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Workplace Health and Safety Culture

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SafeCare BC Workplace Health and Safety Culture Framework Overview

INTRODUCTION

This framework is heavily informed by and indebted to the Manchester Patient Safety Framework (MaPSaF), as well as the Patient Safety Culture Improvement Tool, developed by Mark Fleming and Natasha Wentzell (2008). While these frameworks are specific to patient safety culture, they have been adapted to address workplace health and safety culture within the continuing care setting.

In so doing, this framework has been developed to reflect OHS legislation and regulation, as well as the content of Accreditation Canada's (2013) *Required Organizational Practices Handbook 2014*. However, the specifics the *Handbook*, as well as British Columbia's *Occupational Health and Safety Regulation and Residential Care Regulation* have not been detailed within the framework. This exclusion is by no means intended to diminish the importance of what, in fact, forms the very foundations of a safe workplace. Rather, it is that their inclusion runs somewhat contrary to the very intent of safety culture frameworks, in that they are meant to broaden users' perceptions of safety and focus attentions on the complexity of how safety actually functions, above and beyond regulatory compliance.

To that end, the goal of this framework is to:

1. Enable users to understand safety culture as a multi-dimensional concept with observable and measurable characteristics,
2. Illustrate what varying levels of cultural maturity look like across a variety of dimensions,
3. Facilitate self-reflection and encourage dialogue about safety culture in users' organizations, and;
4. Provide a reference point for the development, implementation, and assessment of continuous improvement initiatives.

DEFINING SAFETY CULTURE

For the purposes of this project, the UK Health and Safety Commission's (1993) definition of *safety culture* has been adopted, wherein safety culture is conceptualized as: "The *product* of individual and group values, attitudes, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety programmes. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures" (cited in Cooper 2000, 114 emphasis added).

THE SAFETY CULTURE FRAMEWORK IS DESIGNED TO BE USED TO:

- Help your team recognize that workplace safety is a complex multidimensional concept;
- Facilitate reflection on the workplace safety culture of a given care organization, site, and/or team;
- Stimulate discussion about the strengths and weaknesses of the workplace safety culture in your organization;
- Show up any differences in perception between staff groups;
- Help understand how an organization with a more mature workplace safety culture might look;

Help you evaluate any specific attempt to change the workplace safety culture of your organization and/or team.

THE SAFETY CULTURE FRAMEWORK IS NOT DESIGNED TO BE USED:

- For performance management or assessment purposes
- To apportion blame when the results show that an organization and/or team's workplace safety culture is not sufficiently mature.

HOW TO USE THE SAFETY CULTURE FRAMEWORK:

The Safety Culture Framework is best used as a team based self-reflection and educational exercise:

- It should be used by all appropriate members of your team;
- For each of the eleven aspects of safety culture, select the description that you think best first your organization and/or team.
  Do this individually and private, without discussion.
- Use a T (team) or O (organization) on the evaluation sheet to indicate your choices. If you really can't decide between two of the descriptions, tick both. This will give you an indication of the current workplace safety culture profile of your organization.
- Discuss your profiles with the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus.
- Consider the overall picture of your organization and/or team. You will almost certainly notice that the emerging profile is not uniform – that there will be areas where your organization is doing well and less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your organizations not more like that? How can you move forward to a higher level?

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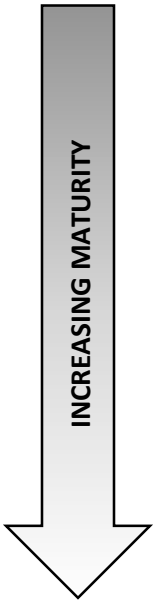
LEVELS OF STAFF SAFETY CULTURE EXPLAINED



LEVEL		DESCRIPTION
A	PATHOLOGICAL	Why do we need to waste our time on staff safety issues?
B	REACTIVE	We take staff safety seriously and do something when we have an incident.
C	CALCULATIVE	We have systems in place to manage staff safety.
D	PROACTIVE	We are always on alert, considering staff safety issues that might emerge.
E	GENERATIVE	Managing staff safety is an integral part of everything we do.

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DESCRIPTIONS OF SAFETY CULTURE DIMENSIONS

LEVEL	DESCRIPTION
1. Commitment to prevention and continuous improvement	Examines general commitment and attitudes towards prevention and continuous improvement, including purposes of policies and procedures.
2. Priority given to staff safety	Examines organizational priorities, as well as the role of risk management systems and the extent to which they are implemented.
3. Perceptions of the causes of staff safety incidents and their identification	Examines organizational understanding of the causes of incidents, reporting systems, and whether incidents are recognized as opportunities for blame or organizational improvement.
4. Investigating staff safety incidents	Examines extent to which incidents are investigated, how the information gathered is put to use, and timeliness of responses.
5. Organizational learning	Examines extent to which organizational learning is systematically integrated, and how change is implemented and managed.
6. Communication and consultation	Examines the extent to which there are formalized communication strategies and record keeping systems in place, as well as the degree of transparency between and within all levels of the organization.
7. Staff and safety issues	Examines organizational approach to recruitment, selection and retention of staff, including systems of support and performance appraisal.
8. Staff education and training about safety issues	Examines organizational approach to staff education, including motivation for training staff members, and extent of resources and support made available for training purposes.
9. Team and partnership working	Examines the extent to which the organization encourages team and partnership working between and within all levels of the organization.
10. Leadership commitment	Examines the extent to which leaders are trained regarding safety leadership behaviors, including interpersonal competencies, and techniques used to evaluate leadership performance (i.e., leading indicators).
11. Workload management	Examines the extent to which the organization recognizes and adheres to evidence-based staffing levels, and implements and monitors an active fatigue management plan.

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1 COMMITMENT TO PREVENTION AND CONTINUOUS IMPROVEMENT				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
The organization exhibits little commitment to prevention and continuous improvement. Consequently, minimal time or resources are invested in preventative systems, except those measures required to comply with regulatory standards. There is lack of systematic analysis or audits of safety systems and suggestions for improvement are rarely acted upon. Policies and procedures are designed to meet regulation, but are rarely put into practice.	Continuous improvement framework exists, but there is little motivation to implement it in any systematic way. Analysis tools are used for major events and for planning major organizational changes. Audits are initiated in response to major incidents or external forces, however, there is little response to findings. Policies and procedures are devised to prevent previous incidents from reoccurring, with little consideration as to how they fit within the broader system or their effects on it. Except in the wake of incidents, policies and procedures are often ignored when safety is confronted with competing demands (e.g., time, cost containment, staffing levels).	Prevention and continuous improvement efforts are motivated by external forces and management's desire for recognition. Staff feel that responsibility for these efforts resides with management. Auditing occurs frequently, led by specialists, with involvement of staff encouraged. However, safety analysis and audit tools are applied mechanically, without a systems-level perspective. Findings inform analysis of future incidents. Many procedures are in place, and are understood as protective barriers to prevent incidents, but are rarely implemented. Input from staff may be considered, but no real engagement occurs.	Commitment to prevention and continuous improvement exists at all levels of the organization, with significant efforts devoted to proactive measures. A wide range of staff able to use safety analysis and audit tools, which incorporate a systems- level view, and encourage input from all staff, residents and the public. Organization compares outcomes to other organizations when reviewing performance. Outcomes are routinely used to identify gaps and implement preventative measures, and facilitate organizational learning. Policies and procedures are developed based on Required Organizational Practices (ROPs), and other validated preventative protocols to reduce the risk of adverse events. With the involvement of staff, procedures are monitored, reviewed and refined when necessary.	A culture of prevention and continuous improvement influences all levels of the organization and decision-making processes, supported by a shared belief in the value of safety. Management is actively committed and, through visible leadership, motivates staff to work safely, providing them the resources and skills to do so. Teams are responsible for audit process, with systematic identification of risks and hazards integrated into daily activities and effectiveness is continuously monitored. Robust policies and procedures are in place, however reliance on them is minimal as all staff are skilled in applying best-practices and are highly attuned to safety risks. Staff input is sought in all prevention and continuous improvement initiatives.

2 PRIORITY GIVEN TO STAFF SAFETY				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Staff safety is a low priority for the organization. Minimal planning is done and few systems are in place, with little management oversight or supervision to ensure work is being conducted safely. As a result, the few safe work procedures that are formalized are rarely applied and remain token-efforts. No clear lines of responsibility are established with respect to staff health and safety. Risks are worth taking as safety measures are considered financially burdensome.	Staff safety becomes a priority only following an incident, but overall motive is compliance with regulatory standards. What planning occurs is aimed at preventing previous incidents from reoccurring, with little to no systematic use of preventative measures developed. Emphasis remains on the efficient and time-sensitive completion of tasks. Some financial investment is made to enhance staff safety (e.g., equipment maintenance) but risks are still taken to cut costs.	Staff safety is a fairly high priority, with increasing efforts devoted to hazard analysis and point-of-care risk assessments (e.g., violence prevention, exposure, MSI prevention). Preventative systems are in place, however they are generally inflexible and not easily adaptable to emergent situations. Staff awareness of and feedback regarding existing risk management systems is limited. Responsibility for staff safety resides with a designated individual, creating an "imposed" culture. Balance between cost-saving measures and safety is “juggled”	Staff safety is promoted throughout the organization, with input and active participation by all staff members encouraged. Everyone, including residents, are included in the implementation and review of risk management systems. Risks and hazards identified are corrected in a timely manner. Safe work procedures are understood by staff as being in their own best interests, and are standard practice. There is one delegated organizational lead for staff safety, however, staff safety is also included in all management- level portfolios, with clear lines of accountability established. Organization-wide recognition that safety measures are cost saving.	It is a moral and ethical imperative to protect and promote the health and safety of staff. Hazard analysis and risk assessments are central to daily practice. Safe work procedures are continuously monitored, reviewed, and refined, with input from all levels of staff welcomed. Safety is everyone's responsibility, and is reflected in all contracts and job descriptions, including support staff. Cost-saving measures and safety are held in balance.

3 PERCEPTIONS OF THE CAUSES OF STAFF SAFETY INCIDENTS AND THEIR IDENTIFICATION				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Staff incidents are considered unavoidable, and beyond organizational control. Individual staff members directly involved are often targeted as the source of the problem, and responsibility is placed on them for incidents that occur. Ad hoc reporting systems exist, but reporting generally only occurs in response to a major incident. Strong blame culture, focused on disciplinary action.	Incidents are considered a matter of bad luck, often blaming staff directly. Punitive measures are invoked (e.g., warning letters), and retraining often ensues following an incident. Attempts are made to remove "bad apples" rather than evaluating systemic issues contributing to the problems. A rudimentary reporting system is in place, however, reporting is not generally encouraged or supported. When reports do occur, they are not communicated to upper levels unless circumstances dictate it necessary to do so. Blame culture discourages staff from reporting.	It is understood that a wide range of factors contribute to staff incidents, not just individuals. Management decisions, lack of resources, as well as faulty equipment are all assessed as potential contributors. An anonymous reporting system exists, which is heavily reliant on the completion of forms. Despite organizational claims to the contrary, staff nevertheless feel vulnerable in the wake of an incident given lack of genuine organizational support or clear lines of accountability.	Systems, procedures, and policies, as well as individual (management and staff) decisions and behaviours are all considered potential factors contributing to staff safety incidents. All levels of staff, as well as residents, are encouraged to report through accessible, user- friendly reporting methods. Resulting data and identified trends are understood as opportunities for organizational learning. Staff feel safe reporting near misses and other incidents, and are supported in doing so. Open, fair, collaborative culture.	There is culture of accountability throughout the organization, and root causes are sought when conducting incident investigations. Staff feel empowered to report near misses, errors and incidents due to the clarity of the evaluation process and the fair judgements made following a report. As a result, staff have confidence in the reporting and investigation processes (both internal and external). This is a "just" culture, characterized by high levels of trust and transparency.

4 INVESTIGATING STAFF SAFETY INCIDENTS				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Investigations of staff safety incidents generally only occur following a major incident, where the goal is to identify the individuals to blame, take disciplinary action, and proceed with business as usual as quickly as possible. Investigations are only superficially conducted by a junior manager, and there is little consistency in the process. Outcomes of investigations are only shared when necessary, and remain missed opportunities for organizational learning.	Investigations of staff safety incidents are undertaken as a means of damage control and identifying those to blame for the incident. Investigations are tokenistic in nature, and narrowly focused on immediate causes (i.e., the individual's contributing actions) and are assessed in isolation from other similar incidents. Band-Aid solutions are proposed, but rarely implemented or systematically followed-up.	Investigations follow detailed procedures, which include senior management involvement. This process often involves the completion of a cumbersome amount of paperwork, and a great deal of data is gathered. While there is some analysis of the interplay between individuals and systems, investigation of staff safety incidents generally does not entail a formal root cause analysis. Following an investigation, the organization concerns itself with reviewing existing policies and procedures, and how they are being communicated to staff.	The organization has systems in place to investigate incidents, implement change and monitor for improvement. All involved in an incident contribute to the investigation process, including audits and root cause analysis. External input is also welcomed. Using a systems-level approach, findings are used to identify gaps in risk management systems, and develop strategies for improvement. Information is shared across the organization, and is used as an opportunity for learning.	Standardized policies, procedures and systems are in place to ensure that staff safety incidents are investigated in a timely manner, complete with root cause analysis and corrective actions implemented and monitored for effectiveness. Information is culled from a variety of incidents to offer a more comprehensive understanding of incident causation. The process is participated in and reviewed by all stakeholders, and staff feel safe, secure and supported during the process. Investigations enhance organizational learning, rather than apportioning blame. As a result, fewer incidents occur. The organization is characterized by a culture of inquiry.

5 ORGANIZATIONAL LEARNING				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
There are no systems in place to facilitate organizational learning. Following staff safety incidents, no changes are made except for those directed at the individuals most immediately involved. Information is not communicated within the organization unless doing so is a mandatory requirement enforced by regulatory standards or professional bodies. As a result, similar incidents tend to reoccur because there is no formal engagement process to learn from past failures.	Organizational learning is directly proportional to the amount of impact an incident has had on senior management. Significant events are investigated and corrective actions put in place to prevent reoccurrence. Learning is linked specifically to the particular incident. Changes made are not sustainable as they are imposed from above, with little input from or dialogue with staff.	Rudimentary systems are in place to facilitate organizational learning. Reported incidents are investigated, and corrective actions identified. However, the processes are applied mechanically. Information is not communicated throughout the organization, meaning solutions are localized, and given the lack of staff engagement in the process, changes are not fully implemented.	The organization has an integrated investigation system in place. Detailed results of investigations, including root cause analysis, and audits are discussed within relevant departments, units and teams, and summary results are shared across the organization. To help facilitate sustainable change, processes are in place to ensure involvement of all stakeholders, including staff and residents. This is an active-learning culture, characterized by forward-looking planning, openness, fairness and collaboration.	Organizational learning is a core value, evidenced by the organization's commitment to continuous improvement and willingness to learn from incidents (internal and external), and share these learnings widely (internally and externally). Systematic incident reporting, retrospective reviews and audits are routine, and outcomes are used as opportunities to engage all stakeholders in dialogue. Input from all levels of staff, as well as residents, is considered equally when assessing potential improvement initiatives. The shared belief that learning is an ongoing process wards off complacency, and staff are self- motivated to seek out safety issues. Organizational learning itself is also evaluated.

6 COMMUNICATION AND CONSULTATION				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Communication throughout the organization is poor, and there are no systems in place for staff to report safety issues and concerns. Management shares little to no safety information with staff, and what it does share tends to be negative and blame-focused. There is no collaborative dialogue or consultation with staff members regarding decisions affecting their safety. Consequently, important insights staff might have are not communicated or heard. Messaging that is conveyed is remains top down.	Upwards communication only occurs in response to serious incidents. Messaging conveyed back is restricted to those immediately involved, and is often directive and instructional, narrowly referencing specific events and the prevention of their reoccurrence. In the absence of consultation and communication with staff, these cursory safety directives are not integrated into daily practice and are not sustainable.	The organization has a communication strategy in place but its effectiveness is limited. A great deal of safety information is available to staff, however, there is limited opportunity for bottom up communication. Health and safety initiatives are frequently introduced. However, there is limited effort to consult with staff regarding the development, implementation and effectiveness of these preventative measures.	The organization has a communication system in place, which is audited regularly for effectiveness. Processes are in place to ensure staff engagement and feedback from all organizational levels. Commitment to two way dialogue is evidenced by regular briefing sessions, in which staff themselves are given the opportunity to contribute to the agenda. Communication strategies are flexible in order to meet the varying needs of residents, staff, and external organizational stakeholders.	There is a strong commitment to open communication between and within all levels of the organization. Communication processes are characterized by transparency, and consultation with all staff is highly valued. Senior staff and management recognize and value the wealth of knowledge and insight staff have to offer. It is expected that all staff share openly about their experiences in order to enhance organizational learning, and communicate their ideas about strategies for risk management and continuous improvement. This is a “praising" organization, where innovative ideas are encouraged, full participation expected, and open communication an integral part of daily operations and practice.

7 STAFF AND SAFETY ISSUES				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
A basic personnel policy exists, however, no references are made to occupational health and safety. Safety is not a topic addressed during recruitment, or a factor considered in the hiring process. Poor health and attendance are considered disciplinary matters rather than indicators of gaps in support systems, or hazards in the workplace. Staff do not always have access to the necessary resources to perform their work safely (i.e., team support, equipment, time), and staff development programs are lacking. Staff are viewed as a means to an end and, as such, there is no genuine commitment to their health and safety	Basic human resources policies are in place, with some focus on selection and retention. Historically, the majority of these policies were developed in response to previous incidents, and therefore are quite inflexible given that they focus narrowly on past failures. Some attention is given to safety in job descriptions when and where indicated necessary by past events. In general, staff receive limited organizational support.	The organization has formalized recruitment and retention policies, often involving a great deal of paperwork. Policies are made accessible for all staff to review. Performance appraisals and occupational health procedures, as well as staff development programs are in place, are often used as managerial control tools rather than indicators of deficiencies requiring improvement and opportunities for learning. As such, they are not used to their full potential.	The organization is committed to ensuring that staff have the competencies (e.g., knowledge, interpersonal skills, emotional intelligence) to fulfil their positions. Staff are encouraged to contribute to the development of safe work practices, and express their ideas. Support systems recognize the unique needs of individuals, rather than a "one size fits all" approach. When poor performance is an issue, attempts are made to understand why this is the case, and not simply seen as deserving of punitive measures. There is a genuine concern for the health and safety of all staff, with routine appraisals, monitoring and review, encouraging continuous improvement on all fronts.	The organization is genuinely committed to staff's personal development, physical safety and psychological health and well- being. Personnel management is not an isolated domain but is integral to daily operations. Safety performance is routinely reviewed at all levels, and managers receive organizational support to implement necessary health and safety processes. Everyone shares responsibility for safety. When incidents occur, a systems analysis is conducted. To ensure consistency and fairness throughout the process, incidents are investigated using a standardized tool (e.g., the SHELL model, which considers a variety of different social, environmental, organizational and cultural factors).

8 STAFF EDUCATION AND TRAINING ABOUT SAFETY ISSUES				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Education is a low priority for the organization, as staff are thought to come equipped with all the knowledge and skills they need. Staff tend to receive only mandatory/regulatory training. As the organization considers education to be a costly and time consuming venture, staff are often not released to attend courses. Given the lack of importance placed on staff education, training programs are not monitored for quality or effectiveness.	Training is primarily aimed at changing staff behaviour and attitudes. Training often occurs following a serious incident, or as indicated by obvious high-risk tasks. Little effort is made to maintain motivation, or provide staff with the skills or resources to implement the changes training is meant to initiate. Information on training is provided to new staff, but they are left to their own devices to determine how they pursue it. Some financial resources are devoted to training, but this funding is often the first to disappear in the wake of organizational cost-cutting measures as, overall, training is considered a luxury.	A more formalized approach to staff education is taken, and competency matrices are developed to identify staff training needs. These matrices, however, are not always properly used and tend to lack sufficient resourcing to put them into full practice. Standard training occurs regularly, but is not necessarily relevant to those in attendance. Acquired knowledge from training is confirmed through test-based measures. In general, training is conducted in response to organizational needs and priorities, as opposed to a genuine commitment to staff professional development.	Staff education and training is highly valued, strategically planned, and well-funded. Staff are able to recognize and identify their own training needs and are eager to further their education. Knowledge is tested on the job, and staff are enthusiastic about demonstrating their skills. Attempts are made to coordinate the training needs of the organization with those of individual staff members, and education is considered central to the professional development of all staff.	Leadership recognizes the importance of developing interpersonal skills, and shaping staff attitudes. Education is not approached as a "one off" event, but is understood and approached as an ongoing process. Staff are actively involved in their professional development, and are not simply "receivers" of regulatory training.

9 TEAM AND PARTNERSHIP WORKING				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Staff tend to operate in isolation, with little to no emphasis on team and partnership working. Teams, where they do exist, tend to be inefficient and plagued by hierarchical structures. There is a lack of focused unity within these groups, as members often feel pulled in different directions in trying to accomplish and meet their respective tasks and responsibilities. There are often breakdowns in communication, and as a result teams are generally ineffective at managing risk.	Teams are guided by a common goal, but staff lack the know-how or are not supported in working together to achieve the goal. Clear hierarchies persist in the team, reflective of those prevalent throughout the organization. Teams often only form in response to a staff safety incident. For example, increased emphasis on teamwork may arise after a staff injury occurs while transferring a resident with no assistance.	The organization states that team and partnership working are beneficial and desirable, however this is not demonstrated in daily operations or practice. There are no structures in place to enable team cohesion or ensure their effectiveness, and as a result they tend to lack a shared vision in how to pursue common goals. As such, partnership working towards improved risk management is not common procedure. Ideas, innovations, and information are not well communicated across teams.	Teams are fluid in nature, and hierarchies are increasingly flattened, with each member assuming the role most effective for the immediate circumstances. Team members are not restricted to an organization's staff, but may extend to include participation of members from external organizations or agencies. Teams are evaluated as a team, not simply on the performance of any one individual. Partnership working is routine within some levels of the organization (and across organizations), but is not consistent practice throughout	Team membership is fluid and flexible, with new members joining in when their expertise and experience are appropriate for the immediate circumstances. Partnership working is integral to daily practice, with strong levels of communication between and within teams. Team-based care, supported by team building and interpersonal skills training, facilitates improved risk management. These are high-functioning teams, with a shared vision and compelling purpose to encourage safety leadership at all staffing levels. Staff feel they are valued equally and can contribute at all levels of the organization, without fear of overstepping hierarchical boundaries. There is effective partnership working at strategic and operational levels.

10 LEADERSHIP COMMITMENT				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Leaders receive no education or training on staff safety. As a result, leaders often do not possess knowledge of the fundamentals of staff health and safety, nor the leadership skills to motivate and promote safe work practices. Given the lack of emphasis on leaderships' role in health and safety programs, these elements are not incorporated into their performance reviews.	Leaders are provided with basic information on staff safety, including policies, procedures and measurement techniques. Staff safety (promotion and assessment) is incorporated into their job descriptions. However, performance evaluation with respect to this area generally only occurs following a significant staff safety incident (i.e., lagging indicators).	Leaders are provided knowledge-based training about the role their behaviours play in promoting staff safety. Systems are in place to monitor leadership performance and evaluations are conducted. Regular discussion of incidents occurs in order to continually monitor and assess leadership behaviour and overall performance. Evaluation is premised on outcomes.	Leaders receive skills-based training to improve interpersonal skills, in order to motivate staff regarding the importance of safety. Training occurs at least annually, and leaders are encouraged to set personal goals to improve their leadership skills. Routine evaluations of performance occur, including input from colleagues. Results are openly discussed with the individual, emphasizing two-way communication, enhancing organizational learning. Evaluation focuses on processes rather than outcomes.	Mandatory training in the form of tailored individualized learning programs is provided to all leaders. The form and content of this training is premised on the outcomes of previous performance evaluations (based on leading indicators), and behavioural observation monitored through a formal, ongoing process. Peer-to-peer feedback is routine practice, fostering an open and collaborative learning environment.

***Please note: Within the content of this dimension, the term leader is taken to refer to senior managers, physician and nurse leaders, middle managers, and front-line managers.

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11 WORKLOAD MANAGEMENT				
PATHOLOGICAL	**REACTIVE**	**CALCULATIVE**	**PROACTIVE**	**GENERATIVE**
Little to no consideration is given to either workload or fatigue management, nor the impact they have on staff safety. Fatigue is considered part of the job, and/or a sign of one's dedication to their job. In times of need, staff are left to make do with what resources they have available to them, often leaving them shorthanded and pushed for time. There is a cultural normalization of "doing more with less". As a result, the organization tends to experience difficulties with recruitment and retention of qualified staff.	The organization uses guidelines to determine ratios of staff to residents. Little attention, however, is given to a variety of different factors influencing overall workload, such as staffs' skill levels or patient acuity. Fatigue is recognized as a contributing risk factor to staff health and safety. Tactics pursued to manage fatigue emphasize limiting hours worked per shift and/or week, rather than adopting a more holistic approach in the form of a comprehensive fatigue management program. .	Minimum ratios of staff to residents are set, monitored and enforced in alignment with evidence-based best practice. Attempts are made to manage fatigue and reinforce safe scheduling based on a strategic plan to modify shift scheduling when contraindicated by best practice. This narrow focus on ratios and scheduling continues to overlook the multitude of factors contributing to staff workload and fatigue above and beyond hours worked and the scheduling thereof.	In managing staff workload, consideration is given to the composition of staff members on a particular shift rotation (e.g., experience and skill levels), as well as resident acuity. As part of its fatigue management program, the organization promotes scheduling that allows for adequate recovery time during and between shifts. Managers encourage all staff to take allotted breaks. All staff (managers included) are educated to recognize the signs and symptoms of fatigue, recognizing its impact on staff members' physical and psychological health and safety. The organization promotes a healthy lifestyle for all staff members.	A holistic approach is adopted when managing staff workload. Factors such as intensity of work, resident acuity, and skill levels of team members are all taken into consideration. Additional supports and resources are made available in times of need, for example when emergent situations or staff skill levels mean staff safety is put at risk. With a formalized fatigue management program in place, there are processes to document the effects of fatigue on staff health and safety, retention and recruitment. The organization supports open acknowledgement and identification of fatigue, as it is understood as posing an unacceptable risk to staff and patient safety. The organization and all staff share and are guided by the ethical obligation to maintain "fitness to practice".

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LEADING INDICATORS CHECKLIST FOR SAFETY CRITICAL DIMENSIONS

LEVEL	LEADING INDICATOR
1. Commitment to prevention and continuous improvement	The entire organization values continual improvement in safety.*
2. Priority given to staff safety	This organization considers safety at least as important as production and quality in the way work is done.*
3. Perceptions of the causes of staff safety incidents and their identification	This organization understands that both human and systemic factors contribute to staff incidents, and supports staff in the reporting process.
4. Investigating staff safety incidents	Staff safety incidents are thoroughly investigated and corrective actions taken in a timely manner.
5. Organizational learning	Formal safety audits at regular intervals are a normal part of our business. *
6. Communication and consultation	Staff are always involved in decisions affecting their health and safety.
7. Staff and safety issues	Everyone has the tools and/or equipment they need to complete their work safely. *
8. Staff education and training about safety issues	Workers and supervisors have the information they need to work safely. *
9. Team and partnership working	Team and partnership working are integral to daily operations and practice.
10. Leadership commitment	Those in charge have the authority to make the changes they identified as necessary. *
11. Workload management	Those who act safely receive positive recognition. *

* These leading indicators are quoted directly from the Institute for Work & Health Organizational Performance Metric (IWH-OPM). (http://www.iwh.on.ca/iwh-opm-questionnaire)(accessed 28 May 2015).

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