

### Sharps Injury Investigation Form

<b>Details of person involved</b>	<b>Where and when the Incident occurred</b>
Surname	Dept/Ward
Forenames	Date of Incident
Job Title	Incident Form No

1. Was the sharp being used as part of a procedure. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes what procedure ?.....	
2. Was the sharp a : Needle <input type="checkbox"/> Butterfly <input type="checkbox"/> Canula <input type="checkbox"/> Glass <input type="checkbox"/> Other <input type="checkbox"/>	
3. Was the sharp? <input type="checkbox"/> Being handled by the injured party <input type="checkbox"/> Being handled by someone else <input type="checkbox"/> Badly disposed of by someone else <input type="checkbox"/> Other, please specify:-	
4. Which statement best describes when the incident occurred? <input type="checkbox"/> Before the sharp had been used. <input type="checkbox"/> During the use of the sharp. <input type="checkbox"/> Immediately after using the sharp. <input type="checkbox"/> Whilst transporting the sharp for use/disposal. <input type="checkbox"/> Whilst disposing of the sharp. <input type="checkbox"/> Whilst undertaking another activity. <input type="checkbox"/> Other, please specify:	
5. Have the following actions been taken? <input type="checkbox"/> Sample of own blood taken <input type="checkbox"/> Attended A&E <input type="checkbox"/> Sample of donors blood taken <input type="checkbox"/> Contacted Occupational Health <input type="checkbox"/> Not applicable no blood borne contact	
6. Please indicate which best describes the causes of the injury (tick all that apply), and the management actions taken to prevent a recurrence.	
<u>Cause of injury</u>	<u>Management action taken</u>
<input type="checkbox"/> Self inflicted injury	
<input type="checkbox"/> Handling error	
<input type="checkbox"/> Resheathing needle	
<input type="checkbox"/> Loss of concentration	
<input type="checkbox"/> Lack of awareness/training	
<input type="checkbox"/> Unsafe practice/technique	
<input type="checkbox"/> Injury inflicted by other person	
<input type="checkbox"/> Patients reaction/movement	
<input type="checkbox"/> Being transported unsafely	
<input type="checkbox"/> Over full sharps bin	
<input type="checkbox"/> Not disposed of in sharp bin	
<input type="checkbox"/> Other, please specify:	
<b>Signature</b>	<b>Date</b>