Safety Science in Wisconsin: Systems Change Review

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Child Welfare Across the U.S.

Time for Something New

NEWS

Tennessee child welfare officials draw on lessons from aviation, call for "safety culture"

<p>IMAGE DISTRIBUTED FOR COMMISSION TO ELMINATE CHILD ABUSE AND NEGLECT FATALITIES & Staffers from the Tennessee Department of Childrenás Services Offices of Child Health and Safety Noel Hengerbrok (from left), Scott Modell, and Michael Cull speak during a public meeting of the Commission to Eliminate Child Abuse and

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Smith deserves some cr
#Tigers

Contrasting Reviews

Turkish Air flight TK1951 received erroneous information from the plane's radio altimeter system. The crew's response resulted in a fatal crash that claimed the lives of 4 crew members and 5 passengers.

Contrasting Reviews

A 2 y/o girl in foster care drowns in the family's swimming pool.

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Expert Findings

- The Captain had close to 11,000 hours on the Boeing 737 alone. This combination of training standards and experience is apparently not enough **to protect crews from the subtle effects of automation failures** during automated, human-monitored flight.
- The documentation and training available for flight crews of the Boeing 737NG leaves important **gaps in the mental model that a crew may build up about** which systems and sensor inputs are responsible for what during an automatically flown approach.

(Dekker, 2009)

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Expert Findings

- It is indisputable that OKDHS was **well aware of the hazard associated with the pool**.
- The home **should never** have been approved without a specific and shared understanding between OKDHS and the foster parents about the pool.
- The pool **should have been** removed or a suitably protective fence **should have been** placed around it.
- **No children should ever** have been placed in the home before one of these things happened.
- By **failing to ensure** that this hazard was either removed or mitigated, OKDHS **violated** CWLA and COA **standards** and its own **policy**.

Goad, 2011

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Developing a Safety Culture

Three Transitions

Blame to Accountability
To understand how to learn and improve as an organization.

Applying quick fixes to understanding underlying features
To make meaningful change and address the real problems.

First Stories to Second Stories
To dive beneath surface level descriptions of events and understand the true sources of failure and success.

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Systems Change Review

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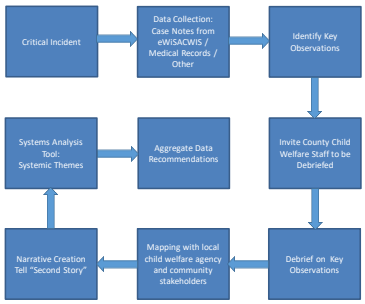
Systems Change Review

- Departs from Blame and Increases Individual and Systems Accountability
- Integrates safety science into the learning process
- Establishes an environment that promotes staff engagement
- Values staff perspective
- Compatible with complexity of work

Systems Change Review Process Flow



Systems Change Review

- Key Features
  - Human Factors Debriefing
  - Systemic Mapping
  - Systemic Analysis

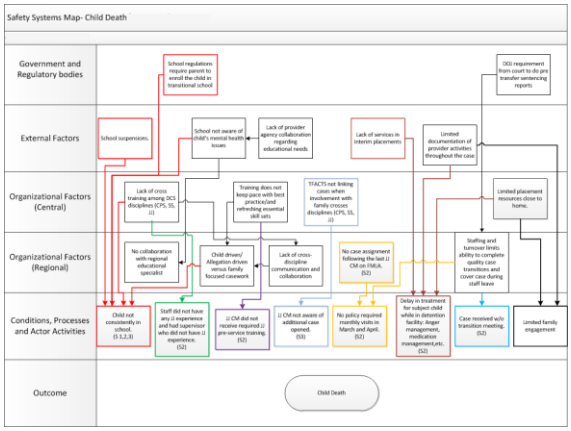
Human Factors Debriefing

- Conducted by Wisconsin Reviewers
- Characteristics of Debriefing
  - Voluntary
  - Supportive
  - Safe
- Uses Human Factors Techniques
  - Understands decisions made in context
  - Explores Local Rationality

Systems Mapping

- Facilitated by Wisconsin Reviewers
- Multidisciplinary
- Based on AcciMap model
- Explores identified Learning Points and their influences at different levels of the system
  - Frontline
  - County
  - State
  - External
  - Government/Legislative

Sample Map



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Narrative Creation

- Created by Wisconsin Reviewer
- Derived from Mapping process
- Turns Mapping product into contextual narratives
- Scored with Systems Analysis Tool

Example Narrative

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Narrative Example

- Event: A JJ supervisor was assaulted by a youth
- Learning Point: Youth was left with one staff person

Narrative Example

- Narrative: The historical practice of not using the county detention facility to hold youth on the weekends influenced the decision to bring the youth to the office. An absence of role clarity between the agency and law enforcement in processing youth after-hours supported the decision of law enforcement to leave the office before a transportation plan had been finalized. This resulted in the Social Worker and Supervisor adapting procedures around being alone with youth so that one of them could secure the required vehicle needed for transport.

Narrative Example

- The youth's continued calm demeanor and history of non-violence with the Social Worker and Supervisor contributed to their perception of the effectiveness of this modified plan. Overall staffing patterns, without after-hours backup from the agency and law enforcement, placed staff in a position of having to choose which work requirements to prioritize in order to accomplish the task of transporting the youth to the identified placement setting.

Systemic Analysis

- Identifies Underlying Systemic Themes
  - Examples:
    - Teamwork/Coordinating Activities
    - Service Availability
    - Prescribed Practice
    - Demand-Resource Mismatch
- Targets resources and interventions during recommendation process
- Integrated into broader CQI efforts

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Final Discussion