The Business Value of a Common Safety Language

By Peter T. Susca

This article series chronicles the principles and techniques that readers can apply to transition safety and the safety profession closer to the core of what organizational leaders value. The foundational philosophy is that safety challenges stem from larger organizational issues. By understanding the core business values, OSH professionals can begin to work from the inside out to engage business leaders, rather than the typical outside-in approach to integrating safety with business. If leaders tap into this information, they can use it to improve the organization as a whole, and move safety from a purely moral imperative to an indicator and facilitator of organizational health.
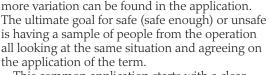
If you have ever been in a country where you do not speak the language, you know how frustrating it can be to get a point across or have your basic needs met. You may also know the frustration of not understanding what is being communicated to you. By the same token, OSH professionals often speak a language that does not fully resonate with other business functions. The potential result, poorly managed hazards and risks, can lead to bad things happening which can be undesirable to all stakeholders.

OSH professionals need to respect that the language we use for safety is often foreign in the business world. Basic terms such as *safe*, *hazard*, *risk* and *controls* are used in almost every safety conversation. Even though terms such as *risk* have similar meanings in finance, quality, reliability and safety—to communicate effectively, the concept of *safe* and acceptable safety risk must be crystal clear to all. The point of this article is to ensure that safety is viewed and communicated the same way so that everyone is speaking the same language. If we do not maintain a strong foundation of common understanding, we cannot build a better business relationship for safety.

Safe or Safe Enough?

Safe is likely the most commonly used word in the language of safety. Asking for the definition of *safe* from a sample of employees often yields a wide variety of perspectives. Is it okay to have a wide variation in the interpretation of safe (or safe enough) in an organization? Ask the quality or financial department the same question about their key measures; there may be little latitude. The definition of *safe* should not be based on perception. The more variation in the definition, the

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more variation can be found in the application. The ultimate goal for safe (safe enough) or unsafe is having a sample of people from the operation all looking at the same situation and agreeing on the application of the term.

This common application starts with a clear understanding of hazard and risk. To best understand risk, it is important to start by focusing only on hazards. A clear definition of *hazard* and *severity* must be solidified before discussing risk. In the fatality prevention world, we use "a fatal level of energy" to clarify fatality hazards. Calibrated by the simple question, "Does this energy (electrical, hydraulic, potential, chemical) have the capacity to kill?" This is not hazard or risk assessment, it is more about reaching consensus on the significance of a hazard. While risk can change quite frequently, hazards do not. The hazard does the harm, therefore, an organization should see hazard management as its first priority.

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Variation in Risk Perception

Risk is a term that skews the perspective of safe. If the term *hazard* is clear and universally understood, the addition of probability (of events, exposure, failure or controls) invites diversity of opinion. OSH risk should be calculated using human proximity or duration of exposure to the hazard. Probability factors such as failure modes or rates and event history do not add as much value to OSH risk as they do process risk. The human aspect best factors into the reliability of the control.

To simplify the types of controls used to reduce exposure for the management team, I break them into two categories: good day controls (GDC) and bad day controls (BDC). GDC (e.g., rules, procedures, knowledge, skills, PPE) are those that require a human to consistently act a certain way for the control to be effective. BDC are fixed in place and require no human action to be effective. A good example of these are the two controls that prevent a driver's ejection from a car upon frontal impact. The seat belt is the GDC because it only works if donned and worn properly. On a good day when you put it on and keep it on, it can save your life. On a bad day when you are not making good decisions, the BDC (the airbag) will save you. Without any action on your part, it may save your life despite poor judgement.

When hazards do not result in injuries or sig-

nificant close calls after long periods of exposure, people begin to develop faith in the control and sometimes lose respect for the hazard. This outcome experience can turn the calibration for *safe* into a perception based on personal experience. The determination of safe/safe enough based on outcome frequency and personal perception creates a wide variety of challenges in an organization. It impacts inherent risk levels, operational decision making, employee morale, union engagement, leader perception and the culture's overall health.

Calibration of Safe & Unsafe

Every organization needs a simple, common way to agree on and communicate *safe* and *unsafe*, not as a replacement for risk assessment, just as a customary way to converse on and respond to safety on a daily basis. The creation and collective use of guidance for the consistent determination of safe and unsafe is essential. The three levels of safe (supported by simple decision making guidance) are an example:

1) Safe enough: No action required other than acknowledgement, positive reinforcement and continued validation.

2) Not safe enough: Moderate or low severity hazard, control is not in place or not working effectively. Although the potential for harm may not be immediate or severe, an interim measure is required to reduce the risk (e.g., a barricade around a wet area on a walkway prior to it being cleaned).

3) Unsafe: Immediate danger with serious or fatal consequence with the possibility of exposure. Action must be taken immediately to safely stop the process, prevent potential exposure or control the harm.

When coaching on the common language of

risk, I often use the following analogy to help the participants visualize the goal, which is consistency, looking at the same situation and seeing it the same way.

It is like teaching archery. Get the student in a comfortable shooting position: body aligned, with proper posture and grasp of the bow and string, arrow nocked, index feather up, and consistent sighting and release points. The next step is to have the student shoot three or four arrows down range aimed at the bullseye. I then ask, "Where would you like the arrows to go?" The answer is usually, "The bullseye." Although that is a good answer, a better one is, "All of the arrows in a tight group." In shooting, like risk prioritization, consistency is the first priority. Once you establish consistency you can become consistently accurate. If you are inconsistent (like determining *safe* by perception) it results in too many variables, which offers little hope of getting your organization in agreement.

What Does Safe Look Like?

The last article in this series (*Professional Safety*, Feb. 2018) suggests that the OSH professional calibrate to senior management's safety expectation. When senior management is asked the question, "How good do you want to be at safety?" the answer is typically, "We do not want our employees to get injured at work." This statement captures the leader's definition of safe from an outcome perspective. Although the expectation is solid, the understanding of what it takes to get there usually is not. The leader must have a practical understanding of what safe looks like.

Once satisfied that members of senior management can consistently apply the simple safe unsafe guidance, take them to the operation. Start with

a discrete area, such as a maintenance shop, and ask, "How would this area have to look (conditions, practices and behaviors) to fulfill your zero-injury goal?" By doing so, you are creating a visualization exercise. If they cannot see it, you must coach them with that goal in mind.

Break down the area into subsets, processes, machines and activities, then speak with the employees. Ask, "What is required for this process be safe/safe enough and still allow you to be productive?" Begin to document the solutions with concrete actions supported by visuals of the future state. Subsequently, when the process of planning and budgeting begins, the management team members will have a visual expectation that aligns with your requests and they can see the changes immediately in the workplace. This approach is much more incrementally visual for management than the traditional alternative of the OSH professional requesting money, resources and time to manage risk, and management expecting an immediate zero-injury result.

The Business Value of Hazards

Employees and leaders need to be experts in their local hazards, not just from a safety perspective. The best business and operational success opportunities linked to safety are in the management of hazards, not risk. Elimination of hazards (especially those with high-severity potential) is the first priority. Tolerating low-order risk controls (GDC) as the sole protection for high-severity hazards is a catastrophe waiting to happen. Our role as OSH professionals requires that we coach the organization to make better business decisions with safety in mind, rather than just safety decisions. Just as PPE is our last choice in controls, making a safety decision without making a corresponding good-for-business decision should also be a last choice.

"What is the business value of this hazard?" Although it sounds like an odd question, it really is a great business proposition. "If we can agree that this hazard has the capacity to seriously injure or kill, then let's focus on why we keep it around." This table turn on hazards forces the business to define the value of the hazard in terms

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TABLE 1

Typical Hazard Decision Points by Function

Business function	Hazard decision points
Finance	Accounting and financial management decisions impact operations, storage, inventory, transport, raw materials/parts, storage, schedule, staffing, facilities and operating locations
Business development	New clients, new product and service expectations, new work locations, schedules, client cultures, and expectations
Process improvement	Process change decisions on hazards and risks, exposures, controls, tooling, equipment, maintenance, rates of production, staffing and service schedules
Purchasing/supply chain	New contractor and supplier risks, quantity and quality of products/services and stock storage
Research and development	New materials, chemicals, processes, methods and technology
Engineering and design	Manufacturing and service processes, tools and equipment, methods, work practices and conditions
Human resources	New employees, job change/rotation, fitness for duty, leadership capacity, roles and responsibilities, knowledge and skill building and validation of capacity
Legal	Liability exposure versus inherent risk exposure, governance and decision-making guidance
Reliability/maintenance	Failure-based risk assessments and decision making, failure prevention versus repair, exposures to machines, equipment, tools and materials, and work environment

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of its quality, performance, customer value and cost. If the hazard is good for business, then the business should be able to prove it with data. If the business cannot prove the hazard's value and there is a better way to succeed at the business factors (and eliminate or reduce the hazard), then the return on investment for the process change may make sense. If the hazard is eliminated and the manufacturing process is measurably improved, it is a win/win for the business.

When looking at a process, it is helpful to combine a good-for-business and a good-for-safety mindset. While on a recent tour through a manufacturing plant, I witnessed a worker operating a cut-off saw. The bar stock feeding the process was stored in a wooden crate about 4 ft out and down from the saw. When I asked the worker how he went about cutting the bar stock, he and his associate demonstrated the process of wearing PPE and team lifting the 35-lb billets into the saw.

Clearly, the plant had identified the safety risk and had put safety controls

in place, but was their approach good for safety and business? The hazards and risks were not what drew me to the process, they were just the frosting on the cake. The "cake" was the process, which appeared to be non-value-added. With all of the safety risks, what business value do these two workers add by hand feeding this saw? Could this loading have been accomplished by the forklift when it brought the case to the saw?

When we stepped back and looked at the stock and loading process for this machine we saw numerous safety hazards, exposures (to nails and wood splinters, struck by forklift, strain/sprain, struck by dropped billet, cuts) and wastes. After a short discussion with purchasing, we decided to order the stock in a reusable container that would facilitate quick loading of the machine with no other workers in the area. We removed hazards, the exposures, saved expenditures on controls, significantly reduced process time, cost and waste all in one good-for-business decision.

Now let us run the situation forward

with the original process and controls. Is an injury foreseeable here? One failure mode might be the operator's reluctance to call the second associate, resulting in lifting alone; the outcome might be a sprain or strain from awkward lifting. The result of the incident will be pain and suffering for the worker, productivity loss, exposure of a new worker to harm and many other bad-for-business implications. So, what would be the result of the investigation? What would we fix? Most likely discipline/counseling, behavior change, new procedure, retraining or maybe even a new hoist. Would any of these solutions be good for business or offer sustainable safety? Not really.

Hazard Gatekeepers

Operations and functional (e.g., finance, human resources, quality, process improvement, supply chain) leaders need to clearly understand their role as hazard gatekeepers. These leaders and their groups manage the organizational entry or decision points (gates) for hazards (Table 1). Although risk assessment and management of change processes are valuable tools, they can never replace the vigilance of a leadership team that serves as the front line of acceptable hazard and risk. The acceptance of hazards and risk is not the responsibility of the OSH professional; it is a business decision and, therefore, must be made by business leaders. Organizations and their leaders need to take a stand on unacceptable hazards whenever possible and use acceptable risk as a fallback position.

Organizations, at the idea phase, must appropriately balance the operational value of new hazards with their harm potential rather than accepting hazards for their operational value and dealing with the OSH risk later. For example, in the precision manufacturing industry it is common for engineers to use heating and cooling to join two close tolerance parts. One part is cooled (usually with dry ice) and the other is heated to approximately 400 °F. Both the hot part and the dry ice are hazards capable of causing serious bodily injury. In an organization that manages OSH by risk, a risk assessment would be performed at the design or engineering phase and decisions on appropriate controls would be made. Unfortunately, in many cases, the risk assessment is performed and a combination of low order controls such as PPE, procedures and training are determined to be sufficient. A great first step for engineering might be an edict of no more PPE. This could mean no new product or process can add PPE to the shop floor. Is your leadership team ready to draw this line?

Organizational Risk Understanding

Where is your next serious injury going to be? This is a great question to ask the management team and employees at any level of the organization. Independent of the health of the safety program, the responses and information that come from the question will be telling. Feedback may range from respondents having no idea or having a point of reference based on past incidents to having a respect for specific hazards, risk assessments and a concern for the effectiveness of controls.

This data represents an informal evaluation of the safety approach. The true test of safety system effectiveness is measured by the capacity of those at risk and their managers. If the majority of the respondents speak intelligently about their risk and control effectiveness, the organization is well on its way to a predictive and preventive safety capacity. Data from these answers can be used as an ongoing indicator of safety system health. Have leaders periodically ask the question of their staff and collect the results.

Conclusion

Several methods and techniques have been outlined that will test and strengthen the foundation of an organization's safety conversation and decision-making capacity. Creating a strong organizational culture that has safety at its core is like building a high-rise structure on a strong foundation. To move safety forward, the values, language and decision making (the foundational bricks and mortar) must be robust and consistently applied. Use these techniques to evaluate the organization's safety foundation; success with one of these can make a huge difference in the future of safety.

1) Assess the consistency by which the organization determines safe and unsafe.

2) Provide a simple, consistent approach to assess and agree on safe and unsafe (not risk assessment, just risk consensus).

3) Test how well the organization understands and agrees on its risk.

4) Evaluate the status of hazard prevention and reduction as a business opportunity.

5) Check the gates and gatekeepers' roles in keeping new hazards and additional PPE out.

6) Use the good-for-business perspective in evaluating processes and hazards.

7) Help leaders visualize safety expectations and progress toward goals.

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