Influencing Without Authority

Cory Worden, PhD*(ABD), MS, CSHM, CSP, CHSP, ARM, REM, CESCO

May 26, 2021
Today’s Objectives

- Identify the principles of high-reliability operations.
- Identify the components of a safety management system.
- Identify the purpose of culture change and positive reinforcement.
- Identify methods of influencing a culture without direct line authority.
“High-Reliability”

- A High-Reliability Organization views management, procedural, technical, and cultural factors as all playing a part in controlling the socio-technical system.
- HRO proponents focus on the reliability of the system as a function of the relations between the components and their human operators (Haavik, 2011).
- Catastrophic accident prevention through:
  - Value of safety
  - Standardized and specific design and procedures
  - Limited trial and error
  - Redundancy
  - Decentralization
  - Exercise
  - Leading indicators
  - Integration of conditions and behaviors

(Boin & Schulman, 2008)
HRO Principles

- Preoccupation with Failure
- Deference to Expertise
- Reluctance to Simplify
- Sensitivity to Operations
- Commitment to Resilience
Hazard Analysis

- Risks
  - Strategic Risk
  - Operational Risk
  - External Risk
  - Hazard Risk
ERM

- Enterprise Risk Management

<table>
<thead>
<tr>
<th>Risk Control</th>
<th>Risk Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Acceptance</td>
<td>Risk Avoidance</td>
</tr>
</tbody>
</table>

Efforts may intertwine (Risk Control leads to Risk Transfer)
# Hazard Analysis

<table>
<thead>
<tr>
<th>Stagnant</th>
<th>Dynamic</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Don’t change</td>
<td>• Consistently change</td>
</tr>
<tr>
<td>* Require one Job Safety Analysis</td>
<td>• Require a Job Safety Analysis to determine hazard controls but</td>
</tr>
<tr>
<td>* If the determined hazard controls are used, employees will be safe</td>
<td>require constant situational awareness to determine what hazard</td>
</tr>
<tr>
<td></td>
<td>controls to use and when</td>
</tr>
<tr>
<td>* If an incident occurs, it’s either because the hazard controls</td>
<td>• Multiple variables may apply (environmental, patient, visitor,</td>
</tr>
<tr>
<td>weren’t used properly or because the hazard controls were not</td>
<td>equipment)</td>
</tr>
<tr>
<td>sufficient</td>
<td>• If situational awareness is not maintained, the hazard could harm</td>
</tr>
<tr>
<td></td>
<td>someone before they even realize to use the hazard control</td>
</tr>
<tr>
<td></td>
<td>• If an incident occurs, it could be because the hazard wasn’t</td>
</tr>
<tr>
<td></td>
<td>identified in time, because the hazard control wasn’t used,</td>
</tr>
<tr>
<td></td>
<td>because the hazard control wasn’t sufficient or a combination of</td>
</tr>
<tr>
<td></td>
<td>these factors</td>
</tr>
</tbody>
</table>
Hazard Analysis - Heinrich

- Unsafe Acts: 88%
- Unsafe Conditions: 10%
- "Acts of God": 2%

Art
Science
Hearts and Minds

- Defiantly Unsafe: 25%
- Subject to local culture: 50%
- Diligently Safe: 25%
Cultural Steps to Safety

- Know the hazards
- Know the controls
- Have access to controls
- Know how to maintain situational awareness to identify real-time hazards
- Know how to respond when hazards are identified
- **Choose** to follow safety protocols
- **Choose** to engage in safety improvements

- High Reliability Operations enable each of these steps intrinsically
Program Development

- Communication - Committees, Coaches, Huddles, and more
- Hazard Analysis / Risk Assessment
- Hierarchy of Controls
- Information Program
  - Leading Indicators / Incentive/Recognition Programs
  - Targeted Controls and Information
  - Lagging Indicators
    - Root Cause Analysis / Preventative and Corrective Actions

Accident Numbers
Culture Development and Influence
Employee Safety – everyone participates, everyone communicates and everyone wins

Communication, Feedback, Input, Suggestions and more

Campus or Organization Leadership
Set the vision, values and expectations; respond to requests for support

Safety Committee or Environment of Care Team
“Big Picture” Indicators - # and types of leading indicators, # and types of lagging indicators and current initiatives

Delegation and development of leading indicators and local expectations and communication (set observation/inspection goals and more); Implement hazard controls or request support

Employee Safety Committee (can communicate with other Committees as needed)
Analyze operational indicators and make requests for support when needed

Dual Accountability

Consult and Advise

Department Leadership

Engage

Dual Accountability

Employees
Develop leading indicators, (perform observations and more) provide feedback and input

Dual Accountability

Line Authority
Hazard Identification

- Employee engagement opportunity
- What hazards exist?
  - Conditions
  - Behaviors
  - Hazard identification challenges
  - Transitions
  - Individual Assessments
  - Management of Change
Hazard Control

- Training
- PPE
- Admin
- Engineering
- Substitution
- Elimination

Art

Science
Training

- Does training focus on the hazard or the behavior expectation?
  - Controls must be in place
  - Expectation must be set
  - Training ensures the control and the expectation are known
  - Inspections ensure the controls are in place
  - Observations ensure the expectations are performed
  - Operations and safety are not separate
Occ Disease or HIP

Observe

Patient is infectious

Orient

Norms

Training

Expectations

Hazard

Risk

Decide

Treat Patient – Be careful!

Act

Find PPE / Follow Procedures

Protect Yourself

Patient symptoms

Need hazard control or assistance

Need equipment, need assistance

Reassess situation

Need hazard control or assistance
Due Diligence

- Hazard controls must be:
  - Communicated
  - Trained
  - Available
  - Accessible
  - Convenient
  - Overseen
  - Dually Accountable
Communication and Engagement

- Human Resources/Organizational Development SME’s say that information must be presented 100 different ways to become hard-wired
- Educators say that it must be presented seven different ways seven times each
- Frequency
- Volume
- Reiteration
- Subliminal Effects
What are Indicators?

**Leading Indicators**
Predict future events and/or positive efforts towards the prevention of injuries and/or illnesses.

**Lagging Indicators**
Come after the event has already happened.
Leading Indicators

- Participation and Engagement
- Safety Performance
- “Can’t Kill Your Way to Victory”
  - Not playing ‘Gotcha!’
  - Not a punitive system
- Performance Issues vs. Safety Issues
- Dual Accountability
Lagging Indicators

- Indirect Costs (Short-staffing and more)
- SafetyNet Report
- Open Medical Claim
- SNIR
- Effects on Employee Culture
- Effects on Compliance
- Effects on Employee Health
- Incurred Costs (Direct Costs)
- Days Away, Restricted, and/or Transitional Duty (DART)
- OSHA Recordable TICR
- OHSA Recordkeeping Criteria
Reliability and Validity
Implementations in order:
- Ongoing engagement
- Ongoing post-accident investigations
- Safety Committee
- Hazard Analysis
- Hazard Controls
- Information Program
- Observations/Inspections
- Continual Improvement

Case Study - 1,500 Employee Acute-Care Hospital
Full Circle

START

Hazard Analysis / Risk Assessment and Hierarchy of Controls implementation - allow for buy-in with hazards and risk analyzed and controls in place, safe behavior and safe conditions can become performance expectations.

Information Program - Provide recurring and consistent safety messages, training, education, bulletins, and more through all facets of communication.

Targeted Controls and Information - Using leading indicator data, hazard controls and information program materials can be revisited to ensure effectiveness. If unsafe behavior exists with patient handling, do we have the best controls? Do we have information being communicated (training, education, oversight)?

Leading Indicators - Observations, Near-Miss Reporting, Inspections, and other leading indicators provide insight into unsafe behavior and conditions as well as overall program participation; this gives insight into the probability of future accidents.

Lagging Indicators / Preventive and Corrective Actions - Accident causes can be determined through Root Cause Analysis; information from this RCA can then be used in Hazard Analysis.
Engagement and Support
Summary

1. Engage!
2. Prevent!
3. Communicate!
4. Validate!
5. Investigate!

10 Minutes a Week!
If each team member takes 10 minutes a week for safety, we can make a huge difference! This may be reporting a hazard or making a recommendation on a necessary hazard control. This may be communicating a safety expectation such as using PPE or following a particular process. This may be doing a quick inspection or observation to check for safety. There are many ways to help improve safety and each team member’s input is hugely valuable.
Questions?

- Questions?
- Cory Worden, PhD*(ABD), MS, CSHM, CSP, CHSP, ARM, REM, CESCO
- the.wordens01@gmail.com


Thank you!

Join us at nsc.org/divisions