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	YES	NO	If "YES", what contributed to this factor being an issue?	Is this a root cause of the event? YES	Is this a root cause of the event? NO	If YES, is an action plan indicated? YES	If YES, is an action plan indicated? 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?