

ORGANIZATIONAL SAFETY FROM INDIVIDUALS' POINT OF VIEW

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ABSTRACT: *This paper discusses the crucial importance of the mindfulness of every individual within an organization of Safety. The very real possibility of damage and injury to the persons populating the premises of the organization must be clearly articulated, behaviors and activities that work towards minimizing that risk rewarded while those that undermine it effectively discouraged. While such risk always exists, it is within the best interest of the of the organization to make the physical and psychological wellness of its individuals a primary pillar of its vision in that way.*

KEYWORDS: organizational safety culture, safety management, safety climate

INTRODUCTION

In recent years, there has been a shift in emphasis within the safety literature, away from individual level factors that might be responsible for accidents and incidents, such as error or non-compliance with safety procedures, towards organizational factors, such as safety climate. A key assumption of much of this literature is that the relationship between safety climate and system safety is at least partially mediated by individual safety behavior.

A structure culture that supports safety is crucial for the bar of injuries and unwellness. Management systems and programs will give an efficient safety framework; but, it ultimately is that the worker's perception of the worth of safety to himself and also the importance of safety to the organization that governs safety performance. Simply put, for true performance, you would like each the underlying systems associated with a structure culture that supports them. typically, this can be often known as "safety culture." the idea of safety culture has attracted a good deal of analysis attention from a spread of educational disciplines. Inevitably, the views are taken, and points of stress vary, and their area unit many in progress debates within the literature, as an example regarding the excellence between culture and climate, and regarding the scope of the idea. it's not inside the scope of this paper to supply a scientific review of that literature. many glorious reviews have already been revealed [1] [2].

Organizational Safety Culture

Safety culture refers to the ways in which issues of safety square measure addressed during a work. It usually reflects "the attitudes, beliefs, perceptions and values that staff share in respect to safety." The manner that issues of safety square measure addressed within the work and the way associate degree leader will profit by listening and asking queries of their staff is crucial to developing a lasting safety culture. It's ne'er a "my manner or the highway" however associate degree

understanding and agreement to however “our manner of safely doing business” works for the mutual good thing about the leader and worker. Safety culture is that the angle, beliefs, perceptions and values that staff share in respect to safety within the work. Safety culture may be a part of structure culture and has been delineated by the phrase “the manner we tend to do things around here “. That saw simply doesn’t cut it any more. Today’s staff square measure higher educated and business and social media savvy that they will see that the previous position of “my manner or the highway” is dead on arrival with today’s employees. They apprehend that it’s their lives that square measure at stake once job tasks associate degreed operations square measure allowable to be tired an unsafe manner to drive down manufacturing and production costs at their expense. It is understood that small companies must control their costs to complete locally, domestically and in some cases, internationally. Companies have known that in order to be competitive they must find ways to reduce the costs of raw materials, supplies, parts, labor, and increase production volume to the highest levels possible, based on anticipated sales. What is often missing from these costsaving measures is how many of these business decisions adversely affects their employees their employee’s health and safety. [3]

Studies have found that workplace-related disasters square measure results of a breakdown in AN organization’s policies and procedures that were established to contend with safety which the breakdown flows from inadequate attention being paid to issues of safety by management. Decent safety culture is often promoted by senior management commitment to safety, realistic practices for handling hazards, continuous structure learning, and care and concern for hazards shared across the men. The U.K. Health and Safety Commission developed one among the foremost normally used definitions of safety culture: “The product of individual and cluster values, attitudes, perceptions, competencies, and patterns of behavior that verify the commitment to, and the vogue and proficiency of, AN organization’s health and safety management. Organizations with a positive safety culture square measure characterized by communications based on mutual trust, by shared perceptions of the importance of safety and by confidence within the effectiveness of preventive measures.” [4]

The third issue of relevance to research on safety culture is the extent to which it is amenable to change. While some aspects of culture may be relatively static, there are nevertheless some levers for change and development. For example, a change in the top leadership, or the introduction of a revised safety management system might be expected to influence the culture of an organization. Thus, it can be argued that a useful framework ought to include developmental aspects of safety culture. The thinking of sociologist Ron We strum (1993, 1996, 2004) is pertinent here. He suggested that one way to distinguish between organizational cultures was according to the sophistication of the way that safety-related information was handled in the organization. He developed a typology of cultures, each reflecting a characteristic way of handling information flow, and representing increasing levels of advancement. The three types he identified were labelled pathological, bureaucratic and generative [5].

Pathological	Bureaucratic	Generative
Information is hidden	Information may be ignored	Information is actively sought
Messengers are "shot"	Messengers are tolerated	Messengers are trained
Responsibilities are shirked	Responsibility is compartmentalised	Responsibilities are shared
Bridging is discouraged	Bridging is allowed but neglected	Bridging is rewarded
Failure is covered up	Organisation is just and merciful	Failure causes inquiry
New ideas are actively crushed	New ideas create problems	New ideas are welcomed

How different organizations respond to information concerning safety [6]

Defining High Reliability Organisations

Traditionally, HRO researchers have relied on accident statistics as proof that the associate organisation meets the 'high reliability' criterion of just about error-free performance. However, these statistics are criticised as lacking judgment and unsupportive responsibility with safety. particularly, Hopkins (2007) noted that responsibility isn't equal to safety because the 2 will usually pull in opposite directions. as an example, Hopkins (2007) cited as associate example associate electricity company, that was known as associate HRO on the idea of its ninety-nine .95% record of continuous energy offer, and argued that reliable energy offer may come about at the expense of safety (e.g. by cutting corners for example), while in different cases maintaining a secure operation might involve shift off the energy offer, therefore, compromising responsibility. To resolve the problem relating to the adequacy of accident statistics in characteristic HROs, Rocklin (1993) argued that HROs square measure distinguished by the approach within which they manage their innately risky and sophisticated technologies.

Characteristics of High Reliability Organisations

Research on HROs was initiated by a team based at the University of California, Berkeley approximately 20 years ago who studied three 'error free' organisations the Federal Aviation Administration's air traffic control, Pacific Gas and Electric Company's operation of its nuclear power plant and the US Navy's nuclear-powered aircraft carriers (Roberts, 1993). The researchers used a multi-method approach to study these three organisations, which included facilitated workshops with high level operators and managers, interviews, observations and surveys.

- Deference to experience throughout emergencies: Decision-making is hierarchal throughout the routine, periods during a transparent differentiation of responsibilities on the World Health Organization is liable for what. However, in emergencies, decision-making migrates to people expertly no matter their hierarchal position inside the organization.
- Management by exception: Managers monitor selections however don't intervene unless needed, sometimes once there's a random deviation in a very course of action (Roberts, 1993). This management vogue is commonly brought up as 'management by exception' whereby managers target strategic, military science selections and solely get entangled with operational selections as and once needed (e.g. Bass, 1999). [7]
- The climate of continuous coaching to reinforce and maintain operators' data of the complicated operations inside the organization, improve their technical competency and alter them to acknowledge hazards and reply to 'unexpected' issues suitably. coaching is additionally seen as a way of building social trust and credibleness among coworkers (the i.e. belief that colleagues are well-equipped to try and do their jobs).
- Several channels are wont to communicate safety crucial info and to make sure that experience is often accessed in a very timely manner particularly in emergencies. for example, nuclear steam-powered craft carriers use twenty completely different communication devices starting from radios to sound steam-powered phones (Roberts, 1990).

In-built redundancy together with the availability of back-up systems just in case of a failure, internal cross-checks of safety-critical selections and continuous observation of safety crucial activities (e.g. Roberts, 1990; Hofmann, Jacobs and Landy, 1995). for example, nuclear steam-powered craft carriers operate a 'buddy system' whereby activities administered by one individual are determined by a second member of workers (Roberts, 1990). [8]

Safety Considered From the Individual Level

In the accident literature, individual attributes that contribute to unsafe behavior have most often been lumped under the heading "human error." Traditionally, when this term was used by engineers, it could be taken to mean "random*" variables with little or no hope of predictability. The point is not to ignite a debate with engineers, but simply to point out that even among engineers, there has been (and still is) an inchoate recognition that there is variability at the individual level that influences organizational safety (the term "human error" is frequently found in "root cause" statements). It might also be added that oftentimes this category of causal attribution for accident occurrence has been used as a "catch-all" category lumping together individual, micro organizational, and macro organizational variables. For example, Kletz (1985) reports that accident statistics, mostly from the chemical and oil industries, indicated that 50% to 90% of industrial accidents were due to "human failing." As we will see below, these "human errors," while often being classified as the root cause of accidents/failures, may be influenced by larger, organizational issues, some of which can implicitly encourage unsafe acts. Thus, the rather

high estimates of “human failings” may be unwarranted given that any number of other organizational influences have not been taken into account. It should be mentioned at this point, however, that several individuals within the engineering literature have begun to acknowledge and discuss the potential influence of organizational factors on safety. As the recent acknowledgements regarding the influence of organizational factors indicate, there is no doubt that individual attributes significantly influence the safety performance of organizations. Given this, it is important to first consider the influences of individual attributes on safety performance. [9]

Organizational climate and safety climate

The organizational climate could be a two-dimensional construct that encompasses a large variety of individual evaluations of the work atmosphere (James and James, 1989). These evaluations might ask general dimensions of the atmosphere like leadership, roles, and communication (James and McIntyre, 1996) or to specific dimensions like the climate for safety or the climate for client service. General perceptions of the structural context will impudence interactions among people, attitudes toward structure rewards and effective responses to the work atmosphere (Michela et al., 1995; Hart et al., 1996a). Perceptions of the final structure climate develop as people attribute timing to their structure context supported the significance of the atmosphere for individual values (James et al., 1990). structure climate, therefore, is assumed to exert a robust impact on individual motivation to realize work outcomes (Brown and actress, 1996). General structure climate has conjointly been found to impudence data and skills by increasing participation in activities likecoaching. Safety climate could be a specific style of structure climate, that describes individual perceptions of the worth of safety within the work atmosphere. a variety of things has been bound as being necessary elements of safety climate. These factors include management values (e.g. management concern for worker well-being), management and structure practices (e.g. adequacy of coaching, provision of safety instrumentation, quality of safety management systems), communication, and worker involvement in geographical point health and safety. a variety of studies have demonstrated that these factors predict protective outcomes, like accidents and. [10]

The Concept of Climate and Culture in Safety Research

Psychological research into industrial safety during the 1990s has been dominated by studies attempting to measure safety culture or safety climate. A proliferation of definitions and methods has resulted in a mass of research lacking a coherent theoretical framework. Consulting the broader organizational literature suggested that it was possible and useful to distinguish climate from culture when studying dimensions of organizational life such as creativity, productivity or safety. The following discussion presents a brief review of the relevant safety research that deals with the fundamental social context for safety and its manifestations as an underlying culture or more transient work climate. From a theoretical perspective, safety culture has been described in terms of values, beliefs, attitudes, social mores, norms, rules, practices, competencies, and behavior.

Measurement of Safety

Zohar (1980) was one of the first to describe what he called a "climate for safety" in twenty Israeli industrial organizations. His measure of safety climate was a summary of molar perceptions

employees shared about their work environment and the relative importance of safety behavior. Based on questionnaires completed by over 400 employees, Zohar concluded the following organizational practices, procedures, and rewarded behaviors were linked to an organization's safety level (measured in terms of safety inspectors' ratings).

1. Importance of safety training.
2. Effects of required work pace on safety.
3. Status of safety committee.
4. Status of safety officer.
5. Effects of safe conduct on promotion.
6. Level of risk at the work place.
7. Management attitudes to safety.
8. Effect of safe conduct on social status.

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