Introduction to Culture of safety
June 23, 2025

Scott Schifsky, Disability Services Division

Data Privacy/Tennessen Warning

This session is being recorded

- The recording will be posted on the DSD Training Archives for attendees to reference as needed.
- If you do not wish to be recorded, keep your camera and microphone off.
- For further information, refer to the Department of Administration’s FAQ.

Objectives of today's meeting

- Participate in a brief overview/refresher of the foundational principles of safety science.
- Review safety science examples from Minnesota.
- Discuss how culture of safety/safety science can support our existing work.

Old view vs. New View

Two Views of Safety

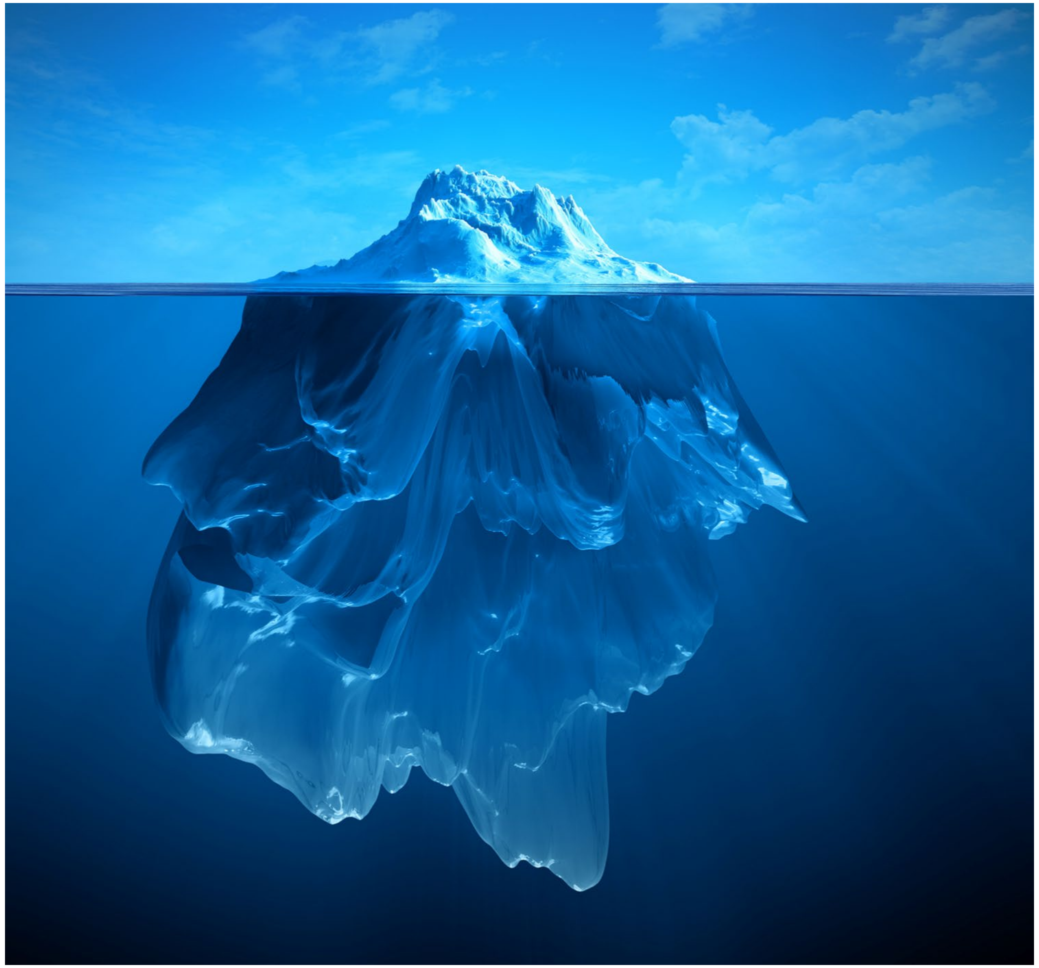
Old View vs. New View

Important features

- Human Error: What was the worker's role?
- Causation: How did this happen?
- Methods of Learning: How will we learn?
- System Improvement: What do we fix?

Safety science & trauma-informed practice

- "What happened to you?"
- Being safe and feeling safe are different:
  - Individual differences.
  - Cultural differences.
- Decisions and actions are shaped by past experiences and trauma.



Safety science & person-centered practices

Multiple Perspectives

- Supports accessing perspectives from those with lived experience

Creating a Safety/Learning Culture

- Reduces defensive practice

Defensive Practice Evidences in:

- Imbalance of person center living
- Increased use of antipsychotics in LTC
- Increased use of more restrictive placements
- Decreased quality of life

Safety science & Equity

- Supports an environment and work culture that invites and builds trust and conversation
- Values and utilizes multiple perspectives for learning and system improvement
- Antidotes to White Supremacy Culture Characteristics
- Systemic analysis:
  - Structural and systemic racism
  - Biases

What was the worker's role?

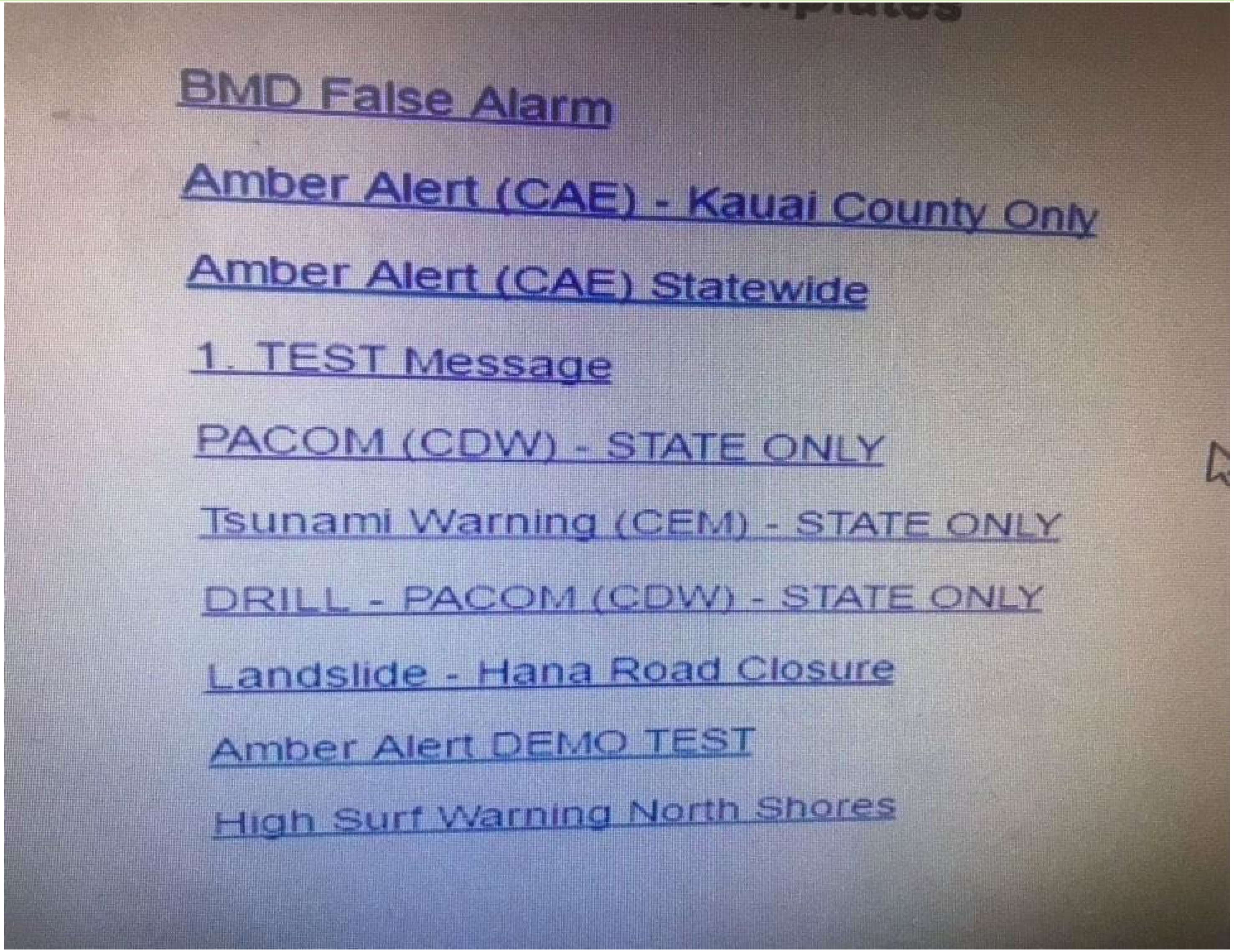
Old View Beliefs

- We believe people are the cause of failure
- Trauma Informed Practice: What’s wrong with the person
- Our learning ends with bad practice
- Our interventions target people
- We assume people should do better with what they have
- We treat people as a problem to control

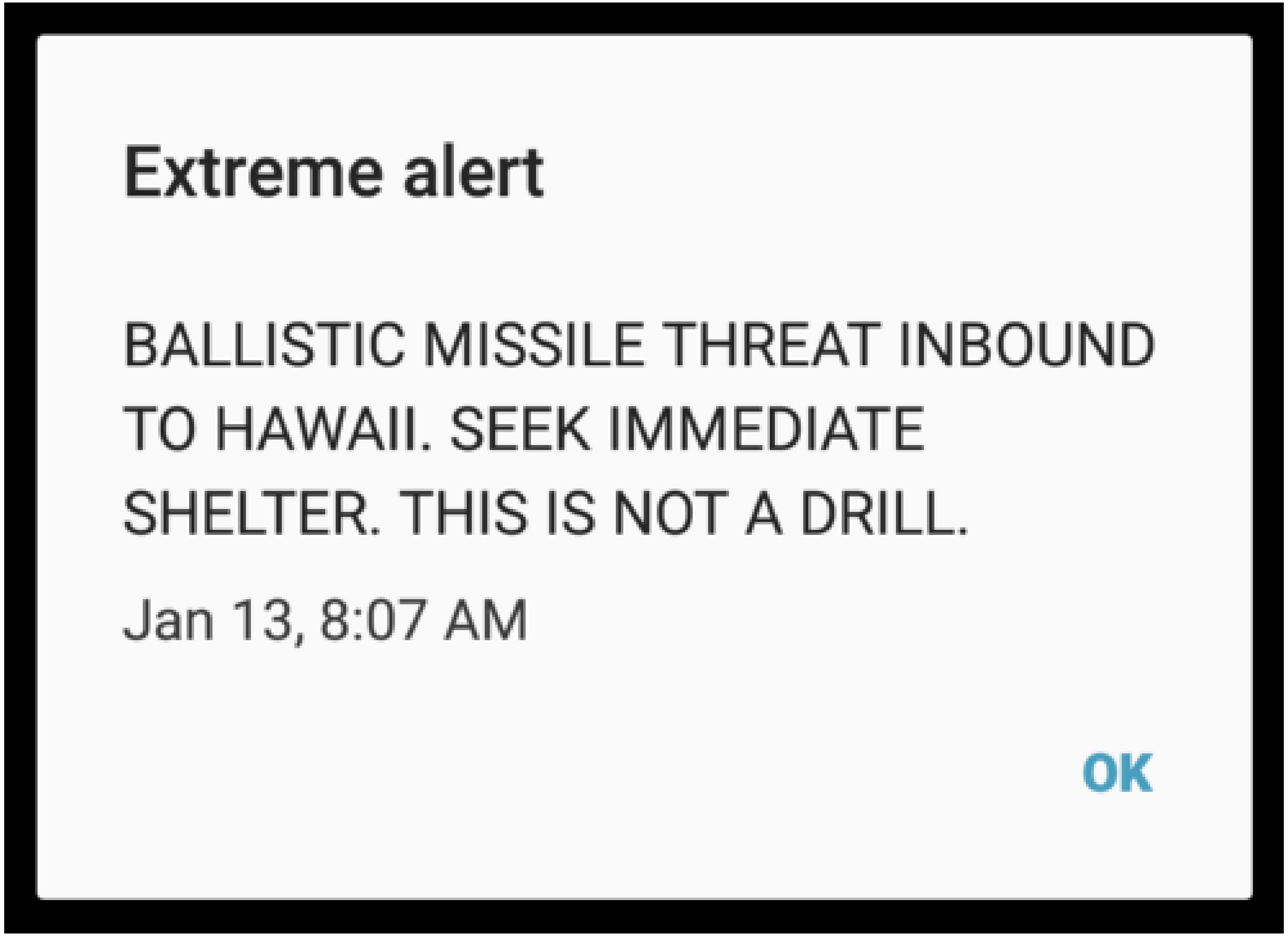
Sidney Dekker's Bad Apple Theory

- Systems are perfect
- "Human errors" cause accidents
- Failures are unexpected
- Systems should identify the 'bad apples' and remove them
- Outcome bias: the worse the outcome, the worse the punishment

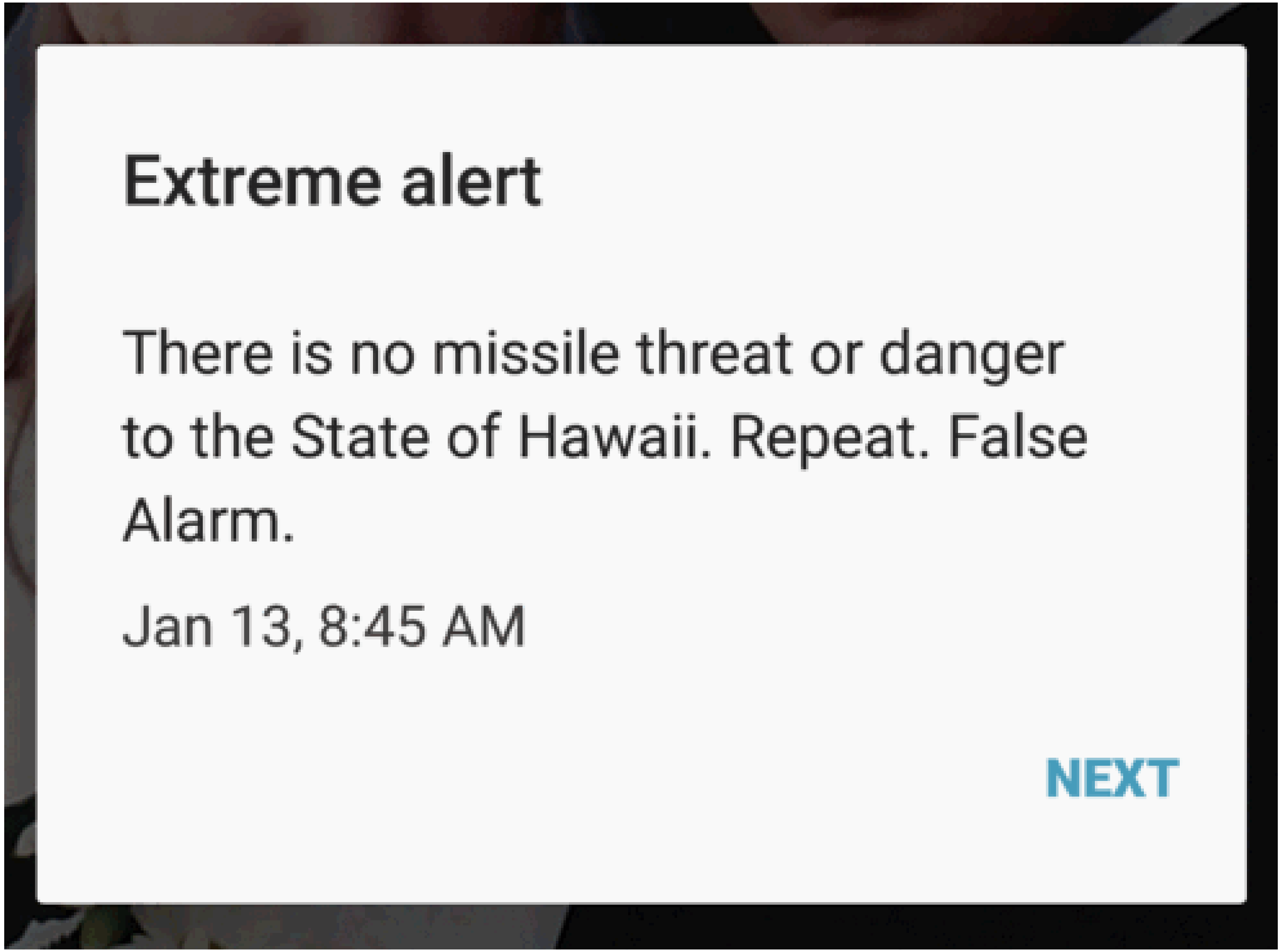
Hawaii Emergency Alert System



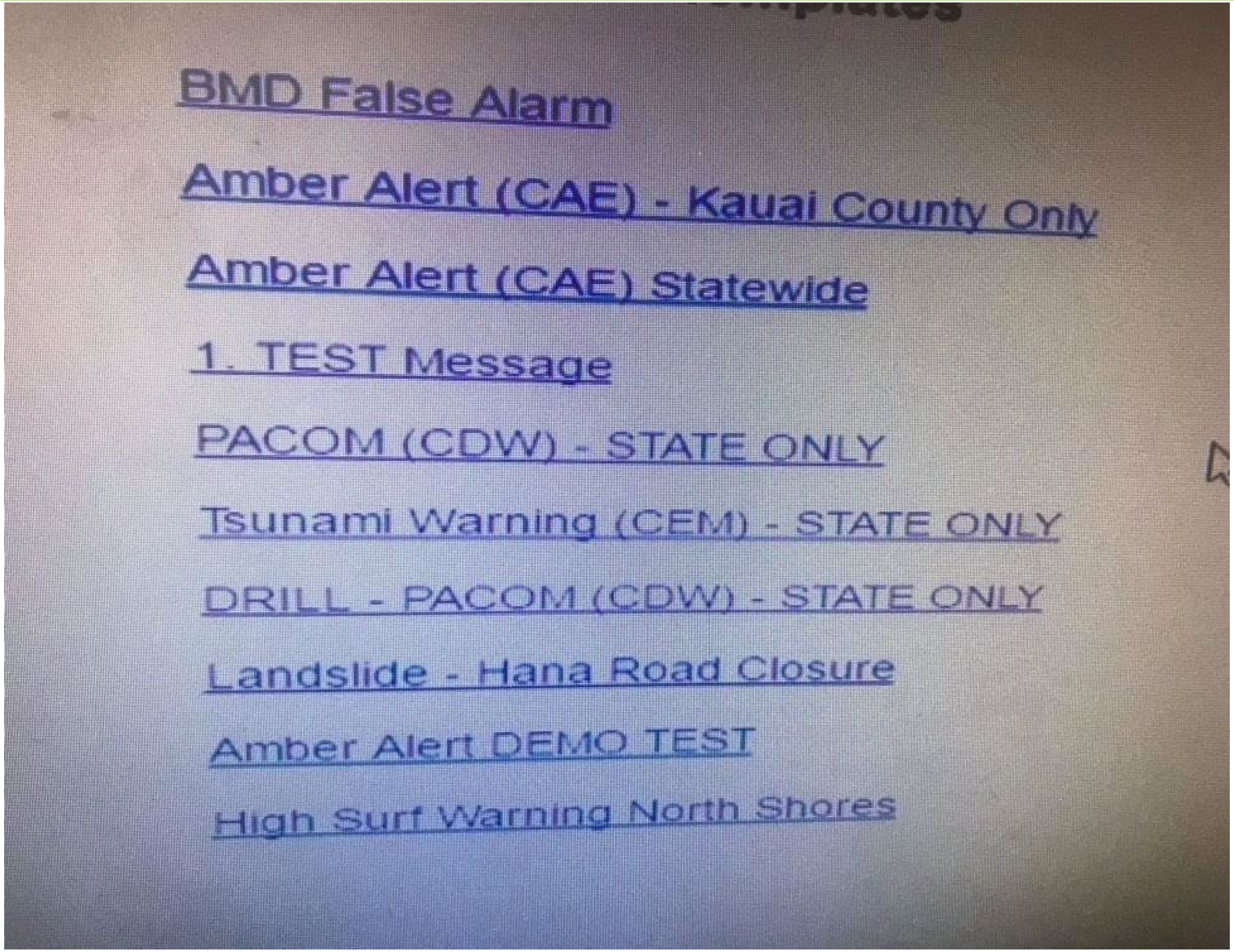
First Alert


Extreme alert
BALLISTIC MISSILE THREAT INBOUND TO HAWAII. SEEK IMMEDIATE SHELTER. THIS IS NOT A DRILL.
Jan 13, 8:07 AM
OK

Second Alert



Hawaii Emergency Alert System



What happened?

New View beliefs

- We believe failure is a consequence of deeper problems.
  - Trauma Informed Practice: What happened to the person?
  - White Supremacy Culture Antidote: Recognition that mistakes are learning opportunities.
- Our learning starts with practice deviation
- We understand that better system design promotes better outcomes
- Our interventions target the context of work
- We realize that people are why our systems work

Old View limitations

Oversimplify Causation

Biased by Outcome

Oversimplified Causation

We assume there is a linear trajectory of events:

- Walk back string of events
- Single causal path
- Objectivity – requiring people to think in a linear fashion

We assume there is a single cause:

- Stop at the visible cause
- Typically, people
- White Supremacy Culture: either/or thinking

Examples:

- Root Cause Analysis
- Domino Model

Biased by outcome

We assume Cause and Effect are proportional:

- If the outcome is very bad, then the work prior must have been very bad.

Our responses are impacted by the severity of the outcome:

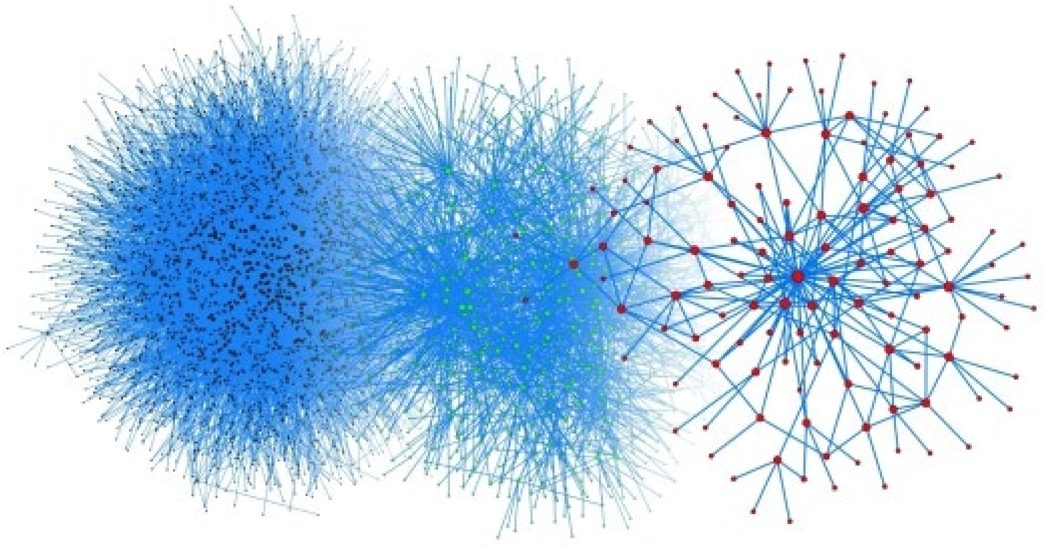
- Bad outcomes promote reactionary responses.
- Good/benign outcomes may not promote a reaction to begin with.

Miracle on the Hudson

New View

Understand Systems Thinking

Embrace Complexity



Systems thinking

We avoid understanding and fixing component parts in isolation:

- e.g., success of training is determined by curriculum, teaching quality and roll out.

We focus on how system components interact:

- e.g., success of training also considers access to training, staff shortages, pressure to fill positions, varying interpretation, work as imagined vs work as done.

Embrace complexity

We must understand the complexity of our work.

Systems are made of many different components:

- People, partners, guidance, regulations, political change, etc.

Systems are made of the tangible and intangible:

- Tracking metrics vs how metrics make people feel in their job

Complex event tips

Our explanations of events reflect this complexity:

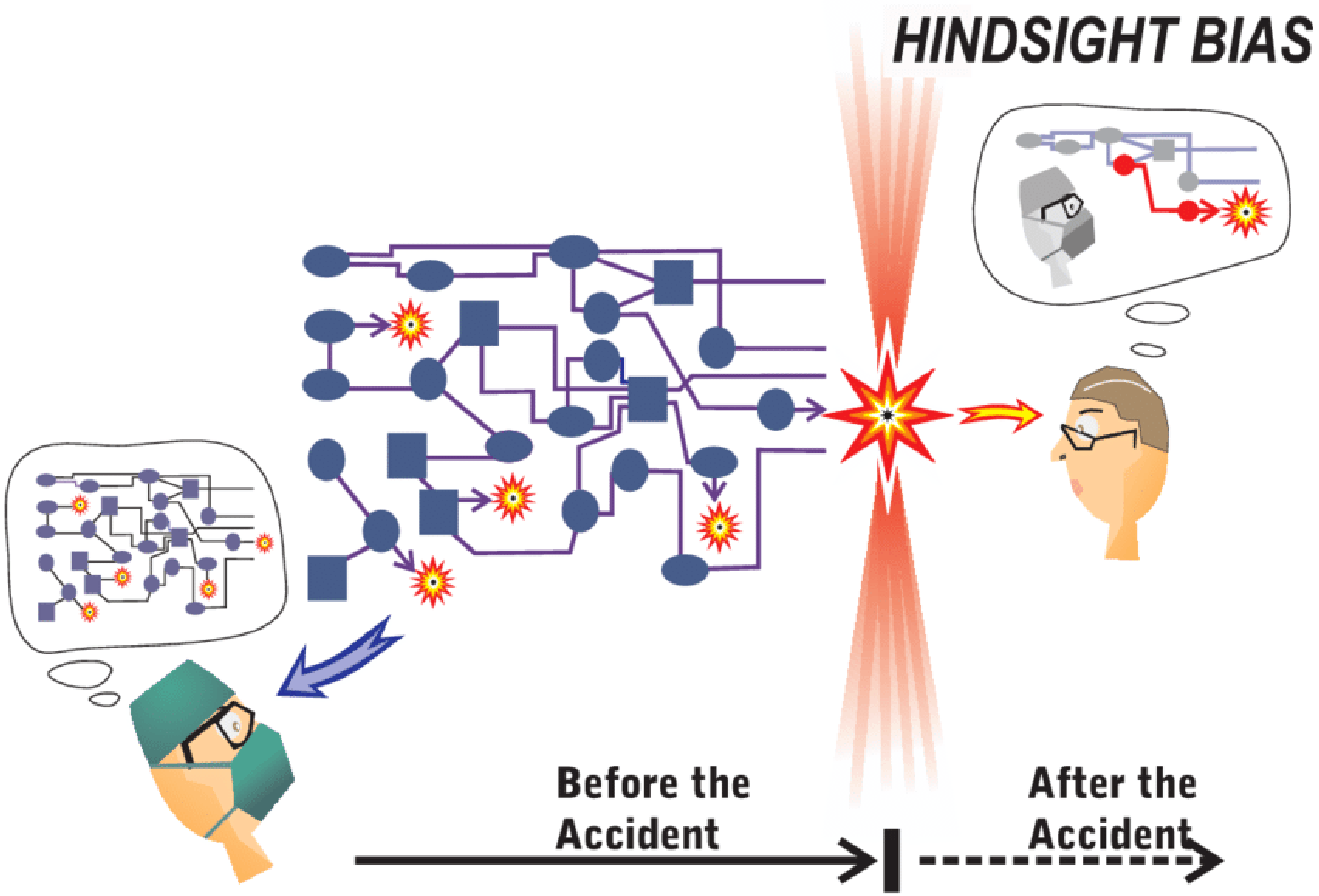
- Learn to recognize when people are simplifying complex issues.
- Avoid simple explanations.
- Discuss local workplace environmental features.
  - e.g., workload, efficiency pressures, staffing, guidance
- Discuss high level system features
  - e.g., budget, initiatives, statute, regulation
- Make connections

Methods of learning

How will we learn?

Old View method

- Have Hindsight Bias
- Rely on Counterfactuals
- Try to Assign Blame


HINDSIGHT BIAS
Before the Accident
After the Accident

Hindsight bias

We assume workers should have known what we know now

- We know what is going to happen (outcome knowledge), we have all information available, and we have benefit of time
- We oversimplify how decisions are made

We simplify how events happen

Counterfactuals

We use language of “should have,” “could have,” “if only.”

- Proposes possible alternate set of events.
- Assumes better outcome.

We stop the learning at these statements.

- This indicates worker failure, so we stop exploring.

We communicate our judgement more than explain what happened.

Assign Blame

We prioritize the goal of identifying the cause of an incident.

- We identify cause to achieve our goals.

We are most likely to identify people as a cause.

- Based on data available and procedure, this is the most easily constructed cause.

New View method

Access Second Stories

- Challenges sense of urgency and perfectionism

Value Multiple Perspectives

- Challenges only one right way
- Challenges power hoarding

Understand Work as Done

Access Second Stories

We go beyond the first story.

- First story is what we see in practice.

We ask questions that help us understand the “why” and “how.”

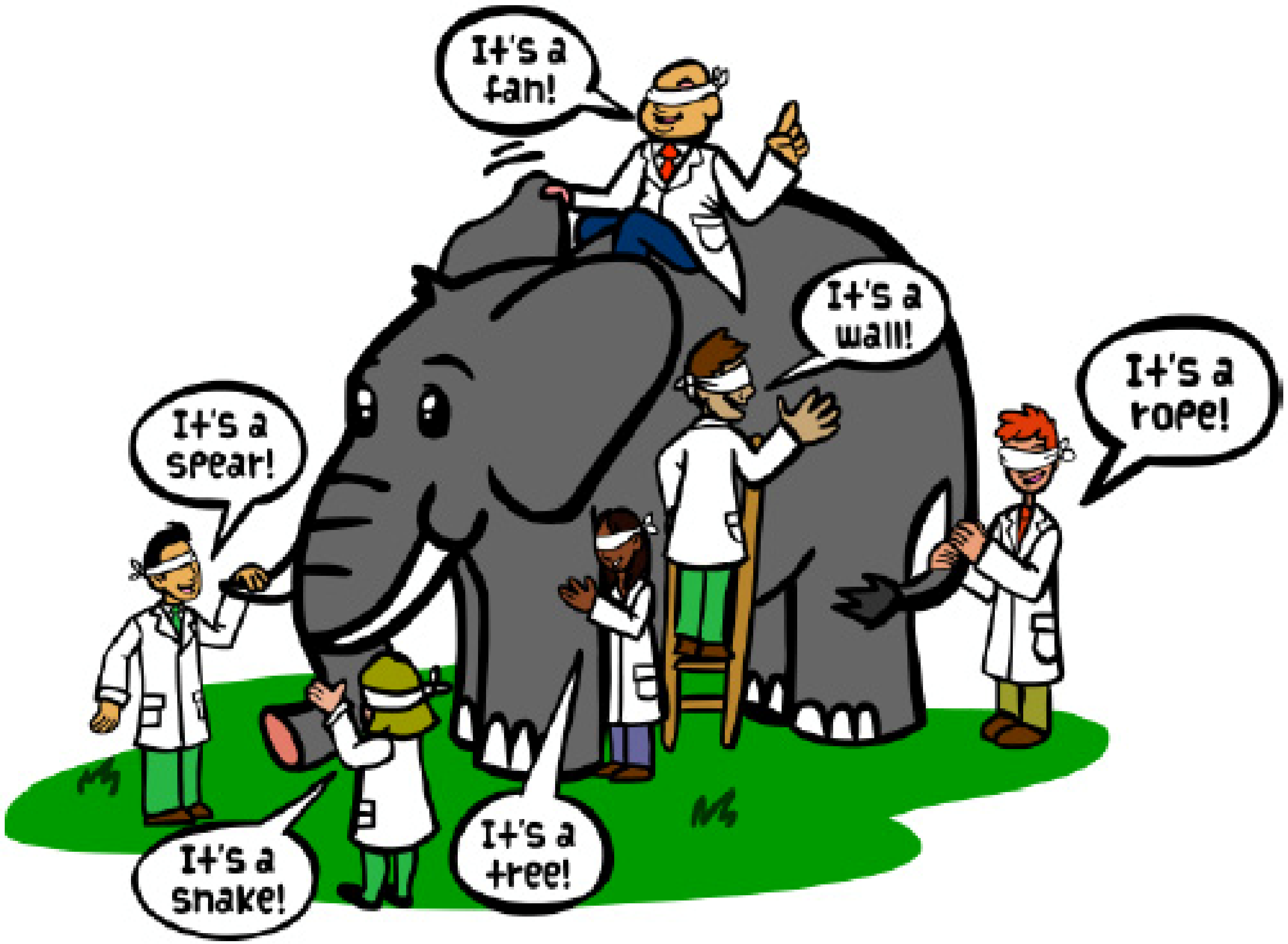
- Local Rationality.
- Understand work as done.
- Prioritize explanation that captures system barriers.

Access second stories, cont.

We change the narrative:

- Change the fixing strategy.

- Focus is placed on the context and environment in which work takes place.


It's a fan!
It's a wall!
It's a rope!
It's a spear!
It's a snake!
It's a tree!

Multiple perspectives

We gather varying perspectives to better understand how our system works.

- Systems function within a social context
- People can best explain their own work environment

We give credit to multiple perspectives without dismissal.

- Intention vs. impact

We realize that the less perspective we have the more assumptions we need to make.

- This leads to oversimplification
- Rarely accounts for the disconnect between work as imagined vs work as done

Understand work as done

We understand that deviation from work as imagined is normal in complex systems.

- Resource constraints, efficiency pressures, conflicting guidance makes adaption a necessity.

We prioritize the study of the environmental features that make this deviation seem necessary.

- We address the environment, not always the person.
- Not all adaption is bad.

Systems improvement

What will we fix?

Old View

Rely on quick fixes

Add to the system

Quick fixes

We rely on fixes that are easier to implement

Our focus is typically occupied with changing people

- We miss the opportunity to impact environmental influences
- We are more likely to see recurrence

Adding to the system

We make work more difficult to get done.

- We add tasks, compliance and forms that exhaust time and resources.

We unintentionally make our systems more complex.

- Added difficulty of managing time pressures and compliance tasks impacts quality.

New View systems

Target system change

Prepare for unintended consequences

Systems change

Our focus is directed at improving the context of work.

This prioritizes resource constraints, demands, pressures, teaming

We realize change may need to occur outside of our control.

This allocates time to talking about centralized change, statute change, community partner engagement

Key Concepts

Language

Safety Culture/Learning Culture

Accountability

Accountability up and responsibility down

Accountability

What do we mean by “Accountability?”

The Dekker definition of “to account” is to literally to account for what happened and for people to share their “account” of what happened.

What is the goal of accountability?

To reduce the likelihood of an incident/error/mistake/bad outcome happening again.

To learn and improve from these incidents.

What is accountability from a COS lens?

- When the system accounts for what happened, all levels of the system have a role to play in the learning and improvement process, going beyond isolated explanations of accountability that only focuses on staff or individual decisions.
- Accountability is supported by a process that staff trust and see value participating in. A process that helps an organization learn and subsequently improve from that learning.

Supporting

Supporting a Culture of Safety and a Culture of Learning

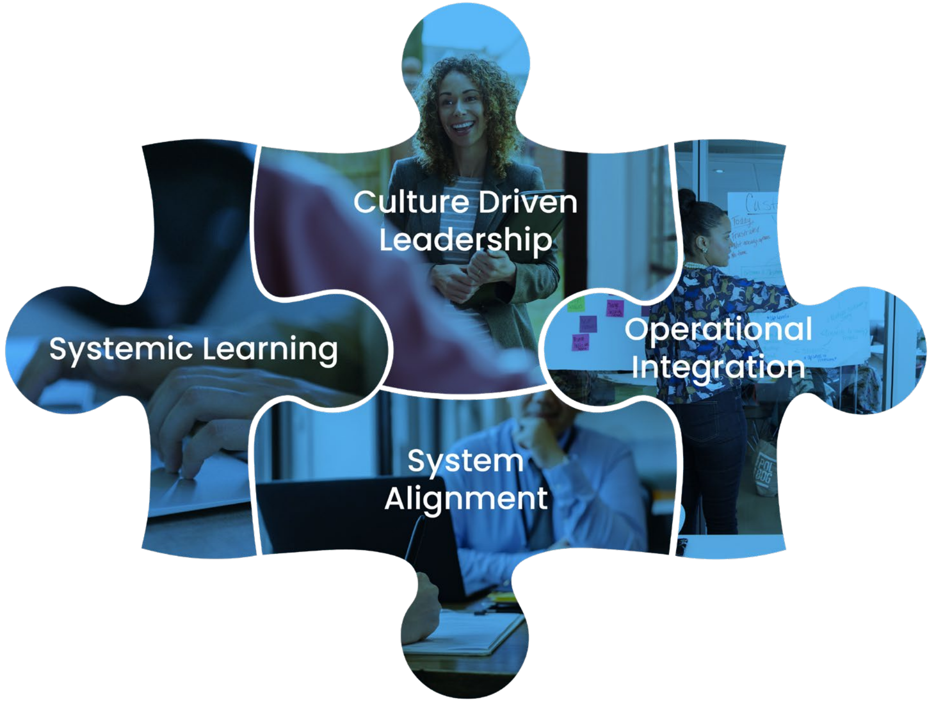
Culture of Safety framework

Culture-driven leadership

Systemic learning

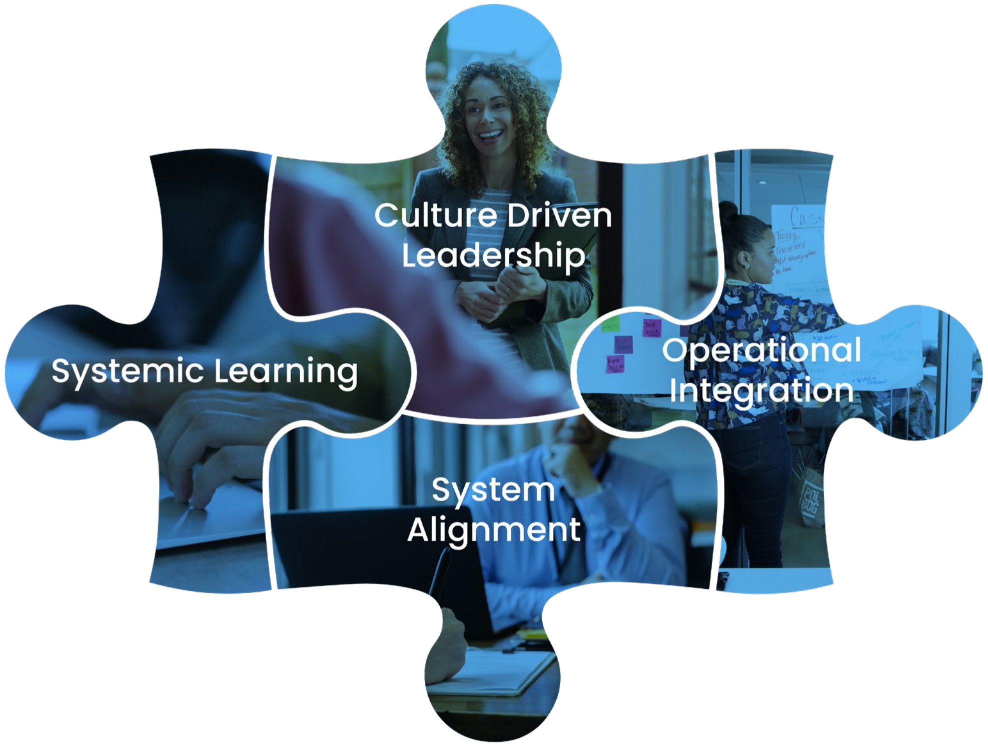
System alignment

Operational alignment



Collaborative Safety Framework

- Culture-driven leadership
- Systemic learning
- System alignment
- Operational alignment



Person-centered practices and culture of safety

- They compliment each other using discovery tools that are value based and in alignment.
- They shift the control within the system from power over to power with
- They help people get a better understanding of our system which influences positive future outcomes and system change.
- They work together by not adding onto the system or blaming people. They support existing services, policies and efforts to help people in Minnesota.

Culture of safety training

- Orientation: a three-hour overview of safety science.
- Advanced Practical Training: two full day deep dives into safety science and findings in Minnesota.
- Safety Leadership Institute and leadership labs: leadership learning about safety science and adopting the thinking into their work.
- **2,000** people in Minnesota have participated consisting of advocates, people with disabilities, counties/tribal nations, and providers of service!

Annual reports and recommendations

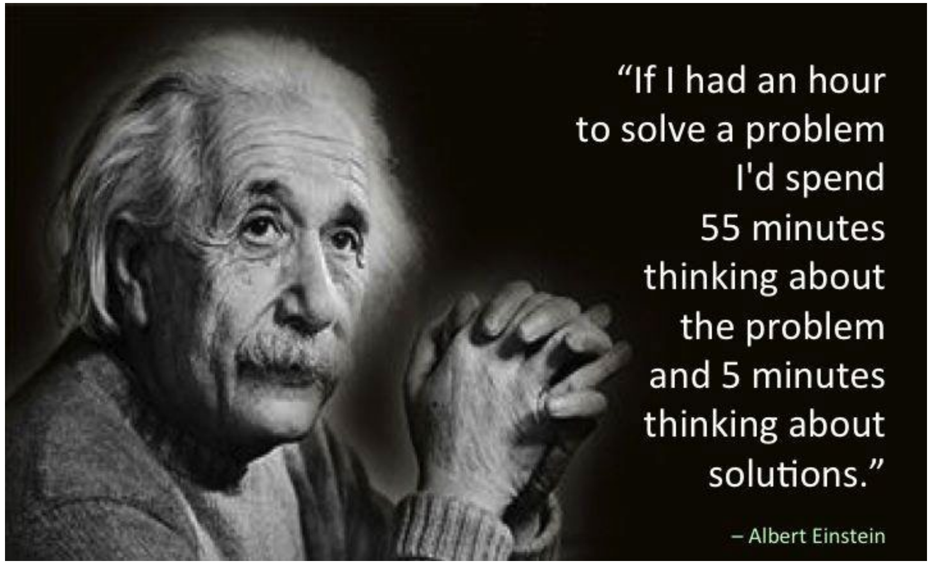
- Culture of Safety, Systemic Critical Incident Review: Annual public report (PDF) (October 2024)
- Culture of Safety, Systemic Critical Incident Review: Annual public report (PDF) (October 2023)

Where do we go from here?

How can culture of safety support the work in Minnesota?

- Psychological safety/culture
- Community feedback/feedback loops via the safety action group
- Breaking silos
- Understanding what is not going as expected in your work.
- Assessing the language in policies.

Discussion and next actions



Resources

- [DHS/DSD, Culture of Safety]
- [Collaborative Safety, LLC]
- [Pre-Accident Investigation Podcast]