Three Overlooked Elements of a SUCCESSFUL SAFETY CULTURE

By Wyatt Bradbury

Substantial discussion has taken place in professional circles surrounding the creation and maintenance of safety cultures. Many of these conversations have resulted in insightful and innovative programs that engage employees in the safety process and attempt to develop the seemingly ever-elusive safety culture.

However, three key elements are often not addressed in those discussions: defined roles and responsibilities, holistic incident review, and the "pulse of safety" on a job. The specific programs or policies surrounding these elements can be less tangible and emotionally gratifying than the implementation of a visible safety culture or rewriting the training program, but they are critical in the evaluation of a safety program.

1) Defined Roles & Responsibilities

It is difficult to perform duties when, in some cases, those duties are not well defined or understood. When it comes to employee safety, if responsibilities for safety functions are not clearly defined along with expectations for productive work tasks, employees may tend to allow safety functions to fall to the back burner. It should be made clear to the worker that s/he is equally responsible for safety functions and productive output.

ANSI/ASSP Z10.-2012 (R2017), Section 3.1.3, discusses responsibility and authority in relation to the implementation of a safety management system. While top management is responsible for the program overall, one critical component described is "defining roles, assigning responsibilities, establishing accountability and delegating authority" (ANSI/ASSP, 2017) to ensure the success of the system with the expectation that these roles and responsibilities are documented. Section 3.2 of the standard further provides an overview of the minimum requirements that should be established surrounding employee participation. It states that employees should be provided the time and resources to assist in planning, implementation, evaluation, corrective action and preventive action of the OSH system (ANSI/ASSP, 2017).

In a review of the BP Texas City refinery explosion in 2005, a key failure was unclear expectations surrounding the behavior of management leading to severe inconsistency in policy application and the disempowerment of employees from participating in the safety process (Manuele, 2014). Manuele includes the following in his conclusion about ANSI/ASSP Z10, Section 3.0: "Leaders are responsible for establishing the conditions and the atmosphere that lead to their subordinates' successes or failures."

Employees can only function within a system when they understand exactly what that system requires them to do to ensure its function. Defining the roles, responsibilities and qualifications of the employees at the outset and regularly reinforcing them are first steps toward building and maintaining a culture of safety within an organization.

2) Holistic Incident Review Process

Incidents are where the safety culture undergoes the most stringent test possible. When the system fails to work as designed and catastrophe occurs, the response and nature of the investigation determine whether the result is buy in for the suggested corrective actions or a desire by employees to cover their tracks. Incident investigations are designed to collect facts, not find fault or blame (Goetsch, 2015). When management turns an investigation into a witch hunt looking for a singular employee or behavioral root cause, the truth may be buried or mutilated out of self-preservation. However, investigations conducted to gain a thorough understanding of the events leading up to and surrounding the incident result in an increased likelihood of support and engagement in the process (Baker, 2018).

Goetsch (2015) makes it clear that a consistent process or framework should be developed for all investigations. ANSI/ASSP Z10 (2017), Section 6.2, backs this need for procedure but allows for companies to define the conditions for such investigations and reporting. Although investigators may deviate from this framework as conditions lead them, employees can still depend on a baseline procedure to keep bias and politics out of the investigation. It should also be noted that companies with a strong safety culture see employees driving the reporting and investigation process on their own. Because they have ownership of their system and culture, these employees know how to recognize near-hit incidents, report those incidents to the appropriate party, and participate in the investigation process so that a full understanding can be gained and appropriate real-world alterations can be made. These employees do not live in fear of blame games and witch hunts, and instead seek to engage with investigations for the betterment of themselves and their team.

Beyond the framework, however, is the goal of the system. Manuele (2014) makes the claim that many incident investigations find the "technical flaw and individual failure" but fail to look or take corrective actions beyond this point, neglecting many other contributing factors that could be mitigated or potentially removed. Solomon (2016) calls this "looking beyond the first causal factor." Manuele stresses that a company with a strong investigation process and desire to protect its culture will also look to the cultural, technical, organizational and operational factors. Baker (2018) echoes this sentiment by asking, "How many decisions are made without changing the probability of the situation occurring?"

Companies with a strong safety culture will have not only a consistent process to handle reporting and employee buy in, but also an approach that allows for dynamic situations to be evaluated as they are so that the appropriate controls can be implemented. When investigations work to improve the human in the system, not blame them, and strengthen the defenses of the system to protect the human, it is evidence of a strong safety culture (Baker, 2018).

3) The "Pulse of Safety"

A final item to evaluate is the nature and depth of conversations taking place

in the facility surrounding safety. CRB Regional EHS Manager Rob Upleger (R. Upleger, personal communication, June 2018) has coined this as the "pulse of safety" on a job site. What is the tone of safety-related conversations? When do they occur? How do they occur? Who starts the conversations and what parties are they between? If people are not discussing safety, then either it does not matter to them or they are in an environment where they feel completely secure from harm.

Solomon (2015) makes the point that the stories and messages communicated between employees offer insight into the priorities and items of importance. A prime example is the daily start-up meeting. Its name and form used are not important; the key is whether safety is given lip service or "given prominence by integrating it into discussions regarding daily planning, production, targets, strategy, human resources and budgets" (Solomon). When conversations surrounding the concepts of safety occur naturally during work, employees will begin to normalize safe work practices into their behavior and hold each other accountable for their actions.

Along these same lines is the importance of maintaining these conversations as an active and dynamic dialogue. Zabriskie (2018) notes that only occasionally providing employees with feedback is akin to asking them to use 1940s technology to complete their assigned administrative tasks and calculations. Zabriskie's point is that informal, formal, negative or positive feedback should be consistently delivered to employees allowing them to evaluate their actions, beliefs, attitudes and approaches in real time as they make decisions.

When safety concepts are given the necessary and appropriate time to be discussed, an increased likelihood exists that such conversations will become normalized within the organization's culture. As this happens, it will transform from a dedicated discussion to an ongoing dialogue. As leaders reinforce the importance of safety with specific and regular feedback, employees will be able to interact more effectively with the system in place and take control of their weakness or feel acknowledged for their strengths. Complex work situations can quickly get out of hand from a safety perspective.

When a relationship and procedure for dialogue is in place between employees and supervisors, it allows for conversation to focus less on the emotional or personal aspects of the situation and more on the systematic issues contributing to the behavioral shortfall (Zabriskie, 2018). When safety on a site moves from a program designed to control human behavior to a place of evaluating the current systems in place and how humans can get in the way of those systems, a strong and lasting culture is evident.

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Conclusion

Cultures can be difficult to understand and evaluate. However, when the system and norms that the culture aligns to are evaluated along with the interactions of humans with that system, it becomes easier to decipher the key elements at play. In the evaluation of a safety culture, it is critical to look at the system, interactions with the system and behaviors resulting from those interactions. Defined roles, consistent, system-focused incident review and an evaluation of the pulse of safety are key indicators of the strength or weakness of an organization's culture. As the system, interactions and behaviors progressively mature, so too will the safety culture. **PSJ**

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