The Swiss Cheese Model of Accident Causation suggests that systemic failures, or accidents, occur from a series of events at different layers of an organization. A system is similar to slices of Swiss cheese. There are holes which represent opportunities for failure, and each slice is a layer of the system. When holes in the layers line up, a loss (or accident) occurs. Each layer of the system is an opportunity to stop an error; the more layers, the less likely an accident is to occur. The major layers of a system are: Unsafe acts, Conditions (for unsafe acts), unsafe Supervision, and influences of an Organization. Below are selected examples of each layer (NOTE: This is not a complete listing).

### Errors
- **Decision**
  - Improper procedure
  - Misdiagnosed issue
  - Wrong response
  - Exceeded ability
  - Inappropriate act
  - Poor decision
- **Skill-based**
  - Failed to prioritize
  - Inadvertent use of equipment
  - Omitted step in procedure
  - Ignored checklist item
  - Poor technique
  - Overcontrolled the situation
- **Perceptual**
  - Misjudged
  - Spatial disorientation
  - Visual illusion

### Violations
- Failed to adhere to brief
- Failed to use equipment
- Violated training rules
- Used an unauthorized approach
- Used an overaggressive maneuver
- Failed to properly prepare
- Not current / qualified for task
- Intentionally exceeded limits of the equipment
- Unauthorized actions

Unsafe Acts of people can be loosely classified into two categories: errors and violations (Reason, 1990). **Errors** generally represent the mental or physical activities of individuals that fail to achieve their intended outcome. **Decision** errors represent intentional behavior that proceed as intended, yet the plan proves inadequate or inappropriate for the situation. **Skill-based** errors occur when people operate without significant conscious thought. **Perceptual** errors occur when one’s perception of the world differs from reality; typically when sensory input is degraded. **Violations**, on the other hand, refer to the willful disregard for the rules and regulations that govern the safety of work. They can be habitual by nature, as well as atypical actions.
Conditions for unsafe acts of people can be categorized into two categories: substandard conditions of people, and substandard practices of people. **Substandard conditions of people** involve adverse mentality or mental states (stressors and personality traits), adverse physiology (conditions, such as illness, that preclude safe work), and physical/mental limitations (when work requirements exceed the basic sensory capabilities of people at the). **Substandard practice of people**, on the other hand, refer to human resource management (poor coordination among employees), and personal readiness (when people are not at optimal levels when they show up for work).

Unsafe supervision can be categorized into four areas: supervised inadequately, planned inappropriate operations, failed to correct problems, and supervisory violations. When people supervised inadequately, there is a general failure to provide the opportunity to succeed. When those in charge planned inappropriate operations, personnel are generally put at an unacceptable risk (i.e., improper pairing of team members). When supervisors failed to correct problem(s), there are known unsafe conditions that allow to continue unabated. Finally, violations of supervisor(s) occur when there is mismanagement of assets, followed by a tragic sequence of events by people under those supervisors.
Organizational influences are the fallible decisions of upper-management that directly affect supervisory practices, conditions, and actions of people. **Resource management** encompasses the realm of organizational-level decision making regarding the allocation and maintenance of assets (i.e., people, money, and equipment/facilities). **Organizational climate** refers to a broad class of variables that influence worker performance (i.e., the working atmosphere). **Organizational process** refers to decisions and rules that govern everyday activities within an organization (operational procedures and oversight programs to monitor risks).