It's Always Bigger Than Safety

The Relationship Between Organizational Culture & Unwanted Outcomes

By Peter T. Susca

This article series chronicles the principles and techniques that readers can apply to transition safety and the safety profession closer to the core of what organizational leaders value. The foundational philosophy is that safety challenges stem from larger organizational issues. By understanding the core business values, OSH professionals can begin to work from the inside out to engage business leaders, rather than the typical outside-in approach to integrating safety with business. If leaders can tap into this information, they can use it to improve the organization as a whole, and move safety from a purely moral imperative to an indicator and facilitator of organizational health.

We must start working safety from inside the business core.

Over the past 35 years in the OSH profession, I have been exposed to a wide variety of organizations and cultures. Early in my career, I was introduced to a few savvy safety professionals who mentored me in the value of management systems. Once I understood how a management system worked, I was hooked. I never realized how much of a process thinker I was until I started to see the management system elements in my head, not only their purpose but also their relationship to each another. Over time I began to see management systems and their elements as a way to assess the operational health of more than just safety.

Based on my experience working with hundreds of organizations from manufacturing, services, primary metal/mining to pharmaceuticals, at the executive level and alongside those making it happen every day, I consistently found that where safety issues (e.g., ineffective processes, excessive risk) existed, organizational and operational issues existed too. I began to see safety issues as symptoms of organizational health rather than as a discrete set of problems to solve.

I believe that the future of the safety profession requires its practitioners be respected for more than their subject-matter and safety discipline leadership expertise; they need to be equally respected for their organizational savvy and ability to add value to the core of the organization.

This article outlines the relationship between organizational culture and unwanted outcomes from a safety perspective. It is a first step in the greater understanding of how organizations can use these principles to improve their operational health.

Peter T. Susca, M.S., is a principal at OpX Safety and has 35 years of environment, health and safety, business leadership and process improvement expertise. He has served in various EHS technical and senior management positions in large multinational corporations. He has developed EHS management systems, rating systems, auditing and auditor certification programs, risk assessment processes, educational management systems, executive EHS development programs, quality and EHS systems integration, incident investigation and high-risk industry fatality prevention programs for a wide variety of clients. Susca is a member of ASSE's Connecticut Valley Chapter.

In 1966, Abraham Maslow wrote, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail." Much has been written about the validity and applicability of H.W. Heinrich's theories regarding incident causation and the relationship between unsafe acts and injuries. With the hammer that Heinrich had, he probably did a pretty good job correlating the safety data of his era. Today's safety practitioners can agree that there is more to be considered beyond the data and analysis provided by the Heinrich pyramid. In recent safety management history, a wide variety of enhanced practices have evolved, such as advanced safety standards and regulations, management systems, human factors/behavior and risk assessment techniques. Despite these advances, we still struggle with the common denominator of success and failure: the human decision.

To understand what really creates safety challenges, OSH professionals need to look beyond safety into the culture and decision-making routines of an organization. This article reviews the common elements of an organization that create unwanted operational and safety outcomes. Applying these principles and the predictive information they offer allows safety practitioners to use safety information as proactive indicators of organizational health. If your organization sees incidents and injuries as just safety issues, perhaps it is time for a new tool.

While the safety profession has worked diligently to get the attention of leadership through the moral/ethical as well as the financial loss value associated with good safety, we must start working safety from inside the business core. In the business world, the core is primarily financial: meeting profit, growth, customer and stockholder expectations. Many organizations, typically through enlightened leaders, have done a tremendous job of pulling safety into the essence of their organization. Unfortunately, some benchmark safety organizations have lost their safety course and momentum when the visionary leader of the value is no longer at the helm. These leaders are often the glue that connects safety to the core of the organization. Without the glue, safety falls off.

To drive safety forward in a sustainable manner we can no longer treat it as an independent variable; the reasons for safety success (or failure) are always related to the health of the organization as a whole. The future opportunity for the safety practitioner is to tap into predictive indicators (Figure 1), not just as ways to enhance safety, but to further the value of safety as an indicator of core business health and sustainability.

This relationship applies to more than safety; it applies to all aspects of organizational success. Shortcomings in culture, systems, processes/programs and decision making create risk. If not

identified and effectively controlled, risk results in unwanted outcomes in all operational aspects: financial, quality, customer satisfaction, employee retention, safety, environment and ethics. If safety practitioners can become savvier in the ways that organizations become unhealthy, the symptoms we see in safety can be used to prevent damage to the core of the business. We move safety from something to "fix" to a proactive business health indicator.

Unwanted Outcomes

Before discussing risk, we must acknowledge that most organizations measure the health of their business approach (including safety) by outcomes and outcome metrics. Unwanted outcomes are the manifestations of risk. They include conditions, practices, situations and events.

An example would be the unwanted outcomes associated with the safety risk of texting while driving. Such outcomes might include being called out by a passenger, being pulled over by a police officer, receiving a warning or a ticket, losing one's license, nearly hitting something or someone, a minor incident with no injuries, an incident with minor injuries, or an incident resulting in serious injury or death. While the roots of the outcomes in this example are the same, their significance (influence on behavior change) is based on the perceptions and culture of people and organizations.

Therefore, different people and organizations will respond differently to the same outcomes. For example, an A student will be unhappy with a B grade on a test, while a C student will be elated with a B grade. The grades are the same, yet the reaction to them is relative based on the perspective of each student.

Risk

Risk is the potential for harm and is applicable to all aspects of a business, not just safety. The trouble with managing by outcomes is that they can mask great risk for long periods. A bad process (and significant risk) can consistently provide "good" outcomes. It all goes back to how we identify, report and measure outcomes. Looking at the driving example, many outcomes described may not appear on a person's driving record, so using that as a measure of a person's driving quality, a risky driver may look great. In this case, bad process (risky driving) = good outcome (clean record).

Management's knowledge and appreciation for risk is the first step in creating a predictive and preventive safety management approach in an organization. No organization that maintains high order safety expectations (e.g., zero injuries, no harm) can wait for outcomes to prevent outcomes. Accordingly, these organizations must define and act on unacceptable risk with the same intensity and resources as after an event has occurred. Unfortunately, organizations that operate in reactive or "firefighting" mode tend to wait for outcomes and think of risk from the perspective of outcomes. This perspective not only perpetuates organizational firefighting, it also allows smoldering situations (poorly managed risks) to ultimately ignite into tomorrow's fires.

FIGURE 1
Organizational Culture to Unwanted Outcomes Relationship

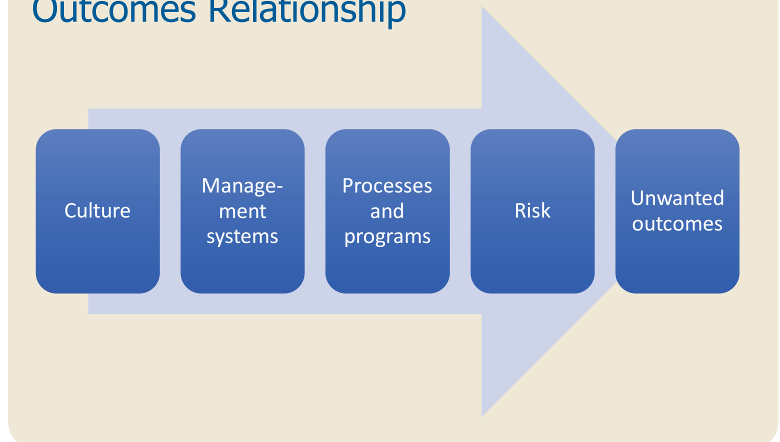
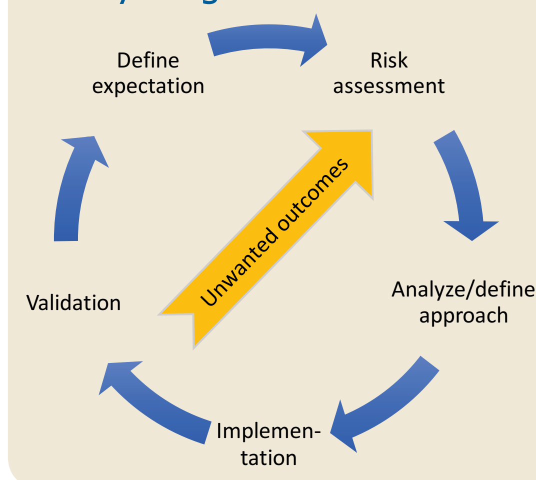


FIGURE 2
The Cyclic Elements of a Safety Program



Processes & Programs

Although risk knowledge and decision making are important aspects of a predictive and preventive approach, such an approach will still be reactive if the organization does not understand and maintain control over how risk is created/changed. The vast majority of risk is created by decision

Society Update
is your ASSE member e-newsletter.
http://societyupdate.asse.org

making at all levels of an organization. To control risk in decision making, in organizations and society, we create processes.

A process is the method by which purposeful activities are carried out or the way decisions are made. Processes can be thought of as formal or informal, and usually involve a series of steps and activities. Brushing teeth and getting ready for work are informal processes, while controlling hazardous energy is a formal process with procedures that define a certain order of steps. As with hazardous energy control, the degree of process formality (i.e., the specificity and order of the steps) built into the process is typically associated with the perceived benefit or harm.

Programs are defined as formal processes that are designed to manage a particular aspect or risk. High performing programs are designed within a continuous improvement cycle (i.e., plan-do-check-act or define-measure-analyze-improve-control) to achieve and sustain a specific standard of care (Figure 2, p. 41). To have any chance of achieving a high standard of safety performance (e.g., zero injuries), safety programs must be designed to achieve a defined level of acceptable residual risk (i.e., risk remaining after controls are implemented). Therefore, if the expectation is zero injuries, then safety programs calibrated to OSHA compliance may not offer enough risk reduction to meet that goal.

The more complex an organization becomes (e.g., size, diversity, frequency of change, amount of hazard), the more difficult it becomes to manage safety risk by programs alone. When programs and processes are deployed without an overarching management system to connect and evaluate them, with little or no forewarning, process/program shortcomings can manifest themselves into risk, then ultimately into unwanted outcomes.

Management Systems

Management systems are made up of a series of interconnected elements that drive the continuous improvement of a particular discipline or aspect of an organization (e.g., safety, quality, environment). They create the overarching and strategic approach to which all actions are tied and data is processed. Because these systems operate on a continuous improvement cycle, the elements of the system not only must be robust, they must "talk to each other" in an effective manner. When these systems are operated effectively, they can predict unwanted outcomes.

Management systems should be thought of as a universal connector for all of the disciplines and aspects of a well-balanced organization (e.g., financial, production, sales, quality, safety, ethics/integrity, human resources). Since the foundational management system elements are consistent across all disciplines, there should be management system synergy and cohesiveness across the organization, in essence, one operational management system that can connect and balance all of what it takes for an organization to be sustainably healthy.

Culture

Culture is the trump card for all organizational systems, processes and decision making. Merriam-Webster defines culture as the set of shared attitudes, values, goals and practices that characterizes an institution or organization. Organizational culture has a tremendous influence on all elements of an organization, especially decision making. When cultural deficiencies exist, they create decisions that can blow a gaping hole through the best organizational systems and processes. These holes often create excessive risk and poorly balanced decisions and, ultimately, unwanted outcomes in all areas of the business.

We have worked our way through the relationship of organizational culture to unwanted outcomes depicted in Figure 1 (p. 41). Each element of the relationship is predicted by the upstream elements that preceded it from culture to outcomes. Knowing this, the more capable a safety professional is at assessing the health of each element, the better s/he will be in predicting risk and outcomes in all areas of an organization. Safety is a great place to start, but it is not the place to fix the problem. The reasons for safety issues are always connected with the reasons for organizational issues. When you help the organization improve its health, savvy leaders will see you and safety in a different light.