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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***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**

|  |  |  |
| --- | --- | --- |
| **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?