

Comic Strip Conversation: Reconciling “Work as Imagined” and “Work as Done”

Activity

Have you ever questioned whether 99 percent compliance in an audit truly reflects the reality of safety performance? As part of [Rethinking Patient Safety](#), we are encouraging an exploration into the reliability domain of the [Measurement Monitoring of Safety Framework](#) (MMSF). **Reliability** asks the question, “Are our clinical systems and processes reliable?” It gauges the probability that a task, process, intervention or pathway will be carried out or followed as specified (Vincent et al, 2013).

Healthcare organizations develop hundreds of policies and procedures and carry out numerous audits to check how reliably they are being implemented. For example, hand hygiene compliance, falls risk assessment, care-planning documentation completion, availability of equipment in the operating room, missed medication administration and whether staff carry out vital signs and therapeutic observations are just a few!

This activity helps healthcare professionals who deliver care and leaders who manage care – including policy developers and those who receive audit results – to hold fun, reflective conversations that shed light on the reliability of practices. By exploring the difference between “work as imagined” and “work as done”, participants can gain valuable insights into why practices may not be implemented as intended. The goals of this activity are to:

- uncover and reflect on the gaps between work as imagined and work as done
- discuss potential unintended consequences of efforts to ensure reliability
- work towards bridging the gap between work as imagined and work as done
- move beyond compliance-driven safety strategies toward more meaningful solutions

Understanding work as imagined and work as done

Work as imagined describes what **should** happen under normal working conditions. It reflects the work we imagine others do and the work that we imagine we do, currently or in the future. The imagination of human work takes place within organizations, between organizations and from outside them, such as by regulators, accreditation bodies and government agencies (Shorrock, 2016; Hollnagel, Wears & Braithwaite, 2015).

Work as done describes what **actually** happens, what people do and how work unfolds over time in complex contexts. It takes place in an environment that is often different than imagined, with multiple, shifting goals, variable and often unpredictable demands, limited resources (staffing, competency, equipment, procedures and time) and a system of constraints and incentives – all of which can have unintended consequences. **Work as done** is mostly achieved through adjustments, variations, trade-offs and compromises that are necessary to meet demand. These adaptations are based on operational knowledge but often have not been subject to formal analyses such as risk assessment, which can struggle to reflect the reality of everyday work (Shorrock 2016; Hollnagel et al, 2015).

Why the difference matters

It is often believed that safety can be achieved by ensuring that work as done is identical to work as imagined. However, safety is not the result of people simply following procedures. Rather, it comes from people making thoughtful and reasonable adjustments in response to the demands of a situation. Understanding these adjustments and learning from them is essential to delivering safe and reliable care (Hollnagel et al, 2015).

What are comic strip conversations?

Comic strip conversations are simple visual stories that help teams explore the gap between how work is supposed to happen (work as imagined) and how it actually happens (work as done) in real settings.

Participants draw the steps of a process using basic sketches or stick figures and capture what they experience from the perspective of either work as imagined or work as done. These drawings provide a shared reference point for reflection and conversation.

Curious to try it? Keep reading to learn more. Don't worry about your drawing skills – just have fun with it! (See an example in Appendix A.)

Why do this activity?

This activity promotes a shared understanding of safety challenges and supports meaningful discussion about improving reliability in healthcare. It helps board leaders, managers and care providers:

1. uncover and reflect on the gaps between work as imagined and work as done
2. discuss potential unintended consequences of efforts to “ensure” reliability (refer to slides 6 to 10 of the accompanying [slide deck](#))
3. work towards bridging the gap between work as imagined and work as done
4. move beyond compliance-driven safety strategies toward more meaningful solutions

How to host a comic strip conversation on work as imagined versus work as done

The time you need

Set aside about 1.5 hours, which includes:

- 20 minutes – introduction and presentation accompanying [slide deck](#)
- 50 minutes – comic strip exercise
- 15 minutes – debrief
- 5 minutes – wrap-up and evaluation

Number of people

- Minimum, eight participants
- Maximum, 100 or more, depending on space

Who to include?

You need a mixed group from your healthcare team that includes those who develop policy and seek assurance of its implementation (work as imagined) and those who do the work (work as done). The mix you choose depends on the healthcare system and process you choose to focus on.

For example, if you want to focus on hand hygiene compliance, include clinical and nonclinical staff such as doctors, nurses, allied health professionals, infection prevention and control professionals, volunteers, patients, residents, clients and care partners. Also include those who carry out hand hygiene audits, board leaders and middle and senior managers, along with those who sit on safety committees, where hand hygiene compliance is discussed and audit results are reviewed.

What you need

- The comic strip conversation accompanying [slide deck](#) presentation accompanying this activity
- Flip chart paper, markers and sticky notes
- Space for drawing and discussions
- A method for recording insights and action items, such as notes, photos, shared documents

Planning your activity/event

1. Define your target audience, such as all staff, specific care areas.
2. Determine the event format, such as staff meeting, focus group, workshop.
3. Decide whether to pre-select a healthcare process or allow participants to choose.
4. Choose a date, time and venue.
5. Invite participants, ensuring you include people who can bring perspectives from work as imagined and work as done.
6. Identify a facilitator and brief them on the purpose and flow of the activity.

Hosting the activity

Step 1: Organize your participants

Organize participants into groups of about eight. Each group must include people who develop policy and procedures and seek assurance (work as imagined) and people who do the work/deliver care (work as done).

Step 2: Conduct an ice-breaker (optional)

If participants do not know each other, consider doing an ice-breaker activity before embarking on the task. For example, have participants introduce themselves and share something about themselves non-work related. You may have your own icebreakers. The main goal is to create an environment where participants get to know each other, feel included and have a light-hearted moment before the activity begins.

Step 3: Introduce the Measurement and Monitoring of Safety Framework

In the introduction, briefly introduce Rethinking Patient Safety and the Measurement and Monitoring of Safety Framework. Make the connection that this activity focuses on the **reliability** dimension of safety by exploring and reconciling work as imagined and work as done. The accompanying [slide deck](#) can support this introduction.

Step 4: Deliver the background presentation

Introduce what is meant by work as imagined and work as done. The accompanying [slide deck](#) helps set the scene for the activity.

Step 5: Introduce the activity

Describe what a comic strip conversation is and ease any apprehension about drawing by reassuring participants that simple drawings such as stick figures are all that is needed. Show an example of a comic strip (see [slide deck](#) and appendix A) and explain the purpose of the activity. The [slide deck](#) can support this introduction, but you may adapt your wording to fit your needs.

Step 6: Select the healthcare process

- If you have pre-selected a specific policy or process, use this time to introduce it.
- If participants will choose their own process, give them time to discuss options and select one.

Step 7: Create the comic strips

Ask each group to organize themselves according to who aligns with work as imagined and who aligns with work as done.

- The work-as-imagined group creates a comic strip that captures the official process as described in the policy and procedure, the audit approach and audit results. A question to frame this conversation could be, "Imagine you are sitting on the safety committee in your organization. What data do you receive on the chosen healthcare process? What do the audit results tell you?"
- The work-as-done group illustrates how the same healthcare process unfolds in real-world conditions, such as on a unit or in a patient's home, residential care home or community. This group considers the pain points, barriers, adaptations and trade-offs they make when delivering care related to the chosen process. A question to frame this discussion could be, "Imagine you are working today. What pain points or barriers do you encounter and what adaptations do you make when carrying out the task your group is focusing on?"
- Appendix B gives examples you can use to get groups to begin thinking about work as imagined and work as done.

Step 8: Share, compare and discuss

Once both groups have developed their comic strip, they come together to present their work. The share and compare discussion should focus on the gaps between work as imagined and work as done. Some guiding questions include:

- Is there a disconnect between what is documented versus how care is delivered in the real world?
- If so, where are the gaps?
- Do you think it is possible for staff to deliver the process exactly as written, 100 percent of the time?
- Do your audit results better reflect work as imagined or work as done?

Step 9: Discuss potential unintended consequences of reliability measures

Think about examples of unintended consequences from the [slide deck](#) (slides 6 to 10). Ask the group, “Are there any unintended consequences linked to how you currently measure and monitor the healthcare process you have focused on? If so, what are they?”

Step 10: Discuss potential strategies and solutions

After exploring the gaps between work as imagined and work as done, brainstorm ways to reduce those gaps. Guiding questions include:

- Given what you have discovered, what could you do differently in the future to improve the reliability of the process?
- In what ways could your organization improve its approach to measuring and monitoring this process?

Step 11: Debrief

Following the activity, debrief with participants by asking for volunteers to share what they discussed, what they learned and actions they plan to take. The facilitator should summarize what was heard and add any key messages not covered.

Step 12: Evaluate

To evaluate the session and strengthen future offerings, ask participants:

- One thing I learned...
- One thing I will do...
- What went well?
- Even better if...

Tips for success

- **Foster psychological safety** – Create an open, inclusive space for honest discussion. It is important that people feel comfortable sharing how work is actually done.
- **Ensure a mix of participants** – Include people who lead quality and safety initiatives and policy-making and those involved in work at the point of care.
- **Clarify the purpose** – Reinforce that the activity focuses on reconciling the disconnect between work as imagined and work as done. It is not about telling people to follow safety policies and procedures or criticizing audit approaches, which are often set nationally or regionally. It is about having a reflective conversation and building a shared understanding.
- **Encourage creativity** – Reassure participants that artistic skills are not required. Remember not everyone is an artist and simple stick figures are fine!
- **Challenge assumptions** – Emphasize that compliance does not equate to creating safety and that the activity will help them explore this further.
- **Use the slide deck** – Ensure participants understand work as imagined versus work as done before starting. Set the scene by using the accompanying [slide deck](#).

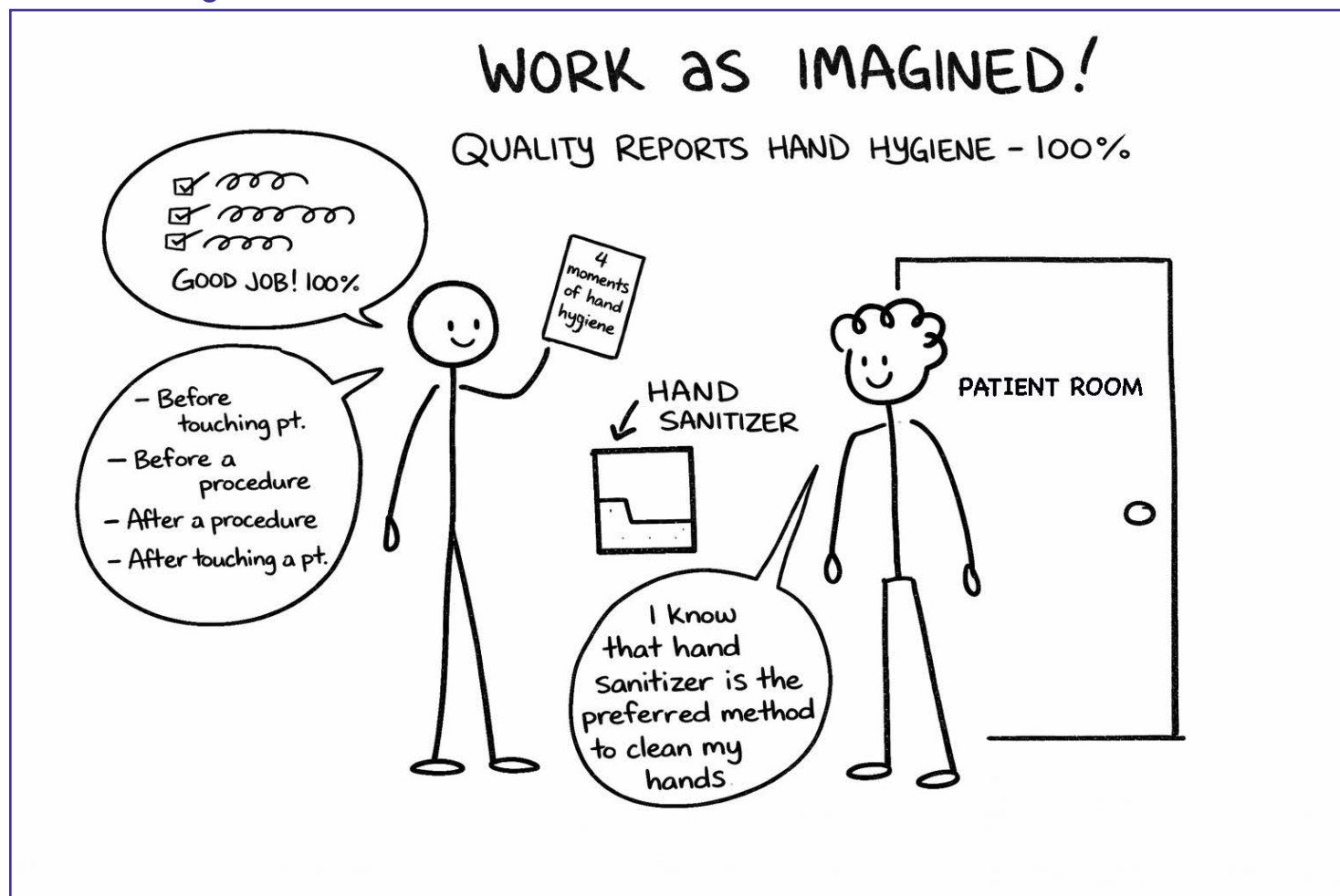
References

Shorrock S. The varieties of human work. Humanistic Systems. 2016. <https://humanisticsystems.com/2016/12/05/the-varieties-of-human-work/>

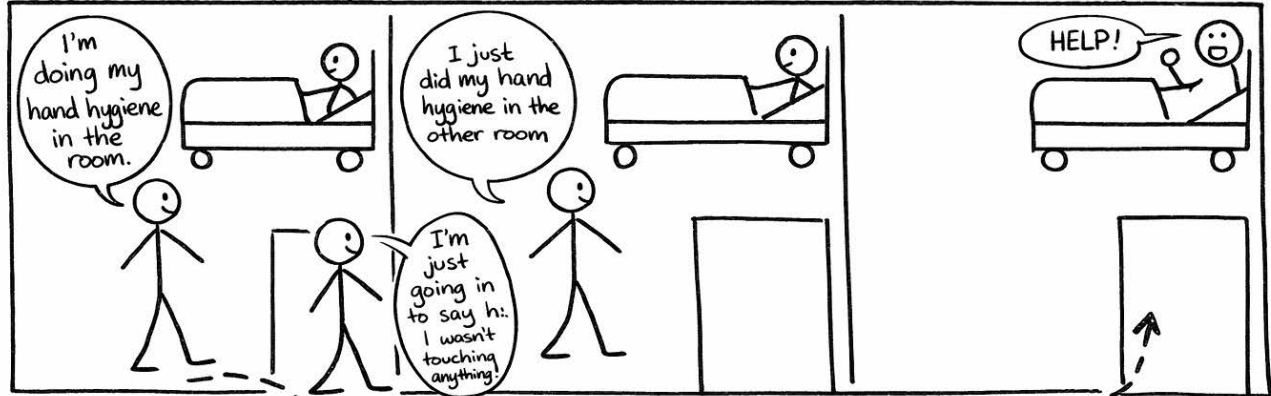
Hollnagel E, Wears RL, Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net. 2015. Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

Appendix A – Comic strip conversation about hand hygiene compliance

Work as imagined



WORK AS - DONE



Appendix B: Examples facilitators can use to highlight work as imagined and work as done

Work as imagined	Work as done
<p>The patient safety committee receives the quarterly audit results for hand hygiene, falls, pressure ulcers and therapeutic observations. Most areas are colour coded green, with two amber areas and two red areas. The conversation therefore focuses on what is happening with the red-rated areas and how to improve their levels of compliance.</p> <p>The safety policy and procedure for healthcare process X states that staff must document the care patients have received immediately after that care has been given. To the board leaders and managers, this is reasonable because documentation must be accurate. Their expectation is that staff record care immediately after providing it.</p>	<p>Hand hygiene</p> <p>You go to clean your hands, and the gel dispenser is empty. The environment where you are delivering care means equipment and supplies are not located at the bedside or near the patient, so you clean your hands then contaminate them again when getting supplies.</p> <p>Falls or pressure ulcer risk assessments, care planning in the home</p> <p>You have three admissions on the unit in close succession, so you end up cutting and pasting from a previous falls or pressure ulcer risk assessment. Or, when you deliver care in the home, the way your caseload is allocated means there is no time factored in to find a parking space. You are under time pressure and drift into autopilot as you complete the care planning documentation.</p> <p>Therapeutic observaions</p> <p>You are allocated three patients who are on intermittent observations on an in-patient mental health unit. As you walk around the unit, another patient asks you to make them a drink, and you leave the observations sheet in the kitchen. You go back and complete it later in your shift after searching and finally finding it. Or, the electronic records tablet does not work because of poor network connectivity, so you cannot document the observations at the point of care.</p>