How to Conduct an Investigation

Office of Healthcare Facilities Licensure and Certification

The mission of the South Dakota Department of Health, Office of Health Facilities Licensure and Certification is to partner with consumers, families, healthcare providers, healthcare organizations, and other regulatory agencies to ensure the health, safety, and appropriate care of patients and residents in South Dakota.

SOUTH DAKOTA DEPARTMENT OF HEALTH

Version August 10, 2016

Welcome

This training was developed by the Office of Healthcare Facilities Licensure and Certification to assist healthcare providers to better understand how to conduct an investigation of an event or incident involving a resident under the care of the provider.

The objectives of this training are:

- To ensure understanding and consistency by provider community of what constitutes an investigation process.
- To ensure the appropriate leadership and/or authorities are notified of resident events/incidents.
- The State Survey Agency receives more clear and concise reports from providers.

The goals of this training are:

- Review different types of incidents.
- Identify staff member(s) responsible for initial reporting, conducting the investigation, reporting results to appropriate leadership and authorities.
- Take all necessary actions dependent on the results of the investigation.
- Report to the State nurse aide registry or licensing authorities any knowledge of any actions by a court of law that would indicate an employee is unfit for duty.

The goals of this training are *(continued)*:

- Analyze occurrences of incidents to determine what changes are needed, if any, to policies and procedures to prevent any further occurrences.
- Review the Who, What, When, Where, How, and Why questions.
- Include the use of the Root Cause Analysis.
- Utilize Fall events and Elopement events for examples.

Types of incidents requiring an investigation are:

- Abuse, neglect, & misappropriation of resident property.
- Falls – mindful, NOT all falls are reportable.
- Elopements.
- “Injuries of unknown source”.
- Any event that is not consistent with the routine care of the resident is worthy of investigation.
- All others per Administrative Rules of South Dakota (ARSD) located at http://doh.sd.gov/resources/statute-rules/ .

What staff members responsible for the investigation process?

- The administrator is responsible for the overall operations and events in the facility.
- All of the following may vary from one facility to another.
  - Initial reporting.
  - Conducting an investigation.
  - Reporting results to the appropriate leadership & authorities.
- The facility must develop and implement policies and procedures to include these seven components:
  1. Screening,
  2. Training,
  3. Prevention,
  4. Identification,
  5. Investigation,
  6. Protection, and
  7. Reporting/Response.

What are the necessary actions of an investigation?

- The actions taken by the facility are often the policy of the organization.
  - Use of suspension during the investigation, re-education of the individual, etc.

The State nurse aide registry and licensing authority

- The Department of Health, Office of Health Facilities Licensure and Certification is responsible for the nurse aide registry and is the licensing authority.

Carefully analyze occurrences of incidents

- Review the individual
  - Is there a change in condition?
  - Was the care plan followed?
  - Was there any change in medications or treatments?

- Review tracking and trending
  - Are the same residents involved?
  - Are the same staff involved?
  - What time of day?
  - What day of the week?
  - Any change in equipment or resources?
  - Was there any change in policy or procedure?
  - Was it a toileting issue?

Focus on the “problem”

- Clearly identify the problem.
- Stay on message, say it clearly, and say it simply.
- Use simple terminology whenever possible.

Review the Who

- Identify resident(s) involved, staff observers, family or visitors.
  - It is best to get a first person report in writing whenever possible.
  - If interviewing another resident, a family member, or other visitor, quote as much as possible.
  - Each nurse that is involved in any way should provide documentation for the investigation.
  - There may be one nurse who is providing the “story” in the record.
  - The investigation report is separate from the resident record.

Review the What

- Describe the event. Use your senses, but be objective.
  - See - pallor, sweating, deformities, bruises, edema, redness, body fluid color, pupil reaction.
  - Feel - dampness, localized heat, pulses, localized coldness.
  - Hear - moaning, breathing, heart sounds, complaints of pain.
  - Smell - fruity odors, fecal odors, foul smelling drainage, odor of alcohol.

Review the When

- When is more than just documenting the time.
  - Beginning of shift,
  - End of shift,
  - Special event,
  - Day of the week,
  - Weekend.

- Accuracy of time is vital to your investigation.

Review the Where

- Document the location.
  - Resident's room,
  - Resident's bathroom,
  - Spa/shower room,
  - Dining room,
  - Common resident space.

- Be as descriptive as possible. Draw a picture, diagram the space.

Review the How

- Describe how the event may have occurred if there were no witnesses and the resident is not a good historian.

- Use the information gathered from the Who, What, When, & Where to recreate the event as best as possible.

Review the Why

- Are there other particulars happening such as –
  - Care plan not followed,
  - Facility policy/procedure not followed,
  - Staff not available,
  - Resident contributing factors.

- These are areas that may be used for litigation, but are also a great opportunity for a review of the system and necessary education or re-education.

Root Cause Analysis

- Focusing on continuous quality improvement involves using root cause analysis.
- To be able to determine why a system failed, you must first know what happened during the event.
- Identify what systems were actually in place at the time of the event.

Root Cause Analysis *(continued)*

- What was the sequence of events that led up to the incident being investigated?
  1. What happened or what was cited?
  2. What normally happens? This step is often overlooked.
  3. What do the policies and procedures require?
     a. Knowing the norm helps determine the reliability of the process and how often staff cut corners to get the work done.
     b. Sometimes the policies don't work.
     c. There is a need for constant feedback.
  4. How was your facility/the organization managing the situation before the event?
  5. Often people feel compelled to simply educate staff to follow the existing policies and procedures instead of really looking at the problem and discovering WHY.
  6. What factors, if corrected or eliminated, would have prevented the event or reduced the consequences?

Root Cause Analysis *(continued)*

- The problem identified is a causal factor. Each causal factor is analyzed independently.
  - Why did it happen? Examine proximate cause.
  - Why did that happen? Examine processes.
  - Why did that happen? Review underlying systems.

- Once you thoroughly understand what happened, you are ready to analyze why it happened.

ROOT CAUSE ANALYSIS EVENT REPORT FORM

1.	THE EVENT – Describe what happened and any harm that resulted. Identify the proximate cause, if known.		Team members, staff that may have been involved.
2.	BACKGROUND & FACTORS SUMMARY – Answer the following questions (brief).		
2.1	What was the sequence of events that was expected to take place?		Description:
2.2	Was there deviation from the expected sequence?	Yes_____ No_____	If Yes, describe the deviation.
2.3	Was any deviation from the expected sequence likely to have led or contributed to the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe with a causal statement.

ROOT CAUSE ANALYSIS EVENT REPORT FORM *(continued)*

2.4	Was the expected sequence described in policy, procedure, written guidelines, or included in staff training?	Yes_____ No_____ Not Known ____	If Yes, cite source.
2.5	Does the expected sequence or process meet regulatory requirements and/or practice standards? Cite references and/or literature reviewed.	Yes_____ No_____ Not Known____	If No, describe deviation from requirements/standards.
2.6	Did human action or inaction appear to contribute to the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe the actions and how they contributed.
2.7	Did a defect, malfunction, misuse of, or absence of equipment appear to contribute to the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe what equipment and how it appeared to contribute.

ROOT CAUSE ANALYSIS
EVENT REPORT FORM *(continued)*

2.8	Was the procedure or activity in the event being carried out in the usual location?	Yes_____ No_____ Not Known____	If No, describe where and why a different location was utilized.
2.9	Was the procedure or activity being carried out by regular staff familiar with the resident and activity?	Yes_____ No_____ Not Known____	If No, describe who was carrying out the activity and why regular staff was not involved.
2.10	Was involved staff certified/skilled to carry out the tasks expected of them?	Yes_____ No_____ Not Known____	If No, describe the perceived inadequacy.
2.11	Was staff trained to carry out their respective responsibilities?	Yes_____ No_____ Not Known____	If No, describe the perceived inadequacy.

ROOT CAUSE ANALYSIS EVENT REPORT FORM *(continued)*

2.12	Were staffing levels considered to have been adequate?	Yes_____ No_____ Not Known____	If No, describe why.
2.13	Were there other staffing factors identified as responsible for or contributing to the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe those factors.
2.14	Did inaccurate or ambiguous information contribute to or cause the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe what information and how it contributed.
2.15	Did lack of communication or incomplete communication contribute to or cause the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe who and what and how it contributed.

ROOT CAUSE ANALYSIS EVENT REPORT FORM *(continued)*

2.16	Did any environmental factors contribute to or cause the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe what factors and how they contributed.
2.17	Did any organizational or leadership factors contribute to or cause the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe what factors and how they contributed.
2.18	Did any assessment or planning factors contribute to or cause the adverse event?	Yes_____ No_____ Not Known____	If Yes, describe what factors and how they contributed.
2.19	What other factors are considered relevant to the adverse event?		Describe:

ROOT CAUSE ANALYSIS
EVENT REPORT FORM *(continued)*

2.20	Rank order the factors considered responsible for the adverse event, beginning with the proximate cause, followed by the most important to less important contributory factors.		
	Was a root cause identified?	Yes_____ No_____ Not Known____	If Yes, describe the root cause.

ROOT CAUSE ANALYSIS EVENT REPORT FORM *(continued)*

3.	RISK REDUCTION ACTIONS TAKEN – List the actions that have already been taken to reduce the risk of a future occurrence of the event under consideration. Note the date of implementation.		

ROOT CAUSE ANALYSIS
EVENT REPORT FORM *(continued)*

4.	PREVENTION STRATEGIES – List from highest priority to lowest priority the recommended actions designed or put into place to prevent a future occurrence of the adverse event.		
Rank	Strategy	Cost	Special Considerations

ROOT CAUSE ANALYSIS
EVENT REPORT FORM *(continued)*

5	INCIDENTAL FINDINGS	List and describe any incidental findings that should be carefully reviewed for corrective action.	May attach.
6	SIGNATURE OF PREPARER: Members of Review Process:	DATE:	

At the conclusion of investigation, document your findings.

- Prepare a summary statement that indicates an allegation or suspicion of abuse/neglect was either substantiated or not substantiated.

- Example of documentation.
  - *With the completion of the internal investigation, we were able to substantiate the allegation that (name) made inappropriate advances toward (name), it was our administrative decision to terminate employment. The Board of Nursing was notified; the (provider) made changes to policy/procedure; education/reeducation was provided for staff; care plans were reviewed/revised as necessary; a plausible explanation was gained for how an injury of unknown origin occurred, personal property was found or restitution was made.*

Follow-up at the conclusion of an investigation

- Terminating an employee or having them terminate themselves doesn't automatically indicate whether the provider was able to substantiate an allegation.
- In the event of reporting a death of other than natural causes, missing person, these are times where a staff "debriefing" may be needed and is an opportunity to evaluate system processes and provide learn opportunity.
- Documentation is needed to reflect the standard of care was met.
- Documentation should indicate who met the standard of care and preserves the evidence and recreates the circumstances of care or an event.
- Risk management requires good documentation. Nurses' documentation can be the evidence of what actually was done and can serve as proof that the nurse acted reasonably and safely.

Practical Review of a Resident Fall

Questions to ask at the time of a resident fall

1. Ask the resident: Are you OK?
2. Ask the resident: What were you trying to do?
3. Ask the resident or determine: What was different this time?
4. What is the position of resident?
    a. Did they fall near a bed, toilet, or chair? How far away?
    b. On their back, front, left side, or right side?
    c. Position of their arms and legs?

Questions to ask at the time of a resident fall *(continued)*

5. What was the surrounding area like?
   a. Noisy? Busy? Cluttered?
   b. If in the bathroom, what were the contents of the toilet?
   c. Poor lighting? Visibility? Glare?
   d. Position of the furniture and equipment? Bed height correct?
   e. Correct bed height – marked.

6. What was the floor like?
   a. Wet floor? ~ Urine, water, liquid on floor? Uneven floor? Shiny?
   b. Carpet or tile?

Questions to ask at the time of a resident fall *(continued)*

7. What was the resident's apparel?
    a. Shoes, socks (non-skid), slippers, bare feet?
        i. Correct footwear.
        ii. No gripper socks, no crepe soles.
        iii. Fully enclosed toe and heel, slip resistant.
        iv. Correctly fitting – easy on, easy off.
        v. Footwear color contrasted to floor color.

8. Poorly fitting clothes?

9. Was the resident using any assistive device?

10. Did the resident have glasses and/or hearing aids on?

Questions to ask at the time of a resident fall *(continued)*

11. Who (other resident, staff, family, or visitor) was in the area at the time of the fall?

12. What medications was the resident receiving?

13. Any psychotropic medications?

14. Any antihypertensive medications?

Questions to ask at the time of a resident fall *(continued)*

11. Any medication changes in the last 7 days?

12. Did the resident have any unusual activities or behaviors observed within 4 hours prior to the fall?

13. Were alarms in use at the time of fall? Were they working?

14. Any other relevant information that could have contributed to the fall?

Tips for fall prevention.

1. Position ~
   a. Does the resident look comfortable?
   b. Ask the resident, “Would you like to move or be repositioned?”
   c. Ask the resident, “Are you where you want to be?” Report to the nurse.

2. Toilet ~
   a. Ask the resident, “Do you need to use the bathroom?”
   b. Ask if they’d like help to the toilet or commode. Report to the nurse.

The “4Ps” for fall prevention *(continued)*.

3. Pain ~
   a. Does the resident appear to be in pain or uncomfortable?
   b. Ask the resident, “How are you, are you in pain or uncomfortable?”
   c. Ask them what you can do to make them comfortable. Report to the nurse.

4. Placement ~
   a. Is the bed at the correct height?
   b. Is the phone, call light, TV remote, trash can, water, urinal, tissues all near the resident?
   c. Place them all within easy reach.

You may want to consider hourly rounds

Fall scenario 1

This is an initial/final report that was submitted.

- Betty is a 98 y/o female with a most recent BIMS of 4, indicating significantly impaired cognition. Her primary diagnoses are major depression, atrial fibrillation, anxiety, and osteoporosis. She is typically alert/conversive, but clearly confused with safety judgement and limited ability to make decisions. She uses a w/c to propel herself throughout the building.

- Betty was found on the bathroom floor this am, lying on her back. She was alert/confused as usual. She reported significant right hip pain. The physician was notified and orders obtained to send to ER for evaluation. Family was notified and consented to an evaluation in the ER. The ER phoned, resident has fractured right ankle. Betty will be undergoing surgery today.

Fall scenario 1 *(continued)*

- The investigation of the fall found:

  The resident had not activated call light, as usual, and had self-transferred to the bathroom in order to self-toilet. The typical pattern for the resident is that she sleeps until around 8:00 am. Staff had checked on her 45 minutes prior to the fall. She was resting quietly in bed. The environment was safe and non-contributory to the incident, adequate lighting, no obstacles were noted.

- Staff noted a yellow liquid on the floor in front of the toilet. The w/c was beside the toilet with anti-locks brakes in place. The w/c was examined and noted to be working appropriately. No apparent change of condition noted.

- No abuse or neglect substantiated.

Fall scenario 1 *(continued)*

- This scenario needs to be reported to SD DOH.
  - Rationale:
    - This was an unwitnessed fall with the resident sustaining a major injury.

Fall scenario 2

This was submitted as an initial report.

- Sam was seen by a CNA ambulating in the hallway with his walker toward the dining room. He went to turn in the dining room and fell onto his left hip hitting his head. His walker then toppled over onto him. Charge nurse called to the incident. Resident examined and noted to have pain in his left hip and noted significant leg shortening on the left. Hematoma noted on left side of the head 5 cm X 8 cm. Neuros assessed and noted elevated B/P and sluggish pupil response. Physician and family notified of the situation. Resident sent to the ER for evaluation.
- Investigation in process.

Fall scenario 2 *(continued)*

- This scenario will need an 5-day (final) report submitted to SD DOH.
  - Rationale:
    - The report will need to include an evaluation of the environment as a possible cause of the fall.
    - The report will need to indicate if a major injury was sustained or not.
    - The report will need to have some follow-up on the abnormal neurological assessment if returned to the facility.
    - The report needs to substantiate or unsubstantiated abuse.

Fall scenario 3

This is an initial/final report that was submitted.

- Martha was walking in the hallway, independently per her usual routine. Nurse observed Martha falling in the hallway. The resident was assessed and no injury noted. Resident able to tell what happened. Physician and family updated.

- Environmental observation noted no irregularities or concerns.

Fall scenario 3 *(continued)*

- This scenario does not need to be reported to SD DOH.
  - Rationale:
    - Witnessed fall with no injury.

Practical Review of a Resident Elopement

Elopement(s) definitions

- An elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so.
- An “Authorization” is an order for discharge, or leave of absence (sign-out).
- Resident vulnerability is based on risk factors including resident functional status, medical condition, cognitive abilities, mood, and health treatments (includes medications). Vulnerability may change over time.
- “Risk” is any external factor or characteristic of an individual resident that influences likelihood of an accident.

Elopement(s) definitions *(continued)*

- Unsafe wandering and/or elopement is when a resident leaves a facility or a secured unit unnoticed and sustained or had potential to sustain serious injury, impairment, harm or death, and the facility had no established measures or practices, or ineffective measures or practices that would have prevented or limited the resident's exposure to hazards.

- "Supervision/Adequate supervision" – refers to intervention and means mitigating the risk of an accident or harm. The facility is obligated to provide adequate supervision to prevent accidents or potential for harm.

- Adequate supervision is defined by type and frequency of supervision, based on individual assessed needs and identified hazards in environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Example of adequate supervision tools and/or items such as personal alarms can help monitor a resident's activities, but do not eliminate the need for adequate supervision.

The Risk Assessment and Elopement

- Answering Yes to any one of the following questions or a combination of them can identify the resident at risk for wandering and potential elopement.

1. Is the resident independently mobile?
2. Does the resident have cognitive impairment or is he/she “thinking and aware?”
3. Does the resident have competent decision making capability?
4. Does the resident wander?
5. Does the resident have exit seeking behavior?

Risk Assessment and Elopement

6. Is there a past history of wandering or exiting a home or another facility without the needed supervision?
7. Does the resident accept their current residency in the facility?
8. Does the resident verbalize a desire to leave?
9. Has the resident asked questions about the facility's rules about leaving the facility?
10. Is there a special event/anniversary coming due that the resident normally would go to?
11. Is the resident exhibiting restlessness and/or agitation?

The first few weeks after admission, a change in diagnosis/condition, or a special event seem to be the higher risk time frames for elopement.

Elopement scenario 1

This is an initial and final (5-day)report.

- Alvin was returned to the facility at 10:15 a.m. by a city police officer. He had been found at the local McDonald's restaurant (2 blocks away). Resident assessment completed with no injuries noted. Alvin had been dressed appropriately for the outside temperature. Alvin states he was looking for home. Alvin's BIMS revealed a 9 of 15 score, indicating moderate cognitive impairment. There has been no exit seeking behavior noted since admission. MD and family notified of elopement.

Elopement scenario 1 *(continued)*

- Environmental review noted alarms on exits in place and in working order. Review of the exit door closest to McDonald's found it was near the outside garbage dumpsters. Usual routine is for staff to dispose of garbage between 9:30 a.m. and 10:30 a.m. using that door.

- Staff interviews conducted with CNA's that were working on the unit in which Alvin resided. The CNA last saw the resident at breakfast, approximately 8:30 a.m. The CNA who was assigned to care for Alvin last saw Alvin at 10:00 a.m.in his room resting in his recliner watching TV.

Elopement scenario 1 *(continued)*

- The pharmacist reviewed of Alvin's medications revealed a potential side effect of restlessness with one of his medications. The MD was updated on pharmacist's recommendation of dosage decrease.

- Review of the cameras on the exits revealed a staff member taking garbage out to the dumpster. Resident followed the staff member out and turned right, out of the staff member's vision upon return to the building. Staff member had punched the code in to override the system upon taking the garbage out.

Elopement scenario 1 *(continued)*

- Education provided to all staff members to ensure no residents follow them out of the exits when going to/from the building. Making sure the doors are secure before leaving them.

- This needs to be reported to SD DOH.
  - Rationale:
    - Resident was away from the facility without staff knowledge.

Elopement scenario 2

This is an initial report.

- Susie was seen at 0600 this morning visiting with staff, a CNA. Susie was in the hallway walking with her walker.
- At 0605 the bus driver came in to the facility to pick up another resident and stated to staff he saw Susie walking with her walker down the street.
- The bus driver and CNA went to pick resident up. At 0630 when staff arrives at the resident, she is in the store purchasing cigarettes and a lighter. The CNA asked resident to get on the bus but she was reluctant as she wanted to get a bus ride back to (specific town). She also stated the only way she would come back is if she was allowed to smoke.
- Susie returned to the facility, she arrived back in the facility at 0730. She was dressed appropriate for the weather outside.

Elopement scenario 2 *(continued)*

- The nurse performed an assessment and discovered she had fallen on the way to the store. She was noted to have a skin tear on her elbow and c/o hip pain. MD was notified and orders received to send resident to ER for evaluation. Susie's most recent BIMS was 15, indicating no memory impairment. Susie had stated to the nurse she "cut off" her Wander management bracelet and "pushed the buttons" to get out of the facility.
- The Wander management bracelet was found in her dresser drawer.
- Susie has been admitted to the hospital for sepsis.

Elopement scenario 2 *(continued)*

- This report could be combined as an initial and final report.

- This needs to be reported to SD DOH.
  - Rationale:
    - Resident was away from the facility without staff knowledge.
    - Resident obtained an injury when out of the facility.

Elopement scenario 3

- Frank was seen exiting the south door by a CNA. The door alarms sounded. The CNA followed Frank out the south door and returned with him into the main entrance. No injury occurred. MD and family notified.

Elopement scenario 3 *(continued)*

- This does not need to be reported to SD DOH.
  - Rationale:
    - Systems were in place and the resident was accounted for the whole time.

This is the end of

***How to Conduct an Investigation*.**

For any questions, please contact our office:

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SOUTH DAKOTA DEPARTMENT OF HEALTH