Reflective Learning – Facilitator Guidance

Running a reflective learning campaign

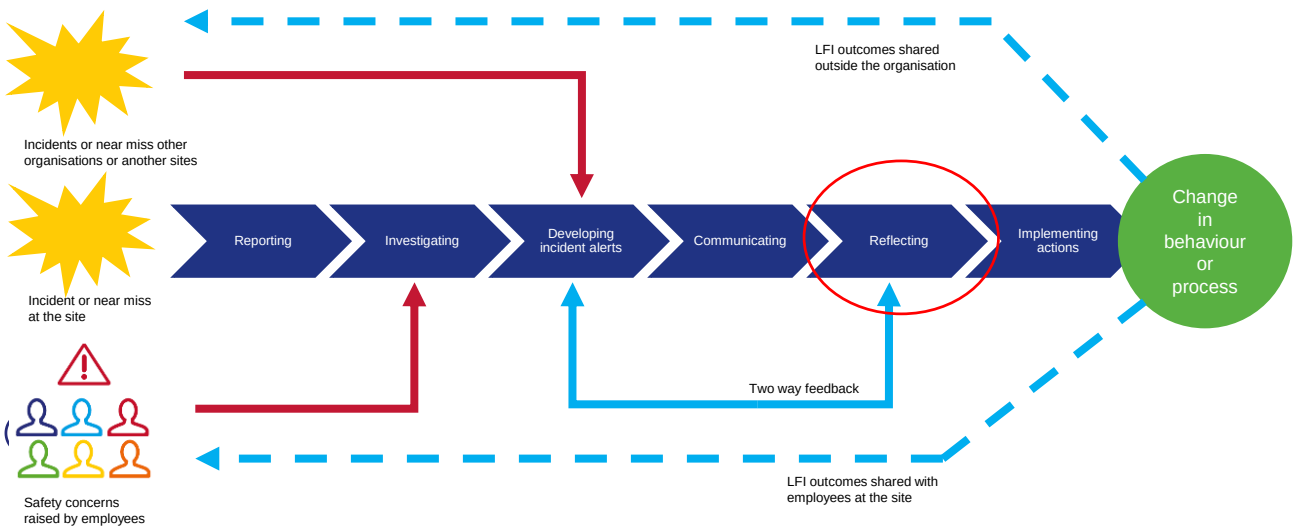
Why reflective learning?

Reflective learning is a method to learn from previous incidents by focusing on behavioural change:

- It is a learning method aimed at personal reflection and individual change.
- Through a structured facilitated engagement session participants reflect on incidents and their own behaviours.
- Reflective learning is a face-to-face facilitated group discussion, supported by simple and engaging materials (to make the emotional connect).
- People learn in different ways. The engagement styles that have been used traditionally for sharing learning from incidents only focus on 1 or 2 learning styles (reading and listening).
- Reflective learning caters for different styles of learning (reading, listening, watching, discussing) and research has shown that this method maximises the opportunity for learning and actual behavioural change.

Remember: A Reflective learning exercise is NOT about watching a video! It is about the engagement and reflective discussions with colleagues.

Learning from incidents (LFI) life cycle



The missing link

Research has shown that reflective learning is a key part of the LFI life cycle. It forms a link in the chain between 'communicating' about incidents that you want your organisation to learn from, and people actually making changes and implementing actions to prevent these incidents happening again.

Running a reflective learning campaign

A reflective learning campaign has five parts:

1. Run a reflective learning session (e.g. using one of the videos provided).
2. Observe the effects at site.
3. Agree actions to address issues observed at sites.
4. Implement the actions.
5. Measure the success. Reward the team and share the effects with other teams.

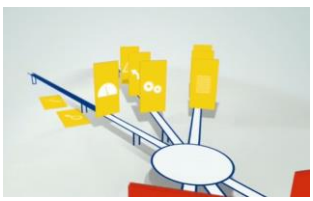
Campaign life cycle

Reflective learning materials

We have created 9 videos to help you run reflective learning sessions – but you could run reflective learning sessions with other videos, incident alerts, etc.

Chronic unease

I own my barrier



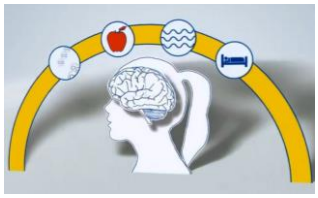
I keep my barrier strong

Stay out of the line of fire

Together we can lift safely

Stop drops

Sleep matters



Remove the hazard

Working together

The key role of the facilitator

The video and supporting materials are of high quality and designed so the target audience can easily understand and **make an emotional connect to the incident(s)**.

- **However, a high quality discussion requires a high quality and trained facilitator** that can guide participants through the learning process and maximize the potential for behavioural change.
- **Key is to not provide the answers,** but to pose the right questions to guide people through their own learning process.

The Energy Institute provides a free e-learn to help you become a facilitator:
https://heartsandminds.energyinst.org/toolkit/learning-from-incidents2

It is also suggested that an initial workshop is ran with those who will be expected to facilitate reflective learning sessions.

'Train the trainer' workshop

Run a workshop with potential reflective learning facilitators (HSE staff that support line leaders with reflective learning sessions). This should cover:

Part 1 - Information
- Introducing reflective learning
- Hearts and Minds reflective learning videos

Part 2 - Practice
- Practice facilitation (use one of the videos, and ask participants to facilitate some of the discussion at the end of each part of the video).

Part 3 – Implementation (optional)
- Learning from incidents culture (Hearts and Minds)
- Follow-up and Implementation (sharing good practices)

Preparations
- E-learning Reflective Learning for facilitators (on Hearts & Minds site)
- Review Reflective Learning websites & Materials
- Survey "Understanding your Learning from Incidents" Culture

Tips for implementation

On facilitation
- **Practice, practice, practice...** Don't be afraid to make mistakes.... Learn from them!
- Have an **experienced facilitator coach you** during a reflective learning session.
- **Preparation is key** - read the tips in the facilitator guidance for each topic carefully.
- **Coach line leaders** in becoming good Reflective Learning facilitators - a facilitator learns a lot from every session too!

Overall
- Embed reflective learning in your business improvement journey - make it part of the yearly HSE improvement plan.
- The time needed for a good session (at least one hour) is a big time investment – don't do more than two per year.
- Join forces with your contractor partners.
- Be aware of your 'LFI culture' – the support and behaviour of seniors leaders is key. If you are too busy investigating incidents, try to get out of the 'reactive modes' (e.g. focus investigations on the higher potential consequence events, or those where there is more learning potential).

There are no new incidents, only new victims!
Don't let the same incidents, that happened elsewhere, happen at your locations!

LFI culture

LFI is an important part of safety culture. Before considering reflective learning, first be sure that you have the right level of maturity. Reflective learning will not be effective if the organisation is lower on the culture ladder – i.e. unwilling to learn, blames the workforce. Reflective learning can help take the organisation from calculative to proactive.

Generative
'HSE' is how we do business around here

- Leaders are trusted to listen to, and act upon, what they are told by the workforce.
- 'Incidents are caused by complicated interactions between systems, processes and people'. Managers want to know the part they played.
- All meetings are genuine learning opportunities to discuss anything.
- Incident reports are seen as learning opportunities. Managers ask 'What are we missing' if no problems have been reported.
- Investigations uncover the underlying causes and system interactions.
- The frontline drives learning.

Proactive
'Safety leadership and values drive continuous improvement'

- Leaders visit the workplace, talk with staff and try to fix issues.
- 'Incidents are caused by poor procedures and systems'. Managers admit they have a role to play.
- HSE can be raised in any meeting. There is genuine interaction between workers and managers.
- There is a clear and efficient system for reporting incidents. Quality is more important than quantity.
- Detailed investigations identify underlying causes. Managers accept the findings, even when they are implicated.
- Teams are engaged to learn from incidents specific incidents.

Calculative
'We have systems in place to manage all hazards'

- Leaders know what to say, but not how to listen.
- 'We have a management system so why are we still having incidents?' – it is believed 'behaviour' causes incidents.
- There are regularly scheduled HSE meetings, but little workforce/ management interaction.
- There is a complicated process for reporting incidents – and targets for number of reports and observations.
- Detailed investigation reports produce lots of information, but underlying causes are not addressed. Managers do not readily accept the findings.
- Lots of 'learning actions' – but too many to implement.

Reactive
'Safety is important. We do a lot every time we have an accident'

- Leader's say they care, but workers' basic needs are not always met.
- 'Incidents are caused by 'bad luck''. 'The workforce cause most of the problems'.
- HSE is a small part of meetings – but it is not considered 'real work'.
- Incidents are reluctantly reported – and often reclassified to make them seem less worse.
- Specialist investigators are bought in to investigate incidents. A few easy fixes are made then the report is ignored and forgotten about.
- Learn by retraining those involved in the incident.

Pathological
'Who cares as long as we're not caught'

- Leaders just want the job done - showing little care for the workforce.
- 'Incidents are an unavoidable part of the job' caused by 'reckless people'.
- Safety is not discussed in meetings.
- Incidents are not reported. 'Shoot the messenger' – there are negative consequences for those who report incidents.
- Investigations are superficial. They aim to find out 'who is to blame?'
- We don't learn – we punish.

LFI culture exercise

1. Decide where you would like to be on the culture ladder in 2 years time (‘declared near future’).
2. Determine where you are now.
3. What could you do to close the gaps?

- Start with senior leaders
- Define and agree critical process improvement indicators (to monitor progress)
- Involve staff in the process

Video 1 – Chronic unease

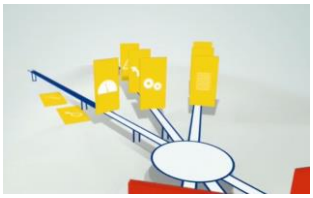
Key lessons

- Being in a constant state of ‘chronic unease’ can help to identify weak signals.
- The impact of ‘mind traps’.
- How our brain works (fast thinking and slow thinking).

Content

- The first part of the video is called ‘Chronic Unease’. There we see what chronic unease means, using different practical examples from daily life.
- The second part of the video is called ‘We are all human’. There we see how our minds work and how this relates to the actions we take or don’t take related to safety.
- The last part is called ‘Mind traps’. It explains the biases that we have and how they can affect our actions related to safety.

Video 2 – I own my barrier



Key lessons

- Participants understand their role in managing process safety barriers.
- Participants understand that we cannot rely on just one barrier.
- Individuals go out and verify that the barriers they are responsible for are in place and working.

Content

- The first part of the video makes people aware that incidents can happen if barriers are not in place. Piper Alpha is used as an example.
- In the second part, the bow tie is described. There are hardware and human barriers, which are supported by critical processes.
- In the last part of the video we see a petal model appear, a visual representation of asset integrity. ‘We know our assets and we know they are safe!’

Video 3 – I keep my barrier strong

Key lessons

- Stop, step back and review, when faced with new threats and hazards.
- Stabilise, slow down, shut down if you cannot operate within safe limits!

Content

- In the first part of the video we see two scenarios, one about a ship that enters the 500 meter safety zone, and one about a pigging operation. Note: the examples are simplified illustrations and therefore do not include all operational details that would exist in real situations.
- In part 2, the story develops and we see the situation changing. New threats and hazards appear.
- The last part of the video explains normalisation of risk and the fact that we are often too optimistic about the outcome of our actions and plans.

Video 4 – Stay out of the line of fire

Key Lessons

- Awareness to stay out of the line of fire.
- Learn about hardware and human barriers, and the critical processes that support the barriers to prevent line of fire incidents.

Content

- First part of the video makes people aware of ‘line of fire’ situations.
- Second part of the video shows a number of ‘line of fire’ incidents.
- Last part explains how to prevent ‘line of fire’ incidents, introducing a simple barrier concept.

Video 5 – Together we can lift safely

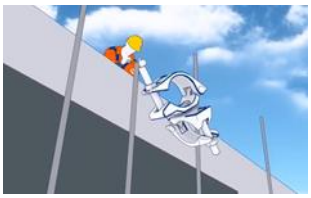
Key Lessons

- Understanding the role that gravity plays in lifting operations.
- The importance of creating and maintaining strong barriers in every phase of work.
- Having situational awareness in the office and on-site and the ability to imagine what could go wrong.

Content

- In the first part of the video we see an apple and a tool falling from a tree, illustrating the power of gravity. Examples of industry lifting and hoisting incidents are shown.
- In the second part of the video, the importance of every step in the process is explained. It all starts with planning. We see an incident evolving over time, starting in the office and ending on site.
- In the last part of the video, situational awareness is explained. Imagine what could happen next and having a clear understanding of your role in owning barriers or critical processes is crucial to reduce the risk of lifting and hoisting incidents.

Video 6 – Stop drops



Key lessons

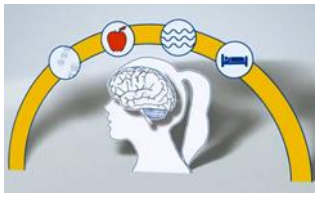
- We have many barriers and controls to reduce the risk of dropped objects in the workplace, but they still happen.
- Behind every dropped object there is a story, and we’re all part of it.

Content

In the video three different types of dropped objects incidents are shown:

- In the first part of the video, we see workers on top of a tank. Various barriers and controls are in place, but a flange that is being removed slips out of their hands.
- In the second part of the video, we see a corroded bolt lying on a walkway of an offshore platform. Later, a piece of angle iron falls to the walkway in the same area and strikes a worker.
- In the last part of the video, a story is presented about a dropped object incident on a drill ship during a lifting and hoisting operation.

Video 7 – Sleep matters



Key lessons

- Participants understand why getting sufficient sleep is important for their safety and the safety of those around them.
- Participants understand what could happen if they become fatigued and what they can do to prevent this from happening.

Content

- In part 1 of the video, the concepts of sleep and fatigue are introduced and where fatigue situations may occur in the workplace. It is stressed that one might not be aware of being fatigued.
- Part 2 gets the audience ready to reflect on their sleeping arrangements, environment and habits and to see how they can improve the quality of sleep for themselves and the whole family.
- In the last part of the video we look at how recognising fatigue and respecting sleep needs is a shared responsibility, involving the individual, their family and work colleagues.

Video 8 – Removing the hazard

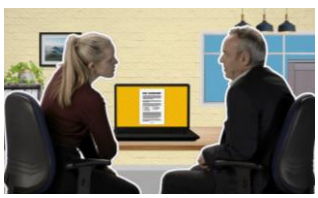
Key Lessons

- Participants understand the importance of applying the hierarchy of control.
- Participants can identify what risks they have normalised.
- Participants discuss their dilemmas within their team, and with the line manager.

Content

- In part 1 the ‘hierarchy of control’ is introduced, showing some examples of how it can be applied.
- Part 2 explains the fact that people may accept hazards. It includes examples of how people may have become blind to risks they take every day.
- In part 3 the ‘hierarchy of control’ is further explained, showing more examples of how it can be applied. The importance of taking care of yourself, your colleagues, family and friends is emphasised.

Video 9 – Only together



Key lessons

- Only together can client and contractor manage safety.
- A contract HSE plan needs to be more than just a piece of paper – bring it to life!

Content

- In part 1 two stories unfold – a contractor wants to impress a new client, and a client wants to get a routine job done quickly – resulting in disaster for the contract workers.
- Part 2 explores what went wrong at the client/contractor interface level.
- Part 3 explores what makes a good contract HSE plan, and how to turn paper into practice. Only together can we manage HSE.