More safety lessons from the field

More reflections on journeys to incident free, harm free and care filled workplaces

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Beyond limits

More Safety Lessons From The Field

REFLECTIONS ON JOURNEYS TO INCIDENT FREE, HARM FREE AND CARE FILLED WORKPLACES

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A previous version of this paper was published 10 years ago. At that time, it relied on 15 years of experience helping various organizations assess, design, develop or implement strategic change for incident-free and care-filled work environments.

With an extra 10 years of experience in helping clients create safe workplaces, we have gathered to update those learnings. We have added some elements we now believe are crucial, especially in large, multisite workplaces, to produce incident-free, harm-free and care-filled work environments

Context

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 the intent of interventions must be to practically support the development of an incident-free and care-filled environment to improve the organization.

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 workplace.

Whatever the reason for the desired outcome, our experience suggests that real and sustainable traction towards 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.

What we now know more clearly:- In the last decade, so much real and substantial change has occurred across the world many of us would not have contemplated, and these changes have had a profound impact on how organizations conduct themselves, but more importantly, on how difficult it is for senior executives to stay focused. One of us has described some of these changes and their impacts on executives in the background paper Times for a Change and outlined the complexity behind being a leader of modern times in the paper Balancing It All.

Ten years ago most of us would not have anticipated the global covid pandemic or the Ukraine war both of which have been significant triggers for many other flow-on impacts that include the transformation of workplace relationships, global supply chain constraints, global food shortages, significant global inflation, healthcare transformation,

significant widespread industry sector reform and uncertainty, a significant displacement in large sections of the world's population and associated significant global homelessness, to name but a few.

Nowhere is this more stark than in a review of recent global inflation figures. Venezuela's economy used to be one of the best in South America with large per-capita wealth thanks to the largest oil reserves in the world. But, that reliance on petroleum left the country vulnerable to oil price fluctuations. When oil prices plunged back in 2016, the country's economy was never able to fully recover. At the time of writing this document, it now tops the world with a current annual inflation rate of 1,198% as it tries to weather the forces described in the previous paragraphs.

These factors may seem quite removed from the frontline supervisor or middle manager bent on trying to ensure none of his or her employees suffer an injury on their watch.

But in today's large matrix organization, that same manager or supervisor faces many and competing demands from their own more senior line leaders along with a myriad of special and often highly centralized functional services e.g. human resources, asset management, quality excellence, each making competing demands on their time. The larger and more global the organization the higher this world of competing demands rises inside that organization and the more difficult it is to achieve consensus that the safety and welfare of employees is the actual, real number one priority.

Over the last 10 years organizations and employers have come to realize they have as much responsibility for psychological and psychosocial safety of their employees as they do for their physical safety. It has become an imperative.

In May 2021, the Australian state of New South Wales implemented the ***Code of Practice: Managing psychosocial hazards at work***. By

doing so, they became the first Australia/New Zealand jurisdiction to implement an approved code of practice addressing psychosocial hazards. Western Australia (in February 2022), Tasmania (in January 2023) and Queensland (from 1 April 2023) have also introduced similar codes of practice in their respective jurisdictions. The Northern Territory is currently working on their Code of Practice, which is expected to be published in or around July 2023. In July 2022, Safe Work Australia published their own code.

This transformation and expansion of the conventional understanding of what makes for safety has been nothing short of a revolution and it is in full swing across all western countries. The psychological and social elements of safety have always been present and pervasive in workplaces but until recent years hidden from view and thus lacking attention.

As focus and understanding has increased the massive impacts – both positive and negative - that these psychosocial factors have on both organizational and individual performance and well-being is slowly being appreciated, almost as a lag phenomenon to the sea change in respective legislations.

Added to whatever was a leader or front-line supervisor's already overloaded set of responsibilities, the last decade now requires that they manage psychosocial risk.

A psychosocially safe, injury-free and care-filled environment is the responsibility of all leaders, managers and frontline supervisors.

Due to the factors mentioned above, turning this into an aligned and actual priority at the top of an organization is much harder than it was 10 years ago. The result is often goal displacement, corporate inertia and an internal political maze to be negotiated: we as an organization say safety is our priority but this is not lived out by the way we make contradictory demands on our line managers or the way we make decisions.

In the last decade, we have come to realize the vital and absolute importance of the leader of an organization in creating the environment in which safety can flourish, including but not

limited to their courage in making decisions and clearing the space for line managers to be real safety leaders who enjoy the unequivocal support of their organization. CEO's and their teams with an unswerving and clear focus on safety is now an absolute imperative.

If these things are not in place, agile, aligned and coherent then the result is what we colloquially call bureaucracy. The result is individuals have a higher probability of being hurt: physically injured or psychologically and socially damaged.

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.

We have learned that the resourcing of this work is effective only when it is largely internal to the organization, by those experienced and adequate to the task. As a last resort it can be supported by outside expertise.

What we now know more clearly:- Where and how the resources are provided, who provides them and the context in which they are delivered is vital. The drive by the economic rationalists to create and engender more and more efficiencies in the pursuit of additional shareholder value through the 1990s and the first two decades of this century has created workplaces that lost corporate memory and deep capacity to stay focused on their priorities.

Along with the widespread social malaise that has accompanied this generally massive reduction in corporate know-how, the many "work arounds" not only don't work effectively but create more problems of their own.

We have a client who has outsourced its induction training to an external provider. This provider's personnel who deliver the training have never set foot inside a very complex and potentially very dangerous workplace to which they are introducing

the inductees, their teaching material is decades out of date and largely irrelevant to the environment that these new employees are about to enter.

Moreover, no senior executive or manager usually visits these inductions – real corporate leadership around safety is simply absent. And the poor corporate neonates are subjected to a mind-numbing 300 PowerPoint slides.

Another client has removed their front-line supervisors' requirement to monitor safe and unsafe acts of their subordinates and contracted it to an outside provider. This provider group quickly became known as the "safety Nazis" and among many operator teams we found active collusion in some teams to evade and trick these people with unsafe or safety-compromising behaviors.

In other words, their presence triggered the very opposite effect from that intended. Yet another client has introduced a similar set of providers to fulfil a similar set of requirements with their operators but without relieving their front-line managers of their accountability for safety.

Within 9 months of this action occurring we noticed political dynamics at work in some operator teams along with confusion among the front-line managers as to what exactly they were responsible for.

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.

What we now know more clearly:- We would add two other key types of resources:-

> Deep aligned explicit commitment to make safety the top priority in resourcing and decision-making by all line and functional managers at

Dick Knowles

the top of the organization.

> The induction, training and management of personnel by the company's own employees: we have learned that you cannot outsource safety.

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 on the experience of Dick Knowles at the DuPont plant in Belle, West Virginia. Bradley simply added a front end to the model (related to "no development" at all) and made the curve 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 it is possible to run these in parallel and this has been the basis of the work we did together originally in CSR throughout Australia. It still continues to be the basis of the work we are doing with companies in the resources, transport 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

The late Ralph Stacey split problems we face into a number of categories based on the degree of predictability associated with known solutions to the problem and the degree to which all the players agree as to the nature of the problem.

We knew 10 years ago that, in terms of Stacey's diagram, work on improving safety is most successful when it is 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.

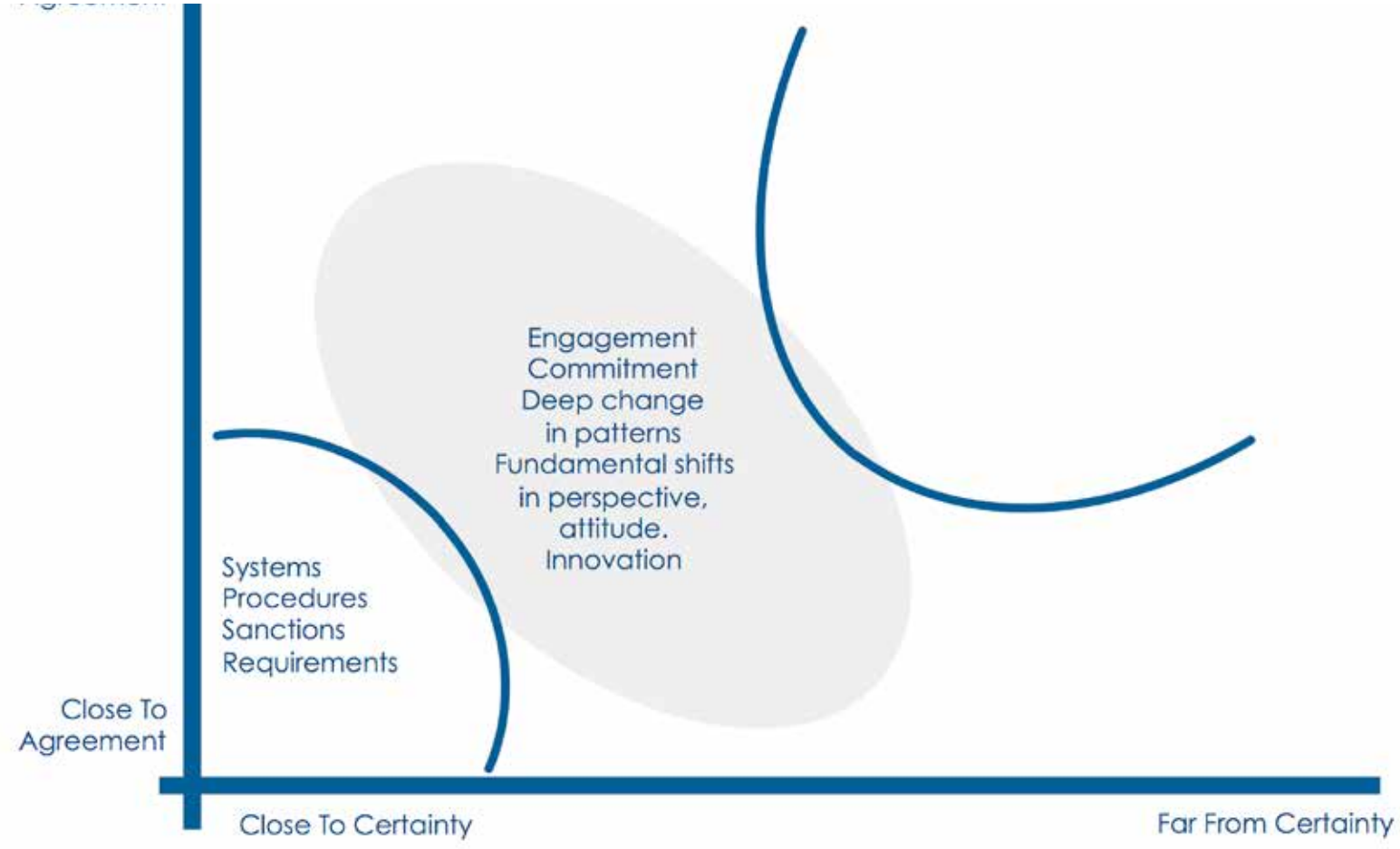
This necessarily means effective supervision, the clear involvement of middle management, visible senior leader support, along with a motivated workforce supported by positive and flexible management systems, procedures and processes.

It also means changing the nature of relationships in the workplace 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.

What we now know more clearly:- These two modes of thought do not necessarily sit side by side that comfortably in many organizations, especially those with a high engineering orientation. Equally, some smaller education and health related clients with which we have worked in the last decade find it hard to focus on mandated standards, protocols and systems.

It is not a case of "either or" but really of "both and". Bitter experience in the last 10 years has demonstrated the vital need to work not only on the systems, processes protocols and equipment but also on the underlying social fabric. Without this, any improvement in safety performance is temporary. The system quickly reverts to the way it "was" and injuries start to climb back up.

In some cases, there is a mountain of work to be done on the basic systems, processes, protocols, equipment and adherence to standards that those working on these get focused so much on these things that they lose sight of how fragile this work will be without the social fabric that must underpin it.



In other words, a journey that does not include improving the social and emotional relationships among intact work teams. Dick Knowles demonstrated this at a basic level in the Du Pont safety journey he created, but in the last decade we have come to appreciate how intentional intervention to achieve this both speeds up the safety journey and at the same time makes the improvement sustainable.

We have also learned in the last decade that just how impossible it is to leave out senior and middle management in any safety change initiative yet still expect success. This really is one thing where their prior engagement and enrolment in the anticipated improvements becomes pivotal to sustaining the change.

Authentic conversations

Safety improvement interventions must find expression at the "shop floor", 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 monthly "strategic and powerful" conversations sit on top of daily conversations at a much more operational level, e.g, pre task hazard identification, 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, consistently without fear or favor.

What we now know more clearly:- This is enhanced by establishing explicit social contracts within teams. These contracts themselves become powerful vehicles for sustained safety improvement within intact teams. Moreover, the operating teams are then held accountable at a site level for the monthly reviews of how well they are living up to their contracts. .

Piecemeal does not work

Our experience suggests that this work will fall if it is done piecemeal. By piecemeal, we mean not so much in terms of "chunks" of 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 is sufficient.

What is far more effective is where the client forms a partnership with one provider 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 and importantly linking to and building from existing company processes.

Values are key to context

Over the last decade, we have come to see just how important context setting is to effective change management. Nowhere is this more so than when trying to impact changes in safety and safety related behaviors.

So much research on what makes for successful organizations tends to focus on the importance of shared values. The more successful the organization the fewer espoused values they will have and the more focus there will be in the language used to describe them.

We have come to understand that all individual and group behavior is both informed and filtered through tacit and explicit values people possess. Moreover, in every collection of humans there are two types of values – those we espouse and those we actually live by. Closing this gap is key to performance.

Much shared identify arises from ritual and ritualism, i.e. repetitive and symbolic behaviors in groups that express those things the group holds as important. This is very evident in the strong loyalty that football clubs create among the followers through the weekly rituals associated with the sport. So, too, regular religious practice.

So, too, the monthly book club. When this group culture forms it is expressed in shared and espoused values.

Where these values are spoken in a way that engenders a moral purpose they will have far more impact.

For example, trying to instill changes in behavior by appealing to economic and financial benefits, or even, on one occasion, to avoiding punishment is an exercise in either high control for compliance or futility. Put simply, appealing to negative consequences will have far less impact in creating new behaviors than an appeal speaking to concern and care for the welfare of other human beings.

Clear, simple values are essential elements in forming and shifting cultures - they guide us to find a way to put into practice a whole range of principles and behaviors which ultimately, speak much louder than words. They are an expression in much more practical terms of the type of safety culture we desire.

All this is to say we have found that

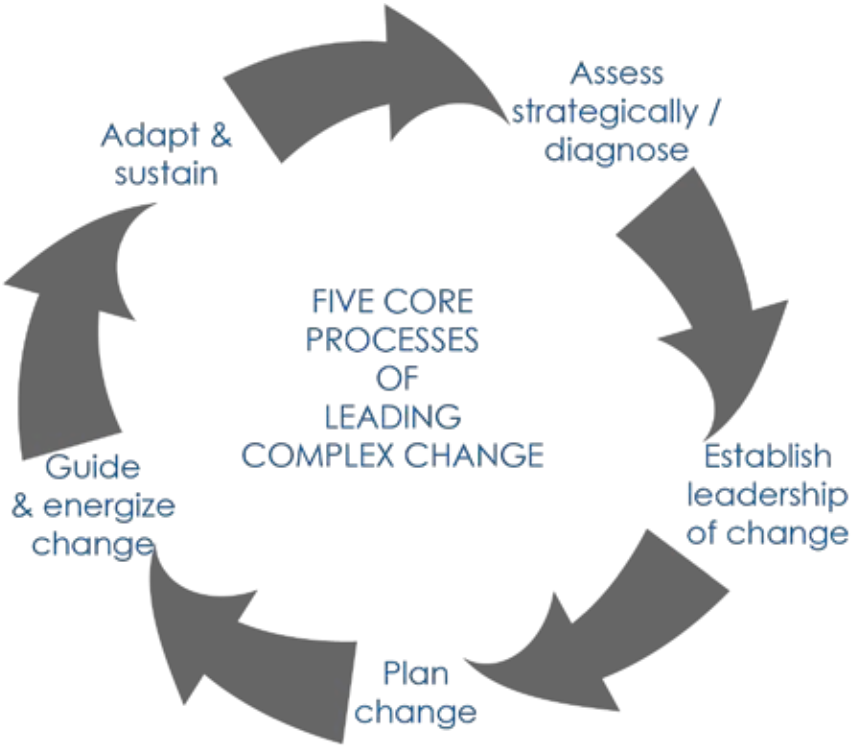
> where an organization requires all its operating teams reflect on what is important to hold dear in the light of their company's values,

> when they contract to review these and be held accountable for this review on a regular basis, then

the social fabric that arises becomes the foundation for sustained safe behaviors and zero injuries. It is at this point that operating teams have a shared strong values-based context in which to look after one another and stay safe.

This does not occur by just stating that it should be so. Or simply having a once off conversation about it. Using the separate works of both Dexter Dunphy and Patrick Hudson we can identify 6 different types of safety cultures: a shared strong

Level	Label	Style	View of Safety
1	**Rejection**	Act without regard for consequence	None. Safety – what's that?
2	**Pathological**	It does not matter what we do, as long as we do not get caught	Management really believes accidents are caused by stupidity, laziness, fear of not delivering, inattention and, even, willfulness on the part of employees. But they don't state this publicly.
3	**Reactive**	We do a big safety drive after things go wrong, and then we stop until the next time things go wrong	Safety becomes a priority after an accident. It can be a temporary stage for otherwise pathological organizations
4	**Calculative**	We have systems that can manage all hazards. We continue to work on problems that we identify.	Management both has a process and uses it. It is reasonable to run the risk of going through the motions of safety management
5	**Proactive**	We continue to work on problems that we identify.	Make the processes and systems that are now in operation truly effective and use them to anticipate safety problems before they arise. Top is still driving safety
6	**Generative**	We are constantly looking for new areas of risk and we do not take past success as a guarantee against future failure.	We are constantly looking for new areas of risk and we do not take past success as a guarantee against future failure. We all do this; we care for and hold each other accountable.



values-based context that creates injury free workplaces is Level 6.

Level 6 requires a strong localized social fabric in all operating teams and among all middle management. It is our sad experience that many well-meaning organizations and leaders are in fact operating inside Levels 2 and 3, even though they say all the right things. Most seem to be operating at Level 4.

Change management

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

What we now see more clearly:- And almost all current versions of change management describe this process as cyclical as expressed in the diagram abve.

We cannot imagine and have not ever seen a successful and sustainable reduction in injuries without first enrolling the leaders, middle management and frontline supervisors in the planning and roll out of the changes, be they rational such as new equipment, processes, systems and protocols but especially in the arena of supporting social fabrics.

Surprise

It was Myron Kellner-Rogers who once said the only known consequence of organizational change is that there will be unintended consequences.

Being open to surprise and using it as an opportunity for reframing and improving approach - this has become critical to success over the last decade.

A simple 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 acknowledged the need and are working towards meeting it.

More often, surprise is a common companion when dialogue is employed as the basic process for bringing people together around issues of safety. In fact, some would suggest it's a necessary companion. Real breakthroughs at any level of a change process, focused on improving safety, are far less likely to occur if debate, discussion, or conversation are the primary mechanisms of engagement.

The origins of the word dialogue lie in ancient Greek language and infer the finding of common meaning. When we look back on the successful implementation of significant safety improvements, they invariably involve, the use of dialogue and an openness to surprise.

Major elements

The key elements are more or less predictable. Although they have been called many different names by different groups they generally describe

1. A conversation for delineating outcomes, commitment, understanding, expectation setting and scoping by an executive leadership cohort and involving the CE 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, i.e. senior managers and first line supervisors

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, equipment changes and always: 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 starting with executives, then middle management, then front line supervisors and finally operators. 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 program focused on critical controls and the reliable management of fatality risk, often it seems derived from the work of James Reason and others.

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 are probably obvious, but worth stating:-

1. This can't be done without strong visible belief-based leadership from the very top down through executives, middle management to front line supervisors.

2. This leadership must be displayed in a consistent manner from the very top down.

3. This leadership can and must take various forms at different levels, including very diligent operational leadership that holds clear accountability for minimum behavioral and operational standards, systems and processes.

4. It is much harder to achieve in a geographically dispersed organization designed within a matrix paradigm for the alignment among line and functions is more difficult.

5. Setting minimum non-negotiable standards and supporting them with the appropriate consequential management is mandatory.

6. Engagement at every level is key. and must involve senior managers and front line supervisors for enrolment

7. Piecemeal is a waste of time, money, effort and, sadly, goodwill.

8. Sustained change will not occur without engaging, at some stage and through a regular persistent repetitive process, every single employee.

9. Dramatic short-term improvement is easy if you attack only one aspect. However, dramatic and sustained improvement needs a whole of system process.

10. It should be led, driven and deployed by internal personnel wherever possible.

11. This is not, in fact, equivalent to turning a battleship: 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.

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

Epilogue

We have been relatively light on the use of the word culture. This is worth a closing comment. Most times, when people talk of culture, organizational culture and safety culture, 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. We have described an appropriate cultural paradigm in Level 6 on Page 12.

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, not an input to be manipulated directly, if for no other reason that so many elements of 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 fabric development. When attacked in a whole of system manner, then dramatic and sustained business integrated change is possible, and this produces a strong safety culture.

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