Workflow Your Safety Communication

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Welcome to Safety Culture Excellence. Today's topic: Workflow Your Safety Communication. My name is Shawn Galloway, and I'm proud to be your host.

Greetings from Cuijk, a nice little town located in the Southern part of the Netherlands. This weeks' topic is part five of our six part Safety Process Communication Loop series. Today you'll hear an excerpt of a talk that I gave recently, and where I provided examples on how to workflow your safety communication. I'll also discuss ways in which you can value stream map your communication, including some of the qiestopms that you should ask, to both map out your current state and your future should-be state.

I hope you find value in this week's podcast, as you listen into my thoughts, and as always, we're always open to hearing yours. Here we go.

"I really like this, and I don't know; it's just something that was shared with our organization about four, five, six months ago by the site safety manager, and I really like what they put together here. Essentially, what this looks like - and this is dataflow process, and not enough sites actually workflow their data. And look at it and say, 'How does communication happen? What-if statements: when this happens, does this validation of communication?' So let me read this to you. It says, 'BBS observations performed by safety champions.' Now they've got a safety committee, and they've got people that they call safety champions, who represent all the shifts, all the departments, all the areas of the facility. They are volunteers, people that got involved, and their term for them is safety champions.

"Some of you guys call them observers; some call them safety coaches. So, observations performed by safety champions. Data collected and entered into BBS database. Reports in graphs generated each month for review by department managers, safety council, and steering committee. Not all the reasons for concerns and that stuff, but enough leading indicator information to go to the department areas to say, 'What can they do to improve their own safety?' Because a lot of sites are getting past that, 'It's a safety manager's responsibility.' Safety can't be somebody's responsibility. Safety can't be viewed as a departmental objective; it has to be everybody's responsibility. That's where you get towards true excellence. But the reports are generated and reviewed by the safety council and steering committee and the department managers.

"That stuff goes to each department manager. They address the concerns and improve it in their area. Then it goes to the safety council. They review and relay the concerns and improvements at their safety committee meetings. They're telling people, 'This is what we heard. This is what we did. This is the result.' Too many times, we get a lot of stuff in our work order systems, and we don't give people status. Even if the status is, 'We're working on it. We're trying to get the capital expenditure approved. That's going to probably be honestly about a nine-month process, but we're working on it.' Sometimes that right there can be very effective to a group of folks. But a lot of times, we don't really give that information back. It's just in status, it's in queue. We're waiting to get around to it.

"That's where you sometimes find problems because we ask for people's further involvement, whether it's getting on a committee or becoming an observer. Quite frankly, the employees really look at that and say, 'I have been involved, I've been sharing my concerns with you. I've been turning in employee suggestions.' A lot of times, that's viewed internally as involvement. But, yet, they're not getting any feedback, any status on those suggestions. So, it's hard to get people to continue to be involved. So, what happens is, is they review it in their own safety meetings because, remember, they all sponsor their safety champions for each one of the areas. They then sponsor that, and then that goes to the HSE steering committee. They review and give feedback for areas of improvement and issue findings as needed.

"That information is then posted. The data is posted on facility bulletin boards and covered in safety meetings and toolbox topics. I kind of like that because, essentially, what they're trying to accomplish here, the review's then relayed in their area safety meeting. So, they're telling people one time, then that goes around. And then it's posted, and they're telling them again. It's posted in the different safety meetings. The feedback from the work areas gathered by safety champions at safety meetings and toolbox meetings, that information's gathered. The safety champion then communicates the progress and feedback from employees of the safety council's monthly meeting, and that goes to the department managers.

"This becomes a perpetual cycle until everything gets addressed. Over what period of time would one cycle be completed? So, what's the timeline from the first box? So, maybe the guys can help me out there. If something comes in and something's identified – so what you're saying, to make sure I understand. So, when an observation's completed, how long until that get communicated to the folks? How long until it goes through the loop and close down? Less than a month.

"That's the goal about this, is that you want to be looking at it on a monthly basis. And that's the objective for these monthly meetings, is not to sit there and analyze the data. And you spend the time analyzing the data because that's something an easy trap to fall into, is you spend your time analyzing data, and then nothing's ever done with it. You have great understanding of the data, but nobody does anything with it. So, the average site needs to communicate these things out on a monthly basis. If you remember the example that I gave earlier, what happens is, is they share the additional stuff on a monthly basis with the additional department heads and supervisors.

"The following month, there's an expectation of, 'Where are we on this?' And it's different stuff that the site had come up with that are outside of their precautions that they were focusing on. If you think about it, are any of you guys doing Six Sigma or Lean Manufacturing at your sites?

"There's something called DMAIC, and it essentially means: design, measure, analyze, improve, and control. It's a continuous cycle that people get in, but you have to realize that the centerpiece for this, in order for it to be effective, is dialog. These processes aren't successful in a vacuum. They've got to be continuously looking at, 'Where's value here? Are we still focusing on value? Is what we're doing perceived to be valuable?' Because support can be lost, too, if people no longer recognize the value in this.

"Here's a little bit more complicated one. This comes out of a book called Transforming Performance Measurements. Any of you guys are interested, guys and gals interested in performance management, it's a fantastic book. I don't know if we, anyone in the audience that's read it before. Dr. Dean Spitzer's a good friend of the company, and he helped Terry start the company 15 years ago. This is a great book that was released in January of 2007, but one of the things that he talks about here in this performance management cycle is, 'regardless of where you started, the centerpiece is dialog,' And this was taken right out of his book there. The centerpiece is dialog - plan, select, collect, analyze, interpret, decide, commit, take action, review, plan, and that's a continuous cycle. But, regardless of the continuous improvement cycle, the centerpiece has to be dialog. There's that old joke that, 'Continuous improvement was great yesterday, but it's gone on too long.'

"If we're not communicating those things back to people as part of every step in the cycle, what we're trying to do is not gonna be supported anymore. So, there's something that I'd like to propose that's called 'value stream mapping', and it's taken out of Lean Manufacturing, Six Sigma. We've done a couple of these projects with folks, specifically accomplishing this. And we don't have all the time in the world to go through this, but I wanted to at least consider this. It's, essentially, you want to map two different states. One's called the as-is state: where are we in communication right now? What does the workflow look like? And you need to map that out. You need to go out and talk to people and say, 'What are we doing right now? What are the channels? How are we actually communicating with folks?'

"You want to identify those weaknesses and the waste in the process. But map them in and categorize them in three different areas. Those that do provide value; those that don't provide value but are necessary to the process; the things that we have to do that don't necessarily show value to somebody, but they're kind of necessary, they're critical; and those that don't add any value and can be immediately eliminated. Look at that in your own communication. There's a lot of waste in the general BBS process. And I don't want to get into all the process waste that we see, but let's keep it in the confine of communication. Look at all the things that we over-communicate, that aren't so necessary; and there's a couple of things that might be hypercritical.

"The next thing, one you identify workflow that out, get some butcher paper. Hang it on the wall, do it on a table. If you have Lean Manufacturing or Six Sigma, do it as a Kaizen event. Get a group of workers together and just do nothing but that for a couple of days, and really workflow out, 'What does communication look like right now? When we have a process, all the elements of communication, where are the channels? How do we use those channels? What's the effectiveness of these channels? What's the value perceived by those channels?'

"In order to consider this, here's a few mapping questions that I want you guys to consider. First off – who knows if something exists? I go to a lot of sites that have a process in place, that were implemented by somebody several years ago. And their BBS – 'What does BBS stand for, or whatever it is? We have a safety committee, really? Who's on it?' A lot of these things, we have the structure in place, but a lot of people don't recognize that we have those things.

"So, first off, 'Who knows your initiative, what you're trying to accomplish exists?' The next question is that you need to look at, 'How often is it communicated? How many times do we communicate the message?' The third question is, 'Is the communication delivered in a way that makes sense and seems personal?' If the communication's not personal, if it continues to just be organization objectives, that's not gonna be personal value.

"People don't necessarily – I mean, there's a lot of organizational objectives and values who want people to follow. But just recognize: the more personal it is, the more things are going to be sticky. Does the information make it home? There's a consultant – I can't remember the guy's name, so I apologize for not giving him credit. But his statement was at the National Safety Council last year. 'Would people stand in line and pay for the right to go to your safety meetings?' If you had to charge for your safety meetings, how much would people pay for them, your safety discussions?

"There's several times when you could say, where people come up and shake your hand afterwards, and tell you what a great job that safety communication was, that safety meeting was. Does the information make it home? Is it successful enough that people are sharing with their family members the important things in safety? Not sharing PPE that we provide them to take home, but critical things? Are they sharing your checklist with their kids? Are they sharing it because they know that what they're focusing on could impact them and their children? That's what we need to look at. How successful is it? And does it help build support and grow involvement? Does it create additional channels of support? Does it grow that support? We don't want to force people into things like this. Forced change is almost always temporary. You and the force go away, and so does the change.

"We want that seed of change to grow internally, where people start saying, 'Hey, how come you guys aren't observing me over here? I'm unsafe, also, in some of the stuff we do.' Or, 'Why don't you guys come over here and look at this? When I do this task, it's really dangerous.' That's what you want to start growing in this. Also, how often are success stories and results of the process shared with stakeholders? Your stakeholders are the people that are essentially owning this process, and that's everybody at the site. It's not just employees. Managers get hurt, too. Supervisors get hurt, too. Stakeholders are everybody.

"How often is the feedback on the initiative solicited from all levels? How many times do we go out there and say, 'Hey, just out of curiosity, how's this process working for you? Is it helping you be safe? Do you like the things that we're doing here?' You gotta ask for that feedback and continuously listen to the culture there. And how often does the team communicate to identify trends? When you see those things, it's gotta be a monthly communication. Some sites, it's not that easy or logistically challenged.

"There's an oil tools company that give their folks little iPod players – the cheap iPod players. And they put the safety communication message specific on their site to where they only have access to it. And they put their safety messages, and the folks that are driving around to all the different rigs are obligated that once a month, they have to download these podcast, these personal safety messages that come from their site, which is a great way to share information. That's a barrier. How do you communicate to folks you don't see, that are essentially roaming all over the United States to rig to rig, that you don't have opportunities to really give them the information? They identified podcasts. That might not work for some sites, but it worked for them.

"How many action plans were communicated in the past 12 months? If people don't know what you're working on, they're not going to continue to support the initiative out there. Last couple of things – do they know the status of the action items? I mentioned that several times. People have to know what we're working on. And what successes do they know about? I made the recommendation, when I was at a site not too long ago, 'What about putting a sticker somewhere that says: success was here? Say the team logo is: safe; let's just say that. Safe was here.'

"There's a site that said they put up a little fluorescent flag in the area whenever they've had a success in this initiative, and they posted it up there. They don't tell anybody what it is because they know that people are going to start asking about it. 'Well, what was fixed over there?' And it gets people started becoming inquisitive about it, but maybe some sort of sticker that says, like on a machine or something, on a process line, putting some sort of indictor that says, 'Hey, we accomplished this right here.' That gets people looking for success rather than just avoiding the failure out there. And how many items of personal focus can they remember? What's their personal safety focus? Can you put that on your checklist that says, 'Knowledge of Precautions'?

"At the end of the observation, if I say, 'Just out of curiosity, we have four things on our checklist. Roger, do you know what those four things are?' If Roger tells me that he can remember two of the four, that's 50 percent. If he can remember three of the four, that can be an actual thing that you can put in the software that'll measure the percent-safe of knowledge. How many items do people actually remember? That also helps communicate the positive reinforcement that, sometimes, it's easy for people to forget. A lot of times, they'll skip over the positive reinforcement, and just talk about the things that concern them. It helps reinforce that if we're actually talking and physically saying, verbally saying, what those items are.

"What triggers an observation? Are observations triggered because of a number requirement, or are we doing the focusing observation based on the data that we see? Too many sites fall into the trap of, 'We have to hit our target number of observations, so let's go do more observations.' And we get what Jim over here called 'drive-by observations'. We're trying to hit that target number of observations. 'So, you want a number? I'll give you a number. Here's some. You got a fork truck that I can borrow? Here's one of these. We can kind of trade them out like baseball cards.' I've seen that happen at sites.

"What triggers an observation? It should be triggered by the data that we collect, the trends that we identify. To go out there and say, 'Wow, we really need some deeper understanding of what the organizational cultural issue is that's prompting this risk.' A lot of times, it's not somebody's decision. It may just be the way that we do things. It may be what's called 'onboarding norms'. When we bring people up to speed, how are they onboarded? How are they trained? How are people trained on new tasks? Those are the things that we have to identify. And does the initiative continue to answer the 'What's in it for me?' question.

"Sounds kind of selfish. Everybody in the world is tuned into that famous radio station, WIIFM. They're always wanting to know, 'What's in it for me?' You try to answer that in the beginning, but are you still answering it? Do people really know what's in it for them to be involved, and to have this process going on at the site, and what was the last form of communication about? A lot of times, even in safety, the incident reports, a lot of people can't tell you the big items on the thing because, again, remember: people can generally only remember about three of the incidents long enough to have an impact.

"Then you've gotta map the future state. You've gotta map, 'What would ideal look like?' And then work your way backwards. You could look at it and say, 'What do people need to see? What do the supervisors need to see? What do the managers need to see? What do the workers, the additional observers, need to see? What would ideal look like?' Map your way backwards. This is something you can do as a committee exercise. You could even possibly use a Lean Manufacturing consultant, a Six Sigma consultant. Or, if you have a black belt at your site, one of these process gurus, they know how to do this. This is the thing we applied to BBS a while back, but use some of the resources at your site to teach you how to do this.

"So, mapping the should-be state, what would be helpful to know? What would they want to know? These are just some of the questions that we've come up with. If you have any process experts at your site, involve them. They'd be very helpful to help you out with this as well. We can give you additional insight. When should they want to know it? This is what I call W3H3. What should they want to know, when should they want to know it? When should the information be sent to them? How should they receive that information? What's the most effective way for them to receive the things that we're trying to focus them on? And, how will it help everyone improve? How will it help the individuals improve their own personal safety? How will it help the committee be successful?

"How would it help everyone to know? And, lastly, how will we measure improvement? What would improvement look like if we improved communication at the site? What would be the results? What are we trying to target? That's the end goal there. But you need to develop that as far as – when you're trying to map out your strategy of what successful communication looks like, look at the ideal first, and then map upstream. Go the opposite towards where you are right now. That'll help you in identifying what the potential barriers could be long-term. And, also, listen to the voice of the customer. Again, the voice of the customer. They're your stakeholders, the people that are involved in the process. What do they like and dislike about the process? What do they want to know?

"Too often, we define what we perceive to be valuable. Ask them. Have them define what would be valuable to them. Where do they place value? Where do they see the value in what we're trying to accomplish here? What, really, would answer the 'What's in it for me?' question? We can't determine what would answer that 'What's in it for me?' question for other folks. Too many people try to do that. Talk to them; let them tell you what would be valuable, what would be the answer for them."

This concludes this week's podcast. Tune in next week for part six, "Successful Communication is Sticky." Have a great week.

Until next time, remember: "In safety, prevention trumps reaction." For more information on Safety Culture Excellence or if you have a topic to suggest, please e-mail us at podcast@proacsafety.com.