Influencing Without Authority

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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 trail 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

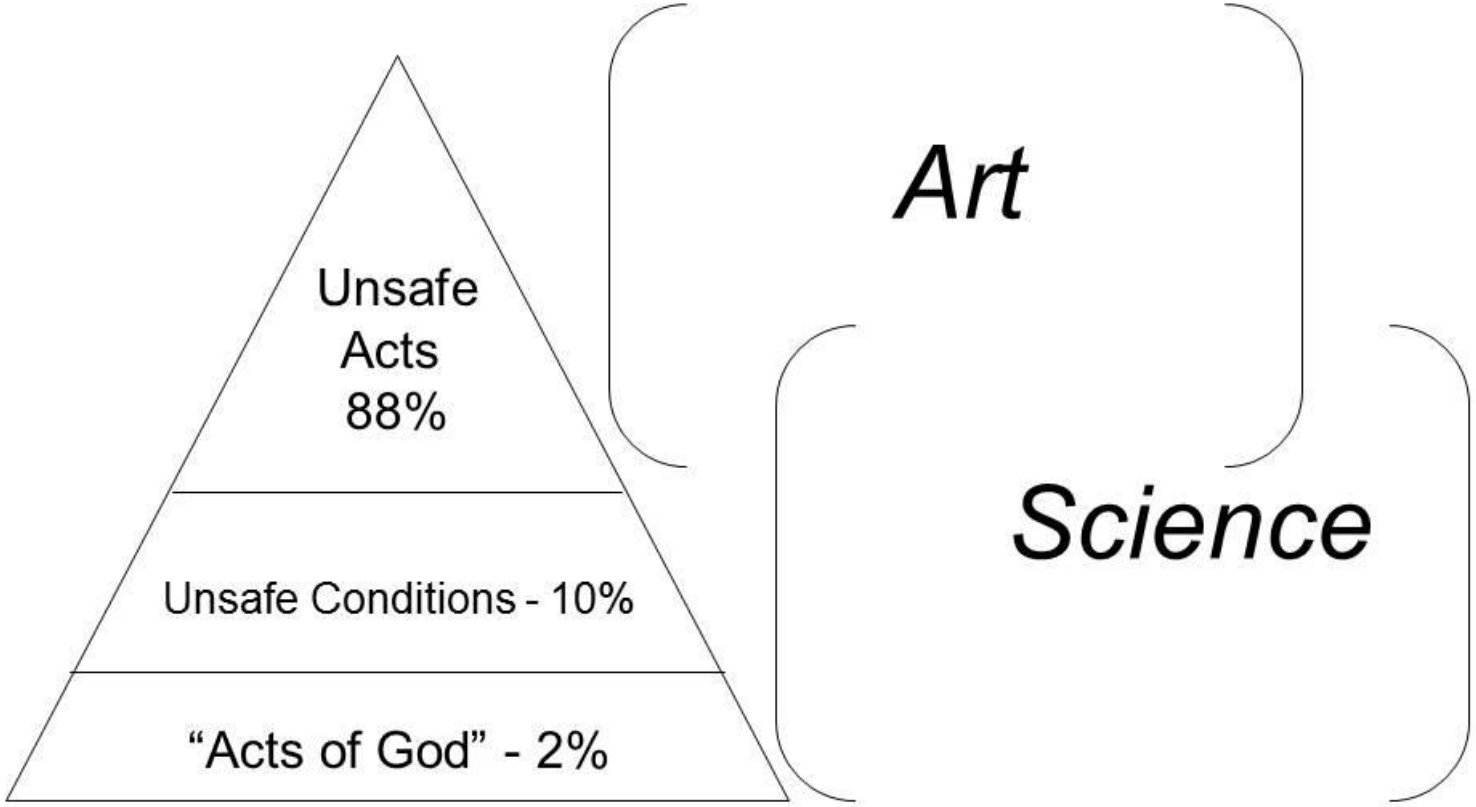
Risk Control	**Risk Transfer**
Risk Acceptance	**Risk Avoidance**

Efforts may intertwine (Risk Control leads to Risk Transfer)

Hazard Analysis

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

Hazard Analysis - Heinrich



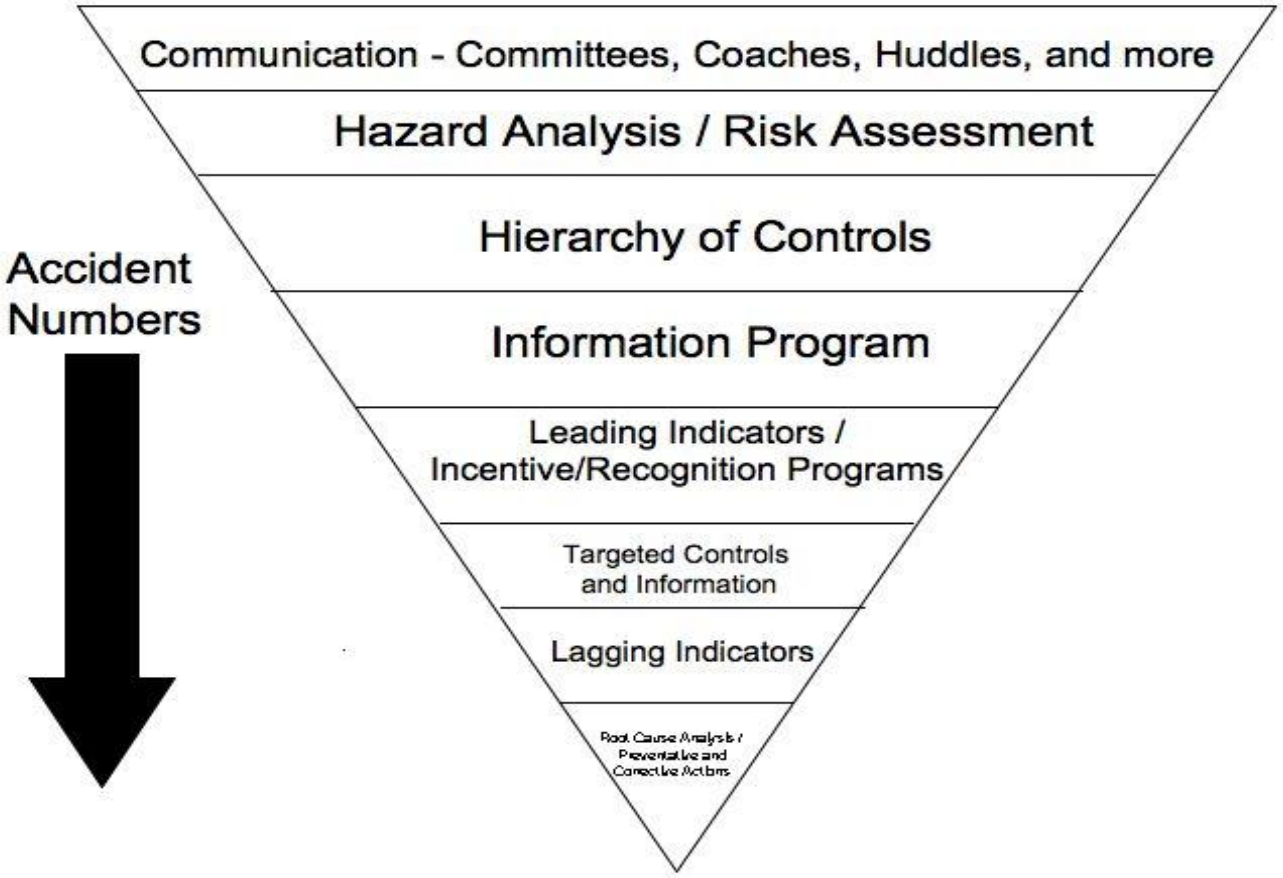
Hearts and Minds

Cultural Steps to Safety

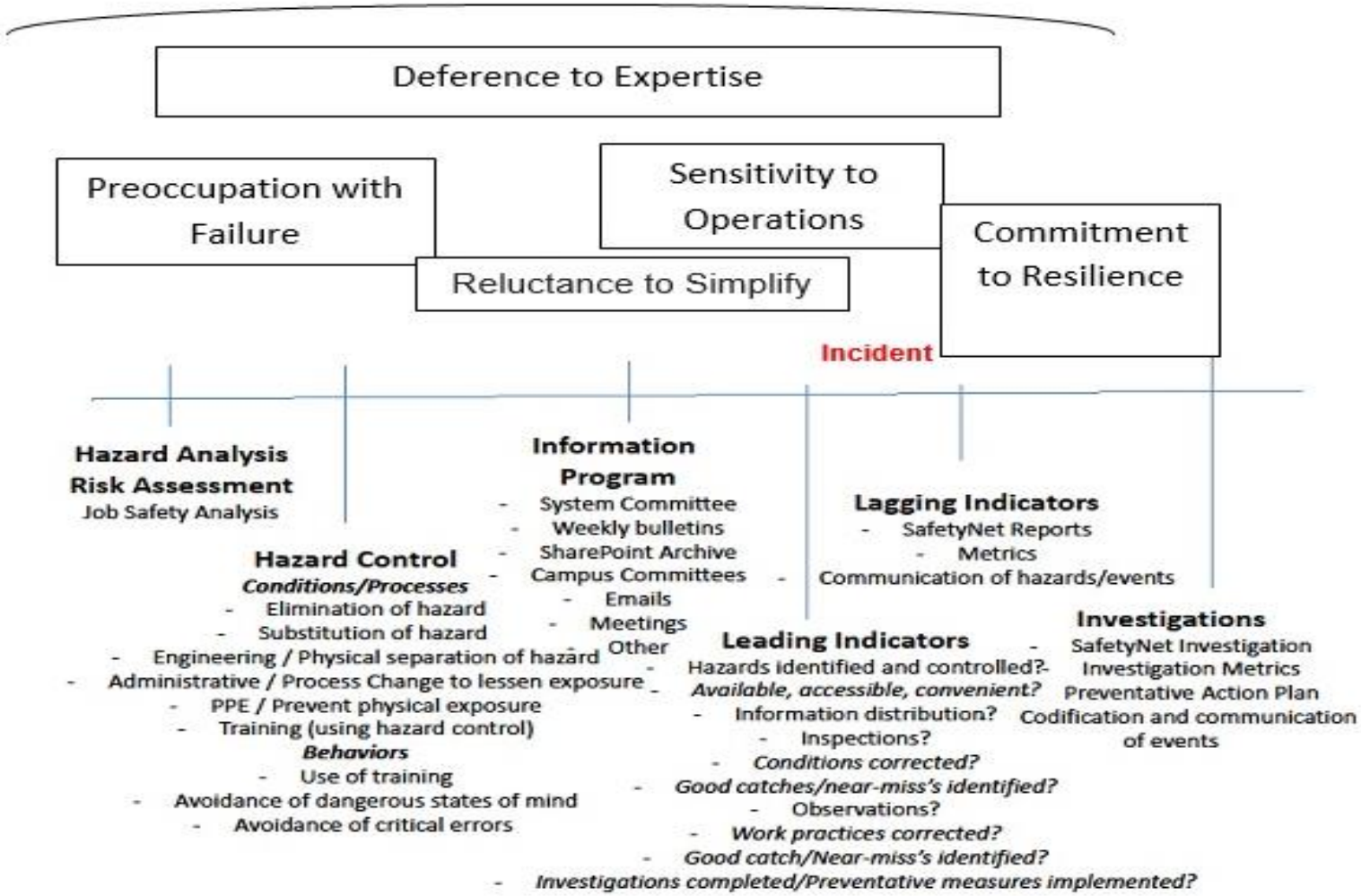
- Know the hazards
- Know the controls
- Have access to controls
- Know how to maintain situational awareness to identify real-time hazards
- Know how to respond when hazards are identified
- **Choose** to follow safety protocols
- **Choose** to engage in safety improvements

- High Reliability Operations enable each of these steps intrinsically

Program Development

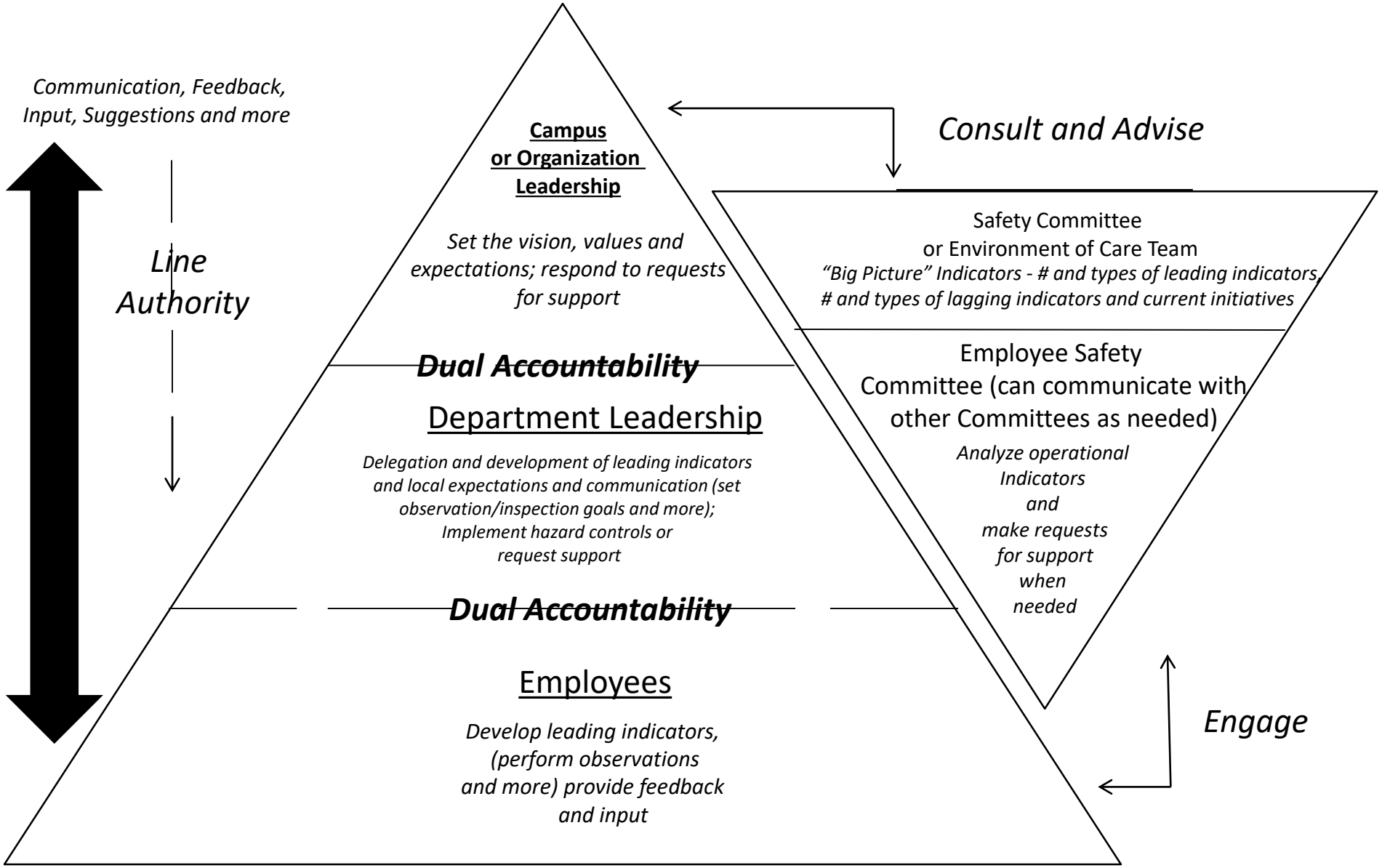


HRO Operationalization



Culture Development and Influence

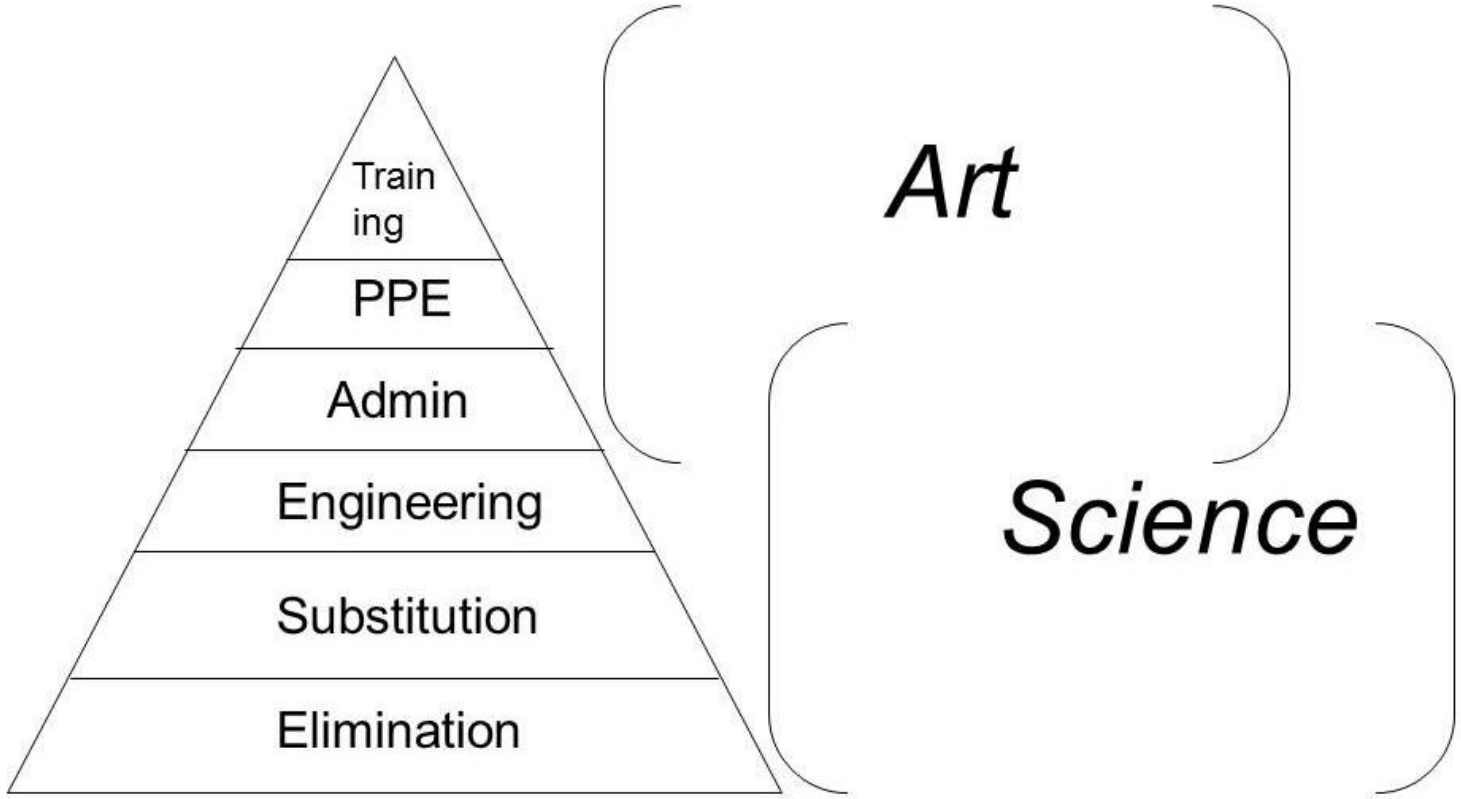
Employee Safety – everyone participates, everyone communicates and everyone wins



Hazard Identification

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

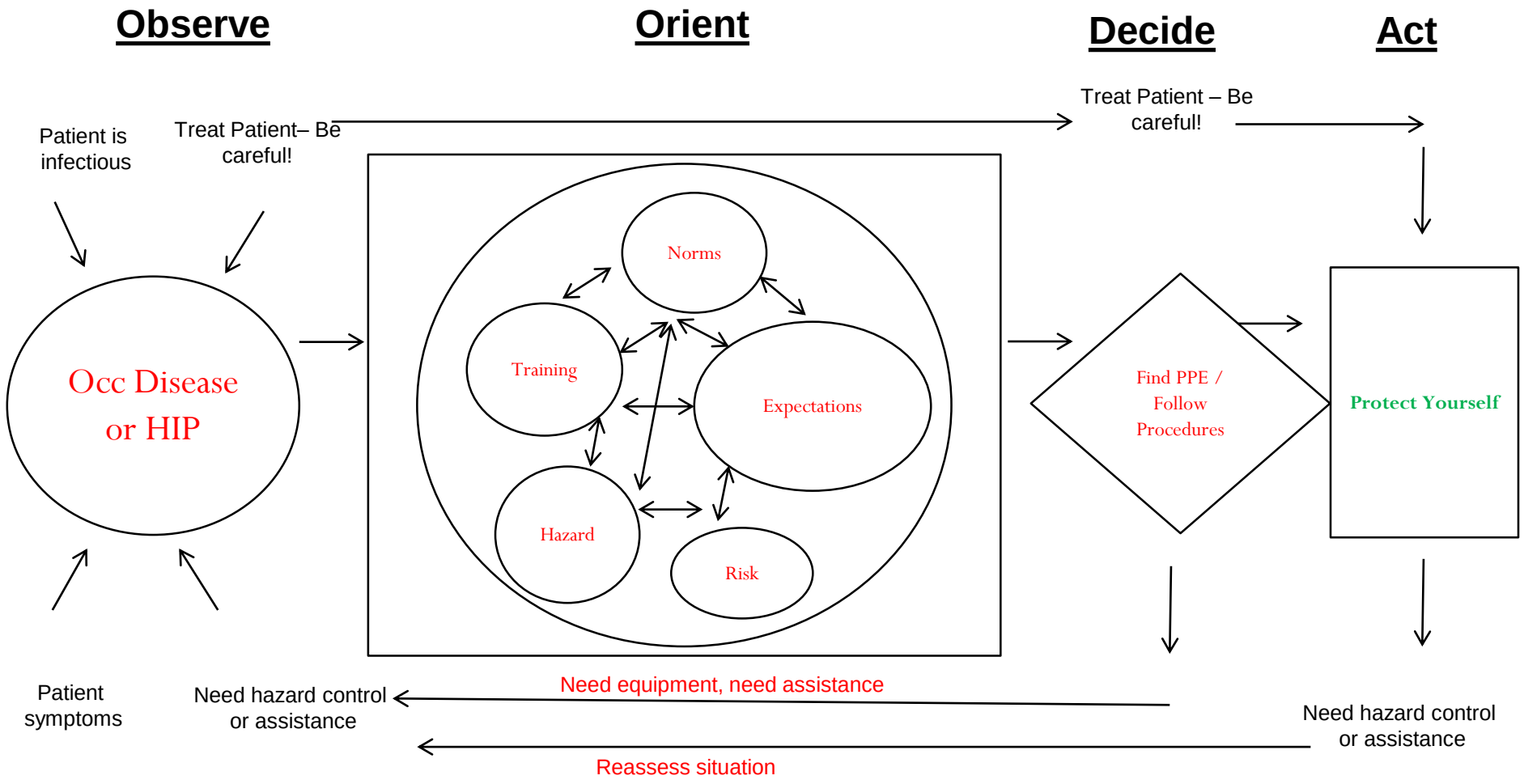
Hazard Control



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

Colonel Boyd's OODA Loop



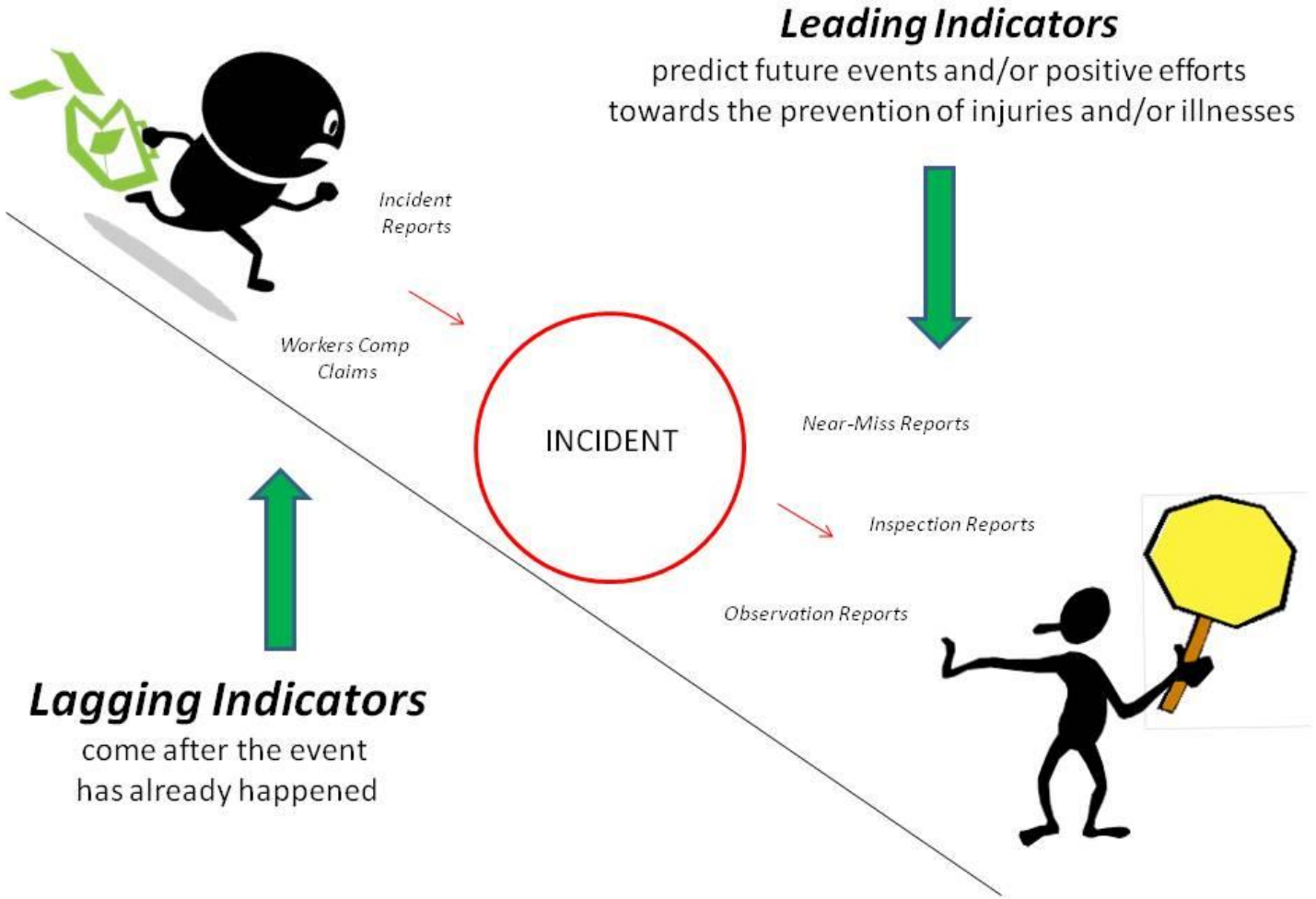
Due Diligence

- 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

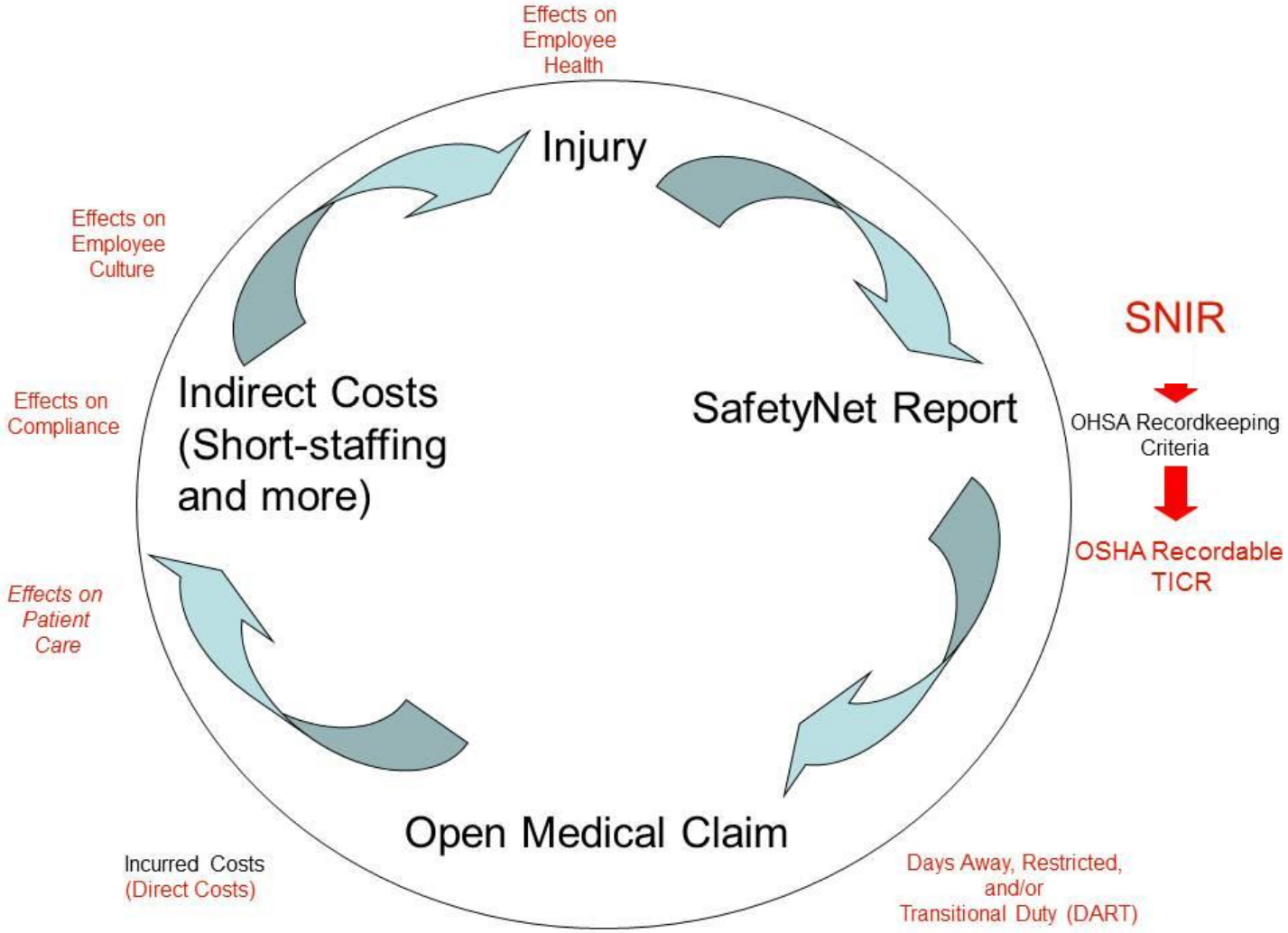
What are Indicators?



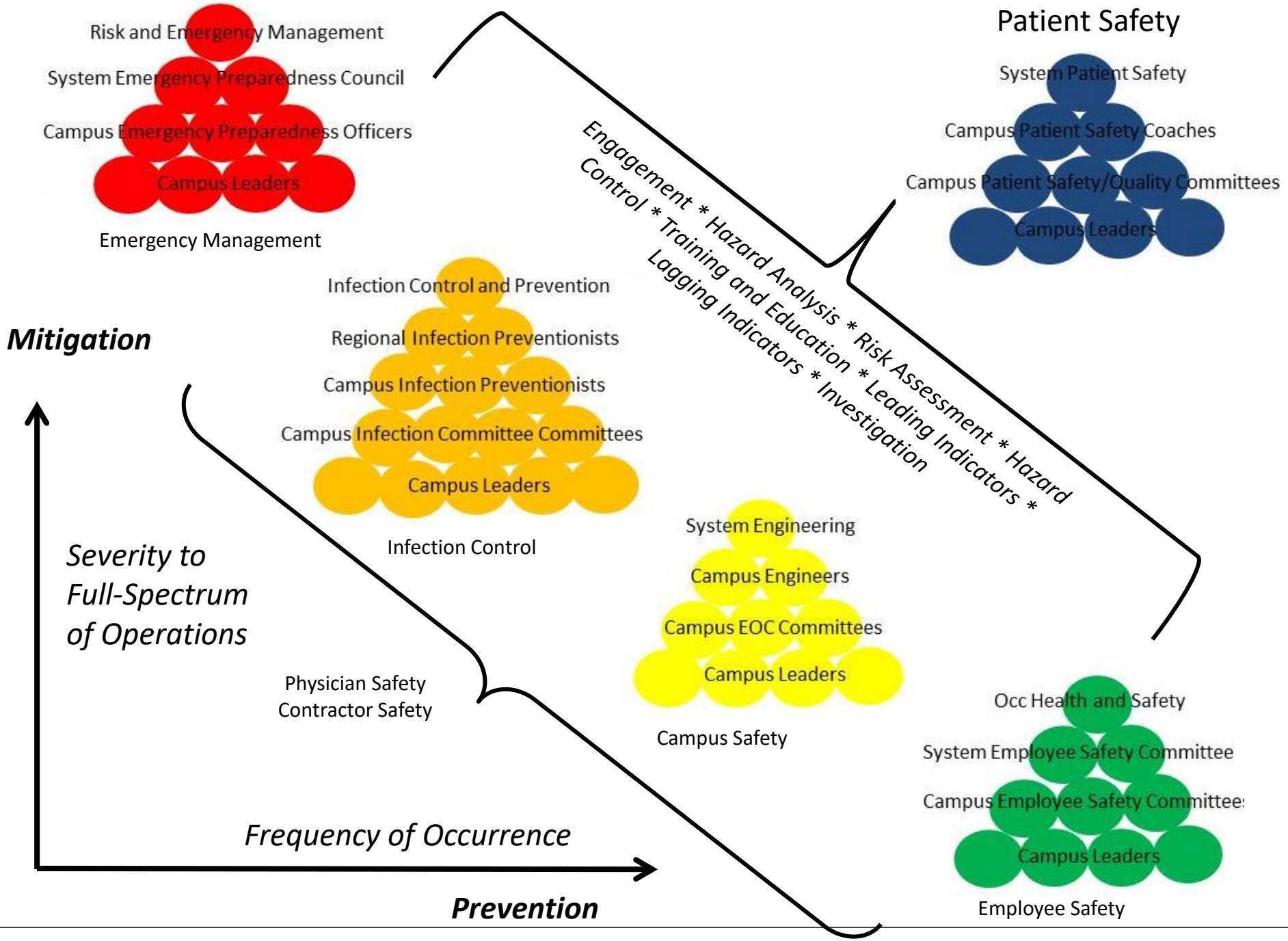
Leading Indicators

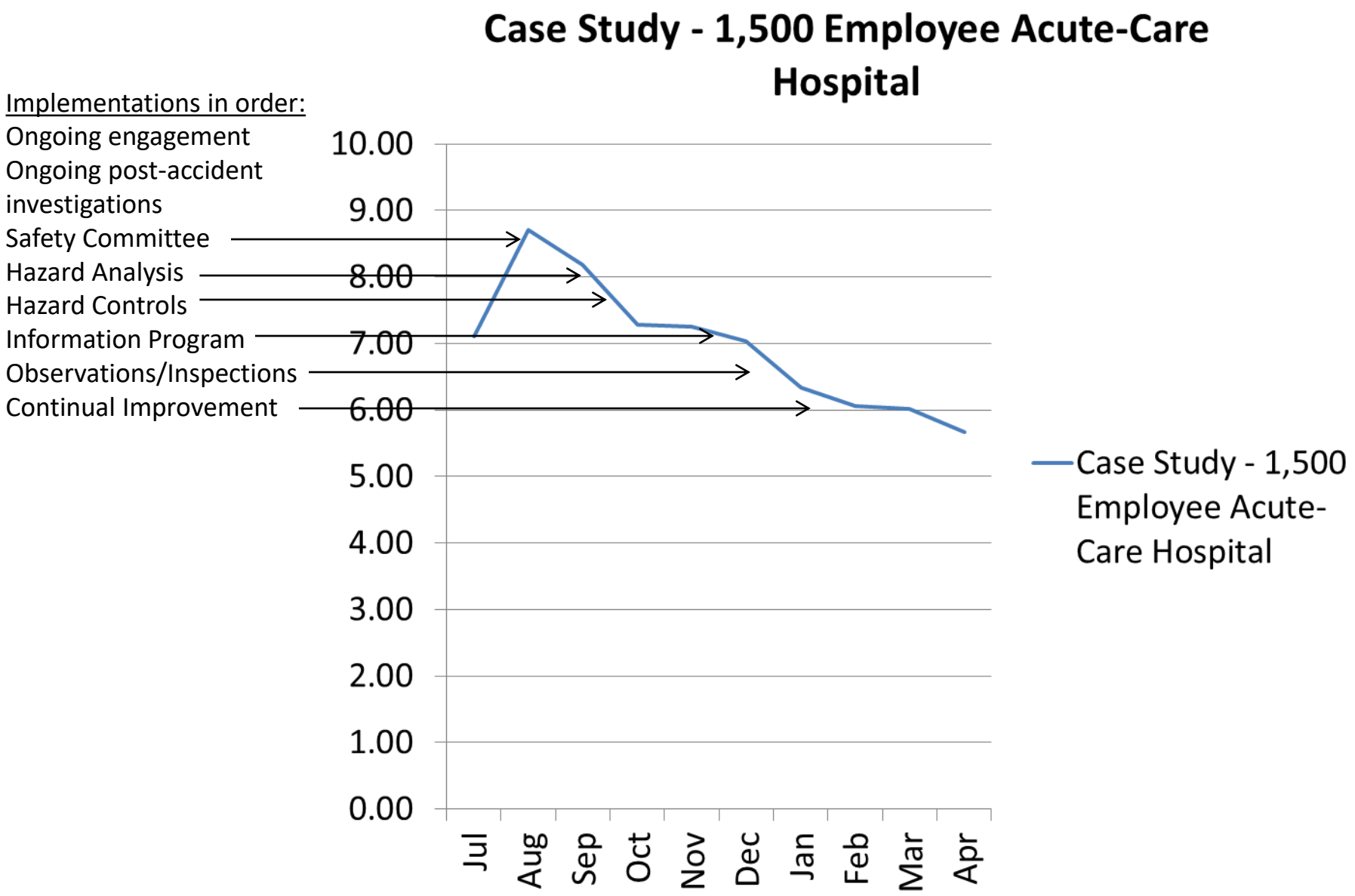
- Participation and Engagement
- Safety Performance
- "Can't Kill Your Way to Victory"
  - Not playing 'Gotcha!'
  - Not a punitive system
- Performance Issues vs. Safety Issues
- Dual Accountability

Lagging Indicators

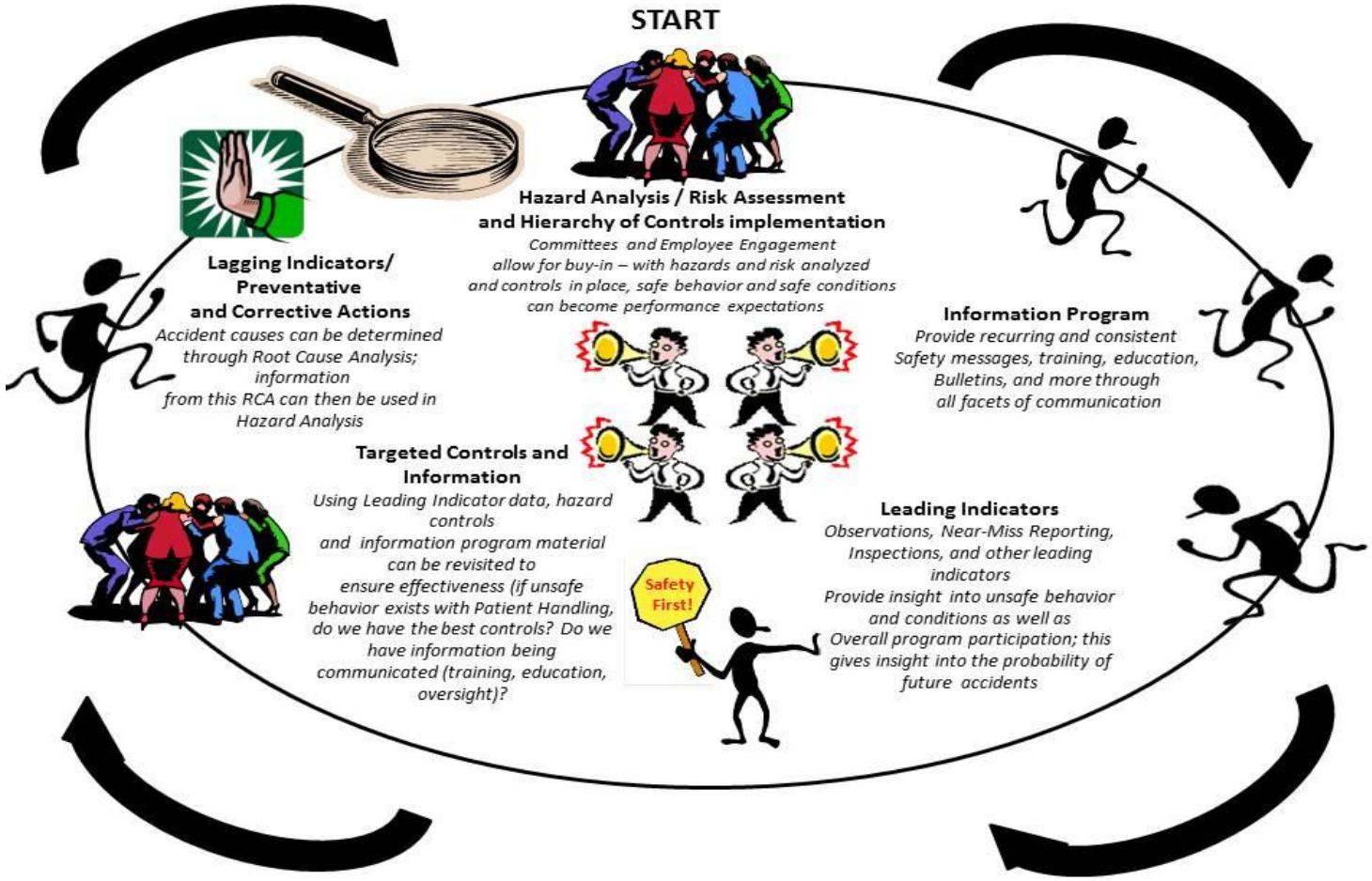


Reliability and Validity

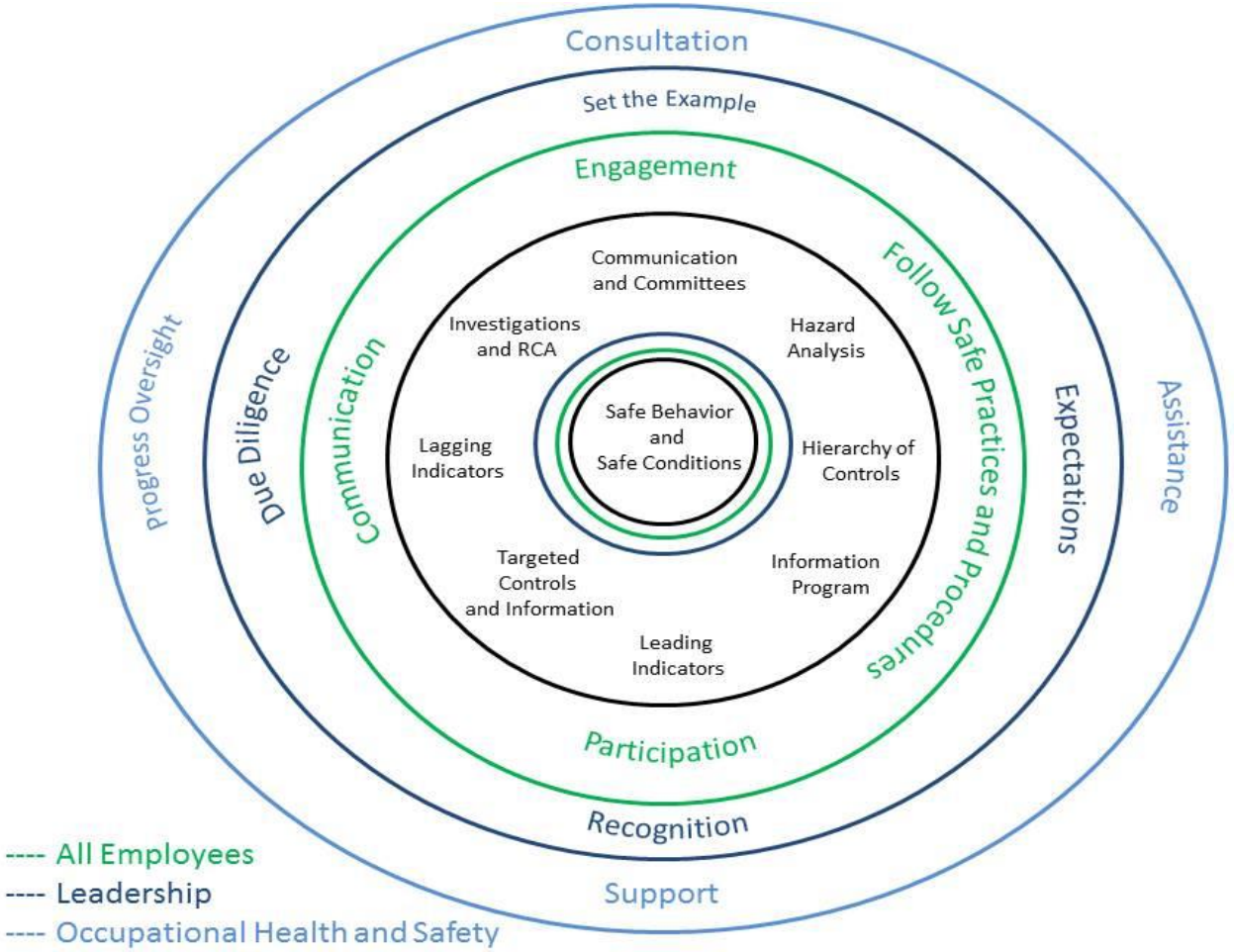

Risk and Emergency Management
System Emergency Preparedness Council
Campus Emergency Preparedness Officers
Campus Leaders
Emergency Management
Patient Safety
System Patient Safety
Campus Patient Safety Coaches
Campus Patient Safety/Quality Committees
Campus Leaders
Engagement * Hazard Analysis * Risk Assessment * Hazard Control * Training and Education * Leading Indicators * Lagging Indicators * Investigation
Mitigation
Infection Control and Prevention
Regional Infection Preventionists
Campus Infection Preventionists
Campus Infection Committee Committees
Campus Leaders
Infection Control
Severity to Full-Spectrum of Operations
System Engineering
Campus Engineers
Campus EOC Committees
Campus Leaders
Physician Safety
Contractor Safety
Campus Safety
Occ Health and Safety
System Employee Safety Committee
Campus Employee Safety Committee
Campus Leaders
Employee Safety
Frequency of Occurrence
Prevention


Case Study - 1,500 Employee Acute-Care Hospital
Implementations in order:
Ongoing engagement
Ongoing post-accident investigations
Safety Committee
Hazard Analysis
Hazard Controls
Information Program
Observations/Inspections
Continual Improvement
10.00
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
Case Study - 1,500 Employee Acute-Care Hospital

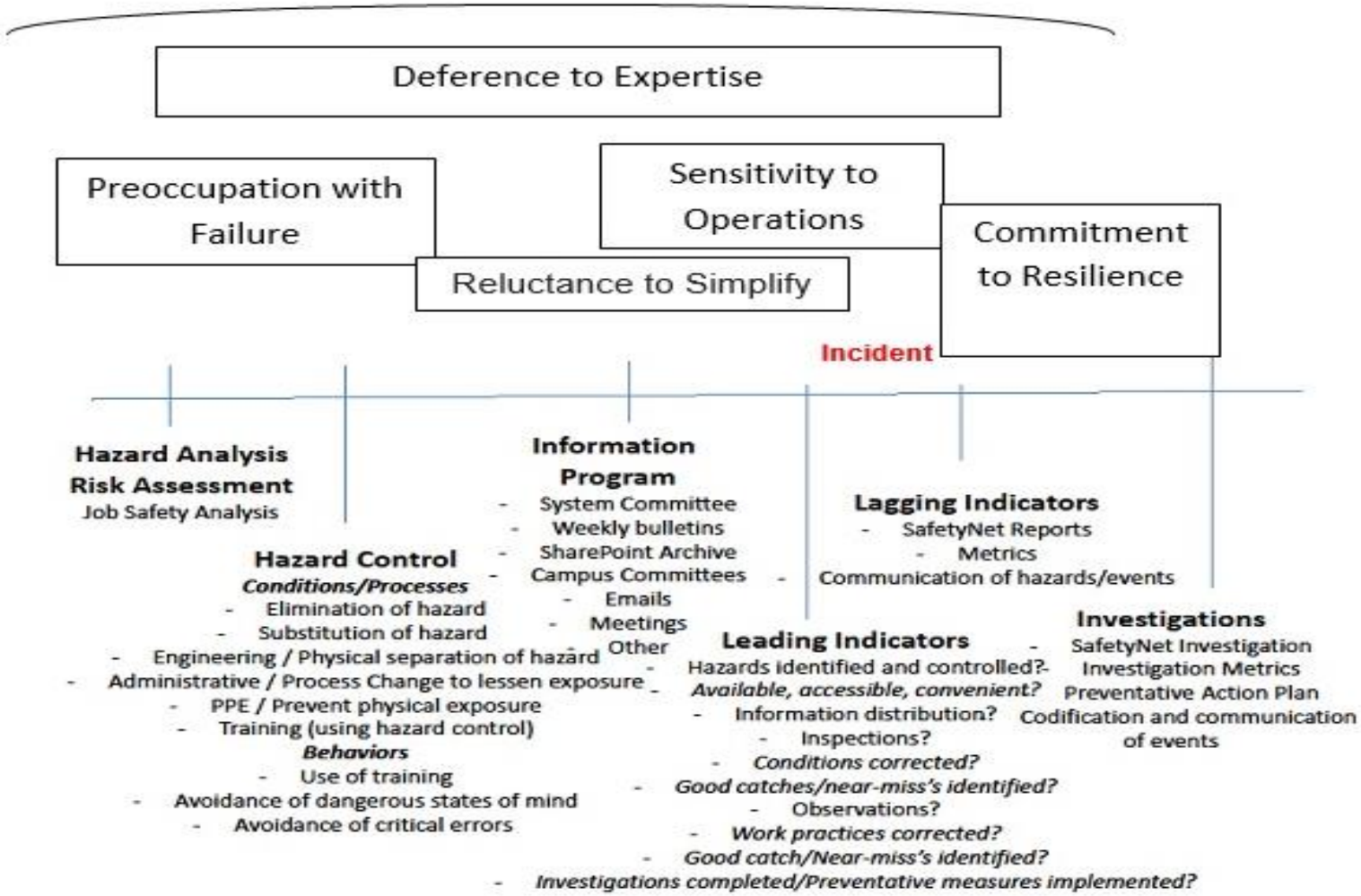
Full Circle


START
Hazard Analysis / Risk Assessment
and Hierarchy of Controls implementation
Committees and Employee Engagement
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
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
Safety First!
Targeted Controls and
Information
Using Leading Indicator data, hazard
controls
and information program material
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)?
Lagging Indicators/
Preventative
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



HRO Operationalization



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?
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References

- Baran, B.E, & Scott, C.W. (2010). Organizing ambiguity: A grounded theory of leadership and sensemaking within dangerous contexts. *Military Psychology*. 22, 42-69.
- Blanchard, P.N., & Thacker, J. (2010). *Effective training: Systems, strategies, and practices* (Custom 4th ed.). Upper Saddle River, NJ: Prentice Hall.
- Haavik, T.K. (2011). On Components and Relations in Sociotechnical Systems. *Journal of Contingency and Crisis Management*. 19(2), 99-109. Retrieved from Business Source Complete.
- Stephans, R.A. (2004). *System safety for the 21st century*. New Jersey: Wiley-Interscience.
- Worden, C. (2013). *Safety diligence*. Houston: Organizational Impact Safety Solutions.
- Worden, C. (2015). *Situational safety*. Houston: Organizational Impact Safety Solutions.
- Worden, C. (2018). *Countering insurgent behaviors*. Houston: Organizational Impact Safety Solutions.

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Thank you!

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