

***Health Care Worker Injury Prevention Project***  
**Informed Consent – OR Safety Questionnaire**

**Participation:**

As part of the evaluation we are asking employees of [insert facility name] some questions about safety in their workplace. We would like for you to participate by responding to two questionnaires. One will be collected today. A second one will be collected in about 2 months. The questionnaires ask about occupational health and safety at [insert facility name]. They also ask questions about you and your attitudes and behaviors, particularly about protection from bloodborne pathogen exposures at work. Your participation is voluntary. Refusal to participate will involve no penalty or loss of benefits. Participation will take about 20 minutes of your time for each questionnaire. The success of the study depends upon as many people as possible completely filling out both questionnaires, but you are free to withdraw from participating at your will, and there will be no repercussions to withdrawing or refusing to participate.

**Confidentiality:**

Your confidentiality will be protected. Therefore, no identifying information will be given that will allow your employer to know what information you specifically share on either questionnaire.

**Risks:**

Every precaution will be taken to ensure that you do not suffer any risk including loss of privacy and/or physical harm. Results of these questionnaires will be made available only at the group level (at least three people with the same characteristics in each group). There are no records that connect the five-digit number or letter sequence you selected with your name. Individual results will not be released. Questionnaire forms will be destroyed after they are analyzed.

**Benefits:**

Your participation in this effort will provide you an opportunity to share your feelings, thoughts, and concerns, regarding safety in your workplace. The information learned through this evaluation will also assist other health care organizations with sharps injury prevention efforts.

**For More Information:**

Please contact [insert contact name]: ext. 9999.

**Take this form with you for reference if you wish.**

**Please send your completed survey to [insert contact name, department, and address] BY [insert date].**

## OR Safety Questionnaire

Please write five letters or numbers in the blanks below. They must be letters or numbers that you used in the pre-test about two months ago.

\_\_\_\_\_

*Please circle the number below that indicates how much you agree or disagree with each statement. Circle one number for each statement.*

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
1. I worry about the risk of sharps injuries to members of my surgical team.	1	2	3	4
2. Safer sharps devices reduce the quality of surgical care.	1	2	3	4
3. Using safer sharps devices would reduce sharps injuries to members of my surgical team.	1	2	3	4
4. Reducing sharps injuries in the OR is an achievable goal.	1	2	3	4
5. My hospital will have difficulty with the higher cost of safer sharps devices.	1	2	3	4
6. Sharps injuries are the most significant health risk faced by OR staff at this hospital.	1	2	3	4

**Please continue on the next page.**

For each of the items on the following page, circle one number that best describes your exposure to that kind of information over the last two months in the OR department. If you do not remember hearing or seeing such information, circle 5. If you do remember, consider whether it was information that you already knew well (circle 1), information that was all new to you (circle 4), or somewhere in the middle (circle 2 or 3).

	I've seen or heard this type of information and . . .				or . . .↓
	I knew the information well	It reinforced what I knew	Some information was new	It was all new information	I did not hear or see info
7. Sharps injury rates in the OR department	1	2	3	4	5
8. Instrument loading and passing techniques	1	2	3	4	5
9. Neutral zone passing techniques	1	2	3	4	5
10. Sharps devices with safety features	1	2	3	4	5
11. Personal protective equipment (gloves, gown, eyewear, etc.)	1	2	3	4	5
12. Injury reporting procedures	1	2	3	4	5
13. Stop Sticks Campaign	1	2	3	4	5

14. How many contaminated sharps injuries have you experienced while working in an OR department? *Check one response below.*

- None       One       Two       3 or more

15. What is your role in OR?

- Attending MD                       Resident                       CRNA  
 RN                                       LPN                               Scrub tech  
 Operating room assistant       Instrument tech  
 Student  
 Other (specify) \_\_\_\_\_

16. What is your employment status?

- Permanent full-time  
 Contractor full-time  
 Permanent part-time  
 Contractor part-time

**Please continue on the next page.**

17. How long have you been employed in the health care field?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Less than 1 year | <input type="checkbox"/> 10 to < 12 years | <input type="checkbox"/> 22 to < 24 years |
| <input type="checkbox"/> 1 to < 2 years   | <input type="checkbox"/> 12 to < 14 years | <input type="checkbox"/> 24 to < 26 years |
| <input type="checkbox"/> 2 to < 4 years   | <input type="checkbox"/> 14 to < 16 years | <input type="checkbox"/> 26 to < 28 years |
| <input type="checkbox"/> 4 to < 6 years   | <input type="checkbox"/> 16 to < 18 years | <input type="checkbox"/> 28 to < 30 years |
| <input type="checkbox"/> 6 to < 8 years   | <input type="checkbox"/> 18 to < 20 years | <input type="checkbox"/> Over 30 years    |
| <input type="checkbox"/> 8 to < 10 years  | <input type="checkbox"/> 20 to < 22 years |   |

18. Have you participated in any sharps related safety training within the past year?

- Yes       Not sure       No

*For each item below, please circle the number that reflects how often you do that specific technique as you work in the OR. Circle 5 if the technique is not part of your job.*

	<b>Always</b>	<b>Frequently</b>	<b>Sometimes</b>	<b>Never</b>	<b>Not applicable</b>
19. Dispose of sharps in designated sharps containers.	1	2	3	4	5
20. Use my hands for retraction.	1	2	3	4	5
21. Use Neutral Zone passing techniques	1	2	3	4	5
22. Perform sponging only on surgeon's request when sharps are in use.	1	2	3	4	5
23. Recap used needles.	1	2	3	4	5
24. Communicate with other team members to prevent exposures.	1	2	3	4	5

**Please continue on the next page.**

*Finally, please indicate how much you agree or disagree with each of the following statements about safety behavior in the organization where you work.*

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
25. New employees quickly learn that they are expected to follow good safety practices.	1	2	3	4
26. There are no significant compromises or shortcuts taken when worker safety is at stake.	1	2	3	4
27. Where I work, employees and management work together to insure the safest possible working conditions.	1	2	3	4
28. Employees are told when they do not follow good safety practices.	1	2	3	4
29. The safety of workers is a big priority with management where I work.	1	2	3	4
30. I feel free to report safety violations where I work.	1	2	3	4

**Thank you for your participation.**

**Please send your completed survey to [insert contact name, department, and address] BY [insert date].**