"The Message is in the Measure" by Pete Susca 3/29/16

As a leader, what you measure and how you respond to the results drives the behavior of individuals and your organization as a whole. If you measure or respond the wrong way, you will have unintended results. We see this situation occurring in many organizations, especially in the realm of safety. The failure of well-intended organizations to select and appropriately manage their safety measures/metrics creates an insidious degradation of their safety and operational culture.

The safety performance measures that many organizations headquartered in the U. S. use today are based on the OSHA Record-keeping requirements. The "Recordable Injury" was defined in the Occupational Safety and Health Act of 1970 and 29 CFR Part 1904 which required employers to prepare and maintain records of occupational injuries and illnesses. OSHA uses this data in measuring and directing the agency's regulatory efforts and assisting safety and health compliance officers in making OSHA inspections.

The OSHA Recordable Injury Rate (the ratio of a company's OSHA Recordable injuries to the work exposure of their employees) is commonly used by organizations to track their safety performance and to compare themselves with other similar organizations. Although the "rate" was not designed for this purpose, many organizations are using it to measure the health of their safety program. Organizations use these rates to measure organizational and plant safety performance as well as to drive management accountability for safety performance at all levels.

In reality, the rate is much more helpful to companies with immature programs and high levels of injuries. Ample injury data allows organizations to Pareto injuries and focus on those that have the highest commonality of occurrence. Many organizations have achieved years of success lowering their incident rates primarily by this approach. However, as the organization becomes successful at managing to these injuries and the rate begins to approach one and below, using the rate as the primary metric becomes problematic as a safety management tool. When injuries occur within organizations with low rates, they typically catch management off guard and are perceived to be "behavioral" issues. This perception is typically due to management's belief that they have created a robust safety program and done their part well – after all, they have invested considerably to improve the organizations injury history. Subsequently, when

employees at risk are identified as “non-conforming”, the reasons can’t possibly be within the management approach? Could they?

If the organization believes the behavioral root is the at-risk employee, their causal analysis is usually flawed. All of the "employee fixing" activities that organizations see as corrective actions are interpreted (many times rightfully so) as a form of blame. Blaming employees without effective causal analysis not only degrades the safety program it has a negative impact on employee engagement and their trust in management. The negative impact of this on an organization is much bigger than safety.

The real reasons lie in the leadership and management’s approach to safety. A large part of this dilemma is caused by organizations equating safety risk to outcomes (incidents/injuries); believing that low levels of injuries (including serious injuries and fatalities) = a low level of safety risk. This, for the most part, is a fallacy. Sure all injuries are caused by some form of risk, but reported injuries are by no means representative of an organizations overall safety risk. Relying on reported injuries as your primary measure of risk, is asking for failure of the worst kind.

The difference between the potential for injury and actual injury is like playing Russian roulette with a revolver. It is possible to spin the cylinder and pull the trigger on an empty chamber for quite a while without shooting yourself. After doing this for some time you may even question whether there is actually a live round in the gun! But, if you play long enough, sooner or later, you will lose. In this example the history of no negative outcomes (the number of times you pulled the trigger on an empty chamber) would not be a good indication of the hazard severity or the frequency of exposure, we call that risk. No harm no risk, right? Wrong.

In addition, if an organization chooses to reduce its injury rate solely by tactical initiatives (e.g., procedures and compliance edicts, training and administrative controls), a false sense of security and/or a change in "fault" perspective may evolve. The symptoms of this condition include:

- A belief that the safety programs/controls are robust and therefore injuries are the fault of the injured
- When injuries occur management becomes frustrated with their safety programs, practitioners and initiatives - they can't figure out what to "fix"

- Getting caught off guard by serious injuries and fatalities
- Dissecting parking lot injuries while ignoring high risk areas
- Safety professionals spending most of their time chasing incidents - trying to prove that an incident shouldn't be an OSHA Recordable (to meet the goals/objectives)
- Management negotiating with Safety professionals that an incident should not be an OSHA Recordable (to meet the goals/objectives)
- The behavior of managers/supervisors who don't understand how to meet their injury rate goals drives injury reporting "underground"
- Equating the organizations risk level to its injury rates
- Failure to perform effective causal analysis - fixing symptoms not reasons
- The behavior of managers/supervisors who don't understand how to meet their injury rate goals drives injury reporting "underground"
- Employees and labor unions become disenchanted with the leadership's value for safety and the overall safety approach

The safety message that is being received throughout the organization is that lowering the OSHA rate (and meeting ones objectives) is more important than reducing the risk of injuries to employees. This along with the impact of employee blaming, results in a negative impact on all of the elements of a healthy safety approach and has a negative impact on the functionality of the organization as a whole. From an employee perspective, communicating safety hazards, unsafe acts, poorly performing people and processes, procedural and program gaps, close calls, mistakes, non-conformities and in general, going out of one's way to help the organization, goes underground.

See No Risk **Hear No Risk** **Speak No Risk**

Many organizations are moving toward the use of "leading indicators" to remedy these maladies. They are creating and tracking measures that they believe are predicting the

likelihood of injuries. Unfortunately, while trying to do the right thing some organizations fall into the same "rat hole" by selecting the wrong leading measures and/or reacting to them improperly. For example, tracking training completion as a leading indicator without effectively evaluating the quality of the training, many times results in “warm seats and signed sheets” and little other risk management value. When the attendance objective is achieved management feels comfortable that the control is healthy; and unbeknownst to them, because the training was ineffective employees are going back to work without the necessary survival skills and feeling that the organization doesn’t really value safety. Furthermore, when those very same “trained” employees get hurt doing their job, many times the organization blames them and as a corrective action, sends them to retake the same dysfunctional training. Stick a fork in it, employee trust and engagement is done!

In summary, organizations don’t set out to injure employees or fail at their safety approach. They are attempting to do the right thing for their organization and their employees. Unfortunately, even with good intent, inappropriate measures and actions are will produce an unhealthy organization.

As the leader of your organization (and of safety) here are some things to consider when creating and responding to safety metrics:

- Talk with your workforce and understand their perceptions about how important safety really is – this is your baseline
- If you have gone off-course and your workforce is disengaged, a sincere and personal mea culpa and new approach may be in order
- Integrate safety into your organizational decision-making processes at all levels
- Create some foundational/basic expectations that you (and your staff) can support with daily actions
- Plan, develop, deploy, check and become accountable as a team – cross functional including employees, Union, etc.
- Frequent follow-up, communication and accountability for action is essential – this is where many organizations fail
- Build metrics to measure the effectiveness (not just the conformance) of the safety management system
- Your primary metrics should be predictive of outcomes and improving them should be straightforward

- If your performance still isn't were it needs to be – work hard, as a team, to understand the real reasons (get out of the blame game) and address them