Safety: Lessons from the field

Reflections on journeys to incident free, harm free and care filled workplaces

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A paper from Dalmau CONSULTING

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This reflection is based on 15 years of experience helping various organizations assess, design, develop or implement strategic change designed to create incident free and care-filled work environments.

They are more a reflection on what I have learned and are described in three sections

Establish context and pre-conditions

Identify major elements

Identify cautions and caveats

Pre-conditions

Firstly, let us distinguish between means and ends, processes and outcomes. This has caused significant initial confusion in many of the settings in which we have worked.

It may sound obvious but it is surprising that the point of most interventions must be to create an incident free and care-filled environment. The reasons for this can vary from a perspective that says this is the responsibility of all leaders through to a desire to reduce the cost (both real and opportunity) that comes from people being injured in the work place.

Whatever the reason for the desired outcome, our experience suggests that real and sustainable traction towards and achievement of this outcome requires a deep and unwavering belief among the executive leadership cohort that this outcome is both achievable, worth attaining and that they play a vital (but not the only) part in its realization.

In a large, complex and geographically dispersed organization this also requires the same of key regional operational leaders. In other words, symbolic and actual commitment about the outcome needs to always start at the top, but strong operational leadership for the outcome may come from different levels depending on the size and configuration of the organization.

Dick Knowles

Resources

Resourcing is another key issue that has come to notice in many of the instances where we have worked in this field. Client organizations who rely on outside providers to educate and "transform" their employees around safety are inevitably throwing hard-won shareholder moneys up against the proverbial wall. The resourcing for this work should largely be internal to the organization, experienced and adequate to the task and supported where necessary by outside expertise.

The resources provided have largely fallen into three categories:

- an internal person or function with the technical know-how to install and develop the systems and processes to improve safety,
- the time money and effort to put those systems in place, and
- the aligned leadership from every level to instill the mind set and values among employees that is required.

Journey

Creating an incident free and care-filled environment rarely, if ever, happens in one step. In fact most experienced wisdom says the pathway to zero harm is a journey with some known and predictable stages.

There are various descriptions of these but they all tend to have the same characteristics. One in vogue at the moment is the Bradley Curve, developed by Verlon Bradley who worked for DuPont at Parkersburg Texas. He built his model directly after the experience of Dick Knowles at the DuPont plant in Belle, West Virginia. He simply added a front end (related to no development at all) and made it visually look smoother than it tends to be in real life.

Whatever model is used, they all tend to suggest that the initial phase involves technical and systems development to ensure as safe a work environment as possible, with a high focus on leader directed change. There is then a phase that seeks to have the individual change their awareness and their commitment,

and finally a phase based around teaming that generates the sustainable long term and dramatic reductions.

Dick Knowles believes that it is possible to run these in parallel and this has been the basis of the work we did together in CSR throughout Australia and continues to be the basis of the work we are doing with companies in the resources and manufacturing sectors.

It is possible to get a far more dramatic improvement in the safety and care in the work environment and for this change to be sustainable than had previously been thought, but one thing is for sure: unless you get to the third phase, whatever is done by directive leadership and pressure to commit will be largely unsustainable.

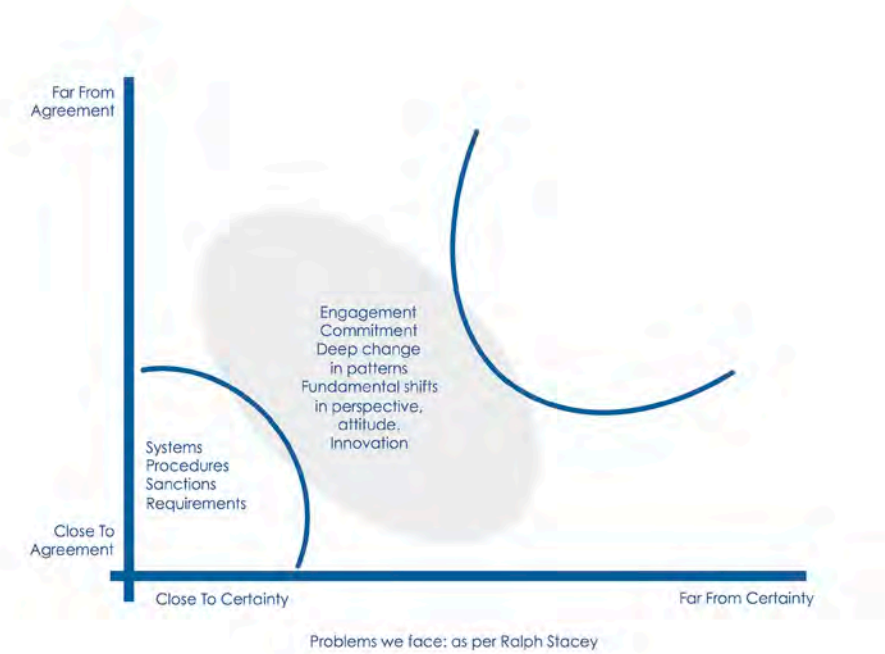
Dick Knowles work and all the work we have done is premised on attacking all three elements.

Simultaneous perspectives

In terms of Ralph Stacey's diagram, the work needs to be driven by two types of thought and strategy simultaneously: what is known as bottom left hand thinking and middle ground thinking. That is thinking derived from analyzing the problem and breaking it into its parts plus thinking that comes from looking at the issue from a whole-of-system viewpoint.

This necessarily means systems, procedures and processes, but it also means changing the nature of relationships in the work place so that a safe and care filled environment comes from the mutual responsibility that each person takes towards his/her colleagues and their welfare. It is only when you get this second piece of the puzzle in place that you get dramatic and sustained improvement.

The good news is that this is not that hard to do with the right thinking and a commitment to persistence from the top leadership all the way down.



Problems we face: as per Ralph Stacey

Authentic conversations

But it does and must find expression at the "shop floor" so to speak, in a regular (monthly or quarterly at the very least) meetings of working groups and teams to have authentic discussions about their own commitment to each other and to creating a harm free care-filled workplace. These "strategic and powerful" conversations sit on top of daily conversations at a much more operational level, e,g, tool box meetings, daily operational review meetings, etc that always include safety as a core and important topic.

Invariably, those places that have made dramatic improvements have also established non-negotiable standards that are enforced persistently and consistently without fear or favor

Piecemeal does not work

Our experience suggests that this work will fall if it is done piecemeal. By piecemeal, I mean not so much in terms of "chunks" or work, but more in terms of segmenting the nature of the work or handing different parts to different providers.

The truth is there are any number of providers who will talk all the right language and provide a comprehensive suite of interventions. We have probably worked alongside or with at least 10 of the big name providers in Australia in this space, providers who cater to the resources, engineering and aviation industries. We can count on two fingers those who would recognize the pre-conditions outlined above and work to them.

The more common experience is that the provider promises to deliver cultural change (an oxymoron) and addresses it from one of three common perspectives: systems, processes and procedures, changing the attitudes and beliefs individuals, or leader driven social discourse towards commitment. The fact is that there is merit in each of these, each is necessary but none are sufficient.

What is far more effective is where the client forms a partnership with one provide who takes a "whole of system" perspective and organizes the development of all aspects by the client organization itself with its own resources, drawing on relevant technical assistance in specific areas when needed.

Change management

Another way of describing this is to say that the path to zero harm is a journey best managed through comprehensive change management practices by an informed companion to executive leadership? This is true of all those situations where we have seen it work well.

Finally, surprises: it was Myron Kellner-Rogers who said the only known consequence of organizational change is that there will be unintended consequences. For example, to our surprise in working with a client across 5 manufacturing sites recently it became apparent that one of the key hindrances to creating a safe and care-filled work environment was the fact that many supervisors (and above) were unconfident and under-resourced with the requisite skills to have the difficult conversations that leaders at all levels need to have once the organization commits to this journey.

This was not foreseen or expected, but the client's leadership group have acknowledged the need and are working towards meeting it. I cannot for one moment imagine what the equivalent surprise might be in other organization, but I would expect that one will arise.

Major elements

The key elements are more or less predictable. Although they have been called many different

names by different groups we have worked with or along side they generally describe

1. A conversation for delineating outcomes, commitment, understanding, expectation setting and scoping by an executive leadership cohort and involving the CEO directly. It inevitably involves articulating some core beliefs and values around safety against which the organization is going to measure itself. Sometimes this is a once off event, on other occasions it has taken a number of gatherings. Alongside is usually a range of one-to-one discussions with key members in this cohort and the layers below.
2. The next phase usually involves a functional assessment of greatest areas of need, and areas for most leverage and gain. In some cases this has involved an outside provider, in other cases not: the difference is usually due to the competency and extent of the internal resources.
3. Often, there is then a "conversation" between this current state assessment and the executive leadership cohort to establish priority areas of work, big rocks so to speak. This generally leads to endorsement and further resourcing. The big rocks may be knowledge and know-how upgrading, leadership development, systems

development, processes deployment, or engagement mechanisms.

4. The next element is the development of a comprehensive whole-of-system change management program that will deliver the outcomes sought and as such will inevitably involve elements of team development, leadership development and communications/engagement.
5. The next phase is usually a roll out of a conversation for commitment that becomes institutionalized into a regular habit for every single employee of the organization. Although about safety, this element delivers productivity and alignment benefits way outside the scope of delivering just a harm free and care filled environment.
6. This is often accompanied with the roll out of some form of behavioral safety program, often it seems derived from the work of James Reason.
7. By the time this phase is embedded there are usually a range of bottom up leadership and change initiatives happening and the organization can find itself in a position of trying to keep up
8. Thus, as with all good change management, where we have seen this work well there has usually been a core group of senior operational leaders who meet regularly for peer and expert coaching to drive and institutionalize the whole process.

Cautions and caveats

In the light of the above they probably obvious, but worth stating

1. This can't be done without strong belief based leadership
2. This leadership can and must take various forms at different levels
3. Engagement at every level is key
4. Setting non-negotiable standards and supporting them with the appropriate consequential management is mandatory
5. Piecemeal and segmented is a waste of time and goodwill
6. Sustained change will not occur with engaging at some stage and through a regular persistent repetitive process every

single employee

7. Dramatic improvement is easy if you attack only one aspect
8. Dramatic and sustained improvement needs a whole of system process
9. It should be led, driven and deployed by internal personnel wherever possible

This is not, in fact, equivalent to turning a battle ship: difficult, slow and huge in size, complex. If all the elements described above are in place it can produce dramatic and sustainable change in a relatively short time.

But it does require a whole of system, informed and well resourced plan.

Epilogue

I have been relatively light on the use of the word culture. This is probably worth a closing comment.

When people talk of culture, organizational culture and safety culture, most times they are misinformed and uttering what turns out to be a logical fallacy.

It is true that you can tell a place that has a productive safety culture and where the environment is actually safe by all measures. You can feel it, see it and almost touch it when you come across it. So a strong positive safety culture is a good thing.

But the mistake often made is to think of it as something that can be created or engineered directly. Culture is an output of other things you do, and not an input to be manipulated directly, if for no other reason that so many elements of culture and safety culture are in fact unconscious and not amenable to direct, rational, conscious intervention. Culture is effect, not cause.

Therefore providers who promise to (and leaders who ask for) culture change are engaged in an exercise in futility.

Where strong safety cultures have developed, in our experience they have arisen from direct influence of the inputs to the organizational process, starting with leadership, but extending to and encompassing all of technical (safety) knowledge, skills, processes and social systems development. When attacked in a whole of system manner, then dramatic and sustained change is possible, and this produces a strong safety culture

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