Identify influence to change safety behavior

The most important thing in changing human behavior is the person’s motivation,” said Milton H. Erickson, a well-known American psychiatrist and psychologist. A large manufacturing plant once contacted me with a concern about a 10-year-old process, asking employees to conduct safety observations with the goal to change behavior. The required level of observation activity for this effort was at the desired amount, yet it was yielding no improvement in safety performance. I was hired to conduct a brief research project to determine what was occurring and why.

Within the first 10 minutes of conversations with some of the employees, I discovered that employees were trading completed observation forms with the observer’s name not yet filled in — like baseball cards in the locker rooms. What was the motivation to do this? In the early stages of the process their previous consultant deployed, the approach was perceived as a valuable tool for the workforce. It was the first time a sense of empowerment was felt. Observations of work and subsequent conversations identified previously unknown risk exposure. These issues were captured on a form and turned over to the team overseeing the effort, but nothing was done with the information. The consultant missed this important part.

After six months with no positive responses, a small group began wondering if anyone was actually looking at the forms. They began using the names of Disney movie characters instead of their own on the completed forms. Nothing happened. It was apparent that this was a safety black hole. As a result, the level of activity diminished. When a site leader looked into why this was occurring, the fake names were found and a new edict was presented: All employees were to complete these observations and turn them in to their supervisor at the end of the work week, and if any fictitious names were used, disciplinary action would be taken.

Employees quickly perceived that this was a black hole and the only thing that mattered was the number of completed observations. Be cautious about what you measure, as people will work toward the measurements. Moreover, if the motivation is not to fail or to avoid discipline, a culture of fear-avoiding “have to” rather than “want to” is created. I’ve never seen a culture feared or punished into excellence.

Another group, part of a military unit, was found using homemade tools to work on aircraft that needed to be returned quickly to the operating theater. The influence? The group had increased personnel with outside contract labor and did not increase tooling availability. In another example, a chemical plant proactively discovered operators around lunchtime were rushing, climbing on the sides of machines and ladders, and heating their food on steam pipes. The influence? Not enough microwaves in the break area.

A construction department, part of a major national laboratory, discovered 28 percent of its injuries could be prevented by getting help with heavy or awkward lifts and loads. Upon completion of work observations, they discovered the influence to risk-taking: a work order system supposedly facilitating better project management that was put in place long ago and was no longer needed. This system held individuals accountable to the minute for completion of work, encouraging risk-taking in the form of shortcuts and lifting without assistance.

There will always be influences and motivation for behavior. If you want help, facilitate desired, safe work behavior to identify, understand and address the motivation to behave otherwise.

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