**Sample Form for Performing a Simple Root Cause Analysis of a Sharps Injury or Near Miss Event**

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| ***Description of Event Under Investigation*****Event:** Date\_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_\_ AM PM **Weekday:** **Location:** **Details of how the event occurred:**  |
| **Contributing Factors** |  | **If YES, what contributed to this factor being an issue?** | **Is this a root cause of the event?** | **If YES, is an action plan indicated?** |
| **YES** | **NO** | **YES** | **NO** | **YES** | **NO** |
| Issues related to patient assessment? |  |  |  |  |  |  |  |
| Issues related to staff training or staff competency? |  |  |  |  |  |  |  |
| Equipment/device? |  |  |  |  |  |  |  |
| Work environment? |  |  |  |  |  |  |  |
| Lack of or misinterpretation of information? |  |  |  |  |  |  |  |
| Communication? |  |  |  |  |  |  |  |
| Appropriate rules/policies/ procedures or lack thereof? |  |  |  |  |  |  |  |
| Failure of a protective barrier? |  |  |  |  |  |  |  |
| Personnel or personal issues? |  |  |  |  |  |  |  |
| Supervisory issues |  |  |  |  |  |  |  |

**Root Cause Analysis Action Plan**

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| **Risk Reduction Strategies** | **Measure(s) of Effectiveness** | **Responsible Person(s)** |
| **Action item #1** |  |  |
| **Action item #2** |  |  |
| **Action item #3** |  |  |
| **Action item #4** |  |  |
| **Action item #5** |  |  |

**Sample Trigger Questions for Performing a Root Cause Analysis**

 **of a Blood or Body Fluid Exposure**

1. Issues related to patient assessment
	* Was the patient agitated before the procedure?
	* Was the patient cooperative before the procedure?
	* Did the patient contribute in any way toward the event?
2. Issues related to staff training or staff competency
	* Did the healthcare worker receive training on injury prevention technique for the procedure performed?
	* Are there training or competency factors that contributed to this event?
	* Approximately how many procedures of this type has the healthcare worker performed in the last month/week?
3. Issues related to the device
	* Did the type of device used contribute in any way to this event?
	* Was a “safety” device used?
	* If not, is it likely that a safety device could have prevented this event?
4. Work environment
	* Did the location, fullness or lack of a sharps container contribute to this event?
	* Did the organization of the work environment (e.g., placement of supplies, position of patient) influence the risk of injury?
	* Was there sufficient lighting?
	* Was crowding a factor?
	* Was there a sense of urgency to complete the procedure?
5. Was a lack of or misinterpretation of information contribute to this event?
	* Did the healthcare worker misinterpret any information about the procedure that could have contributed to the event?
6. Communication
	* Were there any communication barriers that contributed to this event (e.g., language)
	* Was communication in any way a contributing factor in this event?
7. Appropriate policies/procedures
	* Are there existing policies or procedures that describe how this event should be prevented?
	* Were the appropriate policies or procedures followed?
	* If they were not followed, why not?
8. Worker issues
	* Did being right or left handed influence the risk?
	* On the day of the exposure, how long had the worker been working before the exposure occurred?
	* At the time of the exposure, could factors such as worker fatigue, hunger, illness, etc. have contributed?
9. Employer issues
	* Did lack of supervision contribute to this event?