Culture Change Agent

The Overarching Role of OSH Professionals

By Fred A. Manuele

IN BRIEF
• Overcoming management system deficiencies occurs only by modifying the way things get done—that is, only if an organization's culture is changed with respect to its system of expected performance. Thus, the safety professional's overarching role is that of a culture change agent.
• This article recognizes the difficulties when the safety culture is negative and cites resources designed to help safety professionals become more effective culture change agents.

All safety professionals should view all hazardous situations as indicators of inadequacies in the safety management processes that relate to the existence of these situations. Assume that management takes corrective action to eliminate every hazardous situation identified. Safety professionals should realize that relatively little will be gained if no effort is made to eliminate the management system deficiencies. Eliminating those deficiencies will require changes in an organization's culture.

This idea, in a sense, extends the goal of the planning requirements established in Section 4 of ANSI/ASSE Z10-2012, Occupational Health and Safety Management Systems, which states, "The planning process goal is to identify and prioritize occupational health and safety management system issues (defined as hazards, risks, management system deficiencies and opportunities for improvement) and to establish objectives" (p. 9).

Overcoming management systems deficiencies occurs only by modifying the way things get done—that is, only if an organization's culture is changed with respect to its system of expected performance. Thus, the safety professional's overarching role is that of a culture change agent. To substantiate that premise, this article:
• defines overarching, systems, processes, culture and culture change agent;
• provides examples of situations in which safety professionals did not recommend the necessary systems and culture changes;
• reviews job descriptions;
• comments on a safety culture within an organization's overall culture and how the advice given by safety professionals affects the culture;

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•recognizes the difficulties when the safety culture is negative;

•provides resources with respect to safety professionals as culture change agents;

•proposes that the proposition made here be tested against the requirements of ANSI/ASSE Z10.

Definitions

Let's begin with a review of several key terms.

•**Overarching:** A composite definition is:

Encompassing everything; embracing all else; including or influencing every part of something. This premise, that the safety professional's overarching role is that of a culture change agent, applies universally to all who give advice on improving operational risk management systems.

•**Systems and processes:** These terms are discussed because systems and processes must be modified to achieve culture change. These terms are commonly used for the elements of an operational

risk management system. For example, in ANSI/ASSE Z10, the words *process* and *system* appear 120 times in the first numbered 29 pages. From the many definitions available, those presented are from the online Business Dictionary (**www.businessdiction ary.com/definition/system.htm**).

a) Process: Sequence of interdependent and linked procedures which, at every stage, consume one or more resources (employee time, energy, machines, money) to convert inputs (data, material, parts) into outputs. These outputs then serve as inputs for the next stage until a known goal or end result is reached.

b) System: An organized, purposeful structure that consists of interrelated and interdependent elements (components, entities, factors, members, parts). These elements continually influence one another (directly or indirectly) to maintain their activity and the existence of the system, in order to achieve the goal of the system.

One can argue that the terms *process* and *system* are synonyms. When a process or a system is modified and that modification is successful, a culture change is achieved.

•**Culture:** Many definitions of *safety culture* are available. Most, if not all, imply that harmony exists with respect to safety at all levels of employment. Composite definitions follow, representing definitions typically found in the literature.

a) Safety culture is defined as entrenched attitudes and the shared values, beliefs, assumptions and norms that may govern organizational decision making.

b) Safety culture reflects attitudes, beliefs, perceptions and values that employees at all levels share.

c) Safety culture refers to ingrained attitudes and opinions that a particular group of people share with respect to risk and safety.

The literature does not, however, provide a description of a safety culture that recognizes that management decisions made over time may result in the existence of a multitude of unacceptable risks within an operation. The cumulative result in such situations is a negative culture, one in which harmony does not exist; in which shared values or common beliefs are few; and in which group attitudes about safety are negative. In some organizations, employers may believe that certain operational risks are acceptable, while employees may have other views and conclude that those risks are unacceptable. Thus, employees may not share the views and beliefs that management holds with respect to safety and operational risk levels.

An organization's safety culture, which is a subset of its overall culture, derives from decisions made at the governing entity level (e.g., board of directors, group of owners) and at the senior management level that result in acceptable or unacceptable operational risk levels. Outcomes of those decisions could be positive or negative. Safety is culture driven, and management establishes the culture. An organization's culture is translated into a system of expected performance that defines the staff's beliefs with respect to what management wants done.

Although an organization may issue commendable safety policies, manuals and operating procedures, the staff's perception of what is expected of them and the performance for which they will be measured—the system of expected performance—may differ from what is written.

In reality, what management does may differ from what management says. What management does defines an organization's culture and its com-

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mitment or noncommitment to safety. Employee perceptions of management's position on safety are, in effect, employees' reality. These perceptions, realistic or unrealistic, are their truths.

Safety, defined as being free from unacceptable risks, will improve only if the culture changes, that is, only if the system of expected performance undergoes major changes.

•**Change agent:** Definitions of this term are numerous as well. The following composite fits well with the safety professional's position.

> A change agent is a person who serves as a catalyst to bring about organizational change. A change agent assesses the present, is controllably dissatisfied with it, contemplates a future that should be, and takes action to achieve the culture changes necessary to achieve the desired future.

Overlooking Necessary Systems & Culture Changes

A study aiming to improve actions on serious injury and fatality prevention concluded that safety professionals should identify risk situations that could be precursors to serious injuries and fatalities and recommend corrective action to eliminate those precursors. It was not suggested that deficiencies in management systems relative to the existence of these precursors be identified. However, it is highly probable that if a company makes no changes in the relative management systems and decision making, then those systems will continue to create such precursors.

An organization decided to initiate a prevention through design system involving all operations personnel. Employees were educated in hazard identification and analysis, and risk assessment. Numerous situations were identified for which risks should be reduced, and the design revisions for the workplace and the work methods were commendable. The safety professionals involved were asked how these revisions were communicated to design personnel. They indicated that no such communication had occurred, that no attempts were made to change the original design system. Not sharing information about the design measures taken meant that designers would continue to produce designs that included the risky work situations.

Job Descriptions for Safety Managers

For simplification, the term *safety manager* was selected as a caption for the many examples of job descriptions for safety professionals. These descriptions may encompass environmental risks and OSH risks. A few also include product safety, waste management or fire protection. They refer to functions (e.g., develops, performs, assists, analyzes, implements), but rarely delineate an overall purpose. Several job descriptions contain the following statement: "Models and promotes an organizational culture that fosters safe practices through effective leadership." (For an example, visit **http://bit.ly/1PAZcM8**.)

However, none of the job descriptions reviewed state that the safety professional's overarching role is that of culture change agent. As the OSH field continues its progress toward becoming recognized as a profession, that role should be understood, and that awareness should influence how individual practitioners promote the practice of safety.

Safety Professionals & Safety Culture

What is the safety professional's role with respect to an organization's safety culture? Assume that safety is a core value in an organization and that senior management is determined to achieve and maintain acceptable risk levels in all operations. Usually, the safety professionals in such organizations are well qualified, they have stature, and the advice they give is well received and seriously considered.

Even in such organizations, change, favorable or unfavorable, is a constant. The safety management systems in place will continually develop information indicating that certain safety-related processes can be improved. Then, acting from a sound professional base, the advice given by safety professionals in their role as culture change agents is welcomed, mostly. In this role, they:

•Perform diligent data gathering and analysis to identify process shortcomings.

•Propose and arrange for the performance of hazard identification and analyses, and risk assessments.

•Give advice on prioritizing risks.

•Recommend actions that management should take for improvement.

However, not all organizations have superior safety management systems in place. In these settings, being a culture change agent is more difficult, particularly if senior management believes that all is well and that changes are unnecessary. The safety professional's operating base in such situations remains the same as the bulleted list just offered, but the skill level required to be a successful culture change agent can be exceptionally demanding. Therefore, patience is required. Satisfaction may derive principally from small steps forward. But the goal remains the same: Try to positively influence the safety culture toward achieving acceptable risk levels.

Now, assume that the organization's culture has always been negative or is drifting into a negative state. Safety professionals must recognize and discuss this concept of drift, particularly since significant expense reductions in recent years have caused some companies to drift into a negative state with respect to safety. As Rasmussen (1997) writes:

> The scale of industrial installations is steadily increasing with a corresponding potential for large-scale accidents. Companies today live in a very aggressive and competitive environment which will focus the incentives of decision makers on short-term financial and survival criteria rather than long-term criteria concerning welfare, safety and environmental impact. (p. 186)

The word *drift* has been attached to Rasmussen's premise. For example, Dekker (2011) references Rasmussen's work:

> Drift occurs in small steps. This can be seen as decrementalism, where continuous adaptation

around goal conflicts and uncertainty produces small, step-wise normalizations of what was previously judged as deviant or seen as violating some safety constraint. (p. 15)

When a safety professional senses drift occurring due to decisions that result in violating some safety constraint, or more likely several safety constraints, as a culture change agent, the safety professional must attempt to deter or slow the pace of drift. Using the same diligent data-gathering and analysis methods to identify process shortcomings and risk prioritization, a safety professional can counsel management on the facts and the pace of the drift toward danger. The goal is to make management aware that the organization is putting in place elements that increase the potential for a large-scale incident and to encourage management to slow or stop the pace of deterioration in processes. Assessing and prioritizing risks and emphasizing the growing potential for the occurrence of low-probability, severe-consequence events acquire greater importance.

At sites where safety culture has drifted into a negative state or has always been negative, safety professionals likely have limited resources. Thus, their communications with management should contain information on safety-related decisions that should be made, on a priority basis, so that these limited resources can be applied to achieve the greatest good. Again, this requires priority setting and focusing in particular on preventing low-probability, serious-consequence events.

A safety professional will not likely easily achieve success in such situations. However, the probability of success will be enhanced if s/he is viewed as an integral member of the business team. That will result from giving well-supported, substantiated, and convincing technical and managerial risk management advice that is perceived as serving the organization's interests.

Thus, to be successful culture change agents, safety professionals must operate within the business framework of the organizations to which they give counsel. Thus, safety professionals should seek to obtain additional knowledge and skills that will bolster their qualifications to do so:
•business management basics;
•financial analysis tools, such as cost/benefit analysis;
•language of finance, which is the language of management;
•budgeting process;
•impact of adequate or inadequate cash flow;
•elements that may influence executive decision making.

Relevant Resources

Spigener and Groover (2008) discuss the safety professional's emerging role as change agent:

Staying relevant as an organization changes [means] learning how to leverage your knowledge, skills and experience in new ways. . . . If you are a technical expert in [EHS], the good news is that you already have the skills and knowledge to contribute to safety strategy. The hard part will be

gaining fluency in organizational change management.

Spigener and Groover (2008) also identify core competencies of change agents. They:
•are forever inquisitive and never-ending learners;
•advance performance by identifying what ought to be, deciding how to get there and influencing decision makers to adopt their ideas;
•do not leave their expertise behind;
•leverage their knowledge and experience to develop strategies to positively influence actions that result in higher performance levels;
•recognize that to be influential in achieving change, they must acquire change management skills;
•become aware of the culture in place and learn how to manage within it to effect change;
•recognize the effect of management decisions and actions on the culture;
•find ways to tactfully inform management when they believe that management decisions and actions may have negative results.

Simon (1999) opens his culture change chapter in *Safety Through Design* (Christensen & Manuele, 1999) as follows: "A full explanation of what culture change is and is not, who is involved, why it is necessary and can achieve world-class safety through design, and how to make it happen is provided in this chapter" (p. 37). Although the chapter focuses on safety through design, it is generic with respect to what is required to achieve a culture change.

Swuste and Arnoldy (2003) examine the challenge of becoming an agent of organizational change. Let's review their article's abstract.

There is a great need for health and safety advisers/managers to act as agents of change, both in respect to the technology of the company and the design of its workplaces, and in the organization of the company health and safety management system. This article reports on the development of training to meet these increasing needs. The postgraduate masters course "Management of Safety, Health and Environment" of the Delft University of Technology has now introduced a course-module of 1 week, addressing the issue of the learning organization and the specific role of the safety adviser/manager.

The course-module starts from the assumption that for a health and safety adviser/manager his/her personal effectiveness and ability to influence and stimulate others are qualities as important to a company as the quality of a safety and health management system. This paper will describe the development in the role of the safety adviser/manager and the mainstream thinking on change management and training. The consequence for the content and program features of the course-module is presented as well as the results of the evaluation of its effectiveness.

For emphasis, let's consider again this sentence:

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Kello (2005) also examines this topic as shown in the following excerpts.

So what is the proper role of the safety professional in the total safety culture, to which many organizations today aspire? It is definitely not the same old technical expert role, even with a broader bandwidth. It is fundamentally, qualitatively different in its approach.

In the field of organization development [OD], OD practitioners have been referred to as "change agents" from the very beginnings of the discipline. My central thesis is that, whether they normally think of it in these terms or not, to be truly effective in the flexible, team-based high-performance organization, safety professionals must perform as change agents, too. In my view, much like organization development consultants, safety professionals encourage and help people make constructive behavior change, to do things differently, to challenge longstanding habits and to get out of their "comfort zone." Further, and also like the OD consultant, they are almost always more of an influencer than a director.

Kello (2005) adds, "Modern safety professionals are agents for positive change in their organizations. They are trying to build deep working relationships that allow them to effect constructive change through influence, even when the client system may not want to change."

A U.S. Department of Defense slide presentation pertaining to patient safety identifies and discusses the eight steps of change [citing Kotter (1996) as the source of these steps] in order to help viewers:

•Describe the actions required to set the stage for organizational change.

•Identify ways to empower team members to change.

•Discuss what is involved in creating a new culture.

•Begin planning for the change in the organization.

If safety professionals presented this slide series as they attempt to influence others on how to achieve organizational change, they would be serving as culture change agents. Readers are encouraged to review this slide series for its informative value.

Why Culture Change Initiatives Fail

Kotter's (1996) book *Leading Change* is a foundational work. The thought pattern presented is largely based on what Kotter learned from practical applications. As he reports, many change initiatives fail. As culture change agents, safety professionals should be well informed on how change initiatives succeed and fail, and on how success and failure are measured. The following references address failed initiatives:

•"Five Reasons Why Leaders Fail to Create Successful Change" (Eikenberry, 2005).

•"Seven Reasons Why Organizational Change Fails" (Brazier, 2007).

•"Why Change Efforts Typically Fail: 15 Predictable Reasons & Situations to Avoid" (posted at **http://bit.ly/20L3Dck**; based on Blanchard, 2009).

•"Leading Change: Why Transformation Efforts Fail" (Kotter, 2007).

Experience shows that change initiatives fail for various reasons. The first reason is the most important.

1) The culture embedded in place and how to work within it is largely ignored.

2) Leadership and commitment necessary at sufficiently high levels to achieve the change may not in reality exist because the change agent has not invested the time necessary to achieve the required commitment.

3) Decision makers are not seriously enthuiastic about the change proposed because the supporting data are shallow and unconvincing.

4) The importance of becoming aware of the power structure and determining how to work within it has not been sufficiently recognized.

5) Team building, which is vital to success, has been inadequate.

6) Preparing for the typical resistance to change at all levels comes up short.

7) Communication to all personnel levels that would be affected by the change is less thorough than needed.

8) Management personnel who are assigned responsibility for the change may not be held accountable for progress by those to whom they report and, in time, the urgency and importance for the change diminishes.

9) People assume that a process or system has changed without determining that it has. Some refer to this as declaring victory too soon. Some advise that one should not claim success in culture modification until at least 1 year has passed. Too often, supervisors and operators revert to previous methods.

10) Change agents are not sufficiently aware that achieving a culture change may take a long time.

A Basic Guide

Environmental Management Systems: An Implementation Guide for Small and Medium-Sized Organizations (NSF International, 2001) is largely devoted to environmental management, yet many parts of the downloadable guide are generic and, thus, basic to almost all change initiatives. Readers are encouraged to add this publication to their professional resource library. A few excerpts follow.

Objectives & Targets

Objectives and targets help an organization translate purpose into action. These environmental goals should be factored into your strategic plans. This can facilitate the integration of environmental management with your organization's other management processes.

You determine what objectives and targets are appropriate for your organization. These goals can be applied organization-wide or to individual units, departments or functions—depending on where the implementing actions will be needed.

In setting objectives, keep in mind your significant environmental aspects, applicable legal and other requirements, the views of interested parties, your technological options, and financial, opera-

tional, and other organizational considerations.

There are no "standard" environmental objectives that make sense for all organizations. Your objectives and targets should reflect what your organization does, how well it is performing and what it wants to achieve.

Hints

•Setting objectives and targets should involve people in the relevant functional area(s). These people should be well positioned to establish, plan for, and achieve these goals. Involving people at all levels helps to build commitment.

•Get top management buy-in for your objectives. This should help to ensure that adequate resources are applied and that the objectives are integrated with other organizational goals.

•In communicating objectives to employees, try to link the objectives to the actual environmental improvements being sought. This should give people something tangible to work towards.

•Measureable objectives should be consistent with your overall mission and plan and the key commitments established in your policy (pollution prevention, continual improvement and compliance). Targets should be sufficiently clear to answer the question, "Did we achieve our objectives?"

•Be flexible in your objectives. Define a desired result, then let the people responsible determine how to achieve the result.

•Objectives can be established to maintain current levels of performance as well as to improve performance. For some environmental aspects, you might have both maintenance and improvement objectives.

•Communicate your progress in achieving objectives and targets across the organization. Consider a regular report on this progress at staff meetings.

•To obtain the views of interested parties, consider holding an open house or establishing a focus group with people in the community. These activities can have other payoffs as well.

•How many objectives and targets should an organization have? Various EMS implementation projects for small- and medium-sized organizations indicate that it is best to start with a limited number of objectives (say, three to five) and then expand the list over time. Keep your objectives simple initially, gain some early successes and then build on them.

•Make sure your objectives and targets are realistic. Determine how you will measure progress towards achieving them. (p. 29)

A Test of the Premise

As noted, the content and purposes of the planning section of ANSI/ASSE Z10-2012 support the premise that a safety professional's overarching role is that of culture change agent. If management system deficiencies exist, safety professionals must propose changes to eliminate those deficiencies. If those changes are successful, the culture will be changed. Attempting to achieve culture changes is a foundational practice of safety.

As stated at ANSI/ASSE Z10, E1.1, "This standard provides basic requirements for occupational health and safety management systems, rather than detailed specifications" (p. 1). Z10 is a management system standard and it clearly indicates that management must have certain systems and processes in place to conform with the standard. Correcting system and process shortcomings will require changes in the system of expected performance. If the revisions are permanent, the culture will be changed.

The sidebar above presents a portion of the table of contents from ANSI/ASSE Z10. Readers are asked to review each section and subsection list-

ed to try to locate exceptions to the premise that overcoming management system deficiencies will require changes in the system of expected performance and, thus, an organization's culture. It is difficult to conceive of a situation in which a hazard, a risk or a management system deficiency exists for which a change in a process and the system of expected performance are not a remedy.

If the process change is successful, the organization will achieve acceptable risk levels. However, remember this caution: One must examine revisions in a process and, thereby, a culture change, over time. Such examination will confirm whether personnel have reverted to previous practices after what seems to be a success in the short term; ensure that the modification is delivering the expected outcomes; and verify that no unintended consequences are created that increase risk.

Conclusion

One can make a sound case to support the premise that safety professionals' overarching role is that of culture change agent. Thus, to enhance their capability and effectiveness, safety professionals should:

•Recognize the validity of this premise.

•Focus on the premises set forth in ANSI/ASSE Z10 that "the planning process goal is to identify and prioritize occupational health and safety systems issues (defined as hazards, risks, management system deficiencies and opportunities for improvement)."

•Be aware that hazardous situations are indicators of inadequacies in the safety management processes that relate to these situations' existence and that corrective actions must eliminate those deficiencies in order to be deemed adequate.

•Become familiar with change management principles (e.g., resources cited in this article).

•Develop a champion at the senior management level by presenting the results of analyses of incidents and the deficiencies in the relative management systems that should be eliminated for effective operational risk management.

•Recognize that achieving culture changes may take a long time.

While serving as the managing director for a safety and fire protection consultancy, the author recognized that giving advice to clients was the only product the firm sold. Advice given was based on the staff's superior technical and managerial knowledge and skill. Success was determined by whether clients believed that this advice provided value relative to the fees paid.

Think about it. Are not most safety professionals primarily providers of advice to achieve change? Safety professionals are most often in staff positions and their role is to provide advice to decision makers on hazards, risks and deficiencies in management systems so that changes can be enacted to achieve acceptable risk levels and culture change.

Many organizational change initiatives fail because the prevailing culture is ignored. Achieving permanent change is difficult. Therefore, safety professionals must understand an organization's existing culture; acknowledge how deeply certain practices are embedded within processes; determine who presumes to have ownership of them; and embrace the need to plan and communicate to achieve change. Safety professionals must be perceived as members of the management team. Change methods they adopt should align with the procedures with which the management team is comfortable in order to avoid major conflict. Safety professionals have always been culture change agents. By recognizing the reality of this role, they could become more effective in counseling management and influencing decisions. **PS**

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