Continuous improvement through:
Event analysis – injury, incident, near miss

saif

Company name: _____

Employee: _____ Department: _____ Occupation: _____

Supervisor: _____ Location: _____ Shift: _____

Date and time: _____ (mm/dd/yy hh:mm) Date and time reported: _____ (mm/dd/yy hh:mm)

Witnesses: _____

What happened/What could have happened:

Consider system context that contributed to the event.

Remember, human error is normal, but blame fixes nothing. How leaders respond to failure matters.

Context					Context
	Management ***Supervisor:*** Preparation Relationship Support ***Communication:*** Systems Effectiveness ***Defined processes:*** Defined Management of change ***Hazards:*** Recognition Control/Correction ***Other:*** Production priority Proper resources Job safety training Hiring practices Maintenance	**M**anagement	**E**mployee	**Employee** ***Conditions of Work:*** Shift work Adequate rest and recovery Work demands Overtime Stressful conditions Distractions Recognition and rewards Role clarity Compensation and benefits ***Worker:*** Fatigue Hydration Nutrition Stress Fit for task	
	Equipment ***Maintenance*** Preventive focus ***Tools:*** Availability Selection ***Safeguards:*** Guarding Warnings (visual/audible)	**E**quipment	**E**nvironment	**Environment** ***Exposures:*** Chemical Noise Temperature Vibration Lighting Radiation Biological Weather Terrain ***Facility:*** Facility design Ergonomics Ventilation Housekeeping	

This is not an exhaustive list, there may be other contributing conditions

Where else could this happen?	What else should be known about this event?

How can we improve?

Consider (in order of effectiveness):
Eliminate – eliminate working conditions that threaten safety, health, and well-being
Substitute – substitute health-enhancing policies, programs, and practices
Redesign – redesign the work environment for safety, health, and well-being
Educate – educate for safety and health
Encourage – encourage personal change

Improvements/Best practices:	Who will implement?	By when?	Date complete	Follow-up date
Person(s) conducting analysis: Other sources consulted:		**Date:**	**Copy to:** Safety committee, management, owner, or president	

If an injury requires medical treatment beyond first aid, you must complete the workers' compensation claim form (801).
Legal requirements for recording and reporting work-related fatalities, injuries, and illnesses also may apply.
Please visit **osha.oregon.gov/Pages/topics/recordkeeping-and-reporting.aspx** for additional information.

A learning culture focuses on protecting people, products, and property from human error. Within the culture it is recognized that human error is normal and blame fixes nothing. Performance improvement is pursued through engaging employees in identifying hidden weaknesses within the operating systems and building systems that are more error tolerant.

Benefits of conducting an event analysis using learning culture principles

- Demonstrate leadership's attention to worker safety and health
- Learn from the event
- Improve conditions of work and the workplace
- Prevent recurrence
- Uphold legal requirements

How to use this form

Event analysis should be conducted by a team which can be made up of safety committee members, the safety coordinator, supervisors and managers. The impacted workers should participate as they can provide valuable input. Seek out knowledgeable sources, such as maintenance staff, engineering, and others that have expert understanding of the system.

The form explores four organizational systems: Management, Employee, Equipment, and Environment (MEEE).

Prompts in each box are designed to encourage open dialogue and communication about any factors, however minor, that may have contributed to the event.

There are four steps to this event analysis:

1. Get the story of what happened.
2. Learn by looking at system factors and consider context.
3. Decide how to improve.
4. Implement and follow up.

Step 1: Get the story of what happened
Ask questions about the work: What was happening? What tools were being used? What difficulties did the job involve? What were the production pressures? Where are the system weaknesses? What conditions led up to the event?

Step 2: Evaluate the system
As you ask the story of what happened, consider the context; Management, Employee, Equipment and Environment. Record your findings.

Step 3: Learn and improve
Prioritize the system factors you have identified. Engage workers in making improvements. Determine who is responsible for making the improvement and when it should be done. This information can be updated or revised as needed. The following are descriptions of ways to improve:

- Elimination – eliminate working conditions that threaten safety, health, and well-being
- Substitute – substitute health-enhancing policies, programs, and practices
- Redesign – redesign the work environment for safety, health, and well-being
- Educate - educate for safety and health
- Encourage - encourage personal change

Step 4: Implement and follow up
Management and the safety committee should follow up to make sure improvements were implemented. After a suitable amount of time follow up and evaluate the effectiveness of the improvement action.