The People Part of Safety:

How to jumpstart a safer workplace

You play a critical role in helping your team follow safety and health practices every day. Your actions shape what people do in real moments—especially when things are busy, unclear, or competing priorities arise. This guide is designed to help you create the conditions where the right behaviors happen consistently.

Using this guide, you will be able to:

- Recognize what gets in the way of safety and health behaviors
- Use simple tools to support people in doing the right thing, the right way
- Create conditions where safe practices are easy, expected, and meaningful
- Make small changes that lead to more consistent, reliable actions over time

Washington Food Coalition
wafoodcoalition.org

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The People Part of Safety was written by Mark Nilles and Nancy Bacon.

Nancy Bacon CONSULTING
revolutionizing the role that learning plays in the nonprofit sector

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Overview

There are 5 main topics for you to know related to people and safe behaviors.

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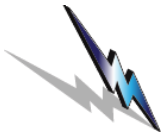
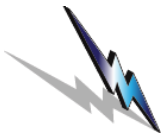
This course is accompanied by a series of short videos, available from nonprofitsafetyhero.com.



We recommend that you print this document and have a pen or pencil handy. We've provided exercises where you can reflect on your situation and make plans. The first one is below.

Before we start…Think of a real situation in your food bank.

Write a few notes. You'll come back to this example throughout the guide



Who is someone you want to support? (a volunteer, staff member, or team)

What is one behavior you want to see happen more consistently? (e.g., logging temperatures, using seatbelts, checking food quality)

When does this behavior break down? (e.g., busy times, shift changes, unclear moments)

What tends to happen instead?

A Day in the Life of a Food Bank

On a busy Thursday afternoon, things at the food bank were moving fast. A late delivery just arrived. The line outside was already wrapping around the building. Volunteers were packing boxes as quickly as they could.

Maria had been a reliable volunteer for years and was considered a mentor for newer volunteers.

As she worked the packing table, Maria opened a box of donated chicken from the late delivery. It felt a little warmer than it should have. Not warm exactly… just not cold. She paused for a moment, weighing her options.

But the line was long. People were waiting, and she was eager to distribute food and help fulfill the bank's important mission of food distribution. Plus, another experienced volunteer was helping to unload the late delivery, so she assumed everything had been checked.

She packed the chicken into the food boxes and kept working.

Two days later, the bank manager got a call from the county health department. A mother who had picked up food that Thursday afternoon spent the night in the emergency room with severe food poisoning. Her eight-year-old son was sick too.

The health department traced the tainted food back to the bank.

Maria was devastated. She kept replaying it in her mind — the moment she felt unsure and chose speed over safety.

The food bank closed for two weeks while the health department investigated. Families who depended on their food were forced to find alternative sources. Food bank staff spent their time supporting the investigation and sanitizing the food bank rather than serving the community.

And the hardest part? **Everyone involved cared deeply**. Every volunteer and staff member simply wanted to help.

But caring isn't what keeps food safe. Practices do: the good behaviors that become habits; the agreed-upon non-negotiables; the small decisions; the moment you stop when things don't seem quite right; the extra five seconds you take to buckle your seatbelt on the forklift. All of the times you risk disrupting or delaying food distribution to follow the correct health and safety practices. These practices - small or significant - matter.

Because every box of food handed to someone carries something bigger than groceries. It carries trust.

What resonates with you from the opening story?

What close calls have you experienced?

When have good intentions not led to safe outcomes?

1. Good intentions are not enough

You work with people who care. They show up because they want to help. They want to do the right thing for their neighbors and for each other.

And yet—mistakes still happen. Food gets handled in ways that aren't quite right. Steps are skipped. Something feels "a little off," but the work keeps moving.

This doesn't happen because people don't care. It happens because the real world is messy.

- There are competing priorities.
- There is time pressure.
- There are assumptions that someone else has taken care of it.
- There are habits that take over when things get busy.

In those moments, people are making the best decision they can with what is in front of them. As a leader, this gives you an important starting point: **If you want behavior to change, you have to understand what is shaping it.**

Before we look at tools or solutions, let's pause and look more closely at those moments when things don't go as expected.

Think about your organization

What are the moments in your food bank when people are most likely to skip a step or take a shortcut?

What tends to happen in those moments? (For example: rushing, unclear roles, missing tools, long lines, distractions)

Think of a specific situation where a step was skipped or someone got hurt. What do you believe was going on for that person at the time?

2. Understanding behavior

Behavior is what a person actually does in the moment as they work—whether driven by deliberate decisions or habit.

Human behavior is complex. Have you ever wondered:

- Why do good people sometimes fail to follow good practices, even when they know them?
- Why is "doing the right thing" not always clear, especially when faced with competing priorities?
- How can you support your staff members and volunteers to do the right thing reliably, even under challenging circumstances and even when no one is watching?

Let's explore **behavior change** and practical steps you can take to create conditions where safe and healthy practices are known, understood, prioritized, and followed. And more importantly, where the mission of your food bank is fulfilled.

One popular model that helps explain human behavior has three essential conditions for behavior: **Capability, Opportunity, and Motivation**. This is known as the COM-B model (the B stands for Behavior). We can introduce it with the following questions:

- **C**apability – Can they do it?
- **O**pportunity – Is the situation set up so it's easy to do?
- **M**otivation – Do they want to do it, even when it's mildly inconvenient?

As a food bank leader, COM-B helps you ask, "When someone skips a safety step—like a seatbelt on a forklift or a temperature check—**what's really getting in the way, and what can I change to fix that?**"

Think about the person you described on page 1.

Which of these three ideas might be getting in the way? (Capability, Opportunity, or Motivation).

Let's explore these ideas in more detail one by one.

A: Capability – Can they do it?

Capability is about whether someone has the knowledge, skills, and confidence to carry out a task successfully.

- **Knowledge** – Do they know what to do?
- **Skills** – Can they perform the task correctly?
- **Confidence** – Can they do it reliably, even when they're busy or something feels off?

Even when people care, they may skip a safety or health step because something is missing in one of these areas.

Practically speaking, this might look like:

- They aren't aware of the health and safety practices they're supposed to follow (**knowledge gap**)
- They've heard what to do, but haven't been shown how to do it step-by-step (**skills gap**)
- They were shown once, but haven't practiced enough to feel confident (**confidence gap**)
- They know the steps, but forget them in the moment—especially when things are busy or stressful
- They aren't sure what to do when something doesn't look or feel right, so they keep going

When capability is the issue, the solution is not more reminders—it's better learning, practice, and support in the moment.

Think about a task in your food bank that people don't consistently get right.

- Is this a knowledge gap?
- Is this a skills gap?
- Is this a confidence gap?
- I don't know. *That is a perfectly fine answer.*

How does identifying the gap lead you to possible solutions to improve safety practice?

Two knowledge cautions

Knowledge matters—but how you build it matters just as much.

Two common challenges show up in nonprofits:

1. People forget
Many staff and volunteers are part-time or episodic in their work schedule. Even when something is explained clearly, they may not remember it later—especially when things get busy. Forgetting is human.

2. Too much information creates overload
It's easy to respond by adding more instructions, more detail, or longer orientations. But when people are given too much to hold in their heads, they are more likely to miss steps in the moment.

So what works?

Focus on how learning shows up in the work:

- Keep it to a few critical steps, not everything at once.
- Show and practice, rather than just explain.
- Place reminders where the task happens.
- Build learning into the flow of work, not separate from it.

The goal is not for people to remember everything. The goal is for people to do the right thing at the right time.

B. Opportunity – Is the system set up for success?

Opportunity is about the conditions around the work. It's the environment, tools, timing, and workflow that make a behavior easy—or hard—to do.

Even when people know what to do and are capable of doing it, they may skip a step if the situation doesn't support it.

Opportunity answers the question: *"Does this environment make it easy to do the right thing?"*

Practically speaking, this might look like:

- They know they're supposed to follow safety and health practices, but there's limited time. Other urgent tasks feel more important.
- The tools or supplies required to follow safety and health practices don't function properly, are hard to find, or are in short supply.
- The steps are not built into the normal flow of work, so they feel like an "extra" rather than part of the job.
- The physical setup (layout, spacing, storage) makes it difficult to follow safe practices.
- There is no clear or consistent way of doing the task, so people create their own shortcuts.

When opportunity is the issue, the solution is not training or telling people to try harder—it's changing the conditions so the *right* behavior is the *easiest* behavior.

Think about the person you described on page 1. Look closely at how the work actually happens.

- Where does this task break down? (start of shift, during busy times, handoffs between people)
- What makes it harder in the moment? (no time, too many steps, unclear order, interruptions)
- What is missing or out of place? (tools, supplies, labels, working pens, clear instructions)
- Where are people creating their own shortcuts or workarounds?

Now focus on one point in the process:

What is one thing you could move, remove, or simplify to make this easier to do right?

Write down one small change you could test:

C. Motivation – Do they want to do it now?

Even when people are capable and the system supports them, they may still skip a safety step if they don't feel a strong reason to follow through. That's where motivation influences action. Motivation is about what matters to people the moment they are making a decision. It's not just about knowing what to do. It's about whether the person *chooses* to do it—especially when it's inconvenient.

Simply put, **motivation answers the question:** "Is this worth doing right now?"

Two factors shape motivation:

- **Agency** – Do I believe my actions make a difference?
- **Relatedness** – Do I feel a shared responsibility and a connection to the organization's mission?

Practically speaking, this might look like:

- They know they're supposed to follow health and safety practices, but it doesn't feel like their actions make a real difference (**low agency**).
- There is little reinforcement—positive or negative—so the behavior doesn't feel important (**low agency**).
- They feel like safety steps are "just rules," rather than part of caring for neighbors (**low relatedness**).
- They feel disconnected from others and/or the organization's mission (**low relatedness**).
- The practices feel imposed or out of sync with how work actually gets done.(**low relatedness**)

Think about the person you described on page 1.

Do people believe this behavior makes a difference?

What gets noticed or praised right now?

What is one small way you could increase either agency or relatedness?

3. Behavior: From insight to action

When a safety step is missed, don't jump to conclusions. Start by asking: What's getting in the way? Use the questions below to sort what you're seeing.

Here's the thought process.

Scenario	Capability (C)	Opportunity (O)	Motivation (M)	What could you try?
What happened?	Do they know how to do it?	Is the system set up for success?	Does it feel worth doing?	What is one small change you could test?

Go back to the example you identified earlier.

What happened? Work through our questions to identify something to try.

Scenario	Capability (C)	Opportunity (O)	Motivation (M)	What could you try?
What happened?	Do they know how to do it?	Is the system set up for success?	Does it feel worth doing?	What is one small change you could test?

How does this process differ from how you identified solutions in the past?

How might it be helpful in the future?

4. Safety and health systems

The behaviors you see every day are shaped by how your food bank operates. What people do—especially in busy or uncertain moments—reflects what is expected, what is supported, and what is reinforced over time.

In this section, you'll take a closer look at how your current system is working and where you can strengthen it. You will:

- Assess what's already in place
- Identify one area to improve
- Use practical tools to make safe and healthy behaviors easier and more consistent

You don't need to change everything at once. Start with one area, take one step, and build from there.

If you want to go deeper, see the Safety Leadership resources for additional tools and examples.

https://nonprofitsafetyhero.com/courses/safety-leadership/

A. Safety and Health Systems Assessment

As a food bank leader, *you* play a critical role in developing a system that supports safety and health.

The self-assessment on page 18 explores eight domains that influence the system. Each domain has three statements, and each rating is assigned a point value: the truer you find the statement, the more points that statement receives. After you rate the three statements, write the domain point total in the space above the statements.

REFLECTION

Review your responses and circle the domain that received the lowest score or that you feel is your greatest priority.

What is one step you can take in the next month to improve in this domain?

What other statements or domains are important for you to think more about as you strengthen your safety and health system?

B. Psychological Safety

Safety and health systems depend on how well you foster psychological safety within your team.

As noted in a study of psychological safety at hospitals: "*Team psychological safety is a shared belief by team members that it is acceptable to explore possibilities, express ideas and concerns openly, speak up with questions, and share mistakes, without fear of negative consequences. Psychological safety fosters work environments that enhance team performance, innovation, creativity, resilience, and learning.*"

Fostering psychological safety does not mean being soft on safety. When you foster psychological safety, you make it safe for everyone to be open about risks, mistakes, and near-misses. This enables you to *avoid harm* rather than deal with the consequences of human error and risky behaviors.

Reflect on these questions to help gauge the level of psychological safety in your food panty:

Think of the last time someone pointed out a safety risk (e.g., no seatbelt on a forklift, blocked exit, warm fridge). What did you say and do at that moment?

On a typical day, how many safety-related questions do you hear? If the number is "almost none," could that be a sign people don't feel safe asking?

After an incident, do you ever say to the team: "Thank you for telling us. Let's figure out how to make it harder for this to happen again"?

Some practical steps to foster psychological safety:

Idea	How this might look
Adopt a "first response" habit. Decide how you will respond the next time someone points out a risk or mistake.	*Step 1:* Say "Thank you for catching that." *Step 2:* Ask "What do you think would make this easier to get right next time?" *Step 3:* Share with the team one change you'll test based on what you heard.
Build a standing "safety moment" into one meeting each week.	At the start or end of a shift: *Ask:* "Did anyone notice a safety concern or near-miss this week?"

	Briefly discuss what you learned and one small change you'll try (a sign, a layout tweak, a reminder). *Recognize* at least one person who spoke up or took a safe action so the team sees that speaking up is expected and appreciated.

Even these small, regular actions send a clear message: **"In this food bank, it is safe—and expected—to talk openly about safety so we can protect our neighbors and each other."**

C. Understanding mistakes and responding fairly

At this point you know it is important to understand what's behind individuals' actions and behaviors. The same is true when developing safety and health systems. There are various reasons why problematic issues and mistakes happen. As a leader, you can treat errors fairly and adopt learning-focused strategies that will reduce future incidents. We will consider three broad types of mistakes and issues:

- **Human error** ("honest mistake"): A volunteer was trying to do the right thing, but prioritized the wrong thing, forgot, or was confused.
- **At-risk behavior** ("risky shortcut"): Someone makes a choice that increases risk, often to save time or effort, without fully seeing the danger.
- **Reckless behavior** ("major violation"): Someone knowingly ignores a serious rule, with clear warnings, or does something obviously dangerous.

Fair and learning-focused strategies in each of these situations can look like this:

Mistake type	Example	Suggested response	Your priority
Human error	A volunteer misreads a label and stores an item in the wrong place.	*Console and coach*: "It's helpful to identify these types of issues. Let's solve this problem and make it easier to get this right next time."	Improve the environment; take steps to reinforce safe and healthy knowledge and action (e.g., clearer labels, better job aids, practice sessions).
At-risk behavior	A forklift operator skips the seatbelt on "just a quick trip," or a staff member doesn't record temps because "the cooler seems fine."	*Explore and coach*: "What made skipping that step seem okay?" Together, agree on safer practices.	Change incentives and support good habits (e.g., make the safe way easier, explain the risk, set expectations).

Mistake type	Example	Suggested response	Your priority
Reckless behavior	Driving the forklift too fast in a crowded aisle after being warned, intentionally bypassing important safety steps, or driving under the influence.	*Formal warning or disciplinary action*: "Some actions are strictly off limits here. We need to protect others first."	Health and safety are paramount. Make it clear that certain behaviors are not acceptable here.

Think about a recent mistake or close call.

Which type was it: human error, at-risk behavior, or reckless behavior?

What was likely behind it?

How did you respond? What might you do differently next time?

5. Systems: From insight to action

What people do in the moment is shaped by the system around them.

When safe and healthy practices happen consistently, it's not by chance—it's by design. It's because the right conditions are in place. People know what to do, the work is set up to support it, and it feels important to follow through.

Let's revisit our opening story and see how events might unfold when those conditions are in place.

Another Day in the Life of a Food Bank

On a busy Thursday afternoon, things at the food bank were moving fast. A late delivery just arrived. The line outside was already wrapping around the building. Volunteers were packing boxes as quickly as they could.

Maria had been a reliable volunteer for years and was seen as a mentor for the newer volunteers.

As she worked the packing table, Maria opened a box of donated chicken from the late delivery. It felt a little warmer than it should have. Not warm exactly… just not cold.

She didn't debate it. She didn't try to convince herself it was probably fine. She grabbed the thermometer, and a few seconds later she had her answer. It was not safe to distribute. The chicken went straight into the discard bin.

Someone nearby asked, "Is it bad?" Maria shrugged a little and said, "Not cold enough. Not worth the risk." Maria made a mental note to tell her supervisor so he was aware of what happened and could consider additional steps to prevent future problems.

And that was it.

No emergency. No health department call. No sick families. No food bank closure.

What made this possible?

In this version, nothing dramatic happens—and that's exactly the point. What did Maria do differently?

Look deeper:

What had to be true in this pantry for Maria to act this way?

What made it easy for her to stop, check, and act?

What signals do you see about expectations, tools, or speaking up?

Bring it back to your pantry. Think about your own setting.

Where do you already see these conditions in place?

Where are they missing?

Now take action

Use the **One Page Action Plan** on the next page to test one small change.

1. Start with one behavior.
2. Make one small change.
3. See what happens.

Here's an example:

Behavior goal: Cooler temperatures are checked and logged 3 times per day

Step	Idea	Example
Plan	Pick one behavior and identify what's getting in the way (Capability, Opportunity, Motivation). Choose one small change to test.	Logs are often missed mid-shift. The log is not near the fridge (Opportunity), and new volunteers haven't practiced (Capability). Move the log to the fridge and do a quick show-and-practice.
Do	Try your idea for a short period of time.	Test the new setup for 2–4 weeks. Use a clipboard on the fridge and assign a "Cold Chain Champion" each shift.
Check	Look at what happened. What worked? What didn't?	Logs improved from 3/7 days to 6/7 days. Mid-shift is still sometimes missed on busy days.
Act	Decide what to do next: keep it, adjust it, or try something new.	Keep the new system. Add a reminder to the shift checklist and include training in volunteer orientation.

One-Page Action Plan

Behavior you want to improve:

PLAN	
What's happening now?	
What is getting in the way?	☐ Capability (knowledge, skills, confidence) ☐ Opportunity (time, tools, setup, workflow) ☐ Motivation (meaning, connection, relatedness)
What is one small change you will test?	
DO	
Where will you try this test?	
When will you start?	
How will you know it's working?	
CHECK	
What did you notice?	
ACT	
What will you do next?	☐ Keep it ☐ Adjust it ☐ Try something new Next steps…

Ways to Support Safe Behavior

These examples help you identify what might be getting in the way of safety and health behavior—and what you can change to support it across capability, opportunity, and motivation.

Capability

Do people know how to do this, have they practiced it, and are they confident—even when things are busy?

Examples	Initial steps you can take
☐ A volunteer has never been shown how to label allergens correctly. ☐ A new staff member was told "use the forklift seatbelt" but never practiced the full start-up checklist. ☐ People forget the steps—especially when things are busy. ☐ Staff and volunteers are uncertain how to follow health and safety practices correctly, especially when it's busy or new to them. ☐ People have been shown what to do, but haven't practiced enough to feel confident doing it on their own—especially when it's busy.	• Pick 1–2 high-risk behaviors (e.g., forklift use, temperature checks, allergen labeling) and run a 5-minute "show and practice" session at the start of a shift. • When someone learns a new task, say: "Let's practice this together twice, then I'll watch you do it once and give feedback." • Use buddy training: pair a newer person with an experienced one to walk through the exact steps while they actually do the task. • Create simple, step-by-step job aids (with icons or photos) and post them where the task happens (e.g., on the forklift, on the cooler, at the labeling station).

Opportunity

Does the environment and workflow make it easy to do the right thing?

Examples	Initial steps you can take
☐ Forklift seatbelt is hard to reach, twisted, or uncomfortable, so people skip it. ☐ There's no standard way or time to organize donations and supplies. ☐ The temperature log is kept across the room from the cooler, and working pens are difficult to find. ☐ Health and safety practices are one task among many other competing tasks with no clear prioritization. ☐ Cleaning supplies are in a locked closet, so spills are left "for later." ☐ The right behavior takes extra time or extra steps, so people default to faster or easier options—especially when things are busy.	• Put tools at point-of-use: seatbelt untangled and ready, temp log and pen attached to the cooler, labels stored in a clearly marked container at the packing table. • Adjust layout: create a clear space around forklifts and storage aisles so safe driving is possible (no clutter, no tight corners). • Build safety into the workflow. For example, "We always check and record the cooler temp before opening the doors," or "We can't move the forklift until the pre-use checklist is completed." • Use small visual cues (stickers, arrows, "Stop! Seatbelt First" signs) to be seen at the moment of action.

Motivation

AGENCY

Do people find health and safety practices are meaningful?

Do they feel they have some say in how they do their work?"

Examples	Initial steps you can take
☐ Staff and volunteers see some practices (like logging temperatures or cleaning the shelves) as extra work that slows them down, rather than as part of caring for neighbors. ☐ Long-time volunteers feel, "We've done it this way for years and no one got sick," so new safety steps seem like overreaction or lack of trust in their experience. ☐ A forklift operator thinks, "I'm just moving this pallet a few feet," so skipping the seatbelt feels harmless and normal. ☐ Staff and volunteers feel that safety rules are "handed down from above" without asking for their input, so they don't feel much ownership over them. ☐ People don't feel like their individual actions make a real difference	• Share brief stories (not scare tactics) about why these steps matter: "Wearing the seatbelt means your family sees you come home," "Temperature checks keep kids and elders from getting sick." • Offer choices: "Would you rather manage the temperature log or stock the cooler?" • Involve staff/volunteers in improving safety steps: ask, "What makes you want to skip this step? What would make it easier or more worth it to you?" and act on their ideas. • Use a simple script when introducing a new practice: "I know this adds a step. Here's why it matters. How can we make this work in our space?"

Motivation continued

SHARED NORMS AND CONNECTEDNESS

Do people feel a shared responsibility and do they feel connected to the food bank's mission?

Examples	Initial steps you can take
☐ Staff and volunteers see some practices (like different roles (warehouse, front-of-house, intake, drivers) see health and safety as "someone else's job," so no one feels fully responsible for catching problems. ☐ Volunteers feel like "free help," not part of the team, so they hesitate to speak up about unsafe situations or propose improvements. ☐ People feel more pressure to keep the line moving or please donors than to pause for safety checks, so safety feels secondary to "being nice" or "being fast." ☐ When someone does the right thing (like stopping a forklift to clear an aisle, or pulling questionable food), it goes unnoticed, so the social norm tilts toward speed over safety. ☐ Staff and volunteers don't feel a sense of ownership or say in how the work is done ☐ People don't see how their actions make a difference or connect to the larger purpose of serving their neighbors	• Start a shift by reminding the team how health and safety practices support the mission ("Safe food is part of respecting our neighbors"). • Invite the team to finish the sentence: "Our food bank is safe because we…" and write their ideas on a poster. • Use "safety shout-outs" at the end of shifts: name specific people and actions ("I saw Maria stop to re-check the fridge temp—thank you" or "Thanks to Luis for stopping to buckle up and do the forklift checklist, even when we were in a rush"). • Use "we" language: "We always wash hands before handling food," instead of "You must…"

Safety and Health Systems Assessment

	Rarely true	Sometimes true	Usually true	Consistent-ly true
Points	**1**	**2**	**3**	**4**
Management Commitment to Health & Safety as a Value				
Leaders make it clear to everyone that health and safety is more important than speed				
When health and safety practices come into conflict with "getting the line moving," we slow down to do it right.				
Leaders follow the same safety rules they expect from everyone else (e.g., PPE, rules for using forklift and other equipment).				
Supervisors and Day-to-Day Leadership				
Supervisors talk about safety regularly, not only after a problem.				
Supervisors notice and praise safe behavior (e.g., using seatbelts, filling logs).				
Supervisors step in promptly if they see unsafe behavior.				
Accountability (Fair and Consistent)				
Everyone, including long-time staff and "star" volunteers, is expected to follow the same safety rules.				
When someone skips a safety step, we address it and help them improve; we don't look away.				
We focus on problem solving, not on blaming individuals, when something goes wrong.				
Staff & Volunteer Involvement				
Staff and volunteers are asked for input when we change safety procedures.				
People feel they can suggest ways to make safety steps easier to follow.				
Some safety ideas from staff and volunteers have actually been tried.				

	Rarely true	Sometimes true	Usually true	Consistent-ly true
Points	**1**	**2**	**3**	**4**
Communication and Reporting				
People know how and to whom they can report safety concerns.				
When concerns are raised, leaders respond and share what changed.				
Near-misses (e.g., almost backing a forklift into a pallet, noticing a warm fridge just in time) are discussed and learned from, not hidden.				
Training and Learning				
New staff and volunteers receive basic safety training before being assigned to higher-risk tasks (e.g., forklifts, pallet jacks, cold storage, cleaning chemicals).				
We provide refreshers and ongoing practice sessions, not just one-time training.				
We often ask, “What did we learn from this?” after incidents or close calls.				
Equipment, Environment, and Resources				
Health and safety equipment (e.g., seatbelts, spray bottles, PPE) is available and in good working order.				
Tools to support safety (e.g., logs, labels, sanitizer, pens) are kept where they are needed.				
The layout makes safe behavior possible (e.g., clear aisles, marked forklift paths, safe storage).				
Stakeholders and Community Trust				
We think about how our health and safety practices affect guests, donors, and community partners.				
All staff members and volunteers can explain our health and safety practices to a guest or inspector and feel proud.				
We see food safety and equipment safety as part of respecting our neighbors.				

Additional Resources

Additional Reading

Behavior Change and Motivation

For more on helping people follow through on safe practices, look for resources and guides on the COM-B behavior change model and Self-Determination Theory. Two useful resources:

- Website that reviews the COM-B model and explores case studies: The COM-B Model for Behavior Change
- A short guide to Self-Determination Theory (SDT): Unlocking Motivation & Wellbeing

Safety and health Systems

To go deeper on strengthening your safety and health systems, look for toolkits that include self-assessment checklists, sample questions for staff and volunteers, and basic action-planning templates designed for smaller organizations. For example:

- Safety Leadership in this "Nonprofit Safety Hero series.
- A downloadable "Food Safety Culture Toolkit" for small and medium organizations (with stories, metrics, and discussion tools).
- Resources designed to help your team create lasting change and foster a system where everyone takes ownership of food safety: Navigate Food Safety Solutions

Psychological Safety for Frontline Leaders

To help staff and volunteers feel safe to speak up about risks, look into leader guides on 'psychological safety.' Two good resources:

- A short leader guide based on Amy Edmondson's work on psychological safety, focused on how to invite concerns, respond to mistakes, and model vulnerability: Psychological Safety at Work
- This set of psychological safety survey questions for teams gives you early warning signals before performance, innovation or retention start to slide.: Psychological Safety Survey Questions

Just Culture and Fair Responses to Mistakes

To strengthen a fair, learning-focused response to mistakes, look for brief overviews of 'just culture.'

- Article that includes a 3-category breakdown (human error, at-risk behavior, and reckless behavior) and guidance on coaching vs. system fixes vs. discipline: The Differences Between Human Error, At-Risk Behavior, and Reckless Behavior Are Key to a Just Culture
- Case study from the health care industry: Making Just Culture a Reality: One Organization's Approach

Continuous Improvement and Leadership Tools

To keep improving over time without getting overwhelmed, look for Plan-Do-Check-Act (PDCA) templates and short 'frontline safety leadership' guides.

- Guide for each step of PCDA with actionable advice, practical examples, and tips to help you avoid common mistakes: Mastering PDCA: A Step-by-Step Guide to Continuous Improvement Success
- Guidance for equipping managers and supervisors with world class level skills to drive risk reduction: DEKRA's Safety Leadership Development Approach

Free resources, videos, training, and more from

www.nonprofitsafetyhero.com

Jumpstart your safety program with our newest guides:
“Volunteer Safety,” “De-Escalation,” and “Manual Pallet Jacks.”