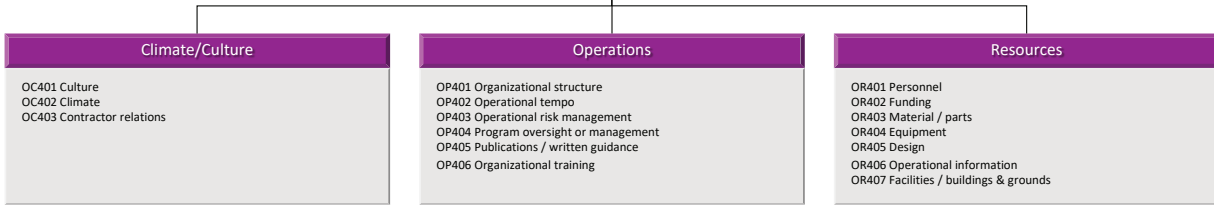
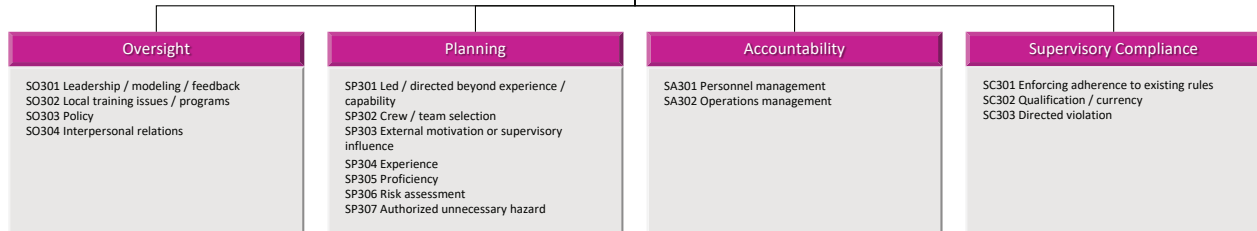




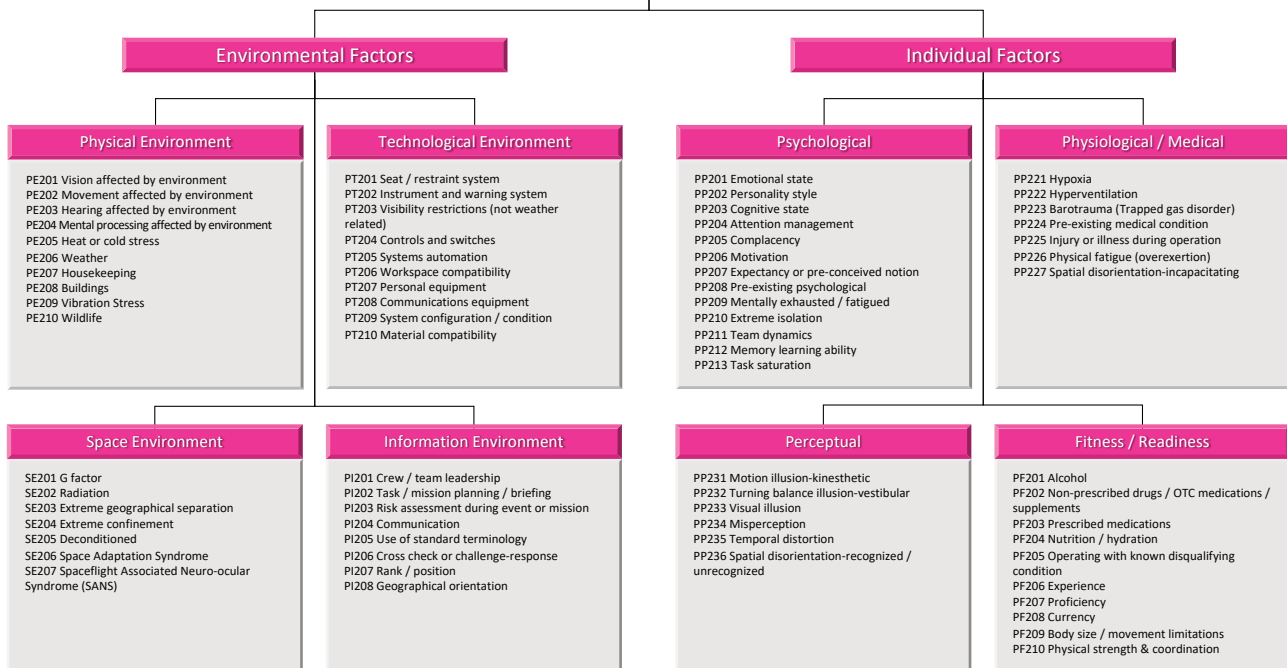
## ORGANIZATION



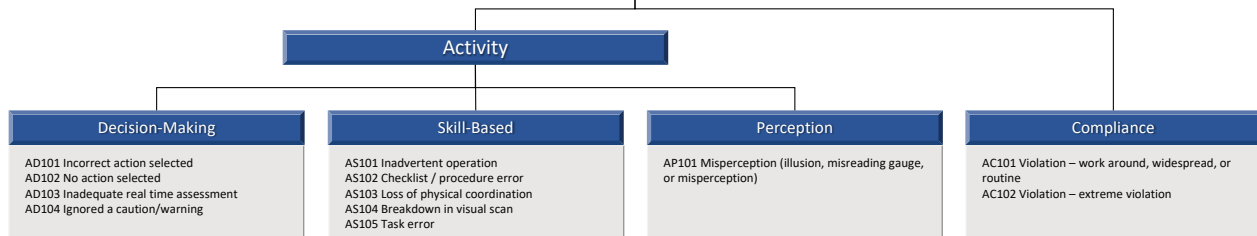
## SUPERVISION



## PRECONDITIONS



## ACTS





## NASAHFACS Weighting Chart

0 **Present** but not a factor, has potential for future mishaps

1 **Minimal** impact on mishap scenario. However it is a noted departure from processes or procedures

2 **Moderate** impact on mishap scenario. It is a departure from process / procedure however its elimination by itself would not have prevented the mishap

3 **Major** impact on mishap scenario. Its elimination could have prevented the mishap

4 **Causal** impact if eliminated from mishap chain of events prevents its occurrence

**Acts** are errors of commission / omission, or violations. These factors are often observed at the time of the mishap.

**Preconditions** are pre-existing environmental, individual, or personnel factors associated with the mishap.

**Supervision** includes guidance, training, feedback, oversight, modeling, discipline, selection, and other expectations associated with supervisory accountability and responsibility associated with the mishap.

**Organizational** include processes, policies, resources, and climate/culture that effect unsafe supervision, preconditions and/or acts associated with the mishap.

### How to apply NASAHFACS

Ask: What **Acts** did the person or team do?

Was it an error? Skill, Decision or Perception?

*(Made a decision error or pushed the wrong button, misinterpreted the gauge reading etc.)*

Was it a violation, i.e. deliberate departure from established process? *(Violated Directives, Requirements or Procedures)*

### Determine the Preconditions:

What conditions existed before the person committed the unsafe act? Was the physical or technological environment a factor? *(Bad weather, visibility restrictions from dust / smoke, blind spots, bad location of switch / control etc.)* Was it the Physical or Mental limitations of the person / Team? *(Personal life issues, complacency, trying too hard to complete the task, lack of sleep, illness, prescribed medications etc.)* Communications, planning or self-stressors play a factor? *(Nutrition, lack of proper rest PT, alcohol, poor communications, improper planning, poor situational awareness etc.)*

**Supervisor Issues:** Who knew about the preconditions but did not take steps to prevent the act? *(Did the Supervisor fail to provide proper guidance, training opportunity or act as a proper role model?)* Did the Supervisor improperly plan the operation and why? Did the Supervisor fail to correct a known problem with the subordinate, provide training, or stop hazardous practices? Did the Supervisor violate policy?

**Organization Issues:** Are there organizational vulnerabilities that affected Supervisory practices and/or set the stage for unsafe preconditions or acts? *(Did policies, climate, Ops Tempo, inadequate risk assessments, processes or funding have a role?)*

### Points of Contact

OSMA / Tracy Dillinger

Human Factors Program Manager

[tracy.dillinger@nasa.gov](mailto:tracy.dillinger@nasa.gov)

(202) 358-1680

