

Scott Fowler

This episode of the Case for Safety Podcast is sponsored by Safe Start. Hello, everyone, and welcome to the Case for Safety Podcast. I'm your host, Scott Fowler. I appreciate you joining us today.

We're going to be talking about, you know, some common issues safety professionals are facing today, as well as solutions to help you address them. And here to share her thoughts and experience with that. I'm very happy to welcome back to the show Rhonda Piggy Johnson. Rhonda is implementation specialist at SafeStart. Rhonda, welcome back. Welcome back. Great to be talking with you.

Rhonda Piggee Johnson

Nice to be talking to you as well, Scott.

Scott Fowler

Excited for the conversation. We're going to get into a lot of really interesting topics, you know, some you know problems and solutions, if you will, that, you know, we're gonna be sharing with the safety pros out there. But as we get started, you know, before we get into that, I thought we could start by kind of taking a look at your world as a safety consultant.

I know you know you travel quite a bit with your work. And I wonder if you could just tell me a little bit about your work, you know, why folks bring you in to, you know, take a look around and help them improve safety and health at their job sites.

Rhonda Piggee Johnson

Yeah, absolutely. I do travel quite a bit. and one of the things that I love about this work is that no two sites are exactly alike. when a company brings me on site, I don't come in necessarily thinking I'm the consultant, I'm here to tell you everything you're doing wrong. That's not generally how I work.

Most organizations are doing a lot of things right. I want to understand what's working, what's important to them, where they're struggling, and where there may be opportunities for improvement. So I spend a lot of time listening. I talk with the leadership, supervisors, and most importantly, the people actually doing the work. I walk the floor, I look at the processes and procedures, but I also pay attention to how the work really gets done.

And if I may continue on, because I get super excited when I talk about my travel, particularly my client work, with everything I mentioned, that's where human factors become important. You can have good procedures, good equipment, good people, and still

have things like rushing, frustration, fatigue, distractions, complacency, all of those things affecting how work actually gets done.

So one of the tools that I use is the human factors framework, which shows how systems, individuals, and outcomes are all connected because it helps us look at the whole picture. We're looking at the individual, but we're also looking at the technical systems and the people systems surrounding that individual.

Because when something goes wrong, rarely is the most useful answer simply somebody made a mistake. I want to understand what contributed to that mistake, what conditions were present, and most importantly, what we can learn from it, with no blame mindset, of course.

Scott Fowler

Absolutely. I'm glad you mentioned, you know, human factors and complacency and we'll be getting into those a little bit more in a little bit. And you know, talking about, you know, getting that perspective, having those conversations, you know, at all levels of an organization, you know, in your mind, you know, why is it so important to, you know, for you know, safety consultants like yourself, like having a fresh set of eyes, you know, at an organization so valuable when it comes to safety?

Rhonda Piggee Johnson

Yeah, for me, I believe is because familiarity, it's kind of a funny thing. the longer we're around something, the less likely we are to really see it.

Think about your own house, and we were just talking about mine in the background here. You can walk past something that's been sitting in the wrong place for three weeks and eventually you don't even notice it anymore.

Then somebody comes over, or in my case, like you're on the computer screen, they say, Hey, what's that doing there? And suddenly you see it again. The same thing happens at work. When people have worked around the same equipment, followed the same process, or dealt with the same workaround for years, they can start to feel normal.

Now that doesn't mean that they don't care about safety, it means that they're human. That's why I like the idea of fresh eyes. I'm looking at something with all of that history attached to it. Sometimes I'll ask what seems like a very simple question: why do you do it this way?

And the interesting thing is that I'm not always the one who finds the answer. Sometimes that question gets the employees to stop. Yeah, look at something they've done a thousand times and say, you know what? I don't know. and that's powerful though, right?

Because now we're seeing the work again instead of simply moving through it. That fresh eye perspective can help people see risks that familiarity may have made almost invisible.

Scott Fowler

No, I love that. Like to your point, you know, you see things and do things in a certain way for so long, you can reach point like, I never thought of that. Like you get you do you can and I know we're gonna get into the complacency, but you just get so set in your ways that you may you know, just have blinders on to that outside perspective that can give fresh eyes to, you know, a process or a way of doing things.

Rhonda Piggee Johnson

Yeah, absolutely.

Scott Fowler

Kind of switching gears a little bit, I mentioned at the top, you know, kind of some of those common problems and potential solutions, challenges safety professionals are facing out there today. You know, what are, you know, those common trends or issues that that you're seeing, you know, in your work lately?

Rhonda Piggee Johnson

Alright. I've actually been putting a lot of thought into this because you're not the only one that asked clients ask as well. And so I've kind of narrowed it down to kind of a top three. that's organizational complacency, turnover, and time management.

And when I say organizational complacency, I'm talking about something bigger than an individual becoming comfortable with the task. Sometimes an entire organization can become accustomed to the way something is being done. A workaround that lasts long enough that it becomes the way we do it. A condition that has been there forever and nobody has gotten hurt. So eventually people just stop questioning it.

I've seen situations where deviations have been around so long that people don't even recognize it as a deviation anymore. It has simply become normal. and I would love to share an example with you. A very simple, I'll try to make it quick. We know I can be a little long-winded.

But I was at a client's site, and per usual, we're walking around the site just so that I can kind of see again how that work is really being done. And as we're going around, me and my site escort occasionally we'd stop and we converse with employees in several situations. And I'll start with the first big situation that stood out to me. We stood next to a piece of equipment that was being guarded.

The guards was I'd say about yay size, if y'all can see that, and as we were sitting there talking, I would notice my side contact lean against the guard. And occasionally, as we're talking, those fingers are inside the guard. I'm thinking to myself, huh, I wonder, you know, what's going on there. But I don't interrupt because I'm here to observe at first. and then as another employee comes over, that employee leans and does the exact same thing. So we continue on with our tour, and I'm making a mental note.

And as we're moving around, I'm seeing other pieces of equipment that's guarded, or I'm seeing other little landing places that people can put a little elbow on. And my brain starts to think, at that very first stop that we were on, putting your hands through.

I know you're gonna cringe at me saying this as a safety professional, but a little low risk because where the equipment was in the center of the guard. It would be a far, far stretch for those fingers to make it all the way to that piece of equipment. But think about us normalizing that behavior and then we do that same behavior on another area where the hazardous energy isn't so far from that guard.

So we had a conversation about that. And it was one of those times where fresh eyes was super important because no one really realized that they had normalized that particular behavior. So that's what I have to say about the organizational complacency piece. So I'll move on, if that's okay, to the second one that I mentioned, which is turnover.

When experienced people leave the organization, the organization doesn't just lose a person. It can lose knowledge, experience, mentoring, and all of those little things experienced employees know because they've seen them before. At the same time, you have a ton of new employees coming in who are learning the job, the hazards, and the culture, and that can be a mixed bag.

And the third issue that I'm seeing is that time management, as I stated, more and more initiatives, meetings, and responsibilities are being added to people's plate, but very little is coming off. I picture someone juggling balls. This is the example I like to use. They're doing fine with three balls, three initiatives. We have it, I'm excelling, I'm doing great at my performance review. Then somebody throws them another one.

Okay, they adjust. Then here comes another one, and another one, and eventually a ball is gonna hit the floor. I'm particularly interested when leaders tell me I need to spend more time on the floor with my people, but then I look at their calendars and they're in meetings all day long. And so, yeah, those three issues may sound separate, but they can interact with each other, and that's when we think we need to look a little bit deeper for sure.

Scott Fowler

That that gives a good foundation. We'll get into kind of each of those issues in a little bit. But when you think about, you know, the complacency, the turnover, time management, you know, why do you think these are such recurring issues that you see in a lot of organizations?

Rhonda Piggee Johnson

I think it's because organizations adapt, and adaptation isn't necessarily a bad thing. People find ways to solve problems, keep production moving, and get the work done. And that's where human factors framework gives us a useful lens. Looking at the big picture, you can start to see things, and people don't work in a vacuum.

We have internal factors affecting the individual, but we also have technical systems and people systems influencing how work gets done. So maybe staffing changes, but the workload doesn't. Maybe we add another initiative, but we don't remove anything.

Maybe there's a temporary workaround because equipment is down and that workaround solves today's problem. Six months later, nobody has gone back and asked, why are we still doing this?

Eventually people adapt to those conditions. That's why when I see something happening repeatedly, I don't want my first question to be, what's wrong with the employee? I actually want to ask, what is it about the way we work or the way the work is set up that's making this behavior make sense? Then that question can lead to a very different conversation.

Scott Fowler

Going back to those issues you mentioned, you know, starting with the organizational complacency, you know, to some folks out there that might you know seem kind of amorphous and you know, kind of tough to pin down. So, I mean, you mentioned, you know, the leaning against the piece of machinery, for example, but like how can organizations go about diagnosing that kind of thing when that complacency is happening? And then, you know, where do they go from there to go about addressing it?

Rhonda Piggee Johnson

One of the first things that I do is I listen. There are certain phrases that get my attention. We've always done it that way. That's never been a problem. No one's ever gotten hurt doing that. When I hear those things, I get curious. So you can get curious too. Then I start looking for patterns. And you can look for patterns too.

Are there workarounds everybody knows about? Are there conditions people have stopped reporting because they've been there forever? Does the procedure say one thing while the actual work requires something different? Are close calls happening but being dismissed because nobody got hurt? And most importantly, I talk to people about doing the work. I have to say that one over. And most importantly, I talk to people doing the work.

That usually know where the friction is, but I don't think the remedy is walking up and telling everybody you need to stop being complacent. What are they supposed to do with that? Right? Yeah. I'd rather help them kind of make that risk visible again.

And one way that I do that is with fresh eyes, going back to fresh eyes, you know, again. Have someone from another department look at the work and ask questions. Use close calls as opportunities to learn. Ask, how could that have been worse? Look for a recurring pattern. Talk about human factors before work starts, not only after something goes wrong.

I'm also gonna point out that leaders have a huge role in this. If somebody raises a concern and nothing happens, eventually people may just stop raising concerns altogether. But if they raise something and see action or at least receive feedback about what happened with the information, you've reinforced it and you've reinforced that speaking up matters.

The goal isn't to make people afraid of familiar work, it's to help them see familiar work clearly again.

Scott Fowler

One of the other issues you mentioned was turnover. And, you know, on the surface people may think, you know, that's a human resources issue more than, you know, a safety and health issue, but you know, you're talking about the impact it can have on safety. You know, you've got people who have been in an organization a long time that move on, you have new people coming in. So, you know, what are the sorts of things that safety professionals can do kinda to kind of mitigate the those effects of turnover on the on their job sites?

Rhonda Piggee Johnson

Yeah. First I think we have to recognize what actually leaves the building when an experienced employee leaves, right? So it starts at HR but it doesn't stay at HR. It's not about head count. It's experience. It's hazard recognition. It's knowing the sound a machine isn't supposed to make. It's knowing which part of the job looks easy but can get you into trouble. It's knowing what happened the last time somebody tries something a certain way.

Some of that knowledge is written down, but a lot of it isn't. So when turnover is high, I would look very closely at onboarding and mentoring. Are we only teaching new employees the procedure, or are we helping them understand the risk? Are experienced employees sharing their knowledge, including close calls and lessons they've learned?

Are supervisors checking for understanding, or are we assuming that because somebody completed training, they're ready? And there's another side of turnover that sometimes gets overlooked. We need to pay attention to the experienced people who remain.

If they're constantly training new employees while also trying to keep up with their regular responsibilities, what have we just added to their workload? Now we may have rushing, we may have frustration, we may have fatigue, we may have divided attention.

So I would encourage safety professionals to look at turnover through a human factors lens and ask, what has changed in the work because those people left, and what new risk did that change introduce? That turns turnover from just an HR statistic into something we can actually examine from a safety perspective.

Scott Fowler

Sure. You also mentioned time management, kind of going back to your point there, you know, the juggling analogy, the people, you know, continually having things, you know, added to their plate, more responsibility. And, you know, that may potentially improve productivity, but it can cause, you know, cause safety issues as well, like you just mentioned. So how do organizations go about addressing that?

Rhonda Piggee Johnson

Yeah, and I mean I think you hit it head on. I too go right back to that juggling example. If I'm successfully juggling three balls and you toss me a fourth, I may be able to adjust. Give me a fifth, maybe I can manage that too. But if you keep throwing balls at me and never take one away, eventually something is again going to hit the floor. You know, organizations can unintentional do the same thing to people.

We're going to add this initiative. We need this report, we need to attend this meeting, complete this training, track this metric. Individually, every one of those things may make perfect sense. The problem happens when nobody steps back and looks at the total demand we're putting on the person.

And I think leaders need to look at what they say they want versus what their systems actually allow. If you tell a frontline leader, we want you to be visible on the floor, talk to your people, coach them, understand what's happening in the work.

I agree with all of that. But then I look at that leader's calendar and we've scheduled them into meetings most of the day. We've created a system that competes with the very behavior we're asking for.

So instead of automatically asking, how do we fit one more thing in, I like to ask, If we're adding this, what can we stop doing? What can we simplify? What can we combine with something we're already doing? And that's my ultimate favorite when we can integrate into things that we're already doing. Sometimes improving safety isn't about doing more. Sometimes it's about creating enough space for people to do the important things well.

Scott Fowler

Let's talk a little bit more about that. You know, we we've talked about, you know, those common issues, problems organizations are facing. What are the solutions you're seeing out there that that you're providing that, you know, folks are really interested in to, you know, help them get back on the right track?

Rhonda Piggee Johnson

Yeah, so the biggest thing I would say that I'm being asked about more often is benchmarking. Clients always want to know what other organizations like us are doing. Or you've been to a lot of facilities, what are you seeing that's working? And I completely understand why they ask. Nobody wants to reinvent the wheel. And why should we, right?

But I'm careful with benchmarking. I don't believe in simply taking something that works at Company A and dropping it into company B. Every organization has its own people, processes, risks, and operating realities. And of course, I protect the confidentiality of the organizations that I work with. What I can share are patterns. I can say, here's something I'm seeing organizations do successfully.

Maybe they're incorporating human factors conversations into meetings that they already have instead of creating another meeting. Maybe leaders are spending more time asking questions instead of immediately providing answers. Maybe they're learning more from close calls and small errors instead of waiting for an injury before they investigate. So for

me, the value of benchmarking isn't tell me exactly what someone else is doing so I can copy it. It's actually 'Show me what's possible. Show me the patterns that are working. Then let's figure out what makes sense for our people and our operation.'

Scott Fowler

Let's talk a little bit more about benchmarking. And I know for a lot of safety professionals it, you know, basic benchmarking things like total recordable incident rate, injury rate, you know, is just something they've, you know, they've always done, you know, OSHA OSHA record keeping, things like that. But beyond that, you know, what bet benchmarking, you know, would you recommend that can be useful for organizations? And along with that, you know, how do you benchmark things like human factors as we've been talking about?

Rhonda Piggee Johnson

That's actually a really good question. injury rates tell us something important, but they're looking backwards. They're telling us about an outcome that's already happened. I also want to know what's happening before we get to that particular outcome.

When we're talking about human factors, I don't think the goal is to create a score that says our people were 20% less complacent this month. We've been there, done that, it really tells us nothing. Human factors don't really work that way. Instead, I would look for patterns and indicators. For example, what are we learning from close calls and small errors?

Are we seeing reoccurring solutions involving rushing, frustration, fatigue, distractions, or complacency? Are certain jobs, shifts, or conditions showing up repeatedly? And here's another one that's really important to me. Are people comfortable talking about those things?

Because an increase in close call reporting isn't automatically a sign that safety is getting worse, it could mean people are becoming more comfortable speaking up and we're getting better information. I would also look at leadership activity. Are those leaders spending meaningful time in the field with their people? Are they asking open-ended questions? Are they listening? When employees raise concerns, are those concerns being addressed?

Are we closing the loop and telling employees what happened as a result? The last part is huge. If I'm an employee and I keep giving you information, but I never see anything happening with it, eventually I may decide there's no point in telling you. Like I'm just gonna stop. I also think organizations can sometimes overlook one of the most useful benchmarks themselves.

We can go out today, we can establish a baseline. Where are we today? What are employees telling us? What patterns are we seeing in close calls? What human factors are showing up? Where are we seeing repeat issues? How consistently are leaders engaging with their teams? Then we can come back to those same measures over time and look for movement.

The human factors framework can help us because it keeps us from only measuring the individual. We're looking at the individual, including their internal factors and the actions they may make, but we're also looking at the technical systems and the people systems around them, which affect their internal factors and also contribute to the outcomes. So instead of stopping with, did somebody make an error?

We can ask what did we learn from that error and what changed as a result? To me, that's really valuable benchmarking. Because ultimately, I don't just want to know how many people got hurt. I want to know whether we're getting better at recognizing the conditions that can lead to somebody getting hurt and doing something about them before they do.

Scott Fowler

Very well said. So many important things to keep in mind with all this to, you know, help address all these issues and you know, get organizations where they need to go. Well Rhonda, I will give you the last word. Any final thoughts?

Rhonda Piggee Johnson

Yeah, I just encourage you all to listen to this podcast, not once, not twice, but three times. and as you go along, jot down some of those questions and try to answer them. And if you can't answer them the first time you listen, go out, solicit information, come back, listen again, and take down some of that feedback. You can always reach out to me on LinkedIn as well.

Scott Fowler

Encourage all of our folks out here listening and watching to do that. Well thank you so much again for coming on, Rhonda. I think these are such important issues for EHS professionals to remember, you know, as we've talked, you know, complacency, all these other things can creep in and you wanna, you know, do what you need to do to get on the right track before it turns in into an incident. So I really appreciate you coming on and sharing how organizations out there can do that. So thank you so much again.

Rhonda Piggee Johnson

No problem, Scott. It's My pleasure.