAILED PLANNING (need to 'home in'; not to remain at the superficial level; in-depth reflection and re-assessment for the design of strategy; prioritisation to deal with most urgent issues first or at the exclusion of less serious issues to optimize the use of limited resources)

xxi. NEED FOR CONTSTANT RE-EVALUATION (re-evaluation of meaning, roles, objectives and deliverables of team felt necessary; one reason is the failure to execute such that team repeatedly feels the need to identify what it can do to achieve demonstrable results; constantly re-establishing focus; repeated regeneration)

xxii. APPRECIATION OF GOOD WORK (celebration of achievement; identification and acknowledgements of 'positive deviants', achievers sought; eagerness to show results)

xxiii. RARE TANGIBLE ACHIEVEMENTS (requests are sometimes heeded often at unexpected moments such that they are often met with 'surprise')

xxiv. VALUED EXPERIENCE (experience of outsiders or people in previous senior position is always valued and sought; deference for experience)

xxv. NOT STICKING TO AGENDA (not sticking to own promises, plans; undisciplined)

xxvi. MONOPOLY SOUGHT AND GIVEN (when someone sticks his head everyone else retracts; limelight sought and others are so happy to acquiesce; dominant people allowed to steal the show)

xxvii. OVERPOWERING PERSONALITIES (some professionals have a dominating personality and these people tend to seek to dominate any discussion; personalities who are not adept to listen to what other less-dominating people want to say; overwhelm other members of the team to the extent that some people give up and let them take unopposed control or else submit to their control)

xxviii. NO ONE HAS A CLEAR OVERARCHING/ EXECUTIVE OVERSIGHT (fragmentation and duplication of effort; conflicting work; most senior management does not have an exhaustive picture of what is actually happening)

xxix. 'REAL' AUTHORITY RESIDES OUTSIDE MDH (MDH is not autonomous and dependent on the higher authority residing outside the hospital and permeating from the Ministry or even from higher up in the political echelons; decisions such as transfers are taken undeterred by the possible consequence of discontinuity; MDH objectives are also often subjugated by external dictates and pressures which usually prioritize outputs over outcomes)

xxx. RECOGNITION OF NEED TO LEARN (not by everyone; still generally in its infancy; not prioritised; low generally at organisational level; systems for learning generally resisted and feared/ suspicious; recognition that knowledge about patient safety is generally lacking)

xxxi. HEAVY BUREAUCRACY (decision making is slow and long-winding; multiple approvals needed for anything to happen especially if money is involved; no 'real' authority vested even in the topmost people; reflective of a highly centralised and politically influenced system)

xxxii. MULTI-PRONGED ACTIVITY REQUIRED (achieving something is never simple; complex considerations)

xxxiii. SELECTIVITY (territoriality; cautious of who to admit into 'restricted' circle; difficulty of working in a multi-disciplinary team; several members are not effective team members; several members are too individualistic/ prefer to work on their own)

xxxiv. ACHIEVING VISIBILITY IS A PRIORITY (several efforts/ proposals to market and showcase activity; ground-work is unappreciated before effect becomes perceptible; eagerness to show results; recognition that dissemination of lessons is the end game; visibility for viability)

xxxv. PERSONAL AGENDAS (seeking personal visibility; dominance; arrogance; propensity to ascribe to personal merit)

xxxvi. NATIONAL CULTURE AND UNIQUE CONTEXT (interventions need to be compatible with our national/ organisational culture and context; local values; adapt implementation methods so that they synchronize with - rather than go against -our local values; understanding what works in our culture; MDH is a micro-culture of Malta)

xxxvii. INTENTION INFLUENCED BY EDUCATION, MOTIVATION, SYSTEM (intentions as a composite of • Attitude• Strength of belief• Evaluation of outcome• Subjective norm• Perceived expectations• Motivations to comply• Perceived control• Facilitation/ impedance• Perceived factor influence; identification of a 'win' for stakeholders)

xxxviii. NEED DISPEL 'BLAME CULTURE' (dispel fear of recrimination; enforce the modus operandi that identifying errors is to learn from them and move forward and not to 'nail' the individuals involved; psychological safety proclaimed; 'non-blame' operations do not have legal background)

xxxix. ENTHUSIASM FOR PROFESSIONALISM (eagerness to appear professional; can be a 'win' in its own right; aspiration to be seen as having integrity and being competent; appeal to the professionalism of staff in healthcare)

xl. ABUNDANCE OF IDEAS (ideas for improvement abound; a lot of reflection takes place at individual and collective level; people feel that they can contribute solutions for quality improvement; individual initiative common)

xli. NEED FOR PREPARED LEADERS (leadership skills are scarce; people who volunteer to lead are few and often hampered by several factors especially heavy workload)

xlii. SENSITIVITY & PERSERVERANCE FOR CHANGE (need to be patient, persistent, persuasive, creative and try several methods in tandem; need to be sensitive and responsive change and perceptions of change)

xliii. FAILURE TO EXECUTE (a lot of detailed planning but implementation success is rare; dependent on individual effort and interest; organisational support is often less than required to ensure sustained execution; failure to actually execute decisions)

xliv. ISOLATION (enforced and sought; not very good teamwork participants; self-sufficiency can be a virtue and a barrier; difficulties to support travel abroad and networking with centres/ peers overseas)

xlv. NEED TO COLLECT DETAILED & COMPREHENSIVE INFORMATION (collection of data as an important tool to evaluate operations and outcomes is recognised; time consuming and often falls prey to other duties; need to show objective picture; need to show results; need for meticulous investigation to find the root causes of failures/ adverse events)

xlvi. OFTEN OVERTAKEN BY OTHER PROJECTS & COMMITTMENTS (role of team is too vulnerable to outside pressure to take on new functions at the expense of its own objectives; teams objectives are too bendable and ill-focused)

xlvii. NEED FOR MORE PATIENT FOCUS (whatever is done needs to be patient-centred or to improve patient's experience, otherwise it will be more professional centred and this will not necessarily/ or will not result in quality improvements in care but will only serve the narrower needs of the providers; alignment of patients with providers' needs; 'win-win' solutions)

xlviii. WISH TO ADOPT POSITIVE APPROACHES (less whining and more solution oriented; celebrating achievements; identifying positive deviants)

xlix. BOTTOM-UP APPROACH (best result achieved when front-line staff [grass-roots/ clinical micro-systems] is engaged and owns QI; where best value is attainable; where area-specific and topic-specific unsafe practices can be identified and investigated)

l. RECOGNITION OF NEED TO REDUCE VARIATION AND WASTAGE (recognition of inefficiencies leading inconsistent practices and possible wastages; deployment of limited resources for optimal use especially in the face of expanding demand)

li. ORGANISATION SWAMPED BY OPERATIONAL ISSUES (often in crises management mode; overwhelmed operational issues which should be tackled at lower levels but are instead often escalated to the most senior levels; strategic organisational development often takes lower priority, remain long-standing pending issues and end up never reaching implementation such as insurance, legal support, patient safety, quality improvement; pending issues that have been neglected for a long time and need to be addressed keep accumulating)

lii. LACK OF FUNCTIONING/ DYSFUNCTIONAL HOSPITAL STRUCTURES (lack of structures is negatively affecting the implementation and survival of ideas that are developed; lack of Hospital structure with which to interface and thence micro-management remains with senior management; some structures are present but are perceived to be dysfunctional, inefficient or insufficient)

liii. LACK OF SUPPORTIVE NATIONAL FRAMEWORKS (lack of supportive national framework such as legal backing and autonomy of public organisations; lack of services outside hospital especially in community care – to help keep patients away from hospital for as long and safely possible)

liv. OUTCOMES ARE SIDELINED FOR THE SAKE OF OUTPUTS (quality has been generally subservient to other perceived 'priorities'; unwittingly neglecting several 'things' including quality, inter-disciplinarity, breaking silos, investing in own people, mindfulness, joy and meaning in work; side-lined for the sake of outputs which are more easily visible. Taking decisions for safety and quality are often the unpopular decisions)