Developing An Effective Safety Culture A Leadership

Recent serious and sometimes fatal accidents in chemical research laboratories at United States universities have driven government agencies, professional societies, industries, and universities themselves to examine the culture of safety in research laboratories. These incidents have triggered a broader discussion of how serious incidents can be prevented in the future and how best to train researchers and emergency personnel to respond appropriately when incidents do occur. As the priority placed on safety increases, many institutions have expressed a desire to go beyond simple compliance with regulations to work toward fostering a strong, positive safety culture: affirming a constant commitment to safety throughout their institutions, while integrating safety as an essential element in the daily work of laboratory researchers. Safe Science takes on this challenge. This report examines the culture of safety in research institutions and makes recommendations for university leadership, laboratory researchers, and environmental health and safety professionals to support safety as a core value of their institutions. The report discusses ways to fulfill that commitment through prioritizing funding for safety equipment and training, as well as making safety an ongoing operational priority. A strong, positive safety culture arises not because of a set of rules but because of a constant commitment to safety throughout an organization. Such a culture supports the free exchange of safety information, emphasizes learning and improvement, and assigns greater importance to solving problems than to placing blame. High importance is assigned to safety at all times, not just when it is convenient or does not threaten personal or institutional productivity goals. Safe Science will be a guide to make the changes needed at all levels to protect students, researchers, and staff.

While worker safety is often touted as a company’s first priority, more often than not, safety activity is driven by compliance to legislation rather than any safety improvement initiative. Lean takes a proactive approach – it is not contingent on legislation. A serious Lean effort will tear apart an old inefficient entitlement-riddled culture and build it into something effective. Lean Safety: Transforming your Safety Culture with Lean Management takes lessons learned from Lean and applies them to the building of a world-class safety-first organization. Based on 30 years of experience with successful implementation of continuous improvement, Robert Hafey focuses the power of Lean improvement on the universal topic of safety. In doing so, he shows how Lean and safety are linked; that the achievement of one is often dependent upon achievement of the other. In this book, written for managers and executives as well as workers on the line, Hafey: Challenges each stakeholder to think proactively and accept individual responsibility for safety Emphasizes that the building of a top safety program requires the building of a world-class safety culture Demonstrates how basic Lean tools are as applicable to safety as they are to Lean, such as the A3 problem-solving process and the facilitated kaizen blitz Removes fear from the accident investigation process so that root causes are addressed rather than hidden Establishes standards and metrics for safety management that are clearly definable and measurable Any lasting improvement must become both institutionalized and perpetually capable of adaptation. World class safety is not about writing correct rules, but more about righting the culture responsible for the well-being of its stakeholders. Listen to what Robert Hafey has

to say about Lean Safety.

When the Space Shuttle Challenger exploded on January 28, 1986, millions of Americans became bound together in a single, historic moment. Many still vividly remember exactly where they were and what they were doing when they heard about the tragedy. Diane Vaughan recreates the steps leading up to that fateful decision, contradicting conventional interpretations to prove that what occurred at NASA was not skullduggery or misconduct but a disastrous mistake. Why did NASA managers, who not only had all the information prior to the launch but also were warned against it, decide to proceed? In retelling how the decision unfolded through the eyes of the managers and the engineers, Vaughan uncovers an incremental descent into poor judgment, supported by a culture of high-risk technology. She reveals how and why NASA insiders, when repeatedly faced with evidence that something was wrong, normalized the deviance so that it became acceptable to them. In a new preface, Vaughan reveals the ramifications for this book and for her when a similar decision-making process brought down NASA's Space Shuttle Columbia in 2003.

This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

This book evaluates and compares risk regulation and safety management for offshore oil and gas operations in the United States, United Kingdom, Norway, and Australia. It provides an interdisciplinary approach with legal, technological, and sociological perspectives on their efforts to assess and prevent major accidents and improve safety performance offshore. Presented in three parts, the volume begins with a review of the technical, legal, behavioral, and sociological factors involved in designing, implementing, and enforcing a regulatory regime for industrial safety. It then evaluates the four regulatory regimes that encompass the cultural, legal, and other contextual factors that influence their design and implementation, along with their reliance on industrial expertise and standards and the use of performance indicators. The final section presents an assessment of the resilience of the Norwegian regime and its capacity to keep pace with new technologies and emerging risks, respond to near miss incidents, encourage safety culture, incorporate vested rights of labor, and perform inspection and self-audit functions. This book is highly relevant for those in government, business, academia, and elsewhere in civil society who are involved in offshore safety issues, including regulatory authorities and industrial safety professionals.

This book helps in Achieving food safety success which requires going beyond traditional training, testing, and inspectional approaches to managing risks. It requires a better understanding of the human dimensions of food safety. In the field of food safety today, much is documented about specific microbes, time/temperature processes, post-process contamination, and HACCP–things often called the hard sciences. There is not much published or discussed related to human behavior–often referred to as the “soft stuff.” However, looking at foodborne disease trends over the past few decades and published regulatory out-of-

compliance rates of food safety risk factors, it's clear that the soft stuff is still the hard stuff. Despite the fact that thousands of employees have been trained in food safety around the world, millions have been spent globally on food safety research, and countless inspections and tests have been performed at home and abroad, food safety remains a significant public health challenge. Why is that? Because to improve food safety, we must realize that it's more than just food science; it's the behavioral sciences, too. In fact, simply put, food safety equals behavior. This is the fundamental principle of this book. If you are trying to improve the food safety performance of a retail or food service establishment, an organization with thousands of employees, or a local community, what you are really trying to do is change people's behavior. The ability to influence human behavior is well documented in the behavioral and social sciences. However, significant contributions to the scientific literature in the field of food safety are noticeably absent. This book will help advance the science by being the first significant collection of 50 proven behavioral science techniques, and be the first to show how these techniques can be applied to enhance employee compliance with desired food safety behaviors and make food safety the social norm in any organization.

Gain information on the practical methods that can be used to ensure safety and protection in peaceful activities involving radiation or radioactive materials. Covering such topics as: nuclear installations, nuclear fuel cycle activities, transport of radioactive material, radiation protection and safety for workers and the public, medical aspects, emergency preparedness, accident response and recovery, radioactive waste management, safety assessment and environmental impact, this series is particularly notable for its descriptive titles.

Job Hazard Analysis: A Guide for Voluntary Compliance and Beyond presents a new and improved concept for Job Hazard Analysis (JHA) that guides the reader through the whole process of developing tools for identifying workplace hazards, creating systems that support hazard recognition, designing an effective JHA, and integrating a JHA based program into occupational safety and health management systems. The book goes beyond the traditional approach of focusing just on the sequence of steps and demonstrates how to integrate a risk assessment and behavioral component into the process by incorporating elements from Behavior-Related Safety and Six Sigma. This approach allows businesses to move from mere compliance to pro-active safety management. This book methodically develops the risk assessment basis needed for ANSI/AIHA Z10 and other safety and health management systems. It is supported by numerous real-life examples, end of chapter review questions, sample checklists, action plans and forms. There is a complete online solutions manual for instructors adopting the book in college and university occupational safety and health courses. This text is intended for lecturers and students in occupational safety and health courses as well as vocational and degree courses at community colleges and universities. It will also appeal to safety and health professionals in all industries; supervisors, senior managers and HR professionals with responsibility for safety and health; and loss control and insurance professionals. Enhances the JHA with concepts from Behavior- Related Safety and proven risk assessment strategies using Six Sigma tools Methodically develops the risk assessment basis needed for ANSI/AIHA Z10 and other safety and health management systems Includes numerous real-life examples, end of chapter review questions, sample

checklists, action plans and forms

Provides a clear road map to instilling a culture of safety excellence in any organization Did you know that accidental injury is among the top ten leading causes of death in every age group? With this book as your guide, you'll learn how to help your organization develop, implement, and sustain Safety Culture Excellence, vital for the protection of and improvement in the quality of life for everyone who works there. STEPS to Safety Culture Excellence is based on the authors' firsthand experience working with international organizations in every major industry that have successfully developed and implemented ongoing cultures of safety excellence. Whether your organization is a small regional firm or a large multinational corporation, you'll find that the STEPS process enables you to instill Safety Culture Excellence within your organization. STEPS (Strategic Targets for Excellent Performance in Safety) demystifies the process of developing Safety Culture Excellence by breaking it down into small logical, internally led tasks. You'll be guided through a sequence of STEPS that makes it possible to: Create a culture of excellence that is reinforced and empowered at every level Develop the capability within the culture to identify, prioritize, and solve safety problems and challenges Maintain and continuously improve the performance of your organization's safety culture Although this book is dedicated to safety, the tested and proven STEPS process can be used to promote excellence in any aspect of organizational performance. By optimizing the safety culture in your organization, you will give the people you work with the skills and knowledge to not only minimize the risk of an on-the-job accident, but also to lead safe, healthy lives outside of work.

Developed to provide safety and health students with an understanding of the how-tos of implementing an occupational safety and health initiative, the first edition of Occupational Health and Safety Management soon became a blueprint for occupational safety and health management for the smallest- to the largest-sized companies. Competently followin

In Safety Culture: Building and Sustaining a Cultural Change in Aviation and Healthcare, the four authors draw upon their extensive teaching, research and field experience from multiple industries to describe the dynamic nature of a culture-change process, particularly in safety-critical domains. They use a "stories to numbers" approach that starts with felt experiences and stories of certain change programs that they have documented, then proceed to describe the use of key measurement tools that can be used to analyze the state of a change program. The book concludes with a description of empirical models that illustrate the dynamic nature of change programs.

Today's fragile economic climate requires new solutions to the problem of high healthcare costs. Organizations simply cannot afford runaway medical expenses, unproductive workplaces, and sick workers. In this landmark book, Dee W. Edington, PhD, former Director of the University of Michigan Health Management Research Center, draws from his 30 years of research and experience to explain how organizations can control health management and disability expenditures while keeping their workforces healthy and productive. Dr. Edington's message is straightforward, yet profound. His three key strategies, "Don't Get Worse," "Keep Healthy Employees Healthy," and "Create a Culture of Health," can help reduce the healthcare and productivity-related costs that are bankrupting American businesses. Zero Trends: Health as a Serious Economic Strategy provides the guidance and the inspiration organizations need in their search for lower medical expenditures and higher-performing workplaces.

Over the past two decades, the healthcare community increasingly recognized the importance and the impact of medical errors on patient safety and clinical outcomes. Medical and surgical errors continue to contribute to unnecessary and potentially preventable morbidity and/or mortality, affecting both ambulatory and hospital settings. The spectrum of contributing variables-ranging from minor errors that subsequently

escalate to poor communication to lapses in appropriate protocols and processes (just to name a few)-is extensive, and solutions are only recently being described. As such, there is a growing body of research and experiences that can help provide an organized framework-based upon the best practices and evidence-based medical principles-for hospitals and clinics to foster patient safety culture and to develop institutional patient safety champions. Based upon the tremendous interest in the first volume of our Vignettes in Patient Safety series, this second volume follows a similar vignette-based model. Each chapter outlines a realistic case scenario designed to closely approximate experiences and clinical patterns that medical and surgical practitioners can easily relate to. Vignette presentations are then followed by an evidence-based overview of pertinent patient safety literature, relevant clinical evidence, and the formulation of preventive strategies and potential solutions that may be applicable to each corresponding scenario. Throughout the Vignettes in Patient Safety cycle, emphasis is placed on the identification and remediation of team-based and organizational factors associated with patient safety events. The second volume of the Vignettes in Patient Safety begins with an overview of recent high-impact studies in the area of patient safety. Subsequent chapters discuss a broad range of topics, including retained surgical items, wrong site procedures, disruptive healthcare workers, interhospital transfers, risks of emergency department overcrowding, dangers of inadequate handoff communication, and the association between provider fatigue and medical errors. By outlining some of the current best practices, structured experiences, and evidence-based recommendations, the authors and editors hope to provide our readers with new and significant insights into making healthcare safer for patients around the world.

This book provides traffic safety researchers and practitioners with an international and multi-disciplinary compendium of theoretical and methodological concepts relevant to the research and application of Traffic Safety Culture aiming towards a vision of zero traffic fatalities.

First published in 2000, Risk Management is a two volume set, comprised of the most significant and influential articles by the leading authorities in the studies of risk management. The volumes includes a full-length introduction from the editor, an internationally recognized expert, and provides an authoritative guide to the selection of essays chosen, and to the wider field itself. The collections of essays are both international and interdisciplinary in scope and provide an entry point for investigating the myriad of study within the discipline.

At a time when more and more of what people learn both in formal courses and in everyday life is mediated by technology, Learning Online provides a much-needed guide to different forms and applications of online learning. This book describes how online learning is being used in both K-12 and higher education settings as well as in learning outside of school. Particular online learning technologies, such as MOOCs (massive open online courses), multi-player games, learning analytics, and adaptive online practice environments, are described in terms of design principles, implementation, and contexts of use. Learning Online synthesizes research findings on the effectiveness of different types of online learning, but a major message of the book is that student outcomes arise from the joint influence of implementation, context, and learner characteristics interacting with technology--not from technology alone. The book describes available research about how best to implement different forms of online learning for specific kinds of students, subject areas, and contexts. Building on available evidence regarding practices that make online and blended learning more effective in different contexts, Learning Online draws implications for institutional and state policies that would promote judicious uses of online learning and effective implementation models. This in-depth research work concludes with a call for an online learning implementation research agenda, combining education institutions and research partners in a collaborative effort to generate and share evidence on effective practices.

Developing an Effective Safety Culture implements a simple philosophy, namely that working safely is a cultural issue. An effective safety culture will eventually lead to the desired goal of zero incidents in the work place, and this book will provide an understanding of what is needed to reach this goal. The authors present reference material for all phases of building a safety management system and ultimately developing a safety program that fits the culture. This volume offers the most comprehensive approach to developing an effective safety culture. Information is easily accessible as the authors move first through, understanding the cost of incidents, then to perspectives and descriptions of management systems, principal management leadership traits, establishing and evaluating goals and objectives, providing visible leadership, and assigning required responsibilities. In addition, you are given the means to systematically identifying hazards and develop your own hazard inventory and control system. Further information on OSHA requirements for training, behavior-based safety processes, and the development of a job hazard analysis for each task is available as well. Valuable case studies, from the authors' own experience in the industry, are used throughout to demonstrate the concepts presented. * Provides the tools to rebuild or enhance a desired safety culture * Allows you to identify a program that will fit your specific application * Examines different philosophies in relation to safety culture development

In a global survey by the Katzenbach Center, 80 percent of respondents believed that their organization must evolve to succeed. But a full quarter of them reported that a change effort at their organization had resulted in no visible results. Why? The fate of any change effort depends on whether and how leaders engage their culture: the self-sustaining patterns of behaving, feeling, thinking, and believing that determine how things are done in an organization. Culture is implicit rather than explicit, emotional rather than rational—that's what makes it so hard to work with, but that's also what makes it so powerful. For the first time, this book lays out the Katzenbach Center's proven methodology for identifying your culture's three most critical elements: traits, characteristics that are at the heart of people's emotional connection to what they do; keystone behaviors, actions that would lead your company to succeed if they were replicated at a greater scale; and authentic informal leaders, people who have a high degree of “emotional intuition” or social connectedness. By leveraging these critical few elements, you can tap into a source of catalytic change within your organization. People will make an emotional, not just a rational, commitment to new initiatives. You will elicit enthusiasm and creativity and build the kind of powerful company that people recognize for its innate value and effectiveness.

Cliff Florczak has been an integral part of a number of highly successful zero incidents safety culture development programs. Here, he shares the details of these programs in order to provide others with the necessary information to assess their own safety culture. After a brief background on safety cultures themselves, the author utilizes some of the basic safety principles, combines them with some of the basic management theories and puts all of this to use in real life situations. Aims for zero incidents to control costs and losses Packed full of real-life examples and analogies Learn what to look for, where to look for it and how to go about making improvements

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extensive teaching, research and field experience from multiple industries to describe the dynamic nature of a culture-change process, particularly in safety-critical domains. They use a stories to numbers approach that starts with felt experiences and stories of certain change programs that they have documented, then proceed to describe the use of key measurement tools that can be used to analyze the state of a change program. The book concludes with a description of empirical models that illustrate the dynamic nature of change programs.

Despite the fact that workplaces have implemented and followed new safety innovations and approaches, the majority of them have seen little, if any, significant progress in the reduction of accidental deaths and injuries. Changing the Workplace Safety Culture demonstrates that changing the way an organization views and practices safety will impact the behavior of all employees including executive and line managers. It delineates how safety culture change can be implemented and defines the roles of everyone in the safety culture, including management, employees, and unions and their members. Rather than focus on behavior-based safety measures, this book provides step-by-step procedures on how to establish a long-lasting integrated safety management system in any organization. It explores how to change the safety personality of an organization. The author covers the management principles and functions that need to be applied to bring about safety culture change and includes many real-life examples. He goes on to explain the activities needed to implement safety change and the benefits of getting others involved in the safety management system. The only way to ensure that accidents and their consequences are tackled at the source is to identify and eliminate the workplace risks before, rather than after, the event. To be truly effective, safety activities must be integrated into the day-to-day business and become a way of life for management and employees of the organization. This book provides a blueprint for creating an active safety culture that prevents accidents before they occur and becomes the key component in ongoing safety success.

Facility safety is an important commercial risk and it has to be managed insists John Taylor in Safety Culture. Following an accident, the lack of a 'good' safety management system, compounded by a 'poor' safety culture, is a charge often laid on organisations. Accidents can take up to thirty percentage points off annual profits and, often, failure to manage safety has a much larger social cost that can involve fatalities or serious injury to members of the workforce and public. This has been starkly demonstrated in the railway industry, the international atomic energy industry, and through events in the oil exploration and refinery industry. In business terms, the ultimate cost can be receivership. Safety Culture highlights examples ranging from the loss of the Titanic, to Bhopal, and the Tokaimura criticality event. In it Dr Taylor argues that to minimise risks, any hazardous facility requires robustly engineered safety systems, an effective management system and a developed organisational safety culture. Safety culture is a complex social/scientific concept and Dr Taylor demystifies it with reference to theory normally associated with mainstream business development and change processes. Sections of the book deal with using safety culture theory as a predictive model, the assessment of safety culture, and how to influence culture change to produce the desired organisational behaviours. This is a practically focused book from an author with vast experience at the top level of high hazard

industries, he brings together current academic thinking on the concept of safety culture and provides authoritative practical guidance for operational executives, managers and for students in science, safety technology and engineering disciplines.
The International Civil Aviation Organization has mandated that all of its member states implement Safety Management Systems (SMS) in their aviation industries. Responding to that call, many countries are now in various stages of SMS development, implementation, and rulemaking. In their first book, Safety Management Systems in Aviation, Stolzer, Halford, and Goglia provided a strong theoretical framework for SMS, along with a brief discourse on SMS implementation. This follow-up book provides a very brief overview of SMS and offers significant guidance and best practices on implementing SMS programs. Very specific guidance is provided by industry experts from government, industry, academia, and consulting, who share their invaluable insights from first-hand experience of all aspects of effective SMS programs. The contributing authors come from all facets of aviation, including regulation and oversight, airline, general aviation, military, airport, maintenance, and industrial safety. Chapters address important topics such as how to develop a system description and perform task analyses, perspectives on data sharing, strategies for gaining management support, establishing a safety culture, approaches to auditing, integrating emergency planning and SMS, and more. Also included is a fictional narrative/story that can be used as a case study on SMS implementation. Implementing Safety Management Systems in Aviation is written for safety professionals and students alike.
Described how to implement an effective safety culture that will lead to the desired goal of zero incidents in the work place
Do you want to make a difference? There are many ways someone in a leadership role can have a positive impact on the lives of their employees. Perhaps there is no leadership responsibility more profound than creating a sustainable, injury-free workplace. Every person who goes to work expects to return home in the same condition. When someone is hurt, the adverse effects of their injury ripple through the employee's family and friends. Achieving an injury-free environment is one of the most difficult problems many leaders face. Indeed, during 35 years in manufacturing I never discovered a singular solution to this challenge. However, over these years I observed quite a few leadership actions that significantly contributed to less risk-taking, greater hazard awareness and genuine collaborative efforts among employees and supervisors. Leaders who understood, embraced, and implemented these strategies saw a dramatic reduction in incidents and injuries at their facilities. In my experience, organizations with the best safety performances do not have a secret. They simply do a lot of small things collectively and strategically well. That's really what this book is about. It is a collection of leadership concepts, thoughts, words, and actions that (when strategically implemented) can move your organization toward a better safety future. There are no 'silver bullets' here. On the other hand, you don't have to do all of these things to be successful in your safety journey. The first section of the book takes a look at some fundamental concepts everyone who is striving to achieve safety excellence should understand. It includes a discussion on compliance versus commitment, how to develop a safety strategy, why people make mistakes and take risks, and an overview of a Just Culture. The core of the book reviews some key research findings in social psychology, sociology and neuroscience. I share personal experiences of highly effective leadership. And I recount other situations that exemplify the wrong approach. In each

case, I discuss how you can leverage these concepts in a practical way to improve your safety leadership skills. Topics include: how our thoughts can drive our behaviors when it comes to safety, how the words we use can be influential on personal decision-making, how social influence and leadership actions can drive safety performance, and how to facilitate the right personal safety conversation. At the end of each chapter, there is a segment called the SAFETY LEADER'S TOOLBOX. This toolbox contains over 70 practical tools and tips for being a more effective safety leader! Readers are encouraged to consult the SAFETY LEADER'S TOOLBOX for small changes in what you think, say, and do to shape your safety culture. I invite you to put on your safety shoes and walk with me. Together we will consider how you can lead your organization to exceptional safety performance. Spoiler alert! One essential leadership skill is knowing why, how, and what to talk about when it comes to safety. Where do you begin? Start with a "Why" of caring. If you start with caring as your personal motive, you won't have to do everything perfectly. Your employees will want to do the right things for the right reasons. You can read this book in chapter order. You can also go to a specific chapter to learn more about a particular topic. Either way, you are encouraged to consult the SAFETY LEADER'S TOOLBOX throughout this book for small changes in what you think, say, or do to shape your safety culture. Choose a set of tools from the TOOLBOX that will enable you to move toward your safety vision. Start making a difference in the lives of others!

As leaders increasingly understand the importance of good safety practice to support their business objectives, safety and health practitioners develop better tools and solutions. However, there is still a gulf between these two groups where engagement, communication and shared understanding can be found lacking. From Accidents to Zero opens up the field of safety culture and breaks it down into bite-sized pieces to facilitate new, critical thought and inspire practical action. Based on the concept of creating safety, as opposed to just preventing accidents, each of the 26 chapters in this user-friendly book includes explanation, commentary, reflections and practical activities designed to systematically and sustainably improve workplace safety culture. Core topics range from behaviour to values, daily rituals to unsafe acts, felt leadership to trust. Andrew Sharman's practical guide blends current academic thinking with authoritative guidance and sets up the opportunity for all parts of the organization to close the gap by providing very clear steps to thinking and acting differently. It sparks insight into how both traditional methods and novel approaches can be brought to life in real world situations. From Accidents to Zero offers a clear route to culture change through over one hundred pragmatic ideas to motivate and lead people, influence behaviour and drive a positive evolution in workplace safety.

The objective of this book is to help at-risk organizations to decipher the “safety cloud”, and to position themselves in terms of operational decisions and improvement strategies in safety, considering the path already travelled, their context, objectives and constraints. What link can be established between safety culture and safety models in order to increase safety within companies carrying out dangerous activities? First, while the term “safety culture” is widely shared among the academic and industrial world, it leads to various interpretations and therefore different positioning when it comes to assess, improve or change it. Many safety theories, concepts, and models coexist today, being more or less appealing and/or directly useful to the industry. How, and based

on which criteria, to choose from the available options? These are some of the questions addressed in this book, which benefits from the expertise of its worldwide famous authors in several industrial sectors.

Surveys the online social habits of American teens and analyzes the role technology and social media plays in their lives, examining common misconceptions about such topics as identity, privacy, danger, and bullying.

Risk science is becoming increasingly important as businesses, policymakers and public sector leaders are tasked with decision-making and investment using varying levels of knowledge and information. Risk Science: An Introduction explores the theory and practice of risk science, providing concepts and tools for understanding and acting under conditions of uncertainty. The chapters in this work cover the fundamental concepts, principles, approaches, methods and models for how to understand, assess, communicate, manage and govern risk. These topics are presented and examined in a way which details how they relate, for example, how to characterize and communicate risk with particular emphasis on reflecting uncertainties; how to distinguish risk perception and professional risk judgments; how to assess risk and guide decision-makers, especially for cases involving large uncertainties and value differences; and how to integrate risk assessment with resilience-based strategies. The text provides a variety of examples and case studies that relate to highly visible and relevant issues facing risk academics, practitioners and non-risk leaders who must make risk-related decisions. Presenting both the foundational and most recent advancements in the subject matter, this work particularly suits students of risk science courses at college and university level. The book also provides broader key reading for students and scholars in other domains, including business, engineering and public health.

This work presents the key factors in achieving a high standard of safe operations. First the principles and standards are set out, then the necessary training, followed by motivation and creation of a safety culture. The book goes on to consider hazards and risk levels, safe systems of work, occupational health hazards, safety audits, planning for emergencies, the safety management system and more. Detailed checklists and charts provide practical guidance throughout.

Attention Safety Communicators: Do you want everyone Speaking the Same Language on Safety?Your workforce is going to give you about one minute to convince them to work safely.Do you know what to say, or write, in those first 60 seconds?Employees quickly tune out when they hear bland, irrelevant safety messages. For too long they have been fed complicated, legalistic communication written for compliance that totally ignores that people actually want to feel safe at work.What is needed is a new and easy way to create compelling, targeted risk communication that catches attention and keeps it. Yet, at the same time builds a safe, thriving and productive environment. This new way is “Transform Your Safety Communication.”This is the book for you, if you want to:• Create clear, consistent safety messages, so everyone works to a common standard.• Understand the psychology behind why people don't listen. • Engage workers on safety, no matter how cynical.• Learn how to produce authentic and heart felt communication that builds trust.• Quickly generate relevant safety communication with easy to use frameworks and templates.• Accelerate your communication skills to boost your career prospects.”””” What other Safety Leaders are Saying:“A thoroughly enjoyable read and will now take the place of my dictionary as the most used book on my desk.”Michael Carney, HSE Manager

Sydney, StarTrack“Simple sound theory backed up with experience, filled with tips and examples of the good, the bad, and the ugly of safety communication, finishing with a “how to” guide.” Rachel Murphy, Health Safety and Compliance Coordinator, IHBI Queensland University of Technology"If you want to engage others and change their behaviour through effective communication, then this book is for you." Paul Harper, CEO/Principal Mining Engineer, AMC ConsultantsYou'll Wish You Could Have Read it Years Ago!If you want to be the inspirational safety leader that you've always dreamed of being, then get your copy today.

An essential guide that offers an understanding of and the practices needed to assess and strengthen process safety culture Essential Practices for Developing, Strengthening and Implementing Process Safety Culture presents a much-needed guide for understanding an organization's working culture and contains information on why a good culture is essential for safe, cost-effective, and high-quality operations. The text defines process safety culture and offers information on a safety culture’s history, organizational impact and benefits, and the role that leadership plays at all levels of an organization. In addition, the book outlines the core principles needed to assess and strengthen process safety culture such as: maintain a sense of vulnerability; combat normalization of deviance; establish an imperative for safety; perform valid, timely, hazard and risk assessments; ensure open and frank communications; learn and advance the culture. This important guide also reviews leadership standards within the organizational structure, warning signs of cultural degradation and remedies, as well as the importance of using diverse methods over time to assess culture. This vital resource: Provides an overview for understanding an organization's working culture Offers guidance on why a good culture is essential for safe, cost-effective, and high quality operations Includes down-to-earth advice for recognizing, assessing, strengthening and sustaining a good process safety culture Contains illustrative examples and cases studies, and references to literature, codes, and standards Written for corporate, business and line managers, engineers, and process safety professionals interested in excellent performance for their organization, Essential Practices for Developing, Strengthening and Implementing Process Safety Culture is the go-to reference for implementing and keeping in place a culture of safety.

Current safety and risk management guidelines necessitate that organizations develop and formally manage their understanding and knowledge of the standards and protocols of risk management. The impact of communication and human performance on the identification and control of hazards and associated risk must be addressed in a structured manner. This core reference provides a complete guide to creating a comprehensive and effective safety culture. Safety Culture is a reference for safety and risk professionals and a training text for corporate-based learners and students at university level. The book will keep safety and risk management professionals up-to-date and will provide the tools needed to develop consistent and effective organizational safety protocols. How to develop a foundation to improve the perception of safety, analyze the organizational culture and its impact on the safety management system, and review the importance of developing a influential network Provides a format for establishing goals and objectives, discusses the

impact of leadership on the safety management system and the roles and responsibilities needed as well as methods to gain employee participation Tools to enhance the safety management system, the education and training of employees, how to assess the current safety management system, and the process of curation is introduced

Food safety awareness is at an all time high, new and emerging threats to the food supply are being recognized, and consumers are eating more and more meals prepared outside of the home. Accordingly, retail and foodservice establishments, as well as food producers at all levels of the food production chain, have a growing responsibility to ensure that proper food safety and sanitation practices are followed, thereby, safeguarding the health of their guests and customers. Achieving food safety success in this changing environment requires going beyond traditional training, testing, and inspectional approaches to managing risks. It requires a better understanding of organizational culture and the human dimensions of food safety. To improve the food safety performance of a retail or foodservice establishment, an organization with thousands of employees, or a local community, you must change the way people do things. You must change their behavior. In fact, simply put, food safety equals behavior. When viewed from these lenses, one of the most common contributing causes of food borne disease is unsafe behavior (such as improper hand washing, cross-contamination, or undercooking food). Thus, to improve food safety, we need to better integrate food science with behavioral science and use a systems-based approach to managing food safety risk. The importance of organizational culture, human behavior, and systems thinking is well documented in the occupational safety and health fields. However, significant contributions to the scientific literature on these topics are noticeably absent in the field of food safety.

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on

patient safety.

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS--three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequence--but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda--with state and local implications--for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors--which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health care--it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocates--as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine