

# Why Is Safety Improvement So Difficult? “Taking the Safety Improvement Journey”

Tom Harvey, CSP  
Allied Safety Associates  
Columbia, SC  
tom@alliedsafety.com

Why is safety improvement often so difficult and frustrating? Organizations with world-class safety programs know there are no shortcuts, but there is a proven path to safety excellence.

*Since the inception of OSHA over 30 years ago, great improvements have taken place in workplace safety. Beginning with regulatory compliance, continuing with safety systems and program development, and currently with management practices, organizations have reduced injuries and minimized risks tremendously. However, many organizations now find that they have progressed to a high level of safety performance and have leveled off. The ability to make safety improvement has become difficult.*

## **Safety Improvement Continuum**

A simplistic Continuum of Improvement model includes four levels:

1. Failing – Improvements have not started and are therefore failing. Organizations in Level 1 are struggling to meet minimum standards.
2. Improving – Includes the majority of organizations and covers the widest spectrum of the continuum. A steep rise in safety improvement is seen, but basic regulatory issues and proven safety practices have not been fully implemented.
3. Excellence – Includes organizations with mature safety processes that follow the “5 Basic Principles” and “10 Key Elements” of Safety Excellence.
4. World Class – Includes a very small and select group of organizations that continue to improve at the highest level of safety performance.

An organization reaching for world class safety status is analogous to an obese person striving to become a world-class athlete. Recognizing that improvement is needed and having a good idea how to improve is a critical first step, but it does not mean any improvement will be made. Most people have a good idea of what it takes to lose weight and get into better shape. Once they start, early efforts produce obvious improvements and fuel the desire to continue working toward the desired goal. But as higher plateaus are achieved, the ability to make measurable gains becomes more difficult.

The same holds true for safety. After achieving some success in safety, plateaus are reached and leveling off occurs. The pleasure of past accomplishment does not satisfy, the status quo will not suffice, and the barriers to improvement are strong. Instead of facing this dilemma openly, management often holds to the “continuous improvement” mantra. Inane words of commitment from management without the required knowledge and proficiency to progress will lead to setbacks, frustration, and knee jerk decisions.

In order to continue improving at the excellence and world class levels, safety process strengths are not abandoned, but are leveraged and refined. This approach is not “Back to the Basics”,

which implies starting over. The strategy is to identify weakness in otherwise strong fundamentals, correct the weaknesses, and build on existing success.

## **Safety Performance Measurement**

A continuum of improvement begs the question of measurement. Determining accurate methods of measuring safety is a monumental challenge and unfortunately, no widely accepted method has replaced frequency rates of OSHA recordable injuries and illness. This inaccurate, arbitrary, and downstream measure has been the impetus for much chaos in the field of safety. Using OSHA recordable rates distorts the true picture, measures failure, is reactive, and motivates companies to make bad decisions. Frequency rates are trailing indicators, but are the most popular game in town because it is the law.

The use of OSHA recordable frequency rates become increasingly detrimental as rates become lower and lower. The lower the rate, the greater the impact one OSHA recordable has on the rate. The greater the impact, the more consternation and chaos ensue. Absent more meaningful data, there can be a perception that the safety process is broken and something must be done, now! Consequently, inordinate time and resources are consumed reacting to an OSHA recordable injury without regard to incident severity or hazard potential. When an employee's hand is cut and two sutures are required, excessive resources may be diverted to figure out how to prevent any more cut hands. With the emphasis on OSHA rates, efforts to correct hazards with much greater injury potential, such as fall hazards or zero-energy violations, are neglected. For managing risks and resources effectively, incident severity and hazard potential are more important factors than frequency rates alone.

Management likes frequency rates because it gives them a number. However, rank and file workers very much dislike distilling safety performance down to a number for several reasons: most employees don't understand rates; they don't care about it; they think management is only concerned with the number and not them; and it is a factor over which they have little or no control. Accordingly, basing safety performance on frequency rates is a blunder because they are not a good measurement, they have a negative effect on employees, and they lead to bad decisions.

All the time and effort recently spent by OSHA revising this inveterate system would have been much better spent devising meaningful metrics targeted at critical upstream safety indicators. Accurate data proactively measures performance by assessing and improving the principles, key elements, best practices, and systems of the safety process.

## **Basic Principles and Key Elements**

Regardless of where on the safety improvement continuum an organization may be, a review of safety excellence principles and elements is always valuable.

There are **5 Basic Principles** that lay the foundation required to manage a comprehensive safety process.

1. Safety is a **corporate value**. There is a clear safety philosophy that is communicated and visibly demonstrated throughout the corporation. Words of commitment are seen in action.
2. **Regulatory compliance** is given top business priority.

3. **Leaders** at all levels who are responsible for managing safety throughout the organization are **supported and trained** to do their job.
4. The **10 Keys to Safety Process Excellence** are followed.
5. **Accountability systems** are in effect to ensure that expectations are clear, authority is appropriate, and the safety process is managed to deliver continual improvement.

There are **10 Keys to Safety Process Excellence** that must be followed to build upon the foundation of basic principles:

1. All employees are involved. **Leadership** at all levels set the right example and are supported. Employees **manage** the safety process through wide spread **participation**. Safety professionals provide guidance and expertise.
2. **Communication** of the safety message is organized, planned and carried out in an effective manner.
3. **Policies and procedures** that make sense are in place and followed.
4. Safety **training** is robust. Interesting and effective safety **meetings** are held regularly. Trainers are competent.
5. **Auditing** activities proactively assess how employee actions and workplace hazards are related. Results are used to **manage risks**.
6. Safety **incidents** are **investigated** to determine true causes, which when fixed will prevent recurrence.
7. **Reward, Recognition, Reinforcement, and Incentive** programs are focused on preventive actions and corresponding achievements.
8. Safety considerations are integral to **design, engineering**, and managing workplace **changes**.
9. **Off-the-Job** safety activities promote safe lifestyles.
10. Creative **process-focused** innovations drive improvement.

Companies with mature safety processes will include most of these key elements. But simply including these key elements does not mean best practices for each element are in place. Best practices are learned through experience, technical competence, understanding organizational culture, benchmarking with other companies, and willingness to make innovative change. Benchmarking is used to learn from others what works and what doesn't. Sustained proficiency in the principles and elements of safety excellence is required to apply for membership in the elite status of world-class safety.

### **The New Safety Model**

The new safety model is formed on the foundation of existing successful safety models. The goal is not to look for a new program or panacea. The new safety model is a progression of success and regression of failure. This progression is an arduous and structured process that requires an objective identification and culling of system deficiency and failure, however subtle, insidious, or culturally deep-rooted the deficiencies might be. As deficiencies are eliminated, successful systems become stronger. For example, the 50<sup>th</sup> anniversary edition of the Chevy Corvette is the result of efforts to make the American sports car better with each model by eliminating defects, and improving performance and customer satisfaction.

Continuously forming a new safety model requires a new mindset, new goals, and new measures for success. There must be recognition that no one company has all of the answers. At the point a company becomes satisfied, they have stopped improving and become complacent. The desire for continual improvement is a hallmark of world-class safety.

## Exploring Barriers

Once committed to improving the safety model, the process is surprisingly simple, but it is not easy. Preliminary steps are required. An organization must be willing to explore the barriers to improvement if they expect to experience the breakthroughs they seek. Three common barriers are found:

**Barrier #1** - There is reluctance to modify or abandon long-standing safety activities that have worked well. The new safety model does not call for absolute displacement, but it does call for objective scrutiny and desire to change.

**Barrier #2** - Most deficiencies are not glaring and obvious – they are hard to find. For the most part, outside auditors such as corporate teams, insurance companies, and regulators will miss subtle and insidious weaknesses and be satisfied if basic principles, key elements, and regulatory compliance are in place. This approval can provide reinforcement which may lead the organization to look for improvement elsewhere or attempt to develop another “program.”

**Barrier #3** - Improvements will not be spectacular – they will be small and steady. This barrier is especially important for those organizations searching for a panacea or magic potion. The simple truth is that fine-tuning of existing best practices will produce small yet sustainable gains. Unless these and other barriers are acknowledged and understood, they will thwart improvement. If the organizational commitment is not unified and does not have the same clear objectives, efforts will fragment. Barriers must be expected and understood, and there must be a contingency plan in place to deal with foreseeable issues. As with all successful problem solving models, the upfront work does not produce tangible results. But the upfront work is prerequisite and will streamline the delivery of desired results when the improvement plan is put into action.

## Deficiencies In Safety Best Practices

Ideally, a best practice will not have any deficiency, but in the real world, deficiencies creep in over time. The critical point is, in order to break through to world class safety, deficiency and failure must be exposed, removed, and replaced. A world-class athlete has developed many good habits, but bad habits will form unless there is a willingness and diligence to correct incipient problems as they occur.

There are dozens of suspect areas for improvement; commonly overlooked deficiencies include:

1. Safety meetings and safety training that waste time and money, and bore employees. One of the greatest expenditures of human and financial resources is often regarded by employees as a negative motivator.
2. Incident investigations that overlook system failures, don't find true causes, and place blame. Corrective actions do not prevent recurrence.
3. Many activities; few results. Winston Churchill said, “I pass with relief from the tossing sea of Cause and Theory to the firm ground of Result and Fact.” It does not matter how many teams, committees, sub-committees, councils and programs are in effect. What matters is their impact and results. Every safety activity should be continually scrutinized for productivity and efficacy.
4. Unsafe activities are positively reinforced, condoned, ignored and implicitly approved. The resulting negative impact on safety culture is not understood.

5. Searching for and/or attempting a quick fix, new program or panacea. Especially damaging when imposed from the corporate hierarchy with little or no input from end users.
6. Auditing that generates work for someone else. Finding problems is easy. If problem finders don't help with solutions, they are creating a larger problem.
7. Safety messages from top leadership inconsistent with shop floor realities. Ralph Waldo Emerson said, "Your actions speak so loudly, I cannot hear what you are saying." Actions that support the safety message are what determine the value of safety within an organizational culture. False platitudes about the value of safety ring hollow if actions do not square with shop floor reality. If safety is a matter of convenience that can be compromised depending on production demands or any other factor, bogus words do more harm than good.

Many deficiencies such as these occur below the radar screen of auditors and regulators. They are normally missed, even during management system reviews. Experienced safety practitioners, line leadership, and rank and file employees understand these issues as they often surface as points of contention between management and labor. It is imperative that these deficiencies are acknowledged and improved upon. Aggressively tackling these issues will produce great dividends and shift the safety paradigm to new heights. Employees will be satisfied and trust will be built. Employees will "buy in" and help manage the safety process.

### **Ascending The Summit – World Class**

Breaking through to the world class level demands the discipline to ensure that all efforts are process-focused and employee-managed.

**Process-Focused:** The safety process is comparable to any production process. Great gains have been made in the quality of manufacturing products by focusing on the process instead of simply inspecting the final product. Dr. W. Edwards Deming was a leader in this effort, but had to prove the concept first in Japan before it was embraced in the USA. There is a similar reluctance in the safety field to focus on the process. Fortunately, American manufacturers accepted the process-focused approach and not behavior-based quality or behavior-based manufacturing. Unfortunately, safety improvement has become sidetracked because the behavior-based pitfall was not avoided.

Instead of improving best practices and safety process systems, some organizations have experimented with behavior-based safety (BBS) in recent years. While there is merit in understanding behavior, the time has come to restrict the exaggerated value of behavior-based safety and shift the focus back to improving the safety process.

Organizations with mature safety processes that are considering the obtuse and expensive BBS approach run the risk of taking a step backward. Despite all the upfront promotion BBS requires, employees recognize and resent this elementary approach that questions their ability to behave safely. Employees appreciate a more comprehensive approach that finds hazards and system weakness, and uses their abilities to manage the risks they face.

World-class safety performance is reached by methodically improving upon the 5 principles and 10 key elements. Focusing on the safety process is a comprehensive approach that seeks to understand safety systems. Problem-solving models are applied to systems within the safety process in much the same manner as when solving quality or manufacturing problems.

Why is this difficult? Simply having a key element in place does not mean the element is functioning effectively. For example:

- Merely having an incident investigation process in place does not ensure that employees are not blamed, true causes are found, and corrective actions prevent recurrence.
- Holding regular safety meetings may be of negative value if they are done poorly.
- A vice-president obviates line and staff accountability by telling employees they have a strong safety culture when, in reality, safety is compromised when production demands are high.

Defining issues like these and facing them head-on requires expertise, determination, and courage.

Another reason focusing on the process is difficult is that it appears too simplistic. When the focus is not on the process and OSHA recordables are the primary measure of performance, there is a perception by management that the safety process is broken, and pressure mounts to develop another program. When this happens, organizations are tempted to fall for a new and flashy program like BBS. To keep this from happening, the safety profession must employ creative process-focused innovations that drive world-class safety performance.

### **Employee Ownership**

Organizations functioning at the highest levels of safety have developed safety leaders at all levels. These organizations have done such a great job of training and communication that the safety process is managed outside the safety department. Accountability systems are strong because authority is vested with these safety leaders to make decisions and set policy. Safety is not seen as being pushed from the top down. Safety is owned and powered by employees who manage risks, determine procedures and ensure compliance. Safety professionals function as advisors, facilitators, and technical experts. To understand how this is possible, some explanation is needed.

Who are the employees that own the safety process? Everyone is an employee, not just wage roll or hourly workers. From the top executive to the newest associate, safety leaders develop throughout the organization. A mechanic may lead a lockout/tagout team, and a manager may lead a safety recognition team. Command and control has been subjugated by a cross-section of the organizational hierarchy. Employees understand that decisions are not forced from the top down, but come from within and are based on broad input and participation. When management has a momentary lapse and reverts to top-down control, the employee-managed safety structure short stops the problem and takes control. This structure does not undermine the chain of command, nor does it allow leaders in supervisory positions to abdicate their obligations. What this structure does is allow all employees to contribute and have ownership in the safety process.

Consequently, safety professionals support safety leaders with counsel, advice, and resources because of their technical competencies, facilitation skills, and persuasiveness. Safety professionals can think, manage, and strategize. Safety professionals no longer punt, pass, kick, catch, block, tackle, and carry the ball by themselves. They can actually coach, plan and nurture the safety process with a strong team of safety leaders and empowered employees. Control is delineated and employees manage the safety process.

### **In Summary**

Like a world-class athlete, the safety excellence journey advances success and reduces failure. Basic principles and key process elements are implemented. Early success comes quickly, Weakness is rooted out so the safety paradigm can be constantly shifted forward, ignoring the status quo and gaining proficiency in systems. Barriers are expected and overcome. Safety experts lead the profession and dismiss unfounded methods. Advancement through the safety performance continuum of improvement to the world class level is achieved by strengthening proven fundamentals and best practices, and ensuring that safety efforts are process-focused and employee-owned. The methods and techniques needed to deliver continuous safety improvement are available to every organization.

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**Tom Harvey, CSP**, has over 20 years of operational safety experience in regulatory compliance, safety excellence, leadership and management systems. He is a safety consultant and trainer with Allied Safety Associates who has helped a wide range of companies and trained thousands of diverse employees at all levels. He can be reached at [tom@alliedsafety.com](mailto:tom@alliedsafety.com) or 803.732.3827.

