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RISK RESOURCES

IT'S NOT AN "ACCIDENT"…
AND IT'S NOT "MINOR"

IT'S NOT AN "ACCIDENT"

"ACCIDENTS"	INJURIES AND COLLISIONS
Happen by chance	Predictable
Unexpected	Behavior based
Not preventable	Preventable

If both of these incidents happened at your company, would you treat them differently? Often, the outcome is a function of luck!

CONSIDER THIS SCENARIO: A team member operating construction equipment backs into a small pole. The equipment is dented, and no one is injured. They may dismiss this "minor" incident. However, that pole was actually the size of a small child. It is a matter of luck that the operator hit a pole and not a child means it was his/her lucky day. Had the operator hit a child, the discussion would be vastly different.

To ensure you are promoting a culture where incidents are never overlooked, consider these leadership strategies:

- **Zero is the only goal.** Help your employees adopt the mindset that when it comes to safety, one preventable failure is one too many. If you and your team accept one safety failure, you might as well accept a thousand. Do not rationalize one or more issues by repeating the explanation, "Accidents happen." All team members must understand that safety is an internal commitment carried by every individual and the organization, at all times.
- **Promote an understanding that there is no such thing as a "minor" safety failure.** Shrugging off even one incident because it didn't have catastrophic results is a surefire way to sabotage your culture of prevention.
- **Treat each safety incident with equal attention.** Let your team see you invest time into conducting a root cause analysis (RCA) to look for individual and systematic causes. This does not need to be a complex process. By performing a RCA, you will be able to determine the cause before another incident occurs, and you will create a commitment to continuous improvement among your employees. Remember: all incidents are worthy of investigation. Find out how to perform a successful RCA on page two.
- **Use safety failures as teaching moments.** No matter the incident, communicate what occurred with your team. Allow them to provide feedback and examine the "why" behind the failure. Show them the importance of getting to the root cause and place equal value on each incident so that minor outcomes are never dismissed. To accomplish this, make it comfortable for employees to review incidents with you. When an honest mistake is made, avoid punishment and retribution. Focus on training and continuous improvement.

Acrisure's risk resources team offers on-demand, virtual and live training tools to help you elevate your organization's performance and profitability and gain more control over the cost of your insurance and risk.

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HOW TO PERFORM A ROOT CAUSE ANALYSIS – REGARDLESS OF SEVERITY: SIX STEPS

A ROOT CAUSE ANALYSIS (RCA) is the best way to determine how to prevent future incidents. A RCA does not need to be a complex process. It simply allows you to get to the bottom of what happened. A RCA should be performed whether or not the outcome of an incident is severe.

Performing a RCA regardless of the severity produces two benefits. First, it will enable you to determine the cause *before* another, more severe incident happens. Second, it will create a commitment to continuous improvement among your employees that can benefit all areas of your organization.

A RCA will help you learn and grow. You can't fix the problem if you don't understand its cause. When you understand why a failure occurred, then you can begin to make the needed corrections — both individual and systemic. Without understanding why something happened, you are simply taking a wild guess as to the underlying cause or masking the apparent problem.

Use these six steps as a framework to perform a RCA on virtually any incident:

STEP 1 **Describe the incident. What happened? How often has it happened?**

STEP 2 **Investigate the incident.** Assign cross-functional teams to investigate. Ensure each team produces documentation to support its findings. This may require meetings with people inside and outside the company.

STEP 3 **Investigate the process.** What process was supposed to be followed? Was it followed? If not, define where processes were not followed and why. Look especially for individual versus organizational failures.

STEP 4 **Define solutions based on the investigation.** Ensure the solutions are both practical and highly tailored to the incident.

STEP 5 **Formulate a plan.** Once the solution is defined, what is the action plan for implementation and measurement of success? Who, what, where, when, and how? Communicate the final plan to your whole team; institutionalize the knowledge.

STEP 6 **Document and test.** Document the resolution and test periodically to ensure that the resolution was correct and has taken hold.

LOOK IN THE MIRROR. A root cause analysis can reflect individual, systemic and leadership failures. When completing a RCA, be prepared to take a close look in the mirror. Pointing fingers and casting blame only buys time until the same problem arises again. The RCA is your best means to ensure lasting prevention.

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