

Scenario 1

A lab tech was cleaning a gross dissection room in the department of pathology and accidentally ran her thumb along the length of a dissecting knife. The cut required 15 stitches. The employee was a new employee transferred from a different dept. but there have been other less serious accidents in this room and other attempts to address the safety have not worked. The lab didn't have a SOP for cleaning and daily cleaning was not a habit.

Focused Questions

Was the lack of a SOP for cleaning the only reason this accident happened?

How would you prove the root cause was or was not the lack of a SOP?

Talking Points

The tech had a history of being intimidated by physicians in her previous job and her experience had been that "doctors got mad if you moved their stuff". (this is an example of needing everyone involved in the root cause analysis to understand some of the underlying issues that are involved and the cultural environment of the lab).