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Culture: The Only Way to Get to Zero

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In today's world getting to a recordable rate of 1 injury per 200,000 hours worked or .5 is no longer good enough. Most organizations have set their sights much higher and believe that zero is the only acceptable goal. This is the right goal! The question is, can organizations realistically attain this goal within the current business landscape? As organizations—and employees—are required to do more with less, the demands of maintaining performance, let alone accelerating it, can seem overwhelming.

Fundamentally, changes in on-the-ground dynamics speak the most to the challenge in getting to zero. The thinning manager/supervisor to worker ratio, and increasing demands on the individual worker, mean that traditional leadership methods and cultural status quo are no longer sufficient; organizations need to create an order of magnitude change in the type of leader—and the type of culture—they develop.

Achieving Excellence in Today's Business Environment

Changes across industry have created a world that is infinitely more complex and varied than in the past. Companies are demanding more out of each worker than ever before, with less supervision. Downsizing, mergers, buyouts and closings all contribute to increasing noise in the system and an environment that is less stable and certain. Safety procedures have multiplied in most organizations, sometimes in response to the goal of getting to zero itself. Pressure to cut administrative and labor costs are leading companies to increasingly rely on third party contractors. The workforce is aging, presenting new challenges to engagement and personnel management. Getting to zero in this environment should sound daunting—and these are only the major issues.

Clearly adding layers of additional programs is not the answer; most organizations are already drowning in procedures. The next level of performance requires that we strategically leverage existing systems and rethink our approach to safety functioning. For example, do we see safety as discrete activity of a handful of safety professionals, or do we treat safety as a key business function in which everyone plays a role? The latter level of performance is proved by what is

sometimes called the "3:00 AM test", that is on the third shift, when no supervisors are around and the outside influences for acting safely are minimized, does the employee work safely or not? In the "3:00AM" organization, employees frequently approach each other independently around safety concerns, and move safety issues up the chain of command, even when the news may not be received well. Employees at all levels have ownership for safety outcomes. In other words, the culture itself drives safety functioning.

Understanding the Safety Mechanism

In order to leverage our existing systems, it is helpful to understand how safety outcomes are created. The primary activity of safety initiatives, whether at the site or corporate level, is to reduce the level of exposure that occurs in the workplace. All safety activities, mechanisms, programs, and measures are inherently linked to this fundamental task. The influential factors for creating and maintaining a safe work site include leadership, organizational culture, safety enabling systems, and organizational sustaining systems (Exhibit 1).

1. The Working Interface is the configuration of equipment, facilities, systems, and behaviors that defines the interaction of the worker with the technology. This configuration is where hazards exist and safety excellence is directly related to how effective the organization is at controlling exposure here.

2. Safety Enabling Systems are the basic systems or programs that assure adequate safety functioning. The safety leader needs to know what these systems are, how they are audited, and how effective they are. More importantly, leaders need to see that enabling systems are part of a larger whole, and not rely on them solely for safety improvement.

3. Organizational Sustaining Systems are those processes that sustain enabling systems and assure their effectiveness. They include mechanisms such as selection and development, performance management, organizational structure, employee engagement, and other management systems. Effective leaders understand the relationship between the quality of their sustaining systems, their safety systems, and what occurs in the working interface. For instance, is the structure of the organization such that safety is given adequate emphasis? Does the performance management system meaningfully address safety leadership issues (not just through lagging indicators?)

4. Organizational Culture refers to the driving values of the organization, the "unwritten rules" of the company. Unlike climate, which refers to prevailing influences on a particular area of functioning and is quick to change, culture is deeply embedded and longer lasting. Effective leaders look realistically at culture and identify issues that could undermine safety objectives. Cultural attributes such as low trust, poor communication, or mixed management credibility can neutralize even the best enabling and sustaining systems.

5. Leadership drives both the culture of an organization as well as the functioning of enabling and sustaining systems. In this configuration, leadership refers to seeing the right things to do to reach objectives and motivating the teams to accomplish them effectively. Safety leadership is exercised by decision making which is related to the beliefs of the leader and demonstrated by his or her behavior.

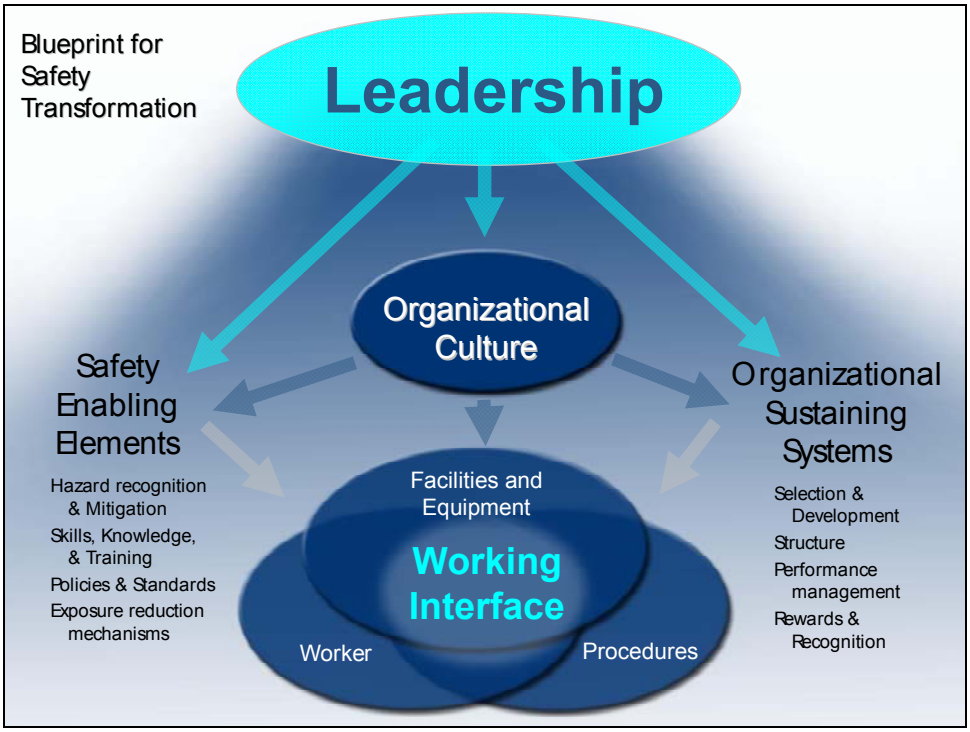

Exhibit 1. The Blueprint for Safety Transformation

Defining the Zero Injuries Goal

Saying that you want to be "injury free" is not the same as actually moving to this level of performance. For one thing, what do we mean by zero injuries? More fundamentally, is such a goal even realistic?

Initially, it might seem that the zero injury culture is defined by incident rate or some other outcome measure. But consider the many examples of organizations with low injury rates that continue to have fatalities, recordkeeping violations, and so on. The reality is that no single lagging indicator (such as lost time or medical case rates) can reliably tell you whether safety systems and practices are aligned and driving performance to a predictable result. (Latching onto a single leading indicator is equally problematic.) Failing to apply statistical analysis to the measurement compounds the problem; injury data are subject to natural variation that may not reflect actual performance. Finally, a numbers focus limits our ability to track success, particularly as performance improves. Once you reach zero in a lagging metric, you are only left with two modes of performance: meeting the standard or failing it. There is no -1 in injury rate.

Although our goal is to eliminate incidents in real terms, the numbers themselves cannot be the defining characteristic of "injury-free" performance. Practically speaking, the injury-free goal means creating an environment where injuries are not acceptable and where we do everything possible to prevent them. The focus is not going forever injury free, which for most people is too hard a concept to support or stand behind. *The focus is continuous, sustainable improvement.* An

injury-free culture is present whenever an organization is saying and doing things such that they realize increasingly longer periods without an injury. For one organization that might be going 45 days without an injury, at which point they set the next milestone at 90 days. In these companies, leaders communicate a reasonable standard in which people can see the logic, and generate alignment around these goals throughout the organization.

Key Elements of the Zero Injury Culture

Creating an injury-free workplace is a radically ambitious undertaking. It means rethinking how we approach safety activities, the measures we use to monitor progress and define success, and the way we approach engagement of employees at all levels. In our experience, the injury-free culture starts with leaders who take ownership for the safety activities, engagement, and outcomes of the organization.

Taking Ownership for Safety

Leaders are the only ones who can create a culture where safety is a driving value, and many state publicly that that is their goal. Yet it's our actions that determine whether people in the organization take our words to heart. A leader must develop this statement into a personal vision that is demonstrated through his or her actions with respect to safety. Chief among these are how we respond to exposure data, how we respond when an incident happens, and how we oversee the incident report process. For example:

- When I receive exposure data, do I acknowledge and thank those who flag exposures? Do I assure we develop action plans based on the exposure's potential?
- When an incident happens, do I demonstrate a personal interest in the wellbeing of the employee? Do I assure the area is secure?
- When the incident report is in progress, do I assure that both immediate and root causes are identified? Do I check that the action plan adequately addresses all causes? Do I make sure we use the hierarchy of controls in our action plan?
- Finally, does our plan includes "check backs" to confirm the exposure has been reduced and the recurrence prevented?

Ownership comes through word and action. Knowing how many people in your group have been injured, the direction safety performance is moving, exposure data and direction, and having ready access to the state of the safety improvement plan and where critical safety action items stand, are all examples that demonstrate ownership.

True ownership is also characterized by optimism; leaders avoid statements that suggest the results or situation is outside their control, rather they express an understanding of the challenges and knowledge of what they are doing to remedy them. Finally, ownership requires that the leader understand the interconnection of culture, leadership and systems. This means that the leader is constantly looking for system causation of variation, instead of assigning blame.

Using Exposure, not Injury, as the Focus of Safety Activities

A goal of zero injuries requires a new way of looking at the basic mechanisms that drive safety performance. First, what drives safety activities? The injury-free culture uses exposure, not

injury, as a trigger for action. A good test of your culture's focus is to ask, what determines the level of investigation here? In many cases the answer is the seriousness of injury, often a result of luck. Organizations serious about an injury-free culture are thirsty for information about near misses and first aid events. They use the likely potential of an event to determine the depth of the investigation. Similarly, exposure-focused leaders determine whether a site is making progress in safety not on the injury rate, but on evidence that it is reducing the probability of injury.

An exposure-focus must be driven by leadership. Exposure is introduced into the organization by variation at the working interface. The higher in the organization one goes, however, the harder it is for leaders to see how their actions or inactions directly contribute to exposure at this interface. Variation can be caused by the employee being unmotivated, untrained, or unskilled; it can also be caused by unsafe conditions, inadequate tools or materials, or by procedures that are inaccurate or even nonexistent. This variation can and should be measured systematically. Exposure can also be introduced upstream of the interface through the decisions that leaders make regarding the systems that provide organizational consequences or that cause a state where employees are feeling psychologically unsafe. A person who is feeling psychologically unsafe tends to be inwardly focused and can be more reactive and volatile depending on the extent of the stress. All this can lead to a person losing focus in the moment.

Aside from affecting psychological safety, exposure-increasing decisions could include staffing levels, how compensation and bonus systems are aligned with values, promotion and staffing decisions (e.g. how we handle leaders who are highly productive but demonstrably unconcerned for employee wellbeing), and ongoing employee growth and development. For example:

- To cut costs, an organization eliminates all shift supervisors, leaving a day foreman as the point of contact for the shift employees.
- An operations vice president position is filled by a leader from the plant with the worst EHS performance but is known for "getting the product out."
- A decision is made to stop lock-out/tag-out verification audits by the supervisors because they are too busy with other paperwork and need to be in their office more.
- A senior leader decides not to communicate the five-year plan, which will include consolidation, plant closures and acquisitions, to the workforce. Instead employees will hear information as it is released or leaked out.

These four scenarios are common organizational events. They all also state explicitly or implicitly what the organization really values. Such decisions may not increase exposure immediately, but given enough time they can strongly influence the decisions, actions, and outcomes at the working interface. The trap here is that in spite of their influence, such decisions will rarely be identified through a root cause analysis as the pivotal or defining moment in the path to an injury. That is why leaders who hope to create injury-free cultures must take a long-term view of their decision's influence on exposure. An effective safety leader not only encourages and accepts input regarding how the decision could negatively impact exposure, culture or systems; the really progressive leaders set up mechanisms that solicit this type of information as a standard part of the decision-making process.

Finally, an exposure focus recognizes that not all exposure represents the same level of potential and designs systems for measurement and control accordingly. One of the worst things that can happen to an organization is to achieve a very low injury rate, then to have a serious injury or

fatality because the related exposure reduction systems have become lax or have been eliminated entirely. For the limited number of exposures that can likely lead to a life altering injury or fatality, exposures need to be well managed. They need mechanisms in place to measure for variation, and to document the cause of the variation and the actions taken. Leadership in particular needs to keep a steady focus on high potential events while moving the organization to longer and longer periods of injury-free experience. They do this by routinely monitoring indicators related to these exposures at the working interface or measures related to their process safety management systems.

Defining Safety Metrics that Paint a Multi-Dimesional Picture

Rather than tie safety performance to the binary thinking of a single metric (i.e., we are either going up or down), the injury-free culture looks at a range of data. The culture we are trying to create is one where we focus on *where the next accident is going to happen, what is happening to the culture and safety climate and how the organization is evolving*. This level of activity requires tools that dig deeper than end results. A comprehensive set of metrics typically includes:

1. Exposure—Exposure measures reflect the alignment at the working interface, the intersection of facilities and equipment, procedures and the employee. Exposure data prompts us to ask what encouraged or discouraged an employee to tolerate or accept the level of exposure? This questioning leads into discovery of the root causes and to the identification of additional measures.

2. Safety & Health Programs—In addition to exposure, organizations need a way to evaluate whether the organization has implemented the necessary programs and whether these programs are having the desired result in reducing exposure. Safety and health programs are designed to deliver and assure alignment at the working interface and typically fall into the several categories that cover both personal and process safety elements, including:

- Hazard Recognition & Mitigation
- Skills, Knowledge, & Training
- Policies & Standards, and
- Exposure Reduction Mechanisms

3. Culture—Safety and health programs function within the broader context of culture and safety climate. Research identifies nine factors that independently correlate to safety performance. They also correlate as a group to safety performance. (See Exhibit 2). These nine factors can be grouped into organizational, team and safety factors. Interestingly, the first two factors are not safety specific. Organizational factors include organizational justice and the relationship employees have with their immediate supervisor, the management team and the organization itself. Team factors refer to the extent that team members treat each other with dignity and respect and whether they can rally together to accomplish a task. Safety factors include employee perceptions of the organization's commitment to safety performance, if their safety concerns are addressed, and the extent to which employees are willing to talk to each other about safety.

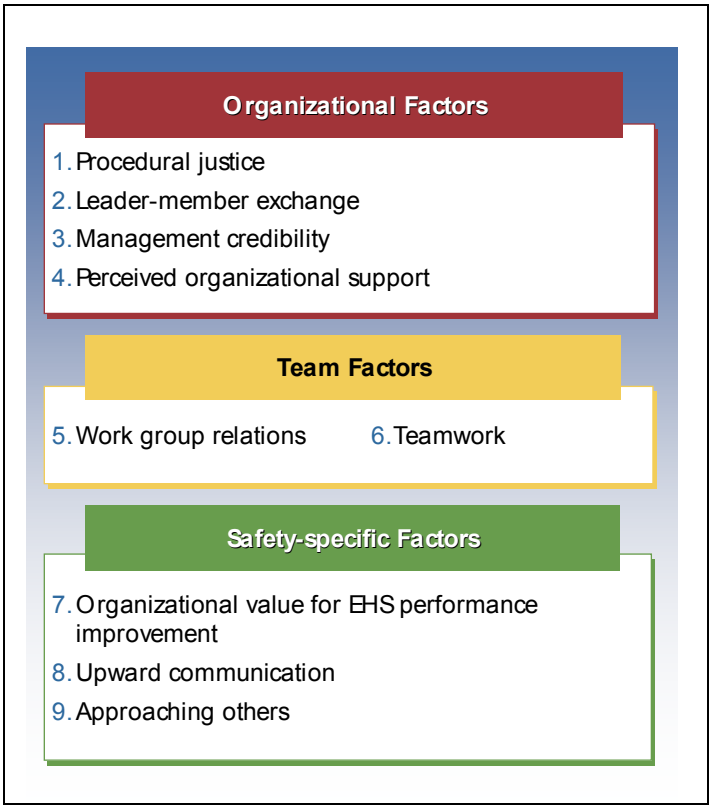

Exhibit 2. The Nine Organizational Factors that Correlate to Safety Performance

4. Organizational Systems & Consequences—The root cause of an incident may trace back years to a decision that was made at a very high level. What we determine about staffing levels, supervisory development, promotions, budgets or new projects all introduce changes into the systems that provide consequences for organizational behavior. When we separate consequences from our declared performance targets, we reinforce old ways of doing things and, in some cases, undermine the change we are trying to create, e.g. telling employees they must report all injuries at the same time as providing attractive incentives for workgroups without injuries. Key systems to measure and asses include:

- Selection and development for all levels
- Organizational structure: Staff level versus expectations, leader to worker ratio, etc.
- Performance management: What is evaluated, the effectiveness of the process
- Rewards and recognition: How are heroes created in the organization? What behaviors and practices are recognized or compensated?

5. Safety Leadership - Leaders make the decisions about the acceptable level of exposure, the safety climate and the type of culture that exists, and the systems to be implemented and that drive performance. In this case, it is helpful to narrow the focus to safety leadership. Research shows that the use of certain safety leadership practices, such as feedback and recognition, collaboration, and action orientation, correlate to higher culture scores and safety outcomes.

Engaging Employees

The final attribute of an injury-free culture is employee engagement. Without it, an injury-free culture is not really possible. Engagement breathes life into the safety process and enables the particulars of an organization's objectives to be executed. At the end of the day, leadership is limited in its ability to provide coverage and even with the best safety programs are only as effective as the level of employee buy-in and support for these systems. Employee engagement in safety can take on a wide variety of looks and applications. Fundamentally, front-line employees can help measure and manage exposure at the working interface, assist in identifying solutions to safety problems, and providing information and feedback about the organization's systems and efforts.

Engagement begins when organizations establish their concern for the employee, assuring that supervisors treat workers in an unbiased and fair manner and with dignity and respect. They also do this when they assure that the senior leadership and the organization demonstrates its concern for employees' well being. These things establish a good relationship with employees and foster a strong sense of reciprocity. In this environment employees tend to go above and beyond their job description because they feel it is the right thing to do for a peer, leadership or the organization. This willingness to follow a procedure, even when no one is watching or to step up and take on leadership in the moment is a sign of a very high functioning organization.

Conclusion

It is important to remember that achieving an the goal of zero injuries is a marathon not a sprint. Continuous improvement and small significant steps is more important than short term gains done for "show". In the end, creating an injury-free culture is possible only by being—or becoming—a truly exceptional leader and organization.

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