A Case Study on the Implementation of a Management Accountability Program for Safety at Company XYZ

by

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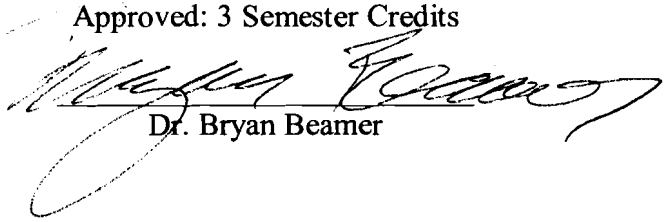

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ABSTRACT

This paper will look at a case study based on the implementation of a management accountability program for safety at Company XYZ. It will provide the layout of the program along with tools used and the measurement of success. This paper will investigate the effectiveness of the program.

A literature review will discuss the aspects of setting responsibility and accountability in the workplace, and the need to do so. Elements of successful accountability programs will be identified according to the Occupational Safety and Health Administration. The literature review will then lead into consequences tied to the achievement or lack thereof in the accountability program, with focus on the impact of positive and negative impacts in the workplace. This section will conclude with tying achievement in safety to performance reviews.

The outline of the management accountability program for safety at Company XYZ will follow. All aspects of the program will be identified and discussed. The results of 6 months worth of data will be explored as total achievement by Company XYZ as a whole. The paper will conclude with recommendations for future studies concerning accountability programs for safety.

Tools utilized by Company XYZ to carry out the accountability program for safety will be provided in appendices. Depending on success of the program and applicability, those tools can be used as a base for implementation at other companies.

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Chapter I: Introduction

"What gets measured gets done!" Such a simple statement, yet the concept can be complex to actually implement in business and industry. There is a lot on the daily "to-do" list for all levels of management. So much, in fact, that the most important tasks are frequently supplanted by the most urgent tasks. Oftentimes, safety tends to be one of those important things that managers do not see as urgent. This is particularly the case if there have been no accidents, few safety complaints and so on, giving everyone the impression of maintenance free safety program.

However, the point of view that workplace safety is fine frequently creates a false sense of security; in this scenario, real improvement in risk control stagnates. It appears to be win-win; if there are no safety issues, then the number of to-do list items relating to safety gets smaller. However, not practicing safety proactively eventually leads itself to accidents, safety issues, and lost time and money. An issue like safety can only be ignored for so long before it gets out of control. When this occurs, a lot of time and energy is wasted trying to reactively fix what has gone wrong. Had safety not been placed on the back burner in the first place, things may not have gotten so out of control.

Getting all levels of management to buy in to a proactive approach to safety can be a big task. This brings things back to the original statement made, "What gets measured gets done." Requiring participation in safety by management, measuring the success of management participation and making this part of management's annual performance review will ensure proactive safety becomes an integral part of everyone's workday.

Purpose of the Study

The purpose of this case study is to show, in detail, an effective management accountability program for safety. Furthermore, the success of this program will be measured in a short case study conducted at Company XYZ. It will be shown that implementing this program can ensure buy-in for proactive safety since all levels of management are being measured on their successful participation.

Assumptions of the Study

1. Perhaps the biggest assumption of this paper is buy-in from the top level of management for the accountability program for safety. Without the support of upper management, a safety accountability program will not function properly.
2. It is assumed that there is someone in the facility whose job is dedicated to safety and can manage and measure the program's success on a regular basis. Without this being done, the accountability program will fail.
3. It is assumed that all levels of management partake in annual performance reviews in which success in the safety accountability program is a factor. There has to be something at stake to make the program work to its full potential.

Definition of Terms

Accountability – Responsible for something (Webster Dictionary, 2000).

OSHA – Abbreviation for Occupational Safety and Health Administration; the governmental body responsible for setting and enforcing minimum workplace standards for safety (http://www.osha.gov/StratPlanPublic/index.html, November 2006).

Limitations of the Study

1. Management accountability programs are most effective with definable levels of management. You always want the top level of management to be responsible for the performance and success of their direct subordinates, who are responsible in turn for their subordinates, and so on down to the bottom level of management. If there are a lot of dual roles in management, it is difficult to define who is responsible for the performance of whom.
2. Someone in the facility needs to have the knowledge to train everyone on how to use the appropriate tools employed in the accountability program. Should a tool be so unfamiliar that the safety manager must conquer it first, it may be inappropriate for the program as it is human nature to reject the unfamiliar.

Chapter II: Literature Review

Accountability in the workplace is key to getting things accomplished. This paper is a case study for determining an effective implementation of a management accountability program for safety. Relevant topics found in literature are discussed below.

Responsibility in the Workplace

A book titled All *I Really Need to Know I Learned in Kindergarten* was written by a humorist author, Robert Fulghum (1998). He claimed that all the basic rules for socially acceptable adult behavior were learned as a young child. The following list details what Fulghum considered a list we learned as a child but don't follow as an adult:

- Share everything,
- Play fair,
- Don't hit others,
- Put things back where you found them,
- Clean up your own mess,
- Don't take things that aren't yours,
- Say you're sorry when you hurt someone,
- Wash your hands before you eat,
- Flush,
- When you go out into the world, watch out for traffic, hold hands, and stick together,

- And remember the Dick-and-Jane books and one of the first words you learned – look (Geller, 1998, page 163).

The preceding basic rules according to Fulghum are all responsibilities. Consider the basic rule of flushing. In modern days, many public facilities have engineered out the responsibility of flushing by placing automatic flushers on toilets. Responsibility to do this most basic task has been removed, consequently resulting in reliance of engineering to do things for us. When responsibility is taken away what is left is a belief in "no personal responsibility." People who believe that their toilet flushing (safety) is the responsibility of automatic flushers (someone else) will be less likely to be accountable for their own basic rules in health and safety (page 163).

Dating all the way back to the 1930's, there has been a tendency to make safety a management responsibility (Peterson, 2001, page 124). All respective levels of employees have a certain set of responsibilities in the workplace. They are different for each level of management and hourly worker. According to the Occupational Safety and Health Administration, top to mid-level managers have a responsibility to set the safety rules and practice personal behavior that sets a good example for all to see. The also have the responsibility to enforce the safety rules they set. That enforcement should be the same for all entities in the workplace (Responsibility, Authority, and Accountability, 2006).

Supervisors have a responsibility, as does the top to mid-level managers, to follow and enforce the safety rules that are set. They additionally have a duty to supply employees with the tools to do their jobs safety. In turn, employees have a responsibility to comply with all company rules, report injuries and health hazards

immediately, and use safe personal behavior (Responsibility, Authority, and Accountability, 2006).

Some companies take it a step further and clearly define all responsibilities for all groups and levels of employees. Company XYZ, a food company based out of the United States, has implemented this type of system. In their safety program, roles regarding safety are clearly defined. The following figures taken from Company XYZ's Key Concepts of Safety, Supervisory Training Participants Manual, outline management and employee responsibilities:

Figure 1: Company XYZ Management's Responsibility

- To set standards expected of the employees,
- To establish accident prevention policies,
- To establish the responsibilities of supervisors,
- To establish the procedures that will be necessary to meet the objectives of the safety policy, through training, education and adequate equipment,
- To provide a safe and healthy place to work,
- To benefit stockholders,
- To provide adequate medical facilities (first-aid),
- To provide engineering, administrative, and PPE controls,
- To provide safety equipment.

Figure 2: Company XYZ Employee's Responsibility

- To work as required by their employer,
- To their families, themselves, and society to return home in the same condition as what they came to work,
- To report unsafe acts and conditions to management to protect themselves and fellow employees,
- To report unsafe acts and conditions to prevent material loss,
- To help the overall program by speaking and acting safety and setting a good example,
- To provide input and feedback to each other,
- To their company to improve safety and performance.

Company XYZ's Key Concepts of Safety goes on to identify specific responsibilities for key people including department supervisors, plant managers, department managers, human resources managers, occupational nurses, plant safety coordinators, and finally employees. It is evident that setting responsibility among different stakeholders in business is the stepping stone of any safety program.

Elements of an Effective Accountability Program

> *"When a man is held accountable (is measured), he will accept responsibility; and if he is not held accountable (not measured), he will not accept responsibility. People will do those things for which they are measured"* (Peterson, 2001).

Dan Peterson, as quoted above, is regarded as an expert by many on accountability and behavior-based safety. His work is referenced in many existing safety publications. The quote above rings true to the need for effective safety accountability programs and holding those responsible for what they must be doing. Accountability programs are not something new. In fact, they originate from the 1960's (Peterson, 2001, page 124). The following paragraph outlines the elements of a modern day accountability program.

There are several elements of an effective accountability program. According to OSHA, there are five: 1) established standards, 2) resources, 3) a measurement system, 4) consequences, and 5) application at all levels (U.S. Department of Labor).

1. Established Standards

OSHA highly recommends using their standards as a minimum requirement that should be surpassed by company specific standards. Standards are not only rules, but also an expectation of what certain work activities, programs, training requirements, and facility conditions should entail. Examples may include general housekeeping, 100% attendance for safety training by department, completion of Job Safety Analysis, etc.

2. Resources

Resources includes the materials to meet the expectations of the established standards, including efficient training, 24/7 supervision, standard formats used across the facility, etc. If the resources are not available, one cannot be expected to perform adequately. Just how does upper management ensure that those accountable have the tools to implement safety correctly? Quite simply, it's a matter of using practical, hands-on training that gives working tools to everyone expected to meet the standards

set forth. This may take time and may require one-on-one time with several individuals who may not understand immediately. But that time spent will be well worth it as long as the results are what is expected. To expect results without providing the proper tools is a poor management decision.

3. Measurement Systems

A measurement system refers to the matrix one uses that specifies satisfactory performance for accountability. The measurement tool may be large and somewhat complicated depending on the components of the accountability program. Safety performance has been measured to (a) determine benchmarks to sense improvement, (b) measure and determine accountability, (c) measure communication/feedback in the management system, and (d) measure costs (Dennis, 1997).

4. Consequences

Consequences can be either positive, negative, or both depending on the organization instituting the accountability program.

5. Application

Finally, application at all levels means holding all respective entities in a business accountable for their responsibilities (Responsibility, Authority, and Accountability, 2006).

The state of Oregon's Occupational Safety and Health Administration takes the elements of an effective management accountability program one step further to include a sixth element: evaluation of the system by a qualified and competent safety and health professional. This sixth step is important as is evidenced by the case study in Chapter 5 of this paper (Oregon OSHA).

Management Accountability and Consequences

While assigning safety responsibilities and accountability takes some time and thoughtful work, determining and living with the consequences of not meeting the standards can be even tougher. It has been shown over and over again that behavior is motivated by its consequences, and so behavior can be changed by controlling the events that follow behavior (Geller, 1998, page 11). There are four alternatives for dealing with safe and at-risk behaviors, and the application of consequences thereof:

1. Increase positive consequences for safe behavior;
2. Decrease negative consequences for safe behavior;
3. Decrease positive consequences for at-risk behavior;
4. Increase negative consequences for at-risk behavior (page 169).

Consequences, both positive and negative, are the most powerful influence on changing behaviors (Williams & Geller, 2000, page 135). Concurrently, predictable positive and negative consequences can be implemented to reinforce desired behaviors and discourage unsafe behaviors. Therefore, by designing and controlling effective workplace consequences, management can increase safe behaviors and discourage at-risk behaviors (Reynolds, 1998, page 23).

Negative Consequences

Punishment is the most frequently used technique of control in modern life. When applying punishment for lack of good results in an accountability program, the outcome may foster very undesirable effects in the one receiving the punishment, those being: escape, aggression, apathy, and counter control. Escape is basically running from whatever is causing the negative consequences. Aggression is quite serious as

lashing out verbally or physically is involved. "Apathy is a generalized suppression of behavior. In other words, the negative consequences not only suppress the target behavior but might also inhibit the occurrence of desirable behaviors. Regarding safety, this could mean a decrease in employee involvement. When people feel controlled by negative consequences, they are apt to simply resign themselves to doing only what's required. Going beyond the call of duty for a coworker's health or safety is out of the question (Geller, 1998, page 173)." And counter control involves trying to intimidate in order to get away with the behavior one desires without getting into trouble. This has to do with the fact that no one likes feeling controlled. If these feelings are influenced, buy-in and involvement are not likely (Geller, 1998, page 172).

Additional research supports the notion of negative consequences having unintended side-effects. Punishment may lead to learning the wrong behaviors, including finding ways to avoid getting caught, and then becoming hostile in the workplace when one does get caught. Applying punitive consequences in the workplace makes it nearly impossible to foster positive working relationships between management and employees due to this negative connotation (Peterson, 2001, page18).

More research shows that gains realized by negative motivation are very short lived (page 18). Behavioral theories show that consequences that are delayed, uncertain, and negative do not have a permanent impact (Swartz, 2000, page 149).

Positive Consequences

The alternative to negative consequences would be positive motivation – be it affirmations, monetary rewards, or just simply a thank-you. Some research suggests that in order for there to be achievement in any safety program, those responsible and

accountable for it must have certain feelings of empowerment, high self-esteem, and belongingness (Geller, 1998, page 11).

Shaping Attitudes with Consequences

The positive or negative consequences linked to the success/failure of the safety accountability program really set the tone for safety in general. The consequences shape the attitudes of everyone it affects, especially if it is done in a negative way. Attitude has a way of affecting performance. Basic psychology lends itself to the idea that attitudes affect how one feels about a person, place, or task (Schwartz, 2000, page 115). Negative consequences, as discussed earlier, can crease feelings of escape, apathy, aggression, and counter control. According to this research, accountability programs linked to negative consequences are doomed. The accountability program in this paper's case study does not agree with this research. It is of the researcher's opinion that, after researching the topic, using negative consequences to get results is not the way to go. In order to get positive results and full buy-in from program participants, praise and rewards should be used to celebrate successes. It is believed that this would gain trust and good faith in the positive aspects of a management accountability program.

Sometimes we behave in a way to achieve a pleasant consequence, such as a reward. Other times we act to avoid unpleasant consequences such as a punishment or penalty. We usually stop performing behaviors that are followed by penalties. But we feel better when working for pleasant consequences than working to avoid or escape negative consequences (Geller, 1998, page 100). One needs to keep in mind the attitude that is desired, and then proceed to develop an accountability program based on that

desire. If ruling with a heavy stick to get people in strict compliance out of fear, using negative consequences is the way to go. If trying to shape the safety culture into one of trust and constant learning, positive consequences should be utilized. Geller recommended a redirection of safety incentives/awards to "celebrate" accomplishments and to sustain the interest in the program (Geller, 1996). While this particular bit of research by Geller is in reference to behavior-based safety programs, it can also be applied to safety accountability systems.

Accountability and Performance Reviews

Much of the research differs on the point of including success or lack thereof in the accountability program on performance reviews. One theory states that one of the principle indicators of management commitment to safety is to include safety performance in the performance review system. Management commitment to safety may be at question if the accountability system is not a factor in the safety performance measures that impact responsible employees financially and on their chances at promotions (Schwartz, 2000, page 22).

While we have recognized that accountability is key, in most organizations accountability systems for safety performance have been lacking. This is due to not being able to either accept or sell the fact that to achieve accountability requires new measures of performance and new reward structures (Peterson, 2001, page 125). The old styles of management rule with that heavy sword and people do what they are told or suffer the consequences. But new reward structures require the use of positive affirmations and celebrations of successes.

Conclusion

This research has taken a look at the general categories of responsibility, accountability, consequences, linking all of such to performance reviews. While the research was not conclusive in any one direction, many conclusions can be drawn. For instance, responsibility must be set for all management areas deemed important. It should be determined for all levels – from top management on down to the line workers. Accountability is a stepping stone for measurement systems – one can't be held accountable for what they are not measured on. The topic of consequences presented in this chapter has been the most debatable. It can be positive or negative, with research being somewhat divided regarding which is the best method. However, there is a general consensus that both create results – it just depends on the attitudes one wants to foster. The research is also divided on linking accountability program outcomes to performance review systems that will have financial impact on the responsible parties. On one hand, financial culpability forces safety accountability to be part of one's working livelihood. On the other hand, it may be used as a fear tactic to get results, creating negative attitudes in the workplace.

Chapter III: Methodology

Accountability in the workplace is key to getting things accomplished. This paper is a case study for the determination of the most effective implementation of a management accountability program for safety. This chapter details the management accountability system recommended at Company XYZ and the methodology for determining its effectiveness.

Research Design

The case study looked at historical data concerning the management accountability program for safety at Company XYZ. This was imperative to the research objectives as success in the program, showing effectiveness, required looking at comparative data. Several months of tracked data after the implementation of the accountability program were compared to similar data in existence prior to the start of the accountability program. Knowledge of effectiveness, or success, of the program should result in a working tool for many organizations to use in the implementation of similar safety accountability programs.

The researcher was knowledgeable of the management accountability program for safety at Company XYZ. After several months of the program being in place, 6 months worth of data was obtained showing overall performance in every category applied to all levels of management. The data collected was specifically done from June 1, 2006 to November 30, 2006. That data was compared in total number to previously existing data in the same categories from the same 6 month period of time a year prior to the management accountability program being started. The comparison

consisted of looking at the total amount of materials received per category before and after the accountability program was in effect.

Subject Selection and Description

The population of anonymous subjects was a naturally occurring management and supervisory team at Company XYZ. All managers and supervisors in their positions at Company XYZ and partaking in the accountability program were included into the overall totals used to determine effectiveness in the program. The subjects and their individual results remained anonymous. Therefore, the population characteristics are undetermined. It was determined that the size of the population consisted of 37 people total. The researcher was granted an exclusion in obtaining human subject consent forms from the International Review Board (IRB) at the University of Wisconsin – Stout. The exclusion was due to the use of existing data that was collected for comparisons of anonymous subjects.

Instrumentation

Much data was collected, consisting of the blank format for measuring success of the accountability program (Appendix B) and individual blank scoring tables (Appendix C); along with the program's written policy (Appendix A). Tools that were required to be used by individuals partaking in the program were also obtained. Those tools were monthly audits forms, job safety analysis forms, training schedules and matrices, behavioral safety checks, incident investigations, safety awareness topics, and incident reports (Appendices D – I). All of the tools collected were gathered from Company XYZ and are the tools used by those participating in the safety management accountability program. This data was collected November 30, 2006. These tools were

identified as necessary for the success of the accountability program by the Safety Manager and Plant Manager at Company XYZ.

Data Analysis

The data was analyzed in a simplistic manner. Totals were taken on all categories being measured in the safety accountability program, and then were compared to total compliance within those categories prior to the start of the accountability program at Company XYZ. If compliance was met or exceeded, the program was considered successful. Those expectations are outlined below:

Table 1: Expectations of Management Accountability for Safety at Company XYZ

Management Accountability Program Categories	**Expectations for Success in each Category**
Monthly Safety Meetings	All management and their respective employees must attend or make up the safety meeting by the end of the month it was given.
Daily Safety Observations	1 per person per shift worked.
Job Safety Analysis with an Associate	2 per person per month
Monthly Safety Audit with an Associate	1 per person per month
Incident Investigations	Must attend and participate if an incident occurred within the department during the month
Department Safety Awareness Topic	1 per person per month
Timeliness and Quality of Incident Reports	Must turn in incident reports and answer all applicable questions by the end of the shift worked.
Completion of Corrective Actions	All corrective actions resulting from incidents or audits must be completed by the due date.
Condition of Department	Everything must be placed and sustained within it's designated /labeled area when not in use; good housekeeping.
PPE Compliance	All employees should utilize proper PPE within the department; non-compliance determined by Plant Manager and Safety Manager during a weekly walkthrough.

Limitations

There were some limitations concerning the data and its analysis:

1. Some of the data was not quantifiable, but rather qualitative in nature. Points awarded in the categories of quality of incident reports and condition of department was subjective and determined by the Safety Manager and Plant Manager at Company XYZ.

2. All managers and supervisors were held equally responsible for the condition of their departments. It didn't matter how many managers and supervisors were present per shift. Therefore, the condition of the department could skew the results for all of the supervisors and manager in one department if expectations for good housekeeping were not met. This holds true even if it was the result of one supervisor not having his employees clean up before moving on to the next task. This fosters and all or nothing attitude and was hoped to promote teamwork.

3. Completion of corrective actions was tracked in a system used at Company XYZ called MP2. It is a tracking device for on-site work orders, requisitions, etc. The Safety Manager could run a report on all open corrective actions to see what was still pending and why. If this system is not available to other companies trying to track corrective actions, a large database would have to be created that could easily follow open and closed items.

4. Daily safety observations were tough to track as one per supervised shift per individual in the program was required. If vacation or sick days were taken off by a participant in the accountability program, it was noted by the person taking

the day off. That way, when the materials were being tracked, the Safety Manager could factor in the vacation and sick days before docking a participant for not complying with the category expectation. The Safety Manager had to use the honor system when tracking results within this category. Results could be compared to Human Resources data on days taken off, Family Medical Leave Act (FMLA), and sick days, but the number of participants in the accountability program would have made this task too time consuming.

Summary

In summary, the data collection was kept simple and anonymous. Totals were taken from all quantifiable categories within the management accountability program for safety at Company XYZ. Those totals were compared to data that existed prior to the accountability program to determine effectiveness. No other statistical analysis was necessary to determine effectiveness as compliance with the program was set as a total expected number of items within each category.

Chapter IV: Results

Accountability in the workplace is key to getting things accomplished. This paper is a case study for the determination of the most effective implementation of a management accountability program for safety. This chapter details the results of the case study completed at Company XYZ.

Monthly Safety Meetings

This category measured full attendance by the staff and hourly employees at Company XYZ in monthly safety meetings. This category was shown to be in full compliance by all departments according to the expectations set forth in Chapter III. The only exceptions to the 100% compliance were departments that had individuals on Family Medical Leave (FML), layoff, voluntary layoff, and vacation. Exceptions were made for those instances since employees were not on site and able to attend make up classes. Make-up materials from the scheduled meetings were put together to assist the departments with getting all their employees through the training by the end of the calendar month.

Daily Safety Observations

Overall, the expectation for the minimum set of the daily safety observations (safety checks) to be turned in for the month was met. However, overall compliance was due to some outstanding factors. For one, some individuals partaking in the accountability program handed in more than they were scheduled to for the month. Also, some departments have hourly employees perform daily safety observations, which greatly add to the total amount completed within the month for the Company XYZ as a whole. This extra turned in made up for the deficiencies of a few individuals.

Within a 6 month time span after the accountability program was implemented, 2,356 daily safety observations were turned in. Last fiscal year at Company XYZ, during the same 6 month span, only 1,590 daily safety observations were turned in, with the bulk of those coming from hourly employees working on the floor.

Job Safety Analysis with an Associate

This category of the accountability program forced interaction between managers, supervisors, and hourly employees. Full compliance was met in this category with all individuals partaking in the program turning in 2 job safety analysis per month. There were a few exceptions at the onset of the program. Several members of management had never performed a job safety analysis and required extra training on how to perform one.

Monthly Safety Audit with an Associate

This category in the accountability program at Company XYZ did not meet expectations overall. About 60% of the individuals were turning in audits monthly, and about 20% of those were not done with hourly associates.

Incident Investigations

There was full compliance in the incident investigation category. Company XYZ uses an investigation too called TapRoot which looks at root cause analysis. Those who had to partake in the investigation included the Safety Manager, Plant Manager, Human Resources Manager, Department Manager, and Supervisor present when an accident took place. Prior to the accountability program being implemented, supervisors only took part in the investigation if they were on shift at the time of the

investigation. The accountability program made it mandatory to come in for the investigation even if it was taking place during a supervisors' off-shift.

Department Safety Awareness Topic

The department safety awareness topic was also a huge success with the concurrent start of another corporate based program called "I CARE" training. The "I CARE" required all shift change meetings to include a safety awareness topic to get everyone thinking about safety every day. Department managers and supervisors were able to use the two programs to fulfill all requirements. The "I CARE" program was supposed to last only 100 days. However, the success of the program has extended it indefinitely.

Timeliness and Quality of Incident Reports

The category of timely incident reports was not so successful. Reports were still being turned in 2-4 days after the date of the incident by at least 15% of the individuals. The Safety Manager noted that while only 15% deficient by individual, about 40% of the incidents occur in that particular department with the deficiency. The accountability program requires reports to be turned in the same day as the incident. Additional training on how to report incidents was conducted by the Safety Manager at Company XYZ during the month of October 2006 for safety training.

Completion of Corrective Actions

The accountability for corrective actions has proven successful. Prior to the implementation of the program, corrective actions were not tracked on a monthly basis. With the measurement system, the Safety Manager has to track completion of the corrective action by individual and assign responsibility. The only issue found was

larger corrective actions that required extra capital expenditures. Those had to be put through a process called Capital Improvement Requests (CIR) which takes time to route through all the required individuals that must review it prior to purchase of services or equipment. Flexibility is given for CIR's.

Condition of Department

This accountability category was made hugely successful due to another corporate initiative started at the same time. That initiative is called 5S. The principles of 5S are sort, set, shine, systemize, and sustain. The entire production facility was put through the 5S process and audited on a monthly basis. Responsibility for cleanliness and housekeeping was assigned to members of management as well as hourly employees. Everyone also takes part in the audit process, so it has built in accountability. Prior to the accountability program for safety and 5S, the condition of departments was not compliant in most cases.

PPE Compliance

This category is measured by Safety Manager and Plant Manager weekly department walkthroughs. If any employee is found not to be wearing all required Personal Protective Equipment (PPE), all members of management in the accountability program were docked points.

Measuring Success

All supervisors, department managers, and the plant managers are required to complete all categories. The success of supervisors is directly tied to their department managers. In turn, the plant manager's success is tied directly to the department

managers. This institutes a lot of responsibility and accountability on all involved. One does not want to be deficient, causing the plant manager to ultimately be deficient.

Table 2: Results of Data Collected for Management Accountability at Company XYZ

Management Accountability Category Measured	**Results Before Program**	**Acceptable?**	**Results After Program**	**Acceptable?**
Monthly Safety Meetings	Average monthly attendance = 210	NO	Average monthly attendance = 320	YES
Daily Safety Observations	1590	NO	2356	YES
Job Safety Analysis with an Associate	0	NO	444	YES
Monthly Safety Audit with an Associate	0	NO	222	YES
Incident Investigations	9 incidents, 5 investigations completed	NO	5 incidents, 5 investigations completed	YES
Department Safety Awareness Topic	0	NO	234	YES
Timeliness and Quality of Incident Reports	9 incidents, 6 received on time	NO	5 incidents, 4 received on time	NO
Completion of Corrective Actions	NA	NA	NA	YES
Condition of Department	NA	NA	NA	YES
PPE Compliance	NA	NA	NA	NO

Chapter V: Discussion

Universality of the Program

There are a few aspects of the study are only applicable to a narrow band of companies. First is the monthly safety awareness topic. This is done at shift change meetings. Not all companies have several shifts where meetings can be conducted with employees still on the clock. Additionally, some companies work over the road and don't have departments that must remain in good, clean condition. For example, constructions companies may have a shop they work in once in a while, but most of their work is over the road. Therefore, this category would not apply.

As for the measurement system, it may not be useful for all companies. The measurement system used at Company XYZ works best with companies that have clearly defined roles and responsibilities. It would be difficult to assign cross-functional members of management to a group when they report to more than one individual. Who would ultimately be responsible for their points earned? It would be difficult to determine such a situation.

Improving the Program

What gets measured gets done...for the most part! Success was realized by Company XYZ through implementation of the accountability program for safety. The program did, however, have some opportunities for improvement. The qualitative categories were very subjective and therefore success was not as inherent. Furthermore, the first month was considered a grace period as there was a small learning curve on the how-to in various categories. For example, the Safety Manager determined through interviews that there was not full understanding on what safety hazards were to be

identified and controlled or abated during the monthly walkthroughs with associates. It was assumed that those managers/supervisors who were not performing audits with an associate were just not comfortable doing so since they were not sure what to look for. To counteract that, the Safety Manager decided to have all managers and supervisors attend a 10 hour OSHA safety course. This was planned to take place before the end of Company XYZ's fiscal year.

Training

More training could have been completed prior to the implementation of the accountability program. Practical hands-on training would have helped get everyone on the same page as far as how to accomplish certain tasks that were set for completion and success in the program.

Start-up Curve

A larger start-up learning curve could have been utilized. As with anything new, it takes some getting used to. To avoid many individuals getting docked points, the first two months could have been used as a grace period for learning and sharing pitfalls.

Tie to Performance Reviews

The success of the accountability program was integrated into mid-year and end of year performance reviews. This is not congruent with the research that was completed in Chapter 2. Being unsuccessful in the program will have negative financial impact on the members taking part in the accountability program. This creates a negative aura and fears individuals into doing the assigned tasks even if they don't want to or worse yet, don't know how.

Improving Research

After completing the research and collection of data, it is apparent that research on effective training of adults would be beneficial. Training on the tools used to meet expectations was a big part of implementing the management accountability program and would warrant additional time a research. Research comparing training in the classroom versus hands-on would be interesting and tie into the study well.

Also, further studies could be conducted on the topic of management accountability programs. Those may include the following:

- A follow-up on the end of year results of the accountability program. After a full year of tracking, will changes be made to the program?
- Financial impact realized by individuals who did not have full achievement throughout the year. The aspect of negative reinforcement with financial ties to results would be interesting to study.
- Culture surveys based on the impact of negative reinforcement tied to the accountability program. What impact did the financial loss of those not successful in the program have on work relationships and overall moral at work?
- The possibility of measuring everyone based on a teamwork effort rather than an individual basis. The approach of "we're all in this together" and are going to make this a better place as a group may foster better results and stronger ties to performance.

Chapter VI: Conclusions and Recommendations

Accountability in the workplace is the key to getting things accomplished. This paper is a case study for the determination of the most effective implementation of a management accountability program for safety. As shown below, this case study detailed and validated a working tool shown to be effective for use at Company XYZ. Furthermore, the management accountability program detailed in this report could be used in many types of organizations.

Summary of data

The management accountability program for safety at Company XYZ had some major success and some opportunities for improvement. Overall, good compliance was found in the categories being measured that were quantifiable. The expectation was set, and the group as a whole seemed to meet that.

- Monthly safety meetings were met.
- Daily safety observations were met.
- Job safety analysis with an associate was met.
- Monthly safety audit with an associate was met.
- Incident investigations were met.
- Department safety awareness topic was met.
- Timeliness and quality of incident reports was not met.
- Completion of corrective actions was met
- Condition of department was met.
- PPE compliance was not met.

Did the program work?

It is the opinion of the researcher that the program did work. The bar was set high, and most of the expectations were met. Those categories that were not easily quantifiable were the hardest to measure and had the lowest success rate. However, there was considerable success in 8 of the 10 categories for the program.

Universality of the Program

Many aspects of Company XYZ's management accountability program can be applied in other businesses. The measurement tool may need to be reformatted somewhat, but that is manageable.

There are several things that can make this accountability program most effective for implementation at other companies:

1. Companies wanting to implement an accountability program should start small. In other words, don't have so many categories to measure individuals on the first year. A program can always be expanded in future years. But it is best to let everyone involved get used to being measured monthly.
2. Train, train, train! Most members of management do not perform job safety analyses and audits often enough to be comfortable with doing it alone. A lot of initial hands-on training should be conducted prior to implementing the program.
3. Success of the program should not be tied to something that is negative. According the most of the research, individuals should be rewarded for completion of all categories, not negatively impacted financially at the end of the year by lack of achievement. Implementation of this accountability

program and its tie to performance reviews should be carefully considered by other companies.

Directions for future research

Further studies could be conducted on this topic. Those may include a follow-up on the end of year results, financial impact realized by individuals who did not have full achievement throughout the year, culture surveys based on the impact of negative reinforcement tied to the accountability program, and the possibility of measuring everyone based on a teamwork effort rather than an individual basis.

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Appendix A

Tips and Tricks for Safety Management Accountability

So, month after month, you have certain expectations set upon you...and safety accountability is among them. I know it seems challenging. I also know that the more organized you have the process, the better trained your people become, and the more opportunities you find to ensure you get all the points possible, the more likely the monthly safety accountability will not feel like a challenge, but rather a tool to help ensure a strong safety culture in your department.

"Working smarter, not harder" gives rise to successes and feeds the continual improvement needed for our processes. So here are some ideas that may help you when it comes to safety accountability...

MONTHLY SAFETY MEETINGS

Once a month, you are required to attend a safety training session. You are also responsible for all associates in your department attending or making up the training by the *end of the month* (unless they are on layoff, FMLA, STD for the entire month!). Getting everyone through training is critical to eliminate lack of knowledge as a reason for safety incidents. Even more so important, your attendance at safety meetings is setting a good example for all associates working at Swiss Miss!

DAILY SAFETY OBSERVATIONS

The daily safety observations allow you to get a snapshot of what your safety culture in your department is every day. What a great way to stay on top of things when it comes to safety. You are required to do only one per shift...therefore, if you are not working, you do not need to do one. Don't forget that if you have an item/issue that needs to be followed up on, put it on the FY '07 HAZLOG so it can be tracked to completion. The HAZLOG is found on the "L" Drive in the Safety folder, under Safety Issues Reporting. The Safety Observation Form that you should be using is as follows: L:\Safety\Safety Checks\Safe Conditions and Safe Practices Guide October 2004.doc For safety observations to be acceptable, you must put feedback on the forms!! There should always be something positive, and more often than not, a negative. We know we are not perfect out on the floor, so let's not paint a rosy picture by glossing over the negatives.

JOB SAFETY ANALYSIS WITH AN ASSOCIATE

Each of you is required to do at least 2 JSA's per month with the assistance of an associate. With a job safety analysis, you break the job down into individual steps and then look at possible hazards and the safety actions you can put into place so people are not at risk. Most departments have a book of JSA's started. New JSA's will have to be created to add to those already existing so each department will have a complete list in their area. But how do I do a new one? Is there anything that could guide me in the right direction? How about using the Job Functional Analyses as your guide to break down job tasks? Use it to assist with filling out a new JSA (L:\Safety\JSA's\Plant - General\JSA Form.doc.dot). Once your books are completed, then all that is required is reviewing old JSA's to be sure the job hasn't changed in any way and adding the new revision date to the form. The JSA's should be used for training of new employee. The completion of JSA books per department is one of the FY '07 Safety and Health Accident Reduction Plan (SHARP) goals assigned to us by Corporate Safety which is due by the end of this fiscal year. ***Don't forget to get the associates involved...they are the experts on the job!***

MONTHLY SAFETY AUDIT WITH AN ASSOCIATE

What a great way to get more safety interaction on the floor! Grab an associate and walk the floor with them. Go look at something specific, or just wander and see what opportunities you find for correction. Either way you go about it, getting associates involved with this audit is important. You should use the following form: L:\Safety\Safety Audits - Inspection Forms\Monthly Walkthrough Audit Report Form.xls This form should be filled out and forwarded to the appropriate parties for hazard correction. If there are open safety items, be sure to place them on the FY '07 HAZLOG for tracking to completion. You also have the option of participating on some of the monthly PERSIS audits with your safety coordinators to get your points. Just document the date, time, and PERSIS audit you helped complete. Not to mention that safety coordinators can just use the PERSIS audits as completion of this category.

INCIDENT INVESTIGATIONS

To earn your points in this category, you must participate on the incident investigation if you have had something occur in your department for the month that requires an investigation. You will assist in the TapRooT process along with the Plant Manager, Safety, the associate(s) involved in the incident, and any other supervisors on shift at the time of incident. So what if I didn't have any incidents in my department for the month? Easy...you just earned your points for this category! However, let's encourage associates to report near misses. This will give us good practice at performing incident investigations and could also help us from incurring a similar, more severe incident!

DEPARTMENT SAFETY AWARENESS TOPIC

The best way to keep everyone thinking safety??? Integrate it into our working lives. Find any topic that you believe pertains to your department...it can be anything from food safety to ergonomics to electrical safety, even defensive driving. Put together a fact sheet, a handout, anything, and distribute it to your associates though meetings, email, person-to-person, any way you see fit. A good tool to use for finding a topic is the internet. Try using Toolbox Topics: http://www.toolboxtopics.com/ Just remember to keep a sign-off with your material so you have a record of who received the information... ***"if it wasn't documented, it never happened!"***

TIMELINESS/QUALITY OF INCIDENT REPORTS

We have a requirement as a plant to report incidents by the next business day to Sedgwick after receiving it from an employee. Prompt reporting of incidents is yet another one of the FY '07 SHARP goals assigned to us by Corporate Safety. This means that your participation in getting incident reports filled out entirely and turned in to Safety is critical! We have to do all we can to reduce lag-time in reporting. So to earn your points in this category, you must fill out ***every category*** of the supervisor portion in the incident reports and turn them in the ***same day***!

COMPLETION OF CORRECTIVE ACTIONS

What do we do when we have an incident or an audit? We find deficiencies to be corrected and assign corrective actions. If you are assigned to a corrective action, it is your responsibility to follow it to completion. To earn your points here, all you have to do is complete action items assigned from incidents and audits, or continue follow up of open action items that are planned projects. A good way to track your corrective actions is to place them on the HAZLOG.

CONDITION OF DEPARTMENT

This category goes hand-in-hand with the 5S concept. You are responsible for the condition of your assigned areas. If your department is found to be unkempt during a walkthrough or audit, you will not receive full points for the category.

PPE COMPLIANCE

This category is simple, but requires the most supervision on your part. During a Plant Manager Audit, if an associate in your department is found to *not* be in compliance with the PPE policy, you do not receive your points for the month in this category. PPE is our low hanging fruit, and 100% compliance is definitely within reach. Lead by example!

FINAL POINTERS

You must keep all of your documentation in a folder to be turned in all at once at the end of every month to the safety department. Your items will be reviewed and then tracked on the Management Accountability Scorecard. The scorecard will be discussed upon completion of tracking at the staff meetings, and those with anything less than 100% will show up in red. This may seem like a huge undertaking at first, but you will find these are all easy points to earn once you get the hang of it. Implementation of this program also fulfills one of the FY '07 SHARP goals listed for us by Corporate Safety, along with the JSA books and promptness of incident reporting. Let's support each other through the process and always remember why we are doing this...***"Safety is everyone's responsibility!"***

FY '07 Management Accountability Recap

Plant Manager	Points Possible YTD 14,400	Total Earned	YTD Average	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
				(Points Derived From Department Managers 1-8)											
Dept. Manager 1	1800														
	0														
	0														
	0														
	0														
Dept. Manager 2	1800														
	0														
	0														
Dept. Manager 3	1800														
	0														
	0														
	0														
Dept. Manager 4	1800														
	0														
	0														
Dept. Manager 5	1800														
	0														
	0														
	0														
Dept. Manager 6	1800														
	0														
Dept. Manager 7	1800														
	0														
	0														

Manager 1

Category	Frequency	June Sch.	June Act.	July Sch.	July Act.	August Sch.	August Act.	September Sch.	September Act.	October Sch.	October Act.	November Sch.	November Act.	December Sch.	December Act.	January Sch.	January Act.	Febuary Sch.	Febuary Act.	March Sch.	March Act.	April Sch.	April Act.	May Sch.	May Act
Monthly Safety Meeting	1 per month	10		10		10		10		10		10		10		10		10		10		10		10	
Daily Safety Observation	1 per supervised shift	15		15		15		15		15		15		15		15		15		15		15		15	
JSA's with associate	2 per month	20		20		20		20		20		20		20		20		20		20		20		20	
Monthly Safety Audit with associate	1 per month	20		20		20		20		20		20		20		20		20		20		20		20	
Incident Investigation	If necessary	15		15		15		15		15		15		15		15		15		15		15		15	
Dept. Safety Awareness Topic	1 per month	10		10		10		10		10		10		10		10		10		10		10		10	
Timliness/Quality of Incident Reports	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Completion of Corrective Actions	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Condition of Department	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
PPE Compliance	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Totals		150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	
Percentage			0%		0%		0%		0%		0%		0%		0%		0%		0%		0%		0%		0

Total Points Possible 1800
Total Points Earned 0
Percentage 0%

Supervisor A

Category	Frequency	June Sch.	June Act.	July Sch.	July Act.	August Sch.	August Act.	September Sch.	September Act.	October Sch.	October Act.	November Sch.	November Act.	December Sch.	December Act.	January Sch.	January Act.	Febuary Sch.	Febuary Act.	March Sch.	March Act.	April Sch.	April Act.	May Sch.	May Act
Monthly Safety Meeting	1 per month	10		10		10		10		10		10		10		10		10		10		10		10	
Daily Safety Observation	1 per supervised shift	15		15		15		15		15		15		15		15		15		15		15		15	
JSA's with associate	2 per month	20		20		20		20		20		20		20		20		20		20		20		20	
Monthly Safety Audit with associate	1 per month	20		20		20		20		20		20		20		20		20		20		20		20	
Incident Investigation	If necessary	15		15		15		15		15		15		15		15		15		15		15		15	
Dept. Safety Awareness Topic	1 per month	10		10		10		10		10		10		10		10		10		10		10		10	
Timliness/Quality of Incident Reports	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Completion of Corrective Actions	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Condition of Department	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
PPE Compliance	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Totals		150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	
Percentage			0%		0%		0%		0%		0%		0%		0%		0%		0%		0%		0%		0

Total Points Possible 1800
Total Points Earned 0
Percentage 0%

Supervisor B

Category	Frequency	June Sch.	June Act.	July Sch.	July Act.	August Sch.	August Act.	September Sch.	September Act.	October Sch.	October Act.	November Sch.	November Act.	December Sch.	December Act.	January Sch.	January Act.	Febuary Sch.	Febuary Act.	March Sch.	March Act.	April Sch.	April Act.	May Sch.	May Act
Monthly Safety Meeting	1 per month	10		10		10		10		10		10		10		10		10		10		10		10	
Daily Safety Observation	1 per supervised shift	15		15		15		15		15		15		15		15		15		15		15		15	
JSA's with associate	2 per month	20		20		20		20		20		20		20		20		20		20		20		20	
Monthly Safety Audit with associate	1 per month	20		20		20		20		20		20		20		20		20		20		20		20	
Incident Investigation	If necessary	15		15		15		15		15		15		15		15		15		15		15		15	
Dept. Safety Awareness Topic	1 per month	10		10		10		10		10		10		10		10		10		10		10		10	
Timliness/Quality of Incident Reports	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Completion of Corrective Actions	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Condition of Department	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
PPE Compliance	Monthly basis	15		15		15		15		15		15		15		15		15		15		15		15	
Totals		150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	0	150	
Percentage			0%		0%		0%		0%		0%		0%		0%		0%		0%		0%		0%		0

Total Points Possible 1800
Total Points Earned 0

July 2006 / Period 2 Proposed Employee Training Calendar **Revised 6/27/06**

- QA / Safety: Electrical Safety, Machine Guarding

Monday 7/3/06	Tuesday 7/4/06	Wednesday 7/5/06	Thursday 7/6/06	Friday 7/7/06
Monday 7/10/06	Tuesday 7/11/06	Wednesday 7/12/06	**Thursday** **7/13/06** Mass Training Day 1 0600: Wet/Dry Conf. Rm. **0700: Wet/Dry Conf. Rm.** **1000: Wet/Dry Conf. Rm.** **1400: Wet/Dry Conf. Rm.** **1500: Wet/Dry Conf. Rm.** **1700: Hassia Conf. Rm.** **1800: Hassia Conf. Rm.**	**Friday** **7/14/06** **Mass Training Day 2** **1700: Hassia Conf. Rm.** **1800: Hassia Conf. Rm.**
Monday 7/17/06	Tuesday 7/18/06	Wednesday 7/19/06	Thursday 7/20/06	Friday 7/21/06
Monday 7/24/06	Tuesday 7/25/06	Wednesday 7/26/06	Thursday 7/27/06	Friday 7/28/06

July 2006

Safety Mass Training Roster

Location/Department	Date of Program: November 2006

Topic Outline and Summary:
QA / Safety: QA Year-to-Date / JSA's / Confined Space Awareness

Attachments include:

Please Print Name of Presenter

Please Sign Name of Presenter

Employee Register

Employee Name (Please Print) Employee Number	Employee Name (Please Sign)

SAFE CONDITIONS and SAFE PRACTICES OBSERVATIONS **October 2004 Revised**

Instructions: Check activities as 'Yes' (safe), or 'No '(at risk). Provide feedback to individuals observed. Return completed forms to the safety department. Report unsafe conditions or hazards to the maintenance department with a description. ***If you observe a hazard or unsafe condition that needs immediate attention, contact the department supervisor, or the Facilities Manager.***

Department – Activity Observed	Observed by	Date and time observed

	Yes	No	N/A	Feedback or Recommendations, Actions Taken
Personal Protective Equipment (PPE)				
Are safety glasses with side shields worn in production areas?				
Is hearing protection worn when machines are operating?				
Are food safety - GMP's followed? (i.e. hairnet, no jewelry or gum)				
Face shield or goggles over safety glasses when required?				
Other PPE – hardhat, apron, gloves, Kevlar sleeves or respirator				
Housekeeping and Access				
Is the area clear of trip and fall hazards?				
Are aisles and exit paths clear?				
Is emergency equipment accessible? (such as fire extinguishers and eye wash stations)				
Conditions and People				
Are people aware and focused on what they are doing?				
Are people working at a safe pace? (not running or rushing)				
Are safe practices or JSA's being followed?				
Are people away from the 'line of fire'? (LOTO applied, machine guards or controls in place)				
Are people in balance? (Ergonomically – such as being able to carry, reach, bend, or lift in a safe manner)				
Tools *(such as utility knives, hand or power tools, ladders)*				
Are the right tools provided and being used properly?				
Are the tools in good condition?				
Vehicle Safety				
Are seat belts fastened while the vehicle is in motion?				
Are vehicles being driven safely? (safe speeds, stopping at intersections and honking the horn, watching for pedestrians)				

Are there any hazards that need to be corrected, or is there a safety issue that needs to be addressed (please describe)

What could we do to improve conditions? (Check the box if a work order needs to be generated ☐)

Job Safety Analysis

Department	*Job or Operation*	*Title of Person Performing Job*

Required and/or Recommended Personal Protection Equipment

Sequence of Basic Job Steps	*Potential Hazard*	*Recommend Safe Job Procedure*
Analysis by:	*Analysis approved by:*	*Date Conducted*
		Date Revised

Date of Inspection: _____

Department of Inspection: _____

Appendix H

Names	Signatures

Instructions: Fill out form noting all discrepancies, submit to Plant Manager, Department Manager, Safety Manager.

Policy instructions are located in BSG under 00.6.5.

SPECIFIC LOCATION / EQUIPMENT	ITEMS REQUIRING ACTION	CORRECTIVE ACTION RECOMMENDATION	PRIORITY LEVEL				PERSON(S) RESPONSIBLE FOR CORRECTIVE ACTION	ANTICIPATED DATE OF COMPLETION	ACTUAL DATE COMPLETED	WC ORI NUM
			A: Immed-iately Repair	B: Repair Less than 5 Days	C: Repair Less than 30 Days	D: Planned Project / CIR to complete				

Employee Incident Report

Instructions: Please complete this report as completely as possible and return it to your supervisor.

Printed Employee Name: _____ Clock or Employee Number _____

Signed Employee Name

Incident occurred on (date) _____ Incident occurred at (time – a.m. or p.m.) _____

Incident reported on (date) _____ Incident reported to (name) _____

Type of Incident (Circle any that apply)

Injury *Illness* *Close Call* *Property damage* *Security issue* *Theft* *Other (describe)*

Assigned department when incident occurred

Department or location where incident occurred

Employee's Job Title Supervisor

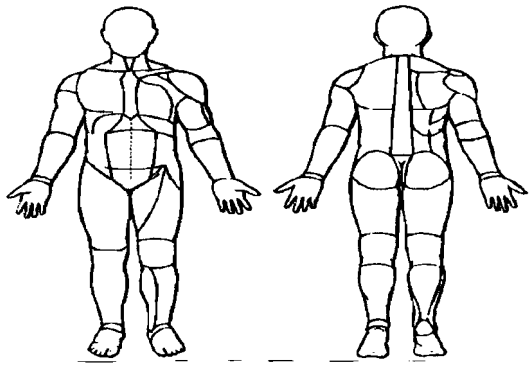
Are there any non-work related factors that contributed to this incident? Yes _____ No _____
If yes, please explain:

Was the incident immediately reported? Yes _____ No _____
If no, please explain why not:

Were there any observers to the incident? If so, please list their name(s)

Describe the injury or illness:

If an injury or illness occurred, draw an arrow to or circle the body part(s) affected:



Describe the accident

Where did it occur?

What happened?

What caused the incident?

Was this incident a result of an unsafe act or unsafe condition?

How could the situation be corrected or prevented from occurring again?

Have you ever had a similar accident occur in the past? If so, please explain

Incident Correction Plan

The following is to be completed by the employee's supervisor on duty or on call at the time of the incident and submitted to the safety department within 24 hours of the incident reported.
Supervisors: Please complete a Supervisor's Incident Report for as well as this report.

Print Supervisor's Name

Sign Supervisor's Name

Date Incident Report Received

Action Taken: Target Completion Date

Final status: (completed by the safety department) first aid ____ recordable ____ LTA ___ other ___