# The Zero-Harm Organization: Shifting Focus from Injuries to Exposures

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#### Introduction

Most companies today have decided that getting to zero-harm is the only acceptable goal. This goal represents a new paradigm in terms of both safety and values for much of the world. The problem is that despite a new goal, many organizations continue to apply the same thinking to their safety efforts. Not surprisingly, where this is the case the results show no significant difference in performance.

Realizing any new goal requires systems, strategies, and practices that support it. Fundamentally, this means aligning our focus so that we deploy our resources effectively. In safety, the focus has long been on injuries. In this old paradigm, accidents are the trigger for action and the measure of change. Yet, if we examine the meaning of "zero-harm," we find that this focus is incompatible with the goal of doing no harm. It is simply too reactive to provide a helpful guide to our decisions and actions.

This paper reviews the zero-harm goal and proposes a new measure for safety change: exposures.

### **New Goal, New Focus**

Companies serious about safety performance often talk about the zero-harm culture. These simple words carry a lot of weight and importance. Indeed, it is hard to know how an organization could espouse any different vision of safety. Yet, saying that you want to be "zero-harm" is not the same as actually moving to this level of performance. For one thing, what do we mean by zero-harm? Is such a thing even possible? The zero-harm goal cannot be simply an extension of injury reduction goals of the past (e.g., "We have achieved 1.0, now let's aim for 0.5"). There are too many examples of organizations with low injury rates that continue to have fatalities, recordkeeping violations, and so on. But if zero-harm is not simply a quantitative goal, what else is it?

In practical terms, it is not useful to define "zero-harm" as "zero injuries," a focus of going forever injury-free is too hard a concept for most people to support or stand behind. Instead, a more useful (and hence achievable) definition might be that a zero-harm organization is "an environment where injuries are not acceptable and where we do everything possible to prevent them." The focus is continuous, sustainable improvement. A zero-harm culture, then, could be said to be present whenever an organization is saying and doing things such that they go increasingly longer periods without an injury. For example, an organization going 45 days without an injury, sets their next milestone to go past 45 days. In these cultures, leaders would communicate a reasonable standard in which people could see the logic, and would generate alignment around these goals throughout the organization.

By this definition, getting to a zero-harm culture is less about the number of injuries or the injury frequency rate than it is about creating organizational functioning consistent with safety excellence. In other words, we are not just targeting a lower number—we are aiming to develop a new way of thinking about safety performance.

### The Injury Focus Fallacy

Given that the zero-harm goal is to do everything possible to prevent an injury, the traditional focus on injuries as the measure of performance and the trigger for change is not sufficient. Injury statistics are too imprecise and too reactive (there is no -1 in injury rates, for example). But there is another reason why zero-harm organizations move their attention further upstream from safety outcomes: an injury focus can lull us into a false sense of security.

The injury focus promotes the fallacy that we can predict with certainty what will (or will not) result in an injury. Because of this thinking, many organizations leave individual employees, supervisors, managers, and senior leaders to "risk assess" their own decisions and actions. The reality is that none of us can truly determine whether or not a decision we've made will lead to an injury. Consider:

- A person who decides to stand on the pump motor to reach a valve.
- A supervisor who allows work to proceed even when the ground is iced over.
- A manager who puts off the repair due to budget constraints.
- A senior leader who decides to miss the company safety summit when it conflicts with another meeting.

Each person is making an assessment of the consequences of his or her actions and betting that no injury will result. The problem is that each person is at the same time allowing exposure, to themselves or someone else, to rise above acceptable levels. As a result, the policies, procedures, best practices, and rules that establish acceptable levels of exposure are routinely ignored or overridden. Every time this happens, the outcome is no better than a roll of the dice.

In almost any incident investigation you will find somewhere in the chain of events a slippage that increased the exposure from known standards. Ask any injured employee (or his supervisor) two simple questions:

- 1. Did you think you or someone else was going to be injured just before you proceeded?
- 2. Did you recognize the exposure was rising?

The answer to the first question will almost always be no; the answer to the second will almost always be yes.

Consider a real life example. Three employees go out to change the medium in a filter. The filter is 15 feet above ground level and not equipped with a work platform. The workers get an impact wrench and a bucket lift to get to the top of the filter. The studs holding the lid on the filter are so corroded, however, that the impact wrench is not strong enough to remove them. So the workers get down and get permission from their supervisor to retrieve a hammer wrench and hammer from the tool room. The supervisor grants the request, telling them to be careful. The workers again use the lift to go back to the top of the filter. Given the need for operating room, not that a hammer is involved, one worker remains below. One worker fastens the wrench on the first nut while the other one swings the sledge hammer, contacting the striking surface of the wrench. The wrench slips from his grip, hits the edge of the bucket, and strikes the third worker standing below on the hand, breaking several bones. When asked about the incident later, the employees agreed that the exposure went up when they made the switch. When asked why they decided to proceed regardless, the answer was not production pressure, but that they did not think the exposure had elevated enough to cause an injury.

The truth is, there is exposure around us at all times. Simply choosing to get out of bed in the morning increases your immediate exposure. The goal for organizations is not a "pie in the sky" world of zero exposure. It is simply managing exposure to the standards the organization *has already set* with its rules, procedure, policies, best practices, and training. Doing this requires a change in mindset in individuals and in the culture itself.

## The Exposure Focus in Practice

Doing everything possible to prevent an injury requires that we shift our focus further upstream to exposure. An exposure focus simply means we are oriented towards finding the potential for injury on the shop floor, and examining the systems, procedures, and decision-making that influence the quality and effectiveness of safety systems. An exposure focus requires leaders to take a long-term view of decisions, and it forces us to think creatively about what safety improvement really means. In practice, zero-harm organizations:

#### Manage Exposure to Existing Standards

Operationally, the exposure focus is active when people at every level re-think any decision that increases risk. Zero-harm organizations don't rely on individual guesswork to determine if a risk is likely to result in injury. Instead they work on developing individual and organizational fluency in the recognition of, and response to, exposure changes. It means asking people to act despite their belief that an injury will not occur—for example, halting the work, authorizing the repair, stopping the crew, or missing the corporate meeting for a safety summit. This change often implies a significant shift in culture.

#### Use Potential to Determine the Depth of Investigation

Ask yourself, what determines the level of investigation here? In many cases the answer is the seriousness of injury, often a result of luck. Organizations serious about zero-harm are thirsty for information about near misses and first aid events. They use the likely potential of an event to determine the depth of the investigation.

#### Get Away From "One-Size-Fits-All" Safety Systems

Zero-harm organizations recognize that not all exposure represents the same level of potential and design systems for measurement and control accordingly. One of the worst things that can happen to an organization is to achieve a very low injury rate, then to have a serious injury or fatality because the related exposure reduction systems have become lax or have been eliminated entirely. For the limited number of exposures that can likely lead to a life-altering injury or fatality, exposures need to be well managed. They need mechanisms in place to measure for variation, and to document the cause of the variation and the actions taken. Leadership in particular needs to keep a steady focus on high potential events while moving the organization to longer and longer periods of injury-free experience. They do this by routinely monitoring indicators related to these exposures at the working interface or measures related to their process safety management systems.

#### Consider Exposure in Business Decisions

Leaders of zero-harm organizations take a long-term view of their decisions and how they influence exposure. This is no easy practice, particularly at first. The higher in the organization one goes, the harder it is for leaders to see how their actions or inactions directly contribute to exposure at the working interface. Yet, they influence exposure all the time. Consider some common leadership decisions:

- To cut costs, an organization eliminates all shift supervisors, leaving a day foreman as the point of contact for the shift employees.
- An operations vice president position is filled by a leader from the plant with the worst EHS performance but is known for "getting the product out."
- A decision is made to stop lock-out/tag-out verification audits by the supervisors because they are too busy with other paperwork and need to be in their office more.
- A senior leader decides not to communicate the five-year plan, which will include consolidation, plant closures, and acquisitions, to the workforce. Instead employees will hear information as it is released or leaked out.

These four scenarios are common organizational events. They all also state explicitly or implicitly what the organization really values. Leaders with an exposure focus are sensitive to how their decisions influence exposure, and affect the decisions and actions of others in the organization.

#### The Role of Culture

In most organizations, an employee who stops a job because an injury is clearly imminent can be sure of organizational support. In an exposure-focused organization, however, we are asking

people to take action when the outcome may be more ambiguous. We want a person to act not just when an injury is imminent, but anytime they recognize "exposure creep"—a change that increases exposure to themselves or someone else. In many cases the change may not even seem likely to cause an injury at all.

Whether or not employees, at any level, take us at our word and respond to that exposure is dependent on the relationship they have with the organization, its leaders and each other—and what they see as valued and rewarded. It is sometimes defined as the "2 AM test;" that is, what happens at 2 o'clock in the morning when no one is around, the consultants are long gone, and the managers have all gone home. Even if no one will know, do employees follow procedures and guidelines because it is the right thing to do?

In simple terms, culture just means the long-term shared values and beliefs of an organization, commonly described as "the way we do things here" or the "unwritten rules." Climate, on the other hand, describes the prevailing, but shorter term, influences on a particular area of functioning (such as safety or quality) at a point in time. There are several culture dimensions critical to high performance in safety, and they can be grouped into team, safety-specific, and organizational dimensions. Of these, the scales belonging to the organizational dimension are the most elemental to the changes required for zero-harm performance. Employee attitudes toward change depend in part on their perceptions of basic aspects of organizational life; for instance, how employees are treated by their supervisor. These variables are also situational and are directly influenced by leadership behavior:

- **Procedural Justice:** Reflects the extent to which the individual perceives fairness in the supervisor's decision-making process. Leaders enhance perceptions of procedural justice when they make decisions characterized by consistency across persons and time, lack of bias, accuracy (decisions are based on good information and informed opinion), correctability (decisions can be appealed), respresentativeness (the procedure reflects the concerns, values and outlook of those affected), and ethicality.
- Leader-Member Exchange: Reflects the relationship the employee has with his or her supervisor. In particular, this scale measures the employee's level of confidence that his supervisor will go to bat for him and look out for his interests. Leaders can enhance perceptions of leader-member exchange by developing positive working relationships with their reports and getting each person to see how achieving organizational goals can be fulfilling both to the leader and to the employee.
- Management Credibility: Reflects the perception of the employee that what management
  says is consistent with what management does. Leader behaviors that influence perceptions of
  trustworthiness include consistency, integrity (telling the truth, keeping promises), sharing
  control in decision-making and through delegation, communication, and benevolence
  (demonstration of concern).
- Perceived Organizational Support: Describes the perception of employees that the
  organization cares about them, values them, and supports them. The extent to which
  employees believe the organization is concerned with their needs and interests strongly
  influences their likelihood that they will "go the extra mile." Leaders can demonstrate
  organizational support by effecting and communicating efforts that go well beyond what is
  required.

These factors contribute to an environment that more readily accepts and promotes the change required for developing an exposure focus and zero harm performance. When an employee is treated with dignity and respect and offered support by his or her supervisor, the employee tends to reciprocate: job performance, extra-role behavior, and loyalty tend to increase. On the other hand, the worker who feels demeaned or disrespected is much less likely to engage fully in the work.

## **Getting to Zero**

If zero-harm performance is to be a reality, not just a nice idea, organizations need to understand what their target means in real terms. The zero-harm organization is concerned with doing everything possible to prevent injuries and creating an ethos where safety is the driving value. An exposure focus allows us to move away from always chasing injuries; we can get out of the trap of looking in the rearview mirror and focusing on where we have been rather than where we want to go. An exposure focus also helps us create consistency in leadership. Rather than waiting until there is "blood on the floor," leaders take action when on the potential of an event.

Asking people to act and think in new ways, particularly around safety, is often a deep paradigm shift. But with persistent attention from leadership, such a change is possible—and richly rewarding.