JUST CULTURE:
A Different Approach to Safety & Accountability

Hollie Colahan Denver Zoo


FELID TAG
CONSERVATION
SCIENCE
HUSBANDRY

WHAT IS JUST CULTURE?

And what it is not

Just Culture is a values-supportive system of shared accountability. The employees can report mistakes, by them or others, and know that that information will feed into the safety management system. However, gross negligence, willful violations and destructive acts are not tolerated.

Just Culture is NOT

- Blame-free culture
- Punitive culture
- Outcome based
- Expectation of perfection

The hard parts

- Humans are fallible
- Severity of outcomes don't matter
- Progressive discipline isn't the answer

5 SKILL MODEL

1. Aligning Values and Expectations – align with mission
2. Designing Better Systems – anticipate errors, support good decisions
3. Making Better Behavioral Choices – understand role of human behavior
4. Learning to Systematically Learn – investigate, analyze, & learn from mistakes
5. Finding Justice –both in the system and for the employee

3 DUTIES

Follow procedural rules

Avoid unjustifiable risk

Produce an outcome

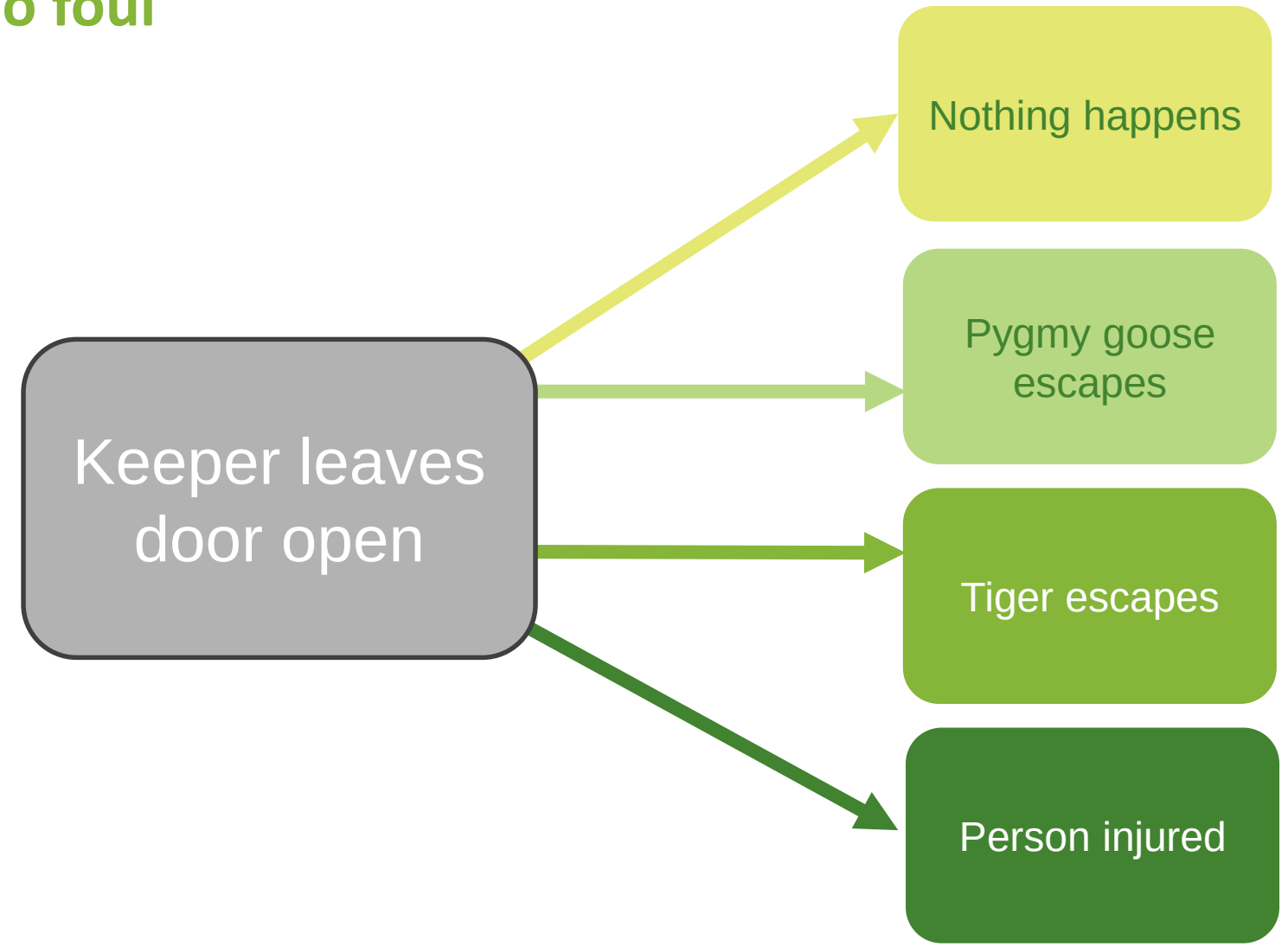
OUTCOME BIAS

The danger of “no harm, no foul”

- We may punish when someone doesn’t deserve to be punished
- We let risky behaviors continue unchecked
- Potentially overreact to singular events and underreact to risk

OUTCOME BIAS

The danger of “no harm, no foul”

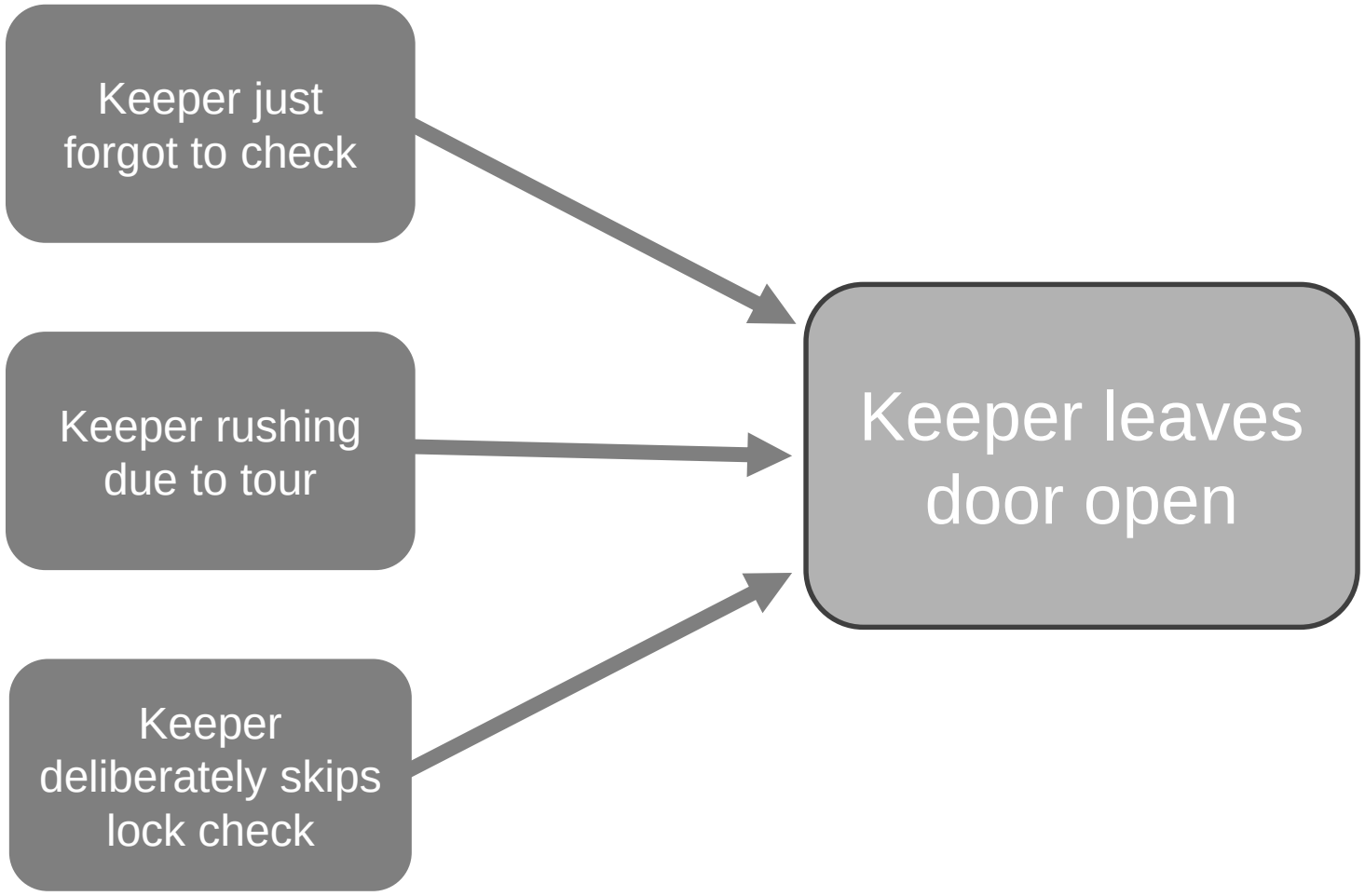


OUTCOME BIAS

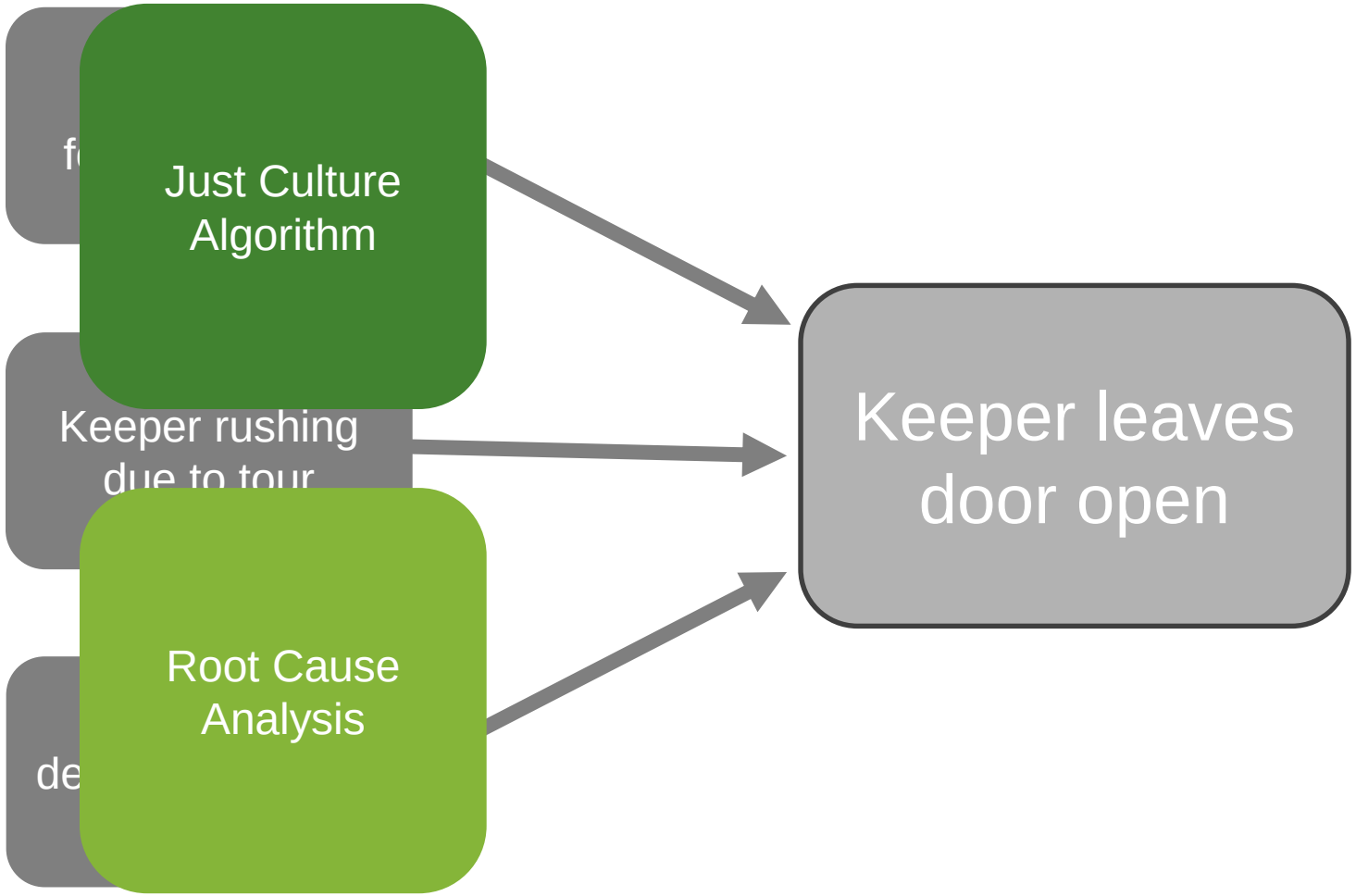
The danger of “no harm, no foul”

Keeper leaves door open

WHY DID THIS HAPPEN?



WHY DID THIS HAPPEN?



THE 3 BEHAVIORS

The foundation of the Just Culture Algorithm

Human Error

Inadvertent action: slip, lapse, mistake

Manage through changes in:

- Processes
- Procedures
- Training
- Design
- Environment
- Behavioral Choices

CONSOLE

At-Risk Behavior

A choice: risk not recognized or believed justified

Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

COACH

Reckless Behavior

Conscious disregard of a substantial and unjustifiable risk

Manage through:

- Remedial action
- Disciplinary action
- Punitive action

PUNISH

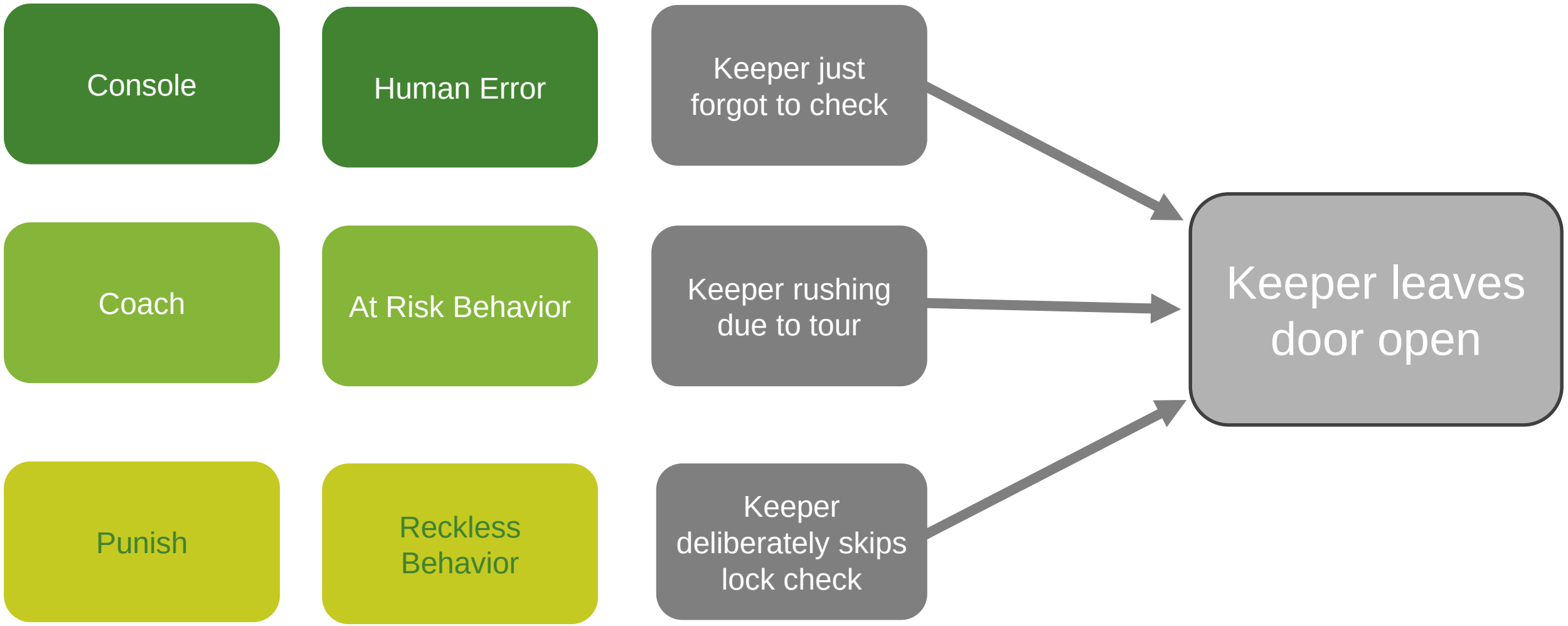
THE 3 BEHAVIORS

Behavior	Definition	General Example	Zoo Example
Human Error	an inadvertent action	Run a stop sign accidentally	Forgot to check animal location before entering
At Risk Behavior	making a risky choice we feel is safe	Drive over the speed limit	Rushing due to meetings later in day
Reckless Behavior	a knowingly unsafe decision	Drive while intoxicated	Tells coworker animals have been checked when they have not

THE 3 BEHAVIORS

General Example	Zoo Example
Run a stop sign accidentally	Forgot to check animal location before entering
Drive over the speed limit	Rushing due to meetings later in day
Drive while intoxicated	Tells coworker animals have been checked when they have not
Potential Outcomes	
Nothing	Nothing
Fatal crash	Animal or human fatality

THE 3 BEHAVIORS



Self-reporting of near misses has increased. That has created a situation where we can investigate the situation and often make policy or procedure changes
have an actual incide
culture facilitates a pr
approach to safety. –

I'm excited to work towards the Just Culture format of finding the root cause of problems so that we are solving what really needs to be solved, rather than putting Band-Aids on problems that end up having to be revisited. –Marcia, Assistant Curator

Just Culture allows mistakes without stigma and encourages discussion and analysis of a problem rather than just a wrist slap. It is a much more comfortable
ation for managers
cca, Curator

People feel more valued because we can have these conversations in a more genuine and trusting atmosphere. – Matt, Assistant Curator

I reported an error I had made to my supervisors. Together, we came up with appropriate solutions and learning opportunities I could work on to avoid making similar mistakes in the future. I also do not feel that my job, work responsibilities, future opportunities or relationship with my supervisors were at risk. – Maureen, Bird Keeper

Because of Just Culture I am unafraid of admitting mistakes and feel truly supported by my team. I also feel appreciated in that I can help managers find solutions to prevent the mistake from occurring again. – Holly, Animal Ambassador Keeper

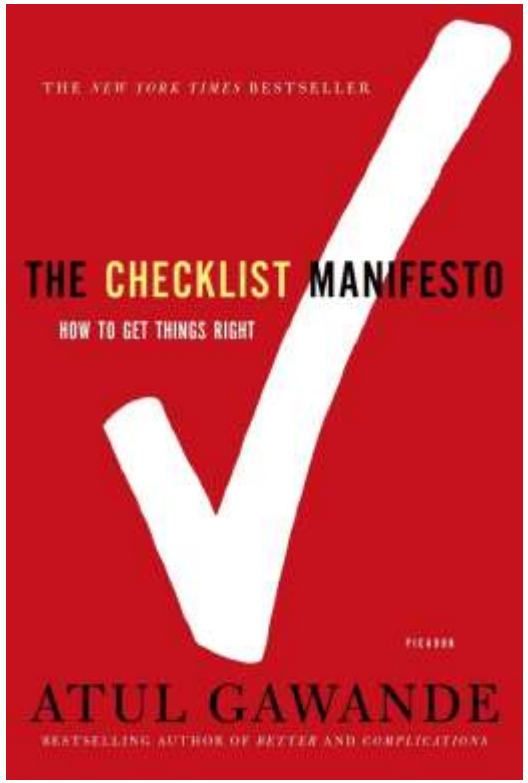
Decisions on consequences of actions are relatively straight forward but solutions to prevent incidents can be elusive. Just Culture provides a platform and process to identify the root cause problem to help ensure it doesn't happen again while creating an open environment to discuss safety incidents. – Brian, Sr. VP for Animal Care & Conservation

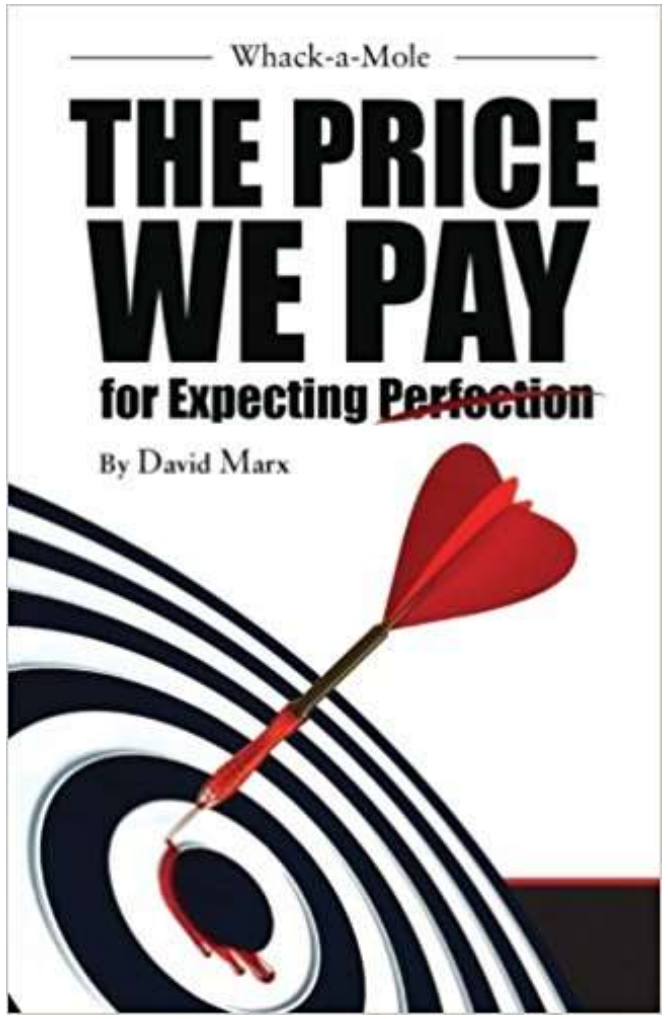
FAQs

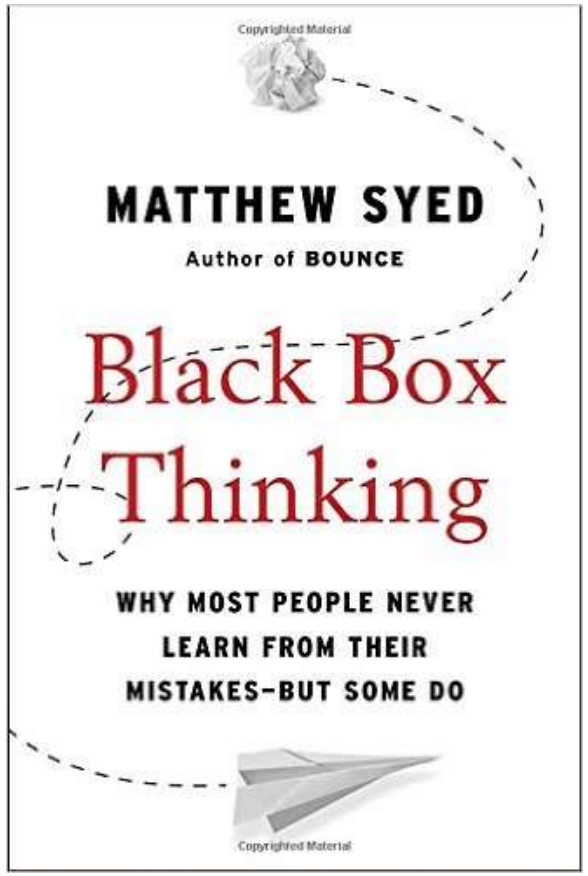
Well, what about…

- What about repeat offenders?
- What if we get sued?
- How would this work with a union?
- What will this cost?
- Can it be applied to things other than safety?

WANT TO LEARN MORE?







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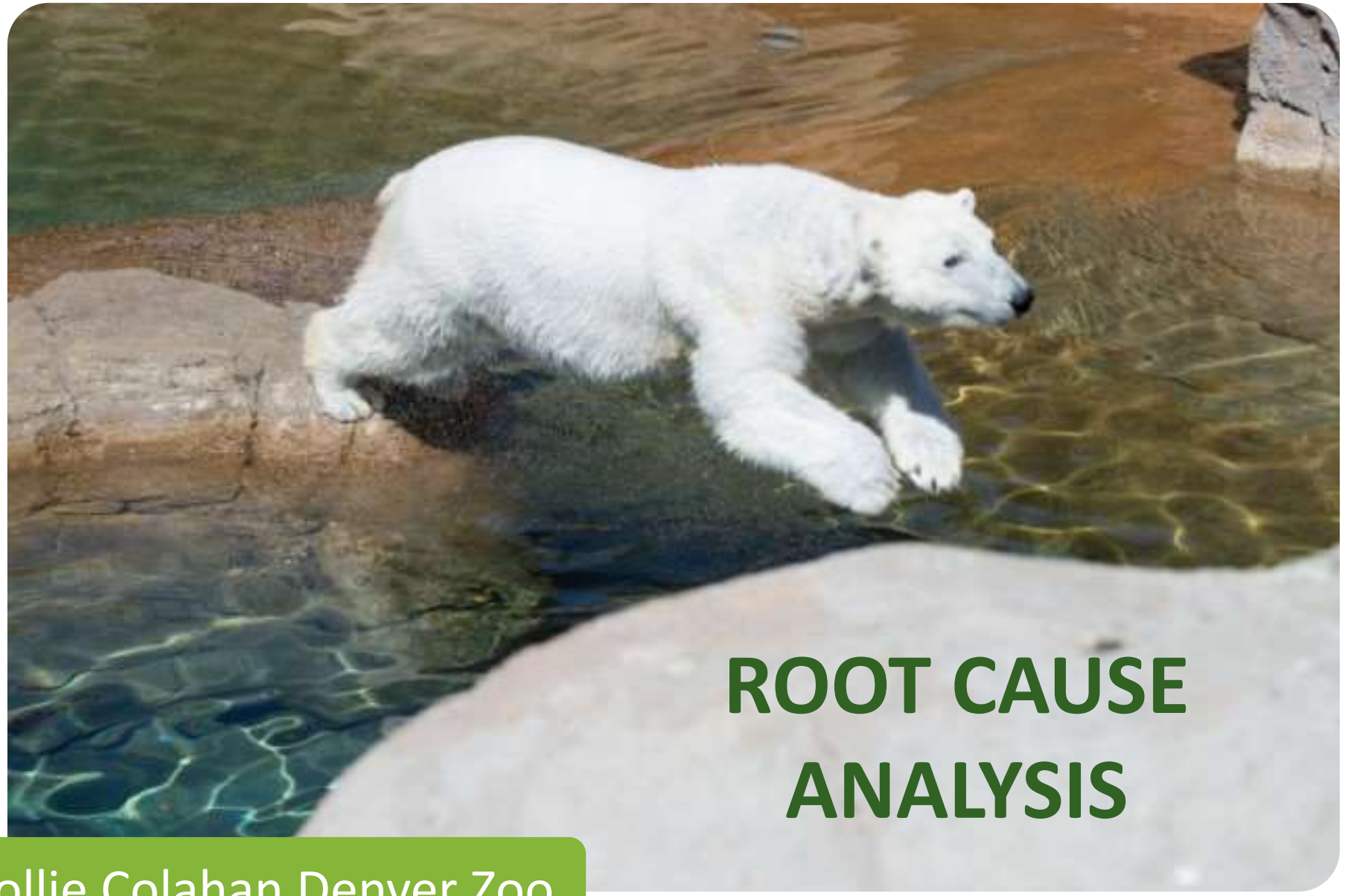
DENVER ZOO



ROOT CAUSE ANALYSIS

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WHAT IS RCA?

The most basic initiating event(s) of a causal chain of human errors, behavioral choices, and/or mechanical failures leading to a negative outcome.

Don’t jump to solutions yet!

We are prone to make inferences based on our own biases and the outcome so RCA focuses on:

1. Outcomes
2. Systems
3. Future Events

OUTCOMES

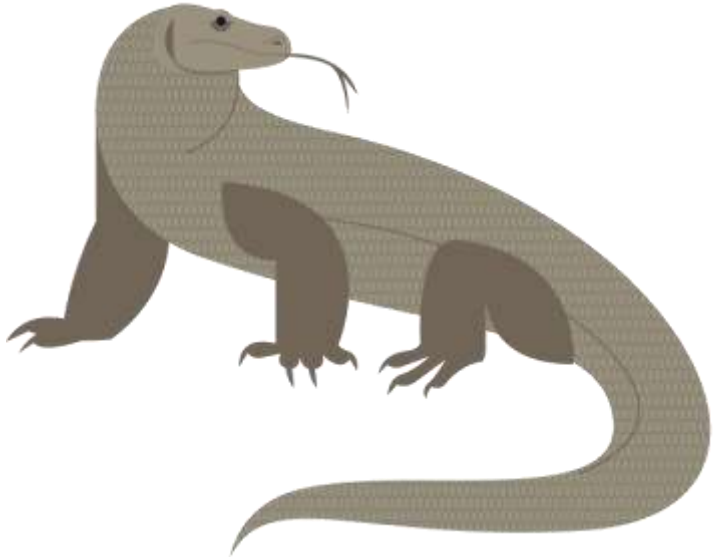
- What happened?
  - anticipated or unanticipated failure?
- Construct a narrative
  - timeline and process flow
- Build out cause and effect relationships
  - identify behavior choices and contributing factors
- Tell the story

SYSTEMS

- What normally happens?
- What does procedure require?
- How are we managing the system?

FUTURE EVENTS

- Actual event rates – statistical analysis
- Identify frequency of at-risk behavior
- What layers of defense exist? Are they working?



WHY USE RCA?

- Systematic and structured process
- Avoids culture of individual blame
- Finds most effective solutions
- Multiple RCAs can help address organizational and system issues

ADVANTAGES OF RCA

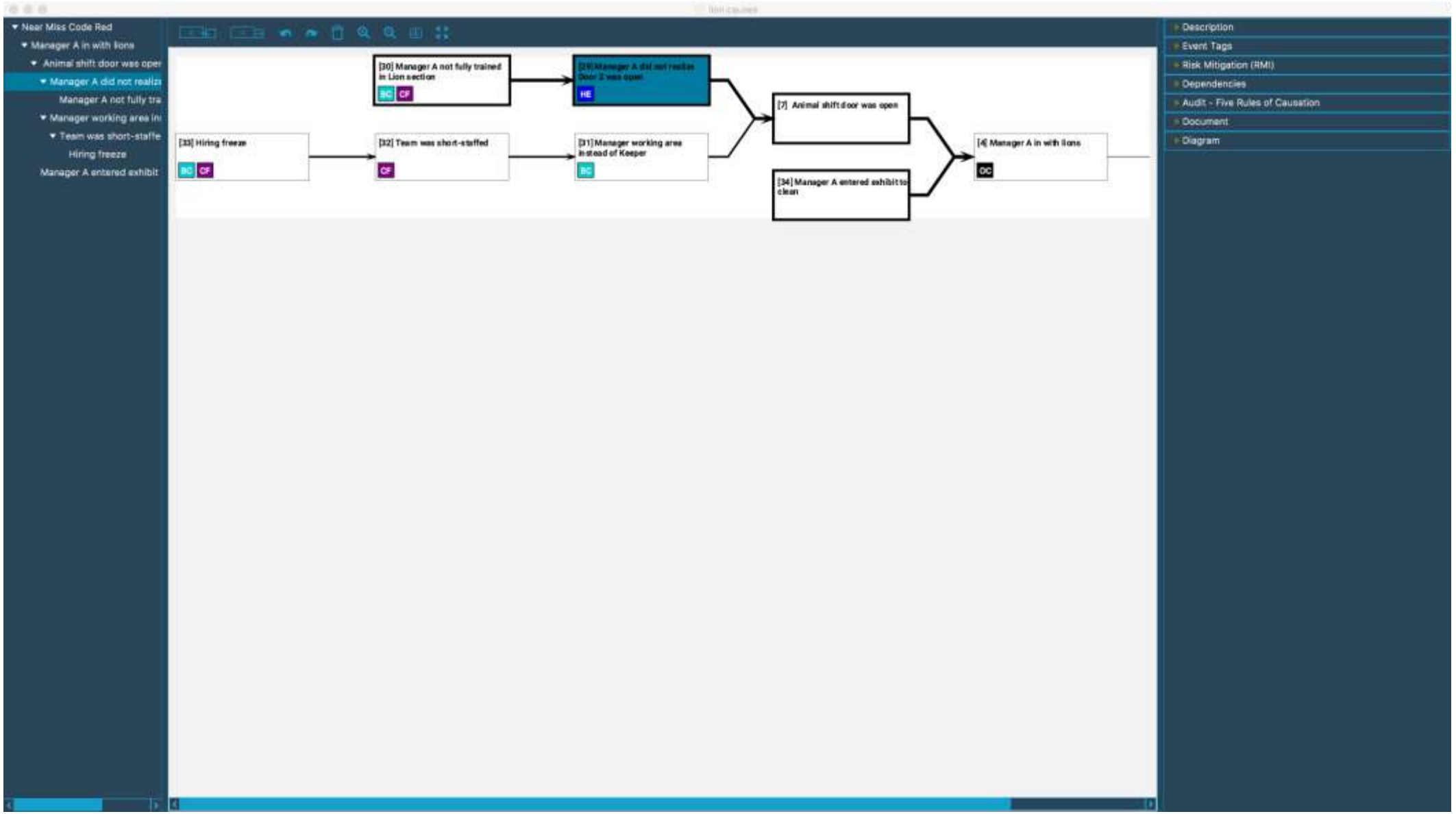
Reactive Learning
- Trial and error
- Event investigation
- Tribal knowledge

Proactive Learning
- Data analysis
- ID common cause
- Audits and surveillance

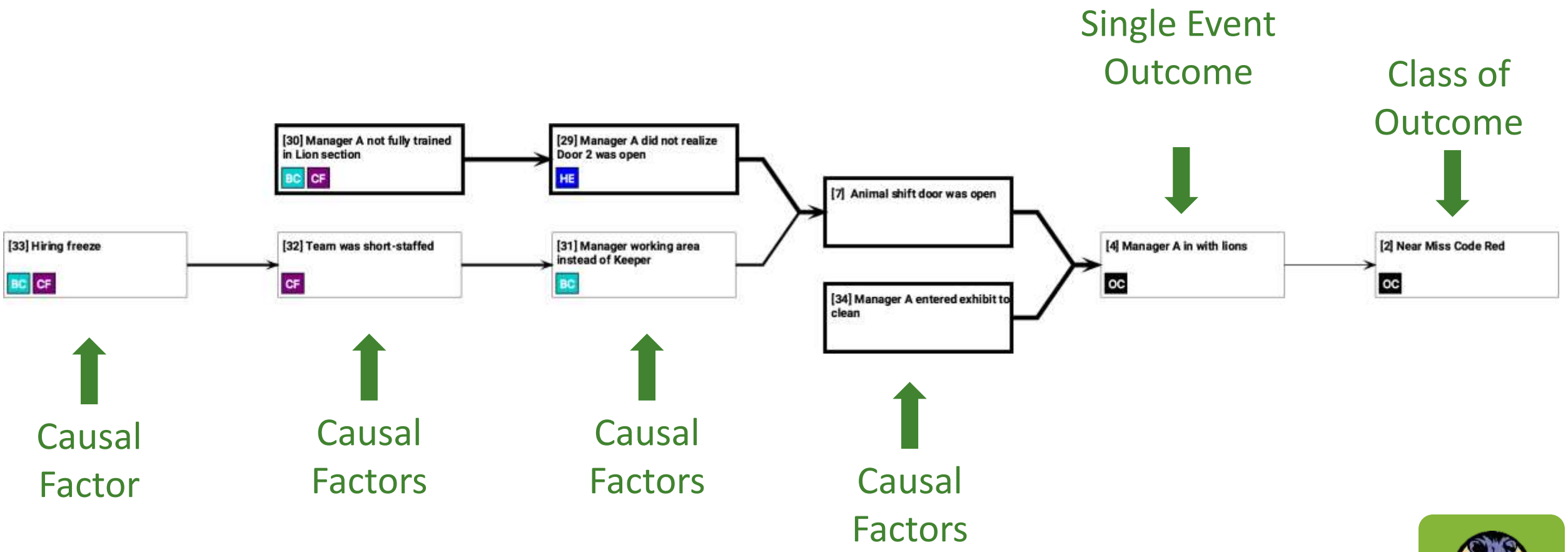
Prospective Learning
- Failure Modes & Effect Analysis
- Trajectories
- Risk Assessment

80% of systemic changes should come from *systemic analysis*, not single events

THE DIAGRAM


Near Miss Code Red
Manager A in with lions
Animal shift door was oper
Manager A did not realize
Manager A not fully tra
Manager working area in
Team was short-staffe
Hiring freeze
Manager A entered exhibit
[30] Manager A not fully trained in Lion section
BC CF
[29] Manager A did not realize Door 2 was open
HE
[33] Hiring freeze
BC CF
[32] Team was short-staffed
CF
[31] Manager working area instead of Keeper
BC
[7] Animal shift door was open
[34] Manager A entered exhibit to clean
[4] Manager A in with lions
DC
Description
Event Tags
Risk Mitigation (RMI)
Dependencies
Audit - Five Rules of Causation
Document
Diagram

THE DIAGRAM


Single Event Outcome
Class of Outcome
[30] Manager A not fully trained in Lion section
BC CF
[29] Manager A did not realize Door 2 was open
HE
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[33] Hiring freeze
BC CF
[32] Team was short-staffed
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[31] Manager working area instead of Keeper
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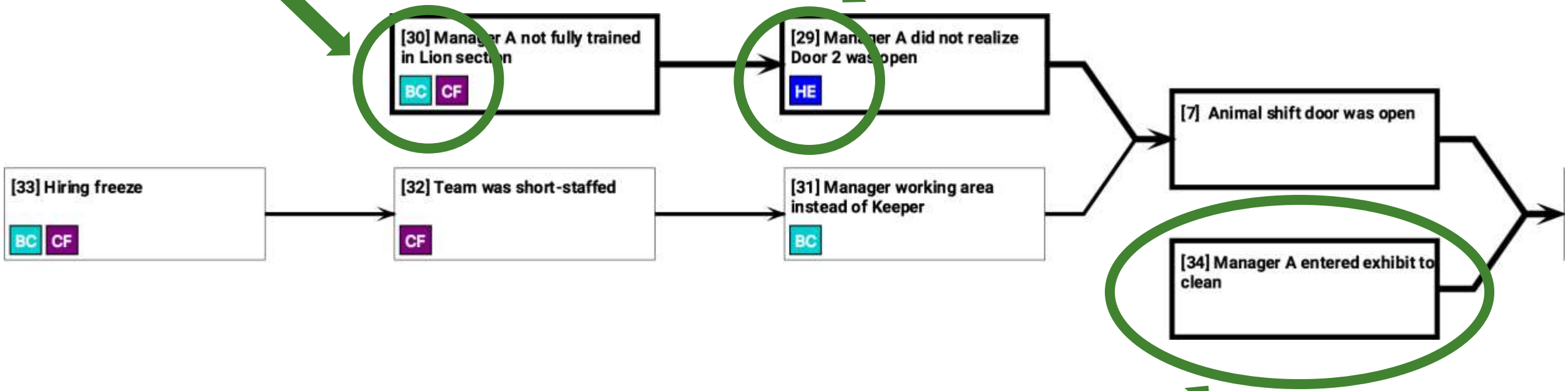
[34] Manager A entered exhibit to clean
[4] Manager A in with lions
OC
[2] Near Miss Code Red
OC
Causal Factor
Causal Factors
Causal Factors
Causal Factors

Behavior Choice: At Risk

Contributing Factors: Interpretation of Risk, Knowledge/Technical Skills

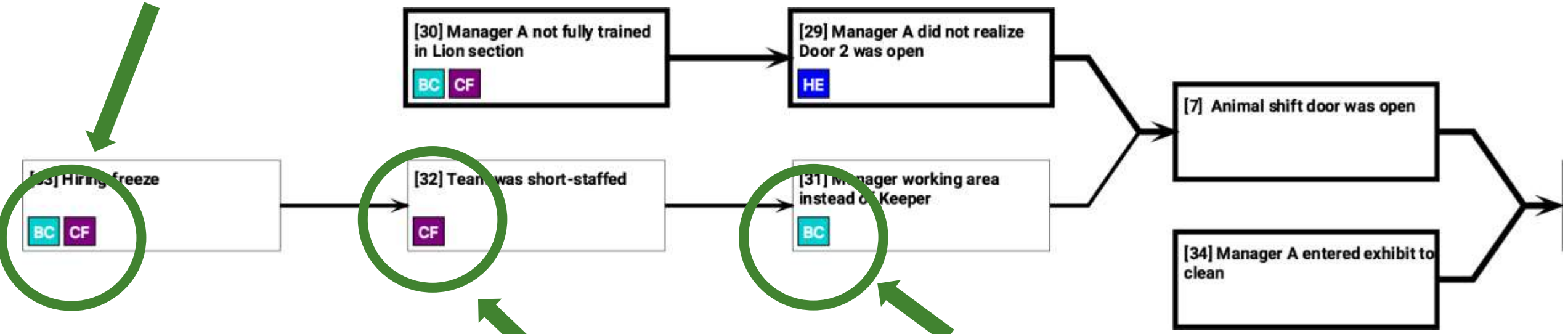
Human Error: Mistake of Fact



Non-Causal (Noise)

Behavior Choice: At Risk

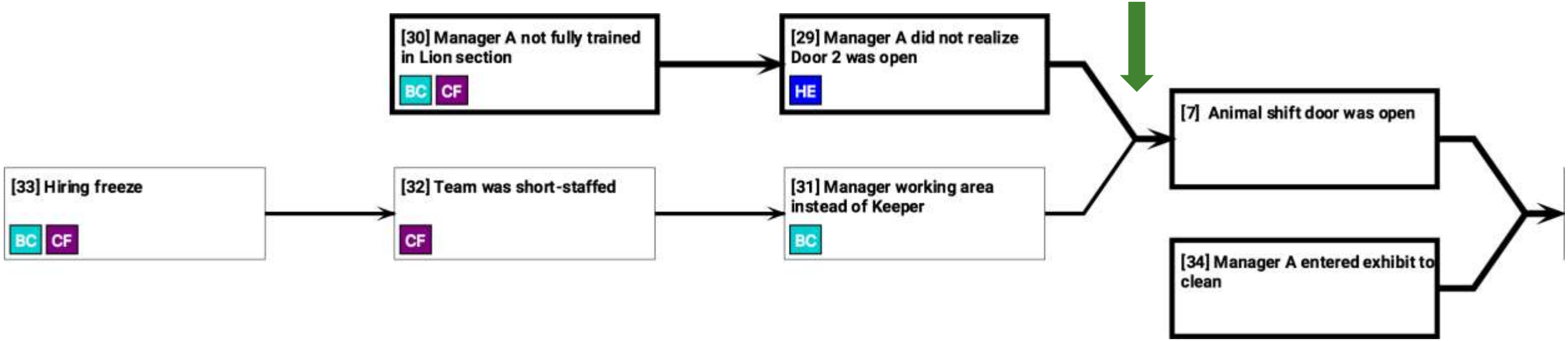
Contributing Factors: Interpretation of Risk, Organizational Factors



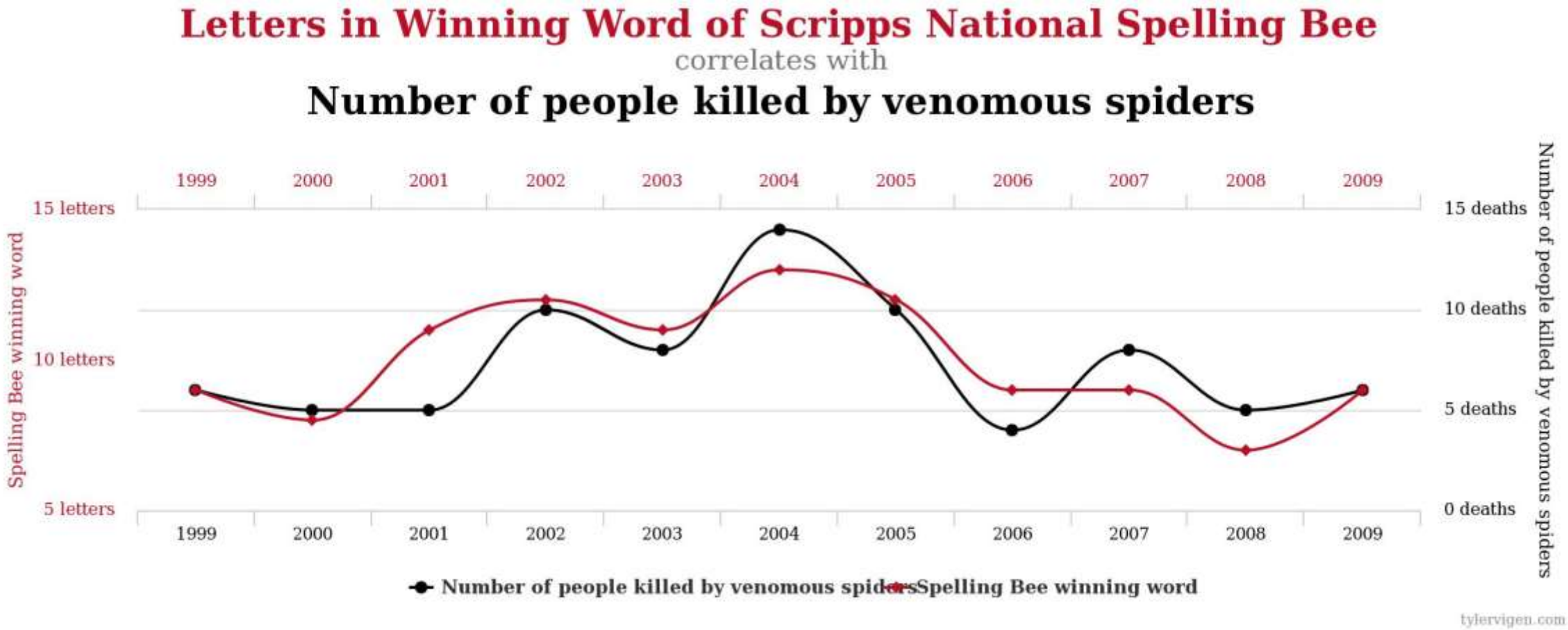
Contributing Factor:
Job/Task

Behavior Choice:
Social Benefit

Line thickness = causal strength

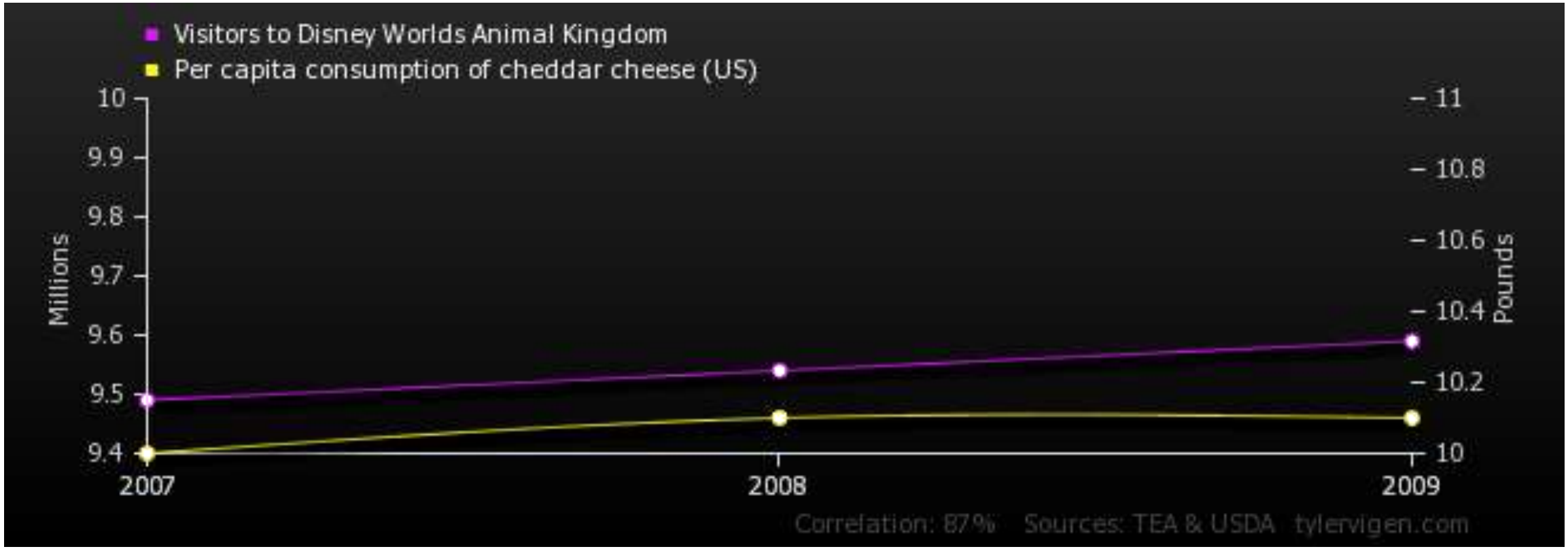


CAUSATION vs CORRELATION



Spurious Correlations by Tyler Vigen

CAUSATION vs CORRELATION



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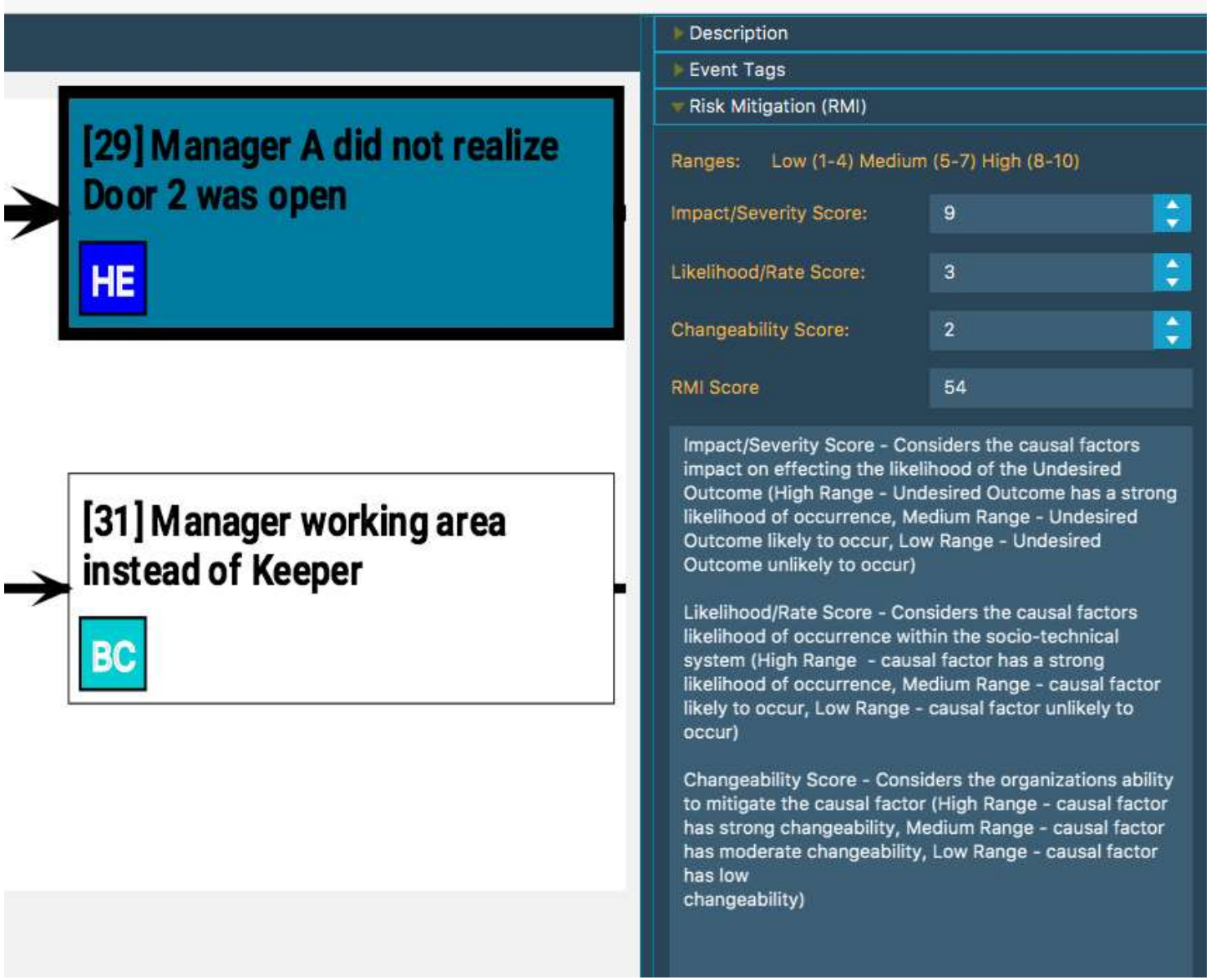
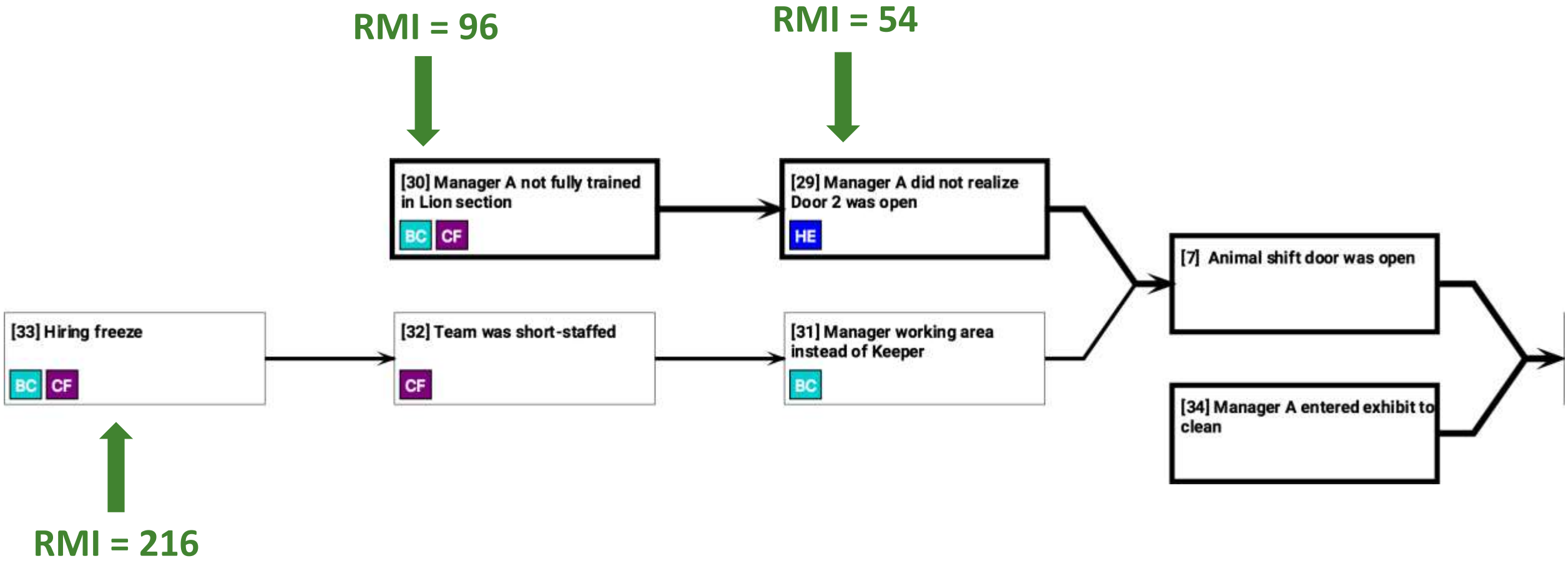


Risk Management Index (RMI)

1. Impact/Severity
2. Likelihood/Rate
3. Changeability


RMI = 96
RMI = 54
[30] Manager A not fully trained in Lion section
BC
CF
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CF
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[34] Manager A entered exhibit to clean
RMI = 216

EVENT INVESTIGATION

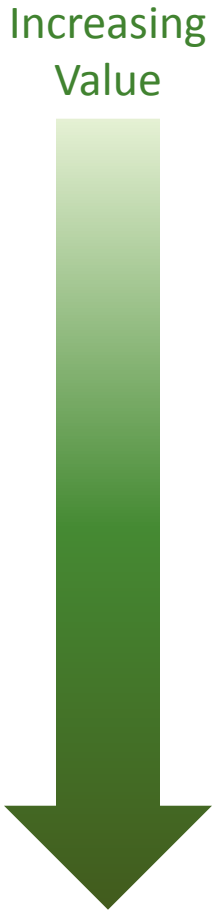
What happened?

What normally happens?

What does procedure require?

Why did it happen?

How were we managing it?



Keep asking
“WHY?”

THANKS!

- Denver Zoo
- Phillip Bolger, Outcome Engenuity
- AZA Safety Committee