So, what is Safety II?
So what is this Safety II?

Dr Suzette Woodward

Sign up to Safety
Agenda

• The journey from Safety I to Safety II – 25 mins

• A conversation together – 20 mins
  – 10 mins talking to each other about your ideas in trios
  – 10 mins sharing ideas with everyone else
Our current approach to safety (Safety I)

• Safety is defined as a state where as few things as possible go wrong

• We seek to improve safety by measuring and then trying to reduce the number of things that go wrong

• This approach is stretched to or beyond breaking point – and the world has changed
10% failure
90% non failure
Policy and practice

• We are fixated on clear and simple explanations of what ‘should be done’ – we try to prescribe tasks and actions in every detail

• When there is a difference between the policy and practice this is used to explain why things went wrong

• Everyone actually doing the work knows it is only possible to work by continually adjusting what they do in a given situation
The general view is that all we should do is tell people to..

• Stop making mistakes

• Stop deviating from instructions or known procedure

• Simply follow the rules
Implications

• Something goes wrong

• Regulators, legal and clinical negligence systems and human resource people look to the policies to see what should have been done

• The people that have deviated from the ‘normal’ policy are found to be at fault
What's wrong with this?

• Crucially, the Safety-I view does not explain why human performance practically always goes right.

• The reason that things go right is not people behave as they are told to, but that people can adjust their work so that it matches the conditions.
In reality

• People **adapt and adjust** to actual demand and change their performance accordingly

• People **interpret** policies and procedures and apply them to match conditions

• People can **detect and correct** when something goes wrong or when it is about to go wrong and intervene to prevent
Performance adjustments and variability is at the core of Safety II.

This is a positive thing but currently interpreted negatively as...

deviations, violations, and non-compliance
Also...

• We ignore what we do everyday simply because we do it everyday

• Habit diminishes the conscious attention with which we do our every day actions
The myth of the solution

• We currently investigate with the mind-set of searching for the nice and clean technological solution

• This has two major consequences
  – Problems are attacked and solved one by one, as if they could be dealt with in isolation
  – The preferred solution is technological rather than socio-technical, probably because non-technical solutions are rarely ‘nice’ and ‘clean’
Explanations that are based on linear causality are dangerously oversimplified

Eric Hollnagel
Safety II

• The ability for people to adjust what they do to match the conditions of work

• The ability to succeed under expected and unexpected conditions alike

• A state where as much as possible goes right
Safety is defined as a state where as few things as possible go wrong.

Safety is defined as a state where as much as possible goes right.
How do we change what we do?
Short → Long
Treasure adaptability

• Adjustments and variability are normal and necessary, and are the reason for both positive and negative outcomes

• Constraining variability will inevitably affect the ability to achieve desired outcomes and is counterproductive

• Thus rather than looking for ways in which something can fail or malfunction, we should try to understand the characteristics of everyday performance variability
Variability

- Variability should not be interpreted negatively, as in ‘performance deviations’, ‘violations’, and ‘non-compliance’

- On the contrary, the ability to make performance adjustments is an essential human contribution to work
Trust people to adapt and to use variation to create safety
Todays emphasis on the rare

• Never events; significant events, serious events
  – These are relatively rare
  – Focusing on rare cases of failure does not explain why human performance practically always goes right
• Instead of looking at the one case in 100 where things go wrong we should look at the 99 cases where things go right in order to understand how that happens
Most incidents and accidents

Normal day to day performance

Exceptional performance

Never events, significant and serious incidents, deaths

Safety I

Safety II
Finding out

• The best source of information is the people who actually do the work
  – Interviews
  – Field observations
  – Exchange people between departments to provide a set of fresh eyes
  – Undertake a tour of the work place
Reporting and learning systems

• In most cases when something goes wrong it will have gone right many times before – and will go right many times again in the future

• Avoid treating failures (incidents) as unique, individual events, and see them as an expression of everyday performance variability

• Capture what we do well together with what goes wrong
Investigations

• Investigating should be with the mind-set of understanding how it usually goes right, instead of searching for specific causes that only explain the failure

• Start investigations by studying everyday performance and then find out what the every day adjustments are as a basis for explaining how things occasionally go wrong
  – what went right during the incident?
  – how do things usually go right?
  – why do things sometimes go exceptionally well?
Combining Safety I and Safety II

• Safety-I and Safety-II represent two complementary views of safety rather than two incompatible or conflicting approaches.

• Many of the existing practices can therefore continue to be used, although possibly with a different emphasis. But the transition to a Safety-II view will also include some new types of practice.
Helping people talk to each other

• With the Safety II mind-set, gather new insights, share experiences, talk about the every day

• Use methods such as appreciative inquiry, cooperative inquiry, storytelling and narratives and safety conversations
Safety Conversations

- Time to speak
- Active listening
- Observing
- Use of metaphors
Questions are the answer

• Do you ever adjust the activity to the situation?

• How do you determine which way to proceed?

• What do you do if something unexpected happens? e.g. an interruption, a new urgent task, a change of conditions, a change of resource
Questions are the answer

• How stable are the working conditions?
• Is your work usually routine or does it require a lot of improvisation?
• How predictable is your work?
• What do you do in case of time pressures?
• What do you do if information is missing?
• What do you do if you can't get hold of certain people?
Safety Huddles
Briefing and debriefing

Before

After
Facilitated debriefing post incident
Trio Methodology

Speaker

Active listener

Observer
A designed conversational process
Fishbowl
Sign up to SAFETY

National Kitchen Table Week
27th March - 2nd April 2017
In summary

• The way forward therefore lies in moving toward Safety-II while combining the two ways of thinking

• Most of the existing methods and techniques can continue to be used, although possibly with a different emphasis

• But the transition toward a Safety-II view will also include some new practices to look for what goes right, focus on frequent events, remain sensitive to the possibility of failure
Key question

If you aspired to create a safety II system ... what would you do differently?
Let's talk...