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A qualitative investigation of the safety culture of two contrasting organisations was undertaken. The research sought to identify categories and themes in the data that highlighted similarities and differences in salient safety issues for employees from the two organisations. The participants were 131 employees attending safety training sessions in a large national retail organisation and a heavy manufacturing organisation. Unobtrusive observation was used to collect data during the safety training sessions. Thematic analysis was used to identify emergent categories and themes from the data. Ten broad categories with relevant themes were identified and provided some insight into the safety culture of the two organisations, with both similarities and differences being evident. Participants from both organisations mentioned management issues in relation to safety, discussed the impact of employee risk-taking behaviour on safety, made reference to a blame culture, and raised integrity issues regarding safety. For the manufacturing organisation, a number of themes focused on contractor issues, while in the retail organisation, several themes highlighted differences in safety attitudes between head office and store-level employees.

KEYWORDS
• CONTENT ANALYSIS
• EVALUATION RESEARCH
• QUALITATIVE RESEARCH
• SAFETY CLIMATE
• SAFETY CULTURE
Qualitative investigation of organisational safety culture

Introduction

In the safety literature, the distinction between safety culture and safety climate is not always clear. Many safety culture definitions reflect anthropological origins of the construct by referring to collectively held safety values and beliefs. However, some definitions of safety culture also refer to safety attitudes, perceptions and behaviour, concepts that are more traditionally associated with climate. Similarly, some safety climate definitions appear to reflect a collective aspect more often associated with culture, using terms such as shared or molar, rather than individual-level aspects typically espoused in safety climate studies. Inconsistencies in respective descriptions of safety culture and safety climate appear to be related to two areas: a group-level versus an individual-level focus; and reference to beliefs, attitudes and perceptions.

The respective historical roots of safety culture and safety climate suggest that safety culture should be measured using descriptive qualitative methods, such as observation, focus groups, interviews and case studies, while safety climate should be measured quantitatively using standardised procedures that attempt to score the construct numerically. However, it appears that studies using qualitative techniques to tap the underlying values and assumptions thought to reflect safety culture are rare, with most research using quantitative survey methodology. Therefore, according to the historical definitions of these constructs, most research appears to assess safety climate, rather than safety culture.

Some researchers argue the benefits of combining qualitative and quantitative techniques to gain a more comprehensive understanding of safety in an organisation. Combining qualitative and quantitative methods, such as case studies, focus groups and surveys, can provide a holistic view of safety through an evaluation of organisational structure, function and behaviour. Mearns and Flin have argued that quantitative methods only scratch the surface with regard to attitudes and perceptions of safety, and that researchers need to become part of an organisation in order to understand and observe its culture, behaviour and interactions of those within it.

Empirical assessment of safety climate can generally be categorised as content-based or evaluation-type research. Content-based research has focused on four main areas: developing scales to measure safety climate; determining the underlying dimensions of these constructs; determining the nature of the climate for specific groups; and comparing the safety perceptions of different employee groups. Evaluation-type research has investigated relationships between safety climate and antecedent or outcome variables.

Quantitative attempts to identify underlying dimensions of safety climate have yielded little consensus, with the number of identified dimensions ranging from two to 19. A review of 18 safety climate scales found that three dimensions were typically used to assess safety climate (appearing in more than two-thirds of the scales): management, risk, and safety system. The management theme comprised perceptions of management attitudes and behaviour in relation to safety; the risk theme included risk-taking behaviour and perceptions of hazards and risks; and the safety system theme included safety policies, procedures and equipment. A similar review of 15 studies also identified management, risk, and safety arrangements as frequently-measured safety climate dimensions. A more recent review of 12 safety climate studies in the health care sector identified four core elements of safety climate: management commitment to safety, supervisor commitment to safety, safety systems, and work pressure. Two of these dimensions, namely, management commitment to safety and safety systems, corresponded with frequently measured dimensions identified in the earlier reviews.

Qualitative approaches to explore employee perceptions of safety are not common, yet qualitative research can yield rich, detailed, valid data that provide contextual understanding of
behaviour and allows investigators to examine individuals' perspectives in detail. Qualitative exploration of a subject is also a commonly used method for developing a quantitative survey instrument. Of the few existing qualitative studies, most are content-based, using interview or focus group data to compare safety perceptions of different groups of employees or to generate items for scale development. Qualitative evaluation-type studies are particularly rare, despite the view that this is the most effective way of understanding the factors that might influence safety attitudes and behaviour. Three evaluation studies have used interviews to investigate factors influencing risk and/or unsafe behaviour at work.

The present study helps to redress the lack of qualitative research in the safety culture and safety climate literature. The primary aim of this study was to provide insight into the safety culture of two contrasting organisations by identifying and exploring categories and themes in the data that highlighted similarities and differences in salient safety issues for employees.

Method

Participants

The participants were 131 skilled workers, supervisors and middle managers (110 males, 21 females). Potential participants were identified on the basis of attendance at pre-scheduled safety training sessions in two organisations in Australia: a large national retail organisation and a heavy manufacturing organisation. Eighty-two participants (65 males, 17 females) were from the retail organisation and most held supervisory or middle-management positions. Forty-nine participants (45 males, 4 females) were from the manufacturing organisation and most were highly skilled workers, including two supervisors.

Rationale and procedure

To minimise the effects of reactivity on the data and to permit naturalistic investigation, unobtrusive observation was selected as the data collection method. Of particular interest were the participants' views of safety arising from discussions during the safety training sessions, which could provide insight into the safety culture of the two organisations. The cross-sectional participant sample (consisting of skilled workers, supervisors and middle managers) also meant that a wide range of employee safety perceptions could be obtained. The unobtrusive observational methodology was deemed to be the least disruptive to the work environment, as well as being the most cost-effective, in that data could be collected without accessing additional employee time.

All of the safety training sessions were interactive, with employees being encouraged to express their views on safety. Seven one-day safety training sessions attended by different groups of employees were observed (four in the retail organisation and three in the manufacturing organisation), equating to 56 hours of observation. The researcher was introduced at the beginning of each session, and consent to observe and record the proceedings via note taking was obtained. Only employee interactions were of interest to the researcher, and note taking mainly excluded comments made by trainers when these took place during the free flow of comments and discussions about safety. Interruptions were also ignored if they interfered with the opinions being voiced by participants. Continuous unstructured observations of employee behaviour and interactions were made throughout each training session, with the researcher attempting to record as many employee comments as possible using a personal form of shorthand. No comments were made directly to the researcher, and the recorded comments were part of the conversations which occurred during the training sessions. At the end of each training session, the notes were expanded and typed into transcripts.

Analysis

The qualitative computer program NVivo 2.0 was used to develop a thematic analysis of the seven transcripts. An inductive approach was used, with
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identified categories and themes emerging from the data. The transcripts were read several times and a list of broad categories was developed and expanded as the analysis progressed. The transcripts were initially coded using 18 broad categories identified in the data. When assigning data to categories, a "unit of meaning" was selected as the unit of coding. A unit of meaning is conveyed by content rather than form. Since participants can express ideas succinctly or expansively, consideration is not given to the number of words but to the meaning conveyed. Once the transcripts had been coded as broad categories, text within the categories was retrieved and read to identify themes within the categories.

To establish sufficient reliability to proceed with the analysis and interpretation of the data, the double coding method was adopted. A second researcher who was familiar with the aims and objectives of the research coded a random sample of 30% of the data. Discussions were then held between the two researchers to reach agreement over the final categories and themes. Refinement of an initial 18 categories (whereby categories were expanded, combined or renamed) resulted in 10 broad categories being established. To establish inter-rater reliability of coding according to the 10 broad categories, a third researcher who was naïve to the aims of the study independently categorised a random sample of 30% of the data. Inter-rater reliability was established at greater than 80%. Analysis of the coded text concentrated on similarities and differences between the retail and manufacturing organisations in terms of the categories and themes generated.

Results

The 10 broad categories with relevant themes identified in the data are displayed in Table 1. Although most categories were pertinent to both organisations, in some instances, themes within the categories were more relevant to one organisation than the other. The data are reported descriptively according to categories and relevance of themes for the two organisations. The two organisations are identified as manufacturing (M) and retail (R).

Knowledge and training

Resource issues in relation to training

Resource issues were of greater importance to participants from the retail organisation than to those from the manufacturing organisation. In particular, employees from the retail organisation appeared to be concerned about their ability to provide adequate safety training to staff without the appropriate resources:

“Our ability to back up information with resources is a problem. We employ a lot of casuals, but we do not provide appropriate training to them. Instead, we rely on the immediate supervisor to convey the safety message.” (R)

Creating awareness about safety

For the manufacturing organisation, comments relating to safety awareness mainly concerned contractors. There seemed to be a feeling that, because contractors worked in many organisations, each having their own safety policies and procedures, contractors' safety awareness may become diminished over time. For example:

“With contractors, they move from one organisation to another. They have to sit through numerous inductions. After a while, I think it becomes too much and they probably do not take it in.” (M)

In the retail organisation, employees highlighted the need for head office departments to be aware of safety issues at the store level, as this could have an impact on business practices:

“I work in the furniture buying office and our buyers do not have any basic information regarding how much an individual can lift. This would affect our buying and ordering system.” (R)
### TABLE 1
Final categories and themes from the thematic analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes within categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and training</td>
<td>Resource issues in relation to training; creating awareness about safety</td>
</tr>
<tr>
<td>Managing safety</td>
<td>Awareness of employees' work environment and the risks faced; reactions to safety incidents, hazards, issues and problems; leading by example; commitment to safety programs, safety resources and hazard elimination</td>
</tr>
<tr>
<td>Communication</td>
<td>Communicating safety information; communicating with others, for example, other sites/Departments; providing feedback and positive reinforcement</td>
</tr>
<tr>
<td>Individual responsibility</td>
<td>Attitudes to safety; taking ownership of safety</td>
</tr>
<tr>
<td>Priority of safety</td>
<td>Existing culture or behaviour, for example, taking shortcuts due to &quot;being busy&quot;; management pressures</td>
</tr>
<tr>
<td>Employee welfare</td>
<td>Concern for employees, for example, not harming, mindful of feelings and treatment of employees; managing injured employees</td>
</tr>
<tr>
<td>Safety policies and procedures</td>
<td>Incident reporting; awareness of policies and procedures</td>
</tr>
<tr>
<td>Employee behaviour</td>
<td>Taking risks or shortcuts; impact of behaviour on others; use of personal protective equipment (PPE)</td>
</tr>
<tr>
<td>Integrity</td>
<td>Reporting incidents honestly</td>
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<tr>
<td>Blame</td>
<td>Emphasis on individual fault rather than system fault</td>
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### Managing safety

**Awareness of employees’ work environment and risks faced**

Employees in both the retail and manufacturing organisations seemed to feel that head office staff and/or managers lacked awareness of the risks faced by employees in their normal work environment:

“No one visits the actual stores to see what the actual problems at ground level are. Until this happens, nothing will change.” (R)

“Do managers ever go out and work on the floor to see what’s actually happening out there and see what the injuries and risks are?” (M)

**Reactions to safety incidents, hazards, issues and problems**

In the retail organisation, employees remarked that a proactive, rather than a reactive, approach to safety might improve the organisation’s overall safety statistics, for example:

“That’s our problem, we’re reactive rather than proactive. Unless we become proactive, we cannot achieve the overall aim.” (R)

Retail employees also indicated that there was a lack of consistency in relation to safety, with safety only being an issue for management once a major incident had occurred. As one employee noted:

“When there are no deaths or serious injuries, then safety is not on the agenda. Once this happens, then suddenly safety is on the agenda. There is no consistency.” (R)

In the manufacturing organisation, employees considered management reactions to safety incidents as unnecessarily negative and exaggerated. These reactions sometimes led to blanket rules being implemented that were impractical and regarded as a form of reproach rather than an attempt to solve the issue at hand:

“It happens here time and time again, management react to accidents by punishing the whole workforce.” (M)


Leading by example

This theme was of particular relevance to the retail organisation. Employees remarked that managers needed to be proactive and to lead by example when encouraging staff to consider safety as an important workplace issue. For example, it was stated that managers should:

“Practice what they preach and follow up on safety matters.” (R)

Commitment to safety programs, safety resources and hazard elimination

Employees in both the retail and manufacturing organisations appeared sceptical about management’s commitment to safety. Participants seemed to believe that, in many instances, cost determined the outcome of safety issues:

“It seems that when it gets to a certain dollar figure, then suddenly it’s not so important because the problem is too expensive to fix.” (R)

“About five years ago, we identified five areas where accidents continually happen but management have told us that there’s no money to spend to fix the problem.” (M)

Employees from the retail organisation also expressed frustration about identified risks and hazards not being acted on by management. For instance:

“Sometimes we have to reflect on whether safety is really one of the four pillars of the organisation because sometimes you identify safety issues and pass them on to your line manager but they don’t do anything about it.” (R)

Employees from the manufacturing organisation also acknowledged that safety-related information was not always understood:

“The lost-time injury (LTI) days are standardised and it’s difficult for the employees to understand. The guys on the floor would like to know what the actual LTI days are.” (M)

Communication

Communicating safety information

In the retail organisation, some employees remarked that injuries might be prevented if there were better processes in place for communicating safety-related information. As one employee noted:

“Often one person knows about the hazard and will inform a local group around them so they know to avoid the hazard. But they do not communicate the hazard further than that and then someone from outside the local group gets injured.” (R)

In the manufacturing organisation, employees also acknowledged that safety-related information was being communicated. However, as some employees pointed out, the nature of the information being communicated was not always understood:

“We’re doing the incident report, risk assessment and follow up, so it seems logical that we should be involved in the claim. We see the outcome of the claim, but it’s always after the event.” (R)

Communicating with others

Communicating with others held particular meaning for the retail organisation. Employees seemed to think that internal communication processes between departments and/or stores could be improved, leading to better outcomes for the organisation as a whole:

“We can see from the shop floor that management are big on things like this safety program for a few months, but then they lose interest.” (M)
"We need reinforcement of safety. Usually after these type of sessions, it’s an issue for a short while and then we forget about it." (R)

Employees from the manufacturing organisation remarked that positive reinforcement of desired safety behaviour should be extended to contractors:

“I don’t think there is enough positive feedback regarding safety and PPE use in the workplace. For example, at shutdown, the contractors used PPE, but no one commented on this. They only focused on the negative, what was not done.” (M)

**Individual responsibility**

**Attitudes to safety**

In the retail organisation, there appeared to be a realisation that employees working in head office departments can have an impact on safety matters. Some head office retail employees acknowledged that they had not traditionally seen safety as an issue for them, but that it was more of a concern at the store level, for example:

“We do not actually see ourselves as part of the safety chain, yet we can have an impact on safety in terms of the products we buy, how they’re packaged, their weight and so forth.” (R)

Attitudes to safety in the manufacturing organisation appeared to contemplate the difference in attitudes between contractors and permanent employees, as is evident in the following comment:

“I was originally a contractor, now I’m a permanent. I think my safety is better as a permanent because as a contractor you can work five to six nights in a row, so you become tired. I also think contractors can be more complacent about safety.” (M)

**Priority of safety**

**Existing culture or behaviour**

In both organisations, employees acknowledged that the existing culture of “doing everything quickly” sometimes contravened safety policies and procedures:

“It’s a matter of trying to change the culture. It’s always been ‘do this quickly’. Now we need to communicate the change, that is, ‘Do this safely and follow the correct procedures’.” (R)

“I think it’s part of our culture where the idea is to get the job done quickly, but not necessarily following the housekeeping rules.” (M)

**Management pressures**

Management pressures were particularly relevant to the manufacturing organisation. Employees indicated that safety was at times compromised because of management pressures to meet production deadlines, as one participant observed:

“The job on the filter boxes takes a long time but we’re constantly questioned by management about why we’re taking so long when they’ve got 300 items to go out and they’re behind on their production deadlines.” (M)
Employee welfare

Concern for employees

In the retail organisation in particular, employees expressed concern about the number of people being injured in the workplace. These participants seemed to think that as a “low-risk” industry, their injury rates were too high and needed to be reduced:

“I don’t think it matters whether we compare with other industries or not, what matters is that we do not injure our people. The idea is to reduce our injuries. As a retailer, we have higher injury stats than some very heavy and risky industries and it’s ridiculous.” (R)

Managing injured employees

There appeared to be a feeling among employees from both organisations that, when an injury occurred, attention was focused on the injury process and the subsequent effect on the organisation, rather than taking an interest in the injured person. For example:

“We tend to ostracise people who are injured. We seem to be more concerned with the injury process than with the person who has injured themselves because we’re busy, short of resources, etc. We should show more concern.” (R)

“You get dragged from the hospital to the medical centre for a few hours, then management say, ‘He’s here now, you can take him home’. This results in no lost time for the company. Are they looking after work or are they worried about the injured person?” (M)

Employees from the retail organisation remarked that it was important for injured staff to know that the organisation cared about them and would endeavour to accommodate them in the workplace:

“After an injury occurs, some employees feel uncertain about what happens next and about returning to work and the return-to-work process. We need to reassure employees about other duties that can be done and what the process involves.” (R)

Safety policies and procedures

Incident reporting

Some employees from the retail organisation were of the opinion that, if they encouraged staff to report safety incidents, including “near-miss” incidents, this would have a negative impact on the organisation’s safety statistics:

“Is it possible that, in the short term, our injury stats may actually rise because of more exposure to safety issues? Because some people may not have reported injuries in the past but now, because they’re more aware of the processes, they will.” (R)

Employees from the manufacturing organisation, on the other hand, acknowledged that incident reporting was a proactive measure in preventing injuries. For example, one employee gave an account of a near-miss incident in which he was involved. When the employee said that he did not complete an incident form, other employees responded with:

“Why? Now no one knows about the risk.” (M)

Awareness of policies and procedures

Employees from the retail organisation especially wanted reassurance that the new policies and procedures being implemented would be explicit to ensure that correct procedures were carried out:

“When an incident occurs, you may not be thinking clearly, therefore it would be helpful to have a flowchart to follow to ensure everything is actioned correctly.” (R)

Employee behaviour

Taking risks or shortcuts

In both the retail and manufacturing organisations, employees conceded that human behaviour was unpredictable. At times, staff took risks and shortcuts that compromised their safety or the safety of others. For instance, it was remarked that:

“The ‘tag it out of service’ procedure I think is dangerous because people will look at it and
decide that it looks OK and will ignore the tag and use the piece of equipment. You’re dealing with people and they sometimes ignore the rules.” (R)

“I’ve seen this happen on our shift, especially when the end of shift is near. We take off the pit covers, but don’t get the barricades because it would take another half hour to get them. So we just work without them. We’re rushing and trying to get finished so we can go home but really we’re not working safely.” (M)

**Impact of behaviour on others**

The impact of behaviour on others held particular relevance for the manufacturing organisation. Employees observed that injuries could be reduced if everyone took more care in following basic housekeeping rules:

“We’ve had heaps of injuries because of housekeeping issues, for example, guys stepping onto spacers when getting off the forklift trucks.” (M)

**Use of PPE**

In the retail organisation, there seemed to be a feeling that inappropriate use of PPE led to injuries. It was maintained that these injuries could be prevented if people used equipment that was suitable to the task:

“There is inappropriate use of equipment, for example, knives for cutting instead of scissors.” (R)

Employees from the manufacturing organisation remarked that there was not a problem with PPE use among permanent staff. However, it was felt that contractors sometimes breached PPE regulations:

“Contractors can be a problem regarding safety here because different companies have different rules regarding safety. For example, they do not have to wear safety glasses in one organisation, and then they think they do not have to wear safety glasses here either.” (M)

**Integrity**

**Reporting incidents honestly**

Employees from both the retail and manufacturing organisations seemed to believe that LTI data were not always reported honestly. There appeared to be a feeling that management misrepresented the numbers in order to show the particular workplace in a positive manner with regard to injuries:

“The LTI data is corrupt. We’re still looking at ours and trying to work out what it really is.” (R)

“A lot of lost work days are not recorded, they are fudged. Management juggle the books to make us look good.” (M)

In the retail organisation, questions were raised about employee integrity with regard to time off work for injuries. Some implied that employees sometimes took advantage of the situation, having more time off than was actually required:

“What about injuries that occurred five to seven years ago? All our lost time now is from these very old injuries and every now and then the person takes three to five days off as a result of these old injuries. I have one employee who has an injury that is 16 years old.” (R)

**Blame**

**Emphasis on individual fault rather than system fault**

In both organisations, employees referred to the existence of a blame culture — particularly in relation to safety incidents, with individuals usually being blamed for these incidents. The following comments represent employee perceptions:

“Our investigation procedures need work. We’re really good at blaming others.” (R)

“The company wanted to implement a new procedure and we identified the reasons why this procedure could be dangerous in certain situations. Yet they still implemented the procedure because really the new procedure was about being able to blame someone when something happens.” (M)
Discussion

Although the data represent a perspective on safety that is limited by the size and composition of the samples, the categories and themes identified provide some insight into the safety culture of these two organisations, with both similarities and differences being evident. Employees from both organisations mentioned management issues in relation to safety, discussed the impact of employee risk-taking behaviour on safety, made reference to a blame culture, and raised integrity issues regarding safety. For participants from the manufacturing organisation, a number of themes focused on contractor issues, while in the retail organisation, several themes highlighted differences in safety attitudes between head office and store-level employees.

The emerging themes in the present study, found to be similarly important for participants from both organisations, are consistent with underlying dimensions typically used to assess safety climate. Specifically, two of the three themes identified by Flin et al and Guldenmund as frequently measured safety climate dimensions emerged as important issues for participants from the two organisations, namely, management and risk.7 These findings provide further support for the primacy of these dimensions in safety culture/climate research.

Participants from both organisations seemed to have a negative view of how safety was being managed. They remarked that managers did not regularly visit employees at “ground level” and therefore lacked understanding of the hazards and risks faced by employees in their normal working environment. They also appeared to be sceptical about management’s commitment to safety. In particular, participants mentioned that managers displayed inconsistent support for safety. They believed that safety was not always a priority and instead depended on cost, the nature of safety incidents, and how recently these incidents had occurred. Some employees expressed the view that managers favoured money and processes over people. This negative view held by employees towards managers and safety management in these two organisations may stem from a lack of understanding about the safety management process.

Negative perceptions regarding safety management could also indicate a poor safety culture in these organisations. It has been found that, when perceived safety culture is poor, there is a significant difference in managers’ and employees’ perceptions of safety.20 In particular, it was found that managers and employees each believed that the other group was responsible for safety, and the two groups disagreed about the extent to which employees engaged in safe work behaviour. As safety culture improved, perceptions of managers and employees in relation to safety seemed to converge. In the present study, finger-pointing and blame attribution between managers and employees appeared to be a consequence of a poor safety culture. Participants appeared to engage in some level of finger-pointing at senior managers, criticising how safety was managed and possibly indicating a poor safety culture in both organisations.

Participants from both organisations acknowledged that, at times, employee behaviour compromised safety. Essentially, this related to a tendency for employees to take shortcuts during work processes or to ignore certain safety policies and/or procedures. Participants seemed to suggest that the reason for this risk-taking behaviour was because of the existing culture to “do everything quickly”, or because of management pressures to meet work demands.

An alternative explanation is that employee risk-taking behaviour could indicate an underlying optimistic bias, that is, a tendency for individuals to underestimate their degree of personal risk associated with future life events compared with others.21 There is evidence that the optimistic bias phenomenon can increase risk-taking behaviour when driving, and that optimistic bias may be a factor in risk-taking behaviour at work.15,22,23 However, no current research links occupational injury risk with optimistic bias. The extent to which optimistic bias might influence workplace risk-taking behaviour merits further investigation.

Participants from both organisations also alluded to the existence of a blame culture in relation to safety incidents. Several participants mentioned a tendency to blame others, while some expressed apprehension
about being blamed. A blame culture could indicate a poor working relationship among employees or between employees and management, possibly leading to suspicion and mistrust in these organisations. It might also mean that, in the past, safety investigations have focused on finding someone to blame, leaving employees unconvinced about the authenticity of these processes. A blame culture can result in a range of negative consequences for an organisation, including: unwillingness to report safety incidents and near misses for fear of retribution; deteriorating relationships between management and employees; a non-productive working environment; and erosion of trust. 20,24-27

Participants from both organisations raised the issue of integrity in relation to safety statistics. Employees seemed to think that LTI data were not being reported accurately and honestly, with the organisations representing a more positive view of injury statistics than was realistic. This disbelief of injury statistics may reflect a lack of understanding by participants about safety statistics in general. It may also suggest a lack of communication between senior management and employees in relation to injury statistics. Questions and comments by participants from the retail organisation seemed to indicate that many did not know how LTI days were calculated. A comment from a manufacturing organisation participant about LTI days being standardised and workers wanting to know what the “actual” days were suggests a lack of understanding or poor communication.

In the manufacturing organisation, contractor issues appeared to be a recurring subject in relation to various categories and themes. Participants made frequent reference to contractors’ safety attitudes and behaviour, implying that contractors were less committed to safety than permanent employees. This perception about contractors’ safety attitudes and behaviour may indicate an in-group-out-group bias, with employees displaying in-group favouritism towards themselves (“We’re committed to safety”) and an out-group bias towards contractors (“They’re not as committed as we are”). Repeated reference to contractors’ alleged inferior safety attitudes and behaviour on the part of employees could also be indicative of a blame culture or scapegoating. Blame and scapegoating are defence mechanisms that individuals may use to redirect accountability and responsibility away from themselves. 26,28 In this instance, to protect themselves from possible blame regarding safety incidents, employees might use contractors as a scapegoat when safety procedures have not been followed.

In the retail organisation, a common topic in relation to the various categories and themes was to compare perceptions of safety at store-level and perceptions of safety in head office departments. Employees commented on the difference in safety attitudes between people undertaking administrative and managerial work in head office departments and those involved in goods handling in stores. There was general agreement that head office employees seemed more complacent about safety. Some participants even suggested that head office employees did not consider themselves to be part of the safety network. The perceived difference in safety attitudes between head office employees and those working in stores may indicate a mutual lack of awareness about the others’ working environment. This in turn may be associated with a general communication problem in the retail organisation, whereby employees from one site or department may lack opportunities to interact and discuss safety issues with employees from other sites or departments.

The two organisations participating in this study can be considered to be very different in terms of level of workplace risk. The nature of the work environment in the manufacturing organisation meant that employees were generally at higher risk of injury than employees in the retail organisation, although some divisions of the retail organisation could be considered as a higher risk, for example, the logistics department. Despite these differences in terms of workplace risk, it was evident from the data that employees in both organisations thought and talked about safety in similar ways, resulting in comparable categories and themes to describe the safety culture of their respective organisations.
Differences that were apparent between participants from these organisations seemed to be related to distinct characteristics of each organisation, rather than differences in employee attitudes to safety or perceptions of safety across the two organisations.

This study has both strengths and limitations. The unobtrusive observational methodology used to collect data meant that the researcher had no direct influence over the type of safety issues discussed or how employees spoke about these issues. However, employees from both organisations appeared to perceive safety issues in similar ways. The presence of a researcher who recorded conversations using note taking could have cued participants’ comments. However, while participants were aware that a researcher was recording conversations about safety, these conversations were driven by the context of the safety training sessions and discussions arising from facilitator and/or trainee questions, and not by researcher input. While video- or tape-recording the training sessions may have produced more accurate transcripts of the safety conversations, these tools might have been perceived as more intrusive and had a greater impact on the naturalistic interactions.

References


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