Breaking the Cycle of Mistrust to Build a Positive Safety Culture

By Rosa Antonia Carrillo, MSOD

The OSHA recordable rate was at 12.8. Then, a near-fatality shocked employees and managers. Bob, a 30 year old with two children, escaped with his life by a quarter inch everyone kept saying. An electrical arc burned the hair off his right arm and temporarily stunned him when he plugged in a piece of equipment. No one came forward to admit that they had failed to tag the electrical outlet as faulty because they knew it would mean days off without pay at best and dismissal at worst.

Everyone was stressed. Morale was low from lay offs and restructuring. There was not enough money for preventative maintenance, a least not enough to address the concerns of the people doing the work. So, the plant manager decided to initiate a series of classes that would focus on changing the culture and behavior. "These near misses and accidents are due primarily to people's behavior," he said, "People have got to understand that fixing all the physical conditions isn't the answer to stopping accidents! I want to turn this culture around and the only way I know of doing this is to get everyone in a room and talk about it."

Consequently for a year, the author facilitated dialogues attended by all employees, including managers. The sessions did not focus on employee behavior as the cause of accidents. Instead, concerns were validated. There was more work to do than there was time to do it. There were physical hazards that had to be addressed. Corporate was thinking of selling the plant. Managers and associates faced reality straight on and ended up becoming the top-performing unit in safety, productivity and positive outlook for the future. This is the story of how one company did it.

Phase I: Breaking the Cycle of Mistrust Dialogues

The initial conversations were brainstorming sessions. Managers, separate from associates, each made a list of their perceptions answering the following questions. 1."What frustrates you about the work processes, working relationships or communication breakdowns around safety?" 2."What do you think the other group is writing down on their list?"

A spokesman from each group presented their own list of complaints and the list they thought the other group might be making. The objective of writing down what the other group might be saying was to force each group to walk in the shoes of the other's perspective. The accuracy of the second list generated both surprise and laughter because things came into the open that many had thought were "undiscussable."

Discussion of the issues was very structured. In the past arguments had broken out and no progress was made. This time you could ask questions of clarification, but you could not argue with the other person's perception. The facilitator often asked people what they had heard and asked them to repeat it until the other person agreed that s/he was understood. It was enlightening to the group that often "disagreements" disappeared when the individuals engaged in an argument really listened to each other and found out they actually agreed on an issue.

The next step was to split back into work groups (supervisor & crew) to prioritize the perceived problems and select one or two for problem solving. Certain issues were assigned to the plant manager and his staff for resolution because crew members did not have the authority or resources to resolve them. The management team took these on, formulated goals, action plans

and began implementation. Crewmembers worked on their own work processes and reached agreement on how to handle specific situations that had caused problems in the past. At this point some of the problems resolved not only improved safety but also production speed and quality.

After the entire plant workforce had been through these dialogues, a pattern emerged. Figure 1 shows the list of the barriers to safety that showed up in every dialogue session. The management staff called them the Safety Culture Toxins. As other plants went through the dialogue process, the same list was generated repeatedly. Let us describe how these toxins showed up in the dialogues because they offer significant insight into the perceptions that cause mistrust in the workplace.

Figure 1. Safety Culture Toxins

1. Meeting deadlines has priority over safety
2. Management not visible in work areas
3. Lack of concern for employee welfare
4. Not keeping commitments
5. Lack of agreement on a common direction or standards
6. Poor accountability
7. Poor communication of important information
8. Blame fixing, personal attack and retribution are the norm in handling conflict
9. Response and follow up to safety concerns is slow or non-existent
10. Fear in the workplace

1. Meeting deadlines has priority over safety.

Managers had told their direct reports stating in very uncertain terms that safety is a priority and that people will not be put at risk for the sake of meeting deadlines. In fact, everyone had been told they had the right to stop an unsafe job. Yet, often, employees worked off the assumption that it was more acceptable in their organization to take a safety shortcut than it was to miss a deadline. This surprised some managers.

Their surprise showed a lack of cultural awareness. Managers did not understand the power of their position and the long-standing expectations that unconsciously drive people's behavior. What we have learned is that most of the time the pressure to put production over safety is implied, not stated. Sometimes it is a miscommunication like a manager's casual comment, "It would be good to have this order ready to ship by next week," being interpreted as a rush order. It is easy for an employee to assume that the supervisor wants the job done no matter what when, in the past, people were expected to take risks to get the job done.

The underlying issue here is, "What is acceptable risk?" The answer is not black and white. The teams arrived at an answer by discussing the facts surrounding each risk at tailboards.

2. Management not visible in work areas.

"There is not enough time in the day for me to do everything I have to do," managers cried. It was clear that employees perceived lack of visible presence as lack of interest. We asked employees why it is so important to see the top person. They said they cannot trust decisions

made by managers who have never been to the job site, haven't demonstrated visible concern, competence, or interest in learning about the real challenges workers face. They saw visibility as a symbol of the importance managers placed on safety.

3. Lack of concern for employee welfare.

We heard many times that managers don't care about safety, only cost cutting. Downsizing and outsourcing had created an atmosphere of distrust that management had the employee's best interest at heart. This was a tough one. Of course, managers did care, but often they did not understand the importance of expressing that care.

Some managers were better at expressing their values. These were the ones that employees felt could be trusted even if the company could not. It wasn't just a matter of saying they cared. They also talked to people one on one, gathered their opinions, their concerns and ideas and acted on them.

Repeatedly, employees demonstrated that they did not expect to get their way all of the time. Once managers took the time to explain their decisions and to show that they did care, many times new avenues of understanding opened up. The animosity and resistance transformed into collaboration.

4. Not keeping commitments.

Many examples of broken commitments arose. For management, the issue was that the union would break their promise not to use safety as a negotiation tool. They also viewed employees as unwilling to commit to taking personal responsibility for their own safety. For union members they saw starting programs and letting them drop, failing to deliver on promised action items, lack of manpower and funding for safety as management's share of broken commitments.

5. Lack of agreement on a common direction or standards.

Managers and supervisors didn't agree on safety goals or standards. One supervisor would enforce a rule, another wouldn't. This was seen as an obstacle primarily by supervisors and led to the next toxin, poor accountability.

6. Poor accountability.

People felt poor performers were not confronted. Many times people were not disciplined for failing to use proper personal protective equipment (PPE), but they were punished for accidents. Managers were seen walking through the plant without proper protection. Management wanted employees to remind each other to wear their PPE, but employees felt that constituted "enforcing the rules," which is a management responsibility. Thus, employees felt management was side stepping their responsibilities.

7. Poor communication of important information.

Many of the miscommunication issues related to over reliance on memos, bulletin boards and e-mails in place of face-to-face contact. People felt they didn't have time to have conversations, but the results of miscommunication sometimes ended up costing a lot more.

An example that caused a lot of animosity occurred when a minimum manning policy was implemented. Grievances were filed because no one knew about it. Yet, it had been posted for over a year on a bulletin board and no one had read it.

We should never assume that letters, memos or reports have communicated important information. One of the Challenger accident investigators coined the phrase, "Information is not communication." All the information about the faulty O-rings was available. No one acted on the information and people lost their lives.

8. Blame fixing; personal attack and retribution are the norm in handling conflict.

If someone tried to stop a job because they felt it was unsafe, supervisors would often say, "It's just a way to get out of work" This behavior resulted in filed grievances. Union representatives said it was the only way to get issues addressed. Accident investigations were seen as punitive. Even amongst union members name calling was the norm. When asked why, one person responded, "It is the only way to get heard."

9. Response and follow up to safety concerns are slow or non-existent.

After a year of dialogues managers came to see that responding to safety concerns and suggestions in a timely manner was at the heart of building trust and credibility. Over and over employees told them this is how they judge the company's commitment to safety. One supervisor wrote:

"I was asked to tell what I was doing to take a shift that had the most accidents two years go to zero year to date. My answer was, people want you to respond to them. We all do, don't we? Problem is that we all do not do that. Why? I don't know. Most people in this plant are only going to tell you a couple of times about getting something fixed. Then, they will fix it (have an accident and then it gets fixed). We have all said many times before, attitude is the #1 factor in people not getting hurt. We as management must build credibility with our people. Then, we'll have a better chance of changing their attitude. This is not the 'whole ball of wax' on reducing accidents in this plant, but it's a darn good place to start."

10. Fear in the workplace.

The main factor that contributed to fear was overuse of the discipline process. People were not held accountable for not following proper procedure but were punished when they got hurt, this caused resentment and anger. Consequently, people began to suppress information and the incident rate increased.

This is the perfect toxin to bridge our conversation to how these issues were addressed because on the surface it is an irresolvable dilemma. The plant manager felt he had an ethical responsibility to discipline such potentially harmful unsafe behaviors and employees saw his disciplinary actions as a set of inconsistent, unfair behaviors that were damaging what had once been a great place to work.

Phase II: Teaching the Concepts

To reverse the cycle of mistrust we had to deal with perceptions and assumptions that dated back many years. Individuals and groups started from the position that their perception was the "right"

one. So, we began by introducing the concept of personal choice and responsibility. Why? Because it is easier to expand your view of the truth than it is to get others to expand theirs.

Fundamental to the success of these dialogues and the ensuing follow up was the introduction of four concepts that are critical for the work of both self change and organizational change. 1) It is our nature to assign meaning to what people say and do; 2) The process of assigning meaning often leads to a cycle of mistrust; 3) We can use the same process to build a path of trust, and 4) How to deal with seemingly irresolvable dilemmas. The final concept of dealing with irresolvable dilemmas was added when the group realized that they did not have control over a lot of the issues that were causing them stress. Even more importantly, some of those issues like speeding up production and cost cutting had to be successfully addressed for the business to remain competitive. For example, they had to cut costs and produce quality work. They had to speed up the work processes and observe all safety procedures.

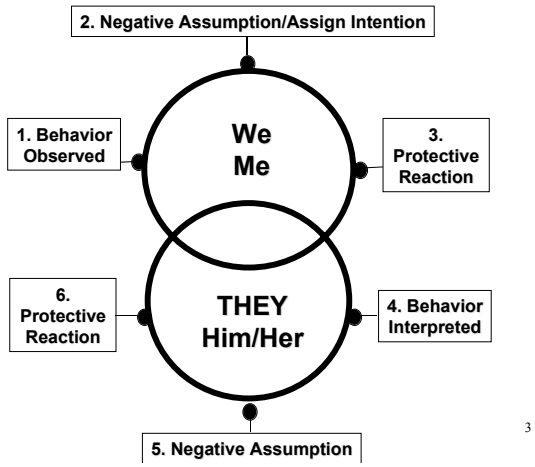
When we are born we are taught how to view the world and how to assign meaning to its objects and events. Over time, our experiences add to our pool of meaning. Psychologists tell us that the emotion we feel when we observe an event is based on our interpretation of it filtered through our experience. For instance, if a caveman were to be beamed into the 21st century to observe a group of surgeons performing heart surgery, what would he feel? Would he feel fear or compassion? Based on his experience, he would most likely feel fear. We provided this concept and example as the backdrop to how mistrust becomes imbedded in the culture.

Figure 2, The Cycle of Mistrust, shows that once there is a we/they situation, each group views the others' behaviors through a negative lens. We or I observe a behavior in step one and assign it a negative assumption in step two, they way we feel triggers a protective reaction on our part in step three. These self-protective actions can range from silent withdrawal to violence.

The recipients, "they," observe our self-protective behavior in step four, assign a negative assumption to it in step five and in turn take their own self-protective action in step six. We or I, of course, see their behavior and feel attacked. Thus, the cycle continues downward as each protective action triggers another negative assumption and reaction.

Our participants saw the truth of this cycle. Some even said that the cycle was beneficial because the continual animosity between union and management was an indication that each group was protecting its position. However, most people wanted to learn how to break the cycle so they could create a better quality of life in their work environment. This provided the opening we needed to introduce the concept of dialogue as the path to trust building.

Figure 2. Cycle of Mistrust



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Phase III: Teaching and Using Dialogue as Part of the Work Process

The dialogue process combined with action planning and active follow up on the part of the plant manager helped to resolve many of the old issues that had created the cycle of mistrust. But how could the mistrust be permanently replaced by trust? What were the behaviors and commitments that needed to be put in place?

The honest, respectful and results oriented conversations that had taken place in the facilitated sessions needed to continue on a one-on-one basis, within work groups and between organizational functions. But we were facing two severe obstacles. 1) Everyone knows how hard it is to bring up a touchy subject, to give or receive critical feedback and 2) when were people going to find the time to have these conversations and how could they do it successfully?

Here are the some approaches and skills that work:

- **Determine who you need to talk to and about what.**
- **Prepare yourself.** Examine your emotions for legitimacy. To be on the safe side, rather than thinking the worst of others, impute good motives. For example, when you're approaching a colleague who did not come to a meeting you called, you might ask yourself, What other possible conclusions could I draw? Or, Why would a reasonable and decent person have done that? When we do this we break the cycle of mistrust and open ourselves to new information and the possibility of improving our working relationships.

- **Start with a mutual purpose.** Don't begin by diving into the heart of the issue. If you do, the other person is likely to become defensive and you'll conclude that you can't discuss the topic without a blow u p. Wrong. Others don't become defensive because of your content, no matter how sensitive. People become defensive because of the perceived intent. If they believe you're out to get them, you're doomed. You can't say good morning without causing suspicion. On the other hand, if others think you have their best interest in mind, you can talk about anything. It's important to begin a delicate discussion

by clarifying how you're looking out for the other person. Don't proceed with the conversation until you're confident that the other person trusts your positive intentions.

- **State an observable behavior, don't interpret it and make assumptions.** Assigning intention to someone's behavior typically generates resistance and defensiveness. The fix is an easy one. Begin with an observable behavior, ("You've been late to the last three meetings"), not your feelings ("I'm angry with you"), or worse yet, your negative conclusions ("I can never count on you!"). If you start with the facts, the other person is far more likely to listen to the issue rather than feel attacked.

- **End by getting and giving commitments.** How you end a difficult conversation is as important as how you start it. Too often, we work through a tough issue only to leave the details unresolved. When we don't clarify exactly what needs to be done, we leave the ensuing tasks to the infamous "them,'" only to learn that nobody took responsibility. End by clarifying who will do what by when. Also, decide when and how you'll follow up. If you don't, count on rehashing the same issues over and over.

These skills were taught and practiced in the monthly dialogue sessions. Each month the team would check in with each other, ask for and receive feedback. The importance of tailboards grew as individuals grew in their awareness of what issues needed to be discussed. Everyone agreed that if the formal dialogues had not continued for a year, the skills would not have gotten into the work culture. In the past, the perception had always been that there was no time for these types of conversations. After seeing the how open, non-blaming dialogue positively affected their work and relationships, many employees continued to use the skills on their own. Equally important was the plant manager's constant insistence that time be allotted at tailboards and other standard meetings for this type of dialogue.

Phase IV: Recognizing Results and People

At the beginning of the project we agreed that we had to have a way of measuring results and recognizing people's contributions. A perception survey was administered in the areas we were targeting for improvement and goals were set in the areas of housekeeping, training completion and near miss reporting. The goals would be measured by monthly audits. The perception survey would be re-administered yearly to measure progress in morale, job satisfaction and teamwork.

The monthly audit results were evaluated every three months to see what was and wasn't working. Sometimes people felt discouraged because they didn't see any progress. Then, we would publish results showing that things were going forward. Sometimes we exceeded expectations. This was the time when we recognized the teams and individuals who were responsible for the success of a project.

Conclusion:

In the year-end perception survey, positive scores had jumped 20% across the board. People felt free to communicate and trust levels were up. It was very rewarding for everyone to see that their efforts had made their plant a better place to work. Perhaps more importantly, they had gone two years without a serious near miss or recordable.

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