Achieving a 100% Employee-Committed Safety Culture: Strategies and Activities

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Introduction

At the ASSE Safety 2011 Professional Development conference we had the honor of presenting Shaw Industries, Inc. Fibers Division's cultural development strategy, tactics and techniques in a presentation entitled **Achieving a 100% Employee Committed Safety Culture**. This presentation encompassed the work of the division during the first two years of its cultural evolution.

This year's presentation will present a summary of the 2011 presentation, an update of the activities conducted since the 2011 presentation, and the results observed, as well as practical, implementation-ready activities and techniques we have found to be effective in evolving an Actively Caring[1], Inclusive, Employee engaged Safety Culture.

Before proceeding we must give thanks to Dr. E. Scott Geller, Director of the Virginia Tech Center for Applied Behavior Systems (CABS) and the research students that comprise CABS for their mentoring and contribution to our journey, along with Mr. Bob Veazie for starting us on this path with his and Dr. Geller's vision, work, and mentorship.

Getting Started

Historically, the Fibers Division of Shaw Industries, Inc. had sent several members of the Behavior Based Safety (BBS) Steering Committee at each of seven plants making up the division to a national BBS conference. The Director of the division realized that a few were gaining access to information at a large expense and that several could be gaining access to information if the division hosted its own BBS conference with this money. The first conference was held in 2008. The conference has continued to be sponsored annually since, and has experienced a steady annual increase in participation. The 2011 conference had 120 attendees from Shaw Industries, Inc. Corporate, the seven fibers plants and other invited guests and speakers.

The guest speaker at the 2009 conference was Bob Veazie co –author with Dr. Geller of The Courage Factor [2]. The presentation delivered resonated with the conference audience so well that an "on the spot" change to the conference agenda was made and Bob spoke most of the day.

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[1] Geller The Psychology of Safety Chilton Books 1996
[2] Geller, Veazie The Courage Factor, Coastal Training Technologies 2009

A copy of The Courage Factor along with a hand written note from the division director was given to each conference attendee. Thus started Shaw Industries, Inc. Fibers Division Actively Caring cultural journey and the work of developing a 100% committed work force.

The foundation of commitment is anchored on the creation of a high personal associate perception of the 5 Personal Factors[3] (Exhibit 1).
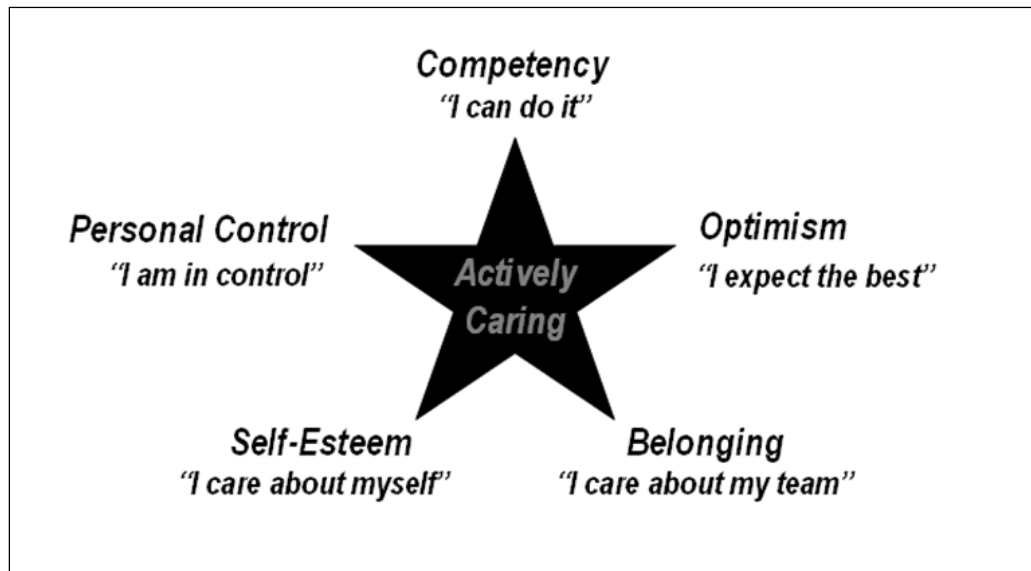

Exhibit 1.

In Dr. Geller's work he refers to the point of the star labeled Competency in Exhibit 1 as self-efficacy. Fearing that the general work force could not relate to this term we labeled this factor competency. Self Efficacy refers to an individual's belief that using their current skills and competencies they can positively influence an outcome aligned with the common good.

If an individual has a high perception of each of the 5 Personal Factors they will have a greater propensity to be committed and have the personal courage to become involved in recognizing and providing feedback regarding unsafe equipment and behavior. We will discuss courage later in this paper.

As the term Actively Caring became a more familiar term in the division's cultural vocabulary it became apparent that the workforce (salaried and hourly associates) wanted more understanding of Actively Caring. During the summer of 2009 Bob Veazie was contracted to visit each of the 7 Fibers Division plants and hold 2 hour training sessions with as many plant employees as possible (approx. 70% of the employee population attended the others saw the presentation via taped broadcast) to explain Actively Caring, its concepts and safety implications. From this initiative two keystone techniques for developing and assessing cultural development were identified:

- All members of the organization being encouraged to have the personal courage to get involved when observing an unsafe act and later telling the story of that communication and involvement. The lessons in leadership, communication and

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[3] Geller The Psychology of Safety Chilton Books 1996

safety observation that these "Moment of Courage aka Actively Caring" stories have been fundamental to cultural evolution. (see example, Exhibit 2),

- Utilizing a simple Likert Scale base survey to assess associates personal perception of the 5 personal factors and associated attributes of employee inclusion (see first survey used, Exhibit 3).

MOMENT OF COURAGE

While working with another technician who was trying to jack out a spindle.
I notice that the jack was at an unsafe angle.

I suggested that he put something under the jack to level it out and remove the front panel (plate).
He tried it.
His response was "Thank You"

Cynthia Crawford
Twisting C shift
Shaw Plant #78

Exhibit 2.

During these presentations a quick 8-question Likert scale based survey was introduced (Exhibit 3) that participants anonymously completed on scratch paper. Spur of the moment these survey results were tallied and site averages for all sites was compared to site injury rates, this exercise lead us to a suspicion that a correlation between employee perception and injury rates existed (Exhibit 4).

	Question	Description – Score 1	Description – Score 10
1	I am heard	I never get feedback on my ideas	I always get feedback on my ideas
2	My ideas contribute to the business	I can't make a difference	What I think makes a big difference
3	I belong here	I cannot stand coming to work	I love coming to work
4	I receive recognition	I never receive any recognition	Recognition is excellent
5	I am competent at my job	I do not know hat I am doing	I am very capable at my job
6	I am learning	I am not learning anything	I learn something new everyday
7	I have control in how my job is done	I have no control in how my job is done	I have control in how my job is done and I follow policies and procedures
8	I serve others	I never get involved when I see someone in danger	I always get involved and help/talk to the person I see in danger

Exhibit 3.

Plant	Ave Survey Score	Medicals
1	6.062	6
2	6.8	1
3	6.075	8
4	6.6625	5
5	6.90	1
6	6.8125	2
7	6.275	22

Exhibit 4.

When examining the data presented in Exhibit 4. it was realized that Plant 7 employs 1500 associates and collectively had a mean survey score using the questions contained in Exhibit 3 of 6.3 with 22 recordable injuries year to date, while plants 2,5 and 6 employ 1500 associates collectively have a higher average survey score and had 4 recordable injuries year to date.

Organizing to Continuously Improve
Toward an Actively Caring Culture

These observations led to agreement that cultural evolution was desired by management and associates. Division Directors, Plant Managers and corporate representatives from the Risk Management and Training departments came together to create a business plan of how to sponsor the evolution of an Actively Caring Culture.   The Fibers Division purposefully called this an evolution of culture to let it be known that we were all evolving towards continuous improvement of the current culture, not a radically new culture.

The agenda and outcomes of this meeting included:
- Brainstorming the question
  - "*What skill development and management expectations are needed to close the gap between the proposed Actively Caring Safety Culture Vision and what employees have said via the 8 Question Survey?*"
- Affinity Diagramming of responses
- Prioritization of topics resulting from this Affinity Diagram
- Establishment of a Fibers Division Actively Steering Committee (all members who attended this meeting plus site HR Manager)
- Establishment of four work teams representing the top 4 topics identified during the aforementioned prioritization exercise
  - Communications (how we communicate)
  - Training (skills and competency)
  - Recognition
  - Survey (associates personal perception of culture)
- Agreement to begin randomly and anonymously survey 10% of the population at each plant each month to monitor culture on an ongoing basis.

The four teams began to meet and Steering Committee meetings were held monthly with reports of activities and results from individual plants and work teams comprising each meeting agenda. The Division Actively Caring Steering Committee continues to meet periodically to network, share the work of each sites 4 teams and learn form each others successes and challenges.

Creating, Communicating and Committing to a Vision

As part of evolving the culture, a division Vision Statement was drafted. The Vision Statement was reviewed, revised and adopted by the division and site committees. This Vision Statement is shown as Exhibit 5
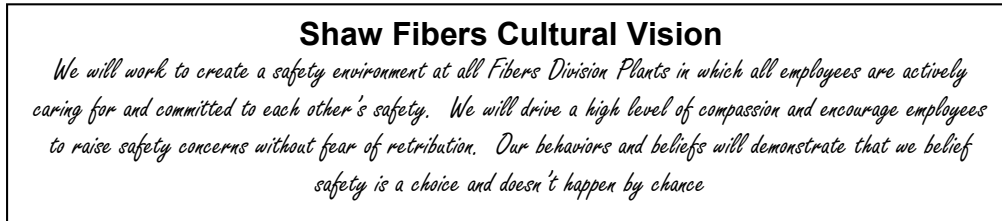
> **Shaw Fibers Cultural Vision**
>
> *We will work to create a safety environment at all Fibers Division Plants in which all employees are actively caring for and committed to each other's safety. We will drive a high level of compassion and encourage employees to raise safety concerns without fear of retribution. Our behaviors and beliefs will demonstrate that we belief safety is a choice and doesn't happen by chance*

Exhibit 5.

Some Fibers Manufacturing sites had this Vision printed on large banners. The sites then placed the banners at the plant entrance with a supply of markers and communicated to employees that if they were committed to the vision to please sign the banner. These signed banners are displayed within the plant as a reminder of these commitments. One of the signed banners is shown as Exhibit 6.
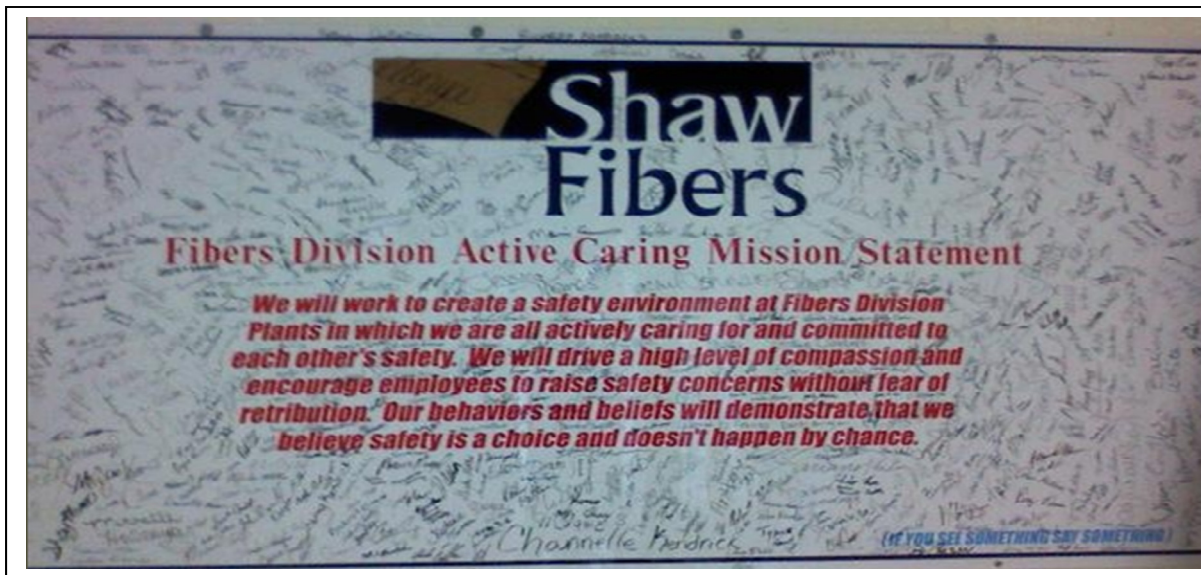

Exhibit 6.

A letter was sent to each Fibers Division associates home introducing the Vision Statement to them and their families. Only one of seven sites provided negative feedback regarding this communication technique. The letter is shown as Exhibit 7.

Exhibit 7.

Using Focus Groups to Better Understand the Survey Results

During the spring of 2010, desiring to better understand what associates were telling the organization via the monthly survey results, two recent psychology graduates and members of CABS at Virginia tech were hired as interns to conduct plant focus groups. 40% of the population at 5 of the 7 Fibers Division plants participated. The subject question of these focus groups was "What would the organization have to do for you to be able to rate each survey question 10?"

These focus groups while answering this question also identified that the survey itself had some problems. The question "I belong here" lead an ethnically diverse work force to be

confused and a ninth question added was a compound question seeking information regarding willingness to accept negative feedback and correct behavior based on feedback.

Given this information work was done with CABS to rewrite the survey questions. The rewritten survey is represented as Exhibit 8. The survey continues to utilize the Likert Scale of 1 to 10 for associate response. The subject matter of the survey questions links back to The 5 Personal Factors.

Fibers Division Actively Caring Survey
2011

1. I feel that I am heard because I get feedback on my ideas or concerns.
2. The ideas I contribute make a difference at my plant.
3. I have a sense of belonging among my work team.
4. I receive recognition for my contributions at work.
5. I am competent at my job.
6. I learn and develop knowledge and skills at work.
7. I am self motivated to do my best work at my plant site.
8. I have personal control over how safely I work each day.
9. I actively care about the safety of others at work.
10. I receive corrective feedback from my peers.
11. I willingly accept corrective feedback from my peers.
12. When I receive negative or corrective feedback, I react to improve my behavior.

Exhibit 8.

A Strong Correlation of Survey Question Response to Injury Rate

After several months of using the original survey, statistical correlations were performed between survey question results and injury results year to date. These correlations provided the division with the assurance that the work being done was related to and significant in improving safety results. These correlations are represented in Exhibit 9.

Fibers Division Correlation - OIR to Actively Caring Question 9/28/10

Plant	N	OIR	1	2	3	4	5	6	7	8	9
6	136	2.76	6.25	6.46	7.31	6.25	7.87	7.26	8.09	8.37	7.31
7	560	2.03	5.64	5.49	6.69	5.40	8.04	7.72	8.23	8.27	7.35
4	180	1.95	6.27	5.89	7.03	6.32	8.00	8.00	8.48	8.70	7.77
3	260	1.82	5.88	5.85	7.20	5.99	7.76	7.77	8.47	8.55	7.07
1	140	1.15	6.61	6.43	7.34	6.48	8.19	7.76	8.52	8.45	7.63
5	100	0.00	7.81	7.11	7.82	7.38	8.58	8.21	9.20	9.00	7.96
2	260	0.00	6.58	6.44	7.00	6.66	8.06	7.77	8.68	8.50	7.72
Correlation - OIR to Question			-0.73	-0.73	-0.39	-0.73	-0.71	-0.66	-0.88	-0.57	-0.69
R square			0.53	0.37	0.16	0.53	0.51	0.43	0.77	0.33	0.48

		Questions
1		I am heard
2		My ideas contribute to the business
3		I belong here
4		I receive recognition
5		I am competent at my job
6		I am learning
7		I have control over how safely I choose to work
8		I actively care about the safety of others
9		I accept negative feedback and take aciton to improve based on the feedback

Exhibit 9.

For more information regarding Shaw Industries, Inc. Fibers Divisions experiences in its first year of cultural evolution please refer to the Safety 2011 ASSE Professional Development Conference proceedings paper **790 Achieving an All Employee 100% - Committed Safety Culture** and or the ASSE January 2012 **Professional Safety** article **In Pursuit of an Actively-Caring Safety Culture: Practical Methods, Empirical Results, and Provocative Implications**[4]

2011 Actively Caring Culture Focus

Early on in our cultural journey we were taught and intuitively understood that the level of courage required to engage in a safety conversation with someone when they are observed behaving in an unsafe manner correlates to the closeness of the relationship between observer and observed. It requires much less courage to provide a close family member safety related feedback than it does a stranger. Many conversations in the division have identified several reasons for this phenomenon. These reasons range from "did not have time on my way to do something else" to "I knew a confrontation was going to develop and I do not need that", as reasons for not engaging in a conversation caring for and getting involved in another person's safety.

Knowing these things to be true, the Actively Caring Steering Committee has continued to ask for "Moment of Courage aka Actively Caring" Stories from associates attending meetings and continues employing techniques to collect and publish these stories for others to learn from. Whenever one of these stories is told, everyone listening receives four 1 point training lessons:
1. An example of how a safety conversation can be started.
2. What a particular task being performed in at risk manner looks like
3. What the task being done safely looks like
4. A leadership example in having the courage to Actively Care

Two interesting observations have been made from this cultural norm of telling "Moment of Courage aka "Actively Caring" Stories.
- As more and more stories are being shared stories involving seemingly minor "at risk" acts are becoming less frequent, which is concerning.
- As the norm of story telling becomes more engrained in the culture, more people are becoming involved in telling their stories of Actively Caring., This can be likened to how the Old West was settled first came the explorers and as they came back and told of their experiences and observations pioneers ventured out. Upon them returning and telling their stories and observations others realizing the risk was small also moved west, these were the settlers. Finally came the squatters, those people who realized there was little risk but much reward in a different place and culture.

It has also been observed that (even though at face value it appears a play on words) "What is talked about defines culture and culture defines what is talked about". This simple sentence continues to remind us of the importance of Actively Caring stories describing "small" events such as a shoe being untied followed by the question "I do not want you to trip on your shoelace, would you tie your shoe please?" However the phenomenon being observed is that some people believe telling stories of "small" events are unworthy of being told. Our challenge is to ensure that all associates understand the value of any intervention and ensuing story, as many injuries are

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[4] ASSE **Professional Safety** January 2012, E. Scott Geller, Joseph E. Bolduc, Matthew Foy, Joseph Dean

the result of "small" unsafe behaviors and/or conditions as interventions that on the surface required more emotional courage.

Another realization is that the First Line Supervisor is the closest link between management and associates and that they are the major source of business communication and job feedback for associates. Supervisor communication skill and competency (this emphasizes the aforementioned Self Efficacy point) and the ensuing supervisor-associate relationship will influence how an associate perceives several of the 5 Personal Factors. A high personal perception of the 5 Personal Factors has effect on the propensity of one person to have the internal courage to be committed to Actively Caring for another. Given this realization the Actively Caring Steering Committee sponsored four communications classes at each of the seven Fibers Division plants for first line supervision. An abbreviated course was held with site senior and middle management for each course to familiarize them with the skills being taught and the vernacular used to facilitate management being able to coach, mentor and audit communication skill use. The four communications skills being taught and a brief description of each are as follows:

- **Improving Results through Face to Face Communication:** A course that explores ways to improve the face to face communications that must occur in our everyday work environment and how these conversations can improve trust and bottom line results. All participants have the opportunity to practice what they have learned through a series of challenging role plays designed to reflect the material covered in the class.
- **Strength Deployment Inventory**: This course helps a leader identify his/her own leadership style and the strengths associated with that style through use of the Strength Deployment Inventory assessment. In addition, it helps the leader identify the leadership styles of others and the way to address the potential conflicts that may arise while interacting with those who have another style. The course also looks at how the various roles that a leader fulfills may actually influence that leader's style
- **Managing Conflict in Today's Workplace:** The course is built on the premise that conflict is good if it is dealt with constructively and unmanaged or ignored conflict is detrimental to our working relationships. This course helps leaders understand the dynamics of conflict through an analysis of each individual participant's conflict management style. In addition, there is discussion on what are the true root causes of conflict and how to effectively work together to manage the conflict
- **Creating Positive Discipline:** An interactive course for leaders that addresses how to conduct corrective action sessions with employees. The course focuses on five steps to addressing performance issues with a positive approach that results in gaining employee commitment to correct the behavior or performance issue. Participants complete skills practices that enable them to apply the concepts to gain hands-on experience.

It is being observed that the use of this training and the communication self-efficacy developed from training, organizational mentoring and coaching is strengthening inclusion and commitment in the culture. For 2012 and beyond the same training will be delivered to all associates in the Fibers Division. A number of internal trainers are being qualified.

2011 Results
The table below shows survey question and correlation to injury rate (2011 data) (Exhibit 10).

Average Survey Scores 2011

Plant/Question	3	7	6	5	4	1	2	R^2
1	7.05	6.18	6.36	7.73	6.73	6.68	6.90	-0.84
2	8.07	6.27	6.52	7.73	6.73	6.71	7.55	-0.82
3	7.19	7.17	7.64	8.41	7.66	8.06	7.77	-0.39
4	8.30	6.14	6.81	7.67	6.65	7.30	7.55	-0.62
5	8.30	8.49	8.50	8.99	8.52	8.45	8.50	-0.53
6	8.81	8.26	8.24	8.72	8.40	9.03	8.33	-0.01
7	8.91	9.03	8.91	9.09	9.15	9.39	8.93	-0.43
8	9.21	9.09	9.17	9.35	9.11	9.41	9.02	-0.08
9	7.60	9.31	9.18	9.20	9.32	9.49	9.16	0.31
10	8.34	6.86	7.43	8.16	7.64	7.40	7.89	-0.84
11	8.11	8.15.	8.10	8.77	8.50	8.03	8.44	-0.79
12	8.00	8.52	8.35	8.67	8.44	8.56	8.42	0.07
OIR	1.29	2.48	1.90	0.55	1.60	2.52	0.92	
Total Score	97.88	85.32	95.21	102.49	96.85	98.51	98.46	

Questions

1. I feel that I am heard because I get feedback on my ideas or concerns.
2. The ideas I contribute make a difference at my plant site.
3. I have a sense of belonging among my work team.
4. I receive recognition for my contributions at work.
5. I am competent at my job.
6. I learn and develop knowledge & skills at work.
7. I am self-motivated to do my best work at my plant site.
8. I have personal control over how safely I work each day.
9. I Actively Care about the safety of others at work.
10. I receive corrective feedback from my peers.
11. I willingly accept corrective feedback from my peers.
12. When I receive negative or corrective feedback, I react to improve my behavior

Exhibit 10.

Observations: Exhibit 10

2011 data presented in Exhibit 7 indicates that questions 1,2,10 and 11 have the highest correlation to injury rate. These correlations are all negative indicating that as the divisions population has a higher perception of each of these questions injury rate trends lower. Interpretation of the data indicates that when associates know their ideas and concerns are heard, they see their ideas make a difference along with receiving feedback and having the humility to accept corrective feedback are potential influencers of injury rate. All associates having the courage to Actively Care by giving feedback and the humility to accept that feedback are probable game changers in further evolving to an Actively Caring and committed safety culture.

Collectively the Actively Caring Steering Committee believes the largest challenge currently present is identifying the competencies, skills and support structures necessary for a first line supervisor with many reports to have the relationship with each report that is capable of empowerment, inclusion as well as gaining and sustaining the compliance and commitment of every associate they work with.

Reducing Injuries through Lean Principles and Actively Caring Shaw Industries Group, Inc. Plant 22, Thomson GA

M. Vince Shivers III – Plant Manager

Our story of injury reduction at the Thomson Plant involves changing our plant's culture over a 10 year period. The evolution was not meant to be an effort to reduce injuries only, but an effort to impact everything we set out to accomplish.

To tell the story it is helpful to describe the workforce's former culture. In a nutshell, the culture was one that needed higher trust between workforce and leadership, one where the workforce lacked voice in decisions, and one that needed a higher level of teamwork within the workforce.

It is also helpful to describe the leadership team's former approach, because this was a direct reflection on workforce culture. We had an autocratic leadership style, we were not good listeners, and we did not place a high enough emphasis on the potential and strength of our people.

The evolution also coincided with my personal development and growth as a leader; starting 13 years ago as a first time manager of a large group of people who wanted to have the final say-so in too many decisions, tried to control too much, and could have listened and communicated better. My main concern was serving my boss, who wanted the final say-so in too many decisions, tried to control too much, and did not listen or communicate well enough.

Seeing the pattern here yet? Workforce culture was a reflection of leadership team's approach; leadership team behavior was a reflection of the plant manager's approach, plant manager behavior driven by his leader's approach. What was it going to take to change the cycle?

It usually takes some significant event to drive change. It can start with a single significant event or it could be a chronic long-term bad result that you just get fed up with. For us, and luckily, our significant event did not involve someone's health or safety. It was a just a process that was in the ditch and had been in a poor state for along time. There were many causes: machines were old and poorly maintained, materials processed poorly, methods that were not adequate, manpower was frustrated and fed up dealing with it, and leaders who individually had no solution.

The collective pain experienced by all in the organization forced us to come together and rely more on each other. We began better communicating the need to do things differently. We began listening more closely to each others ideas, especially our people on the shop floor who were running the process. We stopped worrying about who was in charge; everybody was in charge. We began trusting and relying on each other. We turned the process around. We got a victory, and we liked the way it felt.

Now what does this have to do with safety? We'll get to that, but the answer is: Everything!

We found a new way of accomplishing things that worked. We began tapping into the energy and intelligence of each other. We began changing our culture.

As this was taking place in our plant, we began studying and implementing lean manufacturing principles. Yes, removing any and all forms of waste was important, but the human aspects of lean thinking were where we really bought in and saw value. We began to realize that people were our most important resource. Without them we were nothing.

The human aspects I speak of are:

(1) <u>Respect for Each Other</u>- That is taking everyone's frustrations and problems seriously, and making every effort to take responsibility for each other's success. First and foremost in this is watching out for each other's health and safety in a dangerous work environment. So now, finally, the concept of safety and Actively Caring for each other comes into play. Taking the time to communicate is also an act of respect. Additionally, taking the time to recognize accomplishment is an act of respect.

(2) <u>Teamwork</u>- The idea that everyone is important, everyone matters, everybody has an individual contribution to make to the team. In this it is important that leaders take the time to invest in training and developing individuals by building confidence and allowing everyone to find their voice. The safety connection here I think is in the enabling the courage component of Actively Caring for each other's safety and well being.

Just prior to our culture transformation the site had implemented a behavior based safety process, but when we began instilling these ideals into it the process became much more powerful. Our people began giving each other feedback not just because it was a new program we had handed them, but because it was just the right thing to do. It was an act of respect and required high teamwork. Injuries began reducing.

As we starting implementing these lean and Actively Caring ideas into the site through programs and tangible activities we did not use a consultant. We joined alliances in our area and began visiting other operations outside of our industry where we picked up on great ideas that matched what we wanted to accomplish. We shamelessly borrowed them, with approval of course, and tweaked these ideas into one's that fit our operation. I can't stress enough the value of periodically getting outside the four walls of your daily work environment and benchmarking programs, methods, activities that can facilitate the culture you desire to create.

Here are a few of these ideas that are now institutionalized into our operation and bring to life these principles of Respect, Teamwork, Communication, Personal Development, and Recognition.

<u>Use of focus Groups:</u> Not really a novel idea, but we are finding many ways to leverage them. When we have the opportunity to give recognition to groups or the entire workforce, we assemble a group of associates and ask them, "Here is what we want to recognize, this is how much money we can spend, now what do you want the recognition to look like?" We have done this with communication, "what information do you want to know?" We use it in problem solving, "hand injuries are our number one opportunity, what do we need to do differently?" (Respect, Teamwork, Inclusion, Buy-in, Having a Voice, Trust, Communication)

<u>Supervisor Boot Camp:</u> We have come to the conclusion that our frontline Supervisor is where the rubber meets the road. They are the key link in creating the desired culture and can make or break the effort. We do a bi-monthly 4 hour training session. Our leadership team instructs it because we believe that the leaders must be the teachers. We refresh them on consistent policy administration, but the more important topics we cover involve emphasizing the desired

behaviors we want them to portray as leaders like showing empathy, listening, humility, and ways to build community on their teams. We do this through role play where volunteers act out these behaviors and everyone sees what the desired behaviors look like. An effective and fun way to teach this is getting them to act out the opposites of these behaviors. (Personal Development, Communication)

Suggestion Boards: We have always had a program where associates can submit an idea to improve safety, quality, or productivity. This idea just makes the process more user friendly. We have placed cork boards throughout the plant with small note cards available. The board is divided into 4 categories: Idea, Can do, Doing, & Done. An idea is documented and placed in the Idea section. The area leader decides it can be done, and moves the idea to the next category on the board as it progresses. Associates can easily walk by the board and quickly see their idea's status. The volume of ideas has increased. (Communication, Having a Voice)

Continuous Improvement Technician: This is the Suggestion Board idea on steroids. An hourly associate has an idea to improve a process. Except in this program we ask the associate to choose their own solution, pick their own team of other associates to participate, provide with the means and tools, then cut them loose to go get it done. We put them through a one day training course, taught by the leadership team, teaching basic tools like how to conduct a meeting, how to manage an action item list, and basic data analysis. They are assigned a salaried mentor only to help them remove roadblocks they may incur. When their project is complete their recognition is a large sign hanging in the area, "John Doe has left his thumbprint on this area", or "Jane Doe had an idea and made it a reality." At the end of the project we hold a graduation ceremony; they present their project to the leadership team, and are awarded a plaque. Over 50% of the ideas are one's to make the plant environment safer. (Personal Development, Leadership, Inclusion, Recognition, Teamwork)

Safety Commitment Wall of Fame: A large banner hangs in a central area of the plant. There are stars pasted on the board. When associates are ready to make a commitment, and only if they want to, they publicly profess and testify their own reason or area of safety where they have great passion, they post a small paragraph describing it with their picture on it. It may take us a few years to completely fill the banner but that is OK. Associates are able to review the board and it is prompting others to find their area of passion and then be willing to make it public to the entire team. (Inclusion, Personal Development, Diversity, Recognition)

All of this remains a work in process and will continue to be. However, our operation is completely different than the one described initially. My personal approach to leadership has evolved from using my position to obtain compliance to my ideas, to focusing on the personal and professional development of the people I serve, making the journey fun for them, and helping people find their personal contribution to get the desired results

Clemson Plant

Collen M. Hydrick – Plant Manager

At the time Actively Caring was introduced at our facility, our safety record was already world-class, TCIR <1.0. What interested me was two-fold: maintaining our safety record and increasing the level of inclusion, commitment, and self-motivation at our facility. As the concept of Actively Caring started to spread around the division, our site was the first to begin asking for Moments of Courage to be shared at every meeting. Most examples were from instances outside

the plant such as "reminded a neighbor of the dangers of wearing flip flops while weed-eating" or "asked my spouse to get a ladder instead of standing on a chair". The important part at this point was we were beginning to share these examples and building the habit. This habit of sharing moments of courage spread from our leadership team meetings, to department safety meetings, to employee meetings, and finally to meetings with other sites and other divisions. In the summer of 2010, our BBS Steering Team was charged with creating a strategy for rolling out the concept of Actively Caring to all employees. They accomplished this with two goals:

1) Change the summer safety survey program to ask an Actively Caring question. Each summer, our site has asked employees to turn in safety stories for the months of June, July, and August. Each month, those that participate receive a token gift and a nice T-shirt or gift for completing all three months. The question was changed to ask "Do you Actively Care about your co-workers and/or family members' safety? Tell us your story or moment of courage." Followed by the question "Did they have the humility to accept the Actively Caring Feedback? What was their response?" (Exhibit 11) That first summer of 2010, we received over 250 Actively Caring Stories.

Exhibit 11 - Summer Safety Survey Card.

2) Change the BBS survey card to include a question on the back of "Do you have an Actively Caring Story to share?" This change began in September 2010 and during those last 4 months of the year, 22% of all the surveys conducted included a discussion of an Actively Caring Story. By January 2011, the team selected a goal for the Site Annual Goal Scorecard of increasing the number of Actively Caring Stories on Survey cards from 22% to 35%. The concept of Actively Caring was definitely spreading throughout the site.

So by the beginning of 2011, we had people sharing stories to begin meetings, on cards during the 3 summer months, and during BBS surveys. We also had 40% of our Site's Goals directed at safety, with 35% at leading indicator type items and only 5% on the resulting TCIR (Exhibit 12). And this is for a site whose TCIR was 0.35 for the year of 2010

Metrics Operational Definition and Measurement Tool	Weight %
Retire Pinpoint Behaviors	10
Maintain near miss incident/first aid reporting.	5
Maintain TCIR <= 0.5	5
Reduce Safety/Environmental work order cycle time	10
Increase the # of Active Caring stories on EAGLES surveys.	10
Reduce the Off Quality Charge backs from our customers	5
Increase %Q1 product	10
Increase %Winder Uptime in Area 1	10
Maintain Winder Uptime in Area 2	5
Reduce Energy Usage (BTU/LB)	10
Reduce % Reactive Work Hours	10
Perform at least 100 - 5S audits in 2011	10
	100

Exhibit 12 Site Goals – 40% relating to safety.

On the inclusion side, I wanted to make it easier for all employees to attend quarterly meetings with the site leadership and I wanted to ask for feedback and ideas during these meetings. Starting in early 2010, I began having meetings with all employees during their work days at least 3 times a year. This required me to conduct at least 16 meetings to accommodate all schedules and the relief that was required to keep the jobs running, but I really wanted everyone to be able to attend. During these meetings, I began taking 10-15 minutes to ask the room to break into small groups and give feedback on a topic. One time it was "What Goals would you like to see on our scorecard?" Another time it was "If you were in charge of communications for the site, how would you get information distributed?" It may seem trivial, but people really enjoyed being a part of the discussion and we got some great ideas. And even learned some things we were totally missing such as, each employee wanted their own personal copy of the plant newsletter and we were not producing enough. Easily fixed!

We also looked for ways to make sure our employees had a way to make sure their ideas for quality, safety or cost improvements were heard. The standard suggestion box felt too much like a "black hole". We developed our Process Improvement Program (PIP) to include written feedback to the employee within a 2-3 week time frame. Obviously, not all suggestions could be addressed in this time, but at least the employee got some feedback such as "we are entering a work order" or "this will take a capital project review" or "materials have been ordered" or "we have addressed this issue with an alternative". The important part is they know someone read and responded to their suggestion. For a site of approximately 300 employees, we receive an average of 230 PIP's each year. We have also allowed employees to report near miss events through this same process (Exhibit 13).

Plant 8T Process Improvement: PIP Card/Near Miss: Thank you for participating. Make suggestions for Safety, Quality, Cost Savings, Near Miss, etc.
Please use the back if you need more room. Please include your name to be eligible for prizes.

Name (optional) _____   Shift_____
Date_____
Your Department _____   Department affected by your
comments_____

***Do you want this to be considered for a CI Tech Project?
_____***

Your comments: Please give a statement regarding the issue, problem, suggestion, etc.
You can also suggest a solution.
        For a near miss, please describe what happened, where it happened,
contributing factors, and possible solution.
_____
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Exhibit 13. Example PIP card.

        Our next endeavor was to enhance our current behavioral-based safety process with a second part. The existing part was to have specially trained "champions" conduct behavior based surveys with their co-workers. The results are shared anonymously with the leadership team in the form of % safe, % at-risk, and comments. Our survey process is supported by a steering team made up of members from each area of the plant and an hourly employee team leader who is elected by his/her peers to serve for 2 years. Yes, the 2 year-term results in turnover of this position every two years; however, this transition time is outweighed by the new energy and focus that each new steering team leader brings to the group. This group is supported by two salaried facilitators who are there to aid the steering team in whatever they request. Often these teams need help in how to get approval for a new idea, how to order t-shirts, or even how to schedule a room. This steering team also conducts quarterly "safety blitzes" to remind everyone to be safe as they come into work. Examples of blitzes are: "We're nuts for safety" (Peanuts), "Don't be tricked into at-risk behavior" (Halloween candy), "Don't snicker at safety" (Snickers Bar), and "100 Grand can't replace a hand" (100 Grand bars).

        The enhancement is a process called "pinpoint." Pinpoint first involved all salaried employees. We were asked to talk to a given number of employees every week concerning their safety. More specifically, we needed to positively reinforce a safe behavior with 2-3 employees, give positive feedback to 2 employees about their activity as a safety champion, and talk with a supervisor or manager about their support of the behavior based safety process (Exhibit 14). The positive reinforcement of a safe behavior had a profound effect on our workplace. All of the

sudden, a salaried person comes to talk to you and instead of fussing about something, they are complimenting you for wearing your gloves or for having your ear plugs in well. Most employees' reaction was to stand a little taller and get a big smile on their face. Well worth the few minutes of effort that it took! Once the salaried team had the hang of this process, we moved onto team and lone workers. At-risk behaviors were chosen and each team or individual began monitoring their behavior daily and looked for evidence of the habit being changed. A goal for our site was to have everyone participating in some way. Safety is everyone's job, right? So, we included all office support staff in this pinpoint process. The behaviors are different, but no less important to maintaining a low injury rate.

Department Manager BBS Scorecard		
Week		
Name		
Weight	Support Behavior	Score
20	Talk with a supervisor about their Eagles support behavior	20
40	R+ 3 employees for observed safe behavior	40
20	R+ 2 Eagles Champions about their BBS activity	20
20	Transmit scorecard to Eagles ST leader	20
	Total	100

Exhibit 14. Example Pinpoint Scorecard

Even in this process we listened to our employees and used their feedback to further improve the process. Approximately 1/3 of our employees were doing pinpoint as a "lone worker" where they picked one behavior and monitored their own safe/at-risk behavior. Beginning in late 2011, we trialed a "hybrid version" where 3 jobs were picked to monitor and as employees rotated through that job task, they marked the card either safe or at-risk. This gave more opportunities for interaction or discussion about the behavior and encouragement among the members of the 3-5 person group. The trial was a success and in 2012 we will be rolling out this "hybrid version" to another 20 people. And you may have guessed…..It is on our Site Goals for 2012!

What does all this activity and effort get a site that already had a good safety record? It gets us the ability spend less time enforcing safety rules and more time to teach the "whys" and "share the stories" so that more employees want to work safely, not because it is the rule, but because they WANT to. We took this approach in 2011 with glove use. In most of the site, glove use was minimal and rarely mandated by the lesson plan or safety rule. Even for those tasks where it was mandatory, it was not unusual to find people without gloves on. In 2011, the division saw a need to increase glove use. At my site, we chose a unique approach. We began asking employees to try gloves. We spent a lot of time finding new gloves and sharing the many styles available to employees. We spent a lot of time positively reinforcing those that were

wearing gloves. Today, almost a year later, glove use is still not 100%, but it is routinely greater than 50%. I had a machinist tell me that he has a pinpoint to wear gloves on every task he does. He has yet to find one that he can not wear some type of glove. Even while handling the smallest parts. Several employees have said they "can't perform their job without gloves any more. It just doesn't feel right". We fully realize it will take longer to reach 100% participation in glove use this way, but we will not spend the next 15 years taking disciplinary action and wondering how many are taking them off as soon as we turn our backs. Once they are wearing them, they will wear them for life. Several are even wearing them for more and more tasks at home.

Maximizing Your Influence as an EHS Professional

F. Turner Plunkett – Group Director Fibers

During the past year we have had the honor of being able to tell the story of our cultural journey to a number of audiences and a few companies who have asked to network with us for the purpose of learning from each others successes and opportunities. During this time it has become apparent that we have only been speaking with a partial segment of the audience that may benefit form our story. Executives, Managers and those directly accountable for the accomplishment of organizational goals and objectives my benefit from what we are learning. But, until we are able to participate in an audience with them I will share from an executive point of view how you as Safety Professionals might be most influential in helping establish, implement and continuously improve safety efforts.

1. **Develop Expertise**
In order to evolve culture fundamental safety compliance programs must be in place and sustainable. This requires you as a safety professional being a compliance expert. Evolving culture requires education and proficiency in the ability to teach, apply and interpret human behavior principles and data.

2. **Be a Systems Thinker**
When preparing to present management with a program idea, present the total picture; Vision, Strategy, List of Potential Activities, Cost/Gain, Measurement Process, Who will be involved, etc. Do not present an idea until these are all well thought out. Sharing your ideas with others and asking for them to help you develop the idea promotes inclusion and synergy. This synergy will typically produce better plans and support for your idea. Be sure and understand the risk/reward of the system you propose and be prepared to present both and discuss. If the risks are far greater than the reward it may be wise to refine your plan before presentation.

3. **Be a Smart Change Agent**
When we present ideas, not all of them, no matter how well thought they may be will be immediately accepted. When presented with initial rejection of an idea, each of us has a number of behavior options. We can become angry and work to argue our point until management submits and grudgingly agrees, we can just drop the issue (pick up our marbles and go home) and hope to fight another day or we can thank management for their time and take the attitude of the farmer as he grows his crop, plant a seed walk away and come back later to see how fertile the ground is and if our seed (idea) has started to grow. I have found the approach of the farmer to be most effective.

4. Develop Great Group Facilitation Skills

Inclusion has become the norm in today's business world. Possessing the skills and competency to facilitate multiple peoples working together on a common issue with each having input and seeing the result of their work leads to committed organizations. Learn group facilitation techniques and methodologies that allow everyone to be included. Some examples are brainstorming, affinity, process mapping, flow charting, problem solving, etc.

5. Use Data

Track, Measure and report data (both leading and lagging indicators) in ways that are quick and easy for management to observe where the system is healthy and where opportunity for improvement exists. One example of this is a Safety Systems Scorecard (see Exhibit 15).

Shaw Fibers — Fibers Division Monthly Composite Scorecard - December 2011

Issue / Leading Indicators	1 CM	1 YTD	2 CM	2 YTD	3 CM	3 YTD	4 CM	4 YTD	5 CM	5 YTD	6 CM	6 YTD	7 CM	7 YTD
Site SLO Attendance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	96%	100%	97%
Weekly Safety Meetings Held	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%
% Observations Completed	100%	121%	92%	90%	47%	93%	48%	72%	100%	102%	80%	102%	72%	89%
% Observers Completing Expected	92%	89%	60%	58%	37%	76%	52%	83%	95%	96%	72%	90%	44%	43%
% of Observations with Comments	5%	41%	44%	42%	13%	47%	55%	43%	96%	98%	47%	43%	93%	96%
% BBS Observation Courage Factor	5%	7%	35%	34%	20%	31%	52%	34%	8%	15%	33%	54%	60%	66%
% ASA Participation	98%	99%	81%	82%	88%	95%	96%	99%	92%	95%	94%	93%	97%	97%
% ASA Courage Factor	43%	43%	87%	90%	73%	81%	85%	95%	70%	70%	58%	68%	100%	93%
Safety Training Completed vs. Planned	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	95%	95%	95%	99%
Shift Safety Committee Meeting Held	100%	100%	100%	100%	100%	97%	50%	85%	100%	100%	92%	99%	100%	100%
IAPP Action Items Completed vs. Planned	2	7	100%	90%	100%	83%	100	100	100%	100%	Complete	7	100%	100%
# of Safety Compliance Audit Recs Open	0		0		9		0		4 minor		3		0	
# of Env Compliance Audit Recs Open	3 of 10		0		0		0		0		1		1	
# of SMS Recommendations open	0		0		0		0		0		0		0	
# of MOCs completed ytd	10		33		27		25		0	9	0		1	
% Veripro Fittings Complete vs. Planned			100%	70%	100%	13%	0%	42%	0%	2%	0%	91%	100%	100%
% of ASAs Hand Safety Focus	20%	41%	26%	29%	52%	60%	27%	22%			45%	52%	24%	23%
% of BBS Observations Hand Safety Focus	30%	37%	32%	29%	11%	39%	0%	19%			60%	70%	96%	96%
Lagging Indicators	CM	YTD	CM	YTD	CM	YTD	CM	YTD	CM	YTD	CM	YTD	CM	YTD
OIR	0	2.13	0	0.61	0	0.79	0	1.42	1	0.99	0	1.71	0	2.09
# of Medical Cases	0	7	0	3	0	5	0	7	0	2	0	6	0	25
LWCIR	0	0	0	1	0	0	0	2	0	0.35		0.29	0	0.17
First Aid Cases	2	48		19	0	38	1	29	1	30	4	37	1	71
Hours Since Last Lost Time Incident	894,536		181,370		1,355,862		362,185		~237,921		686,204		947,925	
Date of Last Lost Time Injury	9/8/2010		9/9/2011		11/25/2010		8/20/2011		8/17/2011		1/7/2011		7/25/2011	
# of Medical Recordable Cases YTD	7		3		5		7		3		6		25	
Workers Comp Cost/Payroll Hour YTD	0.006		$0.052		$0.013		$0.122		0.115		$0.265		$0.065	

Exhibit 15.

6. Network

Look for opportunities to discuss and learn about other organizations successes and opportunities. Apply these lessons to your business.

7. Stay the Course

When you are leading your organization in an improvement area, personally stay and help the organization stay focused on the area of improvement. Too often organizations are lead from "new and improved mousetrap to newer and more improved mousetrap" and never realize true improvement due to several distractions and not having the discipline to stay the course. Be that steward. Also work with management to understand how much activity can occur at one time, continuous improvement and urgency of new idea implementation are exciting, but only effectively realized at the pace the organization can handle. Too many ideas and little results can be an impediment of a safety professional's credibility.

8. Have Integrity – Walk the Talk

Be the example, no matter the circumstance do the right thing, even when no one is watching. This form of leadership is very important, your behavior as a safety professional most importantly protects your personal safety but helps set the norm of what is acceptable safety behavior within the organization. If something is not working do not employ heroic efforts in hopes of maintaining pride while the hole is getting deeper. Remember the first rule of the hole: If you're

digging a hole, throw the shovel away. Admit that it is not working and synergize with others to strengthen or redefine the strategy. This could be perceived by the organization as the admirable personal traits of integrity and humility.

9. Be a Great Listener and Communicator

Ask good open questions to learn. Open questions will generally start with one of these words; Who, What, Where, When, Why or How. Listen to responses, ask probing questions to learn more and understand others ideas and thoughts. If there is follow up necessary always get back to the person(s) who were part of the conversation with the status of the follow-up item. This is a tremendous credibility builder.

10. Develop Relationships

Throughout Shaw's cultural evolution it has become increasingly evident that the closer the relationship between two parties the less courage is required to recognize and coach unsafe behaviors. Get to know people and understand their wants and needs, they may not be the same as your own. This information will help guide you in facilitating/establishing the culture and systems that people will be most included, engaged, empowered and successful in.