ESTABLISHING A CULTURE OF WORKPLACE HEALTH AND SAFETY: THE NORTHERN HEALTH WAY

by

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Abstract

This paper presents a synthesis of the literature exploring the key drivers required to establish a culture of workplace health and safety. Culture is important to Northern Health. Northern Health's strategic plan articulates a focus on its people and a commitment to establish a culture of workplace health and safety. The way in which this task is accomplished is the primary focus of this paper, recognizing this task is a first step and may possibly be easier said than done. Essentially, how can the leadership of Northern Health establish a culture of workplace health and safety? Culture is a reflection on how organizational values are demonstrated, or the "way we do things around here". It is anticipated that the findings from this project will provide Northern Health with a solid plan and framework upon which it can establish and develop a culture that will flourish and be sustained within all sectors and levels of the organization.
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Acknowledgment

I would be remiss if I failed to thank the instructors and staff at the Business School of University of Northern British Columbia, for their time, advice and guidance during the past two years. I would also like to acknowledge the ongoing support and good humour of my cohort members; it has been a pleasure to be part of the team.

I could not have completed my MBA Project without the ongoing support of leadership and colleagues of Northern Health. Particular thanks go to our Workplace Health and Safety Department.

Finally, I would like to recognize the sacrifices made by my wife Kerry and our boys. It has been a challenging two years full of valuable lessons and opportunities. I truly am both fortunate and blessed.
Introduction

Northern Health has identified and stated its strategic direction to be: “A focus on our people” and a strategic priority to: “Establish a culture of workplace health and safety” (Northern Health Strategic Plan 2009 – 2015). Northern Health’s strategic plan was developed in collaboration with the organization’s internal and external stakeholders. In order to accomplish such a strategic priority, the organization must clearly understand and address the necessary components (key drivers) that are required in this journey.

The health care industry enjoys a number of advantages over other industries. The workforce in health care consists of a large proportion of highly educated workers. In direct patient care areas, a higher percentage of the workforce is college or university educated, than is typically found in other industries. There is a broad universal understanding of legislative requirements due to a significant number of staff and resources specifically dedicated to safety teams and Joint Occupational Health and Safety Committees (JOHSC’s). New technology, such as online incident reporting, is being introduced to support risk mitigation.

Quality patient care is the nature of the business of health care, as opposed to a more traditional manufacturing enterprise that creates “widgets” for distribution. Patient care is paramount, and can often inadvertently trump worker safety. Staff occasionally regard safety regulations as a hindrance to the provision of quality patient care/safety. For example, standard operating procedures relating to a falling patient may be to allow the fall by lowering the patient to the floor - staff reaction may be to attempt to prevent the
fall, thereby resulting in injury to both staff member and patient. This is a crucial link in health care, and one that needs ongoing recognition and attention.

Embedding safety into an organization’s strategic and business plan is an important and vital step for the following reasons:

- The right thing to do – it is the employers ethical and moral responsibility to take every reasonable step to ensure staff safety.
- Employee engagement – staff are more likely to be engaged if they are able to see that their employer cares about their health and safety. An engaged employee is key to driving safe behaviour.
- Client confidence – if health care users observe bad safety protocols, their confidence in the quality of their care is compromised.
- Cost avoidance – by concentrating on safety measures, an organization is able to reduce time loss claims, driving down insurance premiums and avoiding replacement of injured workers (which is often at premium rates).
- Legislation – non-compliance of provincial and federal laws and statues may result in financial penalties, criminal penalties and inspections.

An organizational approach to culture tends to assume some degree of organizational change. In a systematic review, deMonteflores-Werbner & Smailes (2011) found “little evidence that strategies for changing organizational culture differ from strategies recommended for organizational change” (p. 19), and that there is still a “significant gap in the understanding of how cultural change works” (p. 20).
Organizations have a duty to exercise due diligence in providing a safe work environment. In order to effectively meet legislative requirements and support health and safety in the workplace, an organization must be able to prove that they have taken all reasonable steps to prevent incidents. Northern Health has established various systems to create a culture of workplace health and safety. Recognition is the first step in creating a safe work environment, followed by the development of a culture that will flourish and be sustained across all sectors and all levels of the organization.

An organizational approach to establishing a culture of workplace health and safety assumes, to some degree, the need for organizational change. Change will become reality if Northern Health establishes a culture of workplace health and safety.

**Statement of Problem**

Northern Health has a sophisticated Workplace Health and Safety department, as well as a number of specific and innovative safety programs and information systems. New staff participate in general safety orientation prior to beginning work, specific safety orientation on their first day and ongoing training throughout their career. Some of this education and training includes violence prevention, transportation of dangerous goods, annual training for the organization’s 40 plus joint occupational health and safety committees, respiratory fit testing, etc. Despite these efforts, Northern Health experiences significant safety related incidents, either through time loss claims or reports that indicate potentially unsafe working conditions.
Information systems, safety programs and management systems (including the necessary organizational structure, accountabilities, policies and procedures) are only helpful if they are used, understood, and leveraged effectively.

Accountability within the health care environment is different than a typical industry which is not involved in the business of human care. Within the non-health care industry, mechanical hazards (such as saws and kilns) are more obvious and for which safety guidelines can be established in a more straightforward manner. With the health care industry, safety hazards often present during, or result from, client interaction. When human interaction is the risk, it is much more challenging to identify standard processes that may, in the health worker’s opinion, jeopardize the patient’s care. Health care is an essential service to the community, and unlike industry, is not motivated by profit or the bottom line. Health care is perceived as a safer working environment than other industries containing more mechanical hazards. The perception is also that health care professionals would have a greater awareness of health and safety practices than their counterparts in other industries. However, as Table 1 shows, the injury rate is as high as or higher than other industries perceived to be more hazardous.

For health care, these statistics may be low and not indicative of safety performance due to under-reporting: medical staff may choose to engage in an unsafe practice to provide immediate comfort to patients (health care professional “martyr” syndrome). Other reasons why occurrences may not be reported (specifically relating to “near miss” incidents) include perception of not enough time to report; however, all staff should treat safety as an important and equal part of their roles and responsibilities within
the organization. Since reporting is now completed online, lack of computer skills and lack of access to hardware may also contribute to the under-reporting.

Table 1: Comparison of 2011 statistics of entire sector from WorkSafeBC (WSBC):

<table>
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<th>Sector (2011)</th>
<th>Injury Rate*</th>
<th>Serious Injury Rate*</th>
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<tr>
<td>Northern Health</td>
<td>4.3</td>
<td>1.3</td>
</tr>
<tr>
<td>General Construction</td>
<td>4.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Wood Products Manufacturing</td>
<td>3.0</td>
<td>1.2</td>
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*per 100 employees

Simply stating that Northern Health will establish a culture of workplace health and safety will not be sufficient to develop a culture that will take root and flourish across all sectors and all levels of the organization. A deliberate, focused and supported plan of implementation is required.

Focus Area

Northern Health takes pride in its Strategic Plan, its mission statement is: “Through the efforts of our dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners” (Northern Health Strategic Plan – 2009 - 2015, 2009). The strategic plan’s slogan is, “the northern way of caring,” which effectively portrays and communicates a vision of caring for oneself and others, in a true spirit of collaboration and optimal safety for all.
Northern Health is one of the five health care regions of British Columbia’s health care systems, funded and governed by the Provincial Ministry of Health. Geographically, it is the largest health authority, accounting for 65% of the land mass of British Columbia. Northern Health is considered rural and remote to its neighboring health authorities. The need for developing a competitive advantage over the other health authorities is great, thereby driving the urgency for an improved and sustained health and safety culture for its staff. Northern Health is divided into three Health Service Delivery Areas (HSDA’s), namely the Northern Interior, the Northwest, and the Northeast. Each HSDA is unique, especially in regards to geographical size, number of staff, accessibility of services, and staffing shortages. Consistent with the rest of Canada’s health care system, Northern Health has experienced, and continues to experience, organizational restructuring, especially during a time when the sustainability of the Canadian health care system is in jeopardy and under constant scrutiny.

As an employee of Northern Health, I support the organization’s strategic priority of establishing a culture of workplace health and safety. I am interested in identifying the key drivers and ‘how’ such a task can be accomplished. Northern Health should be recognized and applauded for beginning this undertaking. Accomplishing such an endeavor is easier said than done, which is why I am committed to assisting in the fulfillment of this goal.

In my current role of Regional Director, Human Resources Operations, I have a vested interest in proactively addressing the risks/hazards that may negatively affect our employee’s health and safety. The creation of a culture of workplace health and safety is
an important step in the retention of health care’s most valuable asset: its staff. I consider this personal and academic interest to be closely aligned with Northern Health’s Strategic Plan. Establishing a culture of workplace health and safety is, in my opinion, the most effective way to sustain a positive, engaged workforce; whereby staff attend and leave the workplace in the healthiest and safest way possible.

Purpose Statement

The purpose of this paper is to acknowledge the organization’s strategic priority in establishing a culture of workplace health and safety, and attempt to identify the key drivers to accomplish such a task. This study will consist of a thorough review and synthesis of the literature. In identifying the key drivers, and subsequently adoption by Northern Health, it is anticipated that Northern Health’s culture of workplace health and safety would effectively develop and flourish across all sectors and all levels of the organization.

Significance of the Paper

Culture is a reflection of and reaction to what organizational values are demonstrated, or “the way we do things around here”. The traditional health care culture leads to more individual risk taking whereby the worker adopts the heroic task of protecting the patient and providing quality patient care at their own expense. This “heroism” often leads to unsafe behaviors and unsafe practices. Supervision as defined by
WorkSafeBC (WSBC) means the following: “A system used for the planned and ongoing measurement of behaviours against expectations” (WSBC Managing Safety Program). A Supervisor is “A person, who instructs, directs and controls workers in the performance of their duties” (OHS Reg 1.1.). Supervision and Supervisor are the most overlooked element in a safety management system. An estimated 80% of incidents are caused by human behavior (Health and Safety Executive, 2009); therefore the focus needs to be on people. Supervisors in health care do not always recognize their responsibilities within this definition, possibly having less understanding as to the ‘supervisory’ responsibility as it relates to safety within the workforce. Supervisor is defined by a person’s activity and not by job title (for example: charge nurse, team lead, department head, head nurse, etc.)

Culture has little to do with slogans, or posters on the wall, yet everything to do with ‘how’ an organization demonstrates values articulated within its culture charter/statement, etc. Establishing a culture of workplace health and safety implies action by way of an action plan. The literature identifies key drivers for such a culture to develop and flourish. Northern Health has communicated its intent to establish such a culture. Northern Health also communicates a ‘northern way of caring.’ It is logical that this northern way of caring could be effectively demonstrated via the key drivers identified in the literature. This, in turn, would become the Northern Health Way of establishing a culture of workplace health and safety. And that, in turn, will benefit all workers and help sustain the efforts of Northern Health’s dedicated staff and physicians.
Research Question

In acknowledging the organization's strategic priority in establishing a culture of workplace health and safety, this paper will explore the following research question: what are the key drivers (essentially the 'how') in establishing a culture of workplace health and safety in Northern Health?

Research Experience

Throughout my career, I have been introduced to various research opportunities, primarily within various human resources initiatives as well as the other partners of our human resources team (such as Organizational Development, Recruitment and Workplace Health and Safety). For the most part, these opportunities have been informal in nature by being indirectly involved in the actual research and academic streams themselves. This paper is my first formal research opportunity.

Philosophical Assumptions and Limitations of the Paper

This paper will use a synthesis approach on reviewing the literature regarding the key drivers required to establish a culture of workplace health and safety. I have assumed that all relevant studies have similar themes and are described within the context of larger, more complex organizations. The limitations of this paper include the fact that Northern Health's strategic plan encompasses a fixed period of time, and therefore will presumably change by 2015. It is unknown whether a similar strategic direction and priority will be
maintained. The recommendations of this paper require careful review and hopeful adoption by Northern Health’s leadership team. The studies being analyzed may be influenced by management systems and/or infrastructure that may not currently exist at Northern Health. Finally, the paper will look at the organization as a whole, without dividing Northern Health into the several health service areas that it is known to have. It must be recognized that unique cultures could exist within these health service areas, irrespective of the overall Northern Health culture.

**Anticipated Results/Conclusion**

This paper will focus on the Northern Health Authority as a whole, without geographic regard to the three different health services areas that Northern Health is known to be divided in. As such, the culture of workplace health and safety is the culture of the entire organization, irrespective of the cultures that could be in existence within the different health services areas.

An organizational approach to culture will require some degree of organizational change. It is anticipated that change will be a reality if Northern Health establishes a culture of workplace health and safety.

Organizational change is driven by the leaders of the organization. For example, healthcare leaders must recognize and embrace their legislated responsibility as it relates to workplace health and safety. Furthermore, leaders must be visible and accessible to the
employees for whom they have responsibility. Employees must feel comfortable and safe in reporting incidents, including near misses. The environment must be safe for everyone who occupies it: workers, patients, and the public.

Although existing efforts and progress may suggest that Northern Health has an established culture of workplace health and safety, it is anticipated that this paper will provide Northern Health with a solid plan and framework upon which they can further establish and develop a culture that will flourish and be sustained within all sectors and levels of the organization.

This task is only made possible by a leadership team that has articulated that they are focused on their people and that they will establish and champion a culture of workplace health and safety. This is why Northern Health leaders have the ability to establish a culture of Workplace Health and Safety the Northern Health Way.

Key Drivers of a Culture of Health and Safety – Literature Review

Highlights from the Literature Review

- Cultural attributes are rooted in values. A number of studies note that safety is a value, not a priority. Priorities change, but health and safety protection should be constant (Schwerha, 2010; Ruchlin, Dubbs & Callahan, 2004; Barling, Kelloway & Loughlin, 2002).

- When leadership clearly identifies and consistently lives the mission, vision and values of the organization, it serves as a powerful motivator toward cultural change
because it taps into the passion of staff, and "they embrace it wholeheartedly" (Stubblefield, 2005, p. 20). Also, effective participation by staff at all levels of the organization is recognized as an essential element in gaining their commitment to the organization's vision, values and goals. (Clark, 2002; Rose, Thomas, Tersigni, Sexton & Pryor, 2006; Stubblefield, 2005; Armstrong & Laschinger, 2005).

- "When examining the safety effectiveness of other high hazard industries, the industries that provide the highest level of safety have made safety management organization-wide, comprehensive, pervasive and visible" (Goodman, 2004, p. 44). "A committed leader who is personally involved in safety activities and who takes an interest in working conditions conveys to staff a sense of the importance of safety for the organization" (Fernandez-Muniz, Montez-Peon, & Vasquez-Ordas, 2007, p. 628).

- It appears there is no "neutral position when it comes to workplace safety" (Kelloway, Mullen, & Francis, 2006, p. 83). Organizations experience better safety records and more positive safety outcomes when leaders are actively involved in safety (Wu, Lin & Shiau, 2010; Fernandez-Muniz, Montez-Peon, & Vasquez-Ordas, 2007), whereas passive involvement (ignoring safety-related issues, being uninvolved in safety) leads both directly and indirectly to adverse safety outcomes, rather than null effects (Kelloway, Mullen, & Francis, 2006).

- Worker safety and patient safety are linked. "For patient safety, attempts are often made to develop a safety structure and safety culture intended to address patient
safety while excluding other aspects of healthcare organizational safety. Compartmentalizing problems into patient and non-patient categories suggests that culture tends to drive structure in the healthcare industry” (Goodman, 2004, p.44). “Evidence indicates that healthy work environments are at the heart of the solutions to significantly affect patient outcomes” (Heath, Johanson, & Blake, 2004, p. 524).

- Key to the development of a culture of health and safety is an understanding of the concept of the Internal Responsibility System (IRS) which is the underlying philosophy in occupational health and safety law. The IRS is a “hierarchy of responsibility, authority and accountability related to health and safety; a set of values and principles; a system of processes and activities with built in devices for monitoring, feedback and control; and a way to involve the perspective, experience, skill, and creativity of every person in the organization.” (Strahlendorf, 2008, p. 172). It expresses “respect for the human element in the workplace” (Strahlendorf, 2008, p. 59) because everyone sees that “protection and promotion of human life and health are primary values.” (Strahlendorf, 2008, p. 37).

- Stubblefield (2005) emphasizes the importance of a consistent, ongoing investment in developing leaders at every level of the organization in order to change and sustain culture. Wu, Lin, and Shiao (2010) recommend that training programs be designed to help leaders at all levels to understand their safety roles.
A Culture of Health and Safety

The terms “safety culture” and “safety climate” are used (often interchangeably) in the literature to describe a subset of organizational culture related to the safety-related attitudes and behaviours of an organization’s members. Fernandez-Muniz, Montez-Peon, & Vasquez-Ordas (2007) provide a definition of “safety culture”:

“A set of values, perceptions, attitudes and patterns of behaviour with regard to safety shared by members of the organization, as well as a set of priorities, practices and procedures relating to the reduction of risks, implemented at every level of the organization and reflecting a high level of concern and commitment to the prevention of accidents and illnesses.” (p. 628)

Since safety culture can be seen as a subset of organizational culture, and because establishing a safety culture assumes some degree of organizational change (from an established baseline), some discussion about strategies for changing and measuring organizational culture may assist in establishing context.

In a systematic review, deMonteflores-Werbner & Smailes (2011) found “little evidence that strategies for changing organizational culture differ from strategies recommended for organizational change” (p. 19), and that there is still a “significant gap in the understanding of how cultural change works” (p. 20); they suggest that including
measurement of cultural change as part of organizational change studies may increase understanding of cultural change processes.

“Organizational cultural change means a change in the basic assumptions which govern work related behaviour. Changing behaviours, routines, methods, etc. is not equivalent to changing culture. Real cultural change affects all aspects of organizational life and results in a new perspective and a new way of approaching problems.” (deMonteflores-Werbner & Smailes, 2011, p. 19).

Appelbaum and Wohl (2000) discuss the differences between change and transformation in healthcare. Whereas change can be described as incremental improvement to enhance performance within the existing context of the organization, transformation is the creation of a new context. Some current approaches to change in healthcare include Total Quality Management (Adamson, 2010; Searl, Borgi, & Chernali, 2010), and user-centered design (Searl et al., 2010). Ruchlin, Dubbs & Callahan (2004) as well as Reinertsen, Bisognano, & Pugh (2008) note that while many project-level efforts have resulted in patient safety improvements, it has been much more difficult to achieve organization-level results. Similarly, occupational health and safety programs have traditionally focused on worker training and specific safety performance goals (e.g. lost time accident rates) rather than larger-context organizational behaviour models (Zohar, 2002b). Porter-O’Grady (2003a) argues that attention to macro issues such as organizational culture and a systems approach are required in order to transform the
overall context of safety in an organization. Furthermore, Reinertsen, Bisognano, & Pugh (2008) articulate the need for a “comprehensive strategic improvement framework” (p. 3) in order to achieve organization-level results.

Clark (2006) provides perspective on the need to integrate change and transformation efforts: “finding leverage points from various aspects of a culture to change practices...often seems a more feasible approach than aggressive attempts at changing the culture itself, especially over the short term” (p. 269); however, it must be recognized that “climate and culture are modifying and moderating factors in influencing safety...and in implementing change and innovation” (p. 270).

One factor that may contribute to the gap in understanding about cultural change processes is the complexity of measuring organizational culture and climate, as illustrated in a systematic review of organizational culture and climate measurement tools in healthcare by Gershon, Stone, Bakken & Larson (2004). They note a lack of clarity and uniformity in definitions, terminology and measures used in the literature around organizational constructs, but were able to identify 116 sub-constructs, which they categorized into four major dimensions of organizational culture: “(1) leadership characteristics (2) group behaviours and relationships (3) communications and (4) structural attributes of quality of worklife” (p. 35).

There is increasing interest in using specific tools to assess the constructs of organizational culture and organizational climate (Jones, Skinner, Xu, Sun & Mueller, 2007). Gershon et al., (2004) argue that use of valid and reliable measures of the constructs of organizational culture and climate are necessary for leaders in order to plan
and manage change. Flin & Yule (2004) state that “if management commitment to safety is important at all levels, then it is necessary for organizations to gather diagnostic data on how this is perceived by those reporting to these leaders (e.g. safety climate surveys or upward appraisal technique).”

Another factor which may influence understanding of cultural change processes is the complexity of how organizational culture and climate influence both the healthcare workplace and patient quality of care outcomes. Lowe & Chan (2006) proposed a healthy work environment logic model which links organizational context (organizational enablers, strategy, leadership, culture), drivers (work environment factors, job factors, human resource supports), worker outcomes, and organizational outcomes. Further work in developing structural equation models that include both distal and proximal factors have begun to demonstrate the complexity of these inter-relationships and the relative significance of each variable; (Pearson, Laschinger, Porritt, Jordan, Tucker, & Long, 2007).

In a report for the Royal Commission on the Future of Healthcare in Canada, Champagne (2002) synthesized the vast amount of literature on organizational change into a framework of ten perspectives and proposed a comprehensive model of the important determinants of organizational change implementation: implementation climate (including political and practical organizational conditions, and trust), compatibility of change with organizational values, effective stakeholder involvement, and structural characteristics. These factors influence the “nature of learning and collective leadership
processes” (p. 21) necessary for successful change implementation, and are reflected in the literature related to safety culture.

**Safety as a Value**

“One aspect of safety culture is that safety is explicitly recognized as a value by members of the organization.” (Wu, Lin & Shiau, 2010).

Values are communicated through behaviour, especially those values affecting people, quality, and integrity. Stated values will be discredited if there are discrepancies between the stated values and actual behaviour. When leadership clearly identifies and consistently lives the mission, vision and values of the organization, it serves as a powerful motivator toward cultural change because it taps into the passion of staff, and “they embrace it wholeheartedly” (Stubblefield, 2005).

**Internal Responsibility System and Due Diligence – Relationship to Safety Culture**

Organizations with strong cultures of health and safety are successful at linking the vision and values-based strategies and practices to individuals through individual responsibility and accountability within an established structure (Stubblefield, 2005).

Key to the development of a safety culture is an understanding of the concept of the “Internal Responsibility System” (IRS) which is the underlying philosophy in occupational health and safety law. “The IRS is a system, within an organization, where everyone has direct responsibility for health and safety as an essential part of his or her
job. An individual practices health and safety in a way that is compatible with the kind of work that person does. Each person takes initiative on health and safety issues and works to solve problems and make improvements on an ongoing basis. A person does this both as an individual and in co-operation with others.” (Strahlendorf, 2008).

Strahlendorf (2008) also states that the IRS is a “hierarchy of responsibility, authority and accountability; a set of values and principles; a system of processes and activities with built in devices for monitoring, feedback and control; and a way to involve the perspective, experience, skill, and creativity of every person in the organization.” It expresses “respect for the human element in the workplace,” because everyone sees that “protection and promotion of human life and health are primary values.”

The purpose of the IRS is to drive risk down as much as possible, thus the system goes beyond simply avoiding losses. The IRS integrates quality improvement concepts and promotes creative improvements in work processes, by empowering all members of an organization to take the initiative to solve problems or make improvements (appropriate for their level of responsibility and authority); however, the system is designed such that unresolved system issues are communicated upwards for resolution (Strahlendorf, 2001).

The responsibility and accountability of IRS is linked with due diligence, which is a standard of performance related to this responsibility / accountability. Due diligence is often seen as meeting compliance with regulatory requirements, or “taking every precaution reasonable in your circumstances to avoid harm,” but it can also be a philosophy of taking “every measure reasonable in the circumstances to improve
processes you are involved in” (Strahlendorf, 2008). Safety outcomes are improved when the safety processes in an organization are driven by its beliefs, not by external regulations, because proactive safety behaviours arise from each individual’s sense of ownership and commitment (Ruchlin et al., 2004).

Moving to a culture of health and safety requires “clearly assigned safety and health responsibilities with documentation of accountability from top management to line supervisors.” (Goodman, 2004, p. 46). Plummer, Strahlendorf & Holliday (2000) provide an outline of participants with direct responsibility in the IRS and those with contributive roles (See Figure 1).

Figure 1: Basic Structure of the Internal Responsibility System

Adapted from Plummer, Strahlendorf, Holliday (2000).
Two significant factors influence the effectiveness of the internal responsibility system in healthcare. First, organizational structures common in healthcare may contribute to lack of clarity around roles, responsibilities, and accountability in the IRS (Flin and Yule, 2004; Frankel et al., 2006). Secondly, “high levels of attention to [safety] leadership skills in selection, training, and competence assessment in industry may not be typical of the healthcare sector” (Flin & Yule, 2004).

**Links between worker safety and patient safety culture**

The literature identifies strong links as well as dynamic tension between patient and staff safety. “Evidence indicates that healthy work environments are at the heart of the solution to significantly affect patient outcomes.” (Heath, Johanson & Blake, 2004, p. 524).

However, “Analysis of the relationship between healthy healthcare workplaces and improved patient care identifies major barriers to change, including heavy workloads, fear of power loss in some professions, the lack of opportunities to bring perspectives from different disciplines together, and a traditional emphasis on patient needs, which often subsumes worker well-being.” (Lowe, 2002, p. 54)

The goal of a “positive safety culture is to create an atmosphere in which staff are aware of the risks in their workplace, are continually on guard against them, and avoid taking any unsafe actions.” (Fernandez-Muniz et al., 2007, p. 627). It is now recognized that while active failures or human error are the proximal cause of incidents, latent
conditions or organizational factors, “enacted by the humans managing the organization at
the tactical and strategic levels” (Flin & Yule, 2004, p. i45) are the distal factors which
“create the safety culture that influences the probability of the proximal failures”
occurring (Flin & Yule, 2004, p. i45). Furthermore, in healthcare both proximal and distal
factors are “linked directly to two types of failures: negative patient safety outcomes, and
injuries to workers” (Flin & Yule, 2004, p. i46).

Some principles of safety management used in industries such as aviation and
nuclear power, which have achieved very low error rates in high risk complex
environments, have been adopted in the development of patient safety and quality
initiatives. However, the “safety structure and safety culture intended to address patient
safety have excluded other aspects of health care organizational
safety…Compartmentalizing problems into patient and non-patient categories suggests
that culture tends to drive structure in the healthcare industry.” (Goodman, 2004, p. 44).

Goodman (2004) suggests that models for staff and patient safety should be the
same, and adds that “the high-hazard model requires that all aspects of safety, including
employee safety, be included in the development of an organizational safety culture” (p.
45) and if it “is to be successfully applied to health care, it should include all of its parts”
(p. 46).

“When examining the safety effectiveness of high-hazard industries, the industries
that provide the highest level of safety have made safety management organization-wide,
comprehensive, pervasive, and visible. Change requires a focus on safety, not
occupational safety or patient safety, but just safety.” (Goodman, 2004, p. 44)
Quoted in Clark (2002) the Institute of Medicine report “To Err is Human” (1999) states that a “safer environment for patients would also be a safer environment for workers and vice versa, because both are tied to many of the same underlying cultural issues.” (p. 210). A culture of workplace health and safety creates “realignments based on principle rather than on cultural norms or business decisions” (Clark, 2002, p. 212) and “transcends all levels of an organization without being distorted by the segmentation inherent in most organizations” (p. 210).

It is essential that occupational health and safety initiatives be integrated into core business practices, which in healthcare is the business of safe, high quality patient care. Nielsen, Randall, Holten & Gonzalez (2010) state:

“To date too little attention has been paid to how we may integrate occupational health interventions into daily work practices. Occupational health interventions are often seen as something separate from running the daily business and ensuring high performance (that is, as a “nice to have” rather than as integral to the effectiveness of the organization). There are powerful arguments for organizations to pay special attention to occupational health issues.” (p. 252). For example, “where task restructuring interventions were implemented with the sole purpose of improving performance, they sometimes had detrimental effects on employee health and well-being,” (p. 252) and occupational health and safety interventions are vulnerable to organizational changes and restructuring when they are not integrated into daily business.
Quality work-life factors

The link between worker safety and patient safety is further supported in the large amount of literature in the area of healthy workplaces. Adamson (2010) states that the "healthcare sector cannot succeed in transforming itself until and unless we deal with the truth about the health of our work environments" (p. 30). The emerging consensus among researchers in this area is that a holistic and integrative approach to workplace and organizational factors is needed.

Past models of workplace health and safety have focused on trying to link specific safety behaviours or programs to outcomes such as lost time accident costs. While there have certainly been successes in this area, senior managers often have to balance investments in health and safety with other requirements, leading to cost comparisons that may not take into account all relevant information such as organizational context (e.g. safety culture and climate) or drivers (e.g. work environment factors, human resource supports) which can influence outcomes significantly (Lowe & Chan, 2006).

Viewing workplace health and safety as part of the larger healthy workplace environment supports the notion that "excellence in health service delivery is achieved by enabling and supporting workers to be physically, emotionally, mentally, and socially healthy and well" (Lowe & Chan, 2006; Strelioff, Lavoie-Tremblay, & Barton, 2007). Healthcare organizations are aware of their need to attract and retain skilled staff. Stordeur, D’Hoore and the Next-Study Group (2007) found that hospitals where nurses perceived dramatically lower exposure to physical-health hazards (due to systematic
reduction of hazard exposure), along with desirable scheduling and lower job demand stressors, had much higher ability to attract and retain nurses.

There is increasing recognition of leadership's role in influencing the social context in organizations (Smokler, Lewis & Malecha, 2011; Kelloway & Barling, 2010; Oandasan, 2007; Lowe, 2002). Patterns of interactions between leaders and workers have significant effects on the culture, context, and content of work. Shared decision-making, collective problem-solving, effective communication and trust are essential in maintaining quality work relationships (Lowe, 2002; Porter-O'Grady, 2003a; van Dierendonck, Borrill, Haynes & Stride, 2004; Heath et al., 2004).

Kelloway & Barling (2010) state that the links between leadership quality and employee well-being are clear:

"Data linking the quality of leadership to other individuals' well-being has been available for almost 50 years, and evidence linking poor leadership to impaired well-being in followers is particularly well established. These effects are far reaching and include effects on both employee safety and health." (p. 262)

Stewart (2010) states that staff participation is crucial in developing healthy workplaces; programs need to be aligned with employee needs and "collaborative relationships, a sense of community, engagement, and distributed leadership, are features that will support the long-term health, resilience, and sustainability of an organization and its people" (p. 14).
Leadership commitment

Organizations experience better safety records and more positive safety outcomes when leaders actively promote safety (Wu et al., 2010; Fernandez-Muniz, 2007). More strikingly, it has been demonstrated that "passive" leadership (ignoring safety-related issues, being uninvolved in safety) leads both directly and indirectly to adverse safety outcomes (rather than null effects). It appears there is no "neutral position" with regard to workplace safety (Kelloway, Mullen, & Francis, 2006).

"Leaders must consistently make safety a top priority in their decision-making. Safety must be supported at all levels of the organization and by both administrative and clinical leaders. It is common for staff to believe that financial considerations consistently trump quality and safety concerns." (Joint Commission, 2009)

A number of international standards state the importance of leadership commitment to occupational health and safety performance. The Canadian Standards Association CSA Standard Z1000-06 (2006) states "commitment, leadership and effective participation are crucial to the success of an Occupational Health and Safety Management System (OHSMS)." (p. 4). The patient safety literature also recognizes that effective leadership is required to ensure patient safety as a cornerstone of high quality care (Reinertsen et al., 2008; Wilson 2000; Conway, 2001; Institute of Medicine, 1999).

Leadership commitment to safety can be manifested as positive attitudes toward safety management activities, and in safety behaviours visible to workers (Fernandez-
Muniz et al., 2007). Zohar (2002a) states that safety behaviours often conflict with other aspects of performance (e.g., speed and productivity) especially when work pressure increases. Frontline supervisors generally set priorities based on the relative priorities communicated by higher levels of management, and leaders who focus on productivity or financial goals may inadvertently deter from employee safety (Kelloway et al., 2006); therefore, senior leaders can communicate commitment to safety by ensuring safety is part of the operating philosophy (Flin & Yule, 2004).

Goodman (2004) identifies a number of specific strategies for integrating a comprehensive safety management program (i.e., all aspects of safety) into an organization’s operating philosophy:

- Senior management’s personal involvement in all aspects of safety compliance
- Safety and health are managed in the same way as productivity and quality are managed
- Clearly assigned safety and health responsibilities and accountability from senior management through to frontline supervisors
- Necessary resources provided to meet responsibilities
- Annual safety and health program evaluations with written reports, recommendations for improvements, action plans and verification procedures.
Safety Leadership

Outcomes such as productivity, profit, turnover and worker satisfaction are familiar topics in the field of leadership research; increasingly, leadership quality, style, and behaviour is being linked to a wide a variety of occupational health and safety as well as patient safety outcomes, both positive and negative (Kelloway & Barling, 2010; Shamian & El-Jardali, 2007; Lowe, 2002; Conway, 2001).

Safety specific transformational leadership has been shown to predict safety climate, safety consciousness, and safety outcomes (Kelloway et al., 2006; Barling et al., 2002; Zohar, 2002b). “When transformational leaders focus on the importance of safety and encourage staff to think about safety, employee safety consciousness is raised. When individual safety consciousness is raised and leadership actions result in favourable perceptions of the safety climate, safety-related events are minimized” (Barling et al., 2002, p. 490). Safety-specific transformational leadership creates a “culture of inclusion, where every member has a role and feels responsible to actively, willingly and with principle place priority on safety in influencing collective behaviours” (Clark, 2002, p. 210).

Leaders also play an important role in fostering sub-cultures of a culture of health and safety (Ruchlin et al., 2004):

- Reporting culture – the organizational climate supports members reporting incidents and near misses without fear of blame, retribution, or punishment.
• Just culture – all members of the organization are aware of the clear delineation between acceptable and unacceptable behaviour. There is an atmosphere of trust and fairness.

• Flexible culture – ability to shift leadership from hierarchical to distributed models as needed depending on the situation. Depends greatly on respect, effective communication, and teamwork.

• Learning culture – “the willingness and competence to draw the right conclusions from the safety information systems and the will to implement major reforms when indicated” (p. 53).

Zohar (2002b) examined two complementary models of the leadership-safety relationship, and demonstrated that one model augments the other in improving safety outcomes.

• Transactional leadership behaviours “gain compliance from followers, set goals, get agreement on what is to be accomplished, monitor performance, and administer reinforcement accordingly” (Flin & Yule, 2004). This approach is effective in attaining expected safety performance levels and is essential for creating reliability and predictability.

• Transformational leadership is “characterized by value-based and individualized interaction” (Zohar, 2002b); it inspires and motivates staff toward adopting the organization’s vision and values, and influences the discretionary efforts of staff in improving safety performance beyond expected levels (Flin & Yule, 2004).
A number of studies identify further key characteristics in leadership behaviours influencing safety culture at three organizational levels, supervisors, management and senior leadership (Wu et al., 2010; Flin & Yule, 2004).

**Supervisors** can influence safety behaviour (e.g. compliance with regulatory requirements), perceptions of fairness, and safety outcomes through supportive and "high involvement" supervision, high quality 'leader member exchange,' actively modeling and reinforcing safety behaviours, and encouraging worker involvement in safety initiatives. By being open and responsive, supervisors can influence reporting of hazards and incidents. Supervisors also direct work and communicate based on the organizational values and priorities related to safety and productivity. Supervisors can directly influence safety climate perception, which in turn informs workers of "organizationally sanctioned ways of performing a job, allowing them to anticipate supervisory approval or disapproval in a variety of situations, especially when prior information is not available. Effective supervisors monitor work in progress, particularly through work sampling (i.e. direct observation) and act accordingly" (Zohar, 2002a, p. 162).

**Managers** influence perceptions of the organization as a whole, organizational policies, and conditions of safety at the workplace. Managers influence safety outcomes by demonstrating a commitment to safety, prioritizing safety over productivity, involving workers in decision-making, promoting workgroup cohesion and cooperation, engaging in one-to-one interactions with workers, and relaying the corporate vision for safety to supervisors.
Senior leaders have the greatest potential to influence organizational outcomes. Transformational leadership for safety at this level involves demonstrating visible and consistent commitment to safety by allocating resources (time, money, and people), providing support to management, and by the status given to health and safety. Senior leadership decisions influence the priorities, attitudes, and behaviours and therefore the commitment to safety of managers, supervisors, and workers.

Trust is often specifically mentioned as an important aspect of the employee-manager relationship related to safety performance (Adamson, 2010; Gershon et al., 2004; Zohar, 2002b). Christie, Barling and Turner (2011) indicate that leadership must be “authentic” in their transformational leadership, based on a moral foundation with a focus on the collective good, and on congruency between stated organizational values and actions of leaders; “pseudo-transformational leadership” has negative effects on leader-follower relationships, attitudinal and behavioural outcomes.

Reinertsen et al., (2008) state that “the currency of leadership is attention. What leaders pay attention to tends to get the attention of the entire organization” and there appear to be “three key ways in which effective senior leaders channel attention to system-level improvement: personal leadership, leadership systems, and transparency. In concert, these three methods form a powerful leverage point for achieving system-level results” (p. 14).
Employee involvement

Effective participation by staff at all levels of the organization is recognized as an essential element in gaining their commitment to the organization’s vision, values and goals (Clark, 2002; Rose, Thomas, Tersigni, Sexton and Pryor, 2006; Stubblefield, 2005; Armstrong & Laschinger, 2005). “Occupational health interventions have the best chance of achieving a significant impact if they follow a structured and participatory intervention process” (Nielsen et al., 2010, p. 235).

In the overall context of the organization, worker behaviour is part of a larger cultural set of safety practices; however, workers also have a role in determining the safety climate. When workers are empowered to become an integral part of the internal responsibility system, they demonstrate more proactive safety initiatives as part of their job responsibilities (Zohar, 2002b).

Current research in employee engagement indicates that engaging the workforce is essential in improving business performance. A strong correlation is noted between employee engagement and managers who ask for and act on employee input (BlessingWhite Employee Engagement Report, 2011). Porter-O’Grady (2003b) states that leaders need to assume a wide range of skills in creating a new context for workers. “Passion is embedded in great process, not in persons. Leaders’ ability to capture the energy of creativity and innovation and allow it to thrive is critical to staff engagement” (Porter-O’Grady, 2003b, p. 177).
More detail is provided by Mendelson, Barling & Turner (2011); their study on high involvement work systems validated the relationship between eight organizational practices: employment security, selective hiring, extensive training, contingent compensation, teams and decentralized decision-making, reduced status distinctions, information sharing, and transformational leadership with job satisfaction, affective commitment, trust in management, and organizational performance (productivity, profitability, customer satisfaction, workplace safety, and lower turnover, waste, and inefficiency).

Rose et al., (2006) state that distributed influence, which is promoting desired behaviour without command and control, is an effective structure for ensuring employee participation, and that “leaders need to understand front-line workers’ perspectives, not filtered through hierarchies or levels of management.” (p. 436). Increased opportunity for employee participation and influence in decision-making, combined with specific and reasonable responsibilities, authority and goals in their jobs, leads to improved safety outcomes (Kelloway & Barling, 2010).

Of utmost importance in creating a culture of health and safety is “encouraging and fostering the identification of problems from all levels of the organization and the subsequent implementation of appropriate corrective actions” (Clark, 2002, p. 212). Ensuring all staff feel safe to report errors, problems, near misses, incidents, and injuries is based on trust, and “flattening of power distances to facilitate speaking up” (Searl et al., 2010, p. 4).
Safety management systems

The Canadian Patient Safety Institute recommends a framework for managing patient safety:

"A culture of patient safety is created and maintained by two interdependent factors. The first is an organizational framework that enables and sustains a culture of patient safety. The second is the appropriate expertise, attitudes, behaviours and values of those who work within that system. Both of these conditions are necessary."

Occupational health and safety and patient safety management systems are based on root-cause analysis and continual improvement models; therefore, alignment of systems, processes, risk identification/control and prevention to integrate both perspectives may avoid duplication of efforts, avoid creation of new/unforeseen hazards when system changes are introduced, or promote efficiencies by integrating both perspectives in system changes.

The safety management system infrastructure provides a platform for the "relentless pursuit of improvement through measurement, accountability, and follow up actions" (Lowe & Chan, 2006).

Ruchlin et al., (2004) state that an information system is an important aspect of a safety culture because it provides information about the "human, technical, organizational, and environmental factors which determine the safety of the system as a whole" (p. 53) and can assist an organization in moving toward an "informed culture", once a reporting culture and a just culture have been established. The ways that leaders at all levels obtain,
use, and disseminate information impact the development of an informed safe culture (Jones, Skinner, Xu, Sun & Mueller, 2007). For example, reporting systems will not facilitate increased reporting in a punitive culture.

Leadership development

Despite data linking "virtually every outcome variable in the field of occupational health psychology" to organizational leadership, leadership education is rarely considered as an occupational health and safety intervention (Kelloway & Barling, 2010). Similarly, many patient safety studies outline leadership qualities and behaviours required for creating a safety culture (Jones et al., 2007; Rose et al., 2006; Frankel et al., 2006; Ruchlin et al., 2004; Porter-O’Grady, 2003a; Clark 2002; Johnson, Bookman, Bailyn, Harrington, & Orton, 2011).

Safety attitudes and outcomes are enhanced for both leaders and staff when the leaders are trained in safety-specific transformational leadership (Kelloway & Barling, 2010, p. 268). Authentic transformational leadership has been shown to have beneficial effects on employee performance, including safety outcomes and safety consciousness, and well-being, including specific health-related effects. This challenges traditional notions that “safety” interventions are separate from daily operations and ensuring high performance, and that employee health promotion is outside the realm of the employer (Kelloway & Barling, 2010). Procedural and relational justice in organizations influence employee perceptions of safety climate and are predictive of “context-specific mental
health” which can include minor psychiatric morbidity and sick absences (Kelloway & Barling, 2010, p. 266).

Shamian & El-Jardali (2007) recommend that employers demonstrate that employee health and well-being are an integral part of their strategic plans, along with more on-the-job training to help supervisors and managers do a “better job of managing the tension between productivity and workers’ health and safety”. Integrating safety-specific, organizational culture and healthy workplace education relevant to the organizational level (supervisors, managers, and senior leaders) in leadership development programs is recommended (Kelloway & Barling, 2010; Wu et al., 2010; Flin & Yule, 2004; Schwerha, 2010).

Reader, Flin, Mearns and Cuthbertson (2009) outline a team performance framework wherein effective team leadership for safety is a key element; leadership affects development of a “shared mental model” (p. 1790) that guides team processes such as communication, coordination, and decision making.

Stubblefield (2005) emphasizes the importance of a consistent, ongoing investment in developing leaders at every level of the organization in order to change and sustain culture. Adamson (2010) advocates a formal leadership development program focused on creating healthy work environments in order to produce a “balanced set of outcomes.” He also specifies a major focus on emotional intelligence in their leadership development program, as part of their goal to become a learning organization, build trust, and foster quality relationships, because it raises self-awareness and empathy, and it provides a common framework and language for addressing underlying interpersonal dynamics.
Available data do not indicate optimal length or configuration of safety specific leadership training, but range from 3 hours to 5 days with various combinations of workshops, individualized feedback, and coaching. In addition, the literature identifies significant numbers of intervening variables, as well as the indirect and delayed effects, which create practical challenges in designing and demonstrating effectiveness of health and safety specific leadership development interventions (Kelloway & Barling, 2010).

Frankel et al., (2006) propose three priority focus areas for moving healthcare toward high reliability functioning:

- Development of a fair and just culture
- Leadership “Walk Rounds”
- Systematic and reinforced training in teamwork and effective communication.

Jones et al., (2007) elaborate on education provided to managers to support changes toward a just, flexible, and learning culture, including

- nature of human error and organizational accidents
- concept of a just culture
- concept that the same individual responsible for employee discipline should not collect or analyze safety information
- teamwork knowledge, skills (communication, situation monitoring, mutual support) and beliefs
- use of tools such as team huddles, Leadership Walk Rounds
Wu et al (2010) recommend that training programs be designed to help managers at all levels to understand their safety roles. Kelloway & Barling (2010) state that “leadership development appears to be a promising means of primary intervention, focused directly on improvement of workplace conditions that lead to occupational health and safety outcomes” (p. 270).

**Current Culture Efforts in Northern Health**

In 2011, Northern Health administered a baseline Teamwork and Safety Climate survey (Northern Health 2011) at three residential care facilities: Dunrovin Lodge, Rotary Manor and Acropolis Manor (See Figure 2 and 3).

Table 2 shows the overall teamwork and safety climate score at the three sites combined was 3.6 (out of a possible score of 5), and the scores for teamwork and safety climate subscales were at 3.7 and 3.5 respectively.

<table>
<thead>
<tr>
<th></th>
<th>Northern Health (3 Sites)</th>
<th>Acropolis Manor</th>
<th>Dunrovin Lodge</th>
<th>Rotary Manor</th>
</tr>
</thead>
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<td>Overall Teamwork and Safety Climate Score</td>
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<td>3.2</td>
<td>3.6</td>
<td>3.8</td>
</tr>
<tr>
<td>Teamwork Climate Score</td>
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<td>3.3</td>
<td>3.7</td>
<td>3.9</td>
</tr>
<tr>
<td>Safety Climate Score</td>
<td>3.5</td>
<td>3.0</td>
<td>3.5</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Overall, 114 participants completed the Teamwork and Safety Climate survey. The participants were primarily care aides (56%) followed by LPNs (16.7%), and the
majority were female (92%). The mean age was 42 years and on average, the respondents had 5 years of experience at their positions.

Figure 2: Mean Scores of Teamwork Survey Items by Facility

Acropolis Manor provided lower scores for the following survey items: “staff input being well-received” (2.5), “staff working as a well-coordinated team” (2.8), “satisfaction with the quality of collaboration with the care coordinator” (2.7), “feeling safe being treated as a patient” (2.5), “culture of learning from others’ errors” (2.8), “receiving appropriate feedback” (2.9), “management not compromising staff safety” (2.9), “leadership driving the facility towards safety-centerdness” (2.5), and “suggestions being acted upon” (2.8).
Dunrovin Lodge and Rotary Manor both had moderately positive scores for teamwork, 3.7 and 3.9 respectively. Rotary Manor also had a moderately positive score for safety climate (3.7). Acropolis Manor, however, had teamwork climate score of 3.3 which was significantly lower than Rotary Manor. The safety climate at Acropolis received a score of 3.0; it was significantly lower compared to the safety climate scores at Dunrovin (3.5) and Rotary Manor (3.7).

The staff at Dunrovin Park Lodge also provided negative scores for the survey items regarding “receiving appropriate feedback” (2.6) and “difficulty discussing errors” (2.9), as well as the previously mentioned “sufficient staffing levels” (2.6).
The overall teamwork and safety climate score at the three sites combined was 3.6 (out of a possible score of 5), the overall mean score for teamwork (3.7) was moderately positive and the score for safety climate was at 3.5.

The main concerns of the staff at Acropolis (as highlighted by the survey items) were that the staff did not believe their inputs on safety issues were well-received or suggestions were acted upon. There were also negative responses to the survey items regarding “culture of learning from others’ errors”, “receiving appropriate feedback”, “management not compromising staff safety”, and “leadership driving the facility towards safety-centeredness”.

This survey suggests that there is a lack of trust relating to teamwork and safety issues within the sample facilities. It would not be unreasonable to suggest that similar outcomes could be expected at other facilities or worksites at Northern Health.

As discussed, Northern Health has a number of support systems, process and procedures in place to enable staff, supervisors and managers to be safety aware. Training is provided – but the survey results show a lack of clarity and understanding in the frontline, which provides opportunities for Northern Health Leadership to “walk the talk” as it relates to safety in the workplace.

Discussion

“It is clear that leaders drive values, values drive behaviours, and behaviours drive performance of an organization. The collective behaviours of an organization define its culture. Without the right values supported by robust structures and systems
established and sustained by the governance boards, senior administrative leaders, and clinical leaders, it will be impossible to become a high reliability organization that embodies a true culture of workplace health and safety.” (Frankel, Leonard & Denham, 2006, p. 1707)

It is becoming trite to say that in today’s workplace, the only constant is change. It is however true and particularly so in the health care industry where outside influences such as changes in political leadership, innovative technology, and financial pressures have a direct impact on the services that we provide. Due to economic and political imperatives, Health Authorities are continually asked to improve financial effectiveness. Decisions regarding how best to make change are not always within Northern Health’s control, however, the implementation of change is generally left to Northern Health to manage. This has led to a number of successful change initiatives within our health authority, but has also lead to a sense of “change fatigue” throughout all levels of the organization. Human Resources play a role in supporting the organization through the required change initiatives to achieve our stated goals.

Communication of the responsibilities and accountabilities of all staff as it relates to safety is extremely important, and can be done in a number of ways – through memo, newsletter, face-to-face, and video conference meetings, although we need to rethink sole reliance on these traditional methods. A move from directed change to planned change will lead to a shared purpose, supported by common understanding (Buono & Kerber, 2010). If all members of Northern Health, at all levels understood their shared responsibilities, they may welcome an opportunity to be included in the planning process,
enhancing acceptance of the changes necessary to move toward a safety culture. A
cultural journey involves change, whether this is at a more macro or micro level.
Establishing a culture of workplace health and safety requires organizations to do things ‘a
little bit different’ and to do things ‘their way’, in this case, the Northern Health Way.

There are a number of integrated, iterative processes to enable change, one of
which is to develop and choose a change management team (Mento, Jones & Dirndorfer,
2002). Northern Health could initiate an organic working group using representatives
from human resources, frontline staff and hiring managers for the purpose of initiating the
planning. Members who possess the requisite knowledge, and who are credible enough to
become change champions within the organization, should be selected. Trust is important,
and is a key factor of employees embracing change (Peus, Frey, Gerkhardt, Fischer, &
Traut-Mattausch, 2009). Meetings would need to be attended by management and
leadership so that mutually agreed upon decisions can be implemented without delay.
This does not necessarily require Northern Health to establish new committees; Joint
Occupational Health and Safety Committees (JOHSCs) exist at the majority of the
worksites. These existing groups should be provided with more focused and deliberate
support in order for them to engage in more meaningful discussions with all levels of the
organization. The JOHSC’s can work collaboratively with key personnel throughout the
organization to assess and identify possible systemic factors that may influence Northern
Health’s abilities to establish and sustain a culture of workplace health and safety.
This working group would require champions of change to empower and encourage other staff members and client managers to expand their knowledge and embrace the new way of doing business.

Acceptance of the new way of doing business will not be universal. One of the biggest challenges Northern Health has experienced with process change in the past has been staff resistance to change from various sources; leadership, staff, or both. Staff at all levels could possibly feel that requirements to comply with safety procedures would be adding workload to them without adding additional value to their workplace. Whilst that perception may be understandable, it is not fully accurate. A significant amount of the effort managers and staff will be asked to follow through on is already a key part of their current responsibility.

A concept that may be effective in engaging staff and leaders to accept change is the Internal Responsibility System (IRS) perspective. Essentially, everyone at every level takes an active approach in ‘doing their best; carrying their best effort forward’ in establishing and ‘jelling’ that culture of how ‘we want it be to around here.’ Within Northern Health, there are various stakeholders that may be instrumental in promoting the IRS. Perhaps the key stakeholder is the human resources team, which effectively carries the overall mandate of supporting leaders and their staff in addressing and subsequently removing barriers to change.

Traditional views of safety have been focused on the three Es: engineering, education, and enforcement (Kelloway & Francis, 2008). The objective is to develop engineering solutions to secure safe work environments, equipment, and personal
protective devices. Health and safety professionals were tasked with *educating* supervisors and employers in the use of equipment. Existing health and safety regulations were *enforced* through administration of policies and procedures. Whilst these traditional processes have had success, and workplaces are generally safer, the three E’s do not provide a total solution.

Although established systems, processes and procedures are important in supporting safety in the workplace, safety is ultimately a people issue. Effective safety programing is dependent on the motivation and skill set of individual staff and supervisors. Although health and safety professionals are part of the larger Human Resources department of Northern Health (this is also true for a number of other industries), they are not the only human resource personnel that can be supportive of health and safety in the workplace. Figure 4 illustrates the role that human resources departments can perform in support of leadership and staff in achieving a culture of safety.

As discussed, safety leadership and safety climate are predictors of good safety outcomes (Barling, Kelloway & Loughlin, 2002). The entire Human Resources team can support these areas by supporting appropriate orientation and ongoing training, designing appropriate job descriptions, ensuring that workplace safety outcomes are included as deliverables in organizational performance management systems, etc.
Ultimately, the entire human resources team can support leadership by removing barriers that create obstacles in accepting change, presumably the perception that working safer and complying with safety procedures adds to one’s workload. Education, modeling safe behaviour and engagement are important. If staff considers safety reporting processes to be difficult and time consuming, these issues need to be identified, explored and the barriers removed, amended or adapted. Perhaps attention to safety should be a part of every leader’s performance plan.
Even when change is carefully introduced, staff can be predisposed to resist it (Lamm & Gordon, 2010), this includes leaders, especially as they can become disenchanted with the amount of new processes and procedures they are asked to comply with. Even when they are aware of the need for change, they resist the parts that appear too major, too risky or too “different” (Appelbaum & Wohl, 2000). We need to acknowledge their concerns and allow them the opportunity to express or vent these concerns. Northern Health’s Executive Team is fully supportive, however a disconnect may exist between the Executive’s support and how that translates to all management and staff. An understanding of resistance is necessary, with a subsequent removal of any barriers. Northern Health needs to recognize that everyone has time constraints, but reinforce the message that safety is everyone’s business and a value that needs to be nourished.

Resistance to change is human nature; it is therefore normal and should be expected (Stensaker & Langley, 2009). If there is resistance, it may reflect an issue that has not adequately been prepared for, and investigating what is behind the resistance can be enlightening and provide opportunity to address the root cause of many issues. It is important to overcome rather than overwhelm resistance (Sherman & Garland, 2007). Northern Health has an ethos of encouraging feedback, but despite that fact, there are times when negative reaction is not reported to the appropriate channels. Throughout the planning, implementation, and review stage of any initiative to establish a culture of workplace health and safety, communication needs to be as transparent as possible.
Communication will help reduce fear of the unknown, and provide opportunity for feedback, whilst enhancing understanding.

As noted, Northern Health’s Executive Team is supportive of this direction. What is just as important is the fact that they are supportive of developing leaders at all levels of the organization, which is a key to impacting change (Tichy, 2003). Visible support of the vision by the Executive Team, Senior and Frontline Management, will ensure more direct and pointed messaging to frontline management and staff.

Recommendations

The following actions can be used to enhance current safety success and assist Northern Health in reaching the stated goal of a strongly established health and safety culture:

- Integrate health and safety into the organization’s core business functions, and set and communicate a clear, compelling safety vision. To a manager, safety should be given as much consideration in their portfolio, as financial or operations management functions. To an employee, this means acting safely and reporting injuries and near misses of self and others without fear of negative reaction. In fact, reporting is something that should be celebrated, as it provides opportunity to reduce future risk.

- Valuing and empowering personnel. Begin initial discussion and education about the importance and the rationale for enhancing organization-wide, comprehensive, pervasive and visible approach to health and safety with leaders at all levels of the organization. This includes, but is not limited to, ensuring appropriate written policies
and procedures are in place to ensure due diligence is achieved. Policies and procedures can be reviewed often to determine if they are too complex, or whether they can be simplified.

- Engaging actively in the effort to improve safety. Leading by example. Develop and support implementation of a program of Leadership Walk Rounds, whereby leaders connect with staff in their respective areas with specific intent to hear their perspective on health and safety issues. If staff know they are respected and valued and can see that their personal safety matters to the organization, morale, engagement, and overall commitment will improve, all of which lead to increase safety behaviour.

- Focus on system issues. Develop an inventory of all leading and lagging indicators currently being measured for health and safety performance. Link the inventory to easily understood metrics that all levels of the organization can understand and embrace or celebrate.

- Education/training. In collaboration with WorkSafeBC, develop an Internal Responsibility System / Due Diligence (IRS/DD) awareness education that would be applicable to all leaders of the organization. Work together with Organizational Development to have IRS/DD education included as part of core leadership development programs and new manager/supervisor orientation. Develop a curriculum specific to root-cause analysis in investigations, leading to corrective actions focused on system issues vs. person specific issues. Include safety performance in annual appraisals.
• Safety Partnering. Enhance working relationships with WorkSafeBC and other external safety stakeholders. Focus on knowledge sharing, in particular around the concepts of the internal responsibility system and due diligence. Look beyond compliance in sustaining collaborative working relationships towards a culture of health and safety.

• Formalize Human Resources support to Internal Responsibility System. As Figure 4 outlines, processes for recruiting and promoting staff can be developed to recognise safety awareness as a key performance indicator. Work design functions can be utilized to review and recommend functional changes in departments with high levels of injuries, Job Descriptions could include statements relating to safety so all staff have a clear understanding of what is expected of them at work. The key is to recognize that while the Human Resources department supports and champions the establishment of a culture of workplace health and safety; authority, responsibility and accountability reside with the appropriate level within the organization.

• Assessment of Safety Culture. Consideration of more review and research to assess current safety culture with the organization. Although there is a time when data review needs to end and action taken, it may be advisable to undertake additional assessments of safety culture at other worksites throughout Northern Health. This could be undertaken by survey, or more effectively by focus group interview. This would assist with identifying other trends, and also provide a baseline to measure improvement.
Conclusion

Based on the evidence reviewed in this report, there are several key drivers for Northern Health to achieve the goal of establishing a culture of workplace health and safety. Existing processes need to refocused, including a deliberate attempt to develop a strategy that supports leadership development and education in health and safety.

The most effective and sustained change agent required to achieve this shift in culture does not rely nor rest with any specific individual or department. On the contrary, it rests with the Internal Responsibility System whereby every workplace party is an active participant. Frontline staff, supervisors, managers, senior managers and executive all have a part to play. Safety is not “someone else’s” responsibility; it is “everyone’s” responsibility. The Human Resources Team has a dual role to play. As staff and managers of Northern Health they have accountability for their practices and an expectation to lead by example. They also have the duty of supporting the organization to meet their values and accountabilities, a challenging and worthwhile mission.
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