Change Is the Hazard



The next serious loss may already be underway, even though nothing is broken and nobody has been hurt.

A supplier changed. A production target increased. A machine was moved. A new supervisor took over the night shift. A temporary bypass is still in place. A software update changed an alarm screen. A contractor substituted a different piece of equipment. None of those decisions necessarily looks like a safety event.

But each one changes the conditions under which people work. When several happen together, the risk picture can move much faster than the procedures, training, supervision, and controls designed for the old version of the job.

> **Organizations are usually good at managing projects. They are much less disciplined about managing the thousands of small changes that quietly alter risk.**

Risk rarely stands still

Traditional safety systems often assess hazards as though the workplace were a stable object. Inspect the machine. Write the procedure. Train the worker. Audit the process. Then repeat at a scheduled interval.

Real operations do not wait for the next audit. They change continuously.

People leave. Production grows. Materials change. A customer requests a different specification. New software is installed. A maintenance problem creates a workaround. The organization adds a second shift. A layout is tightened to create storage space. Contractors arrive with unfamiliar methods. Small decisions accumulate until the work being performed is no longer the work that was originally assessed.

That is why change itself deserves to be treated as a risk signal.

Process safety already knows this

OSHA’s process-safety framework has long required covered employers to manage changes to process chemicals, technology, equipment, procedures, and facilities before implementation. The logic is straightforward: a change can invalidate assumptions that made the previous operating condition safe.

OSHA’s updated 2026 Process Safety publication gives concrete examples. Changes in production rates, raw materials, equipment availability, new equipment, computer programs, alarms, interlocks, operating conditions, and instrumentation can all require review. It also warns that temporary changes have contributed to catastrophes and can quietly become permanent when their duration is not controlled.

Most workplaces are not covered by the Process Safety Management standard. The insight is still useful far beyond refineries and chemical plants.

If a change can alter exposure, control effectiveness, emergency response, competence, or the interaction among work groups, somebody should ask what the change did to risk.

Small changes can create large interactions

Consider a distribution operation that makes four ordinary decisions in the same quarter.

- Warehouse volume increases 18 percent.
- A second staffing agency is added to cover vacancies.
- Racking is reconfigured to create more pick locations.
- A new fleet of faster lift trucks is introduced.

No single decision is reckless. The combined effect is different. More temporary workers are learning a changed layout while traffic density is rising and equipment characteristics are changing. Supervisors are also busier because throughput has increased.

The original pedestrian plan may still exist. The orientation may still be current in the LMS. The lift-truck course may still show as complete. Yet the operating context has moved.

> **The hazard may not be any one change. The hazard may be the interaction among several changes that the organization assessed separately.**

Measure change load, not just individual

changes

This is where a useful new concept emerges: change load.

Change load is the cumulative burden created when operational changes occur faster than people, procedures, supervision, training, maintenance, and controls can absorb them.

A rapidly growing business can therefore become riskier even while every individual project appears well managed. Its systems are absorbing more new people, more equipment, more exceptions, more information, and more coordination demand at the same time.

For safety managers and insurers, that matters because loss history is backward-looking. Change load can be an early indicator of tomorrow’s loss experience.

A simple change-load screen

Signal	What to ask	Why it matters
People	**Are there new hires, contractors, supervisors, or staffing models?**	**Experience, communication, role clarity, and supervision may change.**
Production	**Has volume, pace, schedule, or overtime increased?**	**Exposure and time pressure can increase even if the task is unchanged.**
Equipment	**Has machinery, software, tooling, attachment, layout, or guarding changed?**	**Existing procedures and training may no longer fit.**
Materials	**Has a product, chemical, supplier, packaging, or raw material changed?**	**Hazard properties and handling assumptions may change.**

Signal	What to ask	Why it matters
Organization	**Has ownership, reporting structure, maintenance support, or contractor responsibility changed?**	**Controls can fail at interfaces even when technical hazards remain the same.**
Emergency response	**Would the old emergency plan still work under the new condition?**	**A new layout, process, shift, or staffing level can invalidate response assumptions.**

Use SHIFT before the change becomes normal work

A practical change process does not need to become a bureaucracy. The purpose is to identify the changes that can alter meaningful risk and make sure the right controls move with them.

S: Spot the change

Create simple triggers so operational changes are visible to safety, operations, maintenance, HR, and other affected functions before implementation. Do not rely on the safety manager hearing about the change informally.

H: Hazard-assess the consequences

Ask what new hazard is created, what existing hazard changes, and which old assumption may no longer be true. Consider both the changed task and its interfaces with nearby work.

I: Identify affected controls and people

Which procedures, alarms, guards, PPE, permits, emergency plans, qualifications, contractors, supervisors, or inspections are affected? Who needs new information before the change goes live?

F: Fix capability and documentation

Update procedures, job aids, training, orientations, permits, and maintenance information. Assign learning by role rather than sending a generic message to everyone.

T: Test before normalizing

Verify the changed system in practice. Observe the work, ask workers what changed, confirm critical controls, and close temporary measures instead of allowing them to become the new normal by default.

Temporary is a risk category of its own

Temporary controls deserve disproportionate attention because people adapt quickly.

A temporary barrier becomes part of the scenery. A temporary bypass survives the outage. A temporary traffic route stays because production likes it. A temporary procedure is printed, copied, and eventually treated as permanent even though nobody formally reviewed the long-term consequences.

OSHA’s process-safety guidance is particularly useful here. It recommends time limits for temporary changes and a process to return equipment and procedures to the original or intended condition when the temporary change ends.

Every organization can borrow that discipline. A temporary change should have an owner, an expiry date, a compensating control where needed, and a clear decision about whether it will be removed or formally adopted.

Training lag is one of the clearest warning signs

One of the easiest ways to see that change load has exceeded the system’s capacity is training lag.

The new equipment is already operating, but the course still describes the old interface. The procedure was updated, but contractors have not received the revision. The layout changed, but the orientation video still shows the previous traffic route. A new supervisor has authority over a high-risk process but has not been trained on the site’s escalation rules.

At that point the organization is asking people to bridge the gap with informal knowledge.

That is exactly where SafetyNow can support the training layer without pretending to be the entire change-management system.

Scaling the training layer

When a change alters what workers need to know or do, the organization needs a reliable way to move from the change decision to workforce readiness. That may mean updating custom content, assigning a short change briefing, retraining one role, refreshing contractor orientation, adding a safety talk, or documenting an equipment-specific assessment.

SafetyNow can support that part of the system through role-based assignments,

custom content, mobile delivery, multilingual learning, instructor-led resources, assessments, and centralized records.

A learning platform does not replace engineering review, hazard assessment, supervision, Management of Change, or field verification. Its job is narrower and useful: make sure affected people receive the right learning intervention and give the organization evidence that the intervention occurred.

Explore: SafetyNow Online Training | SafetyNow LMS

The insurance question should become what changed

Loss-control reviews often begin with historical performance. What claims occurred? What recommendations remain open? What does the incident trend show?

Those questions matter, but they describe the business that existed yesterday.

A more forward-looking insurance conversation adds another question: What has changed since the last review?

A policyholder that has doubled volume, added temporary labour, installed automation, changed suppliers, opened a second shift, and reorganized maintenance may have a materially different risk profile even if its loss history still looks excellent.

That is why change absorption capacity could become a useful qualitative measure of risk quality. The strongest organizations do not merely make changes. They have a repeatable process for absorbing those changes into procedures, training, supervision, maintenance, emergency response, and field verification.

The financial risk appears before the claim

Change also has a cost before anyone is injured. Poorly absorbed change creates rework, downtime, overtime, quality problems, supervisor intervention, contractor confusion, maintenance errors, and startup delays.

Suppose a production change affects 80 employees and creates an average of 20 minutes of avoidable confusion or rework per employee per week for eight weeks. At a loaded labour cost of $46 per hour, that friction alone is about $9,813. The calculation is illustrative, but the principle is useful: change that is not absorbed cleanly creates measurable operational drag long before it produces a claim.

If the same change also weakens a critical control, the downside becomes much larger. The organization may be carrying both productivity loss and elevated severity potential at the same time.

The Operational Change Risk and Training Trigger

Safety managers can start with a one-page trigger rather than a complex governance project. For every meaningful operational change, ask whether any of the following changed.

Trigger	Question
Task	**Will people perform a new step, sequence, frequency, or pace?**
Equipment	**Did machinery, tooling, software, alarms, controls, guarding, or layout change?**
Hazard	**Did energy, chemical, ergonomic, traffic, environmental, or public exposure change?**
People	**Are new workers, contractors, supervisors, or roles involved?**
Interface	**Does the change alter how departments, contractors, vehicles, or processes interact?**
Emergency response	**Would the old emergency plan still work?**
Competency	**Does anyone need a new skill, qualification, decision rule, or refresher?**
Documentation	**Do procedures, permits, orientations, inspections, or job aids need revision?**

If the answer is yes, add three follow-up questions: Who needs to know? What do they need to learn or verify? How will we confirm readiness before the change becomes normal work?

A 60-day change-load audit

Period	Action	What to learn
Days 1-15	**List significant operational changes from the last six months. Include people, production, equipment, materials, software, contractors, and temporary measures.**	**Where change occurred outside the formal safety process.**
Days 16-30	**Select the five changes with the highest potential consequence or widest workforce impact.**	**Which procedures, controls, and training were affected.**
Days 31-45	**Observe the changed work and interview workers and supervisors.**	**Where work-as-performed differs from the updated plan.**
Days 46-60	**Close the highest-risk gaps and establish a simple SHIFT trigger for future changes.**	**Whether the organization can absorb change deliberately instead of reactively.**

The next claim may begin as a change request

Many losses look sudden when viewed from the moment of failure. Look further back and the story is often slower.

Something changed. A workaround appeared. A workload increased. A supplier substituted a product. A new worker entered the system. A control no longer fit the job. People adapted until the deviation felt normal.

The lesson is not to resist change. Growing, competitive organizations must change.

The lesson is to make risk move at the same speed.

> **The next serious loss may not begin with a broken rule. It may begin when the work changes faster than procedures, training, supervision, and controls can keep up.**

Key takeaways

- Treat meaningful operational change as a risk signal, not merely a project-management issue.
- Use change load to think about the interaction among multiple simultaneous changes.
- Apply SHIFT to Spot the change, Hazard-assess consequences, Identify affected controls and people, Fix capability and documentation, and Test before normalizing.
- Put owners and expiry dates on temporary changes so they do not quietly become permanent.
- Watch for training lag as an indicator that the organization is absorbing change too slowly.
- For insurers, ask what changed since the last review, not only what losses occurred.
- Use SafetyNow only for the training and communication layer, not as a substitute for hazard assessment or operational change management.
- Measure change-related operational friction as well as injury outcomes.

Download the full guide below.