Safety Problem-Solving: The Incredible Effort to Improve the Past

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Trying to solve problems is like trying to prevent accidents that already have happened.

Organizations constantly ask if I can help them solve their safety problems. Think about this: Problems are things that already have happened. They cannot be changed or improved.

Yes, past problems, if not addressed, potentially can repeat, so preventing their repetition certainly is a worthwhile pursuit. But trying to solve problems is like trying to prevent accidents that already have occurred.

Herein lies the problem: Safety has a history of investigating accidents and "solving problems." We often call these solutions "corrective actions" and assume that they will prevent future events. In truth, these actions are designed to affect further performance, or in other words, they are "interventions."

Problems are what happened in the past. Interventions are what we do in the here and now. Planning is what we do for the future. Mistaking one for another sub-optimizes safety improvement efforts. All these activities work best when they are guided by an overarching strategy for safety.

Goals vs. Safety Strategy

In reality, most organizations have no such safety strategy. They have safety goals and programs they believe will help them meet their goals, but this is a programmatic – rather than a strategic – approach to safety. A true safety strategy begins with a vision of what the desired safety processes, culture and performance look like. This vision becomes the standard by which every safety program is measured: Will it help to accomplish the vision?

Programs should affect perceptions and capabilities. Perceptions and capabilities should affect performance. Performance should affect the lagging indicators of safety (i.e. recordable rates, severity rates, workers' compensation offsets, direct and indirect costs of accidents, etc.). Measuring each of these phases of safety efforts creates the balanced scorecard for safety I have described in earlier articles. Such multiple metrics can generate what Deming called "profound knowledge" of the processes that can produce accidents.

The idea that workplace accidents are problems that can be solved is very limited thinking. Accidents come from workplace risks that are conditional or behavioral, or a combination of the two. Workers who are injured either are unaware of the risks, unaware of how to deal with the risks or simply didn't do what they knew they should do on this occasion or on a consistent basis. The latter can be due to a number of factors including, but not limited to: inattention, production pressure, disregard for safety rules and procedures, lack of skills or training or simple lapses in performance.

Once an accidental injury has occurred, determining the exact cause and preventing future occurrences is an inexact science, at best. Yet, this is what we tend to call "safety problem-solving."

So, what is wrong with this process (other than the obvious)? It is based wholly on lagging indicators and human supposition. The accident already has happened and no longer is preventable. How it could have been prevented almost entirely is a matter of supposition. The supposition largely is based on eyewitness accounts and/or the memory of the accident victim, both of which are proven to be unreliable. Organizations with camera surveillance of work areas regularly find that eyewitness accounts often disagree with camera footage.

Another problematic issue is how accident investigations are conducted. Many of them involve rank amateurs with little or no training, supervisors who often are fearful of personal blame, nearby co-workers who might have seen or heard something related to the accident, workers who are fearful that the organization will add insult to their injury through blame and/or punishment and middle managers or safety professionals whose training varies greatly. This individual or team gathers information and writes a report, which largely is a fill-in-the-blank form designed by others with little or no training, or copied off the Internet.

The "corrective actions" from such investigations have an alarming similarity to each other: Send worker to re-training, remind worker of danger, put worker on probation, direct supervisor to observe worker while performing this certain task, etc. The whole process is suspect, and using training for punishment is just short of criminal.

Solutions

So, what is the solution? Many organizations have trained senior managers about the differences between the past, present and future of safety. They have developed overarching strategies for safety excellence. They have utilized greater expertise and advanced technology to investigate accidents and determine appropriate countermeasures. They have adopted balanced scorecards for safety to gain insight into the effectiveness of: processes on culture and capabilities; culture on performance; and performance on lagging indicators.

As a result, they begin to understand what really prevents accidents and what does not. They continually adjust their strategy toward what is effective, and eliminate programs and processes that no longer add value. They divorce themselves from the pursuit of preventing accidents and strive to add measurable value to the programs that truly contribute to safety efforts. They know and understand that zero accidents is a by-product of their efforts and can't be controlled directly.

Quote books are full of references to "giving up all hope of improving the past" as the definition of forgiveness, the beginning of progress and the ultimate wisdom of effectiveness. The overutilization of accident data to drive safety efforts has clouded that effort.

We use accident data because it is a more discrete metric than our leading indicators. But often, an indiscrete metric of the right thing is more useful than a highly discrete metric of the wrong thing. Measuring accident frequency and severity is necessary, but it is not prescriptive. It prompts us to try to improve the past rather than try to shape the future. It puts us in hopelessly reactive modes of management in which we try desperately to avoid failure while neglecting the efforts to achieve success.

We learn the hard way that the only way to improve the past is to improve the present long enough for it to become the past.

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