CHAPTER 2

Enhancing Accountability

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

- Define personal and organizational accountability and list their advantages.
- Discuss ways that accountability can affect health and safety within fire and emergency services.
- Explain the process of using NFPA 1500 to improve the accountability related to the health and safety of an organization.
- Discuss implementing the combination of accountability and no-fault management.
- Discuss the need to create health and safety parameters for organizational accountability.

You Are the Fire Fighter

© LiquidLibrary

It's been a couple months since you got assigned to Engine 265 and you've enjoyed working with some of the best fire fighters in the area. In fact, you couldn't have gotten assigned to a better lieutenant. He has the respect of your entire crew as an experienced fire fighter, instructor, and leader. One day he asks you if you know what the key to being a great fire fighter is. You think about it and respond with words like bravery, knowledge, and safety. He tells you they are all important, but without personal accountability, none of them really matter. You walk away trying to figure out what he meant.

1. What is personal accountability?
2. What does bravery look like without accountability?
3. What are the advantages of organizational accountability?

Flames: © Jag_cz/ShutterStock, Inc.; Steel texture: © Sharpshot/Dreamstime.com; Paper: © silver-john/Shutterstock, Inc.

Initiative 2

Enhance the personal and organizational accountability for health and safety throughout the fire service.

Header background: © Eky Studio/ShutterStock, Inc. ; Steel texture: © Sharpshot/Dreamstime.com

Introduction

Did you ever wonder what makes one fire department better than another? How can two fire departments that have similar equipment, finances, and response areas consistently come up with different results? Take two departments with a common border that even share some personnel, and yet they still operate differently. Why is it that some organizations just click and some do not, and why is it that some members might leave one organization for another? Words like *leadership* and *accountability* are often used to describe the difference. It's easy for members of a department with problems to play the "blame game." The fact is that a lack of accountability is one of the biggest complaints of employees in any profession, and firefighting is no exception. With so many employees in so many industries throwing out the "no accountability" flag, they must be onto something. So what exactly is accountability, and why is it so hard to find?

Accountability

Many times the words *accountability* and *responsibility* are used interchangeably. They are similar in meaning, but are actually quite different from each other. Say a fire chief has been given the order to reduce his operating budget by 20 percent for the remainder of the year. With this directive, he is now **responsible** to cut costs, which then makes him **accountable** to everyone involved; in other words, responsibility is assigned to you by a superior, which then makes you accountable to your superior, your subordinates, the general public, and even yourself. The fire chief has several ways he can accomplish the cuts and must make tough decisions based on his vision, opinions, and values. He may decide to cut staffing through attrition or layoffs. He may decide to close a fire station, combine companies, or delay the replacement of apparatus. Possibly the cuts will be made to maintenance, training, or fire prevention. No matter how he chooses to reduce

the budget, he is accountable to various persons and groups, often with differing perspectives and wishes. If he fails to cut the budget as ordered, the mayor will hold him accountable to the fact that he did not do his job. If the decisions he makes are unpopular with the fire fighters, the chief is accountable to them. If the fire department fails to respond to an emergency in a timely matter due to his decision to close a company or station, he is accountable to the public. Finally, he is most accountable to himself. Any decision he makes will have immediate effects on lives, and may even have unforeseen future results.

In this case, it would be very easy for the fire chief to claim that the city administration is actually responsible for the cuts. Although this would be an accurate statement because the mayor is responsible for balancing the budget, the mayor did not actually cancel the order on the new truck and decide to run Engine 33 into the ground. This is where the fire chief either exemplifies accountability or chooses the easy way out and plays the blame game. If he is truly accountable, he explains to his members that his decision was the best option at the time. He shows leadership by creating a team approach to making E-33 the best it can be. He asks for the fire fighters' suggestions and assistance in making the existing vehicle both safe and functional for another year or two. He also offers to do whatever he can to provide the resources they need to keep E-33 in a ready condition.

If the chief leads by example and stays accountable, his decision creates a succession of accountability. By explaining to the personnel that they would not be replacing the engine, the *responsibility* to make old E-33 ready to serve the citizens in a safe and efficient manner for a couple more years is issued to the officers, fire fighters, and maintenance crew. They are now *accountable* to make sure that it happens Figure 2-1. Imagine the feelings of a fire fighter who was on the truck replacement committee and helped write the specifications for new E-33. His natural reaction would be that all the work he did was wasted, and could become very bitter as a result. He could blame the fire chief for "not standing up to the mayor" and "making us drive an unsafe piece of junk." He may even be tempted to sabotage a component of the old truck just to prove his point. If he chooses this road, he essentially breaks the succession of accountability at the shift level and destroys accountability for everyone. Interestingly enough, a person like this that throws out the claim that the supervisor lacks accountability is usually the real person who is unaccountable. Intentionally sabotaging not only shows no ability to be accountable, but also demonstrates a destructive attitude and a potentially dangerous character flaw.

Figure 2-1 Older equipment does not necessarily mean unsafe equipment, but the maintenance may require more accountability.

The succession of accountability travels up the chain of command as well. If the mayor believes in accountability, she defends the fire chief for his decision to delay apparatus replacement; she does not blame the taxpayers, or even the economy, for a decrease in revenue. Accountability was a tribute that some politicians, such as President Harry S Truman, personified. He even had a plate made for his desk that said "The buck stops here,"[1] derived from the slang phrase of "passing the buck," which meant to blame someone else. Rather than passing blame, the quality of accountability instead looks at a problem and asks what "I" can do about the situation. Effective leaders look at a hurdle or a failure by evaluating all the causes of the situation or "breakdown," starting with their own contributions. The chain of command dictates that every boss is responsible for

every action initiated under his or her position, as discussed in the chapter, *Defining a Cultural Change*. Therefore, blaming a subordinate has no benefit.

Blame

Besides providing a great excuse, blaming someone or something has some nice side effects. Blame deflects faults or weaknesses, which in turn boosts egos. It makes some people feel better about making a mistake or having a poor performance because they can convince themselves that they were not at fault; rather, they can conclude that they were simply a victim of circumstance. For instance, one evening at work, you walk into the ambulance bay after dinner and see that your ambulance is parked outside. You know you left it inside earlier, but it appears your partner pulled it outside to clean the bay floor. It's getting late, so you decide to put it away. As you back into the bay, you feel resistance and hear a loud crash. When you get out and look up, you see the crushed bottom panel of the bay door wrapped around the light bar. Apparently the overhead door was not all the way up when you backed into it.

What is your first reaction? It is easy to blame your partner. After all, he put the ambulance outside and did not put it back. He left the door halfway down, just asking for someone to hit it. There may even be a policy he broke about doors being partially closed. He does it all the time, he never finishes anything. And where is he now while you are working? He's probably on the phone or asleep in a chair. Now that you think about it, the only thing that points to you at all is the fact that you did it. Maybe it's anger, maybe it's embarrassment, or maybe it's a fear of discipline. Whatever it is, it probably will lead to blame. By blaming someone else for the failure or loss, you essentially make yourself the victim. Some people enjoy being a victim, and rely on it for esteem issues. Some just use it to keep from becoming the villain. If you are able to convince others that you are the victim, they tend to look for and turn on the villain. Victims always receive more sympathy than villains.

One interesting aspect of this **victim syndrome** is specific exclusively to emergency services. It's a well-known fact that when call volume drops, so does morale. More than one chief has claimed that nothing cheers up fire fighters like a fire. It's not that fire fighters enjoy seeing someone lose their property; it's just that periods of inactivity tend to be breeding grounds for personnel issues. The biggest reason may be that fire fighters were trained and equipped to handle serious emergencies and that not much of recruit school is dedicated to odor investigations and fire alarms. When all they seem to get is "smells and bells" and there is a prolonged lack of significant calls, they feel underutilized and become disappointed. Having all the emergency equipment and gear may lead to the feeling of "all dressed up and no place to go." They may see nonemergency functions such as fire safety inspections or hydrant flow testing as "busywork" during these times.

Unfortunately, sometimes fire fighters just feed off each other negatively in slow times. It could begin with nitpicking and blaming between them, and potentially evolve into an all-out shift war. They might fight changes from administration and file complaints or grievances over situations with which others would not have a problem. They might blame their problems on the attitudes or training level of the new fire fighters joining and relish "the good old days." They could think the old apparatus was garbage and the new is built poorly by "low bid." Whatever the situation, they paint the picture of being constantly victimized by their coworkers, their shift captain, or the chief. Everything they discuss points the finger at someone or something else. It's not fair, and none of this would have ever happened back when they joined. Their audience is anyone who will listen, and the stories of how bad it is continue to get exaggerated each time they are told. You might actually think that things have gotten pretty bad in this department.

Compare this crew with one that makes a mistake on a call, such as the discussion in the chapter, *Defining a Cultural Change*, about Dave and Kelly working on Medic 36. Remember that they beat out hundreds of students and potential hires for their jobs and are essentially the cream of the crop. They passed tests and screenings most professions do not even use. What could make the two groups so

different? The answer is a lack of accountability. In this case, a lack of activity at work and some potentially bad attitudes have been fertilized, cultivated, and harvested into one bad situation. It may not be too late to save them. In fact, at the next major incident, they may actually shine and impress everyone. One theory at work here has to do with the human psyche and the victim syndrome. If the personality of an emergency services worker is caught in a victim syndrome cycle, then a conflict occurs when there is a real victim. During an emergency, responders automatically identify and help the victim. Because the victim role has already been filled, the emergency responder takes the role of hero. Victims receive attention, but heroes get more. That's why there is very little arguing and blame on emergency scenes. In fact, most emergency responders agree that personnel interact much better on scenes than back in quarters. You could say it's hard to be the victim when you are helping one. The only way to prevent blame from taking over is to make a genuine commitment to being personally accountable.

If a lack of serious calls is a problem, we can expect that it will be more prominent in the future. If you've been a fire fighter for some time and you feel that you do not respond to the number of fires you used to, you are correct. According to USFA and National Fire Protection Association (NFPA) statistics from 1986, fire departments responded to 11 million emergency calls, 19 percent of which were fires.[2] Throughout the next 25 years, there was a steady increase in emergency responses, yet a further decline in fires. In 2010, calls for service reached 28 million, but the number of fires dropped by 40 percent, making up a total of only 5 percent of all responses. The reduction in fires does not mean there should be a reduction in preparedness. Fire fighters must still be equipped and trained to handle incidents, and actively work to prevent them.

As a result, many departments look to expand services and improve the department's public image with new programs. Maybe the department begins offering residential fire inspections or door-to-door smoke detector tests. It could be reading a fire safety book to children at the library on Tuesday nights or performing blood pressure checks at the mall on Saturday mornings. Other departments plan for downtime by designing stations and assigning personnel based on a special skill or interest. A fire station may house self-contained breathing apparatus (SCBA) repair with all the necessary testing equipment and tools, while technicians on each shift are trained to make repairs. Other stations might have a wood shop, welding shop, or sewing shop. Sometimes pump testing pits or lakes are adjacent to stations to facilitate pump testing, while others have adjoining public education facilities, such as a safety village **Figure 2-2**. Besides the fact that members keep busy doing something they enjoy or even learning a new skill, a properly designed specialty shop can save the department money. Fire departments are commonly looking at new ideas to share resources and save money, and a specialty shop is a great way to do that on a regional basis. Even if the department does not offer specialty shops, the personalities of some people tend to focus their unused energy on other suitable projects. They might join a special team and devote slow times to that. A member who is active on the dive rescue team could spend Saturday afternoons on shift organizing the dive

Figure 2-2 Specialty shops such as pump testing facilities not only can save a department money, but also can keep fire fighters trained, active, and interested.

Courtesy of Bob Lloyd

trailer or inspecting dry suits. A person interested in the history of the fire department might spend downtime clipping old articles or researching the history of Station 2. Sometimes being involved simply means reading online articles of firefighting tactics or National Institute for Occupational Safety and Health (NIOSH) **line-of-duty death (LODD)** reports.

Safety

Is there something that interests you in your department that could keep you involved? Taking ownership of a project is a great way to practice personal accountability as well as improve your department.

Personal Accountability

The term **personal accountability** refers to the ability of an individual to take responsibility for the present situation and to react to the circumstances without attributing faults to other factors or people. In other words, you have the ability to account for all of your results. This definition points out several key components. The word *ability* infers that someone learned the art of personal accountability, much like learning other skills. The ability of an engine operator to estimate friction loss at 4 a.m. while supplying three handlines and a standpipe is not a God-given gift. An honest effort to become proficient at hydraulics is the only reason a pump operator can pull it off. For most, accountability makes hydraulics look like a piece of cake. Some could be simply born with it, but most would agree that being accountable is not the way most humans are wired. From childhood to adulthood, the typical response when something goes wrong is to pull out an excuse. Sometimes the defense mechanism blurts it out so fast that we do not even realize how ridiculous the excuse is until we hear ourselves say it. It takes a conscious effort to learn to put on the brakes and *not* to blame.

The technique is simple in theory, but it's difficult to master. Say you are a newly assigned fire fighter on a busy engine company. Your first 3 months have gone well, and your lieutenant is happy with your progress. One day you get dispatched second-due to a house fire in a two-and-a-half-story wood frame building from the 1930s. You pack up en route while Gene in the other jumpseat tells you to grab the line if needed and he will take the tools. Your engine is assigned to pull a backup line through the kitchen on the **Delta side**. After entry, it's clear that first due put a pretty good hit on the fire in an adjacent room and you hear the incident commander assign your lieutenant to change to overhaul operations. Your boss gives you vague instructions to retrieve more pike poles. He leaves the kitchen while Gene begins to pull ceiling. You start to lay the line down on the floor, but second-guess leaving it on the steps and in the doorway where someone could trip over it. You ask Gene what he thinks, and he tells you to pull it back out to the driveway.

As you return to the house with more tools, you are greeted by crews yelling and scrambling for a line. Gene apparently had opened up a hot spot that erupted into fire when it got oxygen. The fire is now visible in the kitchen windows and is working its way down the hall. You pick up the abandoned hoseline and feed it to fire fighters at the door who push the flames back. They extinguish the fire and account for all personnel. Your lieutenant exits the building visibly upset and heads right for you. He tears off his mask and gloves and begins to berate you in front of everyone, including the neighbors. With a generous use of choice adjectives and adverbs, he basically asks why the line was removed from the building. This is it. This is the point where the hair stands up on the back of your neck and blood rushes to your brain. You flash back to seeing your father holding a baseball by a broken window. You scan the scene for excuses and prepare your list: "It was a trip hazard, there was a line inside with the other crew, you did not tell me to leave the line there, I thought you wanted me to take it out when you told me to chase tools," and the big one—"*Gene* told me to." The ability to take responsibility is the first part of the definition of personal accountability. The act of not answering

with an excuse is an ability that can be learned and is a vital step in becoming accountable. If you had learned this technique, your first reaction would be to hold your tongue and investigate all the influences you had on the situation and its progression.

The second part of the definition worth noting is in regard to "taking responsibility for the situation." As you were being yelled at by your lieutenant in the driveway, it's hard not to defend yourself and keep your cool. Take a deep breath and start to prepare a mental list of how *you* could have been responsible for what just happened. After reviewing the facts:

1. *You* pulled the hoseline.
2. *You* were assigned another task, but were not told to remove the line from the house.
3. When they needed it and it was gone, it was because *you* put it in the driveway.

This is exactly how everyone else sees the facts, which is very similar to the old technique of trying to "put yourself in someone else's shoes." By looking at this list, you agree that it was at least partially your fault, but that there were contributing factors. Your lieutenant and partner should take some of the credit for the mistake. To prove it, you put together a list of contributing factors that include the following:

1. Not getting clear orders about what to do
2. Not anticipating the potential of fire spread during overhaul
3. Listening to Gene instead of your lieutenant

Sure, you could blame your supervisor for muddy orders, but it is up to you to ask for clarification. He knew what he meant when he said it. Similarly, nobody said Gene was the right person to ask. You chose to do that. Actually, if you look at each contributing factor, they too are your fault. Blaming anyone but yourself for what happened is wrong. Therefore, the first words out of your mouth would consist of an apology, followed by an explanation of misunderstanding the orders, capped off by an honest promise to learn from the event to ensure that it never happens again. Not blaming someone or something else is not necessarily "jumping on the hand grenade" and taking blame for something you did not do.

Safety

Think back to the last time you were blamed for something, or blamed someone else for something that happened to you. Consider the facts and the contributing factors from the event to identify ways you can improve your ability to maintain accountability.

A **postincident critique,** or after action review (AAR), at the fire station should be used to explain all the reasons for your actions without blaming anyone. If Gene and your lieutenant are both accountable, they will offer their responsibility as well. The training that could come out of a situation like this is that your lieutenant will do a better job of communicating orders and you will ensure clarification. It could evolve into discussions of manned hoselines being present during overhaul and ways to reduce trip hazards at fire scenes. If you really commit to getting better at personal accountability, it's amazing (and entertaining) how many times you notice others blaming their circumstances on other people or even inanimate objects. We all end up in situations we would rather not be in. The situation can be uncomfortable, embarrassing, or even downright horrifying. Regardless of the circumstances, personal accountability can work.

Examples of personal accountability, both good and bad, are found every day in professional sports. In no other occupation is a person's performance at work under such a public microscope than in sports. Players are constantly compared to their peers, and even ranked by their strong points and weak points. Baseball even keeps track of mistakes in the form of errors committed by a fielder. Imagine for a minute the levels of this accountability being subjected to fire fighters. Take the greatest published fire officers of all time: Bowman, Norman, Carter, Mittendorf, Brunacini, and Dodson. Picture them lined up in their Class A uniforms sitting behind a wide desk with bright lights on them and cameras rolling. They

replay your performance at a structure fire last night in slow motion and question why your chief is even "playing" you. Everyone sees the replay on the news of you lapping the aerial twice, opening every compartment door looking for a salvage cover. "Nope, still not there," they joke. They talk about how you lost your temper and threw your helmet in the locker room after the fire. They point out that you're usually the last one to drill and the first to sneak off, and it's showing in your performance every week. Imagine your mayor reading the reports in the paper about your waning performance: 2 for 12 on successful intubations, or three backing accidents in the past 14 months! Maybe the citizens even call in and say you are a washed-up has-been. "Trade him before he gets promoted," they write.

Safety

Take a minute and consider the influence that cell phone pictures and videos, combined with social media, can have on your personal performance review. You may be so involved in pulling the hoseline, bagging the patient, or yelling at the crowd to "get back" that you do not even notice that you are being recorded from several different angles. Since the potential exists for you to be a movie star, the only way to perform well is practice, practice, practice.

It may be a little unconventional to even imagine it, but luckily we are not subjected to this level of public scrutiny. It is clear that athletes are held accountable to the public for their achievements and actions both on and off the field. Whether the player is truly accountable or not is another subject. In his autobiography, *Get in the Game: 8 Elements of Perseverance that Make the Difference*,[3] Hall of Famer Cal Ripken, Jr. reinforces the importance of personal accountability as he tells a story from his career. He was thrown out of a game in the first inning for arguing with an umpire. He later found out that a fan had brought his young son all the way to Baltimore to see his favorite baseball player play, but never saw him take one swing. The boy was heartbroken, and the press ran with the story. Cal felt horrible. He began evaluating what was important to him and where he needed to improve. He settled in on the subject of personal accountability. A short time later he was playing a game in Toronto. As he took the field in pregame warm-ups, he noticed the sod where he played shortstop was raised up to a hump. Apparently the irrigation or drainage system had leaked the night before and froze under the turf. His first thought was to complain to the umpires and groundskeepers. He could have chosen to ask them to delay the game to fix the field or he could have used it as an excuse if he had a bad game. Instead, he chose to suck it up and play a couple feet in from his normal spot, making the most of it. He decided he was not going to allow outside circumstances to affect his performance. He played that game without a complaint and went on to continue playing every game for the record of most consecutive games played in the history of professional baseball.

If only everyone involved in sports was so accountable. When confronted about their performance, many players blame their teammates or the coaching staff. Some players complain that they are carrying the team or not getting the play time they deserve. The referees or umpires are always wrong. When a player is called for a penalty, most deny it ever happened or complain that it was actually someone else's fault. Even with proof on instant replay, some continue to argue. Not many players who test positive for performance-enhancing drugs come clean with their fans. It's usually blamed on vitamins, herbs, allergies, or some sort of interaction from something a trainer gave them. Some teams blame a losing season on injuries or on an unfair schedule. Some owners blame it on an old stadium and move the team to another city. Coaches blame it on poor farm teams, draft picks, or even opposing fans. Sometimes it's a salary cap, or outdated league rules. Even when they seem to take a little

accountability, they use obviously vague phrases that show no accountability like "we failed to execute" or "we were not mentally prepared."

Personal Accountability in Leadership

People in leadership positions have even a greater need for accountability. How many times have you noted a popular politician, movie star, church leader, or public safety official plummet in disgrace as the result of a scandal? Many sources suggest that as people work their way higher in an organization, the hard work and accountability to get there has been replaced by an entitlement once they arrive. In his book, *Why Great Men Fall,* author Wayde Goodall theorizes that the failure of leaders is not necessarily one big misstep, but rather a series of temptations that eventually are reasoned as a privilege.[4] In his farewell speech, Senator John Ensign apologized for his actions that came easily with "more power and prestige."[5] Many leaders that ignore personal accountability when they are successful make poor moral decisions, yet carry on with their business as though nothing happened. Eventually, the behavior catches up, and the leader is forced to give up everything that was earned.

As a result, emergency workers must realize that although personal accountability is a tough skill to master, promotions will only make it tougher to maintain. A fire fighter who works his or her way up through the ranks to a chief position will find that it might be easier to come in late, take a longer lunch, or leave a little earlier at the end of the day. Failing to meet minimum training requirements might be rationalized as less relevant than completing administrative duties. Unfortunately, this example also can carry over to accountability for safety. Many agencies can provide pictures of emergency scenes where an officer is not wearing proper personal protective equipment (PPE). Maybe they reasoned that they were only entering the hazard zone to "take a look," or that they were not "actively involved" in the incident so their risks were lower. All members must learn ways to improve personal accountability for health and safety regardless of rank.

Improving Personal Accountability

Improving personal accountability is key to eliminating blame and ultimately improving safety. There are several ways to help achieve accountability, including making the decision to be accountable, becoming an active member of your department, speaking up, taking responsibility for the outcome of calls, and taking responsibility for safety.

Make the Decision to Be Accountable

The first thing to remember about personal accountability is it's a personal decision—you cannot force it on others or take it on with half interest. Changing may not even be noticed by others right away. It could be considered an internal struggle, trying to break free of the addiction of blame. It takes determination to make it work, just like a choice to eat healthier or exercise more. The most important point is that there is nobody stopping you from making the change, and anyone can do it. Some think you have to be an optimist to achieve accountability. Although the argument could be made that it might make learning accountability easier, it's certainly not necessary. Imagine a fire fighter hits a mailbox while backing up a pumper. An optimist looks at the damage and notes that it was better than backing into someone's car. An accountable person looks at how he or she is responsible for the crash and vows to put mechanisms in place to prevent future backing incidents.

A great example of a decision to become personally accountable for health and safety is a commitment to being healthy (Initiative 6). Personal accountability can strengthen the desire to make conscious decisions to improve your own health.

Although it's not possible to change someone else's lifestyle, you can make alterations to your own and encourage others to eat healthier and to exercise. A person who does not know how to operate a treadmill has little effect on improving the health behaviors of others.

Safety

Senator Ensign suggests that leaders can enhance their ability to maintain accountability by surrounding themselves "with people who will be honest with you about who you really are or what you are becoming." Since officers may have trouble noticing a change, it's vital that they are ready for it and use colleagues or family members to maintain an awareness for them.

Figure 2-3 Staying involved in your organization can help improve accountability.

Courtesy of Lt. Rob Gandee

Become an Active Member of Your Department

One obvious way to improve your accountability is to practice by being an active member of your department. By being an active participant in change, you can make the department better and work on accountability at the same time. Someone who "does eight and hits the gate" or "does 24 and hits the door" with only the bare minimum while on duty is likely to circumvent opportunities to be accountable. Volunteers can choose to be more active or can just meet the minimum requirements. You could say that being involved puts you in a position to practice accountability Figure 2-3. Whether it's a promotion or involvement with a committee, everyone tends to keep an eye on the one who is attempting to make a change. It could be that they support the change or that they are truly worried about how the change might affect them. Maybe they just like to root for the underdog. For whatever the reason, you have their attention. Adopting personal accountability has some great motivational affects on others that witness it. As discussed in the chapter *Defining a Cultural Change*, some embrace change, especially if there is success.

Suppose you are a lieutenant assigned to the training division and you want to work on implementing Initiative 1 in your department. With a broad goal of putting fire fighter safety first in a true **safety culture**, you decide that the first step is to involve all of management in your safety training programs. By having chief officers actually assist with training, you can show the department's commitment to changing the culture and increase member buy-in. Your first meeting with the chief goes well, and she seems somewhat interested in teaching the drill. She asks you to put together an outline for the presentation on what you envision. You leave the meeting excited, and even tell others about the plan. Most of them tell you that you are wasting your time, and that nothing will come of it. Undeterred, you check out the **Everyone Goes Home (EGH)** website and download a great safety culture lesson plan. It's full of examples from new equipment to sample standard operating procedures (SOPs). It even has video scenarios for group discussions that should fit your department nicely. You transform it into a slide presentation, complete with pictures of your

apparatus and personnel, and lay out the department's safety plan. You make a copy for the chief and set up a time to go over it with her. It does not take long for you to notice that she is less than impressed with your lesson.

It turns out that some of your plans are a little more drastic than what she envisioned. She feels safety is a subject that has more to do with fire fighters' attitudes and actions, and less about increased funding. She believes that if existing SOPs were followed, a safety culture would already exist. She wants to keep fire fighters safe at fire scenes, but she does not believe a change in policy is necessary. For instance, your suggestions about **risk management** and rapid intervention teams would involve commitments she does not agree with. You realize that some of her points are valid, but that there does not appear to be any improvements she would be willing to make in administration or operations. She tells you what she wants removed from the program and sends you back to the drawing board. As you walk back to your office dejected, you try to take in all that she said and figure out what can be salvaged with the drill. Even more difficult is how you could possibly remain accountable in this situation.

It appears as though your marching orders are clear. She outlined what the lesson plan would include and what it would not. You have been given the responsibility and are therefore now accountable for designing the lesson plan she wants. It would be easy to throw the project down and say forget it. It might be tempting to use sabotage and set the presentation up in a way to embarrass the chief. You might consider talking to the fire fighters ahead of time and giving them ammunition for arguments when she tries to present it. It's easy to blame the chief for not wanting to change her old-fashioned ways or not really caring about the safety of her crews. But accountability does not allow you to follow the easy paths. The fact is, the drill could still be a success, and could very well be the first step in defining the safety culture in your department that you desire. Do not throw out your original presentation. Look at it as the second or third step in the progression that you can use in the future. Personal accountability does not blame the chief's opinion—it considers the impact *you* had on the failure of her approving the proposal. In other words, maybe it was a little too drastic. Maybe your idea of what the drill would be was never what she saw. It could be that your presentation would have actually pushed fire fighters away, and they simply were not ready for that big of a change yet. It's time to pick up the pieces, start over, and create a presentation that will meet the expectations of the chief, as well as be acceptable to you.

Speak Up

Another way to improve personal accountability is to speak up if you see something that does not make sense or is just plain wrong. Allowing a questionable activity to continue just because it has always been that way does not make it acceptable **Figure 2-4**. Ambulances regularly exchange linens at hospitals, including towels, sheets, and blankets. Everyone agrees that the intention of the service is to exchange dirty linens for clean after they are used during an

Figure 2-4 Speaking up when something is not right should be encouraged in every fire and emergency service organization.

Courtesy of Lt. Rob Gandee

emergency medical services (EMS) call. Most emergency medical technicians (EMTs) and paramedics feel that using hospital towels to decontaminate the inside of the ambulance after a call is also an appropriate use of linens. Some feel that keeping towels at the station to wash the ambulance exterior is acceptable, and others think sleeping on hospital sheets while on duty is permissible. A select few think it's okay to take hospital linens home with them for personal use. So what exactly is acceptable use of hospital linens? Morals and opinions guide us in everyday decisions, but personal accountability is what holds us to what we do or do not do. If personal accountability was easy, we would all be doing it. That is precisely why we have to practice accountability.

Take Responsibility for the Outcome of Calls

Another way we can improve our personal accountability is to actually take responsibility for the outcome of the emergency calls we respond to. We have always taken the approach that we did not create the emergency and that buildings will continue to burn down and people will die despite our best efforts. These are true statements, and we have to realize that we are not here to change the world. However, it's difficult to make an argument for personal accountability and then dismiss the most important component of our job as "out of our control." It's true that deciding when personal accountability can be applied is directly tied to the amount of control we have over a specific situation. Fire and emergency services have three specific components of an emergency that we deal with that dictate how much control we have over them. They are uncontrollable, semicontrollable, and controllable components.

Uncontrollable Components

Emergency calls are initially uncontrollable. If a man has a diabetic emergency while driving and ends up parking his Buick on a crowd at a street fair, there's not much we can do about it. That's why fire and emergency responders will never "prevent" themselves out of a job.

Semicontrollable Components

Immediate response to the pedestrians struck is partially controllable. There are various ways our actions prior to the incident could change the outcome. We may have influenced getting enhanced 911 in the town. We could have taught first aid classes and pushed to have automated external defibrillators (AEDs) at public events. We may have met with the festival committee and ensured there were good maps for us and that fire lanes were kept open. We have worked in the past with the police who arrive on scene before us, and they give us the information we need to make decisions.

Controllable Components

Based on dispatch and police reports, we call for extra equipment. We pick our route to the call, and decide on the speed and style of our driving. Training has taught us how to rapidly triage and handle a mass-casualty incident. In no time, we have all the manpower, ambulances, and helicopters we need to give the best possible medical care.

Take Responsibility for Safety

The safety aspect of situations follows the same model as the outcome of calls. We do not have much influence over safety when the emergency occurs. Our influence on safety increases when we are responding, and is entirely our responsibility when we get on scene. That's because if we examine emergency calls, we discover that they are not a single event waiting for us to arrive and take command of; they are actually a progression of foreseeable and unforeseeable independent events. At any point during this dynamic process we can make a conscious decision to act or not act in a specific manner that either changes or does not change the outcome. Even on significant incidents where numerous emergency responders converge, a decision for personal accountability has an influence on the potential outcomes of the incident.

Personal Accountability to Safety

The first component we must look at is our accountability to safety: for us, our crew, our victim, and the general public. Taking responsibility for our own safety is the main component of a safety culture. If we remain uninjured on the scene, we can continue to be a resource rather than another liability. Our seat belt, our hood, and our crew integrity are our concerns. Without personal accountability to safety, the incident is destined to have a bad outcome. Everyone is responsible for safety.

Personal Accountability to Training

Nothing affects the outcome of an emergency call more than how prepared we are for it. This can be evident in both common and rare emergencies. For example, passenger train derailments are not necessarily a common occurrence for emergency responders. Even if we have rail service through our community, chances are that most responders will never work on a derailment. Even so, knowing the location of fuel shutoffs and being aware of the existence of high-voltage power and extrication techniques are important. Practice is the only way to perform effectively for the rare occurrence of high-risk incidents. Just as important are the everyday events we respond to. Lack of training on the common occurrences leads to bad habits, the use of antiquated techniques, complacency, and, often, injuries. The old adage "If you don't use it, you lose it" applies to emergency responders. Training reinforces our actions and knowledge of how to handle a given situation, and how to improvise when we have never seen it before. Without training, we are forced to improvise every day. A well-trained responder has a distinct effect on the outcome of a call.

Personal Accountability to Equipment

Improving equipment is one of the most obvious ways to improve the outcome of emergency events. The availability of gas meters, thermal imagers, and 12-lead electrocardiogram (ECG) monitors has allowed responders to improve the quality of the job performed. This could be by doing our job quicker, more safely, or by saving more lives and property. Being aware of what new equipment is on the horizon and persuading those capable of providing the equipment to do so is everyone's job. Some choose to simply complain about outdated or lacking equipment rather than solving the problem. There's no argument that AEDs on all emergency response vehicles save lives; it's just a matter of figuring out how to pay for them.

Safety

Furthering your knowledge through training and education may be the best way to improve your personal accountability for safety. Whether it's department sponsored drills or individual studies, continual learning about your job will ultimately make you and your crew safer.

Personal Accountability to Services

If we never improve our level of service, we remain stagnant. We must be cognizant of what needs evolve in our jurisdiction and how the rest of the industry is reacting to their needs. We must reevaluate what we do and how we do it, and make appropriate alterations in our techniques. Much like lobbying for better equipment, we must also lobby for improved services.

Personal Accountability to the Organization

By increasing our personal accountability, we motivate others to come up to our level. This is already evidenced by groups of emergency responders who seem to be more proficient and act as a team better than others.

Organizational Accountability

The next logical progression in improvement from personal accountability is organizational accountability. **Organizational accountability** involves everyone working together to achieve the vision and mission of the organization. In addition to the need for personal accountability, consider the various aspects of a safety culture and the advantages of no-fault management (NFM). We discussed blame, and how it's easy to use it as an excuse when things go sour. Now meld these theories together and see what they look like in a work environment with organizational accountability. Remember when you were putting the ambulance away after your partner left it outside and you smashed the bay door? The following is what that situation would be like with the safety culture model we have been developing.

When you get out of the ambulance and realize you broke the door, your first thought is not fear that you are in trouble, but rather fear that you may not be available to respond to an emergency call. You feel disgusted it happened, but because of NFM, you do not blame your partner. Instead, you remain accountable. When your coworkers come out to see what the noise was and ask what happened, you simply respond, "I backed into the door." Your coworkers ensure that the ambulance is safe to keep in service, and the door is bandaged up. Statements by you and your partner concentrate on the contributing factors to the failure, as opposed to who is at fault. NFM forces the involved parties to identify system failures. System failures in this example are communication, policies, and procedures. By being involved in the investigation, you and your partner decide the first step in preventing future incidents is better communication. Besides discussing things such as moving the vehicle, you recall times in which equipment was forgotten at a residence or the hospital and agree that communication can be improved in several areas. You even talk about putting these ideas into a communications drill for the entire district. You ensure there is a policy about doors that are all the way open or all the way closed to prevent future accidents, and look at an electronic system that opens the door all the way if it is left partially closed for a certain amount of time. You even talk about suggesting a walk-around policy to administration and you both agree to back each other in it when possible.

Some might consider these theories of discipline as ridiculous and the equivalent of a "time-out for adults." The fact remains that you are a highly trained, valuable professional who made a stupid move when you backed through a door that was not fully open. It was an expensive mistake with the potential for injury, but really no more of a mistake than forgetting an axe at the scene of a structure fire or dropping a gas detector into a manhole. You are human, and humans will always make mistakes. You did not intend to do it, and wish it never had happened. In fact, the chance that you ever will do it again is slim, whether or not you receive any form of discipline.

Following the traditional method of discipline, you would be written up and the letter would be put in your file. It's actually just a slap on the wrist compared to how embarrassed you feel already. In fact, the only organizational benefit to writing you up for an incident like this is a paper trail to keep track of those who have a pattern of poor decision making. If that's a concern for the organization, they can always file the investigation report rather than a letter of discipline. The paper trail is not very accurate anyway; very rarely do near-misses make it to a personnel file, because most of the time they are not reported. You may have been the one who hit the door this time, but other people have just been lucky.

On the other hand, the benefits of NFM to instituting a safety culture are very effective. Rather than hiding from the facts, the members are directly involved in the solution, and thus prevent future incidents. Critiques or AARs should occur after department incidents, just as they do for emergency incidents. There should never be blame, only

findings of what happened and how to prevent it from happening again. Nobody got hurt this time, but the next accident that was prevented by exposing the contributing factors may very well save a life. Because the members were less involved in pinning blame on each other, morale was improved. Teamwork was encouraged throughout the fact-finding investigation and solution-developing process. Finally, identifying and eliminating contributing factors affects an entirely different realm of accidents that have nothing to do with bay doors. The discussion you and your partner had about communication and avoiding leaving equipment at the hospital or patient's home may have resulted in a district-wide communications and accountability drill. That training may spark the interest of members who would apply the skills to other aspects of their job. Once the predominant trait of the members is personal accountability, the scales tip and the department cannot resist becoming accountable. Personal accountability takes time, but organizational accountability is suddenly an overnight success.

By mixing personal accountability and successful management techniques, an organization can grow exponentially. Organizational accountability has less to do with individual job responsibilities and more to do with the overall picture. Breaks in communication, however, can lead to failure. For example, say you are a fire fighter on an engine company that responds to a fire in a small bungalow and arrives second-in. The family is safe outside, and the first-in engine crew is upstairs fighting a room and contents fire. Your lieutenant receives the order to stand by "on deck" at the front porch to relieve the upstairs crew if they run out of air or need anything. You look in the front window and see a neatly kept house with surprisingly nice furniture in the living room. There are numerous pictures on the walls, as well as statues and various pieces of art amid the white and gold-trimmed furniture. There are no signs of fire extension, smoke, or water in the area, but you can hear the handline operating upstairs and figure that it's only a matter of time before dirty water works its way down. Your lieutenant points to the now sagging ceiling and asks you how long you think it will be before it breaks through. You ask if he wants some salvage covers so you can make a water chute out the window or collect some of the belongings and move them to the garage. He denies your request, explaining that you were assigned to stand by for relief of the crew upstairs, not to perform salvage operations. Freelancing is not permitted on the fireground and will not be tolerated.

Our fire service culture has done a great job over the years of creating rules in an effort to make a safer scene and more efficient operations. One of the biggest obstacles to creating organizational accountability or establishing a safety culture is that some of these improvements seem to fly in the face of established rules. There is no doubt that freelancing is an unsafe practice that cannot be tolerated on a fire scene. However, the order to stand by was given by someone who may not have all the information. If this situation had been part of a "skull session" in a training room, the assistant chief who is incident commander, your lieutenant who is assigned to stand by, the lieutenant who is upstairs fighting the fire, and even the viewers watching at home would say grab the pictures or a salvage cover. The department mission statement probably alludes to something about protecting lives and property (if a life is not an issue, save the property). With personal accountability, the crew standing by sees the events unfolding and forecasts that a bunch of valuables are going to be trashed in a matter of minutes unless they act now. If the lieutenant was personally accountable, he would forward the newly discovered information to the incident commander, who could then make an informed decision. The incident commander may see from his vantage point that the fire is spreading and that he may need the backup crew to ignore salvage and pull another line. At least he will have all the information he needs. Again, the biggest mistake that

can be made in NFM is failure to communicate a potential problem.

It's interesting that the developers of the 16 Life Safety Initiatives put culture changes and accountability right up front when it comes to saving fire fighters' lives. So many times we blame the trusses or the lack of the seat belt as the cause of our problems. What we forget—or simply ignore in some cases—is that by the time the trusses are collapsing or the seat belt is needed, we have already had several failures in the system Figure 2-5. Author Dave Dodson has said that structural firefighting gear is the last line of defense for a fire fighter. This means that we cannot blame a burn injury on failure of the gear, as several failures have already allowed a fire fighter in the gear to get to the point of it being tested. In other words, the events that lead to an injury or death are usually a failure in both accountability and lack of a safety culture. Before we can even think about risk management or situational awareness at emergency incidents, our organizational accountability for health and safety must be shored up. By taking what we've learned about personal and organizational accountability, we can now apply them to health and safety.

Figure 2-5 Many times we view undesirable events as the failure of a component, when the root cause can be traced to accountability.

Courtesy of John Kloski

Health and Safety Accountability

For an organization to implement accountability in health and safety, it should already be proficient in the practices of personal and organizational accountability. It's an ongoing process that eventually works its way into every aspect of the operations of an emergency services organization.

NFPA 1500

NFPA 1500, *The Standard for Fire Department Health and Safety*,[6] is a great reference and standard for where we should be. Although many departments cannot financially meet all the components of the standard, several sections can be applied to everyone. Many departments use NFPA 1500 as a guide to making continuous improvements.

The standard comes with a checklist so that a fire department can establish where it stands with regard to compliance. Many significant steps can be taken toward compliance without spending additional money. There are also several components that have become commonplace. One standard referenced is NFPA 1403, *The Live Fire Training Standard*. There literally is no excuse for not complying completely with this standard. A fire chief may not "choose" a budget reduction that does not include annual physicals for each member, but they certainly can "choose" to not use live victims and gasoline in an abandoned house used for live fire training. Once the checklist has been completed, a list of noncompliant items out of NFPA 1500 can be assembled in one of three different categories: (1) those that require no effort, (2) those that require some effort, and (3) those that require long-term planning.

No Effort

These changes will have no impact on the budget of the department, and will not have a significant effect on operations. They can be completed quickly and with

little effort. An example is the section (6.2) regarding apparatus drivers and operators. By simply combining some outdated policies, adding a couple new ones on apparatus operation, and establishing a better training program, the department becomes compliant.

Some Effort

Chances are that you will come across a section that will take a little more work. Breathing air compliance might be a good example. You may already have your airpacks bench tested annually and ensure that bottles are hydrostatically tested when due. However, your department just cannot swing buying a fit test machine (7.12). Your efforts might work toward saving money to buy the needed equipment, hiring an outside company to complete the testing for you, or purchasing the equipment on a regional basis.

Long-Term Planning

Other elements of the checklist are far more difficult. For instance, your dispatch center might be shared with the village police department and be quite antiquated. It may even be controlled by the police department. Section 8.1.9 cross-references dispatch and communications systems to be compliant with NFPA 1561 and NFPA 1221. For the low introductory rate of several million dollars, you could bring your dispatch center up to the standards and comply with both. It's obvious that you may never see compliance with this section. Instead, it is important to relay the deficiencies to the police chief and village council while concentrating on smaller components of 1561 and 1221.

Each section in NFPA 1500 has the capability of saving lives. Each should be used as a safety culture reference that assists fire departments in achieving their goals. Section 4.5 is one of the most important when it comes to health and safety accountability. By creating an occupational safety and health committee that meets regularly, you preload the organization for accountability. Safety committees are an open forum to bring in concerns as well as to work toward compliance with NFPA 1500. If an issue is brought up in this environment, accountability prevents blame from taking over and forces the members to address the concern from each level. For instance, assume you are a member of your department's safety committee, along with members representing various ranks. Someone brings up an issue of loose contaminated IV needles in EMS jump kits on the engines. Apparently the EMS bags contain a sharps container for collecting used needles from EMS scenes in one pouch of the bag. Dirty needles were found outside the container but still in the pouch, either from carelessness or the fact that the pouch is much bigger than the sharps container. The problem is that a loose needle could pierce the bag, exposing a member to pathogens. Accountability forces each rank to take responsibility for the loose needles. Paramedics must ensure proper disposal, while fire fighters carefully check the bag each day. Line officers work on better plans for needle disposal by providing separate sharps containers or ones attached outside the bag. Training increases the crew's knowledge of the flaw in the system while staff officers put out safety bulletins. The safety committee lays out a plan with a deadline to fix the problem and promptly reports the condition as a near-miss (Initiative 9).

Safety

Creating a safety committee should be the first step to complying with NFPA 1500. The committee is defined in the standard, and the committee is charged with the responsibility of evaluating their department against the standard. A properly assembled committee that meets regularly will have a profound effect on organizational accountability as well as safety.

Rating Your Department

Organizational accountability can also be evaluated through the use of rating systems. They can be effective in monitoring the progress of an organization in achieving goals. Additionally, organizations that receive a good rating tend to take pride in it. One of

the problems with the evaluation of the fire service, and safety in general, is that our main rating system achieves the goals of the insurance industry rather than our own.

Insurance Services Office

The most identifiable measure used by the fire service is the **Insurance Services Office (ISO) Fire Suppression Rating System (FSRS) Public Protection Classification (PPC)**. This number is assigned to fire departments by a fire insurance industry organization that rates their fire suppression capabilities based on several components, including manpower, equipment, and water supply. Theoretically, a department that has a PPC of 5 would protect the insurer's investment more effectively than a department with a 6 rating; therefore, many departments devote significant resources to drop their PPC and thus the insurance rates for their community. This third-party rating has a significant impact on both public and political awareness of what the department has and what it needs. Sometimes ISO ratings convince governmental boards of the need for increased funding. For instance, their suggestions may lead to an increase in staffing or construction of a second station, something the fire chief may have been fighting to get for years. Other times they put up a strong argument for a piece of apparatus such as an aerial ladder.

Unfortunately, ISO grading schedules have very little to do with a department's accountability to health and safety. The scoring system[7] is not always indicative of specialized equipment that some departments need for their local hazards, such as radiological monitoring equipment. They do not consider the strength of command and control at emergency scenes (safety officer or SOPs), national standards like the National Incident Management System (NIMS), or specific safety procedures (personnel accountability reports). Although they do take into account training hours and time of day, subjects get less attention. Some of the hottest training topics in firefighting these days are related to fire fighter safety and survival, rapid intervention, air management, situational awareness, and risk management. Teaching subjects like these means nothing to the rating system compared to a having a drill tower behind the station that may not even be used. An ISO rating for a community is a fire insurance industry standard, not a fire department standard. The PPC should be a tool to measure cost-effectiveness related to an investment in fire protection (e.g., "An annual investment of an additional 15 percent of the fire department's budget would reduce the average commercial property insurance rate by 12 percent."). Although some fire departments are proud of their PPC rating, other industries might have more to be proud of from their rating systems.

International Organization for Standardization

The familiar **International Organization for Standardization (ISO)** creates standards for industry that can be used worldwide. This ISO[8] is based in Geneva, Switzerland, and serves 162 countries. Much like NFPA, once a need is identified, a technical committee takes suggestions for the standard and develops drafts, which undergo revisions until they eventually become standards. The advantage for a business is that when a component supplier for a manufacturer is certified in a certain standard, you can trust that their systems are effective. You probably have seen an ISO 9001 flag flying over a business in an industrial area. The flag simply makes a statement of accomplishment—in this case, it's one for quality management Figure 2-6. ISO has hundreds of standards, and it's apparent by their standards under development that the hottest topics for them are in the medical fields. Although ISO creates the standards, they do not "certify" compliance. Companies that wish to claim they are certified can hire an outside third party to certify them, or simply use the guidelines and complete an in-house audit. The company claiming to be ISO registered or compliant maintains records in case someone disputes their claim or an issue surfaces. This desire for organizational accountability is obvious by every company that flies the ISO flag. Is it possible the same theory could have a place in the fire service?

Figure 2-6 An ISO flag is a common way for industry to show the world they are accountable.

FLSI 16 Safety Rating

A campaign is under way to create a more effective rating for the fire service. Similar to the ISO 9001 program, a **Fire and Life Safety Initiatives (FLSI 16)** registry would allow departments to display their organizational accountability based on meeting specific safety criteria, including adoption of the 16 life safety initiatives. A registered department would also have to complete specific components of NFPA 1500. The advantages of having such a system are twofold.

Besides the dedication to a safety environment that is both measurable and achievable, the rating system could be a source of tradition and pride in the fire service. Until now, the best way for a department to judge itself was with the ISO PPC. Many times the number was painted on the side of their apparatus or printed on their department letterhead. As discussed earlier, the ISO PPC is not necessarily the best way to rate ourselves. Just like the machine shop in the industrial park flying the "ISO 9001 Registered" flag, fire and emergency services would be able to fly the "FLSI 16" flag.

Safety

Creating an FLSI 16 rating system would be beneficial to Initiative 2, but equally to Initiative 10, "*Grant programs should support the implementation of safe practices, and/or mandate safe practices as an eligibility requirement.*" By requiring departments to be registered as FLSI 16 compliant to be eligible to receive funds, the National Fallen Firefighters Foundation (NFFF) can design a best-practices system that can be changed as needed. An online list of criteria and registered department could easily be maintained.

Successful Implementation

In order for organizational accountability to health and safety to successfully take root in fire departments, it must be established continually throughout every aspect of the fire service. These include recruit schools and fire academies, fire fighter orientation, daily operations, promotional exams, training, and effective emergency scenes.

Recruit Schools and Fire Academies

Textbooks must be written from a safety culture's viewpoint. Rather than devoting a chapter or a sidebar to safety, it must be mixed into the lessons. For instance, donning eye and hearing protection is actually one of the steps to starting a chainsaw, rather than a so-called safety tip. Rookies need to know how to address safety concerns with a supervisor without appearing insubordinate (Initiative 4). Practical applications must design safety into the skills. Instructors should be trained to the technician level in safety systems and ensure that evolutions are done under strict compliance to standards. Even testing situations should comprise a fair amount of safety questions, including scenarios in which they must make task-level decisions based on risk analysis.

Fire Fighter Orientation

Once a fire fighter completes basic training, safety should be continued through orientation and probationary periods. The candidate's commitment to safety should be included in written evaluations. Although most evaluations have only one or two lines about the person's attitude toward safety, it should be an entire section that covers the expectations for specific aspects of personal accountability and learning the safety culture. Physical training and healthy lifestyles must also be part of the fire fighter's orientation.

Daily Operations

Whether a fire fighter is a volunteer who enters the fire station once a week or an employee who walks in every day, the safety culture must be applied religiously. Using personal accountability as a stepping stone, constant effort must be put forth until safety is a normal part of daily operations. Safety practices range from using ladders to change light bulbs in the station to using power tools to fix a broom bracket on the wall. Safety in the fire station leads to safety on the fireground. Time set aside daily for physical activity must be encouraged. Whether it is time in the weight room or time spent in group activities, maintaining a healthy, active lifestyle must be lived every day.

Promotional Exams

If an organization is truly operating under a safety culture, they will not promote anyone that does not have personal accountability to safety. Promotional exams must include reading material and testing situations involving safety information as well as scenarios to ensure that the leaders of the organization understand the importance of safety systems

Training

Drills are no exception and must follow the same safety culture aspects. Far too many fire fighters are injured or killed every year in training accidents. This may be because we tend to be less cautious in nonemergency situations where there is less apparent danger. More importantly, we tend to work like we train and we need to work safely. Trainings should mimic firefighting skills as much as possible—for instance, it does no good to simulate roof ventilation without having full gear and SCBA in place. The body has to be seasoned to increased temperatures in firefighting gear on a regular basis to be ready for fire scenes.

Effective Emergency Scenes

Emergency scenes are where the rubber meets the road, and the results of a safety culture pay off. After a high-stress emergency call, responders sometimes claim that they really did not think about what to do or how to do it. They say they did not really think about the danger either—they just did what needed to be done, what they were trained to do. If we have spent our nonemergency time practicing a culture of safety, when the emergency does come, then safety is already second nature. Take running a chainsaw, for instance. If safety glasses are an afterthought at the station, you will not remember them at an emergency when stress levels are up. The best way to perform emergency scene duties safely is to not know how to perform them unsafely.

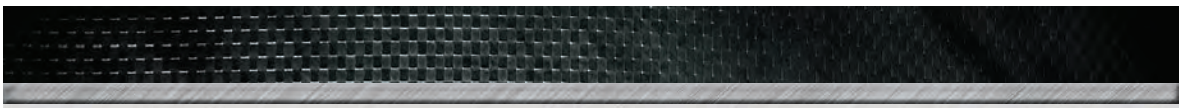
Learning the aspects of personal accountability is a skill needed to develop a safety culture, as well as to grow as a person. Looking back on your best mentors, teachers, or leaders, you will see aspects of personal accountability. Likewise, if you ever worked for a great company, department, or division, you probably saw what organizational accountability looks like. Because these people and organizations are led by human decisions, even the best will trip up occasionally. Virtually every time this happens, lack of accountability is at the root. If it happens, simply recognize it for what it is, pick yourself up, and take responsibility. These attributes are vital if fire and emergency services are going to be truly accountable for health and safety.

Conclusion

Enhancing accountability is an effective way to improve safety, and starts with *you* in the form of personal accountability. Decisions you make every day not only can make your job more productive and safer, but can even raise your job satisfaction. Some people might be unaware of the importance of accountability, and others may instead choose to attribute blame to others or the organization. Many risks to a fire fighter are affected by personal decisions made at emergency scenes and on the training ground. We therefore are charged with the choice to be accountable for our own safety and the safety of our peers, or simply blame someone else for risks, mishaps, injuries, and death.

In the chapter, *Defining a Cultural Change*, we identified the need to establish a safety culture. One of the first steps to making a safety culture a reality is to accept the responsibility associated with accountability for health and safety. A decision to remain accountable has the ability to spread to others throughout the organization. For instance, a fire fighter that stays accountable by eating right and exercising tends to encourage others to do the same. As he or she begins to pursue his or her own accountability for health and safety, the organization begins to tip the scale in favor of organizational accountability. Other industries have utilized components of NFM as a way to increase personal accountability for safety and should be looked at as a possible solution.

Organizational accountability can best be accomplished through a conscious decision by the leadership of the organization. Besides instituting policies and procedures to ensure that safe practices are followed by the members, personal accountability can be demonstrated by a fire chief who adheres to a strict personal accountability for safety. The fire service as a whole needs to have a registry of organizations that put an emphasis on safety and are therefore accountable. An FLSI 16 registry would provide information and checklists to provide departments with criteria, and could be used to qualify for certain financial incentives such as grants. A combination of organizational and personal accountability for safety has the best opportunity for reducing injuries and deaths.



"Often, attitudes develop within the ranks that foster a culture where the organization is assumed to take full responsibility for accountability of fire fighter health and safety. No program can be fully effective if individual fire fighters are not held accountable as well."[9]

WRAP-UP

Chapter Summary

- Although used synonymously, responsibility and accountability are different. Responsibility is something that is assigned to you, thus making you accountable for completing it. Personal accountability is both a trait and personal choice to be held to a certain standard. Similarly, organizational accountability is the ability for an agency to reflect a specific standard.
- Blame is a way to circumvent personal accountability. Rather than accept the responsibility for your part in a failure, blame pushes it to someone else.
- Emergency responders are familiar with responding to emergencies and are trained and prepared to help victims. Victim syndrome can occur during periods of inactivity, when responders are forced to spend their time working on other projects, such as fire inspections or hydrant flow testing. It's important to keep morale high during these periods.
- Specialty shops are a great way to keep busy, improve the department, and even save money.
- Personal accountability is a skill that can be learned, allowing an individual to remain accountable for the present situation rather than place blame on someone else.
- There are several ways to improve your personal accountability, including a conscious decision to remain accountable, becoming an active member in your department, speaking up, taking responsibility for the outcome of emergency calls, and taking responsibility for safety.
- Emergency calls can be broken into three categories: uncontrollable events, semicontrollable events, and controllable events. Concentrating on the events we can control will improve the outcome of emergency calls.
- Taking a responsibility for safety can include personal accountability to safety, training, equipment, services, and the organization.
- Organizational accountability can occur when members apply personal accountability, and the agency uses techniques such as no-fault management to build a comprehensive system.
- NFPA 1500 is a great reference for health and safety accountability. Evaluating your department against the checklist that the standard provides can show you how your organization is doing. Deficiencies can then be broken into lists that require no effort, some effort, and those that will require long-term planning.
- Most departments use their ISO rating to evaluate how good their department is. However, ISO classifications are an insurance standard, not a fire service standard. To improve health and safety accountability, the fire service should design a rating system based on safe practices. An FLSI 16 certification would provide guidance for departments, and could easily be used as criteria for applying for grants (Initiative 10).
- Successful implementation of organizational accountability requires it to be referenced in all aspects of the fire service, including recruit schools and fire academies, fire fighter orientation, daily operations, promotional exams, training, and emergency scenes.

WRAP-UP

Key Terms

accountable Similar to the term *responsible*, it describes a person who is held liable for completing a specific duty.

Delta side The right-hand side of a structure.

Everyone Goes Home (EGH) A prevention program created by the National Fallen Firefighters Foundation in an effort to reduce future line-of-duty deaths. One of the major accomplishments was the creation of the 16 initiatives, the basis of this text.

Fire and Life Safety Initiatives (FLSI 16) Proposed rating for fire departments and EMS agencies based on their dedication to safety; could be used for grant eligibility.

Fire Suppression Rating System (FSRS) A system of grading used by the fire insurance industry to establish rates.

Insurance Services Office (ISO) A fire industry organization.

International Organization for Standardization (ISO) A global organization that provides registries of companies that comply with certain standards.

line-of-duty death (LODD) Fatality that is directly attributed to the duties of a fire fighter.

organizational accountability A term used to describe the ability of an association to be held to certain standards.

personal accountability A term used to describe the ability of a person to be held to certain standards.

postincident critique An evaluation of an incident after it occurs, specifically examining successes and areas for improvement.

Public Protection Classification (PPC) A number assigned by the insurance industry to fire departments and districts based on several components, including equipment, staffing, and water supply.

responsible Similar to the term *accountable*, it describes a person who has been given the authority to carry out a specific duty.

risk management Identification and analysis of exposure to hazards, selection of appropriate risk management techniques to handle exposures, implementation of chosen techniques, and monitoring of results, with respect to the health and safety of members.

safety culture A philosophy that prioritizes safety as a paramount value and relies on it to guide many of an organization's decisions.

victim syndrome The desire for an individual to be portrayed as a victim, usually for esteem benefits.

Case Study

It seems as though you have become the target of a prank at the station. After leaving some of your personal belongings out and going home, others interpreted it as you not cleaning up your mess, again. As a result, someone decided to make "a work of art" and prominently displayed your belongings in an embarrassing fashion. Everyone (but you) finds it very amusing, and the cell phone picture spreads rapidly. You are furious and vow to inflict revenge on the parties that were involved. You complain to your supervisor, but she doesn't take your complaint as seriously as you would have hoped.

1. You may consider that in this case you are the victim, and those responsible for messing with your belongings are the villains. What is the best way for you to convince others that you are the victim, thus obtaining sympathy?

A. To blame others
B. To call your supervisor
C. To throw a fit
D. To storm out

2. After collecting your belongings and calming down, you consider the application of personal accountability, and what you did to contribute to the event. What are the first words that should come out of your mouth?

A. An explanation of how you feel
B. Why the perpetrators should pay
C. The reasons why morale is so bad
D. An apology for not cleaning up

3. In your quest to become more personally accountable, you decide to improve your health, your relations with other emergency responders, and even your job performance. Although it's not possible to change someone else's lifestyle, what is true about others witnessing your actions?

A. They will believe you because actions speak louder than words
B. They will know you are improving your health
C. They can encourage others to become more accountable
D. They help promote the victim syndrome, thus making you the victim

4. Although NFPA 1500 has some components that may be expensive and require some long term planning, what should be done?

A. Write a letter to the financial manager listing the deficiencies to reduce your liability if something occurs
B. Concentrate on smaller components of the expensive standard(s) that can be achieved now
C. Skip the section and work on other sections that are achievable
D. Make suggestions to NFPA to reduce the standard to an achievable level

WRAP-UP

Challenging Questions

1. What are the definitions of personal and organizational accountability? List an advantage of each.
2. What are some of the ways that accountability can affect health and safety within fire and emergency services?
3. How does the process of using NFPA 1500 improve accountability related to the health and safety of an organization?
4. How you could implement accountability and no-fault management together?
5. Why is there a need to create health and safety parameters for organizational accountability?

End Notes

1. Harry S Truman Library and Museum. "'The buck stops here' desk sign." 2010. http://www.trumanlibrary.org/buckstop.htm. Accessed September 23, 2013.
2. National Fire Protection Association. "Overall fire statistics." 2013. http://www.nfpa.org/research/statistical-reports/overall-fire-statistics. Accessed September 23, 2013.
3. Ripken, Jr., C. and D. T. Phillips. *Get in the game: 8 elements of perseverance that make the difference*. New York: Gotham Books; 2007.
4. Goodall, W. *Why great men fall: Winning strategies to rise above it all*. Green Forest, Arizona: New Leaf Press; 2005.
5. Ensign, J. "Farewell to the Senate." *C-SPAN video*. May 2, 2010. http://c-spanvideo.org/appearance/599920240. Accessed September 23, 2013.
6. NFPA 1500, *Standard on Fire Department Occupational Safety and Health Program*, 2002.
7. ISO Mitigation Equipment List 2010. http://www.isomitigation.com/ppc/3000/ppc3003.html. Accessed September 23, 2013.
8. International Organization for Standardization. "About us," (n.d.) http://www.iso.org/iso/home/about.htm. Accessed September 23, 2013.
9. National Fallen Firefighters Foundation. *Firefighter Life Safety Initiative 2 White Paper*. 2007. http://www.everyonegoeshome.com/summit/whitepapers.pdf. Accessed September 23, 2013.