EuLA
European
Lime
Association

EuLA Safety Toolkit

A useful toolkit for all EuLA Members to help improve safety in their companies

First Version: September 2021

Contents

Introduction

EuLA Safety Leadership Roadmap

Tool to enable companies to assess their safety maturity profile

This brief has been created to support EuLA members in measuring their performance against a list of selected key themes using an xls table. The key themes address enablers of effective Leadership for Health & Safety and align with the topics addressed by the EuLA H&S Workshops. The 8 selected key themes are identified on the second tab of the xls.

Approach

A nominated Senior Leader from each member organisation will accept accountability for the completion of the Maturity Profile. Each nominated Senior Leader will ensure that the Maturity Profile will be completed by an agreed date. They will then review the content for completeness and accuracy and sign off the Maturity Profile as complete at a stated date.

The Maturity Profile is completed by answering a set of pre-determined questions documented in the Maturity Profile against 8 key themes. The individual completing the Maturity Profile shall review each question and determine if the required action is complete or incomplete.

The questions must be answered in sequence from left to right (lowest maturity to highest maturity). When all of the questions at one level of maturity for one specific theme can be answered as complete, then the organisation can move onto the next question set and start working through the questions at that level of maturity.

It is likely that a wide diversity of stakeholders would be involved in collecting information to complete the Maturity Profile. The nominated Senior Leader should make an objective review of the level of maturity identified. There is no value in overstating the identified level of maturity. The action plan generated from completing the maturity profile is unique to each company and its specific situation.

Review

It is recommended that the Maturity Profile is reviewed and updated every 12-18 months.

Feedback

EuLA members are requested to provide qualitative feedback about the benefits of completing the maturity profile and the key areas of focus for improvement they have adopted. It is proposed that this feedback informs the creation of supporting resources by the EuLA H&S Task Force.

Safety leadership roadmap

Leading Safety Conversations

To achieve higher safety performance, senior leaders need to address the weak signals which are hidden from sight including those areas which people are reluctant to speak about.

Relationships are vital in humans; we need them to survive and thrive and we rely on the quality of information we receive.

To change the behaviour of a group, you must first become part of it. This starts with a conversation, so speak to the members of the workforce.

Thoughts, emotions, beliefs and relationships are very difficult to measure, but are the most influential part of teamwork. As a leader, this is what you need to identify and work alongside to improve safety performance, because safety culture and organisational culture are linked.

7 Steps to Leading Safety Conversations

Key skills 4 – Monitoring

- Quality over quantity
- Discuss outputs
- What are the themes?

Observe & engage

- Observe the work environment
- When safe introduce yourself
- Build rapport – don't talk about work too soon, find common ground
- A friendly chat – Ask how they are, talk about sport, family, the weather

Key skill 1 – Rapport

- Build a sense of trust
- Smile, relax
- I like you, you like me

Follow-up

- Write up the outputs and ensure they are followed up
- Respond back to any questions
- Reflect about the conversation
- Discuss the quality of the conversations with your team and line manager
- Are there any themes?

Recognise

- Recognise good behaviour
- "Work seems to be going well, do you have time to talk me through it?"
- A simple well done or thank you can be motivating to the workforce and shows you are interested

Thanks

- Let them know you are grateful for their time and input
- Leave them with a good impression
- Good conversations create a positive opportunity to engage with the workforce & supply chain

Discuss

- Once rapport has been built discuss the works observed
- Discuss what it's like to work there, what makes their job difficult, what helps them to do their job well, has their work changed over the years?
- Can you use "In an ideal world what would this look like?"

Key skill 3 – feedback

- Make it genuine, timely and specific
- Meaningful and actionable

Ask

- Do they have any questions for you?
- Answer them honestly and politely
- If you are unable to answer or provide immediate help, let them know when you will get back to them

Agree

- Are there any changes which would help make the task safer?
- Would any extra planning be required?
- What would good look like and what could be done to get there?
- Agree what the way forward is

Key skill 2 – Active listening

- Pay attention
- Withhold judgement
- Clarify and summarise

Further training on the key skills, coaching and leadership is available from Broadhead Global

broadhead GLOBAL

Hints and Tips for Leading a Safety Conversation

Preparation

A conversation can be held in an office, over a cup of coffee in the canteen and at a physical task location on a site.

Think in advance as to which location to visit:

1. What work is going on?
2. Will you be a distraction to a safety critical process?

Is there a safety culture message of the month or campaign you can discuss such as mental health awareness week?

3. If so, think about, where to find information, is there anything you can take such as leaflets etc.?
4. Think in advance the types of questions you can ask around it, e.g. What have you heard about this month's campaign on …? Have you experience of it? How could it impact on you at work?
5. Use your own examples as stories.
6. How does it link to safety?

If there is no message of the month, think about your own personal values and vision and how you can bring that into a conversation.

Plan the time in your calendar and keep the appointment. This shows your commitment and engagement to the workforce.

Let the Manager know in advance you are going and meet with different team members and always make sure you set a strong example when you are on site (correct PPE, following sites rules etc).

Building Rapport

When a person feels put down, unsure what is happening, micromanaged, excluded or mistreated, they will automatically react in a fear mode and go into either a fight, flight or freeze response.

Therefore, before chatting about safety you must first build rapport and then build trust.

Before your first words take a few seconds to look at the surroundings for conversation starters such as photos, awards or anything which has been given a prominent position.

1. Show interest in them and ask questions about them, their job, their family.
2. Share stories; sharing your own stories shows you are human and also vulnerable.
3. Listen to the words, the tone and volume. Pay attention to what they are saying and if you are just getting short answers you have not built rapport yet.
4. Look for emotional cues such as excitement, annoyance and body language.

When rapport has been built people are more likely to engage in positive, cooperative behaviour which in turn increases employees to share ideas and new ways of working together.

Psychology of Positive Work Relationships

The desire to feel connected to others is a basic human need. Interpersonal relationships have a significant impact on mental health and physical wellbeing.

Positive social interactions at work directly affect the body's ability to build, maintain and repair itself

The brain releases chemicals (hormones) in response to good social interactions, and these chemicals are linked to trust and motivation.

Giving genuine praise lights up the reward receptors in the brain, so include positive findings.

When we feel trust, cooperation and fairness, the reward centre of the brain activates, and employees believe the best in each other. It inspires us to do our best.

Do

1. Introduce yourself
2. Use open questions and active listening
3. Be genuine and friendly
4. Stay professional and polite
5. Lead by example, coach, use integrity and involve the workforce
6. Think of the workforce as experts
7. Try to understand what the job is and any issues they raise
8. Look for success/commitment
9. Remember who they are for next time you see them
10. Make it a regular occurrence
11. Regularly discuss your interactions with your line manager and reflect qualitatively on the conversations.

Don't

1. Don't stop someone when it may be dangerous or inconvenient
2. Don't use closed questions
3. Don't think you have the answers; technological advances mean equipment and ideas change rapidly
4. Don't treat employees disrespectfully
5. Don't offer help when you can't help
6. Don't give a promise you are not able to keep
7. Don't interrupt a tea break or lunch

Self-Reflection

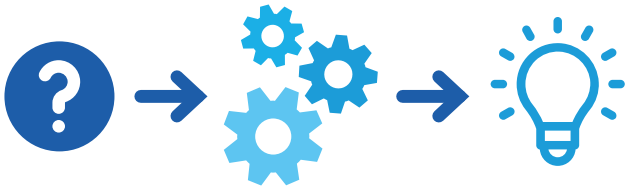
1. Did it feel a natural conversation?
2. Were open questions used?
3. Did I use proactive questions?
4. Was something praised?
5. Can the promises I made be followed up?
6. Did it feel enjoyable?
7. **Will anything be different as a result of the conversation?**
8. Did I listen to their ideas?
9. Did I present our Safety Vision with clarity?
10. Did I come across as a genuine promoter of safety?
11. What could I do differently next time?

> "To help you get the most out of the conversation, engage in a positive way and build constructive social interactions with the employees"

The Importance of Root Cause Analysis During Incident Investigation

EuLA European Lime Association

A root cause analysis allows the employer to discover the underlying or systemic, rather than the generalized or immediate, **causes of an incident**. Correcting only an immediate cause may eliminate a symptom of a problem, but not the problem itself.



By conducting a root cause analysis and addressing root causes, an employer may be able to substantially or completely prevent the same or a similar incident from recurring. In this way, employers will reduce the risk of death and/or injury to their employees.

An employer conducting a root cause analysis to determine whether there are systemic reasons for an incident should consider all possible "what," "why," and "how" questions to discover the root cause(s) of an incident.

This document presents a list of tools that may be used by employers to conduct a root cause analysis, with an analysis of their pros and cons. This list is not exhaustive, and a combination of tools can be often used.

> "A root cause analysis allows the employer to discover the underlying or systemic causes of an incident"

5 Why Analysis

- Analysis 5x Why? – is one of the tools allowing to detect the root causes of problems.
- It was developed in the 1930s., but became popular in the 1970s.
- It is effective tool for simple or moderately difficult problems.
- When starting the analysis you should define problem/incident.
- The method is quite simple: when a problem occurs, you go down to its root cause by asking "Why?" five (or less) times. Then, when a countermeasure becomes visible, you follow it through to prevent the problem from re-occurring.
- Follow Deming Cycle Action Plan (PDCA) or PDSA (Plan/Do/Study/Act).

Remember! It's OK if there is less than 5 "Why". But if "Why" is more than 5, you should return to the description, find experienced facilitator or choose another method (maybe the problem is too complex for 5Why).

Example of how to use 5 Why method

Note:

A countermeasure is an action or set of actions that seeks to prevent the problem from arising again.

A solution may just seek to deal with the symptom.

Positives
Effective tool for simple or moderately difficult problems/ incidents
Method is quite simple to use
Requires short induction before use
Doesn't require very experienced facilitator

Negatives
Doesn't work well with complex problems/incidents
Can lead to pursue a single track or a limited number of tracks
Easy to "manipulate" – it means it's easy to jump from problem to solution if there is no facilitator
If "Why" is more than 5, you should return to the description, find experienced facilitator or choose another method (maybe problem is too complex for 5Why).
Sometimes needs continuation with different method
Asking "Why" can be understood in some cases as looking for "Who"

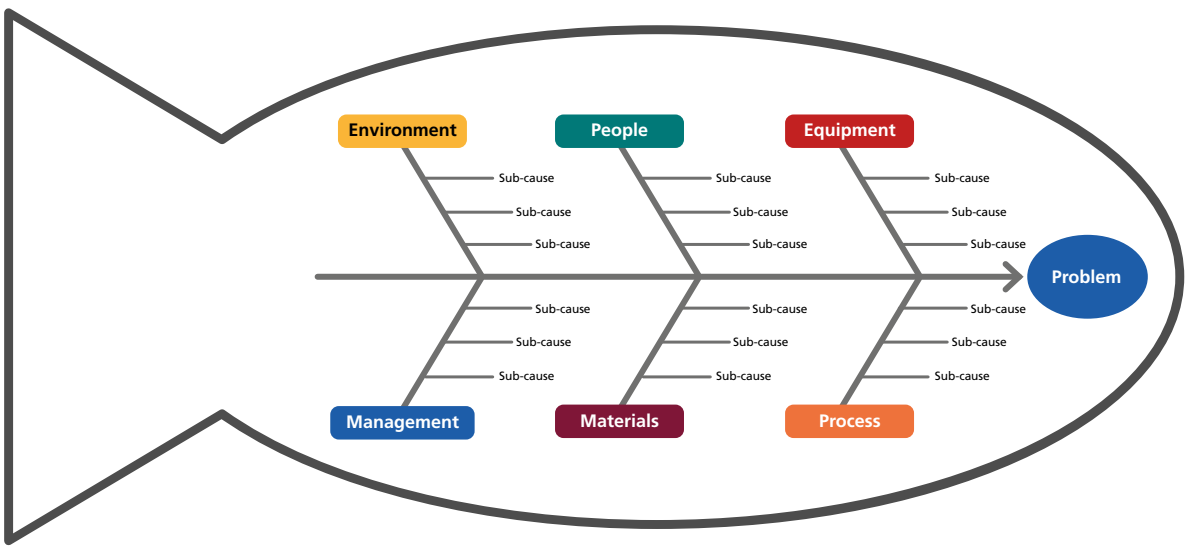
Fishbone Analysis

- Fishbone Analysis was devised by professor Kaoru Ishikawa in the 1960s.
- It is also called a cause and effect graph and because of its distinctive appearance – a fish bone graph.
- This tool combines Brainstorming with Mind Map.
- It can be used to:
  - Discover the root cause of a problem.
  - Uncover bottlenecks in your processes.
  - Identify where and why a process isn't working.
- Preparation of fish bone analysis must always be a team action. The team should consist of people with appropriate specialist knowledge and open minds.
- There are 6 categories (causes) in this method: human, method, material, machine, measurements, environment, which are the main bones. Each category can be divided into sub-categories (sub-causes – small bones). All this finally leads to the fish's head – the analysed problem.
- Depending on the type of the problem it is also possible to use other categories, i.e. equipment, information, procedures, processes, work organization, competition, suppliers.
- The starting point is the definition of a clearly formulated problem (head/effect). The next step is to identify the causes and sub-causes.

Positives
Effective tool for simple or moderately difficult problems/incidents
4-stage process
Shows the causes and sub-causes (grouping)
It is also possible to use other categories than 6M
Combines Brainstorming with Mind Map
Can be used with post-its (silent brainstorm)
Requires short induction before use

Negatives
Requires setting rules before start of analysis (possible causes or only confirmed causes?)
Requires additional method of causes/sub-causes prioritization
Requires strong focus and identification of root causes as pre-final step

How to use this tool:



Apollo Root Cause Analysis

- It can be used to look for root causes of complex problems/incidents/accidents.
- Methodology is a 4-stage process (see picture).
- In this method the "problem" is defined by answering specific questions.
- The causes and effects that led to problem/incident occurrence are determined by asking questions: "caused by ...".
- The uniqueness of the method lies in the assumption that:
  - each effect is the result of at least 2 causes,
  - causes are divided into condition and action,
  - elimination of causes defined as "condition" gives a greater chance of minimizing or eliminating the possibility of such an event in the future, because people's behaviour ("action") is a less predictable and controlled element.

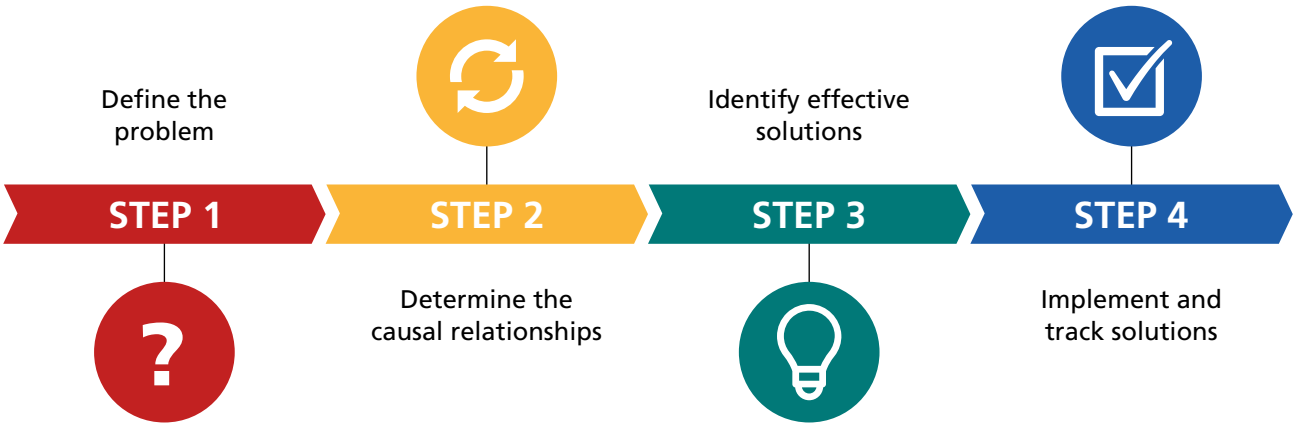
All causes must be examined to find a way to change them with a solution that is:

- Within your control.
- Prevents recurrence.
- Meets your goals and objectives.
- Does not cause other problems.
- This approach shows clear causal connections between your solution and the defined problem.

Positives
It can be used to look for root causes of complex problems/incidents/accidents
4-stage process
Can be used with post-its (silent brainstorm)
Provides wide perspective
Provides graph of causes from present to past (visualisation)
Doesn't focus on "Who" or "Why" – only on "Caused by"

Negatives
It should be used for existing problems/incidents/accidents.
Requires training before use and experienced facilitator
Requires strong focus and identification of root causes as pre-final step
For small/simple problems can be too time consuming
Requires data/evidence (preparation phase)

Source/more information:



Fair and Just Safety Culture Model

Strong safety performance relies on an open and honest culture where safety incidents and opportunities are readily reported and there is trust that the business will deal with these positively and learn from them. Employee behaviour often plays a key part in any safety incident, but it is critical that employees do not perceive the business to be focussed on blaming individuals, or there will be a reluctance to report issues openly. This model can act as a guide on how to approach dealing with an individual when an unsafe act has led to a safety incident. Following the model recognises that people make mistakes and that organisational failings can lead to unsafe acts but also that where wilful negligent behaviour occurs, this also needs to be dealt with.

EuLA Safety Tools: List of Good Lead Indicators

Lagging or outcome indicators of safety have been used for many years in industry (including the lime industry) to track when damage, injury or harm has occurred. They provide a measure of safety performance, allow comparisons between industries and help to show whether improvement actions taken are being effective or not. However, lagging performance indicators do not show the full picture and focussing too greatly on them can drive undesirable behaviours, such as the under-reporting of safety incidents.

Leading or activity indicators are proactive and predictive as they measure the direct and indirect precursors to harm. They give advance warning before an event occurs, providing an opportunity for preventative action to be taken. They can also be used to monitor and manage the implementation of safety initiatives which have been introduced to improve safety performance.

To be effective, leading indicators must be integrated with the overall business objectives, strategy and decision-making processes to deliver on desired performance. The closer an organization gets to "zero harm", as measured using lagging indicators, the more difficult it is to ensure safety through tracking lagging performance, and to determine the factors that contribute to improved performance. It is also unreliable to make any generalized causal inferences based on these rare events. Management efforts should therefore be focused on more frequently measurable **leading indicators of precursor circumstances**. This said, it is important to select appropriate leading indicators. The selection of lagging indicators is straightforward and often obvious given the goal of safety management being to prevent harm. By contrast there are a large number of possible leading measures and the best ones for a given business may change over time due to changing areas of focus. The list over the page gives an idea of some possible leading indicators and their potential use.

Area of focus	Purpose	Examples of Indicators
Visible Felt Leadership 	Measures leadership roles' engagement in safety conversations with others.	• Number of Safety conversations • Safety conversations as a percentage of target • Number of safety conversations completed alongside line manager • Quality/impact of safety conversations (difficult to measure)
Safe working conditions 	Monitoring the conditions of the workplace, seeking to make it safer and to encourage workplace pride and safe mindset.	• Completion of workplace order/cleaning plan • Number of hygiene inspections • Workplace dust and RCS (respirable crystalline silica) measurements • Workplace light/noise/vibration measurements • Walk-round inspection scores • Completion/coverage of 5S exercise • Number of dust hotspots
Safety in action 	The completion of safety tasks, safety improvements and correction of unsafe conditions is vital in maintaining a safe working environment. Prioritising safety action over other work.	• Number of Risk Assessments done • Completion of safety audit plan • Number of safety improvements completed • Number of safety actions outstanding (%) • Number of investigations outstanding • Reactive maintenance vs planned maintenance
Safety learning 	The engagement with safety material aimed at increasing awareness and knowledge of the workforce.	• Completion of training plan • Number of safety training hours • % of competency/certification/authorisation within date • Completion of toolbox talks
Safety Reporting & Communication 	An open and honest environment for reporting safety concerns, incidents and ideas/opportunities is essential for safety improvement.	• Number of near misses raised • Number of potentially serious incidents raised • Number of safety suggestions • Number/proportion of types of safety observations (unsafe behaviour, unsafe conditions etc)
Best Practice Sharing 	Learning from others can accelerate learning and improvement by seeing opportunities and hazards without having to experience them all oneself	• Number safety suggestions shared/received • Number of safety incidents shared/received • Completion of safety best practice meetings

Risk Assessment Tools

Risk assessment is a key prevention technique in safety management. It makes it possible to identify the risks present in an organisation or process and define and implement preventative measures.

It is a fundamental task that must accompany and adapt to the organisation's evolution, and that is critical to its ongoing operation. Risk assessment can be carried out on tasks performed by employees and subcontractors, on technical installations from design to implementation, when purchasing equipment or substances, and last but not least, in real-time in the field.

To be comprehensive, it must take into account all risk factors, not just technical risks. For example, it must include risks related to factors such as the working environment, emergency situations, hygiene and psychosocial factors.

The EuLA Safety Toolkit includes two tools dedicated to risk analysis. The first tool, called **Risk Assessment Plant Level**, is intended to analyse risks specific to a production site as a whole without going into the details of the facilities. For each type of risk identified, the probability of its occurrence can be rated, along with the consequences (low, medium or high).

The consequence assessment addresses three kinds of consequences:

- **People:** assessment of potential impacts on human lives, i.e. fatality or number of injured employees.
- **Operations:** evaluation of the impacts on the operation, i.e. reduction of production capacity or difficulty in supplying customers.
- **Business:** evaluation of the other impacts identified by the company, i.e. financial, legal or reputational.

Companies using the assessment must decide which hazards should be associated with the low, medium or high levels according to their needs and circumstances.

The overall risk rating is obtained by combining the probability of the occurrence with the severity of the consequence(s).

Risk Assessment Plant Level

The second tool, called **Risk Assessment by Task**, is designed to analyse a task, function or workplace. For each topic analysed, a list is produced identifying the associated hazards and quantifying the level of risk using the Fine & Kinney method. This method, which is recognised in the field of health and safety and insurance, involves calculating the criticality (relevance and severity) of hazards through predefined factors and defining a risk score.

Based on this risk score, the method defines the acceptability of the risk and the urgency of the need to intervene. The tool makes it possible to associate preventive measures with each risk and check the risk level following their implementation.

Risk Assessment by Task

EuLA AISBL
Rue des Deux Eglises 26
box 2 (6° floor)
B-1000 Brussels, Belgium
+32 (0)2 210 44 10
info@eula.eu