Event Investigation Guide

Use the reliable How? When? Where? Who? What? and Why? questions in a consistent manner to assure that you have examined all elements of and influences on the event.

Answer and document all of the following questions concerning the event in question:

HOW was the event identified or discovered?

WHEN was the event identified or discovered?

- When did the event happen? – At what time?

WHERE did the event occur?

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

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:
o Start by using open-ended questions and allowing direct witnesses to tell their stories about what happened;
o Consider degree of agreement or disagreement among witness statements;
o Consider facts and what was actually observed by individuals – do not consider opinions not supported by evidence and corroborating statements.

WHAT happened?

o Describe the actual event in detail;
o Reconstruct the sequence of events;
o Remember to consider preceding activities that may have impacted the event.

① 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!)

② 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 did the event occur?

① Identify any and all factors contributing to the event.
② What behavioral choices related to the event did each involved nurse or individual make before, during, and following the event?
② What behavioral choices would a similarly prepared and experienced prudent nurse (or other involved person) have made in the same situation?
② If individual(s) deviated from standards, policies, or procedures, identify rationale for decision to deviate.
② 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?
② What was the nurse to client ratio at the time of the event? – Was this a safe, acceptable, manageable ratio?
② Describe any variable factors, such as busy unit, staff call-outs, etc., that influenced workload at the time of the event.
② Was this the usual assignment/unit for the nurse(s) involved in the event?
② 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:

① Documentation and records;
② Audit current and past records, if indicted, to identify documentation discrepancies, deficits, and omissions;
① 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