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Practical Application & Integration of Human and Organizational Performance, Incident Analysis, Procedure Excellence and Leadership Development
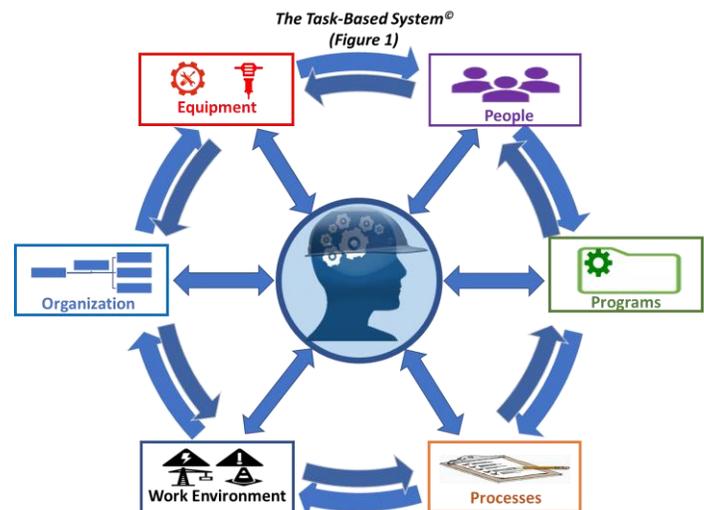
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Why can't we seem to stop slips, trips, and falls?

This Robservation discusses some of the understandings and misunderstandings of safety, human and organizational performance (HOP) and the overlaps. Specifically, when an organization uses concepts like HOP and safety markedly improves (which is one of the natural outcomes if HOP is done right), what tends to be left are incidents that organizations put into the category of "isolated errors and incidents." It baffles and frustrates organizations because they spend so much time and get such good results over a short period of time, and then they look around and people are still slipping and tripping, sometimes resulting in falls that produce injuries. Whether same-level falls or falls to a different level, the injuries result when some part of the body forcefully contacts the ground, or we twist, sprain, strain, or fracture a body part trying to reduce the impact of the fall. Unfortunately, once organizations get that first set of good results, they sometimes revert to applying blame to the individual for things like slips, trips, and falls.

Let's revisit what some of the thought leaders have been teaching for a few years now related to safety as an OUTCOME. This opens the door to understanding that some safety outcomes are systemically preventable by the organization and some (<10% if you believe Deming and others) where the individual component is the primary driver. Either way, most of these incidents have a systemic element associated with the outcome, and the organization should make every effort to discover these systemic drivers. Organizations are typically not very good at understanding the difference, or at evaluating the circumstances of a bad safety outcome to determine the systemic drivers, including the individual components. It is not about fault or blame; it is about understanding the conditions and drivers that are associated with an outcome. HOP was never about making organizations 'error-free.' It is about preventing some errors that lead to outcomes, reducing the probability of other errors, or mitigating the consequences of the errors you cannot prevent. Initially, upon rolling out the concepts of HOP, organizations tend to see a downturn in the systemically driven incidents because the organization has better risk recognition and mitigation capability by using the concepts. Once the "low-hanging fruit" is understood, then the capability of humans within a system starts to be revealed. The human fallibility associated with distractions, multi-tasking, overconfidence, System 1 thinking, and others, then becomes more obvious. It's not that it wasn't there all along, but that the organization had so many other systemic drivers that needed to be discovered and taken care of, that they were always overshadowed as a primary contributor. Using a systems approach ensures that the organization learns everything they can learn, and doesn't stop at the individual component, even when it seems like that is the easiest thing to do.

The Task-Based System© (Figure 1) shows that on any task at any time, the individual performing the task is within a system. The individual is surrounded by *other People, Programs, Processes, Work Environment, Organization, and Equipment*; otherwise known as "systemic drivers." The systemic drivers are dynamic, not static and as they shift throughout the task, they all impact each other, they all impact the individual, and the individual must respond to these shifts in systemic drivers. Different people with different personality tendencies will both see risk coming from different systemic drivers and tend to react to those changes differently.

The Task-Based System©
(Figure 1)

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While we want to be able to tell people "be careful and pay attention" and have that be enough, it rarely is. The human brain is wired in such a way that environmental stimuli (external – something outside of us demands our attention) distract us without conscious thought to the distractions. This also applies to what we think about (internal - tell me you haven't wondered if you closed the garage door after you got to work!). Even though they do not appear to be systemically controllable, they have to be taken into account within the framework of the system on all incidents, including things like slips, trips, and falls. The organization needs to understand what is systemically controllable and what is not. But in addition, they have to understand that those things that may not be systemically controllable don't necessarily require them to blame the individual for being human.

For example, a company recently bought a building for their operation. With all the fixing up, remodeling, and operations, they failed to recognize that the handicap ramp that had been installed by the previous occupant did not align with the front door. It wasn't until an employee left one day and stepped off the curb and onto the ramp and almost fell that is came to their attention. In some organizations, they would simply tell people to be more careful and watch where they were walking. In reality, the organization can reduce the probability someone gets hurt here by aligning the ramp with the front door. It will NOT eliminate the possibility that someone steps off a curb and twits their ankle or falls, but it systemically reduces the probability. For this reason, the modification should be made.

The same can be said for holding handrails going up and down stairs. The "rule" to hold the handrail is to reduce probably and provide some mitigation if you do trip, not to eliminate the possibility that you will trip and fall on stairs. If organizations have stairs, they will have someone that will trip on them. If people routinely hold handrails, it will reduce the probability someone will fall on the stairs and may even mitigate the consequences when they do fall, but it won't stop all people from missing a tread or slipping on one on a stairway!

Using the Task-Based System$^©$ approach on every incident, whether or not the management thinks they already know what happened and why, ensures that all incidents, near-misses, and near-hits are looked at to discover the systemic drivers. Using HOP / HP concepts in organizations tends to reduce probability (even for non-systemically controllable incidents), but not eliminate the possibility. Organizations that understand this tend to fix more of the smaller systemic controllers and drivers, improving morale, engagement, and safety culture.

If you have any follow-up questions regarding our capabilities, or if you would like to contact Rob for any other reason, he can be reached at +1 802-233-0760 or via email at Rob.Fisher@ImproveWithFIT.com .