Safety Culture Enrichment-Dealing with the Root Cause of Losses (How to Measure and Manage Safety Culture Enrichment)

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What Is The Root Cause of Losses?

Almost every seasoned safety professional knows that process predicts performance. Some processes are designed to succeed and some are designed to fail. Even those that are well designed will fail if those in charge of implementation do not have an attitude that facilitates effective application. So the root cause of losses is found in the social sciences not in the natural, physical, or even behavioral sciences. We must gain a greater understanding of safety culture and then how to measure and manage it if we are going to make progress on reducing losses.

Several case histories are instructive. The readers of this paper probably have many similar stories they could tell. I would encourage them to document those "cases" and I'd welcome them being shared with me.

History can be a way to learn lessons and avoid mistakes of the past. It is said that they who refuses to learn from their mistakes are condemned to relive those failures. Unfortunately, learning often doesn't take place because history is not properly documented or the lesson learned is not properly understood or interpreted; but that is no excuse for ignoring history.

A noted historian said, "Apparently our present-day education has forgotten the ancient world, to our loss, for theirs is the history we are even now repeating."

Values-Driven Safety™ is based on a foundation of the historical teachings in theology, philosophy, psychology, and – notably – sociology. The concept is rooted in sociology but draws on the other social sciences as well.

These case histories supplement timeless truths revealed in the social sciences with more modern day examples that confirm what we have known for centuries.

As Values-Driven Safety™ is applied, we are confident that stories will continue to emerge that validate the core concepts in the process.

What do Case Histories Tell Us?

<u>CASE HISTORY #1 A wood-products Company with world-class safety?</u>

Background A major wood-products Company believes they are best-in-class with regard to safety performance but recognize a disparity between their best and worst operations in harvesting, milling, and paper making. They desire to bring all their operations up to the performance of their best performers in each business sector.

The Story A consulting project is undertaken to benchmark world-class safety in industry in general and then specifically in the wood products industries and then to analyze best and worst performers in each business sector of the client company and suggest how over-all performance could be improved by adopting world-class methods from all viewed sources.

First, it was determined that the first-in-class claim was probably over stated with the possible exception of the best units in each business sector. Those best units were visited to assess their methods for consistently leading their sectors in safety performance. Although they were in vastly different businesses, planting and harvesting, milling, and paper making, they had several characteristics in common.

- None of them had a full-time safety professional on staff. They all said they used to have one but had outgrown the need for full-time safety consulting. They assigned special interest areas such as compliance, ergonomics, and personal protective equipment to individual managers on the plant staff and they accessed specialized knowledge they did not possess through corporate staff or outside consulting.

- When asked about traditional safety performance measurement such as OSHA Incidence Rates, company audits, or workers' compensation costs, all the plant/general managers indicated that they did not know the numbers but did know they were best in sector and that others in their organization kept those numbers but they were more concerned with the process than the numbers…confident that if the process was working the numbers would take care of themselves.

- In all three top performing units (all of which had achieved OSHA Star Status), there was a clear air of confidence that their process was working and that they could continue to operate relatively accident free. There was a confidence and openness that was palpable.

When the consultant asked to visit the worst performing units in each sector there was some stalling. When subtle pressure was applied, it was admitted that access to those units was being denied not only to the consultant but also to corporate staff. When a draft report was submitted suggesting that the claims of best-in-class safety performance may be overstated, the project was terminated.

Lessons Learned Top performance in safety doesn't require full-time safety professionals. Actually, they are only needed to lay the foundation for success and their mission should be to work themselves out of a job. Top performers tend to be more concerned with process than statistics. There is something palpable in organizations that consistently outperform their competitors; that something could be called attitude or culture.

The Conclusions The secret to success in safety -- or for that matter any endeavor – appears to be rooted in confidence and self-assuredness. Those characteristics seem to be closely related to practicing a process that works.

CASE HISTORY #2 A Food Company with a plant that manufactures injuries.

Background A large and prosperous food company is distinguished by being highly automated, having a dominating market share, and a sophisticated leadership with exceptional marketing expertise. Profit margins are far above industry norms. Safety performance in all but one unit range from acceptable to better than industry average. One location, located in an agricultural area and engaged in canning as well as product production has an incidence rate more than ten times industry average.

The Story The food company is part of a large and diverse corporation with a sophisticated approach to loss prevention and a staff of highly competent professionals. Every location has at least part-time safety professionals. The over-all company performance is significantly better than industry averages. There are procedures and practices that are followed throughout the organization. There is considerable uniformity.

The mal-performing location follows the essential safety procedures and practices in much the same way they are followed at other division locations. Considerable effort is expended to determine the cause for the poor safety performance. Unlike many instances of poor safety performance, this location performs extremely well when it comes to productivity, quality, and virtually all other areas of performance that are traditionally measured.

The location general manager periodically and dramatically assails the managers at staff meeting about their poor record of accident avoidance.

All of a sudden, the incidence of injuries -- dramatically -- virtually ceases. Debriefing reveals that the general manager, who had always been regarded as an over-achiever – with the single exception of safety performance – changes his tactics. Instead of theatrics, he begins to take a hands-on approach. He goes out and investigates accidents himself; he penalizes supervisors who do not take safety seriously by reducing their annual pay increases; he talks seriously about safety issues at the *beginning* of each staff meeting.

Further investigation reveals that, earlier in the year, the general manager, had been severely penalized for his poor safety performance by a significant reduction in his annual bonus.

Lessons Learned Some operations such as seasonal harvesting work have – as part of their culture – not only an acceptance of injury but almost a glorification of injuries as indicators of giving a full effort. This kind of attitude is prevalent in war and some sports where part of the culture is to glorify the injured.

Until that is overcome, injuries are – in effect – badges of accomplishment. Hence, they are clearly not to be avoided in spite of some rhetoric that is seen as meaningless management mutterings. Until the leadership "attitude" is changed, not much else will change.

The Conclusions The reason for poor performance is often very subtle. But, "at the end of the day", when the root cause is unveiled, the solution will invariably be found in the social realm, not in the procedures or technology.

CASE HISTORY #3 A shoe company laden with inconsistencies.

Background The shoe industry, which is now largely non-existent in mainland USA, incorporates all the ingredients necessary to produce upper extremity soft-tissue injuries. There is lots of repetition, significant force, and often the need to work at angles that are not anatomically friendly. During the waning days of the shoe manufacturing industry in Maine one plant in a small town in central Maine experienced an epidemic of hand, arm, and shoulder injuries.

The Story At the same time, another plant, doing similar work had virtually no injuries. The afflicted plant was a new facility with modern machinery and amenities unfamiliar in the shoe industry such as a nice cafeteria and excellent lighting. Most of the workers were young and generally fit. The old plant with almost no complaints was in an old mill building and populated with older workers many of whom had arthritic conditions at various degrees of advance based partly just on aging but undoubtedly as least partly due to a lifetime of hard repetitive work. Workers were used to eating their bag lunches at their machines. Both communities had medical communities that were not highly rated in the state; both communities had aggressive legal communities who knew how to use the "system."

Solutions were sought for the problems at the new plant. Among them was an exercise program designed to provide warm-up, strength building, and stress relief. Few employees willingly participated so it was decided to provide the time with pay. Still, not many employees willingly participated.

An educational program analogized the workers as para-athletes and demonstrated the benefits of exercise and illustrated problems and methods. Workers were provided with illustrated booklets and posters reinforcing lessons learned. Local authority figures advocated exercise. In time, employees participated willingly and finally, not participating came to be thought of as dumb and was even stigmatizing.

Lessons Learned The culture in the afflicted town was a strong contributor to the injury epidemic. In the injury free plant, being out of work and receiving compensation was frowned upon. At the new plant, it was a sign of savvy to milk the system and whole families had honed the process to an almost fine art. Everyone was experiencing some discomfort; some people were willing to "play hurt"; others were not. Corrective measures – however valid – were not effective until implemented as part of a comprehensive program of job redesign, exercise, early intervention, leadership support, and aggressive legal/medical programs.

The Conclusions Nothing worked until culture changes took place among the workers (as it related to exercise); the supervisors (as it related to early intervention and education); and the community (as it related to work ethic and not taking advantage of workers' compensation laws).

CASE HISTORY #4 Educational institutions that can't teach and can't learn.

Background A group of top universities have a group captive insurance company to provide insurance coverage for their auto fleet and general liability exposures. They come to realize that the worst performers in the group of fifteen are costing the best performers a lot of money. They seek to determine what differentiates the best from the worst and apply that knowledge to reduce costs for all the members.

The Story After two years that included four visits to most of the campuses, it is determined that there is a reason for the disparity in performance but it is not what had been expected. The worst performing school had a large safety staff and prolific documentation. When questioned, department heads at that school were generally unfamiliar with the hazards they may encounter and certainly not what they needed to do to protect those under their supervision and stewardship.

The best performing school had no full-time safety professional and no documentation to speak of. The practices within each school department were well known and adequately documented. The individual department heads were well aware of the hazards in their departments and had plans, programs, and procedures that they took charge of to mitigate the perceived hazards.

The schools that had a good to excellent safety culture were receptive to suggestions that could further enrich their safety cultures; the schools that had safety culture problems were not receptive to suggestions as they pertained to their cultures – or for that matter almost anything else.

Lessons Learned Organizations that don't listen are usually not accident resistant because they have a tradition of failing to listen and make adjustments.

The Conclusions Documentation and professional safety staff do not always correlate with accident free performance; actually, in mature organizations there is some anecdotal evidence that they correlate inversely. At the "end of the day" culture, not documentation, technology, or behavior manipulation predict loss resistance.

These case histories represent real situations that are based on first-hand experience. Names have not been used due to confidentiality needs. The conclusions are those of the author and do not necessarily reflect the opinions of those involved or affected. These represent a very small portion of the experiences that the author is aware of on a first-hand basis. There are many more situations that suggest the same conclusions that have been seen and reported by others.

Overall Conclusions from The Case Histories

Over time, as Values-Driven Safety™ is popularized, I am confident that stories that demonstrate these points will become legion and legend. As data is accumulated, the correlation between safety culture and safety performance will become more obvious and eventually commonly accepted. The result, if safety professionals take the lead, will be recognition for the profession that has to date eluded them.

What Then?

It is incumbent upon all serious seekers of truth and those committed to avoiding needless losses to seek after the root causes of losses and be seriously involved in prevention.

The *National Safety Council* has said that safety culture is the future of this business. Lewis Gerstner, in his book *Who Says Elephants Can't Dance*, says that when he took over at *IBM* he thought that culture was important. Then when he left ten years later, after saving them from bankruptcy, he said that he realized that it was the only thing that was important.

Values-Driven Safety™ holds the promise to change the way safety is practiced and the way organizations view safety professionals. The cornerstones of the Performance Map™, the Safety Culture Barometer™, the Bridge Metaphor™, and Exercises for Improvement™ form a firm foundation for measuring and managing safety culture and have the potential to be applied to all organization and individual development.

The Values-Driven Safety™ *Applications Manual* provides the "tools" for any practitioner to apply the methodologies in their work.

Others have spoken and written of the importance of safety culture. It is past due time for every safety professional to address the issue. I have proposed one method/solution. I encourage others to pioneer new and better ways to accomplish the same thing. I believe that if we don't address this issue, we have little future; if we do, we could be the beacon that has always been the ***potential*** of our profession.

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