**ROOT CAUSE ANALYSIS OF INJURY/ILLNESS**

**(Supplemental Form)**

Injured Employee Name:

1. What task was the injured employee performing prior to the accident / near miss?

2. Describe any tools, machinery or equipment that was being used at the time of the incident?

3. Was the employee working alone? Yes No With?

4. How much experience did the injured person have in performing this task?

**STEP 1 – OBTAIN AND REVIEW PHYSICAL, PEOPLE, AND PAPER EVIDENCE PERTINENT TO THE INVESTIGATION.**

* **Physical: Sample Results (Air, Noise, Bulk, etc.)/ Photographs/Drawings/Equipment Manual/etc.**
* **People: Witness Statements & Interviews/ Employee Report of Incident**
* **Paper: Policies/Programs/Procedures/Training Records/Maintenance Records/Prior Incident Reports/etc.**

**STEP 2 – DIRECT, CONTRIBUTING, AND ROOT CAUSES**

* **Use this listing as an aid for identifying the factors that lead to the incident.**
* **Don’t be limited by the categories listed--add items (Other) as needed. Check all that apply.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| POLICIES/PROGRAMS | ✓ |  | COMMUNICATION | ✓ |
| Not Developed or Inadequate |  |  | Insufficient Planning for Tasks |  |
| Developed – Not Communicated |  |  | Lack of Worker Communication |  |
| Developed – Not Understood |  |  | Lack of Supervisor Instruction |  |
| Developed – Not Followed |  |  | Work Team Breakdown |  |
| Lack of Disciplinary Policy |  |  | Confusion After Communication |  |
| Disciplinary Policy Not Enforced |  |  |  |  |
| Other |  |  | Other |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HAZARD(S) | ✓ |  | FACILITIES/EQUIPMENT | ✓ |
| Unidentified or Not Labeled |  |  | Poor Facility Design |  |
| Known But Not Corrected |  |  | Poor/Faulty Equipment Design |  |
| Known But Not Reported |  |  | Awkward Workstation Design |  |
| Created By External Factors |  |  | Equipment Not Guarded |  |
| Documented But Not Repaired |  |  | Equipment Repair Deficient |  |
| Condition Changed Not Conveyed |  |  | Lack of Preventive Maintenance |  |
| Equipment Repaired Deficiently |  |  | Lack of Storage |  |
| PPE Not Adequate or Defective |  |  | Other |  |
| Other |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PRODUCTIVITY FACTORS | ✓ |  | WORK BEHAVIOR | ✓ |
| Heavy Workload |  |  | Shortcuts Taken |  |
| Tight Schedule |  |  | Required PPE Not Used |  |
| Long/Unusual Working Hours |  |  | PPD Not Used Properly |  |
| Falsely Perceived Need to Hurry |  |  | Tool/Equipment Used Incorrectly |  |
| Staff Assistance Unavailable |  |  | History of Accidents/Incidents |  |
| Staff Assistance Inadequate |  |  | Disregarded/Refused to Follow Procedure(s) |  |
| Changes in Process |  |  | Staff Assistance Required – Not Requested |  |
| Other |  |  | Horseplay |  |
|  |  |  | Other |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| TRAINING | ✓ |  | ENVIRONMENT | ✓ |
| Deficient Orientation Training |  |  | Weather, Temperature |  |
| Deficient Job-Specific Training |  |  | Poor Housekeeping |  |
| Insufficient Training for New Process/Task |  |  | Poor Lighting |  |
| Lack of Supervisor Follow-Up/Reinforcement |  |  | Poor Visibility |  |
| Lack of Supervisor Training |  |  | Air Quality |  |
| Hazards Overlooked in Training |  |  | Noise |  |
| Other |  |  | Other |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PATIENT HANDLING | ✓ |  | BLOOD & OPIM EXPOSURE | ✓ |
| Transfer/Positioning Equipment Not Used |  |  | Needless System Not Available |  |
| Transfer/Positioning Equipment Not Used Properly |  |  | Needless System Available-Not Used |  |
| Transfer/Positioning Equipment Not Available |  |  | Needle Device (needle cover, etc.) Not Used |  |
| Equipment Not Adequate for Patient Weight and/or Size |  |  | Sharps Container Not Located as Close as Feasible |  |
| Area too Small to Use Transfer/Positioning Equipment |  |  | Sharps Container Overfilled |  |
| Combative Patient |  |  | Sharps Container Not Used (stuck in bed, etc.) |  |
| Care Plan Not Adequate |  |  | Contaminated Needle Recapped |  |
| Care Plan Did Not Fit Patient Handling Policy |  |  | Stuck w/Contaminated Needle/Sharp by Physician or Other Staff |  |
| Care Plan Not Updated When Patient Condition Changed |  |  | Contaminated Waste Not Labeled |  |
| Care Plan Not Followed |  |  | Blood/OPIM Not Properly Stored |  |
| Other |  |  | Other |  |
|  |  |  |  |  |

**STEP 3 – CAUSE(S)**

* **From the categories identified, circle the major cause(s) of the incident.**

**POLICIES/PROCEDURES COMMUNICATION HAZARD(S)**

# TRAINING PRODUCTIVITY FACTORS WORK BEHAVIOR

**FACILITIES/EQUIPMENT ENVIRONMENT PATIENT HANDLING**

**BLOOD & OPIM EXPOSURE**

**STEP 4 – ANALYSIS OF ROOT CAUSE:**

|  |
| --- |
| Why did this happen?\* |
| Why…? |
| Why…? |
| Why…? |
| Why…? |
| How can this be prevented: |
| Corrective Steps for Root, Contributing, and Direct Causes: |

*\* For each answer to “why?” seek one or more causes.*

*\* To assure elimination of all hazards identified above, it may be necessary to repeat the above five steps several times if a major cause appears in more than one category.*

Supervisor’s Name & Signature Date Employee Representative’s Name & Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Designated Person (Name, Title, Signature) Date

Witness Name & Signature Date Witness Name & Signature Date