Different kinds of gaps

Combined values and partial connections in fall prevention in long-term health care

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When observing the improvement of fall prevention in long-term care institutions, various types of 'gaps' will be encountered. Fall prevention is aimed at simultaneously diminishing risk and increasing freedom, two values that can contradict one another and thus require 'groping for good care.' This paper discusses care organizations that encounter a diversity of gaps while working on the improvement of the quality of care. The improvement takes place in the process of a national quality improvement collaborative. When using ethnographic research methods to evaluate the quality improvement collaborative and the participating care organizations, it became evident that, while managers worked hard to build a better place for their clients, professionals were confronted with a new reality – a considerable number of concrete gaps and holes – that increased rather than decreased the risks of falling incidents. Investigating the activities of the improvement team in an organization of care for mentally disabled people, a familiar issue gained prominence: the management professional gap. Marilyn Strathern's work on partial connections was used to reframe this symbolic gap from dichotomy into complexity. Analyzing the empirical findings from the perspective of partial connections, it could be demonstrated how health care professionals and managers are complexly connected and how they both cope with the same contradictory values in providing 'good care'. Consequently, this study shows that the use of a non-dualistic perspective can lead us beyond the management professional gap.

[quality improvement, long-term care, empirical ethics, management-professional gap, partial connections, good care, fall prevention, the Netherlands]

Caregivers' fall prevention dilemma – stopping clients from falling and breaking bones – becomes tangible in the contradictory choices they have to make between reducing risks on the one hand and reducing freedom on the other. More freedom often means a higher risk, while a decrease in freedom decreases risk. A worrying Parkinson's patient could be stopped from breaking his hip by being bound to his chair

or by administering sedatives. However, research shows that using physical restraints does not enhance safety (Hamers & Huizing 2005), and that the subject requires ethical and practical reconsideration as well (Andrews 2006).

While caregivers often deem the contradiction of the values of 'freedom' and 'risk' as 'incommensurable values' (Berlin, in Gray 1996), this paradox seems conflicting and almost fully incompatible. According to Berlin, these contradictions can have multiple manifestations, and cannot be resolved in a simple manner. Indeed, hard work is required to find ways of balancing such incommensurable values in decisions and actions. Professional caregivers have to be creative in finding possibilities to combine the values of freedom and risk. The story of Mrs. Black illustrates this point. Mrs. Black is an elderly woman living in a home for mentally disabled people. Although she wobbles and totters about, wildly flailing her arms, Mrs. Black is utterly convinced that her walking is fine. Lacking insight into her condition, she refuses to use a walking stick and is very stubborn about accepting aids. As her caregivers point out, "She won't even accept false teeth." Nevertheless, the caregivers do find a solution by offering her a most appealing red tricycle. Mrs. Black accepts it gladly and now she moves around fast and freely, but most importantly, a lot more safely.

This paper is based on a study aimed at better understanding the various processes of improvement in long-term care organizations and to understand if or how improvement is incorporated and situated in the daily practice of care organizations. During my ethnographic research on the construction of a fall prevention project by a so-called 'quality collaborative' in long-term care institutions, I encountered various types of 'gaps'. Firstly, fall prevention is aimed at simultaneously diminishing risk and increasing freedom, two values that can contradict one another and thus require ways of improvising and seeking alternatives in order to bridge the abstract gap between the contradicting values. Secondly, fall prevention deals with concrete gaps, the physical holes and obstacles within the geographical space. Thirdly, clashes and divisions between policy and practice (Mosse 2004), ill-fitting improvement plans that are to be 'rolled out' onto the wards have been observed, as well as clashes and divisions between managers and professionals.[1] This has been demonstrated by a substantial number of scholars of modernized healthcare organizations (Pollitt 1993; Harrison & Pollitt 1994; Clarke & Newman 1997; Freidson 2001; Glouberman & Mintzberg 2001a and b; Hunter 2003; Gray & Harrison 2004; Duyvendak et al. 2006; Noordegraaf 2007; Stoopendaal 2009; Reay & Hinings 2009). While managers tend to delegate the translation of the planned improvement – making it all fit – to the improvement teams, managers themselves do not often seem involved in the 'tinkering'[2] processes of adequately implementing and balancing the seemingly incommensurable values of care. The division between managers and professionals is often described by the metaphor of a 'gap'.

This paper will demonstrate how a quality collaborative program works and, more specifically, what the improvement projects in health care organizations entail. First of all, it will be described how this specific improvement policy became successful, despite the abstract and concrete gaps. Secondly, one of the best-known problems in health care will be reconceptualized: the management-professional gap. The notion

of ‘gap’ is quite often used in implementation theories, in which it usually implies an opposition or dissimilarity. The implied action usually amounts to ‘closing or bridging the gap’. Instead of reifying the gap by further analysis of the causalities of the gap between managers and professionals, ways will be found to highlight their “interdependencies, and their joint experiences” in which they both try to make sense of the often competing professional and managerial logics (Noordegraaf & Schinkel 2011).

In order to interpret the empirical findings two different sensitizing theoretical concepts will be highlighted: the ‘management professional gap’ and the concept of ‘partial connections’ (Strathern 1991). The study’s setting and methodology will then be outlined, followed by the analysis of empirical findings. Lastly, this paper will reflect on the usefulness of the concept of ‘partial connections’ in reconsidering and overcoming dualistic perspectives, leading to the conclusion that good care can be considered a product of the partial connections between professional and managerial work.

The management-professional gap

Managers often use improvement plans that have to be implemented into the daily work of professionals (Jensen 2007). Plans made at the macro level of organizations are thought to order and control the micro level work from a distance. Innovation in organizations is often considered as top-down policy that is ordered onto the working environment, the micro level. The rationale of steering in accordance with plans that are yet to be implemented takes place within a certain indication of scale, which in turn is related to power. The dualism between the supposedly small – the micro – and the supposedly large – the macro (Jensen 2007) – has long been an issue in sociological and anthropological debate (Knorr-Cetina & Cicourel 1981).

Implementation of macro policy into the micro ordinarily takes place on the periphery of a vertical hierarchy, where more centrally located managers and executives often disparage local contextual knowledge (Yanow 2004). Macro policy becomes translated in macro policy documents and subsequently into protocols that can control micro behaviour at a distance. According to Callon et al. (2001) action happens by *inscriptions*. As documents and protocols are “material into which it [a meaning, an interest, a value] is inscribed” (Callon 1991), they are the translations of interests into texts, behaviour or materialities (Monteiro 2000). Inscriptions can make innovations transportable and durable at the same time, as ‘immutable mobiles’ (Latour 1987). They enable action at a distance, because they stabilize and standardize the work, so that it can travel across space and time (Law 1986). Innovations invented here can be implemented somewhere else by using inscriptions. Specific kinds of inscriptions include plans to implement certain macro invented improvements.

A considerable number of scholars has nonetheless demonstrated that a planned implementation of macro policy is a complicated and not always successful process (cf. Pressman & Wildavsky 1984; Mosse 2004). Jensen (2007) states: “Plans for development – as conceived by many involved people – are formulated in political

offices (macro) in order to be disseminated ('rolled out') at hospital wards (micro)." Macro plans are often feared because they do not fit into micro contexts. The abstractions used by managers to direct professionals sometimes deviate from established daily practice (Orr 1996) and this can lead to the well-known notion of employee resistance (Yanow 2006) and to the equally known clash or gap between managers and professionals. This gap is a classic problem in public management in general (Lipsky 1980; Realin 1985) and health care in particular, as a result of specialization, methods of governance, standardization and increase in scale (Harrison & Pollitt 1994; Freidson 2001; Mintzberg 2009; Stoopendaal 2009) where professionals emphasize their professional knowledge, skills and service orientation in order to justify professional autonomy. Simultaneously, managers try to coordinate standardization and to enhance professional output (Noordegraaf & Van der Meulen 2008).

Managerial plans and behaviour within the working environment are often perceived, both in health care practice as in literature, as two incommensurable things and to use the words of Kipling (1892): "never the twain shall meet." Jensen (2007) warns us that those worlds will certainly fail to meet if researchers stick to the common sense categorization of macro and micro scales used "to sort the important from the insignificant." The constant reification of gaps in discussions and descriptions seems only to reinforce them. Every time a manager professional gap is distinguished on the micro-macro levels, the intervening gaps are labelled a problem that is to be tackled, integrated or bridged in order to get organizations to work. We do not escape from this dualism. On the contrary, it is strengthened by these dualistic conceptualizations.

Partial connections

Jensen (2007) draws on the work of Marilyn Strathern to overcome this micro-macro dualism, not by bridging the gap or integrating the incommensurable worlds, but by reframing the dualism instead, opting for a fractal approach. A fractal is a rough geometric shape that can be split into parts, each of which is (at least approximately) a reduced-size copy of the shape as a whole. Just think of clouds, snow and cauliflower: substances that are composed as such. Strathern (1991) used the notion of fractals and 'partial connections' to describe the complexity of Melanesian society where confusing social forms and unexpected replications in modes of thought required an explanation. Elaborating on the role of scaling in comparative anthropology, she criticizes the anthropological method of coping with complexity by using different perspectives and switching scales.

Anthropologists often say that the world can be found in a village. In other words, the macro can be found in the micro. Others see the macro as built up by micro elements, as for example in Hobbes' Leviathan. Hobbes' idea was that social order is possible through a social contract between individuals in which they agree to become associated with each other and thus express their wishes through a 'Leviathan': a super actor that seems to be much larger than the individuals that constitute it. Callon

and Latour make clear that the difference between micro and macro is not due to their nature, but to the associating and negotiating done by micro actors. By associating and networking, micro actors create networks. As these networks acquire relative stability, they begin to be perceived as macro actors (Callon & Latour 1981). Taking a closer look at the consistency of the macro, it becomes apparent that it has been conceptualised by aggregation on the one hand or representation on the other (Knorr-Cetina & Cicourel 1981). Aggregation indicates that macro phenomena are made, upwards, of aggregations and repetition of multiple micro episodes. Representation demonstrates that micro situations are seen as representing macro structures downwards, such as 'finding the world in a village' indicates. Within the scope of this vision, the macro is actively constructed within micro social action.

Strathern (1991) takes another stance, arguing that neither aggregation nor representation can capture complexity. In her view, the world is 'ontologically multiple' (cf. Mol 2002). The reason she introduces the fractal approach and the concept of 'partial connections' is, as she herself states, "… not only is there no totality, each part also defines a partisan position" meaning that everything and everyone consists of or comprises only partly connected heterogeneous elements. They are partly connected, "more than one and less than many" (Strathern 1991: 35).

The concept of partial connections not only breaks down classical notions of scale in social theory. After all, infinite detail would in that case be found in each empirical situation (Jensen 2007) and neither micro nor macro scale can be imagined as the basis for the other. 'Partial connection' also presents the opportunity to overcome segmentation, levels of division and opposition. This post-modern stance leads not to the certainty of bridges and integrated wholeness. On the contrary, it leads to the discovery of more gaps, creating room for more complexity. Nevertheless, this conceptual reframing could not only lead to the discovery of more and other gaps, but also to the discovery of specific relations or partial connections between separated domains and seemingly incommensurable worlds and values.

The dualistic conceptualization of the management professional gap and the concept of partial connections both emerged from and were compared with the empirical findings. First the study's setting will be outlined, followed by the description of methodology and the analysis of empirical findings.

Background

In 2005 the Dutch Ministry of Health launched 'Care for Better', a nationwide improvement program for quality of care and patient safety in the long-term health and social care sectors. The political incentive behind the program was driven by the media craze surrounding the controversial 'pyjama days'[3] caused by government cuts to the health sector. Set up as a quality collaborative, Care for Better was designed as a planned national improvement program, focusing on domains that particularly addressed levels of care on the wards, such as decubitus ulcers, fall prevention, patient autonomy and 'washing with care'.

Quality collaboratives as 'Care for Better' are increasingly being used to achieve large-scale improvements in health care performance. Multifaced methods are used in order to implement evidence-based practices through sharing knowledge (Voss et al. 2010) and stimulating learning within and between settings (Zuiderent-Jerak et al. 2009). The improvement teams of care organizations from all parts of the country have consequently been coming together in national working conferences, where experts in change management and the content of the various domains discuss best practices and demonstrate change methods.[4]

Care For Better was a grand-design national project, dealing with many attentive and common problems for clients in long-term care, including falling injuries. Research has shown that up to 30% of people over 60 falls over every year (Øvretveit 2009a; Gillespie et al. 2009). Falling incidents in health service and nursing home or home care settings are even more frequent. Such episodes can have substantial impact to the elderly in particular. About one in five falling incidents requires medical attention, although less than one in ten results in a fracture. Of patients who fall, about 30% experience a physical injury resulting in a longer stay in hospital or home and higher costs to the health care system (Rizzo et al. 1998; Nadkarni et al. 2005; Hektoen, Aas & Luras 2009; Heinrich et al. 2009). The Netherlands has comparable figures. According to the standard of prevention of fall incidents by elderly people (Dutch Association of Clinical Geriatrics 2004) the average client in Dutch elderly care falls twice a year. Dutch scholars have discussed both physical injuries and psychological problems – fear, depression and deprivation – that occur after falling incidents (Vaal & Neyens 2008). In care institutions for the mentally disabled as well as psychiatric care units, falling incidents are a problem for a subsection of patients. However, a considerably small proportion of research into fall prevention specifically addresses this kind of institutions.

The fall prevention project in Care for Better is aimed at identifying interventions, like the red tricycle, that establishes a safe environment and simultaneously respects people's freedom of movement. Physical restraints used to prevent people from falling haven proved to be inadequate and often have adverse effects (Hamers & Huizing 2005). It may be impossible to prevent patients from falling entirely, but changes to treatment, care regimes and the environment can be made to reduce the likelihood of falling incidents, especially for those most at risk. The interventions developed for health care organizations include multifactorial fall risk assessment (identifying patients who are at a high risk of falling), exercise programmes, environmental modifications, education of personnel and patients, and drug reviews (Øvretveit 2009a). A 'safety intervention' can be any action taken to prevent or minimize harm. The term is used generically to describe action taken at a clinical, organizational and national level on all different kind of scales, carried by various actors. This ranges from policy makers constructing a five-year national strategy to managers budgeting non-slip floors to caregivers buying non-slip socks for their clients at the local market. Both macro level and micro level actors, seemingly large and seemingly small interventions appear to be equally important elements within the construction of the Care for Better program.

Methodology

Improvement programs the size of 'Care for Better' are rare, especially with regard to long-term care. Limited evidence underlies the approach of such programs and qualitative research is lacking (Øvretveit et al. 2002; Mittman 2004; Schouten et al. 2008; Øvretveit 2009b). The Department of Health Policy and Management was therefore asked to evaluate the implementation activities of the Care for Better collaborative. This study combines quantitative-survey research with qualitative-ethnographic research, including document analysis, interviews and observation. The research team used a conceptual model (adapted from Cretin et al. 2004) as the starting point for investigations at client, project, organization and program level. We investigated the effects of the collaborative method, using quantitative research methods. In addition to this, our research team used qualitative methods to understand the various processes of improvement that take part in changing long-term care organizations. In order to learn about the history and development of Care for Better, interviews were conducted with the initiators of the program, as well as with various actors involved in the improvement projects. These included politicians, representatives of insurance companies, branch organizations and patient organizations, administrators from the Dutch Organization for Health Care Research and Development (ZonMW), and the project leaders of the executing organizations (Vilans). Field documents and scientific literature on relevant topics were analysed for the research team to become acquainted with the program itself. Furthermore, attention was paid to the program's specific thematic conferences, as well as both national and project leader meetings. With the purpose of understanding if or how improvement is incorporated and situated in the daily practice of care organizations, small ethnographic case studies on all different domains of the Quality Collaborative in the participating organizations were conducted by the author. Within the scope of these case studies, improvement team members were interviewed and, in collaboration with the people involved, specific moments were identified so the project could be observed 'on the job'. Occasionally the research consisted of strolling round while talking to one of the professionals, who provided information about the project and the process on the spot. The interviews were recorded and transcribed verbatim. Observations were captured by means of detailed field notes. Within the fall prevention project, the author visited two national working conferences, as well as five organizations working on a fall prevention project. This paper draws specifically on both the qualitative research findings at program level and on the findings in the ethnographic case studies in the organizations working on the theme of fall prevention. All respondents consented to the interviews and observations. The gathered material was coded iteratively. The emerging themes were compared to the original text in a constant comparative method yet were abductively (Charmaz 2009) conceptualized through theoretical interpretation.

The empirical findings will show the nitty-gritty work that took place at both macro and micro levels in order to involve different actors and find ways of providing good care and making legitimate choices between freedom and risk. Firstly the effects and content of the project are showed from a program perspective; secondly the learning

and cooperating that was necessary to cope with fall prevention are described from an organizational perspective; thirdly the relation between managers and professionals in one of the organizations that took part in this project is described and this relation is analysed and reconceptualised by the use of the conceptual lenses of partial connections.

The effect and content of the fall prevention project

The fall prevention project turned out to be a success. At baseline, the average prevalence of fall incidents over all 24 Care for Better improvement teams was 23% and significantly decreased to 8%, which corresponds with a relative improvement of almost 60%. The results showed that 19 teams were able to achieve the improvement target of a 30% decrease in prevalence of falling incidents. Project leaders reported an increase in forms of risk evaluation and signalling risk factors, both of which partly contributed to a decrease in falling incidents (Strating et al. 2009). Consequently, the fall prevention project reached the general target set in Care for Better, which states that 70% of the participating wards should achieve a 30% reduction in falling incidents within one year. By following the project and the actors, the research team attempted to get a glimpse of understanding what kind of work had to be done in order for the project to be that successful.

During the national Care for Better conferences, the improvement teams were first trained to register falling or near-falling incidents better. At the conferences the improvement teams learned to fix small yellow Post-it® stickers on a large sheet of paper each time a fall incident occurred. Each Post-it message had to describe the time the incident occurred, the degree of physical harm and information regarding what caused the incident. Then the Post-it messages were collected in an MS Excel® spreadsheet. Subsequently, the improvement teams were taught how to analyse the falling incidents. The risk factors were subdivided in internal factors, such as muscle power and vision, blood pressure problems, medication (Zermansky et al. 2006), and external factors, such as environmental hazards like dangerous stairs or lack of light (Chang et al. 2004). Team members were taught and encouraged to take regular multifactorial inventories of both intrinsic and extrinsic risks of falling.

At the conferences, specific interventions were highlighted. Interventions such as increasing clients' balance and muscle power through exercise had proven successful (Gillespie et al. 2009), as a result of which some organizations set up special exercise groups. Other interventions included patients wearing non-slip socks in bed and non-slip shoes in the bathroom, improving lighting and serving clients caffeine-free coffee to diminish their dwelling and worrying. These practical interventions are aimed at primary fall prevention. Secondary prevention measures were also applied, such as alarm systems and mobility aids, as well as tertiary preventions such as hip protectors and bone-strengthening medicines.

Learning and cooperating to prevent falling incidents

By using a multi-factorial fall risk assessment, team members of the organizations involved not only sharpened their observational skills, but their analytical skills as well. The complex causes of every fall are a puzzle to be solved: which factors were involved and how could falling incidents be prevented in specific situations for individual clients? Considering this, it may be illustrative to see how a substantial amount of puzzling and 'tinkering' (Mol et al. 2010) occurred with regard to one of the patients. This example may show how the programme had direct results in daily care. The patient suffered from Parkinson and Alzheimer's disease. He was a constant worrier and so very restless he could never sit down, as a result of which he was often exhausted by the end of the day. He was only relaxed enough to sit and rest for a while during his wife's daily visits, which used to take place in the mornings. While discussing this patient's falling incidents, the professionals decided to ask his wife to switch over to afternoon visits. This worked out to be a highly successful intervention.

Puzzling on causalities and tinkering with preventions of falling has been proven (Close et al. 1999) to be more effective in multidisciplinary meetings. Such meetings did not take place commonly in all organizations. After all, in order to establish these meetings in the time-bound structures of organizations, negotiation with other professionals and management was required, as well as managerial attention. Very occasionally, managers themselves took part in the improvement teams. Most commonly these involved managers becoming the spokesmen of the improvement team, and in their speeches at the national conferences they often used the stories of the puzzling and tinkering to report on both the processes and results of their improvement team. More frequently however, the managers of the teams' organizations were not involved as team members in the improvement processes (Strating et al. 2008), since they had decentralized the responsibility of improving care to the wards themselves. The use of excel spreadsheets of falling incidents and their causes, invited the managers into the improvement processes, as they were made responsible for collecting information on monitoring quality of care. In return, they were in a position to use this information as a directory device, a dashboard, serving to improve quality of care if and where necessary. Some interventions needed managerial attention and authorisation, for instance in order to establish multidisciplinary meetings, choose better moments to clean floors and increase the number of supervising staff members in the day rooms.

The importance of informing and introducing not only managers but also clients and their family to the project soon became evident. Paradoxically, involving clients in the fall prevention project can make them anxious; their fear of falling makes them move less, potentially leading to an even higher risk of falling. The contradictory message to clients was therefore to keep moving, but to be careful as well. Family and other informal caregivers are in this case able to help by accompanying the client during their movements as well as in finding some rest. Clients do not always take good care of themselves, as one caregiver in a home for the elderly tells*:* ´Clients create dangerous situations themselves. When we rearrange furniture to make the ward cosier, they often move it again." It could be useful to persuade them – the clients

who are still considered to be mentally sound – to behave more safely. For this reason the improvement team of this organization asked one of the clients to help them. She was a decidedly feminine lady who, as one of the team members put it, "brought in a whiff of reality." She had outspoken views about the relation between fall prevention and shoes: "Whatever happens, I will keep wearing my high heels." However, this client turned out to be a substantial help in getting the aims of the improvement project across to other clients of the ward, during coffee breaks in particular (cf. Yardly et al. 2006). The members of the improvement team in this organization arranged meetings between clients and technicians to check and improve mobility aids. In one organization for elderly care, all walking frames were adjusted properly and their handbrake cables were tied up with special binding.

These empirical examples demonstrate that the improvement project turned out to be not only a learning device but that it had intermediating power between different actors at different levels of the organization as well. It provided a discursive space where the respective social spheres of professionals, managers, clients, informal caregivers, cleaning personnel and technicians could meet. In this respect the project made room for collaboration and connection between different professionals, between clients (their family) and professionals and between professionals and managers. Fall prevention was brought about through a set of practical improvisations and by organizing cooperation. In other words the fall prevention project was made successful by social processes that not only disperse project agency (cf. Mosse 2004) but also assemble it.

Introducing the world into a village

Following the fall prevention project into the specific organizational surroundings, the focus of this research shifted to an organization for mentally disabled people geographically located and built as a small 'village'. The management of this organization was aware of the benefits of the Care for Better program and nominated some of its professionals to join the fall prevention project. The ward of older, multiple disabled clients was selected as taking part in an organizational pilot project. The clients of this ward were considered to be increasingly instable, due to the combination of their aging and handicaps. Diseases of the elderly, such as Alzheimer's and Parkinson's are likely to increase their risks of falling. The day rooms, bathrooms and bedrooms are among the risk zones. However, risks also lie outdoors, for example when clients cross the grounds to visit the activity centre or to work or visit the farm, or when they walk into town for shopping. Nevertheless, instead of working to decrease risk, the managerial choices actually enlarged the clients' risk of falling.

The 'village' of the organization for mentally disabled people is located in idyllic surroundings, in the midst of beautiful woods not far from the 'Randstad', the economic hub of the Netherlands. Not surprisingly, the site is considered a superb location for project development. The top managers of this organization had a mission: their clients should be integrated within normal society as much as possible. They found

a ‘window of opportunity’ to combine this vision with their economic interests and material challenges. They converted their societal integration policy – usually meaning that clients go out to integrate in society – into a policy of *reversed integration*, opting to integrate society within their organization. Following their strategic plan, the top managers joined forces with a real estate developer, collaborating to start building 480 ‘outsider’ residences. Unfortunately, both construction activities and new urban planning rationalities have since led to higher risks of falling and less safety for the inhabitants of the village. Heavy trucks driving in and out of the grounds to unload building material have caused dangerous potholes in the thoroughfares. Moreover, all the inhabitants of the 480 new homes will create a considerable amount of daily traffic, whereas the former inhabitants were not used to any traffic at all.

With their *policy of reversed integration*, the management found a way to combine economics and care; two factors often regarded as incommensurable values. The profits of project development could however be invested in improved care and the infrastructure of the organization.

After having operated for a number of months, the improvement team presented their findings at conferences of the national fall prevention project. Their improvement plan focused on multidisciplinary meetings, serving to enhance the competence of health care workers in noticing and analyzing fall incidents. Their initial aim was to make fall prevention one of the goals of the care programs for clients with fall risks. Their ultimate aim was to develop policy that would decrease fall incidents within the organization as a whole. Due to the mental status of the client population, the professionals are used to working with pictograms. Consequently, the project team initiated its presentation terms, outlining the risks most clearly by displaying a skit showing someone slipping on a banana skin. The team leader of the organization for the mentally disabled where the case study took place stated that one of their important insights was that they began to realize how prone to falling their group of clients was: “You know, our clients behave rather strangely, and we’re used to that, which is why we often did not notice their impairments. Multifactorial fall risk assessment was new to us, and we found it very useful.” Furthermore, it became suddenly evident to them how risky the surroundings of their clients had become by the building activities that accompanied the process of reversed integration. In addition to following the clients’ activities inside the ward, they also walked with them through the parts of the grounds where the reconstruction of the village was taking place. In connecting with the daily activities of their clients, the professionals realized that the concept of reversed integration, as well as the construction work had created a substantial number of additional risks for clients.

Back in their organization the improvement team performed the same banana skin skit for the Client Council, doing so again at a lunchtime meeting for colleagues. They subsequently prepared a presentation for the executive management, which involved showing a DVD movie about the environmental hazards and providing some ideas to increase external safety.

Specific 'partial connections'

Reversed integration was perceived by members of the improvement team as a policy invented by managers at the macro level of the organization. During the fall prevention project the members of the improvement team became more aware of the fall risks in the surroundings of their vulnerable clients. In the opinion of the team, macro plans for the innovation of the terrain and structure of the organization did not fit with the micro processes the team was working on in trying to find ways to combine freedom and risk to prevent clients from falling. The professionals subsequently became disgruntled at the managers for initiating the construction to implement the reversed integration policy while being dedicated to work on a fall prevention project at the same. As a wake-up call for their managers the professionals made a DVD movie on the gaps and risks that the implementation of the policy of reversed integration was causing for the multiple handicapped and older clients. They recorded all the environmental hazards, such as dangerous potholes in the pavement and routes intended for clients using walking aids or wheelchairs. The movie ended with a slightly cynical shot of the village entrance: it is neatly paved for visitors. With this shot the professionals implicitly questioned the intentions of managers and in doing so they placed them at a distance, emphasizing the classical dichotomy between managers and professionals.

The movie was consequently able to act as a 'dividing device' between managers and professionals, whereas it might have been intended also as a mediator between these two worlds. According to the professionals, the managers were blind to the new risks posed to 'their' clients. The movie was designed to make the managers aware of the risks arising from their concept of reversed integration. Here the gap was literally shaped in the eyes of the beholder.

The project team then brought professionals and managers together in a meeting held to discuss the dilemmas of fall prevention and freedom-restrictive measures, as well as problems related to care provision. The managers, having initially delegated this task of combining the values of risk and freedom to the improvement team, now found themselves closely involved in the quality-improvement network too. During this meeting it became apparent that while managers worked hard to build a better place for their clients, professionals were confronted with a new reality that contained a substantial number of concrete gaps and holes, consequently increasing rather than decreasing risks of falling. At this meeting they were able to share their knowledge and experiences, discussing the ambiguities of external causes of fall incidents, budgetary questions, facilitating multidisciplinary team meetings, accountancy spreadsheets, as well as the groping and tinkering activities required to provide good care.

In the debate on the dilemmas of fall prevention and freedom-restrictive measures initiated by the project team, both professionals and managers discussed the problem of how to provide good care. Tacitly, they started to stress the similarities found on the macro and micro levels. Just as professionals do when considering the 'incommensurable values' of freedom and risk when deciding on the use of physical restraints, the managers showed that they too weighted the increased risk of the policy of reversed integration against the improvement to quality of life, under the

assumption that reversed integration would lead to better social integration and more freedom of mentally disabled clients. The professionals realized that their managers also balanced and compared various other benefits and risks. The similarities between the managerial level and ward level came up for discussion. After all, professionals also struggle with comparable complexities of patient autonomy increasing risks of falling in their own daily working practices. Professionals and managers came to the conclusion that they were both seeking creative solutions to overcome contradictions and combine the different values in shared legitimate agreements or justified choices (cf. Boltanski & Thevenot 2006). Professionals and managers found recognition in each other's specific tinkering with comparable incommensurable values, understanding that both of them, in organizing as well as in providing care are 'groping for good care' (Willems & Pols 2010).

Conclusion

The contradiction and tension between freedom and risk is found on both macro and micro levels – albeit thought of in different shapes or forms. To find ways of providing good care and making legitimate choices between freedom and risk requires an ongoing discussion and reflection on the subject of what 'good care' is. The empirical findings show that balancing freedom and risk takes place on and between management macro level and micro ward level. The 'world of care' in which professionals and managers operate is 'ontologically multiple'. Using the metaphor of the partial connected cauliflower, it can be said that although capricious and complex, the micro and the macro are indeed similar. Both professionals and managers are trying to find ways to provide good care. The provision of good care can indeed be shaped as a red tricycle or as a new village planning. This is what politics could be about: finding pluralistic solutions to profound contradictions. Politics, according to Berlin, is about actively and cooperatively seeking creative ways to overcome contradictions in combining the different values into shared legitimate agreements or justified choices (Berlin, in Gray 1996).

The theory of partial connections has proven to be useful in reconsidering and overcoming dualistic perspectives of classical gaps, not by bridging the gaps, but by conceptual reframing. Good care can be considered a product of the partial connections between professional and managerial work. Following the actors and analyzing their behaviour and concerns enables the observer to meet the often-argued need to reconceptualise the relationship between health management and professionals in terms of their shared responsibility for the provision of good care. Observing and describing the nitty-gritty basics of the work means provides an opportunity to reconstruct the provision of good care not as a dual collaboration of related parties but as the shaping of partial connections, involving all actors in various pluralistic ways. In this respect we have gone beyond the gap.

Notes

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1 The distinction between healthcare 'professionals' – or 'caregivers' – and health care 'managers' is based on the distinction between 'giving care' and 'organizing care' (Stoopendaal 2009).
2 To tinker is to make small changes to something in order to repair it or make it work better (Longman Dictionary of Contemporary English 2009). Mol et al. (2010) describe tinkering as seeking a compromise between different 'goods', as 'attentive experimentation'.
3 Due to the sector cuts, some Dutch care providers argued they could not afford the staff needed to dress elderly clients every day.
4 The 'breakthrough method' in particular. It was developed for issues such as falls prevention by the Institute of Healthcare Improvement (IHI) to create advances in quality of care through rapid cycles of improvement and feedback. Three fundamental issues are involved: selecting best practices, setting goals, and establishing measures. The improvement process is structured according to the Nolan model that consists of those three fundamental issues and introduces an improvement device: the plan-do-study-act cycle (Langley et al. 1996; Øvretveit et al. 2002: 346; Strating et al. 2008).

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