Safety & Health Committee Meeting Minutes (Amended)
October 25th, 2018
2:47 PM – 3:31 PM
Bldg. 25, Boardroom

Present:	Al Brown, Lynn Corliss, Sheryl Kermoade, David Knoblach, Lacy Neal, Rob Shailor, and Karl Shenkel
Absent:	Raymond Bateh, Donna Ching, Carolyn Clark, Tim Goebel, Nicole Gugliotti, Dana Larson, Scott McLean, Lara Semidei, Vida Sherrard-Hannon, Chris Vella, and Missy Yates

The meeting was called to order by Rob Shailor at 2:47 p.m.

The September Safety & Health Committee meeting minutes were approved.

I. Reports
   A. Faculty member Lynn Corliss gave a presentation on the negatives effects of vehicle idling and pollution from vehicle exhaust. Lynn commented that she has noticed several students idling in the parking lot. The committee recommended that she take her concerns to the student senate to get involvement ideas for this topic.

II. Accident/Investigation
   A. Employee was unloading chairs from a vehicle; the lift caused a strain to the right shoulder.
   B. Employee was pushing an L-shaped desk to a different location and felt a sharp pain in the lower back and left hip.
   C. Employee was crossing the street near parking Lot F and came across an uneven stepdown from the sidewalk to the street. The uneven space caused the employee to fall; the fall caused impact to the right shoulder, forearm, and ribs.
      Follow up: Rob Shailor investigated this incident and put in a facilities request to correct the uneven surface.
   D. Employee was cutting shrink wrap off of a pallet when the knife snagged. When the knife came free it stuck into the employee's left forearm.
   E. Employee was moving a carpet machine, the machine malfunctioned and caused an impact to the employee's left wrist.
      Follow up: Karl Shenkel investigated this incident and found that the machine had been returned from the shop with incomplete maintenance.
   F. Student was slicing bread in the culinary kitchen and cut the right index and middle fingers.
   G. Student was shredding cabbage with a chef's knife and cut the pad area of the left thumb.

H. Student was cleaning the kitchen area and the right index finger brushed over a knife blade while cleaning.

III. L & I Report (from Lacy Neal)

A. For the month of September 2018 there were three (3) claims totaling Three Thousand Five Hundred Thirty Five Dollars and Eighty Cents ($3,535.80). The College has not received claim information for the month of October 2018.

FY 2016-2017	# of Claims	$$	FY 2017-2018	# of Claims	$$
July 2017	8	$8,785.08	July 2018	4	$1,874.89
August 2018	8	$4,924.72	August 2018	4	$2,415.72
September 2017	4	$2,188.95	September 2018	3	$3,535.80
October 2017	7	$3,419.15	October 2018		
November 2017	10	$5,734.10	November 2018		
December 2017	7	$4,093.78	December 2018		
January 2018	5	$5,559.80	January 2019		
February 2018	3	$1,688.23	February 2019		
March 2018	3	$1,656.64	March 2019		
April 2018	3	$1,624.19	April 2019		
May 2018	5	$1,860.18	May 2019		

Year	# of Claims/Year	Average Claims/Month	Yearly Cost	Monthly Average Cost
2015-2016	87	7.25	$78,342.27	$6,528.52
2016-2017	74	6.17	$49,363.97	$4,113.66
2017-2018	64	5.33	$42,791.77	$3,565.98
2018-2019	11	3.67	$7,826.41	$2,608.80

(The claims and dollar amounts that are reported in the L&I Report: The claims listed above are from present and past employees that were injured on the job and are still claiming benefits. The original accident could have happened many years ago. Payments for these claims come out of the state L&I account and may or may not have anything to do with what we are currently paying to L&I out of our paychecks.)

Rob Shailor and Lacy Neal gave a report on recent consultation visits with L&I. The first visit was with a Safety Program Manager to review and give feedback on the College's Accident Prevention Program. The second consultation was with a Risk Manager who provided the College's injury and cost profile, as well as an overview for how to reduce our rates and control worker's compensation costs.

Rob and Lacy continue to work on improvements to the Accident Prevention Program, and will report back to the committee once the formal L&I Consultation assessment comes in.

IV. Health and Wellness Update
   A. The annual chili cook-off is scheduled for Wednesday, October 31st.
   B. Lacy Neal continues to work on wellness committee activities planning for the 18/19 academic year.

V. Emergency Management
   A. Rob Shailor reported that the Great Shakeout drill on October 18th was successful.

VI. Old Business

VII. New Business

VIII. Adjourn

Our next meeting is scheduled for:

November 29th, 2018
2:15 PM – 3:00 PM
Building 25, Boardroom

PLEASE PUT THESE MEETING DATES ON YOUR CALENDAR:	Date	Time	Location
	December 27, 2018	2:15pm-3:00pm	Bldg. 25 Boardroom
	January 31, 2019	2:15pm-3:00pm	Bldg. 25 Boardroom
	February 28, 2019	2:15pm-3:00pm	Bldg. 25 Boardroom
	March 28, 2019	2:15pm-3:00pm	Bldg. 25 Boardroom
	April 25, 2019	2:15pm-3:00pm	Bldg. 25 Boardroom
	May 30, 2019	2:15pm-3:00pm	Bldg. 25 Boardroom
	June 27, 2019	2:15pm-3:00pm	Bldg. 25 Boardroom

Washington State Department of Labor & Industries

Injury and Cost Profile *for*

SOUTH PUGET SOUND COMMUNITY CO

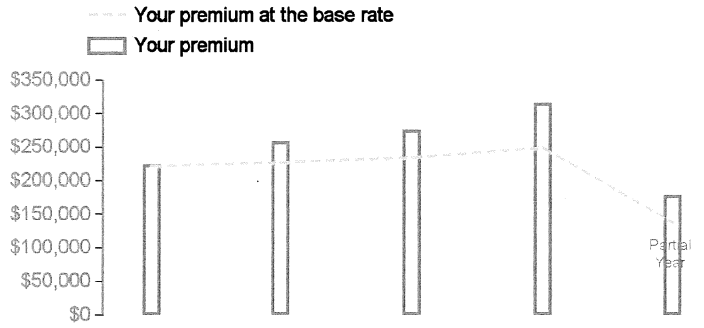
Questions? Call your Risk Manager	
Jay Doughty	(360) 896-2393
Account ID:	546,112-00

See how your injury claims affect your premiums. Compare your injuries with what's typical for your industry. Then take steps to make your workplace even safer – *and* control your workers' compensation cost. Contact us!

Your 5-year history of premiums and injury claims

You paid $186,871 over the base premium rate during this entire 5-year period.

High claim costs will negatively affect your experience factor and increases your overall insurance premiums.



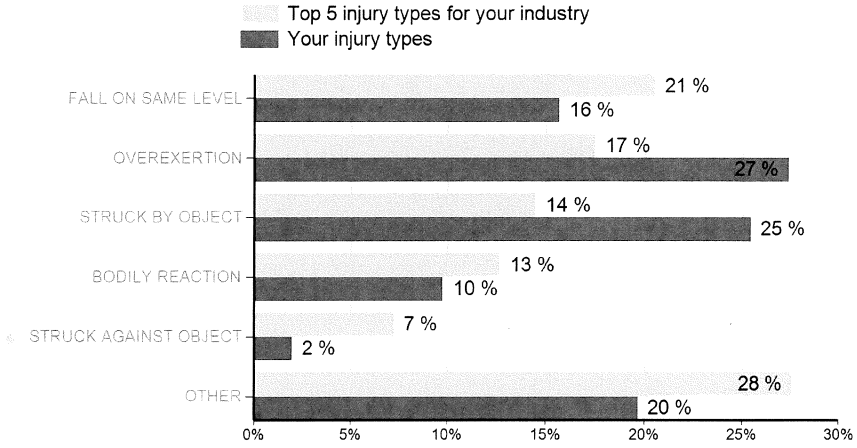
Calendar year	2014	2015	2016	2017	2018
Hours you reported	690,537	675,900	673,144	716,305	388,574
Your premium	$225,017	$258,628	$275,977	$316,924	$179,319
Payroll deduction *(employee share)*	$62,412	$68,238	$71,983	$80,366	$45,666
Employee rate for class 4906 Colleges & Universities (100 % of your total premium)	$0.09/hr	$0.10/hr	$0.11/hr	$0.11/hr	$0.12/hr
Claims	14	12	11	12	4
- Medical Only	10	10	7	8	4
- Time-loss or disability claim	4	2	4	4	0
Experience Factor	1.0219	1.1900	1.2448	1.3779	1.4309
Claim-Free Discount?	no	no	no	no	no

Compare *your* injuries with what's typical for your industry: Junior Colleges

To protect your workers from injuries, please focus your accident prevention program on these common hazards.

Let L&I help you take steps to make your workplace even safer – and control your workers' comp costs.

Visit us at:
www.Lni.wa.gov



Injured Worker Toolkit

☐ **REPORT** the injury immediately to your supervisor

☐ **SEEK** immediate medical attention, if necessary. Use the provided map in the toolkit indicating the closest Urgent Care/ER facility available. This Injured Worker Toolkit includes important information and forms for you and the healthcare provider(s). Bring this packet with you to the medical facility.

☐ **COMPLETE** the ***Worker's Report of Accident*** as soon as reasonably possible

☐ **PROVIDE** the Light Duty job descriptions included in this packet to the doctor for approval, if you are restricted from your normal job duties

☐ **SUBMIT** all injury related paperwork, including this Injured Worker toolkit, to your supervisor during the shift/day the incident/injury occurred.

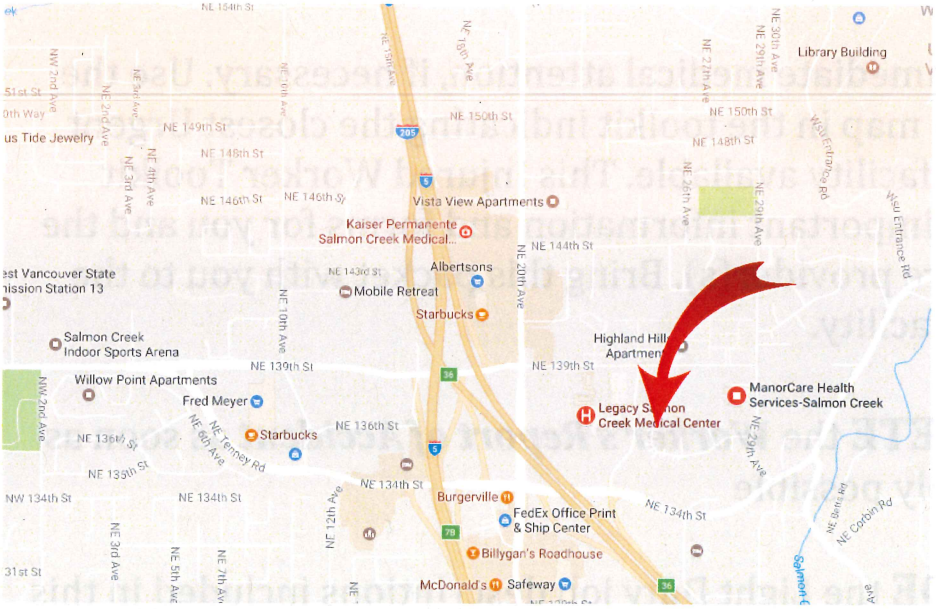
☐ **FOLLOW** treatment instructions as defined by your medical provider

☐ **COMMUNICATE** your treatment plan with your Supervisor

Where to go to seek Medical Treatment

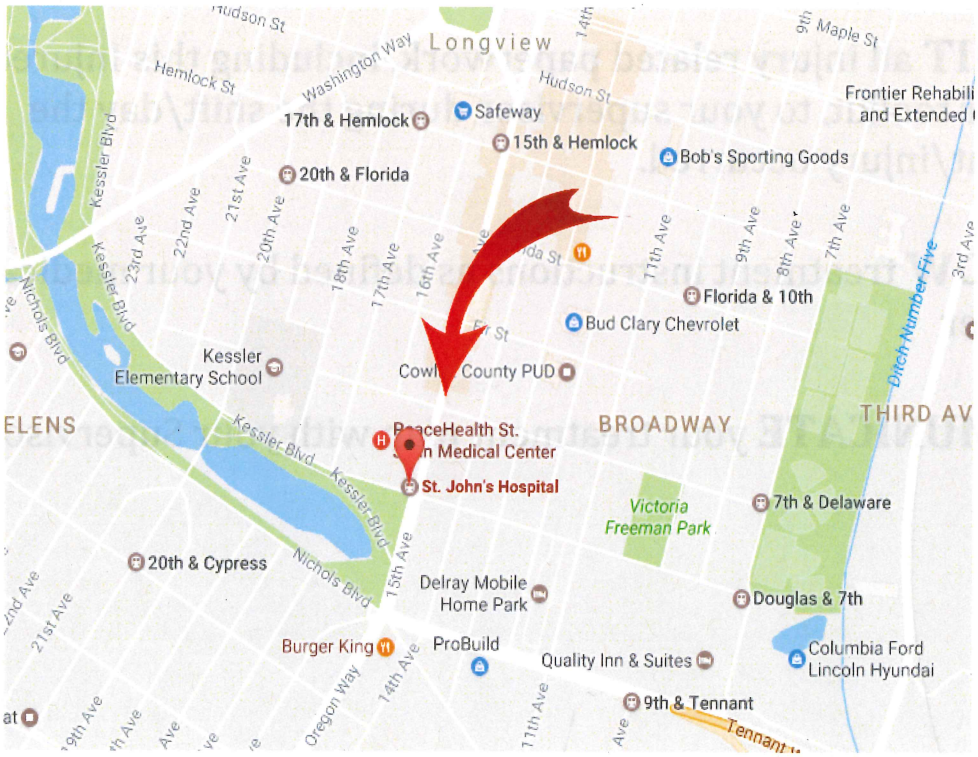
Urgent Care

ABC Urgent Care
1234 E Main Street suite 111



Emergency Room

DEF Emergency Room
1414 W 4th Street



Worker Report of Accident

Section 1: Worker Information

Worker Name:	First	Middle	Last	Hire Date:	☐ Male ☐ Female
I am reporting a **work-related**:	☐ Injury	☐ Illness	☐ Property Damage	☐ Near Miss*	
Date of Incident:		Time of Incident:		☐ AM ☐ PM	
Date incident was first reported:		To whom?			
Supervisor:		On overtime?	☐ Yes ☐ No		
Job Title (at time of injury):		Normal Job Title:			

* Skip sections 2 & 3

Section 2: Injury/Illness Information

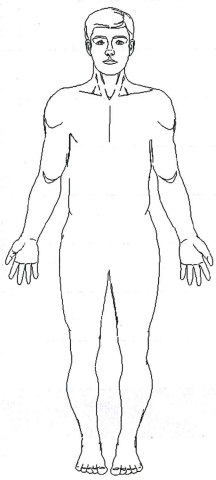
Was this a **SUDDEN** injury that can be attributed to a specific event? ☐ Yes ☐ No Date:

OR did symptoms develop over time? ☐ Yes ☐ No Date first noticed symptoms

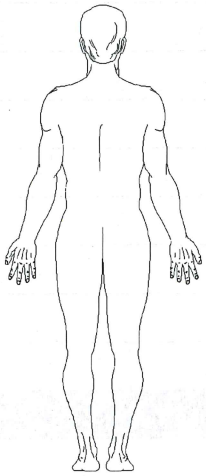
Have you experienced pain or injury in this body part before? (if Yes, explain) ☐ Yes ☐ No

Have you seen a doctor? ☐ Yes ☐ No If yes, who?

WHERE AND WHAT WAS THE INJURY OR ILLNESS? (mark all that apply)



Front



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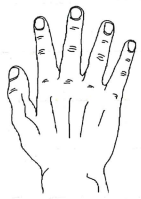
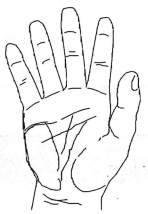


Back



Front

Mark the areas of the body that were effected
Right ☐ Left ☐

- ☐ Strain, sudden
- ☐ Strain, gradual
- ☐ Sprain
- ☐ Fracture
- ☐ Cut/Laceration
- ☐ Scrape/Abrasion
- ☐ Bruise/Contusion
- ☐ Pinch/Crush
- ☐ Eye Irritation (Foreign Body)
- ☐ Loss of Consciousness
- ☐ Throat/Lung Irritation
- ☐ Burn: Heat/Chemical/Radiation
- ☐ Puncture/Sliver
- ☐ Hernia
- ☐ Chemical Exposure
- ☐ Hearing Loss
- ☐ Multiple Injuries
- ☐ Skin Irritation
- ☐ Amputation
- ☐

Section 3: Property Damage Information

What was damaged? ☐ **Product** ☐ **Equipment** ☐ **Structure (describe & extent of damage)**

Estimated down time? Approximate $ cost?

☐ Replace ☐ Repair ☐ Other:

Worker Report of Accident

Section 4: Incident Description

Where did the incident occur? Exact Location:	

Describe incident/near miss in detail – before, during, and after. What was the result or possible result?

What could have been, or could be, done to prevent the incident or prevent future incidents?

Were there any witnesses? (list)	
Worker's Signature:	

Return-to-Work Authorization

(Required to be approved by Doctor)

Company name & address
Contact name & number

Employee:
Job Title:
Date of Injury:

Dear Attending Physician:

We are a proactive company and care about our workers. We recognize early Return-To-Work as being important to the workers' psychological and physical well-being.

Your assistance is appreciated!

Attached you will find the job description, including the physical demands, of our worker's normal job. We have also included a job description for a ***modified / light duty / transitional*** position we have available if our employee is not released to their job of injury. Further adjustment to these positions may be possible if needed.

Please complete the Activity Prescription Form and include any comments on our employee's ability to work. Please give a copy of the completed form to our employee.

Please call if you have any questions.

Sincerely,

_____ _____
Attending Physician Date

Please insert a copy of the Activity Prescription form here.
Form is also located on L&I's Website:
http://www.lni.wa.gov/forms/pdf/F242-385-000.pdf

Job of Injury
Description

Department of Labor and Industries

Physician billing codes for Review of Job Analysis and Job Description:

1038M – Limit one per day

1028M – Each additional review, up to 5 per worker per day.

Employer's Job Description Form

- ☐ Job of Injury
- ☐ Permanent Modified
- ☐ Light Duty/Transitional

Worker Name:	Claim Number:
Company Name:	Job Title:
Phone Number:	Fax Number:
Hours per day:	Days per Week:

Essential Job Duties:

Machinery, Tools, Equipment, and Personal Protective Equipment:

Frequency Guidelines:

N: Never (not at all) **S:** Seldom (1 – 10% of the time) **O:** Occasional (11 – 33% of the time)
F: Frequent (34 – 66% of the time) **C:** Constant (67 – 100% of the time)

Physical Demands:	L	R	B	Frequency:	Description of Task:
Sitting					
Standing					
Walking					
Heights/Ladders/Stairs					
Twisting at the Waist					
Bending/Stooping					
Squatting/Kneeling					
Crawling					
Reaching Out					
Talking/Hearing/Seeing					
Working Above Shoulders	☐	☐	☐		
Handling/Grasping	☐	☐	☐		
Fine Finger Manipulation	☐	☐	☐		
Foot Controls	☐	☐	☐		
Driving	☐	☐	☐		
Repetitive Motion	☐	☐	☐		
Vibratory Tasks H☐ L☐	☐	☐	☐		
Lifting ( ) lbs.	☐	☐	☐		
Carrying ( ) lbs.	☐	☐	☐		
Pushing/Pulling ( ) lbs.	☐	☐	☐		

Comments/Other:

Employer Name (Please Print) | Title

Employer Signature | Date

For Healthcare Providers' Use Only

Approval ☐ Yes ☐ No ☐ Approved with Modifications | Hours per Day: | Days per Week: | Effective Date:

If no, please list the objective medical finding:

If approved with modifications, describe the modifications needed:

Healthcare Provider Printed Name | Healthcare Provider's Signature | Date

Light Duty
Description

Department of Labor and Industries

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Employer's Job Description Form

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Crawling					
Reaching Out					
Talking/Hearing/Seeing					
Working Above Shoulders	☐	☐	☐		
Handling/Grasping	☐	☐	☐		
Fine Finger Manipulation	☐	☐	☐		
Foot Controls	☐	☐	☐		
Driving	☐	☐	☐		
Repetitive Motion	☐	☐	☐		
Vibratory Tasks H☐ L☐	☐	☐	☐		
Lifting ( ) lbs.	☐	☐	☐		
Carrying ( ) lbs.	☐	☐	☐		
Pushing/Pulling ( ) lbs.	☐	☐	☐		
Comments/Other:					

Employer Name (Please Print) Title

Employer Signature Date

For Healthcare Providers' Use Only

Approval ☐ Yes ☐ No ☐ Approved with Modifications Hours per Day: Days per Week: Effective Date:

If no, please list the objective medical finding:

If approved with modifications, describe the modifications needed:

Healthcare Provider Printed Name Healthcare Provider's Signature Date

Worker's Comp Policy

1. For all work-related injuries/illness' (no matter how minor) please take the following steps:

    a) Complete an in-house Accident Report and submit to your supervisor or the HR Department

    b) If medical treatment is necessary, please notify your supervisor

2. When seeing a Doctor, please supply the medical staff with your Return to Work Authorization form.

3. If a work-related injury/illness causes lost time from work you must check in with your supervisor or HR Department once a week on _____. Medical authorization for all lost time from work due to work-related injury/ illness must be obtained from the doctor and submitted to your supervisor or HR.

4. If you are released for ***Light / Modified / Transitional*** duty you must:

    a) Report your medical status to your supervisor or HR within 24 hrs

    b) Obtain written Return-to-Work authorization from your doctor and submit this to your supervisor or HR

    c) Cooperate with company's efforts to provide ***Light / Modified / Transitional*** duty work for you while you recover

    d) Communicate any concern or change in physical abilities to your doctor/ HR/ CM

5. Carefully follow all doctor instructions:
    a) Keep all appointments

    b) Communicate any concern or confusion to the CM/ doctor/ employer

6. Promptly respond to any request for information from the Department of Labor and Industries

Sign name: _____

Print Name: _____