

# Culture: Values and Practices - can you have one without the other?

*(Or why a focus on critical controls is good for your organisation's culture)*

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## Introduction

I was recently asked why I recommended a focus on *practices* as a means to improving an organisation's culture. I was also asked to give some examples of *practices*, (see Annex). The same question was raised a couple of months ago as well, after a public presentation I gave in Perth<sup>1</sup> entitled "SMS – Safety Management *Shelfware*." I suggested that implementing good safety *practices* is an essential (and very practical) route to developing a good organisational culture. Emeritus Professor Andrew Hopkins, who gave the key note address at the conference, talked about the inherent problems with the term "safety culture"<sup>2</sup> and defined culture as "... the collective practices of the group – the way we do things around here."

We had not colluded but Hopkin's presentation strongly reinforced my argument about the value of a focus on practices to develop a suitable organisational culture. He provided intellectual heft and rigour to my practitioner's opinion. I was encouraged because much of my work as a safety practitioner tends to focus on improving critical controls intended to reduce the probability or consequences of major accidents. "Critical controls" is just another way of saying those important organisational *practices* that reduce the chance of a risk occurring. Hopkin's presentation supported my focus on critical controls.

Hopkin's defined culture as the way we do things around here – or to put it another way the *practices* used in an organisation. Yet in day to day conversations when talking about safety culture, I frequently come across senior leaders talking about the importance of a *values* led approach to improving safety culture (and safety performance). So what are the links between values, practices and culture?

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<sup>1</sup> IFAP Fluoro Conference 10/11 November 2015 <http://www.ifap.asn.au/fluoro>.

<sup>2</sup> There is controversy with the whole concept of *safety culture*. See Safety Institute of Australia, *OSH Body of Knowledge: Organisational Culture*. In particular, the Abstract<sup>2</sup> states that, "...safety culture remains a confusing and ambiguous concept in both the literature and in industry, where there is little evidence of a relationship between safety culture and safety performance." Abstract <http://www.ohsbok.org.au/wp-content/uploads/2013/12/10.2-Organisational-Culture.pdf?ce18fc> accessed 24 December.

### *Values, Practices and Culture*

“A company’s values are the core of its culture,” according to John Coleman writing in the Harvard Business Review, *Values* are said “...to offer a set of guidelines on the behaviours and mindsets to achieve... [a company’s]...vision.”<sup>3</sup> In the context of ethics they are sometimes said to provide a moral compass for an organisation. Company’s often have a safety *value*, amongst other *values*. For example, BP has as one of its five Values the following:

*Safety is good business. Everything we do relies upon the safety of our workforce and the communities around us. We care about the safe management of the environment. We are committed to safely delivering energy to the world.*<sup>4</sup>

But what is the value of such a “Value” statement without the means to deliver? Actions speak louder than words – so says the old proverb. John Coleman in his Harvard Business Review agrees. He says, “...*values* are of little importance unless they are enshrined in a company’s practices.”<sup>5</sup>

What is meant by the term *practices*? In this context a *practice* is defined as:

*A method, procedure, process or rule used in a particular field or profession; a set of these regarded as a standard.*<sup>6</sup>

For example a not untypical safety value could be expressed in the following terms: *nothing is so important that it cannot be done safely*. What would constitute a *practice* that reflected the above quoted *value*? If a company is handling a hazardous fluid such as high pressure hydrocarbon gas, in a piping system and on occasions needs to isolate one part of the system from another for maintenance, is a single valve isolation acceptable? Alternatively, should they require a double block and bleed, i.e., two valves closed in series? The second method is a higher standard with less chance of a release of fluid and is a *practice* which would more accurately reflect the *value*.

Of course the actual isolation standard would depend on many factors not discussed here but the key point is that workplace practices must match the espoused values. We cannot articulate safety *values* and then adopt practices which are seen as incongruent with the espoused *Value*. Any discrepancy is quickly detected and not just by the workforce. As a former regulator I have experienced countless induction videos on arrival at facilities which express fine sentiments only to find that out on the plant, the *practices* did not match those sentiments. Such a situation is unlikely to foster positive feelings about an organisation’s approach to safety. I conclude from this that any discussion on *values* in an organisation should also ensure that organisational *practices* are consistent with the *values*.

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<sup>3</sup> See “Six components of a Great Corporate Culture” John Coleman, Harvard Business Review May 06, 2013 accessed via <https://hbr.org/2013/05/six-components-of-culture> on 23 December 2015.

<sup>4</sup> Safety is one of 5 values of BP Global. See “Our Values” <http://www.bp.com/en/global/corporate/about-bp/people-and-values/our-values.htm> accessed on 23 December 2015.

<sup>5</sup> Ibid, Harvard Business Review May 06, 2013.

<sup>6</sup> See the “Online Business Dictionary” <http://www.businessdictionary.com/definition/practice.html> accessed 31 December 2015.

This is not a new idea. Hopkins discusses this in *Culture, Safety and Risk*,<sup>7</sup> and quotes from a number of other well-known academics in this area and provides examples of the links between *values* and *practices* both in safety and academic organisations. Having *practices* which match *values* is important. But there is another characteristic of *practices* compared to *values* which is also significant. *Practices* are more easily measured than *values*. If we decide to change the way we do things, (for example by changing from a single valve isolation to double block and bleed) we can measure the changes to the *practices* in a way we cannot measure what people think about the *values*. I can say what I want about *values* and who can prove me wrong? However, *practices* are usually more easily observed and thus measured. I can say I respect my colleagues but persistently arrive late for meetings. My late arrivals can be observed as something inconsistent with the espoused *value*.

In a sense it may not matter too much if people (in private) do not accept the *values* as articulated – so long as they follow the required *practices*. Interestingly Hopkins has pointed out that repeated practices become “how we do things round here” and that these then represent features of the culture of that organisation.<sup>8</sup> This suggests that so long as the *practices* are good ones then their effective adoption would help develop a positive culture, even if people did not personally sign up to the relevant company articulated *value*. Implementing practices is a leadership responsibility and requires great care to avoid unintended consequences and active monitoring<sup>9</sup> to check they are applied as intended. This is a subject in its own right and is not discussed further here.

I conclude from this that *practices* are at least as important as *values* in terms of developing an acceptable culture in a workplace. Both are important but not on their own. Values must be supported by appropriate practices. Furthermore, *practices* repeated by a group become part of an organisation’s culture. Critical controls to prevent a major incident are just another way of describing important organisational practices. In this sense it could be said that a focus on *practices* is a more useful than a focus on *values* – at least practices can be measured. Ideally of course, we should have both.

As Frank Sinatra could have sung in relation to a slightly different type of social construct:

Values and practices, Values and practices

Go together like a horse and carriage

This I tell you brother

You can't have one without the other

(From “Love and Marriage” with apologies to Songwriters: James Van Heusen, Sammy Cahn)

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<sup>7</sup> See for example Hopkins, A (2005), *Safety, Culture and Risk*, pp 6 – 11, CCH Australia Ltd.

<sup>8</sup> Ibid p8.

<sup>9</sup> For a description of “Active Monitoring” in the context of major accidents, although the principles have wider application, see: [http://www.csb.gov/assets/1/7/Wilkinson\\_Active\\_Monitoring.pdf](http://www.csb.gov/assets/1/7/Wilkinson_Active_Monitoring.pdf) Accessed 31 December 2015.

## ANNEX

### SOME EXAMPLES OF ORGANISATIONAL PRACTICES FROM DIFFERENT DOMAINS

	DOMAIN	EXAMPLES OF GOOD ORGANISATIONAL PRACTICES
1	Health Care	So called “Red Rules” (practices which must be followed). For example it is compulsory for relevant clinical staff to participate in briefings before invasive procedures in some health care environments. <sup>10</sup>
2	Process Safety	The focus placed by companies and the regulator on implementing appropriate standards for safe and effective communications at shift handovers.
3	HR/Training/Continuing Professional Development	The practice of describing the objectives of training in terms of what trainees will learn and be able to do after attending training.
4	Managing Organisations	Role clarity: Discussing, defining and documenting the respective roles of team members.
5	Aviation	Using checklists in the cockpit which require (at critical times – e.g., prior to taxiing, take-off and landing) a question from one, pilot and a check that the appropriate action has been taken and verbal response to confirm this by the other.
6	Any work domain	Formalised checking (active monitoring) that to check that <i>really important</i> rules, procedures, practices and standards are being achieved in practice and not waiting for evidence of failure to manifest itself.

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<sup>10</sup> See for example “High reliability organisations – a review of the literature,” Health and Safety Executive 2011, <http://www.hse.gov.uk/research/rrpdf/rr899.pdf> accessed 31 December 2015.