

Getting Senior Management to Invest in Changing Safety Culture

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Introduction

Many organizations struggle to get senior management actively involved and visibly committed in supporting safety excellence efforts. Over the years we have developed a one-day executive roundtable training and engagement seminar designed to address the problems and deliver solutions to this frequent and important safety shortfall. This paper outlines the approach that has been successful across many industries in multiple countries. The problems, data, and proposed solutions are the result of personal observations by the author and the safety culture improvement organization he works with. They are based on practical experience with a healthy dose of detailed foundational academic research that was performed by the late safety pioneer, Dr. Dan Petersen. As an example of this, Dan Petersen's Six Criteria of Safety Excellence tell us that senior management's *visible* commitment and middle management's *active* involvement in safety are critical criteria to safety culture performance excellence.

Problems

There are at least three common problems around gaining and engaging the upper management support necessary to achieve significant safety initiatives:

1. Unreliable, non-robust, dated approaches that are not integrated with current management techniques;
2. Lack of executive knowledge about safety culture realities, including how to lead; and effectively engage in order to achieve an excellent safety culture; and
3. Inadequate, meaningless, non-proactive safety metrics.

Unreliable, Non-robust, Dated Approaches

The Regulations. For more than 40 years, safety efforts have predominately focused on fulfilling government mandated safety regulations. This approach is mostly related to conditions in the workplace and almost entirely reactive. In contrast, upper management generally looks for proactive approaches that:

- Don't wait for a problem to occur
- Go beyond the plethora of government promulgations
- Focus on actions that both cause incidents and solve them *permanently*

They recognize that the “One Trick Pony” of government regulations is at best a very weak safety culture approach. They know it will not get them anywhere near zero. This “level 1” regulatory approach provides a satisfactory “check in the box” to weak management. Upper management teams that are committed to zero will reject this dated, level 1 approach as ineffective and look to find better solutions.

Observation Programs. While being a good addition to an outdated regulations-only approach, the ever popular “catch-and-correct” programs that teach line employees to observe and report:

- Do not deliver zero
- Tend to abdicate management of leadership responsibility
- Are not easily integrated into other management functions throughout the organization

However, if implemented as a part of a robust system that includes proper accountability and training, they can become a valuable element of the safety toolbox. This “level 2” tool is often viewed as:

- A stumbling block by hourly employees that both react to peer pressure and desire active upper management participation. Checking off forms and tracking (often) questionable data inspires neither the hourly employee nor upper management.
- A quick safety awareness improvement tool that unfortunately also quickly becomes both ineffective and an expensive non-value-added frill.
- A reactive approach that is both foreign to and lacks credibility with executives. No where else in the many decades of operations excellence is such a “check on (rat on) your fellow worker” approach used.

Non-aligned Safety Managers: The main safety resource for many organizations often has difficulty gaining credibility with upper management. The safety manager’s training and experience typically has little to do with operations. Additionally, they are often viewed both negatively and as being in opposition to operations, “a group that is focused on ways to shut down operations for alleged infractions.” There are some other strikes that frequently exist with the safety manager position:

- A level 1 and level 2 tool set that is almost totally reactive and is often viewed as of questionable value by operations personnel
- A safety culture that stands alone and does not participate or integrate well with the operation’s culture
- Presentation, training, and/or communication skills that are generally viewed as weak
- Neither a credible safety excellence vision nor a credible way of achieving it

Lack of Executive Knowledge about Safety Culture Realities

It is not that management is “clueless;” it is just that all their background and training has had little focus on what is effective in solving safety culture issues. In other words, “They don’t know what they don’t know.” This is an educational problem. If given understandable, credible

training in safety culture excellence, they should be able to perform well, just like they do in their performance-oriented operations culture. Their hearts are almost always right when it comes to safety; no one really wants to have employees injured or at risk. Common problems of upper management with respect to improving safety culture include:

- Minimal understanding of safety culture realities beyond the regulations
- Low level of inspiration to do anything about an issue they know so little about
- Little credible visibility to line personnel/employees with respect to safety
- A lack of proactive safety metrics that measure what we want to accomplish, rather than just tracking things we don't want to occur (injuries)

All these above-mentioned problems lead to safety frequently being viewed as a “bolt on.” Safety becomes what is done after the cost, quality and customer service demands of the operation's culture have been addressed. These issues act together to keep safety outside the inner circle of leadership, excluding safety from becoming an integral part of the core of the organization's key values.

Solving These Problems

We have worked across many industries in numerous countries. The above-explained problems associated with achieving meaningful upper management engagement in improving safety are often laid to rest by educating and motivating these same executive leaders and managers. The highly participative and practical, *full day* training described below is what we currently use to motivate a change from management's weak safety paradigms into a strong safety commitment with viable, appropriate engagement. The training is as described below.

Engaging the Organization in Developing and Leading a Zero-Incident Process

Inspiration: Are other companies successful in getting to zero? What have they done? How were hourly and salaried personnel engaged in the process? What were some of their moments of clarity? What is their story, and how do they share it with their total organization? A short (10 minute or so) video from a compilation of various organizations that have successfully developed a zero-incident performance safety culture is shown and discussed. A commitment to achieving excellence begins to bud.

What is Important to Your Organization: Executives tend to judge their commitment to safety by their heart and intentions. Nobody in the senior ranks is interested in employees getting hurt. However, employees judge what is *really* important by what they *see* happen to themselves every day. Employees often say their boss talks to them multiple times daily about production, quality and customer service. Discussions about safety are often not very detailed, infrequent, and lacking intensity when compared to similar production talks. Safety is mostly focused on, “Did we have any accidents?” (i.e., negatives). Employees can't see your heart or your intentions. They need to see positive, sincere, frequent actions that match, or exceed, production and quality discussions. Most of the time it's not that the executives won't engage; they just don't know how, when, and where to do so.

Safety Culture Models that Resonate with the Executive: A number of practical models are presented and discussed in a participative, roundtable format. Many of the models have diagnostic exercises that drive home the messages of the safety culture realities that are shown.

- **The Accident Reaction Cycle:** Why do we always seem to go back to “business as usual?” How can we get out of the “rats in a squirrel cage” approach to addressing safety incidents?
- **What Causes Injuries:** Incidents predominately result from unsafe acts, not unsafe conditions. With all the focus on the regulations, why does this keep happening? The discussion centers on the realities of workplace norms and cultures, and the fact that both line personnel and executive personnel have at fault “skin” in this deadly game. It is rarely the sole “fault” of the hourly person who gets hurt or their supervisor. What are some “indicators of impending doom” that are common to your organization?
- **The Six Criteria of Safety Excellence:** Safety pioneer Dr. Dan Petersen’s 50+ years of industrial experience boils down to six fundamental criteria. There is a diagnostic as to the organization’s safety maturity as measured against this superb practical standard of excellence
- **Six Levels of Safety Performance:** A practical model that takes the organization from a fundamental safety regulations approach all the way through to an organization that is passionately engaged in leading the relentless pursuit of a zero-incident safety culture
- **The Safety Culture Diagnostic:** This is another excellent safety tool developed by Dr. Dan Petersen. The result of his team’s 10-year study delivered a statistically validated diagnostic of an organization’s true safety culture. What is “between the ears” of all levels of your organization’s personnel when it comes to safety (“the good, the bad and the ugly”)? This baseline reality enables a focused, in-depth approach to safety culture improvement
- **Continuous Improvement Teams in Safety:** The quality revolution started by Dr. W. Edwards Deming relied on hourly and salaried personnel working together to solve the many problems that continue to occur in industrial work cells. This same approach is somewhat modified, explained and practiced by roundtable participants
- **Safety Accountability:** Personal accountabilities are fundamental to performance excellence in sports, professions and personal lives. This same type of day-to-day, excellent activity accountability is required if you are to achieve a zero-incident safety culture
- **Zero Incident Performance (ZIP):** The organizations that achieve excellence in quality and productivity cultures all have a “Plan-Do-Check-Act” type of model that keeps them focused on a relentless pursuit of zero errors. This zero mindset, as well as the energy to engage and achieve it, has a parallel in safety, the ZIP process. Our ZIP model has the following steps:
 - **Engage** upper management with this educational safety culture roundtable
 - **Assess** the true state of the safety culture with viable diagnostics
 - **Build** the improvement plan based on the safety culture diagnostic data

- **Develop** the needed safety process solutions and personnel resources with cross-organizational continuous improvement teams
- **Implement** these new processes and solutions after a pilot trial has occurred
- **Check** the implemented solutions with activity-based audits and recheck the culture periodically with a valid safety perception survey

Conclusion

Getting senior management to invest in changing an organization's safety culture begins with the education necessary for them to understand what needs to occur and what "skin they have in this game." The executive education roundtable is also designed to:

- **Create dissatisfaction** and, in so doing, power an initiative to relentlessly pursue a zero incident safety culture.
- **Inspire the participants** to "go forth and conquer" with a tool set and approach that fits an operations' culture mindset.
- **Begin the process** of achieving zero in all that they do. In other words:
 - **Begin the initiative.**
 - **Form a continuous improvement team.**
 - **Live your principles.**