Improving Organizational Performance Through Learning

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Online Evaluation

Today's Goal

ORGANIZATIONS

HUMAN PERFORMANCE & CULTURE

INTERVENTIONS & LEARNING AS A FRAME

Now you talk

- Tell me how you define culture…..?
- Why do organizations exist?

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A Culture of Learning and Engagement

- Leaders Must Change
- Measures Must Change
- Learning Must Change
- Accountability Must Change

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Organizations

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Organizations

Safety competes with other departments for organizational resources, Organizations have stakeholders (employees, customers, regulators, investors) with competing interests to satisfy (Burnham)

"Leadership has a direct relationship on decision making. Leaders must be willing to make difficult decisions and must determine the right balance between safety and production" (Cadieux, 2014)

Organizations don't exist to work safely; they have some other reason for being

Trade Off's

'Loss of Control' Boundary

Boundary: Economic Failure

Operating Point

Boundary: Asset Failure (Safety, Env., Quality)

Boundary: Capacity / Capability Overload

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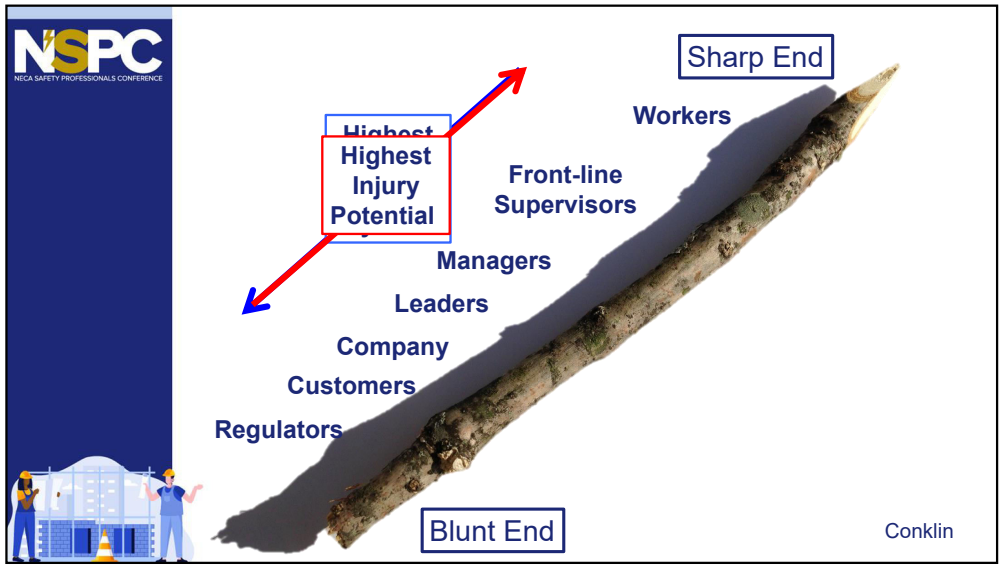

This is just crazy……or is it?

First thing we ask workers to do is remove primary safeguard or create the hazard:

- Remove Electrical Panel Cover
- Work energized
- Remove Access Cover on Confined Space
- Dig a big hole (trench) to enter it
- Remove machine guard to make repairs

Our work is **not** inherently safe. People create safety in practice (Conklin)

We make Trade Off's

As Leaders, we need to realize that ….	If demands for productivity are high;	If demands for safety are high;
• People routinely make a choice between being efficient and being thorough (safe); • It is rarely possible to be both at the same time.	• Thoroughness is reduced until productivity goals are met.	• Efficiency is reduced until the safety goals are met.

People are expected to be both efficient and thorough at the same time – or rather to be thorough, when with hindsight it was wrong to be efficient.

Safety Performance Journey

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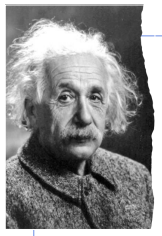
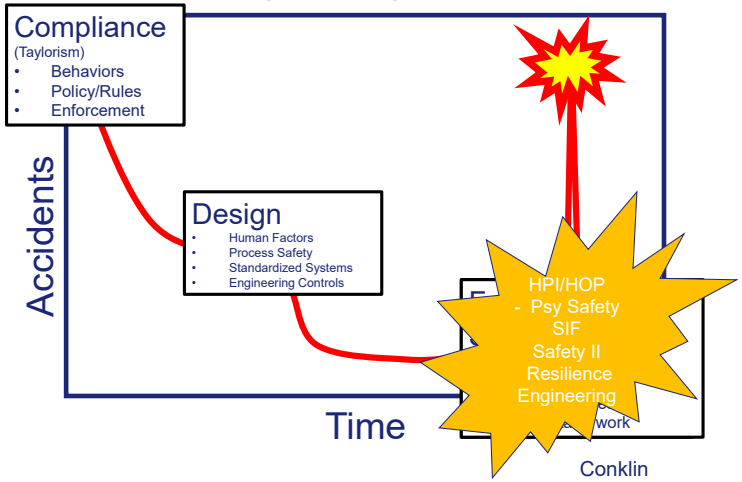
Some of the things you count don't matter



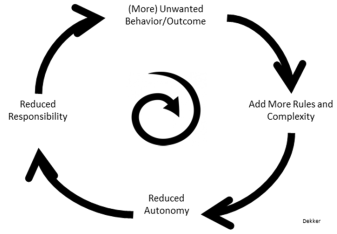
"Not everything that can be counted, counts."

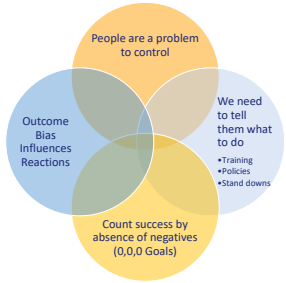
- Albert Einstein

The Safety Journey So Far…



Safety Currently





How has the been working?

Let's talk about the people part of this…..

I believe that . . .

"Fundamentally,

people come to work to do what?

Good work!"

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Our **Goal** . . .

. . . is to become **less surprised** by human error and failure . . .

. . . and instead, become a **lot more interested in and a lot better at operational learning!**

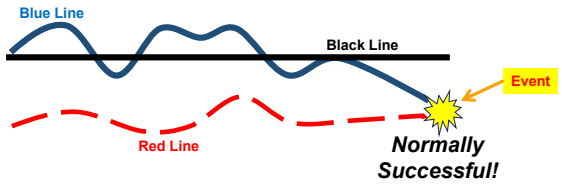
Basic Principles

- Error is Normal
- Blame Fixes Nothing
- Context and Systems Drive Behavior
- Learning & Improving is Vital
- Response Matters

Planned Work vs. Actual Work

Black Line – Work as Expected/imagined
Blue Line – Work in Practice
Red Line – Hidden Conditions

Work as Planned
Vs. Work in Practice (Actual Work)



"Masters Of The Blue Line"

Culture?

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But we are a safe company!

Safety Culture

In layman's terms culture can be described as the way things are done in an organization

The "shared and fundamental beliefs, normative values, and related social practices of a group that are so widely accepted that they are **implicit and no longer scrutinized**. (Shanafelt, Schein, Et. Al., 2019).

"Discussions of culture encompass almost all aspects of organizing, so it is difficult to draw boundaries between cultural approaches to safety and other approaches to safety". (Griffin Et. al. ,2016)

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Our mindset has to shift from control to influence

Reason (1991) noted that "few things are so sought after and yet so little understood'' as safety culture.

Pupulidy (2020) "Creating a safety culture is a fluid construct and must be uniquely designed for each environment or part of the organization, and its evolution is likely never finished"

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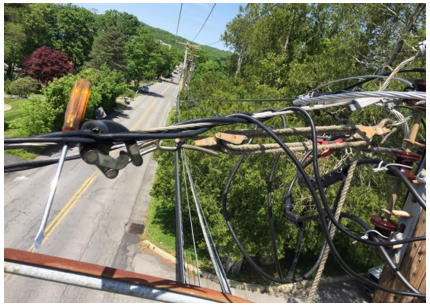
A story about culture & learning



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How we respond

My organization would…..?

- Send a supervisor to investigate
- Be curious about what influenced this event
- Ask the safety team to complete an analysis
- Continue to work, these things happen in line work
- Hold a stand down to prevent this from happening again
- Re-train the crew
- Some of the above

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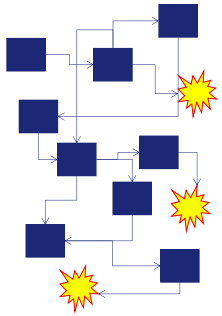
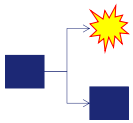
Hindsight Bias

Before the event



Because you know the **outcome**, hindsight gives you almost unlimited access to the true nature of the situation that surrounded people at the time;

After the Event



"Cause is not something you find. Cause is something you construct"
(Dekker, 2014)

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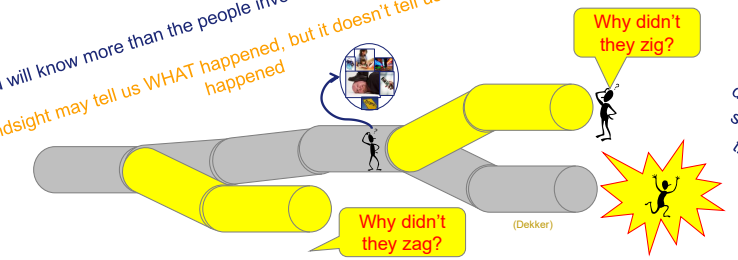
They should have….

You will know more than the people involved thanks to hindsight.

Hindsight may tell us WHAT happened, but it doesn't tell us WHY it happened



Learn why the decisions made sense at the time…..

"The results of investigations, called 'factual reports,' chronicled accidents from the often-biased perspective of the investigation team". Pupulidy & Vesel (2017)

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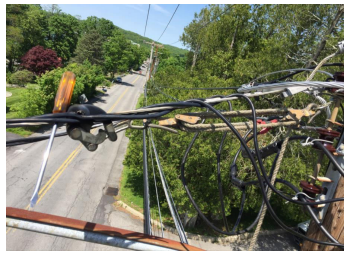
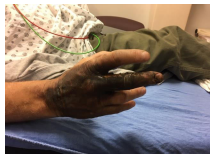
Back to the story





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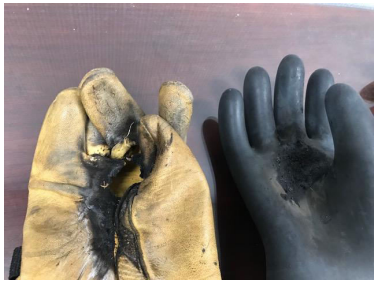
Wait! Something doesn't make sense



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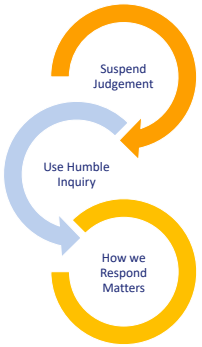
This is where it got tough….

Curiosity moves you forward



The Rest of the Story

- 30 Year Employee
- No “history” of safety issues
- Model lineworker
- Hey – This isn’t my truck
- I need to get on the road
- How the decisions made sense to me
- When the flash happened I thought

Accountability - What did we contribute?

What is it about the way We Are that promoted or Permitted this event to happen?

What is it about the way I Am that Promoted or Permitted this event or Culture?

B. Nelms

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What the organization learned

Lineworkers had been observed working distribution service lines without rubber gloves by senior leaders and site level leaders multiple times

The response was a "strong talking to" with no documentation or action

Outcome bias was influencing the desire to punish in this case

As leaders the question was…..?

- Is this who we want to be
- How does this reflect how we promote our values

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Learning as a tool for performance improvement

Information is "the currency of safety" (Pupulidy, 2020)

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Why Operational Learning Matters

Risk Centric Cultures are great at operational learning

Learning from failure:

- See failure as an opportunity to learn
- Failure is apart of life
- Be prepared to have failure or error
- We cannot prevent all failure, we must defend and safeguard against it.
- Fragile systems cannot withstand failure
- Most systems are normally out of control
- Manage capacity to fail

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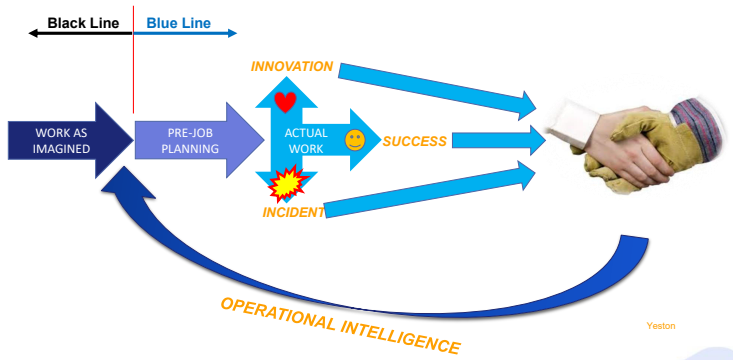
OPERATIONAL LEARNING BEGINS WHERE THE BLACK LINE ENDS



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Steps in the Journey

Set the stage	Ask about	Use systems and structure to	Keep	Build

• Learn about
  • HP/HOP
  • Systems Thinking
  • Complex Systems
  • Resilience Engineering
  • Learning Teams
	• Organizational perspective on risk
	• Remember – Everyone else is managing risk too
	• We are all guessing, if we were not, we would not be dealing with risk
		• Create opportunities to choose learning
		• Learning Teams
		• As a forum to establish norms related to learning and risk
		• Build thoughtful conversations to drive action
			• The conversation about HOP, Risk, Controls, and Operational Learning Alive
			  • Not as a documented outcome of the system….but as part of the cultural norm
				• Quality communications from leaders
				  • They are key to shaping how we respond

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Increase your value (Safety) to the workers and organization

Be a visionary	The currency of safety is information – Provide Reality	Use Management System structure to
•Design the organization as to what it will look like going forward •Become the "Change" you want to see the in the organization •Establish the idea of ALARP	•Share critical facts to act on in advance of injuries, illnesses and mishaps •Less KPI's more facts about the reality of work as done •Show work as imagined vs. work as done	•Identify risk that are existing and as they emerge •Create opportunities to chose learning •A forum to establish norms related to risks •Build capacity to work in your environment •Build thoughtful conversations that drive action

"The purpose of a safety professional is to create foresight about the changing shape of risk and facilitate action before people are harmed". (Provan, 2021)

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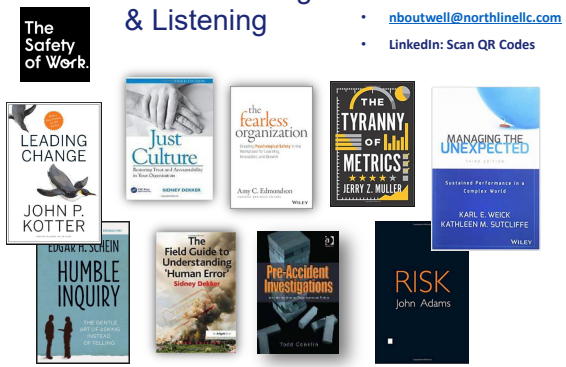
Final Thoughts

- Essential Reading & Listening



How to contact Me

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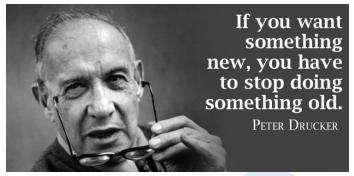
- **LinkedIn: Scan QR Codes**



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