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**A Guide to the Framework
of Standards For Health
and Safety Audits**

Document: JIC-002 - 2.3

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Joint
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Committee

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Introduction

1.1 Background to the Framework of Standards

Document: JIC-002-2.3

A. The Joint Industry Committee (JIC)

The opportunity to improve workplace health and safety is growing in Saskatchewan. Every year thousands of unnecessary and unacceptable workplace illnesses and injuries occur. More importantly, they are preventable. Approximately one person out of every ten is injured at work and requires medical attention. The societal consequences of these illnesses and injuries are wide in scope and far-reaching. Although various efforts are being made to address health and safety, an opportunity for positive, systemic change exists.

Positive and systemic change requires increased collaboration to uncover common ground, create synergy, and develop effective methods which address workplace health and safety. A coordinated and structured effort can provide a solid foundation from which to develop tools resulting in sustainable injury reduction and productive workplaces. When we work together towards a common purpose, we are more likely to achieve the success we need.

Working together invites many different stakeholders to be involved, including workers, occupational health committees, occupational health committee representatives, employers, industries, government and other entities with a vested interest in positive outcomes for workplace health and safety. With a common purpose and commitment to cooperation, stakeholders can focus on the issue of reducing illness and injury, while at the same time enabling industry in Saskatchewan to effectively address loss prevention issues.

History shows that worker participation is key to successful health and safety programs. Since such programs are designed to enhance the health and safety of workers, it is both logical and imperative that workers participate directly in program establishment and design, as workers are the ones exposed to hazards. In Saskatchewan not only are participation and consultation needed, legislation also requires that the Occupational Health Committee/Representative be directly involved in program design and implementation through regular meetings and inspections.

To create and sustain significant reductions in the provincial workplace injury rate, logic tells us that more employers will need to implement effective safety programs. To begin the process of systematically reducing workplace illness and injury, the Saskatchewan Workers' Compensation Board (WCB) has established a voluntary Joint Industry Committee (JIC). This committee is a vehicle to increase support for positive change to the way health and safety is viewed and managed. With the increased support of a number of industries, preventative action to drive down occupational illness and injuries in Saskatchewan is likely to occur. Many industries and employers across Canada have benefited from similar collaborative approaches.

To benefit from a systems approach to loss control, several interested Saskatchewan stakeholders have come together as the JIC. Collectively this group is striving to develop and enhance management systems for loss control. Thus the committee is a mechanism for sharing best practices during the development and/or enhancement of a framework of standards for industry health and safety programs, audits and certifications.

B. Framework of Standards: Rationale

With voluntary industry buy-in, a valuable provincial template/framework of standards for health and safety audits can be developed. The framework will assist industries in voluntarily developing and maintaining certification standards for health and safety management programs to meet individual industry needs.

This framework of standards for audits is a way to create economy of effort; it molds consensus on shared issues among industries and enables different industries to take the information in the framework and apply it to their individual needs. This concept aligns with the strategic focus of the JIC - to create a business culture in Saskatchewan where workplace health and safety is integrated with other business components such as efficiency, quality, and profitability. Another strategic focus is to create a workplace culture where injury and illness is prevented through buy-in of all workplace parties (owners, managers, supervisors, workers, occupational health committees, safety representatives, etc.), companies, and industries. The common belief that loss (including injuries) is preventable and predictable should stimulate the appropriate action of all in the workplace.

Several efforts undertaken in the past have made an impact. Increased compensation costs and increased surcharge amounts have impacted on the employer's bottom line. As well, a dedicated crown prosecutor and regulatory enforcement for occupational health and safety violations have sent a strong message. The proposed framework of standards for audits is not a tool to replace these initiatives. Rather, it is a method for seeking ways to inform industry and employers about how to meet and exceed legislation, while reducing injuries and costs.

C. Document: Content and Purpose

The next section of this document explains the concept of health and safety program audits, the purpose of audits, components, reasons the components are important, and their interrelationships. This information outlines how the health and safety program audit is a means to move toward continuous improvement in health and safety. The information also stresses the importance of integration with other business functions such as productivity, quality and efficiency. The final pages offer insight into the next steps and provide information for further assistance related to the framework of standards.

You, as active readers, are asked to ponder the concepts presented in this document and consider how each component of the health and safety program audit applies to you, your co-workers, your place of business, and your industry. If you actively engage with what follows, we trust you will find the information both interesting and beneficial.

1.2 The Safety Program Audit

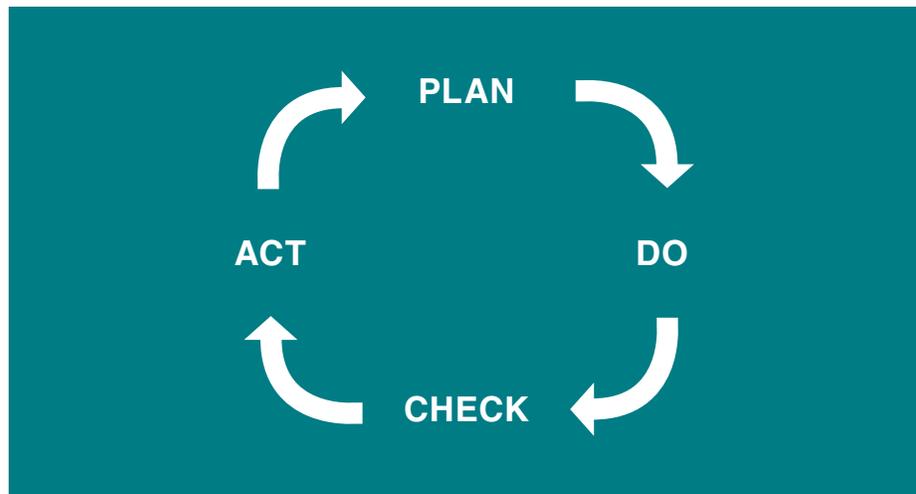
Rationale

As discussed in previous documents, the JIC views a health and safety program as a systematic, organized approach to prevent workplace loss associated with incidents. Workplace loss includes personal injury, equipment damage, property damage, environmental damage and other issues relating to an incident. The prevention of workplace loss is the goal of an effective health and safety management program. An organization needs to be proactive by developing and implementing tools that prevent workplace loss.

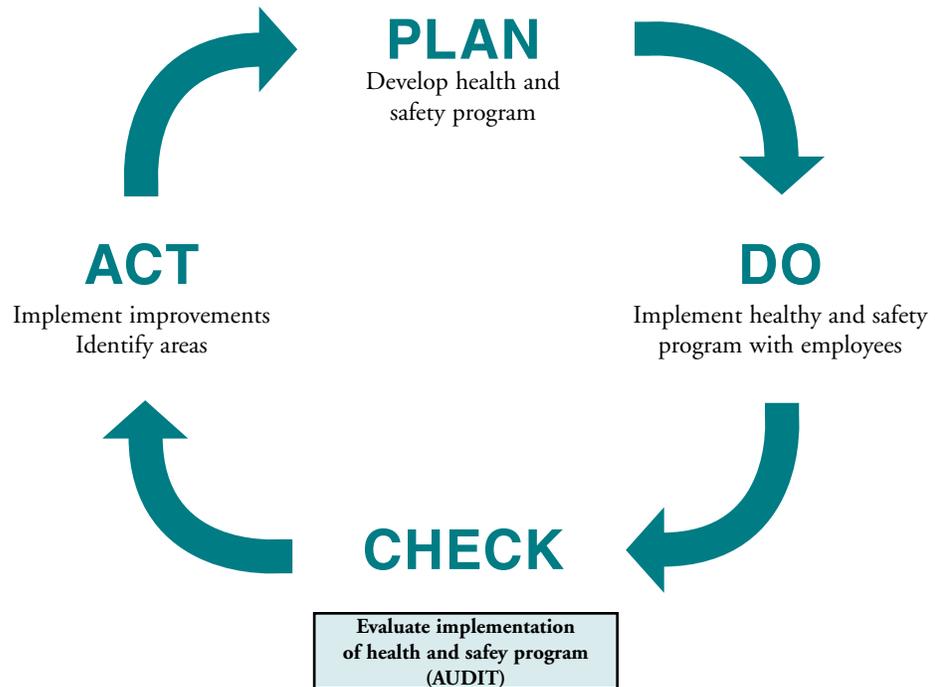
Creating an effective safety management program is the critical first step towards sustained injury reduction. Effective implementation is equally important. Program maintenance requires continual quality evaluation to confirm that the program is working as intended and that improvements are being made. Therefore, quality evaluation is paramount to the success of any safety program.

Logic and experience confirm that ongoing improvement contributes to both successful safety programs and positive business growth. Proactive organizations understand that positive change or improvement happens only when they assess what they do and dedicate time, energy and resources to improve areas that require change. The JIC believes the best way to identify areas for improvement to the health and safety program is through a comprehensive evaluation of the program. Commonly referred to as an audit, this systematic and objective evaluation can lead to management goal-setting based on prioritized risk and can provide the data needed to plan for continuous improvement.

A Continuous Improvement Model



Continuous Improvement in Health and Safety



As the above illustration shows, continuous improvement to the health and safety program includes checking how well the program was developed and implemented. The above illustration also differentiates between engaging in health and safety activities (implementation) and managing health and safety through a cycle of continuous program review and improvement.

In previous documents, the JIC outlined the framework of standards for health and safety programs. Effective safety program development and implementation are equally important. Both of these processes require continual quality evaluation to confirm that the safety program is working as intended and that improvements are being made. In the same way that organizations perform quality checks on their products and services, they also need to perform quality checks on their health and safety program.

An effective safety program naturally focuses on the critical two-step system of hazard identification and hazard control; however, to achieve continuous improvement in injury reduction it is equally important to administer a safety program audit. The data from this comprehensive evaluation of program development and implementation will direct the continuous improvement of both safety programs and business outcomes.

Simply put, evaluating the effectiveness of the health and safety program and identifying targets for improvement are good business practices.

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Audit Details

2.1 Safety Audit Components: Overview

The information in this section broadly describes the primary components of effective health and safety program audits as identified and agreed to by the JIC. It clarifies the components and shows how they interrelate.

Safety Program Audits: Introduction

The underlying purpose for any safety program audit is to identify areas of the program that are functioning well and to identify areas of the program that, if improved, will lead to fewer losses. These losses could include, but are not limited to:

- Injury and illnesses to people
- Related losses of injury and illness to workers, co-workers, families and society
- Production losses/downtime
- Product damage
- Equipment damage
- Plant damage

To identify whether the health and safety program has been effectively implemented, the organization will need to undertake a comprehensive evaluation. This evaluation is commonly referred to as the health and safety program audit. There are several key considerations when industry develops the measurement tools to accurately assess whether the health and safety program has been implemented and is operating as desired.

The following are the primary components of effective health and safety program audits as identified by the JIC:

1. Auditor
2. Audit Tool
3. Audit Process
4. Audit Type
5. Audit Scoring

Safety Program Audit: Components

The first component to effective audits is the **Auditor**, which refers to the person(s) conducting the audit. Measuring health and safety program implementation requires a skilled person to conduct the evaluation. Audits can be complex due to the scope, industry specific hazards, legislation, safety program standards and audit protocols. An effective **Auditor** will possess the necessary skills to evaluate the entire safety program against the given standards. By having a skilled **Auditor** complete the audit, an organization is more likely to achieve a valuable measurement that will identify both areas of strength and areas where improvements can be made to the program.

The second component is the **Audit Tool**; this refers to the document the auditor uses to assess the status of an organization's safety program. If a skilled auditor has the right tool for the job, there is a greater probability the measurement will accurately reflect

the status of the organization's safety program. The **Audit Tool** is an intricate part of quality audits. It provides the framework from which to identify and communicate the status of the safety program to those who can put in place the appropriate hazard controls once the audit is completed.

Audit Process is another key component of effective audits and refers to the manner in which the audit is conducted. With the right tool for the job, and a skilled **Auditor** using the tool, an organization is more likely to achieve an accurate snapshot of the implementation of the health and safety program. A clearly defined **Audit Process** offers strong communication prior to engaging in the various phases and aspects of the audit. A clear understanding of the purpose, extent and expectations of the audit will lead to understanding the audit results. The **Audit Process** leads to significant findings, which are readily understood and that are acted on to improve the health and safety program.

The **Audit Type** refers to the distinction between audit scopes, timelines, methods, auditors, and purpose and is another component of effective auditing. For example: an audit may need to be conducted as a result of a significant incident, for certification, for specific program elements, or as a method of preventative maintenance for the entire health and safety program. The **Audit Type** will be dictated by the needs of the organization and is an important element for continual improvement to the health and safety program.

Audit Scoring refers to the quantified measurement of the health and safety program implementation and essentially assigns value. It is with this value that an organization can determine areas of priority for program improvements. When developing and using audits, the component of **Audit Scoring** becomes important, as the scoring can assist with a balanced approach to the evaluation. This aspect of Auditing will ensure that all audits are using similar measurement criteria. The element of **Audit Scoring** is a key consideration to effective auditing, leading to valuable improvements in workplace health and safety.

The audit components presented are synonymous with effective auditing. A critical understanding of effective safety program audits is that all audit components need to be in place, of high quality and clearly communicated.

Identified by the JIC as the fundamental components of effective health and safety program audits, this information is preliminary to a more detailed explanation of individual audit components. Detailed description of the audit components will assist in creating the framework of standards for safety program audits.

2.2 Individual Components: Sub-components and Rationale

Preface

The following information broadly describes the components and sub-components of effective health and safety management program audits as identified and agreed to by the JIC. While health and safety program reviews are legislated in most industries in Saskatchewan, the intent of the following information is to outline a best practice approach to creating and implementing health and safety program audits as agreed to by the members of the JIC. The information is intended to serve industries as they develop or refine certification programming specific to their industry needs and to assist companies with evaluating their health and safety program. As well, it provides the framework of standards for future development of certification programs.

Components of Effective Health and Safety Program Audits

1. Auditor
2. Audit Tool
3. Audit Process
4. Audit Type
5. Audit Scoring

Component #1: Auditor

Introduction:

Measuring health and safety program implementation requires a skilled person to conduct the evaluation. Audits can be complex due to the scope, industry specific hazards, legislation, safety program standards and audit protocols. An effective *Auditor* will possess the necessary skills to evaluate the entire safety program against the given standards. By having a skilled *Auditor* complete the audit, an organization is more likely to achieve a valuable measurement that will identify both areas of strength and areas where improvements can be made to the program.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Auditor*.

The component of *Auditor* includes developed processes to:

1. Verify no conflict of interest exists on the part of the *Auditor*(s) that would adversely influence the outcome and validity of the audit, including the potential for the *Auditor* to gain financially based on audit outcomes, or the ability of an *Auditor* to conduct an external audit for an organization for which the *Auditor* is employed;
2. Verify the *Auditor*(s) follows pertinent legislation and an industry established code of ethics, including issues such as honesty, confidentiality, fairness of judgment, and consistency of audit application;
3. Establish a baseline for *Auditor*(s) knowledge of the industry, including a basic understanding of industry operations;
4. Confirm *Auditor* competency, qualifications, and knowledge of the evaluation process;
5. Confirm *Auditor* knowledge of audit protocol and JIC framework of standards for health and safety programs and audits, which may include the ability to interpret other systems (i.e. CSA, ISO, etc); and
6. Verify the skill set of the *Auditor* including:
 - a. communication and observation skills;
 - b. investigation and interviewing skills;
 - c. a measured understanding of safety management programs;
 - d. ability to understand pertinent legislation;
 - e. ability to analyze documents, records and other pertinent health and safety program data; and
 - f. ability to comprehend and summarize findings.

Rationale

Within the continuous improvement loop, a health and safety audit will naturally lead to action. While the audit will identify safety program strengths, it will also identify opportunities for improvement requiring change to the way elements of the program are managed. To manage the required change, organizations will dedicate energy, resources, and time. Thus organizations need to ensure they focus their efforts in the right areas.

An objective audit, therefore, is imperative for improving the health and safety program. When focusing on the component of *Auditor*, organizations will need to verify the *Auditor* has no conflict of interest and abides by a code of ethics. If the *Auditor* has a vested interest in the outcome or does not exercise sound judgment, the audit process will not be value-added. An *Auditor's* lack of objectivity might skew audit results and misdirect an organization's planning for improvement. The organization might mistakenly dedicate resources and energy to improve program elements that are functioning well, and fail to address areas of greatest need for improvement or change.

Aside from issues of conflicts and ethics, human error is also an important consideration when having an audit conducted. To minimize the possibility of human error, organizations will need to confirm and verify the knowledge, competency and skill-set of the *Auditor*.

An *Auditor* possessing knowledge of the industry is more likely to understand the unique risks involved with the type of work the organization undertakes. This *Auditor* will also better understand the distinction between the inherent hazards and the induced hazards within the industry. With a basic understanding of industry operations, the *Auditor* is also better equipped to identify situations where improvement is required and better able to relate to the workforce.

An *Auditor* possessing the appropriate qualifications is another important consideration. While a basic understanding of the work being performed is important, equally important is a sound grasp of the audit process and protocols since they will vary by intent, system, industry, province, and country. The understanding of effective auditing is directly linked to the understanding of health and safety management principles, so the *Auditor* needs to possess and be able to demonstrate a solid understanding of both.

The skills needed to effectively audit a health and safety program are robust and varied. An *Auditor* essentially evaluates the quality and interaction of documentation, records, activity and comprehension of the entire program. These skills include interviewing and communicating, investigating leads, analyzing documents, records and data, observing activity, and understanding legislation, safety management programs and findings. With such a variety of skills required, an organization will want to verify the skill set of the *Auditor* before engaging in the audit. Some organizations may need to verify that the *Auditor* possesses the appropriate certification as an *Auditor*; other organizations may need to establish criteria and evaluate the skill set of the incoming *Auditor*.

Conclusion

Within the continuous improvement loop, a health and safety audit will naturally lead to action. If organizations first ensure that the *Auditor* has the appropriate level of understanding, knowledge, skill and competency, the probability of a successful audit increases. Subsequently, the action that stems from audit findings will be appropriate and will benefit the health and safety program and the people it is designed to protect.

Component #2: Audit Tool

Introduction:

If a skilled *Auditor* has the right tool for the job, there is a greater probability the measurement will accurately reflect the status of the organization's safety program. The *Audit Tool* is an intricate part of quality audits. It provides the framework from which to identify and communicate the status of the safety program to those that can put in place the appropriate hazard controls once the audit is completed.

Sub-component content:

The following sub-component content expands on what processes are anticipated to be in place for the component of *Audit Tool*.

The component of *Audit Tool* includes developed processes to:

1. Confirm the information gathered on the *Audit Tool* is, at a minimum, related to all element and sub-element content identified in document JIC-002-1.2;
2. Confirm defined indicators are used to validate findings, including points, *Auditor* comments and recommendations;
3. Confirm a combination of methods are available to gather information and evaluate each sub-element in the *Audit Tool*, including documentation and records review, observations of work, and cross-sectional interviews;
4. Confirm the existence of *Auditor* guidelines which assist in determining how to interpret and use the *Audit Tool* and validate the findings;
5. Confirm the existence of a point system to indicate audit results by element and in its entirety;
6. Confirm the existence of minimum points assigned to each element that is balanced with all other elements;
7. Summarize audit findings including a point summary and executive summary which reveals the key issues, recognized strengths and recommendations for action; and
8. Seek post-audit improvement to the health and safety program for identified areas, complete with an established time frame for implementation of improvements.

Rationale

The *Audit Tool* refers to the document the *Auditor* uses to assess the status of an organization's safety program. Its usefulness hinges on one key quality: clarity. First, the *Audit Tool* requirements must be clear and specific so that the *Auditor* can complete the tool accurately and efficiently. Secondly, the information on the completed *Audit Tool* must be clear and specific so that the end-user can understand exactly what needs to be improved.

Because action to improve the health and safety program will stem partly from reviewing the *Audit Tool*, the information gathered on the tool must relate to the entire element and sub-element content identified within the framework of standards for health and safety programs. With such information organizations will be able to align auditing with continual improvement of their program.

When auditing, a clear and consistent approach is invaluable. A process which includes defined indicators, points, comments and recommendations helps to establish meaningful findings that the user can readily understand.

Audits gather and coordinate otherwise unknown information as to how the health and safety program is being managed. It is a 'snap-shot' in time and extends further than documents and records because it looks not only at lagging indicators, but also at leading indicators. Leading indicators include items such as work activity at the time of the audit and current understanding of the health and safety program by the workforce. Thus the **Audit Tool** needs to provide a combination of methods to gather information and evaluate the findings. This process includes confirmation that representative sampling of documents and records is reviewed, work is observed, and interviews are conducted in the context of the existing organizational structure.

To strengthen the reliability and validity of audits over time, it is important that the audit asks consistent questions and that those questions be interpreted the same way each time an audit is conducted. **Auditor** guidelines within the **Audit Tool** will assist in this area and will bring more clarity and objectivity to the **Audit Process**.

The objectivity of the audit should also extend into the point system; as well as an overall score, results should also be indicated by element. A structured and balanced approach for awarding points, which is scripted within the **Audit Tool**, increases the probability that the post-audit action will be directed towards the elements of the program that need it. As well, a balanced weighting of the importance of documents, records, work activity and program understanding will ensure that the process for improving the program considers and assesses the efforts of all in the workplace.

When all elements of the safety program have been evaluated, it is necessary to communicate the evaluation to people in a position to enact change. A solid management system targets objectives and goals based on prioritized risk. The **Audit Tool**, therefore, needs to have within it the ability to summarize the findings to reveal the key issues. Both the point and written summaries should parallel each other, as well as identify areas of strength and growth opportunities. An effective **Audit Tool** will also call the audited organization to action and establish a time frame for implementation of improvement, again feeding into the continuous improvement loop.

Conclusion

The **Audit Tool** is an important component for reaching objective and valuable findings about the status of the health and safety program. A well designed and structured **Audit Tool** can clarify the **Auditor's** role, can provide tangible recommendations, and is the 'measuring tape' used to build and renovate health and safety programs. For the purpose of continuous improvement it can be relied upon long after the audit is conducted.

Component #3: Audit Process

Introduction:

Audit Process is another key component of effective audits and refers to the manner in which the audit is conducted. With the right tool for the job, and a skilled *Auditor* using the tool, an organization is more likely to achieve an accurate snapshot of the implementation of the health and safety program. A clearly defined *Audit Process* offers strong communication prior to engaging in the various phases and aspects of the audit. A clear understanding of the purpose, extent and expectations of the audit will lead to understanding the audit results. The *Audit Process* leads to significant findings, which are readily understood and that are acted on to improve the health and safety program.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Audit Process*.

The component of *Audit Process* includes processes to:

1. Determine the minimum sample protocol that will be used, including documents, records, observations and interviews;
2. Determine the minimum percentage of work locations to be included as part of the evaluation;
3. Determine the minimum percentage of peak available workforce required at the time of the audit;
4. Engage in pre-audit communication with affected workplace parties prior to site audit activity which determines audit scope, logistics and expectations;
5. Execute the audit within established guidelines for audit duration, interview duration and site timelines;
6. Establish the combination of verification techniques to be utilized through standardized questions and guidelines for each question;
7. Establish guidelines for the verification techniques including:
 - a. suggested documents and records to review and related processes;
 - b. observations of conditions and acts and related processes; and
 - c. interviews representative of the workplace population.
8. Summarize findings in a concise manner that accurately reflect the findings of the audit score, and include an executive summary with recognition of program strengths and recommendations for program improvement;
9. Bring the audit to a close, including presenting a final report, calling the audited organization to action and determining follow up to be completed post-audit; and
10. Approve the audit, including audit signature by current senior management and verification that the audit has been completed to the protocol developer's standards.

Rationale

If we plan what we do, and then do what we planned we are more likely to be successful. If we consider how the previously depicted continuous improvement model applies to health and safety audit, we quickly conclude that we need both a plan and a process for carrying out an audit effectively.

The ***Audit Process***, the manner in which the audit is conducted, requires both consideration of the organization being audited and communication of the audit steps. First is the accurate representation of the organization at the time of the audit. Factors to consider may include work locations, number of people, documents, records, observations and interviews. The audit worth, therefore, is a function of the reliability of information reviewed. For example, if a seasonal company operates in multiple locations in the summer and in winter downsizes its operations significantly, what is the best time for an audit? Obviously an accurate measurement of the safety program is more likely to occur in the summer months, when workload and productivity are at their peak. Again, the goal of the audit is to be objective and complete. Because the audit is a 'snap-shot' in time, it is critical that the ***Audit Process*** defines when the audit is conducted and what the extent of data collection will be.

Second is the communication of the audit steps. For people who are unaware of the fundamental purpose of audits, the ***Audit Process*** can appear to be a daunting and worrisome task. Communication with affected workplace parties prior to audit activity can dispel many misconceptions about the health and safety audit. Pre-audit communication can also assist in the planning stages for the audit by helping to determine scope, logistics and expectations.

When plans are made to conduct the audit, it is important to conduct the audit according to those plans and to meet the expectations of time spent in various audit activities. By doing so, all parties begin the ***Audit Process*** with the same understanding, and if all parties understand the objective nature of the process resistance will be minimal during the audit. Clearly established guidelines for questions to be asked and verification techniques to be used will strengthen the ***Audit Process***. If there is a shared understanding of the ***Audit Process*** at the outset, the organization and people will benefit from the experience.

Once the audit has been executed according to the plans, the information needs to be compiled and summarized. As with the safety program, the messaging and detail of the audit need to be tailored to suit the audience. For example, presenting an executive summary is key to the process as management may allocate resources to effect change.

Regardless of the findings, it is important within the ***Audit Process*** that the audited organization is called to action. This expectation includes an organization establishing plans and timelines to address the program issues identified through the audit. If we are committed to continuous improvement, we likewise must be committed to achieving positive change through data-driven decision-making and action.

The final part of the ***Audit Process*** includes endorsement of the audit by current senior management and verification that the audit is completed according to the protocol developer's standards. This last step helps ensure the audit was conducted as intended and communication was clear.

Conclusion

Auditing health and safety programs may seem to be a complex process; however, potential confusion can be effectively minimized with a consistent approach to the communication and intent of audits. Clear understanding of audit purpose, extent, and expectations will lead to understanding audit results. If the audit is an agent for positive change to the way health and safety is viewed and managed, the need to create a strong *Audit Process* is clear.

Component #4: Audit Type

Introduction:

The *Audit Type* refers to the distinction between audit scopes, timelines, methods, *Auditors*, and purpose and is another component of effective auditing. For example, an audit may need to be conducted as a result of a significant incident, for certification, for specific program elements, or as a method of preventative maintenance for the entire health and safety program. The *Audit Type* will be dictated by the needs of the organization and is an important element for continual improvement to the health and safety program.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Audit Type*.

The component of *Audit Type* includes developed processes to:

1. Determine the internal audit requirements, including persons responsible for completing the audit, schedules and use;
2. Conduct internal audits as established;
3. Determine the external audit requirements, including a timeline between external audits and completed by an industry-protocol qualified external auditor;
4. Conduct external audits as established;
5. Conduct a limited scope audit when one or more elements do not meet the audit standard for either internal or external audits, complete with an established time frame for re-evaluation; and
6. Determine the requirements for and conduct post-event audits after a serious incident to identify safety program improvements.

Rationale

If, within the continuous improvement model, an evaluation of the health and safety program is needed, two fundamental questions arise: when should the evaluation be performed and what is its purpose?

Often, the timing of audits will be at the sole discretion of the organization seeking the audit. However, legislation requires that the health and safety program be reviewed at specified intervals, and some audits within certification programs also specify when the audit is to be conducted. While it appears logical to 'check' the implementation

of the safety program, the timing of audits is directly related to their purpose. Because purposes vary, there is no definitive timeline for all audits. Nevertheless, clarification can be reached about the timing of an audit by determining what kind of audit is needed. To decide what type of audit to seek, purpose must be clearly understood.

Audits serve different purposes and are used for different reasons. If an organization has recently implemented a health and safety management program, it will want to evaluate how well the development and implementation of the program has occurred. Often this assessment is done within the organization as an internal audit. This action will enable the organization to internalize findings and refine their program prior to an external audit or a significant incident.

If an organization is seeking certification, an external review of the program, or third party audit, can objectively establish how effective the program is against a previously established set of program standards. A variety of industry, government, provincial and national standards are available for such a review.

If an organization has had a significant incident, it will likely seek to understand, through a post-event audit, the parts of the management system that failed and where improvements can be made. In the same way, organizations may also need to evaluate specific elements of the safety program that are not functioning as desired. Commonly referred to as a limited scope audit, this type of audit can help bring individual element performance into alignment with the other elements of the safety management system. Limited scope audits can do so, by acting on initial audit recommendations within an established time frame.

Conclusion

Several types of audits are available, each with an individual purpose. The importance of establishing the requirements for each *Audit Type*, however, cannot be overstated. Equally important is that once the requirements are established by *Audit Type*, they be conducted as required. By setting appropriate audit requirements and following through, organizations can demonstrate a degree of due diligence, seeking proactive improvement by planning, doing, checking and acting on findings.

Component #5: Audit Scoring

Introduction:

Audit Scoring refers to the quantified measurement of the health and safety program implementation and essentially assigns value. It is with this value that an organization can determine areas of priority for program improvements. When developing and using audits, the component of *Audit Scoring* becomes important, as the scoring can assist with a balanced approach to the evaluation. This aspect of auditing will ensure that all audits are using similar measurement criteria. The component of *Audit Scoring* is then a key consideration to effective auditing, leading to valuable improvements in workplace health and safety.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Audit Scoring*.

The component of *Audit Scoring* includes processes to:

1. Determine the overall score required for successful audit completion;
2. Determine the minimum requirements for scoring by element complete with a balanced weighting between all program elements; and
3. Determine the minimum requirements for validation techniques complete with a balanced weighting for the validation techniques.

Rationale

As previously discussed, a health and safety audit is a comprehensive evaluation of the implementation of the program and a critical piece within the context of continuous improvement. Essentially, audits are a way to measure quality and implementation. Within this measure, the importance of the component of *Audit Scoring* becomes increasingly clear.

Audit Scoring provides a benchmark for future program improvement and assists with establishing priorities in action. Realistically, working on every area of program slippage at once may be difficult and time-consuming and ultimately lead to minor improvements at best. Instead, a structured, planned approach to improvement that focuses on identified priorities will more likely result in positive outcomes and growth. To manage the improvement process well, how is an organization to know exactly what its priorities are? *Audit Scoring* will provide that information. To use an analogy: *Audit Scoring* provides numbers for the tape measure, helping to build and refine the safety program. These numbers establish values that can indicate priorities, in other words, where to focus the most resources, time and energy. The key then, is that efforts to improve are focused.

To focus efforts, a scoring structure must be set up that identifies specific priorities for action. For example, if a structure requires only an overall score, then an organization could focus only on documentation and essentially pass an audit. Obviously such a scoring structure would miss the intent of the entire audit exercise and be of no value to the organization.

It is important then that *Audit Scoring* places the appropriate emphasis on the intent of the system. First is the overall audit score, which establishes the benchmark at an industry level. This sub-component will give organizations a snapshot summary of their system. Just as a tape measure or bank account balance without numbers is meaningless, the same may hold true for safety program evaluations without numbers or “scoring”. A numeric snapshot summary of a system, however, may have significant meaning because it can show an organization how its health and safety program ‘stacks-up’ against a standard. For organizations in a competitive marketplace, this comparative information can be an important issue.

Of importance also is having balance within the overall scoring. If all the elements of the safety program are important, then the scoring mechanism needs to place appropriate weighting on each element that comprises the overall score. Just as fine-tuning an engine keeps it running smoothly, so using a balanced approach to the weighting by element will keep the audit program ‘firing on all cylinders’.

A final consideration is the validation techniques used to arrive at the audit score. If all validation techniques of documentation, observation and interviews are viewed appropriately, the scoring will balance the techniques used to award merit. Obviously, the opposite holds true. If points were awarded for documentation alone, then the quality of the entire audit program would be questionable.

Conclusion

Scoring within audits can be a delicate operation; however, if planned well and properly executed, scoring can establish otherwise unknown priorities for improving the health and safety program. This component of audits also performs the critical function of recognizing areas within the health and safety program that are functioning well, offering positive feedback for efforts and success in health and safety. A balanced approach towards scoring can drive forward the improvement process, solidify the value of auditing and be the catalyst to creating safer workplaces.

Individual Components: Summary

The above information is the foundation for detailed development and execution of effective safety audits. From this framework of standards for safety audits, the standards for certification specific to individual industry needs will be developed.

Creating a safety audit is a critical step towards continuous safety program improvement and sustained injury reduction. However, effective execution is equally important. Program maintenance also requires continual quality evaluation to confirm that the program is working as intended and that improvements are being made. An audit, therefore, is a critical piece in the cycle of continuous improvement.

2.3 Interaction of Components: Safety Auditing

The components presented above collectively form the basis for developing a health and safety program audit. Successful planning, design and execution require a balanced approach between identifying realistic, meaningful goals and making sure the audit components fit. Although keeping individual components in perspective and aligning them with the goals of the continuous improvement process can be challenging, such balance is invaluable for achieving future success and realizing economy of effort.

If audit components are developed as stand-alone units, both the components and the audit will be of questionable value. Developing components without considering their impact on the audit may negatively impact the health and safety program, as program improvements often stem from audits conducted. One such consequence is the view that the component is completely different from or foreign to the company. If the component is viewed as foreign, the company might think that the audit needs to occur separately from the work being conducted. If this thinking continues over time, the component and resulting audit will exist as a practice separated from the company. If a company feels that one component needs to be separated from other audit components, in all likelihood it will see the safety audit as operating separately from their safety program and other business functions such as quality, productivity or efficiency.

The aim of continuous improvement is, however, the opposite. The aim is to integrate the safety system and the audit with the work being completed, integrated to the point of becoming invisible, a behind-the-scenes driving force that helps the company and its people do the best work possible. Therefore, as the audits are developed, careful consideration needs to be given to how the components are interrelated and how they relate to the program and the continuous improvement process as a whole.

Since the components operate as critical pieces in a puzzle, industries and companies will need to internalize component intent and actively seek a deeper understanding

2.4 Equitable Management: Integrating Safety with Productivity, Quality and Efficiency/ Profitability

of how the audit components interrelate. For example, it would be difficult to improve the program if a skilled *Auditor* used a faulty *Audit Tool* or *Audit Process*. If developed and executed appropriately to each organization, the audit will be viewed as an opportunity to effectively improve the safety program, eliminating future loss and increasing organizational capital.

The health and safety program needs to be dynamic rather than static; it is to be a live, ever-changing process that improves the operation of a company and the safe working ability of its people. Health and safety audits are no different. This program paradigm becomes achievable when the intent of the audit components, their relationship and interaction and the best practices for meaningful program evaluation are understood.

When a company understands that the safety program and auditing are tied together and that they interact with one another, it will see how safety impacts quality, productivity and other issues affecting the daily operation of the business.

“Effective companies operate their business in a way that efficiently protects the business from loss and protects people from harm.”

A Guide to the Framework of Standards for Health and Safety Programs, Joint Industry Committee JIC-002-1.3.

The above view maintains that safety is synonymous with good business practice. Companies want to pursue business practices that increase their net profit. They can accomplish such growth in several ways. One practice might be to take on more work while realizing efficiencies. Another option is to minimize the loss or the potential for loss. In this option an effective health and safety management program is the key. Safety is the control of avoidable loss, so if a company engages in controlling avoidable loss, it minimizes loss. If the company minimizes loss, it maximizes profit.

Safety is not something separate from work activity; safety is part of the activity itself. Safety is an integral part of the business function. Leading and progressive companies often manage health and safety in the same way that they manage other business considerations. As a result, health and safety is valued because it is part of the consistent message within the workplace. An approach of equitable management means that productivity, quality, cost-effectiveness, health safety and environment are in balance; one is not compromised for another. Leading companies strive to ensure each one of these areas is progressive and follows best practice.

What gets measured gets done. This statement and similar management concepts are common themes in current business policies and practices. There is real value in this assertion because it relates to program development, implementation and controlling avoidable loss.

To control avoidable loss and be progressive, these companies support health and safety management programs as a necessary tool for improving their businesses. One of the most effective instruments progressive companies use, is measuring the management of the health and safety program. Within a continuous improvement cycle, progressive companies seek to understand how to improve by measuring what they do and how well they do it. In other words, these companies perform quality checks on products and services they provide, including performing quality checks, or audits, on the health and safety management system.

Effective management goal setting, based on prioritized risk, can be achieved by a company that first uses effective audits to understand what the priorities are and then plans continuous improvement to address the identified priorities.

Utilization of Framework

3.1 The Framework of Standards: Applications within Companies and Industries

Preface

The overall purpose of this document is to develop structures, tools, and understandings relevant to health and safety program audits. If the development and implementation of effective program audits is undertaken, organizations are more likely to be engaged in continuous improvement. This goal of developing and implementing tools to address primary prevention in a methodical and structured way is synonymous with an effective health and safety program.

Subsequent to reviewing the framework of standards for health and safety program audits is a discussion of how the framework can be used to benefit all workplace parties. The use of this document will be examined within two contexts, application within companies and application within industries.

Application within Companies

This document can serve a variety of purposes for companies. The framework of standards, if considered in detail, can offer insight into some basic principles of loss control and continuous improvement. Regardless of how developed a company's health and safety program may be, this framework can generate questions that motivate safety program development and/or refinement.

Provincially regulated employers, if prescribed places of employment, are required to comply with Section 13 of the *Saskatchewan Occupational Health and Safety Act, 1993* and Section 22 of the *Saskatchewan Occupational Health and Safety Regulations, 1996*. For these employers the requirement to develop a safety program that meets the criteria is mandatory. The framework of standards can assist such companies in deepening their understanding about issues that need to be addressed in an effective health and safety program audit and indicate a shared best practice approach aligning with the spirit of the regulations.

Those companies that are not prescribed places of employment can access and use information from this document in the following ways. Given the scope of duties placed on all workplace parties by occupational health and safety legislation, regardless of whether a prescribed place of employment, the framework of standards can assist with compliance efforts for the remaining sections of occupational health and safety legislation. If a health and safety program is truly synonymous with loss prevention, it is difficult to argue that engaging in loss prevention and continuous improvement will not assist with regulatory compliance. In fact, the desire of the JIC is to deepen the understanding of minimum requirements and enable companies to exceed them. If goals are targeted towards best practice, best practice will more likely be achieved.

A best practice can be perceived in many different ways. The scope of operations, the nature of business and the capacity to address health and safety will undoubtedly alter the depth and detail of a health and safety program audit. The intent is that a company takes the information from the framework of standards, and molds

or tailors that information into a workable ***Audit Process*** which addresses health and safety based on that company's individual needs. As described in previous documents, everyone in the workplace needs to buy into the program for it to be useful.

Some companies may already have chosen the best practice approach as their goal in health and safety management. Other companies may feel overwhelmed and require assistance in developing effective health and safety management programs and in understanding health and safety program audits. For companies in the final phase of program implementation, this resource document provides information in a user-friendly format to assist them in the ***Audit Process***.

The framework of standards for health and safety program audits is a resource intended to assist individual companies. We ask that you consider and discuss the framework's concepts within your workplace. Two positive outcomes of such discussions may be people having a greater chance of being free from harm, and companies creating safer working environments and more productive workplaces.

If your company requires further assistance in understanding the framework of standards, or is in the final phases of program development and is seeking an audit, please contact any one of the resources listed in the Acknowledgements of this document. Companies with an existing safety association already have an available resource to provide further assistance. If your company does not have a safety association, consider contacting your industry association, the Saskatchewan Workers' Compensation Board, Saskatchewan Labour Occupational Health and Safety Division, or a resource listed in the Acknowledgements.

Application within Industries

This document also provides to various industries quality guidance on a common and best practice approach to development of health and safety program audits. Every industry faces unique challenges. Therefore, the priority and focus on specific audit sub-components will vary according to individual industry needs. Different industries will consider more specifically how the framework of standards applies to the unique needs of their industry. Possible industry-specific outcomes of the framework may include a stronger support network of resources, development of industry training tools for companies, and the provision of resources to support increased numbers of employers developing audit processes and requesting audits.

The reader is encouraged to consider the framework of standards as reassurance for existing efforts, as well as a growth opportunity for untapped development of program audits, components, and sub-components. If you are part of an industry represented on the JIC, please contact your representative for further information related to the framework of standards. If you are part of an industry that has not yet engaged in the framework of standards, consult with your peers, or contact any one of the resources listed in the Acknowledgements for assistance.

3.2 Next Steps

Effective health and safety programs are intended to be living and ever changing, constantly adapting to improve the work being done. Ongoing refinement of the health and safety program requires two actions: first, identifying the need for change, and second, specifying the areas in which refinement is necessary. To assess an existing health and safety program, specific kinds of assessment tools or strategies are needed as outlined in the framework of standards for health and safety audits.

Another important consideration to the development of suitable evaluation mechanisms is their worth beyond the company. To recognize quality safety programs, several industries have developed certifications that can encourage organizations to verify, through third party audits, that their health and safety program meets an industry established set of standards. Certification programs, if developed appropriately, can transparently stimulate proactive continuous improvement within the health and safety programs of companies and industries.

The next task of the JIC will be to develop a suitable framework of standards for certification and quality assurance. For industries seeking certification against the framework of standards for programs and audits, a framework of standards for certification and quality assurance will perform two important functions. First, from the collaborative process used, the framework will help industries understand the variety of communication and quality needs that surround the certification process. Second, it will provide a voluntary, flexible and uniform approach to issuing certification that will be more widely recognized, accepted and valued.

If we acknowledge that effective business management systems use reliable data to guide decision-making and validate action, we will see the importance of developing certification mechanisms which accurately verify implementation of health and safety programs.

4

Conclusion

The framework of standards for health and safety program audits is a key resource in the process of refining, maintaining, and evaluating voluntarily developed safety management programs. Achieving decreased loss potential and sustained injury reduction in the workplace, the goal of health and safety programs, requires data-driven planning and action in a continuous cycle of improvement. Health and safety program audits will provide the data critical to ensuring ongoing safety improvements and business growth.

Beyond program development and implementation is maintenance. Maintenance requires continual monitoring to confirm that the program is working as intended and is being improved over time. From this framework of standards for audits, the standards for certification specific to individual industry needs will be developed, as well as quality assurance mechanisms, which will guide the ongoing renewal of safety management programs.

Appendix A Preface

Framework of Standards for Health and Safety Program Audits

The JIC is comprised of the Saskatchewan Workers' Compensation Board, Saskatchewan Labour Occupational Health and Safety Division and voluntary safety leaders representing a variety of industry rate codes. Through this committee various industries voluntarily promote effective health and safety programs and certification standards, with the expectation of increased industry and employer participation in these fields. Such increased industry and employer participation will lead to significant and sustained injury reduction for Saskatchewan employers and employees.

This document broadly describes the agreed-upon components and sub-components of effective health and safety program audits. While health and safety programs are legislated in most industries in Saskatchewan, the intent of the following information is to outline a best practice approach to auditing health and safety programs as agreed to by the members of the JIC.

The purpose of this document is to serve industries as they develop or refine certification programming specific to their industry needs. It provides the framework of standards for future development of certification programs.

NOTE:

- Supporting background information about safety programs can be referenced in documents JIC-002-1.1, JIC-002-1.2, JIC-002-1.3.
- Supporting background information about safety program audits can be referenced in documents JIC-002-2.0 (*Safety Program Audit Profile-Dacum*) and JIC-002-2.1.
- Detailed explanations with supporting information can be referenced in documents JIC-002-2.2 and JIC-002-2.3.
- Employers and employees should be aware of pertinent health and safety legislation. For example, a provincially regulated Saskatchewan employer should refer to the *Saskatchewan Occupational Health and Safety Act, 1993, Section 13* and the *Saskatchewan Occupational Health and Safety Regulations, 1996, Section 22*.

Components of Effective Health and Safety Program Audits

1. Auditor
2. Audit Tool
3. Audit Process
4. Audit Type
5. Audit Scoring

Component #1: Auditor

Introduction:

Measuring health and safety program implementation requires a skilled person to conduct the evaluation. Audits can be complex due to the scope, industry specific hazards, legislation, safety program standards and audit protocols. An effective *Auditor* will possess the necessary skills to evaluate the entire safety program against the given standards. By having a skilled *Auditor* complete the audit, an organization is more likely to achieve a valuable measurement that will identify both areas of strength and areas where improvements can be made to the program.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Auditor*.

The component of *Auditor* includes developed processes to:

1. Verify no conflict of interest exists on the part of the *Auditor*(s) that would adversely influence the outcome and validity of the audit, including the potential for the *Auditor* to gain financially based on audit outcomes, or the ability of an *Auditor* to conduct an external audit for an organization for which the *Auditor* is employed;
2. Verify the *Auditor*(s) follows pertinent legislation and an industry established code of ethics, including issues such as honesty, confidentiality, fairness of judgment, and consistency of audit application;
3. Establish a baseline for *Auditor*(s) knowledge of the industry, including a basic understanding of industry operations;
4. Confirm *Auditor* competency, qualifications, and knowledge of the evaluation process;
5. Confirm *Auditor* knowledge of audit protocol and JIC framework of standards for health and safety programs and audits, which may include the ability to interpret other systems (i.e. CSA, ISO, etc); and
6. Verify the skill set of the *Auditor* including:
 - a. communication and observation skills;
 - b. investigation and interviewing skills;
 - c. understanding of safety management programs;
 - d. understanding pertinent legislation;
 - e. analyzing documents, records and other pertinent health and safety program data; and
 - f. ability to comprehend and summarize findings.

Component #2: Audit Tool

Introduction:

If a skilled *Auditor* has the right tool for the job, there is a greater probability the measurement will accurately reflect the status of the organization's safety program. The *Audit Tool* is an intricate part of quality audits. It provides the framework from which to identify and communicate the status of the safety program to those that can put in place the appropriate hazard controls once the audit is completed.

Sub-component content:

The following sub-component content expands on what processes are anticipated to be in place for the component of *Audit Tool*.

The component of *Audit Tool* includes developed processes to:

1. Confirm the information gathered on the *Audit Tool* is, at a minimum, related to all element and sub-element content identified in document JIC-002-1.2;
2. Confirm defined indicators are used to validate findings, including points, *Auditor* comments and recommendations;
3. Confirm a combination of methods are available to gather information and evaluate each sub-element in the *Audit Tool*, including documentation and records review, observations of work, and cross-sectional interviews;
4. Confirm the existence of *Auditor* guidelines which assist in determining how to interpret and use the *Audit Tool* and validate the findings;
5. Confirm the existence of a point system to indicate audit results by element and in its entirety;
6. Confirm the existence of minimum points assigned to each element that is balanced with all other elements;
7. Summarize audit findings including a point summary and executive summary which reveals the key issues, recognized strengths and recommendations for action; and
8. Seek post-audit improvement to the health and safety program for identified areas, complete with an established time frame for implementation of improvements.

Component #3: Audit Process

Introduction:

Audit Process is another key component of effective audits and refers to the manner in which the audit is conducted. With the right tool for the job and a skilled *Auditor* using the tool, an organization is more likely to achieve an accurate snapshot of the implementation of the health and safety program. A clearly defined *Audit Process* offers strong communication prior to engaging in the various phases and aspects of the audit. A clear understanding of the purpose, extent and expectations of the audit will lead to understanding the audit results. The *Audit Process* leads to significant findings, which are readily understood and that are acted on to improve the health and safety program.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Audit Process*.

The component of *Audit Process* includes processes to:

1. Determine the minimum sample protocol that will be used, including documents, records, observations and interviews;
2. Determine the minimum percentage of work locations to be used as part of the evaluation;
3. Determine the minimum percentage of peak available workforce required at the time of the audit;
4. Engage in pre-audit communication with affected workplace parties prior to site audit activity which determines audit scope, logistics and expectations;
5. Execute the audit within established guidelines for audit duration, interview duration and site timelines;
6. Establish the combination of verification techniques to be used through standardized questions and guidelines for each question;
7. Establish guidelines for the verification techniques including:
 - a. suggested documents and records to review and related processes;
 - b. observations of conditions and acts and related processes; and
 - c. interviews representative of the workplace population.
8. Summarize findings in a concise manner that accurately reflect the findings of the audit score, and include an executive summary with recognition of program strengths and recommendations for program improvement;
9. Bring the audit to a close, including presenting a final report, calling the audited organization to action and determining follow up to be completed post-audit; and
10. Approve the audit, including audit signature by current senior management and verification that the audit has been completed to the protocol developer's standards.

Component #4: Audit Type

Introduction:

The *Audit Type* refers to the distinction between audit scopes, timelines, methods, auditors, and purpose and is another component of effective auditing. For example: an audit may need to be conducted as a result of a significant incident, for certification, for specific program elements, or as a method of preventative maintenance for the entire health and safety program. The *Audit Type* will be dictated by the needs of the organization and is an important element for continual improvement to the health and safety program.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Audit Type*.

The component of *Audit Type* includes developed processes to:

1. Determine the internal audit requirements, including persons responsible for completing the audit, schedules and use;
2. Conduct internal audits as established;
3. Determine the external audit requirements, including a timeline between external audits and completed by an industry-protocol qualified external auditor;
4. Conduct external audits as established;
5. Conduct a limited scope audit when one or more elements do not meet the audit standard for either internal or external audits, complete with an established time frame for re-evaluation; and
6. Determine the requirements for and conduct post-event audits after a serious incident to identify safety program improvements.

Component #5: Audit Scoring

Introduction:

Audit Scoring refers to the quantified measurement of the health and safety program implementation and essentially assigns value. It is with this value that an organization can determine areas of priority for program improvements. When developing and using audits, the component of *Audit Scoring* becomes important, as the scoring can assist with a balanced approach to the evaluation. This aspect of Auditing will ensure that all audits are using similar measurement criteria. The element of *Audit Scoring* is then a key consideration to effective auditing, leading to valuable improvements in workplace health and safety.

Sub-component content:

The following sub-component content expands on what is anticipated to be in place for the component of *Audit Scoring*.

The component of *Audit Scoring* includes processes to:

1. Determine the overall score required for successful audit completion;
2. Determine the minimum requirements for scoring by element complete with a balanced weighting between all program elements; and
3. Determine the minimum requirements for validation techniques complete with a balanced weighting for the validation techniques.

Conclusion

This information is the framework for detailed development of an effective safety program audit. From this framework of standards for safety program audits, the standards for certification specific to individual industry needs will be derived.

A critical understanding of effective safety program audits is that all audit components need to be in place, of high quality, and clearly communicated. For example, it would be difficult to improve the program if a skilled *Auditor* used a faulty *Audit Tool* or *Audit Process*. In addition, for any health and safety program to be effective, there are several pieces that are integrated and dependant on one another. Effective health and safety programs are dependent on the quality of design, implementation, verification and continual improvement. With any one area weakened, there is a greater possibility of a negative chain of events occurring which could result in loss. An audit is a critical link to move towards continual improvement.

To recognize the quality of safety programs, several industries have developed certifications that entice organizations to design, implement, improve and verify their health and safety programs against an industry set of standards. Certifications of effective programs can serve as a launch pad to a further reduction of loss and act as a positive reinforcement for industry. For companies, certification can also act as a public demonstration of conformance to a set of standards resulting from external audits of the health and safety program. Development of a framework of standards for health and safety program certification is the next area of focus for the JIC.

Appendix B

Definition of Terms

Preface

The following definitions are intended to clarify common health and safety terms used in Saskatchewan workplaces. While not all definitions below are referenced throughout the document, they may be of particular use as a company develops, implements and maintains a health and safety management program.

It is important to note that definitions explain words. When words are presented in OH&S legislation, it is imperative to abide by the interpretation of those words as set out by legislation.

Accident – an unwanted, unplanned event that results in a loss; these losses could include production loss, property damage and/or injury including death

Administrative controls – a method of controlling employees' exposure to hazards by rules, procedures, practices, etc.

Assurance of Voluntary Compliance – a formal, written assurance by a person in charge of a workplace to correct a contravention of Part II of the Canada Labour Code in situations which do not call for a direction

Audit – a periodic methodical and in-depth evaluation of an organization's safety programs/systems. Usually the audit is done to a known audit standard

Auditor – a person with the knowledge, skill, training and competency to perform an audit

Audit Process – the manner in which the audit is conducted

Audit Scoring – the quantified measurement of the health and safety program development and implementation

Audit Tool – the document and structure used to assess the status of the organization's safety program

Audit Type – the distinction between audit scopes, timelines, methods, auditors and purpose

C45 – a bill to amend the criminal code in regards to OH&S offenses

Section 217– The amended section of the criminal code dealing with OH&S offenses

Certified – indicating that a person or organization conforms with a standard as judged by a qualified party

Communication – an exchange of information between or among people or groups of people; could include written, spoken, visual, or other forms of multi-media

Competent – possessing knowledge, experience and training to perform a specific duty

Compliance – meeting with the minimum requirements of health and safety legislation

Consultant – one who gives professional or expert advice

Contractor – **NOTE: This definition has two distinct meanings:**

Commonly used dictionary meaning: an individual or organization that provides supplies, services or work for an employer, but not as an employee for wages or salary

Legal meaning (*Saskatchewan Occupational Health and Safety Act, 1993*): a person who, or a partnership or group of persons that, pursuant to one or more contracts, directs the activities of one or more employers or self-employed persons involved in work at a place of employment

Contravention – a violation of a legislative duty and responsibility

Critical – essential to the health, safety and welfare of

Culture – the overall attitudes, outlook and behavior typical of a given organization

Dangerous occurrence – any occurrence that does not result in, but could have resulted in, a condition or circumstance set out in sections 8 and 9 of the *Saskatchewan Occupational Health and Safety Regulations, 1996*

Direction – instruction, order, command, or guidance for completing a task

Document – a form containing process or template information that has yet to be completed or filled out

Documentation – the act or instance of furnishing a record or authenticating an event, process or thing

Due diligence – an action by an individual or organization in regards to OH&S that the common person would see as a reasonable course of action to take; could also be used as a legal defense in OH&S related charges

Elimination – the process of removing a hazardous product, substance or process

Emergency – a situation that requires immediate attention, usually relating to a medical, fire or other such emergency

Emergency preparedness – the overall plan, resources and response required to effectively deal with an emergency situation

Employee – an individual who works for an employer for wages or a salary

Employer – a person, firm, association or body that has, in connection with the operation of a place of employment, one or more workers in the service of the person, firm, association or body

Engineering control – a method of controlling employees' exposure to hazards through the physical design of the workplace and/or process

Equipment – any combination of mechanical parts that transmits from one part to another or otherwise modifies force, motion or energy

External Audit – third party evaluations of health and safety program development and implementation, which are normally conducted by persons external to or outside the organization being audited

First aid – initial emergency care of an injured person; this treatment is usually provided in house

Follow-up – the process of checking to see that corrective action has taken place after an inspection, investigation or loss

Frequency – how often a given type of incident occurs; for example, a lost time frequency would express how many lost time incidents are taking place per a given number of hours worked (e.g. TL/ 200,000 hours)

Hazard – a dangerous object, event, behavior or condition, which could cause hurt, injury or loss

Hazard analysis – a process of identifying the critical steps to a job, the hazards associated with those steps and the actions required to eliminate or reduce the hazards associated with the steps. Also referred to as a Job Task Analysis (JTA) or Job Safety Analysis (JSA)

Hazard assessment – a process for determining hazards associated with a project

Hazard control – a means of reducing the risk of exposure to a hazard and could include elimination of the hazard, substitution of a hazardous product, engineering controls, administrative controls and personal protective equipment

Hazard identification – the recognition through a formal or informal process of a dangerous object, event, behavior or condition, which could cause injury or loss

Health and safety – see definition of “safety”, expands the definition to include health issues

HRSDC – Human Resources and Skills/Social Development Canada, a federal body that enforces OH&S legislation for federally regulated employers

Incident – an unplanned, unwanted event that results in or could have resulted in a loss; these losses could include production loss, property damage and/or injury including death. An accident and near miss are different categories of an incident

Independent safety association – associations formed for the purpose of promoting safety to workers and employers, typically representative of an industry

Inspection – a deliberate, systematic scrutiny or critical examination of an activity, object or process. The examination is often checked or tested against a standard

Instruction – giving information and direction to a worker with respect to particular subject matter

Internal Audit – first party evaluations of health and safety program development and implementation, which are normally conducted by persons within the organization being audited

Interview – the process of gathering information by asking questions to individuals during auditing

Investigation – a systematic process to uncover facts and factors involved in an incident, determining the root causes of the incident and future corrective actions to prevent re-occurrence

Knowledgeable – the state of being well informed and conversant with a subject

Loss – the state in which something of value is lost; these losses could include production loss, property damage and/or injury including death

Loss prevention – a program designed to identify and correct potential incident problems before they result in a loss

Management – the act or art of handling, controlling or having authority over a workplace, including workers who are at the workplace

Management Leadership – the provision of guidance, support, and commitment to processes that will enhance workplace health and safety

Materials – the articles needed to make or do something

Medical aid – an injury for which outside medical treatment was provided and the cost of that treatment was covered by the WCB

Near miss – an unwanted, unplanned event that does not result in a loss; these losses could include production loss, property damage and/or injury including death

Needs Assessment – the identification of organizational requirements that support improved workplace health and safety

No time loss – relating to a WCB claim where an injury results to a person who is able to report for duty on their next regularly scheduled shift

Notice of contravention – cites the contravened provision of the OH&S Act or the regulations, stating the reasons for the OH&S Officer’s opinion and requiring a person to remedy the contravention within a specified period

Observation – the witnessing of actions and conditions

Occupational health committee – an occupational health committee established pursuant to Section 15 of the *Saskatchewan Occupational Health and Safety Act, 1993* and Part IV of the *Saskatchewan Occupational Health and Safety Regulations, 1996*

Occupational health committee member – a person determined by the workforce to be included as part of the occupational health committee

Officer’s report – cites provisions of the OH&S Act or regulations that require remediation

OH&S Division – the government department that enforces occupational health and safety legislation in the province

Act – legislation that assigns OH&S duties and responsibilities to individuals in the province

Regulations – minimum requirements for the purpose of compliance with the duties assigned by the OH&S Act

Code of practice – practical guidance with respect to the requirements of any provision or the regulations

OHC Meetings – a legislative duty requiring the occupational health committee to meet to address occupational health and safety matters

Orientation – the process of familiarizing an individual to a work process, workplace, work site or environment

Owner – a trustee, receiver, mortgagee in possession, tenant, lessee or occupier of any lands or premises used or to be used as a place of employment; and a person who acts for or on behalf of a person as mentioned previous within this definition as that person’s agent or delegate

Personal Protective Equipment (PPE) – a device or item of apparel worn to protect a worker from a hazard or facilitate rescue

Basic – basic PPE might include the minimum equipment that a worker is expected to wear, for example protective footwear. It is important to note that what might be basic to one industry could be specialized in another

Specialized – specialized PPE would be gear that is used above the basic PPE for certain situations, for example, SCBA

Plant – any premises, site, land, mine, water, structure, fixture, or equipment employed or used in the carrying on of an occupation

Policy – a written statement which expresses the philosophy, experience, wisdom and belief of an organization’s senior management for future guidance towards the attainment of stated goals

Policy Statement – see definition of “policy”

Practice – a standardized method for doing a generic job or operation

Prime – of the highest rank, typically referring to “Prime Contractor” in other provinces’ OH&S legislation

Principal – first or highest in rank, importance or value, typically referring to “Principal Contractor” in other provinces’ OH&S legislation

Probability – the likelihood that a given event will occur; often is a combination of how frequently an individual is around a hazard in combination with how likely the event is to occur

Procedure – a step-by-step method for doing a specific job; the procedure usually results from a hazard analysis

Processes – a series of progressive and inter-dependent steps by which an end is attained

Qualified – possessing a recognized degree, a recognized certificate or a recognized professional standing and demonstrating, by knowledge, training and experience, the ability to deal with problems related to the subject matter, the work or the project

Quality assurance – assertion of worth

Records – the completed documents that state events of the past or provides evidence of actions performed

Reports – a detailed account of an action, activity or event

Risk – the probability that during a given period of activity, a hazard could result in an accident with definable consequences

Safety – the condition of being free from undergoing or causing hurt, injury or loss; the art of performing any task in the most accident-free manner reasonably practicable; the control of avoidable loss

Safety association – associations formed for the purpose of promoting safety to workers and employers, usually funded by the WCB through a levy to a specific industry rate code

Safety meeting – a regularly held meeting to discuss safety issues relevant to a company's operations

Safety program – a program of administrative and procedural plans for hazard identification, hazard control and loss prevention; the process of putting them into place, and a method for maintaining their effectiveness; the combined and inter-related processes for the control of avoidable loss

Safety representatives – occupational health and safety representatives

Safety system – see definition of “safety program”

Self-employed – a person who is engaged in an occupation but is not in the service of an employer

Severity – a measure of how severe an accident is; usually expressed as the number of days lost per a given number of hours worked (e.g. days lost/ 200,000 hours)

Skill-Set – the fixed talent or ability

Standards – those morals, ethics, or habits established by authority, or an individual, as acceptable

Stop work order – the cessation of work required by OH&S that involves a serious risk to workers arising from a contravention (see definition)

Sub-contractor – an individual or organization that provides supplies, services or work for a contractor. They usually help to fulfill a portion of a contract that the contractor has

Sub-standard acts – an action by an individual that is less than what is normally expected

Sub-standard conditions – a condition that is below what is normally expected

Substitution – the process of replacing a hazardous product, substance or process with one of a lower hazard

Supervisor – a person who is authorized by an employer to oversee or direct the work of workers

Supplier – a person who supplies, sells, offers or exposes for sale, leases, distributes or installs any biological substance or chemical substance or any plant to be used at a place of employment

Task – a definite piece of work assigned to, falling to, or expected of a person

Time loss – relating to a WCB claim where an injury results to a person who is unable to report for duty on their next regularly scheduled shift

Tool box meeting – also called a tailgate meeting, is a safety meeting that is held to discuss safety issues specific to a crew or specific worksite

Training – giving information and explanation to a worker with respect to particular subject matter and requiring a practical demonstration that the worker has acquired knowledge or skill related to the subject matter

Visitor – an individual who has been authorized to be on or at a workplace

WCB – Workers' Compensation Board, an insurance plan funded by employers to provide benefits for workers injured on the job

Worker – a person who is engaged in an occupation in the service of an employer

NOTE: The following publications were consulted in the development of Appendix B, Definition of Terms:

- *Saskatchewan Occupational Health and Safety Act, 1993*
- *Saskatchewan Occupational Health and Safety Regulations, 1996*
- *Canadian Dictionary of Safety Terms, 1987*
- *Webster's Seventh New Collegiate Dictionary*
- *Webster's Encyclopedic Unabridged Dictionary of the English Language (ISBN 0-517-68781-X)*

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