

Safety Leadership & Organizational Design

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What makes an organization?

Strategy

Information

Processes

People

Structure

Culture

Good Organizational Structure



Maintains and improves communication



Responsive to change



Inspires innovation



Increases productivity

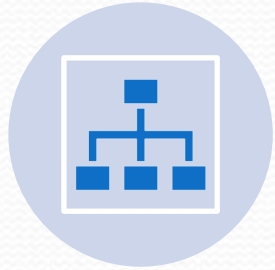


Creates an environment where people work effectively

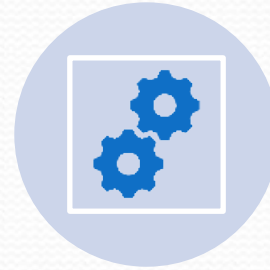


System of accountability

Challenges



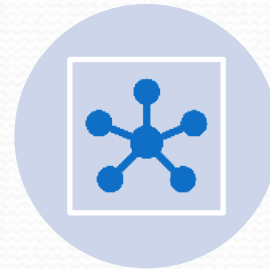
Design across
organizational
boundaries



Engineer processes
into strategic
capabilities



Develop individual
competencies into a
learning organization



Align information
technology with
business strategy



Integrate all the
pieces

What is Organizational Design

- Designing the optimal structure of accountability and responsibility that an organization needs to execute its strategies.
- Clearly defined roles, and authorities

Types Structures

Functional

Market/Divisional;

Matrix

Functional Structure

- work units based on similar activities
- Expertise within the function
- Common standards

Positive	Negative
well define hierarchy	Narrowed perceptive
Good communication within work unit	Reduced cooperation & communication across work units

Divisional/Market Structure

- Defined by organizational outputs
- Service delivery on site
- Closeness to customer for support
- Perception of the organization as responsive

Positive	Negative
small organization	Duplicity of functions
Customer knowledge advantage	Culture reflect of leadership

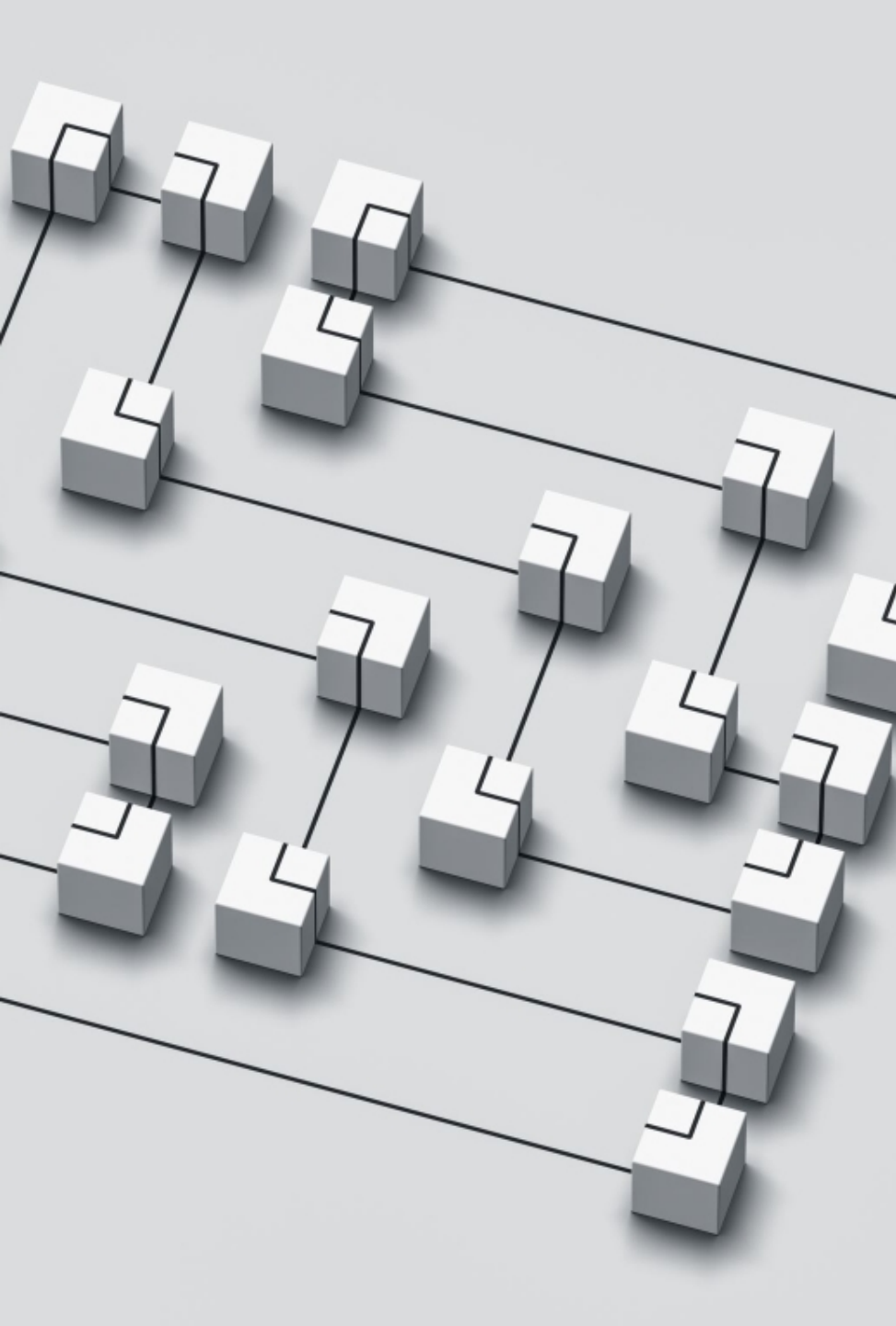
Matrix Structure

- Combines functional and divisional structures
- Employees belong to two groups
- Encourages technical and management training

Positive	Negative
Better cooperation & problem solving	2- boss system susceptible to power struggles
Increased flexibility	Task confusion
Performance accountability	Loss of focus on organization goals
Strategic management	
Customer focus	

Lateral processes of an organization

- Sharing of information and decision processes across different organizational units
- Help focus simultaneously on governments, customers, functions, vendors and products
- Provides flexibility in addressing issues or concerns



Types of Lateral Process

- Informal or voluntary
- E- coordination –Dashboards, IT management systems
- Formal group – team charter
- Assigned Integrators
- Matrix organization



Foster Voluntary Processes

- Helps remove barriers and encourage voluntary cooperation
- Actions which elicit voluntary cooperation
 - Interdepartmental rotation
 - Interdepartmental events
 - Co-locations
 - Consistent reward and measurement systems

E- Coordination or informational databases

- Provides consistent information
- Customer management

EHS customer management systems

- Medical exposure records
- Training records
- Medical surveillance
- Chemical inventories
- Planning exposure monitoring

Formal Groups

- Charter
- Staffing
- Conflict management
- Rewards –aligned to job performance
- Leader's role
- Team dynamics apply

Organizations succeed or fail as a whole

- Leadership
- Committee Structure
- Responsible Officials
- Culture
- Information systems

Safety Culture = Leadership + organizational design + empowerment of the workforce

Complexity of Regulatory Requirements

- OSHA
- EPA
- Unified Building codes
- Fire Codes
- ADA
- NRC
- CDC



Embedded Lab Safety Person

- Understanding of how things are done within work unit
- Easily available for questions
- Internal Expertise
- May have conflicting priorities
- Limited depth of regulatory knowledge
- May become the work unit enforcer which may not fit position authority or personality

EHS Professional Assigned to Lab Safety

- Dual roles
- In-depth regulatory knowledge
- Lab knowledge is based on relationship
- Career ladder
- Lack of specific scientific knowledge
- Lack of lab experience
- Not part of the team
- Not easily available for questions

Process Roll



Facilitator



Educator



Marketer



Auditor



**Business
Leader**



**Business
Partner**



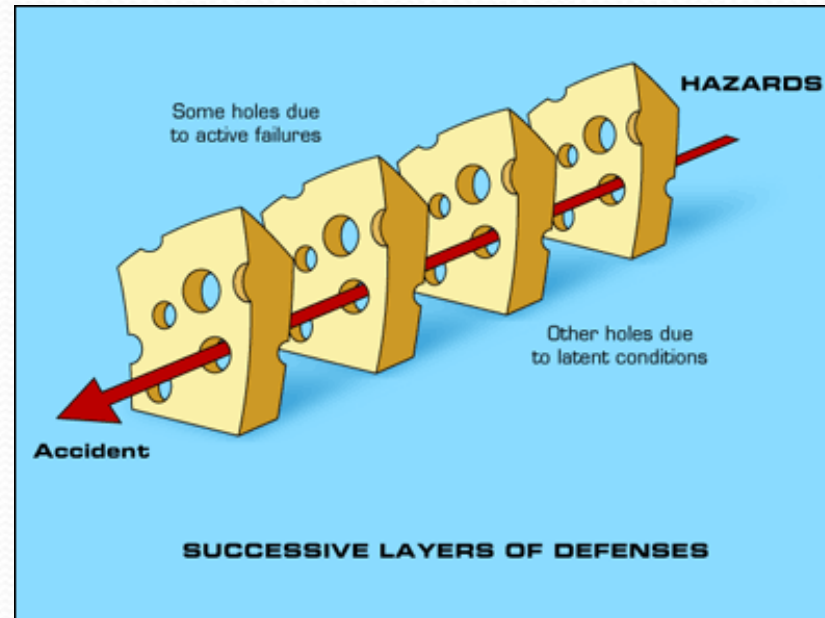
**Knowledge
Resource**



**Regulatory
Liaison**

Accident Causation

- Reason's Swiss Cheese Model
 - Cheese Layer = Safety layers (system defenses) capable of preventing incident
 - Holes = Gaps within each system where failure could occur



- If failures align then an incident or accident will occur!



Main Message to Organization

Collaborator

Recognizes and appreciates other unit's contributions to the health and safety program

There is management system which includes accountability to guide

Why a positive Safety Culture?

- More beneficial than a compliance only culture
- Core element of a successful organization.
- Leadership's commitment of resources drives safety as an unquestionable core value
- Positive use of resources:
 - Strong policies and expectations
 - Open communications
 - Sufficient incentives
 - Resources budgeting for safety

11 Questions to Measure a Safe Workplace

- Do I know what is expected of me to work safely?
- Do I have the materials and protective equipment I need to do my work safely?
- At work, do I have the opportunity to do what I do best every day in a safe environment?
- In the last seven days, have I received recognition or praise for doing a safe job or assignment?
- Does my supervisor, or someone at work, seem to care about me as a person?
- Is there someone at work who encourages my development and safety involvement?
- At work, do I share my safety concerns and do my opinions seem to count?
- Does the mission/purpose of my company make me feel my job is safe and important?
- Are my co-workers committed to doing quality, safe work?
- In the past six months, has someone at work talked to me about my safety performance?
- This last year, have I had opportunities at work to learn and grow in the areas of Safety and Compliance?

I CHOSE TO LOOK THE OTHER WAY

author
unknown

I could have saved a life that day.

But I chose to look the other way.

How could I ever let him die.

He knew the risks as well as I.

He took the casual, I closed my eye.

And that act, I let him die.

If you can't look the other way.

Then you must fight or die or flee.

The greatest risk is doing no one.

Could I have saved the other day.

It's never a life and death game.

Then I hope you never have to say.

I chose to look the other way.
I could have saved a life that day.
But I chose to look the other way.

It wasn't that I didn't care.
I had the time, and I was there.
But I didn't want to seem a fool.
Or argue over a safety rule.

I knew he'd done the job before.
If I spoke up, he might get sore.
The chances didn't seem that bad.
I'd done the same, and he knew I had.

So, I shook my head and walked on by.
He knew the risks as well as I
He took the casual, I closed my eye.
And that act, I let him die.