Incident/Accident/Reportable Investigation Recommended Best Practices

Fact Finding

1. Remember, the emphasis initially is on gathering facts, not placing blame or determining the exact cause of the incident, reportable, or accident.

2. Remain completely objective during interviews and in documentation.

3. Evaluate the Resident, inspect the incident/accident site and any equipment involved as soon as possible.

4. Preserve any evidence or equipment involved. Do not attempt to repair damaged equipment.

5. As directed, take photographs of the area per facility policy and/or make diagrams of the incident scene.

6. Interview the injured party and witnesses as soon as possible after an incident, reportable, or accident. Ask "who, what, when, where, why, and how ″during interviews.

7. If a resident is involved, factually record the pre-incident condition of the patient, the incident's sequence of events, and the resident's post-accident condition in Point-Click-Care. Do not document opinions or that an event report was prepared.

8. If needed, re-interview the resident, other injured party, and witnesses to resolve any conflicting accounts.

10. Keep complete and accurate notes in an investigation file for Quality Assurance meetings.

11. Notify facility Administrator/D.O.N and as indicated, Risk Management consultants for assistance.

Interviewing

1. Obtain statements from the Resident, guests, staff and other witnesses as soon as practical.

2. If practical, interview the resident and other guest/staff witnesses separately in a quiet, neutral environment such as an empty resident room or office.

3. Explain the purpose of the interview and put the resident/witness at ease.

4. When taking notes for Quality Assurance, thoroughly identify the Resident by name, medical record number, and time at facility. If the witness is a guest or family member, record their name, relationship with the resident, and phone number. If the witness is a facility employee, identify them by name, title, years of experience, and home phone number.

5. At the beginning of the interview, let the Resident/witness speak freely and take detailed notes without distraction or interruption.

6. Often ask "who, what, when, where, why, and how ″during interviews;
Ensure that the witness understands the questions.

7. Use quotation marks when recording the exact words used by the witness to describe their observations.

8. Always end by asking "Is there anything else that you think I should know?"

Investigation Reporting/Root Cause Analysis (R.C.A.)

1. The objective of reporting is to provide accurate and thorough information about the incident/accident. Notify facility Administrator/D.O.N and as indicated, Risk Management Consultants for assistance.

2. Describe in detail the incident/accident to include: sequence of events and the type/extent of the injury or property damage.

3. Specify any observed, or credibly reported, hazardous conditions, unsafe work practices, system problems, or unclear/ambiguous policy and procedures.

4. Identify the root cause of each hazardous condition or unsafe work practice.

5. Describe feasible short-term and long-term corrective actions that prevent or eliminate identified hazardous conditions, unsafe work practices, system problems, or address unclear/ambiguous policy and procedures.

6. Describe the corrective actions recommended, the persons accountable for each corrective action, and the approximate timeframe for completion of each.

Corrective Actions

1. Recommend any immediate corrective actions to eliminate or reduce Resident harm, hazardous conditions and/or unsafe work customs and practices.

2. Recommend any long-term actions that may assist in correcting policies, Resident programs, and/or procedures. Refer to existing policy and procedures.

3. If new supplies, equipment, or programs are needed, estimate the cost to implement each.

4. Develop an action plan for each corrective action.

5. Notify the facility Administrator/D.O.N. and as indicated, Risk Management Consultants for assistance to monitor implementation of the action plan, ensure implementation, and follow through.

ANALYSIS: Administrative Risk Management

Consider each factor contributing to the incident. Consider what can be done immediately and in the future to mitigate/control/eliminate the exposure, prevent the hazard and/or accident, and reduce the amount or degree of loss.

The analysis should consider possible system or management failures such as:

1. Employee training and continuing education;
2. Policy & procedures: Absent or unclear/ambiguous;
3. Safe work customs and practices;
4. Accountability;
5. Supervision;
6. Employee participation in a culture of safety taking into consideration:
    * Everyone is accountable for Safety.
    * Unsafe conditions and customs acts may be symptoms of management inadequacies.
    * Safety is a product of the facility's values, accountability and culture.