TRANSFORMING CULTURE | TOGETHER

Collaborative Safety, LLC

www.collaborative-safety.com

Safety Science Overview

The field of child welfare could be considered one of the most complex social systems to work within.

While publicly mandated in the late 20th century, child welfare is certainly not new. Keeping children safe has continuously increased in complexity from pressures to manage and close cases, limited resources such as money and services and limited time. Now, in the 21st century, there has been an asynchronous evolution of safety and quality methods to remain compatible with this increase in complexity

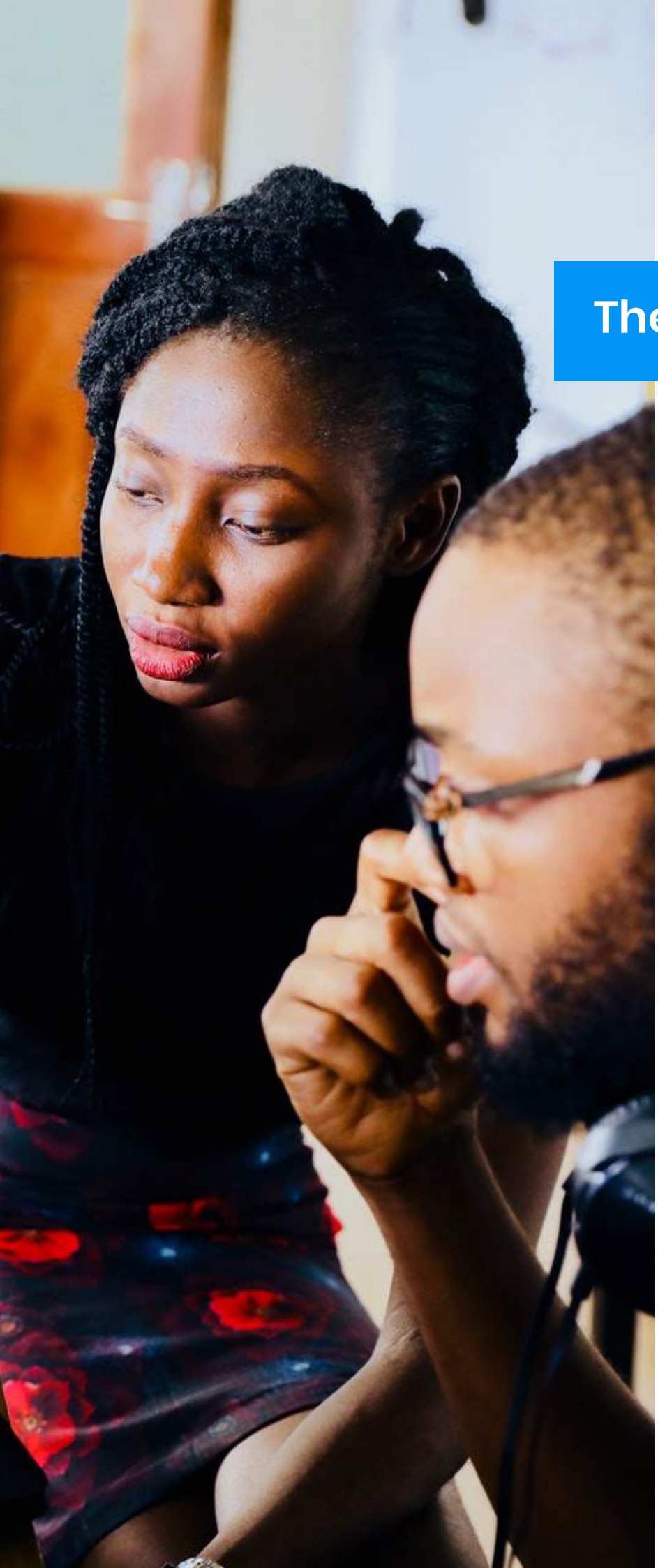
When failure occurs, the common response of child welfare agencies is to use reactionary approaches such as firing employees, writing new policies, or retraining staff. These approaches have poor results when it comes to making systems safer. In fact, they may have an opposite effect. Using reactionary approaches, evidence suggests agencies may be less safe because true accounts of how the system operates and how it can be improved are kept underground. Employees are less likely to account for how things may go wrong and are less likely share how these issues can be avoided in the future because of fear they may be sanctioned or even fired. This may leave agencies with the false impression that they have dealt with a problem, when in fact it may have become worse. Furthermore, these reactionary approaches are detrimental to staff.

Burnout, turnover, decreased engagement and secondary trauma are all concerns for child welfare agencies who can expect to see turnover rates between 20%-40% with a cost between $8 million and $17 million for every 1,000 employees. In addition to the cost of hiring and retraining staff, work outcomes are affected. It has been shown that agencies with high levels of turnover may see a 125% increase in child and family recidivism compared to agencies with low turnover.

The field of Child Welfare must evolve from outdated models of safety commonly used today. Current models of safety engage employees in safety related efforts, establish comprehensive approaches to analyzing adverse events and promptly act upon identified areas of improvement. These models have been championed by safety critical industries such as aviation, healthcare and nuclear power. The industries that use these updated models of safety depart from surface level understandings of how systems fail and seek out the complex interplay of systemic factors. When typical underlying systemic factors are addressed, a child welfare agency can begin to make critical advancements in promoting safe outcomes for children, families, and employees.

In order to promote the shift to a systemic and proactive culture of safety, agencies need to be supported to make three key transitions:

1. From a culture of blame to a culture of accountability.
2. From continuously applying quick fixes to addressing underlying systemic issues, and
3. From seeing employees as a problem to control to a solution to harness



The Three Transitions

1

Towards a culture of accountability

The terms blame, and accountability are too often conflated. When agencies blame and punish workers, they falsely believe that the agency and its employees are being accountable for their actions. Years of research have shown that blame may decrease accountability, since it inhibits the ability of the organization to learn and improve. Accountability engages frontline workers to be a part of the solution by providing their experience of how adverse events may have occurred and how they can be avoided in the future. Additionally, the agency is accountable to make improvements and to focus efforts and resources on becoming a more resilient and reliable organization.

2

Towards addressing underlying systemic issues

In the wake of failure, it is tempting for agencies to use quick fixes such as firing employees, adding new policy or retraining staff. This leaves agencies with the false impression that a problem has been resolved. However, agencies are still left with the systemic constraints and influences that contributed to an adverse event. This is commonly seen as treating symptoms instead of the source of the illness. Instead, agencies need to track and address the underlying systemic factors that are present in many adverse events and are likely to be present in the future.

3

Towards seeing workers as the solution

Common approaches to improvement whether following a critical incident, or not, typically target individual workers within an organization through new policies, training, work-aids or compliance. These approaches often make work more difficult through excessive tasks and increased complexity. Science and practice show that workers are a source of success, not failure. Enhancing safety is achieved through removing barriers and providing supportive systems for workers to achieve organizational outcomes. Additionally, understanding where these enhancements can be added is informed by providing staff with a platform to share their knowledge and experience in a safe way.

Collaborative Safety Model

The primary scientific base for the model is founded in Safety Science which is commonly championed in industries such as aviation, healthcare and nuclear power and has not been integrated across human service agencies until Collaborative Safety developed this model.

This body of science engages disciplines such as human factors engineering, systems engineering, organizational management, psychology, sociology and anthropology. Furthering this unique blend of sciences is the integration of Behavior Analysis, Forensic Interviewing and Trauma Informed Care into the Collaborative Safety model. The integration of Behavior Analysis science into the model supports understanding how staff make decisions in an organizational setting as well as understanding how managers and supervisors shape employee performance to achieve successful outcomes.

Systemic Critical Incident Review

A central artifact of the Collaborative Safety Model is the systemic critical incident review. Collaborative Safety supports human services agencies to develop Systemic Critical Incident Reviews that are uniquely different than current approaches standardly used within these systems. These systemic Critical Incident Reviews depart from surface level descriptions of events that typically place blame on to front line workers and instead uses systemic analysis to understand how decisions, initiatives, resource allocations deeper within an organization and outside of it can surface in the outcomes experienced in everyday work.

Top to Bottom Alignment

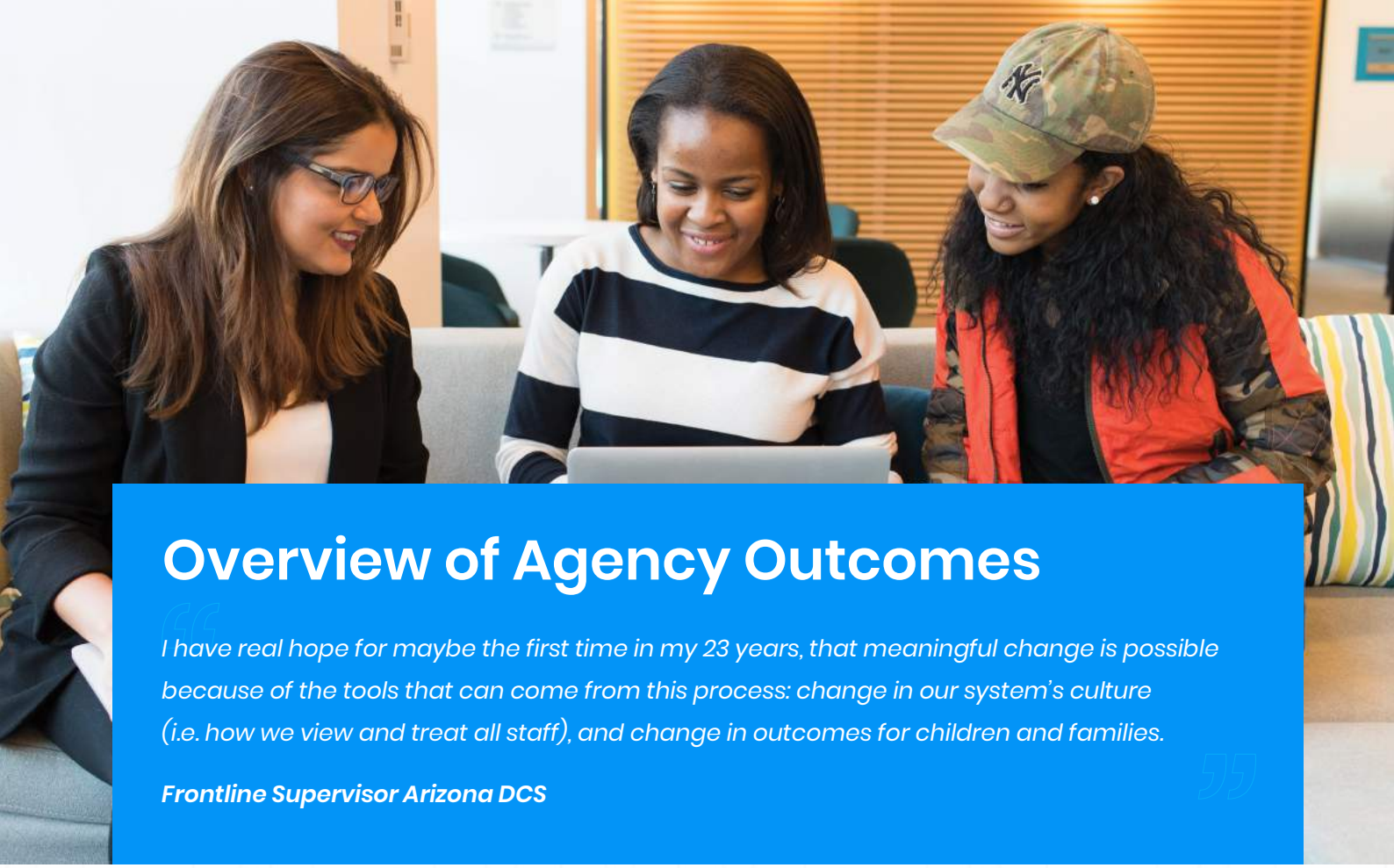
The Collaborative Safety model supports agencies to develop a culture of safety throughout the organization, establishing necessary shared values and education. To achieve this, Collaborative Safety employs top to bottom alignment throughout the organization and systems. This is achieved through a unique set of Institutes and Orientations designed for executives, managers, supervisors, frontline staff, and external stakeholders vital to supporting the agency and system's transition to a culture of safety.

Integration into Everyday Operations

In addition to the Institutes and Orientations, Collaborative Safety provides advanced practical training to specialized positions within the workforce to embed safety science principles and approaches into everyday work and currently existing processes and structures. By embedding these principles into structural processes of the agency as well as the broader system, artifacts are created that reflect the values central to a culture of safety.

Sustainability and Evaluation

To support effective culture change, Collaborative Safety prioritizes the establishment of processes and supports that are sustainable. Human Service agencies are constantly managing change and the Collaborative Safety Model is designed to withstand that change. Evaluating culture change and model effectiveness is greatly important. Evaluation methods and strategies are specifically developed in collaboration with partner agencies to analyze culture change and its impact on key organizational metrics.



Overview of Agency Outcomes

I have real hope for maybe the first time in my 23 years, that meaningful change is possible because of the tools that can come from this process: change in our system's culture (i.e. how we view and treat all staff), and change in outcomes for children and families.

Frontline Supervisor Arizona DCS

1. Improved outcomes from a system dedicated towards improving the reliability and safety of provided services
2. A robust and proactive response to critical incidents
3. A responsive system dedicated to learning
4. Increased trust in the provision of care
5. Increased staff engagement
6. Improved staff morale
7. Improvements in employee retention
8. Improved partnership with partner agencies
9. Increased accountability
10. Improved systems in place
11. Increased public trust