Gulf Safety Culture Survey Tips for Safety Emphasis Themes

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Tips for Safety Emphasis Themes

Background

Four themes have been identified for the Safety Emphasis survey by clustering the 15 items (A through O). For each, advice and tips were gathered from subject matter experts (SMEs) on factors that might have caused participants to respond the way they did and offers ideas for interpreting the results and identifying potential actions to address various needs.

Emphasis/Themes	Items
Theme 1 – Anticipate, prevent, understand, improve Emphasis on anticipating, preventing, understanding, and improving (vs. emphasis on fixing mistakes/errors and determining who is responsible).	A, B, C, G
Theme 2 – Adjust appropriately Emphasis on adjusting to fit needs (vs. emphasis on consistency)	D, E
Theme 3 – Promote psychological safety Emphasis on psychological safety, openness, and empowerment (vs. emphasis on control)	F, H, I, K, M, N
Theme 4 – Prioritize safety Emphasis on safety (vs emphasis on speed or production)	J, L, O

Theme 1 – Anticipate, prevent, understand, improve

Emphasis on anticipating, preventing, understanding, and improving (vs. emphasis on fixing mistakes/errors and determining who is responsible).

Item A. Determining who made a Mistake vs Determining How to Avoid Future Mistakes

Considerations:

- Respondents may feel that the emphasis is on determining who made a mistake to **place blame** rather than fixing a mistake.
- Focusing on understanding "who made the mistake and why" should be **used to minimize future mistakes** – not as a form of retribution but as a means to look at the big picture and avoid it in the future.
- Determining how to avoid future mistakes **does not preclude determining accountability and consequence** but allows for a proactive rather than simply reactive approach.

Tips:

If responses are low and indicate a facility is focused mainly on determining who made a mistake, then you might consider:

- As part of your mistake investigation, it might be helpful to determine if it occurred due to **something the individual did versus something that anyone in that position might do versus a**

problem at the organizational level – which might lead to different ways of avoiding future mistakes.

- o If the **same person** is making the mistakes – it might be a need for coaching or training.
- o If the **same role** is making mistakes – it might be a need for training, change in work task processes or some other factor
- If your responses are extremely high (Determining How to Avoid Future Mistakes) – consider whether you are **gathering enough information on the root causes** of the mistake.
- To determine root causes, it is important to determine "who" is involved (if there is one) – this helps to identify where a problem occurred in the process. But the **more important part of root cause is determining what failed in the process** – everyone works within the process and their behavior is a product of it. Once you know where the problem occurred, you can gain insights into whether competency is an issue. Competency issues can be individual, but they also reflect a breakdown in the process of developing, supporting, and evaluating the competencies of individuals and supervisors.
- Decide what to do as an organization regarding mistakes.
    - o If you are surprised by the responses to this item, you might consider what it tells you about your **safety culture** and about the **actions** that are being taken in response to problems. Is there a disconnect between the two? Do you want operators to feel comfortable reporting mistakes to enable lessons learned to be identified?
    - o Consider exploring **why** operators are indicating low numbers (Determining who made a Mistake) and the past experiences and outcomes that might be driving it. How have mistakes been handled in the past?
    - o Review your mechanisms for identifying and sharing **lessons learned** from mistakes. Identify opportunities to gather and more widely communicate any lessons learned.
    - o Determine whether a **safety awareness refresh** is needed. Do we need to reinforce SEMS and how it adds value? Do we need more systemic safety learning?
    - o Consider whether you need to provide **better supervisor training** on what the focus should be – less on blame and more on fixing the problem now and for the future.
    - o Do we need to gain insights about **management on the asset** to consider their leadership style and its impact on operators? Is Safety Leadership training needed or do we need to encourage more opportunities for visible safety leadership?
    - o Increase your efforts to develop a **safety awareness mindset** with employees to reinforce that the focus should be on gathering information about current mistakes, not for blame, but to avoid future mistakes. Think about the messages that are being communicated.
    - o Be genuine in the belief that **future avoidance** is more important – accountability is needed but a focus on safety should include systemic learning.
    - o Treat safety as a **continuous improvement process** by determining how the system can be changed to eliminate the problem in the future. Individual actions are a system issue because people develop beliefs and make mistakes or have low competence because of the system. To learn from incidents, focus on what can be done to minimize the chances of this happening again (not just the who and the root cause).

Item B. Completing Today's Work Tasks vs Trying to Continuously Improve
Considerations:

- Facilities should work to create a **balance** between today and future planning.
- An individual's responses to the question might vary based on their **position** on the asset.
- These anchors can both occur at the same time and are **not mutually exclusive**. There can be a culture of getting a task done and moving on to the next one. However, good planning leads to better and safer work but it can be difficult to have workers and supervisors embrace this.

Tips:

- For a facility that has **low responses** (Completing Today's Work Tasks):
  - Consider placing greater emphasis on **improvement** than on moving fast and completing tasks.
  - Determine whether you are **more concerned** with completing the task or remaining safe in doing so.
  - Create a **continuous feedback loop** with the front line for learning about improvements and ensure that you are communicating about changes in conditions.
  - Set **clear expectations** about the balance – continuous improvement is doing the task today both safely and well.
  - Review whether **planning** is an issue which leads to a focus on daily tasks.
  - Consider how **experience and complacency** factor into your culture – is that leading to an emphasis on getting the job done over being safe?
  - Examine your **staffing** - if there are staffing issues it can lead to a focus on getting the job done rather than continuous improvement.
  - Review how performance is **measured** – is the driver of performance "finishing your worklist"? Due to regulations, these lists are getting longer and an emphasis on completing it may result in low scores. How is feedback provided on work tasks? How concise is it to ensure that it covers the necessary points but doesn't take too much time?
  - If a **merger or acquisition** has occurred how has the shift from one management system and set of procedures to another affected workers' perceptions? Are they willing to speak up or mainly focused on getting the job done?
- For a facility that has **high responses** (Trying to Continuously Improve):
  - Consider determining if there is a **backlog of work** growing or if deferred maintenance is an issue. An unsustainable backlog may increase the rate of safety issues and create stress and drive unsafe behavior.
  - What is the **crew makeup**? Are there too many chiefs keeping work from getting done or is there an inability to strike a balance?
  - Consider whether there is a **management** issue – too much management and oversight can lead to a backlog which may lead to the cumulative risk growing.
  - Consider how the **asset team is structured** between owner representatives and contractors. Are contractors willing to make recommendations to safety practices? If the equipment being used is a contractor's – do employees believe (from a behavioral and contractual standpoint) that the contractor's processes are the ones that should be used and is there hesitancy to offer changes?
  - An **overemphasis on safety or an "initiative overload"** with too many safety projects occurring may prevent work from being completed. Too high a focus on continuous

improvement could reflect that you are not achieving the desired safe results of a given initiative. It's not a safety issue in itself but could be contributing to a safety issue.

  o Consider whether **organization factors** – such as an emphasis on standardizing across all assets may be leading to practices that do not work well for an "atypical" asset.

Item C. Focusing on the Errors of Individuals vs Focusing on Problems Caused by Systems, Policies, and Practices

Considerations:

- A **balanced** approach to focusing on individual errors and systemic problems helps to develop a safety culture. Focusing on the errors of individuals can infer the blame game. The policies and practices should help with the issues that may have resulted in the individual error.
- If errors occur, the focus should be on **why that error occurred** rather than criticizing individuals – what was the context, what lead to the error?
- By creating a culture that elicits balanced ratings you are creating one that is more **team oriented** and more collective.

Tips:

- Review your **policies and practices** to determine if they are helping prevent errors or if they are lacking in some way.
  - o If someone is following policy or procedure but it has problems – can you blame the individual?
  - o If policies are not being followed – is it because they are not clear?
- Determine if **human factors** are causing incidents even if the policies are followed.
- There should be big focus on life saving rules to prevent fatalities which often are individual errors. But there needs to be an additional focus on avoiding system problems to prevent major incidents. An emphasis on **accountability vs. enforcement** is helpful.
- Examine whether **additional training** is needed:
  - o Examine your leadership styles on the facility to determine if it is contributing to the focus on errors of individuals. Is safety leadership training needed?
  - o Determine whether a competency issue exists and take steps to rectify it. Consider checking on whether operators are familiar with known hazards, the barriers, and their personal responsibility for the barriers to determine if additional safety awareness training is required.
  - o Consider whether Causal Learning training would be beneficial
  - • People learn and retain information differently and an effective assessment of skills and knowledge, while not easy, can help get personnel on a similar foundation.
- Determine whether there are **communication** issues in the field.
- Examine your **hiring practices** to determine if you're hiring the wrong people who have too much focus on the left.
- Conduct **better investigations** to determine the cause of errors.
- Review your asset owner/contractor arrangement to determine if any drivers might lead to assigning blame (e.g., to justify changing contractors or keeping a contract). Consider focusing on the overall performance of the asset and optimizing the owner-contractor relationship.

Item G. Responding quickly to problems vs Anticipating and preventing problems

Consider:

- An effective **continual improvement process**/loop is critical – it should analyze all problems and mitigate their reoccurrence based on the analysis. An effective HazID process should be in place that allows mitigating problems before they occur.
- Experiencing an **emergency** would change the appropriateness of the ratings – those ratings considered red (Responding to problems quickly) may actually be yellow since there is not always time to plan for an emergency.
- The expected **speed of response** might vary for different types of teams. For example, operational teams in areas such as drilling need to be prepared to quickly implement contingency plans as part of everyday work. Teams involved in design or management may be able to take the time to consider all reasonable options and mitigate risk reductions more thoroughly.

If responses are in the red (Responding to problems quickly), ask questions such as:

- **Why** are we continually needing to respond quickly to problems? Why are we **reactive** rather than proactive?
    - Is our continual improvement process working, how is it being operated and how can we determine if it is effective?
- Why are our **planning and processes** not continually reducing the need to respond to problems?
- Do we have a **weak hazard assessment process**?
- Do we have **maintenance** issues?

Theme 2 – Adjust appropriately

Emphasis on adjusting to fit needs (vs. emphasis on consistency)

Item D. Applying the Same Degree of Inspection to Everything vs Applying Different Degrees of Inspection based on Risk

Considerations:

- It is unlikely that maintaining lower ratings (Applying the same degree of inspection to everything) is **sustainable** due to costs. It is not a cost effective or efficient way to run the facility.

Tips:

- **Define the appropriate degrees of inspection** for various areas
- Ensure **appropriate expertise has been involved in the risk assessment** to identify high risk scenarios. Recognize that when some takes over an asset with little operational history, the natural inclination is to focus broadly until sufficient time and knowledge has been accrued to shift to more effective risk-based approaches.
- Adopt the use of **risk-based inspections**. Rank the risk level of problems and focus inspections on those that are medium risk. However, the risk assessments must be unbiased and thorough to ensure an accurate risk level has been identified. Determine whether the individuals who are

assessing risk have the required competencies to make accurate evaluations. Once risk assessments have been completed, act on those findings.

- Focus on the **high consequences** of incidents.

Item E. Following procedures as written without exception vs Recommending procedural adjustments to address unique situations

Considerations

- Modern safety management is based on a **thoughtful workforce** that assess situations, has constant situation awareness, is competent and adjusts the work and procedures to deliver the safest and best outcome. This involves thinking about the work on several different levels: in the JSA, when executing and during a post work analysis. This may lead to modifying procedures, the JSA's, and providing verbal directions to achieve safety. Using an appropriate MOC (that includes supervisors) to discuss, review, and approve the change would be helpful.
- There is always great concern that staff will not follow procedures. A thoughtful staff can participate in planning and make **risk-based enhancements** and adapt and do Management of Change (MOC) as the job evolves. The key is to follow procedures unless a risk assessment/MOC is agreed upon/approved and shows a better safer way.

Tips:

- There should be a **procedural review for all SOP's**. There will always be a situation where deviation needs to occur but if it's consistent, then a review of the entire document(s) needs to occur.
- Recognize that trying to ensure that procedures are **standardized** across all assets can sometimes lead to **processes that aren't a good fit for some facilities**. Examine the emphasis that's placed on standardization to determine if it is working effectively. Do you have a robust way to get field input early and throughout the operational life of assets to enable improvements?
- Determine if **MOCs, communications, and any contractual relationships** might be affecting the overall safety performance of the asset.
- If average scores are low (Following procedures as written without exception):
  - **Examine local management** (this could be done by upper management to determine how it is done and the attitudes of local management):
    - Do they tend towards an autocratic or dictatorial approach in relatively isolated work locations?
    - Do they have a sufficient level of understanding of safety management? The use of thoughtful work planning and execution with a disciplined way to raise and address concerns and respond to local or current situations. Consider whether a refresher is needed on JSA's, stop work and safety management.
  - Upper management should ensure that workers and local supervisors have their **support to use a change and planning process** to execute work in the best manner in the local situation. Ensure everyone knows the list of Life Saving Rules that cannot be violated even with MOC-like confined space entry.

- o Consider whether a **safety culture intervention** is required. It's important to identify why a worker and/or supervisor would never consider doing work a safer way but just blindly follow procedure with no thought. Review whether operators are identifying hazards before starting work. Have they evaluated the area and the equipment involved in the work? If a procedure assumes a condition is not present, does the work stop if that condition occurs or do they follow the procedure?

Theme 3 – Promote psychological safety
Emphasis on psychological safety, openness, and empowerment (vs. emphasis on control)

Item F. Only respecting input from people in authority vs Respecting input from anyone involved in the work
Considerations:

- This requires understanding and balancing the need to have open thoughtful discussions and openly share good ideas but also follow decisions once they are made in a thoughtful and open process. For instance, when an official stop work occurs the concerns and ideas are evaluated, and a thoughtful solution and determination is made when it is safest to restart work. This is made by the ultimate work authority (UWA). When this is made by the ultimate work authority (assuming a fair and thoughtful process exists) the work must restart. The UWA is the authority, and the decision must be respected and followed. **You need the balanced process of considering all knowledgeable input and then following the decisions that result from the process**.
- Past history may suggest that the prevalent culture was "my way or the highway," but the culture in the industry is changing. The key is to create a **management system** that does effective planning that considers the thoughts of the local workers and supervisors, the appropriate procedures and standards, the local unique situations, and makes a thoughtful and good decision on the plan that includes the important parts of each of these considerations. The plan and decision must be made within a process of MOC if deviations from standards or procedures is decided, including the justifications for deviations. The authority has to manage the plan and the MOC but with inclusion and once the decision is made work has to proceed with respect for the authority structure. However, as the plan execution progresses – additional MOC's can occur – as the situation changes and based on good situational awareness.
- Consider whether the **JSA process** may be too limited

Tips:

- If ratings are low/red (only respecting input from people in authority):
  - o Determine whether **leadership at the facility is not providing a safe environment** for communication about safety issues.
  - o Examine whether **stop work** is being used when needed
  - o Determine whether **workers contribute** to the JSAs
  - o Identify whether **hazard analysis** includes all those individuals who are involved in the work

Item H. Reporting your own injuries vs Working through your injuries

Considerations:

- This continuum could reflect whether there is a management or **leadership issue** for the facility.
- Working through injuries could reflect several different factors: a) supervisors are applying extreme pressure to **not report injuries** and not allowing them to stop work through threats, b) the individual's belief of the culture that you must be "macho" and work through injuries, or c) that despite what supervisors say operators feel they will be denigrated by the supervisor or their team if they report it.
- It could also be a "fitness for duty" issue or a lack of **respect** for impairments.

Tips:

- If responses are in the higher/red (working through your injuries):
  - Rethink **leadership messaging** to ensure that the correct messages are being conveyed. Ensure that consistent appropriate messages are being conveyed about injuries and the focus is on what's important.
  - Assess whether any of the above factors are occurring. **Design your intervention** around the factor that is in play.
  - Examine whether upper management is ensuring they do not have a **problem in local supervision**.
  - Determine whether **resource limitations** are contributing to the perception that operators should not self-report.
  - Examine your **contractual relationships and the staffing of unique positions/functions** to determine if staffing is an issue. When there is only one expert for a position it can result in that expert feeling pressured to work through an injury.

Item I. Ensuring everyone is comfortable using stop work authority vs Using stop work authority only when it is absolutely necessary

Considerations:

- Operators should use stop work authority even if have a question about whether it is necessary. Not doing so could reflect the culture on the facility. Both supervisors and peers should support the stop work process and **avoid any retaliation** that might occur because of it.
- There could be pressure to keep the work going regardless of safety and the fear of **retribution** if it is employed.
- It could be a **JSA or SWA** issue – if so, identify the potential situations that might elicit a stop work situation.

Tips:

- Provide practice or role play for **operators to think through** the stop work process and what might trigger it.
- **Recognize** when workers act appropriately in using stop work and speak up if anything seems wrong. This will help to reinforce the importance of stop work authority and enhance worker's belief that there will be no retaliation for using stop work authority.

- Ensure **supervisors support the stop work authority** and have developed a relationship with workers to enable them to feel comfortable with the work that is being performed and empowered to use stop work authority.
- Review **how SWA has been used** by operators. The location, timing, and overall pattern of SWA usage might suggest where there is a training need, a communication gap, or procedural problem.
- Examine how **leadership** is driving, supporting, and building belief and respect into the stop work process. Many companies have senior management locally congratulating, rewarding, and recognizing stop work even when it turns out to not have been necessary. This is like many other items – it's important to identify how to support and ensure that workers believe what you say and mean what you say and they are not just words from a poster.
- If leadership is creating a culture where stop work is embraced, consider whether **workers have this belief despite leadership support** and try to determine what is causing it.

Item K. Communicating widely and openly vs Communicating to those who need to know
Considerations

- Communication plays a role in safety by ensuring that everyone knows the critical aspects of work and processes. However, it is often a **balance** between communicating too narrowly and too widely.
    - There must be enough knowledge across an operation to allow them to work confidentially and safety together and to not have suspicions about lack of transparency.
    - If you only communicate to individuals who need to know then people often "fill in the void" and talk with others (who may or may not know information) to minimize any gaps.
    - On the other hand, if you provide too much information all the time the info can be distracting. There is a large mistake currently by organizations that everyone needs to know everything. The result is over communication, over complication, and people just ignoring most things from communication overload.

- Broadly communicate information regarding safety to ensure everyone who needs to know it does. To determine what information should be broadly communicated:
    - **What information do we need to concentrate on – what's most important**? Otherwise, it may not be actionable if everyone gets the same messages all the time.
    - How are you ensuring **good safe simops** and providing sufficient information among groups to achieve this? Offshore ops are huge simops situations, so communication needs to be balanced. All the groups working simultaneously must know enough to support each other, understand the hazards, and work together safely with all the other groups working there at the same time. If you are in the red (Communicating to those who need to know) you must not be delivering sufficient information to others to allow for well-planned and safe simops.
    - Should some messages be **targeted to specific people or teams**? What do specific groups or teams need to know? Are they getting those messages?
    - **How** are you providing information and is this method working sufficiently?

- Determine whether this might be a **safety participation issue** or a lack of participation in the JSA.

- Check with real workers are they getting to much or too little info in their view and **what they need** to work safely and effectively.

Item M. Asking questions if you are unsure vs Figuring it out on your own
Considerations:

- A **healthy balance between asking questions and figuring it out on your own** is always the right answer. In all respects, every workplace must develop a culture of openness, inclusion, knowledge sharing, respect, and intellectual curiosity. It's important to understand what local leaders are doing or not doing to support this concept.
- What drives a person to never seek help or advice is often some **combination** of – I do not want to appear weak or unknowledgeable, my boss will fire me if I ask questions, I am so smart and such an expert I never need help, or I am in too big of a hurry to take the time to do this.

Tips:

- Determine whether it is a result of the **belief of the workers** and their groups and attempt to understand how they create and support this bad belief. Is this a mentorship or coaching issue with a few individuals who hold this belief?
- Consider the **nature of the teams** that are responding. For teams that perform diagnostic functions or have a large part of their role involved in it, they may answer this question differently – for example, they may think that asking questions is their main role. Others, for example an electrical tech, may be expected to be the person who has to troubleshoot and figure things out.
- It could be helpful to engage in a discussion with a team about **when** they should be asking questions and **to whom**. What should they do when they are "unsure" about something?
- If a culture is driven by local leadership, consider **an intervention to understand** what drives workers beliefs and actions. What might the leadership be doing to reinforce the message of "figuring it on your own" (e.g., never having time for questions, sending workers to reference safety materials, treating workers as inept if they ask too many questions)? What is leadership not doing to support the concept of asking questions?
- Identify any messages or communication that are **inconsistent** with the safety culture you want to establish.

Item N. Speaking up if you have a concern vs Keeping quiet and letting things work themselves out
Considerations:

- This is essentially the **same** as several other questions. People like the question better because speaking up does not sound like bucking authority! Again, the only reason people do not speak up is fear of the boss or fear they will look weak or not a team player.

Tips:

- Determine whether the **stop work authority** is being effectively communicated and used.

- Determine whether this is a **leadership issue or driven by the culture of the individual worker and/or their work team**. Why are people not speaking up? What are leaders doing to support the behavior or speaking up?
- Identify whether your **hazard analysis process** is working as it should and whether any changes are needed.
- Consider whether it's a **communication** issue.

Theme 4 – Prioritize safety
Emphasis on safety (vs emphasis on speed or production)

Item J. Ensuring production remains on budget and on time vs Ensuring work is done safely
Considerations:

- Incidents can be costly, so **avoiding an incident** is the most cost-effective outcome in almost all cases. The focus is typically on higher consequence events, but in incident investigations, you may discover that operators clearly understand that the incident was costly, but they did not clearly recognize or identify the potential risk before the event.

Tips:

- Identify **why** workers believe that the budget and targets are more important than safety.
  - Are they afraid of senior management rationally or irrationally? Why would they risk themselves? What is causing this belief?
- Determine whether **leadership/supervisors** are contributing to the emphasis on production over safety.
  - Do management/supervisor actions and words support the need for safety or do workers feel that they know what supervisors want despite their words and actions?
  - Are management/supervisors actually walking the talk and, if not, determine ways that how can they support and encourage the belief structure they want.
- Does the **cost of incidents or financial pressure** lead to focusing on production over safety? Identify where the pressures are originating from to determine next steps.
- Review the **adequacy** of your hazard identification or risk assessment processes and how hazards or risks are **communicated** to help guide decisions regarding budget vs. safety. What are you currently doing to help operators identify or anticipate potential risks?

Item L. Checking the box on safety vs Going above and beyond to ensure safety
Considerations:

- It is important to understand whether the culture reflects **careless disregard** for themselves and the facility (and are happy with the minimum) or the problem is they think above and beyond is ridiculous, unnecessary, and a waste of their time and resources. It is hard to imagine that any thoughtful and reasonable person would not want to fully protect themselves and the place where they work. So, acting this way is a result of belief supported by experience.
- The fix is leadership driving the belief that that they genuinely want "**above and beyond**" for safety and developing a safety management system and belief in that system. That system would be built through thoughtful people identifying the hazards and building and maintaining barriers to prevent escalation of situations. Reinforcing efforts to continually improve and

conveying that it is the best thing to do and believe in. The enemy of SEMS is people feeling it is only paperwork and busy work and even worse if it is.

Tips:

Diagnosing what is causing the problem – or "checking the box" on safety could involve examining whether it is due to:

- **Personal belief** – Is this based on individuals having a:
  - o Careless disregard for themselves and the facility? A feeling of individual invulnerability?
  - o Lack of knowledge regarding risk and consequences?
  - o Belief that it isn't their role to go "above and beyond" to ensure safety but simply to follow the rules?
- **Leadership/culture** issues -
  - o Is this a belief driven by the leadership, creating a disregard driven by "normalization of deviance" where groups do the minimum or less and nothing bad happens and they begin to believe it is ok. Or is it creating a disregard driven by the belief that anything more than minimum is a waste and unnecessary?
  - o Do operators believe that the company safety auditors are checking the box and don't really "understanding how things really work out here?"
- **A combination** of both?
- Have **hazard analyses** been limited in any way or minimized?
- Is the hazard analysis process viewed as too **cumbersome**? For example, is completing required paperwork interfering with "truly understanding" the hazards?

Item O. Working quickly to keep up with the schedule vs Taking the time to complete the tasks perfectly
Considerations:

- Working quickly without taking proper care is clearly bad. Why would someone do this? There has to be some reasoning that is **driving this behavior** or the belief that the facility values it.

Tips:

- Determine if the problem is at the **individual** level – is the belief driven by fear of supervision, fear of what they think supervision believes, and fear of consequences from supervision? Or is it driven by not wanting to appear weak, unknowledgeable, or not a team player with their peers? What is driving the behavior – supervision or personal/team beliefs?
- If it's a **leadership** issue - how and in what way do supervisor and leadership support good beliefs and behavior? If there is no or little leadership support, it means the work environment must be improved. If the leadership is providing this support – the question is what is the problem with the workers individually or as peer groups who are working in a supportive environment that causes them to believe speed is more important?
- Consider whether **maintenance issues or hazard analysis** are contributing to the perception of the need to work quickly to meet the schedule.
- Examine whether **prioritization issues** exist or whether it's a **management system failure** overall. Is there a feedback loop to management that is broken?