



# The Contributing Factors of Behavior-Based Safety Failures

In the behavioral safety arena, multiple methodologies argue for a dominant position in the marketplace, resulting in confusion; closely-held, magical formulas; and an often-dangerous resolve to do it yourself.

It is hard to decipher which approaches (methodology vs. home-grown) have created sub-optimized results, or in some case, failures. Both often result in substantial barriers to future attempts. With the experience of partnering with hundreds of organizations to break past these previously established barriers, it is hope-



Whether you like it, love it or have never heard of it, behavioral safety processes have created value and controversy for 30 years.

ful that this article will provide some insight into commonly found misconceptions and approaches. This will enable you to ensure your path leads to positive transformation, rather than failure.

## FORCED EFFORT OR INVOLVEMENT

Behavioral safety processes that force involvement typically result in "voluntolds" teams and less-than-desirable levels of engagement and safety improvement. How much passionate and willing discretionary energy do you provide to paying your taxes every year? If a person is working towards an accomplishment because he has to, rather than because he wants to, expect efforts that achieve minimal expectations, rather than efforts that work toward exceeding them.

This also is true when organizations require a certain number of observations to be accomplished by every employee. Individuals who do not want to be involved might not leave the person being observed with a positive experience, thus perpetuating further negativity towards

the process. Remember this principle: Forced change almost always is temporary. When you and the force go away, so does the change.

## A "GOTCHA" APPROACH

Several processes either do not announce the observation or do not ask permission to conduct an observation of common practice. These processes have the misguided impression that spying is a better approach to see true common practice. Clandestine human intelligence often is a necessary function within governments against other governments. It is not a tool to create cultures that break the "us vs. them" mentality sometimes found in the workplace or encourage excellence in any areas of operational performance.

The effective processes either ask permission or, at minimum, announce the observation to make those to be observed aware. The goal is to see if it is possible to take vital precautions. If it is, and we are certain these precautions represent what a safe work environment looks like, then encourage the person to continue taking the specific precautions. If they are not being taken, find out why.



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## INFORMATION USED FOR DISCIPLINE

Behavior-based safety processes that are effective collect insightful information into common practices of work activities. This insight helps determine how to help people work as safely as possible. How is your data used? Some processes have resulted in employees receiving discipline for activities observed during behavioral observations. This often is a gray area in many processes and requires careful consideration.

Organizations need safety rules, and they receive mandates for – and are held accountable for – enforcing these rules. This responsibility, however, often lies with those in management. This is why many effective processes ask employees to conduct the behavioral observations, while asking the supervisors to play a very specific, customized support role, based on the trust levels within the organizational culture. These effective employee-led behavioral processes focus on discretionary behaviors, and the management systems focus on the mandatory behaviors. (There also are opportunities to teach the observation and coaching skills to supervisors, allowing them to become safety coaches; however, take care to ensure the processes are separated if trust issues exist.)

Asking employees to observe and collect data for both mandatory and discretionary behaviors on a checklist is fraught with complications. While the responsibility of an employee who witnesses another employee violating a safety rule doesn't go away, what is he to do if this is witnessed during an observation? My personal recommendation: tear up the card, stop the observation and intervene.

Care is needed because if employees feel they will be disciplined following an observation, how open will they be to being observed or to performing an observation? If the answers to these questions are negative, how valuable is the process?

Consider reviewing the perception of the context of measurement in your organization. Is the goal of measurements to gather insight to

learn, improve and remove all the barriers to safe performance? Or is the goal to catch people doing something wrong, hold them accountable and place blame?

## LACK OF ACTION PLANS OR VISIBLE SUCCESS

Many processes focus on the number of observations, rather than the goal of the tool: improving safety. Behavior-based safety is not the silver bullet or magical solution some have made it out to be. It simply is another tool in the ever-improving safety toolbox. But, this tool does serve a purpose: to gather insight into common practice and the reasons why precautions are not being taken or cannot be taken. This, then, requires the organization to act on addressing these reasons by creating action plans that either improve the process – if the insight isn't in the data – or improve safety if the influences on risks are understood.



Consider your current safety committee. How many detailed successes can you recall from memory? The average BBS steering committee or team fails to celebrate and communicate their results. If the team is not creating action plans that are data-

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driven, completing the action plans, and celebrating their successes, will they be perceived as successful? Who desires to join teams viewed as ineffective? Work to create an environment where anyone approached can recall three successes of the behavior-based safety efforts. Consider expanding this to other teams in safety. If we want employees to volunteer for efforts to improve safety, they have to feel that they are joining, if not a winning team, at least one that is giving it their all.

## UNFOCUSED OR MISFOCUSED EFFORTS

Observations often are performed because there is a requirement to perform them. If people feel the only thing that is measured or reinforced is the number of observations, obtaining observations will not be your problem; safety improvement will be. If we recognize that the goal of BBS is to improve safety, then why are we observing for the sake of observing? Why do we still conduct observations on any

day of week, time of day, tenure of employee, tenure on task, trained vs. not trained, icy vs. humid, etc.?

Regretfully, many processes still are observing far too many behavioral precautions. A significant amount of brain science has proven that a focus beyond four to seven items is not a focus. For further insight into this, read "Why We Fail To See Risk" (EHS TODAY, January 2011). If you have to rely on your checklist to "shape behaviors," you are using the most expensive and unsustainable resource available.

## RETENTION AND INTERNALIZATION IS AN AFTERTHOUGHT

Far too many methodologies rely on implementation approaches that create a dependency on the external consultant. (Disclosure: I am a consultant.) I do, however, have a firm belief that if a company is to achieve sustainable performance in safety, then the tools and capability critical to facilitate the safety performance need to be owned by the company. While this might not always be practical, it is a realistic necessity.

The "gotcha" approach is not an effective BBS strategy and will not improve safety culture.

As many organizations fought their way out of the recent global recession, a realization emerged: When companies were unable to make royalty payments for intellectual property, software payments or training materials fees, their safety performance suffered. Work aggressively to ensure the tools necessary to achieve and sustain safety culture excellence are internalized, not externalized. Seek out new ideas that can be retained and internalized into the



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structure to ensure evolution towards the desirable performance.

## EXPECTING MIRACLES

The goal of a behavioral process is to provide simple strategies that people can internalize as quickly as possible, and to remove the obstacles and barriers to safe performance. Behavioral safety tools primarily are focused at adults. Adults have experienced many things in life that provide a framework for decision. We cannot expect to change that framework overnight.

Behaviors happen for a reason. Often we are too close to the issue to see the true reason. Why do most global citizens drive on the right and others on the left? Sometimes we do something because this is the way we know. Changing this perpetuated belief and action is much more difficult than a checklist and a few "voluntolds." Still, realizing this difficulty, we must not give up. We first need to recognize the difficulty if we are to be successful.

## STOPPING AT BEHAVIOR

Simple, well-intended yet incorrect statements like, "Accidents are caused by unsafe acts," are just the beginning. Prepare yourself; behaviors are not the root cause of accidents or incidents.

There is a common quip among some safety professionals: "What is the root cause of all slips, trips and falls? Gravity!" When someone experiences one of these types of events, incident investigations with minimal effort result in a finding that focuses on employee behavior as the root cause and follow-up action plans such as: "Pay attention," "Employee needs to be aware," "Employee needs to not be distracted" or the all-too-often unrelated one: "Employee needs more training."

People do things for a reason, however, many investigations end at employee behavior because the reason cannot be determined or is not investigated. If your goal is to change or improve performance in another, you have to engage the individual in discussions to learn the reason(s) for the lack of performance.

Very few employees go to work with

the intention of becoming injured. Most are doing their jobs the way they know how or how they believe management expects them to. The key principle here is to look past the behavior and find why the activity is occurring to create a path to sustainable improvement. The best ideas are abundantly available if you keep your ears open.

**EHS**

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