

An unlikely tool to improve safety

Written by Shawn Galloway
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Sometimes the easiest way to improve safety is to ask the simplest of questions.

As we aggressively work to identify further enhancement opportunities, the answers to newly discovered problems can be easier than we safety professionals make them out to be. We often forget that the ones who can help us best understand the risks are the people closest to the issues: the workers. All we need to do is ask for their help.

At a recent gathering, a longtime client recently shared the following example.

Safety at a standstill

Fifteen years of recognized continued improvement in safety was something to be proud of for this company: CEO's Award for Safety Improvement, 1999; Chamber of Commerce Recognition for Safety Efforts, 2003; Suppliers Recognition for Safety Initiatives, 2005. Every year a new plaque joined the corridor wall that was commonly referred to as the "Walk of Pride" in the administration building.

It was the recent two years that had brought a sense of discomfort and even embarrassment. The company had reached a plateau in their safety performance improvement.

Rose Ann prided herself for her passion for safety, understanding of culture and her ability to solve problems, learn and adapt. After 12 years with the company, she believed this is why she had been recently promoted.

In March 2008, she became the site's new health and safety coordinator. Immediately, she began an aggressive campaign to try to identify new ways to improve, as she was familiar with Peter Drucker's quote, "Success always makes obsolete the very behavior that achieved it."

Obviously, what the site had done to get to "good" in safety, would not take them further to "great."

Understanding before responding

Rose Ann's first project was to review the incident and common practice observation data from the past three years. Upon completion, she was able to identify a previously undiscovered concentration of risks around lunch times. Rose Ann determined that more injuries, close calls and common practice risk occurred around the times that different shifts would break for lunch. Interestingly, the exposure wasn't as high during the warmer times of the year.

Rather than giving in to her internal pressure to immediately respond and try to propose solutions to address this newly discovered risk pool within the organization, she wanted to first understand the problem a little better.

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She brought the information to the next meeting of the joint health and safety committee (JHSC). The committee decided, for the next 30 days, to focus on the efforts of the volunteer employee initiative called, The Work Safety Precautions Team.

The individuals in the initiative are trained to observe common practice and identify certain precautions that could prevent injuries. If the precautions were taken, they encouraged their fellow workers to continue. If the precautions were not observed, they would express concern and politely encourage a conversation to gather insight into the influence on risk.

The site realized that multiple people performed similar tasks. If one person was encouraged to take a risk, then others could be as well. For this reason, names were never collected, only what the concerns were and why the individual was taking a risk (whether they realized they were doing so or not).

Heating food on steam pipes?

At the next JHSC meeting, the risk-influencer information was reviewed. Within the anonymous comments were descriptions of people observed climbing on the sides of ladders and machines and working at an unsafe pace. The most interesting finding is that some individuals were heating their food on the steam pipes. Thankfully, the individuals who collected this concerning information had followed through, asking "Why?"

The site was a three-shift operation, averaging 30 people per shift. The type of automated operations allowed for most individuals to break for lunch at the same time. When asked about using the steam pipes to heat food, it was found that the biggest influence for this risk was the lack of microwaves in the break room. People stated that it took a minute or two for each individual to heat their food and you didn't want to be last in line. If you felt you would be late in starting your lunch break, or would have to stay behind, heating the food on the steam pipe was, unfortunately, a second best alternative.

Responding to risk-influencers

In August 2008, the JHSC immediately created and carried out the following three action plans:

- A manager on the JHSC purchased two microwaves and had them installed in the break room the following day.
- For two days, in all the pre-shift huddles, the identified concerns and influence (lack of microwaves) were discussed.
- The Work Safety Precautions Team focused their observations in this area for the next thirty days.

What followed were both a reduction in risk exposure and incidents, and even further improvement in the morale of the culture. This was further validated by the JHSC by periodically focusing the Work Safety Precaution volunteers back in the same area and time of day. They

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observed more precautions being taken (a measurement they called Percent Safe) and very few identified risk practices.

Rose Ann felt this improvement was due to the JHSC properly responding to the right influencer on risk. In December 2009, Rose Ann was given the honor of hanging the new plaque on the Walk of Pride corridor wall, recognizing further safety improvement.

Who vs. what and why

As an organization continues to improve safety performance, the necessity of identifying influences on risk continues to grow. Many will not be as straightforward as the lack of microwaves; they will often increase in complexity. It will be difficult to distinguish these hidden barriers to safe performance unless we involve the people who are performing the work. Only they can help us truly understand what might influence someone performing their task to take a risk.

Remember, like in this situation, if one person is encouraged to take a risk, others usually are as well. Proactively identifying and responding to risks do not require names. Unfortunately, reacting to incidents and reporting the details usually do.

Let's keep the 'who' out of safety and focus on the 'what' and 'why'.

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