How to Select Areas for Interventions

Selection of priority areas for intervention can utilize several techniques:

1. Identification of an intervention area based on knowledge and expertise of the Ergo-Team

   This is the simplest and cheapest technique but there are some downsides. For example:

   - It could potentially result in the intervention being driven more by known complaints from workers and could miss other areas requiring intervention.
   - It could result in the work of the Ergo-Team being seen as favouring team members and their friends.

   Also, using this approach, the intervention will not engage or involve people outside the team during the selection process and will thus lose this opportunity to publicize the team and its work.

2. A review of JHSC minutes and workplace inspection reports

   This technique is also relatively simple and cheap. It could help the Ergo-Team identify areas of concern that have already been brought to the attention of the JHSC and thus has the potential to promote support for the Ergo-Team's work among the committee members. However, many incidents and types of injury (including chronic rather than acute injuries) may not be reported to the JHSC. Reporting is also affected by leadership and training in departments so is likely to be uneven in many enterprises.

   Using this technique to select intervention areas does not allow for input from personnel outside the JHSC and will not help to engage employees in the Ergo-Team process from various levels of the company.

3. Interviews with supervisors and union personnel (if applicable)

   This technique shares the strengths and weaknesses of the techniques discussed above.

   If used alone, this technique also marginalizes the concerns of workers on the production floor and loses an opportunity to engage them actively in the PE process.

4. A review of company files on compensation claims for soft-tissue injuries

Depending on the number of claims, this technique can be relatively simple and inexpensive.

It ensures areas that have had a high incidence of reported injuries and are thus of concern to management are brought to the attention of the team.

However, these data generally do not tell the whole story; certain kinds of incidents are often more likely to be reported than others and some groups of workers (e.g. full-time) might be more likely to file claims than others (e.g. part-time).

Compensation claims contain personal identifying information and there are thus privacy concerns associated with accessing these records that would have to be dealt with by the company prior to their use. One possibility would be for management personnel to generate a summary of claims data for the team showing the nature of the injury, cause of the injury, department where the person worked and when the injury occurred. It might make sense to limit claims data to the last 2-3 years.

5. Administration of an *Anonymous Body Discomfort Survey (Body Map Survey)* to the full plant labour force

(See TrainingWorkbook - Module Four for a fuller discussion of this option)

This technique is probably the most costly and resource intensive of the techniques available.

It would allow the Team to gather input from employees from every department (management and workers) about possible musculoskeletal problems.

The results are largely anonymous, which minimizes concerns about privacy and confidentiality. However, in the case of respondents from small departments it may be possible to identify individual workers based on the information contained in their survey. As a result Ergo-Team members must take care to limit access to the individual surveys and ensure these are not seen by or directly discussed with individuals outside of the team. They should also only release a summary description of the body map findings and problem areas to employees and managers outside of the team.

Surveys have the disadvantage of providing only limited contextual information including participant perceptions about what is putting them and others at risk of WMSDs in that area. An example of relevant contextual information that is difficult to collect in a short survey is the work history of participants, which can play a role in the pattern of WMSDs across departments. For instance, a high number of WMSDs might turn up in surveys from a department to which injured workers have been moved in the past to reduce exposures. Such work areas may appear to be high risk when in fact they are not.

Given that all of the techniques for identification of areas for intervention have strengths and weaknesses, the ideal strategy would employ two or more techniques. However, the number and type will depend on the resources available.

REMEMBER: All of these techniques require, to varying degrees, the potential to gain access to private information about employees. Precautions should be taken to ensure all personally identifiable information remains confidential.

When the Team has collected information on areas that appear to require an ergonomics intervention, how do they decide which area(s) to target and in what order?

The Ergo-Team will be using the first intervention as a training exercise. The whole process will not be well understood by most people in the enterprise. The results of the first intervention, if negative, could seriously hamper enterprise and department-level support for the overall Ergo-Team approach. For these reasons it makes sense to select an area for the first intervention with the following characteristics:

- There is clear evidence that WMSDs or their symptoms are present.
- The area is visible to other employees so they have an opportunity to observe the team at work and to learn about the process.
- The problems to be solved are relatively easy to diagnose and likely to be fixable quickly and without extensive capital investment.
- Workers and management in the area are enthusiastic about the Ergo-Team approach and very open to participating in the intervention.