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Building Your Safety Culture: Practical Applications

Earl Blair, EdD, CSP
Indiana University
Bloomington, IN

Why is Safety Culture Important?

Recently there have been lots of articles, talk and presentations on the topic of safety culture. This attention to safety culture has been given with good reason: we now know that the level of safety performance your organization can achieve is dictated by the culture. Safety culture is an important sub-culture stemming from the organizations' set of practices, and the reasons why things are done the way they are at an organization.

Cultural Contributions to Spectacular Disasters

Over the past few decades there have been a number of spectacular and tragic accidents followed by thorough investigations made available to the public. From these detailed investigations we recognize that the safety culture is often implicated as one of the primary causes in these unfortunate incidents. For example, following the explosion of the NASA Challenger in 1986, we learned that even within an organization that is considered to be state of the art, there were cultural issues that impacted safety performance. The term "safety culture" had been recently coined at the time, and investigation revealed that there were communication issues at NASA, due to a top-down, command and control culture that inhibited the engineers from communicating up the line, and appeared to inhibit the listening of the upper management when the communication was coming up from lower levels in the organization.

The disaster at the BP Texas City Refinery in 2005 was followed by one of the most thorough investigations in history. Andrew Hopkins wrote a book in 2008 entitled *Failure to Learn,* which describes in detail the cultural issues that contributed to the tragedy. In this author's opinion, the decisions that were made at the top levels of BP probably contributed more to the explosion than the proximal causes at the Texas City site. It is apparently difficult for organizations to learn from the past, as in the case of BP where Texas City was followed by the Deepwater Horizon incident in 2010. We are not covering a learning culture in this article, but a learning culture is one of the most desirable kinds of cultures in enhancing safety performance and preventing injuries.

The following strategies for building your safety culture are simple. However, one should not confuse "simple" with easy to do. An analogy might illustrate: for individuals who are overweight, the concepts for losing weight are relatively simple. Basically, losing weight involves using up more calories than one consumes. But as many of us know, this isn't necessarily easy to do. There are many distracters, variables and complexities that make it challenging for many people. Likewise, it can be very challenging for an organization to systematically develop its safety culture.

Three Practical Strategies for Building Your Safety Culture

Strategy 1. Work Toward Becoming a 100% Reporting Culture

The top reason why organizations do not experience higher levels of reporting minor injuries and near-hits is because of the blame and punishment that may result. It is human nature to avoid being blamed and to try not to get into trouble. It is my belief that developing a reporting culture should be a higher value in preventing injuries than a culture that is quick to administer discipline. On the other hand, I believe traditionally, and for most organizations to the present day, discipline is much more ingrained than strategies and techniques to increase accurate reporting.

Disciplinary procedures are a good example of why it is not easy to build your safety culture. What you have traditionally done does not contribute to a better safety culture. Under-reporting may make the safety record look better than it really is, but it does not contribute to a stronger safety culture.

Another reason why near-hits and minor injuries may not be reported is because of the extra time, extra work, and "red tape" involved with following through. It also is human nature to avoid the extra work, especially if employees are not sold on the value of reporting for safety. If the organization does not follow through and give rapid feedback on reports, then reporting appears to not be a value. If an organization does value reporting, it should set up a system to encourage and follow through on reports.

One slogan that creates a major obstacle for employee reporting is "All injuries are preventable." Most psychologists inform us that because we are human we cannot be expected to be forever error-free. Here are 12 reasons why it is not a good idea to use this slogan:

12 Reasons why the Slogan "All Injuries Are Preventable" Should Not be Used:

1. The focus is **downstream** (injuries)
2. It **doesn't prescribe** how to improve your safety process
3. It can be a **feel-good statement** for management
4. Most employees **don't believe it**
5. It can make people who report minor injuries feel like a jerk for being an exception to this **"infallible truth"**
6. It can lead to **under-reporting** or even non-reporting of injuries
7. It may result in **injury management** instead of safety management
8. It may give a **false picture** of safety performance at your site
9. It can **reduce risk perceptions**
10. It can **hurt morale** at your organization
11. It may **reduce employee efforts** for safety since perfection is outside of their control
12. In most cases it probably is **not achievable** over time

This author thinks it is acceptable to hold the *belief* that all injuries are preventable. The problem occurs when "All Injuries Are Preventable" is used as a *slogan.* If the belief inspires management's vision to strive for optimal performance, then it could influence positive results. Keep in mind that optimal performance and perfection are not the same thing. Since most employees don't believe it, and perhaps many in management (secretly?) don't believe it either, the slogan becomes counterproductive.

The following four factors that encourage a reporting culture are adapted from James Reason's book, *Managing the Risks of Organizational Accidents:*

Four Factors that Encourage a Reporting Culture

1. **Indemnity** – Against disciplinary action as far as practical
2. **Confidentiality** – De-identification on incident reports
3. **Ease of Reporting** – User friendly – reduce the "red tape"
4. **Rapid Feedback** – Follow-up and useful, practical, meaningful feedback to all concerned

Strategy 2. Develop Safety Awareness with Meaningful Safety rules

Glenbrook Case Study

In his book *Safety, Culture and Risk: The Organisational Causes of Disasters,* Andrew Hopkins relates the story of a New South Wales (NSW) train wreck that occurred near the Glenbrook Station in Australia in 1999. Hopkins was involved in the investigation of the incident and therefore displays detailed knowledge of the event. As a professor of sociology, Hopkins has developed a high level of expertise about safety cultures.

Just beyond the Glenbrook station was a stopped train, the *Indian Pacific.* A city commuter train coming through the station ran a red light and did not know the *Indian Pacific* was stopped just around the bend ahead. The commuter train slammed into the *Indian Pacific*, killing seven passengers. As with most tragic incidents, the investigation uncovered multiple causes and influences. Most immediately prior to the scene were casual and poor communication between the driver and the signaler. There were cultural deficiencies that allowed the tragedy to occur, and these are useful for students of safety culture to recognize:

Hopkins lists 5 kinds of culture that permeated the New South Wales Railways and influenced the incident:

1. A Culture of Rules
2. A Culture of Blame
3. A Culture of Silos
4. A Culture of On-Time Running
5. A Risk-Blind Culture

The one kind of culture that was positive at NSW Rails was a culture of on-time running. This was greatly emphasized and the railway did a good job of keeping a high percentage of on-time running. The problem, however, was that this culture of on-time running was not counterbalanced by a risk-aware culture. Interestingly, Hopkins believes the impact of a culture of rules resulted in a number of negative outcomes, such as deadened sense of risk awareness, a culture of employee disempowerment, and a culture of blame.

This case study is a study in excess regarding the safety rules. NSW was a rule-focused culture. First, employees were overwhelmed with safety rules – there were eight volumes of them. Hopkins states, "This focus on rules tended to deaden awareness of risks. Moreover, when accidents occurred, the aim of accident investigations appeared to be to identify which rules had been violated and by whom. The obsession with rules led to a pronounced tendency to blame." (Hopkins p. 28).

Here are some of the problems with the safety rules at NSW Rails:

- The organization appeared to hold the illusory reliance on rules as a means of averting accidents, and seemed to believe that a rule could be developed to cover every conceivable risky situation that might be encountered.
- There were eight volumes of safety rules, and amendments were circulated weekly for recipients to update their manuals.
- The sheer volume of safety rules made them virtually unknowable and impractical as a guide for daily use.
- The rules were not written in a user-friendly format. They were written in convoluted and complex ways designed to cover all possible risks. Each rule tended to be several pages long and read like a piece of legislation, or they were vague and difficult to interpret (such as "use extreme caution")…
- Rules were cross-referenced in such a way that even the trainers often did not understand them. In one case, a person had to reference no fewer than 84 rules in order to select the correct course of action.
- The rules were written by people who had no practical experience in the topics they were writing about; As a result, many of the rules were totally impracticable.
- As a result, most employees had little use for the safety rules. They could see no relationship between the content of training for safety rules and what they were actually doing on the job.
- Because of the impracticality of the rules, they were typically not enforced either internally or by the rail inspectors.

This case study is admittedly extreme. On the other hand, you may recognize some symptoms that prevent your organizations' safety rules from providing optimal impact:

1. Do you use safety rules primarily to CYA?
2. Do you have cumbersome safety rules that are impractical and not user-friendly?
3. Does your organization tend to enforce safety rules mostly AFTER someone gets hurt?

Based on the concepts from Reason and Hopkins, I've developed the following "Rules to enhance your safety rules."

7 Rules to Enhance Your Safety Rules

1. Safety rules must be dynamic.
2. Safety rules shall be developed with the assistance of the end users.
3. Safety rules must be practical and relevant.
4. Safety rules must be effectively communicated.
5. Safety rules must be monitored and enforced.
6. Safety rules must be regularly modified and updated.
7. Safety rules shall be continually improved.

In addition to these guidelines, take care to avoid the other mistakes made at NSW Rails, such as the high volume of rules, and thinking that a rule can be made to cover every conceivable situation.

Strategy 3. Ensure that Leaders Understand How to, and Consistently Act to Develop Your Safety Culture

Since the organizational culture, and the resulting safety culture, are primarily influenced by its leaders, this strategy is most important. One of the responsibilities of safety professionals is to give counsel and advice within their respective organizations and to their leaders. Leaders are often intelligent and well-educated, but this doesn't mean they automatically understand specifically how they can best influence the safety culture. This is where the safety professional can assist by providing specific information to leaders on how to best develop the safety culture.

What are the most important things leaders can do to enhance safety culture?

Based on research by Judith Komaki on leadership and safety performance, the two most important activities that distinguish effective leaders from mediocre leaders is:

1. The amount of time they spend monitoring performance in their organization
2. Listening to their employees (Komaki, 1998)

A few years ago there was a management mantra known as "Management by Walking Around," or MBWA. I would like to propose that leaders can best accomplish these two priorities of monitoring the workplace and listening to employees with LBWA, or *Leadership by Walking Around.* Leaders cannot effectively do these activities from their offices. Also, this is not Leadership by Wandering Around – it is walking around with purpose. The purpose is to enhance the safety culture, to talk with employees about safety, to listen to their concerns, and to follow up when corrective actions are needed.

Most companies that practice some form of behavioral safety recognize that they must address behavior at all levels of the organization to be effective. Often, employees provide peer safety coaching and feedback to improve safe work on the job. The behaviors prescribed for leaders and management are more about supporting the company safety efforts, since managers generally do not actually perform the work on the floor or in the field. The suggestion for management is that they develop "self-managed checklists" for these supportive behaviors, and that they be measured on doing them as they would be measured for production, quality and cost control.

These self-managed checklists can be customized in a manner that plays to the strengths of individual leaders, and ensures that they practice LBWA that includes monitoring the workplace for safety and listening to their employees. Examples of high leverage activities for leadership include: 1. Conduct safety walk-arounds that involve A) Discussing safety with employees, B) Asking how they can help make people safer, and C) Focusing on Actively Caring (Geller, 2001) for employees. 2. Ensure the closeout of safety related corrective actions, and develop a measurement system to track. 3. Promote and conduct safety coaching.

An example of a Leadership Self-Managed Checklist is shown in figure 1. This list is based on the concept by Terry McSween in *The Values-Based Safety Process,* (2003) and illustrates different activities or behaviors that management can perform to influence safety culture. Three points about the checklist – it is best to limit pinpoints or behaviors to a maximum of 3 – 5 behaviors instead of 10 (or more!), and there should be a system in place to track and measure that leaders are actually performing these activities they agree to do. Finally, there should be a number of behaviors for a particular time-frame, such as 3 walk-arounds per week.

LBWA: Benefits for Site Leaders

There are safety benefits, as well as benefits beyond safety performance alone, that leaders can enjoy from practicing **Leadership by Walking Around** as described above. Here is a partial list of expected benefits when leaders do a quality job of following this practice:

1. They have a concrete opportunity to demonstrate they care.
2. It will help to ensure that outstanding safety problems are resolved.
3. Employees will see their leaders are genuinely committed to safety – demonstrating visible ongoing support for safety
4. The practice establishes a hands-on safety example for supervisors.
5. Employees will develop greater trust in their leaders.
6. Leaders have multiple opportunities to enforce and reinforce the safety process.
7. Leaders will learn what they don't know.

Leadership Self-Managed Checklist

Name:_____________________ Date:___________

Behavior	Yes	No	N/A
1. Perform safety walkabouts to discuss safety			
2. Ensure the closeout of safety-related corrective actions			
3. Conduct safety coaching			
4. Promote safety coaching			
5. Attend safety related training with team			
6. Recognize employees for working safely			

7. Provide at least one positive safety feedback			
8. Review observation data and it's importance in safety meetings			
9. Actively participate in safety activities			
10. Completed checklist turned in at the end of every work week			

Figure 1: Self-Managed Safety Behavior Checklists for Managers and Leaders.

Regarding point 7, the best ways for leaders to learn what is going on in their workplace is to actually walk around, monitor, and listen. This is far superior to simply using a computer and looking at statistics – at a minimum, it reinforces and adds to the collected knowledge.

For leaders who are passionate about improving safety performance, I recommend Michael Roberto's best seller, *Know What You Don't Know: How Great Leaders Prevent Problems before they Happen.* Safety is all about prevention, and Roberto shows with case studies and research that the best leaders don't simply respond to problems, they discern problems before they become great big problems. And, as you will see if you read the book, the best way to discover the symptoms that are about to become bigger problems in the future is to spend purposeful time on the floor and in the field, walking, monitoring, asking, listening, anticipating…

Conclusions

Three practical strategies to enhance your safety culture have been provided here. There are many other actions one can take to develop the safety culture, things that may be necessary such as developing a learning culture or a more just culture. However, these are three of the most powerful strategies to enhance your safety culture:

1. **Work toward becoming a 100% reporting culture**
2. **Develop Safety Awareness with Meaningful Safety Rules**
3. **Ensure Leaders Understand How To and Consistently Act To Develop Safety Culture**

To successfully implement and sustain efforts to develop safety culture, each organization must customize techniques to accomplish their chosen strategies. A starting point for safety professionals is to gain upper management support for these strategies. Then, design ways to institutionalize or systematize your strategies, in order to maintain ongoing support and focus. For example, managers and employees are likely to support each strategy you implement if related safety metrics are established that hold people accountable for supporting safety in the ways envisioned.

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