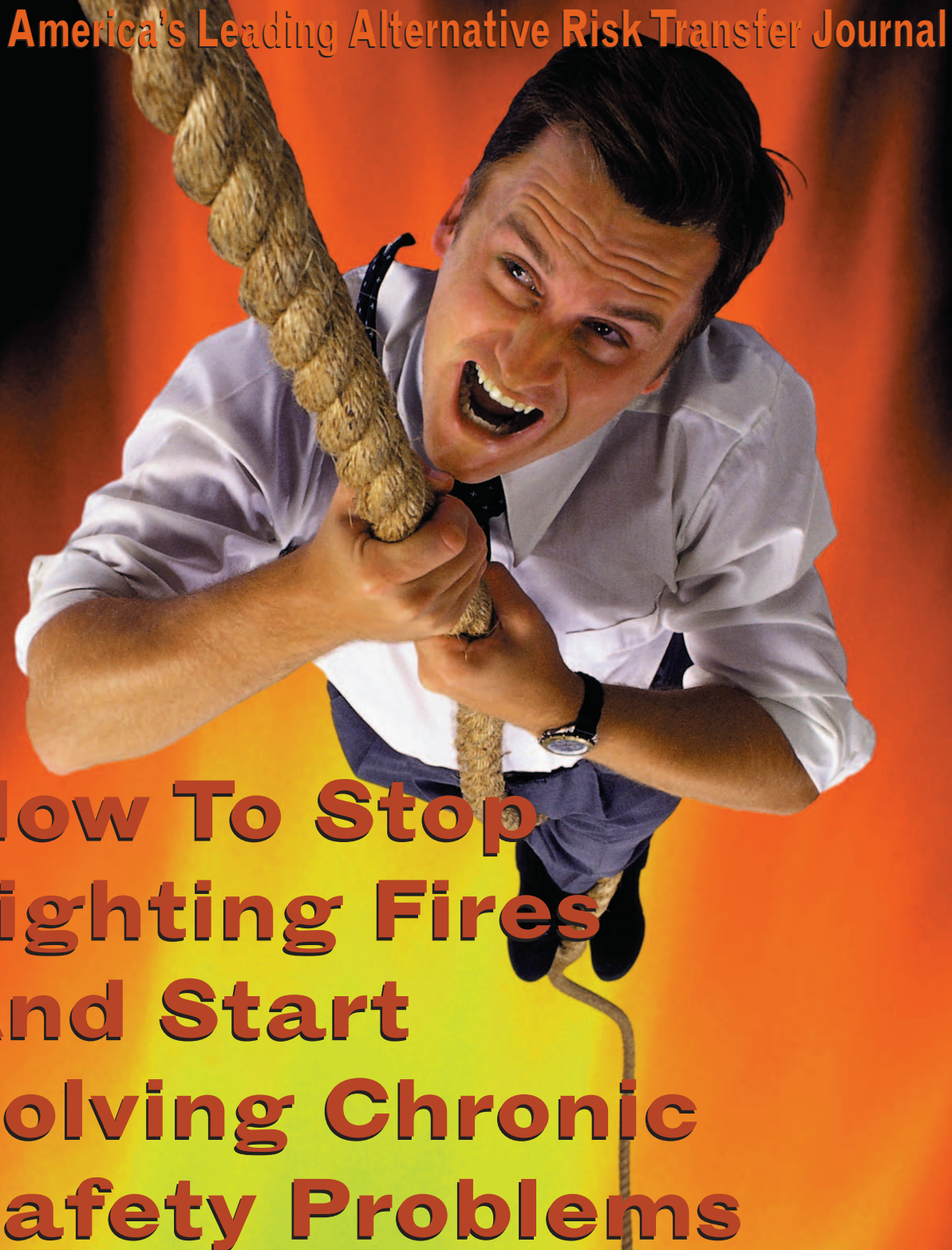


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**How To Stop  
Fighting Fires  
And Start  
Solving Chronic  
Safety Problems**

By Thomas A. Smith, CHCM, CPSM

*Editors Note: This article presents an interesting look at innovative approaches in the management of safety programs. It should be of particular interest to TPAs, employers, and their agents and consultants.*

Organizations do not always behave rationally. This is one of the fundamental reasons why companies often have more problems to deal with than the money, resources and time available to solve them. To counteract this dilemma, managers tend to prioritize the problems they will address, based on what's going on at the moment. They are constantly "juggling" their time and resources to keep production and/or service running smoothly. They react to problems by either taking immediate action or delaying action until they have more time to work on them. Often, unsolved problems of today evolve into problems of tomorrow, either not totally addressed or completely ignored. We call this "firefighting."

Over the last thirty years I've found that safety managers are often trapped in firefighting routines, but don't care to openly admit it. Rather, they offer examples of being proactive, such as asking employees for their input about safety controls when ordering new machinery. But the final decision regarding the implementation of these and similar suggestions or requests rests with supervisors, engineering, and finance departments. Unfortunately, the safety of the workers doing the job is not always the number one priority. Usually, the results we see are patches or quick fixes, instead of finding permanent solutions to chronic issues.

The best way to achieve a continual improvement of safety is to solve chronic problems first. Safety professionals will admit that more gains would be made if they solved chronic problems. Yet they do not, or cannot change their daily work routines, the very changes required to conduct serious problem solving effort. The result – "firefighting."

## How can you tell?

It is easy to identify safety managers trapped in a firefighting mode. Their daily activity involves one or more of the following:

***There just isn't enough time in the day to solve all of the safety problems.*** In a typical industrial setting, there are always more problems than the problem solvers can deal with effectively.

***They investigate every single accident, first aid case, or near hit, looking for a root cause.*** They don't understand the fallacy of root cause analysis and ultimately place blame for the accident on the employee that was injured for not following procedures.

***Their solutions for safety problems are incomplete.*** Often, this means a temporary quick fix is made to prevent an accident but the real causes of why the problem exists is never addressed. The patch is accepted as being "good enough" or "better than doing nothing at all."

***Accidents reoccur and negatively influence other operations.*** When you allow the cause of a problem to continue, accidents tend to repeat, causing low morale, lack of respect for management, and a general attitude of just giving up when it comes to safety.

***Safety problems of today become safety problems of tomorrow.*** Safety managers get so involved with putting out fires that long-term problem solving activity is interrupted, dismissed or ignored, making it even more difficult to uncover what caused them in the first place.

***Questions by workers about what is going to be done regarding a safety problem are explained away without any real answers.*** The safety manager's hands are often tied when it comes to changing the system. Consequently, complete answers to such questions cannot be provided.

***Safety problems elevate to crises proportions.*** Serious accidents occur that could have been prevented by paying attention

to complaints that they were imminent. Beyond the human factors involved, the costs begin to impact other important areas such as workers compensation experience modification factors and corporate profitability.

***Fixing the problem is accomplished by circumventing the system.*** In order to get something corrected, the safety manager has to call in his/her markers. The quickest way to get what you need is to be a maverick. This evolves into managers coercing and even bribing each other to get things done, (putting guards back on machines, adequate time for safety training, etc.) Unfortunately, when a safety manager is successful, he/she is rewarded for putting out fires. It also perpetuates the very system that prevents continual improvement.

## What Causes Firefighting?

Firefighting starts from the moment safety managers and employees are hired. Safety orientations are often cut short or are inadequate. Job safety training is left to on-the-job examples and experience. If safety training is performed, there is little effort to help employees apply and retain what they have learned. Managers are under extreme pressure to increase production. They must choose between safety and production on a daily basis, with production winning in most cases. Consequently, management often institutes regulations and even strict bureaucratic rules geared toward holding the worker accountable for all accidents. Many managers believe that these are sound examples of leadership, when in fact they are the abdication of leadership, and usually lead to demoralization of the workforce.

Instead, the firefighting cycle is intensified. People feel that they are really doing something for the workers. In a sense, they are, but only in terms of patching things up. Finding the way to complete solutions that stop employee injuries is lost.

In most instances, short-term production problems take precedence over maintenance and safety issues. Solving this takes time. The issues have to be prioritized, then analyzed. Each situation is different. Each day, more is put into the system. Management that stresses short-term profitability has little patience for these types of activities. If the number of problems is less than the amount that can be handled by the system, the process can run smoothly. When the incoming concerns exceed the systems capacity, it becomes a pressure cooker and the firefighting begins.

## How to Break The Firefighting Cycle

### Identify fact from fiction

Not too many years ago, quality control managers believed that one hundred percent inspection was evidence of high quality. They felt the way to deliver quality was to inspect every part, separate the bad parts from the good, rework or scrap substandard parts and ship the good ones. Managers now understand that they can't "inspect" quality into their processes or parts. It must be built in. It is not economical to add it at a later time. Customers also know this and demand parts that are built right the first time. We should use the same approach for safety. Antiquated quality methods called for investigating every single problem or defect. Valuable time and resources were focused on after-the-fact quality. Time and resources are better spent working on improving the system so it won't create defects in the first place. If you chose to spend your time on inspections and defect investigations you will never have time to work on the system.

### Use systems thinking

*"Our ability to understand systems is hampered by our inability to accept that the system itself, not some person or process in it, is to blame for what goes wrong." Russell Ackoff -*

former Dean of the Wharton School of Business.

Why not work to improve the system in the first place, rather than wait until someone gets injured? Non-system thinkers generally look to blame someone or some particular thing when things go wrong. They do not appreciate that cause and effect are often not closely related in time and space. Hence, they don't understand that the system is responsible for most accidents, not the individual. They lament that if only employees would follow the rules and procedures, no accident would occur. To that I say, sweet dreams.

A true systems thinker understands that unsafe actions and unsafe conditions are usually not the causes of accidents but rather symptoms of an ineffective management system. A system isn't just the sum of its parts. It is the sum of the parts plus the interactions between all of the parts. Hence, employee attitudes and behavior at work are related to all of the interactions they experience with the work system they face everyday from their first day of work. People commonly refer to this as the "culture" of an organization. If firefighting routines are the norm, then true prevention of system problems never take precedence, and the employees know it.

### Change your systems

How will you change your daily work activities from firefighting to solving chronic system problems? First, scrutinize what you do now and determine how much of it is "firefighting." Then determine how much value is added to safety performance from your work. In his book *The Fifth Discipline*, author Peter Senge points out when you push a system it pushes back. The traditional safety management system of personnel, training, safety inspections, audits, accident investigations, enforcement, reprimands and incentives are the dominant activities of safety managers. It is safe to say, they won't give them up easily even though much better methods are proven and available.

Safety managers will defend their reactive management system with vigor, rationalizing they are mandated by either top management or outside regulatory safety agencies. Fortunately for customers of all kinds of products today, Dr. W. Edwards Deming, Dr. Joseph Juran, and many other quality improvement Gurus' saw the fallacy of depending on such standards. They knew that continual improvement of quality cannot result from following these standards or misguided mandated management policies.

Systems thinkers have discovered control of a system is achieved through freedom — not enforcement. People that work in the system must be allowed to criticize, study, change and improve it on a daily basis. This is in direct contrast to the traditional safety management approach in maintaining the status quo, i.e. meet safety specifications or standards through education and enforcement. This system ultimately tells employees to leave their brains in the parking lot because when it comes to safety, they aren't going to need them at work. Management has done all the thinking and uses rules, regulations and enforcement to decide what's important and how to solve safety problems. This approach did not produce continual improvement in manufacturing quality and it doesn't in the safety effort either.

### Shift your focus to your immediate safety customers. Work to "prevent" fires, not put them out.

Apply the "customer" principle to safety. Customers are defined as someone who benefits from your product or service. Employees, and in particular those out on the line, are obviously the customers of safety management. Most successful organizations have learned that the customer is King. This principle should be applied in safety management. A customer has needs and expectations. When they are waiting for their expectations and needs to be fulfilled, they are actually a supplier of information to the manufacturer or service provider. Workers are an important part of the customer-supplier chain.

Dr. Deming warned us not to expect instant pudding when it comes to making the transformation from Quantity management to a Quality management system. At the risk of making it sound too easy here are the fourteen points to help you make the transformation to continual renewal and improvement of safety performance a reality. If you can do this, you can transform your safety efforts and get sound, measurable results.

## Safety Management Principles:

### The 14 points - The Road Map for Leaders of Safety

**1. Create a constancy of purpose.** Work constantly to reduce scrap, waste, rework, and accidents to improve the competitive position of the company. Top Management is responsible to all employees in this effort. This responsibility cannot be abdicated to the workers.

**2. Adopt the new management philosophy.** Accidents are the same as producing scrap. We can no longer live with commonly accepted levels of employee injuries, delays, mistakes and defective or improper equipment. Work to satisfy the needs and expectations of your internal (workers) and external customers everyday.

**3. Cease dependence on mass safety inspections.** These are after-the-fact activity in the name of safety. Instead, require statistical evidence that safety is built-in, and eliminate the need for fire fighting routines.

**4. Find problems.** It is Management's job to continually work on the system. (People, materials, methods, machines, environment.) Management can improve the system by identifying problems, with the help of all employees.

**5. Use teams.** For decision-making (consensus) and problem solving of systemic safety problems. Common causes are buried deep in your system and usually beyond the ability of one individual

to understand and solve. Teams outperform individuals when it comes to problem solving and are necessary if real solutions are to be discovered.

**6. Provide leadership.** The responsibility of supervision must be changed from managing the numbers to being leaders, facilitator's, coaches and counselors of work systems. A manager's job is to remove the barriers around the workers and safety teams that prevent them from doing their jobs safely and solving common cause safety problems.

**7. Responsiveness.** Management must create a system that responds immediately to reports from teams about barriers that prevent continual improvement of safety. Work on chronic problems such as; superficial training, persistent and consistent accident frequencies, improper maintenance, faulty equipment, and unclear operational definitions of "safe."

**8. Drive out fear.** Insure that everyone can work effectively and safely for the company. Eliminate the use of reprimands and incentives (bribes) as management tools to control the actions of employees. Fear destroys intrinsic motivators. All human beings have intrinsic motivations to be safe.

**9. Break down barriers.** All departments must learn to cooperate with each other so they can work together on solving the problems of common and special causes of injuries. Using operational definitions of what is "safe" will eliminate barriers between departments.

**10. Allow process units and employees to set their own safety goals.** Eliminate management set objectives which are put forth in numerical quotas, incentive programs, posters, and safety slogans, none of these improve safety or the system. Self-set goals create individual ownership of safety. It creates mutual accountability.

**11. Remove any barriers that would prevent the worker from working safely.** Eliminate the need for making

choices of "quality and production vs. safety." All are important and none will be optimized if the other is ignored. Safety is the sum of the parts of your system plus the interactions of all parts of the system.

**12. Instill pride and joy in work.** Work to reduce turnover. Turnover devastates the quality, productivity and safety effort in all areas of a company. Work to put pride and joy back into all jobs.

**13. Institute a vigorous program of education and retraining.** Teach everyone in the company the new philosophy of continual renewal and improvement of performance.

**14. Create a structure** in Top Management and throughout your organization that will push every day on the above 13 points.

Idealistic? Hardly! Far too many success stories exist that are a result of corporate efforts in quality systems management and continual improvement applications. While a seemingly radical departure from the now century-old approach to traditional safety management approaches, it appears that quality management in the accident prevention arena produces the same highly desirable results that it has in many other segments of industry and commerce.

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