A Zero Incident Safety Culture is No Accident

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Introduction

Are zero incident safety cultures possible, or are they figments of our imagination like Sasquatch, mermaids and unicorns? Some safety experts believe the idea of a zero incident culture is so unrealistic that pursuing such a strategy actually does more harm than good, namely by demoralizing employees and eroding management credibility (Behavioral-safety 1993).

Other safety experts say that any safety goal *other than* zero incidents gives the impression that management is not serious about employee safety and signals a lack of leadership. These safety experts point to examples of companies achieving and sustaining zero incidents as proof the goal is realistic and doable (US Army Corps of Engineers 2002).

How does OSHA weigh in? It can be argued that OSHA's Injury and Illness Prevention Programs (I2P2) initiative is proof of the agency's support of a systematic and proactive approach to eliminating workplace hazards, not unlike a zero incident approach. To that end, OSHA recently issued a white paper on I2P2 that serves as a good starting point for anyone considering such a method.

The debate over zero incident cultures is not a new one, and today, the global debate continues, online in LinkedIn safety groups, on safety blogs, at conferences, and perhaps most importantly, in the offices of safety managers around the world. As with most difficult topics, there is likely no singular "right" answer, which is why the aim of this discussion is not to persuade the reader to join one side of the argument over the other.

Instead, this discussion will focus on providing a tangible blueprint for adopting I2P2 (with a nod to the zero incident approach). It is done with the understanding that each reader will decide for themselves the best application of the ideas presented. Even if you do not agree with a zero incident approach, you will likely concede that many of the ideas inherent in OSHA's I2P2 and the zero incident approach are beneficial to every workplace looking to improve employee safety, reduce costs and gain efficiencies.

Additionally, because part of creating and maintaining a safe workplace includes staying current on regulatory issues, discussing I2P2 is beneficial from an OSHA compliance perspective. To that same end, time will also be given to related OSHA initiatives like electronic submissions of injury and illness data, whistleblowing and GHS.

I2P2

At the beginning of 2011, OSHA Director Dr. David Michaels called the creation of an I2P2 standard a top regulatory priority (OSHA Chat 2011). However, as the year progressed, anti-regulatory sentiments in Washington, budget restrictions and concerns about the effect a standard would have on small businesses led OSHA to scale back its I2P2 ambitions (ISHN 2011).

Today, Dr. Michaels continues to call it a priority and many OSHA observers believe a standard is inevitable (DOL 2013). Independent of its regulatory rollercoaster ride, I2P2 warrants investigation based upon OSHA's investment in it and the strong support it has received from many corners of the safety community, including respected organizations like the AIHA (AIHA 2011).

OSHA defines an Injury and Illness Prevention Program as a "proactive process to help employers find and fix workplace hazards before workers are hurt." It is commonly referred to as the "find and fix" approach (OSHA White Paper).

The ideas behind I2P2 are not new, and OSHA acknowledges that its proposal draws from a number of existing Occupational Health and Safety Management Systems (OHSMS) such as: Voluntary Protection Program (VPP), the Safety and Health Achievement Recognition Program (SHARP), ANSI/AIHA Z10 — Occupational Safety and Health Management Systems, the Occupational Health and Safety Assessment Series (OHSAS) 18001, California's I2P2, and OSHA's 1989 Safety and Health Program Management Guidelines.

(Note: Many of the programs listed above, employ the "Plan-Do-Check-Act" (PDCA) approach which will be discussed in greater detail later.)

OSHA identifies six keys to an effective I2P2 implementation:

- 1. Management Leadership
- 2. Worker Participation
- 3. Hazard Identification and Assessment
- 4. Hazard Prevention and Control
- 5. Education and Training
- 6. Program Evaluation and Improvement

These keys are very similar to the four components of OSHA's 1989 Safety and Health guidelines:

- 1. Management Commitment and Employee Involvement
- 2. Worksite Analysis
- 3. Hazard Prevention and Control
- 4. Safety and Health Training

The main differences between the 1989 list and the current list are that the I2P2 list breaks out management participation and worker involvement under their own headings and adds a separate heading for program evaluation and improvement.

Following, is a breakdown of each component.

Management Leadership

The Holy Grail of zero incident cultures and of every health and safety management system is management leadership. It is the most important element and often the hardest to secure. Too

frequently, the responsibility for the safety culture is delegated to lower level supervisors and employees who have neither the clout nor the resources to be successful.

To be blunt, employees know if safety is important to the company leadership. If it is, then it will be important to them as well. If it is not, then it does not matter what is said, how many posters are put up, or how much training is done, there will be a trust gap on safety. OSHA says "Management leadership provides the motivating force and the resources for organizing and controlling activities within an organization" (OSHA 2007).

Safety professionals know better than anyone how important top-down support is for safety initiatives, making the above another example of preaching to the choir. The real questions that need answering are the following: how do you get leadership buy-in and what does effective leadership participation look like.

The answer to the first question, "how do you get leadership buy-in" is by any means necessary. Here are three steps that can help:

- 1. **Identify leadership's current position on safety.** To get leadership buy in you must first get leadership's attention, which is to say, you must provide a compelling argument for a greater focus on, and involvement in, safety. To do that, you have to figure out where leadership stands on the issue of safety today. It is possible that leadership thinks the organization's safety culture is fine as is. It may believe safety is outside of its expertise and that there is little it can do. It may believe the benefits of improving safety beyond current practices come at too great a cost. Knowing where leadership stands on safety today, provides direction for the next steps.
- 2. **Identify allies on the leadership team.** The above paragraphs talk of "leadership" as a homogenous unit, when in reality, leadership at most companies is made up of individuals with unique perspectives and talents. The trick at the onset is to find an ally at the top of the corporate ladder and to start building a bridge there. You may not find an ally, but at the very least, look for someone who will give you a fair hearing and try to get as high up the executive ladder as you can reach— to someone with influence. Making your case for safety will be easier if you are not the only one making it.
- 3. **Craft an argument to get leadership's attention.** Once you know how leadership thinks about safety, you can begin to craft an argument for why safety deserves its attention. As you do this, think about your audience. Most executives like concrete facts and figures, especially those that show improvements to the bottom line. Luckily, in today's digital age, it is easier than it has ever been to access data showing the financial benefits of safety. Numerous studies and reports outline how safety improves operations, employee well being and profit. Style wise, as you make the argument, take into account human nature. People are more likely to support ideas they believe are their own. In other words, the more you can help executives arrive at the right decision by presenting the "facts", the more likely they will be to go to bat for the ideas. Similarly, do not be afraid to play up to their sense of importance when it comes to safety, which in this case happens to be *the truth*.

The answer to the second question, "what does effective leadership participation look like", will be different for each organization. In general, leadership participation must go beyond *calling* for a safe workplace; it must actively help shape safety policies and goals (AIHA 2011). This does not mean that leadership must provide policies and goals in a vacuum. Including employees from all levels of the company and every department in the creation of the policies and

goals can go a long way toward getting buy-in companywide. Collaboration between leadership and employees at every level also provides the all-important leadership visibility that forms the foundation of the safety program.

A great outcome from leadership and employee participation in the setting of policies and goals would be a written plan — a tangible document that outlines roles and responsibilities for everyone in the company and the specific actions to be taken to achieve the stated goals (AIHA 2011). Someone once said, "In your head it's a dream. On paper it's a plan." As you take actions, these should also be recorded and preserved. Such records can go a long way in demonstrating a "good faith" effort, which OSHA can take into consideration if it ever audits or takes action against your company (OSHA 2010).

Worker Participation

Creating a safe work environment is a cultural phenomenon that requires the participation of leadership, safety professionals and workers. Yet ultimately, it is the workers who will have the final say by choosing to do things safely at any given moment. Bringing employees into the safety conversation early and giving them a strong voice can help bring about the best results, since they undoubtedly have the best understanding of what is happening on the work floor and where improvements can be made (OSHA Fact Sheet 2005).

Their participation can also help turn them into safety advocates. Too often, safety professionals carry out their tasks with little support from above or below. The more safety professionals can engage and rely on workers and leadership to manage safety issues, the easier their jobs become, and theoretically, the more time they will have to focus on proactive safety measures, rather then reactive ones.

Hazard Identification and Assessment

What is a hazard? According to OSHA, a hazard has "the potential for harm. In practical terms, a hazard often is associated with a condition or activity that, if left uncontrolled, can result in an injury or illness" (OSHA 2002).

At the heart of I2P2 and zero incident cultures is the finding and fixing of hazards — hazard identification and assessment deals with the "finding". It is this piece that most confounds opponents of I2P2 who say it is redundant (FDRsafety 2011). For instance, employers are currently bound by OSHA's General Duty Clause of the 1970 OSH Act (29 USC 654) to provide work environments "free from recognized hazards that are causing or are likely to cause death or serious physical harm" to employees.

Some point to this standard and say everything I2P2 would purport to achieve is already outlined in that general responsibility. Furthermore, they point out that I2P2 could result in employers being cited and fined twice for the same infraction, which would amount to double jeopardy.

OSHA and others might argue that the General Duty Clause is too vague and does not go far enough into delineating employers' responsibilities to actively seek out potential hazards. They would likely also argue that the process needs to be more systematic. To that end, OSHA and others provide numerous resources, checklists, etc., that can help get the process started. According to OSHA's Voluntary Safety and Health Program Management Guidelines and OSHA's Handbook for Small Businesses, steps to finding hazards include:

- 1. Assessing existing workplace conditions
 - a. Surveying employees on worksite safety and health
 - b. Analyzing worksite for hazards (via self-inspection and/or third party), including hazards associated with processes. Areas to look at include (but are not limited to):
 - i. Processing, Receiving, Shipping and Storage
 - ii. Building and Grounds Conditions
 - iii. Housekeeping Program
 - iv. Electricity
 - v. Lighting
 - vi. Heating and Ventilation
 - vii. Machinery
 - viii. Personnel
 - ix. Hand and Power Tools
 - x. Chemicals
 - xi. Fire Prevention
 - xii. Maintenance
 - xiii. PPE
 - xiv. Transportation
 - xv. First-Aid Program/Supplies
 - xvi. Evacuation Plan
- 2. Tracking of near misses, along with accidents and injury and illness trends
- 3. Setting up a reliable system that encourages employees to notify management about hazardous conditions as they arise without fear of reprisal
- 4. Repeating these steps with regularity to ensure new hazards are identified along with preexisting hazards that may have been overlooked

An electronic management system can help simplify all of the above steps, especially the collection, processing and reporting of hazard information. Item 3 from above, is especially important given OSHA's recent emphasis on whistleblowing, which will be discussed later in this article. For now, employers should consider that employees without an effective outlet for sharing concerns within the company may seek to redress issues outside the company.

In addition to utilizing OSHA's Voluntary Safety and Health Program Management Guidelines and OSHA's Handbook for Small Businesses, the actual OSHA standards themselves may shine light on some of your workplace hazards. The following are examples of common standards employers may need to comply with as identified on OSHA's Safety and Health Management Systems eTool:

- Respiratory Protection, 29 CFR 1910.134
- Lockout/Tagout, 29 CFR 1910.147
- Confined Space Entry, 29 CFR 1910.146
- Hazard Communication, 29 CFR 1910.1200
- Blood borne Pathogens, 29 CFR 1910.1030
- Hearing Conservation, 29 CFR 1910.95
- Laboratory Chemical Hygiene, 29 CFR 1910.1450

Hazard Prevention and Control

The second half of the "Find and Fix" approach is of course fixing the hazards. AIHA strongly recommends using the "hierarchy of controls" model (AIHA 2011). Under the hierarchy of controls model, hazards are addressed in the safest way possible, with order of preference being (CDC 2011) the following:

- Elimination
- Substitution
- Engineering Controls
- Administrative Controls
- Personal Protective Equipment (PPE)

In other words, the best method for controlling a hazard is to eliminate the hazard all together. For instance, maybe there are chemicals in your facility that are no longer needed or in use, which could then be disposed of. If a hazard cannot be eliminated, then the next step is to see if a substitution can be made. Again, in the example of chemicals in the workplace, could a dangerous chemical be replaced with a less hazardous alternative? If not, the next control to try is the engineering control. Engineering controls are actions that remove or place a barrier between the worker and the hazard and that require little effort from the worker. When engineering controls are not possible, the next option to evaluate involves administrative controls, which contrary to the previous option rely on worker behavior to mitigate hazards. Administrative controls can include actions like reducing employee exposure by limiting the amount of time spent in exposure-risk areas. Finally, the last resort and often least effective control is providing employees with PPE.

Other steps that can be effective in preventing and controlling hazards include: setting up safe work procedures, especially when changing an existing process or adding a new one; keeping up with routine/scheduled maintenance and emergency planning; and getting the appropriate contingencies in place in case of a medical emergency (OSHA Small Business 2005).

Hazard prevention and control is also the cornerstone of a zero incident culture — companies pursuing a zero incident approach know that it is not enough to track injuries and illnesses or even to track near misses. The idea is to identify hazardous situations and processes and then fix them before they even make it to the near miss stage.

Yet, we should not jump over near misses so quickly. Recording near misses and treating them as seriously as you take injuries and illnesses is one of the most powerful paradigm shifts a company can make in preventing accidents. For that reason, good electronic incident management solutions provide tracking and reporting on near misses that is as robust as OSHA Recordkeeping tracking and reporting.

Another great tool, and the one that is at the center of OHSAS 18001, the international OHS system that is widely considered the best safety management system, is the Plan, Do, Check, Act (PDCA) model. PDCA (also known as the Deming or Shewhart cycle after the two most well known proponents of the model) is an approach to identifying and fixing hazards in a systematic and continuous manner — a routine that never ends, thus bringing about continuous improvement in the workplace (PKPINC.com 2009). It is a more scientific approach in which problems are identified, actions are planned and enacted on a small scale, results are evaluated, and a corrective action is taken.

Anyone familiar with Six Sigma principles will recognize the similarities between PDCA and DMAIC. In Six Sigma, DMAIC stands for define, measure, analyze, improve and control. It is one of the processes at the heart of achieving Six Sigma quality. GE, known for its use of Six Sigma, says, "To achieve Six Sigma quality, a process must produce no more than 3.4 defects per million opportunities. An "opportunity" is defined as a chance for nonconformance, or not meeting the required specifications. This means we need to be nearly flawless in executing our key processes."

In today's push towards lean manufacturing and quality improvement, many companies have applied Six Sigma techniques to operations and other critical areas of business because it "actively links people, processes, and outcomes in a rigorous, adaptable way to get results" (Briefcasebooks.com 2002) which is also why many safety professionals advocate taking a Six Sigma approach to safety (EHSToday 2007).

Of course, from a Zero Incident perspective, 3.4 defects per million opportunities would not be an acceptable goal. In turn, challengers to the Zero Incident approach would say an understanding of Six Sigma principles just shows the fallacy of making zero incidents a goal. Either way, you don't have to adopt Six Sigma wholesale to benefit from the approach which tries to drive errors or defects out of an organization or its processes. When it comes to Six Sigma, some people get intimidated by the terminology and rigor; the best advice is not to let the fears of doing it imperfectly prevent you from doing something.

Education and Training

A primary driver of safety and certainly, a key focus for OSHA, is worker training. Look up the top ten most frequently cited OSHA standards and you'll find that issues related to employee training are behind a significant number of the citations.

Unfortunately, many employers fail to make their training comprehensive and engaging. For proof, just check out Twitter hashtag OSHA (#OSHA) or hashtag Safety (#Safety) on any given workday and you'll see a stream of Tweets from employees venting their frustration at safety training that they find ineffectual and a waste of time. OSHA training is often a frequent target in tweets like this one:

@sillly_willy22. (2012, March 1) "An 8 hour OSHA lecture I'd rather change Betty Whites diaper"

To combat the antipathy, especially in this age of short attention spans and multimedia, safety trainers must be conscious of their audience's preferred learning style and take steps to make training relevant not only in content, but delivery.

Best practices for worker education and training include:

- Ensuring workers are aware of all of the known hazards to which they will be exposed and that they are never expected to do a job before they have been properly trained on it, or if it appears unsafe
- Combining health and safety training with overall job performance and practices (OSHA 2007)
- Making the training specific to the work environment and the actual hazards and conditions present in the workplace
- Utilizing blended training that incorporates presentations with hands on exercises, online learning, and evaluations and feedback
- Recognizing and adjusting for multiple learning styles

- Addressing trainees in a language they understand and accounting for any learning barriers, like illiteracy
- Including new hires, contract workers, employees who wear personal protective equipment and workers in high risk areas (OSHA 2007) as well as employees moving to new areas of responsibility (OSHA Small Business 2005)

I2P2, or a zero incident perspective, adds another emphasis to worker training. It demands an understanding that employees are also responsible for their own safety and as a condition of their employment. They are to be proactive in identifying potential problems and in taking action prior to beginning dangerous tasks. Under I2P2 or zero incident cultures, it is understood that the employees' role in safety is equal that of the safety professional and company leadership.

Program Evaluation and Improvement

One element that differentiates OSHA's I2P2 from other attempts by the agency to enact a proactive approach to health and safety is the emphasis on program evaluation and improvement. The addition recognizes that it is not enough to make bold plans and take strong actions, a period of reflection and adjustment is also an important element to creating safe workplaces. The Plan, Do, Check, Act model in I2P2 occurs at both the micro and the macro level.

Similarly, a zero incident safety culture is not a one and done scenario; it is about affecting a self-renewing safety culture that consistently delivers safe workplace outcomes. To that end, the emphasis is on culture — the enduring attributes of the collective actions and thought processes of the workplace community. Get the culture right and safety becomes a meaningful byproduct. However, by the same light, get the culture wrong and safety becomes a much harder target to hit.

So what is the best way to evaluate? Two things come immediately to mind, data and employee feedback. For the former, companies using an electronic system will find reviewing data and doing trend analysis is a relatively simple task. The most difficult part is using the evaluations to make improvements. AIHA recommends making management review a requirement (AIHA 2011).

I2P2 Adoption: The Case For

The struggle OSHA is having trying to get I2P2 up and running has already been discussed. What has not been discussed, however, is how widespread the approach already is in the United States and abroad. Domestically, OSHA may be struggling on the federal level, but according to OSHA's White Paper on I2P2, 15 states already have mandatory regulations for employers around illness and injury prevention programs. Those states include: California, Colorado, Michigan, Minnesota, North Carolina, New Hampshire, Nevada and New York.

Another 19 states have laws or regulations that encourage participation in the same. Additionally, some 3,900 companies reportedly participate in OSHA's Voluntary Protection Program (VPP) and Safety and Health Achievement Recognition Program (SHARP). Internationally, OSHA points to Australia, the European Union, Norway, Hong Kong, Japan and Korea as examples of countries that have taken a hard line on illness and injury prevention programs.

OSHA's White Paper also provides persuasive numbers justifying an injury and illness prevention program. First, it notes the number of workplace deaths and injuries each year, 4,500 and 4.1 million respectively. Then it cites studies that suggest an additional 60,000 workers die each year from occupational illnesses, with one such study saying between 10,000 to 20,000

workers die from cancer due to occupational exposure and another 5,000 to 24,000 die from Chronic Obstructive Pulmonary Disease.

Understanding the business case that needs to be made, which is not dissimilar to the business case this paper encourages safety managers to make to their leadership, OSHA pointed to several studies on the costs of injuries and illnesses in the workplace, saying workers comp benefits paid in the United States annually are in the \$53-\$60 billion range. This does not include the indirect costs associated with accidents, which include lost productivity and repair costs.

Regarding the effectiveness of I2P2 type programs to move the needle on reducing injuries, OSHA cites numerous studies that show states with mandatory prevention programs saw reductions in injuries and illnesses between 9 percent and 60 percent. OSHA's own estimates are that I2P2 programs will reduce injuries between 15 percent and 35 percent (OSHA White Paper 2012).

Supporting OSHA's claims about the benefits of safety initiatives, a 2001 Liberty Mutual Executive Survey of Workplace Safety survey found returns on investment (ROI) for safety to be over 3 to 1. In other words, every dollar spent on safety netted three dollars in return. In a more recent survey, details of which were published in ASSE's April 2009 *Professional Safety* magazine found the expected return was closer to 2 to 1. Nevertheless, both surveys demonstrate what safety professionals have known for some time — that safety in the long run is an investment, not an expense.

Getting I2P2 or a Zero Incident Culture Up and Running

As mentioned earlier, there are a number of mature systems that have been developed to assist companies in the implementation of an injury and illness prevention program. Some systems — like the ANSI/AIHA Z10 or OHSAS 18001 — provide granular level plans for bringing a facility into compliance.

And increasingly, achieving OHSAS 18001 certification is an "order qualifier" necessary even to compete in the international marketplace for some industries (Judy Mieding 2010).

Still, not every company will need such a robust system. For many, simply following the guidelines provided here and using the resources available on Websites for OSHA, NIOSH and CDC will suffice. Regardless of how a company chooses to implement a prevention program, an important item to consider is role technology will play. As was discussed, tracking, analyzing and reporting data is an important element in I2P2 methodology.

These days a good electronic solution can serve as the informational hub, bringing together the various stakeholders of an I2P2 implementation, allowing them to submit information that administrators can access and leverage via real-time analytics to identify hazardous trends and proactively implement corrective actions that can ultimately prevent accidents. Such systems can help jumpstart an alignment with I2P2. They can also be used to help manage OSHA Recordkeeping compliance.

OSHA's Recordkeeping Standard (29 CFR 1904) requires businesses and organizations that are not partially exempt from the standard to track and report injuries and illnesses. Recording is currently done via three forms, Form 300, 300A, and 301. Form 300A is then required to be posted between Feb. 1 and April 30 in a location where all employees can see it. The standard also requires all employers to report any death or the hospitalization of three or more employees from a single incident.

One of the tricky aspects of trying to comply with OSHA's Recordkeeping Rule is understanding when an injury or illnesses is actually a recordable incident. This is another area where an electronic solution can provide assistance by actually guiding the user through the process of filling out of the form. When the form is completed, it can easily be printed out for submission to OSHA and/or the Bureau of Labor Statistics (BLS) if necessary. Electronic systems should also make the switch to electronic filing easier, which is likely to become increasingly important as the next section demonstrates.

OSHA's Current Regulatory Agenda

Even with the combative environment in Washington slowing the regulatory process for OSHA, there are number of issues related to injuries and illnesses that OSHA continues to press forward on, namely, revisions to HazCom, changes to injury and illness reporting criteria, the modernization of the Injury and Illness Data Collection Process, increased enforcement and improved worker protections for whistleblowing, and cracking down on improper safety incentives.

GHS

OSHA is currently revising the Hazard Communication Standard (HCS) to align with the Globally Harmonized System of Classification and Labelling of Chemicals (GHS). It is likely to be the next standard OSHA will publish in the Federal Register. It has already passed the Office of Management and Budget, which means by the time this article is made available, GHS should be a reality in the United States (OMB 2012).

It is the most significant change to the HCS in years and will have long and lasting effects on employee safety. The three biggest changes GHS brings are to chemical classifications, safety data sheets and safety labels. OSHA's adoption of GHS will necessitate employee training and an updating of all safety data sheets maintained by end users of hazardous chemicals.

Changes to Injury and Illness Recordkeeping

Under the current OSHA Recordkeeping Standard, employers must notify OSHA in the event of any deaths or the hospitalization of three or more employees. OSHA is currently developing a change for the standard that would require employers to report, within eight hours, all work-related fatalities and all work-related in-patient hospitalizations, and within 24 hours, all work-related amputations (OSHA Occupational 2011). Requiring the reporting of all work-related hospitalizations and amputations would represent significant changes that could affect all employers.

Injury and Illness Data Collection Modernization

An important OSHA priority that has received little attention is the agency's move toward electronic collection of injury and illness data. The initiative, called the Modernization of OSHA's Injury and Illness Data Collection Process, was first introduced in 2010, and just this past February, OSHA made it one of its major budgetary items for 2013, requesting \$1.75 million for the project (DOL 2012).

Currently, companies are required to keep records, but are not necessarily required to report information directly to OSHA. An establishment may be asked submit information to OSHA or BLS upon request as part of the annual OSHA Data Initiative (ODI) survey of approximately 80,000 private-sector establishments in selected high-hazard industries, or to take part in the Bureau of Labor Statistics'(BLS) Annual Survey of Occupational Injuries and Illnesses (SOII),

which is sent to a relatively small sample of about 200,000 establishments across the country, or to participate in both surveys (OSHA 2010). In any of these cases, a company may not necessarily be required to report every year. OSHA's modernization efforts would likely change that.

According to the 2013 budget request, OSHA says the "modernization of its injury and illness data collection system will provide the agency with timely, establishment-specific injury and illness data to reduce the amount of resources needed to identify the most hazardous worksites. The new recordkeeping system will also enable employers, employees, employee representatives, government agencies, professional and trade associations, and researchers to get access to better workplace injury and illness data."

In real world terms, it means employers could be responsible for submitting OSHA Recordkeeping information electronically to OSHA on an annual basis. This is an item to keep an eye on as it has significant consequences for every employer covered by the Recordkeeping Standard.

Whistleblowing

Based on the size of the 2013 budget request and recent comments from OSHA Director Dr. David Michaels, a main priority for OSHA is for increased whistleblower protections (DOL Q&A). For 2013, OSHA is requesting over \$20 million for whistleblowing programs, an increase of nearly \$5 million, which is significant given the reductions seen elsewhere. Dr. Michaels maintains the extra resources are needed to deal with the backlog of cases.

OSHA has turned up the heat on whistleblowing in recent years, following a critical report from the Government Office of Accountability (GOA), which found serious flaws in OSHA's handling of whistleblowing cases from 2009 in 2010. In recent months, OSHA has revised guidelines for investigating whistleblowing cases and has made a concerted effort to build awareness and promote its resources for whistleblowers.

Whistleblowing is something every company should take seriously. OSHA makes no secret that many of its inspections (and in some regions, most inspections) are the result of the agency being contacted by someone from a company concerned about unsafe practices. Companies would do well to see such events as failures on their own part to capture and address employee concerns before those concerns are escalated.

It goes back to the workplace culture. Espoused values are not enough, simply telling workers that safety is important and that you want them to share their concerns will not produce results. There must be a process in place that routinely collects those concerns and then addresses them. Employees must see that their employers are truly committed to finding and fixing hazards and turning espoused values into enacted values. An I2P2 approach can help create that culture.

Safety Incentives

In recent years, Dr. Michaels has been speaking out against safety incentive programs that reward low injury and illness rates. He says such programs encourage underreporting. OSHA wants employers to stop rewarding employees for having fewer accidents, and instead, recognize actions employees take to prevent accidents from occurring. It may seem like a minor shift, but it is not. For years, companies have built their rewards programs around injury and illness statistics. It is a metric that is concrete and verifiable. However, OSHA has serious concerns about such programs, because, as Sean Roark describes it in a 2011 *OH&S* article, "The criteria for these rewards often include having a defined period without an accident, and this result-based milestone is an problem for OSHA, because they see any award that is based on an absence of an accident as also containing the implied underlying message to employees that if an accident is reported, they will lose benefits."

What can employers do? Dr. Michaels champions incentive programs that "feature positive reinforcement when workers demonstrate safe work practices, and when workers take active measures such as reporting close calls, abating hazards, and using their stop-work authority to prevent a workplace tragedy" (OSHA Plenary 2010).

Conclusion

There is no denying OSHA has been bloodied in recent years. Looking at its regulatory agenda from a year ago compared to its most recent offerings, it is clear the agency is tightening up its focus and going after the battles it thinks it can win. One of the primary losers in this process is I2P2. Still OSHA continues to aggressively push for its acceptance and adoption in the safety community.

Politics aside, I2P2, as we have seen, can serve as a useful tool around which a company can organize its health and safety program. Similarly, the tenets of a zero incident culture do not need to be dismissed out of hand just because the end goal is thought unattainable by some. Every workplace and workforce is unique, yet the end goals are the same for every employer and every employee — make some money, and make it home alive.

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