H-E-A-R SAY

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Pre-Task Plans: Why Bother?

Everyone understands that the intent behind a Pre-Task Plan (whether a JHA, JSA, PTW, etc.) is to help the job go smoothly, with no nasty surprises. In reality, many employees cringe at the idea of conducting a JSA. In their experience, the Pre-Task Plans exist to protect the company rather than the employee.

During the safety meeting, we sign about 30 JSAs and do not go over any of them.

We do a verbal JSA, open the book to the correct JSA for the job and leave it there so if anyone shows up and asks, I tell them: it's right there.

How many times have we done these JSAs, thought about how stupid they are, and just hurry up and pencil whip them?

Look in the "Brutal Mirror of Truth" and ask: how useful are these processes at helping a job go smoothly?

The only effective pre-task plan is one that causes people to actually do the activities called for in the plan. If hazards are not identified and mitigated, then the risk of an unplanned event remains.

By making specific assignments that are relevant and effective in mitigating a recognized risk at the appropriate moment in the job process and then verifying it has been done, the exposure while doing that particular task is reduced or eliminated.

For example, if the hazard assessment reveals a realistic potential of an explosion or fire from paint vapors, make a specific assignment for someone to set up fans and ensure appropriate ventilation right before mixing the paint. If there is a risk of slips / trips due to clutter at the worksite, make a specific assignment for someone to do an hourly clean up of any potential trip hazards. While these are relatively basic examples, the same principle holds true for more significant exposures.

Those who have been trained in applying the vPSI Test™ to evaluate corrective actions can use it to verify and confirm the effectiveness of the individual assignments on a Pre-Task Plan. The application of such techniques not only ensures no nasty surprises but helps protect the worker and the organization.

When employees clearly understand the relationship between the mitigating actions required and their real-life exposures, they see real value in pre-task planning, and as a result substantially increase the odds that they will embrace the process and actually execute the identified precautions. Everybody wins!

Inside This Issue:

A Free Online Tool

vPSI offers a free web-based library of Pre-Task Planning documents that can be accessed, modified, or shared from anywhere with web access. It can be found at vspionline.com.

vPSI can also develop a private library for individual organizations to use. More information can be found by contacting vPSI Group or attending a Pre-Task Planning workshop.

Get More Out of BBS and Management Site Visits

Behavior Based Safety (BBS) programs are well established in a broad range of industries. BBS programs are popular with management partly because they are seen as a way of encouraging and empowering employees to help identify problems in their operations and processes. Unfortunately, employees often see BBS as adding little real value or even as pointing the finger of blame. Stories abound of employees documenting their behavioral observations before even getting to the job site so that they can meet their quota without interrupting their "real" work.

In terms of overall effectiveness in improving future safe work performance, many BBS implementations have either stagnated or are actually hindering further progress. BBS does not and cannot address systemic issues, since the workers charged with completing BBS observations simply don't have the authority to implement organization-wide change. In addition, lack of follow-through when such issues are documented cause a distrust of the utility of the BBS process.

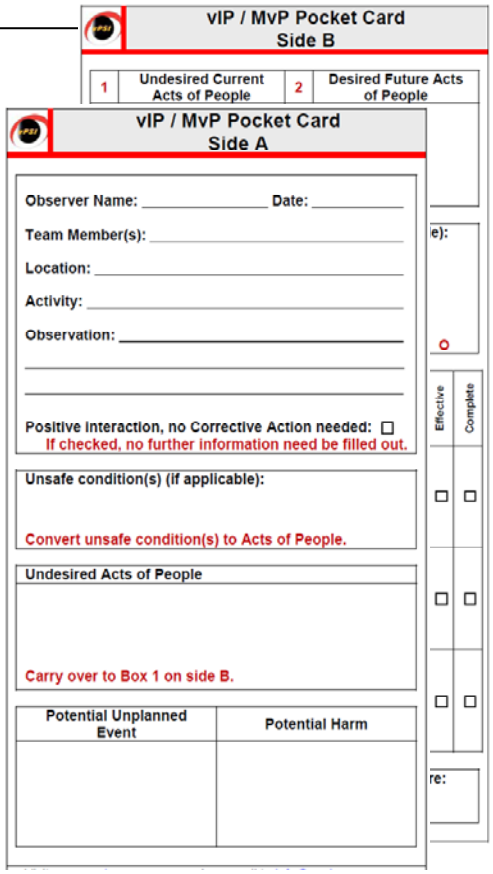
In some cases, problems with BBS programs can be attributed to the incorrect application of its fundamental principles, such as rewarding employees for no recordable incidents or punishing employees *after* an unplanned event occurred.

Management by Walking Around (MBWA) is a management technique that involves site visits, talking to front line employees with the objective of sharing information, building rapport, and seeking ways to improve. In the safety world, such visits are intended to encourage appropriate behaviors and discourage employees from taking short cuts or acting in an unsafe manner, essentially promoting a "safety first" culture. Studies have shown that MBWA programs struggle to highlight underlying cultural issues and can be detrimental unless they identify and resolve real problems.

vPSI Group has applied its problem solving expertise to these issues so that clients can maximize the value of their BBS programs and management site visits. The result is two new programs in the vPSI suite: vPSI Intervention Program (vIP℠) and Management Site Visit Program (MvP℠).

Both tools include all of the benefits of the standard BBS and MBWA processes while avoiding their pitfalls. vIP℠ and MvP℠ encourage and reward desired behaviors: identification of real problems, development of relevant and effective solutions to the problems, and implementation of the solutions created.

Both programs require that the people involved in the observation (generally field personnel and an observer/manager) develop a concrete solution to the issue identified. The solution must pass the vPSI Test™, meaning it must have a route to action and be relevant to and effective against the problem identified.



The double-sided Pocket Card used in the vIP℠ and MvP℠ processes

MvP℠ follows the Plan-Execute-Check-Improve cycle. There are four very necessary and distinct steps involved to getting this right and extracting maximum value for the organization. Some activities take place in the office and some take place in the field, as shown in the diagram to the left.

MvP℠ in particular promotes and rewards enterprise-wide solutions. If such a systemic solution is created (a "Type 3" in vPSI-speak), the observer / manager remains accountable for obtaining the appropriate authority to implement it and drive it to completion.

Combining Business with Pleasure

vPSI consultants travel extensively in the course of their work and, wherever possible, try to fit in some pleasure alongside their serious business.

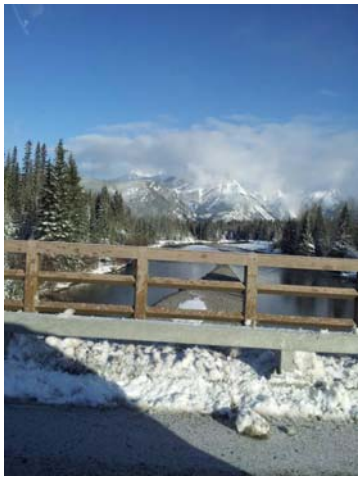
One consultant recently undertook a whirlwind tour of the Middle East to train Noble Drilling employees in the Fundamentals of vPSI Problem Solving (the entry-level vPSI class). Destinations include Qatar, a surprisingly wet Saudi Arabia, and the United Arab Emirates.

View from hotel room in Al Khobar, Saudi Arabia

At this point, this article would usually be about fabulous restaurants or unique tourist spots, however in this instance mention must be made of the mode of travel. Since Turkish Airlines has expanded operations (almost tripling its destinations in the last 10 years), vPSI decided to try them out with happy results. Impeccable customer care made the Turkish Airlines experience one worth repeating.

Turkish Airlines logo

Nexen, Inc. (now a subsidiary of CNOOC, Ltd.) recently started a winter project in Canada and called upon vPSI Group to provide Incident Investigation and Management Site Visit Program (MvP[SM]) training to the large project team. This meant that for several months, vPSI Group essentially had a Canadian satellite office, allowing our consultants to see the best of Calgary and the surrounding areas.



View en route to Kananaskis

The Canadian adventure involved practically the entire staff of vPSI decanting for a week to the breathtaking cold and spectacular scenery of the Delta Lodge at Kananaskis, 60 miles west of Calgary.

A vPSI Consultant waiting for the train in downtown Calgary

Subsequent trips had consultants staying in Calgary proper. Houston has virtually no public transit to speak of, so riding the train to work in Downtown Calgary during rush-hour was something of a novelty for at least one vPSI consultant, who took several trips to get used to the melted snow on the floor but commented: "At least it was difficult to fall over while wedged solidly between sardine-packed commuters."

This article would not be complete without mention of at least one restaurant, and blink (sic) Restaurant and Bar in Downtown Calgary has earned that honor.

Decorated with local art, white tablecloths, and subdued lighting, the warmth and beauty to be found in this elegant restaurant is more than complemented by the cuisine. From the appetizer to the dessert, not a note was missed by the chef. Friendly and efficient service rounded out the experience to make for a couple of happily sated vPSI consultants.

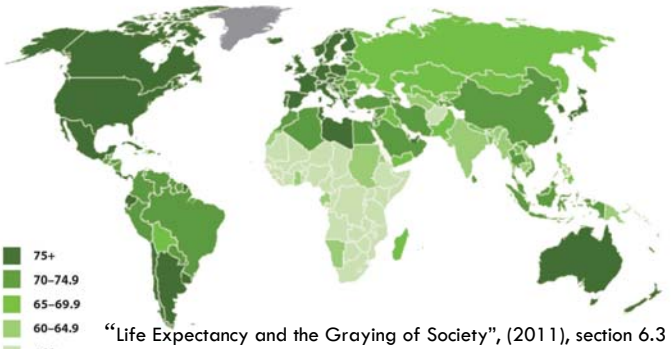
blink (sic) Restaurant and Bar in Downtown Calgary

More vPSI travel photos can be found on our Facebook page.

Medical Adverse Events

In a previous issue of H-E-A-R Say (*Should* is a 4 Letter Word, Vol3Iss3), reference was made to outrageously high medical error rates in the UK and elsewhere. Subsequent studies demonstrated that this is a wide-spread problem.

A new report by the Journal of Patient Safety in the US has brought new focus to these "adverse events," the term coined to signify preventable harm suffered by patients. This report suggests the number might be significantly higher. Backed by credible research and endorsed by renowned medical experts, the newest report, issued in late 2013, found serious adverse events in 21% of the cases reviewed, with 1.4% of them lethal.



"Life Expectancy and the Graying of Society", (2011), section 6.3 from the book A Primer on Social Problems (v. 1.0)

This means that approximately one-sixth of the deaths in the US are caused by these adverse events, making medical mistakes the third highest cause of death in the US, behind heart disease and cancer. The American Health Association (AHA) prefers to believe the more conservative Institute of Medicine report, which estimates that "only" 98,000 per year die in the US due to medical errors.

With a life expectancy of 79 years, the US lags behind many other developed countries, placing 33rd out of 193 countries. In healthy life expectancy, where "years of ill-health are weighted according to severity and subtracted from the expected overall life expectancy to give the equivalent years of healthy life," the US is not doing much better, ranking (in 2013) 26th on the list. Although still closer to Japan (with the highest life expectancy of 83 years) than Sierra Leone (with the lowest at 47 years), it is clear that by any measure and whichever medical error report you believe, it is past time to find a way to stop these incidents. The vPSI Test™ question is, who has adequate and appropriate authority to turn this aspirational statement into reality?

Data Quality Ladder

Poor quality data does not provide an adequate basis for an investigative effort. If data is unsound, the cause and effective analysis and any corrective actions based on it will have a greatly reduced probability of affecting the likelihood of similar unplanned events happening in the future.

Not all evidence types are created equal; they can be visualized as rungs on a ladder, with the most reliable at the top.

When investigating unplanned events, all witness statements and assertions in interviews must be verified and cross-checked against each other and against physical evidence obtained. It is vital to recognize any pieces of evidence that are not either facts or deductions. Such data does not have to be discounted entirely, but extreme caution must be used when using it in cause and effect analysis or to develop solutions.

10497 Town & Country Way, Suite 225 • Houston, Texas 77024
Phone: +1-713-460-8888 • info@vpsigroup.com • www.vpsigroup.com