## H-E-A-R SAY



## vPSI Group, LLC

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### How We Respond Matters: The 5A Approach

The way we react to news of an unplanned event or negative outcome can have significant unhelpful consequences both culturally and on future performance. One of the guiding principles of HOP (aka Safety Differently or Safety II) is "How We Respond Matters," which encourages organizations and individuals to handle incidents in a way that fosters curiosity, learning, and resilience rather than blame, punishment, and fear.

rather than immediately reacting angrily to those involved. It helps create a blame-free environment where learning is the primary goal.

Tip: Ask yourself, "What can I learn from this event?" rather than "Who is at fault?"

2. Absorb: Once you've accepted the event, it's important to take the time to absorb what happened. This is about slowing down and allowing the emotional and cognitive impact

The 5A Approach

Accept

Absorb

Assess

Adjust

Act



The 5A approach is a practical method for structuring responses to events—particularly those with negative or unexpected outcomes. By following these steps, individuals and teams can react thoughtfully, avoiding rash decisions or assumptions, and instead focus on constructive growth and improvement.

1. Accept: The first step is acceptance. What has happened, cannot be "unhappened". Acknowledging that the event is now in the past helps prevent dwelling on the idea of "what could have been." Acceptance allows you to focus on what can be done moving forward

of the situation to sink in. Internalizing the situation helps you better understand it in its entirety, which can lead to deeper insights when it's time to assess the event.

Tip: Consider how the event impacts you, the team, and the broader system. What are the emotional and operational implications?

3. Assess: After the event has been absorbed, it's time to assess. This step is all about gathering information and analyzing what happened. Here, you'll want to focus on understanding the causes and consequences of the event. How did it affect goals, operations, and peo-

Inside this issue:	
How We Respond Mat- ters: The 5A Approach	1
Complacency	2
At the Podium	2
Combining Business with Pleasure	3
Compliance Consulting	4

ple? What were the conditions that led to the event? This is where learning opportunities are identified in accord with another of the HOP Principles: "Context Matters." It's important to reach widely in time and space to gather this information. Consider a broad range of actors and factors: human, process, technical, equipment, and environmental at a minimum. If there was equipment involved, don't just look at the operator of the equipment, assess the design and maintenance of the equipment.

Tip: Use questions like, "What were the contributing factors?" and "What can be improved?" to guide your assessment.

(Continued on page 3)





Our next Safety Leadership Workshop is scheduled for November 19<sup>th</sup>-20<sup>th</sup>, 2024 in Houston, TX. Contact us to book your seat now!

#### Complacency

At vPSI, we review thousands of incident investigations from a wide variety of organizations and industries, and as a result we can spot common threads in how HSE and Risk professionals define the causes of Unplanned Events such as incidents, near misses, etc. In the last several years we have noticed an uptick in the identification of "complacent" and its derivatives on the part of the worker(s) as the cause of an incident. The question we have come to ask in such cases is, "What do you mean?" It transpires that many wildly different connotations are encapsulated, with several of these being pejorative and worker-blaming. This vagueness is problematic because, to be effective, a corrective action must be relevant to the issues causing or allowing the occurrence of the unplanned event in question, and you can't be certain of relevance when the named cause is as nebulous as "complacency."

To highlight this lack of clarity, for the last five years or so we have been running an experiment in our Safety Leadership and Learning from Incidents workshops. Here are the instructions we give workshop participants when someone mentions complacency:

"Let's write down the first two ideas or words that pop into our heads when we hear the word 'complacent' or related in the context of an incident. Don't overthink it, we're looking for instinctive responses."

We then go round the room and have everyone read out their answers. The breadth of variation is fascinating and always thought-provoking for participants. We recently began collecting the responses.



Interesting, isn't it? The revelation here is that there's no way to be sure what someone means when they use the term "complacency". Perhaps it has value as an intermediate step in the analysis of an unplanned event, but certainly cannot be named as a correctable cause. As we learn more about HOP, brain science and the body's energy budget, we also are less likely to accuse someone of being "complacent" when it is simply reflective of the brain's operating systems.

We really should have thought of the word cloud idea long before this, but in the spirit of better late than never, not only are we going to continue gathering background data to refine the word cloud as we go forward, but we invite all our readers to participate within their own organizations. Please run the same experiment as described and send the results to us. We will update the word cloud every six months or so and share the results.

Have fun and remember: the use of complacency as an incident cause is inherently complacent!

#### At the Podium

This year marked the 100th anniversary of SPE's flagship conference, the ATCE, held in New Orleans, Louisiana, September 23rd-25th. During the conference, vPSI Principal Consultant Tom Knode moderated a panel session entitled "Leadership and Culture: What Do Leaders Need to Know, and Do, to Improve Safety Culture?" The session featured speakers from Aramco, Helmerich and Payne, and CEDEP. It was a lively and engaging discussion around current and future skills required to lead safety from an operational standpoint.



That same week, vPSI consultants attended the ASSP Region III Professional Development Conference at the Hurst Conference Center outside of Dallas, Texas. In addition to having a vendor exhibit booth at the event, two of our consultants had the opportunity to present at break-out sessions for the attendees. On the first day,

(Continued on page 4)

# PSI

#### How We Respond Matters: The 5A Approach

(Continued from page 1)

4. Adjust: Once the assessment has provided clarity, adjustments need to be made. This is where actions are planned based on what was learned during the assessment phase. Whether it's revising schedules or plans, adding resources, modifying procedures, providing additional training, acquiring new tools, or implementing new systems, this step focuses on changes that will allow progress to continue towards organizational goals and potentially prevent similar events in the future.

Tip: Don't just fix the symptoms—adjust at the systemic level to prevent

recurrences. In vPSI terms, look for a Type 3 corrective action.

5. Act: The final step is to put those adjustments into action. While it's important to plan thoroughly, this step reminds us that change only happens when those plans are executed. Take decisive action based on the adjustments made in the previous step and ensure the changes are communicated clearly to those involved.

Tip: Communicate the actions and adjustments openly with your team, reinforcing the lessons learned. Follow up to ensure adoption and staying power of the plan.

The 5A approach—Accept, Absorb, Assess, Adjust, Act—is a simple yet effective framework for responding to incidents in a way that encourages learning and system improvements. By following these steps, you can create a culture that focuses on growth rather than blame, allowing your team to respond to challenges in a thoughtful and proactive way.

Next time you encounter an unexpected event, try to bring the 5As to mind. This approach can help you respond in a "HOPropriate" way, guiding you through an effective process of learning, adjusting, and growing.

#### **Combining Business with Pleasure**

The past few months have taken vPSI consultants from Oblong to Abu Dhabi and provided ample opportunity for them to follow the company's philosophy of combining business with pleasure whenever possible.



Oblong is the location of the Illinois Oil Field Museum which Norman Ritchie and Tom Knode were able to visit while delivering Fundamentals of Learning

from Incidents training workshops at the nearby Marathon Robinson refinery, which this year celebrated its 100th year of operation.

Although not as densely spaced as in some areas, such as West Texas, this part of Illinois is dotted with many small pumpjacks and has been producing since 1906. Although the first oil well is no longer in production, a wooden replica of the original derrick stands on its site.

At the Oblong Museum, John Larrabee, who along with a team of dedicated volunteers has been running the museum for many years, treated Norman and Tom to a personal tour of the fascinating collection of artifacts, documents, and photographs. Among the items on display were some very interesting photos from a historical risk and safety perspective. In the photo here from the early 1930s, the slogan "Safety First" is clearly visible on the truck's front bumper, ironic given



that it is full of laborers who don't have access to seat belts, or even seats.



In other photos from the 1930s, it is clear that records were being kept of worker injuries and companies were celebrating numbers of days since the last "Lost Time Accident". This piqued the curiosity of our consultants, since it

predates the advent of health and safety legislation in most countries of the world by many years, for example the US OSH Act of 1970, which was enacted some 40 years after the picture.

#### Sustainable Continuous Improvement



#### At the Podium

(Continued from page 2)

Principal Consultant Angel Simmons presented to a packed room on the topic of "Fitness for Duty and Incident Investigations." Norman Ritchie, vPSI Co-Founder and Principal Consultant, closed out the conference with another packed room of people interested in his "Riskwashing" presentation.

Prior to these events, vPSI attended the SPE International Health, Safety, Environment, and Sustainability Conference and Exhibit in Abu Dhabi, United Arab Emirates, September  $12^{\text{th}}-14^{\text{th}}$ . Sue Staley, vPSI Sustainability Director and HSES Technical Director for SPE, was a co-chair of the event, a member of the executive leadership committee, and hosted a panel of HSES executives discussing the HSES Function of the Future. Norman and Tom presented several papers and moderated a panel session as described in a previous newsletter.



#### **OSHA** Compliance Consulting

Safety management and compliance can be challenging for the small to midsize business. We're here to help!

# Reduce Employee Injury and Workman's Compensation Costs

By identifying and mitigating hazards in the workplace, injuries and their severity are reduced. This also reduces employee "Lost Time" and the need for replacement employees or overtime to cover for injured colleagues.



# Costs of an Injury Have a Sizeable Impact on a Company's Profit Margins

Injuries must be paid for out of profits; even a seemingly minor injury can require hundreds of thousands of dollars in additional sales to offset direct and indirect costs. We are here to assist employers in protecting their employees from injuries and increasing their profits by identifying workplace hazards and potential gaps in OSHA compliance.

#### OSHA Fines and Penalties Are Significant

For every occurrence of a violation, OSHA may assess a penalty ranging from \$16,131 up to \$161,323.

#### How Can vPSI Help?

A thorough ISEA QSSP / OSHA 30 certified compliance inspection of your facility will identify any compliance issues related to 115 potential citation points in 17 categories, reducing the probability of both OSHA penalties and employee injuries.