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Identifying Practices in the Safety Observation Process in Finnish Organisations

Johanna Pulkkinen, Noora Nenonen, and Maria Lindholm

Tampere University, Tampere, Finland

ABSTRACT

Safety observations constitute a crucial tool for enhancing safety management and culture, thereby supporting the implementation of safety strategies. Safety observations include unsafe conditions and actions, while near-miss incidents are typically defined as unplanned adverse events that could have resulted, but did not, in injury or damage to people, property, equipment, materials or the environment. Although there are no established guidelines for the safety observation process, various practices for collecting and utilising safety observations in the workplace have emerged. While collecting safety observations has become more common across different sectors, the practices vary among organisations. These practices' effectiveness has not been evaluated, and some implementation issues may not have been addressed. This article tackles identifying practices in Finnish companies' safety observation process. The data for this paper were collected from an online survey (n = 21) and interviews (n = 40). The survey targeted safety experts and occupational safety managers in different Finnish organisations. The semi-structured interviews were conducted in five case organisations. In total, 64 people were interviewed. The focus was on questions related to the kinds of practices employed in the safety observation process. In this study, the practices were highlighted in, reporting system, handling of observation and communication about observation.

Keywords: Near-miss incident, Occupational safety, Reporting, Handling, Communication

INTRODUCTION

Safety observations serve as an essential component of effective safety management and the development of a safety culture, supporting the execution of broader safety strategies. These observations typically encompass unsafe conditions and behaviours, whereas near-miss incidents refer to unplanned events that had the potential to cause harm or damage—but ultimately did not affect people, property, equipment, materials, or the environment. A typical safety observation process includes the following stages: making and reporting the observation, processing and evaluating it, analysing the situation, identifying solutions, implementing corrective actions, monitoring outcomes, and disseminating the results (Gnoni et al., 2022). In the absence of established guidelines for the safety observation process (Gnoni et al., 2022; Gnoni & Saleh, 2017), and various practices

for collecting and utilising safety observations in workplaces have emerged (Oswald et al., 2018). The effectiveness of the practices in use has not been evaluated (Gnoni et al., 2022). Although near-miss reporting is a common requirement across organisations, the actual utility of such reports remains ambiguous – particularly regarding their impacts on subsequent risk mitigation measures and the implementation of effective safety controls (Haas et al., 2020). Key factors in the successful implementation of safety observation practices include strong support from top management and adequate training for employees (Gnoni et al., 2022).

Previous research has identified several effective near-miss reporting practices, including the use of electronic reporting systems (Awolusi et al., 2015; Erdogan, 2012), which accommodate organisational requirements and capabilities (Wozniak & Hola, 2024). Employees were encouraged to report all safety observations, and campaigns aimed at increasing reporting were found to be effective (Erdogan, 2012). Bugalia et al. (2021) also emphasised the importance of informing employees about the types of near-miss reports submitted and the resulting actions taken. The intervention implemented in a study (Crane et al., 2017) demonstrated that enabling anonymous reporting, introducing an electronic reporting form and providing staff training significantly increased the number of reported near-miss events. At the same time, these measures helped reduce common barriers to reporting, such as perceived additional workload and concerns about potential consequences.

Key elements of an effective near-miss reporting process include comprehensive employee training in how to recognise and report near misses, as well as differentiate them from unsafe acts or conditions (Cambraia et al., 2010; Bugalia, 2021); an investigation team's involvement in reviewing reports, and the safety manager's role in prioritising them (Awolusi & Marks, 2015). The investigation team is then responsible for determining appropriate corrective actions (Bugalia, 2021). Prompt feedback on reported observations has also been identified as a critical factor (Erdogan, 2012). For example, the safety department was recognised for its prompt response to near-miss reports – typically providing feedback within 2–3 days – and was perceived as strongly committed to safety (Bugalia et al., 2021). Williamsen (2013) emphasises the necessity for management's intentional and transparent action to clearly demonstrate the positive impact of near-miss reporting.

Safety observations play a central role in proactive safety improvement and accident prevention. The practice of collecting safety observations has become increasingly common across various industries (Gnoni et al., 2022), although the methods and procedures vary significantly among organisations (Gnoni & Saleh, 2017). In this context, the present study contributes to prior research by providing more in-depth and updated information about practices in the safety observation process.

MATERIALS AND METHODS

As part of a research project, this study examined the role of safety observations in improving safety management in four organisations and one educational institution in Finland. This study is related to a research project,

where the role of safety observations in safety management is examined. The data for this study were collected from interviews and an online survey. A qualitative research approach (Denzin & Lincoln, 2011) was chosen due to the explorative nature of this study and its aim to collect rich data.

The interviews (n = 40) were conducted between May and September 2024. In total, 64 people representing different roles (reporting, assessing and analysing the safety observation reports, utilising the reports and data, designing the process) in the safety observation process were interviewed. The interviewees comprised employees and their health and safety representatives (n = 22), managers or supervisors (n = 23) and safety or security managers or specialists or other experts (human resource managers, a system's main users, consultants) (n = 19). The participating organisations and their distribution of interviews are presented in Table 1.

Table 1: Background information on participating organisations and distribution of interviews.

Participating organisations	R&D organisation of an oil and gas production company (A) Steel plant of a steel manufacturing company (B) Three business units of a passenger and freight traffic company (C) Company providing industrial scaffolding services (D) University (E)
Personnel (n)	Organisation A (450), Organisation B (2500), Organisation C (3200), Organisation D (330), Organisation E (4200)
Interviews per organisation (n)	Organisation A (6), Organisation B (6), Organisation C (10), Organisation D (10), Organisation E (8)
Interviewees per organisation (n)	Organisation A (6), Organisation B (11), Organisation C (22), Organisation D (11), Organisation E (14)

In the semi-structured interviews, the questions' format and sequence varied; additional questions were also asked. The interviews covered seven main themes related to safety observations: 1) definition and objectives, 2) guidance and instructions, 3) identification and reporting, 4) assessment of safety observations and preventive and corrective measures, 5) dissemination and utilisation of information, 6) follow-up and 7) encouragement and reward. The interview questions were related to current practices, good practices, and issues and development needs. This study focused on interview questions related to current and good practices in the safety observation process. Most of the interviews were conducted remotely using Microsoft Teams or Google Meet (n = 24), but face-to-face (n = 13) and hybrid interviews (n = 3) were also held. The interviews were recorded and

transcribed. From the transcriptions, current and good practices were identified and categorised into four groups (reporting, reporting system, handling of observations and communication about observations).

The members of an association of safety, occupational well-being and workplace environment experts were invited to participate in the online survey conducted in March 2025. The link to the survey was included in an information letter emailed to the association's members (n=281), of the members 21 responded. Most of the respondents (62%) represented the industrial sector. The survey's themes were analysis of safety observation reports and utilisation of collected data, measurement/monitoring, and development needs and useful aspects of the safety observation process. The survey consisted of three open-ended and five multiple-choice questions. The focus of this study is on practices of the safety observation process. The results from the open-ended questions were classified into four groups (Reporting, Reporting system, Handling observation, and Communication about observations). In the next section, the results obtained from the interviews and the survey are combined and presented together.

RESULTS

Various practices used in the safety observation process were identified from the results of the interviews and the survey. Table 2 summarises the identified practices of reporting, reporting system, handling of observations and communication about observations. Most of the practices were related to these themes, which are described in the following subsections. In addition to these main themes and practices, many interviewees discussed artificial intelligence (AI) and its role in the observation process overall, especially the kinds of possibilities it could offer. Many organisations have employed AI in analysing observations, but its use is still in the testing phase.

Table 2: Identified practices in the safety observation process.

Theme	Practices
Reporting	Simple reporting process
	Electronic reporting system, mobile application
	Anonymous reporting
	Writing a description using the passive voice
	Support and training in making reports
	Language versions for reporting
	Access to the reporting system
	Rewarding and motivation
Reporting system	Simple, easy to use
	Clear internet link or QR code
	Simple to attach an image
	Simple reporting form
	Saving a draft of the report
	Tracking the progress of an observation
	Providing feedback
	Reminders about unprocessed observations

Continued

Table 2: Continued

Theme	Practices
Handling observations	Transparency in handling observations
	Prompt initiation of handling observations
	A target timeframe for completing an observation report
	Meeting Practices for handling observations
	Predefined investigation templates and handling guidelines
	Most significant observations are handled in a group
Communication about observations	Continuous communication
	Defined guidelines for and roles in communication
	Summary reports and bulletins
	Discussion of observations in meetings
	Campaigns, safety weeks, and safety sessions
	Votes or competitions related to observations
	Internal communication platforms
	Feedback from observation

Reporting

The simplicity of the process of reporting observations was highlighted as a significant factor in most of the interviews. All of the case organisations used an electronic reporting system, with mobile applications also perceived as key tools for enabling easy and straightforward reporting. The option to report anonymously was considered important as well. In some cases, the culture of blame was associated with reporting observations, which could be mitigated by writing the findings in the passive voice. Providing employee support and training in how to report observations was regarded as essential. It was considered beneficial for the first observation report to be completed together with a supervisor or the safety personnel. In multicultural workplaces, it was perceived as good that employees could write observations in their own language. Everyone working in the workplace should have access to the reporting system. The interviewees emphasised the importance of access for subcontractors and temporary workers, who may otherwise be denied access to the system. Rewarding employees was viewed as an effective way to encourage and motivate them to report observations. In the early stages, numerical targets were deemed good motivators. However, it was noted that rewards should not be given merely for submitting observations but for actions taken or for particularly valuable safety observations. Many organisations have different rewarding programmes, such as Observation of the Month, where the most important, informative or innovative observation is chosen. Rewarding was also implemented by linking observations to performance targets and results-based salaries. It was suggested that rewarding be done in a campaign-like manner; in this way, the absence of a reward would not appear to cause dissatisfaction.

Reporting System

According to the survey results, the electronic reporting system played a key role in successful observation reporting. It was emphasised that both reporting and system access should be made as easy as possible for users. The system should also be well known among employees. A simple and easy-to-share web address was considered important. The use of a QR code to

access the system was regarded as a helpful feature. Attaching images to reports ought to be simple. The system's simple reporting form included only as few mandatory fields as possible. To cite an example, there were only one or two open-ended questions, and the rest were multiple-choice questions. This approach was mentioned as helpful for employees with limited language skills. Another valuable feature of the system was its ability to save incomplete reports, allowing users to save an observation as a draft if they could not complete the report immediately. In some organisations, all employees had access to viewing submitted observations and tracking the latter's progress. The interviewees also highlighted features related to the handling of reports. For example, providing feedback was made mandatory in the system. Additionally, the system sent reminders about unprocessed observations and any open measures.

Handling of Observations

Handling of observations varied among the organisations, but several key practices and principles emerged from the interviews and the survey. One of the most emphasised aspects was transparency of the handling process. Everyone in the organisation should understand how handling the observations happens. For the process to be credible, it should begin promptly after an observation is made. Many organisations have set a target timeline for initiating the handling process, typically within 3–7 days. Several interviewees mentioned that observations were handled daily. Many organisations had established a recommended timeframe for completing the handling process, usually between 7 and 14 days. Weekly meetings were perceived as constituting an effective way to manage and monitor handling times. During those meetings, all unsolved or open observations were reviewed. These meetings were found to improve the efficiency of the handling process even when the person responsible for handling an observation lacked motivation. To support the handling of more serious observations, organisations used investigation models and templates, which aided and facilitated the handling. Simple, clear instructions for handling observations were also mentioned as helpful tools. Often, the observation was recognised as having broader aspects; in this case, handling it was forwarded to the safety group. Handling major or complex observations collectively was perceived as crucial.

Communication About Observations

The importance of continuous communication about observations was emphasised in the interviews. Communication took place through various formats and channels. The interviewees highlighted the need for clear guidelines and defined roles regarding how safety observations and related measures should be communicated within the organisation. The CEO should actively and consistently underscore the significance of safety observations to all personnel. All kinds of summary reports and bulletins were considered useful. For example, in one company, the data visualisation tool was used to compile and analyse observations, which were then included in weekly and monthly reports. The occupational safety manager prepared a weekly bulletin for the occupational safety and health (OSH) commissioners, summarising

recent safety observations. These observations were also reviewed and discussed in every OSH meeting, which was perceived as an essential way to increase visibility and reinforce the value of reporting observations. Additionally, safety campaigns, safety weeks and informational sessions were considered effective communication methods. The interviewees also mentioned organising votes and competitions related to observations as a good way to communicate. Internal communication platforms, such as WhatsApp groups, were viewed as valuable channels for sharing safety observation-related information. It was also considered vital for the person who submitted an observation to receive feedback about the process and its outcomes.

CONCLUSION

This study aimed to identify current and good practices in the safety observation process employed by Finnish organisations. This study's findings suggest that many different practices exist, most of which have been reported in previous studies. For example, the use of electronic reporting systems (Awolusi et al., 2015; Erdogan, 2012), a simple and concise reporting form (Williamsen, 2013; Hasanspahic et al., 2020), an investigation team in handling observations (Awolusi & Marks, 2015), prompt feedback (Erdogan, 2012), employee training (Cambraia et al., 2010) and informing employers about observations submitted (Bugalia et al., 2021) were identified in both this study and the literature. However, several different and less discussed practices were also found.

This study identified more detailed practices of reporting, the reporting system, processing of reports and communication. For instance, the importance of language versions for reporting in multicultural workplaces was highlighted in the interviews. Every employee, as well as subcontractors and temporary workers, should have access to the reporting system. The role of rewarding was also emphasised in this study. Likewise, the study drew attention to some useful features of the reporting system, including easy access to it, the possibility of tracking observations and reminders about unhandled observations. In handling observations, the predefined investigation templates and guidelines were viewed as useful. The participants also stressed the importance of communicating observations. Such communication should be continuous and done in many ways. The guidelines for and roles in communication should be defined. These highlights give organisations a starting point for implementing, developing and improving their safety observation process.

The study's small sample size may have affected the results. However, the interviewees came from different organisations and backgrounds, and the findings reached saturation. The survey expanded the data and offered a broader perspective. Further studies are needed to generalise and apply the results to other countries and fields. However, in countries and organisations with similar settings regarding laws, working life and society, the findings can be utilised to some extent.

To enhance safety observation reporting practices, organisations should invest in user-friendly systems, continuous training and transparent communication regarding the outcomes of reported events. These actions

support the development of a proactive safety culture, where learning from observations becomes an integral part of everyday operations. Despite the growing interest in safety observations, the existing literature presents a fragmented understanding of the associated challenges, benefits and effective practices. This knowledge gap accentuates the need for further research to clarify how safety observation processes can be optimised and meaningfully integrated into organisational safety management in a sustainable way.

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