LOSS CONTROL SERVICES

Root-cause Event Prevention and Improvement Report

Nationwide®

Event Information

Location of Event:	Related Claim or Report Number:
Date and Time of Occurrence	Date and Time Reported:

Employee(s) Involved (Include Names, Positions, and Departments):

Others Involved: ☐ Customer ☐ Gen. Public ☐ Vendor/Contractor

Report Trigger: ☐ Loss Event ☐ Near Miss ☐ At-Risk Observation ☐ Feedback

Event Impact (Select all that apply):	☐ Injury/Illness ☐ Environmental ☐ Waste ☐ Customer Service	☐ Property Damage ☐ Fine/Citation ☐ Production/Delivery ☐ Quality	☐ Public Image ☐ Other (Describe)

Event Result if Injury: ☐ Fatality/Serious ☐ Off-Site Medical ☐ First Aid ☐ Lost/Restricted Workdays

Detailed Event Description (Who, What, When, Where, How, and any resulting damage/injuries) and any immediate action taken:

Event Analysis (See following pages for additional information)

Step 1: Identify factors from the system elements that contributed to the event	Step 2: For each factor identified, use the 5 whys or similar approach to determine the root cause(s)
Environment (Physical/Social/Work Culture):	
Materials and/or Equipment:	
Method:	
Policies:	
Personnel Aspects (Individual or Team):	

Step 3: Use the results of the root-cause(s) analysis to identify actionable improvements

Event Prevention and Improvement Actions

Recommended Improvement Actions	Assigned To	Target Date	Completed
1.			
2.			
3.			
4.			
5.			
6.			

Event Application

List other areas of operation that could benefit from these findings or improvement actions:

Event Analysis Team Leader: Date:

Executive Review and Follow-Up

Did analysis and improvement actions sufficiently address event causes? ☐ Yes ☐ No, Return to the team to address:

Authorized Improvement Actions:

Improvement Actions Pending Review:

Executive-Level Review By: Date:

User Guide

Accidents, incidents, near-misses, breakdowns, and unsafe acts/conditions are related in that they are all undesired events that indicate a problem in the design or deployment of a company's operating plan. This form allows for the analysis of those events to find the underlying or root causes by evaluating each of the key elements of an operation. This can then be used to develop system improvements that eliminate or lessen the root cause and the likelihood of subsequent undesired events and their associated impact.

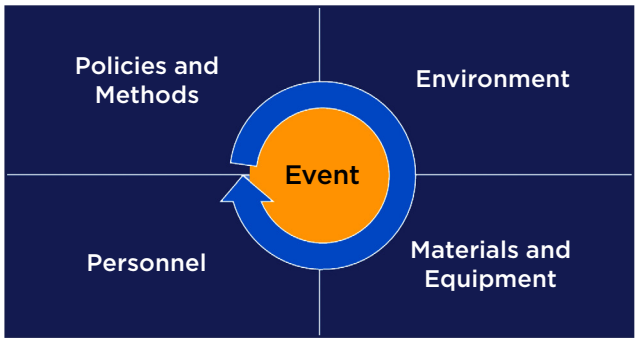
Event information

This section captures the details of the event and its actual or potential impact. If a claim or initial report form has been completed, reference that number in the upper right and provide a copy. Use the Report Trigger to identify what led to the form being completed—moving from an actual Loss Event to Near-Miss where a loss event was likely but narrowly avoided, to an observed At-Risk action or condition, to Feedback provided by an employee or third party. Event Impact provides a means to show the full toll of the event in business operations. The form uses a checkbox format, but a numeric scale (e.g., 0-4) can also be used to give a weighted impact score. Event Result clarifies severity when an event leads to or has the potential for employee, customer, or third-party injury. More than one result box may be checked. The Detailed Event Description is a critical element as the scope of information provided here directly impacts the quality of the event analysis and resulting improvement actions. The description should provide an accurate, thorough picture of the event: the who, what, when, where, how—including the materials, equipment, methods, and conditions that were involved, and any immediate action taken.

Event analysis

Events result from the interaction of a company's core operation or system elements (see diagram). In Step 1, identify the key factor(s) of each operating element that contributed to the event:

- Environment—consider physical aspects (e.g., temperature, humidity, noise, etc.) and the social/work culture,
- Materials—properties of raw, in-process or finished goods,
- Equipment—characteristics of any tools and machinery involved,
- Personnel—physical stressors, limitations, and readiness (individual or team),
- Policies and Methods—consider if they are clear, required, understood and sufficient.



Once the key contributing factors are identified, then in Step 2 determine the underlying causes that led to that factor by asking the question why (or how). Up to five responses may be needed to move from the surface cause to the deeper root cause. Additonal resources Root Cause analysis and using the five Why's approach is available on MyLossControlServices.com.

Event prevention and improvement actions

Moving through each level of Why for the key factors during the *Event Analysis* will clarify where a change or improvement action in the operating system can limit the event from happening. The deeper the analysis, the greater the impact of the changes to not only prevent the noted event, but to provide insight for overall operation improvements. Accountability and tracking of the developed Event Prevention and Improvement Actions are provided using the *Assigned To, Target Date* and *Completed* sections.

Event application

Applying the results of the root-cause process from the specific event to broader applications allows for expanding the benefits of the developed improvement actions. For example, consider a trip near-miss event in the office related to an employee not seeing a snag in the carpet while making one of many trips to the copy machine. One of the improvement actions from the environment root-cause analysis of this event may be addressing poor lighting. Expanding this to the production floor may not only reduce similar events in that area but also result in improvements to quality control by line operators. Similarly, identifying that the office layout led to unneeded foot traffic can give insight for improved layout in the warehouse area to minimize foot traffic, leading to reduced slips/trips and interactions with forklifts, and increasing production.

Executive review and follow up

Once the report is completed, it should be elevated to the appropriate leadership level for review. This allows for effective information flow, feedback and authorization or adjustments to improvement actions. The form should then be provided back to the safety committee and respective management contacts for continued follow up on action items until completion.