

LIVE WEBINAR

Creating an Unstoppable Safety-First Culture

WEDNESDAY

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1-2PM CST



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Before We Begin

All attendees are in “LISTEN ONLY” mode.

You can type in questions by clicking on the question box on the top right of your GoToWebinar panel.

Q&A at the end of the webinar.

Additional questions can be emailed to: SChristenson@smscsafety.com

A recorded copy of the webinar and slides will be made available to all attendees.



Today's Presenter



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Today's Agenda

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2

Generational Differences

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Old View Safety

4

New View Safety





ISO 45001 Elements

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ISO 45001 is the international standard for Occupational Health and Safety Management Systems (OHSMS)

- Designed to help organizations improve employee safety, reduce workplace risks, and create better, safer work conditions.

Core Elements of ISO 45001

- **Context of the Organization**
 - Understand internal/external factors that affect your OHSMS, including stakeholder needs & expectations
- **Leadership and Worker Participation**
 - Top management must demonstrate leadership & commitment, while actively involving workers in decision-making and safety initiatives
- **Planning**
 - Identify hazards, assess risks, and determine opportunities for improvement.



ISO 45001 Elements

Core Elements of ISO 45001

- **Support**
 - Ensures resources, training, communication, and documentation are in place to support the OHSMS effectively.
- **Operation**
 - Implement processes to control risks, manage change, and respond to emergencies.
- **Performance Evaluation**
 - Monitor, measure, analyze, and evaluate the effectiveness of the OHSMS through audits and reviews
- **Improvement**
 - Take corrective actions and promote continual improvement to enhance health & safety performance





Generational Differences

Generational Differences in Today's Workforce

Baby Boomers (1946 – 1964)	Gen X (1965 – 1980)	Millennials (1981 – 2000)	Gen Z (2001 – 2020)
<ul style="list-style-type: none">• Competitive• Optimistic• Driven by Achievement• Recognition • Phone Calls• In-Person Meetings• Direct Communication	<ul style="list-style-type: none">• Independent• Skeptical• Value Work-Life Balance• Efficiency • Email• Efficient & Informal Conversations	<ul style="list-style-type: none">• Collaborative• Tech-savvy• Seek Purpose & Feedback • Texting• Instant Messaging• Collaborative Platforms	<ul style="list-style-type: none">• Entrepreneurial• Socially Conscious• Prefer Flexibility & Authenticity • Visual Content• DMs• Asynchronous Tools





Old View Safety

Old View Safety

Safety is the absence of injuries and illnesses.

- Emphasis on OSHA recordables and other lagging indicators
- OSHA incident rate is the primary measure of health & safety performance

Most activity is directed at improving the parts of the program individually by conducting inspections, incident investigations and audits.

- Underlying assumption is that if the organization can find and fix enough conditions & practices, the system will be safe

Almost all incidents have a single root cause.

- People and conditions are most frequently identified as the cause of injuries and illnesses
- When people are involved, “bad apples” are usually to blame.

Systems are basically safe as long as workers follow procedures and work safely.

Safety and health activity is primarily driven by the safety department.



Safety “Sacred Cows”



“All incidents are preventable”



“Closely examining and preventing small events allows us to predict and prevent big events on the horizon”



“Safe means the absence of negative occurrences”



“Most events are caused by human error”



“If people just followed the rules, nothing bad would happen”



Groundhog Day



So, where do we go?





New View Safety

From Compliance to Care

New View Safety

New view of safety that emphasizes the importance of resilience and capacity

- **Resilience** – system's ability to maintain its core functions despite disturbances, changes and unexpected situations.
- **Capacity** – an organization's ability to effectively manage risks and ensure resilience, even in the face of unexpected events or failures.
- Been around for about 25 years

Includes: Safety II, Safety Differently, Human Organizational Performance (HOP) & High Reliability Organizations (HRO).

- All have similar concepts but each contain unique features



Principles of Safety Differently

Developed in 2014 by Sidney Dekker

- Professor in the School of Humanities, Languages & Social Science at Griffith University in Brisbane Australia
- Founded the Safety Science Innovation Lab
- Globally known for his work in the fields of human factors and safety

Centers around 3 key concepts

- **Workers are not the problem – They are the problem solvers**
- **We do not tell our organizations what to do – Ask them what they need**
- **Safety is not an absence of accidents – It is a presence of capacity**



5 Principles of Human Performance

Developed by Dr.
Todd Conklin in 2019

- Spent 25 years at Los Alamos National Laboratory (15 years on Human Performance)
- Senior Advisor for Organizational and Safety Culture

Error is
Normal

Blame
Fixes
Nothing

Learning is
Vital

Context
Drives
Behavior

How You
Respond
Matters



Start From a Place of Trust

Distrust and blame go hand-in-hand

- **Distrust** – the feeling that someone or something cannot be relied upon
- **Blame** – assign responsibility for a fault or wrong

Blame is easy, it feels good, and it makes us really feel like we are taking the moral high ground by punishing the ones that would dare to break rules

Most organizations view safety as a **“you”** based activity

- Something you choose to get right (or wrong)
- A simple endeavor that only requires enough attention, care and focus. Applied by the end user to get right, and to avoid the occurrence of events.

Many organizations never trusted their workers to get safety **“right”** in the first place

- Establish rules
- Surveillance
- Enforcement



Trust ... even when everything hits the fan



Purpose of a Restorative Culture

Aim

- Creating an environment where the perceived risk of speaking up is low so we learn, adapt, and change

Organization

- Simply, without it we won't know what is going on. Is necessary to effectively monitor the safety of an operation and to understand the capability of our people

Individuals

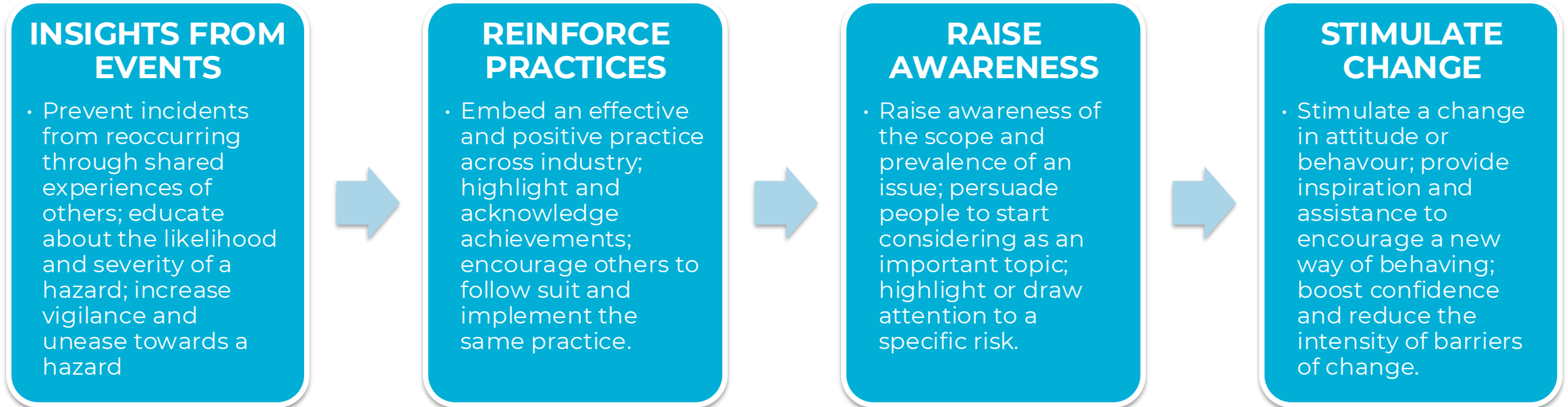
- To feel empowered to concentrate on achieving safe production, rather than limiting personal liability, to feel involved and able to contribute to safety improvements by flagging for weak spots, errors and failures

Customers & Community

- Without it, organizations will be focused on over documentation, hiding or defending decisions – rather than on making better decisions



Why Communicate?



THE INFORMATION ENVIRONMENT



Across most safety culture models and frameworks, a key idea that repeats itself is the “information environment”.

In other words, a “safety culture” is one that promotes unbiased, multidirectional, and free-flow of information about work in an organization.



Learn Deliberately and Often From Those That GSD

Two methods of gaining vitally needed operational excellence

- Learning teams
- Learning explorations

Learning teams are used to explore problems or betterment opportunities, seeking out valuable learning rich and contextualized information, in hopes of generating fixes for particular pain points, issues or problems.

Learning explorations are viewed as casting a wide net to discover opportunities that we should seek to learn more about.



Become Obsessed With The Things That (Actually) Matter

Things look safe, they must be ...

- If we see “safety things”, it means we are doing “safety things”, and that by doing “safety things”, we are making ourselves and other “safe”

Our “safety things” have unintended consequences

- Additional administrative duties
- Creation of employee apathy relating to company safety endeavors
- General frustrations & headache relating to these “safety things”
- Can also create Risk Compensation
 - Also known as risk homeostasis
 - People adjust their behavior to maintain a perceived level of risk
 - Taking more risks when they feel safer and more careful when they feel a greater risk

We seek to manage and manipulate what we think we can



Shift Our Safety Focus

“things that hurt us
are not the things that
kill us.”

- Todd Conklin

Three basic areas of critical risk most organizations face:

STKY – Stuff That Kills You

- Things within our organization that actually kills or maims workers
- Evidence suggests that serious injuries and fatalities are the result of undesirable contact with energy (gravity, motion, electrical, chemical)

STRM – Stuff That Really Matters

- “Things we must always get right”

STBY – Stuff That Bankrupts You

- Can include both STKY & STRM
- Can expand into regulatory concern, legal matters, company image, etc.



Action Plan



Where are we at now?

- Complete safety survey with your team
 - Anonymous
 - Ask simple questions
 - What do we do good?
 - What do we need to improve?
- Accept the hard truth

Where do we want to be?

- Be realistic
- Build a timeline
 - Milestones
 - Celebrations

How do we get there?

- Team effort
- Involve hourly team members





Get Better Everyday

Key Takeaways

Trust	Communicate	Learn	Plan
Trust your team in good & bad	Create an “Information Environment”	Become obsessed with “What Really Matters”	Develop a fluid action plan
Build a restorative culture	Embrace bad news when it happens	Utilize learning teams to understand all aspects of work	Be realistic
Be genuine	Value real, raw dialogue	“Work-as-imagined vs. Work-as-done”	Get insight from all levels in the company
Embrace humanity			Celebrate milestones

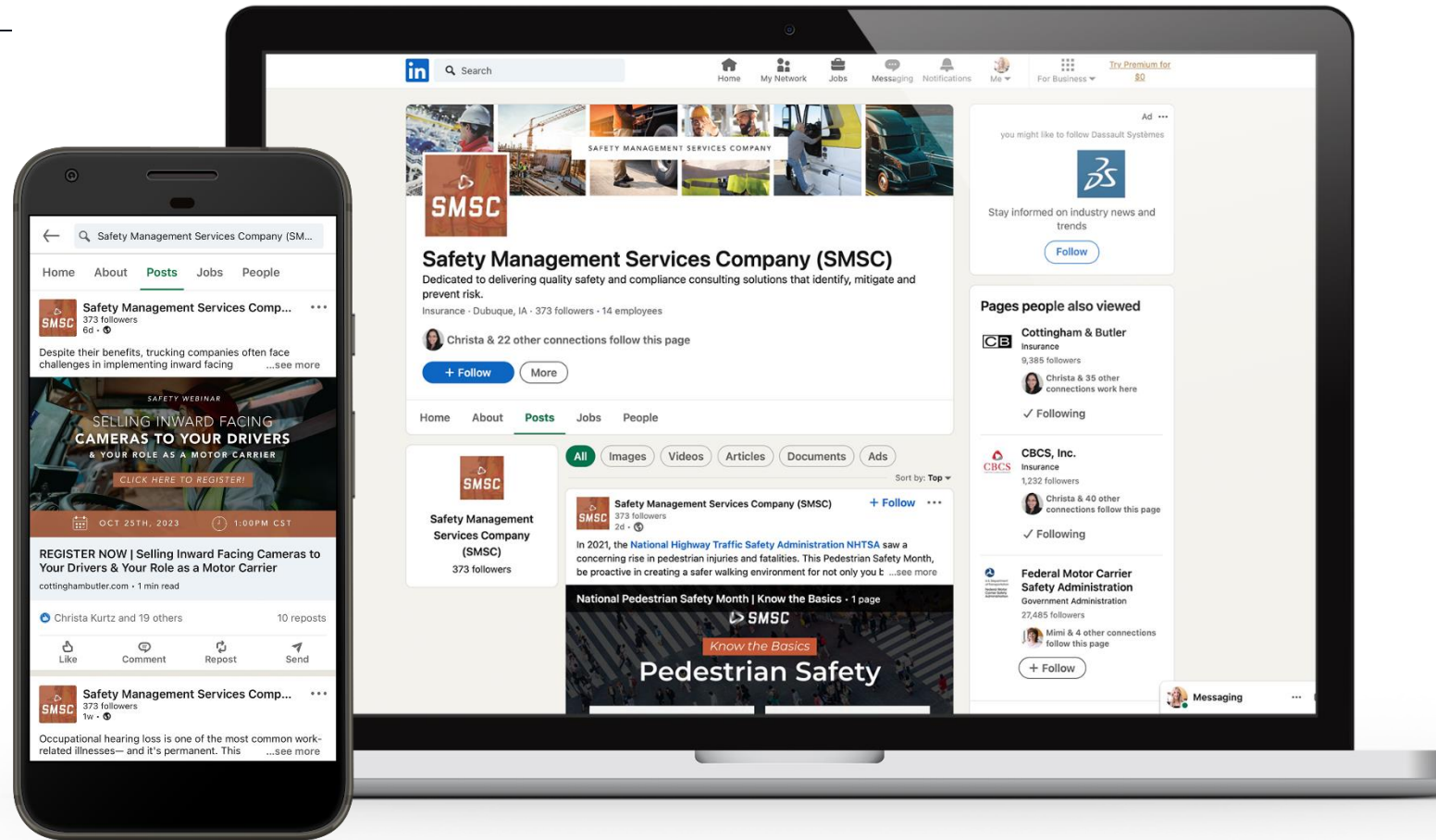




Questions



Let's Stay Connected



@safetymanagementservicescompany(smc)

