**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:

Complete an 801 form ([saif.com/801form](https://www.saif.com/Documents/Forms/801_form_blank.pdf)) if the event was an injury that required medical treatment beyond first aid. All work-related fatalities and events that result in the hospitalization of three or more workers must be reported to Oregon OSHA ([bit.ly/3eA8L0J](https://bit.ly/3eA8L0J)) within eight hours. Report inpatient hospitalization, loss of an eye, or an amputation/avulsion to Oregon OSHA within 24 hours by phone, 800.922.2689. When sharing this form with others, please remove all employee names to protect confidentiality.

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| What happened/could something more serious have occurred? |

**A-C-T-I-O-N**

Here’s a simple six-step process to analyze events in your workplace so you can find and fix issues to prevent similar events in the future. Every step requires an action; use the spaces below to take notes.

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| **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. | Think about how you might get rid of the hazardLook for safer equipment, process, or materialsDo it in a different way, install a barrier, look at scheduling, create a healthier environment.Train employees on safety and healthSupport employees to wear required PPE and make healthier choices |
| **Note solutions**The last ACTION step is to use your notes to come up with specific steps to improve. | 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. |

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| 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**

**Employee slipped and fell in the hallway**

Water on the floor

Leaking water cooler was not serviced

Leaking water cooler, water wasn’t cleaned

No formal written maintenance schedule

No management review of systems/policies

No clean up tools available

Clean up tools were not in budget

Employee did not have time to clean

Inadequate staffing