Lean Behavior-Based Safety

A Natural Evolution

Behavior-based safety (BBS) approaches have impacted the safety and quality community for more than 30 years. While BBS is based on a few core principles, methodologies struggling for marketplace dominance have been slow to evolve. Any methodology providing results must eventually be enhanced or become obsolete. Moreover, any process that is not efficient (i.e., lean) in its search for increasing effectiveness will overburden those supporting it. Lean does not mean less. Rather, it is a focus on value-add and the continued identification and removal of activities and efforts that add waste, or, more simply put: greater value through less work. As the 1990s brought the popularity of lean methodologies and lean thinking, a natural evolution to BBS was not far behind.

Opportunities for Lean

Terry Mathis, creator of Lean behavior-based safety (Lean BBS) and pioneer in the BBS community, discovered this logical progression after implementing BBS in the early 1980s and auditing other consultant-led approaches following the founding of ProAct Safety in 1993. Years later, and after more than 1,000 successful Lean BBS implementations in every major industry and existing process-improvement projects, several opportunities have been identified to make a process more efficient and effective. Eight of these are identified below.

1) Integration. An effective way to minimize resistance to change is to minimize the perception of it. What existing structure, process, team or cultural capability would produce a shorter path to results and create the impression of evolution rather than revolution? Perhaps the 5S team becomes the 6S, or integrating your focus on quality to include safety with behavior-based quality and safety would do the trick? Both have proven successful in the right environment. What about an existing team, subteam or committee?

2) Training. Over-training is a common problem when the focus is on implementing a methodology rather than recognizing rapid and sustainable results. Consider what information is needed at this time to accomplish results in the next 90 days. How can you build on that once success is recognized? Why teach team members how to analyze data and develop action plans until they have their own data?

3) Steering team size. A team that can never get together is not a team. A successful process needs a team representing the interests of the population to make the important decisions of improving process and safety. What that team looks like, how many are on it and the makeup of levels involved is culturally specific and based largely on trust.

4) Checklist size. Effective BBS processes determine the most important behaviors to focus on, based on historical incidents and observed common-practice data. A focus on more than five or six items is not a focus. Moreover, centering attention on the wrong things is not very efficient. If your checklist is not focused, neither is your process. Further, the checklist needs to adapt to fit the needs of the process. A process should never revolve around a checklist or be dependent on others to print and modify it.

5) Observation strategies. Blanketing observations is a tactic to capture a sampling of all common practice. Too often, this becomes the only observation plan. There are four other common observation methods: aimed, blitz, seeing without explaining to every person (SWEEP) and self. Depending on the data and value that must be derived from the process, the observation strategy should evolve to focus on new results. Is it aiming at the right thing, time of day, etc.? Is it blinding where most needed, based on identified influence? SWEEP observations are often used to validate a high percent safe finding, and self-observations are often used with logically challenged workforces.

6) Data utilization. Far too many processes do not analyze their data on a frequent enough basis to understand how to prioritize action plans; address data quantity and quality; identify trends and influences on behaviors; and respond to these influences. Any mature process combined with a healthy safety management system can indicate where, when and why the next incident will occur with a high degree of accuracy, based on observed practices.

7) Voice of the customer. When a process is launched, all who will be impacted should be briefed to begin addressing the “What’s in it for me” (WIIFM) question. Realize, however, the question never goes away, but the answer will change. This process must treat others like the customers they are. If process leaders are not communicating in a way that creates strong knowledge and value recognition (e.g., everyone can name the behaviors of focus and recent successes), the support will wane.

8) Documented roles, responsibilities and results. For decades, change initiatives have experienced middle-management backlash due to bottom-up and top-down
approaches. BBS has been no different. Supervisors must support the process, yet most processes fail to explain and develop approaches to ensure that this occurs. The roles, behaviorally defined responsibilities and results expected must be developed for all involved, from those observing to those supporting, leading (e.g., integrate with leader standard work), and serving only in a customer capacity.

Ultimately, the goal of BBS is to improve safety and help those impacted by it to make safer decisions and address the factors that might influence risk-taking (e.g., perceptions, habits, obstacles, barriers). While there is certainly much more to the lean BBS methodology, consider how you can use this lean BBS thinking to eliminate unnecessary or non-value-added steps and maintain a results orientation rather than a crank-the-process one.

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