North Carolina Board of Nursing's Event Investigation Guide:

A Roadmap for the Collection of Pertinent Investigative Information

The attached guide is intended as a suggestion for use in a facility investigation and is not all inclusive. Be certain to follow all facility policies and procedures related to internal facility investigations.

Helpful tips and overview for use:

The attached guide will assist in answering and documenting the reliable Who, What, When, Where, How, and Why related to the investigation.

Answer each section in the guide. Be advised you may answer in any order as the investigation unfolds. Focus on the facts discovered. Determine if there is additional or tangential information which may be important to the investigation and add the information.

Be certain to collect and protect all evidence as soon as possible. This may include:

- video surveillance footage;
- documentation and records;
- photographs of evidence; and
- supplies, equipment, medication.

Ask the following questions:

Is an audit of current and past medical records indicated to identify documentation discrepancies, deficits and/or omissions?

Is a drug or alcohol screen indicated for the person(s) involved in the event? If so, it is very important that the drug or alcohol screen completed as soon as possible after the event is discovered.

Who should be interviewed about the event? It is very important to interview all witnesses and those with first-hand knowledge of the event (separately) as soon as possible after the event. These individuals may include nurses, certified nursing assistants, non-nursing staff including providers, therapists, security guards, administrative support staff, etc. Be mindful clients, client family members or visitors may also be witnesses to the event. It is recommended signed and dated witness statements be collected in a timely manner.

When addressing why an event occurred be certain to identify any and all factors contributing to the event. These may include:

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- behavioral choices related to the event made before, during and following the event;
- ask what choices a similarly prepared and experienced prudent individual would have made in the same situation;
- if an individual or individuals deviated from standards, policies or procedures, identify the rationale for the decision to deviate;
- determine 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 and manageable ratio?
    - Describe variable factors such as a busy unit, staff call-outs, etc. which influenced workload at the time of the event.
    - Was this the usual assignment/unit for the individual(s) involved in the event?
    - What equipment/supplies were involved in the event? Describe the equipment/supplies and any unusual aspects, malfunctions, availability issues, etc.

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Use the prompts below to answer the following pertinent questions in an investigation: Who, What, When, Where, How, and Why.
Describe the event:
How was the event identified?
Who discovered the event? Include full name(s) and title(s):

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List the date and time the event was discovered:
List the date and time event occurred (note if time is approximate):
Where did the event occur? Include unit/area/hall name and any unusual elements of the environment.
List the evidence collected to include documents, video footage, signed and dated witness statements, drug screen results, etc. Be certain to collect and protect evidence timely.

List witnesses/those individuals with direct knowledge of the event. Include full name and title for each individual. Include all individuals involved including clinical and non-clinical staff including nurses, CNAs, Security Personnel, patients, visitors, etc.

Name Title

List those individuals with name and title from whom written (signed and dated) statements were obtained:

Name Title

Complete a chronological Timeline of Events including date and time:

Why did the event occur?
Who may have been responsible for the occurrence? List name(s) and title(s):
Did an individual or individuals admit or accept responsibility for the event? If yes, list name(s), title(s) and summary of the admission(s).

List individual practice issues which may have contributed to the event:
List systems issues which may have contributed to the event:

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List mitigating (issues which lessen the gravity of an offense or mistake) actors related to the individual(s) and system(s) involved in the event to include possible staffing issues, acuity of patient assignment, etc.
List aggravating (issues which increase the gravity of an offense or mistake) factors related to the individual(s) and system(s) involved in the event to include failure to follow facility policies, prior counseling/warnings for similar issues, etc.

What Happened? Summarize the investigation and conclusion.
List any additional pertinent information:

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