Cultural clarity

Along our journey to safety excellence, accidents may occur. Each provides us with a unique opportunity to learn and take appropriate action to prevent a recurrence. If we miss this chance, we really lose out. In this article, ANDREW SHARMAN explores the concept of a "just culture" in health and safety at work and how it can help prevent a recurrence of accidents

Clarity is key to developing a robust safety culture; transparency rocks! We know it's important that all incidents are reported and processes are in place for investigation and the implementation of suitable preventative actions.

If we truly want our employees to provide us with this information, however, we need to create an environment where they feel able to step forward to offer thoughts and opinions objectively and freely – and for these to be received openly and respectfully by the organisation.

Any processes we use to report accidents, or to encourage feedback and suggestions from our employees, must be easy to use, respect confidentiality and be worthwhile.

By contrast, a workplace where news of negative safety events – such as accidents, injuries and near misses – is met with disappointment and unease is not conducive to developing this clarity. In fact, it drives things in the opposite direction – into the dark depths of forgotten anonymity, underground.

The practice of reporting events is quickly minimised and provided only when forced or extracted, or when such an incident has been unavoidably witnessed by a superior. Near misses tend to be dismissed as "accidents fortunately avoided" through the sheer skill or experience of workers, and written off rather than followed up.

REACHING FOR ZERO

As part of their drive to share what they have learned from their accident investigation process, a new client of ours – a leading global player in the manufacturing industry – would distribute a newsflash summarising every incident that occurred to all its sites. Not a bad idea you might think – surely this might help stop the same things happening over and over again …

Not such a great idea if you were the injured person though, as your name and photograph would be featured in the opening sections of the report. As you might already be guessing, it wasn't long before the company found themselves reaching their aspiration of zero reported accidents – though a corresponding spike in unexplained absences suggested to us that something wasn't quite right.

FINDING THE BALANCE

Organisations that place emphasis on identifying fault and apportioning blame will always encourage a culture of fear, which will, sooner or later, lead to under-reporting when it comes to safety issues.

Yet, at the opposite end of the spectrum, an organisation attempting to operate a totally blame-free work environment is likely to frequently suffer wilful neglect and violation. Finding the balance should be our aim, and appropriate accountability is the route to success.

Balancing our desire to learn from mistakes with the need to take corrective action to reinforce the notion of accountability is the way forward. In safety terms, thanks principally to the work of the Australian Sidney Dekker, this has become known as a "just culture", and can be defined as a culture in which individuals are not punished for actions taken by them that are commensurate with their experience and training.

While it discourages apportioning blame, a just culture is not a "no-fault" system. It doesn't mean we have to operate under the auspices of "no blame", but rather a sense of fair and appropriate accountability is incorporated into what we do.

In a just culture there is an acceptance and understanding that human errors are often caused through system failures as opposed to, but of course in addition to, the potential for personal failures, but where gross negligence, wilful violations and destructive acts occur, these are not tolerated.

In simple terms, a just culture is about being objective, rational and fair, rather than jumping to conclusions drawn from our first steps of investigation or observations. If we are thorough in our accident investigation processes and truly strive to identify what went wrong, we may find that the majority of unsafe acts and behaviours that have occurred are due to unintentional error, rather than deliberate wrongdoing.

Thorough and systematic evaluation of events is key, and investigations into where things have gone awry should include: determining whether the actions were as intended; whether an individual knowingly violated policies, procedures or rules; and, if so, whether there is a history of such violations.

Remember there is a clear distinction between human error and violation. An easy way to note the difference is that, in order for there to be a violation, there must first be a rule, and, second, an intention to break it. If there's no rule, there can't be a violation!

In fact, when we look at those events that we consider to be violations, we may

often find that such wilful incorrect actions have been, quite literally, catalysed in the worker's mind, due to organisational pressure – whether real, implied or imagined – or perhaps an internal self-influence of simply wanting to do the right thing; like meeting the shift production targets, for example.

Where the mistake was inadvertent, or occurred in a system that was not supportive of safety (such as a period of extended, mandatory overtime leading to fatigue), an appropriate response in a just culture would include coaching and education.

Of course, malicious or purposefully harmful behaviour must not be tolerated, and individuals should be held responsible for their actions within the context of the circumstances in which they occurred.

Even where the act is found to be predominantly wilful and malicious, it's worth trying to understand – as objectively as possible – what caused that mindset. Is there something that the organisation did that contributed to it? And could other employees have the same perspective?

BUILDING THE BENEFIT

A just culture embraces the notion that people are, indeed, fallible and will from time to time get it wrong. Building a work environment where individuals feel free to support and improve workplace safety – by offering up ideas, by sharing openly when they spot weaknesses and failures in the system, and by stepping forward when errors occur – creates benefits on many levels. A few that spring to mind are that it:

- Increases transparency;
- Builds trust;
- Enhances worker commitment and motivation;
- Contributes to learning and continuous improvement;
- Empower workers;
- Increases openness of reporting of issues and weaknesses;
- Improves objectivity in analysis and decision-making;
- Brings balance and accountability;
- Promotes safe behaviours; and
- Reduces the frequency of unsafe acts.

Encouraging and sustaining a just culture in your workplace allows people to concentrate on doing their best work, rather than worrying about watching their backs and trying to eliminate every chance of a mistake for fear of repercussion.

A just culture places safety as a core value, part of the organisational DNA, and an intrinsic "way we do things around here". It engenders employee engagement and builds robust, meaningful leadership in safety. **/SHEQ**

DO YOU HAVE A *JUST CULTURE* IN YOUR ORGANISATION?

- Do you feel that all accidents, injuries and near misses are being reported? If so, what gives you the confidence that every event is being reported accurately?
- How do you ensure that your accident investigation process is rational and objective? What measures do you have in place to encourage people to step back and make a thorough and impartial evaluation of the events that occurred?
- It's often easy to view an unintentional error as a wilful violation on the basis that "the person knew the rules". How does your organisation draw the distinction between violation and error? And, are your operational managers able to explain the difference?
- Look back at your workplace accident data for a given period (say a year or two perhaps). Can you categorise them between errors and violations? Where do most of them fall? What does this tell you about your culture?

Sharman on Safety is a series of extracts that ***SHEQ MANAGEMENT*** *is running this year, from Andrew Sharman's new book:* **From Accidents to Zero: a practical guide to improving your workplace safety culture.** *Andrew is an international member of the South African Institute of Occupational Safety and Health (SAIOSH) and chief executive of RyderMarshSharman - consultants on leadership and cultural excellence to a wide range of blue-chip corporates and non-government organisations globally. More at www.rydermarshsharman.com.* ***SHEQ MANAGEMENT*** *readers will receive 20 percent off the price of Sharman's book at: www.fromaccidentstozero.com using the code SHEQSA.*