Dysfunctional Practices

That kill your Safety Culture (and what to do about them)

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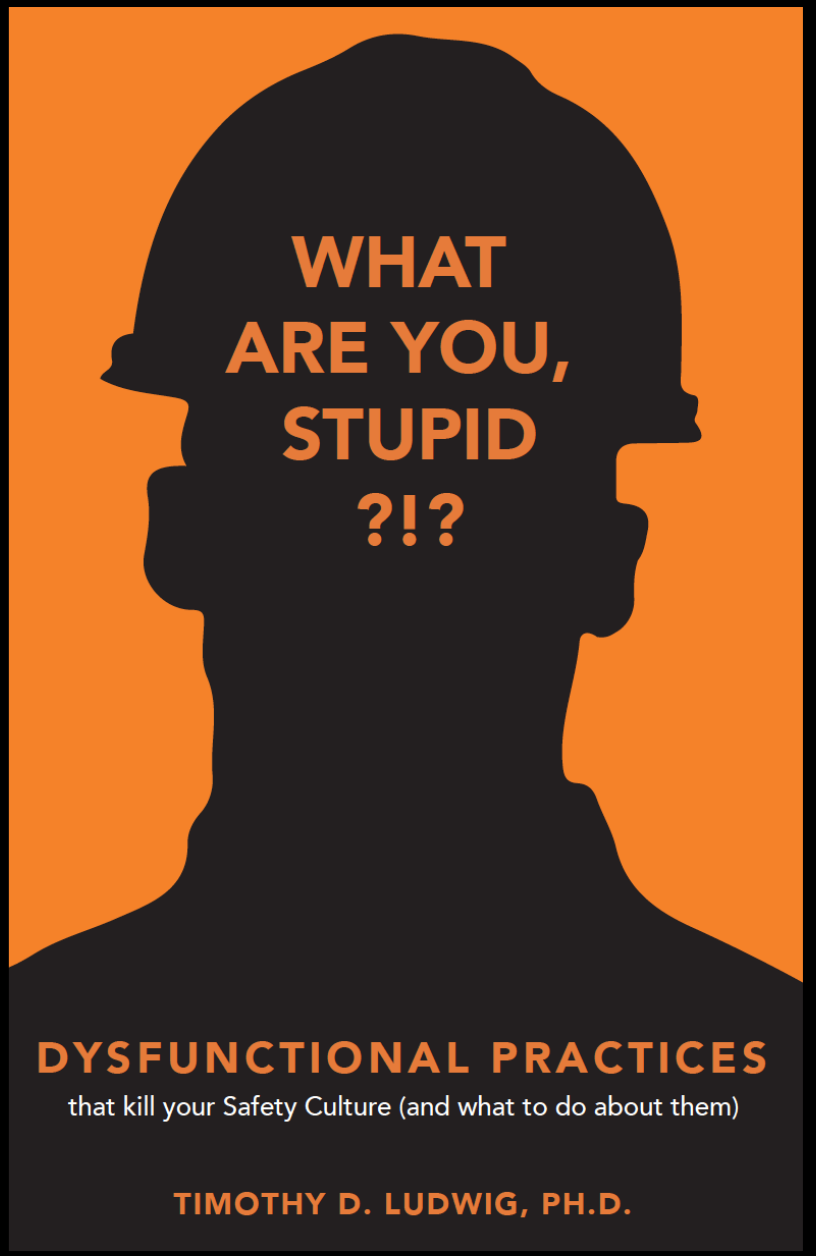

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DYSFUNCTIONAL PRACTICES

LABELING

- Labeling is a natural human tendency. “Stupid” is a label, no one is stupid. Labeling starts arguments and entrenches people against each other.

- You can’t fix a label. After labeling, we may feel enlightened, but the environment doesn't change and we end up acting the same way as in the past as the environment dictated. Nothing changes. Labeling hurts our ability to manage the behaviors of others.

- We should attempt to change the environment, not the person. Instead of asking a person to BE something, focus on how you can help them DO what is required to be safe.

DYSFUNCTIONAL PRACTICES

BLAMING

- Workers are too often blamed for incidents in our incident investigations as well as other processes such as behavior-based safety. The root cause of “Human Error” blames the worker.
- When workers are seen as a root cause we over-rely on exhortations like training, coaching, and instructions. Exhortations direct behavior but they don’t motivate.
- When we blame and try to change the worker through exhortations we leave the real reasons for the incident untouched and hidden.
- If the real reasons that caused the incident remain untouched the risk will be repeated over and again by anyone engaging in that task.

DYSFUNCTIONAL PRACTICES

RUSHING TO JUDGE

- Labeling can be a catharsis when emotions are high, but we will remain frustrated because you can't fix a label. Saying that someone has the wrong attitude is yet another impotent label.

- Labels are mental shortcuts performed by your brain. They are stereotypes based on generalizations and limited analytic judgment. These judgments are generally inaccurate due to our human biases of attribution leading to misinterpretations.

- You can't change attitudes through exhortation. You change attitudes by changing behavior. You act your way into a new way of thinking, not the other way around.

- Find small ways for your employees to promote safety. They will observe their own behavior and experience an attitude change: "I've been talking about safety to my peers, I must buy in to safety."

DYSFUNCTIONAL PRACTICES

FISHING FOR FAULTS

- Managers are shaped to look for faults and favor aversive tactics such as scolding, threats, and discipline. They go fishing, trying to find at-risk behavior based on single data points and miss the behavioral variance that is the real source of risk.

- When we fish for risks we fail to see the plethora of safe behaviors taking place. We fail to see the variation that can help us solve problems and create a safer workplace.
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- Instead of showing variation, measures such as injury rates and violations are binary. Recording a “zero” day after day builds complacency.

- A good measurement system scans your operations objectively, looking for pockets of variation that may reflect hazards and risks.

- Find variance in occurrences of reporting, participation, suggestions, and actions taken based on the insights of employees empowered to participate in your safety program.

DYSFUNCTIONAL PRACTICES

MANAGING THROUGH FEAR

- Fear around hazards keeps us alert and primed for emergency. Fear makes us more aware of our behaviors and in tune with potential severe consequences. Unfortunately, this fear of hazards habituates across time and does not maintain safety behavior.

- Managers who manage safety through aversive tactics create fear. This fear gets associated not only with the risks and hazards, but also with the manager and even the safety systems.

- Humans avoid fear and therefore, they tend to avoid the manager and safety systems that can get them in trouble. Fear reduces participation in safety programs and increases reactive behaviors that sabotage safety programs.

DYSFUNCTIONAL PRACTICES

KILLING THE CONVERSATION

- Not only does labeling make you less likely to talk and listen to your people, it makes them less likely to talk or listen to you.

- Safety culture is not some value-laden, touchy-feely, fuzzy construct of an imaginary utopia. Instead, safety culture is people talking about safety and listening to each other. You can see talking, engage in talking, and experience the consequences of talking. Its universal and it makes an impact.

- A key ingredient to reducing at-risk behavior is to know it is happening. Only then can we analyze the reason why the person was in in the position to take the risk. Only workers truly know the at-risk behaviors occurring; we need them to talk to us. Otherwise, risks will be hidden.

- The premier safety culture is when your peers coach peers (talking) when they see behaviors that put workers at risk, and when peers praise each other for safe practices.

DYS FUNCTIONAL PRACTICES

LABEL THE BEHAVIOR

- Approach behavior with the same unbiased analysis as scientists use with -the elements of physics and chemistry. Behavior is neutral; it is not right or wrong, good or bad.

- The properties of behavior make it particularly open to observation. First, behavior is omnipresent. Behaviors are prolific, visible (unlike attitudes, beliefs, values) and have an impact. All we need to do to change and improve is observable.

- Approach any incident with a clear understanding of the cause and effect relationships between the behaviors related to the risk, and the reasons why that person, either knowingly (on purpose) or unknowingly found themselves in a position to take that risk.

- Behaviors operate on their environment for a purpose. To describe behavior operationally, state the action, what is being operating on by the action, and why. No fluff, only what you can see.

DYS FUNCTIONAL PRACTICES

DISCRIMINATE BEHAVIOR

- Behavior Hacks are “creatively improvised solutions” employees have adopted to manage their own environment so they achieve their safety outcomes more predictively every time. Ask your workers to find out how they achieve this.

- Training must give workers the ability to perceive the appropriate cues in their work environment and discriminate the appropriate behavior to engage. Good discrimination allows workers to verbalize the rule: “*In this situation… If I act this way … Then this will happen.*”

- Consequences choose the behavior. Any consequence that is more PROMPT, PROBABLE, and PERSONAL is more powerful at motivating a behavior.

- Most workers never experience the negative consequence of a serious injury, either to themselves or co-workers. Behavior must come in contact with the consequence in order to be reinforced or punished. In many cases threat of injury will not maintain safe behavior.

~~DYS~~ FUNCTIONAL PRACTICES

PULL THE DOMINO

- Your system is perfectly designed to get the results you received because your system is perfectly designed to produce the behaviors you shaped.

- Human behavior is not the cause of injuries instead behavior is the result of other factors.

- Target the right part of your system to change. Observe behaviors to find risks. Then ask your workers why the risks are taken. Analyze the antecedents (e.g., training, tool availability, instructions, time pressure) that direct at-risk behavior or fail to direct safe behavior. Then identify the consequences that reinforce at-risk behavior or punish safe behavior to save time or trouble.

- An operational definition of safety culture is “people talking about safety.” Talk to your workers and LISTEN! Engage in systems that have them talk to each other. Peers who coach peers are the first line of defense… and the most effective behavior change strategy.

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WALK THE TALK

- Be humbled by the potential of human performance

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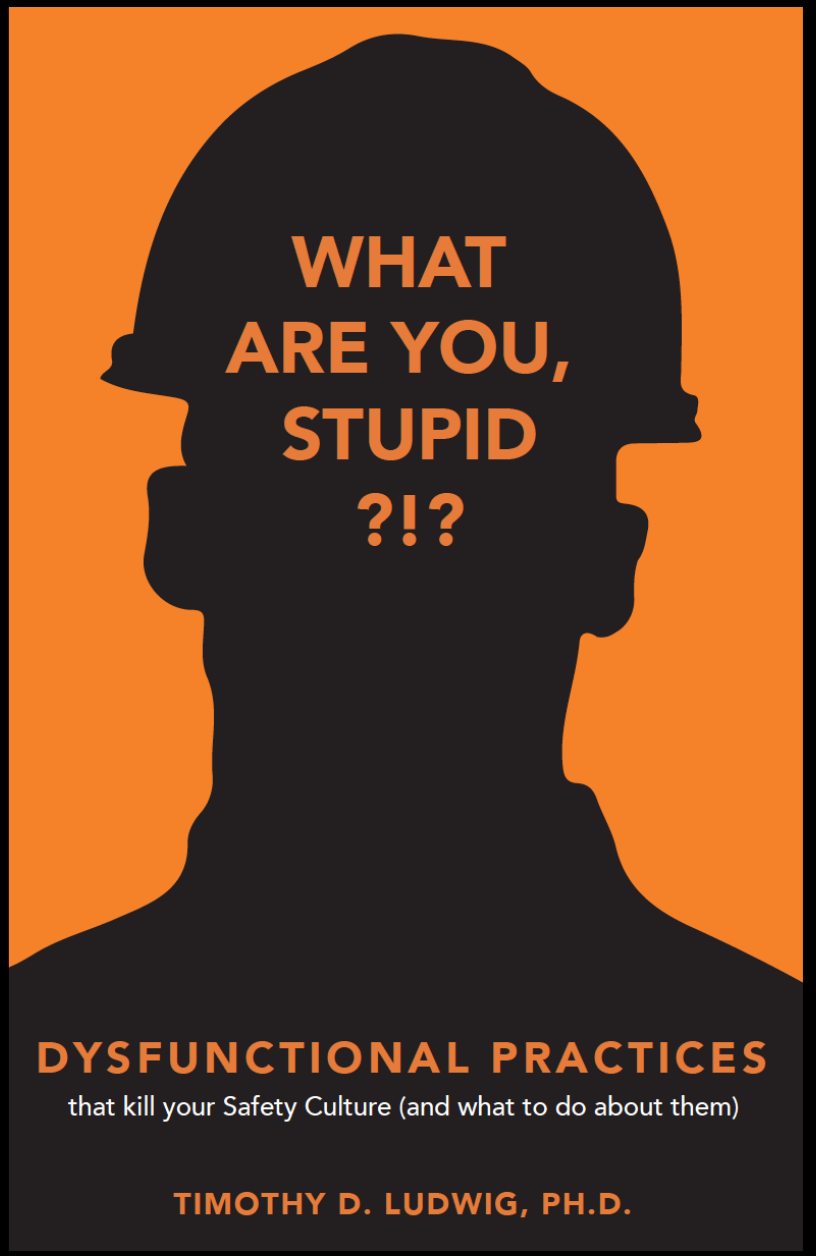

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