



Nearly a World Class Safety Program

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NEAR MISS

an unplanned event that did not result in injury, illness, or damage - but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage. Although human error is commonly an initiating event, a faulty process or system invariably permits or compounds the harm, and is the focus of improvement. Other familiar terms for these events is a "close call", or in the case of moving objects, "near collision".

National Near-Miss Programs

- Aviation Safety Reporting System
- National Fire Fighter Near-Miss Reporting System
- The Patient Safety Reporting System

Aviation Safety Reporting System

The Aviation Safety Reporting System (ASRS) was established in 1975 under a Memorandum of Agreement between the Federal Aviation Administration (FAA) and the National Aeronautics and Space Administration (NASA). FAA provides most of the program funding; NASA administers the program and sets its policies in consultation with the FAA and the aviation community.

<http://asrs.arc.nasa.gov>



National Fire Fighter Near-Miss Reporting System

The National Fire Fighter Near-Miss Reporting System is a voluntary, confidential, non-punitive and secure reporting system with the goal of improving fire fighter safety.

Submitted reports will be reviewed by fire service professionals. Identifying descriptions are removed to protect your identity. The report is then posted on this web site for other fire fighters to use as a learning tool.

For more information, visit

[WWW.Firefighternearmiss.Com](http://www.Firefighternearmiss.Com)

This project is funded by grants from the Department of Homeland Security's Assistance to Firefighters Grant Program and Fireman's Fund Insurance Company. The project is supported by [REDACTED] in mutual dedication to fire fighter safety and survival.

AORN's SafetyNet

An anonymous reporting system to improve patient safety in perioperative settings - a voluntary reporting tool that captures data about close calls and near misses in surgical and procedural settings. Securely designed to promote confidentiality and anonymity with AORN serving as the repository for the data.

By providing nurses with a safe harbor and easy method for reporting close calls and near misses, they will be more encouraged to identify gaps in the patient care process. The data will be aggregated, organized, and analyzed to serve as a basis for the development of new perioperative practice standards, procedures, and educational programs with a focus on improving patient safety in surgical and procedural environments.

Framework for Safety Culture

“Safety” is part of the language of your organization.

Safety is part of your organization’s value structure.

Safety is considered something that is everyone’s job.

Employees are rewarded in a tangible, visible way for promoting safety.

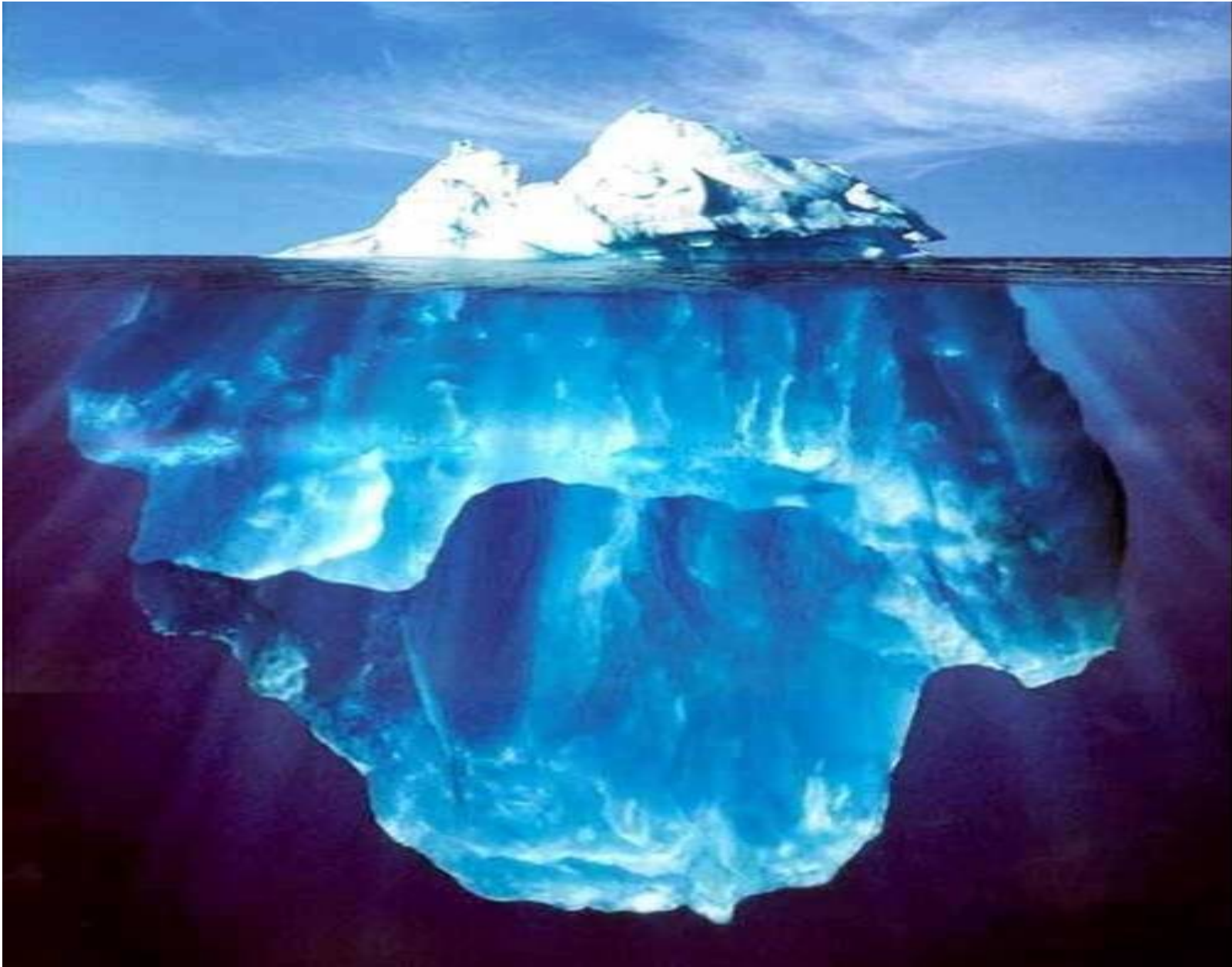
Safe practices are part of the unwritten rules of the organization.

Safety concerns are evident in the interaction among employees and in their interaction with external organizations.

New employees are briefed on safety procedures.

Consequences for ignoring safety practices or engaging in unsafe behavior are enforced.

Well established non-punitive near-miss reporting system.



Critical Factors

- Employees empowered, trained and willing participants
- Leadership Support
- Data Collection
- Data Analysis
- Action

Leadership Questions

- Understand value and make the investment?
- Penalties or incentives?
- Lead effort with visible involvement?
- Resource the fixes for identified hazards?

What does it mean to be a
“learning organization”?

How does a near-miss program relate to “change management”?

Benefits of Near-Miss Program

- Integral Part of SOH Management System
- Critical Element of Change Management
- Requires Management to Focus on Culture
- Shows you if you're are good or lucky
- Raises Risk Awareness
- Encourages Involvement



**NEAR MISS
REPORT**

How do I report a near miss or unsafe condition?

Fill out the opposite side of this form.

Determine if you can do something to resolve the safety problem yourself. If you can, do so and note it on the form.

Send a copy of the form to your local Safety and Health Office.

What's a near miss?

A near miss is an event that could have caused a serious injury or illness, but didn't. For example:

Someone spills coffee or water on the floor and does not clean it up. Someone slips but does not fall

A forklift operator takes a turn too quickly and drops the load which almost hits a nearby worker.

What's an unsafe condition?

An unsafe condition is a condition that could cause an accident or - An accident waiting to happen. For example:

Water or other material(s) on the floor that could cause a slip or fall.

A frayed electrical cord in your office.

How do I correct a safety problem?

Take any action you can to reduce the chance that an accident will happen or that someone will get hurt. You might:

First contact your supervisor/work leader if additional resources are needed to correct the problem.

Contact the Facilities Department/maintenance provider to report a maintenance problem and complete a work order.

Contact your local Safety and Health Office.

**Please return to
your local Safety
and Health office**







開口部注意

外した手すりは必ずもとへ

