ACTION Form

Event analysis: a step-by-step approach that simplifies the analysis process

Company:	Department/Area:	Date/time of event:
Employee:	Job title:	Witnesses:
fatalities and events that result in eight hours. Report inpatient hosp	the hospitalization of three or more workers m	red medical treatment beyond first aid. All work-related ust be reported to Oregon OSHA (bit.ly/3eA8L03) within ulsion to Oregon OSHA within 24 hours by phone, names to protect confidentiality.
What happened/could somethin	ng more serious have occurred?	
A-C-T-I-O-N		
	ess to analyze events in your workplace seep requires an action; use the spaces belo	o you can find and fix issues to prevent similar ow to take notes.
Accident/incident scene preservation Secure the scene as soon as possible, provide appropriate medical attention, and limit area access.		Keep tools and equipment at the scene when possible.
Collect the facts Focus on the event facts; avoid making assumptions. At this step, we are simply collecting information.		Write down what you see at the scene. Take photos and check video surveillance if available. Ask employees and witnesses to tell you what happened in their own words. Review records related to the event like maintenance, training, or policies.
Track sequence of events Write down what happened before, during, and after the event.		Creating a timeline can help identify additional issues.

Identify contributing factors

Every event has a set of contributing factors. These may be physical environment, working conditions, or human factors, such as fatigue or stress.

Look at the diagram on the bottom of this page for an example.

Organize possible solutions

Once the contributing factors have been identified, recommend changes to prevent them from happening again. There will often be more than one recommendation, and you can rank them using this model, which is in order of effectiveness.

Note solutions

The last ACTION step is to use your notes to come up with specific steps to improve.

Think about how you might get rid of the hazard

Look for safer equipment, process, or materials

Do it in a different way, install a barrier, look at scheduling, create a healthier environment.

Train employees on safety and health

Support employees to wear required PPE and make healthier choices

Your recommendations should make a difference and be easy to understand.

Make it clear who will be responsible for each action.

Report your findings to management to get needed resources.

Keep this event analysis in your files.

What are you going to do?	Person assigned:	Completion date:

Make sure to share these recommendations with the safety committee, the management team, and departments affected by the recommendations.

Contributing factors example

