

The Folly of Safety Training: A Fable about Influence

Prior to identifying a problem as one that can be fixed with training, consider asking, “Is training really the answer?”

BY SHAWN M. GALLOWAY

Companies and leaders alike are often quick to point to training deficiencies or lack of an established behavioral pattern (habit) as the root cause of accidents. Training seems to become the easy solution; or, worse, it is viewed as some sort of magic potion. Safety training can certainly be an answer, but is it the right answer? The following is the story of one organization’s quest to identify the influence on risks and answer the age-old question: Will more training fix the problem?

Five years ago, the construction division of a large research and development organization conducted an analysis of its accidents. As a group, they were responsible for demolishing and establishing new testing facilities. They learned that during the past four years of this type of activity, 34 percent of all incidents with

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injury were related to lifting. To the division leaders, this seemed like a problem that was easy to fix. Thus, the “Save a Back — Lift Safe Campaign” was born. Within months, the amazing feat of training all 900 employees on proper lifting techniques had occurred. Subsequently, posters were hung and the incentive and reward program was realigned to focus on safe lifting practices. The final element was to utilize the communication channel of toolbox talks, with the purpose of reinforcing the training and reminding people of the importance of lifting safely.

Enter a New Safety Manager

Toward the end of the year, the leadership decided to employ a new safety manager. Even though he lacked experience in a construction environment, Lloyd had

a past history of phenomenal success. One of Lloyd’s first tasks was to conduct another incident review to determine the impact and return on investment the lifting campaign (authored by his predecessor) provided. To Lloyd and the division manager’s astonishment, the findings were dismal. Upon review of all incidents with injury, lifting injuries accounted for 31 percent. After Lloyd briefed the executives, he was encouraged to increase the frequency of training for all employees and retrain the injured individuals on lifting techniques because, as one executive put it, “They obviously just aren’t getting it.” Realizing he was new to the organization, convincing them of a different approach wouldn’t be easy. With the slightest bit of trepidation in his voice, he asked for permission to try something different.

In Lloyd’s previous position, he had received some training on identifying influences in safety events and became familiar with tactics to observe common practice. This enabled him to significantly and proactively improve safety. The vital thing he learned was that he needed to understand why people do what they do if he were to help them do it safely. Furthermore, he learned that while he was the safety professional, often the people that are doing the work could best spot the risks. It wasn’t easy, but he finally accepted that he didn’t always have the best answers.

Understanding Influencers Prior to Action

Lloyd explained to the executives, “If we are to improve safety, thereby eliminating this category of accidents, we must first understand why people are not lifting in the manner in which they were trained. We know people have been trained on this safety precaution, but what does common practice tell us? Is it that people are making the decision to lift in a different manner? Have they just not developed the habit yet, or is there a reason why they are not doing it? Is there something that makes it difficult or impossible to lift safely?”

Scott, the division vice president, spoke up. “Well,

Lloyd, what do you think? Which one is it?”

The ever-prepared safety manager had done his homework. Prior to the meeting, Lloyd conducted an analysis of the past year’s lifting-related injuries and the four years prior. The incident investigation tactics utilized provided excellent data on the injuries. However, none were as insightful as he needed. What was interesting is that he found one specific precaution that would have affected 93 percent of all lifting-related injuries: Getting Help with Heavy or Awkward Lifts. Lloyd had never worked with this precaution, but had seen it used in other sites employing similar tactics.

Lloyd explained this finding to the executives. There were a few more questions, and Lloyd was able to address them by reading through some of the incident reports. He said if the injured party would have or could have gotten help with the lift, the event either might not have happened or the resulting severity might have been decreased. Two of the executives still favored more training. However, there was a group consensus to support Lloyd’s proposal to put a team together to study common practice and determine whether it were possible for people to “Get Help with Heavy or Awkward Lifts” and identify what might influence otherwise. The executives asked to reconvene in 90 days to discuss the findings.

Lloyd’s Approach

Lloyd set out with a motivated purpose. The next day, he quickly gathered the hourly safety committee and explained his idea. To create ownership in the mission, he took them through the same review he conducted; consequently, the committee came up with similar findings. Over the next couple of days, Lloyd trained the committee, and a few additional individuals the committee felt would be a great asset in tactics, to observe common practice for the ability to take the precaution “Getting Help with Heavy or Awkward Lifts.” He also trained them in interpersonal skills and how to maintain respect in conversations. He felt this was critical to ensure people knew these conversations weren’t to find fault, just to understand whether there were barriers to this precaution taking place. Lloyd then briefed the rest of the managers and supervisors and held communication sessions for all employees to explain the 90-day project. By Friday afternoon, the committee was ready to begin.

A total of 18 employees had volunteered to observe common practice in five-minute intervals for instances of workers taking the precaution. If fellow employees were observed taking the precaution, they pointed out specifically what was being done safely and reinforced the importance of taking the precaution. When an employee was observed not taking the precaution, they had a conversation to determine whether there was a safer way to perform the task or an obstacle or barrier made it difficult or impossible to do so. They gathered this insight on a form the committee had created.

At the end of the first month, they already had obtained some interesting findings. The summary of these findings was shared with Lloyd, who almost fell off his chair when he was told of the influencer that was identified during these conversations. Lloyd asked the committee to continue gathering this data for 45 more days. At the conclusion, he would like to meet with the committee to confirm the magnitude of this “opportunity.”

Unveiling the Findings

The 90-day review came quicker than Lloyd had anticipated. Yet he was, again, ready for the meeting. The trepidation visible in his comments three months ago was absent; instead, a confident safety manager stood before his leaders. He explained the process he had put together. He then began to review the findings by outlining a common finding obtained during an observation.

When an HVAC technician was putting up new ductwork, the tech was quite capable of handling many of the activities unassisted. When the tech would get to a part that was heavy or awkward to lift, he would ask a nearby electrician for help with the lift. The response typically would be, “Can I put this on your work order? I can’t take time off mine.” Lloyd further explained that out of 400 people observed during 90 days, nine out of 10 people who were observed not taking the precaution reported a perception that the work order system that had them document their minutes for each task was the reason they were not helping others. That prompted Doug, the division engineering manager, to say, “That is not the purpose of the work order system!”

Lloyd responded to Doug, “I know that, and I’m sure all of us know that. Do the employees still know that?” Superintendent Chip replied, “Well, we told them when we

made the change that we want them to carry out their tasks as they normally do, because we wanted accurate times.” Lloyd explained that, after reviewing common practice data and talking with the people gathering this insight, “Unfortunately, most of the employees have either forgotten or were not here when the intent was conveyed.”

Scott shook his head. “So, what you are saying,” he said, “is the way the employees perceive it, we have a work order system that is giving the impression that we are managing them by the minute?” Doug added, “Even if employees are trained in safe lifting practices, it seems the fear of a negative consequence for unacceptable time on the work order is a stronger negative influence than the positive consequence of precaution-taking and not getting injured.” Lloyd replied, “Unfortunately, it appears this influence is what is leading to a lot of our lifting-related injuries.”

Neutralizing the Influence on Risk

During the next few weeks, Doug worked aggressively to again modify the work order system by reducing the requirement to identify the exact minutes required for each task. The executives tirelessly explained in all-employee meetings how this misperception was affecting safety. Moreover, Scott personally stood before the employees and communicated how sorry they were for allowing this misperception to be created and to become so widespread. During the following couple of years, lifting-related injuries decreased, ranging only between 4 percent and 9 percent of total incidents with injury. As a result, the division celebrated a significant reduction in accident rates and costs.

Prior to identifying a problem as one that can be fixed with training, consider taking advice from Lloyd and ask, “Is training really the answer?” If we train people, how will this training affect common practice? And how does common practice affect safety? It is amazing how a simple question like, “Out of curiosity, why do you do it that way?” provides profound insight into understanding why people do what they do. **OKS**

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