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From The Director

Each month ISHM publishes a newsletter full of interesting information about ISHM and EHS management.

If you would like to have an article published please forward to manager@ishm.org. The article cannot be published elsewhere where it was copyrighted. Once we receive your article we will submit it to the submission committee for approval.

Interested in participating in ISHM as a committee member? Please let Larry know at manager@ishm.org.

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These shirts are $32.00 and include shipping (slightly more for extended sizes).

Also we have polo shirts in ladies and men's sizes in either black or white. Again with your certification logo. These shirts are $22.00 and include shipping. (slightly more for extended sizes)

Please allow three weeks for delivery of shirt orders.

As always let us know your thoughts and questions.

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**Dual Accountability**

Many terms and phrases are routinely discussed and debated in the scope of workplace safety. Many hairs have been split as to whether safe conditions lead to worker safety, whether behavior-based safety trumps safe conditions, whether 'behavior-based' or 'commitment-based' or 'total safety' or another catch phrase trumps one another, or other topics. Recently, OSHA administrator David Michaels gave a keynote speech at the National Safety Council annual congress pinpointing employer obligation to provide safe conditions via engineering controls and speaking against behavior-based theories referencing employee choices as to safe work practices. Union stances have done the same. Meanwhile, behavior-based safety theorists have veered towards the examination of employee choices as to safe behavior. Ultimately, though, the desired end state success mode remains the same - safe work practices within a safe working environment.

The healthcare industry has historically yielded higher-than-average injury rates. Culturally, compliance with OSHA, Joint Commission, and other applicable organizations has been the measurement of success in workplace safety. However, if by compliance safety can be expected, another explanation for the increased injury rates is needed. The presence of hazard controls, even multi-faceted along the Hierarchy of Controls, may constitute safe conditions, but doesn't necessarily mean safe behavior will be exhibited. For example, safe patient handling requires the presence of a full program complete with
patient handling equipment to mechanically reduce the amount of weight and stress put upon the at-risk employee and reducing the amount of required force needed to handle a patient but, like a Lock Out Tag Out program, the employee is still the remaining variable in the equation - the employee must actively choose to utilize the hazard control(s). After all, unlike many machine guards, programs such as safe patient handling require active controls, those that employees must choose to use. That said, before this can happen, the controls must be in place, available, accessible, convenient, and all employees in the at-risk group must be trained to utilize them. Only then can safe behavior be expected within the safe conditions. With this, dual accountability allows for the closing of gaps that lead to accidents and injuries.

Within the context of high-reliability safety, all angles must be covered to ensure the safest possible work practices are utilized within the safest possible working conditions every time the process is performed. A hazard analysis and risk assessment must be performed with leadership knowledge of all hazards, hazard controls, and those at risk. Employee input and feedback must be solicited and utilized; Safety Committees are great places for this. Hazard controls must be put into place; this allows for the necessary elimination, substitution, equipment/engineering, processes/administration, and PPE to eliminate or mitigate hazards. Hazard controls all require training to ensure employee knowledge of each hazard control and performance of each task utilizing the controls to standard. This is also the opportunity for the development of safe conditions and regulatory compliance. Information programs allow for constant reinforcement and reminders of safe work practices. Leading Indicators such as observations allow for not only validation of safe behaviors but also opportunities for recognition for program participation and safe behavior and coaching for unsafe behavior as well as tracking of safe conditions through inspections. Lagging Indicators and Accident Investigations provide further opportunities for coaching and further preventative measures. For these program components to work, dual accountability must be in place. Leaders must ensure knowledge of all workplace hazards, implementation of hazard controls, consistent information distribution and communication, development of Leading Indicators leading to validation of safe behaviors and conditions, and oversight of Lagging Indicators and investigations to ensure follow-up to accidents. Without these components in place, program gaps will persist and due diligence to employee safety won't be done. That said, employee engagement is required to ensure communication and sharing of recommendations and best practices. Employees must actively choose to
utilize hazard controls. Employees must utilize the Job Safety Analysis, even if in an informal manner, as a mindset to identify and assess hazards - if a hazard control is not in place, this must be communicated to leadership. Ultimately, leaders must ensure the program is in place but, like any performance measurement, employees also have a part to play. Neither side of the equation can possibly bear the entire weight of the effort.

With dual accountability, leaders and employees each have defined and monumentally important parts to play in workplace safety. Focusing on employer-centric safe conditions or employee-centric safe behaviors alone will never garner proactive accident prevention. Instead, focusing on either side alone will promulgate excuses, blame-games, and fault-finding, all of which oppose proactive safety. With dual accountability, however, leaders and employees each have a part to play, parts that are defined and measureable.

Cory Worden, M.S., CSHM, CSP, CHSP, REM, CESCO

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I have been a CSHM since the mid nineties and now have the privilege of serving on the Board of Directors for ISHM. Over the years I have certainly understood the value of being a Manager in Safety, although technical expertise is critical. We have had several testimonials of why it is so important in acquiring management skills in our profession. I would like to share a story in how I realized how critical those skills are.

Several years ago, I became connected with some very gifted safety specialists and coordinators. Their technical skillset was sound and their ability to implement safety procedures at the task level was adequate. However, a colleague and I realized most of the staff was having difficulty in implementing new company wide safety standards and ensuring sustainability in those standards once they were introduced at the facility level.

As we probed more, we found our folks had never understood that the implementation of these new standards was actually project management.
We further assumed that if they did not understand this, they also lacked the appropriate training. So with that, we put a training package together that focused on the management of implementation. We gave them a tool and training presentation for implementation purposes that would enable them regardless of the content or program.

During our rollout of training with our folks we discovered their focus was on the content (the standard, the sop, procedure, etc.) and not any kind of focus on an implementation plan. By turning their focus on project management, they immediately understood the focus was not on the big picture.

Now what we put together was not anything new but very briefly we put these points in front of our folks:

- Develop a consistent message of what the project is, why is it necessary, how it will help the organization, and what will a successful implementation will look like
- Determine a timeline with specific milestones along the way
- Determine who must be "bought in" for the project to be successful
- Break down the project into phases in order to avoid a perception that project is "too big"
- Develop an "owner" for each phase
- Communicate closure of each phase as you are moving to the next
- Measure closure of the project to evaluate if it is aligned with your original message
- Announce completion and recognize the players that were instrumental of the project.

By following this template we realized an immediate turnaround by simply managing the implementation of corporate health and safety standards.

**Randy Morton, CSHM, Chair ISHM Board of Directors**

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**Cell Phones to die for**

We are inundated with ads on television about the dangers of texting
while driving, especially among younger drivers. Yet, even with all the media attention texting while driving is the number one cause of vehicle fatalities in the younger group. For years the focus has been on drinking while driving. Now there is evidence that cell phone use while driving has the same cognitive distraction as does driving while drinking. There is also evidence that hands free is not the solution. It is the talking that causes the distraction, not the listening. That would explain why a radio playing in a vehicle is not a huge concern.

University of Utah Study

Volkswagen ran a commercial in a Hong Kong theater. Movie goers were urged to keep their phones on in the theater.

VW commercial

I recommend that this one minute video be shared with friends and family.

The National Safety Council has a great article on the cost of accidents involving cell phone usage.

Cost of cell phone use while driving

Does your company have a cell phone policy? If so how is it enforced? There is no doubt that one accident involving an employee who is using a mobile phone at the time of the incident will be EXPENSIVE. And have you enacted cell phone policies with your family. What is the cost if you lose a loved one?

ISHM Staff has enacted a 'do not use' while driving policy - will you do the same?

Larry Curtis - CSHM-E

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Ask the Lawyer

Question: What's the overall impact of OSHA's new reporting rule?
Response: The new reporting rule will go into effect on January 1, 2015. At this time, the "overall" impact is not yet clear, but we know it will be significant. Under the new rule, employers will be obligated to report to OSHA substantially more injuries and illnesses than under the current rule. This increase in reporting will not only provide OSHA with greater access to employers' injury and illness data, it will undoubtedly result in a far greater number of OSHA inspections.

Under the current rule, employers are required to report a single fatality or the in-patient hospitalization of three or more employees. The report to OSHA must be made within 8 hours of the incident or the employee's death.

Under the new rule, employers will still be required to report a single fatality. However, employers will also be required to report the in-patient hospitalization of just one or more employees, amputations, and the loss of an eye. Amputations include partial or complete loss of an appendage, including the tip of a finger with or without bone loss. Fatalities must be reported within 8 hours of the employee's death, and in-patient hospitalizations, amputations, and the loss of an eye must be reported within 24 hours of the incident.

The new rule also addresses how the report must be made to OSHA, what must be included in the report, and when the employer is considered to have notice of the injury or illness, among other things. While the "overall" impact remains to be seen, we do know that employers will report many more injuries and illnesses to OSHA.

Darren Hunter is a partner and an experienced OSHA practitioner in the Chicago law firm of Rooney Rippie & Ratnaswamy LLP. This column does not constitute legal advice or the formation or proposal of an attorney-client relationship to or with any person or entity. In addition, this column should not be understood to represent the views of ISHM, the law firm, the individual attorneys at the firm, or of any of the firm’s clients or former clients.
Silica and the health effects of exposure to it.

1. Describe silica and the health effects of exposure to it.

The NIOSH Pocket Guide to Chemical Hazards, 2012, page 278, describes the crystalline silica, also known as: Cristobalite, Quartz, Tridymite, and Tripoli as a colorless, odorless solid. Crystalline silica is one of the major naturally occurring mineral components of the earth’s crust (Levy, Wegman, Baron, Sokas, 2011, pg. 417). These silicates vary in toxicity from very toxic as in asbestos to a relative inert substance. The most common occurring form in the free state, is called silica and may be found or made in both non-crystalline form (pumice or obsidian glass) or as a crystalline form like quartz (Plog, Quinlan, 2012, pg. 183). Other toxic forms of crystalline silica is tridymite and cristobalite, may be formed as the result of heating quartz (Plog, Quinlan, 2012, pg. 183).

Silicosis is a nodular and potentially progressive disease that may be the result of the chronic inhalation of very fine, respirable particles of quartz. The inhalation of quartz also causes lung cancer. This inhalation of the quartz causes a restrictive, ventilatory effect, such as pneumoconiosis, (e.g., asbestosis, silicosis, coal workers pneumoconiosis) and is the results in the scarring of the lung tissue. This decreases the ability to take a breath and therefore introduces less flexibility in the lungs (Plog, Quinlan, 2012, pg. 49). Since silicosis is a debilitating chronic illness making it hard to breath, the immune system may suffer and lead to an increased incidence of Tuberculosis.

2. What industries and workers are exposed to silica and how are they exposed?

Sand blasting both in the industrial and commercial industries provides one of the highest exposures to the silica. Miners are another worker that may be constantly exposed. Processes also historically associated with silica are: sand-casting foundry operations, tunneling, cement cutting and demolition, masonry work and granite cutting (OSHA, 2013). The newest identified exposure is hydraulic fracturing workers.

3. What is the current OSHA standard for silica?

OSHA does not define the standard for silica, but rather relies on the National Institute for Occupational Safety and Health (NIOSH). NIOSHA defines the Time Weighted Average (TWA) 0.1 mg/m^3 for Quartz and Tripoli and 0.05 mg/m^3 for Cristobalite and Tridymite (NIOSH, 2012, pg. 370). There are other references to silica in 29 CFR 1910, 1915 and 1926.

4. Briefly describe the efforts to improve the silica standard and the delays and obstacles to finishing the rulemaking. Be specific about the role of industry, government, and labor in your summary.
New federal rules are waiting to be enacted to help improve workplace exposure limits involving respirable crystalline silica. The current OSHA Permissible Exposure Levels (PEL) of 50µg/m^3, for general industry is based on the 1971 formula recommended by the American Conference of Governmental Industrial Hygienists (ACGIH) and is considered obsolete. The new standard is being delayed and is currently in the Office of Information and Regulatory Affairs (OIRA) (Paintsquare, 2011). The industry and its lobbyist are citing increased costs for enacting new regulatory standards. Though there are many petitions and articles by various labor organizations including the AFL-CIO, but the White House has not urged the movement of the new standard beyond OIRA.

References


Russell Barringer, CSHM, CSP