

# Event Investigation Guide for Employer



This guide is to help you conduct a full and thorough investigation of any incident that occurs at your facility. The How, When, Where, Who, What, and Why questions can help you achieve a complete picture.

## HOW

How was the event identified or discovered?

## WHEN

When was the event identified or discovered?

When did the event happen? At what time?

## WHERE

WHERE did the event occur?

Describe location and any unusual elements of the environment and location.

## WHO

WHO has direct knowledge of the event?

Who discovered or identified the event and how did they do so? How did the event come to their attention?

Who reported the event and how did they do so? How did the event come to their attention?

Who was directly involved in the event?

- ❖ Nurse(s)
- ❖ Physicians
- ❖ Other Staff (e.g., Nurse Aides, Therapists, Secretaries)
- ❖ Client(s)
- ❖ Family Members/Visitors

How were each of the individuals involved in the event? What role did they play in the event?

Interview nurse(s) and other involved staff (each separately) as soon as possible after the event:

- ❖ Start by using open-ended questions and allowing involved staff to tell their stories about what happened;
- ❖ What rationale did they offer for their behavioral choices?
- ❖ What was their perception of risk?
- ❖ Did they acknowledge and accept responsibility for event fully or partially?
- ❖ Were they previously formally counseled (i.e., documented and signed) for same or similar issues?
- ❖ Were they experienced and oriented to this unit, patient type, etc.?

Interview witnesses (each separately) as soon as possible after event:

- ❖ Start by using open-ended questions and allowing direct witnesses to tell their stories about what happened;
- ❖ Consider degree of agreement or disagreement among witness statements;
- ❖ Consider facts and what was actually observed by individuals - do not consider opinions not supported by evidence and corroborating statements.
- ❖ What rationale did they offer for their behavioral choices?

## WHAT

What happened?

- ❖ Describe the actual event in detail;
- ❖ Reconstruct the sequence of events;
- ❖ Remember to consider preceding activities that may have impacted the event.
- ❖ What usually happens in similar situations? Describe what involved staff and non-involved staff tell you about such situations - what is their "normal," current practice? (Make sure they are not just telling you what you want to hear or what policy says!)
- ❖ What should have happened? Describe related policies and procedures. (When actual practice varies from policy, you will want to explore why and address this with all staff - maybe policy is out of date or impossible to follow; or maybe all staff have drifted from safe practice!)

## WHY

Why did the event occur?

- ❖ Identify any and all factors contributing to the event.
- ❖ What behavioral choices related to the event did each involved nurse or individual make before, during, and following the event?
- ❖ What behavioral choices would a similarly prepared and experienced prudent nurse (or other involved person) have made in the same situation?
- ❖ If individual(s) deviated from standards, policies, or procedures, identify rationale for decision to deviate.
- ❖ What was happening with other clients and in the environment at the time of the event and immediately prior to the time of the event?
- ❖ What was the nurse to client ratio at the time of the event? Was this a safe, acceptable, manageable ratio?
- ❖ Describe any variable factors, such as busy unit, staff call-outs, etc., that influenced workload at the time of the event.
- ❖ Was this the usual assignment/unit for the nurse(s) involved in the event? What equipment/supplies were involved in the event? Describe equipment/supplies and any unusual aspects, malfunctions, availability issues, etc.

**COLLECT AND PROTECT** all physical evidence:

- ❖ Documentation and records
- ❖ Audit current and past records, if indicated, to identify documentation discrepancies, deficits, and omissions;
- ❖ Supplies, equipment, medications, etc.

**SUMMARIZE AND DOCUMENT** investigation results and conclusions:

- ❖ Identify all system issues that need to be corrected.
- ❖ Identify all individual practice issues that need to be addressed.
- ❖ Identify all known contributing/mitigating/aggravating factors - system and individual.