

## Are We Our Own Worst Enemy? Optimizing Safety Leadership Skills Through Peer Feedback

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Being a safety and occupational health leader is not easy. In many cases, the position requires enormous responsibility and accountability with little or no authority or resources. Critical discussions regarding hazards affecting team members, patients, visitors and others are required, along with the informal leadership of fellow department leaders working on safety and occupational health issues as an additional duty and without line authority to officially delegate work. There are work assignments for the job itself, work assignments to organize and coordinate programs, and dynamic work that may come up in a moment's notice. Outbreaks and pandemics may exponentially increase workloads but do not negate regularly scheduled work. It is not an easy position, and it can be made much more difficult with unseemly and untimely proverbial tripping hazards causing us to potentially be our own worst enemy. Certain actions and words, both purposeful and inadvertent, can deter organizations and employees from developing a reliable safety culture. If a safety leader intends to engage an organization and develop safety but instead creates disdain, distrust, and disruption, the situation becomes counterproductive. After research discussions with non-safety or occupational health department leaders, peer employees, and third-party safety leaders in health systems, health care clinics, public sector/public health organizations, and private industry/manufacturing and construction organizations, common attributes were noted that are perceived to detract from effective safety leadership. Being cautious of the following can help prevent losses of effectiveness as safety leaders.

### Shortcuts

Within safety issues such as hazard analyses, risk assessments, hazard control needs and communication, many needs are unique to the organization and its operations and many pre-existing initiatives and programs are not or were not entirely effective. In many cases, the reason safety improvement discussions are happening is because the 'norm' is not effective. For these reasons, safety leaders consistently responding with, "Let's see what others are doing" or attempting to directly adapt a pre-existing resource to an operation without further consideration does not lead to an effective solution.

For example, when safety leaders consistently look for solutions already implemented by other organizations, they need to further analyze whether that solution is or has been effective and/or compliant with regulations. Furthermore, they need to also analyze the operation that the solution was implemented in. For example, there are major differences between implementing a respiratory protection program for a clinic with five employees (less than 10 are not subject to OSHA) and no Emergency Department (able to divert patients to other health services where an Emergency Room cannot) versus a health system with 20,000 employees and a full scope of health services.

Whether a hazard control program, a communication/educational resource, a leading indicator program or otherwise, each potential solution requires analysis of effectiveness and relevance; otherwise, these potential solutions are only inadequate shortcuts.

To analyze potential solutions, best practices are to:

- **Analyze the hazard(s) to determine needs.** These may include potential biological hazards (including different diseases of different probabilities and severities affecting personal protective equipment (PPE) and respirator needs and other variables), chemical hazards (with major differences between certain chemicals leading to major differences between regulatory, respiratory, PPE, environmental protection and other controls), patient handling and ergonomics (including differences in patient populations and employee demographics), workplace violence (including differing risk levels, precedents, and available resources such as security) and more.
- **Determine who is at risk for exposures to the hazards.** This determination may affect hazard control needs by scale (how much is required), PPE and respirator needs, human factors and much more.
- **Determine the risk levels for the hazards.** For example, with a high frequency of exposure and a high potential severity, disease exposures and patient handling injuries would be high risks, while other hazards with lower frequencies of exposures and lower severities would be lower-level risks. Determining risk levels helps determine where budgets and resources can be best applied.
- **With hazards analyzed and risks assessed, hazard control needs assessments can be performed.** To begin, certain hazards have regulatory compliance needs that must first be met; these include regulations on walking and working surfaces, PPE, respiratory protection, certain chemicals, bloodborne pathogens and more. Interestingly, certain hazards such as ergonomics and workplace violence have guidance attached to them but not laws in the Code of Federal Regulations. With hazards that have solid regulations, regardless of the risk assessment, if the hazard exists in the workplace, the regulation is required (pending certain exceptions such as employee count); for example, if corrosive chemicals are used the workplace, an eyewash is required per the regulation regardless of whether the organization deems the chemical a low risk or not.

With all regulations accounted for, other hazard control needs can then be determined, whether by hazard elimination, hazard substitution, engineering controls, administrative controls, or PPE. Finally, training and education are required for each hazard control implemented so that all at-risk employees know how to work safely. Training and education

only provide employees knowledge of how to use the hazard controls (such as how to use the equipment, how to follow the process, how to use the PPE, etc.), but training and education are not the hazard control (for example, explaining why COVID-19 is hazardous is not a hazard control; instead, employees require training to explain how to prevent congregations, stay physically separated, use face covers for source control, use social distancing, perform hand hygiene, disinfect surfaces, use contamination control, use PPE and N95 respirators, and more).

- **Compare and benchmark.** If an organization checks with other organizations to see what hazard controls are already in place there, this is a potential means to determine possible control options and assess their effectiveness, or to benchmark with other peer organizations. However, without first determining if the other organizations' controls are comparable and if the controls have been effective, checking other organizations' controls could just be a moot point of reviewing controls that do not work well or are not applicable or relevant to the organization's needs. Ultimately, just because others are doing it does not mean it is a good idea. If a safety leader cannot methodically analyze hazards, determine needs, and present options on the best possible hazard controls for the organization's operations, it does not matter what other organizations doing.
- Finally, this complete assessment of hazards and hazard control needs is important to ensure the most effective hazard controls and because this process enables the High Reliability Principles (Christianson & Sutcliffe, 2011):
  - **Preoccupation with Failure** (to identify hazards and safety needs)
  - **Deference to Expertise** (by seeking input and feedback on hazards and safety needs)
  - **Sensitivity to Operations** (by ensuring the hazard controls are relevant and effective)
  - **Commitment to Resilience** (by ensuring the hazard controls are effective)
  - **Reluctance to Simplify** (by avoiding shortcuts and possibly ineffective hazard controls)

### More Shortcuts

Shortcuts can also be attempted with post-incident investigation and analysis, like checking other organizations' hazard controls without first doing diligence in hazard analysis or needs assessments. For example, with each incident – whether a disease, chemical, blood, body fluid or other exposure, a patient-handling injury, a slip/trip/fall or other cause – an investigation and analysis is required to determine how the incident occurred and what is required to prevent reoccurrence. The process for the investigation and analysis can differ depending on the incident

and needs. In some cases, a full root cause analysis using a fault tree analysis, failure modes and effects analysis, or other method is necessary while, for other incidents, a simple 5-why analysis may be sufficient. However, regardless of the process, the investigation and analysis are important to determine where hazard controls are needed and to prevent incident reoccurrences.

In some cases, peers and leaders have been frustrated when incidents occurred but, instead of doing diligence by determining where the hazards existed, how the incidents occurred and what preventative measures were needed, a safety leader instead relied on incident reports such as first Reports of Incidents (FROI), compensation claims and/or reports from third-party organizations repairing equipment after the incident. For example, in one situation discussed, a formalin (formaldehyde) leak occurred in a laboratory involving a faulty dispenser. The leak required the services of a third-party organization to clean up the spilled formalin and another third-party organization to repair the dispenser. Later, when a team reconvened to analyze the incident and determine what hazard controls were necessary to prevent another leak, the safety leader arrived with only printed reports from the two third-party organizations explaining what services they had provided and details on the spill cleanup and the dispenser's repair. There was no fault tree analysis, no failure modes and effects analysis or other means of determining how the leak occurred and what hazard controls – whether elimination, substitution (different chemical or system), engineering (dispenser repair), administration (process change) and/or PPE along with training/education for the team in the lab – were needed. Ultimately, relying on the third-party reports created an information gap due to the missing root cause analysis and a potential reporting bias (not malicious) as the third parties were not expected to analyze the organization's processes, training, human factors or other aspects of the incident.

Unfortunately, like the need for hazard analyses and needs assessments, the need for post-incident analyses and investigations also enables the High Reliability Principles: Preoccupation with Failure, Deference to Expertise, Sensitivity to Operations, Commitment to Resilience, and Reluctance to Simplify.

### **Unrealistic Recommendations or a Lack of Presented Options**

With hazard analyses and hazard control needs assessments, the most effective hazard control outcomes are needed. Unfortunately, reality also dictates that operational constraints also determine feasibility. For example, after regulatory needs, the Hierarchy of Controls is proven to be the methodology for determining these (CDC, n.d.):

- **Hazard Elimination** – Can the hazard be completely removed or avoided?
- **Hazard Substitution** – Can something less dangerous be substituted for the hazard?
- **Engineering Controls** – Can a physical or mechanical solution be implemented to provide a barrier between the hazard and the employee(s) or to mitigate the hazard(s)?
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- **Administrative Controls** – Can a process or process change be implemented to avoid the hazard or limit/mitigate exposure?
- **Personal Protective Equipment (PPE)** – If a more effective operation is not possible, can PPE be used to prevent direct hazard exposure?

Within the Hierarchy of Controls, the most effective controls are desired, but, without a complete and comprehensive hazard analysis, it is possible to miss the presence of a hazard in parts of an operation or parts of an operation where a particular hazard control may not be effective. For example, within the COVID-19 pandemic, temperature screenings began at many facilities throughout the United States in March 2020. The intention of these temperature screenings was to identify any early indicators of a potentially infectious person such as a 100.4°F temperature or higher, or an affirmative response to certain medical screening questions such as whether the individual being questioned had been exposed to COVID-19 prior to arriving at the facility. With the intention of these screenings being to ask anyone potentially infectious to depart the facility and thus remove the potential for germs being spread, many viewed this as Hazard Elimination. However, being that potentially infectious people would still be arriving at the facility and would still be within proximity to others while being screened, these screenings would only limit exposures instead of eliminating them; with this, this would be an Administrative Control. However, in either case, temperature screenings can be circumvented by a potentially infectious person taking an over-the-counter fever reducer prior to arrival; knowing this, other Administrative Controls are needed inside the facility such as social distancing, face covers (source control), hand hygiene, and surface disinfection to provide redundant exposure prevention control in the event a potentially infectious person gets through the temperature screening control. With this, those promoting only temperature screenings on the assumption that they alone would prevent exposures were presenting a lack of options and providing unrealistic expectations that frustrated peers and leaders.

A different example of this was also discussed regarding workplace violence prevention. In this case, a safety leader consistently promoted what was referred to as risk assessments of potential threats. This was promoted as identifying any indicators of threats such as verbal threats, aggressive body language, profane language, or other potential signs of impending workplace violence. Upon identification, people showing these indicators would then be investigated to determine if they presented any prior history of violence or another reason to believe they would do harm to others. The explanation was that, if someone seemed dangerous, a risk assessment could be performed, and, if they had a history of violence or another indicator of violence, they could be removed from the facility. In theory, this would potentially remove threats of violence. However, this would only be effective if there were overt indicators of violence such as aggressive language or verbal threats, those indicators were identified in real time, the risk assessment was performed, and the risk assessment showed other actionable indicators such as an arrest record or a restraining order. With so many variables and prerequisites that must be met for the process to be



effective, it is possible that a potentially violent person would bypass the process. For example, someone could simply remain quiet until triggered and then attempt to strike another. Or someone could be admitted as a patient and, after a day in a room on a unit, suddenly become violent. With these situations, again, redundant controls are needed to identify potential workplace violence should a potential threat slip by. With this, in addition to the risk assessment/screening process, other screenings such as metal detectors can be implemented to screen for certain weapons. However, these, too, leave gaps, so rooms can be set up so that employees do not need to be in the back corner to reach the computer and inadvertently become trapped. Panic or duress buttons can be installed in rooms. Security can be placed in facilities as deterrents and response capabilities. Employees can be trained to identify real-time indicators of violence and, upon identification, ensure reactionary distance, proximity avoidance, de-escalation and egress. With these hazard controls, there are layers of redundant controls to prevent and respond to workplace violence. This prevents safety leaders from presenting unrealistic expectations or presenting a lack of options. Ultimately, organizations need to know the many ways a hazard can lead to harm, and the various controls needed to prevent them; with these options, unrealistic expectations will not be presented. Organizations can determine the extent of controls they desire and the options of how to implement them. Finally, they can make these determinations based on the pre-existing risk assessment already provided. Without these, the safety leader can leave the organization frustrated and ill-equipped to prevent incidents.

### **A Lack of Perspective**

While safety leadership is a unique skill set, a reality in health care and health care-related organizations is that safety leader staffing is proportionally and relatively low when compared to overall employee populations and employee counts in peer departments. With this, safety leaders cannot expect to have a team of peers, let alone direct reports to work among and delegate work to. Also, culturally, it is beneficial to the organization for a safety leader to plant seeds of knowledge and for the organizational culture created to allow those seeds to bloom among each department to create an optimal safety culture that identifies hazards, recommend hazard controls, communicates safety expectations, monitors for safe observations, and reports near-miss events and incidents instead of relying solely on the safety professional (Worden, 2018). For a safety leader to attempt to do all this alone would be for the culture to not manifest among others. Blind spots may exist in hazard identification due to the safety leader not being present at all operations, let alone being a subject matter expert in most, if not any. Knowing these things, an enormous function of the safety leader is teaching, coaching, and developing the safety culture through the development and promotion of the activities that make up the safety management system: the safety committee, hazard analysis, hazard controls, safety communication, leading and lagging indicators, and incidents investigations and analyses.

As teachers and coaches worldwide could likely attest, these functions require humility, patience and mutual respect. Safety leaders must be cautious to avoid condescension; being a know-it-all will create disinterest in safety, and personal aggravation. Being impatient will turn people away. With safety participation usually being an “other duty as assigned,” it is not normally on others’ performance reviews. Nobody usually receives a bonus for being involved. If safety leaders assume others have the same knowledge of regulations and best practices in incident prevention that they do, others can become confused. While some safety aspects such as incident rate calculation or even the need for a chemical’s safety data sheet may seem elementary to those who work in the field or have been involved in it for some time, someone new to the safety world may have never had a reason to learn these things before and may have never had a supervisor who promoted safety. Understanding that different perspectives exist, being patient, teaching, and coaching prevents loss of productivity and increases engagement. When safety itself is on the line and, with it, people’s lives and wellbeing, optimizing communication and interpersonal skills is necessary.

### **Dictating Instead of Teaching**

In the same vein as acknowledging different perspectives of safety knowledge and experience, safety leaders can also benefit from acknowledging different perspectives of operations. For example, when recommending hazard control options and redundancy to enable safety, even without optimal conditions or resources or with unexpected variables, simply giving orders or directives without regard to operational variables can cause tension among leaders and even get a safety leader removed from the operation.

Especially evident during the COVID-19 pandemic, the ability to analyze hazards and determine hazard control options is imperative, even when operational conditions are not ideal. For example, when planning operations during the COVID-19 pandemic, several organizations noted their safety leaders drawing hard lines by attempting to direct remote work or other more ideal exposure prevention controls. However, if not possible, it is important for safety leaders to know how to plan for contingencies by going to the options of physical separation and, if not possible, barriers. If still not possible, social distancing is an option. If still not possible, but the operation requires employees to be within 6 feet of potentially infectious persons, then PPE and N95 respirators are an option. If NIOSH-approved N95 respirators are not available, FDA emergency-use authorized respirators can be explored on the condition that employees can pass a fit test and seal check with them. These are only a few examples, but the reality is, that very few or no operations are ideal and most or all require contingency planning. Without seeing operational leaders’ perspectives and understanding their constraints, safety directives do not make much sense to them and can instead be unrealistic (Worden, 2020).

Lastly, with an understanding of operational constraints and the need for contingency planning, safety planning can then be taught. While many, if not all, leaders may not be interested to learn safety management on the level of a safety leader, each can benefit from a cursory overview and understanding of the hazard analysis and hazard control processes including why regulations are important, the Hierarchy of Controls, and related information. This provides a basis for understanding why the safety leader is recommending what he or she does and why it is important for the teams' wellbeing. With these explanations rooted in an understanding of operational leaders' perspectives, they can be taught with mutual respect and for mutual benefit.

### Conclusion

Leadership of any kind can be difficult, whether safety leadership or any operation, department, or organization. Understanding the various parts of the system that are inputs and outputs to any operation is important to create humility and a perspective of how to successfully analyze and makes recommendations for safety. Safety leadership can become much more difficult without the ability to identify and plan for each part of each operation and to know how each plan affects other operational components. With these plans, communication and interpersonal skills then enable teamwork and continual improvement. With these notes taken from direct feedback from peers and leaders, all of whom have direct experience working with safety leaders nationwide during a global pandemic, safety leaders can hear their perspective, relate it to best practices in high-reliability safety leadership, and everyone can improve.

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## Public Eye On Safety

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