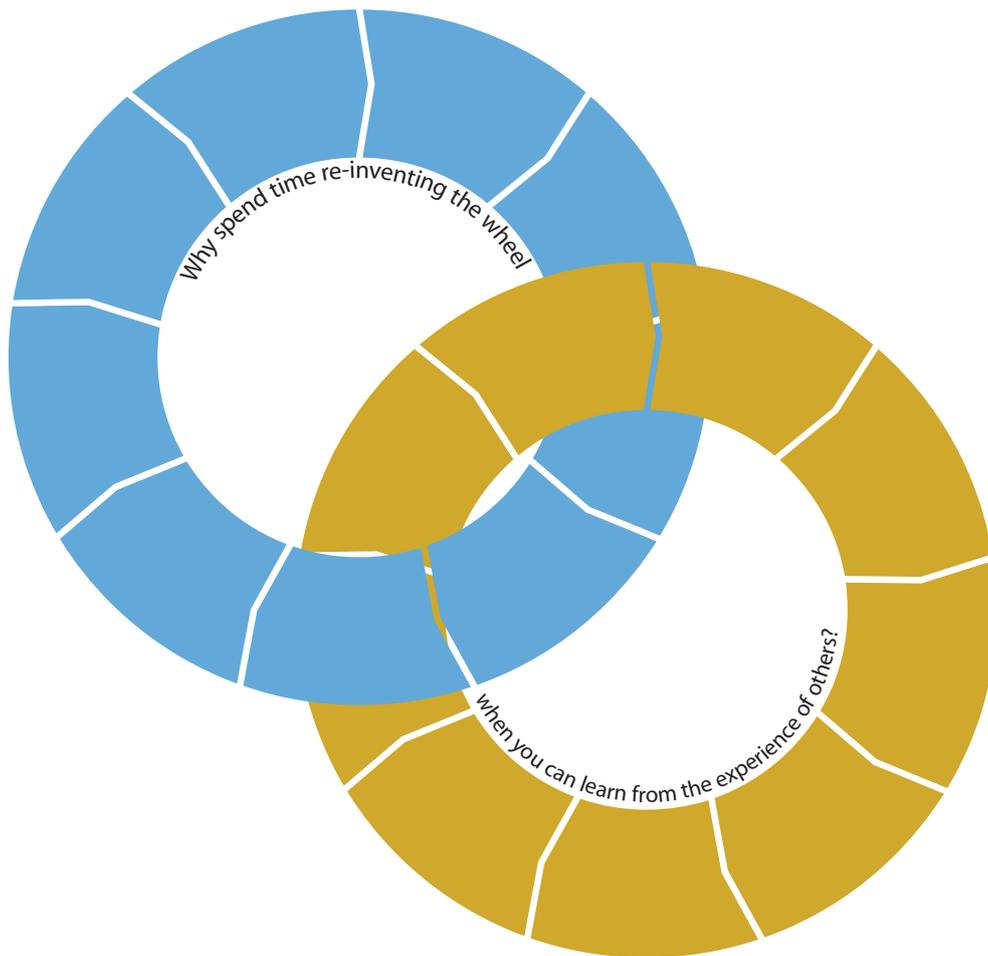
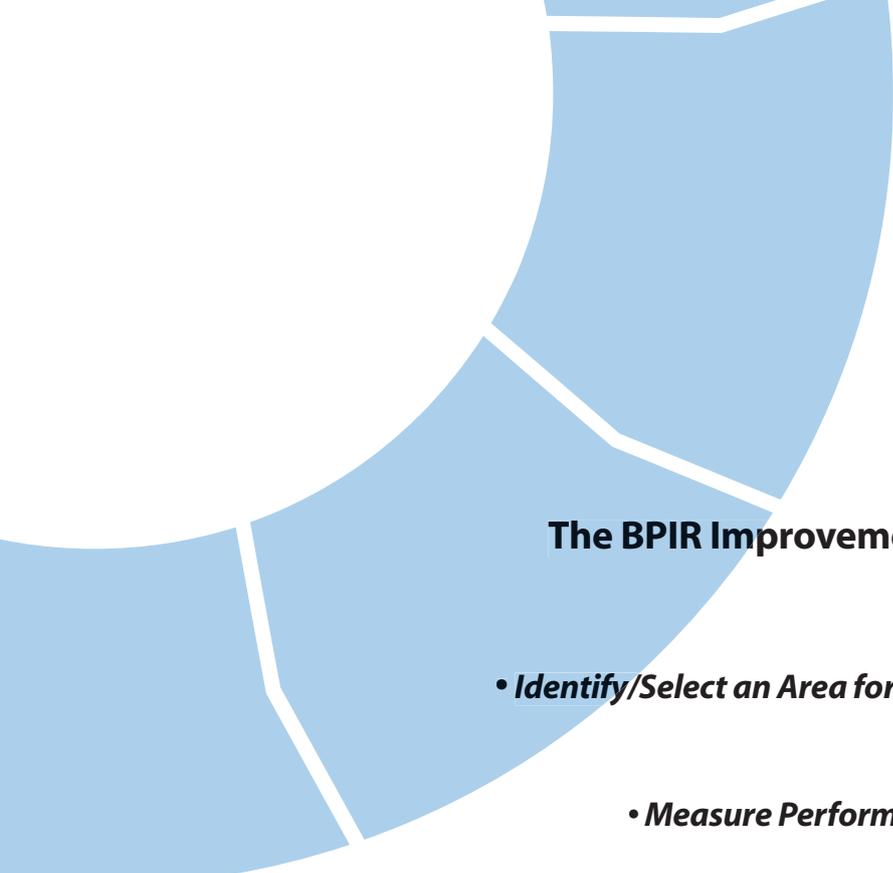


# Occupational Safety





## **The BPIR Improvement Cycle**

- ***Identify/Select an Area for Improvement***

- ***Measure Performance***

- ***Benchmark Performance***

- ***Identify a Relevant Improvement Approach or Strategy***

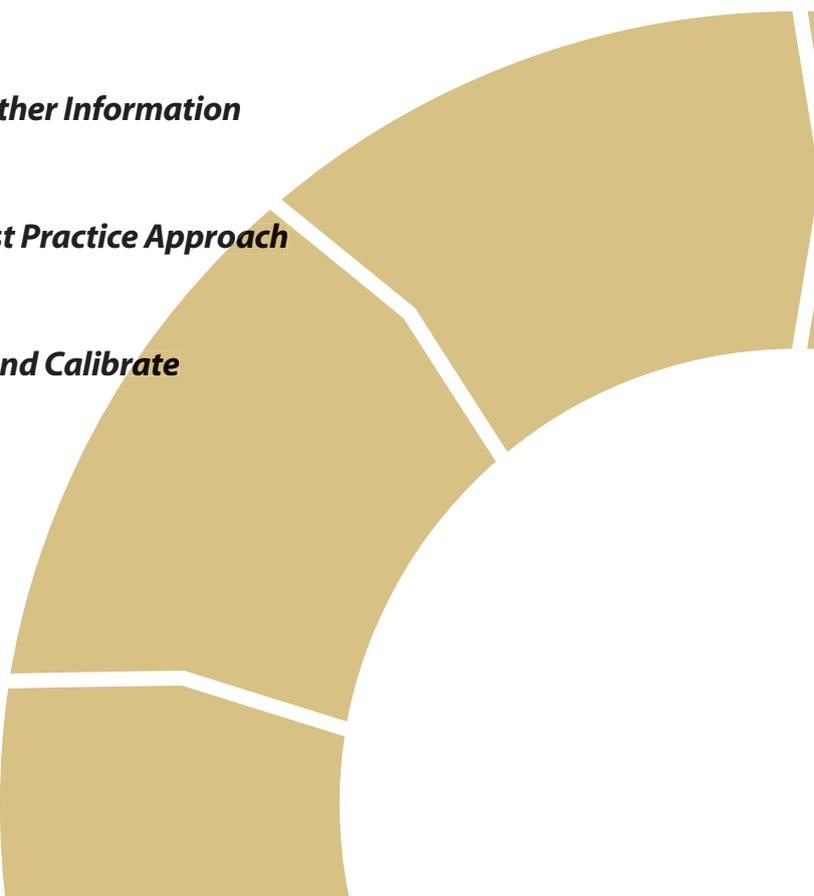
- ***Learn How to Implement***

- ***Identify Best Practice Organisations***

- ***Research Further Information***

- ***Implement a Best Practice Approach***

- ***Review and Calibrate***



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## Occupational Safety: The Definition

Occupational safety means providing employees with a safe environment in which they can work without injury and strain, one in which they are able to maximise their productivity.

## The Stage

Employee safety is inseparably linked to an organisation's culture; consequently, successful safety initiatives must be integrated into everything that an organisation does. Successful safety programmes have to capture the hearts and minds of the people involved in them. When employees are so motivated that they take ownership of occupational safety themselves, accident rates will drop permanently.

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## Expert Opinion

Ian Sutton, a process risk manager with AMEC Paragon in the United States, writes that the root causes of safety and environmental problems often arise from economic pressures. Managers are often put under relentless pressure to cut costs while, at the same time, being expected to increase production rates, implement new initiatives, and install new technology. This can lead to a mindset that has a tendency to cross acceptable safety thresholds. The following six “red flags” indicate when these thresholds are being challenged:

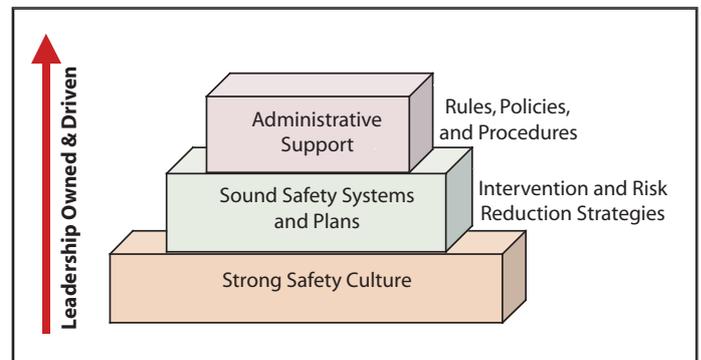
- ▶ **Unrealistic stretch goals:** if an organisation is stretched far enough, major system failures are certain to occur.
- ▶ **Excessive cost reduction demands:** managers are often expected to cut expenses but, at the same time, increase production rates. Eventually, a “do-more-with-less” philosophy can become excessive, and lead to the development of unsafe conditions.
- ▶ **Belief that “it cannot happen here”:** catastrophic events are very rare; this can contribute to what has been called the “I’ll chance it” syndrome. Managers and employees often fail to distinguish between occupational safety and process safety. In fact, the actions needed to improve occupational safety—as measured by the number of lost-time accidents—are quite different from those required to prevent catastrophic, low-probability and low-frequency events. Organisations reporting excellent day-to-day and month-to-month safety figures are often very surprised when they experience a major incident.
- ▶ **Overconfidence in regulatory compliance:** well-crafted regulations, rules, codes and standards may induce a false sense of confidence. Rules alone cannot anticipate the combinations of events that lead to a catastrophic incident—most of which are unusual, and sometimes bizarre. Standards merely provide a framework for successful operational integrity. Detailed hazard analyses must also be carried out.
- ▶ **Ineffective information flow:** a recurrent finding in disaster research is that information about potentially serious problems has often been available within an organisation but never communicated to relevant decision-makers. One reason for this is that most people do not want

to be the bearer of bad news; this can lead to information becoming more and more diluted as it travels up the management chain.

- ▶ **Ineffective auditing:** good audits should attempt to identify the root causes behind any findings. Senior management should give careful attention to audit findings by reviewing in detail the audit, the audit process, and the audit follow-up. This will also provide an opportunity to examine any improvements required within an organisation’s management systems. <sup>[1]</sup>

## Creating a Safety Culture

According to Charles Branham, a principal at the National Rural Electric Cooperative Association in the United States, research has shown that excellent safety performance is usually built upon a strong organisational safety culture—one that is owned and driven by intentional leadership. Excellent safety requires a strategic focus on safety, supported by clear rules, policies and procedures. From this foundation, the workforce can be engaged in prevention-based safety, and use systems that reduce at-risk behaviours and conditions. The components are depicted in Figure 1, see below. Prevention-based safety systems engage both leaders and employees to create an environment in which injuries are not acceptable. <sup>[2]</sup>



**Figure 1: The Components of Excellent Safety Performance** <sup>[2]</sup>

Rick Stasi, chief operating officer for the alternative risk division of insurance provider Avizen in the United States, believes that the best safety programmes begin with a management team that is dedicated and committed to creating a culture of safety. Management must advocate employee involvement and commit to creating zero tolerance for injuries. <sup>[3]</sup> Figure 2, see opposite, outlines ten steps towards the creation of an organisational safety programme:

1	Understand the implications of current laws regarding your organisation.
2	Conduct an initial assessment with employees to identify common areas where accidents occur— and the reason why they occur.
3	Customise safety plans to meet the needs of each site, building, equipment type, and process, as well of specific employees. Strive to make every member of the organisation personally accountable and responsible.
4	Develop written programmes for all employees where certain hazards exist.
5	Train, train and train again. Training is the weak link for many employers. Training can help employees to recognise and prevent accidents. Initiate frequent, continuous, collaborative and engaging employee training exercises.
6	Create personalised incentives that motivate staff to alter their safety routines.
7	Make safety simple. Guidelines should be easy to understand and readily available.
8	Develop a simple and easily used system for reporting incidents.
9	Provide a safety hotline enabling site personnel to submit safety-related questions by telephone or e-mail, and ensure prompt responses from qualified safety professionals.
10	Involve employees at every level of the programme development and implementation. The best safety programmes are collaborative and inclusive.

**Figure 2: Ten Steps for Creating an Organisational Safety Programme** <sup>[3]</sup>

### Building a Safety Culture: Incentives versus Recognition

Safety incentive programmes seldom work as expected, write consultants Carl and Deb Potter of Potter and Associates International Inc. Managers and employers from all industry types confirm that incentive-based safety programmes lead to under-reporting, particularly when performance is related to lagging indicators such as

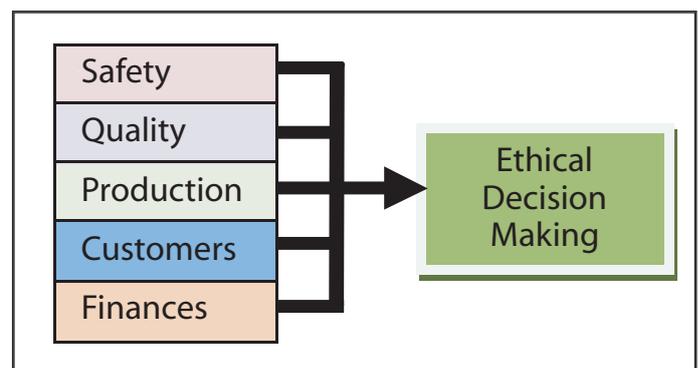
reduced incidents or severity rates. Such under-reporting then leads to a loss of critical information; it may also result in dangerous behaviour or hazardous conditions not being addressed. Over a period of time safety incentive programmes can become:

- a burden, because of the need for constant, tedious paperwork
- ineffective, because they can create an ongoing expectation of entitlements, regardless of results
- “just another routine,” leading to interest and attention falling away over time
- punitive, particularly when group rewards are involved, and where an incident involving only one person may lead to a loss of rewards for the whole group.

Recognition schemes are seen to be superior to incentive schemes because recognition enables organisations to build on observed safe behaviours, and use these positive outcomes to build an improved safety culture. <sup>[4]</sup>

### Safety Improvement Initiatives

Citing Babur Pulat of the University of Oklahoma, Booz Allen Hamilton technology consultant Ryan Burge explains that when making process changes, certain key factors should be considered simultaneously, and that this exercise should be undertaken within an ethical decision-making framework. The key factors for consideration are safety, quality, production, customers, and financial health. Dramatic cost savings may be obtained by reducing the quality of products or services, or reducing staffing inappropriately, or by cutting back on training and safety programmes; however, these strategies combined with poor ethics can lead to undesirable safety outcomes. <sup>[5]</sup> Figure 3, see below, illustrates the relationship between ethical decision-making, while considering these five key factors in parallel.



**Figure 3: Decision Making Using an Ethical Framework** <sup>[5]</sup>

Figure 4, see below, outlines various characteristics required for successful safety improvement initiatives:<sup>[6]</sup>

Characteristics	Explanation
<b>Focused</b>	Traditional initiatives often generate many rules and procedures that overwhelm and diffuse employee attention. Successful safety efforts focus upon the most important dangers and ways to avoid them. When employees begin to automatically take precautions themselves, accidents rates tend to drop permanently.
<b>Transformational</b>	Precautions that produce significant positive impacts upon accidents are called “transformational” ones. Excellent safety efforts do not seek modest gains; they aim to transform accident rates while requiring minimal or practical levels of effort.
<b>Employee-Centric</b>	Safety improvements can be diluted by low worker involvement. Effective safety initiatives must approach risk from both management and employee perspectives.
<b>Clearly Communicated</b>	Effective communication is a trademark of successful safety initiatives, i.e. matching deeds and words creates a clear message.
<b>Results-Oriented</b>	Safety initiatives can emphasise process metrics over results metrics; however, profound safety knowledge comes from understanding both.
<b>Multi-Dimensional</b>	Successful safety efforts benefit from input from quality, technology and behavioural science sources.
<b>Integrated</b>	Successful safety initiatives must become integrated into all organisational activities. Safety programmes that do not mesh with day-to-day activities are seldom successful or sustainable.
<b>Practical</b>	Safety initiatives are advanced by theories, but ultimately they must fit into cultural, procedural and real workplace conditions.
<b>Humanistic</b>	Successful safety programmes must win the hearts and minds of employees.

Figure 4: Successful Safety Improvement Initiatives <sup>[6]</sup>

## Ergonomics

According to Mike Wynn, an ergonomics engineer and vice president of Humantech in the United States, successful ergonomics initiatives are:

- effective—they significantly reduce ergonomics-related injuries
- efficient—work is achieved with reasonable use of the resources available, and
- sustainable—the gains achieved are lasting, not just one-time improvements. <sup>[7]</sup>

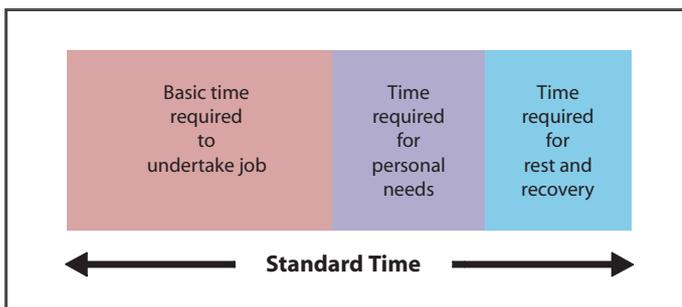
Wynn identifies the following three critical success factors associated with ergonomics initiatives:

1. Integration with continuous improvement: significant beneficial results have been achieved by integrating ergonomics with lean manufacturing methods; this has been found to have a remarkable impact upon employee engagement.
2. Ergonomic risk management: the focus of ergonomic risk management is to resolve hazards that pose the greatest risk of injury to personnel. Organisations have implemented ergonomic risk management by using risk factor surveys involving simple methods to identifying risks and factors contributing to them. Plant floors, for example, may then be mapped using red, yellow and green paint to signify high, medium and low risk areas. This prioritises further ergonomic problem-solving efforts.
3. Design for ergonomics: organisations are achieving breakthrough improvements in health and safety metrics with relatively low investments, simply by anticipating ergonomic challenges and addressing them before injuries occur. Ergonomics is an improvement process in which improvements can be systematically driven and aligned with ongoing work processes.

John Heap, director of the National Productivity Centre in the United Kingdom, states that rest or recovery allowances should be built into the standard time that workers need to carry out tasks under normal working conditions. This assumes that employees will be able to carry out their work without becoming unreasonably tired. Rest/relaxation allowances are derived through considering the following factors:

- posture
- motions
- visual fatigue
- energy output
- personal needs
- thermal conditions
- atmospheric conditions
- other environmental influences. <sup>[8]</sup>

An allowance for rest and recovery may be added as a simple percentage of the basic time required for the job; where work involves a variety of activities allowances may need to be calculated separately for each element involved. A practical allowance, which combines personal needs and fatigue allowances, is typically 10-15 per cent of the basic time required for the job. This represents an allowance of 5.5 to 7.8 minutes of rest/recovery time for each standard hour worked. Figure 5, see below, provides a simple picture of the rest/recovery periods associated with normal work regimes:



**Figure 5: Recovery and Rest Periods and Work Regimes** <sup>[8]</sup>

Note: in practice, other allowances may be added on top of those shown. For example, a contingency allowance may be awarded to compensate for short, irregular interruptions to work.

## A Drug-Free Workplace

Organisational leaders need to support comprehensive drug-free workforce programmes in order to keep the workplace safe and free from the dangers of impaired workers. According to T.L. Stanley of Supervision Magazine, organisations can make a significant difference by proactively addressing substance abuse in the workplace. Through the use of employee assistance programmes, employers can provide a range of responses to help workers that are experiencing personal problems, including drug and alcohol abuse. The existence of

addiction problems in the workplace cannot be ignored. According to the National Research Bureau of the United States, of 16 million people reporting heavy alcohol use, 13 million (79%) were employed; out of 20 million adults classified with substance dependence or abuse, 12 million (60%) were employed full-time. Clear policies and practices are needed to address the reality of alcohol and drug problems, and organisations need to be proactive in addressing this issue.

To establish a successful drug-free programme, the following are recommended:

- random drug testing is necessary
- mandatory pre-employment drug testing
- clear and concise alcohol and substance use policies
- altering policies as workplace conditions change
- the use of “reasonable suspicion” testing by supervisors
- maintaining absolute confidence in employee assistance programmes
- addressing the implications of substance abuse via safety programmes
- a drug-free workplace programme is integrated into the organization’s safety plans. <sup>[9]</sup>

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***A safer you is a safer me.***

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***Just because you’ve always done it that way, doesn’t make it right.***

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# Survey and Research Data

## Unsafe Actions

A ten-year study conducted by DuPont in the United States found that 96 per cent of accidents experienced at the company were the result of unsafe actions—where employees went beyond their limits—rather than unsafe conditions. A 2006 Liberty Mutual workplace safety study further found that more than 50 per cent of all workplace injuries were the result of over-exertion, falls, twisting or other physical movements, and that this resulted in estimated annual workers' compensation costs of US \$46 billion.<sup>[10]</sup>

## Workplace Injuries

A summary of key annual workplace injuries data reported by the United Kingdom's Health and Safety Executive for 2008-2009 included the following:

- ill health
  - 1.2 million workers were suffering from an illness believed to have been caused—or made worse—by their work (551,000 of these were new cases)
- injuries
  - 180 workers were killed at work, a rate of 0.6 per 100,000 workers
  - 131,895 other injuries to employees were reported, a rate of 502.2 per 100,000 employees
  - 246,000 reportable injuries occurred, a rate of 870 per 100,000 workers.
- working days lost
  - 29.3 million days were lost overall (1.24 days per worker), 24.6 million due to work-related ill health, and 4.7 million due to workplace injury.<sup>[11]</sup>

## Giving Critical Feedback

Safety cultures can be improved by optimising safety-related communication throughout an organisation. Safety culture surveys involving hundreds of organisations were carried out by Safety Performance Solutions (SPS) Inc. in the United States. The surveys showed that most employees were reluctant to speak out about behavioural risks that they observed. SPS found that while 90 per cent of employees believed they should caution others they observed operating at-risk, only 60 per cent actually

took action and provided this critical feedback. When respondents were queried about this gap, they felt that giving safety-related feedback may cause interpersonal conflict; they also considered that it was not really their job to give this safety feedback. Sometimes, they did not feel competent to give safety feedback or did not want to offend co-workers that had more experience. There was also a tendency to underestimate the willingness to receive safety feedback; 74 per cent of respondents said that they welcomed safety-related feedback, but only 28 per cent believed other employees felt the same way. <sup>[12]</sup>

## Older Workers Good for Organizations

By 2016, the United States Bureau of Labor Statistics estimated that the number of workers aged 65 and up would increase by more than 80 per cent. Older workers are reportedly more productive. They are credited with less absenteeism, greater job satisfaction, and fewer on-the-job accidents; this is because they tend to be more careful and more focused on the tasks performed. However, when older workers do experience injuries, the severity tends to be more significant. It was found that older workers benefit organisations, and that it is worthwhile to make workplace modifications to prevent or limit the severity of potential injuries to older workers. According to the National Safety Council, 33 per cent of all injuries to workers 65 and older are caused by falls. Other areas of concern include musculoskeletal disorders, which include back injuries, carpal tunnel syndrome and work-related roadway crashes. <sup>[13]</sup>

## Ergonomics Evaluations Save Money

Some 2000 offices in the United States were assessed for the impact of ergonomic conditions, training, and equipment used by office workers. A sample of 299 employee evaluations reported measurable gains in productivity as a result of improved ergonomics, with an average increase of 34 minutes per day. At \$30 per hour this represented \$4,250 per year, per employee. Costs associated with performing the evaluations—along with the average hardware improvement costs—per employee amounted to \$600. Therefore, net savings, without allowing for any injury or illness avoidance costs, was calculated at \$3,650 per employee per year (i.e. \$4,250 - \$600), and the return on investment period was 2.3 months. Considerable savings were also recorded in illness and injury reductions, with an decrease of 28 per cent in cases. <sup>[14]</sup>

## Example Cases

Valuable lessons can be learned from the following organisations:



### **Scarborough Hospital, Canada** *Health and safety programme achieves significant improvements*

Scarborough Hospital was able to significantly improve its safety performance levels by establishing a sustainable improvement framework to effectively engage its entire workforce. The system-wide approach was implemented as follows:

- a senior-level steering committee gave endorsement and became project champions
- a task force was established, representing all staff levels
- a project team was set up with a budget of \$160,000
- 36 corporate policies, which applied to all personnel, and 108 specific job-hazard analysis-related policies were developed
- 48 training programmes were rolled out to all employees
- prizes were awarded, and posters reporting staff testimonials were published.

Continuous quality improvement mechanisms were put in place to monitor progress against benchmarks; this resulted in a 70 per cent reduction in lost-time incidents, i.e. falling from 159 in 2005-2006 to 96 in 2006-2007 and 48 in 2007-2008. <sup>[15]</sup>



### **Union Carbide, India** *Health and safety: learn lessons from the past*

Toxic gas released by Union Carbide in Bhopal, India, killed more than 3,000 people, permanently injuring more than 50,000. This could have been avoided if a few safety precautions had been properly implemented; the following were the major contributing factors:

- lack of a formal hazard identification process
- lack of an adequate management of change program
- lack of an adequate mechanical integrity program
- lack of an adequate emergency response plan.

Astonishingly, a similar disaster had taken place ten years earlier at a chemical plant in Flixborough, in the

United Kingdom, which killed 28 workers and injured 80 more. The major contributing factors were exactly the same as those listed above. Sadly, the lessons learned at Flixborough had not been implemented in safety programmes at Bhopal. The lesson is clear: past incidents should be studied and absorbed by all parties working in related industries. <sup>[16]</sup>



### **Worthington Industries, International** *Workplace safety: behavioural approach gives world-leading results*

Worthington Industries expanded its safety programmes to include injury prevention. Previously, workers had experienced some 1,000 injuries per year, which cost US\$6 million per year in compensation expenses. Employees at Worthington enjoyed significant input into how the business was run. Improvement teams used 5-S workplace improvement tools, which contributed to a 15 per cent reduction in workplace injuries. It was recognised that further improvements could be made by influencing workplace decisions and staff behaviours. Each employee carried 3x5-inch cards, which listed required safety behaviour. The cards were marked by colleagues when they witnessed appropriate behaviour. The safety behaviours listed on the cards were “retired” after 30 days of consistent compliance. Over 2,000 safety behaviours have been retired since the scheme started in 2001. These initiatives enabled Worthington to regularly report world-leading safety and injury rates. <sup>[17]</sup>



### **Large Refinery Plant, United States** *Health and safety gives false impressions*

An idling pick-up truck ignited highly flammable gas at a large refinery plant in the United States; the resulting explosion killed 15 people. An independent inquiry found that management had not distinguished between occupational safety and process safety. Measures at the refinery focused primarily on lagging indicators for occupational safety; this led to an erroneous belief that safety was improving. The explosion occurred even though a prior hazard evaluation had recommended that the equipment involved be replaced. Opportunities to replace the outdated equipment were missed, and a devastating explosion resulted. This underscored the importance for every person at the facility—i.e. from the board of directors to plant operators and maintenance personnel—to be aware of all potential hazards. <sup>[18]</sup>



**Leeds Teaching Hospitals NHS Trust, UK**  
*Teamwork: checklist improves communication*

At Leeds Teaching Hospitals, high levels of teamwork and communication were required during complex surgical procedures. To improve this process, Leeds Teaching Hospitals used a safe surgery checklist; this required the healthcare team to take time out before making skin incisions, to introduce themselves by name and role, and to discuss the patient and possible problems. This action helped to empower all members of the team, and created a shared sense of responsibility. Leeds personnel become far more cohesive as a group, felt safer, and potential misunderstandings were reduced. Patient care also became more personalised. The traditional hierarchy was diminished, leaving the whole team feeling more empowered to speak out. Working relationships improved tremendously, as surgeons became aware of potential difficulties and helped to resolve them. When this checklist was used by hospitals worldwide, surgical deaths and complications were reduced by a third. <sup>[19]</sup>



**PepsiAmericas, Inc, South America**  
*Workplace safety: corporate culture change*

By systematically changing its corporate culture, PepsiAmericas established itself as a world-class industry leader in employee safety. A safety team provided strategic direction and managed safety initiatives. The costs associated with safety issues provided compelling reasons to address safety on an enterprise-wide basis. After benchmarking and compiling statistics, the following model was put in place to create a new safety culture:

- a corporate safety manual and employee safety handbook were developed
- compliance measures embedded into operations
- highly visible score-boarding tools
- cost-containment measures
- communication and recognition tools (e.g. an industrial safety newsletter, a safe-driver recognition programme, and a safe work site recognition programme).

Among the results emanating from this model were:

- 55% reduction in lost time cases
- 29% reduction in OSHA recordable cases
- 14% reduction in overall claim count, and
- 37% reduction in at-fault vehicle accidents.

The organisation’s focused approach to corporate safety was founded on the following safety commitment: “PepsiAmericas is committed to the health, safety and environmental well-being of our employees and the communities we serve. To that end, PepsiAmericas aims to provide a safe and productive work environment consistent with one of the world’s largest growing premier beverage companies.” <sup>[20]</sup>

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***It’s better to lose one minute  
in life... than to lose life  
in a minute.***

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***Safety is a full time job!  
Don’t make it a  
part-time practice.***

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***Life did not begin by accident.  
Don’t let it end as one.***

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## Measure and Evaluate

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The following provide some simple ideas on how workplace health and safety might be assessed:

**Total Injury Rates – Recordable (TIR)**, i.e. total injuries/total hours worked x 200,000. This formula is used by Operational Health and Safety (OSH) in the United States; it measures injuries that generally require medical treatment beyond first aid, and must be recorded in an organisation's injury log. TIR includes injuries resulting in lost time from work and also those involving no lost time.

**Time Lost Due to Accidents or Injuries (LTI)**, i.e. the number of man days lost due to accidents or injury at work or the total number of days lost due to injury per year/total hours worked per year. This measures time lost due to accidents and injuries at work (commonly known as LTIs). This may provide input into any analysis associated with an organisation's health and safety programme. Some organisations publicise these figures widely as part of an awareness strategy for improving individual care in the workplace.

**Worker's Compensation Claims Cost**, i.e. the total value of claims per period as a percentage of total wages. This provides a measure of worker compensation claims, which may be an indicator of other employee-related issues such as satisfaction, morale, health and safety programme effectiveness and overwork. The measure could be segmented to represent, among other things, role types of employees, length of employment or age.

**Occupational Health and Safety (OHS) Assessment**, i.e.:

- accidents – number of
- time lost due to accidents or injuries (LTIs)
- safety audits - number of
- number of disabling injuries, or
- number of hours worked without disabling injury.

This is a multi-dimensional assessment of OHS performance and consists of a battery of measures.

**Cost of Safety**, i.e. cost of prevention + cost of failure (i.e. accidents and ill health). These costs will be broadly determined by the safety standards and the management strategy implemented within an organisation. As safety standards within the organisation rise, the cost of prevention increases to cover the additional cost of the management, physical and HR-related controls required to achieve the higher standards. Ideally, these increased

costs should be counterbalanced by reduced costs related to accidents and illness, as a result of the higher standards and resulting improvements in safety performance.

**Safety Audits – Number of**, i.e. the number of hazard inspections or safety programme audits per year, or the number of hazard inspections or safety programme audits completed versus numbers planned per year. This a measure of the number of safety related audits completed, and may be useful in the analysis of overall OHS assessments

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*Accidents hurt –  
safety doesn't.*

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*Safety is a state of mind.  
Accidents are  
an absence of mind.*

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*A good scare is often worth  
more than good advice.*

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## Self-Assessments

Self-assessments can be used to find out how effective organisations are at implementing various strategies, tools and techniques.

The following self-assessment provides some important concepts related to occupational safety, and helps organisations to identify where improvements in safety culture and practices might be made.

Rank each of the following statements from 1 to 5, as indicated.

<b>Evaluate Your Workplace Culture of Safety</b>	
1	Unsafe employee behaviour does not cause accidents. The reasons lying behind the unsafe behaviour are the causes of accidents. These reasons are organisational or cultural in nature and as such must be addressed by management and leadership.
Rank how your organisation aligns with the statement above. 1= totally unaligned 2=poorly aligned 3 = partially aligned 4 = mostly aligned 5 = totally aligned	
2	Accidents are not the problem; it is the problems themselves that are the problem.
Rank your agreement with the statement above. 1=totally disagree 2= disagree 3 = neutral 4 = agree 5 = totally agree	
3	World-class safety is not achieved by regulatory compliance, inspections or work practice audits. Energy should be put into inspecting to eliminate hazards, plus observing and changing unsafe behaviour and at-risk practices.
Rank the practices in your organisation according to the statement above. 1=totally untrue 2= untrue 3 = neutral 4 = true 5 = totally true	
4	Processes, as designed and administered, determine all business outcomes. Safety is one such outcome and all of them emanate from leadership/management processes.
Rank how your organisation aligns with the statement above. 1=totally unaligned 2=poorly aligned 3 = partially aligned 4 = reasonably aligned 5 = totally aligned	
5	Employees work in the system; managers work on the system; the system produces accidents; employees sustain injuries. Manage one to minimize the other.
Rank your agreement with the statement above. 1=totally disagree 2= disagree 3 = neutral 4 = agree 5 = totally agree	
6	To increase the bottom line, managers must focus on the cost of not having an effective safety strategy.
Rank your agreement with the statement above in regard to your organisation. 1=totally disagree 2= disagree 3 = neutral 4 = agree 5 = totally agree	

**Figure 6: Evaluate Your Workplace Culture of Safety** <sup>[21]</sup>

### Scoring:

Any statement ranked 4 or less provides an opportunity for further investigation, and to improve occupational safety practices within your organisation.

N.B.: the full self-assessment relating to the development of a culture of safety may be found in the member's area at [www.bpir.com](http://www.bpir.com).

## Summary of Best Practices

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The following is a summary of the best practices and/or insights found within this Management Brief:

1. Do not allow economic and business pressures to interfere with the proactive safety culture of your organization. Unrealistic goals and excessive cost reduction demands may conspire towards allowing unsafe conditions to develop.
2. Create open communication channels to ensure that all relevant safety measurements and findings are brought to the attention of senior management.
3. Give careful attention to audit findings; use these to provide an opportunity to launch any improvements required within the organisation's management systems.
4. Build a strong safety culture that is owned and driven by intentional leadership.
5. Commit to creating zero tolerance for injuries.
6. Evaluate safety, quality, production, customers and financial health simultaneously, using an ethical decision-making framework.
7. Regularly review safety policies and clearly define accountabilities.
8. Involve employees at every level of programme development and implementation.
9. Build rest and relaxation periods into employee's work schedules to ensure that they carry out activities without becoming unreasonably tired.
10. Employ ergonomic solutions and capitalise on the benefits of this by integrating good design principles, continuous improvement, lean initiatives, and risk management.

## Words of Wisdom

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- A safer you is a safer me.
- Just because you've always done it that way, doesn't make it right.
- Chance takers are accident makers.
- It's better to lose one minute in life... than to lose life in a minute.
- Safety is a full time job! Don't make it a part-time practice.
- Life did not begin by accident. Don't let it end as one.
- A spill, a slip, a hospital trip.
- Accidents hurt – safety doesn't.
- An accident can ruin your career.
- Safety is a state of mind. Accidents are an absence of mind.
- A good scare is often worth more than good advice.

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***Chance takers are  
accident makers.***

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***An accident can ruin  
your career.***

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## Conclusion

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Economic pressures may push leaders into making decisions that cross over acceptable safety thresholds. To avoid this, careful attention should be paid to factors that have the potential to create unsafe conditions. These include setting unrealistic goals, excessive cost cutting, naive safety policies, poor communication, and ineffective use of safety audit information. Leaders create culture with their every thought, word and deed. Leadership predicts culture, and culture predicts safety outcomes. An excellent safety culture can be built through the use of well-crafted recognition programmes that highlight safe practices and behaviour. Safety programmes based upon recognition have been shown to be superior to incentive-based programmes, which can surprisingly lead to under-reporting, and may even encourage unsafe practices. Effective ergonomic design used in tandem with risk management/hazard identification can greatly benefit productivity, as well as workplace health and safety. Adequate rest and relaxation periods purposely built into employees' daily routines will enable work to be done more efficiently, while minimising unnecessary stress. Excellent safety outcomes are found in those organisations that make safety a core organisational value.

### Note

The techniques and case studies mentioned or summarised in this article may be found in greater detail at BPIR.com, together with the full text of most of the articles and reports cited in the following reference list.

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***A spill, a slip, a hospital trip.***

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