Doing Safety Differently

Your goals!

1. Change thinking around Safety and Health Performance (SHP)
2. Establish a mindset that error is OK
3. Establish that workers are the solution to most problems

Old View:

- Safety is defined by outcomes… the absence of accidents, injuries, etc. (OSHA 300 Logs?)
- Reducing your total injury rates will reduce the number of serious injuries at the same rate… right? WRONG. There is no relationship between frequency and severity!
    - If Heinrich's pyramid is correct, then we should see injury rates and fatality rates descend at the same rate.
- "Old View" – The worker is the problem…Fix them

New View:

a) Safety is defined by presence of capacity… Ability to fail safely
b) Capacity: Building systems that protect people even when there is a lapse in expected behavior
c) "New View" – The worker is the solution…Fix the system using the worker

Human Performance:

a) Error is normal – people make mistakes:
    a. Workers are not machines, errors will happen… It's in human nature! Yes, error is OK!
    b. Errors are predictable… Some examples of error latent processes:
        i. Lack of or a breakdown in management controls
        ii. Unclear Expectations
        iii. Rushing
        iv. High Workloads
        v. Interrupted work
        vi. Multi-Tasking
        vii. Work-arounds
        viii. New technique,1st time performing a task
        ix. Human Conditions (Emotion, complacency, etc.)
b) Blame fixes nothing:
    a. Instead of blaming and punishing someone after an error, try to learn how the error happened from a systems perspective
    b. Use the SHARP end of the stick!
c) Response to error matters:
    a. Do not blame the worker!
    b. Systems factors always contribute to error
    c. Fix the error; do not let its existence continue
    d. **ASK:** Did the worker fail the system or the system fail the worker?
d) ***Context and Systems*** drive behavior:
    a. What have we done in the system that caused someone to act a particular way
    b. Look for nonroutine work that has become normalized – Blue line; black line model

e) Learning is vital:
    a. Learn from failure instead of blame for failure!
    b. Conduct Pre-Accident Investigations: Find Process Flaws and Normalized Problems (latent errors)
    c. Find Process Successes
    d. Create buy in with the sharp end
    e. Build robust systems (capacity)!

f) Learning Teams:
    a. ***How*** is more important than ***why***
    b. **Why** is more important than ***who***
    c. Get the story – Context is important
    d. Build a report
    e. ***Informal*** is better than ***formal***
    f. No management pressures
    g. Use the SHARP end of the stick

Where to start:

Begin a shift of thinking that starts at people make mistakes… and it is OK!

1. Look at old accident investigations and reports.
    a. Is the worker blamed
        i. Fact finding or fault finding?
    b. Was the error corrected?
        i. Can the error happen again?
    c. Who facilitated the investigation?
        i. Pressures associated with management and peers?
2. Begin management leadership training with the focus on helping the worker
3. Change your immediate response to error
4. Begin a systems approach to all error, not only safety: Quality, safety, administrative, etc.