



# Lean Safety – Improving your Safety Culture with Lean Management Tools

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#### Participants must:

- 1. Sign in using attendance sheet in the back of the room.
- 2. Attend at least 95% of the session.
- 3. Complete the session and post-program evaluation.
- 4. Complete a brief assessment with a score of 75% or greater.



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# Earn CE hours for this Session





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**1.0 CM-Lean CE Credit** | AGC of America recognizes the Annual Convention as qualifying for continuing education hours towards the renewal of AGC's Certificate of Management-Lean Construction (CM-Lean).



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# **Speaker Disclosure**



AGC event speakers may have proprietary interests, including but not limited to, exposure to the industry, increased consultation services, book sales and/or receipt of financial compensation/speaking fees.



# **Learning Objectives**

By the end of this session, participants will be able to:

- 1. Discuss how a Lean Safety Culture can make employees safer, happier, healthier, and more productive.
- 2. Use the Lean tool "5-Why" to find the true Root Cause Analysis of an accident.
- 3. Employ Gap Analysis to identify the difference between a safety problem and a safety result.
- 4. Examine the difference between "fact finding" and "fault finding" and how this difference affects a company's ability to solve root cause problems.





# Lean Safety

Improve Your Safety Culture with Lean Tools





# **Safety**



- Definition: freedom from the occurrence or risk of injury, danger, or loss
- Safety Slogans
- Can "SAFETY" be a goal?
- OSHA
  - Compliance Program
  - How do you go from Compliance to Desire?





# **Beliefs**

 Do you believe all your employees show up every day to work safely, be productive, and produce a quality product?

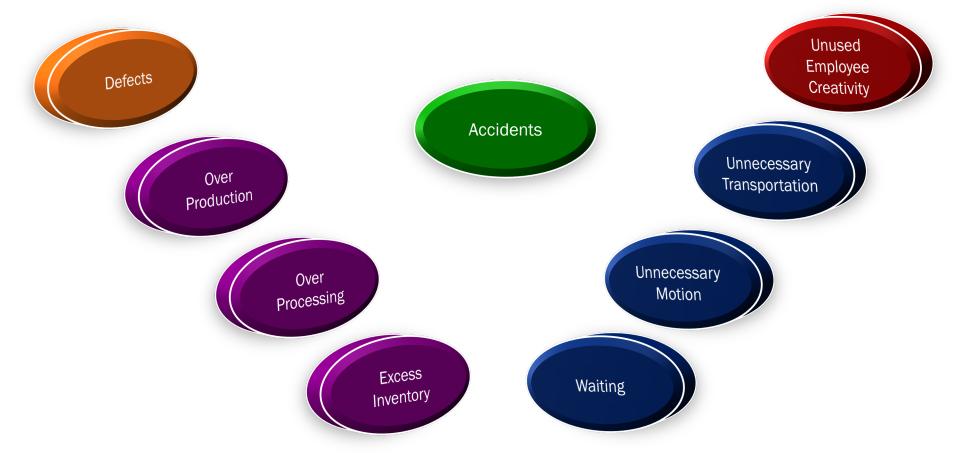
"The truth is that most people want to be successful and will work hard to get there. Good leaders recognize this and collaborate with them, knowing if their people succeed they will as well." -Lee Ellis





#### Lean Improving customer value by eliminating waste





#### **Eight Wastes**

- Who is the "customer?"
- Where does "Safety" fit in?



# Lean Safety

- It is a **Culture** not a set of tools
  - Lean is a culture of continuous improvement that is focused on increasing the value for the customer and developing employees to resolve process issues.
- It is a Mind Set not a program
- Based in the desire to be a World Class
   Safety Organization

"World class organizations do not tolerate preventable accidents."

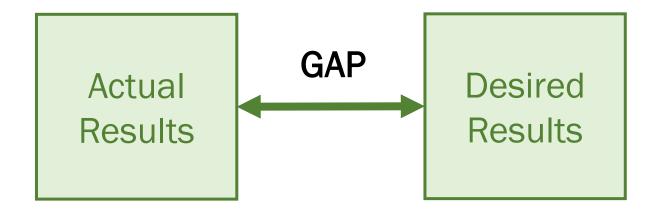
-Secretary of Defense Donald Rumsfeld

# Accident – Is This a Problem?



#### **Accident**

The problem is not the result.



The **Real Problem** is in the **Gap** between Actual Results and Desired Results

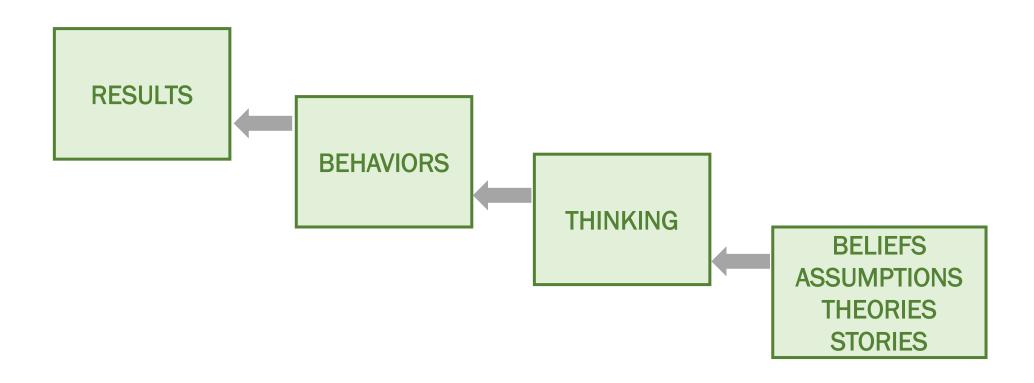


Definition: an undesirable event that usually results in harm, injury, damage or loss



## **Process to Find the Problem (Reflection)**







#### **Beliefs affect Results**



#### Results

 Fall from the top step of a step ladder

#### **Behaviors**

Stands on the top step of a step ladder and reaches

#### **Thinking**

- I only need to reach one item and then I'm done
- The right ladder is back in the trailer – It will take too long to bring it here
- P I want to improve production, so I don't have time to go back and get the right ladder

#### **Beliefs**

- I have stood on the top of a step ladder before and not been hurt
- The "warning" on the top step is for clumsy people – I am not clumsy
- I am expected to get the job done
- Getting the job done justifies taking a safety shortcut

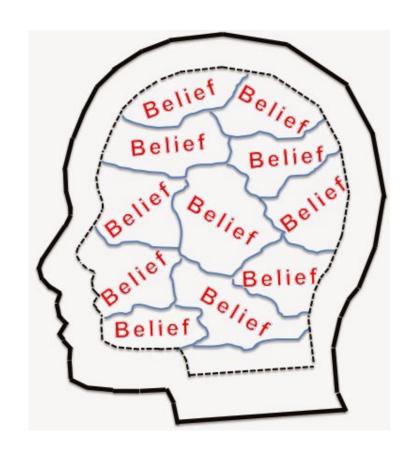




## What Do You Believe?

- Employees come to work to be Productive and Safe
- People are the key to your company success

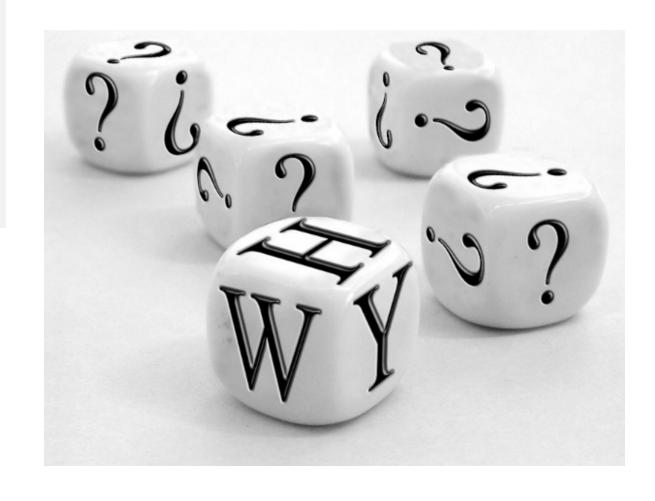
- Which is most important:
   Safety, Cost (Productivity), or Quality?
- ALL jobsite accidents are preventable





# **Accident Investigation**

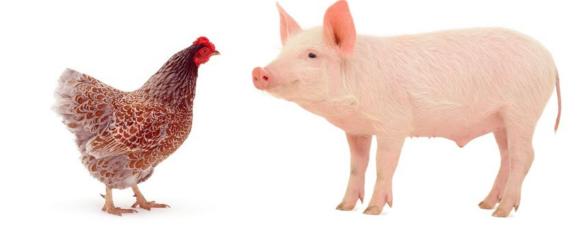
- Incidents, Near Misses & Accidents are Opportunities to Learn!
- Root Cause Analysis
  - Utilize 5-Why
- Behavior is NOT a root cause
  - It is the **Process** not the Person
- Key Question:
  - "What happened in our **Process** that caused the accident to occur?"



### **Building a Lean Safety Culture**

- Start with Trust
  - Engaging employees requires Trust
  - Earn Trust by giving Trust





- Change from focus on employees as a Cost to focus on Engaging People as a Resource
- Management must be Engaged and Committed, not just participate



# **Building a Lean Safety Culture**

- Impacting People
  - Never take Safety Risks
  - <u>Plan</u> for quality, safety, and productivity
  - Never put productivity or customer needs ahead of Working Safely
  - Stop and Think before taking Non Standard Actions
  - Guard against <u>Complacency</u> when completing <u>Routine Tasks</u>
  - The Words we use are Important
  - Caring about employee safety is 24-7



People don't care how much you know about Safety until they know how much you care about their Safety

#### **Lean Tool Box**



$$P-D-C-A$$

- PLAN
  - Objectives Expectations Metrics
- DO
  - Implement the Plan
- CHECK
  - Study actual results Look for deviation
- ACT
  - Adjust and reset the plan if results vary from expected

Adjust your plan to the circumstances.

Ask the front line workers for their opinion.







#### **Lean Tool Box**



#### **A3**

- Define the Problem
- Describe the Current State
- Discover the Root Cause (5-Whys)
- Discuss the Solution (PLAN)
- Implement the Solution (DO)
- Assess the Results (CHECK)
- Adjust as needed (ACT)

#### The A3 Report

THEME: "What are we trying to do?"

Background

- · Background of the problem
- Context required for full understanding
- Importance of the problem

Current Condition

- Diagram of current situation (or process).
- Highlight problem(s) with storm bursts.
- What about the system is not IDEAL.
- · Extent of the problem(s), i.e., measures.

Cause Analysis

- List problem(s)
- . Most likely direct (or root) cause:

Why? Why? Why? Why? Why?

#### Target Condition

- Diagram of proposed new process
- Countermeasures noted as fluffy clouds
- · Measurable targets (quantity, time)

Implementation Plan			
What?	Who?	When?	Where?
Actions to be taken	Responsible person	Times, Dates	
Cost:		·	

Follow-Up		
Plan	Actual Results	
How will you check the effects?     When will you check them?	In red ink/pencil. Date check done. Results, compare to predicted.	





# **Questions & Comments**

## THANK YOU!

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