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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:

4/5/2021

- 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?
 - o Was this a safe, acceptable and manageable ratio?
 - O 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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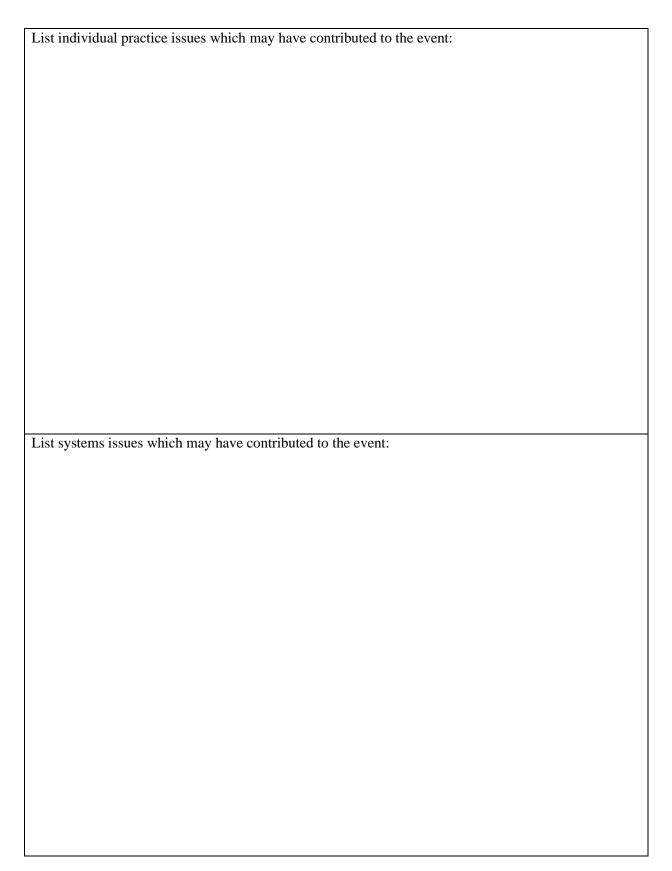
This document is intended as a suggestion for use in a facility investigation. Be certain to follow all facility policies and procedures related to internal facility investigations.

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):
who discovered the event: include full hame(s) and title(s).

List the date and time the event was discovered:
List the date and time event occurred (note if time is approximate):
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Where did the event occur? Include unit/area/hall name and any unusual elements of the environment.
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List witnesses/those individuals with individual. Include all individuals inv CNAs, Security Personnel, patients, v	olved including clinical and no	Include full name and title for each on-clinical staff including nurses,
Name Title		
****		1 11 1
List those individuals with name and obtained:	title from whom written (signe	d and dated) statements were
Name	Title_	_
Complete a chronological Timeline or	f Events including date and tin	ne:

Why did the event occur?
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Who may have been responsible for the occurrence? List name(s) and title(s):
Did on individual an individual and action appears are as a first final and a second of the second o
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).



t mitigating (issues which lessen the gravity of an offense or mistake) actors related to the ividual(s) and system(s) involved in the event to include possible staffing issues, acuity of patient ignment, etc.	
t aggravating (issues which increase the gravity of an offense or mistake) factors related to the	
t aggravating (issues which increase the gravity of an offense or mistake) factors related to the ividual(s) and system(s) involved in the event to include failure to follow facility policies, prior inseling/warnings for similar issues, etc.	
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What Happened? Summarize the investigation and conclusion.
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List any additional pertinent information: