

Results Attributable To The New Safety Program

The entire process was implemented in phase 3 of the project which started in April, 2002, and had all of the exposures that was in the other phases, total of 3 phases of project took over 4 ½ years. The OSHA rates improved dramatically and rates at the end of June, 2003 were as follows:

OSHA recordable rate-	1.92
OSHA lost time incident rate-	0.00

Rates for the project when opportunity for improvement was identified.

Previous OSHA recordable rate-	8.18
Previous OSHA lost time rate-	0.45

Workers compensation direct claim cost per man-hour for the last 15 months:

Approximate cost per man-hour-	\$0.015
Previous approximate cost-	\$0.185

Percentage of improvement for project using design process.

OSHA recordable rate-	Over 76%
OSHA loss time incident rate-	100%
Workers Compensation Total Incurred Claim Costs-	Over 91%

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The improvement seemed much more than just the numbers. It truly became a safety culture; this was especially gratifying when there were many subcontractors with varying degrees of safety cultures. Some of the additional benefits we identified from the additional process items were:

Site Scoring Sheet

With a scoring goal and a process of accountability in place, items that seemed to be repeaters such as proper electrical cord inspection and marking, damaged hole covers, mid rail chains not hooked on scissor lifts, and toe boards became compliant a large percentage of the time. We also had an additional benefit of using the scoring sheet to identify "near misses" and required exposures with a 2 or more score to have an incident review with identification of leading indicators that the supervisor was responsible for and what we could do to help so exposure would not happen again (additional training, etc.)

Indirect Cost Sheet

The benefit that was more than we anticipated when using the indirect cost form was we ended up “completing the circle” in regards to our accident investigation process. When a supervisor said he did not have any indirect cost we could ask him how the employee traveled to the doctor, time filling out the accident form and incident form, time for training, etc. We were able to check on compliance with procedures in place and showed the time and cost for items needed to correct the “root causes”. ([See Sample Indirect Cost Sheet](#))

Pre-task Plan

This became very beneficial when reviewed the day before. Pre-task planning became 100% in use and was available for review at any time. This helped having proper personal protective equipment (PPE) available when work started.

Incident Review Results

Near Miss Incident Reviews

The last two incident near miss reviews was with the same subcontractor who was identified as having two exposures that were scored as 2 or more points on the site safety score sheet. This identified the exposures as a “near miss” and would require an incident review meeting. The items identified as unsafe behavior/conditions were:

1. Worker working on rolling scaffold with wheel locks wired up to allow scaffold to roll while worker is on platform of scaffold. This was in violation of written procedure from the subcontractor.
2. Worker on baker scaffold standing on large tool box (approximately 18” high) which put worker higher than the hand rail exposing them to a fall hazard of approximately 7 feet.

Participants

The incident review meeting included owner safety representative, project manager, corporate safety director and project superintendent for the general contractor, the safety consultant from the insurer, and the project superintendent and safety director from the subcontractor.

Discussion

The safety director and the project superintendent said that the workers have been trained, warned, and would be asked to leave the job if they could not follow safety procedures. We looked at the leading indicators and asked if the supervisors had been in the areas. It was determined that they were in the areas various times previous to the site survey. We then looked at the pre-task plan in place for both instances to see if opportunities for improvement could be made.

Results

It was agreed that the supervisors should have identified the leading indicators and corrected them as soon as they became evident. The supervisors would be trained on their responsibilities on these items. It was determined that having the

supervisors realize that if they walk by a near miss without correcting it was the same thing as training the worker to do the unsafe behavior. The pre-task plan also had some opportunities for improvement that were corrected. The general contractor group asked the subcontractor group if there was anything they could do to help support the supervisors to eliminate this exposure. There has been no repeat of this exposure with this subcontractor.

Conclusion

It is possible to have a safe job site with several hundred workers, many subcontractors, and only one site safety professional. It requires supervisor accountability, minimum subcontractor safety requirements, and to respect the workers on the site as they are usually doing what they “think” their supervisor wants. This philosophy requires focusing on the “leading indicators” and training supervisors that they are responsible and accountable for recognizing and correcting these unsafe behaviors and conditions as part of their normal job task.