



Integrated Safety Management Best Practice: *Corrective Action Program and the Safety Culture*

August 27, 2007





Introduction

- **Electronic Suspense Routing and Tracking System (E-STARS®)**
 - Web based action tracking and work flow management system
- **Problem Evaluation Request (PER)**
 - Web based corrective action management system
 - Module of E-STARS®
- **Together**
 - Problem identification
 - Graded approach management
 - Cause to corrective action assignment and tracking
 - Objective evidence closure
 - Record repository



History

Numerous challenges at Hanford necessitated change:

- DOE performance letter in 2001
 - PER and E-STARS® deployed
- Multiple layoffs, mission acceleration, restructuring, funding cuts
- Significant legacy issues emerged
 - lower level assessment = robust issue identification
- Increased injury and event rates
- Increased stop works and union grievances



HPI Steering Committee Strategy

- Shift the organizational focus -

From:

**Emphasizing
administration in our
processes**

**Robust defense against
second guessing**

**Robust reaction to
events**

To:

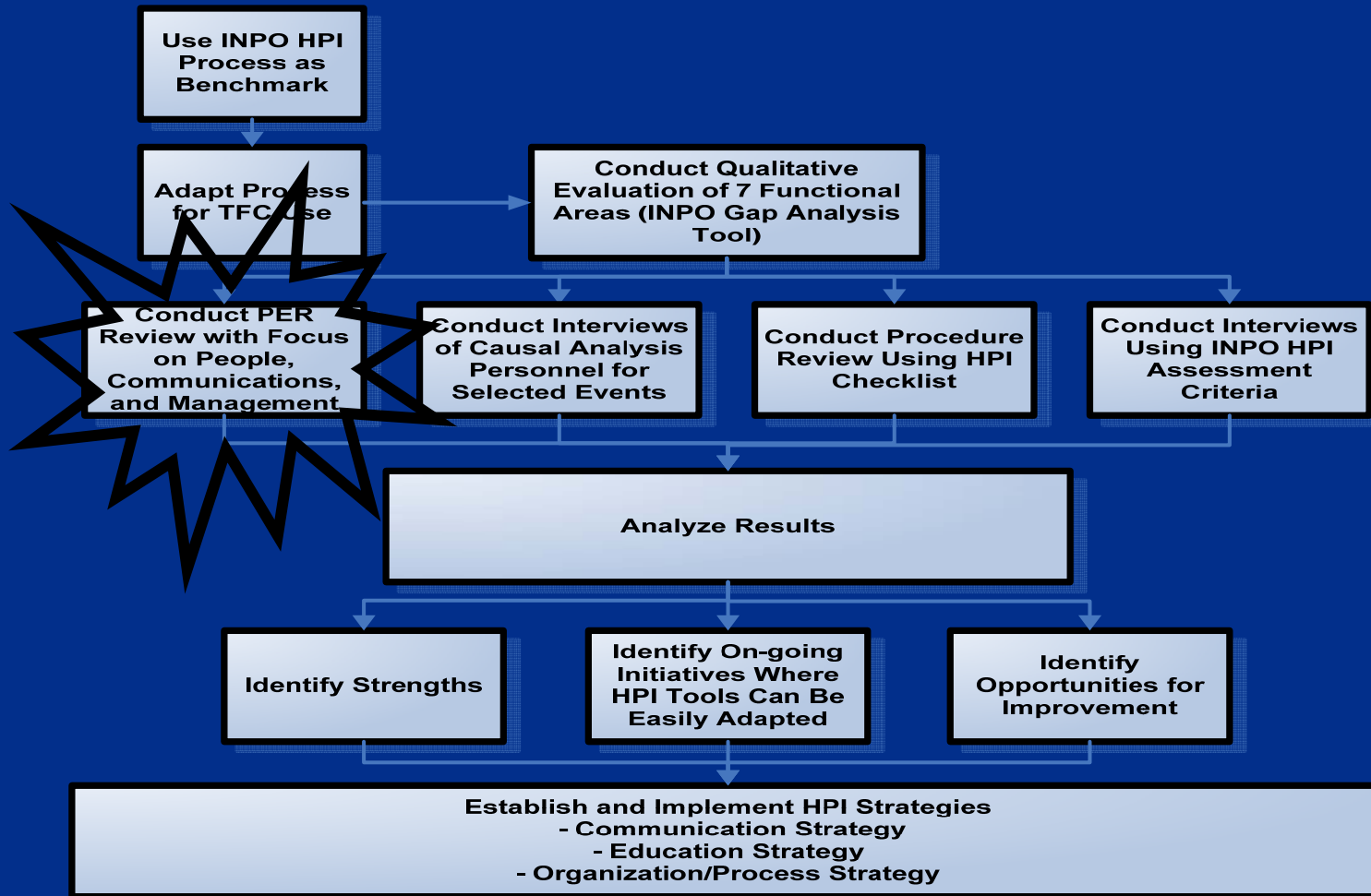
**Robust hazard Identification
and mitigation**

Processes built for the user

Robust prevention of events



Gap Analysis





PER/E-STAR[®] as an ISM Best Practice

- **Enhances productivity through web-based technologies**
 - Built for the users
 - Single problem identification and action tracking system
 - Retired legacy tracking systems
- **Optimizes processing time through system automation**
 - Easier to use = more use
 - Process drives immediate assignment to management
- **Provides real time feedback for continual improvement**
 - Increased user confidence in process



PER/E-STARS® as an ISM Best Practice (cont.)

- **Single point of entry for timely identification and evaluation of conditions and the correction of deficiencies adverse to:**
 - Quality
 - Safety
 - Health
 - Operability
 - Environment
- **Graded approach application to corrective action management**



Worker Level Assessment

- **Enables personnel the ability to:**
 - Identify quality and safety-related deficiencies
 - Request process improvement evaluation
 - Request clarification of requirements
 - Evaluate lessons learned reports
 - Manage concerns, findings, or observations from surveillances, audits, or inspections, and
 - Manage action items, overall
- **Overall increased information flow up and down the chain**



ISMS Continuous Improvement

Worker
involvement

Event
prevention



Problem identification
and resolution

**ISMS Continuous Improvement based on effective
problem identification, worker involvement, and event
prevention**





Safe Work Environment (SWE)



Problem identification
and resolution

ISMS continuous improvement is based on an open work environment where everyone feels free to raise issues without fear of retaliation





Employee involvement

•Originator defined level of participation

Level of Participation	
Would you like to be contacted during disposition of this PER?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input style="border: 1px solid black; padding: 2px 5px;" type="button" value="?"/>
Level of Participation	<p><input type="radio"/> I would like to help define the problem</p> <p><input type="radio"/> I would like to help in investigating the cause</p> <p><input type="radio"/> I would like to review the the corrective actions at closure to ensure they were effective</p> <p><input type="radio"/> Other</p> <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>

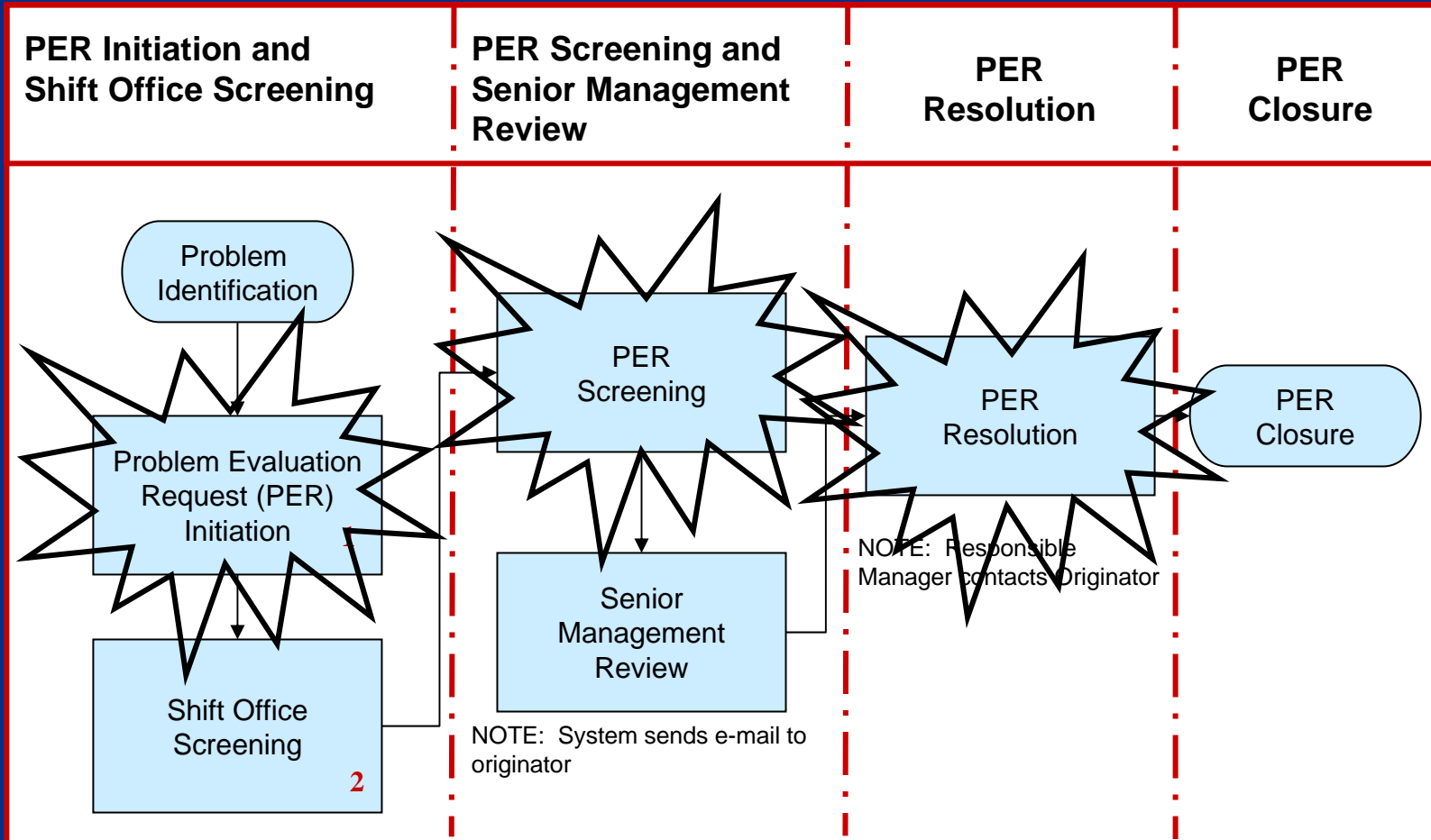
•Automated e-mail notification system

- @ key process steps
- @ closure

•Process Improvement Initiative tracking



Corrective Action Management (CAM) Process Flow





ISM in Action





Problem Identification

- Employee identifies key attributes:

Discovery Date/Time	<input type="text"/> <input type="text"/> (mm/dd/yyyy 2400)
Program/Project	Select One <input type="button" value="v"/> <input <="" td="" type="button" value="?"/>
Location	Select One <input type="button" value="v"/> <input <="" td="" type="button" value="?"/>
How Was The Problem Discovered?	Select One <input type="button" value="v"/> <input <="" td="" type="button" value="?"/>
Description of Concern or Problem	<input type="button" value="Z"/> <input type="button" value="SP"/> <input <br="" type="button" value="?"/> <input type="text"/>
System Identification	None <input type="button" value="v"/> <input <="" td="" type="button" value="?"/>
Equipment Identification Number	<input type="text"/> <input <="" td="" type="button" value="?"/>
Requirement Not Satisfied	<input type="checkbox"/> <input <="" td="" type="button" value="?"/>
Source Document Number Available	<input type="checkbox"/> <input <="" td="" type="button" value="?"/>
Immediate Actions Taken	<input type="button" value="Z"/> <input type="button" value="SP"/> <input <br="" type="button" value="?"/> <input type="text"/>
Recommended Corrective Actions	<input type="button" value="Z"/> <input type="button" value="SP"/> <input <br="" type="button" value="?"/> <input type="text"/>



Trending Based on Key Attributes

- Screening committee assigns trend codes:

Causal Code	No Causal Code Selected	<input type="button" value="Add Causal Codes"/>
ORPS Code	Select One <input type="button" value="v"/>	
Functional Area	Select One <input type="button" value="v"/>	
Work Process	Select One <input type="button" value="v"/>	
ISMS	Select One <input type="button" value="v"/>	
PAAA	Select One <input type="button" value="v"/>	
Consequence Code	Select One <input type="button" value="v"/>	



Problem Resolution

- Responsible Managers evaluate problem and plan corrective actions:

Extent of Condition/ Safety Significance and Generic Implications	Z	SP	?
<input type="text"/>			
Remedial Corrective Action	Z	SP	?
<input type="text"/>			
Causal Analysis, Apparent Cause and/or Root Cause Analysis	Z	SP	?
<input type="text"/>			
Corrective Actions to Resolve the PER	Z	SP	
<input type="text"/>			

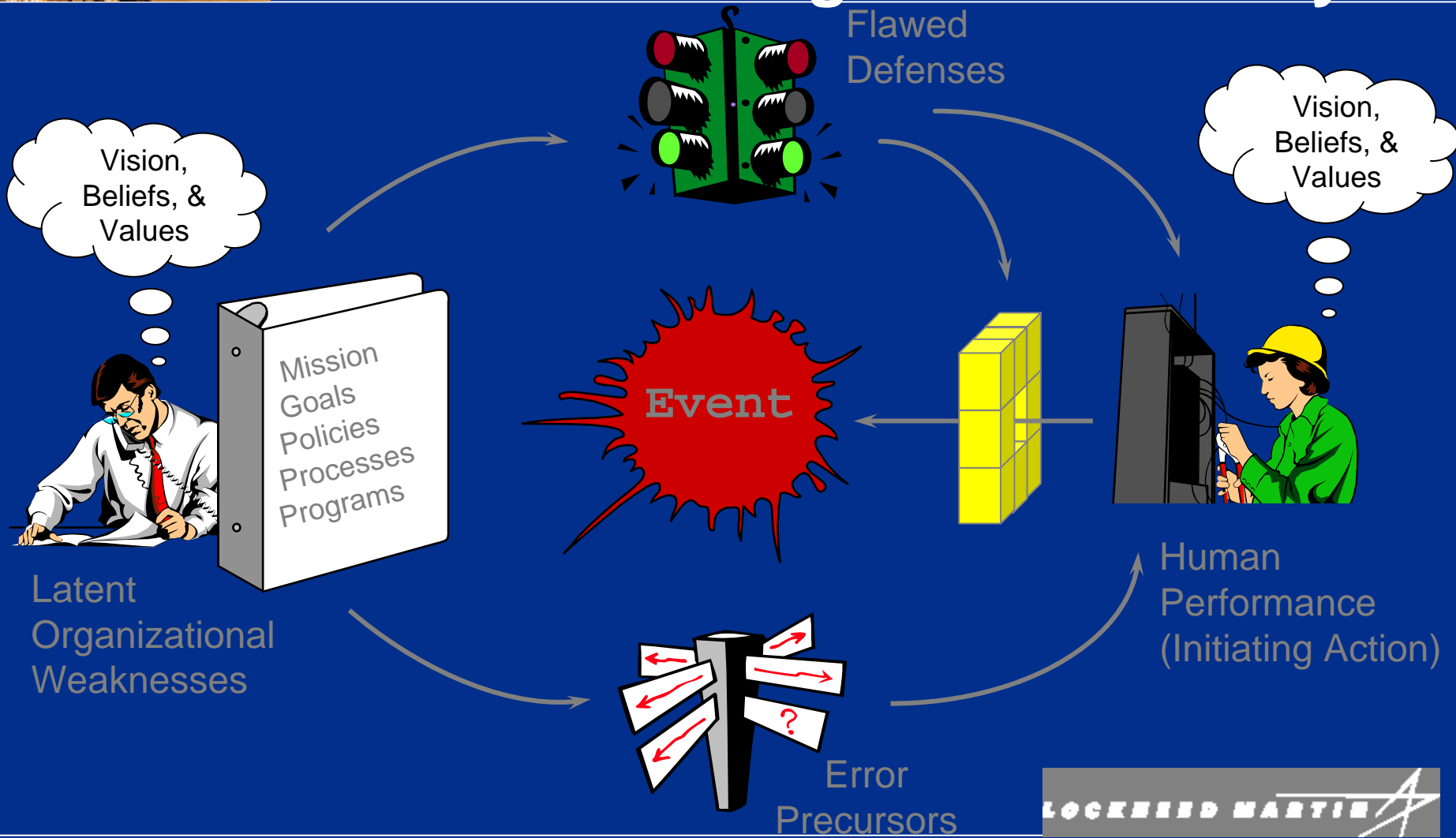


Investigation and Analysis

- **Event investigation and critiques**
 - Consider human factors
- **Root Cause Analysis**
 - Consider organizational weaknesses
 - Consider error likely situations and error precursors



Investigation and Analysis



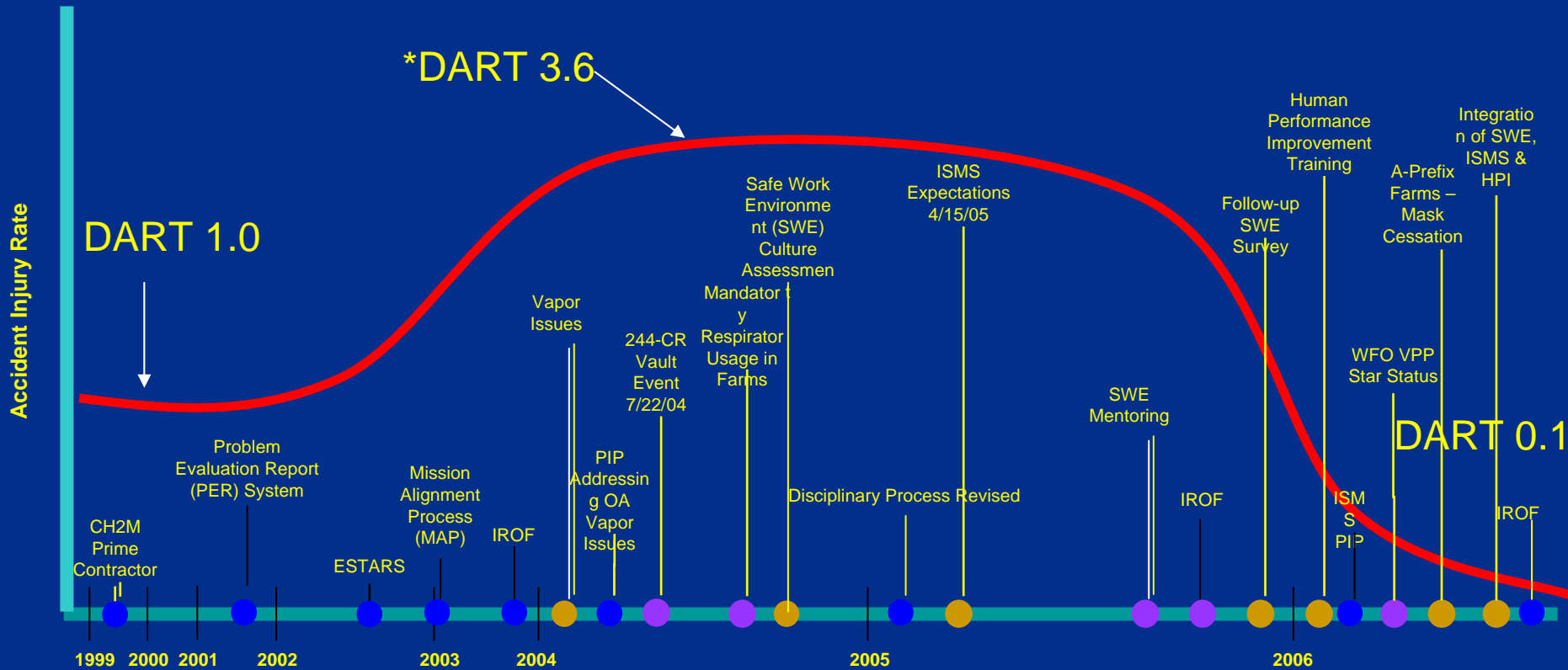


Results

- **Dramatic injury and event reduction**
- **Robust problem identification and resolution**
- **Worker safety perception of company has improved significantly**
- **Worker trust of management high**
- **Raising issues through immediate supervisor has improved**
- **Integrated ISMS expectations clear and evident**



Tank Farm Contractor Improvement Cycle



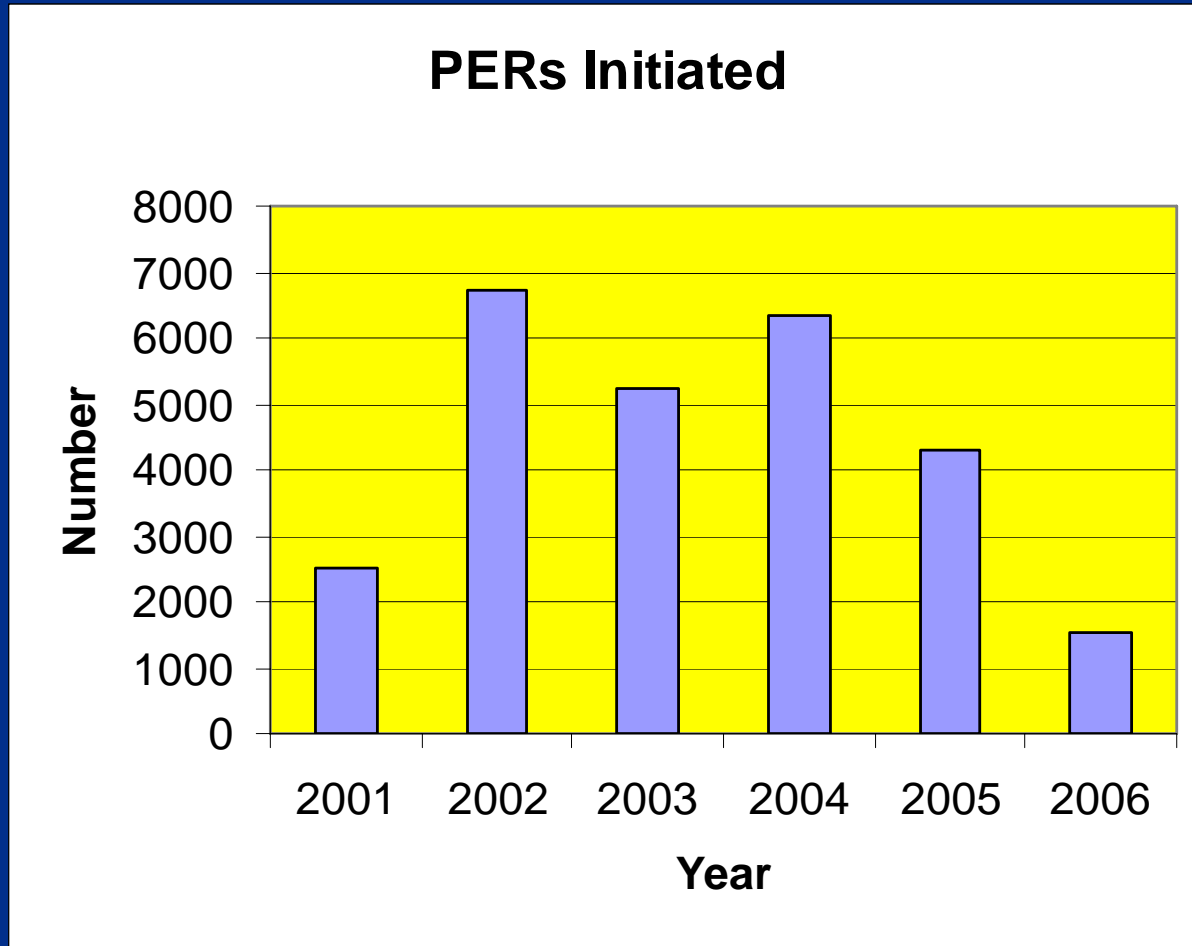
*DART – Days Away and Restricted Time

Not to scale – For illustration only



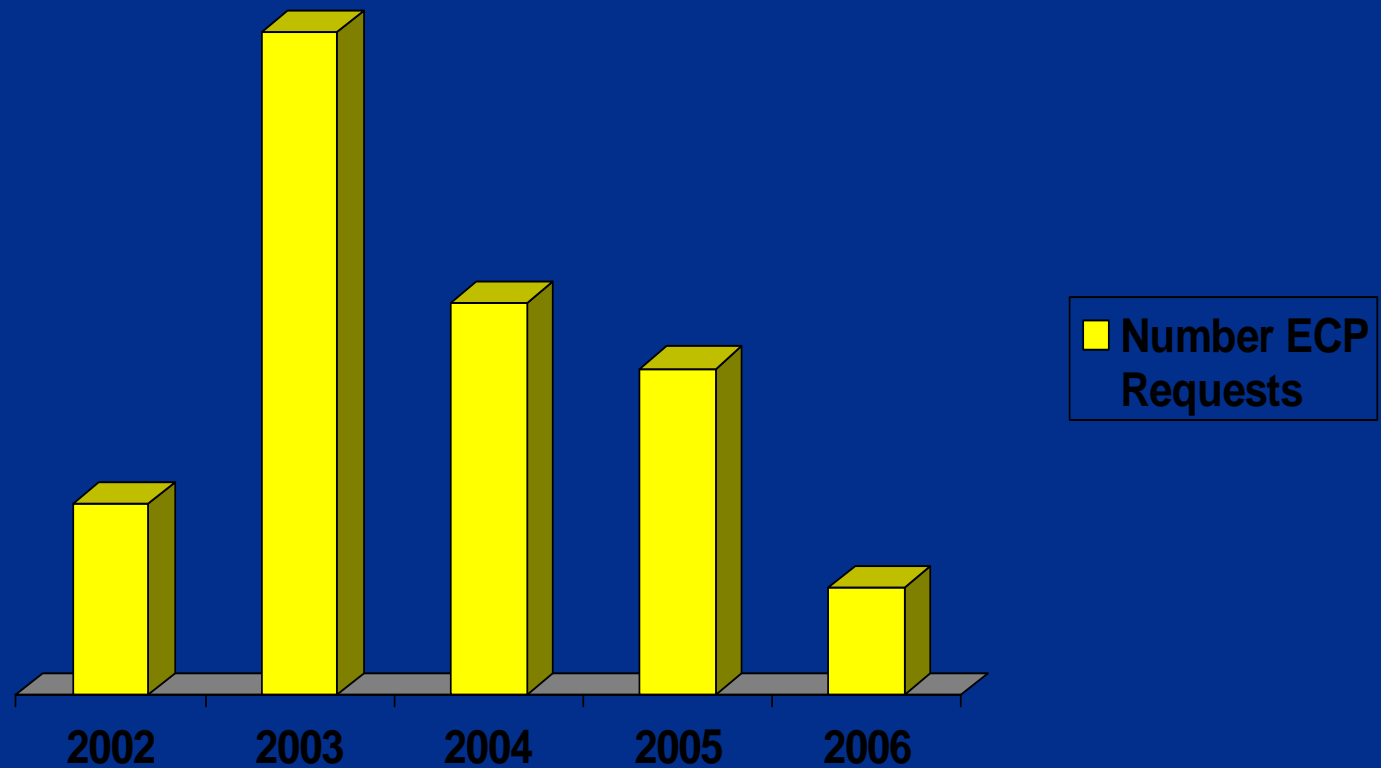


Problem Evaluation Request Cycle





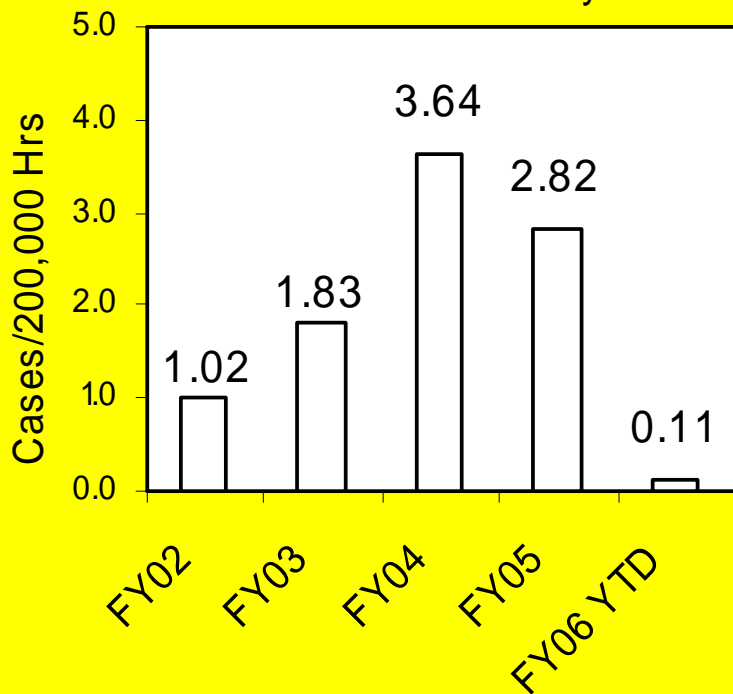
Employee Concerns Cycle



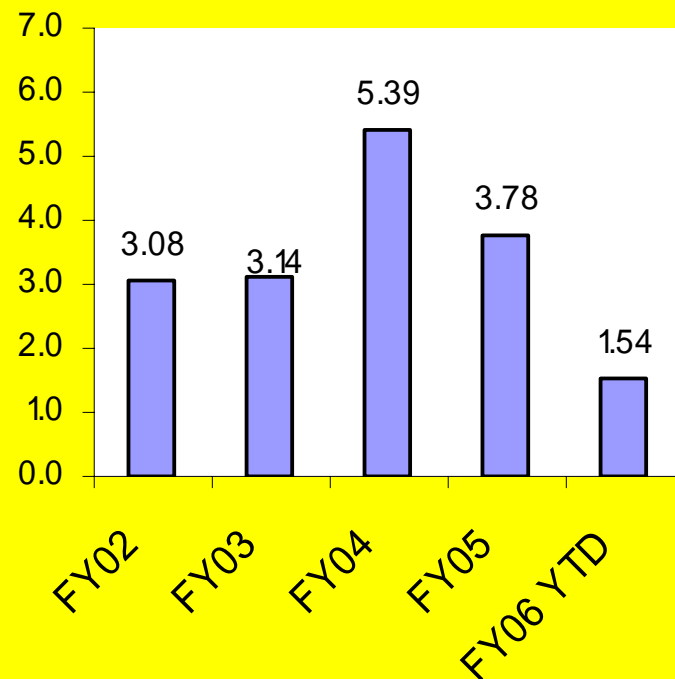


DART and Recordable Injury Cycles

DART Rates
Five Year Summary



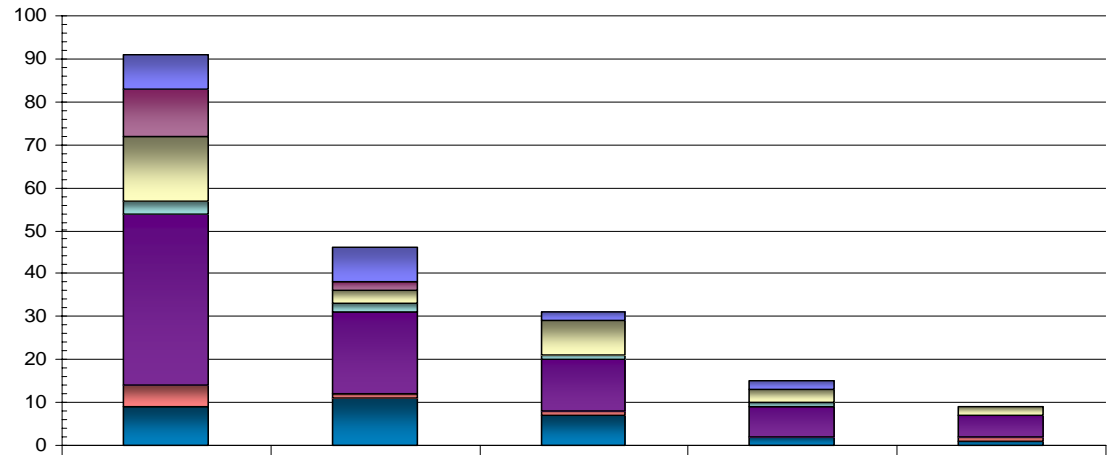
Recordable Rates
Five Year Summary





Conduct of Operations Cycle

Conduct of Operations Index Frequency



	FY2002	FY2003	FY2004	FY2005	FY2006 (Year to date)
■ A) Skin and clothing Contaminations	8	8	2	2	0
■ B) Procedure Not Followed	11	2	0	0	0
■ C) Procedure Problem	15	3	8	3	2
■ D) Training Issues	3	2	1	1	0
■ E) Management Issues	40	19	12	7	5
■ F) Lockout/Tagout	5	1	1	0	1
■ G) Work Control Issues	9	11	7	2	1





Systems Integration





Contact Information

**Marnelle Sheriff, Project Manager,
Lockheed Martin Information Technology**

**For a demonstration of this and other
process automation please call:**

509-205-7520

