CLOSE CALLS AND NEAR MISSES

This easy-to-use Leader's Guide is provided to assist in conducting a successful presentation. Featured are:

INTRODUCTION: A brief description of the program and the subject that it addresses.

PROGRAM OUTLINE: Summarizes the program content. If the program outline is discussed before the video is presented, the entire program will be more meaningful and successful.

PREPARING FOR AND CONDUCTING THE PRESENTATION: These sections will help you set up the training environment, help you relate the program to site-specific incidents, and provide program objectives for focusing your presentation.

REVIEW QUESTIONS AND ANSWERS: Questions may be copied and given to participants to document how well they understood the information that was presented. Answers to the review questions are provided separately.

ATTENDANCE RECORD: Document the date of your presentation as well as identify the program participants. The attendance record may be copied as needed.

INTRODUCTION

When an on-the-job injury occurs, we know that a proper investigation can reveal the root cause of that injury. Then ways to prevent similar incidents can be devised and implemented to improve the overall safety of our workplace. Other sources we can study that provide critical information for improving safety programs are close calls and near misses. Reporting these incidents can lead to the correction of unsafe conditions or actions before an injury occurs.

This video stresses to employees the importance of reporting all close calls and near miss incidents so that proper action can be taken to improve work conditions and prevent injuries. Topics include employee complacency, escalation of unreported incidents, correcting hazards and unsafe conditions, control of emotions and recognizing and avoiding unsafe acts.

PROGRAM OUTLINE

BACKGROUND

- In order to learn from close calls, the incidents must be reported and investigated.

- Employees need to understand that the purpose of studying near misses is not to punish employees or assign blame; it is to improve workplace safety and reduce injuries.

- Reporting close calls leads to improvements in work areas and job procedures while allowing the correction of unsafe conditions before an injury occurs.

- Failing to report even a small incident allows hazards to escalate into more serious situations.

INCIDENT #1:

A forklift driver backed into a storage rack, pushing the rack into the aisle on the other side. This close call went unreported. Then a material handler who was unable to see over his load collided with the rack in the aisle while taking the load to a storage area. Since no one else saw the incident and it had apparently caused no damage, the material handler neglected to report the incident. What he didn't realize was that the collision had punctured a container of lubricating fluid in one of the boxes on the storage rack.

By the time the next shift had arrived, the fluid had formed a puddle in the aisle way. An employee hurrying through the area walked right into the spill but managed to keep his balance. Assuming it was not his job to clean up the spill or report it, he left it as it was. Then a forklift operator, traveling too fast, swerved to avoid the rack and ran through the spilled lubricant. Sliding on the slippery floor, the forklift narrowly missed a group of workers. Fortunately this close call, which could have easily caused a fatality, was reported and an investigation was started.

Results Of The Investigation
The near miss investigation revealed several contributing factors:

- Backing without checking behind the forklift contributed to the first forklift hitting the rack.

- Exceeding safe operating speed contributed to the second forklift swerving around the rack and into the fluid.

- Traveling with an obstructed view contributed to the collision between the pallet jack and the storage rack.

- Not paying attention and being in a hurry contributed a near slip and fall.

- Not reporting any of the three smaller incidents contributed to an escalation of hazards that resulted in the final incident.

- Had all of these incidents been reported, the problems could have been corrected before they could contribute to other incidents.

Safety Lessons To Be Learned
- When operating moving equipment such as forklifts, pallet jacks and other similar items, make sure your vision is not blocked by the load.

- Always operate any moving equipment at safe speeds so you can avoid sudden turns or quick stops.

- When walking about the facility, always look before entering aisle ways and watch where you are going.

- Be aware of dangerous areas by obeying caution signs, checking mirrors and watching for slipping or tripping hazards.

- Take your time when traveling through the facility to be sure you arrive safely at your destination. Never run while at work.

- When safety hazards or unsafe conditions are discovered, correct or report them immediately. Don't put others at risk by assuming someone else will do it.

- Report close call or near miss incidents you may encounter.

INCIDENT #2:

Scott Reiman is a plant employee responsible for loading rolled steel onto rollers and then into the feed line for processing. During one shift, he loaded a roll into the holder and then tried to feed it into the line as required. Having trouble getting the steel into the feeder, he figured the machine was out of alignment but decided to keep the line moving in an effort to finish that shift's run. Thinking he could get it started by hand, he pulled the steel down toward the rollers. He climbed onto the side of the conveyor to get a better grip on the steel.

Scott didn't notice that the apron he was wearing had come untied and continued to move with the steel closer to the feed rollers. Finally, the steel and his apron entered the feed rollers. Scott was pulled down toward the rollers, but fortunately he was able to get the apron over his head and get away from the feed rollers.

Results Of The Investigation
The near miss investigation revealed several contributing factors:

- The conveyor was not aligned with the rollers, making it hard to feed the steel. This contributed to Scott's frustration, prompting him to force feed the steel by hand.

- Scott let his emotions overcome his good judgment about personal safety. His poor decision to climb onto the conveyor and attempt to hand feed the steel into the rollers was a violation of two of the company's safe work procedures.

- Wearing an apron near the moving machine was the final piece of the nearly fatal situation.

- In response to the investigation, the company requires adjusting the feed rollers monthly to prevent additional problems. Also, use of aprons is now prohibited within ten feet of the conveyor system and shirts must be tucked in at all times.

Safety Lessons To Be Learned

- If the equipment you are operating is not working correctly, follow your company's procedures to have it adjusted or repaired.

- Never try to make the equipment work by performing unsafe acts such as defeating guards, climbing onto (or into) machines or placing your hands near moving parts.

- If you are qualified to service the machine, perform all steps in the required lockout/tagout procedure before beginning any repair.

- If you aren't authorized to service the equipment, report the situation to your supervisor so proper maintenance can be performed.

- If material needs to be loaded into moving parts or if jams need to be cleared, use assist devices that keep hands clear of moving parts.

- When working around moving parts such as rollers, gears, belts or other pinch points, remove any loose articles of clothing that may become entangled. Keep long hair pulled back and restrained.

- Remember that staying safe at work is your responsibility. Don't let emotions tempt you into an unsafe act. Stay in control at all times and consider the safety of your actions.

INCIDENT #3

Tom Riggs works in the receiving area, where employees open packages and put the contents onto pallets. Workers in this area use knives to assist in opening the packages. One day he was trying to stay caught up with the employees unloading a truck when he noticed that his knife was getting dull. Rather than get a new knife or change blades as required, Tom continued to use the dull blade so he could keep up with the flow of boxes.

Tom was having a hard time with one of the boxes, so he decided to pull the knife towards his body to apply more force. The knife slipped out of the box, grazing his arm and cutting his jacket.

Results Of The Investigation
The near miss investigation revealed several contributing factors:

• Tom was having trouble keeping up with the boxes because he had to both open and unpack each box. Falling behind made him feel rushed.

• Feeling rushed, combined with the distant location of the tool room, contributed to Tom's poor decision not to change blades.

• The difficulty of cutting with a dull blade contributed to Tom using an unsafe cutting technique.

• As a result of the investigation, the company started storing frequently used tools and supplies closer to work areas so they could be accessed easier when needed.

• Also, two employees are now used to open and unpack boxes. One employee cuts open the box and the other employee unloads it.

Safety Lessons To Be Learned

• When working with any type of cutting tool, the blade must be kept sharp and in good working condition. Using knives, saws or any other tool in poor condition can lead to injury.

• No matter what job we do, safety procedures must be followed. Disregarding safe work practices for any reason puts you at risk.

• When cutting, always cut away from your body. This protects you in the event the blade slips or breaks.

• Don't allow a poor attitude or being in a hurry override your commitment to personal safety.

INCIDENT #4

Rhonda Adams works on an assembly line where job assignments change several times each day to reduce fatigue and strain. To keep from having to walk all the way around the conveyors to get to a workstation just on the other side of the line, employees would climb over a conveyor rather than walking to the nearest approved crossover. This had become routine for employees. Also, the shift supervisor had never warned them not to do it even though he had seen it done.

One day Rhonda attempted to cross the line by standing on the side rails and step over, but she lost her balance, stepped onto the conveyor and fell hard on the rollers. Fortunately, an alert co-worker hit the emergency stop button, shutting down the conveyor. Rhonda was helped off of the line with no serious injury.

Results Of The Investigation

The near miss investigation revealed several contributing factors:

• Failing to enforce the company's rules against crossing the conveyor, the shift supervisor contributed to the employees' unsafe behavior.

• Repeating the unsafe act without incident contributed to employee complacency about the danger of the moving conveyor.

• The failure of both supervisors and employees to recognize the shortcut as being unsafe contributed to it becoming a standard part of the work routine.

• As a result of the investigation, the company is adding conveyor crossings at locations more convenient to employee workstations.

Safety Lessons To Be Learned

- Supervisors must enforce the company's safety policies. Safety rules that aren't enforced don't help anyone and lead to an escalation of unsafe acts.

- Employees must recognize and avoid unsafe acts. If you think what you are doing may be unsafe, check with your supervisor or safety manager for the proper way to perform the task.

- Don't take chances with your safety. When in doubt, find out.

CONCLUSION

- Statistics tell us that most injuries are caused by unsafe acts, but most employees say they don't commit unsafe acts. This discrepancy shows that more attention needs to be placed on recognizing unsafe acts before an injury takes place.

- Being in a hurry or becoming angry tempts you to commit unsafe acts. Don't succumb to temptation; stay focused on your safety commitment.

- Don't let unsafe acts slip into your work routine. Take a moment to consider the safety of every action you take and avoid becoming complacent about the hazards of your work area.

- If unsafe conditions are discovered, correct or report the situation right away. Don't allow a poor attitude to place other workers at risk.

- Remember that reporting close calls and near miss incidents can improve your work facilities and job procedures, which help create a safer, more productive workplace for everyone.

- Some companies have an elaborate system for investigating and tracking close calls, while others may use a more simple approach. No matter what system your company uses, it won't work without your participation.

PREPARE FOR THE SAFETY MEETING OR TRAINING SESSION

Review each section of this Leader's Guide as well as the videotape. Here are a few suggestions for using the program:

Make everyone aware of the importance the company places on health and safety and how each person must be an active member of the safety team.

Introduce the videotape program. Play the videotape without interruption. Review the program content by presenting the information in the program outline.

Copy the review questions included in this Leader's Guide and ask each participant to complete them.

Copy the attendance record as needed and have each participant sign the form. Maintain the attendance record and each participant's test paper as written documentation of the training performed.

Here are some suggestions for preparing your videotape equipment and the room or area you use:

Check the room or area for quietness, adequate ventilation and temperature, lighting and unobstructed access.

Check the seating arrangement and the audiovisual equipment to ensure that all participants will be able to see and hear the videotape program.

Place or secure extension cords to prevent them from becoming a tripping hazard.

CONDUCTING THE PRESENTATION

Begin the meeting by welcoming the participants. Introduce yourself and give each person the opportunity to become acquainted if there are new people joining the training session.

Explain that the primary purpose of the program is to stress the importance of reporting close calls and near miss incidents so hazardous conditions and unsafe behavior can be corrected.

Introduce the videotape program. Play the videotape without interruption. Review the program content by presenting the information in the program outline.

Lead discussions about close calls that have been reported at your facility and the improvements that were made as a result or how the reporting of specific close calls may have prevented injuries or incidents. Use the review questions to check how well the program participants understood the information.

After watching the videotape program, the viewer will be able to explain the following:

- Why it is important to report all close calls and near miss incidents;
- How emotions and poor attitudes can lead to unsafe acts;
- How unreported incidents can escalate into more serious situations;
- What actions can be taken by companies in response to the investigation of a close call.

CLOSE CALLS AND NEAR MISSES
REVIEW QUESTIONS

Name_____

Date_____

The following questions are provided to check how well you understand the information presented during this program.

1. What is the purpose behind studying near misses in the workplace?

a. to find out who is to blame for an incident
b. to punish an unsafe act committed by an employee
c. to satisfy insurance companies and federal regulating agencies
d. to improve workplace safety and reduce injuries

2. Which of the following is a cause of the forklift to nearly colliding with the group of workers in the video's first incident?

a. the forklift operator was traveling too fast
b. the employee who walked through the area earlier didn't clean up the spilled lubricant
c. the three near misses that led up to the incident went unreported
d. all of the above

3. Which of the following did <u>not</u> contribute to the incident in which the employee was nearly cut by the knife?

a. he used the wrong tool for the job
b. he felt rushed to stay caught up
c. he didn't change the knife's blade or get a new knife
d. he made an unsafe cut toward his body

4. The supervisor who didn't say anything when employees crossed over the conveyor instead of using approved crossovers contributed to the incident where the female employee fell onto the conveyor.

a. true
b. false

5. Close calls that could result in minimal or no injury to an employee should not be reported.

a. true
b. false

6. What happened as a result of the investigation of the incident where the worker tried to force the rolls of steel into the feeder and was nearly pulled into the process line?

a. the feed rollers are now adjusted monthly
b. aprons are prohibited within ten feet of a conveyor system
c. work shirts must be tucked in at all times
d. none of the above
e. all of the above

7. Most workplace injuries are caused by _____, even though employees may not recognize this as the cause.

a. faulty personal protective equipment
b. machine malfunction
c. unsafe acts
d. lack of employee training

ANSWERS TO THE REVIEW QUESTIONS

1. d
2. d
3. a
4. a
5. b
6. e
7. c