Understanding the importance of tracking near miss incidents

Presented by
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ICW Group Risk Management Consultant
Know the difference!

ACCIDENT VS INCIDENT
WHAT IS AN **ACCIDENT**?
Any unplanned event resulting in:

• *Personal injury*
• *Illness*
• *Property damage*

WHAT IS AN **INCIDENT**?
Any unplanned event *ALMOST* resulting in:

• *Personal injury*
• *Illness*
• *Property damage*

*But had the POTENTIAL to result in any of those things*
KNOWING EVERY INCIDENT IS IMPORTANT!

10,000 Opportunities!

Your opportunity to prevent accidents!
UNSAFE ACTS & CONDITIONS

- Defective safety equipment
- Ineffective maintenance
- Missing safety devices
- Unrecognized hazards
- Insufficient warnings
- Inadequate training
- Poor housekeeping
- Deficient signage
- Lack of caring

ICW GROUP
Insurance Companies
Based on a loss analysis of 136 accidents over 5 year period 2013-2018

INDUSTRY BENCHMARKING DATA

Risk Exposure Type - Frequency

<table>
<thead>
<tr>
<th>Risk Exposure Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRUCK BY OR AGAINST</td>
<td>35%</td>
</tr>
<tr>
<td>MANUAL MATERIALS HANDLING</td>
<td>19%</td>
</tr>
<tr>
<td>FALLS - ELEVATION</td>
<td>14%</td>
</tr>
<tr>
<td>FALLS - SAME LEVEL</td>
<td>10%</td>
</tr>
<tr>
<td>MOTOR VEHICLE ACCIDENT</td>
<td>7%</td>
</tr>
<tr>
<td>CAUGHT IN OR BETWEEN</td>
<td>4%</td>
</tr>
<tr>
<td>Cumulative Trauma</td>
<td>4%</td>
</tr>
<tr>
<td>OCCUPATIONAL DISEASE</td>
<td>3%</td>
</tr>
<tr>
<td>WORKPLACE VIOLENCE</td>
<td>1%</td>
</tr>
<tr>
<td>ELECTRICAL</td>
<td>1%</td>
</tr>
<tr>
<td>OTHER</td>
<td>1%</td>
</tr>
<tr>
<td>EXPOSURE TO ENVIRONMENTAL</td>
<td>1%</td>
</tr>
</tbody>
</table>

Risk Exposure Type – Costs (Severity)

<table>
<thead>
<tr>
<th>Risk Exposure Type</th>
<th>Costs</th>
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<tbody>
<tr>
<td>STRUCK BY OR AGAINST</td>
<td>$811,314</td>
</tr>
<tr>
<td>FALLS - ELEVATION</td>
<td>$589,898</td>
</tr>
<tr>
<td>ELECTRICAL</td>
<td>$458,109</td>
</tr>
<tr>
<td>MOTOR VEHICLE ACCIDENT</td>
<td>$219,573</td>
</tr>
<tr>
<td>MANUAL MATERIALS HANDLING</td>
<td>$219,290</td>
</tr>
<tr>
<td>Cumulative Trauma</td>
<td>$134,907</td>
</tr>
<tr>
<td>CAUGHT IN OR BETWEEN</td>
<td>$112,252</td>
</tr>
<tr>
<td>FALLS - SAME LEVEL</td>
<td>$19,985</td>
</tr>
<tr>
<td>OCCUPATIONAL DISEASE</td>
<td>$1,794</td>
</tr>
<tr>
<td>OTHER</td>
<td>$1,519</td>
</tr>
<tr>
<td>WORKPLACE VIOLENCE</td>
<td>$243</td>
</tr>
<tr>
<td>EXPOSURE TO ENVIRONMENTAL</td>
<td>$0</td>
</tr>
</tbody>
</table>
Based on a loss analysis of 136 accidents over 5 year period 2013-2018
### MAJOR LOSS SOURCE SUMMARY

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Number of Accidents</th>
<th>% of accidents to total</th>
<th>Sum of Incurred Costs</th>
<th>% of Total Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRUCK BY OR AGAINST</td>
<td>45</td>
<td>35%</td>
<td>$811,314</td>
<td>32%</td>
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<tr>
<td>MANUAL MATERIALS HANDLING</td>
<td>24</td>
<td>19%</td>
<td>$219,290</td>
<td>9%</td>
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<tr>
<td>FALLS - ELEVATION</td>
<td>18</td>
<td>14%</td>
<td>$589,898</td>
<td>23%</td>
</tr>
<tr>
<td>FALLS - SAME LEVEL</td>
<td>13</td>
<td>10%</td>
<td>$19,985</td>
<td>1%</td>
</tr>
<tr>
<td>MOTOR VEHICLE ACCIDENT</td>
<td>9</td>
<td>7%</td>
<td>$219,573</td>
<td>9%</td>
</tr>
<tr>
<td>CAUGHT IN OR BETWEEN</td>
<td>5</td>
<td>4%</td>
<td>$112,252</td>
<td>4%</td>
</tr>
<tr>
<td>Cumulative Trauma</td>
<td>5</td>
<td>4%</td>
<td>$134,907</td>
<td>5%</td>
</tr>
<tr>
<td>OCCUPATIONAL DISEASE</td>
<td>4</td>
<td>3%</td>
<td>$1,794</td>
<td>0%</td>
</tr>
<tr>
<td>WORKPLACE VIOLENCE</td>
<td>1</td>
<td>1%</td>
<td>$243</td>
<td>0%</td>
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<tr>
<td>ELECTRICAL</td>
<td>1</td>
<td>1%</td>
<td>$458,109</td>
<td>18%</td>
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<td>OTHER</td>
<td>1</td>
<td>1%</td>
<td>$1,519</td>
<td>0%</td>
</tr>
<tr>
<td>EXPOSURE TO ENVIRONMENTAL</td>
<td>1</td>
<td>1%</td>
<td>$0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>127</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>$2,568,882</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>
Short round table discussion(s) re: accidents or nm they’ve encountered, each group offer their most unusual or most relevant to the group as a whole.

*Distribute accident summary handout*
SAFETY OBSERVATIONS
FOCUSING ON THE BOTTOM

• Check the effectiveness of training programs
• Promote on-the-spot correction of unsafe acts
• Provide opportunities to compliment and/or reward safe behaviors
• Develop cooperative safety attitudes
• Promote more learning about the employees in your department
• Suggest and identify better job methods, increasing production and making the Supervisors' job easier
NEAR MISS TRACKING PROGRAM

01 Observing
02 Correcting
03 Reporting
04 Tracking
05 Acting
SAFETY OBSERVATIONS

01

OBSERVING
WHAT IS A SAFETY OBSERVATION

• Some are unintentional
• Some are intentional
  – *Part of routine hazard assessments*
• Some are of people, behaviors and actions
• Some of are objects and processes
SAFETY OBSERVATIONS

• Traditional safety efforts focus on the conditions
• 90% plus of all accidents have a critical behavior cause
• Most accidents have multiple causes
  – Behavior
  – Condition
  – Organizational
• Required under your IIPP Element “Hazard ID and Correction”
**Incidental Observations**
- Part of other work activities
- Short observations and feedback sessions

**Deliberate Observations**
- More planning and foresight
- Separate time is set aside to perform the deliberate observation

**Who should be Observed**
- ICWG Benchmark data shows that employees with 6 mo. - 1 year tenure has 21% of accidents, those with 10-20 years have 63% of accidents
- “Problem” people
- EE’s working out of normal scope

**Frequency for Observations**
- New hire - 3 in first month
- Existing employee - 1 per month
- New process
- Post accident/incident or other observation

*Feedback should always be provided using the Behavior Impact Tomorrow format*
Identify who, what, where needs an observation
Decide what you are looking for including job steps, hazards, and proper controls
Look at a scheduling of tasks in the workday and ensure observation coincides to task
Decide if you should tell the employee or group prior to the observation

PLAN
What do you need to do the observation

ACT
Immediately ACT to correct any substandard conditions. Incorporate into PLAN step

DO
Complete observation following guidelines identified during PLAN step

CHECK
To ensure you are meeting standards established during PLAN step
Inspections
Correct conditions

Employee observations
Meaningful feedback

Provide Job Skill Training
Task completion
Safety, quality, productivity

Incentive-deterrent strategy
Consistent, fair, equitable

Control Unsafe Acts

Control Unsafe Conditions

Motivate Employees

OBSERVATION OUTCOMES
HAZARD RESPONSE & CORRECTION

02

CORRECTING
DIGGING INTO THE “W’S” (NOT THE “H”)

- WHO?
- WHAT?
- WHEN?
- WHERE?
- WHY?

Not enough to just ask “HOW DID THIS HAPPEN?!?”
Must also ask, “WHY DID THIS HAPPEN?!?”
And keep asking WHY until you discover the root cause(s).
INCIDENT GROWS INTO ACCIDENT

DIRECT CAUSE

ROOT CAUSE

CONDITION

BEHAVIOR

What accident would the near miss have resulted in?
DIRECT CAUSE:
WHAT DIRECTLY CAUSED THE INCIDENT

Worker (almost) cut off finger

HOW????
• Not using a push block for table saw
• Not using guard(s)

WHY????

CONDITION BEHAVIOR
ROOT CAUSE:
WHY THE INCIDENT OR ACCIDENT OCCURRED

- Company doesn’t own a push block: **WHY?**
- Guards not available? **WHY?**
- Employee not properly trained: **WHY?**
- Employees not encouraged to observe & report: **WHY?**
- General culture is to use regardless of lack of safety devices? **WHY?**
SAFETY OBSERVATION PROCESS

Safety Observation
- Controlling Behaviors
- Focus on Bottom of Triangle

Response
- Preparation
- Tell or not to tell
- Performing observations

Feedback
- Need for feedback
- BIT of information
• Evaluate whether the employee knows how to do the job
• Complete an informed safety observation
• Evaluate how the employee performs their work (do not inform them prior to completing the observation)
• In all cases – always provide feedback
When unsafe behaviors are observed, employees must be coached in the correct method

- Tell them how to do the job
- Show them how to do the job
- Have them demonstrate correct way
- Make corrections or reinforce with a compliment

SAFETY OBSERVATIONS

Hazard correction
Tell the employee that you completed a safety observation

- **Behavior** – Make sure employee understands the positive or negative behavior that was observed

- **Impact** – Link the impact to a personal level, unit level, plant level and corporate level

- **Tomorrow** – What action’s do you expect the employee to complete tomorrow and on
NEAR MISS REPORTING

03

REPORTING
• What to report
  - Consider having a formal program, statement or outline
• How to report
  - Form vs. verbal
• Who should report
  - All employees should have an opportunity
  - Outline the process in your Program
• What to track
  - Facility/Department, Supervisor, Employee, Equipment, Activity or Agent…
• How to track
C:\Users\rskinner\Desktop\NEAR MISS INCIDENT PROGRAM.docx

C:\Users\rskinner\Desktop\NEAR MISS INCIDENT REPORT.docx
<table>
<thead>
<tr>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location (Facility/Dept)</td>
<td>Employee</td>
<td>Supervisor</td>
<td>Brief Statement/Description</td>
<td>Equipment</td>
<td>Activity or Agent</td>
<td>Major Loss Source</td>
<td>Unsafe Behavior/Act</td>
<td>Unsafe Condition</td>
<td>Incidental Causes/Contributing Factors</td>
<td>Root Cause(s)</td>
<td>Corrective Action</td>
</tr>
</tbody>
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04

TRACKING/TRENDING
• Evaluate incident & injury trends to focus safety/risk management efforts
• Use 300 forms, incident logs & reports, inspection reports, etc.
• Use Excel tools analyze
  – Sort functions
  – Pivot tables
• Determine how frequently to review in your Program
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• Identify trends within each heading/category
• Evaluate/rate trends to determine priorities
• Create & implement a mitigation plan
  – *May need to do a root cause analysis first*
• Employee engagement
  – *Discuss incident prevention*
  – *Solicit employee ideas, involve them in solutions*
• Did mitigation work?
• What is outcome?
• More problems?
• Solved?
• Continuously monitor
  (MORE – Observing, monitoring, etc.)