



TECHNICAL LEARNING AND ASSESSMENT DOSSIER

ISO 45001:2018 + Amd 1:2024 – Occupational health and safety

Course + certificate

600,00 €

VAT excluded

Course code

ISO45001-2018

Minimum duration

360 min

Final pass score

70%

Dossier issue

13/10/2026

1. Course identity, purpose and scope

Advanced course on ISO 45001:2018 and Amendment 1:2024, focusing on leadership, worker participation, hazards, risks, controls and improvement.

This extended technical dossier describes the pathway as published in CIWZ Academy on the issue date. It consolidates purpose, references, learning architecture, module contents, assessment system, passing criteria and certificate conditions. It does not replace the official texts of the standards, laws, guidelines or schemes referenced.

2. Normative, regulatory and technical references

ISO 45001:2018; ISO 45001:2018/Amd 1:2024; ISO 45002:2023; ISO 19011:2026

References are used as the learning and assessment framework within the limits of published content and available sources. For professional application, the official and current versions of the referenced documents always prevail.

3. Learning architecture and assessment system

- 8 structured learning modules
- minimum tracked time: 360 min
- intermediate-check bank: 400 questions
- active final-exam bank: 390 questions
- final exam: 30 questions selected from the bank
- passing threshold: 70%
- Access to the pathway through the personal Academy profile or a corporate assignment.
- Sequential study of the modules, with server-side recording of progress and required minimum time.
- Intermediate checks linked to modules to verify understanding, application capability and quality of reasoning.

- Final exam unlock only after the pathway requirements have been completed.
- Protected final exam assembled by the platform through selection from the active course question bank.
- Recording of the result and, where applicable, the option to request the final certificate.

4. Official catalogue technical information

Course technical sheet

Bilingual CIWZ Academy pathway with server-tracked lessons, sequential slides, randomized intermediate checks and a final exam using a no-repeat question bank.

5. Detailed course syllabus

The following syllabus is derived from the active modules published on the platform. Each module shows its minimum study time and the size of its available intermediate-check bank.

01 OH&S management-system foundations and standard status

Minimum time: 30 min | Intermediate questions: 50

02 Context, workers, interested parties and scope

Minimum time: 45 min | Intermediate questions: 50

03 Leadership, consultation and worker participation

Minimum time: 50 min | Intermediate questions: 50

04 Hazards, risks, opportunities and obligations

Minimum time: 60 min | Intermediate questions: 50

05 Objectives, planning and management of change

Minimum time: 45 min | Intermediate questions: 50

06 Support, competence, awareness and communication

Minimum time: 40 min | Intermediate questions: 50

07 Operational control, hierarchy of controls, procurement, contractors ...

Minimum time: 50 min | Intermediate questions: 50

08 Performance, incidents, audit, review and improvement

Minimum time: 40 min | Intermediate questions: 50

6. Developed module-by-module contents

The following pages analytically describe the content actually associated with each platform module. The structure is designed so that learners, companies, HR, Quality, HSE or CISO functions can understand precisely what is studied and assessed.

MODULE 01**OH&S management-system foundations and standard status**

- Minimum required time: 30 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

ISO 45001:2018 remains the applicable published edition, supplemented by Amendment 1:2024 on climate change. A new edition is under development in 2026, but a DIS does not replace the current standard.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “context and workers”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“OH&S management-system foundations and standard status” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Build the system around OH&S risks, prevention of injury and ill health, and improvement of OH&S performance.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.
- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Clearly separate current requirements, guidance and draft documents during training and audits.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “hazard and near-miss reports”, read together with “critical risk exposures and controls”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?

- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is confusing consultation with information only. Another is failing to coordinate contractor interfaces. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

An organization changes procedures based on an unpublished draft: the risk is creating unnecessary internal obligations and confusing audit criteria.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not “does the document exist?” but “does the system reliably produce the expected result and react when it does not?”.

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure,

outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: "OH&S management-system foundations and standard status" is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 02**Context, workers, interested parties and scope**

- Minimum required time: 45 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

The system must understand internal and external issues, relevant needs and expectations of workers and other interested parties, and operational boundaries of the system.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “leadership and participation”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Context, workers, interested parties and scope” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Define the scope including activities, processes, sites, workers and interfaces over which the organization exercises relevant control or influence.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Verify that contractors, remote work, temporary sites and outsourced activities are considered where relevant to risks.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “completed hierarchy-of-controls actions”, read together with “contractor performance”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or

incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is assessing routine activity risks only. Another is managing change after implementation. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

Excluding a third-party warehouse does not remove risks to the organization's workers operating there.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not "does the document exist?" but "does the system reliably produce the expected result and react when it does not?".

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure, outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Context, workers, interested parties and scope” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 03**Leadership, consultation and worker participation**

- Minimum required time: 50 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

ISO 45001 gives a central role to leadership and consultation and participation of workers, particularly non-managerial workers.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “hazards and risk assessment”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Leadership, consultation and worker participation” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Remove barriers to participation, provide time, information and channels, protect those who raise concerns and integrate feedback into decisions.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Look for evidence of genuine worker contribution to hazards, controls, investigations and changes, not just consultation signatures.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “worker participation in decisions”, read together with “action closure time”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or

incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is skipping the hierarchy of controls. Another is analysing human error without organizational causes. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

Workers report a hazard but receive no feedback: the channel exists formally, but participation loses effectiveness.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not “does the document exist?” but “does the system reliably produce the expected result and react when it does not?”.

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure, outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Leadership, consultation and worker participation” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 04**Hazards, risks, opportunities and obligations**

- Minimum required time: 60 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

Hazard identification should be proactive and consider routine and non-routine activities, people, human factors, changes, emergencies and previous incidents.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “objectives and planning”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Hazards, risks, opportunities and obligations” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Use consistent methods to assess OH&S and system risks and opportunities, keep legal and other requirements current and plan actions.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Sample a hazard and trace it from identification to assessment, control measure, competence and effectiveness review.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “critical risk exposures and controls”, read together with “emergency exercise effectiveness”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or

incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is using PPE as the first choice. Another is measuring only injuries that occurred. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

A near miss with no injury may reveal a weak barrier and should feed risk assessment.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not “does the document exist?” but “does the system reliably produce the expected result and react when it does not?”.

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure, outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Hazards, risks, opportunities and obligations” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 05**Objectives, planning and management of change**

- Minimum required time: 45 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

OH&S objectives should translate policy, risks and opportunities into planned results. Temporary or permanent changes require preventive control.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “competence and communication”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Objectives, planning and management of change” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Define targets, indicators, owners, resources and timing; assess risks before introducing different technologies, shifts, layouts, materials or organization.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Verify that change management occurs before exposure and includes communication and training.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “contractor performance”, read together with “incident and systemic-cause trends”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is failing to coordinate contractor interfaces. Another is confusing consultation with information only. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

A new machine is safe in itself but changes pedestrian flows and maintenance: assessment must consider the work system.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not “does the document exist?” but “does the system reliably produce the expected result and react when it does not?”.

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure, outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Objectives, planning and management of change” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 06**Support, competence, awareness and communication**

- Minimum required time: 40 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

Resources and competence should ensure people understand hazards, controls, rights and consequences of failing to follow measures.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “operational controls and hierarchy”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Support, competence, awareness and communication” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Define competence for critical tasks, verify effectiveness, and control relevant communications and documented information.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Field observations and interviews verify whether competence is actually applied.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “action closure time”, read together with “hazard and near-miss reports”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is managing change after implementation. Another is assessing routine activity risks only. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

A valid training certificate alone does not prove that an operator can manage a real hazardous condition.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not "does the document exist?" but "does the system reliably produce the expected result and react when it does not?".

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on "we have always done it this way", a criterion is missing. If it relies only on a procedure, outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Support, competence, awareness and communication” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 07**Operational control, hierarchy of controls, procurement, contractors and emergencies**

- Minimum required time: 50 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

Controls should follow the hierarchy, prioritizing elimination and substitution before engineering, administrative controls and PPE where applicable.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “procurement, contractors and change”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Operational control, hierarchy of controls, procurement, contractors and emergencies” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Integrate OH&S requirements into procurement, contracting, contractor coordination and emergency preparedness; control relevant outsourced processes.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

Verify consistency between risk assessment, selected control and accepted residual risk; avoid automatic reliance on PPE.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “emergency exercise effectiveness”, read together with “completed hierarchy-of-controls actions”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or

incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is analysing human error without organizational causes. Another is skipping the hierarchy of controls. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

Adding PPE without evaluating elimination of the source may be a less effective measure under the hierarchy of controls.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not "does the document exist?" but "does the system reliably produce the expected result and react when it does not?".

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational

capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure, outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Operational control, hierarchy of controls, procurement, contractors and emergencies” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

MODULE 08**Performance, incidents, audit, review and improvement**

- Minimum required time: 40 min
- Available intermediate-check bank: 50 questions

1. Orientation and learning outcomes

Monitoring, compliance evaluation, audits, management review, incident investigation and corrective actions should produce learning and risk reduction.

This chapter is designed to move from understanding the principle to recognizing evidence, making decisions and evaluating effectiveness. The guiding theme is “incidents, audit and improvement”. Memorizing definitions is not enough: you should be able to connect requirement, process, risk, accountability and result.

- Explain the topic in your own words without reducing it to documentation.
- Identify the process or organizational decision affected by the topic.
- Distinguish implementation evidence from effectiveness evidence.
- Recognize when a favourable result may hide a weak control.

2. Standard framework and system connections

Occupational health and safety management requires leadership, worker consultation and participation, hazard identification, assessment of risks and opportunities, hierarchy of controls, management of change, procurement, emergency preparedness and learning from events. Amendment 1:2024 integrates climate-change consideration into context.

“Performance, incidents, audit, review and improvement” does not exist in isolation. In a mature management system, decisions in this area must align with context, policy, objectives, resources, operational control and review. Missing connections often create merely formal conformity.

- Read the requirement in the organization's context.
- Look for interactions with other processes and relevant interested parties.
- Identify the expected result and how it will be measured.

3. From the standard to operational process

Use leading and lagging indicators, analyse systemic causes, involve workers in investigations and verify action effectiveness.

A robust method starts from a real situation, defines decision criteria, assigns an owner, establishes proportionate controls and produces usable information. The sequence should remain reconstructable months later to support continuity, auditability and learning.

- Define the input that triggers the process and the expected output.
- Set criteria and thresholds before judging results.
- Assign responsibility and authority proportionate to risk.
- Embed controls in normal work rather than in a parallel compliance process.

- Review effectiveness when conditions or evidence change.

4. Decisions, risks and proportionality

The topic requires a proportionate decision. Not every situation needs the same level of formalization, but every material decision should be explainable. Consider consequences, likelihood or exposure where relevant, dependencies, applicable requirements and the reliability of available information.

Avoid both over-control that adds no value and weak control justified only by the absence of adverse events. Maturity means selecting an appropriate control level and reviewing it against results.

- What event or change should trigger reassessment?
- Which assumption, if wrong, would change the conclusion?
- Which control prevents the issue and which detects its effects?
- How is the residual risk or resulting performance shown to be acceptable?

5. Roles, leadership and competence

Effectiveness depends on clear accountability. Top management sets direction and priorities, process owners govern criteria and results, people apply controls and report anomalies, and support functions provide competence and tools. Outsourcing an activity does not automatically outsource accountability for the management system.

Competence should be demonstrated in the context of the task. Training, experience and instructions are means; the intended result is the ability to perform correctly and respond to deviations.

- Who decides?
- Who performs?
- Who verifies?
- Who should be consulted or informed?
- Who authorizes exceptions and changes?

6. Evidence: what really demonstrates implementation

A fall in injuries is insufficient if near-miss reporting also drops because workers fear consequences.

A single record is rarely enough. Strong evidence comes from triangulating documented criteria, process observation, result data and interviews with people doing the work. Sources should be coherent; divergence is itself information that deserves investigation.

- Sample more than one period or case for repetitive processes.
- Compare planned practice with actual practice.
- Verify effectiveness, not just control presence.
- Maintain traceability between decision, evidence and conclusion.

7. Data, indicators and weak signals

For this chapter, a useful indicator may be “incident and systemic-cause trends”, read together with “worker participation in decisions”. A single metric can mislead: understand its definition, source, frequency, threshold, owner and the decision expected when it deviates.

A positive trend needs interpretation. It may result from genuine improvement, a method change, reduced activity or incomplete data. Before concluding, check comparability and use leading signals alongside final outcomes.

- Outcome indicator: what happened?
- Leading indicator: what condition may predict a problem?
- Threshold: when is action required?
- Decision: who acts and by when?

8. Common failure modes and how to avoid them

One recurring failure mode is measuring only injuries that occurred. Another is using PPE as the first choice. These behaviours can create an orderly-looking system that cannot prevent recurrence or demonstrate results.

Correct the approach by returning to three questions: what result is needed, what evidence demonstrates it, and what decision will be taken if the result is unsatisfactory?

- Do not confuse documentary conformity with operational control.
- Do not use absence of problems as the only proof of effectiveness.
- Do not leave criteria implicit or dependent on one person's memory.
- Do not close actions without later checking their effect.

9. Applied case

After an incident the operator is replaced without changing organizational conditions that enabled the error: the systemic cause remains active.

Analyse the case as the process owner. Separate facts from assumptions, identify relevant requirements and interested parties, evaluate possible consequences and define the evidence you need before choosing an action and an effectiveness check.

- What is the real problem and what may only be a symptom?
- Which requirement or criterion is involved?
- Which people or processes must participate?
- What evidence would show that the solution remains effective?

10. Audit lens

During an audit, follow the chain requirement -> decision -> implementation -> evidence -> result. The question is not “does the document exist?” but “does the system reliably produce the expected result and react when it does not?”.

When evidence conflicts, extend the sample and determine whether the issue is isolated or systemic. Conclusions should be supported by verifiable evidence and clear criteria.

- Follow a recent example from start to finish.
- Use at least two independent sources for significant risk.
- Verify implementation and effectiveness.
- Distinguish an exception from a local deviation and a systemic issue.

11. Decision laboratory

Imagine that tomorrow a major condition changes: a supplier, technology, requirement, workload or responsibility. Build a five-step response: impact, criterion, decision, evidence, review. The exercise turns the requirement into operational capability.

If your answer relies on “we have always done it this way”, a criterion is missing. If it relies only on a procedure,

outcome verification is missing. If it relies on one data point, robustness is missing.

- Impact: what changes?
- Criterion: what will the decision be based on?
- Action: what will be done?
- Evidence: how will implementation be demonstrated?
- Review: when and how will effectiveness be checked?

12. Summary and preparation for the check

Before taking the check, make sure you can explain the chapter without reading the slides. The questions are scenario-based and require you to distinguish a substantive response from a merely formal one.

Key point: “Performance, incidents, audit, review and improvement” is effective when context, accountability, criteria, implementation, evidence and results are coherent and reviewed. The system should show not only that an activity occurred, but that it achieved its intended effect.

- Can you connect the topic to a real process?
- Can you identify at least two independent pieces of evidence?
- Can you distinguish a useful indicator from a misleading one?
- Can you choose a proportionate action in a new scenario?

7. Assessment system, final exam and passing criteria

- Intermediate checks are linked to individual modules and provide progressive learning control before access to the final assessment.
- The final assessment consists of 30 questions selected from the active course bank. The platform applies an anti-repetition logic for new attempts when the bank size allows it.
- Final question-bank size detected at generation time: 390 active questions.
- Published passing threshold for the course: 70%.
- Questions are intended to assess not only recall but also interpretation, application, evidence selection, scenario assessment and quality of decision-making, depending on the subject matter.

8. Tracking, learning continuity and session integrity

- Path status, completed modules and recorded time are managed server-side when the course uses the Academy learning mode.
- The platform allows the pathway to resume from the recorded point and retains the results of required checks.
- Assessment sessions may be subject to the integrity and proctoring controls enabled by the platform and described in the applicable usage rules.
- Technical and integrity events support assessment and do not replace professional judgement where human review is required.

9. Certificate, use and limitations

The CIWZ certificate, where provided by the pathway and requested after passing, records the result achieved in the stated CIWZ pathway or assessment. It does not automatically replace personnel certification, professional registration, statutory licence, legal qualification or credentials issued by third-party bodies where such requirements are imposed by the applicable scheme.

10. Commercial and tax conditions

- Course + certificate: 600,00 € VAT excluded.
- UAE VAT is applied to UAE customers according to billing data and the applicable tax rules.
- Any specific commercial terms, agreements or corporate orders override the public price only when formally accepted by Certificato IWZ FZCO.

11. Dossier document control

- Document automatically generated by CIWZ Academy from the course data published at the time of the request.

- Course code: ISO45001-2018
- Document language: EN
- Generation date: 13/10/2026
- For normative and professional application, the current official sources and any applicable procedures/schemes prevail.