

## ...ORGANIZE SAFETY

### SAFETY IS SYSTEMIC



EE staff work under an organizational umbrella with many systems as shown in the diagram. These systems influence the program activity and set the stage for safety performance and program outcomes. Regarding program safety, an organization provides raw materials for staff: program design, trip itinerary, properly vetted clients suitable to the activity, equipment, and logistics. In preparation, the organization also provides co-leaders, their training, supervision, oversight, and emergency response procedures.

A layer above these are subtle yet pervasive ideals such as safety culture, risk tolerance, financial pressures, and underlying assumptions regarding safety and the value of risk. These higher level ideals are very powerful and often go unrecognized, yet influence every aspect of daily staff decision making. These 'latent' factors are prominent within safety research and risk management practices that now place the organization as a key player in creating safety performance. The challenge is to align individual actions towards organizational goals without removing individual accountability or authority to act when it comes to safety.

### RECOMMENDATIONS

1. Question and examine your risk tolerance and assumptions. How much risk is too much? This ideal is a basis for all aspects of the program as it exists now and into the future, so articulate this ideal to all staff.
2. Map out the operational systems in your organization. Target expected routines or standard operating procedures and match these to desired performance outcomes or goals. Reduce complexity where possible by simplifying operations.
3. Provide thorough program or trip plans that incorporate options and 'slack' to allow for local adaptation as circumstances change.
4. Pre-plan emergency response with laddered reactions and defined criteria for escalation.
5. Train staff for surprises or non-normal events and for difficult clients or conditions. Provide training by meaningful interaction with the inherent risks of the program.
6. Recognize safety culture as a combination of origin assumptions, top-down mandates, and socially constructed norms that form and reform at all levels of operation.
7. Identify which specific individuals and operational areas have power to make key decisions regarding safety and risk. Scale and distribute this authority throughout various levels of the organization.
8. Empower front line staff regarding safety and risk by reducing hierarchies or barriers to communication within the organization.
9. Incorporate principles of a 'Just Culture', which looks for system interactions, avoids blame, and promotes integrated learning at all organizational levels and in all systems.
10. Recognize co-workers and peer pressure as important and influential. Build positive peer pressure with regards to safety.

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# FURTHER RESOURCES

## BOOKS

- Dekker, S. (2019). *Foundations of Safety Science: A Century of Understanding Accidents and Disasters*. CRC Press.
- Jackson, J., & Heshka, J. (2021). *Managing risk: Systems planning for outdoor adventure programs. 2<sup>nd</sup> edition*. Kobo Algonquin-Thompson.
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- Schein, E. H. (2010). *Organizational Culture and Leadership*. Wiley.
- Senge, P. M. (2010). *The Fifth Discipline: The Art & Practice of the Learning Organization*. Crown.
- Weick, K. E. (1995). *Sensemaking in organizations*. Sage.

## ARTICLES

- LaPorte, T. R., & Consolini, P. M. (1991). Working in practice but not in theory: theoretical challenges of high-reliability organizations. *Journal of Public Administration Research and Theory: J-PART*, 1(1), 19-48.
- Roberts, K. H. (1990). Some characteristics of one type of high reliability organization. *Organization science*, 1(2), 160-176.
- Salmon, P. M., Hulme, A., Walker, G. H., Waterson, P., Berber, E., & Stanton, N. A. (2020). The big picture on accident causation: A review, synthesis and meta-analysis of AcciMap studies. *Safety science*, 126, 104650.
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