

Curtailing the Culture of Blame

Case-study:

Healthy and Productive Work in Prisons

Department of Corrections



NZOHNA – NZISM Conference 2010

New Plymouth

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concordia



CONFERENCE PARTNERS

- NZ OCCUPATIONAL HEALTH NURSES' ASSOCIATION
- NZ INSTITUTE OF SAFETY MANAGEMENT
- INTERNATIONAL NETWORK OF SAFETY AND HEALTH PRACTITIONER ORGANISATIONS



Outline

- Adaptively managed safety culture improvement programme
- ‘Blame culture’ – what is it, and can it be changed in the prison environment?
- Response to Behaviours Plan

Overview

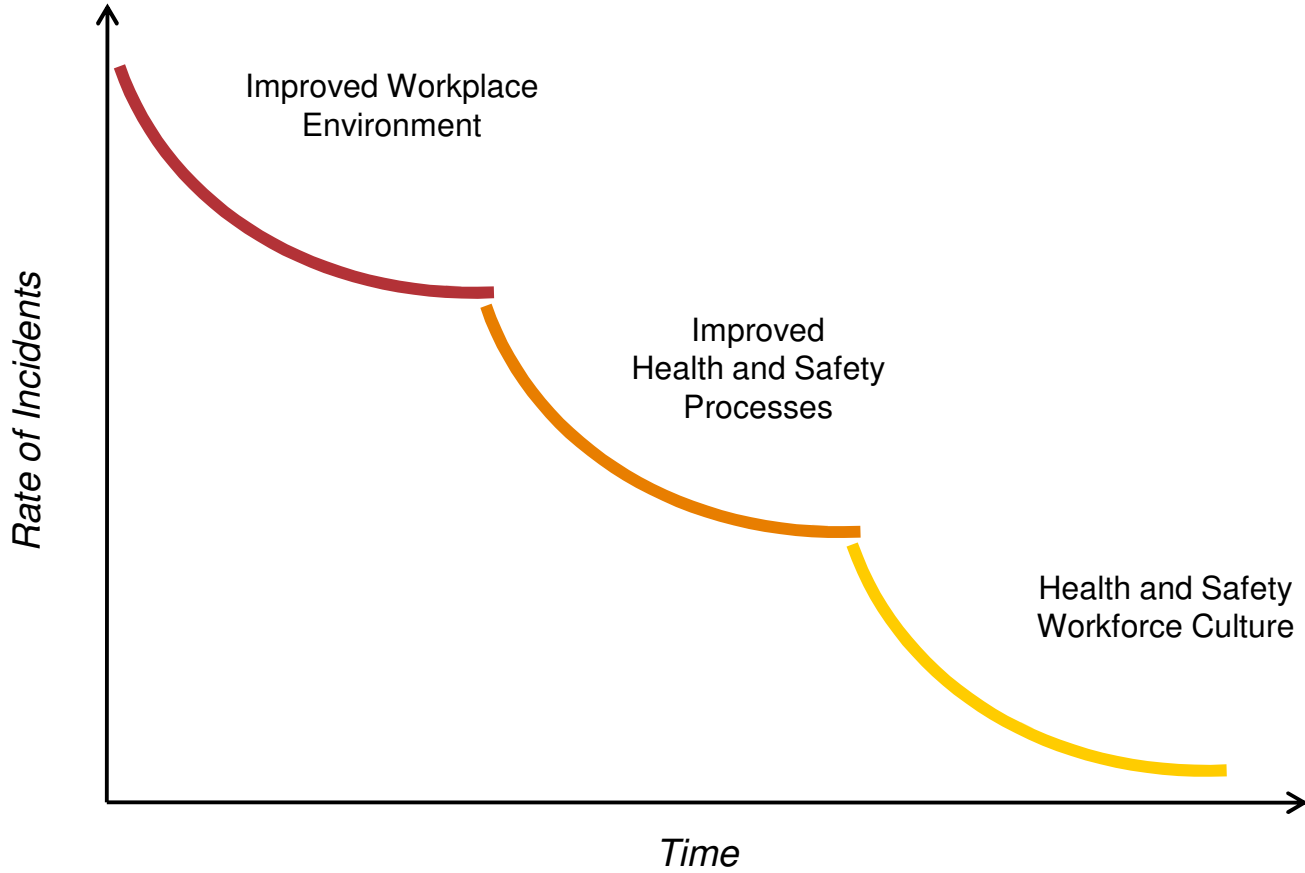
Becoming a 'safety leader'

How do you know when you've got it right?

Digging Deeper



Improving Safety Performance



Levels of Culture

1. **Tangible**

Can be seen, felt and heard by most staff

2. **Professed**

Includes H&S processes and systems

3. **Unspoken**

Deepest level – attributes that are unseen and undisclosed, “what actually happens around here”

80% of organisational culture is attributable to leadership behaviours

and

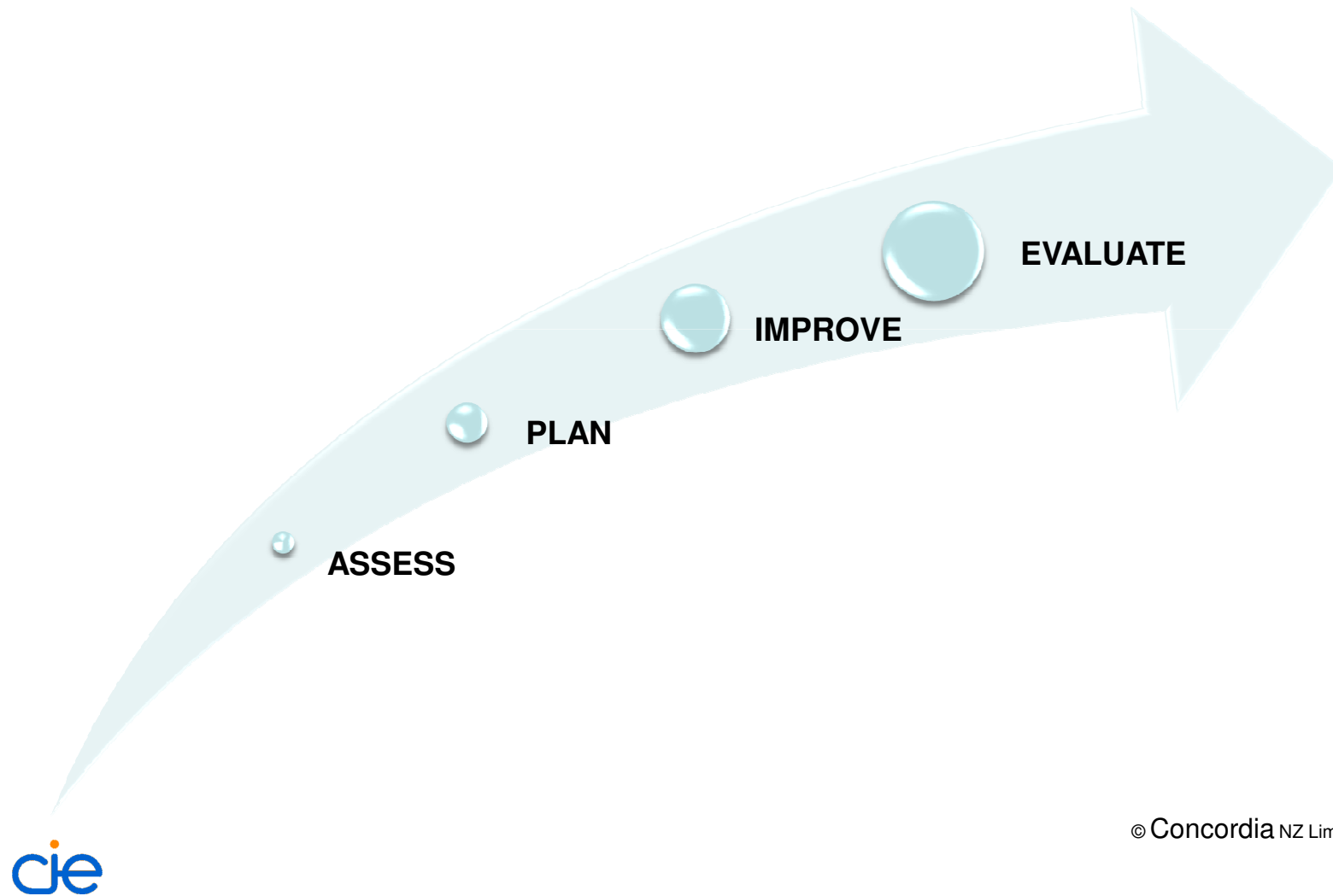
60% of organisational performance is attributable to culture

*Professor Malcolm Higgs
HR, Management and OD
University Southampton*



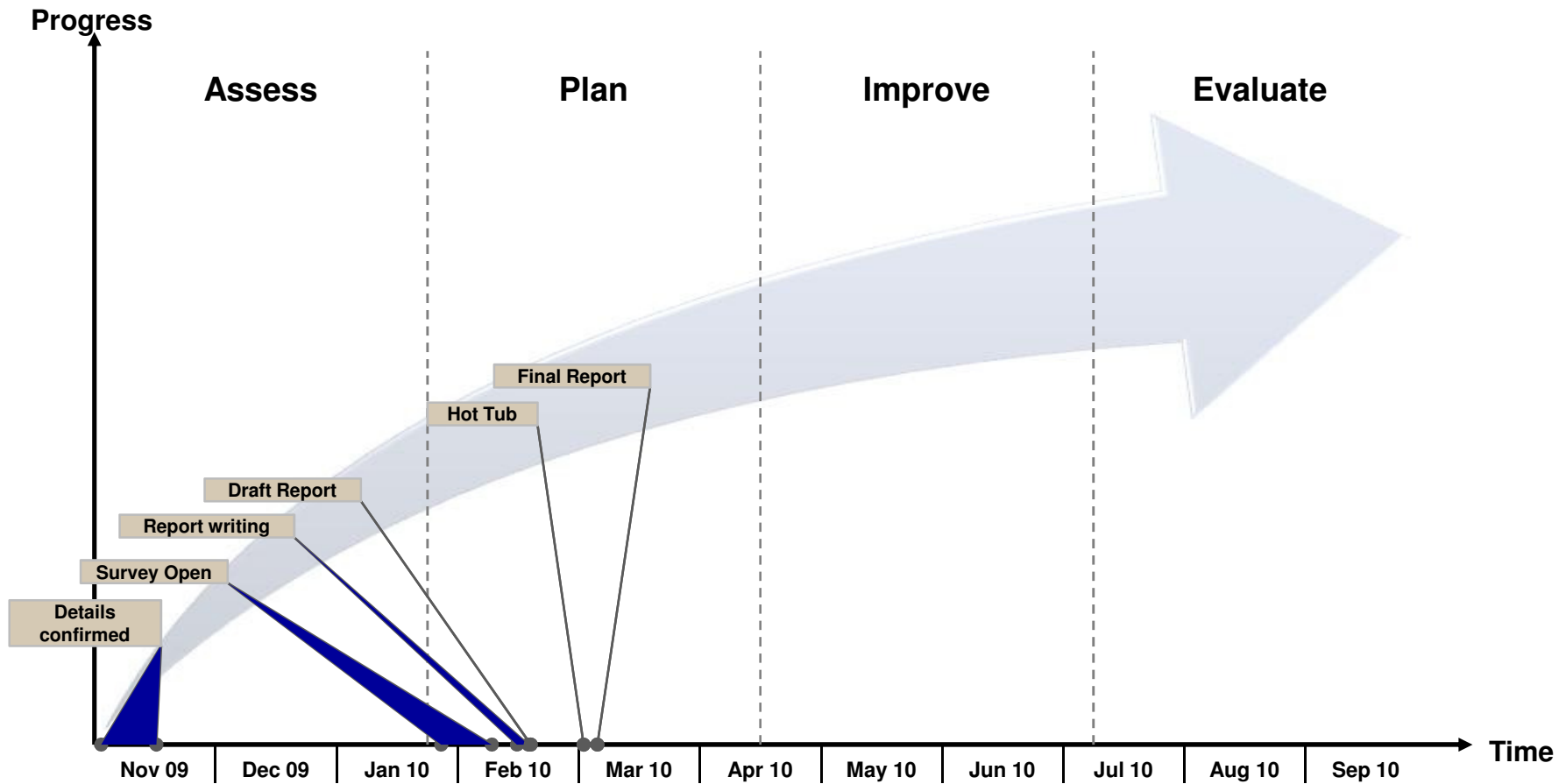
Healthy and Productive Work

Adaptively Managed Improvement Process



Timeline

CORRECTIONS CIE HSC Timeline

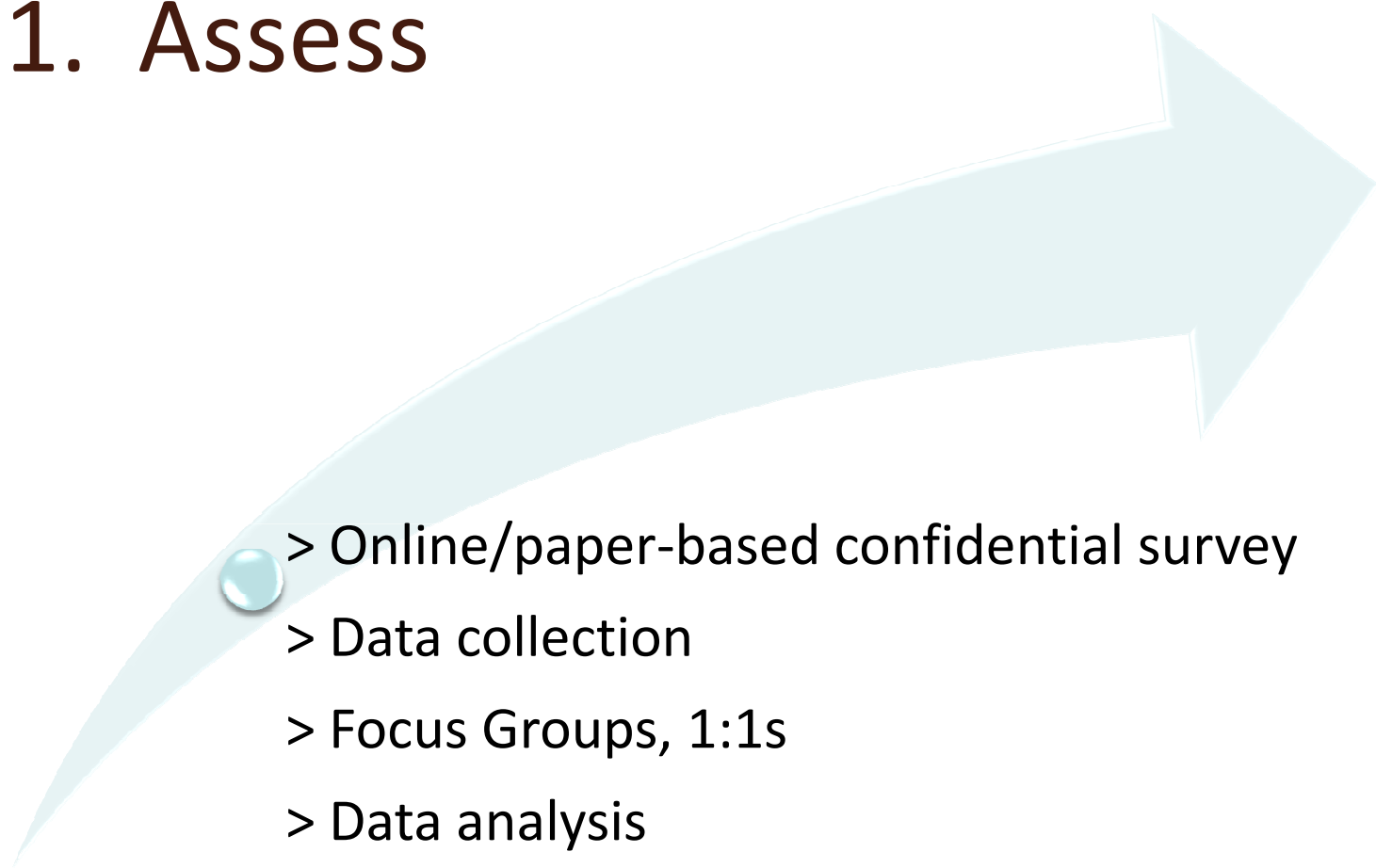


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1. Assess

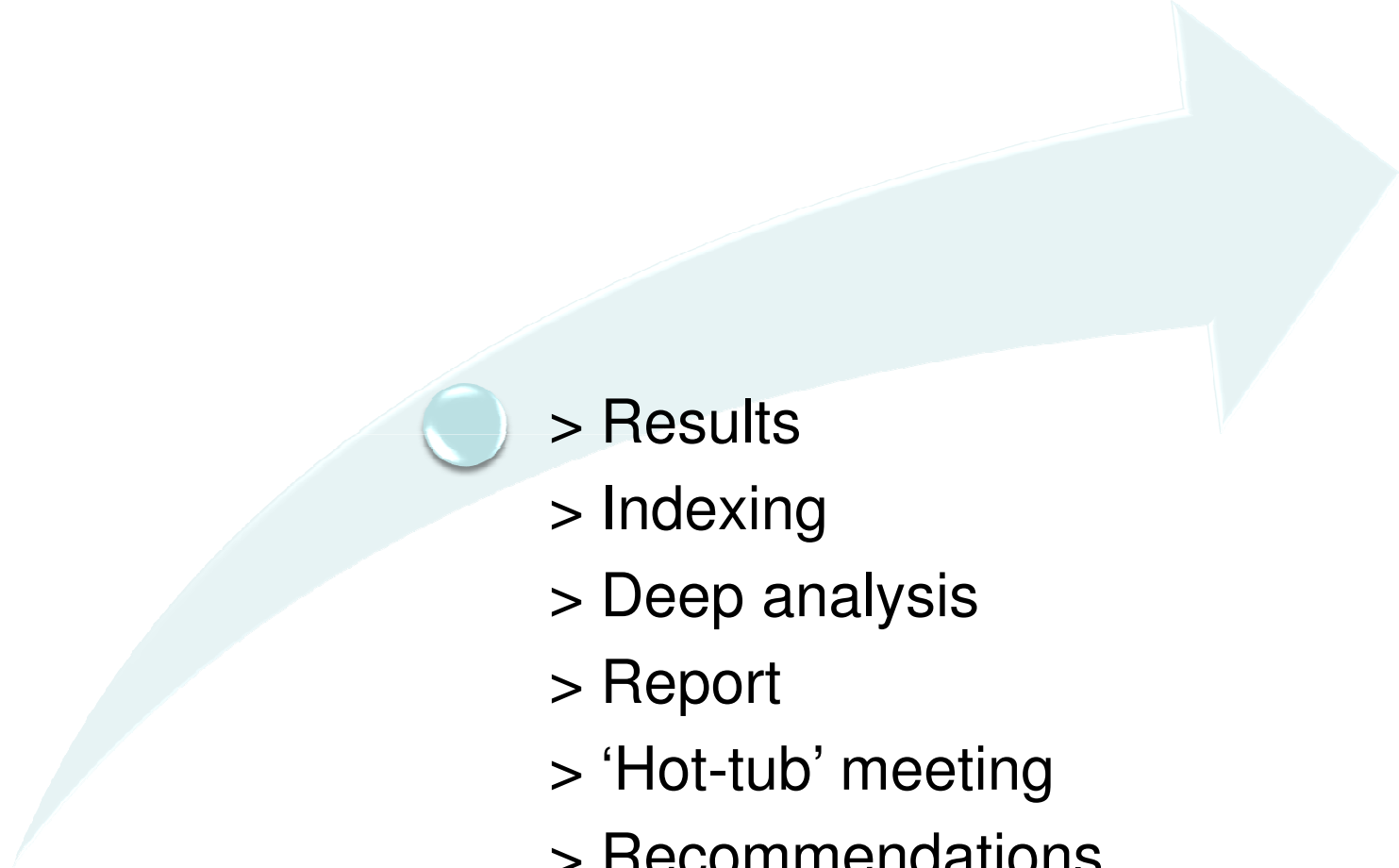
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- > Online/paper-based confidential survey
 - > Data collection
 - > Focus Groups, 1:1s
 - > Data analysis

The Twelve Factors

Average Results: Engineer



2. Plan

- 
- > Results
 - > Indexing
 - > Deep analysis
 - > Report
 - > 'Hot-tub' meeting
 - > Recommendations
 - > Action Plan

Assess - indexing



Taking into account all responses the overall grade for health and safety is:

76%

Action steps...progress?

- Sector improvement plans,
- +ve and -ve aspects,
- Challenges/concerns?



Blame Culture

A significant concern for CIE with index results of:

CIE **47%**

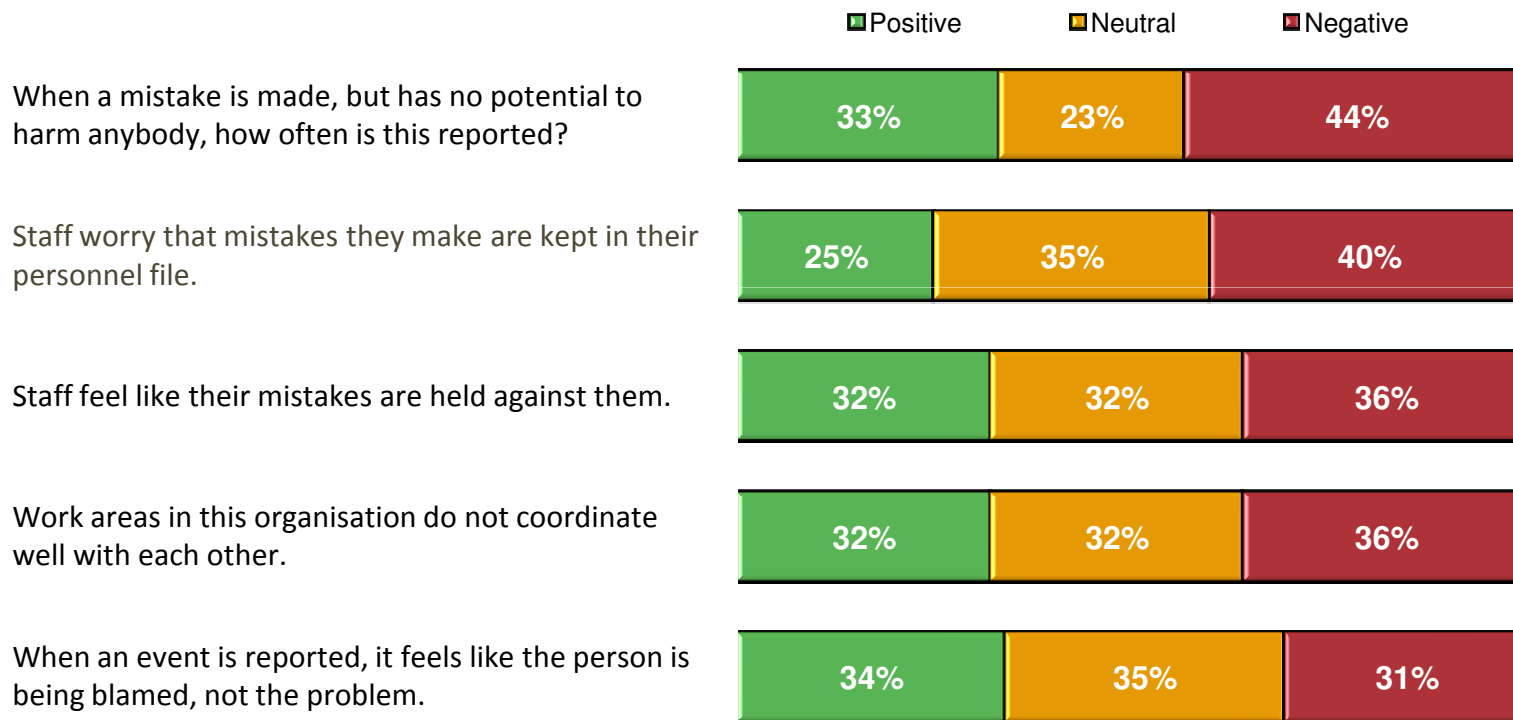
Prisoners **59%**

(Indicative 2008 Corrections result of 37%)



Significance

Bottom 5 Statements for CIE Employees - Overall



Strategic Action Steps for CIE

Improve index for CIE employees by 25% (i.e. from 47% to 60%) by August 2011.

Improve index for prisoners by 10% (i.e. from 59% to 65%) by August 2011.

Introduce in CIE workplaces a “learning” process for employees and prisoners to respond to actions and behaviours.

3. Improve



- > Leadership
- > Communication
- > OD, HR, L&D
- > Action steps
- > **Response to error plan**
- > Support & advice

Improve – partnering approach

- Action step templates
- Advice on successful initiatives
- Help for managers
- Outside perspectives
- Pragmatic solutions

How CIE dealt with error

- Mistakes and errors investigated, then people disciplined – who touched it last? Butt covering? Personal file noted?
- Individuals held solely accountable for actions
- Expectations for perfect performance?
- Focus on perceived individual weaknesses?
- Weed out “bad workers”?

Effects of punitive response

- Errors driven underground
 - Fear of retribution, employment loss, stagnation
 - Fear harsh response - bullying
 - Embarrassment
- No reporting of near misses or errors waiting to happen
- No news is good news mentality
- Top down management of error
- Lack of trust and respect
- Compliance rather than learning environment

Why punitive environments don't work

- Threats and sanctions are de-motivating and inhibit safety progress
- The precipitating causes of error are usually the last links in the chain of events and are the least manageable



What is appropriate?

“Experience suggests that the majority of unsafe acts - perhaps 90 percent or more - fall into the blameless category.”

Managing the Risks of Organisational Accidents - Reason

CIE's Learning Culture

The strength of CIE is that it provides a learning environment for prisoners to develop their life and employment skills



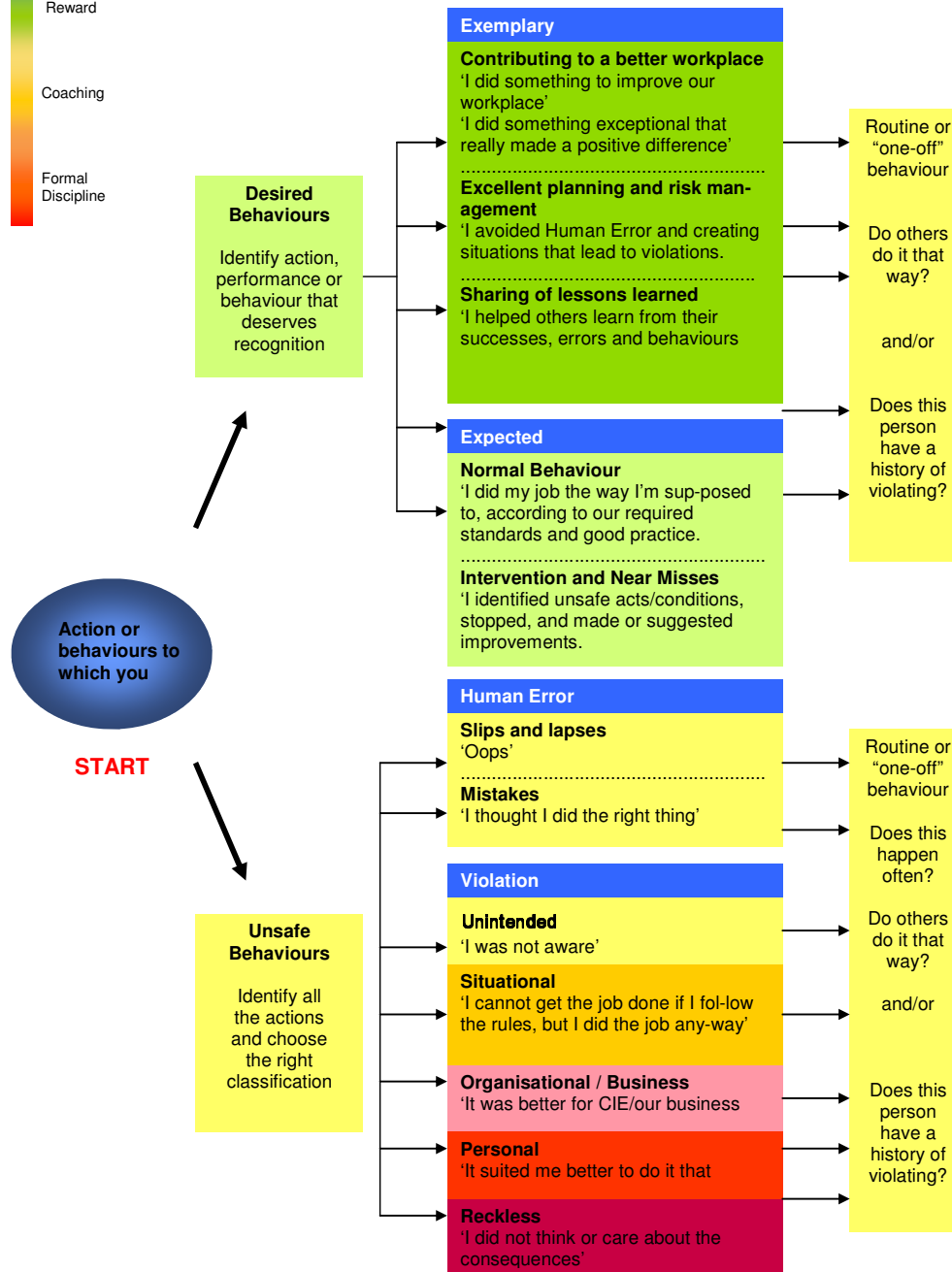
Errors/mistakes/lapses can also be dealt within a learning process

'Learning' Culture

- Acknowledges human fallibility
- Perfect performance not achievable
- Unsafe acts are usually result of slips or honest mistakes
- Anyone can make a mistake
- Vigilance alone cannot overcome error

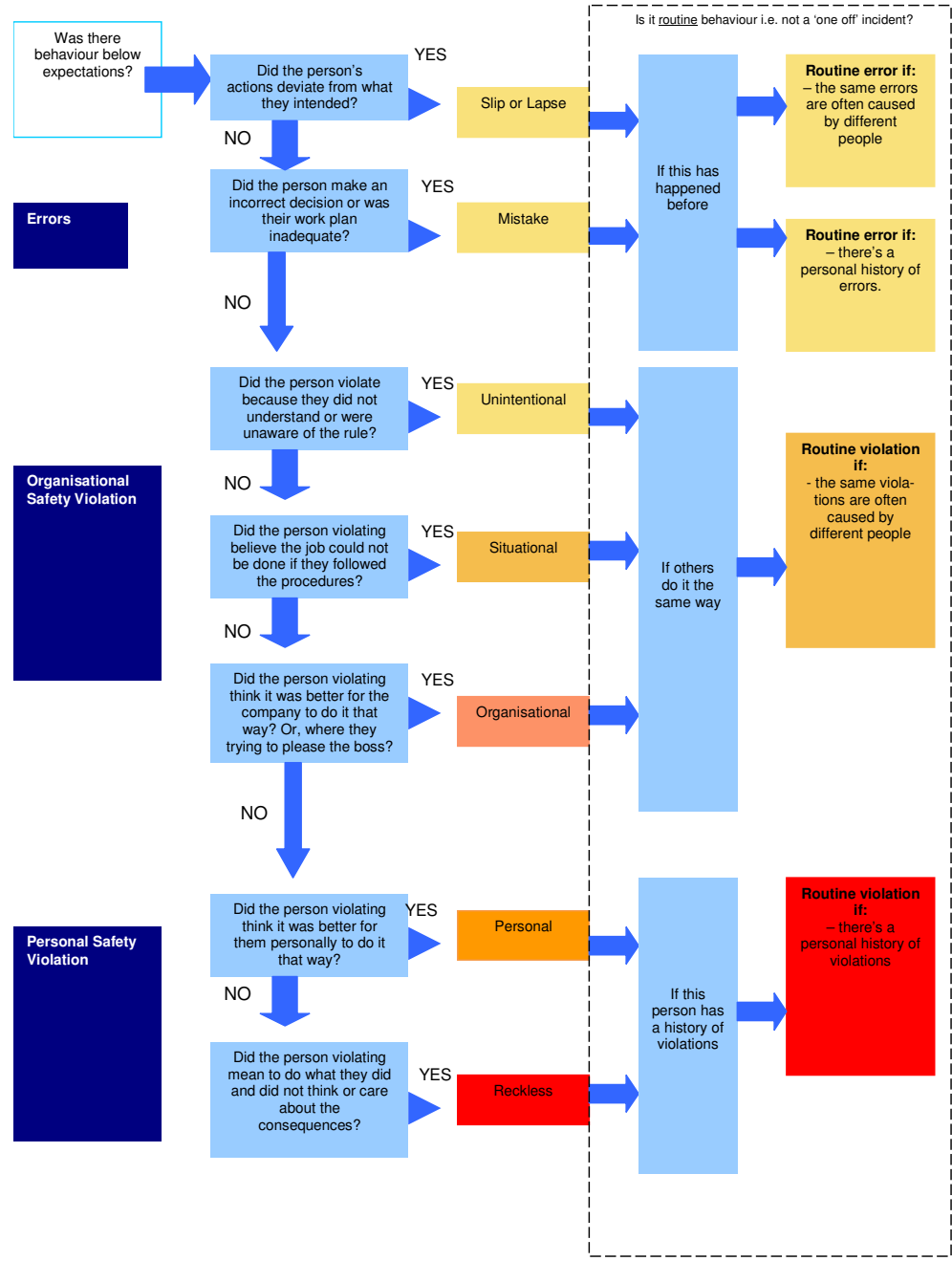
Learning from Actions

Learning and Working Safely - Behaviours Model



Learning from Actions

The Human Error and Safety Violation Flowchart



Substitution test

Given the circumstances that prevailed at the time...

...could you be sure that either you, or your (or the prisoners') peers would not have committed the same or similar type of unsafe act?

If the answer is 'probably not' then blame is inappropriate



Effects of learning process

- Positive actions are acknowledged and supported
- Recklessness and intentional violations not tolerated
- Increase in error reporting
- Reporting of near miss situations
- Increased trust and learning
- Improved engagement and safety performance

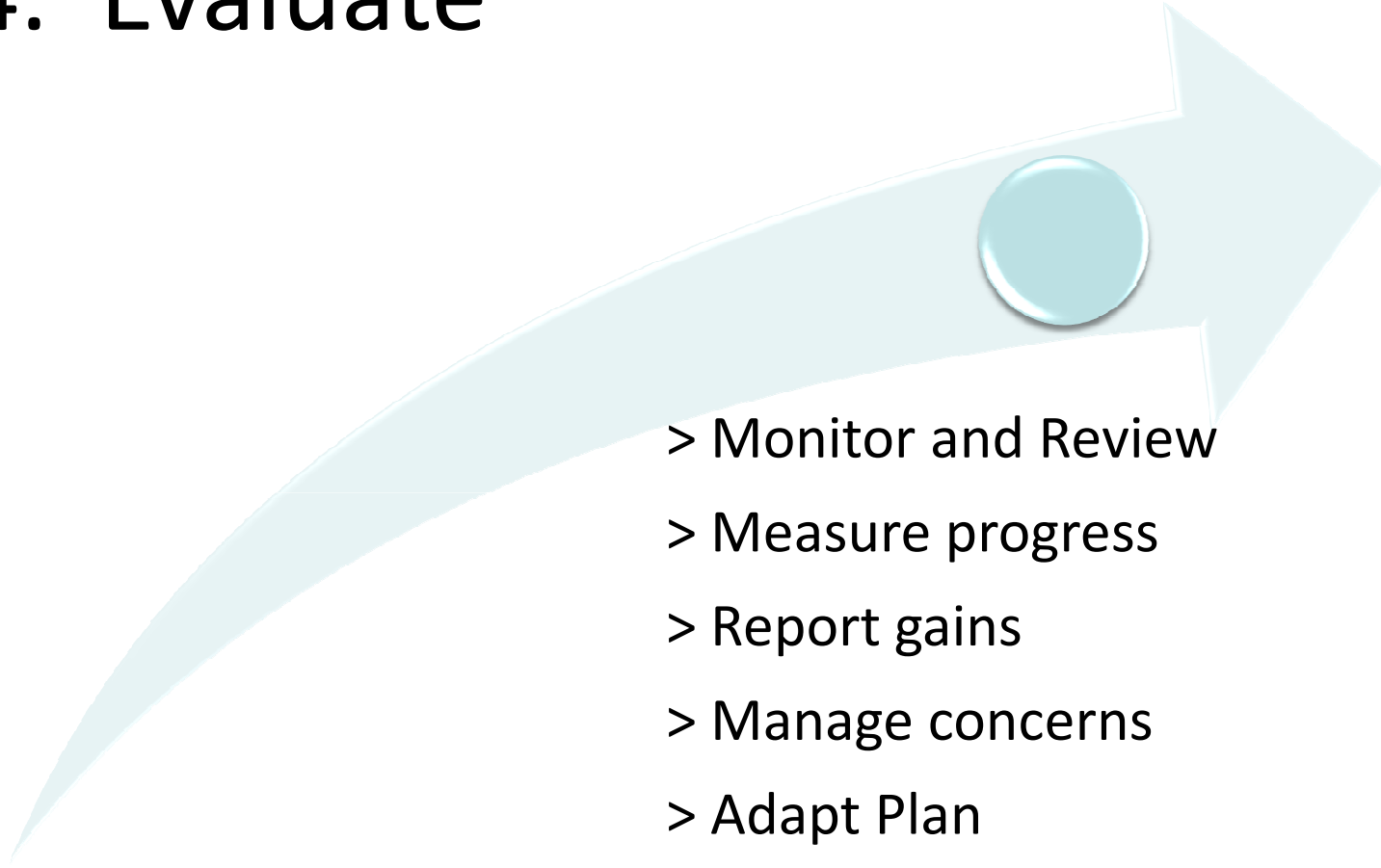


Learning Culture

- Rewards reporting
- Values open communication
- Risks openly discussed
- Shift emphasis to improving processes and systems, rather than blaming people



4. Evaluate



- > Monitor and Review
- > Measure progress
- > Report gains
- > Manage concerns
- > Adapt Plan

Dashboard Reporting

- Regular “high level” monthly surveys
- 6 – 12 Key indicator questions
- Linked to Health and Safety Culture survey
- Random sample 10% of employees
- One page report



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