

Root Cause Analysis Form for CAUTI and CLABSI

Device-Related HAI: <input type="checkbox"/> CAUTI <input type="checkbox"/> CLABSI		NHSN criteria met: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reported Month/Year:	
Patient Name:		MR#:		DOB:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		LTC Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient's age:	
Organism(s):					
Date Device Inserted:		Inserted by:		Unit where inserted:	
Indication for device:			Days between insertion and infection:		
For CLABSIs					
CVC insertion site:		Central line type:			
Event Details:					
Policies/Protocols (check if they were followed):					
Products/Devices (review manufacturer recommendations):					
Patient's recent hospitalizations (including other facilities):					
Patient's Risk Factors / Other Medical Conditions					
Notes:					