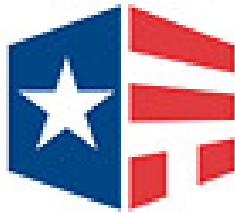


THE  
ULTIMATE  
SHARP  
AUDIT

A Comprehensive  
Audit to help your  
Organization meet  
The requirements of  
OSHA's Safety, Health  
Achievement Recognition  
Program (SHARP)



**SHARP**

Safety & Health Achievement  
Recognition Program  
Consultation: An OSHA Cooperative Program

**Steven J. Geigle, M.A., CSHM**





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OSHA Training Network  
515 NW Saltzman Road #767  
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Telephone: 503.292.0654



# The Ultimate SHARP Audit

This safety management system audit is designed to as a tool to assess and evaluate the effectiveness of the employer's safety management system.

This evaluation tool parallels the safety management system evaluation conducted by OSHA consultants as a part of the OSHA's Safety and Health Achievement Recognition Program (SHARP). Companies working toward SHARP must have a full analysis and evaluation of all 58 elements in this audit evaluated.

All completed audit items should have some justification and/or recommendations under the comment section for questions rated as 0 and 1. All completed assessments should be included and/or referenced in the report sent to the employer.

**Categories:** The audit is divided into the following seven categories (or elements):

- I. Hazard Anticipation and Detection,
- II. Hazard Prevention and Control,
- III. Planning and Evaluation,
- IV. Administration and Supervision,
- V. Safety and Health Training,
- VI. Management Leadership, and
- VII. Employee Participation.

**Metrics:** Each item or sub-element is listed as a survey question. In OSHA's SHARP there are 58 metrics which are considered as building blocks to effective safety and health management systems. All 58 metrics are positive statements which the evaluator agrees with varying degrees of continuity.

## Rating Instructions

Each metric has six possible ratings as described in the following table.

Rating	Description
0	No discernable or meaningful indication that the item is even partially in place
1	Some portion or aspect is present, although major improvement is needed
2	Item is largely in place, with only minor improvements needed
3	Item is completely in place
NE	Not Evaluated: Recognizes that comprehensive evaluations can be incremental
NA	Not Applicable: Must have justification in the comments box why the item is not applicable

Rate each metric based on the attributes (discussed below) and other information. To rate a metric, simply put one of the ratings listed above in the box next to the metric.

**Rating Cues:** An attribute is a specific fact or perception helps justify the rating given to a metric. Each metric is worded as a positive statement. All rating attributes listed below the metric either support/confirm or oppose/negate the statement. Each attribute gives added weight to the rating for the metric. The following table shows how attributes are used to determine ratings.

Rating	Value
0	No CONFIRMING attributes. Eliminated by a single CONFIRMING attributes.
1	Requires a few NEGATING attributes and one or more CONFIRMING attributes.
2	Requires multiple CONFIRMING attributes and a few NEGATING attributes.
3	No NEGATING attributes. Eliminated by a single NEGATING attributes.

Place a plus (+) or minus (-) next to each attribute listed below a metric. Attributes are found in observations and measurement, interviews, and reviews of documentation. There can be multiple cues: initial attributes, corroborating attributes; and conflicting attributes.

**Comments:** The comment section is used to recommend how to improve in the specific metric. Ratings that are "0" or "1" should include a recommendation for improvement. Use the comment area to write a justification for the NA rating.

### Some Suggestions

- In reality, there is a very small gap between the 0 (zero) rating and the 1 (one) rating and between the 2 (two) rating and the 3 (three) rating.
- There is a large gap between the 1 (one) rating and the 2 (two) rating. That gap is the difference between mostly no and mostly yes.
- Look for things that are done well and reinforce these things with personnel for their good efforts.
- The more you can encourage small positive steps, the greater chance that significant positive change will follow and the greater the opportunity for long-term improvement.
- Finally, consider networking with another SHARP company. Networking among SHARP companies is encouraged and has proven to be beneficial to both those companies being mentored as well as to those companies doing the mentoring.

# THE ULTIMATE SHARP Audit

## I. Hazard Anticipation and Detection

**1. A comprehensive, baseline hazard survey has been conducted within the past five (5) years.**

- a. Surveys are conducted frequently enough to timely and effectively address hazards.
- b. Surveys are performed by competent and qualified individuals that can effectively and thoroughly understand the hazards of the industry.
- c. The survey results in an updated hazard list or survey report (action plan).
- d. The survey results in effective controls for hazards found.
- e. The survey drives immediate corrective action on items found.
- f. The survey tries to include outside personnel to help prevent tunnel vision and maintain objectiveness.
- g. The survey was completed by a certified specialist.
- h. The survey identified all serious hazards associated with the facility and resulted in appropriate hazard control programs.

Comments:

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- The baseline hazard survey should be documented in a written report as a requirement for a rating of "3" on this metric.
- Qualified persons such as OSHA evaluators, private evaluators, insurance loss control specialists, or appropriately trained and experienced employees of the organization should conduct the baseline hazard survey.
- The word "comprehensive," used here, does not mean perfect or all-inclusive. It does mean that major operations, especially high-risk operations, during all shifts are included in the baseline survey. It also means hazard categories normally associated with the type of business are addressed in the survey.
- The 5-year time-frame, although a common planning horizon, is somewhat arbitrary. The evaluator will question the validity of your baseline hazard survey, even one conducted during the previous five years, if subsequent changes in the organization appear to nullify the survey's relevance or accuracy. Due to the rapid change that occurs in most organizations, a baseline hazard survey older than five years will usually not be accepted without justification.
- No comprehensive baseline survey is effective unless each identified hazard is immediately corrected or appropriately scheduled for correction in the organization's action plan for safety and health.
- **Deficiencies found in this metric may also indicate problems in these metrics: 22,23, and 54**



**2. Effective safety and health self-inspections are performed regularly.**

- a. Inspections of the workplace are conducted in all work areas.
- b. Inspections identify new, reoccurring, or previously missed safety or health hazards and/or failures in hazard control systems.
- c. Inspections are conducted at least quarterly at fixed work sites, weekly at rapidly changing sites, and as frequently as daily where necessary.
- d. Inspectors have been adequately trained in workplace safety and health rules.
- e. Logs, checklist, or other type of written reports are used to document formal inspections.
- f. All hazard findings are addressed as soon as practically possible.
- g. Hazards identified do not appear on future inspections.
- h. The responsibility for inspections rests with more than one person.
- i. The responsibility for inspections is scattered throughout the organization.
- j. Inspections are conducted by teams.
- k. Appropriate time is provided to conduct the inspections.
- l. The use of tools (such as digital cameras, palm pilots, and computers) are used in the process.

Comments:

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- Inspections are defined as periodic activities or events involving observation and/or testing of selected safety and health aspects of the work and workplace. Essentially, an inspection is a systematic comparison of observed status to expected or desired status. Inspections may be formal or informal.

Formal inspections usually involve the use of checklists and often result in the issuance of inspection reports. Complex inspections should always be supported by a checklist and conducted on a formal basis. The written documentation associated with formal inspections (checklists, logs, reports, etc.) may be used to support a rating of "3" on this metric if the documentation indicates that such inspections were thorough and conducted on a regular basis.

Informal procedures may be effective for routine and limited inspections in which the inspection coverage can be systematically addressed by rote. The thoroughness and consistent performance of informal inspections will usually require evaluation by interview.

- The term "regularly" means recurrence within understood limits (daily, weekly, monthly, quarterly, etc.) and does not necessarily mean a set pattern or firm schedule. The appropriate frequency of inspections depends on the stability and criticality of the factors covered by each inspection. The period of time between inspections may indicate the degree to which the employer tolerates safety and health system failures.
- Self-inspection requires the organization to exercise an internal capacity to conduct effective safety and health inspections. Ideally, this capacity will not reside in a single individual, but will be diffused throughout the organization. Workers should perform or participate in the performance of safety and health inspections of their own work areas or operations. Team efforts are highly desirable, especially for general inspections.
- No inspection is effective unless each identified hazard is immediately corrected or appropriately scheduled for correction in the organization's action plan for safety and health.
- Documented quarterly inspections by supervisors and trained members of the safety committee, when the evaluator verifies them as effective are positive cues for this item.
- **Deficiencies found in this metric may also indicate problems in these metrics: 19, 22, 23, and 54**



**3. Effective surveillance of established hazard controls is conducted.**

- a. Established hazard controls are in place and operational.
- b. The hazard controls are prioritized with the emphasis on engineering controls, safe work practices, and administrative controls before PPE.
- c. Employees understand the hazard control associated with their work areas.
- d. Monitoring evaluation of hazard controls is on-going and known to and by the work force.
- e. Supervisors receive training in surveillance of established hazard controls.
- f. At least some employees receive training in surveillance of established hazard controls.
- g. Surveillance activity is required supervisory duty and is tracked in some fashion.
- h. Some type of trend analysis of tracked surveillance activity is done.
- i. Trend analysis of tracked surveillance activity results in improved performance of established hazard controls.

Comments:

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- Surveillance (observation) is similar to inspection in that both are concerned with the way things are, compared to the way they should be. Surveillance, however, is constant or ongoing while inspection is periodic. This means that surveillance normally provides a shorter time-tolerance for system failures than do inspections. On the other hand, inspections are usually more structured, systematic, and thorough than surveillance. Together, however, these two complementary hazard detection techniques provide the best means to ensure early detection of existing hazards.
- This metric will be evaluated by evaluator observations. Whenever evaluators observe established controls (engineering controls, PPE, safety rules, safe work practices, etc.) are being violated, there is indication that surveillance is missing or ineffective. Likewise, when evaluators observe that established hazard controls are in place and operative, there is indication that surveillance is effective.
- This metric can also be evaluated by interview. Employees, particularly supervisors, can be asked to describe the key safety and health controls associated with their work areas, operations, or job duties; how such controls are monitored; and what steps are taken when problems are detected.
- Surveillance of hazard controls is not effective unless control failures are immediately corrected or appropriately scheduled for correction in the organization's action plan for safety and health.
- **Deficiencies found in this metric may also indicate problems in these metrics: 14, 23, 26, and 54.**



**4. An effective hazard reporting system exists.**

- a. A system for employee hazard reporting is in place and is known to all employees.
- b. The system allows for the reporting of physical and behavioral hazards.
- c. Corrective action is taken promptly on all confirmed hazards.
- d. While waiting for final correction, the employer finds ways to protect those affected.
- e. All personnel are aware that hazards can develop within existing jobs, processes and/or phases of activity.
- f. The system provides for self-correction of hazards when possible.
- g. Employees are provided positive reinforced or incentive for using the system.
- h. There is an informal method of hazard reporting for employees to report hazards to their supervisors.
- i. There is a formal method available to employees to report hazards on a form to the safety department.
- j. Reported hazards are collected and analyzed and used to set priorities and action planning on addressing hazards in the workplace.
- k. There is a mechanism for formal and informal hazard reporting to promptly communicate (to the person reporting the hazard) the status and intended action regarding the reported hazard.
- l. All hazards reported are communicated to the work force in some manner.
- m. Few hazards are noted in the workplace.

Comments:

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- The existence and design of an organization's hazard reporting system is analyzed by interviewing managers, supervisors, workers. The best hazard reporting systems have both centralized (formal) and decentralized (informal) features.

The centralized component of hazard reporting provides a common point for collection of reported hazard information across the organization. In addition to employee reports, hazard incidence information collected at the organizational level includes the results of surveys, analyses, and formal inspections of the workplace, providing a broader information base for priority setting and action planning. In larger organizations, the safety director or safety committee usually collects such information. In very small organizations, the owner-manager or a designee is usually responsible.

The decentralized component allows direct reporting of a hazard to the individual with primary responsibility for the affected work area, operation, or personnel. This direct reporting procedure normally facilitates prompt correction of the hazard by the responsible person closest to the problem. Workers reporting hazards to their supervisors is an example. However, workers should always have the option of reporting to the organizational level whenever they feel that correction of a directly reported hazard has been neglected or ineffective. Likewise, supervisors should always forward to the organizational level any worker hazard report for which the supervisor is unable to take appropriate corrective action.

- A crucial factor in hazard reporting system effectiveness is that each individual who reports a hazard receives prompt feedback concerning when and how the hazard will be corrected or an objective explanation why no corrective action will be taken. Although hazard correction status reports are sometimes provided to employees, such reporting is more often informal. Therefore, evaluation of the feedback feature normally requires interviews with employees who have reported hazards.
- The basic objective of a hazard reporting system is early detection and reporting of hazards effectively known to employees. A hazard is "effectively known" when the employee is both aware of the existence of the hazardous condition or activity and understands, at least generally, the possible harm it represents. Therefore, when uncovering previously unreported hazards, and employees should have effectively known such hazards, the underlying problem may be a training problem, a reporting problem, or both. Interviews with employees will be needed to make a determination.
- **Deficiencies found in this metric may also indicate problems in these metrics: 10, 35, 40, 49, 50, and 54.**

**5. Change analysis is performed whenever a change in facilities, equipment, materials, or processes occurs.**

- a. Changes in space, processes, materials, or equipment at the facility are planned.
- b. Affected personnel are made aware of planned changes prior to implementation.
- c. A comprehensive hazard review process exists and is used for all changes.
- d. The hazard review (analysis) process encourages recommendations for improvement, which are implemented prior to start-up.
- e. The analysis process involves competent, qualified specialists appropriate to the process being evaluated.
- f. There is a formal, written process for change analysis.
- g. Affected employees are involved in the change analysis.
- h. Change analysis procedures include revisions of Job Hazard Analysis (JHA's), Standard Operation Procedures, lockout methods, PPE, and other program elements affected by the change.

Comments:

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- A change analysis program is essentially planning-for-planning. It is, at minimum, a set of policies designating responsibilities for current and future planning activities involving changes in facilities, equipment, materials, or processes, including the safety and health aspects of such changes. Ideally, responsible parties will be in "line" positions. The change analysis program should also include planning procedures that ensure the safety and health input of appropriate personnel such as safety staff, the safety committee, and affected supervisors and workers.
- Change analysis is primarily a hazard anticipation function. Use metrics 11-19 to evaluate the degree to which the organization has successfully addressed correction of any hazards or potential hazards it has identified by change analysis.
- Hazards identified indicate a deficiency in this metric when such hazards could have been identified, and therefore prevented, by effective change analysis.
- Absence of hazards associated with recently implemented changes in facilities, equipment, materials, or processes is suggestive that change analysis in the organization is effective.
- Some OSHA consultation projects have added "changes in environment" to their consideration in evaluating this metric for employers not engaged at fixed work sites.
- **Deficiencies found in this metric may also indicate problems in these metrics: 26, 39, 40, 49, and 54.**



**6. Accidents are investigated for root causes.**

- a. Workplace policy requires a thorough investigation of all accidents and incidents.
- b. All accidents and incidents are investigated as required by policy.
- c. All investigations are conducted by personnel trained in accident/incident investigation techniques.
- d. All investigations include input from all affected parties and witnesses, where possible.
- e. All investigations determine "root causes" and underlying factors.
- f. Recommendations designed to adequately address root causes are made as a result of all investigations and result in prompt corrective action.
- g. Completed investigative reports are routed to appropriate levels of management and knowledgeable staff for review.
- h. Investigations are done by management and employees.
- i. Results of investigations are shared with the work force.
- j. Top management reviews all accidents and incidents to review if root cause was identified adequately.
- k. Standard forms are used to document all accidents and investigations.
- l. Top management participates in investigations.

Comments:

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- Accident investigation must be conducted as a formal procedure, even in the smallest of organizations. Therefore, every employer should establish policies to ensure that thorough and timely accident investigations are specified, performed, and recorded. Although the procedures are formal, the implementing policies in very small organizations may be unwritten and informal, requiring verification by interviews with responsible parties.
- Organizational policy should (1) specify the class of accidents that require investigation. Regulation requires investigation of the class of accidents that involve recordable injuries and illnesses, but the employer may also require investigation of the class of accidents that involve only property losses. Organizational policy should (2) assign responsibilities for performance of accident investigations. Normally, such responsibilities rest with the appropriate supervisor, the safety committee, safety staff, or some combination of these personnel. However, there is an opportunity for top management to exhibit visible safety and health leadership by participating in accident investigations. Organizational policy should (3) adopt a standard recording form for all accident investigations. This standard record may be a workers compensation First Report of Injury form, the OSHA Injury and Illness Incident Report (Form 801), or an equivalent record developed by the organization.
- The objective of an accident investigation is not to assign blame, but to identify root causes of the accident so that corrective measures can be taken. Hazards--unsafe or unhealthful conditions or activities--are involved in all accidents. The underlying personal, organizational, job-related, and environmental factors that result in or allow the existence of these hazards are the root causes of the accidents. Considerable skill and diligence is often required to ascertain the root causes of an accident, and this phase of the accident investigation should be conducted by a qualified person such as the safety manager or safety committee. Records or reports of completed accident investigations are the best source of information to judge if root causes are being discovered by the organization. **As a rule-of-thumb, any accident investigation that metrics single causation has not adequately addressed root causes.**
- Individuals with accident investigation responsibilities can be interviewed to learn if they understand and acknowledge the importance of root cause analysis.
- Accident investigation is not effective unless identified hazards and underlying root causes are immediately addressed or appropriately scheduled for correction in the organization's action plan for safety and health.
- **Deficiencies found in this metric may also indicate problems in these metrics: 23, 26, 36 and 40.**



**7. Material Safety Data Sheets are used to reveal potential hazards associated with chemical products in the workplace.**

- a. Employees understand the hazards introduced to their jobs by chemical use.
- b. Hazards identified in MSDS's are effectively controlled.
- c. Employees have seen and understand the MSDS(s) applicable to the chemicals they use.
- d. Applicable MSDS information is incorporated into written job hazard analysis forms.
- e. MSDS's are periodically reviewed in order to determine if a safer product could be used, or if current JHA's address the hazard adequately.
- f. Information on the MSDS is used by personnel performing change analysis to identify potential hazards related to new chemicals being introduced into the workplace.
- g. The Safety Committee reviews MSDSs to address the prevention, elimination, and/or control of hazards posed by chemical products.

Comments:

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- This metric and the hazard communication standard (29CFR1910.1200) are closely related, but not redundant. The hazcom standard does not directly address the prevention, elimination, or control of workplace hazards posed by chemical products. Rather, its focus is on communication of information about potential hazards and possible protective measures. Nevertheless, the process of detecting workplace hazards associated with chemical products, as incorporated in this metric, cannot be effective until Material Safety Data Sheets for all hazardous products have been obtained and reviewed by the employer as required in the hazcom standard.
- Hazards identified may indicate deficiencies in this metric if such hazards were not effectively known to the employer, but would have been revealed by review of relevant Material Safety Data Sheets.
- The process of detecting workplace hazards from information in Material Safety Data Sheets is not effective unless such identified hazards are immediately corrected or appropriately scheduled for correction in the organization's action plan for safety and health.
- **Deficiencies found in this metric may also indicate problems in these metrics: 26, 29, 36, 40, and 54.**



**8. Effective job hazard analysis is performed.**

- a. There are hazard analysis systems designed to address routine job, process, or phase hazards in place at the facility.
- b. Hazard analysis systems identify or prompt corrective or preventive action to reduce or eliminate work site hazards.
- c. All tasks, job processes, or phases of activity are analyzed.
- d. All job processes, or phases of activity are analyzed whenever there is a change, when a loss incident occurs, or on a schedule of no more than 3 years.
- e. Upon implementation of the corrective or preventive actions identified by the hazard analysis process, the written hazard analysis is revised to reflect those actions.
- f. Employees are involved in the hazard analysis process.
- g. Accident and incident investigation leads to job hazard analysis when appropriate.
- h. Job hazard analysis addresses safety, health, and ergonomic hazards.
- i. There is a standard and uniform format used to document job hazard analysis.
- j. JHA's are posted at work stations.

Comments:

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- Job hazard analysis (JHA) is a formal technique for hazard detection involving careful study and recording of each step in a job, identifying existing or potential hazards associated with each step, and determining the best way to perform the job to reduce or eliminate these hazards. Informal examination of a job does not constitute job hazard analysis. In most cases, completed worksheets will be available to document that the organization is performing job hazard analyses.
- Review of completed job hazard analysis worksheets should reveal the effectiveness with which the procedures have been conducted.
- Hazards identified may indicate deficiencies in this metric if the hazards could have been detected, and therefore corrected, by effective job hazard analysis.
- Job hazard analysis can also include job safety analysis, environmental health and safety analysis, phase hazard analysis, etc.
- Almost all jobs are candidates for job hazard analysis, but it is a rare organization that has up-to-date worksheets completed for every job in the workplace. Therefore, job hazard analysis is an ongoing effort in most organizations that employ this hazard detection technique. However, jobs should be scheduled for attention on a priority basis, with higher priority being assigned to jobs having the highest rates of accidents and disabling injuries, jobs where —close calls“ have occurred, jobs where major changes have been made in processes and procedures, and jobs involving new workers.
- **Deficiencies found in this metric may also indicate problems in these metrics: 20, 26, and 36.**