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Qualitative Research as an Interpretative Key to Risk Management: Ethnographies at The Local Health Authority in Parma

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Premise and Acknowledgements

This paper is the result of a research path on Risk Management in healthcare, a path of deepening and reflection on a discipline already evolving in the pre-covid era and which has been invested, like health systems in general, by an adverse event of epochal importance that has changed the way of looking at uncertainty and the unexpected, elements inherent in the act of care and medicine but which today must also be interpreted in a broader perspective with respect to the social and environmental transformations that have immediate repercussions on the state of health of individuals and populations. The research is the result of a path of contamination between Risk Management and social sciences, an approach that has been experienced from within the discipline, a unique opportunity for the implications of immediate implementation in the operation of the knowledge acquired during the long journey in the field. In these years I have been able to get to know and examine not only the mechanisms of a healthcare authorities at work at the most critical moment, but above all the ability to react and reverse the crisis and by making improvements thanks to the operators I met who gave me a piece of their humanity and professionalism as they do every day with patients. To them, first and foremost, thank you for this meeting. The research also intends to develop, within a technical and sectorial discipline, an insight capable of interpreting the challenge of complexity that health systems cannot escape in the first instance because they deal with an asset, individual and collective health, which is a common good. The challenge, as Annamaria Anselmo, Professor of History of Philosophy and Scholar of Thought of E. Morin, indicates, consists in understanding that the term complexity encompasses a "revolutionary power of ontological, logical, epistemological and therefore also ethical-formative scope... a revolution that invests our way of understanding reality, the image of reality outside of us, the way of organizing knowledge, the setting of disciplines, the horizon of the general sense in which we move" (Anselmo, 2017). The research, as we will see in detail, has experimented with Organizational Ethnography both as a research methodology applied to the case

study of the Ausl of Parma, and as a subject to train professionals involved in a network dedicated to the safety of care. This dual modality has made it possible to analyze the contexts within which Risk Management is articulated from different points of view: as a field observation methodology, it has made intelligible the emergency management methods at the level of Local Health Authority strategic governance and governance of a peripheral territorial structure; As a training process, it has allowed professionals to narrate the problems and strategies implemented to deal with the pandemic and in general the issues related to the safety of care. Like any self-respecting research, it has gone beyond the objectives to be reached to a proposal for the interpretation of Risk Management not only as a technical discipline but as a culture necessary to govern organizations, in every sector and level, as it is able to take care of good health. The most difficult moment is translating into text all the wealth of experience gathered in these years of research. Difficult because to see clearly it is necessary to look at the work by taking a step back in order to grasp its complexity. Risk Management seems to be an immutable discipline, defined by laws and regulations that capture the biomedical and probabilistic point of view but the concept of risk is a purely cultural fact like anthropological disciplines and in particular as the work of Mary Douglas (1991, 1992, 1996) has amply demonstrated. The pandemic has highlighted that the traditional reactive and proactive tools of Risk Management are not sufficient to grasp the contemporary challenges that require a process of taking charge of the health of individuals considered in their unity with the environment that is constantly changing and therefore a harbinger of uncertainties and unpredictability. It is no longer avoidable, on the part of Risk Management, to consider the close connection with the issue of equity intended as the elimination by services of unjustified inequities that are generated, sometimes by health processes themselves. As Ota de Leonardis evokes, the concept of care implies difference as a radical principle of change and social reorganization (de Leonardis, 2022 p. 19) but even more so implies the speaking up of patients and health professionals, the power to

express themselves, which is also a gesture of self-definition (de Leonardis, p. 25) and of enhancement of capacities as a possibility to be activated that also implies the reversal of the approach of services compared with interlocutors (de Leonardis, p. 24). The project takes shape following a path of in-depth study of Organizational Ethnography, promoted by the Health and Social Agency (ASSR) of the Emilia – Romagna Region, aimed at making professionals working within health organizations promoters of knowledge and experimentation of qualitative research methods. The Ausl of Parma, participating in training and field research courses with some professionals, has embarked on a further path investigation, in particular of organizational Ethnography, experimenting its use in the Risk Management sector: in the three-year period 2015 – 2018 in the Local Health Authority of Parma ethnographic research was conducted by the writer at the Pharmaceutical Department and the Integrated Mental Health and Pathological Addiction Care (DAISM – DP) within the Points of Direct Distribution of Drugs (Dodi et al., 2016) and Distribution of Substitution Drugs (Sert), at the direct request of the Operating Units following adverse events (EA). The research, in addition to helping the teams to deal with the complexity of what happened, has made it possible to identify some crucial and just as important elements such as the role of space as an often neglected but complex and conditioning element of the provision of services, the dynamism of the relationships that come into play in all phases of the work and that involve all individuals (even touching on the themes of "Patient Experience"), the function of Non-Technical Skills (NTS) as knowledge of professional competence. The course was fortunate to continue with the Urbeur Executive PhD at the University of Milan Bicocca and therefore to incorporate a more refined methodological rigor from the point of view of theoretical and practical competence. Participation in the executive doctorate, due to the specificity of the collaboration path between Local Health Authority and university, aims to create a circularity between knowledge production and practice, which proves to be very profitable in terms not only of repercussions

on disciplinary knowledge but also of spaces for reflection, which are so necessary in shifting the disciplinary areas from their sectorality.

I owe the surprise of this experience that I consider unique to the foresight of Dr. Lombardi, my precious Health Authority Tutor, Surgeon and Risk Manager from whom I learned the ability to read the complexity of events while bearing in mind an openness to culture / cultures and scientific rigor, a necessary interweaving to grasp the power of relationality which, in my opinion, is the key to interpreting the events that take place in health (and in life); to Dr. Paolo Crotti Forensic Doctor and Risk Manager from whom I learned the importance of methodological rigor and analysis of details to give depth to the arguments in a field as unfathomable as that of adverse events, in which one thing can mean another if not interpreted accurately. I believe that Risk Management should pursue both the aspiration to reflective relationality, intended as a way of opening up to one's own cultures and others, and to methodological rigor to actually constitute a tool for improving quality for health systems, operators and citizens.

I could not have faced this experience without the guidance of my Supervisor, Lecturer Lavinia Bifulco, to whom I entrusted myself, aware of the difficulty of a path that I never thought I could access without solid support. From the Supervisor I learned to decentralize the point of view, without fear of using the critical method to undermine mainstream knowledge and follow autonomous reflections ofinvestigation.

I also owe this experience to my dear friend and English Teacher Nicky McCarthy, who has always encouraged me and allowed me to love a language I did not know.

I thank my family and especially Paul for his sensitivity, intelligence and infinite patience.

"Once again, the solution is to learn
to feed on indeterminacies,
instead of deciding in advance
as the furniture of the world should be".
B. Latour, 2005

Introduction

This research aims to attest the effectiveness of Qualitative Research and in particular of Organizational Ethnography as a methodology that can support health organizations in the Risk Management process, as high proactive and reactive tools in healthcare. I believe that Organizational Ethnography and qualitative research in general can add depth and transversality to a discipline that sees in the continuous improvement of the processes of care the heart of its activity. Today it is called to adopt structural and paradigm changes to cope with the management of ordinary events and public health events caused by disasters and global epidemics. Ethnography, which deals with daily interactions (meetings, formal and informal conversations), written texts (e-mails, workbooks, Local Health Authority policies, communicating with the outside word, stories, narratives, actions (routines and work practices), symbols and languages (technical terms, jargon, common phrases), aims to get an understanding of how members of an organization build meanings, build work practices and how work communities can be modified and change. (Piccardo and Benozzo, 1996). Studying the impact of the pandemic through the lens of ethnography on the very premises of Risk Management, allows us to observe the dynamics of two levels of commitment: a level of "system", in which all health actors that are active in the preparedness of strategies for emergency management related to the collective, population dimension are involved; a second, more operational level, relating to the management of clinical risk in the traditional sense, of translating the daily working practices of the individual operational units in terms of risk control and involving individual structures, the professionals working there, citizens and carers who access treatment. Armondi and al (2021) in a geopolitical reading of preparedness (ibidem, p. 159) argue that there are different rationales of

government dealing with emergency with concepts of risk at their basis: risk is normal in an insurance regime; in a precautionary regime disaster must be avoided; in a preparedness regime disaster is considered unavoidable and for that reason it is necessary to transform threats into vulnerabilities to be mitigated.

Box 1: Preparedness

Preparedness

It is the capacity of ensuring the safety of vital systems against threats of any kind, known and unknown "(Bifulco, Centemeri, Mozzana , 2022). Vital systems are those infrastructures will bring a systematic collapse if they fail (Lakoff, 2008). The purpose is to facilitate the assessment of vulnerability of the context at that particular moment, preparing response measures that will prevent the disastrous event from turning into a catastrophe (Lakoff 2017). As Bifulco point out (2022), for Lakoff preparedness is both an ethos and a set of techniques for reflecting about on and intervening in an uncertain, potentially catastrophic future: "it points to a new form of knowledge about collective life (Bifulco, Centemeri, Mozzana, 2021 p. 11). Preparedness techniques were born during the Cold War period and are subsequently used against terrorism and health emergencies and are based on planning through scenarios, sentinel systems and medical supply chain (Bifulco et. to 2021 p.11; Lakoff, 2006). The pandemic raised the question of the response that governments and health systems have given, with different interpretations: some highlighted the normalization of the state of emergency to justify emergency measures to defend health as the prevailing right (Pellizzoni, 2021; Agamben 2021); others stressed the inability of governments to manage unexpected and exacerbated emergencies (Pellizzoni, 2021). As Pellizzoni suggests this debate, it is linked to the ambiguity of today's governmental rationality that on the one hand, under the neoliberal pressure promoteds a policy of personal responsibility, on the other, in emergency situations prefers a disciplinary approach: during the pandemic recommendations alternated between individual responsibility (hand sanitizing, social distancing, fiduciary isolation) and on the other hand with restrictions on the mobility of individuals, quarantine, ban on socializing (Pellizzoni, 2021, p.62).

Compensation/insurance logic addresses the protection of individuals while precaution supports the safety of the population; preparedness focuses its attention on both critical infrastructure in order to preserve its functioning, and on political, economic and productive systems (Armondi, 2021, p. 162). This consideration is useful for understanding the facets of risk and translating these changes into the logics that support healthcare systems. It is evident in the production of regulations and documents as can be seen in the fourth chapter. Observing these points of view means questioning several levels and implies adopting multidisciplinary approaches and methodologies which are useful in understanding and translating the very complexity of health systems.

Tab.1: Risk Management Approaches

	Approach	Rationale	Target
Risk Management	Compensatory	Probabilistic Reactive	Patients protection
Precaution	Threat to be avoided	Probabilistic Prevention	Population protection
Preparedness	Transforming the threat into vulnerabilities to mitigate	Foreshadowing of scenarios	Infrastructure protection

Source: Author processing based on Armondi text

The work that I have presented in this paper, can be considered a path within the discipline of Risk Management at a time when the most serious adverse event occurred for the first time ever. I have subdivided it by type of event, dissemination and duration and on its impact on social and health indicators of individuals at all latitudes of the world. The pandemic event has changed the "ontological assumption" of the matter because Risk Management, from a form of discipline to the clinical event, acquires a multi-dimensional nature in which a specific clinical sector coexists with a wider spectrum that permeates all areas of health and the daily life of individuals. It makes us more aware of the necessity of activating generative processes of multidisciplinary knowledge in a subject such as the safety of care which has two challenges to face: the first is a deep reflection of what happened and a current production of knowledge in order to be able to face future events; the second is

investing in a coordinated and collaborative approach among local, national and international health agencies, aimed at standardizing interventions and developing basic skills to detect and respond to global critical events (Lakoff, 2022 p.29).

Maria Inglese, in a recent article on the role of caregivers in prison institutions, recalls that M. Crozier attributes an anti-alienating power to creative unpredictability. This power lies on the margins, where people's lives meet, relationships far away from the centre, from formal - hierarchical - authoritarian power (Inglese et al, 2021). This is just what this research is aiming to do: seek the narratives of this creative power, the anti-fragility theorized by Taleb (2013) and Lanzara's (19963) "negative capacity" which are expressed in a particularly critical and creative moment for Risk Management, as it is called, to explore the connections with emerging issues as well, such as equity and the fight against inequalities of access to care, the ecological challenges that affect the future of the new generations and that involve the concept of health as a common good and right for all. The expansion of the complexity, as some authors have argued, and whose thinking will be quoted, due to technological innovations, international mobility and scientific discoveries, introduces new meanings to the concepts of risk and safety, the ordinary and extraordinary critical events for which it is necessary to prepare, as far as possible, to mitigate their impact. The pandemic has, in fact, taught us that a virus can reach all the corners of the globe in a very short time and that it is necessary to work to prepare measures to control and mitigate the effects of the next event. Preparedness then becomes the strategy that allows for the transition from "probable" to "possible", the result, as we will, see of a choice that presupposes awareness and action rather than waiting in the indefinite. From the point of view of health systems, the model of High Reliability Organisations (HRO) and the model of Perrow's Normal Accident Theory, which will be comprehensively presented in Chapter 2, allows the preparedness approach to be aligned with the main tool available to HRO, or the careful awareness of what happens in the systems from the point of view of the operation and that of the processes that do not take place with

automatism but highlight the meaning that the actors attribute to the experiences and relationships that take place in the field.

As De Toni (2018) states, when external complexity increases, systemic solutions alone are not enough. Action on the part of individuals, networks, professional communities and society is required since it is from their experiences, knowledge and professionalism that it is possible to "extract approaches, methods, perspectives: a gym where to train a free, lateral, divergent, creative, generative, visionary thought" (De Toni, 2018, XIX). The "occasion" has allowed us to observe, by experimenting with a multiplicity of qualitative research tools, how the pandemic was dealt with by the Local Health Authority of the Province of Parma, respectively at management level (macro level) in a territorial structure (meso level) and by the components of the network of professionals that make up the Local Health Authority Network Safety of Care (micro level).

Applying Qualitative Research Methodologies has allowed us to gather both the organizational point of view and that of individuals in their capacity as patients and citizens and, in the case of professionals, members of the communities of practice to which they belong. To this regard, in my research I have analysed the impact of the pandemic at different levels of the health organisation: at the level of strategic governance, at the level of structures and at the level of individual health professionals involved in the health crisis. The table presents a map of the research in which the four actions that investigated the objective of the survey are presented: testing the effectiveness of Organizational Ethnography as a Risk Management tool and deepening the management of the pandemic at different levels of Local Healthcare Authority governance.

Tab 2 : Research Map

Risk Management	Actors	Analysis object	Methodology
Macro level	*Governance* International, national and regional	Documents and standards, data, data debate	Documentation analysis
	Governance Parma Health Authority	AUSL Crisis Unit	Conversation analysis
Meso level	*Governance* CDS Pintor Molinetto facilities House of the Villa Ester district	Methods of access and reception of services from the point of view of safety management	Organizational Ethnography
Micro level	*Governance* Care Safety Network	Individual activation on the spontaneous reporting of events	Spontaneous event reporting experiment

Source: Author's elaboration

To further analyse the Risk Management strategies adopted at the a macro level I followed two paths: I analysed the national, regional and local documentation with particular reference to production related to the management of the pandemic. I carried out a second activity that consisted in the observation of the Crisis Unit in order to study the decision-making processes activated by strategic management. With regard to the meso level I carried out an organizational ethnography at a territorial structure of the Health Authority, focusing on the organizational strategies used to face the pandemic and the accessibility of structures for citizens. Lastly, the fourth action, where members of the network were involved in an improvement project and in an organizational ethnography course through which I collected the suggetions of the operators involved in Risk Management activities and formalized a tool to help with the reporting of adverse events. The research highlighted the presence of different meanings and ways of dealing with Risk Management according to these different levels. Qualitative Research has allowed to deepen how the management of safety, in its various articulations, is the result of the influence of several factors that determine the responses to contingent events and extraordinary events and how this affects peripheral responses. Preparedness is a strategy indicated by government structures in its document formalization, the pandemic plan, the drafting and dissemination of which is required of all stakeholders interested in the management of the health crisis; it is a strategy put in place by

peripheral structures and operators who, starting from reorganizing daily life, lay the foundations for the management of the extraordinary: it prepares for the next unexpected event while consolidating everyday activities. Ch. 4 explains how regulations and scheduling plans make up the "artifacts" in which the cultural and social representation of events is deposited and what still needs to be done. Organizational Ethnography and in general qualitative research methodologies allow us, more than other approaches, to observe and analyze the ways in which the culture of safety and quality in health is built, with the aim of interpreting its complexity by taking it as a unique element of research.

The first chapter introduces the pandemic event in the light of the main theories that have highlighted the contradictions of post-modern societies and a development model that has undermined the balance of environmental and social systems aggravated by the pandemic. The chapter, in this regard, will deal with preparedness as a response to the crisis generated by events of such magnitude.

The second chapter introduces the organization of the national and local health system through a brief overview of regulatory references and service programming. The second part of the chapter focuses on the analysis of the structural components that make up the prevalent model of health organizations highlighting their complexity.

The third chapter intends to examine the theme of Risk Management by comparing the main approaches that have identified different meanings as regards the concept of risk and examining Clinical Governance (CG) as a model used by healthcare organizations for the improvement of services and Risk Management.

The fourth chapter addresses methodological issues by reconstructing the phases of research design: formulation of questions, data collection and analysis.

The fifth chapter gets to the heart of ethnographies through the analysis of the thematic documentation produced in the years of the pandemic, with particular attention to national, regional and local documents related to Risk Management and crisis management. The chapter documents the work carried out during the

observation of the Healthcare Authorities Crisis Unit and the conclusions it reached. Ethnography at the Pintor-Molinetto Casa della Salute is a further context in which field observation has been experimented, focusing, in particular, on the issue of accessibility of services during the crisis. Finally, the chapter concludes with the project shared with the safety network of care of the case study Local Health Authority, which has made it possible to make Organizational Ethnography a learning tool for operators and a participatory research model.

1. The Pandemic

The chapter aims to deepen the understanding of the pandemic event in the light of the main challenges and contradictions that Local Health Authority post-modern societies whose model of development based on the exploitation of resources and an ideal of supra-dimensional individual freedom, collides with the finitude of the resources themselves and the interdependence of ecological and social systems. The nature of these slow emergencies (Anderson, 2020) requires a response that involves not only the technical and hyperspecialized knowledge of critical systems but also considers ecological ecosystems and local communities.

An approach, therefore, open to the contribution of different disciplines to observe how health systems have responded to the health emergency and consider the management of the pandemic in its initial critical phases. This was when the limits of the technocratic and rationalist vision emerged since they failed to respond to an event that recorded the most dramatic results at territorial and social levels. Health systems have by the nature of the subject matter they treat, the care of patients and the population, the need to cope with uncertainty and reduce the impact of any events that could cause irreversible damage. For this reason, they are equipped with Risk Management tools that have, as a foundation, the reflection on events and proactive research aimed at continuous improvement and prevention. As we shall see, the advent of the pandemic has made it necessary to overcome the hypersectoral and hyperspecialized approach of the discipline to cope with different types of adverse events.

1.1 The Pandemic as a Social and Health Event

For the first time in the history of humanity, the spread of a virus has put a strain on health and social systems for a great amount of time, involving the population as a whole, with serious repercussions on the economic and social life of countries and individuals. A phenomenon that has caused 643,875,408 infections worldwide (source: WHO December 2022) and 6,600,000 deaths, while in Italy compared with

the 24,709,404 infections the number of deaths is equal to 182,419 (source: Istituto Superiore di Sanità - December 2022).

Yet it was, above all, a process that triggered profound reflections on the resilience not only of health systems but of the development system of contemporary societies. It is no coincidence that the production of literature on the subject involved the arts, sciences and legal disciplines in a truly deep worldwide reflection.

Box 2: Resilience

Resilience in disaster research, is "a system's capacity to persist in its current state of functioning while facing disturbance and change, to adapt to future challenges, and to transform in ways that enhance its functioning" (Keck & Sakdapolrak, 2013, p.8). Resilience also means the ability of an organization to cope with a shock or structural changes resisting them (absorption), with a certain degree of flexibility (adaptation), and bringing small modifications to the system (transformation) (Giaccardi e Magatti, 2020).

Author's elaboration

Edgar Morin describes this event as a global cataclysm that has confined more than four billion people and produced a health catastrophe (Morin, 2020 p. 23); other scholars define the pandemic as a global problem and a crisis on a social, cultural, environmental, and economic level (Lupton, 2020).

Covid has unveiled the close link that connects individuals with other human beings, places, objects, cultures, etc. (Lupton, 2020, condemning humanity to a reflection on the relationship with the world and the world with which it prefigures a common destiny" (Morin, 2020 p. 24). The pandemic, according to Morin, has generated what he defines as a poly-crisis which in addition to affecting the economic, political and social dimensions, highlights the inconsistencies of the paradigm of consumerism and solidarity (civilization crisis), does not work to translate and make intelligible the complexity of the times (intellectuality crisis). It has resulted in an existential crisis in that it has changed the way of life, the way to respond to needs and to pursue aspirations (Morin, 2020). For Latour, as well as being a crisis, this, is to be considered a real ongoing mutation so as to adapt to live in what he calls a "critical zone", a "dangerous and deeply objective" area in which it

is necessary to learn to last a little longer without endangering the habitability of the life forms that will come after (Latour, 2021 p.37). History passes down records of other epidemics of particular impact such as the Plague of 300 and 600, cholera, the Spanish flu of the early twentieth century and recent events such as the HIV/AIDS virus epidemic from the 1980s and lastly, AH1N1 swine flu between 2009 and 2010.

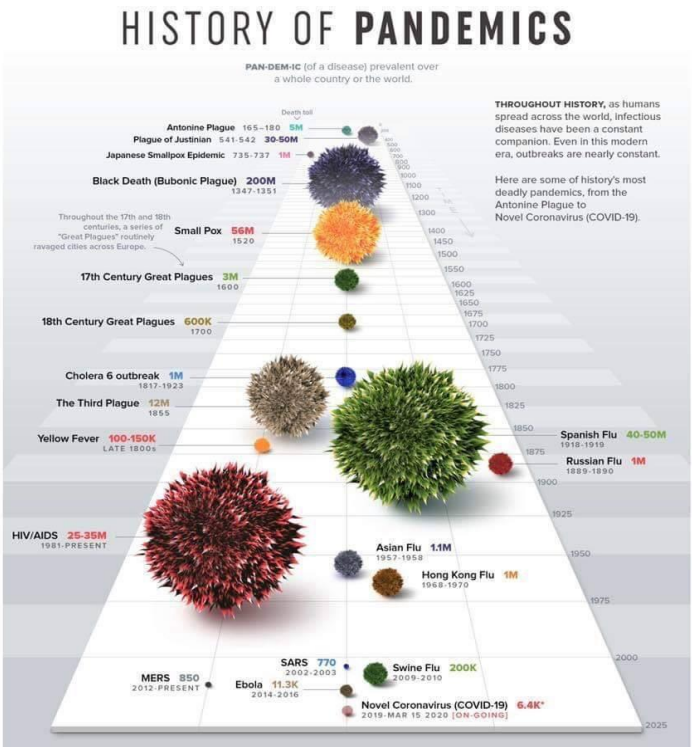

Image 1. Pandemic - Source: https://www.visualcapitalist.com/history-of-pandemics-deadliest/

None of the previous events has had the consequences of the current one that has projected us into a world dominated by radical uncertainty: the future is uncertain and this transforms and puts in crisis the old hypotheses of linear and stable systems susceptible to control (Scoones, Stirling, 2020 p. 2). The uncertainties imply lack of knowledge of the future but also the impossibility to predefine the probabilities of the expected results, sending into crisis the utopia of control. An example is visible in the change brought about by the pandemic with respect to time and space: globalization, with the movements of people and goods and the spread of technology, has made the pandemic an event involving all the countries of the world at different speeds. The virus, in its dissemination, has in fact used the vehicles of globalization, arriving in first class, on jets and high-speed trains. The pandemic has

also marked our perception of time: the postponement of the contagion slows down the progress of the "here and now" of post - modern thinking and forces us to stop (in the first wave) and slow the pace (from the second onwards). Some scholars have defined the time of the pandemic by naming it "Corona time" and have marked it with respect to the phases of the evolution of the pandemic in "time of lockdown", "quarantine time" and "home office time" (Ringel, F, 2020).

This new way of defining time clashes with the paradox of time of the post-capitalist society that has made of the present, with the pivotal concepts of efficiency and performativity (Borghi and Giullari, 2015) the modality to which it is preferable to refer. The pandemic, investigated by Affuso et al (2020), has taken on the contours of a global, social fact, a moment of rupture in social life in which settled practices and beliefs have been overthrown and which, as seen earlier, has uncovered the limits of knowledge of sociotechnical, sociosanitary, economic and welfare systems. Giaccardi and Magatti talk about the transition from the "Risk Society" theorized by Beck (1986) to the "Shock Society" because of the succession of three events that have deeply marked contemporary history: the attack on the twin towers of 2001, the 2008 financial crisis and the 2020 pandemic (Giaccardi and Magatti, 2020 and 2022). The recent war between Russia and Ukraine, with the threat of the use of nuclear weapons, adds to the danger of extinction at the hands of weapons to that induced by the implosion of the planet due to the exploitation of natural resources.

Uncertainties, are defined by some properties (Roe, 2020):

- They have concrete characteristics and materials are produced by unpredictable and complex non-linear systems (Driebe and McDaniel, 2005) so it is impossible to control them “but understanding and responding to unpredictable variability is vital (Funtowicz and Ravetz, 1990), and requires the invention of new forms of science, regulation and management" (Van Zwanenberg, 2020; Roe, 2020);
- They are not experienced in the same way by different people as they are influenced by experiences;

- Perspectives on uncertainties are embodied "become part of who we are, what we think and feel;
- The understanding of uncertainties is reflected in practices, how we act and imagine the future.

As we will see, these considerations are reflected in the experiences that are narrated by the operators we met when conducting the research and who responded to the pandemic with individual and group strategies to cope with uncertainty.

Western societies, for example, must relate to a new way of considering the future not only in individualistic terms but in relation to the destiny of the masses and the planet: climate change, an ageing population and the falling birth rates of post-globalisation societies compared with the exponential demographic increase in emerging or developing countries, with the consequent migration phenomenon caused by resource scarcity and poverty. The impact of the virus in contexts of varying complexity has established a close relationship between health inequalities and health outcomes: the virus has hit hard in the poorest strata of the population and in the poorest countries. The analysis of the direct relationship between the spread and outcomes of the virus and the social determinants[1] of health has favoured the description of the pandemic event in terms of syndemic:

> "Two categories of disease are interacting within specific populations—infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and an array of non-communicable diseases (NCDs). These conditions are clustering within social groups according to patterns of inequality deeply embedded in our societies. The aggregation of these diseases on a background of social and economic disparity exacerbates the adverse effects of each separate disease. COVID-19 is not a pandemic. It is a syndemic" (Horton, 2020).

During the pandemic there was also a generous urge to face the difficulties through widespread solidarity, witnessed by a wide variety of people from different

[1] Health determinants are the factors that affect the state of health of an individual, community or population. Health inequalities are attributable to different factors such as individual genetic and biological characteristics or lifestyles, differences in social and relational networks, cultural and environmental socio-economic conditions

backgrounds such as entrepreneurship, organized volunteering, groups linked to confessional beliefs and individuals. At every stage of the pandemic, but especially during lockdown and during the vaccination campaign, according to Giaccardi and Magatti (2022) there has been a prefiguring of the climatic emergency and the strategies required for the future, that is the need to agree on the issues of sustainability and health safety for example, and their interpretation of common and collective goods (Giaccardi and Magatti p. 59).

1.2 Public Health Emergency and New Uncertainties, Risks and Dangers

The International Outbreak by SARS-cov-2 is classified by the World Health Organization (WHO) as a public health emergency of international importance[2], signifying "an extraordinary event that may pose a health threat to other Member States through the spread of a disease and potentially require an internationally coordinated response". It is therefore a serious, sudden, unusual or unexpected event that occurs "in at least one country, and to have spread to other countries, with disease consistent patterns indicating that serious Morbidity and is likely in at least one segment of the population"(Who, 2009) . Epidemics are defined by the WHO as the new health threats of the 21st century. Threat is the presage, the certainty of adversity, an event that looms but may or may not happen. Anthropological, sociological and psychological disciplines have helped to reflect on the difference between radical uncertainties and risk, linking them, as mentioned above, to the peculiarities of society and the dangers born with the development of late capitalist modernity, such as globalization, the exploitation of resources and the environment, unjustified aggression against nature, the increase in social inequalities. The title of one of Beck's (1986) famous essays is "Society of risk" which defines the transition from modernity, governed by determinable and calculable uncertainties, to late modernity in which risks occur both specifically and localized and non-specifically and universally and are transformed into reality with characteristics that are defined by their size

[2] Public Health Emergency of International Concern (PHEIC), International Health Regulations, IHR, 2005.

They then become real, their characteristics being defined according to size:

- spatial, having no boundaries;
- temporal, future consequences cannot be determined;
- social, the causal link cannot be determined.

Beck adds that the globalization of risks entails the dissolution of the "rules of attribution of causality established by early modernity and with them the series of safety systems devised to protect against risks" (Beck, 1986).

The consequences of the risks, therefore, are difficult to calculate because of "their undetectable nature and potentially unlimited effects" (Lupton, 1999, p. 70). This is a central theme today, as radical uncertainties undermine the logic of control. The society of early modernity considered it possible, through science and technology, to understand and "institutionalize risk" (Beck 2007, p.128): science could study and overcome dangers, even external ones, anticipating and exhausting their transformation from "possible" into "probable" (Abignente, 2013). With the historical changes brought about by late modernity and the crisis of technical-scientific certainties, risk becomes a dimension of the future, a "projected variable" that has its roots in the past and that grows in importance due to its uncertain, invisible and indeterminate nature (Beck, 2007 p. 44). Hence the need for "a still unknown and undeveloped symbiosis" between the natural sciences and the arts, between the "rationality of experts" and the rationality of daily life" (Beck, 1986, p. 37).

The risk for its anticipatory potential of catastrophe is different from dangers, which being unrelated to rational will, occur naturally. Le Breton (2017) provides an insight into the origin of the fear of the unpredictable, intending that it originated from a break from ontological safety where we intend to live our lives in a state of trust that things are as they should be. This attitude enables you to consolidate social relations and daily routines. The loss of confidence in the flow of things implies a fracture in everyday life and a state of vulnerability which is made even more critical on account of the breakdown of social and community relationships (Le Breton, 2017 p. 31). Catastrophes mark the crossing of the border between risk and danger,

between choice and inevitability, beyond which the "possible" is no longer feasible. The dichotomy that Pellegrino, Sociologist and expert in Future Studies, introduces between probable and possible is interesting in this regard: by possible she means "a set of characteristics of the present which, despite having a different degree of potential as well as of conceivability for the mind, are united by the fact of respecting the principle of "non contradiction of the real (Pellegrino, 2019, p. 162)". The possible includes the probable even if, as Pellegrino still maintains, "when we evoke a "possible" the intention is to contradict the probable, the future taken for granted". Tarde (1901), to which Pellegrino refers in his argument, identifies two types of possible: the intangibles possible (imagination and thoughts of what is not yet) and the ontological possible (dimensions of reality that have potential for action, not yet deployed). These types of possible inhabit parallel and distinct regions distinguishing themselves in: as close as possible and as far as possible from the observer's point of view. The possibility of action on the part of individuals is placed in an intermediary area in which "Chance and the Reason can be affected, directing the course of events, connecting random series which would otherwise be more independent" (Pellegrino, 2019 p. 165).

1.3 Emergency Dilemma

As Scoones and Stuirling pointed out, (2020, p. 4) uncertainties are measured by the ambiguity of the presence of different cultural representations. The pandemic, for example, has placed individuals in front of inextricable ethical dilemmas one of which is, as Esposito recalls (2022, p. 155) the relationship between the value of life and that of freedom, the right to move and the need to limit themselves in order not to spread infections, especially as regards young people and families with fewer social, housing and technological resources. Emergency doctors in the first months of the spread of the virus were overwhelmed by the criticality of the number of admissions to the intensive care unit and had to decide with what criterion to choose the patients to be resuscitated. The Italian Society of Analgesic Anesthesia,

Resuscitation, and Intensive Care (SIAARTI) in March 2020, drew up a document[3] in the form of recommendations adopted for triage, the principle of the greatest probability of therapeutic success by defining the criterion of choice based on life expectancy. The document states that in case of lack of resources "It may be necessary to place an age limit on entry into IT. It is not a question of making choices of value, but to reserve resources that could be very scarce to those who have the most survival and secondly to those who can have more years of life saved, in a maximization perspective of benefits for the greatest number of people". The document provoked a very heated debate so that a month later, the National Committee for Bioethics, an advisory body of the Presidency of the Council of Ministers, was forced to rectify the document, declaring that "in the allocation of resources the principles of justice, equity and solidarity must be respected. In this context, the CNB recognizes the clinical criterion as the most appropriate point of reference, considering any other selection criteria, such as age, gender, status and social role, ethnicity, disability, responsibility for behaviors that have induced pathology, costs, ethically unacceptable"[4].

The images of patients alone in intensive therapies showed just part of the suffering of those who had to abandon their loved ones in a caring environment, never to see them again. The choice of collective responsibility, health and safety as common goods, involved the majority of the population in a community rather than individualist logic (Esposito, 2022, p. 160), also induced by government measures imposed in an unresolved ambiguity between the state of exception[5] and the state of emergency[6] that have severely tested the principle for which "there are objective

[3] SIAARTI, "Raccomandazioni Di Etica Clinica Per L'ammissione A Trattamenti Intensivi E Per La Loro Sospensione, In Condizioni Eccezionali Di Squilibrio Tra Necessità E Risorse Disponibili", Marzo 2020

[4] Comitato Nazionale per la Bioetica, "Covid 19: la decisione clinica in condizioni di carenza di risorse e il criterio del "triage in emergenza pandemica", aprile 2020

[5] Faced with the "coronavirus emergency" the Italian Government has acted using the only instrument provided by the Constitution for emergency situations other than war: the emergency decree provided for by Article 77 of the Italian Constitution (source: Comazzetto, G. The State of Exception in the Italian legal system. Reflections starting from the measures of containment of the epidemiological emergency by Covid-19. In: BioLaw Journal - Rivista di Biodiritto, March 2020).

[6] The state of emergency is an institution provided by the cd. Civil Protection Code (d. lgs. 2 January 2018, n. 1), activated in the cases provided for by art. 7 of the same decree; among these there are the "emergencies of national importance connected with

parameters according to which the legitimacy of a decision and the proportion to the situation can be measured" (Esposito, 2022 p. 162). In Italy there has been an important debate that has raised the issue of the legitimacy of the measures taken both in the lockdown phase and in the subsequent phases of pandemic management with particular reference to mass vaccination, in particular against the provision of certificates attesting to vaccine immunity as a passport for free movement. In the health field, the conflict especially regarded the regulation of suspension from work of unvaccinated health workers[7].

The pandemic has certainly made the world face that complexity so argued by Morin (2001, p. 34) whose interest is to acquire the approach and insight for which "the field of knowledge is the phenomenological world as seen, perceived and co-produced by us, is a vision of the world, a "paradigm" that requires to analyze and distinguish, but also - and above all - to connect and join notions that are classically disjoint: system, organization, interactions, existence, being"(Vardanega, 2021).

1.4 Preparedness

The definition of the possible as being distinct from the probable is reflected in the uncompetitive co-existence of Ewald's (2001) precautionary concept and Lakoff's (2017) preparedness concept. In 2001 dialogue, "Le principe de précaution" by the philosopher François Ewald and the 2018 "Unprepared" by the anthropologist Andrew Lakoff, both scholars have elaborated through different approaches the theme of the response to unexpected and catastrophic events using two different approaches.

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calamitous events of natural origin or deriving from the activity of man which by reason of their intensity or extension must, with immediate intervention, be faced with extraordinary means and powers to be employed during limited and predefined periods of time". (Source: Comazzetto, G. The State of Exception in the Italian legal system. Reflections starting from the measures of containment of the epidemiological emergency by Covid-19. In: BioLaw Journal - Rivista di Biodiritto, March 2020).

[7] D.L. 1 April 2021, n. 44 (1). Urgent measures for the containment of the epidemic by COVID-19, concerning SARS-cov-2 vaccinations, justice and public competitions. DECREE-LAW 31 October 2022, n. 162. Urgent measures concerning the prohibition of the granting of prison benefits to prisoners or internees who do not cooperate with the justice system, as well as concerning the entry into force of Legislative Decree no. 150 of 10 October 2022 on vaccination against SARS-VOC-2 and preventing and combating illegal gatherings. (22G00176)

Precaution is understood as a method of thinking and acting aimed at "avoiding having to face unforeseen risks" (Le Breton, 2017 p. 79) but above all, going back to Ewald's belief (2001), is an approach that makes it possible to make the concept of risk socially acceptable, thanks to the methodologies introduced relating to the assessment and management of risks for the purpose of protection against possible damage. The basis of this concept is what Ewald calls "risk technology" which is established when statistics on accidents in the workplace are made known in industry, making the risks calculable and insurable: risk becomes a social category because liability becomes a matter of law (Lakoff, 2017 p. 17). One of the main criticisms of this approach is that risk assessment in this context represents a way of reordering reality so that the new event is "normalized" and becomes a 'predictable event': if it is not possible to determine the probability of the catastrophic event and its consequences cannot be mitigated, it is necessary to do whatever is possible to prevent the event from occurring (Lakoff, 2017 p. 16). The concept of preparedness tends to overcome this conception, as it considers the treatment of particular occurrences to be insufficient (accidents, diseases, unemployment) and the tools measuring their probability, incidence and rate of occurrence inadequate as well. (Lakoff, 2017 p. 16). The principle of preparedness implies, on the other hand, that an event may not be avoidable or that the likelihood of it occurring is not evident. In both cases the aim of preparedness is to facilitate the assessment of the vulnerability of the context, "by preparing response measures that will prevent the disastrous event from turning into catastrophe" (Lakoff, 2017). The precautionary and preparedness approaches are also based on two distinct theoretical assumptions: population biopolitics and life systems biopolitics (Collier and Lakoff, 2015). The objective of population biopolitics is to improve public health and prevent social distress through prevention programs based on epidemiological and statistical studies that can predict the trend of diseases and to estimate the risks with public hygiene as their objective; Biopolitics of vital systems, by contrast, arises in response to the risks of contemporary societies involving critical infrastructures, those systems

that guarantee the continuity of the economic, health and political order (Lakoff, 2017 p. 34). While the first approach is based on probabilistic and statistical calculation, the second refers, instead, to the knowledge of events whose probability cannot be calculated but whose impact can be catastrophic. As Folkers (2021, p. 88) points out, vital systems are critical for the population and for the other systems with which they share a close interdependence: for this reason, to analyze their criticalities, new forms of knowledge such as imaginative practices, simulation and scenario planning are needed as tools to uncover gaps and vulnerabilities in systems so as to correct them. The objective is being prepared, through structural arrangements, to increase the resilience of systems and organizational measures, in particular the development of emergency plans (Folkers, 2021 p. 88). As pointed out by Folkers (2021, p. 89), and as confirmed by the interviews with health professionals within the research that I have presented in these pages, the most effective strategies for preparing for the most serious outbreaks develop in periods of calm, when it is possible to work and perfect ordinary activities.

Resercher: Do you think we're prepared for another pandemic?

Healthcare worker: if we keep the habits of our daily work such as washing and cleaning, cutting our nails and taking off our rings... thirty years ago, when I started doing this job, if you had a hair out of place from wearing your headphone or if you had something in your hands.. until a year ago it was not so (Nurse).

Thanks to the concept of preparedness, it is possible to observe the pandemic in its course over time and observe what happens on the border between ordinary and the extraordinary, normality and emergency, highlighting in what Armondi (2021) defines as "investment in the ordinary".

In this context it is necessary to reason in terms of integration of strategies and knowledge to prepare the health infrastructure for a shared management of emergency and routine activities. In a recent publication Bifulco, Centemeri and Mozzana (2021) invite sociology to treat preparedness and disasters with a critical approach that goes beyond the tendency to normalize emergencies in favour of the

consolidation of an approach that prioritizes technological and hyperspecialized knowledge and that does not research the origins of events in depth (Bifulco, Centemeri, Mozzana 2021). This approach has shifted entirely to the maintenance of critical infrastructure, and loses sight of the impact of the occurrence as regards the vulnerability of territories: in fact extreme events bring about different consequences based on the specificity of the contexts involved, of environmental and social conditions (levels of development, feelings of identity, trust in institutions, etc.) (Mela, 2017). Sheila Jasanoff, Pforzheimer Professor of Science and Technology Studies at the John F. Kennedy School of Government at Harvard University, pioneer in building the field of Science and Technology studies (STS), suggests that in Risk Management, patterns of interaction between experts and the public are reflected in narratives that reflect the dominant thinking in a country's culture and public policies. Quantitative and predictive methods are in fact structured to reassure citizens as to how they can manage uncertainty. Methodologies such as Risk Management, systems simulation and cost - effective analysis, are defined by the author as "hybris technologies" because they are structured on short-term risks and not on long-term ones; the specialized nature of the disciplines whose task it is to manage extreme events does not allow all stakeholders to participate in decision-making which therefore takes on normative characteristics (1989). More recently, Jasanoff proposes a "humble" approach to dealing with occurrences, which allows "to make clear the possibility of unforeseen consequences, to make explicit the normative aspects that are hidden in the technical ones, and to take note from the beginning of the need to include a plurality of points of view and collective learning" (Jasanoff, 2010). "What I offer here is an appeal to humility, not only as an attitude of modesty towards the powerful and yet little understood forces of nature and society, but also as a practice of reasoning and politics that accepts uncertainty as its foundation and mitigation of harm as its goal an approach in which we ask in advance what new vulnerabilities could be produced by our most courageous acts of preparedness and that requires precisely that kind of abnegation from power and

politics: gain greater knowledge because it sees from the margins as well as from the center, and deeper wisdom because it recognizes the imperfections of understanding" (Jasanoff, 2021,). Risk studies also analyse the issue of risks with a multidisciplinary and transdisciplinary approach, highlighting the link between risk governance and risk policing values because, as Muller suggests (2000, p. 195) the tools used by public policies incorporate and set values, interpret the reality on which we want to act, the playing field of the rules of the game. Reality, as Bifulco (2012) points out, is in fact shaped by cognitive frameworks, frameworks that select, for both the community and citizens, what is important and to be pursued for the community itself. Often, for example, there is a process of removal through which we "try to preserve the feeling of living in a normal environment" (Lupton, 1999 p. 69). Disaster and destruction are symbolically mediated concepts that make it easier to think of them as distant rather than close risks. "The catastrophe has this terrible: not only do we not believe that it can be produced, even when we have every reason to know that it will happen. But once it has been produced, it appears to us as if it were in the normal order of things" (Dupuy, 2002). The institutionalized health language, for example, translates the concept of preparedness into a properly organizational mode that underlies "active surveillance, rapid reaction capability, programming of medical and laboratory resources, presence of short and rapid chain of command, pandemic plan and coordinated research at all levels, an exhaustive and transparent exchange of data between the centre and the periphery" (Ambrosino, de Fiore, 2021 p. XIV). During a public health emergency, planning, coordination, timely diagnosis, assessment, investigation, response and communication skills are required. The World Health Organization identifies eight strategic pillars of pandemic response that include:

1. National coordination, planning, and monitoring;
2. Risk communication and population involvement;
3. Surveillance, rapid response team, Case Investigation;
4. Cross-border Entry/Health Points;
5. National Laboratories;

6. Infection Prevention and Control (IPC);
7. Clinical Case Management;
8. Operational and Logistics Support.

Training and scientific research are cross-cutting elements of these pillars[8]. Preparedness, however, does not simply imply technical or organizational logic but is part of a more comprehensive strategy aimed at improving the skills and competences distributed across territories: that is, it acts according to an assumption of care that is ecological care as supported by the interactions between human beings, the material world and living beings excluding man. This vision implies the need to have organizational and operational infrastructures that "act at the service of the generation, promotion and sharing of relevant knowledge, not only of experts but also of inhabitants, associations, policy makers". As Bifulco and Centermeri specify preparedness is to be considered a "socio - ecological transformative opportunity to enhance collaborative ways to address the uncertainties of socio-ecological interdependencies by producing knowledge about them and implementing technologies, strategies and tools to manage them"(2020, p. 4).

1.5 Implications for Risk Management - Capabilities and Territory

This way of understanding preparedness allows us to place Risk Management in a changing global context that requires us to move away from a hyper-specialized logic to move towards an operation that must include, both the management of the individual health act (Clinical Risk Management) and the catastrophic event, and this can only happen thanks to a continuous exchange of knowledge and practices between different disciplines and professions. The pandemic has forced health sectors, which have been historically distinct and separate, to enter into a dialogue not only in an operational but olso in a a reflective perspective: preparedness is the guiding thread through which the flow of events can be followed together with the deciphering of that complexity that compares the variety of environmental and socio-economic conditions, of services and population

[8] WHO (2021) "COVID-19 strategic preparedness and response plan operational planning guidelines to support country preparedness and response" (SPRP)

characteristics, rendering these contexts incomparable (Armondi, 2021). Risk Management, today, needs to identify the boundary between custom and extraordinary, normality and emergency highlighting in what Armondi (2021) defines as “investment in the ordinary" wich means investing in the consolidation of networks between different individuals and recognizing "the different social intelligences in the field and to invest in the capacity of coordination between different levels of action and territorial government” (Armondi, 2021 p 162). Change is in fact, taking place globally and locally with the drive to work together to achieve health and sustainable development goals that prevent, predict, detect and respond to health threats and improve the health of humans, animals, plants and the environment. Goes in this direction and moving towards integration between local and global, the Plan "One Health Joint Plan of Action (2022 - 2026) Working Together For The Health Of Humans, Animals, Plants And The Environment by WHO, a Joint Action Plan for Health (OH JPA) setting targets for global intervention that can prevent, predict, detect and respond to health threats and improve the health of humans, animals, plants and the environment contributing to sustainable development.

> “One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of humans, animals, plants and ecosystems. It recognizes the health of humans, domestic and wild animals, plants and the wider environment (including ecosystems) are closely linked and interdependent. The approach mobilizes multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems, while addressing the collective need for clean water, energy and air, safe and nutritious food, taking action on climate change, and contributing to sustainable development” (Who, 2022).

This approach is aimed at combining care for the ecosystem with the resilience of the territories, a process that involves working to strengthen the systems concerned and their likelihood of reacting positively to adverse events (Mela, 2017 p. 25). The sociology of disasters distinguishes between social resilience and territorial resilience, defining the former as the set of practices and behaviours, representations

and relationships developed in response to an event (Lucini, 2017 p. 44) while territorial resilience means the ability of a specific territory to absorb the impact and respond proactively to the critical event (Lucini, 2017 p. 46). Every adverse event and disaster highlights, in fact, the latent vulnerabilities of the places where events happen but also the resources available (Lucini, 2017, p. 43). The "glocal" nature of the risk (Mela, 2000 p. 225) is reflected, as an unprecedented consequence of the easy spread of the virus, in the recognition of a global and local "range of interconnections" of the phenomena to be managed and of the actors that must deal with the emergency government. The management and control of events is entrusted to several actors in a complex and ambivalent plot that has highlighted a wide range of conflicts during the management of Covid 19.

In Italy, for example, the concept of resilience is to be combined with the different configuration of the responses of regional organizational systems (as a result of the Constitution - Title V, art.117, paragraph 2, lit. M) and the relative delegation of decisions concerning health issues to individual regions. Responses to the pandemic have been inconsistent on account of policy choices made at national and regional level due to the process of reorganization of the public sector by market logic (Bifulco, 2015 p. 144). The market is the answer to inefficiencies, rigidity and bureaucratization of the public administration. These have lost their role as direct producers of services, while maintaining regulatory functions, financing, direction and control and they compete with private companies in the production of services. Bifulco considers how this process required profound changes to the public administration, one of which is the adoption of new public management, a public sector management style that integrates traditional management practices with methodologies translated by the private sector (Bifulco, 2015). The result is the drive towards accountability, performance measurement, control of results and the consequent allocation of resources, in a public - private competition with the goal of cutting costs (Cadeddu and Ricciardi, 2018). In contrast to this logic born in the 2000s, the movement of common goods that poses the question of the removal from

the logic of commodities of those goods, such as health which is closely linked to the fundamental rights of individuals (Barbera, 2016 p. 168). In fact, common goods can be defined as "the things that express useful functions for the exercise of fundamental rights as well as for the free development of the person"(Rodotà Commission 2007, art. 1 letter c). The movement proposes overcoming the logic of profit and global competition in favour of collaboration between citizens and the public administration in the care of common goods with "a strong emphasis on the local, the territory, the community, in a process that orients to the satisfaction of basic needs and the improvement of the forms of coexistence of the reference communities" (Barbera, 2016 p. 171). The pandemic highlighted the critical issues arising from the downsizing of the local welfare system, with a progressive depletion of resources intended for the processes of integration and enhancement of the territory (Gambardella, 2013 p. 32). The health emergency, precisely because of this fragmentation, caused a process of regulatory centralization during the early stages of the pandemic, which can be seen in the production of numerous urgent legislative acts to standardize the response on the national territory, but on the other hand it saw the delegation of the management of the successive phases to local institutions who have had to resort to the third sector and volunteering for assistance for the basic needs of fragile and vulnerable citizens. Community responses can be defined as forms of social resilience., intended as the "adaptation of organizational resources and symbolic and transformational configurations from professional practices and daily social interactions, to ensure, as much as possible, continuity of services, safety and well-being of operators and users" (Bova, Lusardi, 2021 p. 62). As we will see in the Ethnography at the health facilities of the territory, it has been possible to retrace three of the abilities that Bova and Lusardi, quoting research by Keck and Sakdapolrak (2013), connote as peculiar characteristics of social resilience: coping skills in response to acute emergencies; adaptive ability to learn from experience and plan future responses; transformative skills such as the ability of people and groups to contribute to decision making processes to increase safety in view of future

emergencies. The lever of this process is recognizing individuals' "capability for voice" (Sen, 1990; Bifulco and Mozzana, 2011) and that of the territories intended not in a "functionalist perspective (Barbera, 2016 p. 183), as a reservoir of resources, but, as Barbera points out, "as a social space, of relationships and places capable of coping with the destructures put in place by globalization by protecting themselves, but also to remain open not to be isolated and unable to react and as a space to be subtracted from the "extraction of value"[9] (Barbera, 2016 p. 146). Extraction of value is a process resulting from the privatisation of the supply of services whose suppliers may operate under contract (outsourcing) or public interest (financially supported private public sector) or in a private-private regime which, in order to capitalise on the profit or by the nature of those non-profit organizations (third sector) reduce the quality standards of services or implement a containment of the costs by weighing on the working conditions of employees (job uncertainty, salary reductions, increase in workloads) (Barbera, 2016 p. 127). In the case of the production of services by the public, in particular in the health sector, the extraction of value may be attributable to the increase in workloads as a result of blocking the turnover for budgetary constraints, resources becoming increasingly scarce in the face of an increase in the health needs of the population. These mechanisms have an impact on the guarantee of equity and on the mechanisms for access to health care because the risk of delegation to private sectors is that managers are encouraged to "identify beneficiaries that guarantee a greater chance of success of interventions, or a higher social visibility" which guarantees access to other resources but the exclusion of population groups with severe or chronic diseases (Barbera, 2016 p. 131). In health, reflections on the role of the territory have been subjected to critical observations, today, from an epidemiological point of view, but these reflections have been present for several years with issues regarding the reorganization of services, a complex

[9] In healthcare the value expresses the relationship between outcomes of care (outcome) produced and costs incurred (Guerrieri and Campana, 2018 p.373). Gallino understands Finanzcapitalism as "a mega-machine created with the aim of maximizing the value that can be extracted both by humans and ecosystems. Gallino, L (2011) Finanzcapitalismo. La civiltà del denaro in crisi, Torino: Einaudi

process of management and professional institutional integration between realities that exist on the same territory. To this can be added the theme of social and health integration, the pivot on which is based the investment on the Case della Salute (Law n. 296 of 2006 - Art. 1, paragraph 806, lett. a) and Decree of the Ministry of Health of 10 July 2007) and today the Case della Comunità (Ministerial Decree n. 77/2022) which are territorial places of response to the health and social needs of communities. As de Leonardis argues, it is the orientation that makes a circumscribed territory the pivot of a process of integration between the different responsibilities of territorial intervention (de Leonardis, 2020).

2. The Health Services System

This chapter introduces the organization of the national and local health system through a brief overview of regulatory references and service programming. The second part of the chapter focuses on the analysis of the structural components that make up the prevalent model of health organizations highlighting their complexity. The last paragraph gathers the references on the complex organizations that have guided the field research.

Article 32 of the Italian Constitution establishes the duty of the Republic to protect the health of citizens as a right of the individual and the interest of the community. Law No. 833 of 23 December 1978, establishing the National Health Service, in implementation of Article 32, defines the mission and vision of health services that can be summarized in the principles of universality, globality (of the all-round well-being of the individual) and equity, intended as the ability to create equal health opportunities for citizens to achieve their health potential (Whitehead, Dahlgren, 2007). The Health Service is defined as the "complex of functions, structures, services and activities, intended for the promotion of the maintenance and recovery of the physical and mental health of the entire population" (art. 1 and art 10) and the local health unit is identified as an organization which is able to spread these principles throughout the national territory. The law provides for the implementation of a service planning system summarized in the National Health Plan from which the Regional Plans and local plans derive. With Legislative Decrees no. 502 of 30 December 1992 and n. 517 of 15 December 1993, the Local Health Authorities acquired legal personality and increasingly marked forms of autonomy, until the completion of the process of corporatization implemented with Legislative Decree 299/99 with the aim of perfecting the levels of efficiency and effectiveness of companies in a context of growing scarcity of resources. The Local Health Authority, therefore, acquires organizational, administrative, patrimonial, accounting and managerial autonomy (Giorgetti, 2019 p 42). At the same time, at national level, there is a progressive decentralization of competences in the field of health following the

revision of Title V, Part II of the Constitution (Legislative Decree 56/2000 and 347/2001) in a federalism project that guarantees the State a function of guidance and coordination while the regions are entrusted with the task of programming, organization and management of health services, including financing with local taxes (Cardano and Vicarelli, 2020 p. 317). These reforms, as Bifulco, Neri and Polizzi recall (2022), came to being in the 90s under the pressure of several factors: the import of Anglo-Saxon neoliberal models; the perception of a too pervasive political interference in the health system and therefore the need to restore it from these influences; the search for the Italian way to decentralization that is expressed in regionalization. These phenomena translate into the delegation of powers in the field of health to the regions and in the processes of corporatization and managerialization. If, on the one hand, the processes of decentralization to the regions are based on the assumption that the regions as intermediate bodies can act as collectors of the needs and demands for health services present in the territories, the process of corporatization introduces "criteria, methods and techniques of resource management (technical, financial, human) inspired by those of private companies" (ibidem) even more so after the financial crisis of 2008 after which there was a request for expenditure restraint and efficient management of public resources (ibid.). The pandemic has highlighted the effects of different health care regulatory models in different regions. Bifulco, Neri and Poilizzi (2022) compare the Lombard model and that of Emilia – Romagna in which differences in the marketization process are highlighted: the Lombard model is aimed at building quasi-markets in which there is competition between public and private organizations producing services that citizens can choose in complete freedom. In this model the public has the task of regulating competition. In the the Emilia-Romagna Region model, the private sector plays a complementary role to the public and its presence is negotiated both at a regional and local level (ibidem). The difference is also embodied in a greater investment in hospital care in Lombardy, unlike Emilia – Romagna which

invests in territorial health care (with the Case della Salute) and in hospital-territory integration.

At a local level The National Health Service is organized into Health Authorities wich are territorial systems consisting of Hospitals, Districts, Departments, etc.) and University Hospitals or Hospitals (hospitals of national or interregional importance – high specialty.

From an organizational point of view, Healthcare Authorities are divided into Departments that constitute the ordinary model of operational management of all activities within which the Complex Operating Units (UOC) operate, coordinated by a director who has the responsibility for planning and managing resources (Giorgetti, 2019 p 150). If the department performs the function of internal organizational and management model, the District is the organizational-functional structures of the Health Authority on the territory and is governed by regional regulations.

The Districts are realities in which the health and social health needs of the population are integrated, the identification of the needs to be met and the objectives to be pursued and their direct connection with the necessary resources. (Legislative Decree 229/1999 and L.R n.24 of 2004 Emilia – Romagna Region, p. 16). The Districts perform the function of governing demand (role of protection / commissioning and evaluation of which services for which needs) and guarantor of primary care, continuity of care (outpatient, home, residential care) and social and health integration (DGR n. 2011/2007 Emilia - Romagna Region). The Districts have the task of ensuring equity of access, timeliness and appropriateness of care, of implementing interventions to promote health and prevent diseases and disabilities through interdisciplinary and intersectoral programs promoted with local authorities and

promoting communication with citizens. The District is endowed with technical, managerial and economic-financial autonomy.[10][11]

If the governing headquarters of territorial assistance are based in the District, its specific organizational form is the Department of Primary Care (DCP) which consists of the grouping of simple operating structures / services with similar care functions. The DCP has the objective and responsibility of ensuring the achievement of the delivery objectives (quantity, type, quality) of the services and services given to citizens (Local Health Authority of Parma, Resolution no. 75 of 2015 p. 35).

In Emilia-Romagna, the DPC were established by Regional Law no. 29 of 2004, which provided for their territorial articulation into the Primary Care Units (NCP), which constitute the basic organizational units for the provision of care.

The NCP System has come into being thanks to the joint action of general practitioners, pediatricians, nurses, midwives, territorial specialists, and social workers who contribute to developing a model of multi-professional and multidisciplinary integration. General Practitioners (GPs) and Paediatricians of Free Choice (PLS) are linked to the territorial AUSL of reference through an agreement and perform the function of regulator of the demand for territorial and hospital health services. Every citizen has the possibility to choose the MMG or PLS and to revoke it as the patient has a trusting relationship with their general practitioner.

2.1 Primary Care, the Stratification Pyramid and the Chronic Care Model

The role of Primary Care as the first clinical level of contact between citizens and the health system is fundamental to ensure continuity of care and a direct relationship with the population.

[10]Legislative Decree 19 June 1999, n. 229 "Rules for the rationalization of the National Health Service, pursuant to Article 1 of Law no. 419 of 30 November 1998"; L.R E / R n- 29 of 2004 "General rules on the organization and functioning of the Regional Health Service".

[11]DGR n. 2011/2005 "Directive to health companies for the adoption of the Local Health Authority act, pursuant to art. 3, paragraph 4, of Regional Law 29/2004: addresses for the organization of Departments of Primary Care, mental health and pathological addictions and public health".

At the international level, the concept of Primary Care was born in 1978 with the declaration of Alma Ata in which primary health care is recognized as an instrument of social justice as it makes health accessible to individuals, families and communities.

The Declaration establishes the importance of primary care to promote prevention and education of the population and underlines its centrality as a place where different purposes are focused: discussion on the main health problems of the community, interdisciplinary connection thanks to the involvement of different sectors in addition to health; promoting the autonomy of the individual and their participation in the design, organization, operation and control of primary health care itself; capacity building of communities at large.

Primary Care consists of

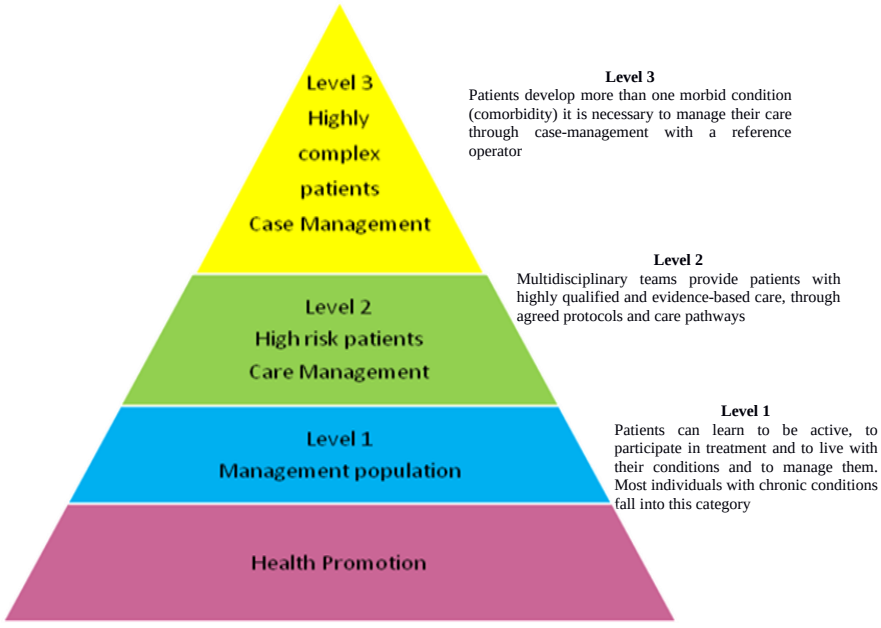
> "Those essential forms of health care which are based on practical, scientifically sound and socially acceptable technologies and methods, made accessible to all individuals and families in the community through their full participation, achieved at a cost which the community and the nation can bear at every stage of their development in a spirit of autonomy and self-determination" (Alma Ata Declaration, 1978).

The conceptual reference of primary care is the *Chronic Care Model* (CCM), developed by Ed. H. Wagner in 1998. The CCM is a useful tool for recognizing the clinical and health conditions of the population that, as reported by Brambilla and Maciocco (2016, p. 29) can be stratified according to severity using a multi-level pyramid as a reference. At the base of the pyramid are placed non-health interventions, though useful in controlingl the socio-economic determinants that affect health:

1. Level 1 is for most of the individuals who live with a chronic disease and who, through adequate support, can learn to manage their condition;
2. Level 2 (high risk): the management of the disease by the patient and the Multidisciplinary Teams is agreed on the basis of protocols and care paths and thanks to the help of specific information systems;

3. Level 3: the complexity of patient conditions requires the presence of a single reference figure (nurses) to manage and ensure continuity of care.

Image 2: Risk Stratification Pyramid



Source: Own elaboration translated from National Health Service documents

The *Chronic Care Model* takes into account two fundamental elements: thanks to the definition of the stage of the patient's condition it is possible to outline a personalized care path in which the relationship with the multidisciplinary teams responsible for assistance is proactive and constantly evolving; patients are included in the definition of the treatment program as they are deemed capable of acquiring and using the tools that are necessary to manage their condition. The patients are to be considered competent. The CCM is a model adopted by the WHO and by several European countries and by the United Kingdom and acts on six areas of intervention (Pierucci, 2010/2012):

- ✓ *Health system*: the management of chronicity must be part of the priorities within the health organization by health care providers and funders;
- ✓ *Delivery System Design*: a precise organization of the care team (primary care doctors, nurses, educators, physiotherapists, etc.) is necessary with a clear

division of tasks between medical and nursing staff and with the separation of acute patients from the planned management of chronic patients;

- ✓ *Decision Support*: decision-making processes must be supported with the adoption of shared evidence-based guidelines that must also take into account patient preferences;
- ✓ *Clinical Information System*: the information system must perform some functions; an alert system that helps the team to follow shared guidelines; feedback on the performance of the team's activity and the care system; planning of individual care plans for individual patients and to identify subpopulations for proactive (*population-based*) care;
- ✓ *Self-management Support: Self-care* support to prepare patients to manage their health and care. In chronic diseases, in fact, the patient (and his family) becomes an active protagonist of the care decision-making processes and is called to acquire skills and confidence in the possibility of governing his own disease;
- ✓ *The Community*: connections with the community. To improve patient care through links with volunteer groups, self-help groups, self-managed senior centers.

This model must be confronted today with the new environmental and social challenges that the pandemic has laid bare and that imply a revision of the very concept of health that becomes a polysemic concept: according to Ingrosso (2006, p. 210) it implies, for example, a combination of intersecting wholes such as the socio-cultural, the psycho-affective, the somatic-sensory-reproductive and the ecological-environmental dimension: the individual is therefore faced with the challenges of complexity with their vital and psychological functions, individual capacities for adaptation and the plurality of ways of responding to individual, social and environmental changes (Ingrosso, p. 216). The concept of health is therefore, according to Ingrosso: "the ability to maintain one's vital balance, to face the events of life, to adapt to changes in one's environment; it needs favorable environments, adequate social

relations and appropriate forms of mutual care" (Ingrosso, 2006 p. 2016). In health systems, citizens bring their own system of cultural, value and social references and this is particularly true when the themes are those of risk perception or fear. In Health Psychology we speak of danger control (*danger control*) to designate the motivations of the individual to act to reduce exposure to risk (Graffigna, 2021 p. 3). According to the Health Belief Model, health behaviors are influenced by the perception of the threat of a risk factor and the assessment that the individual operates to reduce it (ibid., p.23). This evaluation also has an impact on adherence to regulatory and health prescriptions which is determined by multiple existential, motivational and symbolic elements (ibid., p. 25). Graffigna, quoting Brehm, indicates, in psychological reactance, the mechanism by which the individual tends to claim his/her freedom when he/she "perceives it lost in the face of a behavioral imposition or a communication perceived as excessively authoritarian" (ibid., p. 25). Of course, this can imply an increased risk as a result of refusing to respond to preventive measures.

These notions are closely related to the empowerment process, intended as a:

> "Process of social action through which people, organizations and communities acquire competence over their lives in order to change their social and political environment to improve equity and quality of life" (Nicoli, Zani, Marcon, 2011, p. 3).

Empowerment is a complex phenomenon as Ardissone points out, "a multilevel construct that impacts on the doctor/health-patient relationship (micro), on co-participation in organizational choices (meso), on co-participation in health policy (macro)" (Ardissone, 2015 p.158).

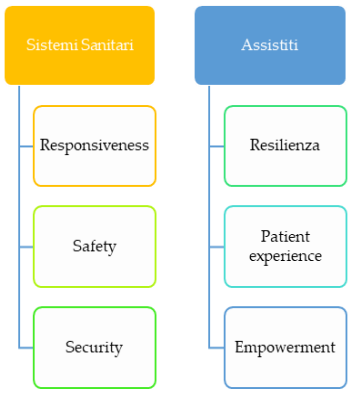
The awareness that the improvement of health systems depends on the participation of the citizen / patient and the relationship that they establish with the health environment, also emerges from the concept of "*Health System Responsiveness*" developed by the WHO (WHO, 2000). Responsiveness means "the way in which individuals are treated by the health system" and the set of characteristics of the environment in which they are treated). *Responsiveness* refers to the ability of health

systems to meet the legitimate expectations of patients in relation to aspects of health care that are not directly aimed at improving their health status. The concept of *responsiveness* includes attention to certain elements (Robone et al, 2014):

1. Dignity. Receiving medical care in a respectful, attentive and non-discriminatory manner;
2. Patient Autonomy. Offering information to patients about their health status and the different possible treatments, together with the risks associated with these treatments, so as to allow the patient to take part in the decision-making process in relation to care and treatments;
3. Confidentiality. Confidentiality of the environment in which medical examinations, treatments, etc., are carried out;
4. Clarity in communication. Effectiveness and transparency of communication between medical staff and patients and willingness of medical staff to offer clarifications to patients;
5. Choice. Possibility of the patient to exercise a choice in relation to the medical staff and the structure that provides the services;
6. Prompt attention. Care should be provided promptly, without wasting time;
7. Quality of basic infrastructure. Quality of the physical infrastructure of hospitals, clinics, nursing homes, etc. and the provision of adequate hotel services;
8. Social support. Possibility of patients, in case of hospitalization, to maintain contact with their families and other social networks.

The Ethnography at the Casa della Salute Pintor – Molinetto has enabled us to understand the relationality between these elements when they had to deal with the broader theme of accessibility, including the concepts of resilience, safety and security.

Image 3: Specific Fields of Interest – Source: Author's Elaboration



2.2 The Casa della Salute (CdS) Model and the Transition to the Casa della Comunità (CdC)

In Italy, the Balduzzi Decree, Law 189 of 8 November 2012 (from the law), identifies two types of structures that translate the *Chronic Care Model* into facts: the Territorial Functional Aggregations of a mono-professional nature and the complex primary care units with high multidisciplinary and interprofessional integration.

The latter include the Case della Salute, set up in 2007 on the proposal of the Minister of Health, Livia Turco. Livia Turco's speech at the conference "La Casa della salute", held by the Ministry of Health in Rome in 2007, is a document that will form the basis for the subsequent regulatory declinations for the establishment of the structures. It cites the reasons for the choice of this facility that can be translated into the need to meet the needs of citizens for continuity of care and for a close, accessible and usable medicine (Turco, 2007, p. 2).

The definition of the CdS points in this direction, which is understood as:

> "A multi-purpose and functional structure able to physically provide all primary care and to guarantee continuity of care and prevention activities, as part of the elementary activities of the district (basin corresponding to 5,000-10,000). The establishment of the CDS has as its main objective to promote, through the spatial contiguity of services and operators, the unity and integration of the essential levels of social and health services".

The CdS is therefore, as reported by the Ministry of Health on the institutional website:

> "the public office where the territorial services that provide health services, including general and specialist outpatient clinics, and social services for a specific and programmed portion of the population are allocated in the same physical space. In it, lifelong prevention is carried out and the local community organizes itself for the promotion of health and social well-being".

The CdS, as originally interpreted by Turco (2007) is not only a physical venue but also:

> "An active and dynamic centre of the local community for health and well-being, which in addition to ensuring citizens' access to the network of services and their taking charge of demand, promotes and enhances the participation of citizens, especially their organizations, ensuring forms of service planning and evaluation of results in the various principals and services" (Turco, 2007, p. 7).

The elements that characterize the CdS, since the original setting are still constitutive elements today:

- ✓ Centrality of the citizen. Through the creation of diagnostic-therapeutic care pathways, taking charge, orientation of patients and family members;
- ✓ Recognizability. The CdS is visible on the territory and is recognizable as the headquarters of taking charge of and continuity of care; a reference point for citizens;
- ✓ Accessibility. The CdS must be physically accessible and organized to make services and activities available, prioritizing the availability of information and booking services;
- ✓ Unity. The CdS collects and organizes services which would otherwise be spread throughout the territory;
- ✓ Integration. Within the CdS there are integrated services in the network, between health and between social and health services;
- ✓ Simplification. The CdS concentrates and integrates services and paths for their access with a view to simplifying bureaucracy;
- ✓ Appropriateness. In the CdS the taking charge and the diagnostic-therapeutic-assistance paths promote and favor the appropriateness of care for the benefit of citizens;
- ✓ Effectiveness. The CdS is the place where the centrality of the citizen, accessibility, integration, simplification and appropriateness are promoted;
- ✓ Network reference point. The Casa della Salute operates in a network with all the services and facilities in the area, representing, in turn, a reference network point;
- ✓ Authoritativeness and reliability. The Casa della Salute aspires to be an authoritative and reliable point of reference for the population and communities of reference.

CdS are initially tested in some regions, including Emilia-Romagna and Tuscany. In Emilia-Romagna, the CdS were established with DGR. 291/2010 at the end of a

process of redefinition of territorial services in which the Primary Care Departments and the Primary Care Units that represent their territorial structures have been established in all the Local Health Authorities. [12] The CdS are intended as the point of reception and orientation for all citizens, a place of health care for urgent outpatient problems, for chronic diseases, for the completion of diagnostic paths that do not require recourse to the hospital. With the DGR 2128/2016 the Emilia-Romagna Region, thanks to 6 years of monitoring action on experimental structures, has improved and integrated certain aspects with respect to the initial design, in particular the attention to the community and[13] patients, caregivers, patient associations and citizens who can find in the CDS a place of participation and enhancement of all the resources of the community, where empowerment can be developed.

The pandemic, whose implications for the territories have seen different outcomes depending on the contexts in which the process of integration between hospital and territory was firmer, has strongly affected the drive in this direction. Ministerial Decree no. 77 of 2022 has established the need to move towards personalized medicine that is based on the needs of individuals in their complexity and that looks in particular at vulnerabilities and chronic diseases, disability and non-self-sufficiency, maintaining a balance between the activation of aid resources but also one's own autonomy where possible (Lusardi, Moretti 2020 p. 239). The decree identifies Primary Care as the most inclusive and equitable model of service delivery to guarantee continuity of care as it is close to the individual's life context and in collaboration with family members and caregivers (Directorate General of the European Health Commission -DG SANCO, 2014). The Decree in this sense activates the transition from the Casa della Salute to Casa della Comunità defined as structures in the vicinity and indicates, in boosting home care, the tool to recognize

[12] DGR n. 291/2010: "Casa della Salute: Regional indications for the realization and functional organization"

[13] DGR n. 228/2016: "Case Della Salute: Regional indications for the coordination and development of communities of professionals and initiative medicine

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the home as the privileged place of assistance. The integrated approach of health and social care implies taking charge of the individual holistically, an effort that requires multidisciplinary and multi-professional coordination "with systematic logics of medicine of initiative and taking charge, through the stratification of the population by intensity of needs" (DM n.77 / 22). The decree enhances the co-planning with the users of the services and calls for the participation of all community resources and the involvement of the various local actors (Local Health Authorities, Municipalities and their Unions, professionals, patients and their caregivers, associations / organizations of the Third Sector, etc.) to the reinforcement of territorial services, with a view to cooperation and co-responsibility. The Case della Comunità are structured in a Hub & Spoke model (National Recovery and Resilience Plan, 2021) that guarantees the capillarity of services in rural and mountain areas, too. Both proposals, which differ according to the number of services present, guarantee a common service offer consisting of MMG, PLS, outpatient specialists, community nurses and basic diagnostic technologies. The territory therefore becomes the center of present and future health planning and introduces innovations such as that of the family and community nurse who is entrusted with the task of becoming the reference point of the territory in which it operates by intercepting the health needs of the population (Legislative Decree No. 34/2020 converted into Law No. 77/2020 and guidelines for family nurses / communities of the Conference of Regions and Autonomous Provinces). Studying access to health facilities therefore provides an opportunity to deepen the current orientation in the direction of proximity health, towards which health systems are addressed by the National Recovery and Resilience Plan (PNRR) which dedicates Mission 6 "Health, proximity networks, structures and telemedicine for territorial health care" to territorial and thematic assistance and by the [14]aforementioned DM n. 77 - 23 May 2022[15].

[14] National Recovery and Resilience Plan (PNRR), approved by the Council of the European Union on 6 July 2021 (10160/21), in particular Mission 6 Health, Component 1: Proximity networks, facilities and telemedicine for territorial healthcare

[15] DM 23 May 2022 n. 77 Regulation on the definition of models and standards for the development of territorial assistance in the National Health Service.

As we will see, this direction implies integrating a new awareness, regarding Risk Management in the field of territorial health, for the attention that the territory has received as a result of the pandemic, but above all for the emergence of concepts such as patient experience, intended as a multidimensional experience (sensory, relational, psychological, cultural) of the patient, and empowerment of citizens. The territory in this perspective assumes the role of:

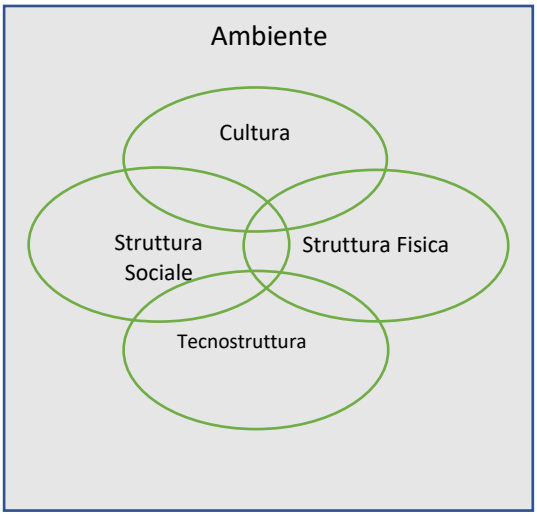
> "A space endowed with anthropological value as meaningful, reified, structured. The territory has historical density that consists of artifacts, material, symbolic and organizational that are repositories of knowledge and communication devices" (Turco, 2010, p. 127).

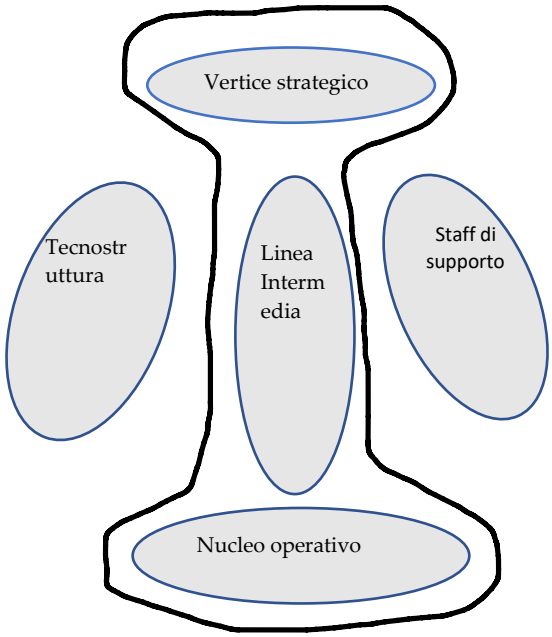
2.3 Dealing with the Structural Complexity of Systems

Throughout my research it was fundamental get an insight into the organization of the national health system considering the hierarchical scale that defines it at the national, regional and Local Health Authority level and that ensures the functioning of the system that is expressed in the rules and practices negotiated at different levels. While the organization is externally influenced by its higher levels, internally, the organization of the Local Health Authority is composed of clearly visible structural elements but also of factors that are not visible such as the culture of the organization, the environment in which it operates, the social structure. Qualitative research and in particular Organizational Ethnography, as we will see in the following pages, enables us to highlight the elements that influence health organizations and that are traceable in their language, in the decisions made, in the documentation produced and in daily practices. The model of health systems is represented as a set of structural elements: resources (personnel, capital, technologies, physical spaces), organizational structure, external environment and results (Damiani et al., 2018 p. 29). The organizational structure refers to roles and relationships, to operational mechanisms (the rules that allow the functioning of the

parties), to culture (fundamental assumptions of a group built, developed and handed down to the youngest), forms of coordination (leadership). The results in health organizations can be ascribed to the overall purpose of producing well-being and health for citizens but are, specifically, differentiated either in output when they translate the outcome of a performance or in outcome when related to the performance of the organization as a whole (Damiani et al., 2018 p. 31). In order to represent the complexity of health organizations, I referred to two models that allowed me to consider, during the research, the structural and hidden elements of health organizations: the model in Figure 1 proposed by Hatch and Cunliffe (2013 p. 32), and the model proposed by Mintzberg (1983) in Figure 2.

Images. 4 e 5. Source: From Hatch Cunliffe, 2013 Source: from Damiani, 2018





In the Mintzberg model (1983), which can be considered the model of the basic organizational form of different organizations, five elements are highlighted: strategic summit, intermediate lines, operational core, technostructure and support services. The Strategic Summit is composed of those who have the responsibility of the organization, who carry out economic governance activities, strategic planning and resource management, as well as the relationship with the outside world; The Intermediate Lines consist of managers who act as a bridge between the strategic summit and the operational

core, translating the general objectives into specific objectives; The operational Core consists of those who carry out the activities related to the realization of products and services. It includes the sectors in which the districts and the structures that constitute the departments are structureded; Tecnostruttura is constituted by those who offer support to organizational activities. It can be of a sanitary type (Department of Epidemiology for the analysis of population data) or of an administrative type (management control and information systems); the support staff consists of units that are specialized in support activities (economic, technical service, personnel administration).

As indicated in Damiani et al (2018, p.32) healthcare organizations can be observed in vertical dimensions when referring to hierarchical levels and specializations of sectors and in horizontal dimensions in reference to integration processes. In addition, structures can refer to functional groupings when they are aimed at achieving objectives or to structural ones when operational units are hierarchically coordinated for the required high level of integration (Tanese, 2001). Health organizations are characterized by weak links (loosley coupling), that is, the components or parts are linked together but maintain a certain degree of independence (Bifulco, 2012 p. 44). This feature allows organizations to be flexible and absorb impacts or changes that come from the environment. When an unexpected event of the proportions of the pandemic occurs, what takes place is what Lanzara calls a phenomenon of "deconstruction and reorientation" until a sort of paralysis of action is reached, due to the change of the conditions of stability in coordination and routine action (Lanzara, 1993 p.146). Management, in particular, operates in a turbulent environment characterised by uncertainty due to lack of information and ambiguity because of, for example, lack of clarity on objectives (Bifulco, p. 37). In the management of critical events, healthcare management must also combine the Risk Management model with a governance model (tending towards new public management) that requires maintaining effectiveness and efficiency in balance, clinical appropriateness and budgetary constraints, in the

performance of the tasks of management, organization, programming, control and evaluation (Damiani et al, 2018). The pandemic, in revealing the critical issues that have faced health systems, in particular in the unbalanced management of responses in different therapeutic contexts (hospital - territory; geographical and administrative realities - regions), has made it urgent to acquire, on the part of decision-makers as well, the systemic approach already in use in Risk Management that considers the complexity of systems, not only their cost effectiveness (Grehennalgh, 2020), and sets the goal of strategic awareness to intercept signals that anticipate accidents or adverse events (Donaldson, 2021). Systemic management assumes, for example, that the management of the epidemic occurs in synergy between the strategic directions of the organizations engaged in system management, Risk Management engaged in clinical Risk Management and public health. In Italy, the DPCM 12 January 2017 "Definition and updating of essential levels of assistance (LEA) ", entrusts to the level of "Collective prevention and public health" the activities and services aimed at protecting the health and safety of the community from risks that are infectious, environmental, work-related and lifestyle-related conditions. In addition to including mass vaccinations, cancer screening and individual counselling for the promotion of healthy lifestyles, Public Health, organized in a Department, has the task of the monitoring, prevention and control of infectious and parasitic diseases, the protection of the health and safety of open and confined environments, surveillance, prevention and protection of health and safety in the workplace. The management of the pandemic has therefore occupied three areas of health services: strategic governance, clinical risk governance and regulating population risk. In a situation of normality, the three areas can manage the sectors of interest independently but in a crisis situation, methodologies and tools of Risk Management must become common knowledge to reinforce each other. The aim of the pandemic plans is to bring Risk Management back to a unified strategy based on the foreshadowing of different scenarios but as already foreseen in Scarcella (2005), the risk of the ineffectiveness of the crisis plans due to the clear separation of ordinary activity from the planning of

emergency activities is high: "this clear separation can lead to the drafting of an emergency plan that risks being closed in the drawer resulting ineffective to the onset of the crisis with operators forced to manage ordinary situations in conjunction with extraordinary situations" (Scarcella et al., 2005). For this reason, the authors argue that crisis management should become one of the routine activities of management. Catino similarly refers to the lack of familiarity with specific routines on unexpected events, the difficulty of health organizations in managing crises (Catino, 2009 p. 27). The crucial issue is the sharing of methodologies and tools suitable for the management of emergencies and sharing these on the part of all strategic management before the event occurs. What Catino defines as a "lack of imagination" often takes place due to a lack of top down and bottom up information: management has the overall view of the event but does not pay attention to information coming from below and vice versa, the most peripheral levels do not have information on the event in general, and find themselves in great difficulty from an operational perspective (Catino, 2009 p. 33).

2.4 Orienting Oneself in Complex organizations

The pandemic has deeply shaken the certainties acquired and taken for granted in the medical-health field and in the managerial and organizational areas of health systems. The latter have had to act based on their resilience potential and on the solidity of the practices of the actors involved in the care processes; very often they have generated solutions leveraging on the creative capacity of the actors involved. Risk Management, interpreted as a tool that governs the processes that affect the prevention and management of adverse events (of whatever degree they are) needs to grasp the complexity of the dynamics in place not only from a technical point of view and aimed at solving contingent and limited issues (those related to the recurrence of errors in operational units or, for instance, those of an ethical/financial nature related to the management of claims) starting from the transdisciplinary knowledge that has identified the elements on which the organizations feed:

1. Complexity. Organizations are social systems made up of individuals with their own norms, values and expectations (Pfeffer, 1995 p. 344), which elaborate frames of meaning, explanations, to reduce the complexity of the surrounding environment and make events acceptable and controllable (Pfeffer, 1995 p. 345). Reflection on complexity has undermined the mechanistic thinking of static systems that use linear and quantitative methods to establish reliable evidence of the effectiveness of complex interventions (Cohn et al., 2013). Health systems are now considered similar to living organisms and ecological systems due to their configuration of complex adaptive organizations (Materia and Baglio, 2012) that face several problems, including uncertainty and predictability of events. In other words, they are called upon to make decisions dealing with incomplete information and the ambiguity of the objectives which limit their scope for action and control of the consequences. Based on the work of Bruno Latour (1986), Barbara Czarniawska (2020) urges us to look for performance-oriented definitions of organizations that from her understanding originate from the social perceptions of the actors who build them with their actions and interpretations of what they are doing, thus changing the context. Organizations, in fact, echoing the thought of Weick (1969, 1995), are not landscapes to be described but assemblages of organizational processes consisting of connections that when introduced between two or more actions, are used to build links between the actors (Czarniawska, 2020 p. 62); through the daily translation of micro-actions, networks of actions are created that gradually connect to other networks of action. Complex systems such as healthcare or cities are complex "networks of actions" in which the actions of individual actors are embedded. Only the actors involved in the network of action possess the knowledge as they are involved in a process of constructing meaning that includes intentions and causal relations (Czarniawska, 2020 p. 74).

2. Sensemaking. Weick defines this sensemaking process: while they are involved in the streams of experience that individuals seek to make sense of, they operate processes of selection, of shaping experiences and of reducing ambiguities to give

stability and order (Bifulco, 2012 p. 58). This task of arrangement and continuous reconstruction of the objective aspects of the environment, takes place through the recovery, in cognitive maps, of the repertoires of meaning shared in the organization. Recovery allows the response to an event to be placed within a defined plot and classified (Weick, 1998). Sensemaking coincides in this way with organizing: the creation of sense produces significant events, structures, constraints and opportunities that were not present before the action translating into artifacts, routines, norms (Lanzara, 1993; Bifulco, 2012). Sensemaking is also a process which is not projected into the future but retrospective: it implies a reworking of what has already happened and, by virtue of this characteristic, projects and feelings of today affect the look and reconstruction of what happened in the past. This approach offers the opportunity to give meaning to the myths, rites and symbols of organizations as resources that hand down the history of groups (Weick, 1988 p. 64) and reveal the reference maps on which organizations base their culture. Thanks to this creative potential, the organization builds the environment to which it responds (Weick, 1998).

3. Culture. According to Butera (2020), one of the most important social action structures of working communities and is the source of the explanation of the fundamental processes of organizations. As Pettigrew (1995) points out, culture defines the system of collectively and publicly accepted meanings, which is relevant to a particular group at a specific point in its history. Schein (1984) broadens this definition by understanding organizational culture as "the coherent set of fundamental assumptions that a certain group has invented, discovered or developed, learning to address the problems of external adaptation and internal integration and which have worked well enough to be considered valid and taught to new members as the correct way to perceive, think and feel in relation to a problem" (Schein, 1984, p. 394). It is evident in its visible dimensions, in technology, in behavioural patterns, in official documents, but it is regulated by implicit

assumptions that are unconscious. Recruits must be guided by new members as they carry out the task of stabilising the internal and external environment.

4. Learning. In recent years, attention has been focused on the ways in which organizations consolidate the mechanisms of transmitting culture and activating learning processes, especially in times of crisis. Through communication we create that practical structure (embodied and enacted) that connects ideas and people and that constitutes the Collective Mind (thinking together), that of logic and proper grammar, that creates worlds, ideas and possibilities (Formenti, 2017 p. 46). As Bifulco (2012) points out, organizational learning is an intersubjective process in which the rationality of its actors is "innervated", therefore making it a complex process. The complexity is given by what Scaratti (2006) defines as the "structural and essential fabric of the professional and subjective identity of the actors that is constituted by the relationship between the processes of attribution of meaning/ meaning and competent participation in the practices in use in an organized community". The generative potential inherent in the relationship between individuals and the environment that generates knowledge and learning (Formenti, 2017), is a quality recognized by some branches of research that consider organizations not as predictable and mechanical structures but as dynamic and interactive complex realities (Bifulco, 2012 p. 32).

5. *Care and Relationship*. In Bateson's thinking (1972, 1979), relationship is the engine that generates knowledge, creative outcome of the interaction between the inner world of the individual and the external constraints that produce change even when situations of apparent stability are given. There is no need for an extraordinary event to generate new knowledge or transform that data. Change is given in a world "where stability and instability, order and disorder, are always intimately intertwined, one made circular by the other. Both outcomes, not at all discounted a priori, of wider existential, interactive and social events that are taking place over time" (Mangoes, 2004 p. 33). Creativity is inherent in processes of innovation and routine, as well as events that bring positive or painful/frustrating outcomes. These

processes use the word through which interactions, images, thoughts and symbolic universes take shape, defining the frames and references with which the complexity of the world is translated.

6. Community of practice. This dynamism is evident in the concept of a community of practice, intended as the places where those taking part define, in their daily lives and in the interactions that develop, what the skills of a given context are. Competence is defined by participation, by feeling united by a mutual commitment, by sharing the purpose of the enterprise and the responsibility of its pursuit; it implies being able to use the shared repertoire that is substantiated in routine, instruments, symbols, stories, language (Wenger, 2000). To use Wenger's words "communities of practice offer the opportunity to mediate competence through the experience of direct participation and are consequently social learning units" (Wenger, 2000 p. 16). Communities are defined by the boundaries that represent the places where interactions with the outside take place: they are the privileged points for learning because different experiences can be found there, provided that the communities of practice are not too far apart in terms of competence and are not too enclosed. Conflicts generated on the borders, can be creative places of productive exchange, a resource for the birth and learning of new practices (Wenger, 2000 p. 283). During the pandemic, the reorganization of hospital wards to make room for departments dedicated to Covid 19 determined the establishment of communities of practice that are different from those to which professionals normally belong. Reorganisation can then be configured as a learning process set in motion in bordering areas between neighbouring communities of practice.

7. Network. Healthcare systems use the term network to designate different devices that indicate learning groups or professional groups that work with certain pathologies. Bruno Latour formulated the concept of network in the theory of the Actor Network, intending it as a trace left by agents in motion (Latour, 2005 p.205). The concept of the network as a record implies the existence of an actor who, to use the words of Latour, is "what is not replaceable... It is a unique event, totally

irreducible to any other" (Latour, 2005 p. 234). The actors of the network are not intermediaries (those who do not convey transformation) but mediators who transform, "translate, distort and change the meaning or the elements they must carry" (Latour, 2005 p 72). The network is therefore a testimony of something that has been reproduced and that conveys transformations through a multitude of means and tools. Therefore, ordinary representations of the networks, according to Latour, do not fully grasp the movement made by the actor who is the one who introduces differences and who represents the greatest source of uncertainty about the origin of the action (Latour, 2005 p. 203). Individuals, as Barbara Czaniawska suggests, may be present in a variety of networks, but they are not static in a single, border region, and for this reason we can only observe their traces. These concepts, on the part of Latour and Czaniawska, are particularly important because they enable us to interpret the networks in their fullest sense, as places of learning, creativity and as an exercise of innovative thinking which, when applied to the world of health, allows you to overcome disciplinary or sectoral boundaries.

The pandemic has revealed the complexity of the relations in the field and the circular interdependence between individuals: citizens, professionals and ruling bodies; between citizens and organizations in a relationship governed by the logic of governance expressed by different individuals; it has raised the issue of participation and communication, rights and duties. It has especially raised the question of what definition of safety governments, organizations, professionals and citizens are willing to consider. Information processes, institutional structures, the behaviour of social groups and individual responses shape the social experience of risk, contributing to the consequences of risk itself" (Renn, 1990 p.289).

3. Anthropocene, Safety and High Reliability Organizations (HRO)

This chapter introduces the topic of safety in health, a multi-faceted concept that refers to different areas such as, for example, the safety of professionals engaged in health, that of the employees and citizens, the methodology of risk analysis and management, infrastructure safety, etc. Today, as we have seen in the previous chapters, we have to confront the risks linked to climate change, to epidemics. Safety, together with effectiveness and appropriateness is one of the fundamental requirements of health and for this reason health services are busy implementing programs and methodologies to reinforce this aspect. The chapter proposes a brief review of the definitions of safety in health and examines some theories that provide reflections on the management of global critical events such as pandemics.

Paul Krutzen defined Antropocene as the geological period in which the human species determines the balance of nature and is able to alter the climate of the earth (Krutzen, 2005). Human activities are changing the features of the environment with repercussions on the survival of different species that inhabit the planet, until their extinction. Technology imprints an accelerated course to this transformation that Longo (2019), echoing the thought of Jonas (1990), describes not only as physical but that, with regard to the integrity and image of man, becomes a metaphysical threat against which traditional ethics can do nothing. Falconieri, Dall'O and Gucc (2022) take up the concept of "crushing the present" (Van Aken, 2020), intended as immobility in the present and inability to think about the future when responding to current environmental crises, which represent the crisis of modernity and its models of development. The authors believe that the policies of risk preparedness or disaster management can be interpreted along these lines and are based on the assumption of the inevitability of disaster and thus concentrate efforts and resources on the development of tools to limit the impact and proposeing an orderly vision of the crisis (Revet, 2020)

The pandemic has made clear the need to rethink the relationship with the environment, overcoming the dualistic conception of biomedicine that has promoted

a clear break between humans and nature. As investigated by Raffaetà (2017), today, we are witnessing the transition from an anthropocentric conception to a cosmocentric one and a shift from a naturalistic to an analogical logic in which nature and society are analogous and indistinguishable because they are united by the effort to protect the planet.

The holistic vision "One Health" is based on what anthropologists define as an "ontological turning point", which is recognized by the European Commission and all international organizations as a fundamental strategy that, based on the concept of integration, seeks to inspire a concept of health in which" multiple *sectors, disciplines and communities at varying levels of society to work together. This way, new and better ideas are developed that address root causes and create long-term, sustainable solutions"* (WHO, 2017). Within the concept of health, this approach includes a space reserved for the environment and man's ability to adapt to its changes: while once health presupposed "the state of complete physical, mental and social well-being, not simply the absence of illness or infirmity" (WHO, 1948), today it is enriched with additional features that integrate with the concept of care: "Health consists in the ability (for humans) to maintain their vital balance, to face the events of life, to adapt to changes in their environment" thanks to "favourable environments, adequate social relations and appropriate forms of mutual and organized care (Ingrosso, 2016)". In a period in which uncertainty permeates daily life, mutual, horizontal and fraternal care (Ingrosso, 2016) constitutes a common good to be promoted and protected (Ingrosso, p. 216) and an ontological quality of the human being in his living environment (Mortari, 2015 and 2021). It is therefore not possible to talk about health without including care as an activity "aimed at maintaining, continuing and repairing our world so that we can live there in the best possible way" (Tronto, 1993).

3.1 Safety in Post-Pandemic Health Systems

The pandemic has involved, as never before, the issue of health safety whose discipline, based on Risk Management, is formalised in a specific area of

management, generally manned by medical or nursing figures given the highly specialized content attributed, in our country, to the issues in question. The experience encountered during the pandemic provides, in this regard, a knowledge acquired in the field, not only of the clinical aspects, but also of those relating to everything that is attributed to emergency management and, to a certain extent, to disasters. This insight significantly broadens awareness of the potential risks to be addressed and the vulnerabilities of systems and territories, which require the development of transdisciplinary strategies, methodologies that are not univocal and rigid but flexible and with multiple rationality. Addressing the issue of safety in health means dealing with the change and challenges of the contemporary world by observing them from a particular vantage point, the world of health protection, highlighted by the pandemic through interdependencies and correlations with other vital macrosystems (environment, animal world, etc.) that create instability and uncertainty. Safety implies a relationship with the feeling of uncertainty which, as Castel pointed out, is "the effect of a difference in level between socially constructed expectations of protections and the actual ability of a society to make them work" (Castel, 2003, p. IX). The growth of the sense of uncertainty has been widely debated so much so that safety becomes, as Casadei points out (2008, p. 42) a "semantic catalyst" that has implemented "many of the other values to which reference is made to legitimize a policy or a decision direction" (Casadei, 2008 p. 47).

3.1.1 Polysemy of the Safety Concept

The concept of safety is a semantic polysemy (edited by Borghi, de Leonardis, Porcacci, 2013) and a multifaceted constitutional asset (Giupponi, 2008) which brings together a set of phenomena, practices, mechanisms and institutions, conceived and created to face increasingly generalized forms of risk (Procacci and Marchetti, 2013).

In different historical periods the concept of risk and as well as that of safety have been interpreted in various ways as an object of public policies with different assumptions (Borghi et al, 2013) where safety can take on the meaning of:

- social safety intended as shelter from life's hardships through public and collectively shared resources; the possibility of being protected from social risks and adversities through public resources and shared by the community in public policies;
- safety as protection of the integrity of the person, of one's assets and individual properties, generated by a society in which policies promote individual freedom in a context in which safety no longer has a collective meaning;
- safety becomes a security discourse that " plays a central role in transforming and constantly updating the semantics of safety, offers the categories for thinking about it, or thinking about its lack, for experiencing it in one's daily life from which new safety needs arise, often induced" (Procacci, 2013). In a context of endemic uncertainty such as that of contemporary societies, the safety paradigm asserts itself as a "set of discursive and non-discursive practices, which include institutional and technological tools, skills and knowledge, on which contemporary safety policies are built. (Procacci, 2013).

3.1.2 Safety in Health Care

The term safety in health has a specific attribution that has brought several definitions over time: from that of Vincent who gives it the task of avoiding, preventing and mitigating adverse effects or damage resulting from the healthcare process (Vincent, 2011 p. 31) to the more articulated one of the World Health Organization (WHO) which defines the safety of care as an attribute of health systems and as a specific discipline of health, applying scientific safety methods to achieve the goal of a reliable care delivery system (WHO, 2011 p. 112). Emanuel et al (2008) defined areas in which the safety of care can be defined:

- The world of healthcare professionals;
- The recipient of health care;
- Infrastructure;

- The methodologies used to manage adverse events.

The Joint Commission on Accreditation of Healthcare Organizations (JCHAO), one of the most influential health services accreditation organizations in the world, identifies patient safety as reducing health and environmental risks for patients, operators and other persons involved in the welfare act (Poletti, Federici, p. 32 2007). Recently the Global Patient Safety Action Plan 2021 - 2030, promoted by the World Health Organization (WHO) with the goal of achieving the maximum possible reduction in avoidable harm due to unsafe health care globally, has defined patient safety:

> "A framework of organised activities that creates cultures, processes, procedures, behaviours, technologies and environments in healthcare that consistently and sustainably reduce risks, reduce avoidable harm, make errors less likely and reduce the impact of damage when it occurs."

As can be observed, this is a more complex definition than the former ones in which priority is the creation of a culture aimed at reducing risks and their probability of occurrence and mitigating any occurring damage. Care aimed at fostering the emergence of a safety culture is highlighted in the plan's seven objectives which comprise specifically organizational issues, relating to family and caregiver participation, the dissemination of data and the creation of multi-sectoral and transnational cooperation networks.

Tab n. 3: Objectives of the Global Patient Safety Action Plan 2021 – 2030. Source: Author's elaboration

SO1: Ensuring that any avoidable harm to patients becomes a state of mind and a commitment rule in planning and delivering healthcare everywhere;
SO2: Building high-reliability healthcare systems and healthcare organizations that protect patients from harm on a daily basis;
SO3: Ensuring the safety of every clinical process;
SO4: Involving and empowering patients and families to help and support their journey towards safer health;
SO5: Inspiring, educating, qualifying, and protecting every healthcare provider so they can contribute to the design and delivery of safe care systems;
SO6: Ensuring a constant flow of information and knowledge to guide risk mitigation, reduce avoidable damage levels and improve safety;
SO7: Developing and supporting multi-sectoral and multinational synergies, partnerships and solidarity to improve patient safety and quality of care.

The plan makes explicit reference to the link between the objectives of good health and well-being with some of the objectives of sustainable development,

including: eradicating poverty (SDG 1), gender equality (SDG 5), water purification and sanitation (SDG 6) respectable work and economic growth (SDG 8), reducing inequalities (SDG 10) and responsible consumption and production (SDG 12). The objectives highlight a close interdependence between safety issues and those relating to the protection of the rights of the population and environmental rights. In a recent working paper (Dodi, Lombardi, Crotti, 2022) I pointed out that the pandemic has made the inevitable link between Risk Management and equity issues even more explicit since risk exposure and resilience of organizations and communities (Magatti, 2020) may be severely affected by the social determinants of health (poverty, inequality and social discrimination, living and working environment). This is especially true in healthcare if, as Chin (2020) points out, "A treatment plan that risks failing due to social challenges is a safety issue. Releasing a patient from hospital when he is medically stable but is likely to have poor results due to homelessness is a safety issue (Chin, 2020)". It is well known that the pandemic has mainly affected populations living in disadvantaged areas and groups living on the margins of society. Climate change, likewise, has serious effects, particularly on deprived communities with fewer resources. This is a central theme and this is where our main challenges will be faced in the coming years, where the culture of care safety and that of equity advance must together as both are frameworks that encourage a redesigning of health systems to make them more reliable and resilient (Sivashanker et al., 2020). This is the challenge called to interpret Risk Management itself as a process leaning towards complexity and continuous learning that is consolidated by looking at "systemic risks", characterized by ambiguity and uncertainty, and the consequences of such risks. This change implies, for Risk Management, opening up to a holistic approach that, unlike the technocratic one, cannot be based exclusively on the probabilistic model that reduces the risk to a two-dimensional cause - effect relationship. The probabilistic approach departs considerably from the mathematical concept of risk, typical of scientific medical literature, which finds synthesis in its definition as a potential event, intrinsic or

extrinsic to the process, which can modify the expected outcome and is measurable: risk is the relationship between the probability of a specific event (P) and the severity of the resulting damage (D) and is synthesized in the formula R= DxP. The human factor's ability to detect and contain the consequences of the potentially harmful event (factor K) in advance is also considered in the risk calculation. Luhmann also delves into the probabilistic nature of the concept as the aspiration of specialists to the safety and measure of what can be achieved in a mathematical and quantitative way (Luhmann, 1996 p. 29).

Pellizzoni, Professor of Pisa University who has long reasoned on the concept of preparedness in these years of pandemic, highlights how this model based on prevention and using statistical and probabilistic devices, is based on a biopolitical vision of the society in which the government administers the living conditions and health of citizens as productive forces of the state, In the 1980s, when the risks associated with technological development and the environmental crisis became apparent. Precaution is based on the impossibility of estimating the actual risk and is established on the concept of proportionality between threat and action which results in hypotheses of scenarios and countermeasures imagined in pejorative terms. (Pellizzoni and Sena, 2021, p. 65). Preparedness is the contrast between prevention and precaution, according to Pellizzoni, for the way they are connected threat and response: while in the first case you know threat, in the second you act to neutralize it (Pellizzoni and Sena, 2021 p. 65). Preparedness differs in understanding both the threat and the response. Threat emerges and explodes without signals thus making it necessary to detect it as soon as possible. Preparedness does not presuppose the neutralization of the threat but its modulation (Pellizzoni, 2021 p. 66). The implications of this change in the epistemological bases of Risk Management in health, are therefore important because they require reflection a methodological adjustment which is a consequence of the different levels in which the discipline is organized. Risks, however, have qualitative characteristics that are not easily restored by standards (Rosa et al, 2014).

3.2 Clinical Governance (CG) and Risk Management

The protection of the safety of care, together with the effectiveness of appropriateness is one of the fundamental prerequisites of health systems that, due to their socio-technical nature as organizations characterized by interactions between people, technologies, means and tools depending on many environmental and context variables, may incur accidents or errors that affect the functioning of systems and patient health. Health systems promote programmes for the improvement of the quality of services and pay increasing attention to methodologies and tools that in economic terms are defined as "corporate governance" (del Vecchio e Cosmi, 2004). The safety of care becomes part of the way in which the quality of services is measured, following a process of reflection on errors in health that has developed after the first complaints of malpractice in the United States since the 1970s and later in Great Britain. Mcintyre and Popper (1983) also covered this in their publication, explicitly asking doctors to recognize mistakes and reflect upon them, looking for them, in order to learn and avoid them in the future.

The publication of the report "To err is Human" (IOM, 1999) marked the beginning of a further change in the direction of the culture of safety of care in a broad sense, reversing the issue of the personal responsibility of doctors in favour of a systemic vision of the origin of errors. "The safety of care is in fact a "normal" problem of all complex organizations as it:

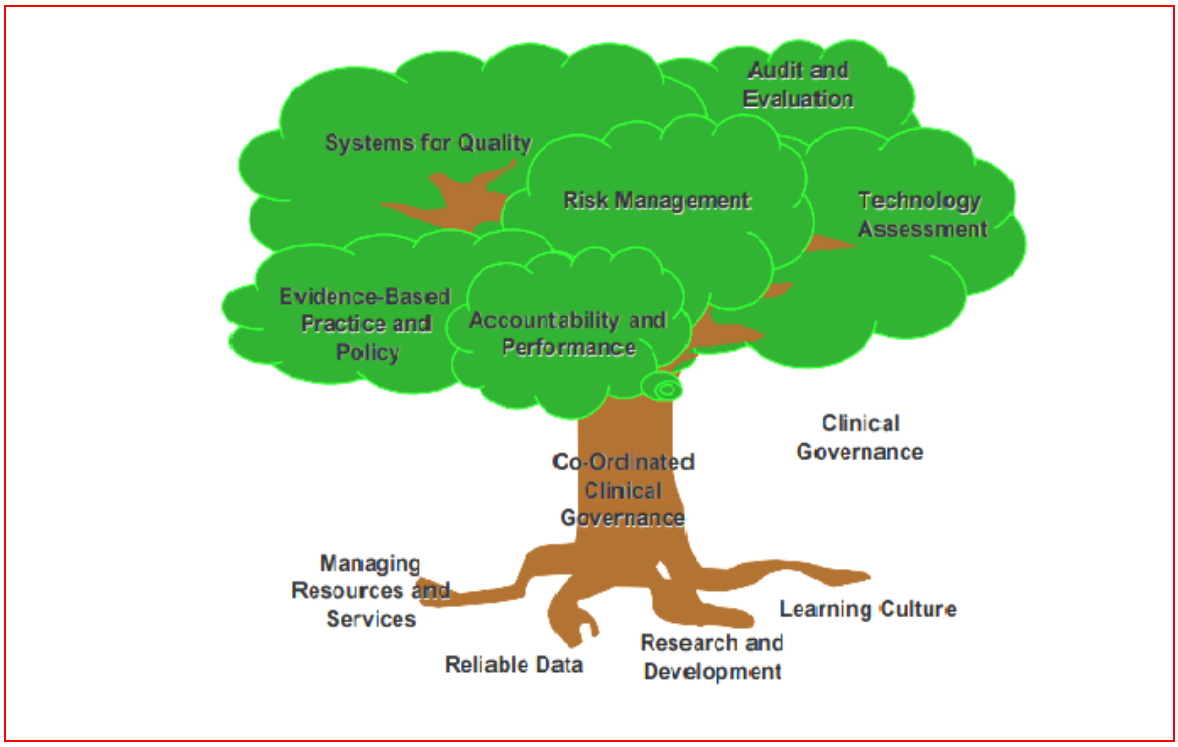
- affects all professions and all levels and forms of clinical, managerial and administrative responsibility;
- equally concerns the conduct of operators and the resources, organisation and functioning of health care facilities;
- its negative consequences have repercussions on victims who have been harmed, but also on its actors, operators who are directly involved, and organizations that suffer reputational and economic effects (second victim)" (Brini and Taroni, 2014 p. 3).

Thanks to the subsequent English report and "An Organisation with a Memory" written by Chief Medical Adviser and confronting Risk Management systems of high-risk organizations in aviation and nuclear power plants, the movement to raise

awareness of the safety of care has become a shared goal globally. An example of this is the activities that the World Health Assembly has promoted internationally with the establishment of the World Alliance for Patient Safety[16] with the aim of developing policies in all Member States, fostering research and implementing joint actions through promotion campaigns on specific themes, research programmes, sharing an international taxonomy, producing design guidelines and reporting systems (Donaldson, 2021 p. 91). The safety of care is a holistic approach (Cinotti, 2004) that translates into Clinical Governance, a strategy through which health organizations are responsible for the continuous improvement of the quality of services and for achieving and maintaining high welfare standards, stimulating the creation of an environment whose goal is professional excellence (Department of Health, 1998). Through Clinical Governance, systems respond to complex problems in complex contexts by way of the principle of self-regulation and the participation of everyone; it is a process that puts at its centre the patient for whom integrated multi-professional and multidisciplinary care must be provided, based on the best scientific evidence used for monitoring the effectiveness and appropriateness of health interventions. The achievement of these objectives takes place through specific tools such as evidence-based practice, data and information management, guidelines, training professionals, collecting information on the effectiveness and appropriateness of services and services, assessment, prevention and Risk Management, quality of services by patients and family members, research and innovation (Damiani and Ricciardi, 2010, p. 324). Through the Clinical Governance it is then possible to observe how connections between institutional levels, professional activities, technologies used, data made available and directed by the duty of responsibility towards the quality of care come about : all this can be summarized by the term *accountability* (Fontana, 2005 p. 17). Chambers' tree represents its stylization.

[16] The World Alliance for Patient Safety, is a partnership between WHO, external experts, health leaders and professional bodies, was formally launched in October 2004 Safer care: shaping the future Liam Donaldson in ricciardi p 84 - 100)

Image n. 6: The Chambers' tree



Source: Damiani, Ricciardi 2018

Ragni and Grilli (2015), invite us to differentiate between the culture of safety of care and the culture of risk within Clinical Governance as they are based on different epistemological approaches (Ragni and Grilli, 2015). The logic implicit in the concept of risk is aimed at searching for human, organizational and technological errors in order to eliminate any source of harm to the patient. On the other hand, the concept of safety implies a cultural model that focuses on the research and study of the relations between individuals and within organizations that are presupposed as complex and interdependent systems. The core of the safety-centred approach is located in the complex system of relationships that health services build, because they are given by humans (technicians and professionals) to other humans (the sick or those suspected of being so). Each protagonist brings into the care relationship his or her own system of values, knowledge and experience within a wider context, the healthcare structure, which in turn is a complex system. In this sense, patient safety is understood as a global dimension of the quality of healthcare that aims to ensure, through the identification, analysis and management of possible risks and accidents

for patients, "the design and implementation of operating systems and processes that minimize the probability of error, potential risks and consequent damage to patients" (Ragni e Grilli, 2015).

Box 3: Risk Management and National Legislation

In Italy, Risk Management is regulated by Law 8 March 2017, n. 24 "Provisions on the safety of care and the assisted person, as well as on the professional responsibility of health professionals". The law in Article 1 defines "the safety of care as a constitutive part of the right to health pursued in the interests of the individual and the community". The law has assigned institutional bodies (Ministry of Health, Agenas, Higher Institute of Health, Regions and their coordination for Clinical Risk within the Health Commission, Local Companies) "the task of spreading the culture of safety by preparing organizational methods, methods and tools for its implementation". The law states that "Care safety is achieved through the combination of all activities aimed at the prevention and management of risks related to the provision of health care and the appropriate use of structural, technological and organizational resources". Its pursuit requires the commitment of all stakeholders and the synergy of all professionals working in the national and regional health system. The norm in Article 2, paragraph 4, provides for the establishment, in each region, of the Centre for the management of health risk and patient safety, which in Emilia Romagna was established by Resolution No. 1036 of 03/07/2018. the Regional Centre has several tasks among which to guide the coordination of risk managers from health companies. They meet periodically and reports of data collected on risks, adverse events and litigation are presented which are then sent to the National Observatory of Good Practice on Health Safety; The centre plans and directs regional activities and provides guidance to health companies on reports to be submitted and on the worker training.

Source: Author's elaboration

Clinical Risk Management is one of the essential elements of Clinical Governance. The literature and official documentation, such as that of the Italian Ministry of Health, define Risk Management as a "clinical and management process to identify, analyse, assess and treat risks in order to improve patient safety". Risks may be current or potential. The type of risks that belong to Risk Management (Damiani and Ricciardi, 2010 p. 324) are divided into:

- Clinical risk specific to clinical practice;

- Environmental risk related to infrastructure and technology risks;

- Protection of workers;

- Insurance risks linked to liability in the performance of health activities (litigation).

Ultimately it is a field of competence that may seem circumscribed for high specialization but acquires, in current events, a potentially amplified prominent place for its self-reflective methodology aimed at connecting information, knowledge, professional and disciplinary networks. Reflexivity is also understood, in this context, as being the ability to respond to circumstances actively; the result of the process through which, while dealing with the issue of risks, knowledge about them is produced (Lupton, 1998 p. 22). Clinical risk, as defined in the report "To Err is Human" (Institute of Medicine, 1999)," is the likelihood that a patient is the victim of an adverse event, that is, experiencing any harm or discomfort due to, even if involuntarily, medical treatment during the period of stay, which causes prolonging of the period of stay, a worsening of health conditions or death". This definition, in the practice of organizations, currently includes a wide range of variables. Today, health systems must, in fact, deal not only with events that occurred in ordinary health practices, but also with the management of events with a high rate of uncertainty as regards prognoses and outcomes[17] and a global dimension with variable reference targets, patients needing treatment unconnected with the epidemic, patients treated for Covid 19, the population in a broad sense. Moreover, health systems have had to experiment with the care of individuals and the care of the population as a whole (as in the case of infection monitoring and mass vaccination), making coexistence explicit, specifically Risk Management operated by several agencies, the management of various risk situations that require coordinated and prepared governance in managing individual cases and emergencies. In addition to traditional methods and tools, Risk Management requires a methodology that,

[17] Outcomes represent changes in the patient's state of health that include mortality, morbidity, and subtle changes in quality of life, patient satisfaction versus care received, and changes in health-related behavior (source: Vincent)

overcomes the concepts of interdisciplinarity and multidisciplinarity, relying on transdisciplinarity, an approach that presupposes overcoming boundaries and cognitive barriers so that individual sciences and disciplines "are transcended to the point of projecting new knowledge, new points of view that go beyond (trans) the same epistemological boundaries of individual fields of study and research... in this space knowledge and disciplines become available not only to learn from others but also to let themselves be contaminated and fertilized so as to become something "other" and "new" (Biagi, 2021). The research presented in these pages, in fact, while being carried out, has found in anthropology, in community psychology, in epidemiology, in organizational studies, in philosophy, in medicine, and of course in sociology the references within which to bring back the phenomena studied, finding in the qualitative research and in the organizational and participatory Ethnography, which will be discussed in the following chapter, the methodology able to observe the discipline both in the operational aspects and in governance. To investigate the evolution of Risk Management it is necessary to examine the organizational and structural configuration of which the systems are composed in order to make their complexity fully visible.

3.3 Models to Address Uncertainties and Failures - The High Reliability Organizations and the Perrow's Model

The centrality of a systemic vision finds correspondence in the approach that presupposes those errors and failures are traceable in organizational processes (Bruni, 2010; Catino, 2006) not just in individual mental processes at the origin of forgetfulness, carelessness and negligence (Reason, 1990). The main branches of research interested in the systemic approach are the Normal Accident Theroy by Charls Perrow (1999) which presupposes the inevitability of failures and the impossibility of systems to intercept errors in a highly complex and unpredictable environment and the High Reliability Organization Theory born from researchers from Berkeley (Rochlin, LaPortee, Roberts, 1998) and implemented by authors such

as Weick and Sutcliffe (2007). Perrow further investigates the Normal Theory by studying the accident that occurred at the Three Mile Island nuclear power plant in 1979 which leads him to focus on the properties of complex organizations. Accidents result from sequences of unforeseen errors that trigger chain interactions turning a small accident into a catastrophe. Accidents, in Perrow's theory, take on important magnitudes due to two characteristics of organizations: their interactive complexity (Bruni, 2010 p.19) for which errors or failures are not always immediately visible; their close-linked structure which means that when one incident occurs it is associated with another, determining a chain of events. Accidents are therefore inevitable and there is no way to reduce the danger despite efforts to improve safety. Perrow makes a distinction between incidents, which produce damage limited from accidents which instead refer to the failure of a subsystem or of the entire system (Catino, 2002 p. 45). In a study dedicated to the failures generated during the pandemic, the 2020 English report "When Systems Fail UK acute hospitals and public health after Covid-19" by The Foundational Economy Collective, reinterprets the experience of the English healthcare system during the crisis, on the basis of Perrow's theory, highlighting the theme of redundancy, which implies the possibility of relying on backups, human, technological and material resources that can easily intervene in the event of a component breaking or blocking. Failure to foresee these mechanisms has weakened health systems that have not been able to count on the necessary resources.

The High Reliability Organization Theory postulates that high-risk organizations (High Reliability Organizations - HRO) can operate safely despite the dangers: they are reliable systems that operate in an uncertain environment where adverse events can occur frequently but where it is possible to operate to avoid or try to minimize their catastrophic impact.

The issue of reliability and its improvement is central and is substantiated in the ability of organizations to restore functioning through the promotion of certain processes: the safety culture is consolidated by leadership that takes responsibility

for decisions; work is organized into teams; the staff is highly qualified with continuous training schemes to get them to imagine creative responses; regular audits are set up to raise awareness in teams and promote improvement actions.

HRO, in the model of Weick and Sutcliffe (2007), focus on critical points such as:

Tab.4: Main elements of the HRO

Concern about failures	Thematizing critical events and treating any error as a symptom of system malfunction; promoting accurate descriptions of errors and learning from "near accidents"
Being careful not to simplify	Maintaining the ability to integrate different experiences to focus on nuances, divergences
Sensitivity to ongoing activities	Are sensitive to actions that take place in the forefront where the actual work is done. The first line, thanks to the awareness of the situation in real time, allows you to make continuous adjustments thanks to the flow of relationships and communications
Commitment to resilience	This is the ability of an organization (or system) to maintain or regain stability to continue activities after a serious accident and/or in the presence of continuous stress. It is the ability to resist shocks and to strengthen the mode of response and resumption of the functioning of the system: this may be, according to Dovigo (2010) through processes of analysis of internal mechanisms and knowledge of existing relationships, in addition to the implementation of the ability to act reflexively. (Dovigo, 2010 p. 20). Finally, resilient organizations learn from experience to imagine and realize new solutions (Bifulco, 2012)
Respect for competence	The decision-making process is transferred to people who, due to their specific knowledge, are able to solve the problem without hierarchical conflicts

Source: elaboration by Weick and Sutcliffe (2007)

HRO focus on safety by anticipating adverse events or by foreseeing how to limit them by pursuing mindfulness, the ability to develop "a rich awareness of discriminating detail" which defines an attitude of attention to situations (Weick and Sutcliffe, 2010 p. 38). Mistakes and failures do not emerge suddenly but are the result of small unnoticed signals that accumulate and explode over time. In this process, expectations that have the power to orient choices towards that something that "is reasonably supposed will happen" have a relevant role (Weick and Sutcliffe, 2010 p. 31). Expectations have an ambivalent nature as they can generate blind spots, states in which negative expectations are neutralized to the advantage of the more reassuring positive ones; this mechanism is defined by Vaughan (1996) as the "normalization of deviance": small elements that deviated from the regular course of events are normalized and open the way to the repetition of other deviations. Programs, for example, as well as routines, can induce you to confirm behaviours

and underestimate other elements that may detect unexpected circumstances. Organizations need to overcome these limits by being alert thus activating awareness (mindful) practices and encouraging the use of imagination that allows you to raise doubts, create new solutions and "to interpret in an original way the small interruptions of expectations" (Weick and Sutcliffe, 2010 p.35). Accounts of what happens during catastrophic events sometimes contain clues to the "negative capacity", the ability to quickly restructure one's own model of action and to design new ones, relying on a cognitive resource capable of innovating, deviating from the routines practiced and giving shape to new contexts. (Lanzara, 1993 p.16). Another approach, which complements the previous one, relates organisations and institutions to citizens' perceptions and interpretations of risks. The Social Amplification of Risk Framework - SARF - (Kasperson et al., 1988) is a theoretical proposal born in the '80s by a group of scholars from different disciplines with the intent to integrate and make technical aspects of risk assessment coexist with the results brought by the cognitive and social sciences. Risky events are signals that may be amplified or attenuated according to the way in which they are perceived and interpreted by individuals, organizations and institutions based on social experience and the type of communication processes through which the signal is processed (Cerase, 2016 p.20). Signals defined by the approach are not risk indicators but information of various kinds from different sources and when conveyed in the form of a message, can be recognized only by experience, knowledge made known through the media, and cultural references from the groups to which individuals belong. Risk indicators, such as information and data from technical-scientific sources, become risk signals only when they are decoded, acquired and interpreted by the public and are not from the scientific community (ibid., 2016). This approach, which gives communication a central role because it is the place where the social meanings of risk are built, allows us to reread what happened in the months in which institutional and media communication shaped reality in the population and health organizations: the initiatives to contain the pandemic were conveyed by messages

from the media and rituals staged by institutions such as in the case of live television on the part of the Civil Protection and the Departments of the Regions. On the other hand, professionals were invested by an over-production of national rules and regulations of an organizational type that trickled down and multiplied on a local level. Furthermore, at this stage of pandemic management, there was a clash over the processing and assessment of data by the regions which were called upon, together with the national technical committees, to decide on the behaviour and freedom of citizens on the basis of the evolution of the contagion. This conflict illustrates the question posed by Lascoumes and Le Galés (2007) of the non-neutrality of the tools for public action which were, instead, intended as vehicles of values, bearers of a certain interpretation of the community and of precise conceptions of the modes of regulation.

Tools, according to Lascoumes and Le Galés (2007), play a role which is not limited to the technical significance attributed to them but expose ongoing relationships between those who produce them and those to whom they are addressed; they incorporate, in fact, the meanings and representations of those who designed them and this is evident especially when observing the practices with which they are put into effect (Mozzana, 2020). From an information governance perspective, for example, Risk Management processes data, manages numbers and statistics from which it draws information about events, defines procedures and draws inspiration from guidelines to direct and organize the work of professionals. As Mozzana points out (2020, p. 19) indicators and information are the outcome of a decision-making and evaluation process, through which what is relevant and what is not is defined; at the same time these tools act retroactively because they affect the way we think and represent reality.

4. Research design and Methodology

4.1 Approaches and Methods

4.1.1 First Placement - Qualitative Research

The pandemic has constituted a watershed for social research and qualitative research: think, for example, of the need to carry out research despite the lockdown (experiences), of the experiences of remote interviews or observations on the web that constitute new disciplines such as netnography (Formenti et al., 2019). the pandemic has not only taught us to do research in other ways thanks to the contribution of technology but has also contributed to making it possible, in the face of the critical uncertainty we mentioned above, to deal with different paradigms to grasp the changing nature of events. In this chapter, the methodological references that have guided this research will be explored. The pandemic influenced the research project by partially modifying its objectives: if in the initial phase it was intended to certify the appropriateness of Organizational Ethnography as a research tool in Risk Management, the pandemic has constituted an important shift in the order of magnitude both in terms of the dimension of the phenomenon to be studied and the methodological tools to be used. This change has accompanied a constant reflection on the theoretical paradigms and methodological presuppositions to be considered suitable for understanding the most complex events. The first outcome of the reflective process was the reference not only to organizational ethnography, which has remained the methodology chosen for the research, but to qualitative research in general: this choice was necessary to keep open all the possibilities for the composition, interpretation and data analysis but also to affirm, in a context such as the healthcare one, regulated by *Evidence Based Medicine* (EBM), the importance of a decentralized vision and welcoming different epistemologies as Scaratti recalls (2021, p. 68 - 69). It is no longer the time of the dichotomy between qualitative and quantitative research since it is essential to include the use of social science methodologies to study clinical practice, *policy making* and patient experiences (Greenhalgh 2018, p. xxiii).

4.1.2 Second Placement – The Reference Paradigms

The research is placed in the interpretative paradigm which has as its premise trying to understand reality and questioning the meaning of experience and events through an inductive reconstruction of events (Benozzo, Priola, 2022 p.41). I consider it useful to consider the Posthumanist Paradigm which allows for access to the concept of rhizomatic knowledge (ibid., p.73), intended as multiple knowledge that advances in all directions, creates connections and detours, has nodes and branches. The methodology to refer to is reinvented with each project (ibid., p.75). This paradigm helps to deal with the uncertainty of the contemporary world, it makes it explicit but at the same time leaves open the possibility of decentralizing the viewing angle thanks to a critical gaze, even with respect to traditional paradigms in the biomedical sector. "The Qualitative research is attentive to the quality of things, which is concerned with describing what exists and what happens, since it is the qualities that structure the essence of a phenomenon" (Mortati and Zannini, 2015, p.16). As Sasso and Bagnasco (2015) point out, the ways in which research builds scientific knowledge have an impact on practice. This is evident above all in the health field which, dealing with the health of individuals, needs to make use of qualitative research to facilitate the understanding of complex phenomena, perceptions and experiences, cultural dynamics on which "attempts to build new knowledge in terms of descriptions insights, theories, interpretations, with the aim of improving care, assistance, and health". (Ghirotto, 2015 p.30.) Qualitative research makes it possible to move through different approaches to approach the organizations and the individuals that compose them, grasping the details and peculiarities of the context (Cardano, 2011 p.18) with techniques which, as Cardano stresses (2011), are characterized by a high degree of interactivity and sensitivity given that their use is influenced by the relationship with the actors participating in the research (interactivity) and by the context which may be more sensitive to the use of a technique rather than to another (sensitivity). Qualitative research, as stated by Saiani and Di Giulio (Mortari and Zannini, 2017 p.46), allows us to explore the

meanings that people attribute to experiences and their behaviors and the way in which values, emotions, points of view and actions influence choices. In the same way, qualitative research provides an insight into the complex system "of organizations within organizations" (Scaratti, 2021 p.15): the first term refers to the specificity of the organizations as the object of investigation (ibid., p.15) while the second refers to the environment in which the research takes place. Research in and of organizations is an activity located within contexts in which modes of interaction, organizational rules, technologies, and practices are at stake and in which it is possible to observe how people live and see events and situations, picking those that Scaratti describes as "the games of interpretations" that professional roles define through rules, negotiations and hierarchical relationships (ibid., p. 18). Individuals learn in a situation, interacting with others in their work practices, thereby acquiring categorizations (everyday pre-understandings, approaches, epistemology) and judgments, adequacy-inadequacy criteria, particular descriptors and indicators, devices and tools. "A professional vision consists of an expert and competent gaze which is not so much a personal or individual disposition, as a set of collective and distributed capacities to listen and interpret reality". (ibid., p. 18). The organization is therefore a social object and as such can be recognized by understanding the general operating principles and thus involving the individual dimension in a dialogue with the collective dimension.

Scaratti (2021) specifies what the characteristics of that "social" feature of organizations are:

- The organization is social since it refers to a widespread and shared explicit or implicit symbolic system;
- It is social because it is the result of a dynamic of joint construction of meaning by people in relationships;
- The organization is social because the systems are produced and reproduced in negotiation, cooperation, conflict activities defining what is adequate and what is not; it is social because it is a combination of a plurality of voices, powers, interests;

- The organization is social in that it generates social capital in the pursuit of its objectives (Scaratti, 2021 p. 32).

"The study of such objects requires a coherent approach capable of grasping references, representations, knowledge, readings that are typical of the experience of those who live within a context, according to a situated declination of the research, attentive to the strong link with the context and to the practices that are implemented within it" (Scaratti, 2021 p. 31).

4.1.3 Third Placement - Methodology and Organizational Ethnography

The research I present in this paper, uses the methodology of qualitative research in organizations as an approach that guarantees access, following the Scaratti's thought (2021, p.38/39), a double register of knowledge: one inherent in the theoretical and technical knowledge, consolidated, codified and publicly accessible; the second non-formal and implicit, connected to the implementation of daily practices and which is expressed in tacit and embedded knowledge. Qualitative research makes it possible to describe in a dense and detailed way interactions, meanings, and processes in the managerial and organizational dimensions.

In this research I have used Organizational Ethnography to verify its effectiveness as a suitable methodology for Risk Management as both an engagement intervention method and as an observation method. Organizational ethnography is tested as a method of investigation to be used in the field to verify its effectiveness together with the traditional techniques of Risk Management; is also tested as a subject to be explored by health professionals to improve non-technical skills wich are useful for deepening the theme of the safety of care. To achieve this goal I worked with the operators of the AUSL network of care safety operators who took part in a course of Organizational Ethnography applied to Risk Management.

Ethnography is a term that derives from the Greek ethnos meaning race, group of people or cultural group and from the term ghraphos, meaning "writing". It refers to and indicates a discipline derived from anthropolgia that describes the ways of

acting of a social group that is being observed. Ethnography that also has its roots in symbolic interactionism and ethnology (Bruni, 2003), is influenced by the constructivist paradigm which can be considered a "toolbox" through which to study social phenomena based on the use of different techniques (Bruni 2003, p.33).

Organizational Ethnography is based on observation, a survey process that allows you to study the behavior of individuals in a particular context, so as to grasp their views, the perspectives, motivations and meanings they attribute to daily practices, the formal and informal rules governing action, norms and conflicts that develop in social relations (De Lillo, 2010 p. 35). The heart of Organizational Ethnography is the culture of organizations, intended as a creative, unique and unrepeatable expression of the social group that has built and remains an organized community (Piccardo and Benozzo, 1996, p.3). In cap 2 I defined the concept of organizational culture as a process of construction and reconstruction of meanings, the process carried out through individual and collective actions and decisions defined by the continuous exchange between the actors and by the negotiation of objectives that are expressed in layered knowledge, schemes and reference models that guide the meaning of the experiences, codes and written and implicit rules that guide the action (Piccardo and Benozzo, 1996, p.3). Organizational Ethnography offers the possibility of observing these processes and of recognizing the cultures that animate organizations in which, as Bruni (2015) observes, can be found in productions and artifacts, missions, visions, values, as well as the set of knowledge, beliefs, expectations and orientations that animate them. Ethnography makes it possible to grasp the individual, collective and institutional point of view by interpreting actions, relational dynamics, language, symbols, shared rituals, methods of control, technologies and artefacts intended as visible organizational structures and processes (Schein, 1998; Bruni, 2003). On this basis qualitative research and organizational Ethnography are affirmed as alternatives to the quantitative rationalist paradigm that is considered unsatisfactory for the analysis of the

complexity of organizations that must penetrate deeper and reveal what is not directly expressed by the actors.

The interpretation of culture must take place by grasping the point of view of the natives through field observation in the context in which the actions take place.

Participant observation, according to Cardano (2011, p.93), studies the social interactions of the actions of individuals and allows us to grasp the points of view, the sense and the meanings that these individuals attribute to the experience because data collection takes place directly in the field. The data can be interpreted as "traces" with which researchers try to discover and explain the ways in which individuals, inserted in specific environments, come to understand, explain, influence and manage the daily situations in which they are immersed. In fact, these people become "informants" (Van Maneen, 1988) or "unaware suppliers of expressive data of the culture of which they are members and which manifest themselves through their behaviors, gestures, languages and symbols" (Piccardo and Benozzo 1996, p. 7). In summary, the researcher, by staying in the field for a certain period of time, has access to situated relational knowledge which is shaped through the participation of individuals in interactive, communicative, social contexts and which are incorporated into daily practices (Lusardi 2012, p. 29-30). This "sensitivity" to the context is essential when approaching those healthcare organizations so severely tested during Covid 19, together with reflexivity, as a guiding principle of research which presupposes, in accordance with the Clinical Governance posture, placing attention on asking oneself questions and favoring the circularity between theories and descriptions in a continuous recourse and attention to what happens in the field. Attention should also be paid, as Manghi underlines, to social representations, interpersonal relationships and institutional structures that shape the research process (Manghi 1996, p. 255) [18].

[18] Lusardi refers to the distinction with which Sergio Manghi (Manghi 2005, p. 28) defines medical knowledge which includes relational knowledge, cognitive knowledge constituted by codified knowledge or in discursive and repeatable and universally shared forms, normative knowledge which it pertains to moral and practical guidelines of a deontological and moral nature.

The pandemic has opened up the possibility of applying different subtypes of ethnography, above all by enhancing the technological dimension of the tools available in situations of closure of social activities such as during global lockdowns. In a recent work and as shown in the table, 11 different types have been classified to meet the need for research during the pandemic and during lockdowns (Cotè – Boileau et al., 2020). This variety allows for greater freedom to choose the most appropriate approach at that time and circumstances and favors an approach that is sensitive to the context but at the same time effective with respect to the specific research objectives.

Tab 5: Ethnographies

Native ethnography	is a subcategory of autoethnography, where the research is conducted by someone who is not a professional anthropologist and who is studying their home community
Netnography	is an ethnographic-adapted online research method, which aims to explore the social practices and interactions in contemporary digital worlds
Ethnography of events	is an ethnographic-adapted method that focuses on socially constructed events to uncover the role of cultural structures in shaping organizational life through time
Multisite ethnography	is an ethnographic-adapted method that study social phenomena that cannot be explained by focusing on a single site
Interorganizational ethnography	is an ethnographic-adapted method that study social and organizational phenomenon that manifests beyond organizational boundaries
Rapid ethnography	consists of applying the traditional organizational ethnographic approach in a compressed manner over time
Team-based ethnography	consists of applying the traditional organizational ethnographic approach with multiple fieldworkers and valuing each fieldworkers' reflexivity in the research process
Autoethnography	is an ethnographic-adapted method that focuses on the researcher's own experience. Self is the source of the data in the form of writing down the day-to-day concrete details of life
Institutional ethnography	is an ethnographic-adapted method that aims to explore the institutionalization of social interactions within institutionalized organizational contexts
Focused ethnography	is an ethnographic-adapted method, which pragmatically applies ethnography over a short period of time, and conceptually focuses on a single organizational or social phenomenon

Source: Author's elaboration of the table of Cotè – Boileau et al. (2020)

Duoethnography is a methodology that involves multiple researchers/individuals engaged in community reflection and writing to give shape to a new type of knowledge (Formenti, Luraschi, Del Negro, 2019). Through this technique the researcher enters a context not as an observer but as a narrative voice (talking about himself) and the individuals are co-authors of the narration. I have found this method particularly interesting for approaching healthcare workers, severely tested by the pandemic, in a non-invasive way and respectful of the experiences lived.

4.1.3.2 Participatory Ethnography

During the research, great importance was dedicated to Participatory Ethnography (Lusardi, 2018 p.19), a method through which the research activity is the result of the involvement of various subjects who come from the empirical field and who cover the role of para-ethnographers (ibid., p.20). In this case, Ethnography is not a methodology applied directly by the researcher but is at the center of a composite process in which health professionals, through an initial phase of theoretical and practical learning, acquire an active role in the application and diffusion of the methodology in their organizational contexts. The experimentation of this approach is consistent with the objectives of Risk Management which sees professionals as the first promoters of the safety of treatments. As underlined by Lusardi (2018, p. 20), the role of para-ethnographer allows one to look at one's daily practices from another position similar to that of the researcher. Participatory Ethnography enables one to gradually overcome the diffidence towards qualitative research and to begin to build, where contexts are worked on concretely, a specific interpretation of the methodology, so as to be able to use and disseminate it in daily practice. Knowledge of the technique of participant observation in healthcare contexts is combined with other specialist knowledge, increasing situational awareness and the same clinical competence as the operators. As we shall see, this approach inspired the improvement project relating to adverse event reporting.

4.1.3.3 Visual Research Methods

In support of Organizational Ethnography, I have used visual methods, in particular photography. Visual research methods rely on using visual materials as part of the evidence generation process to explore research questions. (Rose, 2013 p. 25). Visual methods make use of different approaches based on the chosen tool: photographs, films, video diaries, collages, maps, memory books, graphic novels , photo- diaries (ibid., p. 25) or on the way in which data is processed . Data can in fact be generated directly by the researcher and must respond to the function of

informants of an iconic nature (Losacco, 2012 p.35) or when the image has the ability to record a certain type of reality (Mattioli, 1991 p.67). Data can be the result of a subjective production, they are created by the individuals participating in the research who are asked to visually narrate their point of view (Losacco, 2012 p.45). Finally, the images can act as a stimulus in a semi-structured interview instead of the questions written down in order to allow the interviewee to better express their world of meanings (Faccioli, Lo Sacco, 2003 p. 108). The choice of using visual research methods is dictated by the presence of some strengths: the ability to generate data because they bear witness to the subjective sense of experience and stimulate discourse by activating different and more emotional registers (Rose, 2013 p.28); the awareness that through the visual, which is an "intellectual and speculative act" and which refers to a voluntary perceptive act in which the perspective from which one observes is selected (Mattioli 2015, p. 139), data can be gathered and certain details detected that could otherwise escape an analysis of a different type (Frisina, 2013 p.49). "An image will be considered sociologically valid by its ability to register a certain type of reality and by the validity of the content, i.e. by the ability to act as a visual indicator with respect to the concept of reference" (Mattioli, 2015 p. 168).

4.2. The Research Questions

The reflection on the research questions was constant and went hand in hand with the evolution of the events which stabilized almost three years after the spread of the first infections. The dynamic evolution of the health situation at an international, national and local level has made the availability of contexts in which to carry out research changeable. For this reason, the questions have been adapted to the possibility of being explored in the field. Throughout 2020 and part of 2021, for example, the possibility of accessing the Parma's Ausl Hospitals was difficult due to the restrictions on accessibility set up for safety issues. Local Organizations, due to the nature of the services with general practitioners and specialist outpatients

and therefore aimed at the population as a whole, and in particular at patients with chronic conditions, opened again starting from late Spring 2020.

1st Research Question – Governance

The first research question concerned the question relating to which concept of *governance* underlies *safety* and *preparedness* processes and what the relationship with *Risk Management* is which is a form of management on which themes common to top management converge such as that of appropriateness, accountability, the search for continuous improvement in terms of efficiency and effectiveness as well. As will be highlighted in the documentary analysis, the governance of emergencies is crucial at every stage and is a process that implies cooperation between health and non-health institutions and the active participation of the population. In addition to the analysis of the documentation at national, regional and local level which represents the dynamic regulatory activity of the institutions, the activity improved the management of the Local Health Authority Crisis Unit from October 2020 to May 2021 as a governance tool par excellence in crisis management both in ordinary and extraordinary times. The Crisis Unit is, in fact, a Risk Management tool in the event of extremely serious events involving the deaths of patients following healthcare activities.

2nd Research Question - Territory

What is the role of the territory in reference to *preparedness strategies* from the point of view of Local Health Authority system governance and in its application by individual services? What concept of territory is presupposed in it? What Risk Management model is present, taking into account the current processes of territory-hospital integration and integration of social services with health services?

The first phase of the pandemic had highlighted, especially in Italy, the lack of a preventive approach based on the centrality of resources in the area and the need to activate measures to contain the disease at home and in places of assistance for the

elderly and disabled. In September 2020 a survey of the National Center for Disease Prevention and Health Promotion, (CNAPPS - ISS Higher Institute of Health) that involved the Departments of Prevention from different Regions (Veneto, Piedmont, Emilia-Romagna, Lazio, Calabria), highlighted the problematic nodes and strengths, which can affect the responsiveness of the services of the territory, in the light of the diversified impact of the pandemic between regions and the differences in human and economic resources available to the different local realities. The document emphasizes that in the initial phase it was not simple for the operators to tackle to the events because the organization lacked a sufficient awareness of the timing, the activities to carry out and the necessary competences. The document highlights the importance on the part of the territory of a system of coordination and effective communication consolidating in advance procedures and protocols in order to be prepared for emergencies and to listen to the necessities of all the involved parts (general practitioners, mayors, citizens, ecc.).

From this point of view, the centrality of the role of general practitioners (GPs) was stressed as well as that of health facilities (Case della Salute in Emilia – Romagna Region) in which fundamental services for the care of patients are grouped and provided. A study coordinated by the Sant'Anna School of Pisa, in collaboration with researchers from US universities, has highlighted how during the first wave of the pandemic mortality rates had very different trends in the various Italian regions: by monitoring the trends of infections based on data on mobility, positivity rates, availability of primary care and the size of potential hubs of infection in schools, workplaces and hospitals, these have highlighted the important role of primary care in mitigating mortality:

> "Better proxies and finer resolution may reveal stronger aggravating roles for age, nursing homes, public transport and pollution and better dissect the roles of chronic conditions, households and inter-generational contacts, and ICU availability. But our analysis, notwithstanding limitations in the data, suggests important roles of primary care in mitigating mortality, and of contacts in hospitals, schools and workplaces in aggravating it" (Boschi, Di Iorio, Testa, 2021).

Preparedness in the territory is a complex process that deals with the variety of environmental and socio-economic conditions, the presence of different services and population characteristics that cannot be assimilated between contexts. In this regard, a first research question concerned the role of the territory in the management of the risk related to the spread of the virus and the issue of the safety of the structures:

3rd Research Question - Social Actors Involved

What is the role of healthcare professionals and all other individuals (patients, caregivers, volunteers) involved in the process of managing the crisis? What is the relationship with preparedness? What changes has the pandemic produced in daily Risk Management practices?

A further in-depth aspect concerned the relationship between the pandemic and the presence of the protagonists of Risk Management taking into consideration health professionals and more generally the multiple actors involved in health care pathways (assisted, family members and caregivers , citizens, volunteers): their presence or absence, during the treatment processes, has (had) direct consequences in the evolution of assistance to patients/assisted patients, as demonstrated by the images of loneliness published by the media during the critical period of the epidemic. The others cannot only be individuals "in support of" but resources: experiences undergone by groups of specially trained citizens to help other citizens in the management of natural disasters, have demonstrated the resilience multiplication effect of the macro-environment in which they are part of. (Boin et. al, 2007). A connection with the concept of "negative ability" seems useful, intended as the ability to rapidly restructure one's model of action and to design new ones, based on a cognitive resource capable of innovating, deviating from practiced routines and giving shape to new contexts. (Lanzara, 1993 p.16) and with that of resilience, the ability to learn from experiences to imagine and implement new solutions (Bifulco, 2012). The primary recipient of safety programs is the patient while doctors or

nurses ensure the legitimacy of the care processes for which they are also responsible in the eyes of the law. The pandemic has revealed that professionals are not only healthcare professionals but also workers/patients/citizens to whom Risk Management practices must be directed. During the Covid 19 epidemic, healthcare professionals were exposed to dangers and many of them became patients or lost their lives; but they have also been able to invent organizational solutions to solve critical situations, they have consolidated the ordinary in the emergency to support patients and work groups. Presumably practitioners have established new communities of practice, those non-formalized entities which "offer the opportunity to mediate competence through the experience of direct participation and are consequently social units of learning" (Wenger, 2000 p.16), especially in relation to errors (committed or suffered). As Pipan (2014) has clearly highlighted, adverse events in healthcare can also be defined as a story told by many actors (doctors, patients, operators, managers, lawyers, judges) who incorporate different points of view and knowledge: the result of that situated learning which translates into actions and the production of particularly significant artifacts during and after the health emergency.

4th Research Question - Accessibility

What is the accessibility of local healthcare facilities in the light of the recent changes made to local services by Ministerial Decree 77/22?

In conclusion, a non-secondary role has emerged in the need to rethink the role played by physical space (health services, hospitals, long-term care services): the distancing imposed by the pandemic has had repercussions in the critical phase of the emergency (isolation of patients in hospital and of frail people at home) and in the post-emergency period. The theme of accessibility of services understood as "the possibility that the place is located in a reachable point, in a period of time appropriate to the resources of the individual and at an appropriate time with respect to other tasks (Mela, 2000 p.185)" acquires considerable importance. The principle of

co-location or the grouping of services in the same building (Bonciani, 2018), and has guided the birth of territorial structures (Case della Salute E-R) which were set up to facilitate the care of chronic patients and the promotion of health, while on the other hand highlighting limitations in the acute phase of the epidemic, can be transformed into a Risk Management resource, transforming the structures into a reference point for the community, as we will see by referring to Ministerial Decree n.77/2022 which decreed the transition from the houses of the salute and houses of the communities.

4.3 Unit of Analysis

The natural unit of analysis of the organizational and visual ethnography proposed here can be identified in the hospital and territorial Health Services of the Local Health Authority of Parma, which is grappling today with the implementation of all those measures aimed at preventing the return of the epidemic and the crisis in the functioning of health facilities. The choice was not to prioritize one to the detriment of the other (territory or hospital) as they are regulated by a systems approach and governed by integration processes. In fact, a process of integration of care and assistance pathways is underway which provides for strong continuity in the pathways for taking charge of the patient during the acute phase (hospital) and in those of continuity of care in charge of the territorial health and social services . The Local Health Authority of Parma is involved in a process of integration with the University Hospital (AOU) whose objective is a structural and functional reorganisation, supported by the logic of pursuing efficiency, coherent management and standardization of methods and pathways [19].

4.4 Field Negotiation

The choice of the field of observation is the result of a negotiation process that lasted for most of the first year of the research due to the changes in the Top

[19]Some processes have already concerned the integration of strategic apparatuses such as the Inter-Local Health Authority Department "Human Resources" (Resolution adopted on 09/28/2016 No. 650) or the Inter-Local Health Authority Department with functional value of the "Planning, Evaluation and Control" system (Resolution assumed on 28/09/2016 N.647).

Management of the Healthcare Local Health Authority under observation. A first change occurred at the beginning of the research in the Clinical Governance Complex Operative Unit due to the retirement of the Risk Manager with whom the research was designed and proposed.

The Manager had supervised the research in the role of Local Health Authority Tutor. With the new Risk Manager and in the new management which led to a different organization and denomination of the UOC now known as Risk Management and Forensic Medicine, specific areas of interest have been defined, the product of which is the project to improve the spontaneous reporting of adverse events (ch. 4). The change of many Top Management officials, after the first wave of the pandemic (July 2020), led to a new renegotiation of the field with a request to avoid access to the hospital as it was under great pressure.

This has simultaneously induced the shift of the research field towards territorial structures. Once the research questions had been defined, I defined the contexts of the field research, paying attention to the graduated hierarchical relationship between the areas to be observed in consideration of the objectives, which made it possible to deepen the theme of organizational complexity from three points of view: at a macro level by observing the work of the Local Health Authority Crisis Unit; at the meso level with the organizational ethnography of a territorial structure, the Casa della Salute Pintor – Molinetto and finally at the micro level by means of the improvement project aimed at the Local Health Authority Safety Network in the reporting of adverse events and accidents.

4.5 The Observer's Role and Ethical Issues

The research had the peculiarity of being organized and carried out by an internal worker belonging to a technical Operational Unit operating in the field of Risk Management. During the research I had several roles: I acted as an observer during the Unit Crisis and during the Ethnography at the Casa della Salute Pintor-Molinetto; I was a facilitator and lecturer in the Project of improvement of

spontaneous reporting of adverse events. I carefully examined risk in light of possible distortive effects. This I derive from research carried out within my work context and which, thanks to past research, saw the methodology being applied in some structures. I chose to carry out the research in blanket mode during the observation of the Crisis Unit so that participants would not feel conditioned by the presence of an external observer. I used the semi-covered mode for Organizational Ethnography at the Casa della Salute. The coordinators of the structure were aware of my presence while the citizens, health workers and volunteers were not. A particular comparison of the spaces and the nature of the ongoing services characterized by a significant turnover of attendance allowed me to keep under cover during my observations. The improvement project, on the other hand, due to the nature of the proposed activities was based on continual exchanges with the researcher.

The culture of safety of care, due to the different degrees of sensitivity present in the Ous, turns out to be a particularly difficult issue in the management of the ordinary; in the management of extreme events such as that of the pandemic it becomes even more complex when time has not yet been put aside for reflection on the events. To respect the particular moment experienced by health professionals data collection was based on semi-structured interviews and what Cardano calls "particular types of discursive interactions", unstructured random interviews and backtalk, all the comments and comments of the participants on the observations on the researcher's context (Cardano, 2011 p.118). I found great willingness on the part of all health workers, managers and volunteers to tell what happened before and during the pandemic. A preventive reflection was necessary on some issues concerning the delicacy of the research environment (place of health care) and the use of the camera and the smartphone which, in addition to being data collection tools, are evocative objects of meanings and concerns regarding their use: in particular, the issue of respect for privacy and verification of the appropriateness of their use based on the context was addressed. The first issue was resolved by deciding not to photograph

people directly, also due to the objective difficulty of requesting prior consent. With respect to the opportunity to take photographs in certain environments, I decided to focus my research on open spaces accessible to the public and I excluded the interiors of medical clinics and hospital rooms. The unstructured interviews were recorded with the permission of the respondents who granted without hesitation.

4.6 Data Collection and Data Analysis

I decided to experiment with three different methods of observation and data collection, in order to test the ability of qualitative research in different settings and levels of complexity to explore elements that traditional Risk Management methodologies fail to capture, even if, as we will see in the final part of this report those methodologies, too, due to the very nature of the material they have to shape or rather their relationship and complexity, can be ascribed to research methodologies which are close to qualitative logics.

The interpretation of the data, as several ethnographers affirm, is the creative act of the researchers (Bruni 2003, p. 107) and it is the moment in which it is necessary to recompose all the collected material giving shape to the data. The theme of data collection and analysis raises the question of objectivity/subjectivity that the constructivist perspective, followed here, sees in dynamic interaction in a "dialectical, conversational movement between objects and subjects that continuously give meaning to things. The data do not speak for themselves: they allude to something only if we are able to listen" (Piccardo and Benozzo, 1996 p. 126). Piccardo and Benozzo (1996) propose that the Grounded Theory (GT) be applied, just as Ghirotto and Anzoise (2013) propose visual ethnography as it generates theory thanks to the use of procedures that make the emergence of categories (ibid., p.2) possible. The Grounded Theory, in fact, "listens, retains and, finally, constructs theoretical explanations on the main concern, on the main concern of the participants" (Ghirotto and Anzoise, 2013 p.2). This method is interesting because it delves into the coding process understood as a set of

procedures and techniques used to conceptualize data. Ghirotto and Anzoise (2013) explain the stages of the process: the objective of GT is to build a theory or a set of relationships between concepts or groups of concepts (categories) on which three levels of abstraction are proposed:

- open coding which provides for point analysis of the data fragment by fragment with a first assignment of conceptual labels;
- focused coding: the common conceptual elements are analyzed by grouping them in turn into categories and macro-categories;
- construction of the theory in which the links that connect the categories are highlighted and a coherent and unitary conceptual model is defined (Ghirotto and Anzoise2013).

Van Maneen (1988) proposes the distinction between first and second level concepts where the first level concepts are the observed events and the narratives of the protagonists, while the second level ones are the researcher's elaborations on the "regularities found in the first level concepts" (Bruni 2003, p. 109).

Part of the process of analysis is the writing of the results of the work (ibid., p. 131), an ethnographic narrative that is reworked until it makes sense until reaching that *thick description* by Geertz (1978) which allows you to get closer to the meaning that people give to what they do, establishing a deeper contact with the original cultural meanings, looking through the eyes of others.

4.6.1 Documents Collection

From March 2020 to today, I have carried out the collection of the main Clinical Risk Management and Risk Management documents relating to the pandemic. Both strands have correspondence in documents drafted at an international, national and regional level; local documents are produced in continuity with the evolution of the health crisis. The narratives collected through the interviews portray a rich self-production of documents by the structures or Operating Units that have been necessarily active in adopting an internal organizational strategy for the containment

of the virus. Below is an indicative subdivision of the documents analysed: Macro or governance level, International and National dimension; Meso or organizational level, definition of internal organizational strategies for risk and safety management; Micro or individual level, related to the responses that individuals, professionals, citizens gave during and after the event.

4.6.2 Bibliographic Sources

The multidisciplinary nature of the research, which is based on issues relating to public health, management of complex organizations, Risk Management in healthcare and in relation to pandemic events, makes the search for bibliographic sources a process of continuous integration, taking into account the dynamism of the related events to the Pandemic as well, reflected in a continuous publication rate in health and sociological disciplines. I took into account the dual level of analysis that accompanies the request for research: the state of scientific production of the disciplines in ordinary time and that implemented following the spread of the pandemic, as well as the production of innovative material relating to qualitative research over the time of the distancing.

Main reference areas:

- literature on Clinical Governance and Clinical Risk Management;
- literature on complex systems and health systems;
- pandemic literature;
- literature on Qualitative Research applied to the world of healthcare, with particular reference to Organizational Ethnography and Visual Ethnography;
- literature on Critical Political Geography and Geography of Health Services;
- health and sociological literature referring to the pandemic;
- literature on contemporary economic models;
- literature on the Anthropology and Sociology of Disasters;
- International, national and regional regulations relating to Covid 19;
- Production of national, regional and local health authority planning documents.

In order to direct the research, I created a mind map (Davies, 2011) with which I circumscribed groups of keywords:

Tab. 6: Keywords

Discipline	Keyword
Risk Management	Medical errors, adverse events, Incident reporting, Voluntary reporting, Risk Management, Covid 19, Safety, Population, errors
Qualitative Research	Ethnography or ethnographic research, Visual research methods and Visual Ethnography, Grounded theory
Organizational Studies	complexity, organizations, social systems
Sociology, Sociology of Disasters, Urban sociology, Sociology of Organizations	Governance, Governmentality, Territory, Organization, Community of Practice, Resilience, Fundamental Economy, Welfare State, security, safety

Source: Author's elaboration

Healthcare databases were queried:

- Medline-PubMed: has collected international biomedical literature from 1966 to today in the fields of medicine, nursing, dentistry, veterinary medicine, health organization;
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- TRIP: database (Turning research into practice) clinical search engine for systematic reviews, evidence-based synopses and guidelines. Clinical questions, peer - reviewed journal articles, e-books, images, and videos;
- Cochrane Library: bibliographic database of systematic reviews (RS). For research purposes it was useful to consider some of the 7 databases it is made up of:
- Cochrane reviews (CDSR): systematic reviews and protocols produced by Cochrane, in full text;
- Other reviews (DARE): structured abstracts of systematic reviews published in journals;
- Methods studies (CMR): references of publications dealing with methodology;
- Technology assessments (HTA): studies on health technology assessments.

Platforms used: Curiosone, ProQuest, SageResearchMethods Online

To consolidate knowledge in reference to this topic, I reviewed part of the reference bibliography, deepening the different approaches that have been developed in the last year and looking for an application in the context of Risk Management. I have studied the theme of disaster management and in particular the concept of resilience, a process made familiar by its use in common language but which hides a complex nature as it highlights multiple meanings and declinations and "mobilizes very different visions of the nature of human *agency* and related responsibilities" (Pellizzoni, 2017). The pandemic has exacerbated health inequalities by highlighting the need for health systems to implement equity - oriented policies

and to participate in the reflection on the welfare system, in which resilience and equity can be a central point in the debate together with the rethinking of the role of community and territory. Particular attention was paid to the concept of health by researching new bibliographic sources and participating in conferences which made it possible to combine the concept declined by WHO with [20]a broader definition: "health consists in the ability (for human beings) to maintain one's vital balance, to deal with life events, to adapt to changes in one's environment. Health requires environments favorable to human life, adequate social relationships and appropriate forms of mutual and organized care. The conditions that allow a social group and its members to maintain and develop health constitute a common good to be promoted and protected" (Ingrosso, 2016; 2018). The assumption of this definition has led to the deepening of the concept of care (Mortari, 2015; 2021). The management of the pandemic by the management of healthcare organizations (Czarniawska, 2020; Marsilio and Prenestini, 2020) is an in-depth theme through the reading of manuals, non-fiction and narratives edited by healthcare and social professionals engaged in different roles and disciplines. (Ambrosino and De Fiore, 2021; Venturi, 2020). The need to carry out field research during the closure of services has made it necessary to focus on literature concerning new social research methodologies and techniques (Scaratti, 2021), also drawing on various material produced in open access.

4.6.3 Interviews

I carried out semi-structured interviews with 31 operators who cover different roles and whom I considered institutional informants [21]with respect to the areas and structures they belong to. I divided the interviews into two areas: interviews with healthcare Local Health Authority operators and interviews with stakeholders or knowledge bearers of interest. The interviews were addressed to managers of "

[20] "A state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (WHO, 1948)

[21]Institutional Whistleblowers are defined as those professionals who are entrusted with the task of mediating the relationship with the outside world and facilitating the understanding of the organization by those who are not members of it (Cardano 2011, p. 129)

middle governance ", operators and operators with coordination roles. The interviews with the top management of the Local Health Authority were carried out in collaboration with the researchers of the project Preloc from the University of Milan, Bicocca. Some interviews were carried out remotely but most were carried out face-to-face and within the structures. To reach the operators, I had to negotiate the moment deemed most appropriate for access, in consideration of the state of alert on infections. The questions prepared for the interviews were considered traces to favor what Denzin defines an observational encounter (Denzin, 1970 p. 133), which, as explained in Piccardo and Benozzo (1996, p.112), is to be deemed a social event based on reciprocal observation whose outcomes must be considered on the basis of the context in which they are produced. The semi-structured interview allows for unforeseen themes to emerge and for the expressive narratives of reality of whoever is interviewed (ethnomethodological vision (ibidem p. 114) to be understood; they are the result of the interpretative dynamics of the interaction of the interviewee and the interviewer (symbolic interactionism) as well as the result of the interpretative practices resulting from the interaction between the interviewees.

Tab. 7: Interviews carried out during the research

Local Health Authority of Parma	1.Integrated Home Care Coordinator (ADI) 2.CDS Medical Coordinator 3.CDS Nurse Coordinator 4.Risk Management Coordinator Integrated Assistance Department Mental Health and Pathological Addictions (DAISM DP) 5.Coordinator of Social Workers Services for Pathological Addiction - SerDP 6.Surveillance officer of the AUSL Directorate 7.Volunteer project coordinator 8.Regional Prevention Plan Coordinator 9.Social Assistants Coordinator Directorate of Social Assistance Activities 10.Director of Social-Welfare Activities 11.Hospitals Director 12.District Director of Parma 13.Director of the Department of Public Health 14.Healthcare Director 15.General Director
Province of Parma	16.President

Municipality of Parma	17.Director of Personal Services Local Health Authority - ASP District of Parma 18.Head of Casa della Comunità Villa Ester Municipality of Parma
Municipality of Fidenza	19.Fidenza's Welfare Municipality Councilor 20.ASP District Director of Fidenza 21.Responsible for social and health services Municipality of Fidenza
Volunteering	22.Head of Volunteer Service Center (CVS)
	23.Responsible for the transcultural mediation service of the Casa della Salute Pintor - Molinetto
	24-27..Volunteers at the Casa della Salute Pintor Molinetto (two volunteers AUSER; two transcutural mediators
	28.Safety officers at the Casa della Salute Pinto Molinetto
University of Modena and Reggio Emilia	29.Law researcher
Little Daughters Nursing Home	30.Anesthetist doctor
Archer GRT Solution	31.Risk Manager

Source: Author's elaboration

The interviews, carried out in the temporal sequence of the research, unveil the relationship between lived experience and elapsed time, which dilates memories but it also allows them to be reorganized, as is evident in the interviews with the Top Managers who provided a purely technical vision of what happened.

The interviews with the operators also brought back the emotional experience that they went through while they related those moments.

Tab 8 : Interview Questions

Interview Questions
1. What have you been able to observe, from your point of view, with respect to the impact of the pandemic on: organization Institutions / Local Health Authority; networks – data; Professionals; the Assisted and caregivers?
2. In your opinion, what elements were fundamental in the management of the pandemic during the three "waves" periods (1st period from March 2020 to September 2020 – 2nd period from October 2020 to January 2021 – 3rd period from January 2021 to date)?
3. Are you aware about preparedness?
4. Do you know the National, Regional, Local Pandemic Plan?
5. What tools have you used to monitor the progress of the pandemic in your organization?
6. Has your concept of risk changed during the pandemic? And has the concept of risk of the organization in which you operate changed?
7. Do you think the concept of risk has changed on the part of operators and patients during this experience?
8. What do you think you have learned from this experience from organizations, professionals, the assisted, citizens?

Source: Author's elaboration

4.6.4 Observation of the Crisis Unit (CU) of the Local Health Authority

The Crisis Unit set up by the Local Health Authority of Parma from October 2020 to June 2021 is a management tool that involves the strategic departments called to

define strategies and organizational actions in response to the pandemic. The Crisis Unit meetings were held from October to December 2020 on Tuesday and Friday afternoons from 15.00 to 17.00. From January to May 2021 the sessions took place on Friday afternoons starting at 15:00 and often lasted only one hour. The frequency and duration of meetings depended on the course of the pandemic and the start of the vaccination campaign from January 2021. I attended about thirty Crisis Unit meetings between October 2020 and May 2021. I have drawn up written notes of the events so as to have an accurate account of the issues addressed in the meeting and I have received the minutes written by the Director of the Operational Unit for Risk Management and Forensic Medicine who had the task of drawing up a report of the sessions and send it to participants. The observation of the meetings and the reading of the minutes prepared by the Risk Manager allowed to understand the flow of events and to be updated in real time on crisis management. From a methodological point of view, the analysis of the material available, in paper format, made it necessary to deepen a new methodology, the Conversation Analysis (Fele, 2007). The analysis of the conversation allows us to study "the set of organized relationships that are created between what a person says at a given moment of the conversation, what has just been said and what will be said immediately after" (Fele, 2007 p. 9). The conversation analysis aims to study the interaction of people when they speak, investigating how individuals produce actions (saying something is a form of action), events and objects mutually recognizable in a specific situation, in a given context and considering the identity of the interlocutors (Fele, 2007 p.27).

I also deepened some themes of Anthropology of language, intending to find in the definition of language as a cultural resource and of speaking as a cultural practice (Duranti, 2021 p. 36), a correspondence with the concept of collective construction of risk of Mary Douglas (1985). In organizations, language is visible in artifacts and legislation, as well as in the physiognomy of hierarchical relationships. Observing the Crisis Unit means describing the management of the pandemic from the point of view of the internal logic of the participants involved in this process, revealing the

social structure of reference that the conversations highlight. For the data analysis I transcribed and analyzed the notes taken during the sessions. The data was compared with the reports prepared by the Risk Manager. The analysis work was carried out through a manual categorization following a progressive coding process.

4.6.5 Organizational Ethnography at the Casa della Salute Pintor – Molinetto

It is the second Organizational Ethnography carried out at the Casa della Salute Pintor Molinetto, as it was a source of research for my thesis for my master's degree in Sociology in 2018. In this context, I examined the Case della Salute from the point of view of their evolution from the moment they were set up as an experimental form (2011) to the reform of the Emilia-Romagna Region which already foreshadowed an integrated dimension between services and community participation, as developed in the recent Ministerial Decree n. 77 of 2022. I carried out the observations once a week (as requested in the form of a constraint by the Local Health Authority) from November 2020 to December 2021 for a total of three hours a week. I was able to log in at other times during the afternoon or on Saturday mornings. The observation underwent interruptions following the restrictions on access to health facilities coinciding with the second wave of the pandemic. For this reason, in April 2021, the observations were suspended. This long period of observation made it possible to verify the changes in the management of the structure in correspondence with variations in the prevalence of the virus, the vaccination campaign and the reorganization of clinical activities. In the same period, I conducted some observations at Villa Ester, a structure belonging to the Municipality of Parma which had been active since 2019 in the same neighborhood where the Casa della Salute Pintor - Molinetto operates, as it represents a new model of experimentation of Neighborhood housing in response to social needs and social assistance to the population, on the part of the associations. The intent was to compare access methods in two types of structures that prefigure the Casa della Comunità, established by the National Recovery and Resilience Plan - PNRR (2021)

and in DM 77/22. The data collection took place through the drafting of field notes, through the use of visual methods, in particular photography and through the use of interviews with various interlocutors: the medical area coordinator, the nursing coordinator, a group of volunteers present at reception, two security personnel, a transcultural mediator in charge of reception. The focus of the ethnography concerned two levels of investigation in particular: a first level relating to Risk Management in the structure of the pandemic, a second level relating to the methods of managing security and reception during the pandemic. I have agreed, with the Directorate of the Casa della Salute, to a semi-covered method with the citizens and an open method with the operators present.

For the data analysis I proceeded with the transcription of the notes and the literal transcription of the interview recordings and then proceeded with the analysis of the text through the categorization of the main thematic recurrences. I used the Nvivo software for some parts of the processing that was done, generally through manual categorization processes.

4.6.6 Spontaneous Adverse Event Reporting Project

This project, which had the Care Safety Local Health Authority Network as its protagonist, developed in two phases: a first phase from March to December 2021 in which participants were asked to return a survey form of some items relating to the collection by of the Operational Units for reports of accidents and adverse events; the second phase saw the organisation, in collaboration with a professor from the University of Bergamo, of a course in Organizational Ethnography in the months of May, June and November 2021 and in May 2022. The files relating to the first phase were catalogued and archived through a matrix table in which the answers to the 8 items were recorded. Data were processed using SPSS software. The Ethnography course, on the other hand, saw the collection of teaching material prepared by the teacher and group work elaborated by the participants.

5. Qualitative Research as An Interpretative Key to Contemporary Risk Management. Ethnographies at The Local Health Authority of Parma

Carrying out an Organizational Ethnography in a Local Health Authority during a pandemic means participating, from within, in an extraordinary event not only for the uniqueness of the type of event and its immediate consequences but also for the possibility of observing its prolonged effects over time. In the period in which I am writing, the pandemic is in a stabilization phase that allows polarization between those who believe that the time is ripe to declare the end of the pandemic and others (epidemiologists and virologists) who argue that it is necessary to keep measures to contain infections alive. From an epidemiological point of view, with the relaxation of containment measures, influenza viruses have regained strength and are added to the Sars Covid - 2 virus, with effects that are no longer lethal thanks to vaccines but that are putting hospitals in crisis once again due to the influx in Emergency Rooms, especially pediatric ones. The trend of the influenza virus together with that of Sars Covid - 2 highlights a concept, stressed in the previous chapters, namely the concomitance of emergency management with that of the ordinary: in organizational terms, the reorganization of the structures to cope with the catastrophic or harmful event, once the acute period of the event has been contained, which generally catches us unprepared by virtue of the uncertainty we talked about earlier. It is necessary to support the care of the ordinary based on certain norms and standardized actions that only partially grasp the complexity in the field and which is constituted by cultures, implicit norms, communities of practice, rituals that generally remain concealed. The investigation that I have been able to develop captures this intertwining as soon as it arose. The Local Health Authority under study has experienced, after the first wave of the pandemic, a turnover in the top management that today, after two years of external commissionership (June 2020 – 2022), see the General Manager of the University Hospital at the helm as Extraordinary

Commissioner with the objective, shared by the previous commissioners and on a regional mandate, of unifying the two territorial companies for the declared purpose of optimizing, above all, the clinical paths of patients in a harmonization between hospital and territory. In addition to the commitment to managing the pandemic, the health workers of both management and sector, were called to participate in the future organization of provincial health through the involvement of about 500 professionals from both companies divided into 59 working groups. The research, therefore, portrays a moment in the life of the Local Health Authority in which different changes intersect that imply thinking and thinking in short, medium and long-term transformations. The theme of Risk Management fits into this context because it constitutes the heart of the issues addressed on the issues of uncertainty, risk and safety, as an individual path (of health professionals), and as a collective path in a mixture of levels and intertwining that, in order to be understood, have made multiplying the points of observation necessary.

5.1 Parma's Local context

Research was carried out at facilities belonging to the Local Health Unit that carries out its institutional activities in the Province of Parma divided into 45 municipalities with a total population of 452,638 residents distributed in 3,449 square kilometers of surface. The report on demographic data prepared by the Province of Parma's Statistical Office shows that an 886 unit (- 0.2%), decrease in the population was recorded on 1 January 2022 compared to 2021, in line with that of the previous year. The decrease is the result of a national and regional trend but in 2021 it was aggravated by the consequences of Covid. The pandemic has, in fact, had a consistent impact on mortality, although decreasing compared to 2020. In 2020 there were: + 1,590 deaths compared to the 2015-2019 average, concentrated in March and April and in 2021 there was an increase of 374 deaths deployed uniformly throughout the year.

The report states that the epidemic has also had, in the last two years, a substantial impact on the migratory rate that has decreased compared to previous years:

Table 9: Net Migration (Fewer Members in Municipal Registers Enrolled)

Net migration (fewer deleted members in municipal registers	
2015-2019	+3,537 people
2020	+2.304
2021	+2.523

Source: Province of Parma 2022 statistical data report

The elderly population, after the peak of the epidemic in 2020, has started to grow again, as had happened continuously since the year 2000, while there has been a modest decrease in births in 2021 (-11 children) but have nonetheless reached the minimum level in the last 20 years (3,294 total births), with a decrease of -947 children compared to the maximum of the historical series (year 2010).

5.2 Parma's Local Health Unit (AUSL)

As can be seen from the Institutional documents, the Local Health Authority was founded in 1994 following the merger of 4 Local Authorities and is now divided into 4 Social and Health Districts:[22]

- District of Parma including the municipalities of Parma, Colorno, Sorbolo, Torrile, Mezzani;

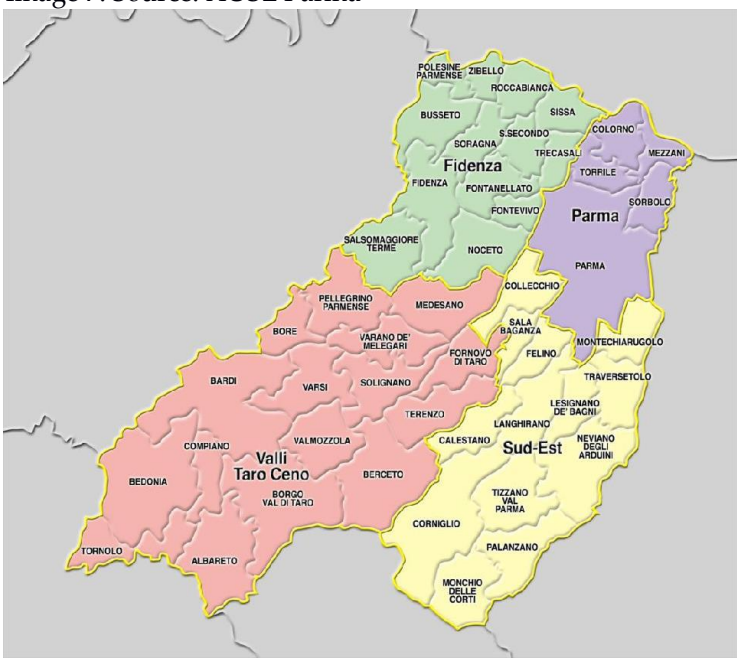
- District of Fidenza with the municipalities of Fidenza, Salsomaggiore Terme, Noceto, Fontanellato, Fontevivo, Soragna, Busseto, Polesine-Zibello, Roccabianca, San Secondo Parmense, Sissa-Trecasali;

- South-East District with the municipalities of Langhirano, Collecchio, Sala Baganza, Felino, Calestano, Tizzano Val Parma, Corniglio, Monchio delle Corti, Lesignano Bagni, Montechiarugolo, Traversetolo, Neviano Arduini, Palanzano;

- District Valleys Taro and Ceno, including the municipalities of Borgo Val di Taro, Medesano, Fornovo, Varano de 'Melegari, Varsi, Bore, Bardi, Pellegrino Parmense, Solignano, Terenzo, Berceto, Valmozzola, Bedonia, Albareto, Compiano, Tornolo.

[22]Resolution of the Ausl Local Health Authority of Parma "Local Health Authority Act" n. 75 of 2015.

Image 7. Source: AUSL Parma



The Local Health Authority, as highlighted in the 2021-2023 Performance Plan, is governed by the General Manager who, based on the principles of participation, decentralization and collegiality, takes strategic decisions regarding the development of the Local Health Authority and the organization of services. The General Management is supported by the Board of Directors composed of strategic directors (Medical Director, Administrative Director, Director of Social and Health activities), District Directors, the Director of the Integrated Mental Health and Pathological Addictions Department and the Director of the Department of Public Health. The technical-professional skills of the Medical Department of the Local Health Authority Hospital Presidium, the Nursing and Technical Management and the Pharmaceutical Assistance Department are also present. The Board of Management is the Local Health Authority's body which operates through its own regulations, carries out tasks of elaboration and proposals to the General Manager for the organization and development of services; training and lifelong learning, research and innovation activities; monitoring of freelance work and waiting times; monitoring of the Local Health Authority's Risk Management program; enhancement of the human and professional resources of operators.

The Board of Directors has responsibilities on strategic Local Health Authority activities such as the Annual Plan of Local Health Authority Actions, the Mission Report, the definition of the criteria for verifying the results achieved with respect to clinical and organizational objectives.

The District, as a key subject of the territorial health government, manages the Regional Fund for non-self-sufficiency to finance social and health services aimed at people in conditions of non-self-sufficiency and those who take care of them, as well as managing its own budget that enables needs to be translated into services by fulfilling the production function attributed to the Health Departments. In Ausl there are departments with territorial value such as the Integrated Care Department of Mental Health and Pathological Addictions (DAISM DP), the Department of Public Health (DSP) and the Departments of Primary Care. The Departments of the Hospital are the Medical and Diagnostic Department and the Surgical Department. The path of integration between the Health Authorities has encouraged the creation of Local Health Authority inter-departments such as the Emergency-Urgency Department and the Pharmaceutical Assistance Department, in the Technical Administrative field the Human Resources Department, the Technical and Logistics Department, the Planning, Evaluation and Control Department and the ICT Interprovincial Department. There is also the complex inter-Local Health Authority structure with structural integration of Economic and Financial Services.

Inter-Local Health Authority integration, as a process incorporated, above all, by top management and the mandate objective of General Managers for the merger of companies (Council Resolution of the Emilia-Romagna Region n. 737, n. 749 25/06/2020), has facilitated the task of organizational coordination in the management of the pandemic, in particular in the processes of reorganization of services on a vertical level. As we will see in the development of research, the structures and services of the territory have not benefitted from an equivalent horizontal integration, based on coordination between similar structures or on the exchange of good practices.

5.2.1 Activities and Services

The Local Health Authority operates in a varied territory through hospital assistance and territorial assistance. Extrapolating some summary data from the Local Health Authority's 2021-2023 Performance Plan (Local Health Authority Resolution of 29/07/2021) some characteristics can be highlighted:

- The Local Health Authority of Parma is a member of the Northern Vast Area formed by seven Health Authorities (Local Health Authority of Piacenza, Local Health Authority of Parma, Hospital / University of Parma, Local Health Authority of Reggio-Emilia, Hospital of Reggio Emilia, Local Health Authority of Modena, Hospital / University of Modena whose objectives are to promote homogeneity of the care offer, sharing experiences and resources.

- Governs the healthcare offer through a structured set of public and private health facilities, with a total of 2,127 beds. The network of public hospitals manages 67.6% (1,439 pl) between the Hospital Presidium (composed of 2 hospitals: Fidenza and Borgotaro, 335 p.l., and the University Hospital of Parma (1,104 pl, 51.9% of the total). Accredited private structures provide 7 structures 636 p.l. equal to 30% of the total. The Accredited Private Hospitals of the Province of Parma have the largest share of long-term care and rehabilitation beds.

As far as Territorial Assistance is concerned, the Local Health Authority operates through 122 public structures and 173 affiliated structures (for a total of 295 structures). Primary Care, which guarantees patients screening for prevention, diagnosis and treatment and access to specialist services, is ensured by

- 284 General Practitioners (GPs);
- 60 Paediatricians;
- 146 Continuity of Care Doctors (MCA) operating in 21 Primary Care Units.

The forms with which general practitioners and pediatricians can provide services in agreement with the Local Health Authority of Parma are of three types:

- Medicine in association: it is characterized by the fact that doctors remain in their surgeries but agree on the opening of clinics to offer patients support throughout the day;
- Online medicine: it has the same organizational methods as association medicine to which is added the fact that doctors are connected to each other by computer systems that allow for the computerized management of patient medical records;
- Group medicine: the doctors who adhere to it use a single site divided into several clinics, use the computerized health records and the forms of collaboration provided for previously.

In the Primary Care Units, the Special Continuity of Care Units (USCA) have been activated since April 2020 following the Covid emergency, to support General Practitioners (GPs), Pediatricians (PLS) and Continuity of Care Doctors (MCA), who have the task of managing suspected or confirmed Covid-19 patients at home, who do not require hospitalization. Primary care is carried out mainly within the Case della Salute of which 24 (77.5%) are already active.

In addition to Primary Care, the Local Health Authority is responsible for other functions such as outpatient specialist assistance that ensures taking on patients even with complex clinical problems as day patients. The 2021 – 2023 Performance Plan pays great attention to specialist assistance as the Covid-19 emergency has had an important impact on waiting times: the document states that since March 2020, the provision of non-urgent specialist services has been suspended, which has led to the closure of booking agendas for scheduled services and the non-payment of what has already been booked. The starting up again of activities from May 2020, based on the indications provided by DGR no. 404/2020, saw the need to adopt organizational measures with a significant impact on the offer of services throughout the province (distancing measures, extended time intervals for the provision of services in order to avoid gatherings and allow adequate sanitation of the environments), with a consequent reduction in the historically guaranteed offer. The most critical issues

were observed for the services provided in urgencies, in particular eye tests, skin tests, endocrinology tests, diabetes tests, gastroenterological tests and pulmonary consults. Many critical issues were also found in the diagnostic department, both high-tech (abdomen and chest CTs and abdomen MRIs) and others (colonoscopy, gastroscopy, echocolordoppler, Holter electrocardiogram, spirometry, stress ECG).[23]

The AUSL has consolidated a network of Intermediate Care that has integrated health and social, residential and home services provided in the context of primary care, fully responding to priority needs to maximize the recovery of autonomy and to keep the patient as close as possible to home. There are 30 beds at the Casa della Salute di San Secondo (10 at the Community Hospital, 10 at the Riabilitation Week Hospital and 10 in Long-term Care); 18 Long-term care beds have been installed at the Borgotaro establishment. Intermediate care beds have also been installed in social and health facilities. As stated in the Plan, the activity carried out in 2020 was particularly affected by the effect of the pandemic: the activity involved 703 patients were discharged. In the San Secondo Parmense structure, consisting of three functional modules, 27 admissions were carried out at the Community Hospital lasting 575 days, 35 in the Extensive Rehabilitation Module and 362 in the Long-term care for 7,589 days. In the Long-term care at Borgo Val di Taro there were 126 discharges. The recently set up Community Hospitals of Collecchio (51 patients for 1,992 days), Langhirano (90 discharged for 2,214 days) and Colorno (12 for 447 days). The high number of discharged patients and actual days of hospitalization is justified by the opening of the M body of Vaio (32 Long-term care beds and 20 in the Hospice / Palliative Care) and finding 38 beds of Long-term care beds in San Secondo starting from 22/04/2020, instead of the pre-existing 10 beds.

The document of the Performance Plan also contains descriptions related to Psychiatric Care and Elderly Care with some data related to the impact of the pandemic: Psychiatric Care is guaranteed through the Integrated Mental Health and

[23] The Day Service is a care model aimed at rationalizing hospital care that improves the appropriateness in the use of the hospital, making it possible to transfer a substantial share of activities from the hospitalization regime, in particular day hospital, to an alternative outpatient care model

Pathological Addictions Care Department which includes the Disciplinary Areas of Child and Adolescent Neuropsychiatry, Pathological Addictions, Adult Psychiatry and Clinical Psychology, is present in the four districts of the USL with an NPIA Operating Unit, a CSM and a Ser.T. and several branch offices. The Area of Adult Psychiatry provides over 210,000 services per year, Neuropsychiatry has to cope with a growing demand which has gone from an average of 23-25 minors in 2015 to an average of about 60 cases in 2020; the Pathological Addiction Service has more than 2,000 patients per year.

Assistance to the elderly is provided through accredited residential facilities, intended for the reception and care of the elderly who are not self-sufficient, and semi-residential services, aimed at offering non-self-sufficient elderly opportunities for socialization, activities to reactivate residual capacities and important support to families, have recorded a significant increase and widespread distribution throughout the territory over the years. The assistance provided by protected facilities and day care centers for the elderly during 2020 was significantly affected by the pandemic situation linked to the spread of Covid-19. For these services, and in particular for protected structures, the pandemic has led to a new organization aimed at protecting its guests, with very high economic and human costs. It should be emphasized that the services on offer for the elderly has diversified over the years and has started to include, in addition to the structures authorized pursuant to DGR 564/00, such as the CRA, the Rest Homes, the Housing Communities / protected apartments, also family-type communities with low-intensity care reception functions, which welcome up to a maximum of six people in difficulty. On 31/12/20 there were 37 family homes in the province with 219 guests.

The Azienda USL also manages:

- Residential palliative care centres (Hospice) which are facilities with the aim of temporary care for terminally ill patients who cannot be assisted at home;
- Family counselling centres that deal with the protection and promotion of the sexual and reproductive health of women, couples and families.

Finally, the collection of data on patients affected by the Home Care Service is interesting, with 9,838,610 more in 2020 than in 2019. In 89.5% of cases, they are assisted patients over 64 years of age with particular concentration in the over 84 range, where the percentage is 47.2% of the total. With regard to the volume of admissions and users involved, taking into account the levels of intensity of assistance, it should be noted that the low intensity patients always represent the main proportion compared with almost all those assisted and accesses.

5.3. Action 1 - Analysis of the Documentation Produced from March 2020 to Date

This activity aims to respond to the first research request that sought to investigate the concept of governance underlying the Risk Management processes implemented at national level, regional and local levels during the second and third waves of the pandemic and in which documents preparedness is traceable.

The paragraph gives a detailed description of the results of the analysis of documents and plans produced by international, national, regional and local health authorities during the pandemic. I have chosen several criteria for analyzing documents, including chronological developments and respect for the hierarchy of sources. The analysis refers, in particular, to the first, second and third waves of the pandemic, when the production of documents, plans and procedures was richer also because of greater experience gained after the first wave when, the absence of updated plans found health systems unprepared to respond to the pandemic. The analysis of the institutional documentation relating to Risk Management procedures before and after the health emergency will allow for the collection of information at different levels of interest. During the pandemic, there was an over-production of legislation at national and regional level. All regulations have been translated into operational documents by local companies which have prepared additional independent documents in case of shortcomings.

5.3.1 The First wave

On January 22, 2020, the first Circular of the Ministry of Health informs the regions, provinces, other institutions of the territory that the Municipal Health Commission of Wuhan (China) has reported to the World Health Organization (WHO) a cluster of cases of pneumonia of unknown etiology in the city of Wuhan. The circular, given the scarcity of data available, limits itself to highlighting the caution for travel to and from China and to indicate some generic monitoring measures near national airports. The circular contains information on airborne transmission from individual to individual and a range of possibilities of health outcomes that can range from the common cold to Middle East respiratory syndrome (MERS) and (SARS). The same note states that the European Centre for Disease Prevention and Control (ECDC) considers the risk of introduction of the infection into Europe to be moderate, through imported cases. On 31 January 2020, the Council of Ministers declared a state of emergency as a result of the health risk associated with the onset of diseases deriving from transmissible viral agents which will end only at the end of March 2022 (Decree-Law of 24 March 2022 "Urgent measures to overcome measures to combat the spread of the COVID-19 epidemic, as a result of the termination of the state of emergency").

The city where I live and work, Parma, was already affected by the pandemic in January 2020: On 24/01/2020 the ausl parma newsletter highlights an alleged case of new coronavirus affecting an Italian woman and resident in the province returning from Wuhan and who will then be affected by influenza. On 31/01 the Spallanzani Institute confirms, instead, that the first two cases in Italy stayed briefly in Parma before falling ill and then being hospitalized in Rome. The chronicles of the city newspapers reassure the population with respect to the harmlessness of the stay in the hotel of the two and the implementation of all the measures to sanitize the environments.

On 21 February 2020, following the hospitalization of 1 positive patient in Codogno (LO), the order of the Ministry of Health "Further prophylactic measures

against the spread of the infectious disease COVID-19 (OJ General Series n.44 of 22-02-2020) is published, in which the first useful measures are identified to delimit the contagion from a virus of which little is known.

On February 23, the journalistic chronicle of Parma writes about the entry into intensive care at the Maggiore Hospital of a covid patient from Piacenza and two patients from the province of Parma. In this last case, the infection involved, in addition to hospitalized patients, another 60 citizens who had gone to a night club by bus, all later traced and placed in isolation. On the same day, the Emilia Romagna Region, as a result of the presence on the territory of another 9 infections, issued ordinance n.1 "Urgent measures regarding the containment and management of the epidemiological emergency from covid-2019" with which schools of all levels were closed as a precautionary measure for a week, public events were prohibited, museums and places of culture were closed and finally health and social care facilities were forced to limit access to visitors. Given the still uncertain nature of the epidemiological chain and the rapid spread of infections, in Lombardy and Veneto the first red zones are established in Codogno and Vo Euganeo in which entry or exit and any form of gathering is prohibited (Ministry of Health Order of 21/03/20 "Urgent measures regarding the containment and management of the epidemiological emergency from COVID-19"). The disorientation for the growing data of infections and the concern for the repercussions on ordinary life due to the closures in Lombardy and Veneto, can be summarized in two news bulletins that appeared on the same day on the website of the municipal administration and the Local Health Authority of Parma: on March 3rd the council and the city council of Parma promote a video with the slogan "Parmanonsiferma" with which it intends to convey a reassuring image especially for economic operators involved in the promotion of Parma as Capital of Culture 2020 (https://www.parmadaily.it/parmanonsiferma-una-foto-per-raccontare-parma/).

"It's time to unite and shake ourselves up. From abroad they see Italy and our cities as places to escape. Places without a soul. But this is not the case. Parma is not an

agglomeration of streets, palaces, squares, houses and gardens. Each of us interprets and lives his own story: who raises the shutter in the morning, who runs from one side of the city to the other, who studies and who teaches, who produces, who invents and who creates. The sum of these stories is the soul of Parma. We are Parma. We must team up like we've never done, help each other like we've never done, unite like we've never done before. Sometimes we will be seized by fear, but in the end, we will overcome fear. If the world sees us soulless, let's show the world that Italy and Parma, Italian Capital of Culture 2020, are strong, alive and ready for the challenge. What? With a simple photo. Each of you take a picture telling your daily life, work, efforts, satisfactions, the beauty of Parma and its villages, life that does not stop. Let's tell Parma in one shot. You choose which one. We only make you one request. Always use these hashtags: #parma2020 #parmacomesempre #parmanonsiferma #lifeinitalynow We contag, in this case in positive terms, the social world with thousands or maybe millions of extraordinary shots of life from Parma and Italy" (Municipality of Parma, 03 March 2020).

The local health authority begins, however, to remodulate the presence of citizens in the waiting rooms and organize the relocation of some specialist appointments:

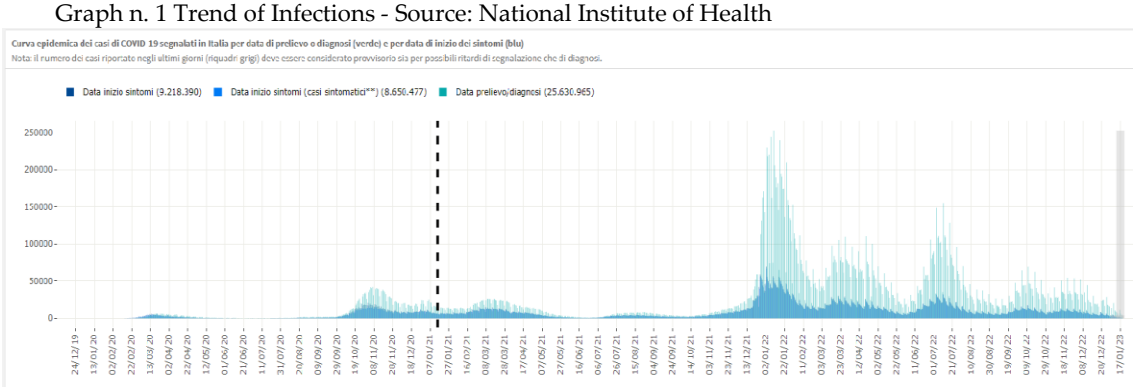
"New organizational measures have been decided by the Management of the USL Local Health Authority to help contain the spread of the coronavirus, and to optimize the use of health personnel in relation to this priority of the moment. The first attention concerns access to health facilities: the presence of clinics in the waiting rooms will be regulated in order to reduce crowding. Another measure concerns all bookings, even in private practice, of visits and examinations in the specialties of ophthalmology, otolaryngology and dentistry ... Another measure concerns the White Point in Parma: activities are suspended from tomorrow (3 March) and until 12 April, and medical personnel can be used in activities related to the containment of the coronavirus ... Finally, it is recalled that, as required by the latest national and regional provisions to protect hospitalized people, measures have been introduced that limit the access of visitors to the hospital areas of Vaio and Borgotaro, as well as in nursing homes for non-self-sufficient: in all these places it is possible to admit one person per patient per day. Outside each hospital in Parma and its province (Maggiore Hospital, Vaio Hospital and Santa Maria in Borgotaro) an advanced pre-triage medical post has been set up where

people with symptoms (fever, cold, cough) are triaged and then, if necessary, safely assigned to hospital wards.

On 11 March 2020, the WHO declares the spread of the coronavirus a global phenomenon that assumes a pandemic character due to its spread. The following graph shows the waves of the pandemic that took place, the first in spring 2020, the second in autumn 2020, the third in winter 2020/2021, the fourth in autumn 2021-winter 2022 and the fifth in summer 2022.

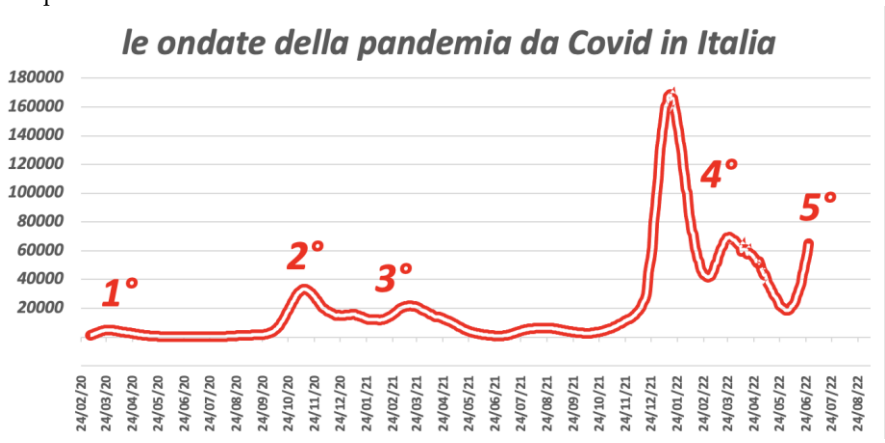
Graph n. 1 shows the trend of cases in Italy (last survey Istituto Superiore di Sanità of 20/01/23): since the beginning of the pandemic there have been 25,630,967 cases in total, 471,236 cases among health workers, 177,421 deceased and 23,970,313 recovered.

Graph n. 1 Trend of Infections - Source: National Institute of Health



The following graph shows the waves that have occurred since the beginning of the pandemic

Graph 2: Waves of the Pandemic



Data Source Provider: Epidemiology & Prevention

This brief chronicle of the very first days of the pandemic allows me to introduce the importance of documentation in the research especially for the reconstruction of the first wave, when the speed and magnitude of the events did not allow, due to the access constraints imposed by the lockdown, direct observation in health facilities. The documentation produced in that first period allows us to reconstruct what happened thanks to the possibility of consulting documents from the Government, the Civil Protection and the Ministry of Health, the Emilia-Romagna Region and the local health authorities which, in addition to specific deliberative acts, noted the events in the news section of the newsletter. While the official documents contain the regulatory point of view, the guidelines, the procedures addressed to health professionals, the newsletters acquire a non-secondary importance since they highlight a strategic narrative of what was necessary to communicate externally to inform citizens and stakeholders about the behaviors to be observed. Observing the latter, together with the national, regional and local databases, we can see the effort to put the events in succession from a hierarchical and chronological point of view with respect to the sources, as if to put order not only for bureaucratic and formal reasons but to make the event easily intelligible and reconstructable even by those who in the future will be able to study such an extraordinary event.

Tab. 10: National, Regional and Local Legislation

National legislation	Government	Over n. 131 acts including Decrees of the Prime Minister, Laws, Decrees-Law
	Ministry of Health	Over n. 245 acts including Decrees, Ordinances, Communications
	Civil Protection Department	Over 108 acts in particular Ordinances
	Extraordinary Commissioner for the implementation and coordination of measures to contain and combat the epidemiological emergency COVID-19	Over 33 acts in particular Ordinances
Emilia-Romagna Region Regulations	Region President	Over 170 acts between Decrees and Ordinances

Source: Author's elaboration data Official Journal and Emilia-Romagna Region website

At a local level, the acts concern a considerable number of areas and disciplines and themes such as, to give some examples, those relating to the internal organization and integration processes between the Hospitals of Parma, Vaio and Borgotaro and between Hospitals and the Territory, regulations for health

professionals and teams (from dressing procedures to the management of covid and non-covid patients in hospital and at home), the management of access to health services, the management of paths alongside patients from SSN and private services. The type of documents present in the local databases include resolutions, determinations, guidelines and standardization documents, the result of a national production enriching itself from time to time with additional elements. For example, we find different versions of the same document on operator safety and the management of personal protective equipment (PPE) that expands and specifies with the passage of time. The common thread between all these elements can be summarized in the growing awareness that the legislation, the guidelines, the internal organization document, in emergency situations, cannot be reduced to being a reporting tool but constitute a map, a reference point that guide the actions of the system and individuals in moments when it is not clear or certain what needs to be done. In these moments, indeed, the risk is to remain in a tragic vacuum of information, in a latency space that must be filled:

"Indications came from the ministry that were then transformed... Before arriving at the territory an indication of the ministry, passed in the region that passed to the health direction and then passed to the district direction. We had latencies even of the 10-day week, sometimes between a national directive and what was lowered at the territorial level ... (Coordinator CdS).

Two critical issues emerge from this reflection: one relating to the structuring of a short chain of governance that allows information and provisions to be conveyed quickly; a second is related to the need to prepare tools and information flows acquired in circular mode (top down and bottom up) in order to guide decisions and therefore the operation of individual structures.

Coping with the emergency is, instead, an issue that each service faces by drawing on its own skills and finding inspiration through all channels, whether formal and informal, that can offer a contribution:

We invented ourselves on the spot, we did not have a maxi-emergency plan as there is for example in the hospital ... (ADI Nurse).

The theme of preparedness and that of the absence of an organizational plan for emergencies, will return in almost all interviews. Most respondents in non-senior management positions said they were not aware of a national, regional or local pandemic plan.

We have produced a sort of internal regulation for nurses, a sort of internal regulation for specialists ... We wrote, we regulated before the indications arrived what had to be done for access. But since, I repeat, they were all things that we finally wrote, we felt the need to write. To try to give order to the chaos we had in here (Medco CdS Coordinator).

On a general level, it highlighted the fragmentary nature of things... Because of the fragmentary nature, everyone has followed their own modalities. In the very first moments, for example, we followed the guidelines given to citizens through internet channels, television. We were lost... and everything was built in itinere (Nursing Coordinator CdS).

Bottom-up production, particularly in the territory, generated in a punctual way, only later managed to formalize itself into standardized products but failed to structure itself in a catalogue of good practices with a view to benchmarking in relation, in particular, to the collection of risk mapping and response strategies.

5.3.2 The Second and Third Waves

A first attempt to report on the documentation produced at local level materialized during the second pandemic wave when the Emilia-Romagna Region, in June 2020, required Local Health Authority risk managers to draw up the Plan-Program for the Safety of Care and Risk Management in relation to the Covid-19 Epidemic, a tool, as stated in the "Guidelines for updating the Plan-Program for the safety of care and Risk Management in relation to the Covid 19 epidemic", aimed at systematizing and "evaluating the actions carried out and to set up an adequate programming and planning of activities taking into account the evolution scenarios of the pandemic". The guidelines are an interesting document as the internal one captures the attempt to give full viability to Risk Management as a method of governance of the pandemic and therefore to affirm the development of a role called

to deal with maxi-emergencies. The document captures the need to develop a prospective rather than reactive vision to respond to events of a different nature and for this reason it recalls the need to place health systems among the highly reliable organizations with those salient elements presented in the second chapter. It reads:

> The Coronavirus emergency has made clear the need for an effective paradigm shift in the approach to Risk Management in healthcare companies, moving from a predominantly reactive approach (re-action after events) of "low reliability" organizations to a systematically proactive approach of "high reliability" sociotechnical organizations, with a culture sensitive to safety and resilience, able to anticipate events. Especially in this historical phase, it is therefore necessary to build and oversee paths, each organization according to its own critical areas, which must therefore be known, analyzed and addressed; in light of the needs posed by the SARS-CoV2 epidemic but also looking beyond and broadening the gaze to other possible maxi-health emergencies (Guidelines for the updating of the Plan-Program for the safety of care and Risk Management in relation to the COVID19 epidemic).

the Local Health Authority Crisis Unit, already in place for very serious adverse events, becomes an updated multidisciplinary and multi-professional model in response to critical events with the coordination of the general manager and made up of top management figures. The Provincial Pandemic Plan is identified as a tool to keep together macro-organizational issues such as the reorganization of activities and paths, staff training, internal and external communication, with issues related to clinical Risk Management, such as the assessment of infectious risk / Infection, Prevention and Control (with reference to all activities that can promote integration and synergy between clinical risk and infectious risk, monitoring of operator safety, mapping of risks in the operational environment). The Plan-Program for the Safety of Care and Risk Management in relation to the Covid-19 Epidemic of the Local Health Authority that arose from it, contains the memory of the first months of the pandemic thanks to the collection, by the Local Health Authority Risk Manager, of all the documentation of what was produced by the Local Health Authority to face the events. In the report we read, for example, that the first documents drawn up immediately after the declaration of the state of national emergency (31/01/2020) were for internal use with the task of promoting contagion containment measures to

make up for the scarce news in circulation. The first document "Pneumonia from the new coronavirus (2019-nCoV): First Indications" still bears, for example, a provisional name for the virus and that will only assume a definitive character in Sars-Cov-2 and Covid-19 (disease) in February 2020). In "Biological Risk Assessment from Covid-19 (pursuant to art. 28 of Legislative Decree no. 81/2008)" by the Local Health Authority Prevention and Protection Service (03/03/20) the Local Health Authority structures the information for operators in the field: in addition to the organization chart of Local Health Authority safety it contains the first notions relating to the identification and typing of individuals exposed to risk, the types of cases, the definition of close contact, therapeutic and diagnostic procedures, the methods of sanctification, in addition to the procedures of dressing and undressing, the inventory of the material and the estimated need for PPE. I am dwelling on this document as it summarizes another area of Risk Management, relating to the internal safety of workers and health workers that is supervised by a different service from Local Health Authority Risk Management with which it shares methodologies and tools and that, for this reason, the literature refers, in any case, to more extensive ways in which Risk Management itself is articulated. The Plan-Program for the Safety of Care and Risk Management in relation to the Covid-19 Epidemic proposes a chronology of events divided into macro-areas. With regard to the Hospital Area: it should be noted that since the beginning of the pandemic we have acted in synergy between the provincial health authorities according to a hub & spoke model that will be the leitmotif of the following two years, with the function of hub exercised by the Maggiore hospital and the spoke function carried out by the territorial hospitals of Fidenza and Borgotaro. The "Protocol of territorial management of covid-19 patients (integration hospital territory)" of April 2020 summarizes the complex mechanism of reorganization of provincial hospitals in relation to the increase in covid cases in which an intensive care organization prevails where patients are grouped according to clinical care needs.[24]

[24] The model of intensive care hospital is a hospital no longer structured in Departments or Operating Units based on the

Tab. 11: Hospital Reorganization According to Risk Levels

	HUB	Spoke
Level 1 From February to March 1st	Maggiore Hospital (AOU) reserved for Covid cases	Hospital of Fidenza and Borgotaro Reserved for general health activities
Level 2 From 1 March to 19 March	Maggiore Hospital reserved for Covid cases	Fidenza Hospital first spoke Covid Borgotaro Hospital other health activities
Level 3 from 20 March	Maggiore Hospital reserved for Covid cases and other urgent conditions	Hospitals of Fidenza and Borgo Val di Taro reserved for Covid cases

Source: Author's elaboration

As highlighted in the Plan, the remodeling of hospitals has required great flexibility, especially on the part of health professionals who have demonstrated the ability to adapt to emerging needs, even renouncing their specific skills and specialist sectors. In the stories collected during the interviews with the operators, their endured struggles emerged, but also the richness due to the possibility of working in teams composed of operators from different operating units in a profitable and rich exchange of knowledge and practices, especially for the return to the ordinary.

In terms of the integration of Hospital – Territory interventions, the Emilia Romagna Region with the document "Guidelines for the establishment of Special Continuity of Care Units" mandates local companies to establish the Special Continuity of Care Units (USCA) In compliance with Article 8 of Decree-Law no. 14 of 9 March 2020 (OJ no. 62 of 09/03/2020) and the document for the homogeneous application of the Commission's Decree of 9 March 2020 Health, with the aim of taking care of patients with symptoms or suspected Covid at home, not in need of hospitalization, in order to allow the general practitioner or pediatrician or the out of hours doctor to guarantee ordinary care activity. In April 2020, the University Hospital established the Multidisciplinary Mobile Units (UMM) composed of specialists from both health companies (internists, geriatricians, pulmonologists, infectious disease specialists and radiologists) equipped with portable diagnostic tools such as blood gas analyzer and multifunction ultrasound, which are useful for performing multidisciplinary

pathology but is organized in areas that aggregate patients according to the severity of the case and therefore to the level of care complexity. The model is developed in three levels: high intensity that includes intensive and sub-intensive hospitalizations (resuscitation, cardiac intensive care unit (ICU), stroke unit for stroke ...); medium intensity including *ordinary hospitalization and short-cycle hospitalization (week surgery, one day surgery)* divided by functional areas (medical, surgical, maternal-child area); low intensity dedicated to post-acute patients

evaluation on all home patients and residents in Residential Elderly Centers (CRA), proposed by the structure doctor or by the Nursing Coordinator. (Meschi, 2021). These interventions have made it possible to support the Public Health Service in the preparation of swabs and to proceed with hospitalization without going through the Emergency Room (PS), relieving hospitals from unnecessary access. This experience of connection between hospital and territory is coordinated by the Institution of the COVID - 19 Emergency Coordination Centre (CCEC) which proved decisive in integrating the network of hospital and territorial professionals and in defining the most appropriate paths for covid patients. The operational Centre has provided for the centralization of all calls for COVID medical-hospital advice thanks to the establishment of a single telephone number dedicated to general practitioners, continuity of care doctors, doctors of the territorial USCA, diagnosis and treatment doctors of the CRA.

5.3.3 The Local Management in the Institutional Acts.

The management of the pandemic on the territory has involved a considerable effort to contain infections, especially in facilities for the elderly and for the disabled who have been hard hit due to the fragility of the patients and by the variety of the type of structures (private social, private accredited, private-private) that were not all prepared in terms of material and professional resources to face a health emergency of such magnitude. If at national level the Prime Ministerial Decree of 4 March 2020 closed access to facilities with the limitation of access for relatives and visitors to hospitality and long-term care facilities, assisted health residences (RSA), hospices, rehabilitation facilities and residential facilities for the elderly, self-sufficient and not, as well as to Penitentiary Institutes and Penitentiary Institutes for minors ", the regional level prepared indications to support the structures and gave a mandate to the directions of social assistance activities to coordinate the monitoring of the pandemic at a territorial level through the resolutions "*Coronavirus COVID-19 emergency: indications for territorial social and health services and residential facilities for*

the elderly and people with disabilities" – note prot. n. 19383 of 23/03/2020"; "*COVID-19 emergency: Document of clarifications and operational indications for residential facilities for the elderly and people with disabilities*" – note prot. n. 19692 of 24/03/2020).

The interview carried out with the Director General of AOU and Extraordinary Commissioner of Ausl Parma was an opportunity to examine the activities carried out at provincial level through a synergistic mode between different actors such as the Mobile Units that were sent to the elderly on the recommendation of general practitioners or structure doctors.

> *"We entered the homes for the elderly in the province. Within 15 days, 80 were visited, where the mobile units first of all did a chest scan. All guests were stratified according to care needs. The public health section assessed the distancing measures adopted within the structures and the expert side of work organization verified the prevention and protection measures of the operators present inside the protected houses. Everything then translated into prescriptive suggestions that were sent to the managing body of the structure and for information also to the mayors of the territories concerned. This was another aspect of great innovation that we brought during the first pandemic wave. Then I will leave out the second, third and fourth, because this is the common thread, now that we have come out of it, but surely we have learned to live together. This organizational model that we have has, let's say what we had thought before Covid that received a strong assessment during Covid is the common thread of the reorganization of the entire care system of the next twenty years. Because first we have to be ready for another wave or other similar things" (Interview with dr. Massimo Fabi).*

The attention towards the social and health structures, social assistance, educational communities, public and private religious communities present in the province was a priority by the Directorate of social welfare activities which organized, for the entire duration of the pandemic, monitoring actions of the guests, regarding positivity, deaths, carrying out coordination and connection functions between the district services for the elderly (SAA), the territorial services of the child protection area, and the Public Hygiene Service.

The following table summarizes the main critical issues detected after the first wave of the pandemic by the Covid Care Safety Program Plan and the document promoted by the 'Companies for the Person' of the Emilia – Romagna Region, which are the main managing bodies of services for the elderly, released in June 2020. The comparison between the issues analyzed by the two institutions highlights above all a double reading of what happened: on the part of the Personal Services Companies,

the health sector is required to have a more solid function of support to social assistance structures in terms of monitoring and response to infections (more timely) and support for training aimed at operators to increase their awareness of health risks.

Tab. 12: Critical Issues Highlighted by the Documents of AUSL and Regional ASP

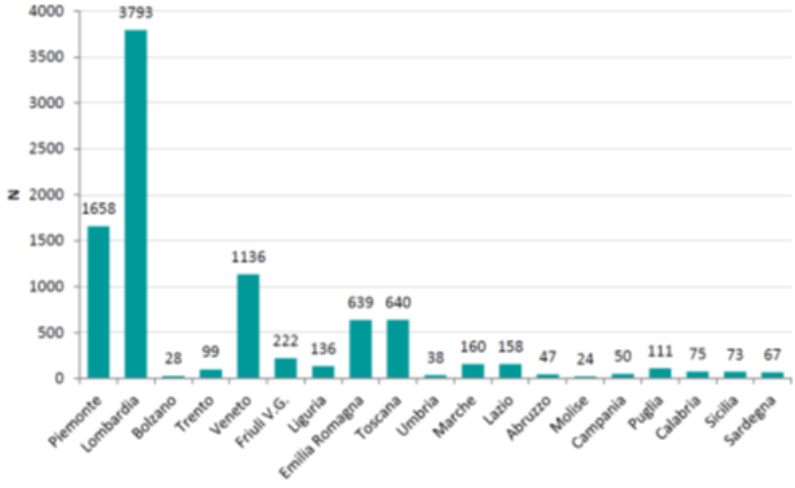
Covid Care Safety Program Plan Ausl Parma	Companies Personal Services Emilia-Romagna Region "Reaction to the crisis, criticality, effects and new needs related to the Covid-19 emergency" (June 2020)
Organisational measures: - identification of "COVID-19 health referents" for a correct coordination of any activity related to the containment of infections; - guarantee of effective information flows and close and constant relations with the reference bodies and structures (Department of Prevention, Districts and Health Companies), - safeguarding communications with operators, residents and family members; - strengthening of standard precautions; **Rigorous verification of access, reorganization of environments and activities** - strict regulation of access to the structure, with selected entry restrictions (up to prohibition) in phases of health emergency; - provision of isolation areas; - management of suspected cases (isolation pending swab results); - management of confirmed cases; - precautionary interruption of group activities; - suspension of sharing common areas; **Material procurement** - sufficient supply of PPE, hydroalcoholic solution, hygiene products and disinfectants, with related training on their correct use; - equipped with infrared thermometers **Precautionary measures** - limiting residents' opportunities for contact with suspected/probable/confirmed cases of COVID-19; - correct adoption of standard precautions and isolation procedures; - standard precautions for care to all residents (hand and respiratory hygiene); - prudential actions for the prevention of contact-borne diseases and droplets during the care of suspected or probable/confirmed cases of COVID-19; - awareness and training of residents and visitors, preparedness of reminders and "signage" for the promotion of correct behaviors useful to reduce the transmission of the virus; - empowerment of operators for symptomatology self-control; - fever measurement at the beginning of the shift for	- Lack of adaptation of the mode of entry into CRA of the elderly through only a preventive telephone triage or interview with family members; - Lack of clear and unambiguous guidelines from health authorities; - Late decision on the closure of Day Care Centers (regional order of 08/03/2020); - Late decision on the prohibition, and not only the limitation, of family members' access (regional ordinance of 08/03/2020); - Lack of clarity on the use by health and social workers of surgical masks; - Lack of collaboration of the Doctor of continuity of care activated during the night in facilities without nursing care H24; - Difficulties in communication with the 118 operators who intervened in the structure especially at the beginning of the emergency; - Need for training of SDGs and nurses with respect to the emergency, and more generally inadequate professional preparedness of the SDGs for a health emergency situation such as the one experienced; - Inadequacy of the level of awareness of the risk of contagion for oneself and for others by many operators; - Fragility, also psychological, of many SDGs / Nurses: many diseases have been recorded with causes of absence not related to Covid; - Need for better coordination with the AUSL with respect to communications on the timing of guest swabs and related results; - Delay of the AUSL, in some territories, in the start of checks by swab or serological test to the staff of the structures, the only subjects who from March accessed from the outside in the structures forbidden to relatives; - Need for better coordination between AUSL and competent doctor on communications and timing swabs and serological outcomes on employees; - Difficulty in respecting the times between the two serological tests carried out to CRA operators (first control in April, second control in June) or even lack of serological kits to carry out both the first and second screening of operators as per AUSL

health workers; - screening procedures for health professionals; - monitoring of the implementation of the measures adopted - timely reporting, by the structure, of any suspected COVID-19 case, for subsequent rapid checks by the doctors of the UMM and the SISP teams.	protocols; - Need for control and monitoring by a person in charge of the dressing / undressing sequences and / or the Red Zone / White Zone passages by the SDGs and Nurses.

Source: Author's elaboration

As we will see later, the attention to facilities for the elderly has mandatorily accompanied the phases of the management of the pandemic in the monitoring activities of cases by Public Health and later in the mass vaccination phase that had already affected the structures in January 2021, given the high number of deaths confirmed by the report of the Istituto Superiore di Sanità " National survey on Covid-19 contagion in residential and social health facilities Update 05 May" which monitored 3417 facilities throughout the national territory. The graph shows the total number of deaths recorded by the survey from 1 February to the date of completion of the questionnaire (26 March-5 May).

Graph. 3: Total Number of Deaths - Data Source Provider: ISS



The review of the documentation of the Local Health Authorities and the news reported by the newsletters help to reconstruct the facts even if here it is particularly difficult to report all the events that were noted in narrative mode every day of the pandemic, or through documents to be used in health and social facilities and by citizens. The "communication" services have been fundamental to guide the influx of citizens in the places where positivity is tracked by the Public Health and the Territorial Nursing Service. The whole phase of tracing of infections (contact tracing)

required a capillary organization that "was done day by day" as reported by the Director of Public Health in an interview, for example by equipping itself with a self-produced information system for data collection, tightening collaborations with external laboratories and organizing the reporting system.

The second wave of the pandemic in autumn 2020, after the summer period that saw the grip of infections loosen and allowed a gradual reopening of health services and facilities, found health systems and territorial services to be more equipped to support the most fragile patients. This is the case of the Casa della Salute San Secondo, in October 2020, becoming reference structures for intermediate care for covid patients, who need more rehabilitation time for previous pathologies. They are elderly with cardiological, respiratory or neurological diseases who need more assistance both in the acute phase and in remission of the disease. As the Nursing Coordinator explains in an interview in the Informasalute review of the Emilia-Romagna Region in April 2021,

"The structure welcomed post-covid patients from April 2020 until October 2020 when the need emerged to relieve the covid department of the Maggiore Hospital of those patients who were clinically stable and could continue the rehabilitation process until discharge "... They are fragile patients but who were previously autonomous and that the disease has debilitated. (https://www.youtube.com/watch?v=Rlje4zx2_1U Informasalute Speciale April 2021 - Covid patients at the Casa della Salute di San Secondo).

The facility from October 2020 to April 2021 hosted 200 positive covid patients.

5.3.4 Pandemic Plans

The Italian Society of Epidemiology has defined the Pandemic Plans as "a sort of orchestral score in which, in the event of a pandemic or similar emergencies, everyone manages to read their own role, in a synergistic and targeted action with the aim of reducing and interrupting the transmission of infections, treating the sick, avoiding deaths, and above all maintaining the continuity of life in the society in which we live. These are enormous objectives to be achieved and certainly the response cannot be improvised in the moment of emergency but must be based on a

well-established daily life and a forecast of what actions to take at the appropriate time and how". (Scienzainrete, 15/01/2021). In this definition, in which we can identify elements that we will find in the narration of ethnographies in the field, the story of a tool that is evolving over time as a result of lived experiences is summarized: pandemic plans that contain rules and regulations for the standardization of common actions and the prefiguration of scenarios to hypothesize pandemic mitigation measures. Plans, as Lanzara recalls, "are resources for action, maps and schemes to which actors refer to build coherence, order and meaning within a system of practical activities" (Lanzara, 1993 p.82). The plan becomes the instrument through which individuals and organizations make circumstances intelligible and redirect actions that, being always situated, require coherence (Lanzara, 1993 p.82). The pandemic plan highlights precisely this potential in grasping the action and attempts of organizations and individuals to translate uncertainty into future scenarios, bearing in mind that events of this magnitude allow us, as highlighted by Lanzara (1993), to study organizational and behavioral responses when the pressure of events is high but also in quiet situations. In this context, errors or accidents, which constitute the subject of Risk Management analysis, can also be read as important vehicles of learning and "generativity" because, by producing interruptions to the daily flow of activities, they allow for the exploration of the social, cognitive and emotional rupture that is produced (March, Sproull, Tamuz, 1991) and promote actions aimed at overcoming obstacles. Organizations, especially healthcare organizations, rely on what Dovigo (2007, p. XX) defines as "transformative knowledge" or the collective learning mechanism that transforms knowledge rapidly and disseminates it so that practices are changed. The contemporary pandemic plans originate from the evolution of the "Influenza pandemic plan"[25], revised in 2005, following the spread of the H1N1 influenza epidemic present mainly in Asia. Following the Covid 19 pandemic, WHO

[25] Influenza pandemic plan. The role of WHO and guidelines for national and regional planning", World Health Organization 1999

has updated its planning documents to support states that have been asked to update their Pandemic Plans. [26]

Tab. 13: Pandemic Plans WHO

2019/2020	2021	2022
2019 Novel Coronavirus (2019-nCoV): Strategic preparedness and response plan - February 2020 Covid-19 Strategy Update - April 2020	COVID-19 Strategic Response and Preparedness Plan (SPRP) February 2021	Strategic preparedness, readiness and response plan to end the global COVID-19 emergency in 2022 March 2022

Source: Author's elaboration

The WHO Plans are interesting because they capture the evolution of the event from an organizational and technical point of view: in the first in 2020 the focus is on the issues of containment of the epidemic and tracking management, international coordination, risk communication and managing the infodemic, the centrality of laboratory and diagnostics to improve surveillance, community engagement and accelerating priority research and innovation. In the second, after a year of experience and the ongoing vaccination campaign, the pillars (from 8 to 10) are expanded, on which the previous one was also based and which will then be implemented by the national plans and which show with completeness the challenges to be faced during the pandemic:

Tab. 14: WHO Program Pillars

Pillar 1: Coordination, planning,financing, and monitoring
Pillar 2: Risk communication,community engagement (RCCE)and infodemic management
Pillar 3: Surveillance, epidemiologicalinvestigation, contact tracing, and adjustmentof public health and social measures
Pillar 4: Points of entry, international traveland transport, and mass gatherings
Pillar 5: Laboratories and diagnostics
Pillar 6: Infection prevention and control,and protection of the health workforce
Pillar 7: Case management, clinicaloperations, and therapeutics
Pillar 8: Operational support and logistics,and supply chains
Pillar 9: Maintaining essential healthservices and systems
Pillar 10: Vaccination

Source: WHO

[26] "WHO global influenza preparedness plan.The role of WHO and recommendations for national measures before and during pandemics" World Health Organization 2005

The 2022 Plan, on the other hand, moves towards the conclusion of the acute phase of the pandemic by amplifying concepts such as *preparedness* and resilience and also opening up to the analysis of issues related to equity and inequalities in the supply of resources by population groups and countries with fewer opportunities. It insists on the theme of research and innovation, cooperation and coordination between countries and concludes:

> "While the global health community reflects of the lessons learned from COVID-19, a boldness is needed to look towards the future. Preparedness for future pandemics starts now, and in fact has already begun. Without swift and coordinated action to strengthen the global architecture for pandemic preparedness and response, backed by the necessary financing, the costs of the next pandemic are likely to exceed those of COVID-19" (2021, p.22).

In Italy, three Pandemic Plans have been drawn up. The "Italian Plan 9 Multiphase Emergency for an Influenza Pandemic (PNEP)" (March 2002) already prefigures objectives to contain and minimize the impact of a possible pandemic and incorporates the division into 5 phases proposed by WHO in 1999:

Tab. 15: Phase Envisaged in the 2002 Plan

Phase 0 Interpandemic period
Phase 1 Appearance of an influenza virus (new virus) outside Italy (Pandemic alert);
Phase 2 Influenza outbreaks caused by the new virus outside Italy
Phase 3 New influenza virus isolated in Italy: imminent pandemic
Phase 4 Pandemic influenza in Italy; Phase 5 End of the pandemic

Source: Author's elaboration

The "National Plan for the Perparedness and Response to an Influenza Pandemic" of 2006 (Agreement, sanctioned on 9 February 2006 at the State-Regions Conference, between the Government, Regions and Autonomous Provinces of Trento and Bolzano – rep. n. 2479 – concerning the "National Plan for the Preparedness and Response to an Influenza Pandemic"), replaces the previous one and represents the reference on the territories as it contains the "Guidelines for the drafting of Pandemic Plans Regional".

The inspiring principle is "the assumption that global emergencies require coordinated and global responses, where the moment of planning must be shared by

decision-makers and the moment of action must be known before the event occurs, so that everyone is able to play their role and responsibilities".

The document defines the pandemic as a national security problem and to address it, it is necessary to structure a shared coordination between state and regions together with other international realities under the guidance of the World Health Organization. Preparedness is a national and local objective and is structured following the four phases defined by WHO for each of which there are objectives, actions, actors to be involved.

Tab. 16: Phases Plan 2006

NEW PHASES	OVERARCHING PUBLIC HEALTH GOALS
Interpandemic period	
Phase 1. No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk[a] of human infection or disease is considered to be low.	Strengthen influenza pandemic preparedness at the global, regional, national and subnational levels.
Phase 2. No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk[a] of human disease.	Minimize the risk of transmission to humans; detect and report such transmission rapidly if it occurs.
Pandemic alert period	
Phase 3. Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.[b]	Ensure rapid characterization of the new virus subtype and early detection, notification and response to additional cases.
Phase 4. Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.[b]	Contain the new virus within limited foci or delay spread to gain time to implement preparedness measures, including vaccine development.
Phase 5. Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).	Maximize efforts to contain or delay spread, to possibly avert a pandemic, and to gain time to implement pandemic response measures.
Pandemic period	
Phase 6. Pandemic: increased and sustained transmission in general population.[b]	Minimize the impact of the pandemic.

[a] The distinction between ***phase 1*** and ***phase 2*** is based on the risk of human infection or disease resulting from circulating strains in animals. The distinction is based on various factors and their relative importance according to current scientific knowledge. Factors may include pathogenicity in animals and humans, occurrence in domesticated animals and livestock or only in wildlife, whether the virus is enzootic or epizootic, geographically localized or widespread, and/or other scientific parameters.

[b] The distinction between ***phase 3***, ***phase 4*** and ***phase 5*** is based on an assessment of the risk of a pandemic. Various factors and their relative importance according to current scientific knowledge may be considered. Factors may include rate of transmission, geographical location and spread, severity of illness, presence of genes from human strains (if derived from an animal strain), and/or other scientific parameters.

Source: WHO

The operation of the plan, we read on page 13, will have to be evaluated through national and regional exercises with the involvement of health institutions and those that may play a role in the possible pandemic crisis. The resolution of the Emilia – Romagna Region no. 975/2007 ratifies national provisions and approves the Regional Plan for Preparedness and Response to an Influenza Pandemic to be translated by the Health Authorities into local plans. Among the regional indications, some key actions are identified.

Tab. 17: Key Actions to Achieve the Objectives of the Plan

1. Improving epidemiological and virological surveillance
2. Implementing infection prevention and control measures (public health measures, prophylaxis with antivirals, vaccination)
3. Ensuring case processing and assistance
4. Developing contingency plans to maintain health and other essential services
5. Developing a Training Plan
6. Preparing appropriate communication strategies
7. Monitoring the implementation of the planned actions by risk phase, the existing resources for the response, the additional resources needed, the effectiveness of the interventions undertaken; Monitoring must take place continuously and transversally, integrating and analyzing data from the various information systems.

Source: Author's elaboration

The National Strategic-Operational Plan for Influenza Pandemic Preparedness and Response (PanFlu, 2021-2023) (Agreement No. 11/CSR of 25 January 2021, published in Official Gazette 23 of 29.01.2021 S.0n7) is the first post-pandemic plan in which the considerations of other preparatory documents have converged:

1. National health plan in response to a possible Covid-19 pandemic emergency of the CTS;
2. Elements of Preparedness and Response to Covid-19 in the autumn-winter season - issued with Ministry Circular 27007 of 11.08.2020;
3. Prevention and response to Covid-19: evolution of the strategy and planning in the transition phase for the autumn-winter period - issued with Ministry Circular 32732 of 12.10.2020.

This plan that combines the recommendations of WHO and, as reported in the introduction, is prepared on the basis of other fundamental programming plans such as the National Prevention Plan (PRP) and the national vaccination prevention plan, combines knowledge and experiences regarding preparedness and readiness addressed to influenza viruses and those, such as Sars Cov 2, which are non-influenza respiratory viruses. The plan is developed in general objectives: protection of the health of the population, operators and personnel involved in the emergency, reduction of the impact on health and social services and essential services, preserving the functioning of society and economic activities; among the specific objectives are the planning of activities in the event of a pandemic, definition of governance at national and regional level, definition of governance at local level and development of training cycles monitoring and continuous updating.

The Plans are implemented at regional level and translated at provincial level.

The Ausl and AOUcompanies have produced two documents from December 2020 to date:

- Contributions to the implementation of the Provincial Pandemic Plan in relation to the Covid-19 pandemic;
- Strategic Operational Plan in Response to an Influenza Pandemic (Panflu 2021 – 2023) in implementation of the Plan.

The first document is the result of a collective work undertaken in the midst of the second pandemic wave and therefore the result of an effort also to reflect on what happened. The objective of the project is underlined in the introduction and is to analyze the "experiential treasure" directly experienced by companies, in all its professional conjugations, in the emergency phases of the pandemic (phase 1 and 2); this need has been accepted in the drafting, by both companies, of the updated document of the "Plan-Program for the Safety of Care and Risk Management in relation to the Covid-19 epidemic", in which not only "what happened" was reported but attention was also paid to "what worked and what did not", with a future vision on the possible actions to be implemented in the case of new phases of the management of the pandemic event and which constitute the prelude to the drafting of the Provincial Pandemic Plan "(p.4). The document incorporates some ministerial indications contained in "Elements of Preparedness and Response to Covid-19 in the Autumn-Winter Season" (Ministry of Health, 11 August 2020) in which explicit reference is made to the theme of preparedness and to any crisis scenarios that will then be the reference of the management of the pandemic by the government in the following months. The document seeks to systematize what happened through an examination of the health, social health, psychiatric and specialist paths of patients through an integrated Territory-Hospital management that is particularly emphasized: the plan is in fact a proof of the way in which the Ausl and AOU operators share the paths in anticipation of the full integration of the two health authorities.

The second document, the Operational Strategic Plan in Response to an Influenza Pandemic (Panflu, 2021 – 2023), follows the setting of the Operational Strategic Plan

for Influenza Pandemic Response of the Emilia-Romagna Region (Regional Council Resolution n. 251/2022). The regional plan is located in the area of Public Health to which the supervision and monitoring of the program is delegated, and requires local health authorities, in addition to the need to adopt a local plan, an effort of prospective vision regarding the pandemic phases also in function of the spread of non-influenza viruses, and a governance and organization of inter-Local Health Authority level activities, in all areas of interest in the territories: Collective Prevention Service and Public Health and DSP, Hospital Assistance Service, Territorial Assistance Service, ICT Service, Technologies and Health Facilities, Social Policies Service, Reference Laboratories. There is a vaccination plan in the different phases of the emergency that includes the issue of logistics management, access to vaccination services and communication with citizens. Ample emphasis is also given to other crucial issues during the pandemic such as finding the resources of health, social health and social personnel, the training of operators, risk communication and community involvement. Wide emphasis is placed on governance activities.

Tab. 18: Phases Envisaged by the 2021 - 2023 Plan

Inter-pandemic phase	corresponds to the period between influenza pandemics. In this phase, the normal epidemiological surveillance of influenza-like and virological influenza syndromes is envisaged.
Alert phase	It is the period in which influenza caused by a new viral subtype is identified in humans. The pandemic alert is officially declared by the World Health Organization and implemented, through the Ministries of Health / Health Policies by the individual countries. Increased epidemiological and virological surveillance and careful risk assessment, at local, national and global levels, are the characteristic activities of this phase.
Pandemic phase	corresponds to the period of global spread of human influenza caused by a new subtype. Within the pandemic phase, each country can observe different phases of the epidemic at national level with: - acute phases in which cases are on the rise, with high numbers and signs of overload of health services; - post-acute phases in which the new cases found per day have reached a peak and, although still in high numbers, have a decreasing trend; - epidemic transition phases in which cases are stable or with limited variations, the incidence is low and there is no overload
Transitional phase	As risk decreases globally, there may be a de-escalation of actions, with reduced national outbreak response activities and a shift towards recovery actions, based on country-specific risk assessments.

Source: Author's elaboration

The Strategic Operational Plan in Response to an Influenza Pandemic (Panflu 2021 – 2023) incorporates these indications by dividing the strategic areas into macro-

areas and declining the activities to be carried out and the matrix of responsibilities for each of the four pandemic phases described above.

Tab. 19: Areas Envisaged by the 2021 - 2023 Inter-Local Health Authority Panflu Plan

Macro Area A – Governance Activities
Macro Area B – Epidemiological (Bacteriological) and Virological Surveillance Activities
Macro Area C – Health Services for Prevention
Macro Area D – Territorial Health Care Services
Macro Area E – Hospital Health Services
Macro Area F – Infection Prevention and Control Activities with Pharmacological and Non-Pharmacological Measures
Macro Area G – Training Activities
Macro Area H – Communication Activities
Macro Area I – Care Planning and Safety Activities
Macro Area L – Safety Planning and Operator Surveillance
Macro Area M – Acquisition, Storage, Monitoring, Disposal of PPE stocks
Macro Area N – Necropsy Medicine

Source: Author's elaboration

The 2021 – 2023 Care Safety Program Plan represents the Local Health Authority planning document in which the clinical Risk Management policies activated by the healthcare Local Health Authority are summarized. The plan is a very complex document because it includes risk mapping, improvement projects and training prepared for the dissemination of safety culture, adverse event analysis tools. The plan has a three-year duration and is the reference document for all Local Health Authority operators in terms of safety.

Tab. 20: Emergency Plans 2020 - 2021

Ministry of Health	**Emilia - Romagna Region**	**AUSL Parma**	**Risk Management**
Elements of preparedness and response to COVID-19 in the autumn-winter season" (Ministry of Health, 11 August 2020 Prevention and response to Covid-19: evolution of the strategy and planning in the transition phase for the autumn-winter period - issued with Ministry Circular 32732 of 12.10.2020	Plan for the management of emergencies of competence of the Departments of Public Health (2021)	Contributions to the implementation of the Provincial Pandemic Plan in relation to the Covid-19 pandemic	Plan-Program for the Safety of Care and Risk Management in relation to the Covid-19 Epidemic (2020) Care Safety Program Plan 2021 – 2023
National strategic and operational plan for influenza pandemic preparedness and response (PanFlu 2021-2023) (Agreement no. 11/CSR of 25 January 2021	Strategic Operational Plan for Influenza Pandemic Response of the Emilia-Romagna Region (Regional Council Resolution no. 251/2022)	Strategic Operational Plan in Response to an Influenza Pandemic (Panflu 2021 – 2023)	

Source: Author's elaboration

5.3.5 Newsletter and social media

A fundamental phase of the research was the reading of documentation produced in Local Health Authority newsletters and press reviews made available to employees every day. Newsletters are the tools that connect companies with the outside world and for this reason they are strategic regarding what you want to communicate with respect to what happens within the organization but are fundamental to send messages to citizens. In ordinary times, for example, through newsletters the initiatives that are present in the area are communicated to citizens, prevention and screening programs are promoted with respect to certain diseases, citizens are informed about the news of the services available to them. During the pandemic, newsletters have carried out the task of guiding and informing citizens about what needs to be done both in terms of behaviour to be adopted (distancing, isolation, tracking) and in terms of accessibility of services and their usability. The web portals of the Ausl have been the depositories of the rules of access to swabs, vaccinations, urgent visits, access to the Emergency Room and the activation of home activities. The internal intranet, reserved for news for employees, played the same role for operators. The visual representation of what was communicated is contained in the photos, videos, posters produced at that time to communicate closeness to the health workers involved in the field. Some images remain in the memory of those periods, especially at the beginning of the emergency when the uncertainty related to Sars Covid - 2 organized the days of the entire Local Health Authority structure:

1. The images of the messages attached to the windows of the Maggiore Hospital in Parma and addressed to the operators involved in the wards;

Images 8 and 9
Source:
https://www.nurse24.it/video-nurse24/web/un-anno-di-pandemia-all-ospedale-di Parma.html

2. The images of the reopenings of the covid wards at the end of the first wave

Images 10 and 11
Source: https://www.nurse24.it/video-nurse24/web/un-anno-di-pandemia-all-ospedale-di Parma.html

3. The project of restitution of the belongings of the deceased at the Hospitals of the Province thanks to the Parma Welfare project and the contribution of the Cariparma Foundation and photographed by Roberto Cavalieri to archive the dozens of objects not yet collected because they belong to [27]unknown patients or to people who died without relatives or because they were rejected by family members because the memories were too painful.

Image 12 - Source: https://www.fanpage.it/attualita/parma-gli-oggetti-delle-vittime unnamed-of-covid-stored-in-a-hospital-room/

We will see later that the role of volunteering during the pandemic has been fundamental thanks to a multifaceted and coordinated fabric that has been present in the territory of Parma for years and that, through agreements with the Health Authorities, participates and offers its contribution in various areas, including the reception of citizens in the Casa della Salute.

[27] Project promoted by local institutions (Municipalities, Health Authorities), the Cariparma Foundation, the Volunteer Service Center, the Consortium of Social Solidarity and some trade unions aimed at supporting fragile or vulnerable citizens with different activities and meeting points, called Community Points.

5.3.6 Concluding Remarks

The paragraph was intended to respond, through the analysis of documentation, to the first research question on governance strategies during the waves of the pandemic. The reading and analysis of the documentation showed that awareness of the actions to be taken and the tools to be adopted gradually increased as a result of overcoming the first wave, when the unexpected event was managed at national and regional levels with the production of numerous legislative acts. In the second and third waves, the documentary production has seen a greater prominence of the regions and local health companies that have been better able to comply with to territorial plans and local health planning.

5.4 Action 2 - Observing the Governance of the Pandemic. The Authority Crisis Unit (UC)

Observing the Crisis Unit was the second action prepared to respond to the research relating to the governance of Risk Management and pandemic management. the paragraph is divided into two parts: the first one is dedicated to examining the aims and objectives of the instrument as shown by the main documents adopted before and during the pandemic; the second part concerns the presentation to the observation of the Crisis Unit of Azienda Unità Sanitaria Locale di Parma.

5.4.1 The Role of the Crisis Unit in the Institutional Documentation

The Crisis Unit is the elective body for emergency management and is regulated by a plurality of formal acts according to the type of crisis in progress. In the field of Clinical Risk Management, the crisis can occur in the presence of events that assume a high level of seriousness causing serious physical and psychological damage, up to and including death. "The crisis that often follows the event brings with it, first of all, a need for clarity and transparency as well as the ability to set priorities and implement appropriate and timely interventions towards patients and families, professionals and the organization, both in the very first hours following the event

and in the following moments." (Local Health Authority - Management of Serious and Very Serious Adverse Events rev. n. 01 of 30/09/2016). In these cases, given the seriousness of the event, the strategic departments may decide to set up a Crisis Unit coordinated by the risk manager with the aim of reconstructing the facts, through repeated checks, as well as collaborating with the media in cases of particular relevance.

The pre-pandemic time Crisis Unit is therefore reserved for the purely clinical setting. "The health Risk Management function. Technical framework document" of the Clinical Risk Sub Area of the Health Commission, Conference of Regions and Autonomous Provinces, published in April 2021, is the first document in which the need for a paradigm shift with respect to the usual meaning of Risk Management is recalled as it introduces the management of the maxi-emergency crisis as a specificity of the discipline

> "In this new context, while respecting the roles and responsibilities, as envisaged by recent programmatic guidelines of the World Health Organization, aspects related to crisis management and aspects related to preparedness and its anticipation, as well as involvement in the planning of the response to maxi-emergencies, can be fully included in the health Risk Management function" (2021, p. 7).

The role of the Crisis Units is subsequently reinforced in two documents concerning the preparedness of a flu pandemic. The documents represent the translation in scale, from the national to the local level, the centrality of governance for the management of emergencies in the Crisis Unit the most effective collegial tool for inter- and intra-institutional coordination and decision-sharing:

1. The "National Operational Strategic Plan for the Preparedness and Response to an influenza pandemic (PanFlu) 2021 – 2023";
2. The equivalent local document of the Emilia-Romagna Region: "Strategic Operational Plan for the Response to an Influenza Pandemic of the Emilia-Romagna Region – PanFlu Emilia-Romagna Region 2021 – 2023";

The National Operational Strategic Plan emphasizes the need to provide for the establishment of a network of public health experts with specific roles in the field of influenza pandemic preparedness and who will have to update and train in the subject matter and above all work to prepare participation in simulation exercises at the base of future updates of the plan. In the appendix to the plan are the indications for the drafting of the regional pandemic plans in which a request is explicitly made to reject, in the general operational aspects, the chain of command responsible in ordinary time for the realization of the plan itself and in times of crisis, emergency response activities. The local pandemic committees, set up in a network to promote an effective exchange of information, are entrusted with the task of coordinating actions with other local authorities and regulating communication with citizens.

The "Strategic Operational Plan for the response to a flu pandemic of the Emilia-Romagna Region - PanFlu Emilia-Romagna Region 2021 - 2023", provides and decrees the state of crisis or regional emergency in accordance with national legislation. It defines its operational organizational structure through the establishment of an inter-directional coordination in support of the regional council aimed at examining the main issues related to the emergency. The plan formalises that health authorities, hospitals and university hospitals are responsible for the implementation of infection prevention and control measures at local and, For this reason, health organizations must prepare an operational plan to respond to the pandemic and establish a network for collaboration with local authorities, prefectures, the Region, the School Office. The Regional Guidelines for the Prepaedness of the Local Plan highlight the need to establish an interdepartmental coordination core chaired by the Director-General of each local health unit which is activated "whenever particularly complex or long-term interventions are needed to overcome the pandemic emergency" (PanFlu, p. 23).

Tab. 21: Regional Guidelines - Description of Interdepartmental Coordination - Author's elaboration

The nucleus is articulated, in its minimum composition, by the General Manager (or his delegate) who chairs it, by the Medical Director (or his delegate) of the Hospital Local Health Authority(s), by the Head of the reference Laboratory, by the Heads of the Departments involved in the emergency event, by the Administrative Manager, by the RSPP, by the coordinating competent doctor and possibly by representatives of external bodies or bodies deemed necessary for emergency intervention.
The coordination unit has the functions of: - Identification, harmonization and monitoring of the activities and resources involved, carried out by the Services of the Departments involved in the event; - Definition of the need for dedicated personnel and methods of extraordinary acquisition of human resources; - Management of procedures for the acquisition of equipment and PPE and DM, with respect to the emergency, also through donations from third parties or private individuals; - Information, updating and training of personnel; - Definition of targeted health surveillance of operators; - Management of external communication limited to specific professional health indications; - Connection with Local Authorities, both with regard to municipal competences regarding the authorizations for the opening and operation of the so-called "withdrawal points", medical clinics, health, social and social welfare facilities, strengthening of the activities of pharmacies and other health facilities in case of placement of mobile structures on public land, and with regard to any contingent and urgent ordinances of territorial value that the Mayors must issue with Utmost urgency; - Link with the Regional Pandemic Committee, through its contact person for emergencies.

Marsilio and Prenestini (2020) carried out research involving 18 health companies in six Italian regions. Their objective was to identify the tools that have enabled health structures to tackle the pandemic crisis. In all the companies involved, one of the main drivers for emergency management has been the establishment of task forces and decision support systems with the aim of identifying the most effective strategies to respond to the pandemic. The research carried out by Marsilio and Prenestini points out that working groups have been set up alongside Crisis Units to translate strategies at Crisis Unit level into action (ibid., p.202). Healthcare Authorities found the availability of information flows and dashboards to support decisions was fundamental. Marsilio and Prenestini (ibid., p. 24) identify two models in the governance of the regional task forces, one strongly centralized and the other, on the other hand, of coordination with wide spaces of autonomy left to the health authorities in the implementation of pandemic containment measures. This is the case of the Crisis Unit of the Emilia – Romagna Region, whose coordination was entrusted to an extraordinary commissioner for the Covid 19 emergency. In the book the "Goccia del colibrì", Sergio Venturi relates

(ibid,, p.12) the moment of the establishment of the Regional Crisis Unit that takes place after the case of patient 1 of Codogno on February 28, 2020. "... *Then we started talking about it seriously. The Government had reserved the competence of supplying all the essential materials, everything we were indicating, starting with the masks and everything else – gowns, ventilators, passed by the National Crisis Unit ".*

Tab 22: The Crisis Unit of the Ministry of Health and the Crisis Unit of the Emilia - Romagna Region

National Crisis Unit established by Ministerial Decree of 27 March 2015 and redisciplined by Ministerial Decree of 7 August 2019. Chaired by the Minister of Health or his delegate, it is composed of: - Chairman of the Higher Institute of Health; - General Commander of the Carabinieri Command for Health Protection; - Director-General of the National Agency for Regional Health Services – Agenas; - Director-General for Health Planning of the Ministry of Health; - Coordinator of the Health Committee of the Conference of Regions and Autonomous Provinces; - Director-General for Health Prevention, Ministry of Health; - Director-General of the Italian Medicines Agency – AIFA. Covid-2019 Regional Crisis Unit established by Decree of the President of the Regional Council no. 25 of 28 February 2020 (pdf163.54 KB). Chaired by the President of the Regional Council consists of: - Councillor for Health Policies; - Councillor for Civil Protection; - Director-General Personal Care, Health and Welfare; - Director of the Regional Agency for Territorial Security and Civil Protection; - National Association of Italian Municipalities; - Representative of the Union of Italian Provinces ; - Prefect of Bologna

Source: Author's elaboration

5.4.2 The Inter-Institutional Crisis Unit of the Local Health Authority and the University Hospital of Parma

In the province of Parma there are two health companies: in addition to the local health authority that, as we saw in paragraph.... has a more territorial character, we also have the University Hospital Authority, organized around the activities of the Maggiore Hospital, offering a full range of local and specialized services for the treatment of diagnostic, therapeutic and rehabilitation services. The hospital provides 1,047 inpatients beds, with 3,850 dedicated staff, and 171 academic doctors.

During the pandemic, the two Health Authorities, set up their own Crisis Unit but consolidated an Inter-Istitutional Crisis Unit for the unitary government of the emergency in the wide territory of competence. The Inter-Istitutional Crisis Unit is an

instrument which had already been activated in the pre-pandemic phase, with the task of preparing for the merger of the two companies as to the regional mandate.

On 31 January 2020, the Local Health Authority and the University Hospital of Parma, activated, on a regional mandate, an inter-Local Health Authority Crisis Unit with the task of coordinating interventions on the territory of the Province of Parma and developed the emergency response plan The act of constitution reads:

Tab. 23: Inter-Local Health Authority UC Memorandum AUSL/AOU

The spread of the new Coronavirus 2019-nCoV requires: - Adequate interventions in the field of provincial health organization, prevention and control of the disease, with relative analysis and management of the related risks; - The adoption, in a short time, of proportionate, flexible and uniform measures for the prevention and containment of the infection in the province of Parma; - The timely management of any emergencies; - The activation of resources identified with defined objectives in relation to the potential relevance of the event; - The indispensability of ensuring the correct application of the criteria and procedures for the management of critical interventions; - Establishing the necessary links with the Collective Prevention and Public Health Service of the Emilia-Romagna Region; - Promoting strong coordination to ensure effective internal communication in each Local Health Authority and between the two Companies and towards Users, aimed at guaranteeing strategic, operational and external communication synergies.

Source: Author's elaboration

In 2021, according to indications from the national and regional programming, was drawn up by the Health Authorities of the province of Parma "The Strategic Operational Plan In Response To The Flu Pandemic in AUSL Parma and AOU Parma" (PanFlu, 2021/2023 - Ed. 0 Rev.1 of 13/9/2022). The document devotes great attention to the issue of governance, as indicated by the regional guidelines that have required local health companies to prepare an entire section for the governance activities of the crisis. The importance of internal organization can be seen from the logic of the section:

> "To face changes, react to difficulties and increasingly dangerous events, it is not enough to respect procedures alone, however careful and punctual, but it is necessary to resort to internal skills and resources that allow us to react to sudden difficulties. To manage ordinary and extraordinary risks, such as the pandemic emergency experienced in recent years, it is therefore necessary for companies to develop the "resilience of organizations". In other words, re-engineering governance systems, laying the foundations for the development of a system capable of adapting to change (p.18).

The following table summarizes the main governance activities planned for each phase of the emergency

Table 24: Crisis Unit Activity

Macro Area A	**Governance activities**
Title/Type of Activity	Coordination between InterLocal Health Authority Crisis Units and External Bodies (eg. Prefecture, Mayors, Civil Protection, etc.)
Referent	*Health Directorate of AUSL and AOU*
Working Group Identified	*Strategic Management (DG, DS, DA, DASS, SIT, Director PO Director RIT)* *District Directors* *Directors Hospital Departments* *Directors of Territorial Departments* *Directors of Administrative Departments*
General Description of the activity	**Interpandemica** - Strengthen and strengthen the public health network aimed at ensuring integrated systems of prompt activation in the event of an Influenza Pandemic; - Monitoring and verification of the progress of local territorial interventions aimed at the development of resilient communities.
	Attentive - Activation by the Inter-Local Health Authority Crisis Unit - established with a formal note of the two Local Health Authority Departments, and with programming and planning functions of activities; - Activation of the Local Health Authority Crisis Unit - Established with the function of programming, planning and operational management of activities at the level of individual companies in line with the guidelines of the InterLocal Health Authority Crisis Unit. Functions: coordination of interventions on the territory of competence in the pandemic phase Strategic interface with the Regional Pandemic Committee - Planning and forecasting of economic and human resources necessary for the social-health and educational system, to cope with a possible pandemic emergency. In addition, if the new virus does not turn into a potentially pandemic strain, the previously defined measures will be relaxed and brought back to the inter-pandemic level.
	Pandemic - Monitoring and coordination of the activities envisaged by this Plan (surveillance, infection prevention and control measures, monitoring and procurement of resources for the treatment of cases, maintenance of health and essential services, training and communication). - Governance of relations with the other Services and Local Authorities involved, - Coordination with early warning systemsVerification and monitoring of resource availability. - Coordination of the pre-hospital phase (118 and Territorial Emergency) and First Aid. The InterLocal Health Authority Department of Emergency Urgency is the area in which the functions of 118 Operations Centre, Territorial Emergency and First Aid / PPI are integrated. - Local Health Authority task force for the coordination of interventions in favor of social health and social care structures. The main tasks of the Task Force are identified in the support, organizational and logistical management aimed at the prevention and management of infectious risk in the structures; as well as in the clinical-care management of patients (certain or suspected) in the facilities and in weekly monitoring.
	Transition - Harmonisation by the Inter-Local Health Authority Pandemic Committee,

	the activities started; - Surveillance of the activities started; - Restoration of activities and subsequent preparation of plans Recovery of the health sector and essential services
Cross-cutting actions with other Services	Region, AVEN, Local Authorities, Law enforcement, MMG/PLS, USCA, Articulations of territorial and hospital services.

Source: PanFlu 2021 - 2023

As stated in the 2021 – 2022 Performance Plan of the University Hospital,

"The local governance model of the epidemic and of the response system as a whole, was focused on the AUSL-AOU InterLocal Health Authority Crisis Units, operating continuously 7 days a week, especially in the first phase. This strategic choice has made it possible to address progressively emerging critical issues in real time, to develop concrete action strategies, including prospective ones, to anticipate the necessary interventions and actions, thus guaranteeing appropriate and timely responses, modulated according to actual epidemiological trends, constantly monitored, and the pressure on hospital and territorial services. This model, with strong integration and vision by processes, has made it possible to "hold" and overcome the shock wave of the various epidemic phases, as well as to effectively govern the "restart" of activities" (Performance Plan 2021-2023 "of the University Hospital of Parma p. 42).

The general managers of the two Local Health Authorities participate in the Crisis Unit organized at provincial level.

"In the provincial *crisis unit everyone was involved: the "Prefetto" coordinated, the provincial representative of civil protection was present, the two health companies, the mayors of the district capitals that are four here, the President of the Territorial Conference or president of the Province, the order of doctors, the order of health professions. So all the institutional technical bodies were there and it was a very operational table that collected information especially from the crisis units of the two health companies that met daily in joint sessions and then applied the objectives to the territory according to the defined command lines. And I didn't say one fundamental thing which is the tool we're using right now. It is a tool that has become ordinary during the pandemic; Therefore, there has also been an enhancement of on-line communication and rapid relationship tools, which we are now exploiting in a much, much more appropriate way than in 2019. In short, we learned, this was one of the positive aspects of the impact*."

The interview with the Director of AOU allows us to reconstruct the activities of the Crisis Units of AUSL and AOU from the first moments of the spread of the virus at local level, a very hard impact since Parma together with Piacenza was one of the five provinces most affected by the pandemic. The Crisis Units of the Health Authorities coordinated immediately:

"*They tried to translate what the need for beds was, what the methods of integration of hospital, territory were and, above all, what home interventions and what strengthening of the*

territory to carry out, given that there was a remarkable bounty of Casa della Salute. And so the key point was to try to synchronize the territorial interventions with the hospital ones."

The Director of the District and Department of Primary Care of Parma underlines the importance of the inter-institutional control rooms that have seen a heterogeneous participation of general practitioners too:

In the USL Local Health Authority and in the Hospital we also had control rooms that met constantly under the guidance especially of the "Prefetto "and therefore involved the mayors as evident custodians of the health of their community of reference and not least I would go on to emphasize the role played locally by the primary care units and doctors in general in terms of associations that in fact have reacted in a very diversified way also due to the characteristics of the components of the group practices.

Tab. 25: Reconstruction of the Emergency in the Territory of Parma - The Organizational Model

First wave from March 2020 to May 2020 Hospital - Territory Integration		
Maggiore Hospital of Parma HUB function	Hospitals of Fidenza and Borgotaro – SPOKE function	Territory
March 2020 first case at the Maggiore Hospital Ps 1700 people in triage and 720 hospitalized Structure of covid wards thanks to pavilion conformation	First phase reception of all ordinary services also coming from Parma Second phase all hospitals welcome covid patients	USCA Constitution Constitution UMM Single Central Operative Constitution in collaboration with MMG and PLS Constitution Covid Hotel Intermediate Care Facility used for Covid discharges not yet able to go home Home Care
Rationale of the model: flexibility in reorganizing provincial hospitals according to the needs of patients and no longer according to the pathology; thanks to the pavilion shape of the Maggiore Hospital, it was possible to organize Covid pavilions and maintain, especially in the second and third waves, the operation of the Departments on other care activities; the territory is organized by the Single Operations Center that receives and reports from MMG and PLS, from continuity of care doctors and mobilizes the USCA and for the most serious cases the Mobile Units that, composed of hospital doctors and highly specialized nurses, perform sophisticated diagnostic operations at home and at care facilities for the elderly. The Department of Public Health performs contact tracing activities in collaboration with the territorial Nursing Service		

Source: Author's elaboration

5.4.3 Parma Local Healthcare Authority Crisis Unit

Unlike the Regional Crisis Unit, the establishment of the Crisis Unit of the Local Health Authority is not reported, as for the Regional Crisis Unit, in documents available for consultation referring to the first wave of the pandemic. I believe this is due to the change in Local Authority governance at the end of the first wave, when the retirement of the Director General in April 2020 led to the commissioning of the Health Authority with the change of a new Extraordinary Commissioner (EC) and of

a new Health Director and the Administrative Director. In July 2020, in fact, a new commissioner governance was established composed of three new apical directors appointed by the Emilia – Romagna Region and from outside the province. Between the first acts of the new special commissioner the establishment of the Crisis Unit which is established in October 2020 as a result of the second wave.

The AUSL Crisis Unit consisted of District Directors, Primary Care Departments, Department of Public Health, Department of Integrated Mental Health Care and Pathological Addictions (Daism DP), Hospital Departments, by the Pharmaceutical Department, the Technical and Human Resources Departments, the Interlocal Department of the Health Authority with functional value of the Programming System, Evaluation and Control; representatives of the AOU Crisis Unit and several guests of interest for the meeting were also invited. The management of the Crisis Unit can be divided into two periods: the first period runs from October to January 2020 and coincides with the second wave of the pandemic. During this period, two meetings were held per week, on tuesdays and fridays from 15.00 to 17.00. In this period the Crisis Unit had to deal with an increase in infections after the summer period and managed the organization of measures for the monitoring of cases and the reorganization of hospital facilities for the treatment of Covid and not Covid patients. From January to May 2021, the Crisis Unit has been engaged in the vaccination campaign of the population that, in addition to virus monitoring activities, becomes a priority activity for the number of infections. On the one hand, this has led to an increase in the effort required (establishment of vaccination centers, organization of vaccine storage, organization of vaccination of the population in the four districts of residence) but has also represented a turning point in the evolution to Covid, with a decrease in the infections and therefore a reduction of pressure on Top Management. At this stage, the Crisis Unit session was reduced to once a week. The Crisis Unit was not the only place where the pandemic was managed: other decision-making were staff meetings convened by the Special Commissioner every Monday morning and the task force established by the

Directorate for Social and Health Activities that met on Friday mornings to coordinate the social interventions.

From October 2020 to May 2021, I was able to attend the meetings of the USL Local Health Authority Crisis. The opportunity to attend the meetings was incidental and depended on the request, addressed to the Local Health Authority Risk manager, my direct Manager, to draw up the minutes of the meetings.

I therefore asked to be able to attend the meetings, facilitated by the fact that the sessions took place remotely on online platforms made available by regional technical systems. I chose to observe the Crisis Unit to get an understanding, from dialogues between the participants the organizational culture shared by the group of managers in dealing with the pandemic emergency. During the meetings, the administrators defined the operational strategies as necessary in order to coordinate the work and shared the main problems that emerged in the peripheral operating units.

I experimented with this type of observation for the first time by following an analysis of the conversation approach which describes the endogenous logic underlying the dialogues between the participants, and in the case analyzed in the research presented here, an organizational meeting in a formal setting. The first theme that I had to examine was the dimensional context of the speech: the situation, the environment, the intentions of the speakers. As Fele points out (2007, p.28) the context is what the participants consider as relevant to their contribution at the appropriate time. The study of the context is therefore the search for what the participants do not say because it refers to something implicit, which does not need to be said.

The analysis of the conversation aims to reconstruct that internal logic through patterns of analysis that consider the systems of taking the turn of speech, the mechanisms of repair in case of problems of emission and understanding of the conversation, the organization of the opening and closing sequences, of question and answers (Fele, 2007 pp. 91 – 116). In institutional meetings there is a sort of

depersonalization of the identity of the participants who interpret the roles assigned: the analysis of the conversation allows one to highlight how the interactions between individuals/roles are manifested and how the construction or consolidation of institutional identities takes place.

The sessions of the Crisis Unit were held in online mode. The online mode, which was mandatory during the second and third waves of the pandemic, allowed for rapid communication between distant locations and the ability to disseminate information simultaneously to different stakeholders. When compared to a meeting in attendance, could be extended to some of the directors'close collaborators of the directors. The weekly meeting was convened by the Extraordinary Commissioner through an email sent to a fixed mailing list. The Extraordinary Commissioner was already leading the session during the initial greetings to the speakers as they connected. The greeting ceremony was important to enable the Commissioner to get to know and be recognized by the group of directors since she was from another territory of the region. The greeting ceremony also allowed the directors to make themselves visible to the new director.

EC: Hello G. Then N and S. good day... I would say that the B had gone for a moment to get a coffee because it was on call until two minutes ago.I see that A is also coming.Here, perhaps public health is late . Let's wait another five minutes (C.U 06/11/20)

EC: Let's start... there are open microphones... I would say that we are all from...(10/11/20)

The topics covered during the Crisis Units were countless and depended on the emergency situation: during the second wave, starting from October 2020, the subject matter at the start of the meeting was the verification of hospital admissions data was the topic with which to start the meeting. *EC: I'd leave right away maybe if we start from hospital.* At the CU there is always a delegate of the University Hospital to encourage the exchange of information and to coordinate the actions. While in the first wave of the pandemic, from what emerged from several analyses in the specialist literature, the response to the pandemic was concentrated in hospitals, from the second wave focus on the territory was been very high: this is evident in

the note the reporting of the actions developed on the territory by the Public Health, which deals with the tracking of infections, by the Special Units of Continuity of Care whose task was to ensure the assistance of patients who did not need hospitalization (Article 8 of Decree-Law 9 March 2020 n.14 - G.U n.62 09/03/2020; Document for the application of DL 09/03/20 - Health Commission 16/03/20).

EC: we must pay close attention to Special Care Continuity Units (USCA).

Director1: Do you think it's appropriate to give a picture to the general practitioners to update them on the path to activate the USCA?(13/11/20)

Several meetings involved the training of USCA and general practitioners. The third topic discussed at all meetings concerned the update of the situation of infections in Care Home for the elderly (CRA) by the Public Health, which was responsible for screening and swabs, the logistical assessment of facilities operated by third-sector bodies to ensure the isolation of infected elderly people and the vaccination of guests, while the Department of Social Health Activities has supported the third sector by managing, coordinating actions and organizing specific training.

Director2: With regard to training we have identified as the first issue to be addressed with some urgency the use of corticosteroids in the territory because we see there is use that goes outside the guidelines that would provide for use only in cases of the need for oxygen therapy therefore in advanced forms (13/11/20).

Director 3: "We were sent the floor plans with indicated subjects, so name and surname, positive and negative subjects The structure was immediately divided into two parts, a completely closed part, an entirely red area and a part of the ground floor, obviously the one related to the rooms destined to the gray areas, which we can define gray (06/11/20).

The Crisis Unit is the place for reflection and exchange of views on specific issues: on 23/10, following signs of the increase in infections, the need arose to oversee home care through primary care, and general practitioners to whom information and training initiatives were put into place "to keep them involved".

The Crisis Unit is the place of dissemination of top-down information: on 03/11/20, for example, the meeting with the Region was reported which, following

the resumption of the pressure of infections on hospitals, mandated companies to start the reorganization of hospital activities for the need to convert beds into covid places. Reference points for the Region are the General Directors of the Health Authorities who have online meetings with the Regional Councilor every Monday evening, but in the most critical moments of the crisis these take place daily or even several times a day. The Crisis Unit was the place where regional indications were clarified through the pooling of information from various sources.

EC: So in today's meeting I wanted to take a look at what the companies represented to the region. Then the situation in the other territories is a critical situation and in short, we also obviously register a pressure of positive cases in the territory and also in the hospitals (06/11/20).

EC: Nothing, I would say that I told everything. In short, I'm looking at whether in the notes... Here's all have very represented the pressure we have in hospitals... Especially on the contact tracing, certainly however on hospitals there is a critical situation at least in some territories. There are many positive cases that we are registering among the health personnel among doctors, nurses. There are some Healthcare Authorities with truly critical numbers that are really putting in trouble even hospital activities (03/11/20).

During the meetings difficulties are discussed regarding monitoring the tasks that in ordinary times can be followed accurately but in times of emergency need to respond to speed criteria: as an example, I will refer to the discussion on the difficulty of the switchboard to keep the monitoring of home-based Covid cases updated, because while these investigations take time the number of patients were increasing (meeting of 03/11). The greatest difficulty remains the recruitment of qualified personnel for public health activities and for care activities. The staff shortages of the Maggiore Hospital of Parma Hub Center for Covid, affected the Hospital Presidium of the Province that had to send its internist doctors to support colleagues in the city, implementing an internal reorganization to cover shifts (Crisis Unit of 03/11 and 06/11).

In the Crisis Unit, the processes of hospital-territory integration on clinical-care pathways are initiated and monitored, as is the case of the community hospital for

long-term care in province of Parma that was converted into a hospital for symptomatic patients in rehabilitation (UC of 03/11 and 10/11). This reorganization has had a long evolution and has been discussed in several Crisis Units as it is the result of a negotiation between the needs of rapid turnover of patients admitted to the Covid Hospital di AOU, patients not in the acute phase of the disease but not yet dischargeable due to comorbidity with other diseases or because they are too frail, and the needs of AUSL to gradually respond to the complexity of incoming patients which are different from those ordinarily managed by the community hospital for long-term care.

Director 4: part of the cases being discussed were cases that were probably not suitable for this intermediate care setting. Last Saturday who had cognitive disorders, who left health facilities, there was one patient and another with a strong decompensation (03/11/20).

The issue of the resignation of patients from Covid wards to Rehabilitation wards is a concern that has accompanied all the acute phase of the pandemic due to the scarcity of available beds on the territory.

EC: …on the topic beds check the white paths...we are working on the resignation dashboard? (27/11/20).

The evaluation of available beds is a constant activity and is carried out in synergy with AOU, which reviews the organization of the facilities to accommodate the needs that the emergency prioritizes. In addition to the synergy with the University Hospital Authority, a support network was created with private accredited subjects that allows to activate places for the discharge of non-covid patients.

Director 5: It's necessary to take a census and activate governance of an infrastructure network that can help us (01/12/20)

The topics addressed were countless and it is difficult to be able to categorize without running the risk of excluding something relevant. There are some macro-areas in which to navigate:

1. Strategic organizational issues. The members communicate their respective priorities to allow widespread coordination in the operation: this happens in the "round table" in which the EC who leads the Crisis Unit calls those present to intervene, one at a time, with the task of updating others. The information shall cover:

- Updating the trend of admissions in the University Hospital Authority;
- Update of the data of the Hospital of Fidenza and Borgotaro;
- Update of Public Health data: contact search, analysis of the evolution of infections and following the vaccination campaign in the territory and in particular in the Nursing Homes for the Elderly (CRA), in the family homes, in religious structures, etc. ;
- Training for internal operators and operators of private structures;
- Updating of the data of the structures of the Department of Mental Health which also includes facilities for disabled people managed by the accredited private sector;
- Update of the Human Resources Department's data on the recruitment of doctors and nurses in times of severe resource shortages.

2. Issues relating to the establishment of networks and synergies with the institutions, municipalities, provinces and private structures in the territory;

3. Issues relating to clinical activities, taking charge of patients (admissions and resignation), the use of diagnostic tools. The first meetings of the Crisis Unit were occupied with the development of the purchase of new tampon machines and the creation of databases to record the records of patients who had been swabbed. In the 20/10 Crisis Unit, for example, problems such as the purchase of new buffer analysis equipment and the lack of reagents were addressed;

4. Matters related to medico-legal matters such as receiving informed consent. In this regard, the issue of informed consent has been discussed both in relation to contact tracing activities and those related to vaccinations aimed at particular

categories of citizens (minors, the non self-sufficient). The Health Authority had to examine and change modulation according to ministerial decrees.

Sub Health Commissioner: Indication to be calm for consents acquired regardless of the decree. The structures have asked for updated forms to be sent. We have interpreted that any consent and form acquired before the issuance of the certificate is to be accepted as valid (08/01/21)

5. Logistical and organizational issues, in particular in the management of contact tracing and the vaccination campaign. The organization of contact tracing involved the nursing service and public health that has repeatedly "buffered" all the orders and grades of schools, accredited private care facilities, law enforcement agencies, parishes, sports centers and associations, in a huge effort in terms of human resources employed and logistical capabilities. During the month of December 2020, the Crisis Unit was engaged in the organization of the vaccination campaign which was opened on Vaxin Day, established at national level, on December 27, 2020. The phase of "mass vaccination" also required a huge organizational effort, made possible by the collaboration between Public Health, General Practitioners, Volunteers, territorial nurses.

Director 6: Tomorrow inspections will start to find a place for refrigerators that reach the temperature at -80 degrees to store vaccines (CU 01/152/20);

6. Legal and administrative issues related to the management of contracts, conventions, tenders, etc.;

7. Issues relating to the technological equipment for the use of management and monitoring software and for telemedicine and tele-consultation interventions;

Director 6: To cope with the situation where citizens asked for information because they were afraid, the call center was a highly specialized point and manned by doctors specializing in answering questions from citizens but also from general practitioners, doctors of nursing homes, etc (interview Director of Public Health).

8. Issues relating to the drafting of reports to be made available to all directors to ensure the monitoring of the most important data and indicators for patient management in hospitals and on the territory. In the Crisis Unit of 23/10, for

example, the question of how to share data on infections with general practitioners and pediatricians, activities in charge of primary care departments, was raised. An important quantity of data coming from several sources was sent every day also to the Mayors of the Municipalities of the territory in order to circulate information and make synergistic activities.

It would not possible to report here the innumerable issues that have been addressed by the Crisis Unit which have concerned, as previously seen, technological, logistical, clinical, material storage, human resource management, building networks of collaboration between organizations and institutions, monitoring and evaluation of actions taken, etc. The observation of the Crisis Unit highlighted that this is the place of the exchange of information between directors and that of the prioritization of organizing actions at lower levels of the organization.

The observation of the Crisis Unit has allowed, however, to identify some clues of that organizational culture that, as mentioned in the second chapter, is expressed in the elaboration of aspects such as language, daily practices, procedures shared by members (Van Maanen and Barley, 1995 p. 154).

The Top management is the center around which the conversation unfolds: The Extraordinary Commissioner starts and ends meetings and coordinates interventions in accordance with a register that may give priority to responses to emergencies or to the distinction between hospital or local issues.

EC: Then I wanted to start from the CRA at this point. What is the situation like? We have two of critical situations, right? (CU 01/12/20). Good morning everyone. Let's start from the hospital situatio (02/04/21).

If there are no urgent answers to talk about, normally the schedule includes:

- Updates from the Aziedna Ospedaliera Universitaria that participates with a representative;
- Update from public health on infections in elderly facilities and schools, update on vaccinations;
- Update on the structures of the Department of Mental Health;

- Update on training for general practitioners and USCA;
- Update on the recruitment of health personnel.

The General Director plays the role of liaison with the region and with other local authorities and has the task of keeping up the commitment to achieve goals, especially after so many months in which health workers have been put to the test.

EC: We must respond to what is asked of us by the regional level and by the ministry to organize the Vaccination Day, which will be Sunday, December 27, then December 27 we will have a unique, I would say epochal event : the start of this extraordinary operation, which will be the largest vaccine campaign in the world. December 27 was set as the day of European vaccination (22/12/20).

The Crisis Unit is the place of internal and external negotiation: each management level must manage relations with stakeholders who represent the boundaries and thresholds of the organization itself: the region, the mayors of the municipalities, the structures of those with private contracts, the University Hospital. They are interactions on boundaries (Wenger, 2000) that involve exchanges within the organization and with one's own environment, among which "that field of tension is created between the skills learned and the experience of other skills (Bifulco, 2021 p. 97) but which can generate conflicts but also bridges from which to give rise to new projects."

Sub Health Commissioner: We are dealing with the municipalities and with general practitioners, from our point of view if we do network, with rapid swabs? It could be very useful especially for those territories ... In short, let's say different from the city. In the Apennine area, where we are interested in being closer to citizens, where maybe the accessibility of our services is difficult. The network we have is not as easy as in the city, so we will also start with this type of route (CU 03/11/20).

Organizational cultures, as Bifulco points out, are the meanings that orient organizational interactions, articulated in cognitive dimensions, the ways of seeing and thinking through which organizations establish what their reality is, and prescriptive dimensions, norms and models of action oriented to the achievement of objectives, symbolic dimensions through which the system of meanings is produced

and transformed (Bifulco 2021 p. 54). This was visible in two pieces of evidence: the gradual sharing of a common language that is the result of a contamination between specialized technical health terms and those typical of hospital jargon, public health, technical and legal disciplines:

- Splint (to indicate new beds);
- White and gray areas to indicate areas free from contagion or not;
- Clean and dirty paths;
- Perimeter, from the legal-administrative lexicon, to indicate areas on which to intervene (home care, facilities for the elderly, disability wings, etc.);
- Surveillance as a technical task for public health; difficult resignation; quarantine, swab, etc.

The pandemic has required health workers to share documents, projects, numerical data and contexts that have formed the reference points on which the organization of health actions was based. During the Crisis Unit of 13 November 2020, for example, the first version of the Provincial Pandemic Plan, jointly implemented by AUSL and AOU, was finished.

EC: We can say that we sent the provincial pandemic plan to everyone and we can send it to everyone you have all contributed, it was a very articulate work very dense very well done. It's obviously something that can be changed, it's that we have to be flexible to deal with the pandemic, but it's like taking a picture of our programming.

The Pandemic Plan is mentioned other times: on one occasion to remember how the drafting of the plan was a moment of common reflection and sharing:

Director 8: what worries me, however, is this... I refer a little to the reasoning that we had made in a pandemic plan... (24/11/20).

In other cases, the Pandemic Plan was appointed as a reference point to define the limits to requests for additional commitments in terms of resources to be made available, thus becoming a tool through which to negotiate:

Director 9 exceeded the quota of patients provided for by the pandemic plan in the University Hospital or even before, of course, and proceed with what has already been written in the pandemic plan, that is also the first floor of the hospital cleared (05/03/21).

Director 10: In AOU we are at number of patients covid + 243 patients, our pandemic plan provides for a total of 300 positive covid cases. Pressure is important (12/03/21).

While the Pandemic Plan is known and cited by the directors participating in the Crisis Unit, the same Plan appears to be little known by the field workers in the formalization sent to the Region E-R. In some cases the plan is named differently.

Social Operator 1: I have always had the directive, that is perhaps also the experience of what it means to give a direction, so I had a direction that in the end was very simple because you have to transmit confidence. But you have to know how to give the right orders and then with the direction, from home, we managed all the social needs of people in teams with the municipality. However, you have to have clear names, that is important, because if you give a random idea nothing happens, but if you have figures of reference that also take responsibility, of course Eh, and this from our point of view has been successful.

Interviews with nurses, coordinators and other social workers have highlighted a reflection on the pandemic plan which has, in any case, entered specialist language as an organisational tool, which, however, deserves an insight to its function also at an operational level.

Nurse Coordinator 1: Probably two years ago. You couldn't have guessed, Absolutely not. I think that's how it is, when you work in everyday life with guidelines that are very clear, after you also deal with everyday life. Meanwhile go ahead, because you are ready to work in everyday life. Everything else after you have to face it at the moment, because you actually don't know why, precisely, because if you don't know then, if there is a basis. Then the essence is that the presence of a pandemic plan, not in the presence of a virus, an important event, allows you to prepare, to simulate. Actually, when an event happens in front of you, you have a different tension compared to a simulation and this is important to me, so at a time when there is no external agent that threatens you and is present ...hypothesize it. It doesn't give you the same tension.

5.4.4 The Crisis Unit as a Space of Relationship

This paragraph aims to explore the concept of governance through the observation of the Crisis Unit of the Local Health Authority. The Crisis Unit is a Risk Management tool that is activated to manage adverse events in the clinical field and to manage extraordinary events such as pandemics. Observing of the Crisis Unit has allowed for an examination of several visible aspects such as the actions prepared to contain the epidemic, and others less visible ones that belong to the local health authority organizational culture such as the methods of leadership, language, management of relations with the external environment. The observation of the Crisis Unit is particularly interesting because it is the place where information is collected and operational strategies are shared: in this context I observed that sharing is circular at the level of top and middle management, while the ways through which information in spread at the base of the organization is more detailed during discussions. A bottom up information movement, is reflected in the experience of DAISM - DP:

Social Worker 1: there was a weekly meeting where the Director asked each service "how are you doing?"…which is not a trivial word. Attention is the word that encompasses all the work you do weekly. You have to let all the other services know what is happening and maybe what the needs are.
Director DAISM-DP: I note that there is a piece of system like mental health that works in emergency in very difficult contexts so I have asked for access to the services of the department and for some proposals for solutions because then the mentally ill are difficult to cure (CU 20/11/20).

This space is the focal point of pandemic management and the translation of national and regional guidelines into operational programmes. At this level of governance, the knowledge of what is happening is complete and circular and translates into the sharing of a language that goes from specialized to common. The activities of the Crisis Units are substantiated by the documents produced and the information communicated inside and outside the health organisation. The Crisis Unit Analysis seems to highlight a well-established system of Practice governance in pandemic management and in the translation of national and regional guidelines

into operational programmes. At this level of governance, the knowledge of what is happening is complete and circular and translates into the sharing of a language that from specialized becomes a common language. The pandemic plan is an example of a useful tool for planning from an organizational point of view but also for spreading a culture of Risk Management that is circular in a top down and bottom-up sense. As we will see in the Organizational Ethnography at the Casa della Salute Pintor-Molinetto and in the improvement project with the Healthcare Safety Network, risk and emergency management is at different levels that are not always in communication.

5.5 Action 3 - Observing the governance of the Pandemic in the Casa della Salute (CdS) Pintor - Molinetto

The paragraph describes the organizational ethnography carried out at the Casa della Salute Pintor - Molinetto in order to answer to the second and fourth questions. The first explains the role of the territory in reference to the strategies of preparedness from the point of view of the Local Health Authority governance and the second explains the model of accessibility of the sanitary structures in relation to the concept of safety.

Brennan and Flynn (2013), state that there is a gap between what is planned for clinical governance that materializes in plans, procedures, regulations and clinical governance in practice. The authors, after examining numerous research through a bibliographic meta- analysis, note that clinical governance is an umbrella concept referable, generally, to structures of responsibility or management processes. Moreover, the presence of various definitions of the concept is founded on this basic ambiguity that may be at the origin of the discrepancy between the organizational vision of clinical governance and the perception of clinical staff (Peack et al., 2005). The ethnography at the Pintor-Molinetto Casa della Salute and the project to improve spontaneous reports of adverse events that will be presented in the following paragraph, together with the research on the Crisis Unit, aimed to explore

this multiplicity of interpretations, in a historical moment in which, as we have seen with the analysis of documents and regulations, organizational skills have had to be combined with skills in Risk Management, organized in different settings. Field observations research the practices that give life to knowledge and safety cultures that are acted out in everyday activities by operators and also by all those who use the services.

Annemarie Mol describes the sense of observing where practices are consolidated:

"*The ethnographic study of practices does not seek knowledge in the subjects who have it in mind and can talk about it. Instead, it locates knowledge primarily in activities, events, buildings, tools, procedures, and so on* (Mol 2002, p. 32)."

Ethnography at the Pintor-Molinetto Casa della Salute has the sense of narrating a long-term story with a first ethnography (November 2017 – April 2018) aimed at investigating the accessibility of different CdS for the master's degree thesis in Sociology at University of Milano-Bicocca and a second (November 2020 - December 2021), aimed at understanding the impact of the pandemic on the structure. The Ethnography carried out in two successive time intervals, allows for collection of information on the ordinary life of the structure and on activities introduced to manage the extraordinary, comparing strategies and actions that have a common thread, as evidenced by the interviews collected during the ethnographies:

We had to be prepared for normality, that is, in the sense that wearing a face mask for, especially for health care workers... rather than hand washing... A distance that also allows you to stay safe, that is, as a rule of natural hygiene, which is normal in a normal situation. We could have been prepared for this (Nursing Coordinator).

Ethnography at the Casa della Salute Pintor-Molinetto investigated two themes:

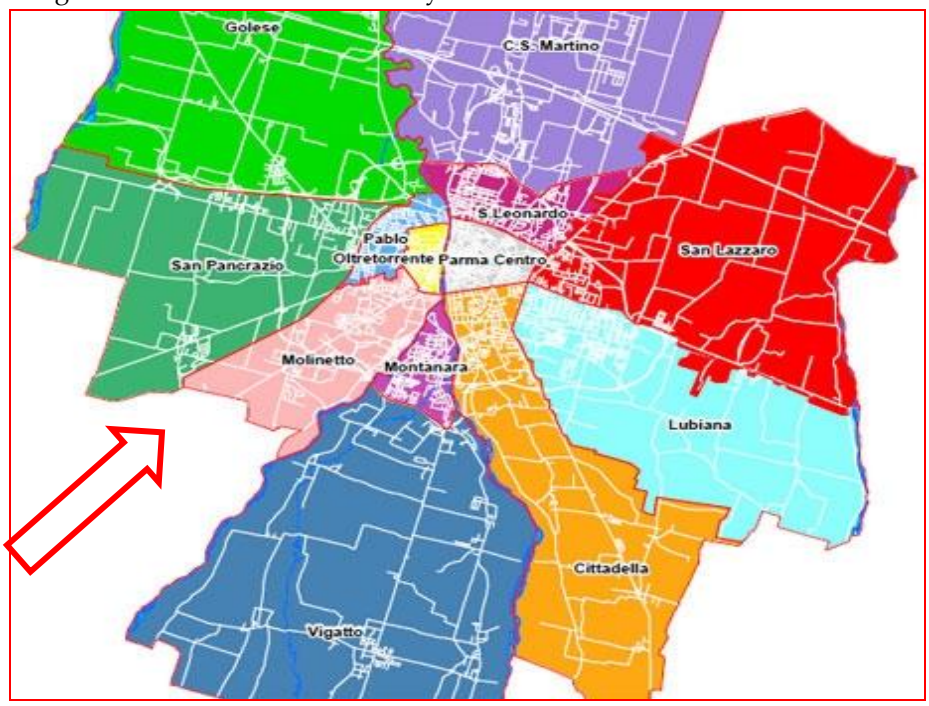
- The organizational management of the pandemic, also with a view to preparedness;
- The accessibility of the structure from the point of view of operators and citizens during the second and third waves of the pandemic.

The themes that complement each other have focused on two aspects: the presence of *bottom-up* crisis management processes that reveal the ability to self-organize as a necessary and "normal" way; the interweaving of *safety* and *security* processes in the management of reception that offer interesting ideas, in an unprecedented way, with a view to *empowerment* of citizens and operators, also in anticipation of the transition to the Casa della Comunità, in which a synergistic relationality between the "inhabitants" of the structures will be the objective to be achieved.

4.5.1 Context data

The Casa della Salute Pintor - Molinetto, opened in 2014, belongs to the District of Parma, and is located in the Molinetto District, a district of 19,443 inhabitants (survey as of 1st January 2022), a small area compared to other more populous ones, but which does not prevent it from hosting a highly complex Casa della Salute which, due to its history and presence of services, has always been seen as a Polyclinic, the reference point for all citizens and for some services for the province.

Image 13: Subdivision of Parma City Districts



Source: Municipality of Parma

The CdS can be divided into *Hub* and *Spoke* models based on the performance of centralized functions at the city, district or Local Health Authority level. This model, as can be seen from the Regional Resolution of reference, represents:

> "The methods of production and distribution of hospital care according to the principle of integrated networks which provides for the concentration of the most complex cases, or which requires more complex production systems, in a limited number of centers (*hubs*). The hubs deal with volumes of activities such as to guarantee the best quality of assistance provided and the best use of available organizational resources. The activity of these centers is strongly integrated, through functional connections, with that of the peripheral centers (*spoke*), which ensure assistance for residual cases" (DGR n. 1235/2002, p. 47).[28]The Pintor-Molinetto Casa della Salute is a HUB as the structure is home to various primary and specialist care services. In fact, there is:
>
> - ✓ the specialist polyclinic with the disciplines of: general surgery, vascular surgery angiology, internal medicine, endocrinology, diabetology, neurology, allergology and immunology, cardiology, dermatology, ophthalmology, orthopedics, otolaryngology, pulmonology, radiology, urology;
> - ✓ Blood drawing center;
> - ✓ Rehabilitation Medicine;
> - ✓ The One of Reservation Center - CUP where it is possible to carry out all the operations of registration with the regional health service, choice and revocation of the doctor, renewal of ticket exemptions;
> - ✓ Diagnostic imaging activities (traditional radiology and ultrasound);
> - ✓ The dialysis service.

The area of General Medicine is overseen by the group of General Practitioners (GPs), called "Galeno", composed of 9 professionals who have a total of 14,537 patients in their charge. The Galeno group activates the clinical-assistance paths dedicated to patients suffering from chronic diseases, cardiology and diabetology, in collaboration with the outpatient specialist service. The Casa della Salute also guarantees the activation of paths dedicated to the management of urgent examinations / appointments to be carried out within seven days in the fields of dermatology and radiology.

[28]Resolution of the Emilia - Romagna Region n. 1235/2002 "Regional Health Plan 1999-2001".

Image 14: CdS Pintor – Molinetto

Source: Author's elaboration

5.5.2. "The territory has seen chaos"

With this expression used by the first health worker I interviewed, ethnography began at the "Pintor", what the citizens of Parma call Casa della Salute. I interviewed the previous coordinator of the Casa della Salute at Pintor in 2018. He had told me about the functions and services present, focusing on some critical issues such as the placement of services of a different nature that attracted a large number of users to whom it was necessary to ensure diversified and appropriate responses. He also mentioned the challenges posed by an aging population and therefore the specialization of the Case della Salute in taking charge of chronic diseases, the meeting and comparison with "other" cultures and therefore the preparedness of ad hoc services, the drive towards a model of health service integrated with social services in which to promote the empowerment and participation of citizens. A very complex challenge for health workers struggling with staff shortages, increasingly limited times for appointments and tests, scarcity of economic resources.

I met the Pintor Coordinator in August 2020, when the facilities were gradually reopening during the period between the first wave and the second (October 2020), when the heat brought a decrease in infections. I recall from that first meeting the willingness to reflect together on a period that operators and, in particular, coordinators had spent holding their breath in their effort to manage the emergency in its thousand directions, from technical and organizational ones to relational ones

because the fear of contagion, in large groups, is a personal matter, intimate and not easy to translate into immediate collaboration. In the first phase, in fact, in addition to the disorientation due to the nature of an event with unknown health consequences, critical issues related to the delay in the transmission of information also emerged "*of a week ten days, sometimes between a national directive and what was shifted to the territorial level ... Before arriving at the territory an indication from the ministry, passed in the region that passed to the health direction and then passed to the district direction* "(Medical Area Coordinator). Delay in giving out information concerned not only news as to the nature and mode of spread of the virus but above all in the directives on containment measures that included, for example, Personal Protective Equipment (PPE). In the very early stages of the pandemic there was a shortage of PPEs throughout the country, making it the subject of conflicts within structures due to their lack of distribution since they were unavailable. The allocation of PPEs is the symbol of how necessary it is to think in terms of *preparedness* and redundancy, as we have seen in the second chapter: both proposals seek to integrate the criticalities of a management model of supply and storage of stocks that minimizes warehouse stocks (just-in-time model) to minimize waste and achieve greater efficiency.

> *"The storage of materials that we saw in the pandemic was zero because they did not arrive, in reality in a normal situation it was underestimated ... So actually, before you get to the extraordinary you have to go further, evaluate the ordinary" (Nursing Coordinator).*

The pandemic, therefore, takes us by surprise and catches us unprepared not only for the extraordinary event but also for the management of activities in ordinary times and reveals a series of management automatisms and daily practices that enter into crisis in the face of an adverse event. The shortage of devices, for example, can be traced back to a lack of reserves for ordinary activities and to a selection, on the basis of completely personal and non-standardized criteria, of those to be used, despite the fact that a wide range of devices are provided for by regulation: *"There are basic devices that, when you go and read the indications, trivially... Even for a blood test, no, use a visor, a face mask, because you are in contact with patients, even glasses ... a drop... We too, sometimes*

we do not use them, but they are provided ... Now unfortunately we are obliged ... because perhaps even compared to what is the daily ... Sometimes things are done carelessly, apart from gloves, so maybe now we are also a little used to it. "(Nursing Coordinator).

The pandemic forces us to rethink the daily practices that overlook given rules, yet fundamental for those who work closely with patients: distancing, hand washing, use of a gown and face mask: "*We had to be prepared for normality, that is, in the sense that wearing a face mask especially for health workers, rather than hand washing, a distance that also allows you to stay safe, that is, as a rule of natural hygiene, is normal in a normal situation (Nursing Coordinator)".*

An unpreparedness that "*then, perhaps, along the way, prepared us"* (Nursing Coordinator) through experiences by trial and error. The counting of individual safety devices to be distributed to operators is, for example, a complex operation for the number of specialists (45 - 47 who rotate on the structure per week) and nurses (n. 20), and the sometimes conflicting indications that changed from day to day. An example of this is also the case of the Local Health Authority risk assessment document that implemented the national guidelines that could present discrepancies for delays in reception and operational application: "*Then a doctor came because he read the guidelines and wanted FFP face masks, two, even if they were not compulsory ... He wanted a visor. Because requests came, and sometimes you didn't know what to say... Why say no? And how to say no? (Nursing Coordinator).*

On the other hand, the commitment to rationalization, "*not the optimization of things*" (ibidem), meaning the commitment to giving meaning to situations and actions, without this being the optimal way to deal with them, passes through solutions designed together creatively: from the preparation of kits for Covid positive patients, to the arrangement of waiting rooms, to sanitization procedures that have been given detailed attention: such as covering chairs with plastic because if they had fabric seats and subsequently purchasing plasticized chairs. Ideas that, while being constructed, become an opportunity for broader reflections on what needs to be done for patient safety in the programming of ordinary times: sanitizing

furniture between one patient and another "*poses the problem even when buying furniture and maybe paying attention to many things* (Ibid)".

5.5.3 Vertical and Horizontal Planning

The theme of programming and planning is central, as we have seen in the previous chapters for the strategic organizational level but it was even more so at the peripheral level which, in an initial condition of lack of information, defined its own strategies following the flow of directives from districts but also retrieving news from operators working in other territories or drawing inspiration from readings " *We always read a lot. No, because after in the end you read but then you can't even read everything because the documents came out one after the other (ibidem).*

The quantity of documents produced in those days at all levels of Local Health Authority articulations compensated for the lack of national, regional and local planning regarding pandemic events. Their production ceased in 2005 as we have seen in paragraph 4.4. The planning of action was also difficult due to the peculiar conformation of the province of Parma with its mountainous, hilly and plain areas due to which standardized operating models were difficult. If the variability of the forms of inter-district planning was accepted, at the same time the horizontal collaboration, the exchange of *expertise* and knowledge, which did not take place in the early days, turned out to be a criticality that forced the structures not only to re-locate repertoires of knowledge and organizational tools autonomously but also to reflect on the lack of value and sharing of the wealth of knowledge, experiences and products tested in the field.

"Each district tried to manage the situation in its own context, but the information... that is, the circularity of the information of the data, of all the things that have been put in place ... it is important because they are an asset of the Local Health Authority, not of the structure or of the individual (Nursing Coordinator)".

The interviews with the operators of the Casa della Salute and the nurses of the Home Care of the Parma and Fidenza districts, reveal the limitations of *governance* that has not invested in horizontal *benchmarking* methods which are useful in

encouraging the exchange of good practices and experiences, also for the purpose of a minor effort in identifying the most effective activities. In the same way, the coordinators highlight the difficulties of a predominantly *top-down* communication, in which the needs and requirements of the individual structures emerged in a few shared directives *"In the end the competent doctor, I called him because I was no longer able, alone, to cope with certain things, certain types of questions, certain situations "(Casa della Salute Coordinator).*

5.5.4 "Collaboration has changed the Climate"

On the other hand, the continuous comparison, the presence, the division of tasks, characterizes the internal relations at the Casa della Salute: the operators, in fact, even in the moments of closure between March and June, faced the emergency by constantly confronting problems and how to deal with them. *"Even the calculation of the needs to understand how much stuff we needed, we did together (Nursing Coordinator)".* The proximity dictated by the emergency and the way of dealing with problems together by way of daily briefings, constitutes a lever for a change in the organizational climate: "*You want new people to have arrived and therefore there has been some change, probably that also certainly helps, you also want us to do briefings where things are said openly without giving space to hearsay*".

The pandemic was a tragic event but it has allowed us to review many things including discovering the humaneness of people *"people came out, for me it was a great moment of discovery" (Nursing Coordinator).*

5.5.5 Accessibility, Safety and Security

The Casa della Salute is a complex system of services that responds to the health needs of the population considering it, in addition to a state of complete physical, mental and social well-being, also the right to demand: "The enjoyment of the highest standard of health attainable without the distinction of race, religion, political beliefs, economic or social conditions" (WHO, 2000).

As De Santis (2015) points out, the impact determined by this definition has been important in various fields such as culture, science, health policies and has implied a broadening of the vision of Medicine which, in addition to the task of fighting diseases, had to / could associate that of protection and promotion of health. Even citizens change their points of view and become an active part in a process, the achievement of well-being, which does not depend only on the intervention of health professionals. The transition is not insignificant and distinguishes one of the most important challenges to which healthcare is called: to make the citizen / patient the protagonist of his own treatment path and participant in the decisions that affect him. Today, the challenge is understanding, in this definition, the processes of exchange between living beings, social groups and the environment (Ingrosso, 2016 p. 203) in the light of the radical uncertainty that this relationship entails (Kay and King, 2020).

The concept of accessibility refers to the ability of health systems to remove barriers that prevent patients from using services for their needs.

In analyzing the characteristics of the structures that determine patient choice, Evangelista (2017) refers to research by Victor et al (2012) which confirms that the choice of reference device is determined by several factors, among which structural ones such as availability, accessibility, type, size, organization but also factors attributable to perceived quality, the availability and experience of human resources.

Schematizing these concepts, Evangelista crosses the dimensions referring to the characteristics of the structure, of the processes taking place in the patient-structure encounter and in the outcomes produced by this process:

Tab. 26: Accessibility and Indicators

Structure	Process	Outcome
Availability Accessibility Type Of Size Organization Quality Team Availability Experience	Interpersonal Factors Waiting Times Continuity Of Care Availability Of Information	Quality Of Treatment Mortality Postoperative Infection Rates

Source: Evangelista 2017

The concept of accessibility is presented with a double role: one linked more to the concept of access, meaning according to Del Biaggio (2005) that "border that separates the outside from the inside of the infrastructure, of the place", or physically its entrance, the information desk or the waiting room; one which underlines the multiplicity of factors that affect accessibility to care including information, geographical distance and travel time, ethnic factors and representations, cost and quality of care" (Del Biaggio, 2005).

Evangelista (2017, pp. 40-41) attributes to access the task of measuring the level of correspondence between the needs of patients and the characteristics of the health system which can be traced back to five dimensions:

- Acceptability: the local distribution of Health Services;
- Economic sustainability: willingness of the patient to bear the costs for travel, depending on the relationship between the availability of public transport and the perception of the distance of the structure;
- Availability: adequacy of supply with respect to the volume of health demand expressed. The presence or absence of services influences the willingness to access them;
- Geographical accessibility: expresses the relationship between the location of services, mobility and patient distribution;
- Availability of specific services: presence of services not only health in order to make the health facility more attractive.

During the pandemic, the concept of accessibility was transformed, as a result of the trend of infections, first into a prohibition of access to facilities, with enormous repercussions especially on the lives of the elderly and fragile who had not received the assistance of caregivers. Subsequently, access was regulated by strict controls regarding the state of health (not having fever, cough or cold), the use of a face mask, the possession of proof certifying the negativity to swabs, the maintenance of a safety distance. All the health facilities of the Local Health Authority have taken steps to equip themselves with control systems by delegating security companies to man

the entrances to the structures. Each entrance was controlled by uniformed operators who asked for personal information regarding the reason for presence (appointment, pick-up, reservation, etc.) and the state of health.

The Casa della Salute is spread over four levels: a ground floor where the radiology and dialysis services are located; the mezzanine floor where there is the CUP, blood test point, specialist clinics and the group of General Practitioners (Galen). On the second floor there are specialist clinics and nursing services while the third floor is for rehabilitation medicine. 2018's Ethnography had highlighted the difficulty in finding their way around for fragile citizens, foreigners and the elderly even in tines of previous access that had allowed for free movement. Inside the entrance hall where the waiting rooms for the Cup and the Blood Drawing Center are located, there is a support desk in the morning, for volunteers who provide information and support for difficult operations such as the electronic payment of tickets. This method of access is consistent with the vision of autonomous, empowered and able users and is interrupted only by the presence of foreigners who must rely on the help of transcultural mediators to overcome language barriers.

2021's Ethnography goes back to the paradox of reception-surveillance.

By surveillance Lyon means "the operations and experiences of collecting and analyzing personal data for the purpose of exerting influence, deciding who is entitled to what and controlling (Lyon, 2020 p.23)". A concept that implies a reciprocity between the observer and the observed who judges its appropriateness by conforming to or opposing it. (Lyon, 2020 p.23). When it comes to public health, the concept of surveillance, intended as recording and processing of data for security or marketing reasons, overlaps with epidemiological surveillance that enables, in emergency public health situations, as was recorded in the second chapter, to impose rigid rules of behavior to the point of being confined to our homes. Access control in health facilities, for strict supervision, is then entrusted to specialized private companies through tenders.

At Pintor, surveillance was entrusted to a well-known city Local Health Authority specializing in security services, to be later replaced by a service cooperative that provided for a substantial reduction in staff hired with temporary employment contracts. The number of health facilities to be monitored initially required an extraordinary recruitment of operators, mainly made up of young people looking for work or still engaged in university studies. Interviews with them showed that the recruitment had taken place through temporary employment agencies and how recruitment had not provided any training, not even for technical-specialized topics related to security. The workers' commitment was in fact limited to the function of regulating space, they themselves being barred from access, and to the management of practical operations such as temperature measurement, distribution of hydroalcoholic gel and asking users why they needed to come to the Casa della Salute . The scanning of the questions was always done the same way, in an order that was repeated for each interviewee in the same sequence: *"Where do you want to go? Why? Have you had a fever, sore throat or cough in the last few days?* The uniform worn by both young men and women, symbolically constituted the emblem of authority, with a paramilitary style in which army-style boots, jacket and blue multi-pocketed trousers were reminiscent of the police uniforms. I am spending a word on the visual description of these figures as for several months they represented the interface of services with the population that went to Pintor, the first accessible stronghold of the public health service dealing with basic medicine, home services and all other services to support citizens. This aspect is central because, in emergency situations such as those experienced during the pandemic but also in ordinary times, the ways in which public services, in particular health services due to the conditions they treat, interface with the territory, with the communities in which they are inserted, with individual citizens, becomes the measure of care with which they intend not only to facilitate access to facilities but also to improve safety and quality of the services themselves. Access to services is not only a phase of transit from one space to another but it is a critical moment, of listening and orientation of citizens, in

particular of the most fragile and vulnerable: during the pandemic, strategies related to safety processes and some aspects of epidemiological surveillance (reporting of positive Covid cases) prevailed, replacing the traditional reception practices that used to be managed by health workers and volunteers. Deciding how to prepare for the moment of reception, to whom to entrust it and how to structure the phases is just as important. Organizing this aspect means reflecting on the logics that oversee it and that pertain to the governance of the processes and practices with which relations with citizens are regulated not only in regulatory or logistical terms but above all in view of that reciprocity that is proper to the health act and that is inscribed in the term community. These observations have reinstated an organization of the reception which, paradoxically, is consistent with what its purpose should be thanks to the dynamic and creative methods of the security officers who, in sync with volunteers and transcultural mediators, transformed security practices into reception practices, listening to and directing users, mediating between the various services. The search for new ways to regulate the queue which, especially during peak hours, extended outside the structure to the street, was symbolic: the management of this delicate moment because it required hours of waiting for one's turn, was managed by going out to literally welcome people on the street, to establish a first contact with those most in difficulty.

"In the management of safety, volunteers, employees take on different roles such as informants, regulation enforcers, researchers of information and are the glue between various public service office operators (Ethnographic note of 12/11/20)".

Uniforms have also played a role in this, becoming an element of immediate recognition for those people asking for information. "Citizens are directed towards uniformed operators who are positioned outside and who are immediately visible to all" (Ethnographic note 27.11.20). In the 2018 ethnography I noted how volunteers and mediators were generally sitting behind the counter at the entrance, waiting for users. This different arrangement was maintained in the 2021 Ethnography even if, the dynamism of the security operators imposed a new rhythm on the entire

reception group: the transcultural mediator, for example, was often physically positioned near the entrance, ready to intercept foreign citizens. This type of reception, by connecting with the public or patients prefigures the future of the Casa della Comunità: paradoxically the overlapping of the principle of safety in that of accessibility and the incorporation by the security staff of the dynamics of reception, represents a very important experience of circular empowerment because it is based on a relationship of trust with citizens, built on a daily relationship. When, on the other hand, only the regulatory or specialized technical aspect prevails, this alchemy is not achieved:

"At 9.30 a.m., an elderly person enters the waiting room of the pick-up point. He arrived too early and is scolded by the nurse: you who can stay in bed... you can't arrive so early. It's not right for you, elderly people, to be out." The old man explains that he arrived early because he wanted to be on time then, taking his leave to return at the right time, says ironically says "thank you for calling me elderly" (Ethnographic note 14/12/20).

In my notes, I wondered about the timing of access to services for the elderly or people with disabilities: I wondered in what context to bring the reflection on the time it takes for the elderly to get to appointments, which road they take, what means of transport, what distance from the polyclinic (geography of health services). Are the same rules for everyone sustainable for everyone?

During the second half of 2021, a drop in infections produced a gradual reduction in the security commitment and the turnover of employees until their work was finished.

Today there is no longer such a well-structured reception service but the process is overseen by voluntary associations, mainly made up of the elderly, who provide first-level information and transcultural mediators who deal with the management of foreign citizens.

With a view to the development of community homes and local healthcare, the reception model of health services is a critical node to be developed, especially by learning from the experiences of the pandemic. The training of volunteers is essential

to help them get a grasp of the answers to be given to increasingly numerous needs, but it is not enough. In my opinion, it is necessary to reflect on the broader model of relationships that health services want to weave with patients and that cannot pass over their initial experience: the patient experience goes beyond the concept of empowerment because it presupposes listening to all the aspects that make up the individual's experience with the health system. The interest in the patient as a direct source of information for the improvement of care stems from what Maciocco calls the cultural revolution that began in 1998 following a seminar held in Salzburg (Austria). The seminar entitled "*Through the Patient's Eyes*" involved professionals from different worlds whose meeting gave rise to the manifesto "Healthcare in a land called People Power: nothing about me without me". The text calls for the creation of a health model in which patients and family members, health professionals and organizations can share a way of working which is open to the exchange of information and knowledge, whose purpose is to improve the quality of care and the well-being of patients. Maciocco (2013) considers both the *Chronic Care Model* we discussed in Chapter 3 and the attention to the patient's experience to be part of this reflection.

The Beryl Institute has formalized a definition of patient *experience* intended as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care" (http://www.theberylinstitute.org). The definition, as specified by the Beryl Institute itself, underlines the complexity and completeness of the dimensions to be considered concerning:

- ✓ Interactions intended as points of contact with people, processes, policies, communications, actions and the environment;
- ✓ Culture, referring to the set of values, vision, people (at all levels and in all parts of the organization) and communities of reference;
- ✓ Perceptions, such as everything that is recognized, understood and remembered by patients and supportive people. Perceptions vary according to individual experiences and are conditioned by beliefs, values, cultural background;

- ✓ Continuity of care, meaning the perception of what happens before, during and after the course of treatment.

5.5.6 " Thank Goodness for Home Care "

Within the Casa della Salute is a Home Care Service (ADI) which offers health care and services, house calls and tests, which are normally carried out in the clinic, at the patient's home. Home health care is free and guaranteed every day of the week, in connection, if necessary, with medical specialists (cardiologists, geriatricians, physiatrists, pulmonologists). The care team ensures the distribution of aids, such as anti-decubitus beds, items (diapers and medicines). The ADI service is also guaranteed to people suffering from cancer thanks to the collaboration with the palliative care network that has a provincial character. The ADI service is guaranteed by the Home Nursing Service (Sid) which operates in conjunction with the general practitioner or pediatrician, with hospital departments, specialist doctors and social workers. The SIDs are present in the four districts at the Case della Salute or Health Poles. During the pandemic, these services constituted the operational branch of the health service since it entered, together with the USCA, the homes of citizens, finding itself on the front line in the first phase of the emergency, mostly without tools and devices. Stories of those moments reflect the words of the district nurses I interviewed at length: "The pandemic digs into people's perception of risk and the relationship you have with yourself ... We operators were absolutely in disarray, there was terror in everyone's eyes and not knowing how to move. Because, anyway, we were absolutely not ready for such a thing ... There were two types of behavior, one was I'm not going out because I'm terrified, the other was I'm going out all the same even without a face mask. So a perception of risk that is difficult to understand, there is probably an exaggeration on both sides (Nurse ADI 1)".

In the words of the operators, the awareness that the territory remained an isolated area in the first period caused a consequent fluctuating relationship with patients: "*We had all our patients waiting for us at home but they saw us as virus spreaders : we*

recived phone calls like, do not come, I do not want to see you, but also desperate phone calls because they did not know where to go to change their catheter" (Infermeira ADI 1).

Therefore, in this context, a spontaneous organization of interventions originated aimed at protecting patients through a process of learning by patients and caregivers who responded by engaging in tasks that were not too familiar:

"We have tried as home nurses to protect our patients. How to do it? We instructed them a lot to avoid going to their homse not because we didn't want to go. However, since we were vehicles moving from home to home, we could potentially aggravate their general condition; so we made an effort to educate caregivers, patients, everyone in order to minimize our accesses to avoid spreading (Nurse ADI 2)".

"We have people, family members who are also very intelligent and very aware, compared to others, who understood that we could not go there ... and they also started learning things that maybe weren't really theirs (Nurse ADI 2)".

However, a point of view of what happened also emerges from the interviews that enriches the mainstream story of an unmanned territory with new elements:

"It is not the fact that there is no direct intervention on a territory, that the territory is abandoned ... It is managed in other ways, that is, and therefore it doesn't mean that there is a crisis there. In some realities patients have been left alone, many have died ... but we have learned on our skin, we have learned that the territory is the one that must respond to Covid, but above all to non-Covid cases. The biggest crisis, from a welfare point of view, was in the oncological terminal patients, when the hospices closed. Then I would like to say I am going there, I am aware that I am there" (nurse ADI 1)".

The difficulties in recognising the signs of a top-down governance strategy or coordination between related services, confirmed by respondents, are circumvented by the use of personal knowledge in other services with which valuable information and common practices are shared. The informal exchange with colleagues in the hospital allows us, for example, to define the strategies to be adopted with patients who need hospitalization

I: This thing of preferring to let them stay at home rather than hospitalization, did you understand it immediately? Yes, because I have one of my best friends, a nurse who was on respiratory triage, so she told me, don't send them to us, no, don't hospitalize the elderly,

because we can't do it... I have 150 hospitalizations a da,y I do not know where to put them, I go around with oxygen cylinders (Nurse ADI 2).

At the end of the analysis of Ethnography and interviews, it seems to me that I can generalize repeated elements in the interviews and dialogues carried out during the field observation:

- ✓ the need to contribute, in times and bottom-up methods, to the creation of shared documents with which to plan activities in ordinary and extraordinary periods:

  "If 1 group made a 150-page document, you can't think of simply distributing it. These documents must be activated, either they start from the bottom or otherwise they are not feasible. In my opinion a pandemic plan is an opportunity, but you have to do it over time, you can't do it one month for the next... it's a chance to get to know your organization (Nurse ADI 1)."

- ✓ the need to periodically meet colleagues from similar services for exchanges of good practices and knowledge but above all for organizational purposes:

  "Sometimes I think it would be better to have a single coordinator. That is, it would be very challenging. For the coordinator, however, it is madness, but sometimes you say, but at least he would know that today there are two of us (Nurse ADI 2)".

5.5.7 Villa Ester

Ethnography at Casa della Salute Pintor – Molinetto was accompanied by Focused Ethnography[29] (De Lillo, 2010, pp. 47-49) at a structure of the Municipality of Parma called Casa del Quartiere, aimed at hosting the activities and projects of voluntary associations and citizens of the Oltretorrente district of Parma. My aim was to analyze the model of conception of the public structure intended as a public good for citizens and for this reason open to collective participation and used by the resident population in a participatory perspective. This project is an alternative model compared to the Casa della Salute, since while in the latter services are

[29] Un type of observation of limited duration, which focuses on a specific aspect.

provided, at Villa Ester activities, projects, experiences are shared. In the comparison between models, I was particularly interested in the conception of time and space: in the Casa della Salute, time is useful for carrying out services, and space is strictly located to the area in which the health service is used. In the Casa del Quartiere, on the contrary, you are not sent home (stay as long as necessary) but it is receptive: the inhabitants stay inside without time and without space constraints (except those attributable to patients sharing). The Casa della Comunità should bring the two models to a synthesis, even if it would be useful to explore, in order to fully integrate the concept of community within the organization of social and health services, the space-time relationship in the terms described above.

5.6 Action 4 - Observing the pandemic working with the Local Health Authority Safety of Care Network: Project to Improve Spontaneous Reporting Of Adverse Events

This last action was aimed at observing the point of view of the operators involved in the Safety of Care Network that the Local Health Authority established in 2014 in order to spread the methodologies and tools of Risk Management in Local Health Authority structures (Operating Units). The network is the space where different roles, functions, knowledge and practices meet and represents the ideal context to understand how the culture of care safety operates at individual and group level. This is the privileged place to observe the risk sensemaking that is highlighted in a particular process, that of spontaneous reporting of adverse events, through which operators report events in which accidents have occurred or events that have caused harm to patients, other operators, caregivers. The reporting of events is the data on which the Local Health Authority's efficiency in terms of Risk Management is measured. In Ausl PR the Incident reporting system historically records figures which are considerably lower than the regional average. This project has actually brought much more than its initial objectives because in working with the components of the Local Health Authority's care safety network, it has made it

clear how operators build, in daily practices, individual and group Risk Management models. Ethnography in this case becomes a tool for learning observation techniques in support of Non-Technical Skills (NTS), useful for situational awareness (Weick and Sutcliffe, 2007) which is a fundamental provision for the prevention of adverse events. The project aimed to investigate the methods of spontaneous reporting of Adverse Events in Hospital and territorial Operating Units through the involvement of the members of the Local Health Authority Safety of Care Network. The members of the Network, divided into group A and Group B (control), were asked to fill in a report form of Adverse Events (EA) and, in group A, to participate in a training course in Organizational Ethnography, proposed by Ausl in collaboration with the University of Bergamo, to promote Non-Technical Skills (NTS) and verify the impact of new knowledge on the reporting of adverse events.

5.6.1 Adverse Event Reporting

The spontaneous reporting system of Events is a method of collecting reports with which health professionals can describe and report:

- ✓ Adverse events (unintentional harm caused to a patient by the healthcare system);
- ✓ Events without harm to the patient;
- ✓ Near miss (errors potentially likely to cause an adverse event, but without harmful consequences, as a result of chance or because intercepted before they actually occurred).

Adverse Events are unexpected events related to the care process that result in unintentional and undesirable harm to the patient. The adverse events affecting Risk Management are preventable ones, those that, as well depicted in the image of Reason's Swiss cheese, managed to pass through the holes because of the flaws in the organization's defense system (Flin et al., 2010 p.12).

The search for the causes of accidents has led several scholars to deepen the individual and organizational dimensions of the phenomena. Ramussen (Ramussen, J et al., 1987) and Reason (1990) proposed an approach in which the factors attributable to the human factor are conjugated with those of the environment and

the systems in which the actions take place. Active failures due to human factors are classified into knowledge-based, rule-based and skill-based errors. While the former (skill-based) refer to skill-based behaviors and are divided into errors of attention (slips) and memory (lapses), the latter (mistakes) refer to errors in the application of the rules or errors of knowledge in situations in which, for example, it is necessary to find an immediate solution to a new problem (Vincent, p. 134). Incidents, however, must also be analyzed with a systemic approach to understand the discrepancies of the context and organizational processes that affect the activities. Reason (1990) defines latent errors as those that are attributable to system conditions determined, for example, by managerial actions or decisions, norms and organizational methods that can remain silent for a long time and that become evident only when, in combination with other active factors and errors, produce a flaw in the system of defenses of the system itself (Forgeschi, Fiorani, 2010, p. 15; Damiani, et al., 2018 p. 346). Today this system-centered model is consolidated and accident is understood as a complex interaction of multiple factors and rarely due to inappropriate conduct of a single professional (Leape, 1993). "Rather than being the architects of an accident, operators inherit system flaws... their role is usually to add the final component to a lethal infusion whose ingredients have already been on the fire for a long time" (Reason, 1990). The systemic approach, in fact, clarifies the dynamics of the interactions between the individuals involved, the tools and the environment in which they take place but also considers the reasons and interpretations that underlie the choices and practices in use (Bellandi et al, p.180). A very complex subject that requires a multidisciplinary effort and the use of a varied range of analysis tools as we will see later.

5.6.2 The Flow of Incident Reporting

The flow of Incident reporting, which originated in high-risk organizations such as nuclear power plants or aeronautics and then adopted in healthcare, is based on the detection of adverse events coming from services and operating units through

the sending of record forms that, when analyzed, enable us to identify the critical nodes on which to prepare review and reorientation processes. The IR record forms describe the accidents and respond to items related to the magnitude of the event (severity) to the presence of elements that have hindered or contributed, to the causes to be sought in different types of factors from systemic and environmental to those related to the competence / behavior of professionals or to the characteristics of patients. Complex elements that require care when filled in, that cannot be limited to a quick editing, as can happen due to the lack of time reported by those who work in these contexts. In the Emilia - Romagna Region, the Health Authorities were involved in an experiment of event reporting (adverse, near miss, sentinel events) which started in 2002 in the operating rooms, then spread to all the Hospital and territorial Operating Units of public and accredited structures (Di Denia, 2012).

This detection system presupposes complex activities for several reasons: due to the nature of the mission which is to promote the responsibility and culture of patient safety in environments in which the fear of sanctions by those who do the reporting and the culture of searching for a scapegoat (Catino, 2022), can constitute a strong barrier to the search for the causes of accidents; the method used is that of collective learning that implies that the reports constitute the stimulus to prepare improvement plans that are useful for avoiding the repetition of mistakes and to prevent future ones. The document "Incident Reporting in Emilia – Romagna 2015/2016 "Underlines how the strength of the IR system is its foundation "on the culture of the "common good" and sharing, for the active contribution of operators on whom an important educational role can act".

But in addition to these strong points, after several years of application of the methodology, some critical issues have begun to emerge, such as the lack of evidence in studies as to an effective reduction in adverse events in the face of large investments in reporting systems or limited evidence on the success of a tool such as the operating room checklist (Tartaglia, 2020). Several researchers have found a reduction in the use of Incident Reporting during the pandemic, highlighting how in

emergency situations the use of IR is not a priority despite its effectiveness in retrospective analysis and predictive analysis in event analysis.

The reporting of adverse events is a process, in actual fact, that is complex because it involves putting together multiple points of view and layers of meaning not only in relation to the event but also on the most appropriate way to behave when an accident happens. Pipan defines error as a rupture to the fabric of meanings, practices and visions of the care process, a rupture that is narrated by many actors (doctor, patient, operators, managers, lawyers, judges) who incorporate different looks and knowledge (Pipan, 2014), as well as being inserted in organizational and environmental contexts that can react to the accident in a different way. For this reason, it is necessary to include, when discussing accidents, a reflection on the communities of practice, the reference cultures, the *processes of enactment* and *sensemaking* of social actors (health professionals, patients, caregivers), in the contexts where these occur.

The improvement project therefore endeavoured to investigate the signalling mechanisms by observing two factors:

- Error reporting as a learning process;
- The role of the network of care safety professionals, a body designed to raise awareness among services on the use of analysis and incident detection tools and to maintain a link with Local Health Authority risk managers for updates in the top down and bottom up direction;
- And proposing the acquisition of basic elements of Organizational Ethnography for several reasons:

- Ethnography, already tested in the analysis of adverse events at Hospital Pharmacies and the Sert of Parma (Dodi, 2016), is a methodology which is able to explore in depth the nature of the events that occurred during health practices (Lusardi, 2020) thanks to the prolonged presence within the Operating Units;
- Ethnography, for the relevance assigned to the visual and analytical dimension in reference to different contextual details (environment, relational and spatial

dynamics, artifacts), reinforces "situational awareness" (Weick, 2007) and supports the importance of the development of Non-Technical Skills (NTS) of operators.

5.6.3 The Improvement Project

The safety of care is defined by some authors as an emergent property of systems (Dagliana et al., 2021) and as a result of the dynamic interactions of structural, environmental, individual and organizational elements that, as noted by Dagliana et al, make it difficult to experiment with an effective improvement project for it to be implemented. The authors propose "implementation research" as an approach that combines quantitative research with qualitative research methods to measure the impact of incidents on operators, organization, the physical environment and ultimately also on health policies (Dagliana, 2021 p.206). Improvements, which can only originate from bottom-up processes, from those who know the contexts and are operational in the situations, therefore presuppose an investigation of the event in relation to the environment, relationships and cultures present in the organizations. Ethnographic research allows us, thanks to the presence of the observer in the field, to grasp the dynamics at play and to explore the hidden elements such as communities of practice, values, rituals, etc. that play a role in daily routines, organizational systems and therefore also in the dynamics of accidents. The proposal of the improvement project stems from the intuition of the need to try to experiment with qualitative research methodologies together with traditional Risk Management methods, without being aware that the working hypothesis could be based on a consolidated approach (Implementation Science). This approach, even if only discovered in the follow-up phase of the project, becomes the theoretical reference point to which it is possible to refer.

5.6.3.1 The Local Health Authority Care Safety Network

The project involved the professionals who make up the Ausl Care Safety Network, a body founded in 2014 with the function, as stated in the act of

establishment, of consulting, reference and verification of the progress of the culture of safety of services and health paths. Professionals not only from Hospital departments, but also from the departments of Primary Care, Public Health, and Mental Health had had already been part of the first organization forterritorial services. This integration between hospital and territorial services was also maintained in the reorganization of the Network that took place in 2021 and which saw a renewal of its composition and structuring as well as in the definition of its mission and objectives, thanks to an innovative approach traceable in the document " Local Health Authority Network for the Safety of Care 2022 – 2024" drawn up by the Local Health Authority Risk Management and Legal Medicine. Today, the network consists of 80 members divided into different functions based on roles, experience and training in Risk Management (expert facilitators, referents, permanent guests, directors).

In May 2022, the coordination of the Risk Managers of the Emilia – Romagna Region released the document "The facilitator for the Safety of Care in the Health Authorities of the Emilia-Romagna Region: functions and activities" with the aim of implementing the "Guidelines on the regional architectures of the Centers for health Risk Management and patient safety", approved by the Health Commission of the Conference of Regions and Autonomous Provinces, in which reference is made to the network of Operational Unit/Department referents (also referred to as "facilitators") coordinated by the Local Health Authority risk manager. The document specifies the role of the network as "a set of subjects that constitute the operational reference within the organization, also to promote reporting and comparison on adverse events and near misses" and defines the profile of the facilitator.

Tab. 27: Profile of the Facilitator of the Network According to the Indications of the E-R Region

The role of the facilitator of the Network of Referents of the Safety Management of Care
✓ Promotes the culture of safety in the organization and among operators;
✓ It favors the reporting of events and *near misses*. Sensitizes its context to the reporting of significant events for the safety of care, supporting colleagues in the overall management of the event;
✓ Guarantees the timely information of the *risk manager* in the event of a sentinel event or any

other major adverse event;

- ✓ Promotes effective management of event communication, both with external interlocutors and within the team;
- ✓ Supports the organization in the analysis of events through the application of methodologies and techniques for the identification of errors, contributing factors and related corrective actions;
- ✓ Contributes to the dissemination and application of legislation and guidelines at national and regional level and related Local Health Authority application documents;
- ✓ Provides support for the definition and / or revision of documents, procedures / protocols necessary for the correct management of health activities and Risk Management;
- ✓ Supports the Director and the Coordinator of the structures to which they belong (if not himself) in the implementation of activities related to Risk Management and safety of care;
- ✓ Promotes the use of Risk Managementtools in the reference context (*incident* reporting and specific reporting forms, event analysis – SEA, RCA; process analysis – FMEA-FMECA; direct observations – OssERvare App; safety visits – Regional Project Visit, etc.);
- ✓ Promotes the introduction of suitable operational tools (e.g. *checklists*) adapted to the context to which they belong;
- ✓ Promotes the collection of data necessary to feed the information flows of interest; - collaborates with the *risk manager* in monitoring and returning data to professionals, encouraging comparison and discussion within the structure to which they belong, with a view to identifying critical issues and possible improvement actions;
- ✓ Collaborates with the subjects involved in the monitoring of planned improvement actions;
- ✓ Collaborates with the *risk manager* in the design and implementation of training events both transversal to the entire organization and specific to its reference context;
- ✓ Contributes to improving the quality of health records, especially as regards aspects related to the safety of care;
- ✓ Supervises Risk Management processes related to the performance and clinical and care pathways of their area;
- ✓ Stimulates the involvement of patients and family members/*caregivers* on actions to ensure safety.

Source: Author's elaboration from Regional indications

The network, however, precisely because of its composition and complexity cannot be considered only in terms of functions and tasks to be performed but must also be observed in its horizontal (peer comparison) and transdisciplinary (comparison between professions and disciplines) relational dynamics, as well as for it being a place of learning and transferral of knowledge and experience from the most experienced members to new ones. The network, according to Latour, is not only a set of functions but a dynamic flow of which we can only observe the trace of the interactions that take place between "human and non-human" actors (Latour, 2005). Latour examines, in particular, the dichotomy between mediators and intermediaries, referring to both human actors and objects, ways of being different depending on whether a transformative and generative power is put into practice in

actions (mediators) or a mere passage of information (intermediaries). In this sense, the project intends to interpret the role of the safety net as a group of agents that generate transformations and that in order to perform this role, need to understand the complexity that accompanies the processes that generate changes which are not only attributable to purely organizational aspects (functions and tasks). We will see how the two actions carried out in the project, the survey form and Organizational Ethnography course, as disclosed by the participants, the fundamental ingredients not only for improving Risk Management programs but for building truly effective processes and methods through the value attributed to the relationship and ultimately to the consolidation of non-technical skills.

5.6.3.2 Project Organization

The project was developed along two lines:

- The first of recognition of the Risk Management activities developed in the operating units with particular reference to the spontaneous reporting of adverse events through Incident Reporting, Falls, etc.;
- The second involved the organization of a course of Organizational Ethnography co-conducted in collaboration with Prof. Lusardi of the University of Bergamo, for the members of the Ausl Parma Care Safety Network and aimed at adding to the competence of professionals methodologies to reinforce their *Non-Technical Skills* which have proved (NTS), fundamental for situational awareness, a characteristic which is especially necessary in terms of safety of care.

The project started in March 2021 and ended in May 2022. In particular:
Request to send the fortnightly survey form – from March 2021 to December 2021;
Participation in the Organizational Ethnography Course – in offline mode for all members of the Care Safety Network from April 2021 to today; From May to November 2021 for group A of the Care Safety Network; from April to May 2022 for group B of the Care Safety Network.

The preliminary phase of the project consisted in the development of two elements: the detection tool and the composition of the groups of professionals to be contacted.

5.6.3.3 The Survey Form

The phase dedicated to the sending of the report detection form on the part of the members of the Local Health Authority Care Safety Network is the result of a process of reflection on three issues:

1. The AUSL has activated the registration of reports of adverse events that are forwarded by individual professionals or Operating Units (OUs) to a Local Health Authority email of the Risk Management Unit which then centralizes the collection, archiving and classification for them to be sent to the Region. The AUSL does not have a similar system of collection, analysis and bottom-up archiving by individual OUs, except for the Department of Mental Health and Pathological Addictions (DAISM DP), which has built an autonomous monitoring system. The lack of an independent risk assessment by the Local Health Authority OUs in the areas of competence, creates very high expectations of the central Risk Management system for the resolution of problems once reported, so the request for feedback is unremitting in a top-down movement that does not consider accidents, physical and relational places where they happen, to be inseparable elements and that change must necessarily be generated in that context and not at the table;

2. The lack of elements for analysis collected by the peripheral OUs does not enable us to analyze the correspondence between the number of adverse events or near miss reported ones with those that actually occurred in the OU, those in line for sending or those not reported purposely;

3. In the process of detecting the IRs in use, some context data are not collected, such as the role assigned to Risk Management issues in the moments of internal coordination of the OUs, if present in dedicated teams or if left to the impromptu of some moments during the meetings.

The process of elaboration of the survey form was shared by the project team, composed of the two Local Health Authority Risk managers who support the project, the writer and a consultant from the training service, the result of which was firstly a very approximate hypothesis that acted as an initial prototype that, after slight changes during the project, was consolidated into a definitive format. The items were chosen on the basis of the trends of the IRs in recent years together with the questions arising from their analysis that led the researcher to question the missing data and information that may point to investment by the Operating Units, for example through the organization of organizational audits, teams that are dedicated and shared with citizens. The survey form consists of three parts: a first part relating to registering the service, with the specification of the Department and the Operating Unit they belong to; The second part, the heart of the investigation, explores the different choices that professionals can make, explaining the events reported officially, those not reported, those still under discussion at the service they belong to. This subdivision allows us to highlight two phases of the process that do not always have consequentiality: the phase of elaboration and internal reflection of the event can result in a final report or can generate different outcomes that, not being part of the questions to be filled in the survey form (the form which is sent), mean the loss of different kinds of information, in particular on individual and / or group reflections and decision-making processes that give the assessment of events a wide range of possibilities. The request to indicate one of the three options was therefore intended to facilitate the professional to bring out even what is not required (keep note of what is not sent) also to highlight any difficulties that have emerged and to be noted in a specially dedicated notes space. [30] The third part investigates the use by the Operating Units of adverse event analysis tools through internal audits; The space dedicated to the safety of care during meetings or just occasionally is also explored. The survey form initially proposes a question about non-conformities that

[30] all those sent to the e-mail address of the Risk Management and Forensic Medicine Unit to which all Local Health Authority employees can write to report adverse events

are defined by quality management system standards as a failure to meet a requirement (ISO 2015: 9001). Different in nature and type of data processed, non-conformities and reports of adverse events share the logical process that underlies them which can be summarized in the Deming cycle which includes a planning phase (plan), an action phase (do), a verification phase (check) and an action reorganization (act), a dynamic of action, evaluation and redefinition of projects aimed at continuous improvement. The question aimed to investigate any overlaps in the use of one type of reporting rather than the other, hypothesizing, if these occur, some reasons such as, for example, a lack of knowledge or a mistaken interpretation of their non-interchangeability.

Tab.28: The Survey Form

Date of sending card □ 1 of the month of: □ 15 of the month of:					
□ January	□ February	□ March	□ April	□ May	□ June
□ July	□ August	□ September	□ October	November □	□ December
Department/District: ... **Operating Unit/Service: …….....**					
1 - HAVE ANY NON-CONFORMITIES been detected? □ Yes □ No					
1a - How many NON-CONFORMITIES have been reported? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10					
What tools were used for reporting?					
□ Reporting forms □ Report □ Recorded minutes □ Informal Report □ Other					
2 - Have EVENTS WORTHY OF FURTHER INVESTIGATION been detected (e.g. adverse events, near misses, falls, ...)? □ If □ No					
2a - How many EVENTS WORTHY OF FURTHER INVESTIGATION have been reported? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10					
What tools were used for reporting?					
□ Reporting forms □ Report □ Recorded minutes □ Informal Report □Other.....					
2b - How many EVENTS WORTHY OF FURTHER STUDY are still to be reported (e.g. under analysis, ...) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10					
What tools were used for the detection?					
□ Report □ Minutes registered □ Informal Report □Other					
2c - How many EVENTS WORTHY OF FURTHER INVESTIGATION have not been reported? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 **Note**……					
3 - In how many non-finalized team meetings has Risk Management been discussed? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ More than 5					
4 - How many (organizational) team meetings on cases have been held? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ More than 5					
5 - How many (organizational) audits on cases have been carried out? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ More than 5					
6 - How many meetings with other Operating Units have been held? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ More than 5					
7 - How many actions aimed at involving patients/patients have been planned? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ More than 5					
8 - How many actions aimed at involving professionals have been planned? □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ More than 5					

Source: Author's elaboration

5.6.3.4 Organizing the Target: Group A and Group B of Network

The project was proposed to about 63 members of the network, from the total number of 80 professionals, directors and operators who are not directly involved in clinical and care activities were in fact excluded. The participants were divided into group A and group B following the following eligibility criteria: equal distribution according to gender, seniority, function and service they belong to. In cases of co-presence of several operators of the same OU, the choice was made to divide them into the two groups according to the distribution of role allocation

Tab. 29: Operators Involved

	n. absolute	%
Hired professionals	n. 53	
Professionals who participated continuously	n. 38	73%
Operating Units that participated continuously	n. 38	

Source: Author's elaboration

The Department of Mental Health and Pathological Addictions (DAISM DP) and Public Health decided to send a single summary sheet for all the Operating Units represented. The DAISM DP set up a secondary project of visits to the RU to collect the data necessary for filling in the form, for filling it in collectively and this gave rise to a discussion and re-mapping of the risks at the level of each individual structure.

5.6.3.5 Data analysis

646 survey forms were collected during the experiment which were sent directly by the members of the network invited to participate. The sending of the forms had a constant trend: the first quarter recorded a high participation (between 70 and 80% of those hired) with an average of 74% which fell to 60% during the summer period and stabilized at 57% in the last quarter. Overall, 65% of those invited to participate in the project sent the required survey forms throughout the trial.

Tab.30: Number of Survey Form Sent

Number of survey forms sent and % of forms sent out of 53 expected ones

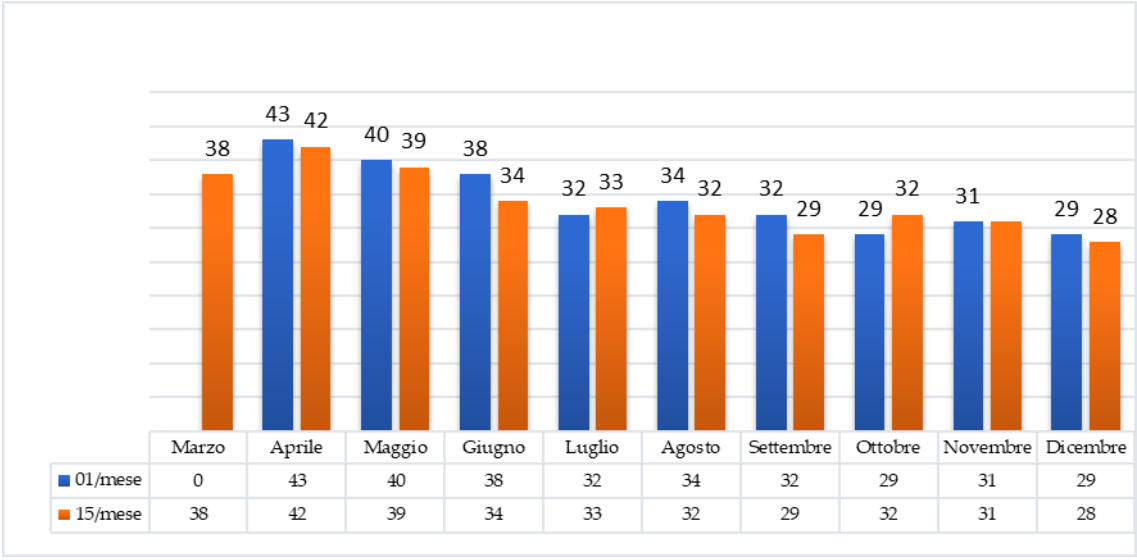
	01/ month	15/m onth	01/m onth	15/mo nth	% to
March	0	38		72%	72%
April	43	42	81%	79%	80%
May	40	39	75%	74%	75%
June	38	34	72%	64%	68%
July	32	33	60%	62%	61%
August	34	32	64%	60%	62%
September	32	29	60%	55%	58%
October	29	32	55%	60%	58%
November	31	31	58%	58%	58%
December	29	28	55%	53%	54%
Total	308	338	65%	64%	65%

Source: Author's elaboration

This figure is particularly significant if contextualized with the historical moment experienced by the operators, engaged in facing the pandemic which, however, did not prevent them from responding. The survey forms were sent to the email of the writer who filed them in order of arrival, date and name. The role of the researcher was important in maintaining contact with professionals through individual and group emails, individualized phone calls and opportunities for exchange at meetings.

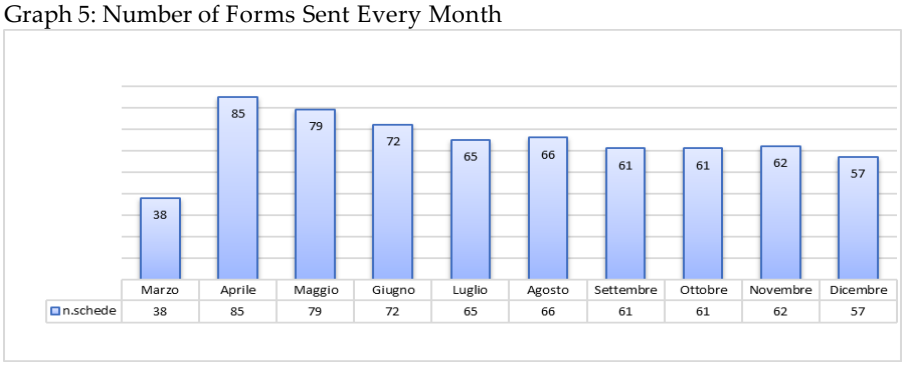
Graphs 4 and 5 show the trend of forms sent in broken down by date and month

Graph 4: Forms Sent by Date



Source: Author's elaboration

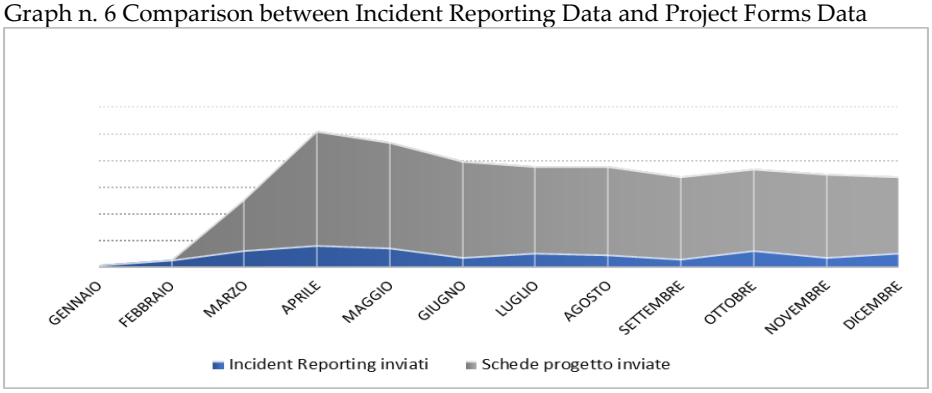
Graph 5: Number of Forms Sent Every Month



Source: Author's elaboration

The most interesting data is related to the comparison between the detection sheets sent and the *Incident reporting* cards sent divided by date. As can be seen from the graph, the trend of the IRs, with peaks of the highest number sent, follows the trend of the detection sheets required by the project. The hypothesis formulated is that the relationship that has been established with the researcher who has continuously formulated, through emails and individualized phone calls, the request to send the project sheets, constitutes a facilitating factor also for sending the IRs that become an instrument without censorship or fear because exchanged in a context of knowledge and mutual trust. In support of the hypothesis that the continuous and individualized relationship with contacts from the network reinforces the reporting processes is seen in the fact that several IRs have been addressed not to the email address but directly to the researcher.

Graph n. 6 Comparison between Incident Reporting Data and Project Forms Data



Tab. 31: IR and Number of Project Forms Sent – Source: Author's elaboration

	N. IR sent	N. Project Sheets Sent
January	2	0
February	6	0
March	13	38
April	17	85
May	15	79
June	8	72
July	11	65
August	10	66
September	7	61
October	13	61
November	8	62
December	11	57
Total	121	646

5.6.3.6 Items Analysis

During the trial, 144 events worthy of being reported were identified by the RUs, of which 27 still to be reported and 25 that have not yet been reported.

The main tools used were reporting forms (No 95), but informal reports (No 18), minutes (No 2) and internal reports (No 3) were also used. The Internal Audit tool has been reported only once as a way of exploring the event in use in the OU.

Adverse events are mainly discussed in non-finalized and episodic meetings (cases discussed in a meeting). Case-focused meetings are mainly organized into one or two sessions, although in some OUs, such as DAISM DP, the choice to deal with sessions in more than five meetings is recurrent.

Tab. 32: Focus question 4 - Source: Author's elaboration

Domanda 4 - riunioni equipe focalizzate sui casi								Totale
mese	0	1	2	3	4	5	99	
Marzo	28	7	0	2	0	0	1	38
Aprile	67	6	2	2	0	1	7	85
Maggio	64	6	1	2	2	0	4	79
Giugno	56	6	4	2	2	0	2	72
Luglio	55	3	3	1	1	1	1	65
Agosto	58	3	3	0	0	0	2	66
Settembre	51	3	6	0	0	0	1	61
Ottobre	47	5	7	0	0	0	2	61
Novembre	48	2	7	2	0	0	3	62
Dicembre	45	1	3	0	4	1	3	57
Totale	519	42	36	11	9	3	26	646

As mentioned above, the use of Audits is reported as an infrequent tool. The OUs report that it was only used 52 times during the year.

Tab 33: Focus question 6

	Domanda 5 - quanti audit organizzativi sui casi					Totale
mese	0	1	2	3	Non ha risposto	
Marzo	31	4	1	0	2	38
Aprile	80	1	0	0	4	85
Maggio	74	2	0	0	3	79
Giugno	63	4	1	0	4	72
Luglio	55	5	3	0	2	65
Agosto	62	2	0	0	2	66
Settembre	53	5	0	1	2	61
Ottobre	49	8	0	1	3	61
Novembre	53	3	3	0	3	62
Dicembre	45	3	1	4	4	57
Totale	565	37	9	6	29	646

Source: Author's elaboration

Otolaryngology at Fidenza Hospital is the most experienced OU in the use of the tool.

Tab. 34: Focus question 5 - Source: Author's elaboration

Domanda 5 - quanti audit organizzativi sui casi			
UO	1	2	3
ADI Sorbolo	1	0	0
Chirurgia Borgotaro	1	0	0
Comparto Operatorio Chirurgia Fidenza	1	0	0
Cure Intermedie San Secondo	2	2	2
Daism Dp	2	1	0
DCP Fidenza	1	0	0
Endoscopia Borgotaro	1	0	0
Neurologia Fidenza	3	0	0
NPIA San Polo di Torrile	1	0	0
ORL Fidenza	11	5	4
Ostetricia e Ginecologia Fidenza	1	0	0
PPIO Borgotaro	1	0	0
Radiologia Borgotaro	2	0	0
Rianimazione Fidenza	9	0	0
Totale	37	9	6

5.6.3.7 The Course "Organizational Ethnography and Risk Management"

The division into group A and group B was used in the second phase of the project which initially provided only for the involvement of group A and was then extended, in May 2022, to Group B. The course aimed to examine Organizational Ethnography as a useful methodology to develop the so-called situational awareness (Weick, Sutcliffe, 2007), the ability to realize and participate in what happens in the context in order to prevent any adverse events. The assumption from which the training project starts is that we can talk about risk; Risk is an object of work that

must be legitimized. The more we talk about Risk Management, the more we can see and work on the safety of care.

This approach requires a change in the culture inherited from the past of the idea that risks can be removed from a process of controlling procedures. This approach is abandoned in favor of the idea that risk is an object, an object, something that you need to live with in organizational life. Organizational ethnography can help stimulate an observation capacity and achieve situational awareness that favors preventive actions. Ethnography and in particular participant observation, allows professionals to observe the context by decentralizing their gaze and, positioning themselves from a non-routine point of view, focus attention on daily work practices. The course, promoted during the second pandemic wave, was organized in the manner required by the emergency, thus favoring remote modalities. The modalities of delivery of the course were an opportunity for in-depth reflections in addition to the commitment required of health professionals (level of depth of the subject, number of meetings, duration of meetings ... etc.) who were still exhausted from their efforts to contain the pandemic. The course was thus divided into two phases: a first part pre-recorded by the teacher and available on Foraven, an e-learning platform supported by the companies of the E-R Region and usually used by all Ausl Parma professionals and one in online presence organized over 3 days, for a total of 9 hours in total. The pre-recorded course, organized by Prof. Roberto Lusardi of the University of Bergamo, is divided into teaching units whose objective is to provide basic knowledge for reading and analyzing socio-organizational processes in the situation, develop greater awareness of the socio-organizational dynamics of one's work environment and promote the spreading of a safety culture. The teaching units provide for a constrained progression (you access the next step after completing the previous one) and provide, at the end, a learning questionnaire, which is also useful for the recognition of ECM credits.

Tab. 35: Course Units

On-line course teaching units
1. Risk (in daily practice)
2. How to analyze practices in healthcare
3. What is organizational ethnography?
4. The ethnographic method in Health
5. The tools of the ethnographer
6. Communicate disagreement

Source: Teacher elaboration

The second phase of the course was organized in mixed online and face-to-face mode. Group A participated in two online meetings (26/05/21 and 16/06/21 from 14.30 to 16.30) and one in presence (25/11/21 from 14.30 to 18.30). For the meetings in online mode, the blackboard platform was chosen to allow those present to participate in group work. The last meeting included going over the exercises carried out remotely. The course was attended by 26 operators of the Safety Network of Care. Group B played the role of control group in the first phase of the experiment and participated during Organizational Ethnography in presence in May 2022 (11/05 – 17/05 and 30/05/22 from 3-6 pm).

The course program has slightly changed compared to the previous one, also including the theoretical part that in the first course was delegated to the module on the e-learning platform. The low number of professionals who had completed the pre-recorded course allowed us to evaluate the effectiveness of the e-learning modality which was probably particularly complex for the historical moment experienced by professionals who, despite the degree of freedom granted in concluding the course, did not respond, as they did for the face-to-face course. 12 professionals took part in Group B. Overall, the course saw the participation of 38 members of the Safety Network of Care, a number that is close to the number of those who assiduously filled out the recognition forms of spontaneous reports.

The Group A training course was organized in three meetings, two on the Blackboard platform and one which was face-to-face. In the first two meetings the participants were divided into 3 working groups with the aim, for each group, to collect the stories of adverse events relevant to each component and choose a case on

which to elaborate a common improvement action. This strategy aimed to promote mutual knowledge and a narration of events among peers, in a context in which the transversality of the professionalism present could exert an influence on the interpretation of events by dislocating the gaze from multiple points of view, not in a hierarchical or sectorial way, but focusing on the relationship as a key to knowledge and understanding of events. The teachers, in fact, decided to divide the groups ensuring maximum heterogeneity and not to intervene in the discussion to avoid any form of external conditioning. The task, therefore, becomes an exercise in self-observation in groups, of the dynamics and elements that can favor awareness and mutual exchange on a theme that is often difficult to talk about. The presence of three classroom tutors facilitated the alternation of voices in a narrative with few boundaries attributed by the teachers. The sessions were not recorded to allow full freedom of expression of the participants. Criticality: the instability of the connection of the blackboard platform made it cumbersome to stay in the groups. Despite the connection problems, everyone managed to contribute to the work. At the end of the two sessions there was a meeting with the tutors to collect impressions and to organize the last session of the work that had the aim of returning the main points that had emerged in the previous days and that were elaborated by the participants in a summary which was then given back to the groups. Group B's training course was organized in three meetings in mixed mode, in presence and online, the course included a theoretical part and a practical part in which participants were asked to simulate an ethnographic observation following an observation card to facilitate the task. Divided into three groups, the students then narrated and commented on the experiences, bringing them back to the plenary in a moment of conclusive restitution. Again, group work allowed for the sharing of knowledge between different OU professionals and the understanding of the interrelationship between them in daily practices.

At the end of the course the participants were asked to produce a paper in which to summarize the ethnographic experience they had had.

During the meetings, a number of topics relevant to Risk Management emerged:

- Role of the network;
- The members of the network never have the opportunity to compare with each other;
- The contact person does not have a clear mandate from the management;
- Difficulty on the part of the referents to spread the issues among peers;
- Lack of authority and legitimacy of those involved in Risk Management within the OUs; redundant bureaucracy;
- The need to enhance the value of operators who care about the culture of safety of care;
- The need to share and replicate improvement actions already identified in some OUs;
- The rigor in the compilation of valuable forms becomes a defect and an occasion for conflict in the OU;

Network function:

- Lack of listening;
- Community moments are missing;
- Dedicated teams are missing;
- There is a lack of an acLocal Health Authoritying process to ensure that awareness can pass from the center to the outskirts.

Common information and languages:

- Lack of information between OUs about what they do about taking charge of the PCs, who does what, particularly at times when the PCs are shared.
- When adverse events straddle different OUs there are different languages and tools that are not mutually known. This causes blocks or barriers to the solution of the problem;
- There is little cohesion between professional figures;
- Fragmentation in the evaluation of the event;
- The remodeling of the work activity with the integration of the various professional figures is problematic. There is difficulty in integration between oss, nurses, technicians. If these figures do not work in absolute and total harmony, the management of the work activity becomes problematic and this generates stress, moments of impasse and consequently the error.

Role of the individual operator:

- Low threshold of attention in routine;
- Difficulty in using the card;

- Breaking habits.

At the end of the meetings, numerous proposals emerged below, summarized below;

- Request for investment in the most widespread safety culture that does not concern only the sector, only the operators but that is widespread at every organizational level;
- Increased sensitivity and culture in the top management;
- Investment on the return of what has been reported, where an interest can be seen;
- Increased staff training at all levels. No longer referring only to the small group of network members but to all colleagues;
- Team meetings focused on general aspects, no team meetings took place, no liaisoning between OU and laboratory, exchange of information.

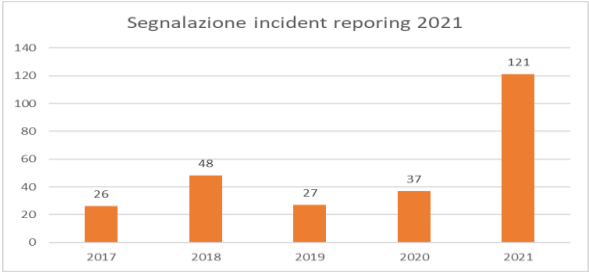
The training project was an opportunity to contextualize the reporting of incidents as a social and participatory practice and as an opportunity to analyze events also using methodologies that can improve the observation point of operators and create connections because they break the daily routine and crystallize processes in standardized activities. Organizational ethnography focuses on the operator and their role in grasping, in the context, the elements that can prevent and mitigate events. The course was therefore an opportunity to develop the knowledge of the discipline but above all to make known the critical issues and expectations of Risk Management, a subject that has the focal point of its effectiveness in relationships: relationships with operators and between operators in a vertical and horizontal sense for its maintenance in terms of recognition of its meaning at an individual and collective level.

5.6.3.8 The Survey Form as a Tool for Connections

The increase in reports highlighted by the graph is attributable to the effort of the Risk Management and Forensic Medicine Operating Unit to spread good practices in the reporting of adverse events in proactive and improvement terms: various training courses and scheduled audits are scheduled in the contexts to reconstruct particularly critical events. The project, which is part of this context of development

of different Risk Management techniques, focused on the need to work with professionals not only on the numerical data but on their ability to observe and anticipate the conditions that can lead to the accident.

Graph 7: Number Incident Reporting by Year- Source: Author's elaboration



Obviously, the improvement of the numerical data is an encouragement to combining traditional techniques with qualitative research to bring out all the complexity and richness that lies behind the raw data. I believe this is the cultural leap that can allow Risk Management to get out of the shadow of the guilt culture that, in daily practices, is difficult to eradicate. Going beyond the data allows us to deepen those elements that are not evident straightaway but that are present and that must be grasped to read the complexity of the phenomena. The following table represents the items that have multiplied by querying the form requested from project participants.

Tab. 36: Comparative Table of Non-Numerical Data - Source: Author's elaboration

Project Data	**Ethnography Course Data**	**Incident Reporting**
N. Members of The Network	N. Guests	N. Reports
N. Project Participants	N. Participants	N. Alerts X UO
N. Cards Received	N. Non-Participants	N. Report Sent by Each Participant
N. Cards Sent by Each Participant	N. Participants Who Completed the Course	N. Report Sent by Operative Units Belonging to the Network
N. Participating Ous	N. Participants Who Have Not Completed the Course	
N. Completed Forms	N. IR Forms Sent Before the Course By Course Participants	
N. Alerts Detected	N. IR Forms Sent After the Course By Course Participants	
N. Undetected Alerts		
N. Reports Yet to be sent		
N. Team Meetings Risk Management		

5.6.3.9 The network as a place of transformation and participation

The spontaneous reporting of events is a relational act that is placed in a context and that takes value only where some fundamental conditions are guaranteed: recognition of culture no blame, presence of recognition of the reporting function as necessary for continuous learning and improvement; errors are reconstructed and relocated in an organizational and collective dimension in which the event is not only a numerical data but the result of a relationship that generates at the same time a break from which further connections, knowledge, changes may arise. Reading events like the pandemic through the eyes of the network means meeting the organizational culture of the group and shared in experiences and knowledge. The project and the formation of Organizational Ethnography have explored the nature of the network that is not limited to being a set of functions and tasks but is an interweaving of relationships in which the actors share an individual and professional heritage that must be given voice and that must be heard. To translate the complexity inherent in this type of relationship, there is a need to refine tools and methods with which to develop networks as spaces for reflection and continuous learning, especially when the issue concerns the safety of care. Ethnography responds to the twofold commitment to improve the non-technical knowledge of operators and to constitute a methodology that delves into phenomena by exploring gray areas, unknown aspects, also with a view to risk prevention, subject of Risk Management study.

Conclusions in the Form of a Proposal

The research presented in these pages stems from the need to verify the effectiveness of qualitative research and in particular of Organizational Ethnography as a methodology to be combined with traditional techniques adopted in Risk Management, a specialized discipline in the health sector that, as a result of the pandemic, is now called to broaden its gaze. The pandemic has helped to influence the way in which the concept of risk and safety is interpreted not only in individuals but also in complex organisations such as health systems. How to observe such changes to the macro, meso and micro levels of health organizations, during a critical event that involved the entire world population, is the question that the research has tried to answer using the Organizational Ethnography as a suitable methodology to explore multiple levels of knowledge and operational practices.

I chose to test the effectiveness of Organizational Ethnography in four areas:

1. Analysis of the national, regional and local documentation produced before and during the pandemic on Risk Management and pandemic management. The analysis sought to identify whether there is a governance model as regards Risk Management activity in the documentation produced at national, regional and local levels;

2. Observation of the Crisis Unit of the Parma's Local Health Authority, a tool through which the strategic management, composed of top management and middle management, has regulated the events related to the pandemic. Observing the meetings meant being able to answer the question of research on the concept of governance implicit in safety processes and decision-making processes implemented in emergency management;

3. Organizational Ethnography at the Casa della Salute Pintor - Molinetto to observe the strategies of Risk Management and as a response to the pandemic implemented at the level of individual health facilities. Ethnography has been identified as a suitable methodology for focusing on the second question of research

related to the governance used in the management of the pandemic by individual services and the role of territorial health realities in preparedness. The Organizational Ethnography was also useful for examining the fourth question of research concerning the accessibility of facilities during the period of the pandemic, given the constraints placed for the containment of infections;

4. Finally, the Project for the Improvement of Spontaneous Occurrence Reporting has involved the Health Authority Safety Network that is the place where operators define their operating practices and share the meaning attributed to the concepts of safety and risk. The observation form filled in the operators was the means to increase their awareness of the working environment. The course of Organizational Ethnography, for operators, has allowed us to grasp the heart of the themes proposed by the third research question, on the role of health workers in the governance process of the crisis, on their relationship with preparedness and with the changes produced in daily practices in Risk Management practices.

The work I have presented in these pages, which is certainly not exhaustive compared to a subject with many facets, has produced a clear result with regard to the objective of verifying the effectiveness of qualitative research among the methodologies to be adopted in Risk Management, a discipline, called today, following the experience of the pandemic, improve the understanding of the complex phenomena in which it is inevitably involved. The nature of the qualitative research methodology facilitated a simultaneous and diachronic view, which enabled me to observe the three contexts simultaneously during the unfolding of the waves of the pandemic. The use of Organizational Ethnography has allowed us to stay in the field and to be in direct contact with the operators.

The research highlighted these main outcomes:

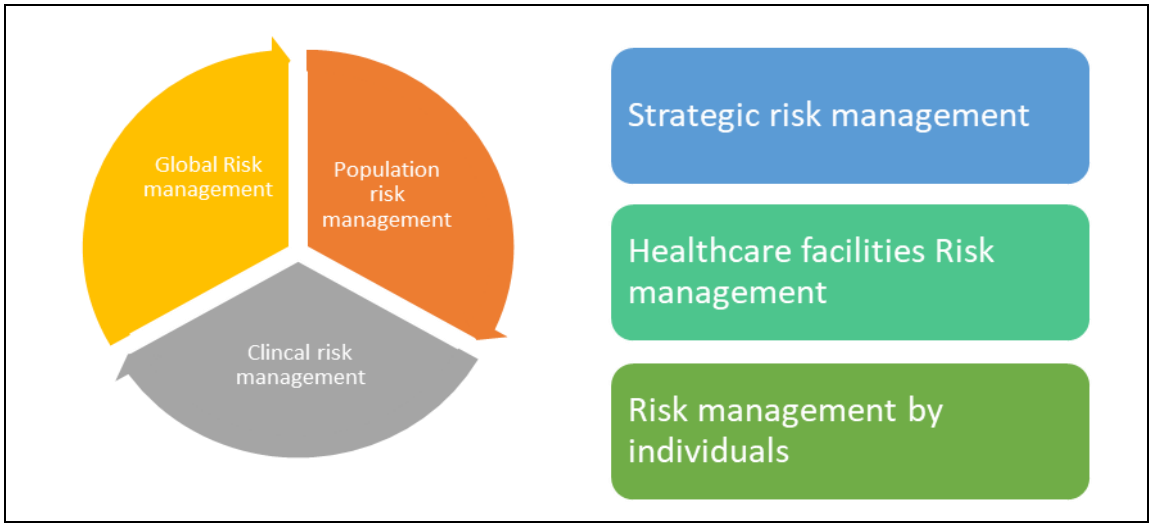
1. Functioning carried out by qualitative research methodologies as a "relational bridge" that is based on listening to the experience in the field and on the interpretation of the culture that has been built in the communities of practice;

- The contamination between tools and technologies used by sociological disciplines is a modus operandi to be actively sought as it presupposes the relationship as a cornerstone to interpret the complexity in which operators, technologies, governance processes interact in a unicum that is the very organization in which they live and operate. The methodologies of qualitative research make it possible to examine system and relational aspects that make explicit how organizations and individuals interpret reality and act. The research has made it explicit, especially in the observation at the Casa della Salute and in the Project to improve the reporting of adverse events that the mainstream "is real only what is measured"(Vincent, 2011), does not grasp the richness of the relationships and individual and group meanings that are behind the data and that it is necessary to equip oneself with trans-disciplinary tools to grasp its complexity. Behind an accident, behind a mistake, behind a critical event there is, in fact, a "story narrated by many actors (doctor, patient, operators, managers, lawyers, judges) who incorporate different looks and knowledge" (Pipan, 2014);
- The tools of Risk Management are similar to those of qualitative research in that they possess, both, characteristics attributable to the meaning of "qualitative" in which the term designates the "value of difference, singularity, idiography of dimensions that become the object of study of an epistemology of the particular and of a practical rationality (Scaratti, 2022 p. 254). A quality that, as Scaratti points out, coincides with the "conjugation of particular and general, of pluri-rationality in the awareness of a condition of non-possession of truth interpreted in the intersubjective tension to reach it" (ibid.). This attitude shows us the way to consciously use data collection tools that themselves have a relational nature (between participants), and are not elements to be dismissed as implicit, but must be thematized andunderstood, especially in a context such as health where different life trajectories and experiences meet and cross (patient experience, professional experience);

- Organizational Ethnography, in particular, in addition to being a methodology that can be used in different settings, programs and projects, becomes a tool available to professionals thanks to its transferability in situated learning paths, as a useful in-depth subject in health contexts in which situational awareness can prevent accidents and adverse events. An example of immediately achievable application could be in programs where health professionals are used for the observation and verification of the correct use of the operating room checklist or the program of correct procedures for hand sanitation: paths to further examine participant observation techniques could guarantee the quality of observations and constitute a field of profitable "hybridization" between disciplines.

2. The second in-depth theme related to the types of governance adopted in the context of Risk Management has highlighted the coexistence of Risk Management logics that pertain to different levels and that determine different ways of perceiving risk, building its meaning, and putting into practice the actions deemed most appropriate

Graph 8: The Risk Management Complexity in Pandemic Era



Source: Author's elaboration

The graph highlights the multiplication of the articulations of the Risk Management discipline which, in the management of the pandemic event, has taken on a global

dimension, one aimed at managing the safety of the population, in addition to a traditional clinical interpretation. This additional complexity required the activation of stratified governance models at several levels: a strategic level with reference to the management of safety processes at a macro system level (institutions, healthcare authorities, municipalities); a peripheral level, of the individual structures, which have constituted, in particular during the pandemic, autonomous microsystems of local response to events; an individual level conditioned by experiences, sensitivity, difficulties:

Anthropologists know what territory is, they know who survives. survives those used to have problems already, to face adversity, people who are within a service because they found the ability to ask. These people are ready. People who are ready are those who have a fragile soul, a soul ready to be helped, to question themselves. They were very prompt... if you tell me to find a number of people who are ready to drive the city, I can find them, but they are not the ones you think (Social Assistant).

These results have led me to explore the following proposals:

1. The discipline of Risk Management must move away from the technicality of a specialization (Clinical Risk Management) in order to deal with the complexity, amplified by radical uncertainty, of health systems and the environment in which they operate;

2. The culture of safety must necessarily be interpreted in a coherently and in a coordinated manner between the different components of the organizations, as the definition of the meaning of risk and safety take place in a relational context both in structural terms and in anthropological and social terms. The most difficult task for organizations is to define a Risk Management system that is able to grasp this specificity, interpreting it through transdisciplinary and relational methods, guaranteed by the circularity of information and spreading of decisions in top down and bottom-up mode. This presupposes the participation of everyone in the construction of the meaning of risk and safety and the sharing of the measure of their acceptability. When these elements are absent, they affect the effectiveness of Risk Management programs: an example is the use of spontaneous reports of events that

are activated when building a relationship with operators or the pandemic plan that is an unknown text and not used because it is a tool which is seldom used, in the drafting of operators, at non-managerial levels;

3. The theme of preparedness emerges as a principle that must be incorporated into that of Risk Management. The ways in which Risk Management is interpreted in the practices of management and operators, are, as we have seen, stratified in several levels. In the same way, different preparedness strategies are put in place as a result of the logic that oversees the various levels: the pandemic plan is the main "artifact" in which the organizational level vision of top management and middle management is made explicit. Creatively generated plans to respond to contingencies are constructed in individual structures, especially in the emergency phase, the result of trial and error adopted to overcome obstacles and experience occurring over time. The methodological bases on which Risk Management is based can constitute a solid reference for multi-located preparedness, provided that the different types that generate it are able to translate into circular reflexivity, participation from below, care of relationships. Risk Management could assume, from this point of view, the role of collector between the managerial models of business management and the communities of practice of the peripheral levels.

I believe that the pandemic has made visible that complexity, for it to be interpreted, needs a complex thinking that must be investigated using all the disciplines that can look into the folds of phenomena. In the post-pandemic, post-modern world, governed by radical uncertainty, it is necessary to equip oneself with extraordinary tools and different points of view and qualitative research can offer a valid help in this direction.

This work has been a privilege because it has allowed me to get to know the organization for which I work in areas that not accessible in the ordinariness of daily commitment. The pandemic experienced within a health organization is a doubly extraordinary event because it has been experienced by the citizen, the health worker and the researcher, three groups that have sometimes overlapped but that allowed

for three different approaches, as I also found through the narratives of the interviewees. I believe that this is the aim of the contribution of this research: to seize the possibilities that are offered to decentralize attention for the construction of knowledge that, in a discipline like that of Risk Management, is undergoing great changes after the experience of the pandemic. I hope, from this point of view, that the discipline and, more generally, health organizations can equip themselves with consolidated and recognized spaces for social research and qualitative research, due to the richness of knowledge they make available.

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