SELF SUSTAINING

How's that?

Definition:

Able to maintain oneself or itself without outside aid

How do we evaluate

PROGRAM CRITERIA FOR EVALUATION: FY2011 - FY2013

1. Management commitment
2. Consultation
3. Trainers Roles & responsibilities
4. Equipment management
5. Workers Training
6. Client reviews / assessments
7. Task risk assessments
8. Competency reviews
9. SOP & Risk Control Management
10. Ongoing program monitoring

Key Performance Indicators *(Please submit KPI's as available in brief $ / No's / %)*

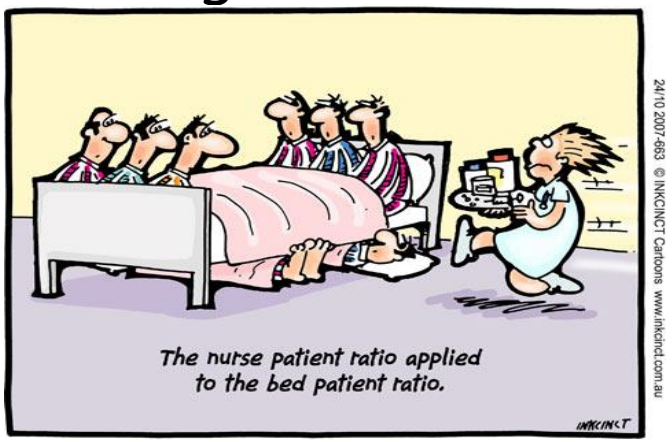
KPI	Methodology (examples)	Outcomes
MSD Incident numbers & Severity ratios'	*Number V's Claims*	
MSD Claims & Costs	*Number claims V's total Cost*	
Premium reductions / escalations	*Estimated annual Figure Variance*	
Percentage of exposure to employees	*% of workers exposed / trained V's EFT*	
Percentage of Competency reviews & results	*% of workers competency achieved V's Number trained*	
Number of departments / units involved	*No. Departments V's Number involved in Program*	
Percentage of involvement after 2 years	*No. departments participating post 2 years of implementation*	
Number of refresher courses (P.I.P.S P/L)	*No. held since initial Program implementation.*	
Trainer movement across the industry	*No of Trainers current V's No. Trained / Department*	
Equipment reviews	*No. of equipment reviews V's Purchases – OHS agenda*	
Replacement planning	*MH Equipment / slings - Replacement plan compliance - % of*	
Preventative Maintenance Program	*Associated costs MH equipment maintenance "All"*	
Falls management program	*Correlation to MH program – Post falls management compliance*	
SOP practice changes	*No. of Risk assessments conducted V's No. of SOP's developed*	
Employee program satisfaction	*No. employees satisfied with Back Attack program management thereof.*	
Employee Health status (P.I.P.S P/L survey)	*Outcomes of Health survey - Results*	

Evaluating Culture “The vibe”

- But when the “vibe” of the organisation has changed, how do you actually demonstrate that?

Safety 1

- *Day-to-day activities at the sharp end are never only reactive*
- *The pressure in most work situations is to be efficient rather than thorough.*



- *This pressure exists at all levels of an organisation*
- *Inevitably reduces the possibilities of being proactive because that requires that some efforts are spent up front to think about what could possibly happen.*
  - *Prepare suitable responses,*
  - *Allocate resources, and make contingency plans.*

It’s always easy to see where we run off the rails

Demonstrating cultural change

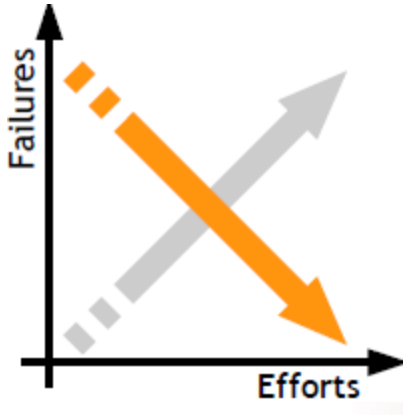
Safety is defined by its opposite
– by the lack of safety (accidents, incidents, risks).

We focus on the events where safety is absent, rather on those where safety is present

"Find-and-fix"

Safety-I – when nothing goes wrong

Safety-I: Safety is the condition where the number of adverse outcomes (accidents / incidents / near misses) is as low as possible



If we want something to INCREASE, why do we use a proxy measure that DECREASES?

Why is a HIGHER level of safety measured by a LOWER number of adverse outcomes?

"Identification and measurement of adverse events is central to safety."

Notice the unnoticeable

"To the curious incident of the dog in the night-time."

"That was the curious incident," remarked Sherlock Holmes.

"Is there any point to which you would wish to draw my attention"?

"The dog did nothing in the night-time."

It is necessary to know what is 'normal' – what usually happens or should happen – in order to notice and/or understand what is unusual.

Safety II – when everything goes right

Safety-II: Safety is a condition where the number of successful outcomes (meaning everyday work) is as high as possible. It is the ability to succeed under varying conditions.

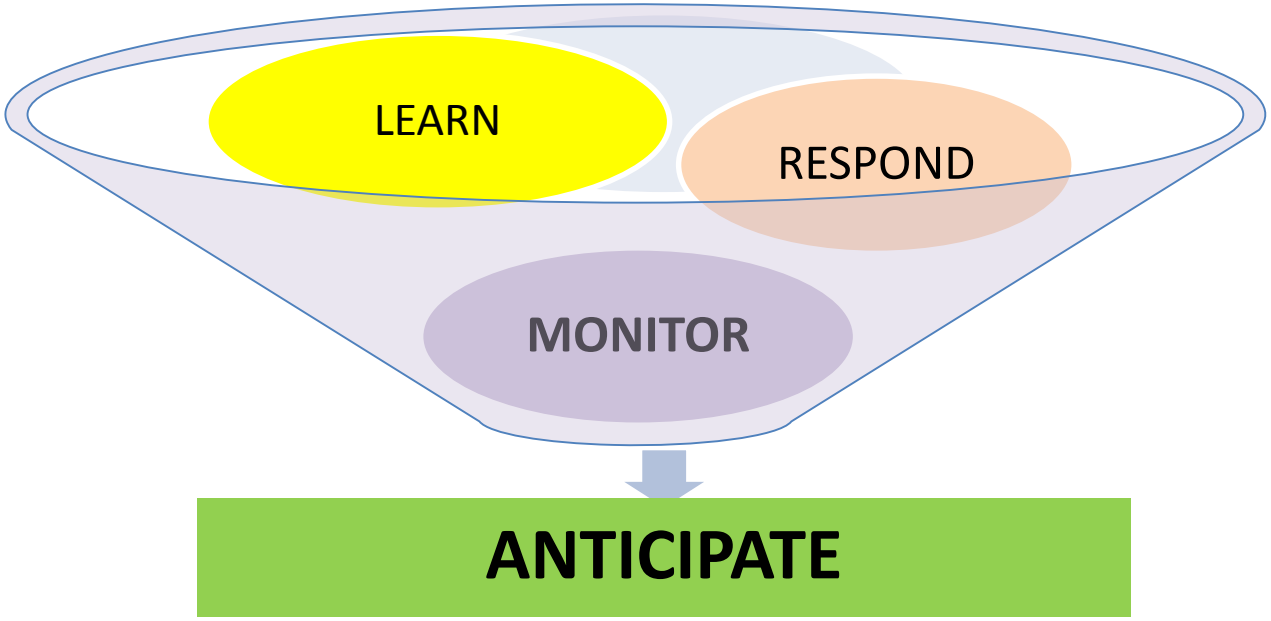
Safety is defined by its presence

The focus is on everyday situations where things go right ! As they should.

Safety-II is achieved by trying to make sure that things go right, rather than by preventing them from going wrong

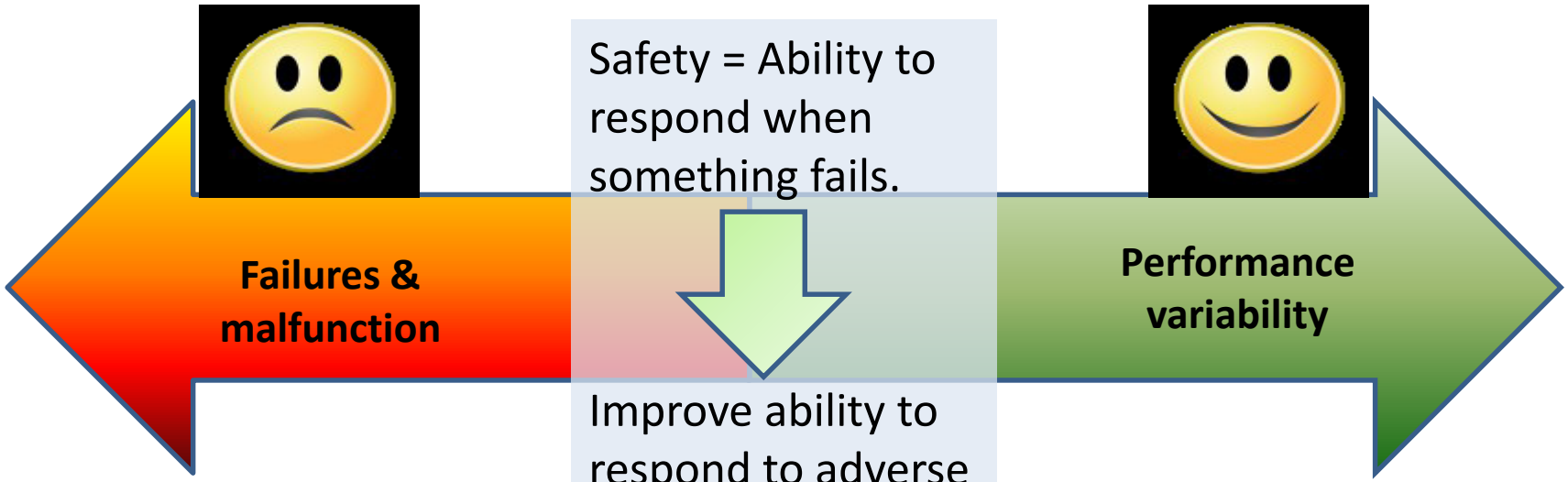
What is Resilience?

A system is resilient if it can adjust its functioning prior to, during, or following events (changes, disturbances, and opportunities), and thereby sustain required operations under both expected and unexpected conditions



In order to be resilient, the organisation must have four basic abilities.

Negative to Positive



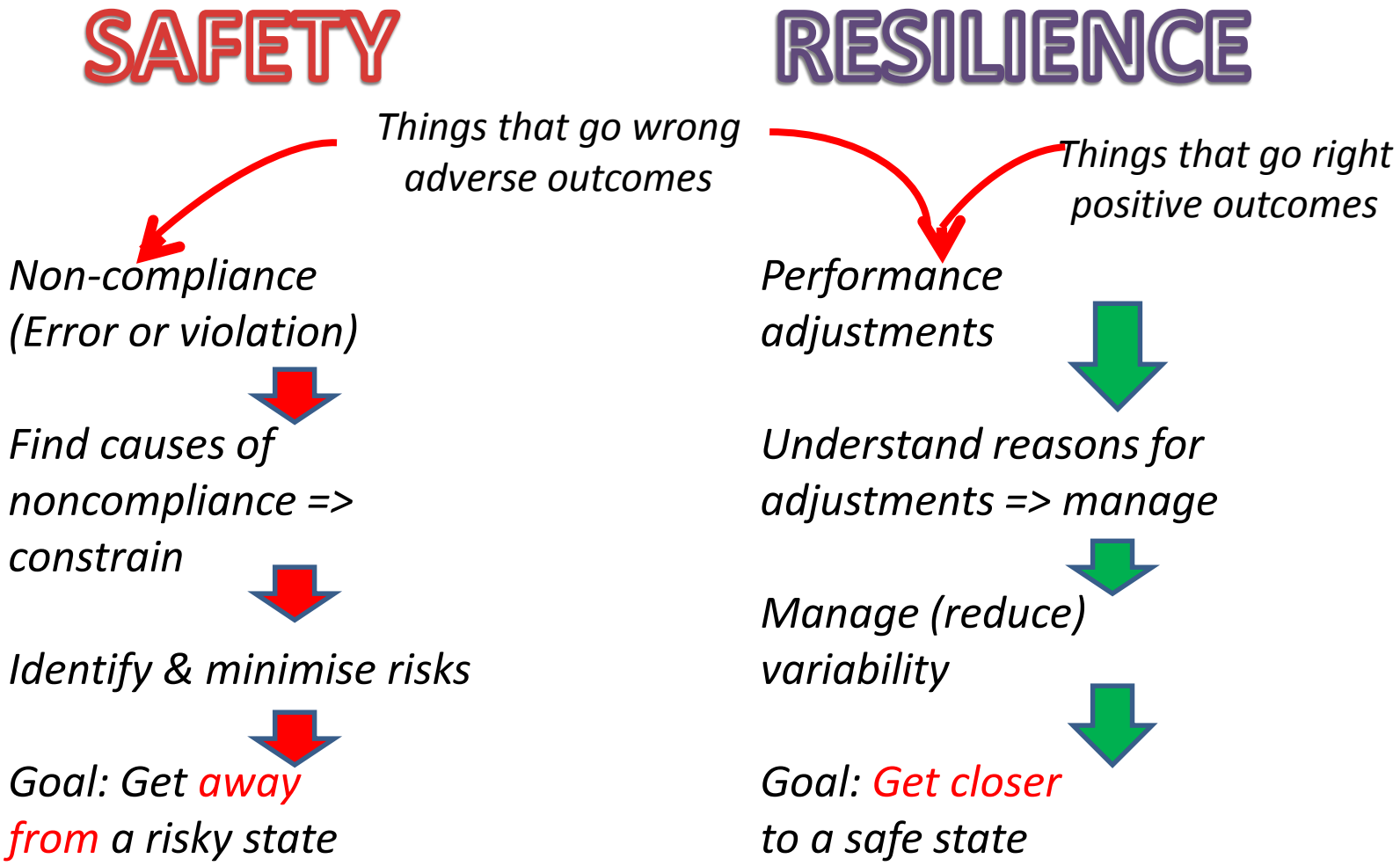
Safety = Reduced number of adverse events.

Eliminate failures and malfunctions as far as possible.

Safety = Ability to succeed under varying conditions.

Improve resilience

Two views


SAFETY
RESILIENCE
Things that go wrong
adverse outcomes
Things that go right
positive outcomes
Non-compliance
(Error or violation)
Find causes of
noncompliance =>
constrain
Identify & minimise risks
Goal: Get away
from a risky state
Performance
adjustments
Understand reasons for
adjustments => manage
Manage (reduce)
variability
Goal: Get closer
to a safe state

Which shows self sustaining?

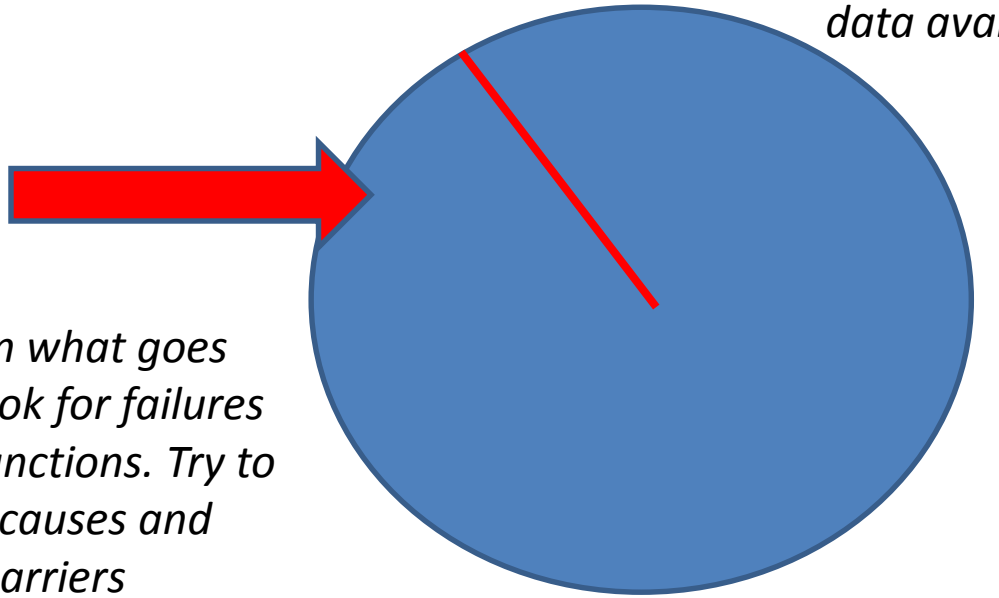
Culture depends on Safety 1

- Migration and executive change = ?

Safety and core business compete for resources. Learning only uses a fraction of the data available

10-4 := 1 failure in 10.000 events

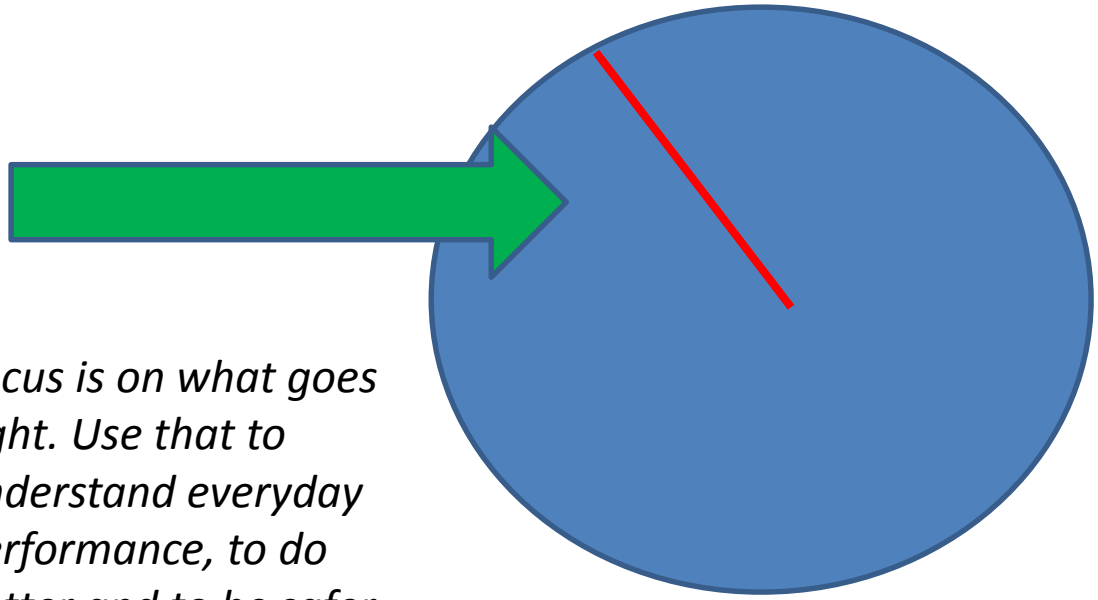
Safety-I = Reduced number of adverse events.



Focus is on what goes wrong. Look for failures and malfunctions. Try to eliminate causes and improve barriers

Culture has achieved Safety II

- Migration is not an issue?
- Is executive change an issue



1 - 10-4 := 9.999 non-failures in 10.000 events

Focus is on what goes right. Use that to understand everyday performance, to do better and to be safer.

Safety and core business help each other. Learning uses most of the data available

Revise evaluation strategies

- *Look for what goes right - 'breadth-before-depth'*
- *Look for 'work-as-done' - the habitual adjustments and why they are made*
- *Creating and maintaining good working conditions*
- *Compensating for something that is missing*
- *Avoid future problems*
- *Learning should be based on frequency of occurrence rather than severity of outcome*
- *Remain sensitive to the possibility of failure (mindfulness)*
- *The arbitrariness of accident analysis*

"By focusing exclusively on failures, the opportunity to learn from successes is lost"

Discussion questions

- ✓ *Is there anything we do now, that we can do even better?*
- ✓ *Is there anything we do now, that we should do differently?*
- ✓ *What are the signs and signals (indicators/trends) that we look for now?*
- *What are the signs and signals (indicators/patterns) that we should look for?*
- *What would be a good "success story" for us? How can we produce that?*
- *What should our first step on the road to Resilience be?*

The difference between what we can imagine and what can happen, is larger than we can imagine

Questions?