

SAFETY CULTURE DIAGNOSIS

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Icsi's guarantees

Anonymity: in the context of the in-depth diagnosis, questionnaires are sealed during the session and sent directly to an independent survey institute for processing.

Confidentiality: individual responses to the questionnaire and interview reports are only accessible to Icsi staff and never transmitted to the entity.

Total independence in the reporting of the results of the diagnosis: only relevant, overall results will be reported. At no time will it be possible to identify individual responses.

What next?

- ▶ **Build a vision**
It is important that the process does not end with the inventory – and equally important not to immediately launch an action plan.
- ▶ **A Vision seminar**, held over 2 days, provides time to co-construct your vision of the desired level of safety culture.



WHO'S IT FOR?

- ▶ All actors working in, or for, the entity concerned

GOALS

- ▶ To understand the current situation
- ▶ To examine each point to identify what you want to change

FIND OUT MORE

- ▶ www.icsi-eu.org

CONTEXT & CHALLENGES

You're not happy with your level of risk management. You're not satisfied with the progress that has been made with respect to safety; safety performance does not meet your expectations. You've tried a lot of things, but you're not seeing the benefits. You know that basic safety rules are still being broken. There are accidents, and you don't know what the root causes are.

You want to bring new life to your risk management approach. It's time to **carry out an objective diagnosis of your safety practices and beliefs**. This is the first key step in any efforts to improve your safety culture.

OBJECTIVES

The diagnosis will encourage all of the actors at your workplace to develop a shared a vision of current perceptions, beliefs and practices and their real impact on risk management. It will help you to:

- ▶ **understand the context** and history of your entity, and the constraints (apart from safety) that it must take into account,
- ▶ **make thoughts visible:** the diagnosis examines beliefs, perceptions and convictions,
- ▶ **understand what you're currently doing:** the diagnosis offers a way to explain safety practices and behaviours, understand difficulties encountered in the workplace and deviations from what is prescribed,
- ▶ **ask questions within the organisation about the coherence and alignment between what you think and what you do,**
- ▶ **identify the levers that can be used to maintain cohesion** where it exists and strengthen it where it is weak.

SAFETY CULTURE DIAGNOSIS

THREE MODALITIES



IN-DEPTH

Draw up a detailed portrait of the safety culture by involving all stakeholders in efforts to develop it.



THE BASICS

Characterise the main attributes of the safety culture in relation to areas identified as needing improvement.



ACCIDENT/ EVENT ANALYSIS

Find the root causes of an event to eliminate them from your organisation.

ORIGIN/ CONTEXT FOR THE REQUEST

Engage in a process that aims to improve the safety culture

Integrate actions/perspectives into an ongoing process

Understand an event to prevent it from happening again

FIELD OF INVESTIGATION

An in-depth understanding of the safety culture

Main and linked attributes related to the envisaged actions/orientations

Attributes specific to the accident

REPRESENTATIVENESS

Close to 100%.

Key positions

Positions directly/indirectly linked to the accident

OBJECTIVITY

Combination of a documentary analysis, field immersion, a questionnaire and interviews about perceptions

Combination of a documentary analysis, field immersion and interviews about perceptions

Combination of a documentary analysis, interviews and observations

POSSIBLE AXES FOR CHANGE
AT THE END OF THE DIAGNOSIS

At all levels of the organisation

Within the scope of the proposed guidelines

Focused on the causes of the accident

BUY-IN OF RESULTS
AND THE NEED FOR CHANGE

By all actors, because everyone is involved in the diagnostic phase

First, by actors involved in the diagnosis. Then, gradually, all employees.

First, by actors involved in the analysis. Then, gradually, all employees.

TYPICAL DEPLOYMENT

- ▶ Preparation (documentary analysis and immersion)
- ▶ Quantitative diagnosis (questionnaire)
- ▶ Qualitative diagnosis (interviews)
- ▶ Summary and reporting back on results

- ▶ Preparation (documentary analysis and immersion)
- ▶ Prioritisation of the field of investigation
- ▶ Summary and reporting back on results

- ▶ Preparation (documentary analysis and immersion)
- ▶ Analysis of the event
- ▶ Consolidation and exploitation of results
- ▶ Summary and reporting back on results

