EVENTSCAPE

INCIDENT INVESTIGATION

1.2 ROOT CAUSE ANALYSIS

ROOT CAUSE ANALYSIS

FACTORS LEADING TO THE INCIDENT *select all that apply*

POLICY / PROGRAM
- ☐ INADEQUATE OR UNDEVELOPED POLICIES
- ☐ DEVELOPED AND COMMUNICATED
- ☐ DEVELOPED— NOT COMMUNICATED
- ☐ DEVELOPED— NOT FOLLOWED / ENFORCED
- ☐ DEVELOPED— NOT UNDERSTOOD
- ☐ LACK OF DISCIPLINARY POLICY
- ☐ DISCIPLINARY POLICY NOT ENFORCED

COMMUNICATION
- ☐ INSUFFICIENT PLANNING FOR TASKS
- ☐ LACK OF WORKER COMMUNICATION
- ☐ LACK OF SUPERVISOR INSTRUCTION
- ☐ SUFFICIENT SUPERVISOR INSTRUCTION
- ☐ CONFUSION AFTER COMMUNICATION
- ☐ LACK OF UNDERSTANDING OF TASK
- ☐ WORK TEAM BREAKDOWN

HAZARDS
- ☐ UNIDENTIFIED OR NOT LABELED
- ☐ KNOWN BUT NOT CORRECTED
- ☐ KNOWN BUT NOT REPORTED
- ☐ CREATED BY EXTERNAL FACTORS
- ☐ CONDITION CHANGED NOT CONVEYED
- ☐ EQUIPMENT REPAIRED DEFICIENTLY

BLOODBORNE PATHOGEN
- ☐ UNAWARE/AWARE OF AIR BORNE HAZARD
- ☐ STUCK WITH CONTAMINATED NEEDLE
- ☐ CLIENT CONTACT/EXPOSURE
- ☐ INMATE CONTACT/EXPOSURE
- ☐ SHARP CONTAINER NOT AVAILABLE
- ☐ IMPROPER CLEANUP
- ☐ CONTAMINATED WASTE NOT LABELED

PERSONAL FACTORS
- ☐ INADEQUATE CAPABILITY
- ☐ LACK OF KNOWLEDGE
- ☐ LACK OF SKILL
- ☐ STRESS
- ☐ IMPROPER MOTIVATION

JOB FACTORS
- ☐ INADEQUATE LEADERSHIP/SUPERVISION
- ☐ INADEQUATE ENGINEERING
- ☐ INADEQUATE PURCHASING
- ☐ INADEQUATE MAINTENANCE
- ☐ INADEQUATE TOOLS / EQUIPMENT / MATERIALS
- ☐ INADEQUATE WORK STANDARDS
- ☐ WEAR AND TEAR
- ☐ ABUSE AND MISUSE

PRODUCTIVITY FACTORS
- ☐ HEAVY WORKLOAD
- ☐ PERCEIVED NEED TO HURRY
- ☐ TIGHT SCHEDULE TO COMPLETE TASK
- ☐ LONG/UNUSUAL WORKING HOURS
- ☐ STAFF ASSISTANCE INADEQUATE
- ☐ STAFF ASSISTANCE UNAVAILABLE
- ☐ MEDICATION, DRUGS, ALCOHOL FACTORS
- ☐ DOUBLE SHIFT
- ☐ CHANGE IN PROCESS
- ☐ EMPLOYEE WAS ILL

WORK BEHAVIOR
- ☐ SHORTCUTS TAKEN
- ☐ SPECIAL INFREQUENT TASK
- ☐ TOOL / EQUIPMENT USED IMPROPERLY
- ☐ HISTORY OF ACCIDENTS / INCIDENTS
- ☐ DISREGARD / REFUSAL TO FOLLOW PROCEDURE
- ☐ REPETITIVE OR PHYSICALLY DEMANDING TASK
- ☐ HORSEPLAY
- ☐ DEVIATIONS FROM PROCESS - COMMON
- ☐ DEVIATIONS FROM PROCESS - UNCOMMON
- ☐ STAFF ASSISTANCE NEEDED
- ☐ GOING ON / JUST RETURNED FROM VACATION

TRAINING FACTORS
- ☐ DEFICIENT ORIENTATION TRAINING
- ☐ DEFICIENT JOB SPECIFIC TRAINING
- ☐ LACK OF SUPERVISOR FOLLOW-UP OR REINFORCEMENT
- ☐ LACK OF SUPERVISOR TRAINING
- ☐ LACK OF EMPLOYEE TRAINING
- ☐ COMMUNICATION OF RULES/POLICY
- ☐ COMMUNICATION OF EXPECTATIONS
- ☐ HAZARDS OVERLOOKED IN TRAINING
- ☐ INSUFFICIENT TRAINING FOR NEW PROCESS OR TASK

ENVIRONMENT
- ☐ WEATHER FACTOR
- ☐ TEMPERATURE
- ☐ POOR LIGHTING
- ☐ POOR VISIBILITY
- ☐ POOR AIR QUALITY
- ☐ NOISE
- ☐ VISIBILITY OF LABELS / WARNING SIGNS
- ☐ VISIBLE AND AUDIBLE ALARMS
- ☐ POOR HOUSEKEEPING

PERSONAL PROTECTIVE EQUIPMENT
- ☐ AVAILABLE
- ☐ REQUIRED
- ☐ REQUIRED BUT NOT WORN/USED
- ☐ ADEQUATE FIT
- ☐ INADEQUATE FIT
- ☐ TRAINED TO USE PPE
- ☐ PPE NOT USED ADEQUATELY
- ☐ PPE POOR CONDITION
- ☐ PPE ADEQUATE FOR JOB
- ☐ LACK OF SUPERVISOR ENFORCEMENT

FACILITY EQUIPMENT
- ☐ POOR FACILITY DESIGN
- ☐ POOR WORKSTATION DESIGN
- ☐ EQUIPMENT NOT GUARDED
- ☐ EQUIPMENT REPAIR DEFICIENT
- ☐ LACK OF PREVENTATIVE MAINTENANCE
- ☐ LACK OF EMPLOYEE KNOWLEDGE
- ☐ EQUIPMENT FAILURE
- ☐ INADEQUATE INSPECTION TIMELINES

OTHER FACTORS *add any other factors not listed above that may have contributed to the incident*

IMMEDIATE AND UNDERLYING CAUSES *explain findings here – what caused or could have caused this incident?*

EVENTSCAPE

INCIDENT INVESTIGATION

1.2 ROOT CAUSE ANALYSIS

RISK ASSESSMENT

PROBABILITY OF REOCCURRENCE	☐ HIGH	☐ MEDIUM	☐ LOW
SEVERITY OF RISK	☐ SEVERE	☐ SERIOUS	☐ MINIMAL

ROOT CAUSE IDENTIFICATION

list the contributing factors and their probability for causing the incident

CONTRIBUTING FACTOR DESCRIPTION	PROBABILITY OF INVOLVEMENT
	☐ HIGH ☐ MID ☐ LOW
	☐ HIGH ☐ MID ☐ LOW
	☐ HIGH ☐ MID ☐ LOW
	☐ HIGH ☐ MID ☐ LOW
	☐ HIGH ☐ MID ☐ LOW
	☐ HIGH ☐ MID ☐ LOW

CORRECTIVE ACTION IDENTIFICATION

describe the action steps taken already to prevent a recurrence of the incident

	DATE IMPLEMENTED

RECOMMENDED PREVENTIVE STRATEGY

list the possible actions to take to prevent a recurrence of the incident

RECOMMENDED ACTION	ACTION CONSIDERATIONS