

Healthy Workplaces

Millwork, Furniture, and Fixtures Industry Final Report

Technical Report Number: 67-3-2003

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TABLE OF CONTENTS

Executive Summary	iii
Tables	ix
Figures	xi
Introduction	1
Significance of the Problem	1
Purpose of the Study	3
Definitions	3
Methods	5
Sample Selection Methods	5
Industry Selection	5
Survey Phase	6
Site Visit Methods	9
Selection of Companies for Site Visits	9
Walk-Through Methods	9
Organizational Assessment Methods	11
Educational Intervention Methods	12
Ergonomics Training	12
Company Tours	13
Results	15
Telephone Survey	15
Demographic Characteristics	15
Organizational Health and Workers' Compensation Claim Rates	17
Additional Findings	22
Site Visit Findings	29
Facility Walk-Through	31
Organizational Assessment	42
Educational Intervention	47
Ergonomic Training	48
Company Tours	50
Discussion	53
Concluisions	61
References	63
Appendices	65

EXECUTIVE SUMMARY

Background

In 1999, the Safety and Health Assessment and Research for Prevention (SHARP) Program developed the Healthy Workplaces Initiative to reduce work-related injuries and illnesses in an industry by 1) determining factors that create workplace health, and 2) disseminating that information throughout the industry. The initiative was created to test the hypotheses that:

- 1) Workplaces with high financial and organizational health also have a high level of employee health and safety;
- 2) The way a workplace is organized determines financial and worker health; and
- 3) Identifying 'best practices' in the healthiest workplaces and promoting those practices throughout the industry will improve health and safety.

In 2001, SHARP began its second Healthy Workplaces industry study in the millwork, furniture and fixtures industry. Although growth in the lumber and wood manufacturing industry is declining, the secondary wood products (millwork, furniture and fixtures) industry sectors are growing. In 1996, Washington State's lumber and wood products industry produced about \$7 billion in manufactured goods, employed 34,692 workers, and paid over \$1.18 billion in wages (Employment Security Department, 2003). In 1998, lumber and secondary wood manufacturers exported products valued at \$1.2 billion.

For the period 1995 to 2001, there were a total of 15,414 accepted Washington state-fund workers' compensation (WC) claims in the millwork, furniture and fixtures industry sectors. These WC claims cost \$50,046,630, or about \$7.1 million each year. Most of these WC claims involved cuts (4,598), musculoskeletal sprains (3,411), contusions (1,836), scratches (1,198), and acute sprains (1,128).

Methods

There were three phases to the study: an industry-wide telephone survey, company site visits, and an educational intervention.

Telephone survey: An industry-wide telephone survey was conducted with 165 companies (a response rate of 55%). A scoring system (based on responses) was developed to determine the company's organizational health. Organizational health included communication, productivity and finances, turnover, company programs, health and safety practices.

Company Site Visits: Site visits were conducted at nine companies. The purposes of the site visits were to understand health and safety hazards and how workers may be exposed; to determine what measures companies have taken to control exposure; to assess organizational factors including policies and procedures, safety training materials and perception of organizational culture; and to identify 'successful strategies' that companies use that are effective in reducing work-related injuries and illnesses.

Educational Intervention: We conducted an ergonomics training with company managers attending the 2002 Kitchen Cabinet Makers Association Annual Conference. Participants were given an educational presentation on risk factors for musculoskeletal disorders. A pre- and post-training survey was used to determine changes in knowledge due to the educational intervention. Participants had the opportunity to apply risk factor identification during company tours the day after the training.

Findings and Conclusions

Overall, this industry-wide study showed few relationships between the organizational health measures and WC claim rates. However, among the site visit companies, we found that the better the company's organizational health, the lower the WC claim rates. Further research is needed to better understand the relationships between organizational health and WC claim rates.

We observed that while many companies had policies, materials, etc., in place, there was a reliance on worker responsibility to wear the appropriate protective equipment and operate the machines safely. Future research should focus on the challenges that companies face in implementing a comprehensive systems approach to reducing or eliminating workplace hazards.

While conducting site visits, we looked for successful strategies that companies used to address health and safety issues. Small companies (with 10 or fewer employees) provided over half of the successful strategies to health and safety problems. Research efforts in the area of successful strategies to control hazards should include small companies because of their innovative and creative solutions to health and safety problems.

Our partnership with an industry trade association enabled us to reach management with training about ergonomics. The training was well received, and participants' knowledge and ability to identify musculoskeletal risks increased as a result. We believe that occupational health and safety researchers and other professionals should consider disseminating their research results and providing educational trainings at trade association meetings.

The Healthy Workplaces Initiative aims to improve workplace health and safety through understanding the relationships between various organizational factors and occupational health and safety. The lack of local trade associations and stakeholder input at various phases of the project hampered our efforts in carrying out all of the study's aims. While unions are another group with which to establish partnerships, the vast majority of companies (90%) did not have union representation for workers. To fully realize this project's potential, more effort is required in building stakeholder relationships with industry leaders and associations. Establishing and maintaining these industry relationships throughout the project is critical for the successful implementation and transfer of technology.

This study has added to the body of knowledge about organizational health and these findings will aid us in better understanding the strengths and limitations of this research as we progress with our third industry study.