IMPROVING LEARNING FROM WORKPLACE INCIDENTS

A Case study in the Dairy Industry

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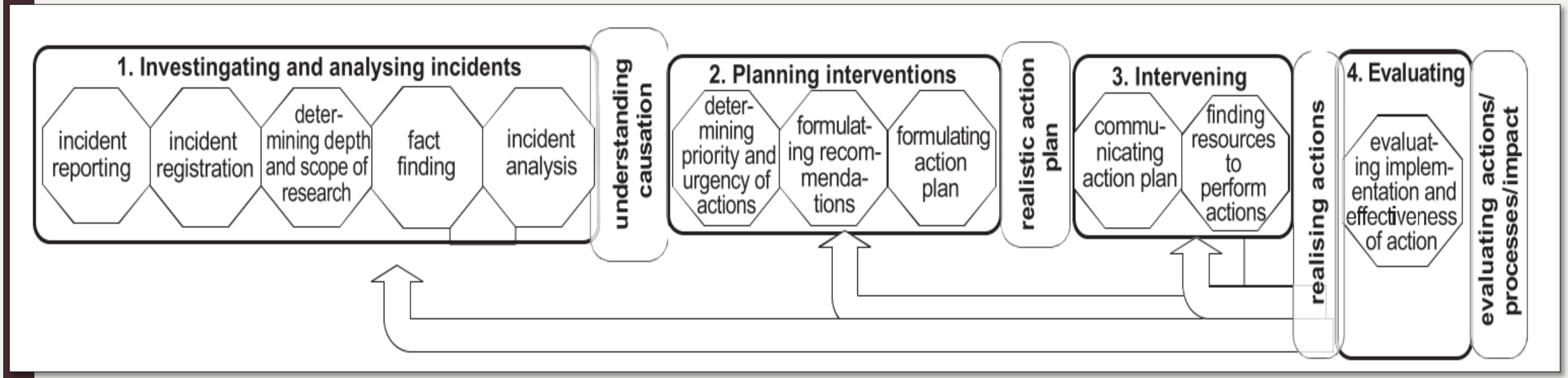
Background

- Dairy farming industry has the highest number of injuries of any industry in NZ
- 2.5 times higher injury rate (per 1000 FTE) than the average for all industries combined
- 334 years lost time due to injury each year between 2008 and 2013 (ACC stats 2014)
- Paucity of research into the ‘learning from incidents’ process within this industry

Aims of the study

- identify the ‘learning from incident’ process in a Dairy farming organisation
- compare this process with the theoretical step-wise model by Drupsteen et al. 2013;
- to test Drupsteen and Hasle’s (2014) method for identifying barriers to learning from incidents in a Dairy farming organisation
- identify barriers in this dairy farming group
- to identify what could be changed to improve learning form incidents.

Process for learning from incidents



Drupsteen, Groeneweg & Zwetsloot, 2013

Kotter –
8 Steps for successful ChangeManagement

1. Establish a sense of urgency
2. Forming a power guiding coaltion
3. Creating a vision
4. Communication – “walk the talk”
5. Empowering others – removing barriers
6. Short term wins
7. Consolidating the improvements – constant reassessment
8. Institutionalising the new approach

Methodology – Case study

- Selection of a Dairy company with a good health and safety systems
  - *owned and operated nine dairy farms*
  - *employed 65 people, including 3 operational managers, each supervising 3-4 four farms and supported farm managers.*
- Interview with H&S Manager to identify:
  - *the learning from incident process*
  - *participants for focus group interviews*
  - *two incidents – one with successful learning and one without*
- Two separate focus group interviews to identify general learning and learning related to two incidents conducted with:
  - *Health and Safety reps*
  - *Managers (including supervising managers)*
- Thematic analysis of interviews to identify
  - *the learning process (and different understandings of it)*
  - *barriers to learning*
  - *How the learning process could be improved*

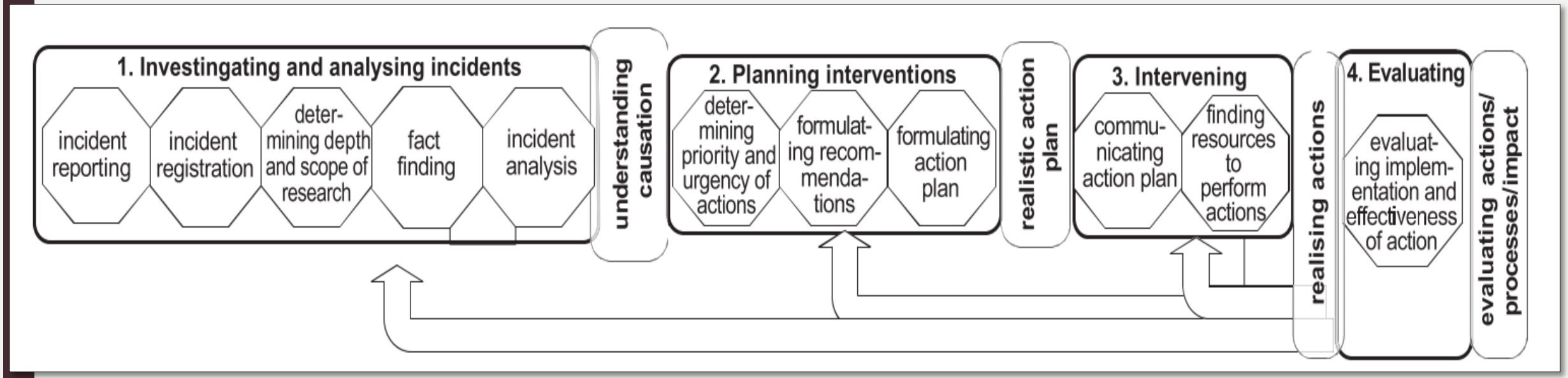
Methodology – Focus Groups
Learning from incident process in general

- Identify the ‘learning from incident’ process as they understood it
- Identified what in the ‘learning from incident process’ worked well and what didn’t
- Identify why steps in the learning process didn’t work well (i.e. identified barriers)
- Identified improvements which could reduce the barriers

Results

- no one individual or group fully identified the process for learning from incidents within this company
- each group showed little awareness of the process outside of their own involvement

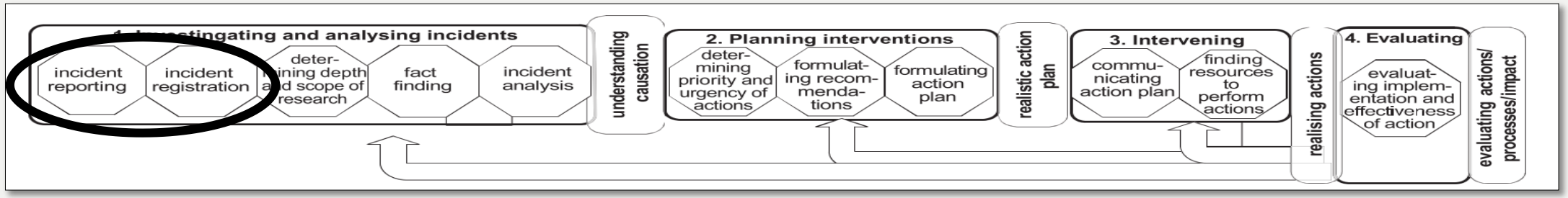
Process for learning from incidents



Drupsteen, Groeneweg & Zwetsloot, 2013

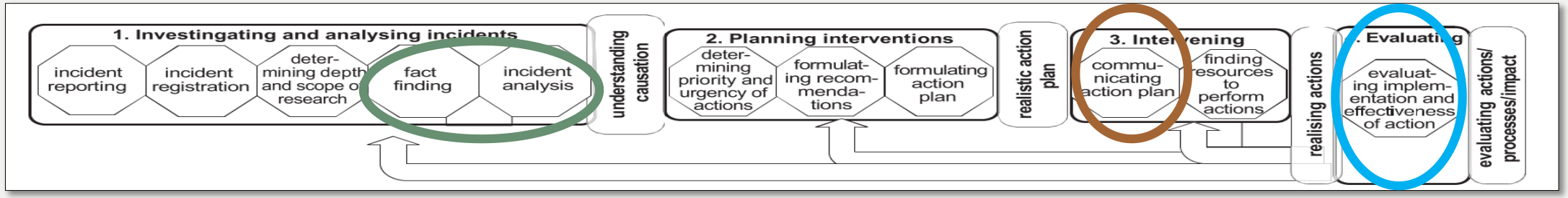
Results - Barriers identified

- reluctance to report incidents
  - *low priority in terms of daily work load; (although largest farm, said they were "too busy not to")*
  - *fear of blame, or perception of stupidity, embarrassment;*
  - *incident not being perceived as serious enough to report;*
  - *'kiwi bloke' attitude;*
- reluctance to have to re-train;



Results - Barriers identified

- *lack of investigative skills;*
- *cancellation/postponement of weekly team meetings*
- *issues not shared amongst staff from other farms within the group;*
- *summary of incidents is too brief*
  - *lacking in detail and "disinfected" by the categorisation process*
- *poor follow up process to ensure implementation of actions;*
- *policy manual too large to be effectively read and understood;*



Methodology – Focus Groups Specific incidents

- Discussed whether the participants believed there had been a successful learning outcome
- Why did they think it had been successful / not successful
- What had changed
- Why had it changed / not changed

Incident One: Leptospirosis

- H&S Manager identified as a successful learning outcome
- H&S Manager wrote a new policy
  - *Delivered PPE and policy to every cowshed*
- Focus Groups identified an un-successful learning outcome
- Staff and managers ‘ignored’ both
- No practice changed as a result of this incident

Incident Two: Detritus in the paddock

- H&S Manager identified as an un-successful learning outcome – because incidents continued to occur
- Focus Groups identified as successful learning outcome
- Paddock Warrant of Fitness (WoF) reinforced on all but one farm
- High emphasis on WoF by all supervisors and managers
- The one farm seen as an ‘outlier’ who needed to be bought into line
- WoF is seen as part of the DNA of the company
- ROUTINE

What was the difference?

- Managers ‘walking the talk’ and enforcing the desired routine behavior
- “Powerful guiding coalition” to champion the change
- Shows lack of understanding of ‘organizational learning’ and ‘change management’ processes
- Follow up to ensure implementation of actions and long term learning

Summary – What did we learn?

- The model for learning from incidents was similar to that used in the chemical and manufacturing industries in the Netherlands
- The methodology chosen worked well in identifying process and barriers to learning from incidents
- The methodology transposed well from chemical and major industries, to dairy farming in this case
- Barriers identified were particularly related to lack of commitment by the managers, especially relative to their commitment to the rest of the business (production of milk)
- Barriers identified related well to John Kotter's organisational learning barriers.

Notes - Summary

- Small piece of research
- Small case study
- Important to have an outside person managing the process of research
- Repeat it to see if it replicates
- Develop the methodology on other farms and other industries

References

Drupsteen, L., Groeneweg, J., & Zwetsloot, G. I. (2013). Critical steps in learning from incidents: using learning potential in the process from reporting an incident to accident prevention. *International Journal of Occupational Safety and Ergonomics, 19*(1), 63-77.

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