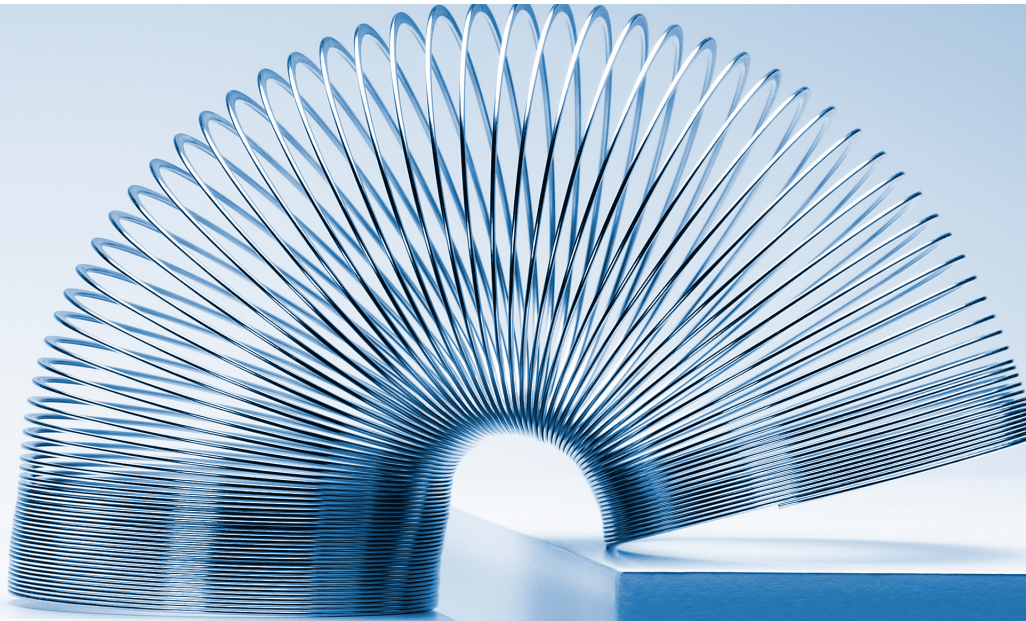




TURNING PHILOSOPHY INTO ACTION: BRIDGING SAFETY THEORY AND PRACTICAL APPLICATION

BY PETE BATROWNY AND PANDORA BRYCE, PH.D.

Contents

Introduction	.....
Using Multiple Safety Lenses to Improve Organizational Outcomes	.....
Examples of Multiple Lenses: Safety and Organizational Philosophies	.....
Moving From Philosophy to Action: Bridging the Gap	.....
Challenges in Turning Philosophy Into Action	.....
Leadership Creates the Conditions for Long-Term Results	.....
A Common Barrier to Turning Philosophy Into Action: The Effects of Habituation	.....
Working With, Not Against, Natural Human Habituation	.....
Practices That Support Sustainable Change	.....
Sustaining Improvements	.....
How the Safety Lenses Strengthen Sustainability	.....
Conclusion	.....

TURNING PHILOSOPHY INTO ACTION: BRIDGING SAFETY THEORY AND PRACTICAL APPLICATION

Introduction

Safety culture is an integral contributor to operational performance, quality and reliability. As companies increasingly recognize this fact, there is growing adoption of new philosophies, models, and frameworks that are intended to guide decision-making about risk, leadership, and operational discipline. These conceptual approaches often promise meaningful transformation. However, substantive evidence regarding the effectiveness of interventions intended to translate safety culture concepts into practice remains mixed.¹

In on-site work with industrial clients in a range of fields, SafeStart's consultants have found that a lack of conceptual understanding is rarely an obstacle to adopting safety culture concepts. Executives and safety leaders are increasingly familiar with modern safety thinking and how it relates to overall organizational performance. The real challenge lies in translating philosophical principles into consistent practices.

“

The real challenge lies in translating philosophical principles into consistent practices.

”

Organizations do not change simply because a new philosophy is introduced. People's daily actions in the workplace tend to follow established routines, cultural expectations, and habituated behaviors that develop gradually as organizational systems increase in complexity. Over time, these patterns become embedded in how work is performed. Even when leaders initiate relatively small improvements to organizational systems or processes, workers often lack clarity on what exactly is changing and what the new practices are, and as a result, they often continue to rely on familiar operating habits and patterns.

This dynamic is particularly visible in safety management systems. Leaders may emphasize learning, systems thinking, and proactive risk identification, yet operational routines still reflect older assumptions. When this occurs, the philosophical aspirations of safety initiatives remain disconnected from day-to-day operations. This paper provides real examples of these challenges and shows how the organizations mitigated the habituation that was preventing the new philosophy from having the desired effects. (These stories have had all names and other specific identifiers removed.)

When leadership embraces a new philosophy, it takes time for it to cascade throughout the organization, and for employees at each level to adjust to any new processes that might be implemented as a result. This is when a clear, practical introduction, accompanied by specific applications of the new philosophy, becomes essential. Employees should be told what's changing and why, and they should be educated on any new process that affects them. They should also be offered support in adjusting to the changes. The adoption of new practices requires more than communication. It requires deliberate processes that reshape the habits and routines that govern workplace actions. Organizations that successfully improve safety performance integrate philosophy and practice.

¹ Bisbey et al. (2019), pp. 376-392

Using Multiple Safety Lenses to Improve Organizational Outcomes

In this paper, we posit that when it comes to turning philosophy into action, it is valuable to include perspectives from multiple sources and approaches, with the caveat that they need to share similar foundational principles. Using multiple lenses gives leaders the opportunity to learn from a wider range of practical examples and adapt the most useful tactics to address organizational needs.

Ultimately, improving safety and performance requires leaders to move beyond philosophical alignment and toward practical elements of integration by embedding new expectations into the daily systems and routines that guide work.

Examples of Multiple Lenses: Safety and Organizational Philosophies

Organizations seeking improvements in safety and reliability have a range of sources to choose from, and there is value in using elements of more than one philosophy to help with assessing a safety issue, particularly those that are persistent. Examples used in the paper include:

- Human and Organizational Performance (HOP)²
- High Reliability Organization (HRO) Principles
- The Human Factors Framework (HFF)
- Safety Climate Success Factors (SCSF)

Each framework contributes valuable insights into how organizations can manage risk and improve reliability. Some emphasize leadership behavior, culture, and climate. Others emphasize system design, process discipline, or operational learning.³ There is value to be found in each of them, given that they help leaders understand why safety matters and how organizations should think about risk and human performance.

Translating these principles into consistent workplace practices is a recurring challenge for organizational leaders.⁴ The distinction between understanding and application is critical. Organizations rarely struggle because they lack a safety philosophy. Often, they struggle because philosophical ideas are not converted into concrete leadership routines, supervisory practices, and management processes.

In other cases, the practical results of new approaches aren't visible early enough in the process for leaders to convince their people that it's all worth the effort it will take. The gap between leadership's intent and the expected benefits gets bigger and harder to close at a time when the implementation of the changes is most demanding on team members.

² Hibbert et al. (2022), Table 1.

³ He et al. (2019), pp. 124-156; Neumann et al. (2016), pp.1721-1724

⁴ Ghezzi et al. (2020), p. 2



When there is friction between philosophy and action, or a disconnect between intention and action, it's both useful and efficient to examine existing tools and processes from related philosophies rather than reinventing the wheel. It's likely that at least one of the safety philosophies has developed a practical method for getting positive action on the pain point that's delaying progress. Leadership that can tap into multiple approaches is better equipped to manage the challenges of putting philosophy into action.

Moving From Philosophy to Action: Bridging the Gap

A useful way to understand the challenge of implementing new safety approaches is to distinguish between philosophy and action. Philosophy is the set of principles and beliefs an organization professes to hold. Action is what people actually do.

Most modern safety philosophies include compelling principles. For example:

- Human and Organizational Performance (HOP) emphasizes that human error is normal and that learning is more effective than blame.⁵
- A High Reliability Organization (HRO) emphasizes sensitivity to operations and attention to “weak signals,” those subtle early signs that something could go wrong.
- The Human Factors Framework (HFF) highlights the impact of physical and internal human factors on the successful (or unsuccessful) outcomes of system design and usage, including both technical and people systems.
- The Safety Climate Success Factors (SCSF) emphasize specific skills for building leadership credibility, engagement, and trust within the HFF. Those skills are taught through active practice during training and on the shop floor, to get leaders to turn their conceptual learning into real action.

Whether leadership sticks to one or blends multiple philosophies, their people evaluate the credibility of safety commitments through observable actions: how leaders respond to concerns, how human factors are integrated into technical and people systems, and whether safety expectations remain consistent under operational pressure. When leaders fail to demonstrate a philosophy through their actions, or when the actions are inconsistent, vague, or overcomplicated, employees will lose trust in the value of the philosophical approach.

Consider the example of a job safety analysis (JSA). The underlying philosophy of a JSA is widely accepted: hazards should be identified before work begins. Yet in many organizations, JSAs gradually become administrative exercises. Forms are completed, signatures are collected, and documentation is filed without meaningful discussion. In these cases, the philosophy remains sound but the action has changed or its quality has deteriorated, and it fails to deliver the desired outcomes.

⁵ Hibbert et al. (2022), Table 1.



Organizations that reinvigorate JSA processes typically do so by strengthening the structured actions of a JSA. These may include structured pre-job briefings, integration of near-miss data, assessment of the potential effects of human factors, and periodic team reviews of previous job plans to identify improvement opportunities. Supervisors may also receive training in facilitating discussions that encourage participation and shared learning. These adjustments transform the JSA from a compliance requirement into a learning tool.

If we review this example using the lens of the Safety Climate Success Factors (SCSF), we see that by strengthening the structure of the JSA, an organization can reinforce several SCSF simultaneously, including trust and engagement, human factors applied to hazard identification, and active leadership. These improvements to the JSA process also incorporate elements from HOP (work as imagined vs. work as performed, learning organization) and HRO (deference to the frontline, not settling for easy solutions).

Thoughtful adoption of a safety philosophy can provide leaders with direction that helps them select tactics and tools that will help solve the safety problems they've identified. For existing processes that have waned in efficacy, the use of one or more additional lenses can help to redirect the process for better outcomes, such as the addition of human factors analysis to hazard identification and training supervisors in facilitating safety discussions. Specific, proven tools developed by practitioners of approaches such as HOP, HRO, and the HFF help to bridge the gap between philosophy and action.

Challenges in Turning Philosophy Into Action

Several recurring challenges complicate the translation of philosophy into operational practice.

1. Conceptual language is difficult to translate into specific workplace actions

Principles such as “learning orientation” or “systems thinking” may resonate with senior leaders but remain abstract for frontline supervisors responsible for managing daily operations.

2. Organizational routines are deeply embedded

Operational habits develop over many years. Even when leadership introduces new philosophies, existing routines often continue to shape behavior, especially if the value of the change doesn’t feel “worth it” when measured against the effort involved in doing things in a new way.

3. Varied beliefs exist within the organization

Executives may embrace new approaches while experienced employees have strongly held preferences for familiar existing processes. Senior executives may also be hesitant to implement change if they believe it will be resisted by employees. In one example from our fieldwork, senior executives were reluctant to switch to a new software vendor because they were aware of the disruption it would cause to core systems, despite having clear evidence of the benefits of doing so.

4. Cultural signals are inconsistent

When leadership messaging, performance metrics, and operational priorities are misaligned, employees are unclear about which actions to take.

These challenges illustrate that cultural change is not only a communication challenge. It is a challenge of reshaping organizational habits in ways that positively influence individual human factors.

Organizations that attempt to implement new safety philosophies often make several predictable missteps:

- Treating new ideas as temporary initiatives rather than integrating them into core management systems.
- Neglecting to build the capability of frontline leaders, where cultural change actually occurs.
- Introducing multiple disconnected programs that overwhelm the organization.
- Underestimating the strength of existing organizational habits.

Avoiding these pitfalls requires deliberate alignment between philosophy, leadership behavior, and management systems.



Leadership Creates the Conditions for Long-Term Results

Organizational leaders play a central role in translating philosophy into worker actions on the shop floor. This may sound like common sense, but it's not as easy as one might hope. The need for leaders to be committed and engaged is a consistent theme in organizational excellence articles, formal research, reports from SafeStart's consultant fieldwork, and anecdotal feedback. Given that it's talked about in so many contexts, one would assume that leaders know that their actions determine whether a new philosophy is a deep commitment or just a 'flavor of the month.' However, it's clear from multiple sources in industry and academia that sustaining safety improvements is an ongoing challenge.

Leadership credibility and visible commitment are among the strongest predictors of a positive safety climate.⁶ Leaders influence safety performance through several processes. First, they connect philosophy with everyday workplace outcomes. Employees are more likely to adopt new ways of doing things when they understand how safety and communication improvements contribute not only to business outcomes, but to what makes their workplace a safer and more human place to work.

Second, leaders build capability. Supervisors and frontline leaders require both the knowledge and interpersonal skills required to have effective conversations about risk, coach employees effectively, and respond to employee concerns with a genuine commitment to making improvements.

Third, leaders normalize discussion of systems and human conditions. Decisions that affect workers should routinely include consideration of workload, equipment design, the impact of systems on internal human factors (such as rushing, fatigue, and psychological safety), environmental conditions, and a clear communication of why the changes matter.

Finally, leaders model expectations. Employees closely observe how leaders respond to incidents, questions, and uncertainty. If a leader is reactive, unwelcoming of bad news, and prone to looking for one individual to blame, employees are likely to feel that speaking up is unsafe. Leaders' responses have both immediate and long-term effects on reporting, problem-solving, and employees' willingness to participate in continuous improvement.

⁶ He et al. (2019), pp. 124-156, p.140, Table 2.

Here's one example from the field that demonstrates the sizeable impact frontline leaders can have. When an organization first launched its "no blame" safety philosophy, the intention was solid: encourage reporting, reduce fear, and shift the culture away from punishment. For a while, it worked. Near-miss reporting increased, supervisors were having more open conversations, and employees felt safer speaking up. But over time, something unexpected happened. Because leaders kept repeating "we don't blame people," many employees began interpreting it as "there are no consequences." Supervisors became hesitant to address repeated risky behaviors, and they were unsure whether coaching someone on a pattern of shortcuts violated the no-blame message. Meanwhile, frontline workers grew frustrated that obvious reckless actions weren't being dealt with. The result was confusion, inconsistency, and a sense that accountability had quietly disappeared.

The turning point came after a preventable "hit by" involving an operator who had been coached multiple times for the same behavior. Instead of defaulting to discipline or doubling down on "no blame," the company brought a multi-disciplinary team together for a joint training session on just culture,⁷ human factors, and system accountability.⁸ Through case studies and facilitated discussion, leaders learned to distinguish between human error, at-risk behavior, and reckless behavior—and how each requires a different organizational response. They also explored how system design, workload, communication gaps, and unclear expectations shape behavior long before an incident occurs. By the end of the workshop, supervisors and frontline workers finally had a shared language: no blame does not mean no accountability; it means fair accountability. When the training concluded, the organization had clearer expectations, a more confident leadership team, and a culture that supported both learning and responsibility.

In summary, effective leadership behavior reinforces having clear criteria for assessing an incident fairly, paired with a timeline and fair accountability. This approach supports outcomes such as trust, engagement and shared responsibility for safety.

⁷ Boysen (2013); Murray et al. (2017).

⁸ Neumann et al. (2016), pp. 1721-1724



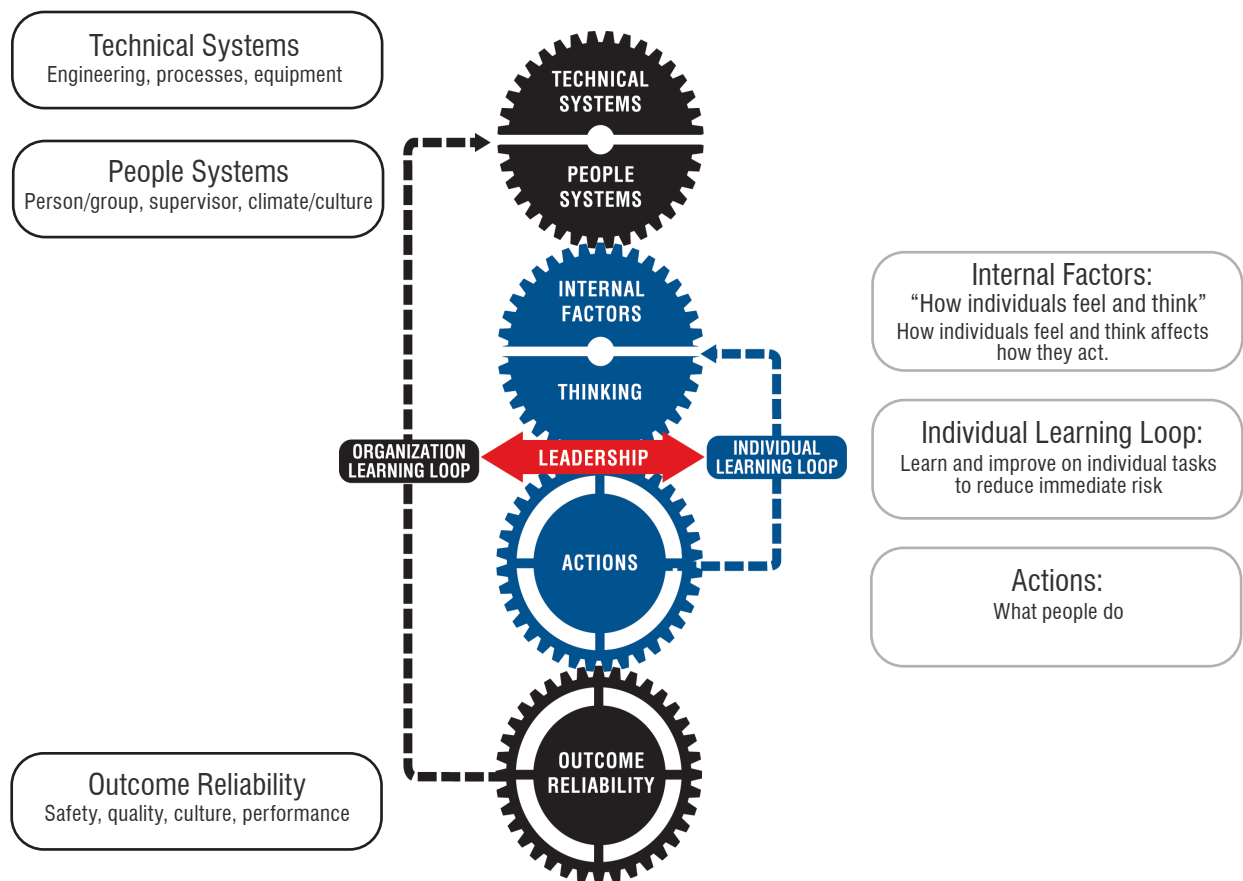
Here is an example of a company embracing a philosophy and then encountering some roadblocks as they implemented it. The organization overcame those roadblocks through actions that brought the philosophy to life.

An organization proudly announced that it was adopting HOP principles after a series of preventable incidents. Leadership held awareness sessions, brought in a keynote speaker, and distributed posters emphasizing “error is normal” and “blame fixes nothing.” Employees appreciated the message, and supervisors liked the shift away from finger pointing. But after the initial excitement faded, nothing changed in how day-to-day work happens. Crews still used the same outdated hazard identification forms. Investigations still focused on what the worker should have done. And supervisors, unsure how HOP applied in real situations, quietly reverted to old habits. The organization had embraced the philosophy of HOP but lacked the practical tools to operationalize it.

The gap became obvious when a high potential near miss (a potential serious injury or fatality) occurred. Leaders wanted to run a learning team, but no one knew how to facilitate one. Supervisors wanted to understand the human factors behind the event but had no framework to analyze workload, task complexity, or system design. And when the involved worker repeated a risky shortcut a month later, managers were unsure whether to coach, discipline, or escalate—because the company had never clarified accountability expectations under a just culture model. The result was confusion, inconsistency, and frustration across the workforce.

Recognizing the gap, the organization built practical HOP tools: a simple learning team guide, a human factors checklist for hazard identification, and a just culture decision tree that clarified the difference between human error, at-risk behavior, and reckless behavior. They trained supervisors on how to use these tools in real work, not just in theory. Within months, the organization shifted from “HOP as a concept” to “HOP as a practice,” and safety conversations became more honest, investigations more insightful, and accountability fairer and more predictable.

The above example can also be used to demonstrate tactics that would draw on elements of the SafeStart Human Factors Framework (HFF). An organization that had experienced recent preventable injuries used this framework for diagnosis and adopting new processes. First, they considered the foundational elements of the framework.



In the illustration, the top and bottom cogs in the framework represent organizational systems and external conditions, which tend to be the elements that leadership is most focused on. The two middle cogs represent what's going on with individual employees. The intersection of the top two cogs invites leaders to consider where their systems may be increasing negative human factors (such as frustration, distraction, cognitive overload, fatigue, or lack of psychological safety) and where there might be opportunities to amplify the positive human factors that keep people safe and engaged at work.

To keep the cogs working together smoothly, there should ideally be ongoing learning and continuous improvement that create safe and effective conditions in both technical systems and people systems.



The company's HFF-related incident analyses uncovered weaknesses in people systems, especially in the quality and effectiveness of leadership's communication with all levels of their people. Leaders were so ineffective in communicating why and how they were analyzing incidents from a human factors viewpoint that their people didn't engage in the learning teams. They were doubtful that leadership was sincere about learning from their people on the front line.

Another example of weak people systems was that leadership was not role modeling effective self-management of their own human factors. Despite knowing the concept that how people feel affects how they act, some leaders were exhibiting toxic behaviors, lack of self-awareness, and no understanding that processes designed for a reasonable production schedule would create risky human factors when pushed beyond workers' capacity to stay physically and mentally healthy.

To mitigate these weaknesses, the organization trained its people managers and line supervisors in a structured process for identifying where human factors were amplifying specific risks in the departments where the incidents took place. They implemented a two-level near-miss reporting system in which near misses with SIF (serious injury and fatality) potential were assessed using a human factors lens in addition to the detailed technical discovery process, and non-SIF near misses were assessed using a simple discussion process at the team level to identify how to prevent them from recurring. All conclusions and corrective actions were communicated clearly and cascaded quickly throughout all levels of the organization. This enabled the organization to reduce incidents and measurably increase communication, trust, and engagement.

Further improvements at both organizations could be achieved by using tools from both HOP and HFF together.



A Common Barrier to Turning Philosophy Into Action: The Effects of Habituation

When a new philosophy is introduced effectively in an organization, it can create enthusiasm and genuine intention to do things differently. If even a small number of people become advocates, it can get some momentum underway to use the new tools and processes. However, there's a natural human gap between intention and action, and it's wired into our brains. The brain develops strong neural pathways for familiar actions, and it's tremendously difficult to change them, no matter how strongly we intend to do so. Anyone who has tried to quit smoking, stop online scrolling, or keep their kitchen tidy can relate to this. Once a behavior or action has become habitual, we do it on autopilot whether it's positive or not, and it takes ongoing concerted effort to make changes.

The influence of habituation on safety at work can be illustrated through a common workplace experience. Consider a technician who has worked in a large industrial plant for nearly two decades. Early in his career, he reported a minor injury sustained during a maintenance task. The resulting investigation focused heavily on identifying him as personally accountable, and the technician received disciplinary action despite the presence of several other contributing factors. Although the incident was relatively minor, the experience shaped his expectations about reporting. Over time, he gradually stopped reporting near misses and minor incidents. This decision was not a conscious rejection of safety policy. Rather, it reflected a human factors-related response to how he was treated during a safety investigation.

Consider what could happen if, years later, the organization introduced new safety philosophies emphasizing learning and openness, such as encouraging reporting of near misses. It's not difficult to see why, despite these messages, the technician would remain hesitant. His responses would reflect a deeply embedded habit that developed because reporting had previously produced negative consequences.

This example illustrates an important lesson. Cultural change does not occur solely through leadership adoption of a philosophy. Expectations already formed through repeated organizational experiences exert powerful influence over the people in the workplace. Rebuilding trust requires consistent reinforcement through positive leadership actions, human-centered system improvements, and credible responses to reported issues.

As seen in the example above, an individual's operational decisions are shaped less by formal analysis than by habituated patterns of behavior. Workers make hundreds of small decisions during a typical shift, such as whether to pause work, raise a concern, request assistance, or proceed despite uncertainty. These micro decisions often happen in seconds:

- “Should I stop this job?”
- “Do I report this issue?”
- “Should I ask for help?”
- “Is this deviation worth mentioning?”
- “Do I take the time to do this step properly?”

Gary Klein's work on naturalistic decision making shows that people make decisions by recognizing patterns, drawing on past experience, and acting on what “feels right” in the moment.⁹ In high-risk work, this intuition, formed by habituation, is powerful—and potentially dangerous—because it is shaped by the system around them.

Over time, these experiences form patterns of expectation. When particular actions are repeatedly reinforced, they become the default response. These responses occur rapidly and are heavily influenced by past experience and organizational signals. If raising concerns consistently leads to constructive discussion and visible improvement, employees gradually develop the habit of speaking up early. Conversely, if past experiences suggest that concerns will be ignored or criticized, silence may become the habitual response.

Understanding this process is essential for leaders. Safety and performance outcomes are strongly influenced by the habitual decision patterns embedded within the organization. Shaping those patterns requires consistent reinforcement through leadership behavior, operational systems, and people systems, all of which require all levels of leadership to deliver frequent communication of decisions, delays and successes.

We've looked at how habituation affects actions by individual workers, and at the need for leaders to be aware that in the majority of cases, individuals rely on their previous experiences and habituated responses they've developed in their work environment. This is where an unsafe or ineffective habit can sidestep conscious decision-making because it “feels right” to take an unsafe action. HOP, HFF, and HRO all contain principles that address the impact of habituation; while the specific points vary, all three philosophies are in agreement that habituation is shaped in part by the system, and not only by the individual.

⁹ Klein (2008), pp. 450-460; Lipshitz et al. (2001)

A HOP approach to habituation says that:

- People don't wake up intending to make bad decisions
- People's choices are shaped by context, pressures, and system design¹⁰
- Error is normal and predictable

For example, when a worker doesn't use their stop-work authority even when there's a clear risk, or doesn't report a near miss, HOP asks: What in the system made that action feel reasonable?

To answer that question, a HOP-driven analysis considers a number of potential factors, including:

- Production pressure
- Past experiences with blame
- A belief that "nothing will change"
- A supervisor who values speed over thoroughness
- A lack of clarity about expectations

HOP reframes unconscious actions (intuition/habitation) by examining system conditions and contexts that make the behavior understandable, rather than treating error primarily as an individual failing.¹⁰

The SafeStart Human Factors Framework (HFF) includes a range of explanations for why habituation affects actions the way it does. Workers' actions are shaped by:¹¹

- Fatigue: reduced attention, slower recognition
- Familiarity: "I've done this a thousand times"
- Time pressure: shortcuts feel justified
- Ambiguity: unclear expectations that lead to inconsistent decisions
- Normalization: risky conditions and unsafe acts feel normal
- People systems cues: "no one else is stopping the job"

The HFF helps leaders understand that individual actions are rarely random, and instead they are the product of conditions, workload, design, and culture. If the climate rewards speed, people will favor speed. If the climate rewards reporting, people will favor reporting.

¹⁰ Ghezzi et al. (2020), p.4

¹¹ Neumann et al. (2016), pp. 1721-1724; Karanikas et al. (2023), article 106045; Bryce & Duncan (2019), p. 10



High Reliability Organizations (HROs) are known for:¹³

- Preoccupation with failure
- Sensitivity to operations
- Reluctance to simplify
- Deference to expertise
- Commitment to resilience

These characteristics shape intuition and habituation by embedding mindfulness into daily work.

For example, when leaders model a preoccupation with failure, workers intuitively look for weak signals (which are potential areas of failure). When teams practice deference to expertise, workers intuitively ask for help sooner. And when an organization avoids oversimplifying, workers intuitively question assumptions.

HROs don't seek to eliminate intuition and habituation; they train it.

Working With, Not Against, Natural Human Habituation

If habituation drives most actions then workplace practices and processes must be designed to positively shape that habituation. This means asking:

- What message do workers receive about what matters?
- What behaviors do leaders reinforce, either intentionally or unintentionally?
- What environmental factors push people toward shortcuts?
- What past experiences shape employees' expectations of reporting, stopping work, or asking for help?

A practice or process is only effective if it influences the moment to moment actions workers undertake under real conditions. For example, a stop-work policy is only effective if workers intuitively feel safe using it. A JSA is only effective if workers see it as relevant, and not as simply paperwork. And a near-miss system is only effective if workers believe reporting is valued and acted upon.

Human and Organizational Performance, High Reliability Organizations and the Human Factors Framework all have insights to offer regarding the ways in which workplace conditions and systems affect individuals in the workplace. These philosophies help leaders understand and shape which actions become habituated in their workplace, and understand how to influence workers to become habituated to safe and effective actions.

To note one way in which these philosophies can be practically applied in the workplace, daily huddles are a powerful opportunity to build leadership habits, anticipatory thinking, and learning behaviors. But they can only do so if leaders are taught how to use them.

Frontline leaders often run daily startup meetings (such as huddles or toolbox talks). They are typically given a safety topic and expected to “cover it.” Without guidance, many frontline leaders simply read from a piece of paper and move on. This creates minimal engagement and misses opportunities to help people build positive safety habits through vicarious learning by hearing and sharing relatable, true safety stories.

A multi-lens approach can transform the safety huddle into a habit building tool. To that end, leaders could be expected to:

- Prepare in advance by reading and understanding the safety message before the meeting
- Connect the topic to real work by providing a practical example relevant to that day’s task
- Anticipate failure by asking their team: “If this situation happened to us today, what’s the worst that could happen?”
- Predict and prepare to mitigate for human factors: fatigue, overconfidence, frustration, cognitive overload, boredom or rushing that could amplify risk
- Build resilience by asking, “What can we do today to prevent or mitigate this?”
- Follow up with employees during the day by checking whether the message was understood and applied

When leaders consistently follow up, workers quickly learn that the huddle is not a check-the-box activity. As a result, workers listen more carefully, knowing the topic will come up again. This creates a reinforcing loop of attention, preparation, and learning.



The use of tools that originated in multiple lenses can support leaders in developing a consistent habit of preparing, contextualizing, and reinforcing safety messages—and it can help workers develop the habit of listening, reflecting, and applying the information. The list below points out topic areas of particular focus in each philosophy.

- **Human Factors:** Leaders learn to routinely consider the organization's effects on human states and error potential in their systems and individuals when diagnosing issues and determining corrective actions.
- **Safety Climate Success Factors:** The six safety climate success factors provide frameworks and tools for a no-blame accountability culture, human factors methods in hazard analysis and safety reporting, and leadership skills for influencing safety, trust and employee engagement.
- **Human and Organizational Performance (HOP):** Leaders approach safety tasks in the context of the five HOP principles: people make mistakes, blame fixes nothing, context drives behavior, learning is vital, and leaders' and peers' responses to mistakes matters for building safety. Leaders are encouraged to ask learning-focused questions rather than compliance-focused ones.
- **High Reliability Organizations (HRO):** The organization is focused on building habits of anticipating failure, preoccupation with risk, and sensitivity to operations.



Practices That Support Sustainable Change

Several practical techniques have proven effective in translating safety philosophy into everyday workplace practice:

Leadership capability development:

Supervisors and managers receive training in people systems (managing human factors, observation, coaching) and systems thinking.

Integration into management systems:

Learning processes and human factors are embedded within incident management, operational reviews, and improvement programs.

Governance and alignment:

Clear roles, strong people systems, and regular review mechanisms ensure that safety and performance initiatives remain coordinated across the organization.

Each of these techniques reinforces sustainable change by strengthening leadership credibility, improving communication, and increasing employee engagement.

Sustaining Improvements

Sustained improvement rarely results from complex solutions. Instead, it depends on disciplined reinforcement of a few core elements:

- Consistency ensures that expectations are reinforced through daily routines (people systems, technical systems).
- Relevance explicitly emphasizes how safety improvements have human benefits for employees as well as positive operational outcomes such as reliability, quality, and productivity.
- Visibility provides learning loops that allow organizations to monitor progress and identify emerging risks.

When these elements are integrated into systems, processes, and culture, improvements to conditions affecting human factors gradually become embedded organizational habits rather than temporary initiatives.



As one example of sustained safety improvements, the SCSF help to maintain the behaviors and leadership skills introduced during safety training by embedding these skills into routine team interactions, such as weekly meetings or one-on-ones.

To turn the success factors into action, a good starting point is to emphasize three leadership behaviors:

- Showing appreciation
- Asking open-ended questions
- Responding rather than reacting

A site leader can deliberately reinforce these behaviors by integrating them into every team meeting. For example, a leader may keep a poster of the success factors posted prominently and consistently ask team members to reflect on them. A simple practice is to take time during safety meetings to invite team members to share one example from this week of a moment when they showed appreciation to a team member.

At first, team members may struggle to provide examples. But with repetition, they begin to anticipate the question and intentionally practice the behavior so they have something meaningful to share. This is how habits form.

How the Safety Lenses Strengthen Sustainability

An ongoing challenge for every initiative is finding the balance between staying the course so that improvements are sustained and driving too much change too fast. The use of multiple related safety lenses can provide fresh ideas and tools while maintaining a consistent through-line that prevents people from feeling like they're being subjected to change for change's sake. Here are a few of the ways that these lenses help organizations develop outcome reliability.

- **Human Factors:** Builds awareness of the effects of human factors to help leaders manage their own and others' human factors. Leaders become more aware of the impact of the organization and leaders on individuals' states like rushing, distraction, or frustration that interfere with positive behaviors and safety outcomes.
- **Safety Climate Success Factors (SCSF):** Emphasizes active leadership (such as walking the talk, solving issues raised by line workers) and communication consistency to demonstrate that these behaviors matter, strengthening trust and psychological safety.
- **Human and Organizational Performance (HOP):** Reinforces learning over blaming; leaders share real examples, including when things didn't go well, which normalizes learning.
- **High Reliability Organizations (HRO):** Encourages sensitivity to operations, with leaders staying connected to day to day realities through reflective discussion.

Leadership behaviors become habitual, expected, and culturally reinforced, not dependent on a single training event.

Tracking progress

Effective organizations embed human factors indicators within existing safety and operational dashboards, and incorporate positive leadership activities into everyday routines. Leaders should be able to view leading indicators of constructive leadership performance with nearly the same clarity as safety, production, and quality metrics. Indicators may include engagement activities (quantity and quality), learning reviews, corrective action closure rates, actions completed on employee reporting, and increased near-miss reporting. These indicators provide evidence of leadership commitment, communication effectiveness, and employee involvement.

Communicating success

Positive change accelerates when organizations share credible stories of improvement. Celebrating successful examples of collaboration, learning, positive leadership, and human factors management reinforces emerging habits and expectations. Safety messaging, peer recognition, and leadership communication all contribute to strengthening trust and engagement.

Conclusion

Philosophy can be quickly forgotten if it isn't put into operational practice. And practice without philosophical grounding is susceptible to being replaced by the next new thing, whether it's an improvement or not.

Organizations that successfully improve safety performance integrate philosophy and practice. They adopt sound philosophical principles while simultaneously taking practical actions that influence everyday behavior, especially those actions that create visible evidence of success. When these positive practices are embedded within leadership routines, systems, and how people communicate in healthy ways, they gradually reshape habits and expectations. Over time, safety and performance become not just short-term initiatives but a defining characteristic of how the organization operates.

Bios



Pandora Bryce holds a Ph.D. from the University of Toronto. Her doctoral research areas included peak performance and adult education. Dr. Bryce has developed empirically based enterprise leadership and performance training for large corporations and now works in the safety industry.



Pete Batrowny is an industry-leading and global environmental health, safety, and physical security executive with a progressive career history. A major hallmark of Pete's career is his ability to transform cultures and build networks of communication and teamwork. He is able to connect with employees, understand their needs, and initiate strategic improvements based on those needs.



References

- Bisbey, T. M., Kilcullen, M. P., Thomas, E. J., Ottosen, M. J., Tsao, K., & Salas, E. (2019). Evaluating the effectiveness of workplace interventions in improving safety culture: A systematic review. *Safety Science*, 115, 376–392. <https://doi.org/10.1016/j.ssci.2019.02.027>
- Boysen, P. G., II. (2013). Just culture: A foundation for balanced accountability and patient safety. *Ochsner Journal*, 13(3), 400–406.
- Bryce, P, Duncan, C. (2019) A Framework for Managing Human Factors. SafeStart publication. <https://safestart.com/guides/hff-white-paper>, page 10.
- Ghezzi, V., Probst, T. M., Petitta, L., & Barbaranelli, C. (2020). Multilevel job demands and resources: Cross-level effects of competing organizational facet-specific climates on risky safety behaviors. *International Journal of Environmental Research and Public Health*, 17(10), Article 3496. <https://doi.org/10.3390/ijerph17103496>, page 4.
- Hibbert, P. D., Thomas, M. J. W., Deakin, A., Runciman, W. B., Braithwaite, J., Lomax, S., Prescott, J., & Fraser, C. (2022). Improving culture of care through maximising learning from observations and events: Addressing what is at fault. *International Journal for Quality in Health Care*, 34(2).
- Karanikas, N., Melis, D. J., & Kourousis, K. I. (2023). Production pressure and its relationship to safety: A systematic review and future directions. *Safety Science*, 159, 106045. <https://doi.org/10.1016/j.ssci.2022.106045>
- Klein, G. (2008). Naturalistic decision making. *Human Factors*, 50(3), 456–460.
- Lipshitz, R., Klein, G., Orasanu, J., & Salas, E. (2001). Taking stock of naturalistic decision making. *Journal of Behavioral Decision Making*, 14(5), 331–352. <https://doi.org/10.1002/bdm.381>
- Murray, J. S., Clifford, J., Larson, S., Lee, J. K., & Sculli, G. L. (2017). Implementing just culture to improve patient safety. *Military Medicine*, 182(3–4), e1609–e1614.
- Neumann, W. P., Kolus, A., & Wells, R. W. (2016). Human factors in production system design and quality performance—A systematic review. *IFAC-PapersOnLine*, 49(12), 1721–1724. <https://doi.org/10.1016/j.ifacol.2016.07.830>
- Weick, K. E., & Sutcliffe, K. M. (2001). *Managing the unexpected: Assuring high performance in an age of complexity*. Jossey-Bass.

www.safestart.com

