Leadership and Safety Culture

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DNFSB Testimony

August 27, 2014

Key Role of Culture

Part of the effectiveness of organizations lies in the way in which they are able to bring together large numbers of people and imbue them for a time with ***a sufficient similarity of approach, outlook and priorities to enable them to achieve collective, sustained responses*** which would be impossible if a group of unorganized individuals were to face the same problem.

(Turner & Pidgeon, 1997)

Culture

- A source of an economical, powerful “similarity of approach.”
- The “similarity” results from shared frames of reference through which people interpret information, symbols and behavior, and which generate the conventions for behavior, interaction and communication.
- Culture is a means of interpreting what other people do, and it is also a mean and a medium through which people express their intentions.

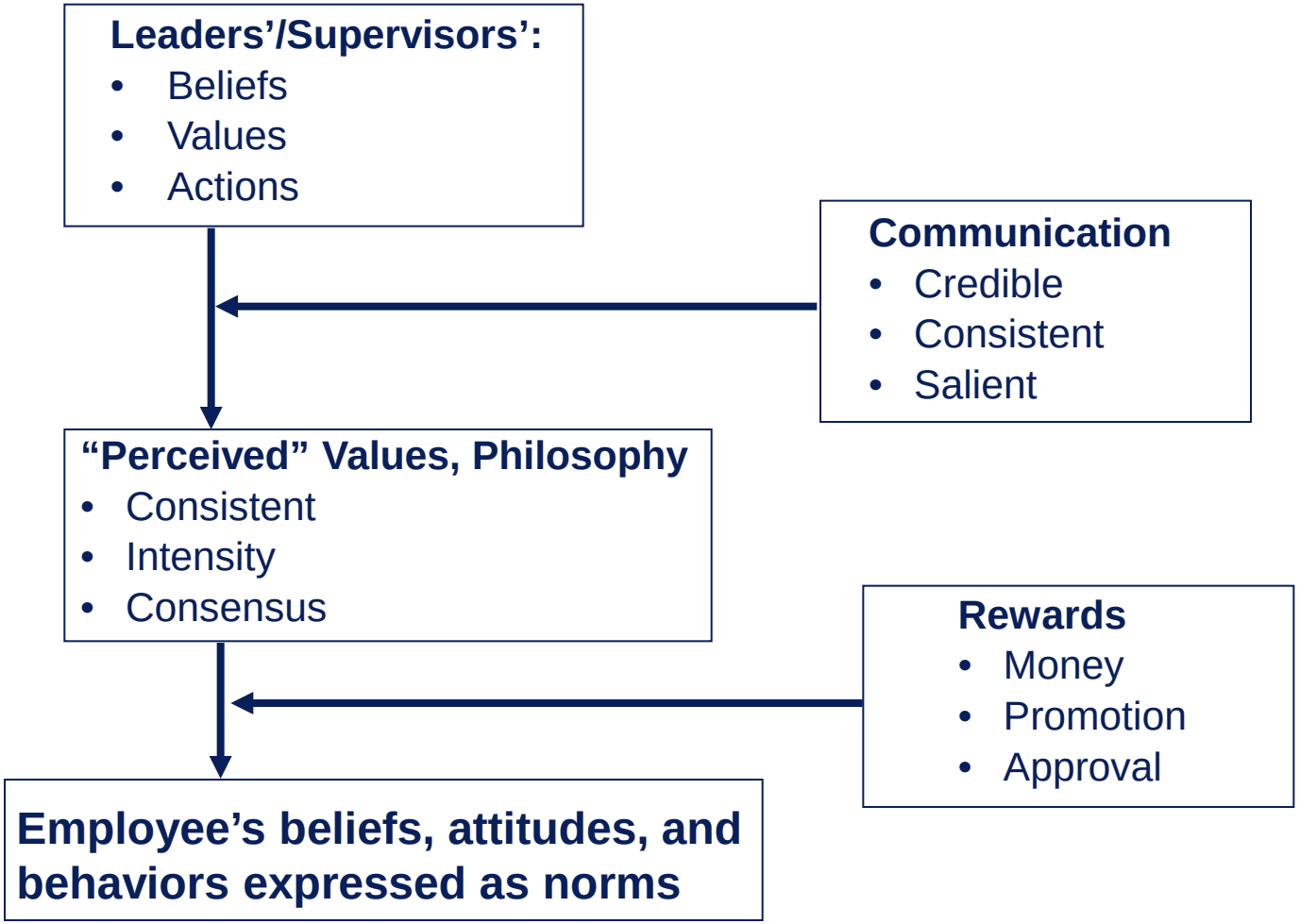
Safety Culture

- Frames of reference for meaning and action, which encompass the skills, beliefs, basic assumptions, norms, customs (e.g. interactions and communications) and language that members of a group develop over time (Antonsen, 2009, p. 79).
- Culture is a way of seeing and acting that is simultaneously a way of not seeing and not acting.
- Thus, culture can be a source of blindspots (Turner & Pidgeon, 1997).

Shaping Culture

- Idea of culture is simple: Be clear about the specific values, beliefs, and norms/behaviors you want.
- Building a safety culture is complex: Many conditions have to fall into place to produce clear frames of reference, values, norms, and behaviors!

How Leaders Can Shape Culture



Adapted from O'Reilly, C. 1989. *California Management Review*, Vol. 31, No. 4.

Building Safety Culture is a Process: Enabling, Enacting, Elaborating

Elements		Observations
Enable	1	Leaders and the organization prioritize safety. They invest in policies and procedures to create a safety infrastructure and take actions that reflect their commitment to safety.
	2	Leaders and the organization collect and disseminate safety information.
	3	Leaders and the organization empower individuals to speak up and act in ways that promote safety.
	4	Individuals perceive that leaders and the organization are committed to safety and that safety is a priority.
Enact	5	Individuals are willing to disclose potential problems, errors, and near misses and are willing to communicate those concerns to others in the organization.
	6	Individuals are mindful of potential risks and problems in their day-to-day activities.
	7	Individuals take preventative action to avoid problems and adaptive action to respond to problems as they unfold.
Elaborate	8	The organization rigorously reflects on safety outcomes and learns from them.
	9	The organization seeks to improve its safety-related policies and procedures.

Vogus, T.J., Sutcliffe, K.M., & Weick, K.E. 2010. Doing no harm: Enabling, enacting, and elaborating a culture of safety in health care. **Academy of Management Perspectives**, 24(4),

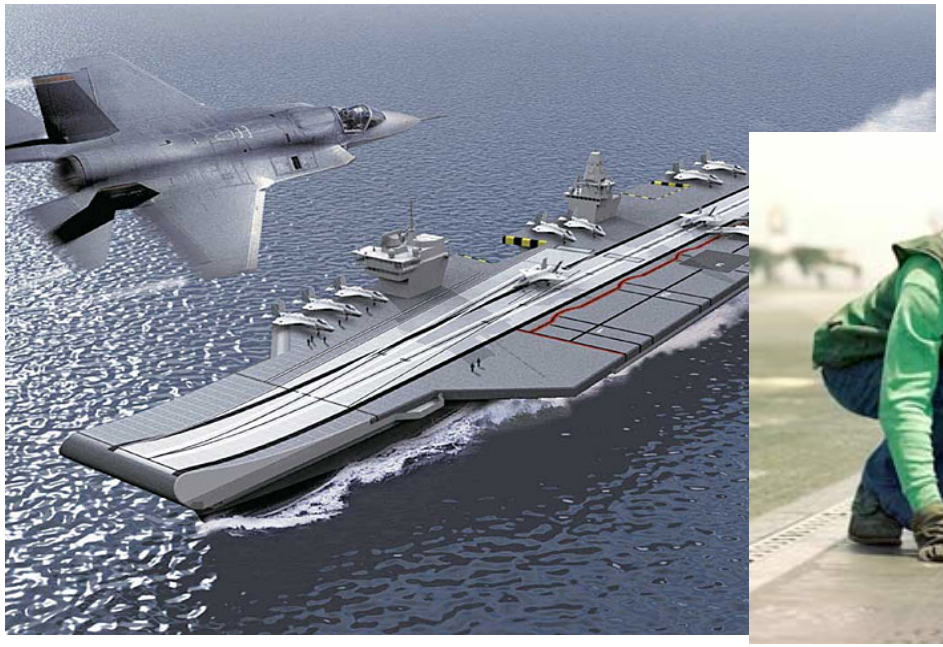
Enabling, Enacting, and Elaborating Safety Culture In Practice

1. Direct attention to safety (safety rounds).
2. Create contexts where people feel safe to speak up and act in ways that improve safety (actively see out bad news).
3. Highlight threats to safety (failure/near miss reporting, etc).
4. Mobilize resources to resolve threats.
5. Comprehensively represent safety outcomes.
6. Use feedback to modify practices and processes.

Why do organizational actors fail to redirect actions when they should?

Complex Systems are Vulnerable

- Interactive components and tightly coupled processes → small mishaps can concatenate (Perrow, 1986; Sagan, 1993; Weick & Roberts, 1993)



Accidents Often Start Small…

- Organizational safety requires
  - ~ vigilance for small cues of potential problems
  - ~ constantly adapting, redirecting ongoing actions as needed (Weick and Sutcliffe, 2007)

Failure of Foresight

- Failure to recognize weak cues signaling system problems (Reason, 2004; Weick & Sutcliffe, 2007)
- Disasters occur due to “accumulation of unnoticed events…” (Turner, 1976)

Failure of Sensemaking

- The act of reassessing an ongoing situation and giving meaning to action
- “What’s the story here? Now what should we do?”
- Sensemaking occurs when the “expectation of continuity is breached,” when activities are disrupted (Weick et al. 2005)

Lack of Interruptions May Threaten Safety

- Momentum: continuing in a course of action without re-evaluation.
  1) Flow of uninterrupted action – as opposed to a decision to escalate
  2) Overcoming momentum requires slowing or stopping, not starting
  3) Implies direction, purpose in action
- *Dysfunctional momentum* implies continuing with a failing action

- What motivates and enables individuals and groups to redirect ongoing action?
- What prevents redirection?
  - ~ Failure of foresight (miss cues)
  - ~ Failure of sensemaking (dysfunctional momentum)
- What are the implications for leadership?

Change Results from Re-Evaluation of Action

Redirect ongoing action

“We did a test fire and it did burn actively but we were kind of anticipating [that]. We started lighting and picked up spot fires almost instantly…by the time they took care of one, there was five or six more fires…the end result was people got a lot of smoke inhalation and throwing up and headaches…it was a real mess.”

Noticing Cues Was Not Sufficient

Re-evaluate situation → **Redirect ongoing action**

“We knew that was a bad place [to light the fire]…Because of the terrain. It was a steep slope up. Trying to stop it at mid slope rarely works. It was a pretty good chance that that was going to be a loser…

Noticing Cues Was Not Sufficient

Two Social Processes Lead To Re-Evaluation.

- Voicing concerns transmits critical information (Hirschman, 1970; Dutton et al., 1997)
- But it was equally important when others *already knew* the information

Voicing Concerns Creates Shared Artifact

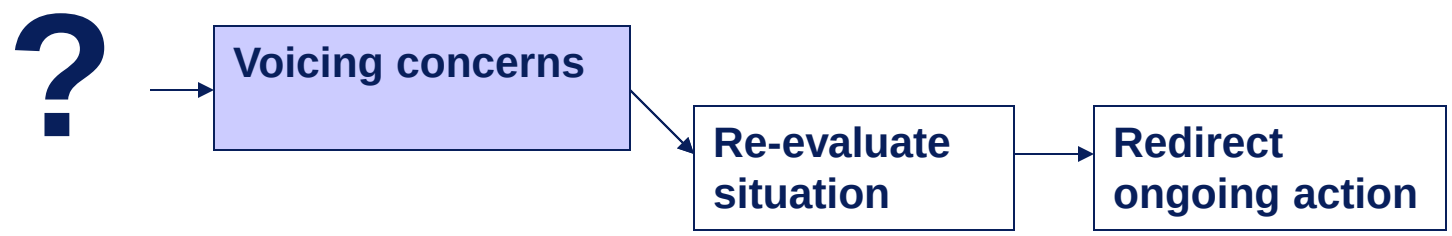
- While the *cue* may be ephemeral, uncertain, ambiguous, the statement is real and tangible.
  - ~ It must be acknowledged or denied, but in any case responded to.
  - ~ Creates an interruption.

Voicing Concerns Creates Shared Artifact

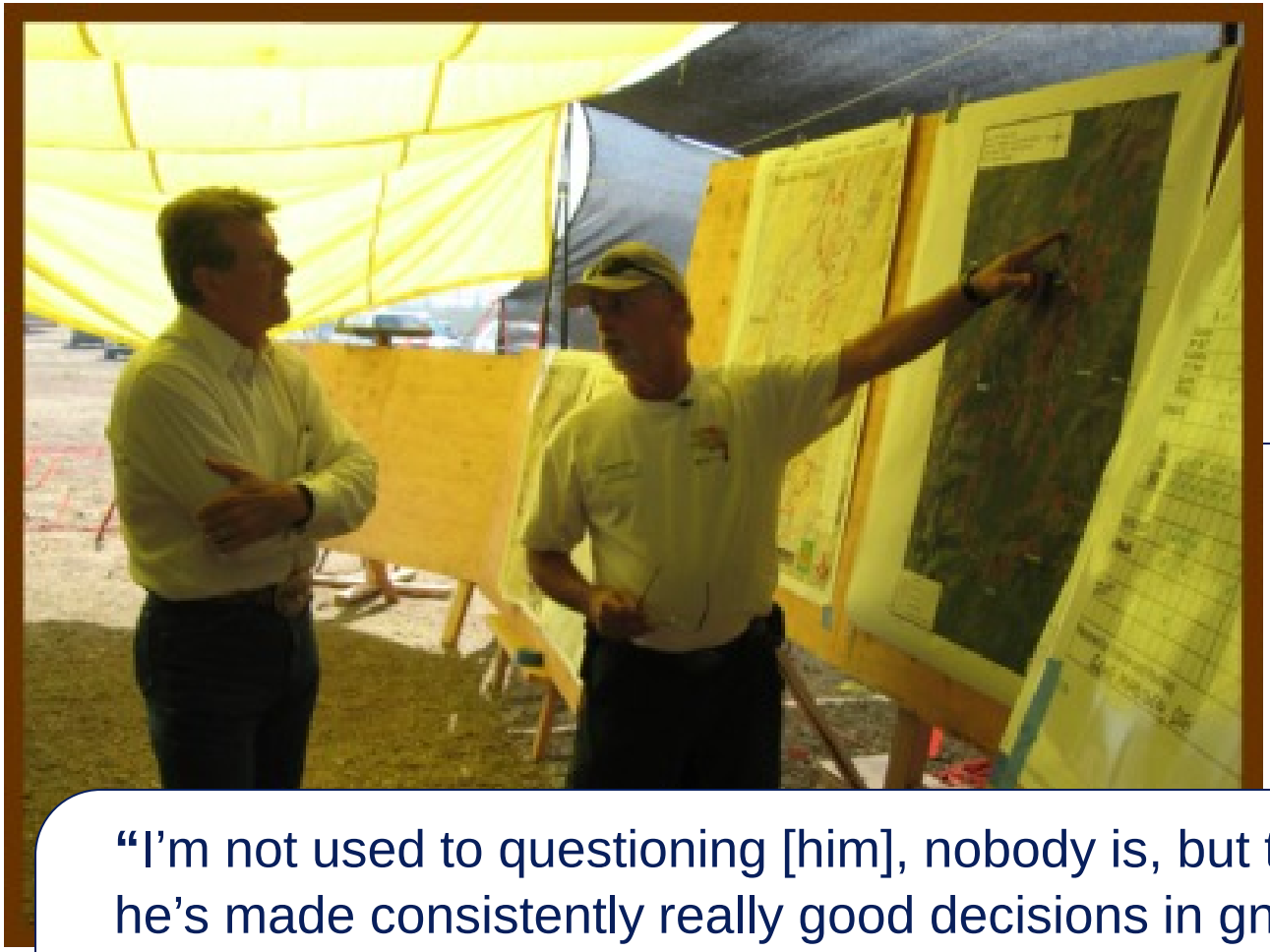
Redirect ongoing action

“I told my boss what we were experiencing and that I didn’t feel safe … I guess, just by hearing one person saying that, you know, it wasn’t worth it, that was enough to make [him] realize that yeah, you know, it is a safety concern …In a way, it was almost like he was waiting for somebody to say something.”

What Enables Voice?



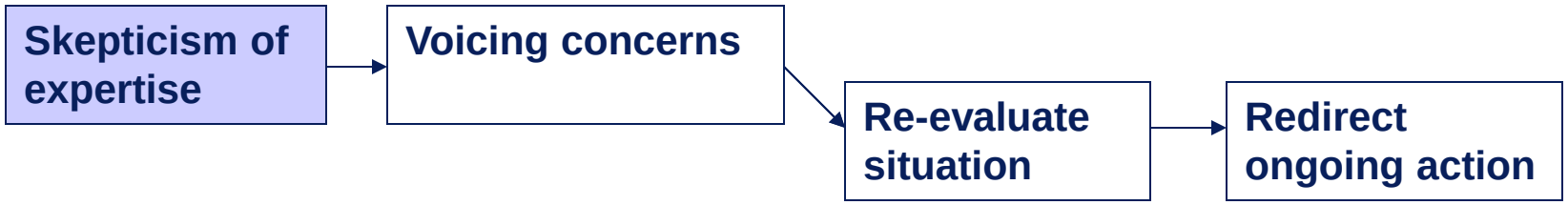
- Interpersonal context influences voice
  - ~ Individuals avoid voice if they fear negative reactions (Hirschman, 1970; Blatt et al., 2006)
  - ~ Our data suggests perceived expertise also influences voice and silence



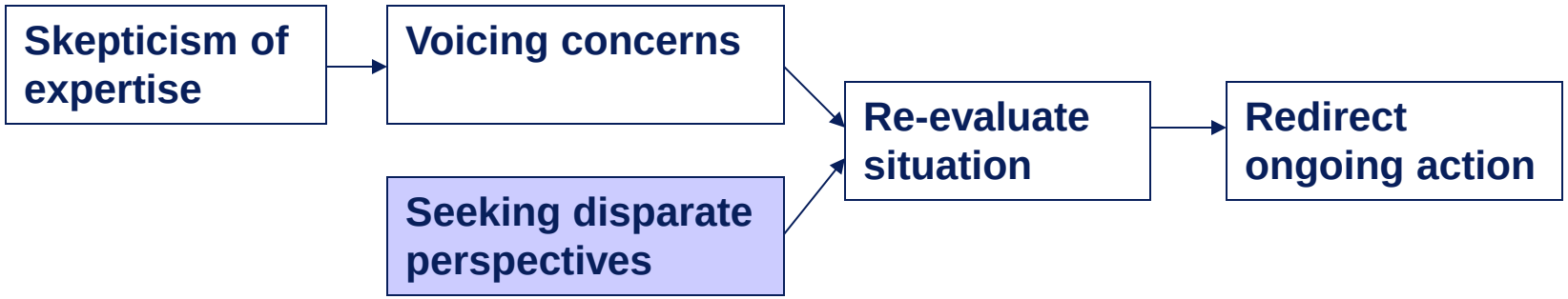
Redirect ongoing action

“I’m not used to questioning [him], nobody is, but that’s because he’s made consistently really good decisions in gnarly situations for 30 some odd years…and, you know, I didn’t feel comfortable about it, but I had the least experience of anyone out there...So I was like, “It doesn’t look great, but what do I know?”

Perceived Expertise Impacts Voice



Two Social Processes Lead to Re-Evaluation



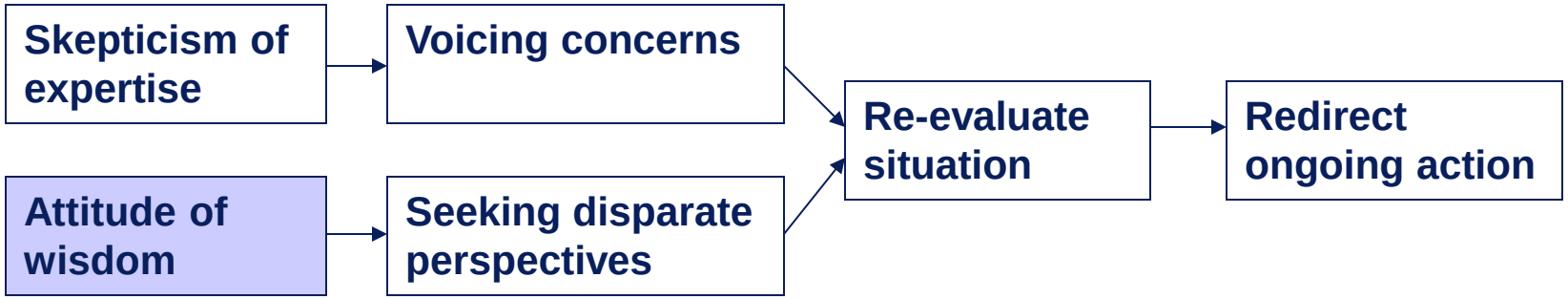
- Seeking discontinuities and checking assumptions creates opportunities for re-evaluation (Weick & Sutcliffe, 2007)
- Individuals who deliberately sought disparate perspectives, were more likely to interrupt and re-evaluate ongoing actions.

Seeking Disparate Perspectives

Redirect ongoing action

"I wanted to get input from the other people too, to see if there were any different views on [the fire], to see if anybody had a different idea because you have a wealth of experience there, so I like to use it all…"

Seeking Disparate Perspectives



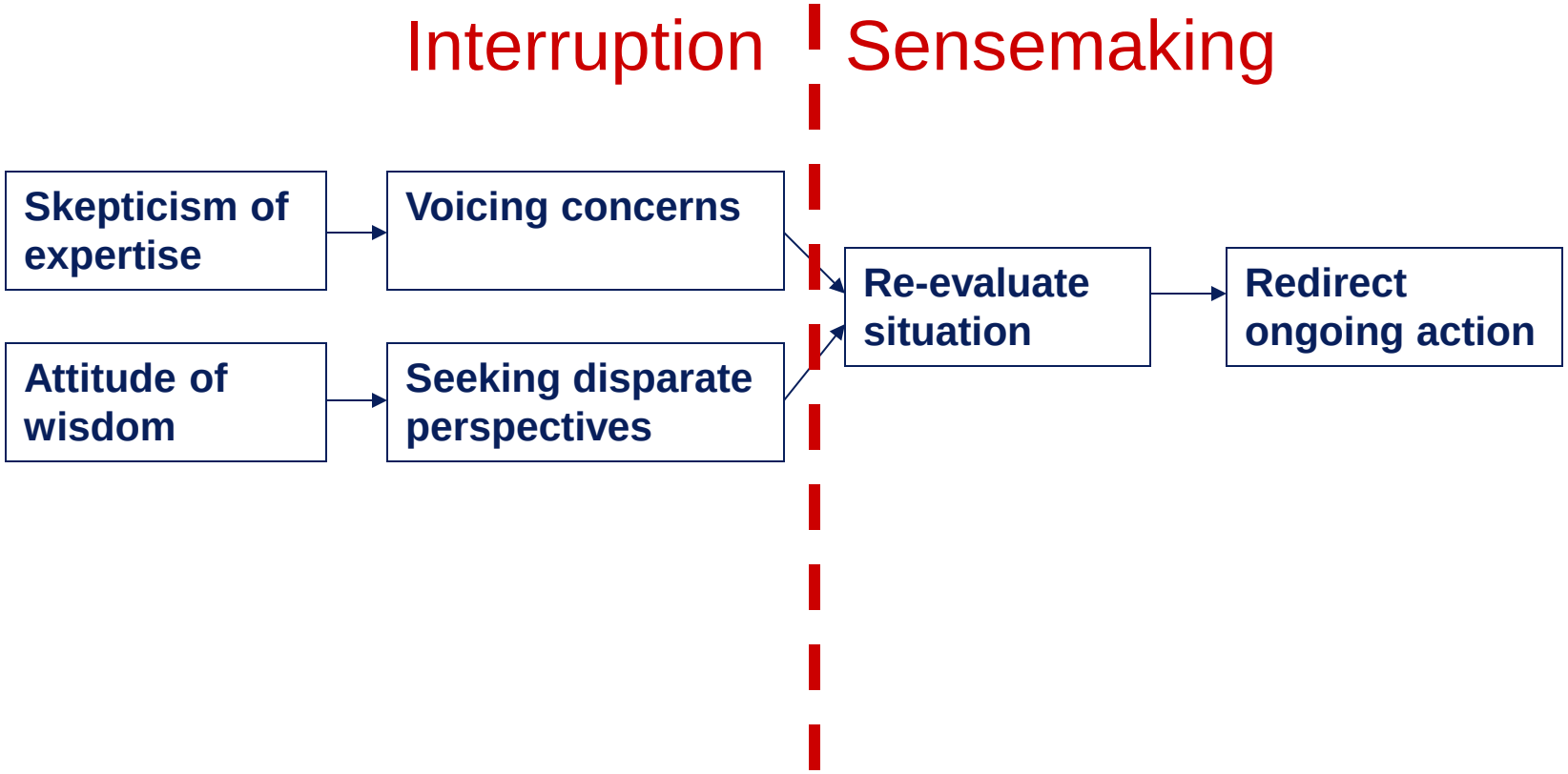
- Can’t fully understand what is happening because no one has seen precisely this event before (Weick, 1993)
- Situated humility arising from deep experience with fire.

Seeking Disparate Perspectives

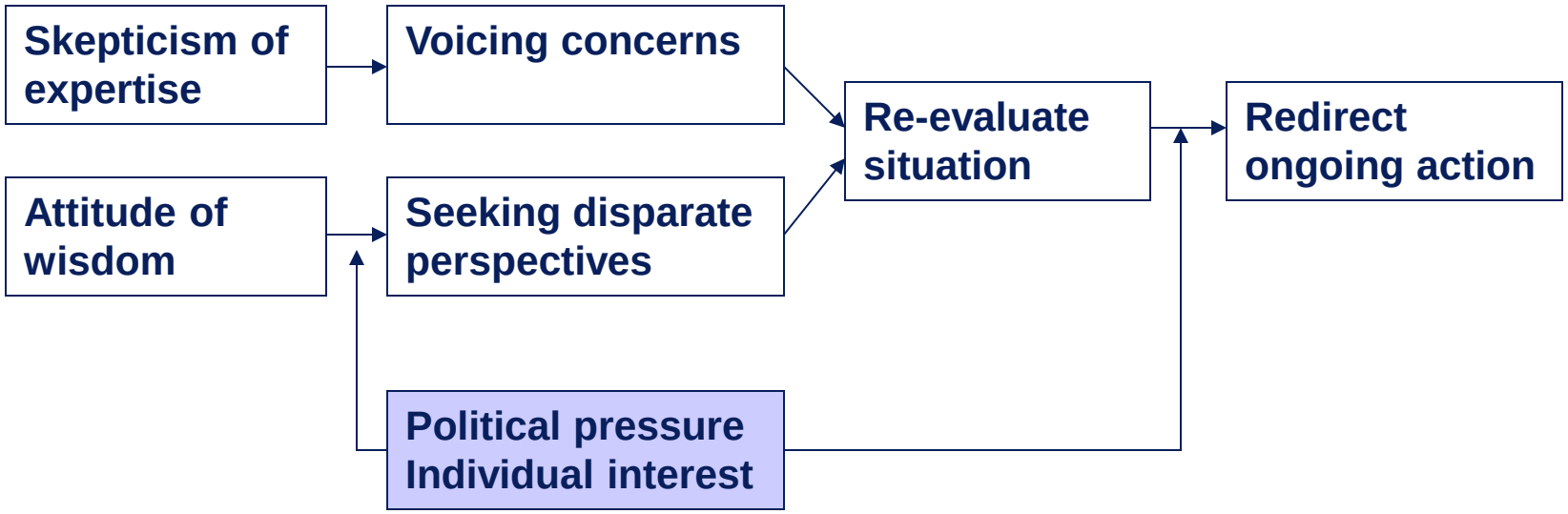
Redirect ongoing action

"As old as I am and as experienced as I am in relationship to these large fires, the next fire that I walk into initially I won't know anything. So I'm not going to come in there full guns blazing on the go…"

Overcoming Dysfunctional Momentum



Overcoming Dysfunctional Momentum



Contributions

- Disasters occur not only because of cultural blindspots (miss critical cues), but also because people become too embedded in ongoing action to incorporate cues into their thinking (dysfunctional momentum).
- Essence of leadership in safety critical contexts is sensemaking – creating interruptions and moments of reflection to reassess the “unfolding story,” determine “now what,” and reorient action.