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Creating a safety conscious organization and workforce

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HEALTH, SAFETY, AND PERFORMANCE AT WORK — IS IT A JUGGLING ACT?

There is often a distinct trade-off between performance and safety that is present in many organizations. The upper echelons of organizations are staunch in their approach to safety: Safety IS First! However, the vast majority of the time this message is poorly translated as it makes it way to the 'shop room floor'. This first became abundantly clear to me from a consulting project for a major Oil and Gas company. In discussions with upper level executives and managers, I routinely heard the message that safety IS first and foremost — always! However, when I held similar talks with employees who worked on the oil rigs, I found that they heard the corporate message, Safety IS First, but the actual message they more readily heard and followed was from their immediate supervisor. The immediate supervisor's message was a more daily message and can be encompassed in two words: 'hurry up'. If you were in such shoes, what would you do? You are on the job to perform at a high rate and are rewarded (e.g., continual employment, financial bonus) for completing assigned tasks in as short of a period as possible. Do you 'hurry up' as suggested by your immediate supervisor or do you follow safety protocol that upper management supports? If you are the manager, what would you be telling your employees? This is the dilemma that is faced by many employees and managers. As a manager, how can you strive for high performance and high safety and health for yourself and for your employees?

IMPORTANCE OF HEALTH AND SAFETY IN ORGANIZATIONS

Thousands of deaths and disabilities occur each year in the United States with an estimated 6,000 deaths accredited to workplace accidents while work-related injuries and illnesses are estimated to reach 4 million in a given year. While these numbers are staggering for individual employees and their families, the organizational costs associated with poor safety within organizations is also staggering. We must also consider the amount of lost time due to employee accidents and associated costs for organizations that experience accidents. Furthermore, there are large financial penalties and governmental mandates that organizations could face for poor health and safety standards and practices. As these numbers indicate, poor occupational safety and health is an important problem that needs to be addressed, yet there is a lack of criticality placed on occupational health and safety. This is not to say that we have not made ground in improving health and safety in organizations. When we look to the past and the state of occupational safety and compare that to today, we have made remarkable progress. For example, regulating agencies have been put in place to govern safety practices at work (e.g., OSHA) and many lessons have been learned from previous industrial accidents (e.g., Chernobyl; coal mining disasters) all of which have helped reduce the occurrence of workplace deaths from 21,000 in 1912 to 5,000 in 2014. While an approximate drop of 16,000 deaths may not sound like a long way to have come, consider that in 1912 there were 95 million people in the United States compared to 300 million today — the ratio of deaths to population is much smaller. We have truly come a long way, but there is still a long way to go.

History

The safety movement and accident prevention initially began by attempting to identify accident-prone employees. This 100+ year search has seemingly failed to identify the accident-prone employee and has virtually been dismissed today. However, this has given way to what many people label 'Human Error'. Human error is the failure of a desired course of action to achieve the expected results, is typically the

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blamed culprit for most occupational accidents and injuries, and has traditionally been cited as the number one cause of accidents. What does human error actually tell us about the reason(s) that lead to the accident or injury? Nothing. Human error is a catch-all phrase for errors that are attributable to a person, but it does not provide much insight to the problem of occupational safety. Human error, just like the accident or injury, demands an explanation. Human error does not consider a host of other factors well beyond the employee's control: the work environment, co-workers, supervision, and resources. In fact, individual employees are typically at the receiving end of many organizational deficiencies resulting in poor safety and health.

Researchers have summarized two views of occupational safety: 'the old view' and 'the new view'. The old view is akin to the traditional human error approach as described above. The old view has apparently failed and is no longer accepted today. The new view on the other hand, sees human error as a symptom and not a direct cause. First, human error is a symptom of a combination of deeper root causes (e.g., personality dimensions, work design). Secondly, system safety is not inherent. That is, people have to create safety because work systems are not always in concert with the multiple goals that employees simultaneously pursue (i.e., work systems are not perfectly engineered for safety). Lastly, human error can be and has begun to be systematically linked to various features of people and the operating environment. This new view suggests that managers need to utilize multiple techniques (i.e., selection, training, development) to create a safer workplace for all employees.

The new view of human error and accidents suggests that occupational safety research needs to begin to address the factors that have previously been swept under the rug of human error (e.g., work design, personality, cognition, leadership/supervision, climate). The 'people, tools, tasks, and operating environments' comprising the new view can all be treated as inputs or antecedents of safety (i.e., safety performance & safety outcomes). That is, each one of these things can be thought of as symptoms of occupational safety to varying degrees. Hence, a more modern thought on health and safety has moved toward looking at a combination of employee characteristics and environmental characteristics and how each one can influence safety related outcomes.

Old view	New view
• Blame human error • Search for the accident-prone person • Safety can be 100% engineered	• Employees are often at the receiving end of problems • Search for underlying characteristics • Safety is not 100% inherent in work design and engineering • Need to examine features of employees, tools, tasks, and work environment together

DEFINING HEALTH AND SAFETY OUTCOMES

The Occupational Safety and Health Act was passed in an attempt to preclude future accidents and poor health in organizations. OSHA has been very helpful to organizations in meeting safety standards and to employees in recognizing their rights. The Act has been instrumental in improving occupational health and safety due to the Act focusing on multiple aspects of occupational health and safety:

> ''To assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in the their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health; and for other purposes'' (the Act, 2004).

Even with the tremendous benefits that have accompanied OSHA, there are still many problems that exist today. Some of the common problems have to do with actually determining what constitutes the criterion domain for safety (i.e., safety criterion problem). This problem is often manifested by management not fully understanding health and safety. To fully address health and safety, employers need to move beyond simple compliance with OSHA, which in-and-of-itself is a very good thing, and begin to build a safety conscious workforce. Given this lack of understanding in the health and safety criterion domain, it is often the case in human resources that action plans for improving health and safety are put into place without fully identifying the outcome or goal. OSHA has been instrumental in defining 'accidents' and providing standards for safe work environments. However, the focus has been narrowly defined. To fully address the entire spectrum of occupational health and safety, a much broader net needs to be cast, as is called for by the 'new view' for occupational health and safety.

In general terms, *occupational health and safety in organizations can be defined as actions, behaviors, and outcomes that employees engage and produce in almost all jobs to promote the health and safety of co-workers, customers, the public, and the environment.*[1] Historically, this has not been the case. As previously mentioned, researchers and HR practitioners have sought to identify the most parsimonious explanation for poor health and safety: the accident-prone employee. This search began in the early 1900s for two primary reasons: (1) transportation, critically important to the success of business, was an emerging field as the United States began expanding and (2) persons affected by the transportation movement (i.e., operators, pedestrians) needed to be kept safe. While this movement failed to identify the accident-prone employee, it has led to the development of two general classes of safety related criteria that HR managers should be cognizant of and utilize in gauging the safety of their workforce: (1) Safety Outcomes and (2) Safety Behaviors — see Fig. 1.

Accidents and Injuries

There are many forms of safety outcomes, yet the most emphasized is the accident. Accidents have been studied across disciplines (e.g., Management, Psychology, Engineering, Sociology, Medicine). Most studies examining accidents

[1] Definition quoted from Burke et al., 2002, *Personnel Psychology*.