The ABC's of Safety – for Safety Management Systems

Author:
Ian Ackland
BE MBA (Tech Mgmt) FIEAust MEIANZ MSIA CPEng CEnvP
Management Systems Assessor and Consultant
BSI incorporating NCSI
ian.ackland@ncsi.com.au
0414 689 077

It's as easy as ABC

From attitude to behaviour and commitment, the successful implementation of any type of management system is determined by the characteristics of an organisation and its staff. NCSI's Ian Ackland discusses the ABCs of safety, quality and environmental management systems, and examines the potential risk of focusing solely on compliance, rather than culture.

Safety management systems should be as easy as ABC.

In April 2010, the Deepwater Horizon offshore drilling rig exploded in the Gulf of Mexico. Ironically, this explosion took place just seven hours after a group of BP and Transocean VIPs arrived for a routine management walk-around, with a focus on checking safety systems.

Ian Ackland, senior safety auditor with NCS International, believes this is just one example of a man-made disaster that could have been averted. For a safety management system to be effective, an organisation needs to achieve a state of 'safety mindfulness', where safety culture is much more than just a checklist or an afterthought in the boardroom.

"So often, the message about safety gets over-complicated," he explains. "But if you keep it

simple, it all comes together from top to bottom in an organisation."

Unified Management System Theory

After many years' conducting safety audits, and working in safety management in the public and private sector, Ian has developed his own 'Unified Management System Theory'.

Like the Unified Field Theory, it brings all interactions together in a single framework and it is very people-dependent. It's as simple as A, B and C, and it applies to all management systems, including quality, environmental and safety.

Attitude

An individual employee's attitude towards safety, the environment or customers will determine what they will or won't do. They need to accept the conditions and constraints of their job or task, even if it seems to them it will take more time.

Then, the actions employees take depends on their awareness of what is required, and how it aligns with the overall organizational system.

Behaviour

Workplace behaviours are black and white; they are either safe or unsafe, they meet customer needs or they don't. Belief systems underpin our behaviour, which is influenced by our 'worldview' of the organization, and ethical and moral considerations.

Behaviour is a significant factor in determining a business culture. The way employee behaviour is manifested towards customers could well determine whether your business retains those customers.

Culture

Many organizations are now moving away from compliance for legislative requirements and towards a safety culture. But what does that really mean? It requires a commitment from senior executive management, and effective communication across the company. Co-operation, collaboration and communication all play a vital role in developing an authentic safety culture.

The same applies to quality culture, where organisations focus on their customers, and an environmental culture, where we

broaden our definition of a 'stakeholder' to include the environment.

These A, B and C fundamentals are common to all management systems, as any system is not simply about documents or processes; it relies on the people involved.

Ian believes a critical part of the journey towards creating this culture is to think beyond customers, and think about how systems apply to stakeholders as a whole. That includes staff, suppliers, and the community at large. By applying management systems to any individual or business that is part of its eco-system, the organization makes a powerful statement about its culture.

"These principles are relevant to any system and organization, so it's important to think about them.

How do you certify a culture?

Ian is starting to see a shift in attitudes when it comes to auditing safety management systems. "We have worked with a major client who wanted to assess behaviour as part of the certification audits, so they can improve safety and environmental outcomes." He sees this as a positive step in moving away from just ticking off what needs to be done for compliance.

"If clients are doing behavioural surveys, it shows a real maturity in the organisation. It focuses the systems on a belief within

the whole company, and they do it because they think it is right, not because they have to."

NCSI has also recently conducted an internal survey, the Mettle Culture Survey, for an independent perspective on how its own culture affects behaviour in the organisation.

The impact of safety mindfulness on behaviour

Looking again at the case of the Deepwater Horizon rig, a focus on checking behaviour rather than conditions could have made all the difference.

In a working paper for the National Research Centre for OHS regulation1, Professor Andrew Hopkins of ANU explains that the VIPs focused their informal audit on checking conditions were as they should be, rather than checking on behaviours. This is not unusual: conditions are relatively unchanging and easier to audit. When behaviour is intermittent, only occurring sporadically, it can be missed. The visitors also did not want to disrupt activities, and limited their time on the floor of the drilling rig.

"A safe system is easily spoilt by the unsafe behaviour of people working within it," says Ian. "Likewise, quality is simply a perception of customer satisfaction. Upset customers can quickly wreck a business, and it is employee behaviour that will upset them, not the systems that are in place."

This is where a safety culture comes into play. "Safety needs to be taken on as an integral and critical part of the business at all levels, rather than being an afterthought in the boardrooms or at organisational management level."

Ian has seen many examples of this. "As an auditor, the first thing I look for is whether the company is still committed to running its system. If they aren't even doing the basics, there's trouble ahead."

"I've seen clients with no evidence of management commitment, and there's simply no point in continuing with certification, because they're not putting it into practice in the workplace." Individual attitudes and beliefs may be aligned to safety, but without top-level commitment the system will fail.

Conversely, he's also seen examples where the CEO says 'safety is our first priority' - yet on the tracks or factory floor that's not evident. "If the processes that should be in place are not actually happening, it's just lip service at senior level." And that's a clear case of communication breakdown.

To properly audit behaviour, which is more subjective in nature, Ian advocates using a Behavioural Audit Checklist. "The auditor would need to look at perceptions, observing how people act or react in a given situation, how they respond to a scenario put forward to them," he explains. "This is not just about workplace health and safety – it applies to all management systems. So the auditor would also need to observe how they behave in relation to customers and other stakeholders, as well as the environment."

Ian's principles of management systems may sound simple. "It's self-evident really," he concludes. "And it's all there in AS 4801, ISO 9001 or ISO 14001 – but it needs to be made less complex for people and organisations to realise how easy it can be to get it right."

Disasters such as that in the Gulf of Mexico also remind us how important it is for organisations to truly understand their safety management obligations. An effective safety management system needs to invoke safety mindfulness, and actively encourage a positive safety culture. Professor Hopkins has recently released a book on this disaster, "Disastrous Decisions – The Human and Organisational Causes of the Gulf of Mexico Blowout"2; which Ian would recommend as prescribed reading for any senior manager or senior executive in an organisation.

Further key letters related to safety

Besides A, B and C, other letters of the alphabet can be equally important and add to the total picture, and are described in the Appendix. Two which are of special interest are 'F' for 'Fitness' at work which is closely linked to 'H' for Health in Workplace Health and Safety.

This has tremendous ramifications when you consider that fitness for work encompasses both physical and

psychological wellbeing, so that the state of a person's health will influence the state of fitness. A major electrical infrastructure services provider has recognised this and has employed a number of occupational health specialists based at a number of locations across NSW to devise and implement a range of programs to manage health issues in the workplace.

These programs range from ergonomic assessments of the workplace, men's health issues, and 'fit for work' exercise programs. Other client organisations also recognise this and conduct or encourage similar programs but on a much smaller scale. Ian says that this is a very good sign, and the importance of paying attention to the health of employees is frequently mentioned in magazine articles published by the Safety Institute of Australia (SIA) and the National Safety Council of Australia (NSCA).

Another significant one is 'M' for 'Mindfulness of safety', as discussed by Professor Andrew Hopkins in his book, "Failure to learn"3, where it is contended that this is something that senior executives in an organisation really have to have if it is to be a high-reliability organisation.

Safety Management System Standards

While AS/NZS 4801:2001 is the most commonly used OHS Management System Standard in Australia, the British Standards Institute (BSI) OHSAS 18001:2007 is also gaining traction in Australia, according to Ian, who works with both standards. They are both based on the Environmental Management Systems Standard, ISO 14001 and in turn invoke the Plan-Do-Check-Act (PDCA) cycle for continual improvement.

In Ian's experience, businesses have a variety of reasons for why they choose to implement a safety management system. Some of these include:

- Duty of care and moral responsibility
- Expectation from interested parties (such as for example, an overseas parent company of a local organization insisting upon it)
- Compliance with legal requirements
- Risk management
- Prevention of, or reduction of the impact of, accidents which always involve costs in one form or another
- Long term survival of the organization
- Reducing compensation insurance premiums
- A consistent approach, allowing business continuity over time and organizational change

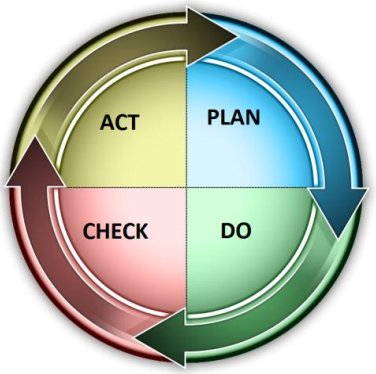
As Ian says, "In itself, a Safety Management System is no magic bullet or "get out of jail free card" that will save an organization from any adverse regulator action, but it is an important tool in demonstrating due diligence. The thought discipline that should go into preparing an effective safety management system (SMS) and its subsequent implementation and maintenance is well worth the effort".

Referring back to the standard, the key steps in the PDCA cycle are as follows:

PLAN:
Establish the objectives and processes necessary to deliver results in accordance with the organization's OH&S Policy

DO:
Implement the processes

CHECK:
Monitor and measure processes against OH&S Policy, objectives, legal and other requirements, and *report* the results



ACT:
Take actions to continually improve OH&S performance

These can be elaborated further in the terms of AS/NZS 4801 (OHSAS 18001 is very similar in its requirements, with some minor differences).

System elements under Planning include:

Policy states organizational intentions and commitment and provides a framework for the SMS objectives

Objectives and Targets define what the organization wants to achieve

Planning for Hazards identification, risk assessment and determination of control measures considers what issues could be present that need to be dealt with Legal and other requirements set external parameters that must be followed, or in the case of Codes of Practice are intended to best practice guidance OHS Management Plans are designed to meet the objectives System documentation, including procedures for Control of Documents and Records Emergency Preparedness and Response Planning allow you to cope with emergencies

The Doing elements include:

- Structure, responsibility and resources
- Training and establishing Competence
- Consultation, Communication about, and reporting performance of, the system internally reporting OHS performance internally and externally to regulatory bodies
- Practical application of Hazard Identification, Risk Assessment and the subsequent control measures, including an evaluation of the effectiveness of this process – in other words operational control measures in organizational activities
- Testing of Emergency Preparedness and Response Plans (Drill and scenario exercises)
- Responding to Incidents and Emergencies

The Checking phase includes:

- Monitoring and measurement of safety parameters and operational issues that can impact upon health and safety, including health surveillance
- Incident Investigation to determine root cause(s) of the incident and subsequent Corrective and Preventive Action, with a final step of evaluation of the effectiveness of any actions taken
- Maintaining and managing appropriate and necessary Records
- OHSMS System Audits to verify that the various processes of the system are working to plan, and Inspections of activities to ensure required procedures and instructions are being followed

The Acting step is managed through Management Review in which top management of the organization perform an overview of the system at regular intervals (often described as a 'helicopter view'), and then decide where changes or improvements are required, including modifying policy, objectives, procedures and adjusting resource needs. Many organizations incorporate this with their business and budgetary planning so that expenditure needs highlighted by the review can be provided.

Once an organization has created and implemented an SMS, it may choose to have it certified against one or both of the standards mentioned above by an independent third party Certification Body, so as to demonstrate in the public domain that it is compliant with the standard. This is one of the functions of NCSI and Ian is one of the many Management System Assessors who perform this function.

In summary then, Ian has a simple sentence which encapsulates the whole idea of a Safety Management System:

"A successful Safety Management System relies upon all people in an organization understanding and managing risk at all levels and in all activities and functions".

This same statement is equally applicable to other management systems, whether quality, environment or food safety. The focus is on the people in the organization – they can cause problems or prevent problems occurring, and they can be part of the solution to problems.
Finally, keep the system as simple as possible, so that it will have a much better chance of working!

References

1. Working Paper 79: Management walk-arounds: Lessons from the Gulf of Mexico Oil Well Blowout, February 2011
2. Hopkins, A: Disastrous Decisions – The Human and Organizational Causes of the Gulf of Mexico Blowout, CCH, 2012
3. Hopkins, A: Failure to learn – The BP Texas City Refinery disaster, CCH, 2008

Appendix

Ian Ackland's Safety Management System Alphabet

Some key concept messages for implementing a safety management system and maintaining a safe and healthy (and thereby more productive) workplace. Many of these concepts are equally applicable to other management systems (environment, quality, food safety)

A Attitude; Awareness; Acceptance; Alignment; Actions; Audit of the system to verify its functionality and effectiveness

B Behaviour; Belief Systems ("World View" or Bias")

C Culture; Communication; Comprehension; Competence; Compliance; Cooperation; Collaboration; Controls, Conversation, Cause and Certainty

D Damage (what we want to prevent or avoid)

E Expectations; Employee, who has a responsibility to follow management direction and also to themselves and fellow employees; Emergency, and Error that can lead to incidents; Engagement and Empowerment

F Fitness for the job

G Generic, as in processes which can be applied to a wide range of situations, but may also require some tailoring for circumstances. This can often be a good starting point if it is not the required endpoint

H Health (as a key component of Workplace Health and Safety); Hazard – what can cause damage; Human Factors which can influence errors

I Identify (Hazards); Incident (actual or potential – we want to avoid); Investigation of incidents to determine root cause(s); Instruction, is the sense of both training, or a given direction of what to do; Inspection of the workplace to identify hazards and to confirm that requirements are being met; Improvement – current management systems standards invoke the principle of continual improvement

J Justification of actions

K Knowledge of the issues, hazards, requirements

L Legislation; Look, Listen, Learn from past issues/mistakes, experiences of others

M Management who have responsibility to ensure a safe and healthy workplace; Mindfulness, a key trait of senior management, as discussed by Professor Andrew Hopkins; Mistakes can cause damage and need to be avoided

N Near hit, a potential incident which can be indicative of a more serious problem emerging, and allow for proactive, pre-emptive action to prevent the possible damage; Notification to regulator of serious incident/injury

O Obligations that must be met; Observation of performance and behaviours; Occam's Razor ("keep things simple")

P Participation; Process and Procedure; Practicality – processes and procedures must be practical, make sense and be achievable; Preparedness – to deal with emergencies by putting processes in place to prevent them, as well as having the means to respond, including training (drills) of staff; Planning for Prevention by being Proactive (and system planning in general)

Q Questioning to assess understanding, challenge accepted or long-standing practices, which may no longer be appropriate; questions are part of the investigation process, determining what happened and why it did

R Responsibility; Response to incidents and emergencies; Reactive means invoking corrective or improvement action after the event of an incident, as opposed to proactive where the idea is to prevent the event in the first place; Root cause – what we need to establish in investigating an incident

S Safety; Simplicity – try for a simple approach first, then add more complexity only if necessary; Supervision

T Training is an absolute essential, and it is critical that it is understood, and that recipients are competent; Team work aids consultation and risk assessments; Testing of Emergency preparedness and response

U Understanding from training and instruction is very necessary

V Verify that systems and processes are functioning adequately by means of audit, inspection and review processes

W Warning of hazards; Workplace, where the legislation now applies; Work instruction; asking "What happened?" and "Why did it happen?" in an investigation

X X-rays and other radiation are a potential hazard where used in the workplace for analytical, diagnostic, treatment (as in sterilization) or monitoring purposes

Y **"**You are the person most responsible for your own safety"

Z Zero harm is an ultimate objective of safety management (and environmental management as well), although it may never be practically achieved