

(to be completed by
SSC Manger, Nurse, Principal or designee

MPS Employee Incident Investigation Report

(instructions on next page)

36. Name _____

37. Injury date: _____

38. Injury Location: _____

PART D

Root Cause Investigation Information

39. Root cause analysis (check all that apply – consider witnesses, location, timing, experience, process, procedures, previous, etc.)

Unsafe Acts

- Improper work technique
- Improper PPE / PPE not used
- Operating at improper speeds
- By-passing safety devices/guards
- Improper loading or placement
- Improper lifting
- Servicing energized machinery
- Horseplay
- Drug or alcohol use
- Unnecessary haste
- Other: _____

Unsafe Conditions

- Congested work area
- Fire or explosion hazard
- Inadequate ventilation
- Improper storage
- Damaged/Wrong tool/equipment
- Insufficient knowledge of job
- Slippery -- Ice / Wet / Grease
- Poor housekeeping
- Inadequate hazard control
- Insufficient lighting
- Other: _____

System Deficiencies

- Lack of written procedures
- Safety policies not enforced
- Hazards not identified
- PPE unavailable / improper
- Insufficient training
- Improper maintenance
- Inadequate supervision
- Inadequate job planning
- Inadequate inspection
- Poor process design
- Other: _____

40. Is the task described in a procedure or policy?

41. Was the task performed properly as trained?

42. Did employee action or inaction contribute?

43. Was the proper equipment or tool used?

44. Were safety steps were missed or ignored?

45. What happened and Root Cause Conclusions/Why – Why did the accident occur (based on data gathered - which action or inaction led to other actions or inaction; consider experience, availability, process, attitudes, management, conditions, support, maintenance, training, personal obstacles, medications, etc.)

Why - _____

Why - _____

Why - _____

Why - _____

PART E

Recommendations/Actions

46. General Recommendations (what would prevent or help prevent this in the future):

- Improve Enforcement
- Improve Clean-up Procedures
- Repair/Replace Equipment
- Corrective Counseling
- Rotation of Employee
- Improve/Change Work Method
- Identify/Improve P. P. E
- Retrain Employees
- Install/Revise Guards/Devices
- Improve Design/Construction
- Improve Illumination
- Change Materials/Supplies
- Improve Storage/Arrangement
- Mandatory Pre-Job Huddle
- Task/Procedure Revision
- Other: _____

47. Action item detail (add to follow up)

Responsible party(ies)

Target date

48. Form preparer name and title

Enter Name

Enter Title

49. Form preparer signature

50. Date prepared

PLEASE COMPLETE THE ENTIRE FORM AND RETURN TO THE FORM WITHIN 48 HOURS OF THE INJURY

SAVE FILE & E MAIL IT TO kkcoleman@mpsomaha.org OR FAX TO KIM COLEMAN AT 402 715 8409

(to be completed by
SSC Manager, Nurse, Principal or designee)

MPS Employee Injury Investigation Report

INVESTIGATION REPORT INSTRUCTIONS

36. Injured employee's name -- FIRST NAME, M. INITIAL, LAST NAME –
37. Date the injury happened
38. Pick where the injury happened then enter room, area or description where it occurred (abbreviate if needed)

PART D **Root Cause Investigation Information**

39. Check the boxes that best describe the acts, conditions, or deficiencies that led to the accident. There may be more than 1 cause. Be sure to consider/analyze the entire process. If the cause is other, check box and list
40. Pick choice and describe
41. Pick choice and describe
42. Pick choice and describe
43. Pick choice and describe
44. Pick choice and describe
45. List what happened & why the accident happened. This is beyond “employee slipped.” These are conditions that led to or contributed to the “employee slipping.” The “whys” can be related & build on each other or can be separate items that contributed to the accident.

PART E **Recommendations / Actions**

46. Check the recommendation (s) that you think will best alleviate or eliminate the hazard or problems. If other, check box and list recommendation
47. List tasks to complete to implement recommendations in block 45. Include who should complete it and estimated date it should be finished. Be sure to add these to your follow up and ensure recommended tasks/changes are completed and/or implemented.

PART F **Required Coordination**

48. Name & Title of person completing form (this should be SSC Manager, Nurse, Principal, or designee)
49. Form preparer's name for signature
NOTE: if saving and attaching to e-mail (preferred) then type name --- if printed to scan or fax, then sign as usual)
50. Date form is completed.

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