

# THE HIDDEN AGENDA

By DANIEL F. ZHLIS

**P**riority is better achieved through the ability to capitalize on similarities than the ability to highlight differences. It is time to focus on what safety has in common with other functional objectives rather than demanding respect for differences and allowing leadership to “agree.”

“People First.” “Safety First.” “We begin all staff meetings with a discussion of LTAs.” “Our strategic imperatives, in order of importance: safety, quality, efficiency, cost.” These are mere slogans. Many companies claim that safety is a top priority and believe that they fulfill this commitment simply by claiming it to be. One firm’s mission statement incorporates this admirable claim: “Safety is the number one priority in our total quality commitment.”

In such an environment, those charged with moving the safety effort forward are forced to compete for resources with functional objectives that allegedly owe reverence to the safety of the workforce. The safety function typically fights diligently and fails honorably. The honor comes in knowing that all company slogans, future meetings and informal discussions with employees will *verbally* promote the priority of safety and reinforce respect for the safety function.

Allowing artificial slogans and meeting agendas to define reality does more than merely slow the process of improvement. Accepting these common practices vali-

dates the inactivity that they instill and ensures stagnation. In other words, it is time to “do so and quit saying so.”

How does today’s safety professional begin to “do so” when reciting non-compliance risks, warning of high costs and associated low morale, and providing reminders of the value of human life frequently fail? When safety is often “talked about” but rarely “walked about”? When the argument that “we are in the business of manufacturing widgets, which generate revenue, not in the safety business” must be acknowledged?

Perhaps the key is to stop talking about safety per se. Instead, the safety professional must begin to explore those functions that receive attention, then design joint processes which serve the “ultimate master” (the employer). S/he must join forces, add value and begin to blend safety principles into the culture of business. Today’s safety professional must become a resource to other functions and strive to integrate safety objectives into the existing processes of resource-rich departments, functions and objectives. In other words, the expansive supply of support tools and techniques that constitute safety must be applied across the organization.

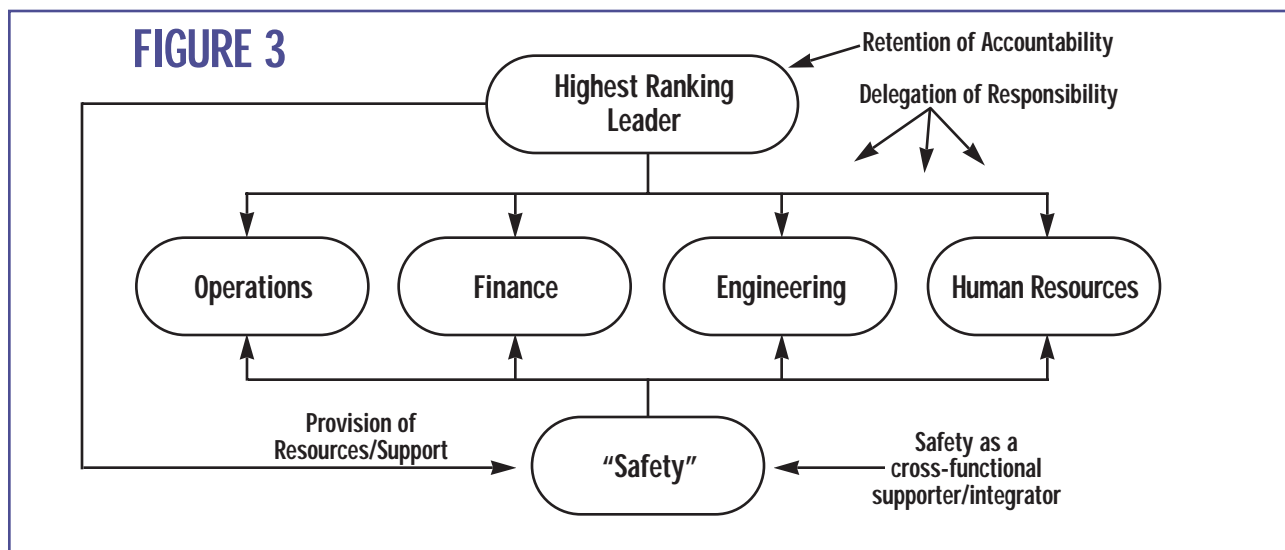
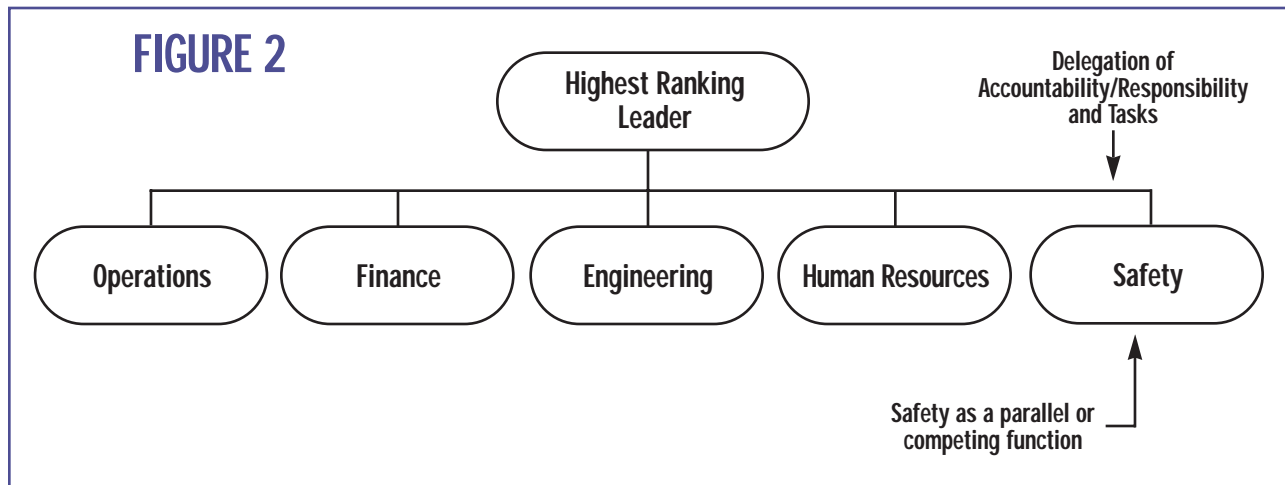
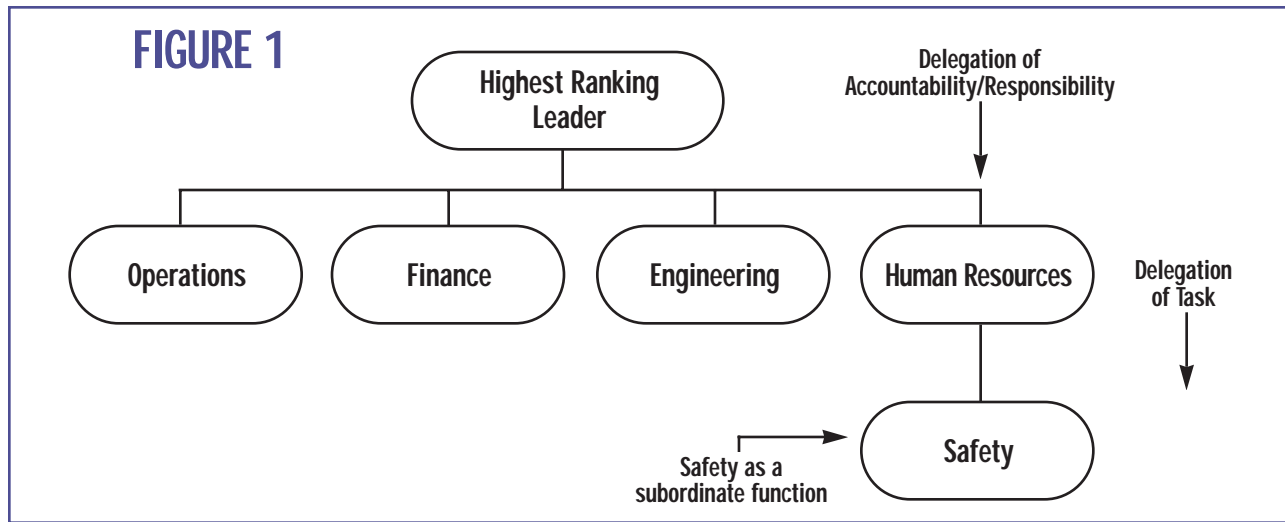
Clear parallels exist between safety and quality. Long before it was popular, safety professionals were unleashing the power of employee ingenuity. Review of Deming’s 14 Points for Management

reveals many basic threads of safety. A firm that understands the need to eliminate redundancy and non-value-added activities has recognized the immediate impact of allowing the safety function to act as a vehicle for organizational development and improvement. This does not mean the company should align safety program implementation with that of an organized quality improvement process. Rather, it should use safety as a *tool* to instill the principles of total quality.

The following examples illustrate cases in which firms have integrated safety systems into other areas in order to capitalize on similarities and tap into the resource-rich employee population.

#### ORGANIZATIONAL STRUCTURE AND SUPPORT

Figure 1 illustrates traditional efforts to Carmelize the workforce around employee protection. The safety function is a resource position attached to a manager (usually human resources or engineering), who is subordinate to the facility leader. In more and more companies, the safety practitioner is attached directly to the leader (Figure 2). Although this shift appears to be an improvement, unless the role itself is regarded differently, firms are doomed to fall victim to the fallacy that one person can accomplish anything independently. This is especially true since the safety professional is often in the least-likely position to command or influence performance through position alone.



To ensure that the safety practitioner is not viewed as the sole overseer of safe working conditions, a firm must begin to view the highest-level leader as the driver of the effort and the practitioner only as a catalyst and resource (Figure 3). This capitalizes on the practitioner's relative freedom to travel within an organization, *without* inherent territorial suspicions, while leaving program directorship in its appropriate location—with the leader.

Once the highest-ranking leader is recognized as the driver and the safety practitioner as a resource, program responsibilities can be delegated throughout mid-management and supervisory ranks—and, in some cases, to line employees (Figure 4). This distribution should be based on individual abilities, with less weight applied to the actual organizational function of program leaders.

Once the structure is identified, pro-

gram leaders should solicit a cross-functional volunteer team of employees most affected by the respective programs. (Although direct program involvement is not a prerequisite, it does help.) This small-team-based approach eliminates reliance on larger safety committees, expands employee involvement and enables teams to make rapid, lasting contributions.

Individual program leaders constitute the steering committee, and they report

directly to the leader (regardless of the formal organizational hierarchy). Teams are also encouraged to identify opportunities to integrate additional functional objectives and expand their influence.

One obstacle for team leaders will be their lack of skill in organizing teams, identifying objectives, ensuring cross-functional communication, and facilitating meetings and problem solving. The good news: Team leaders of this “organization within an organization” become the target for leadership development. The better news: Skills to be developed apply across functions and ultimately lead to a stronger business. Some of these skills include giving/receiving feedback; conducting effective meetings; determining root causes; building and maintaining trust; and encouraging initiative.

In such an environment, the safety practitioner becomes a technical resource, staff-development facilitator and coach. The “safety program” being developed becomes an exercise bike that helps fine-tune leadership and empowerment skills. The structure provides leadership practice via small, manageable objectives and organizations (teams). As a result, the learning is real—and is applied immediately.

#### STEERING THE EFFORT

An integrated firm sees the value of abolishing the traditional “safety steering committee,” “plant safety committee” and “safety coordinator” roles and utilizing administrative committees. During meetings, safety is *one* area of discussion. Local

leaders can also discuss system progress and system needs from a general administrative perspective and satisfy many needs simultaneously (e.g., safety, product quality). Via such an approach, the leader can examine the effectiveness of standard skills being applied to various functional areas; correct diversions; and identify improvement opportunities.

#### BEHAVIOR MODIFICATION

Modifying behaviors to support a common direction requires continued reinforcement of desired behaviors. Many firms address the issue of behavior modification—reinforcing and correcting—as separate functions. Consequently, they overlook the common attributes these functions share. Methods used to reinforce safe behaviors and correct unsafe ones are common and can be learned under one strategy applied across functions. By integrating behavior modification techniques, a firm can streamline both the tracking and learning process—and improve the consistency of communication throughout the organization.

#### Reinforcing Behavior

Figure 5 represents an early version of one company’s list of rewardable activities. Notice that the list is not limited to safety, industrial relations or quality. Instead, it incorporates several functional objectives, and shows that awards are highlighted in a single catalog. By integrating the types of rewardable activities, this firm has developed a method of illus-

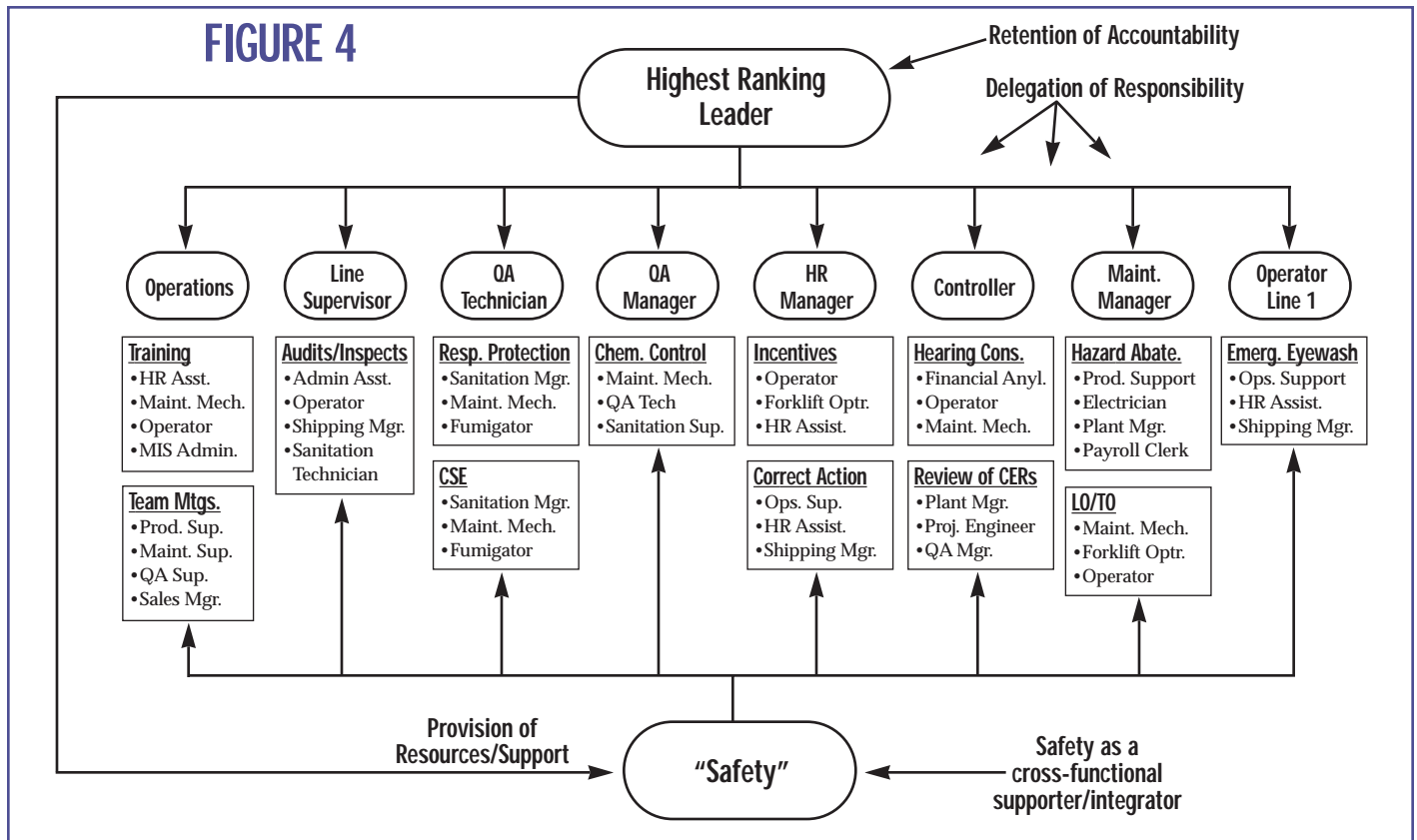
trating the interdependence of various functions. In addition, employees see the flexibility of the list and are encouraged to add items they feel reinforce the process.

Also notice the absence of rewards attached to the occurrence or non-occurrence of *downstream* effects (e.g., LTAs, consumer complaints, efficiencies). This clearly demonstrates a preference for activities that develop the organization and reinforce group contribution through individual accomplishment.

#### Correcting Behavior

A company can enhance behavior modification by improving the techniques of those charged with correcting employee behavior. To accomplish this, the firm can develop a training method that utilizes real-life examples as interactive exercises during training. These exercises should not be limited to one functional area; rather, they should cross functions based on key focus areas (e.g., cost, safety, product quality, customer service, efficiency). By integrating leadership techniques, skills learned once can be applied repeatedly.

Traditional efforts to teach line supervisors how to take disciplinary action in response to safety violations simply reinforce the notion that safety is different from other functions and, therefore, requires a different technique. This only further distances safety from the organizational “big picture” and builds resistance to safety because of the need for additional learning and resources.



### FIGURE 5

CRITERIA	POINT VALUE
Non-repeat suggestion	1
Suggestion implemented	3
Catching a wrong code date	2
Reporting unsafe condition (product or human)	5
Conducting a monthly self-inspection	4
Obtaining a required certification	5
Serving on the plant ergonomics committee	5
Finding and removing a non-naturally occurring foreign object from product	4
Becoming trained as a program trainer	25
Serving a term on a systems team	10
Specialized training received	20
Zero absences	1st six months 5 2nd six months 5 1 year 25
Team meeting presented	25
Verified report of a suspected fraudulent claim	Employee allowed to select a gift from the catalog.
Reported an unsolicited contact by a workers' comp practitioner (doctor, chiropractor, lawyer, physical therapist, etc.)	25
Best suggestion of the week (determined during staff meetings)	5

#### TEAM MEETINGS

Safety meetings are generally mandated by OSHA and certain state programs. Many firms conduct these meetings to accomplish basic compliance, so they tend to overlook the cross-functional opportunities such gatherings present.

Figure 6 depicts a sign-in sheet utilized by a firm that recognized the value of associating safety meetings with other key strategic imperatives. Each topic listed must be covered during each meeting.

This method of topic integration enhances the likelihood that such meetings will occur because it builds cross-functional support for their occurrence. This also means the safety coordinator need not coax participation. Clearly, the adage that a safety meeting should only cover safety topics in order to avoid weakening the message is outdated and unrealistic.

#### INSPECTIONS/AUDITS

OSHA mandates routine inspections of the workplace, while agencies such as the U.S. Dept. of Agriculture require self-inspection of plants that process and package food. Quality assurance and sales departments depend on regular inspections to ensure that specifications are met. Operations groups depend on regular process reviews to reduce the likelihood of downtime and product risks. Maintenance relies on inspections to facilitate preventive actions. An integrated firm designs and utilizes common tools to accomplish multiple objectives—including inspections.

Figure 7 represents an abbreviated version of a pre-startup checklist used by a food-processing firm. This list integrates the myriad regulatory and self-imposed expectations into a common document. As

### FIGURE 6

On this day, \_\_\_\_\_, a team meeting was held for the \_\_\_\_\_ department/line/team. The individuals listed below attended. Each participant was encouraged to interact and ask questions when necessary. The topics covered during this meeting were:

Safety:
Product Quality:
Shrink:
Line Efficiencies:
Labor Relations:

This meeting (did/did not) result in a recommended modification to an existing practice, system or process. The recommendation is as follows:

Supervisor/Team Leader Signature \_\_\_\_\_ Date \_\_\_\_\_

Last Name First (please print)	Signature
1. _____	_____
2. _____	_____

### FIGURE 7

Date and Time of Inspection:	M	D	Y	Time	AM/PM	Page 1			
EQUIPMENT	INSPECTION ELEMENT					OK	NO	ACTION TAKEN	
PRODUCTION	Floor area is free of debris.								
	Pest traps are satisfactory L33, 34.								
	Floor drains are covered. Covers in good repair.								
UTILITY AREA	Packaging materials are staged and are secure.								
	Water hose is in good repair and is coiled.								
JONES CARTONER	Feeder guards and caution stickers are in place.								
	Machine is free of dust and residue.								
	All panel lights are operational.								
	Feeder chain is free of excess oil and debris.								
	Floor mats are clean and in place.								
FEEDING BELTS	E-stops are functioning properly.								
	Belt alignment is acceptable.								
	Feed belt area is free of product from previous run.								
SOLBURN FILLER	Guards and caution stickers are in place.								
	Rotation is adequate.								
	Filler area is free of mold, slime, debris and odor.								
	Safety nozzle and air hose in place . good repair.								
FLAP TUCKER	Fruit capture tubs are in place beneath the filler.								
	Shaker motor oil gauge reads 45 PSI.								
	Water jets are operating.								
WEIGH CHECKER	Belts are in good repair.								
	Fruit capture tray is in place.								
	Caution stickers are affixed to access doors.								
	Scale is calibrated and accurate.								
	E-stops are functioning properly.								
	Weigh checker seat is in place.								

a result, the firm has eliminated redundant physical inspections; illustrated the equal importance of various functions; provided a dynamic tool that incorporates continuous learning; and standardized the technique for conducting inspections.

Initially, this firm's functional leaders resisted integrated inspections, believing that maintenance personnel should gauge maintenance needs; that quality inspectors should monitor product quality; and that safety staff should monitor hazard control. These fears would be well-founded within a company in which management operates the facility along functional lines, yet unthinkable in one where management serves the needs of those who truly operate the facility.



# FIGURE 8

TASK	HAZARD	CONTROL MEASURE	PpPE
ENTERING PLANT	Introduction of hazards to food product	Wash hands prior to walking through plant.	Hairnet Smock  No loose clothing Non-slip, closed toe shoes Earplugs Bump cap
		No smoking, gum chewing, eating food in plant.	
	Collision with forklifts	Remain within the pedestrian walkway along the outside of the yellow berms along wall.	
		Always use pedestrian doors.	
	Contact with moving machinery	Do not place hands into equipment with moving parts.	
	Slippery floors and floor obstacles	Use caution when walking (walk slowly, avoid standing water, do not step over objects - go around).	
		Remove standing water immediately.	
	Slippery stairs	Always use handrails and walk cautiously on stairs.	
Excessive noise	Wear hearing protection at all times.		
Contact with low equipment	Wear head protection.		
Unidentified dangerous conditions	Inform a supervisor immediately of dangerous conditions. If you wish to remain anonymous, use suggestion box.		
HANDLING FRUIT	Introduction of hazards to food product	Never touch fruit without appropriate gloves.	Latex gloves
EMERGENCY EVACUATION	Failure to escape a dangerous condition (i.e. fire, ammonia)	Locate supervisors in your immediate area (blue cap).	
		Familiarize yourself with posted evacuation.	
		Proceed with caution in the same direction as employees evacuating the area.	

### HAZARD ABATEMENT

Hazards are hazards, regardless of the target population. Auditing for the presence of hazards under separate functional objectives (e.g., human safety, product safety, property protection) merely promotes functional thinking and generates redundancies. Within such a system, each functional group must track its findings and communicate them (independently) to those charged with implementing corrective action. This process is often achieved via different formats—and on various timetables—which only further confuses those who must decipher the requests. Consequently, it becomes difficult to manage abatement followup.

One firm developed a tracking mechanism to streamline its tracking, priority setting and communication methods. This firm incorporated all hazard tracking into one system—with one system administrator. As a result, the company was able to clearly communicate where those wishing to report hazards should go (irrespective of the nature of the hazard). Maintenance and engineering personnel also know where to obtain hazard reports—or where to expect them on a regular basis. In this firm, the leader has a single method of tracking hazard abatement—which is projected to the front of the room during steering meetings—and accountabilities are assigned and tracked in “real time.”

This firm’s system is not designed to eliminate only human safety concerns. It tracks *all* hazards interdependently and categorizes them for those interested in a particular type of hazard.

For example, if OSHA asks to review hazard abatement, the facility simply accesses the system and sorts by hazards categorized as human safety. If product quality auditors inquire about product safety, only the sort changes—not the administrator, mechanism or manner of follow-through.

What did this organization learn? Differentiating between hazard categories is challenging—and often leads to disagreements because many hazards appear to affect multiple areas, further illustration of organizational interdependence.

### JOB HAZARD EVALUATION

Job safety analysis (JSA) is a tool used to identify hazards associated with specific job tasks. The simplicity and effectiveness of this tool has prompted several states to legislate it into administrative program requirements. Yet, JSA is under-utilized.

Figure 8 is an edited page from one firm’s general job hazard evaluation (JHE), which is a base training requirement for all workers. Employees must also receive training in JHE’s relative to their jobs. This firm recognizes the value of documenting task review as it relates to multiple functions that produce hazards.

The employer reviewed all tasks that generated hazards—whether the hazards applied to employees or end-users. In fact, the firm created the acronym PpPE (personal and product protective equipment) to reflect recognition of hazards to people *and* products. The site also uses base task lists, identified via the JHE development process, to create accurate job descriptions and standard operating procedures.

If a firm assigns an employee to list every task performed, why not assign several colleagues from other affected functions to help? The end result will be a single document that all functions continue to modify as learning grows. This integrated approach leads to increased continuity via standardized training materials, leadership accountability, system tracking and modification, and organizational communication.

### ADDITIONAL OPPORTUNITIES

The possibilities of program integration are limitless—and today’s market condi-

tions demand compliance integration. Other areas of opportunity include training; suggestion programs; chemical control and hazard communication; ergonomics programs; change management; regulatory inspections and contacts; and capital expenditure review programs.

Determining which functions to incorporate depends on the dynamics of the organization’s leadership. Operations managers who recognize that leadership truly holds safety as a priority will capture this budget value: Incorporating goals outside the function of safety into a function protected by leadership mandate is essential. In firms that hold the quality assurance function reverent, managers can incorporate safety goals into the quality assurance function.

The key is to acknowledge the similarities between functions and reject the practice of saying one thing and doing another. Many will see the opportunity to implement goals and objectives under the firm’s true priority list.

Allowing safety to be mentioned first (as a means of acquiring priority) limits the level of priority to words alone. Imbedding safety principles into the operational culture delivers tangible priority to the safety function while expanding the value of safety practitioners. What ultimately matters is what gets done—and whether what gets done actually improves the process of protecting employee and product safety.

So, what is the hidden agenda? Depending on one’s perspective, it is either 1) implementation of a participative, sustainable employee protection program or 2) a developmental process which improves communication, participation and leadership skills that lead to a healthier business. The irony? The effectiveness of the safety program depends on the firm’s health; in order to accomplish either agenda, safety professionals must solicit the integrated participation of the organization, with an emphasis on leadership. Safety can still be first. ■

*Daniel F. Zahlis is director of change for Johnsey Insurance Agency, Fresno, CA. During his career, Zahlis has held risk management positions within the hazardous waste disposal and food processing industries. A member of ASSE’s Central Valley Chapter, he holds a B.S. in Health Science, Occupational Safety and Health from California State University, Fresno.*

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