OUR CARING CULTURE IN ACTION

A New Vision for Operational Excellence

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SafeStart Forum • Operational Excellence • Wednesday, 8:00 AM

Safety is not a competing priority. It is how consistent performance is built.

SESSION AGENDA

What We Will Do Together

Connect	Human factors to safety, quality, reliability, and retention
Practice	How to distinguish error, at risk behavior, and reckless behavior
Apply	The best leadership response without defaulting to blame
Leave	With one action to make improvements in your operations

Expect Conversation, a Short Breakout, and Practical Leadership Choices.

My SafeStart Story



The same human states kept showing up across different industries and operating systems

Rushing • Fatigue • Frustration • Complacency

Decision Quality Under Pressure

The Same Habits that Prevent Injuries also Prevent:

- Defects and rework
- Equipment damage and downtime
- Process variation
- Turnover and disengagement

Pause • Think • Respond



Four States Can Quietly Change the Next Decision

RUSHING

Speed Narrows Attention

FATIGUE

Capacity and Focus Decline

FRUSTRATION

Reaction Replaces Reflection

COMPLACENCY

Familiarity Lowers Perceived Risk

Quick Reflection: Which State Most Often Shows Up in Your Operation?

One Decision System, Four Business Outcomes



Safety Does Not Compete with Performance. It Stabilizes Performance.

CULTURE BECOMES VISIBLE IN DAILY CHOICES

A Caring Culture is a Safety Culture

01	**People Speak Up**	Before the problem becomes an event
02	**Leaders Listen**	Before they decide what happened
03	**Teams Learn**	Instead of hiding honest mistakes
04	**Praise is Specific**	So the right habits repeat
05	**Coaching is Normal**	So shortcuts (procedural drifts) do not become the standard



People Watch what Leaders Reward, Tolerate, Question, and Model.

Classify the Action, Not the Person

HUMAN ERROR

Unintentional slip, lapse, or mistake

ASK

What in the system made this easier to do?

AT RISK BEHAVIOR

A behavioral choice where risk is minimized or misunderstood and risk is increased

ASK

Why did this choice seem reasonable?

RECKLESS BEHAVIOR

Conscious and knowing disregard of substantial risk

ASK

Was the risk understood and consciously ignored?

Match the Response to the Behavior

MENTOR + IMPROVE



Human Error

Strengthen the system, training, conditions, or controls

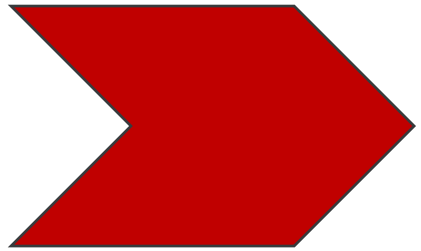
COACH



At Risk Behavior

Make the risk visible and remove reasons shortcuts feel necessary

DISCIPLINE



Reckless Behavior

Protect the team and reinforce clear accountability

Same Outcome Does Not Mean Same Response.

SMALL GROUPS, 10 MINUTES

Breakout: Choose the Leadership Response

1. Choose One Scenario
2. Classify the Action
3. Name the System Factors
4. Select the Response
5. Prepare a 30 Second Report Out

Do not decide based only on the outcome. Decide based on intent, risk recognition, system conditions, and the choices available in the moment.

Pick a Spokesperson. You Will have 30 Seconds to Share.

GROUP WORK – CHOOSE ONE

Three Manufacturing Scenarios

A | ENERGY CONTROL

A maintenance technician understands the energy isolation requirement, has the correct equipment available, has been trained, and knowingly bypasses the process to restore production faster.

Classify • Factors • Response

B | GUARDING

A team member regularly reaches around a guard because the approved access method adds time. No one has been hurt, and supervisors have seen the practice without addressing it.

Classify • Factors • Response

C | CHANGEOVER

During a rushed changeover, an experienced operator misses a setup step. The line starts with material misthreaded. The operator followed the normal checklist but was interrupted twice. Quality suffers.

Classify • Factors • Response

REPORT OUT

Debrief: What Changed When Context Was Considered?

1. What evidence supported your classification?
2. Which system conditions shaped the choice?
3. What response would reduce recurrence?
4. **What would build trust without weakening accountability?**

The Purpose is Learning and Stronger Decisions, not Softer Standards.

6 Practices Integrate Training Into Operations

NO BLAME MINDSET
Pause, Think, & Respond

FRESH EYES
See Risk Before Error

SYSTEMS + DATA
Learn from Patterns

TRUST + ENGAGEMENT
Invite People In

PERSONAL COMMITMENT
Show Care Through Action

ACTIVE LEADERSHIP
Model The Way

Leadership Involvement is not Sponsorship from a Distance. It is Visible Engagement.

EIGHT MONTHS AFTER IMPLEMENTATION

A Manufacturing Case Study

57.5%
Recordable Injury Reduction

53.5%
Lost Time Reduction

44%
Turnover Improvement

22%
Quality Improvement

66%+
Reliability Increase

23%
Waste Improvement

The data does not prove one cause.
It shows why human factors belong in the operational excellence conversation.

What the Site Did to Support Implementation

Visible Leadership Commitment

Plant leaders set expectations and explained the investment.

Every Leader Trained

Every manager and supervisor attended sustainment training, including a makeup session.

Follow-Through in Daily Work

Unit actions in shop floor meetings. SafeStart in one-on-ones and leader walks.

Continued Learning

Leader stories, habit practice, and a locally developed refresher kept concepts active.

Which practice could you build into an existing routine?

ONE COMMITMENT FOR THE NEXT 30 DAYS

Take it Back to Work

STOP One response or practice that creates blame or competing priorities

START One visible leadership behavior that increases engagement

STRENGTHEN One system, metric, or coaching habit to move culture forward

Write One Action You are Willing to Model, not Just Assign.

Driving Injuries Down, Engagement Up & Culture Forward



Two Things to Remember When You Leave This Room

SAFESTART® FORUM

1 Human Factors Training Builds the Awareness and Habits that Improve Operational Performance.

2 Leadership Engagement Puts a Caring Culture Into Action, Building the Trust People Need to Drive Continuous Improvement.

Questions & Conversation

OUR CARING CULTURE IN ACTION

Breakout Reference Sheet

01 ACTION DEFINITIONS

Human Error

An unintentional slip, lapse, or mistake. The person did not intend the action or error.

At-Risk Behavior

A choice that increases risk because the person does not recognize or minimizes it. The choice may seem reasonable, efficient, or justified.

Reckless Behavior

Conscious and knowing disregard of substantial risk. The person understands the risk and potential harm but chooses to proceed or prompts others to proceed.

02 HUMAN FACTORS

Rushing

Haste that narrows attention and reduces the opportunity to pause and think.

Fatigue

Physical or mental tiredness that reduces capacity and focus.

Frustration

Irritation or dissatisfaction in which reaction can replace reflection.

Complacency

Familiarity or comfort with a task that lowers perceived risk and attention to hazards.

03 LEADERSHIP RESPONSES

Mentor + Improve

For human error: Support learning. Improve processes, training, conditions, or controls to prevent recurrence or reduce consequences. Design to “Fail Safely”.

Coach

For at-risk behavior: Build risk awareness and reinforce safe practices. Remove pressures or barriers that make shortcuts seem reasonable.

Discipline

For reckless behavior: Apply disciplinary accountability for knowingly disregarding substantial risk. Protect the team and reinforce clear standards.

Classify the Action, not the Person. The Same Outcome Does not Mean the Same Response.