

Implementing and Sustaining Change

John Carroll:

Think about context around which events are happening.

Think about magnitude of change: incremental or transformational.

Think about content: requiring three things: (relational space: building a community of practices) (conceptual changes) (domains of actions).

How is this happening: top down , up down , emergent, strategic?

Douglas Padgett

30 years.

What is the risk of letting at risk children staying in ICU? We believe that the risk is high. We were closed 3 to 4 times in the process. We believe that hospitals are risky for medically challenged children, and we created a space for them.

Cody some of the stuff the organizations were already doing. 1985. Our workers compensation was in red; it was risky for the organization and the staff. So, the care was not what it ought to be. We then instituted a massive safety awareness program. It was important for the welfare of the organization. Losses were improved. Engaging the staff in the pursuit of staff safety.

It went awry again, a few years ago. We were doing research, doing posters worldwide. Our errors went up one hundred some percent. From 6 % to 110%. We lost our focus.

How many believers does it take for an organization to be considered highly reliable? What is a believer? Who is pursuing with rigor the well-being of the people under our care? We do chronic intensive care.

A new facility in LA with 140 new staff members; however, that organization has not yet matured. It takes more than just people.

Charles Taylor

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IT people in financial industries do not think about safety issues the way nuclear, and aviation industries think. We didn't think that banks can fail.

A Japanese bank, traded by mistakes, cost his institution four million dollars because of the miscalculations of currency exchange rates.

We point to a culture that allows operational mistakes. A few digits were inputted wrong, costing the banks millions of dollars. Creditors, marketers, consumers, need to be managed using the operational methods similar to other industries, so we can do problem solving. We are not doing very well at changing the banking culture. We don't need to have that kind of "high reliability" culture of Aviation, but we need to be "fairly reliable" to not lose money.

Jeffrey Cooper

Can a Subculture be made highly reliable?

Case study: what needs to be done to make such a thing work?

I run an operational department for a health care system. I also run a simulation training lab for medical students. I am also on national patient safety foundation. Operation sides, research sides, accountability sides, my academic department requirements all interweave to influence what I do. I become fascinated with how subculture works.

In a cross- industry study between medicine and aviation, there is only about 5 percent difference in safety scores. Aviation does better, but I am surprised to see how well hospitals do.

Signs of lack of reliability:

- No safety officer, only QA
- Blame base culture
- Lack of response to ix systems in face of adverse events
- Reliance on individual performance
- Conflicts with other silos
- Production trumps safety.
- No requirements for training with new technologies. No rules that say you have to train before using a technology.
- Little practice of emergencies. No practice with evacuation.

How does one engage such a system?

- Engage the leaders?
- Identify and mentor local leaders?
- Engineer safety tools?
- Measure outcomes?
- Tell stories?
- Provoke?
- Wait for disaster?

Suggestions from the audience.

1. Lots of tiny little pieces of practices
2. Accountability, regulation
3. Reward punishment
4. Create a need for change.

5. Quality assessment by third parties.
6. CEOs reward for good behaviors.
7. Incentive systems need to be there.
8. Reward for reporting errors.

Charles Taylor: challenge for traders. There is a delay of financial costs, often wouldn't happen until years later. Or the loss might be small. A banker's trust can collapse if there is an ethical drift, losing responsibility and respect for rules. The best solution is to create the right incentive structure, aligning rewards with the right tasks. People derive from satisfaction from doing a better job.

Question from audience: relentless focus on the part of the leader helps sustain the maintenance of HRO culture in medicine.

Is it possible to accomplish it without leaders, and accomplish it through the subculture's effort? Most do not think so.

Reliability of what? You have to engage the interdependent system. It is hard to do it on the subculture level because of the relational nature of complex problems.

Cooper: It took me years of working in Dupont to have the notion of safety engaged into my being. Now it is my outlook, the lens I see reality.

Taylor: in risk management in the banking industry, we always ask that question over and over. People spend time on it regularly, and when it needs it, in the monthly meetings, on the senior level and other levels.

Douglas: How do I ensure that my legacy lasts? We are not an HRO yet. We will never be there; we are going there. We are taking proactive efforts to make sure that there are plenty of believers in the organization. Yes, I answer, leadership can invoke higher reliability. We support all employees for their mental well being. We make sure that your staff is well supported. We have 12 licensed therapists beyond the hotline for all our staff to call for both professional and personal reasons.

Question from the audience: Leadership comes from the bottom as well.

Question from the audience: Selection processes and socialization of professionals. How do you reward a non-event? Indicators around key performances as well as the processes of tasks. Have two separate ranges for performance: scale for managing things adequately, and scale for managing exceptionally. Never let people get away with being reasonably good.

Industries with particularly high consequences are more apt environments for developing HRO processes. However, other industries can create scales and tools that would not accept mediocrity. How does one create tools for not accepting failures? Personal values find better options elsewhere sometimes. There are career risks for making changes. Sometimes they find kindred spirits in other organizations or other departments.