



WHITE PAPER

Incident Investigation in Aging Services

A SYSTEMS THINKING APPROACH

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In any healthcare management system, effective postincident response is a critical element of a facility's resident and patient safety program and an important part of improving risk management, quality, and safety practices. This is especially true for aging services provider organizations, given the vulnerabilities that people tend to experience as they age. Decisions made and actions taken in the first minutes and hours after an incident set the stage for everything that follows. Consider the following hypothetical scenarios:

A resident falls out of a lift, breaking a hip, but it is unclear what caused the fall. The lift is briefly checked by the staff involved and they see nothing wrong, so the lift is not removed from service while the incident is investigated further. The next day, another resident falls from the same lift in a similar manner.

Evidence and handwritten notes from the initial investigation of a suspected case of theft of resident property are placed in an unlocked office. The evidence goes missing, leading the family to allege that the provider is trying to cover up the incident.

The findings report from the initial investigation of a resident suicide cites failures in resident assessment and monitoring as root causes. Because the investigation was conducted before and outside the analytical steps of the quality assurance and performance improvement (QAPI) process, the report is not protected from discovery in a lawsuit.

In a lawsuit stemming from a resident's elopement-related death, an aging services provider is unable to produce several minutes of relevant security camera footage. The court instructs the jury that it can assume that the evidence would have been unfavorable to the provider if the jury finds that the provider destroyed the evidence intentionally and in bad faith.

The primary purpose of the initial investigation of an incident or near miss is to collect facts, which the organization will later analyze with the ultimate goal of improving care and services. Thus, thorough investigations are the foundation of efforts to learn from incidents and near misses. Even when an investigation is required (e.g., statute, regulation, an accreditor), aging services providers should optimize the opportunity to learn and improve.

When done well, internal incident reporting and initial investigations help to enhance quality and prevent incidents and resulting harm. The facts collected facilitate many post-incident response practices, including but not limited to the following:

- Determining the severity of the incident
- Timely and accurately notifying other healthcare providers (e.g., the resident's primary care physician, the resident or their family, law enforcement, regulatory agencies, others)
- Conducting necessary internal and external reporting (e.g., internal incident report, reports to law enforcement or regulatory agencies), as applicable on an incident-by-incident basis
- Ensuring a comprehensive root-cause analysis (RCA), if an RCA will be conducted
- Helping to drive QAPI
- Managing claims and litigation, should they arise

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However, providers may have concerns about discovery of the results of quality improvement processes in the event of a lawsuit. This can lead providers to avoid conducting investigations at times, perform only cursory investigations, or avoid delving deeply into the findings. In addition, providers should watch for other reasons that can lead to less than effective investigations as well. Sometimes, investigators lack necessary resources or skills, or organizational policies and procedures do not provide sufficient guidance to facilitate effective investigations.

Whatever the cause, ineffective investigations represent a lost opportunity to improve and prevent harm. They may also be

perceived or portrayed as a lack of concern for persons served, an attempt to hide facts about an incident, or an attempt to cover up the incident altogether. This can undermine trust between the organization and the residents and families it serves, increasing the possibility of a claim or litigation. Ineffective investigations may also heighten the risk of regulatory citations or allegations of spoliation of evidence.

Aging services providers can take many steps to support effective incident reporting and initial investigations. This white paper provides guidance from a systems thinking perspective on performing these critical steps.

What Is Systems Thinking?

The systemic approach to management, also called a systems thinking approach, focuses on two fundamental concepts.

The first concept is that “a whole is more than the sum of its parts.” The interactions between the things that make up a system are just as important as the individual parts in fulfilling an organization’s mission and purpose. It also suggests that the whole possesses characteristics that none of the parts individually possess. It has everything to do with organization design: individual positions to teams to departments, the processes that connect them, and the alignment of systems inside and outside the organization. This means that all parts are important to fulfilling a system’s purpose. It also means that removed from the system, a part loses its purpose and the system behaves differently.

The second concept is the development ethic. This concept says that every individual in the system should be encouraged to develop and use his or her fullest positive potential for the benefit of the person and the organization. “The inputs required to do this are a reasonable salary, access to required and desired learning, a managerial system that treats them fairly and encourages development, and a work environment that does not hamper their efforts.” (Roth)

Organizations that incorporate a systems thinking approach share four key characteristics:

- 1. True participation.** All employees affected by a decision have some level of input into that decision.
- 2. Full integration.** This characteristic recognizes the reality of the whole; therefore, activities are coordinated on all levels and between all levels.
- 3. Ongoing learning.** The organization’s activities and processes support and reward continual learning for all employees, which also contributes to the ongoing learning of the system.
- 4. Ongoing feedback and continuous improvement.** The organization has processes that allow it to adapt fluidly to changing internal and external environments.

By using a systems thinking approach, leaders can better understand behaviors of the organization and increase their effectiveness in achieving the organization’s goals and fulfilling its purpose. This includes recognizing older adults as stakeholders. By thinking in terms of parts, processes, and alignment, organizations can create shift-by-shift care environments that promote safety and quality of life for all involved, including the organization itself, and fluidly adapt and improve.

Source: Roth W. A systemic approach to improving corporate performance. *Bus Manag Dyn* 2014 Oct;4(4):27–31. http://bmdynamics.com/issue_pdf/bmd110504-%2027-31.pdf

Internal Reporting and Investigations in Context

The investigation must begin directly after initial notification of the incident because time is a significant factor. The longer it takes to conduct fact-finding after an incident occurs, the greater the possibility that evidence will be lost, memories will dim, and speculation and self-justification will cloud the process. (ECRI “Healthcare Device”)

Figure 1. Overall Postincident Response Process illustrates the many elements of postincident response in three phases. Incident reporting and initial investigation—the topics addressed in this white paper—occur in Phase I.

Postincident response is both ongoing and complex. Depending on the incident, the total process can occur over a long period of time. It comprises a series of identifications, valuations, decisions, internal and external notifications and reports, communications, evaluations and monitoring, analyses, and ultimately changes to care, delivery, and systems.

Figure 2. Postincident Response Algorithm maps the events and processes that make up postincident response, including but not limited to elements that are important to conduct during Phase I.

In addition, postincident response activities do not always occur sequentially—one step might not be completed before the next begins—and several tasks and activities can occur at the same time.

The algorithm in Figure 2 is an example; individual organizations’ algorithms will look and behave differently depending on a variety of factors. These may include whether it is a single-site or multisite organization; whether it is a stand-alone service line or continuing care retirement community (CCRC); what the organizational design is like, including positions and assigned responsibilities; and how the chain of command is structured, among other factors.

Scope of the Initial Investigation

It is increasingly important to recognize the scope and boundaries of a proper initial investigation. Although exceptions exist, fact-finding documents (e.g., incident reports, witness statements) often are not protected from discovery. Analytical tasks, like hypothesizing about the cause of an incident, analyzing evidence, and developing performance improvement recommendations, were once part of the initial

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Figure 1. Overall Postincident Response Process

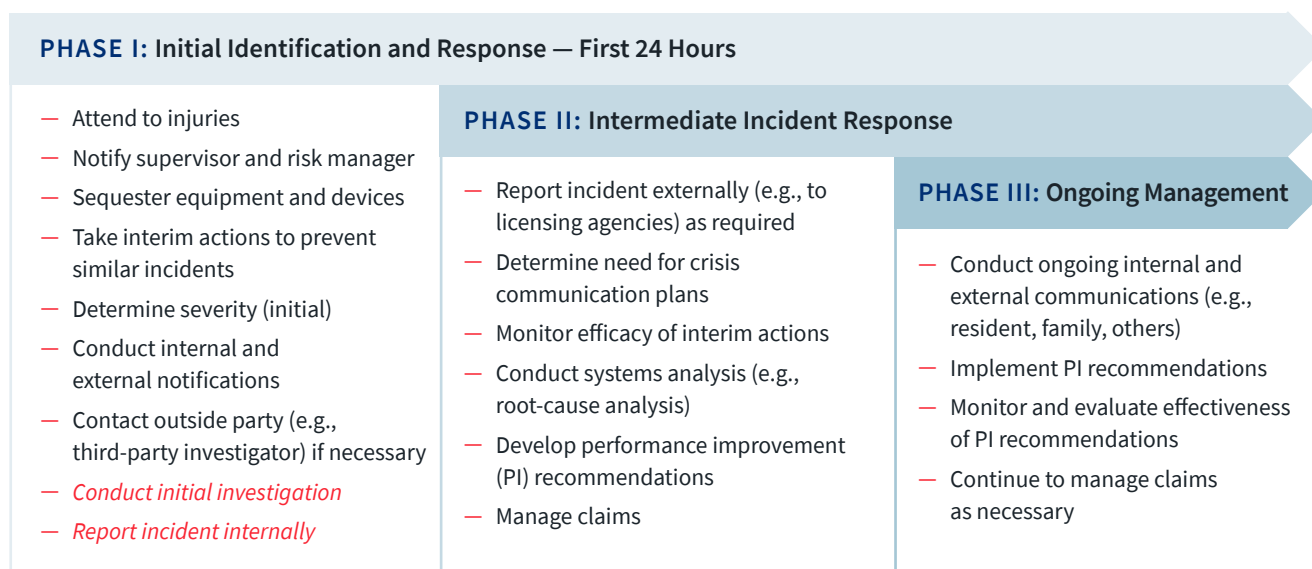
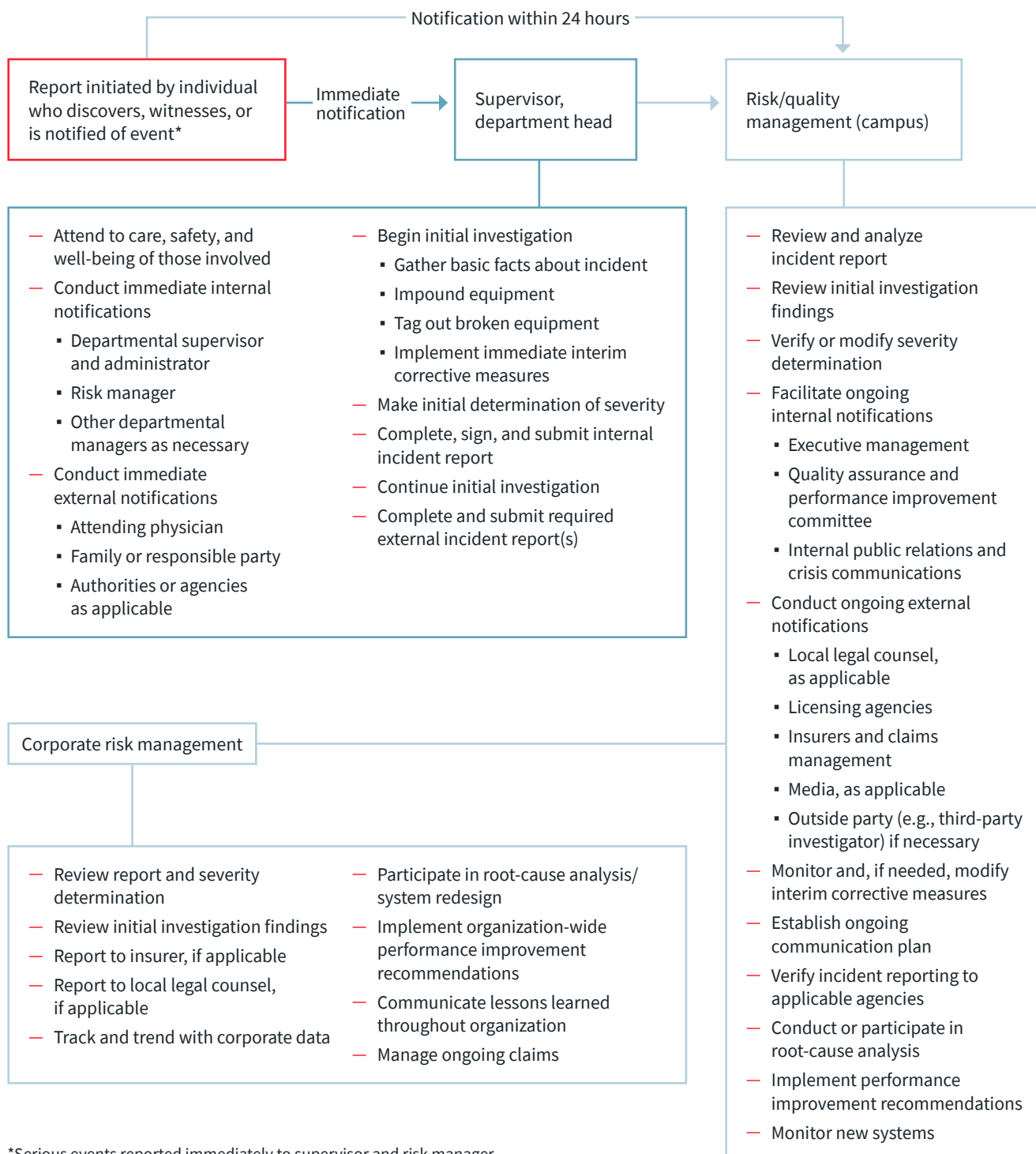


Figure 2. Postincident Response Algorithm



*Serious events reported immediately to supervisor and risk manager

continued from page 4

internal investigation. Today, these tasks must be conducted under the auspices of the organization's QAPI program to be considered quality improvement work product and thus potentially qualify for protection from discovery in a lawsuit. The internal investigation, by contrast, must be limited to fact finding. The investigation's findings then become a source of QAPI information to drive improvement. To learn more about QAPI and discovery in aging services, read ECRI's Systems RETHinking white paper "Legal Discovery and QAPI: A Tale of Two Risks."

An investigation also helps to identify aspects of performance that behaved correctly so that the desired performance can be affirmed and re-created throughout the organizational system. This is often a forgotten focus of investigations and performance improvement. An investigator-in-charge at the National Transportation Safety Board explains this important purpose of investigations (Ward):

When we investigate an accident, we don't only look for the things that went wrong, but we also look for those that went right. Sometimes these "rights" ensure the accident didn't become an even greater tragedy, and sharing them can help crew members and operators in the future ensure the safest flight possible.

This emphasis on identifying what went right as well as what went wrong reflects a transition from the old way of thinking about safety in complex systems, called Safety-I, to a new way, called Safety-II. Safety-I defined safety as "a state where as few things as possible go wrong," or a lack of incidents. When things went wrong, Safety-I assumed that malfunctions or failures of particular components—such as procedures, technologies, or human beings—were the cause. However, human performance almost always goes right because people adjust their performance to ever-fluctuating work conditions. Safety-II recognizes that complex systems need these human adjustments to perform well and safely. Rather than being a liability, human beings create safety. Safety-II views safety as a state in which "as many things as possible go right" and is concerned with understanding how systems succeed under the varying conditions of day-to-day work. Incident investigations must therefore determine what went right as well as what went wrong. (Hollnagel et al.)

Analysis under a QAPI framework will ultimately determine how things went right or how things went wrong. So what does

Safety-II mean for initial internal reporting and investigation, which occur before QAPI analysis? During the initial investigation of an incident, investigators should seek all facts and evidence that could relate to the system's performance. Assuming that a fact or piece of evidence need not be collected because it relates to a part of a process that appears to have functioned well can hamper learning. Seeking all potentially relevant facts and evidence can also help avoid cognitive bias (e.g., confirmation bias).

Finally, providers should not confuse their own internal investigation process with that of outside agencies and authorities, such as regulatory or even criminal investigators. While information from an internal investigation may be requested for an outside investigation, each investigation serves a different purpose. A provider could actually cause additional harm by interfering with a crime scene or conducting investigatory processes rightfully left to others. Understanding the purpose of internal investigations helps the organization define their scope and facilitates the development of policies and procedures for conducting them. Organizational policies and procedures should outline which situations require reporting to outside agencies and authorities and which personnel should liaise with them.

Investigators

The investigator's primary responsibility is to search diligently for fact-based answers about the incident, asking vital questions about the what, where, and when of the incident.

Often, the initial process of gathering facts about an incident falls to the supervisor on duty who receives initial notification about the incident, placing them in an investigator's role. Depending on the severity of the incident, a second investigator, such as a risk manager or administrator, may be assigned early in an investigation. If enough personnel with

Biases can lead investigators to make inappropriate assumptions, undermining the investigation's findings and integrity.



RISK TIP

Consult legal counsel regarding which, if any, privileges from discovery may be available to protect the initial investigation and which may be available to protect the QAPI process. Legal counsel can help the organization develop best practices investigating and learning from incidents to take advantage of available privileges.

investigatory skills are available during the initial investigation, having a team investigate can reduce the risk that cognitive biases will skew the process. Investigatory tasks that continue beyond the initial investigation (e.g., following up on initial findings) may be performed by an individual or team, depending on the scope and nature of the tasks.

Investigators must take care to avoid the following potential pitfalls (Rowe and Amo):

- **First impressions:** Although they may provide insight, first impressions are not facts. They can bias the investigator's thoughts and processes. Avoid jumping to conclusions and making assumptions based on first impressions.
- **Assumptions:** Investigators who work for the organization can have biases that can affect their observations. These biases can lead investigators to make inappropriate assumptions, undermining the investigation's findings and integrity.
- **Skipped investigatory steps:** Investigators may skip steps that they think are unnecessary. For example, an investigator may mistakenly decide not to interview a particular staff member because he or she is an excellent employee.
- **Ignoring evidence:** Evidence collection should be thorough. Investigators who ignore pieces of evidence—because, for example, those pieces do not fit with their hypothesis of the incident—could miss important evidence.

It is important to acknowledge that the investigator role requires several knowledge bases and skill sets—honed over time with training and practice. Ideally, someone who understands and is skilled in the investigative process, such as a risk manager, leads the investigation. Those who lead or participate in the investigation may need additional expertise, such as knowledge of the organization's day-to-day operational policies and guidelines or applicable legal and regulatory requirements. Awareness of enterprise risk management issues and how functions integrate and correlate can be important. Also, interpersonal skills in communication and emotional intelligence can contribute greatly to the investigatory process and, during interviews, can help create a nonpunitive environment that focuses on fact finding rather than blame.

Assigning investigators to each incident is an important decision because the potential for bias could adversely affect the accuracy of details and investigation findings. For example, a direct supervisor or departmental manager with oversight of the department where the incident occurred may have difficulty maintaining objectivity; thus, assigning investigators to each incident is an important decision because the potential for bias could adversely affect the accuracy of investigation details and findings.

Direct supervisors may need to participate in specific, discrete investigatory elements within their area of particular expertise and may institute interim corrective measures. This is because supervisors are generally more familiar with employees, everyday work environments, work processes, equipment, materials, relevant regulations, and applicable guidelines. Supervisors also tend to have a vested interest in maintaining a safe and healthy environment for all stakeholders—persons served, staff, and visitors. (ECRI "Accident and Incident Investigation") In general, however, avoid assigning investigator responsibilities to anyone directly involved in the incident.

The Scene

Much of the evidence collected during an investigation comes from the scene, which plays an important role in ultimately discovering the story of an incident. Special care should be taken to protect and manage the scene after an incident because it is critical to the overall effectiveness of the

investigation, and, therefore, all postincident response activities that occur afterward.

Several important rules apply to scene management, and these rules must be put into effect by the first person of authority who arrives at the scene. In many cases, this is the supervisor on duty, as discussed previously. When a potential crime (e.g., theft of medications, sexual assault) has occurred, there should be no delay in contacting the police, who can advise the investigators how to manage the scene while the police are en route or while they are there. This is important because releasing a scene prematurely or inappropriately could destroy evidence. But assuming no law enforcement or state agency directs otherwise, the following steps should be completed before the scene is released (Rowe and Amo):

1. Conduct a walk-through of the scene.
2. Secure physical evidence.
3. Document the scene (e.g., photograph, diagram, narrative description).
4. Create a witness list.
5. Create a list of documents and electronic files to collect or copy.
6. Conduct a final walk-through of the scene.
7. Release the scene.

As with other parts of the investigation, these initial steps should be clearly documented because they demonstrate diligence in managing and protecting the scene.

Another important consideration for internal investigations is the decision whether to document the scene photographically as a method of collecting evidence. Given the possible legal risks that photographs can pose, a provider's legal counsel can provide guidance for making this decision and developing guidelines for the possibility of discovery and admissibility, should litigation arise. If an organization chooses to include photography as a means of documenting a scene or evidence, it is responsible for the creation, implementation, and training of staff in those practices. As with any evidence, requests to produce photographs can come from inside and outside of the organization—including from law enforcement authorities or state agencies. Special care should be taken in the storage, preservation, and production of photographs throughout the postincident process. The dignity and privacy of those involved in the incident should be respected. In addition, any video evidence (e.g., videotape, digital video files) should be preserved right away.

The Internal Incident Report

The incident report is a form used to document objective facts about the incident and is a major tool in the investigation toolbox for any incident. See Resources for a sample internal incident report form. Information to include in an incident report includes the following:

- Statement that the incident report should not be filed in the resident's medical record (unless state or local law requires otherwise)
- Date and time of the incident
- Date and time the incident was identified
- Date and time the incident was reported to the direct supervisor
- Identity of the person who reported the incident to the supervisor
- Identity of the supervisor to whom the incident was reported, if applicable, and actions that individual took in response
- Date and time the incident report was completed
- Location of the incident
- Identities of people affected (e.g., resident, visitor, employee)
- Identities of people who witnessed the incident
- Identity of the resident's attending physician, whether the incident was reported to this individual and also their surrogate (e.g., telephone service, voice mail, receptionist, nurse), and, if so, the physician's recommendations
- Brief, factual description of the incident
- Key factual observations of the scene of the incident (e.g., in the case of a fall, whether there was something slippery on the floor, bed rails were raised, or appropriate footwear was worn)
- Manufacturer, model, and lot or batch number of any medical device involved
- Condition of the affected individual(s), including any complaints of injury, observed injuries, and a brief summary of any initial care provided at the scene
- Incident classification, such as by type (e.g., fall), location, injured party (e.g., employee, resident, visitor), type of injury, and severity

RISK TIP



Meet external reporting deadlines.

For regulatory requirements, failing to timely report can result in additional citations and associated fines. Failing to timely report to an insurer may even result in a forfeiture of insurance coverage, depending on the coverage terms.

During the initial investigation, it is important to collect facts about key dates and times because they may provide important information during later analysis and QAPI processes. For example, while delays in notification anywhere in the process can lead to additional harm, improvement recommendations differ depending on where the performance gap—the gap between desired and actual performance—exists. Using an unwitnessed fall as an example, if there is a delay between the time when an incident occurs and when staff become aware of it, contributing factors may relate to barriers to staff discovering the incident. If the delay in notification occurs between the times when staff become aware and when a supervisor becomes aware of the incident, contributing factors may relate to supervisor notification practices. Thus, it is important to collect facts about timing during the initial investigation because they can help identify performance gaps, barriers, and root causes more precisely, leading to more effective performance improvement recommendations.

External reporting may be required depending on the nature, scope, and severity of the incident. Incidents may need to be reported to the state survey and certification agency; other state agencies; the Occupational Safety and Health Administration; law enforcement; insurers (e.g., professional and general liability; property; worker's compensation); the National Practitioner Data Bank; the state professional licensure department; or other entities or a combination of entities. Reporting deadlines can vary widely, anywhere from

“immediately” to annually, and the same agency may have different deadlines for initial notification versus final reporting. Several entities have their own incident reporting processes and related forms.

Incident Timeline

An incident timeline is a chronological map of events leading up to, during, and after an incident. As the investigation progresses and facts are discovered, the timeline can also help to identify missing pieces of information and direct the remaining course of the investigation. In addition to aiding the investigator in writing the report, the timeline helps organize the events that led up to the incident, build the fact pattern during the incident, and track the steps of the investigation (Rowe and Amo).

Timelines can also help to illustrate actual postincident response and lead an investigator to areas that warrant deeper investigation. They can also serve as a source of information to identify performance gaps during QAPI efforts, which include adjusting guidelines to describe an organization's expectations about desired performance. In addition, timelines not only help to identify gaps in performance, but can also help to detect effective performance.

Evidence

One of the primary purposes of an investigation is to identify, catalog, collect, and preserve evidence pertinent to the incident. The quality of evidence collected during the investigatory process is an important consideration. The following characteristics of collected evidence can be used to evaluate the quality of that evidence (Rowe and Amo):

- Relevance to the central issues of the investigation and connection to the incident
- Validity and authenticity of the evidence
- Reliability of evidence collection and chain of custody
- Timeliness of evidence collection and presence of time indicators (e.g., time stamps)
- Credibility of the evidence (or if testimonial, the witness) and ability to corroborate with other evidence

In its broadest sense, a working definition of “evidence” may be “anything that can be used to gain knowledge or facts” about an incident. (Oakley) Four types of evidence are commonly recognized in investigatory practice, described by Oakley as physical, paper, people, and photographic (see **Table. Types of Evidence**). Given the ubiquitous use of electronic forms of documentation and communication today, we suggest changing the paper category to paper and electronically stored written evidence.

With an understanding of these four common types of evidence, it is important to include evidence collection and management practices in the organization’s postincident investigation guidelines. These practices include the following:

- Maintain an evidence log.
- Sequester equipment, medical devices, and supplies.
- Establish and maintain chain of custody.

Maintain an Evidence Log

An evidence log is a form used to document all evidence collected during an investigation. It also facilitates management of the evidence, including production of evidence in response to evidence requests. An evidence log may include the following:

- A numbered list of each piece of evidence
- A written description of each piece of evidence
- The location of each piece of evidence at the time it was collected
- The time and date the evidence was collected
- The person who collected the evidence
- The method of collection and preservation of the evidence
- The storage location of the evidence

Table. Types of Evidence

TYPE	DESCRIPTION	EXAMPLES
Physical evidence	Solid material	<ul style="list-style-type: none"> — Chair — Bed — Resident lift — Syringe — Blood — Liquid on floor
Paper and electronically stored written evidence	Written documentation	<ul style="list-style-type: none"> — Clinical records — Staff assignments — Staff schedule rosters — Personnel files
People evidence	Eyewitness accounts (typically statements or interviews)	<ul style="list-style-type: none"> — Written witness statements — Interviews
Photographic or picture evidence	Media for documenting the scene (may be useful for physical evidence that is hard to preserve exactly)	<ul style="list-style-type: none"> — Photographs — Video images — Diagrams — Drawings

Source: Oakley JS. Accident investigation techniques. Des Plaines (IL): American Society of Safety Engineers; 2003

Sequester Equipment, Medical Devices, and Supplies

Because many healthcare-related incidents involve a wide variety of equipment, it is important to treat it as evidence. Equipment performance and failures are important to discover during incident investigations. If equipment failure was a contributing factor in an incident, it is imperative to protect others from experiencing harm from the same piece of equipment. Thus, equipment should be taken out of service, tagged, “locked out” to prevent accidental use, and stored in a secure area.

Also, if the incident involved any equipment, supplies, or medical devices (e.g., syringe), it would be prudent to remove identical items from inventory to serve as examples (i.e., devices that were manufactured in the same “lots” as those involved in the incident). An example from the same manufacturing lot can be tested to help determine if manufacturing defects or other causes contributed to device failure.

All postincident tests and determinations regarding the functioning of equipment should be conducted by authorized service dealers. The tests conducted, along with their findings, should be witnessed, documented, and signed. The organization’s postincident practices should also outline the steps to be followed and who has decision-making authority to put a piece of equipment back into service.

Establish Chain of Custody

As evidence is collected, it should be placed in appropriate storage containers for preservation. Devices should not be cleaned, linens should not be washed, and documentation records should not be altered from their original state—this includes paper and electronic documentation. Chain-of-custody protocols should outline evidence collection and securing. A chain-of-custody policy may include the following requirements (ECRI “Risk Management Tips”):

- Keep collected evidence in appropriate sealed containers labeled with the resident’s name, the dates and times the evidence was collected and secured, and the signature of the person responsible for collecting and securing the evidence. It should also include reference numbers linking it to both the investigation and the evidence log.
- Store collected evidence together in a secured storage area, allowing access only to those who have appropriate permission. Take steps to preserve evidence, especially

RISK TIP



Timely replace equipment that has been taken out of service. Equipment taken out of service due to an incident and subsequent investigation is often care-critical. Timely replacement of such equipment is important to maintaining continuity of care and service delivery.

from accidental destruction, such as water damage or other potential hazards.

- Include a chain-of-custody form any time evidence is released to another party. The form should be signed and dated by the person to whom the evidence is released, acknowledging receipt and responsibility for the evidence. The form should include pertinent information, including a description of the evidence, reference to the investigation number, the evidence log number for that piece of evidence, the purpose of the release, and the name of the individual to whom it was released.
- Include an evidence-access log form. Evidence must often be accessed to be analyzed, tested, reviewed, and even produced throughout ongoing postincident activities, such as QAPI-sanctioned root-cause analyses, claims management activities, and in some instances, litigation. An evidence-access log form should be kept with the evidence, and important information such as the date and time, the person requesting access, and the reason for accessing the evidence should be documented each time. It should also document each time evidence is removed from the area, who removes the evidence and is therefore responsible for it, reason for removal, date and time of removal, date and time of return, and person returning the evidence.

Ensuring that all individuals who are granted access to evidence understand and comply with the chain-of-custody process is key to its success. It also increases the likelihood that evidence will withstand scrutiny. Failure to do so can undermine the integrity of the investigation and, therefore, its findings.

Written Witness Statements and Interviews

While also forms of evidence, witness statements (documentary evidence) and interviews (testimonial evidence) warrant discussion because of both their potential benefits and special risks they can pose regarding discovery and admissibility.

Witness Statements

For the purposes of investigations in aging services, witness statements are written statements provided and signed by the witness for authenticity and accuracy. A written statement describes what the person witnessed (e.g., saw, heard, did not see, did not hear), where the individual was, and what the individual was doing prior to or during an incident. It is important to encourage the person who takes down the statement to give factual information only and to avoid speculation or subjective descriptions.

Interviews

An interview is conducted by an investigator in a question and answer format to gain knowledge about the incident. When deciding whom to interview and what to ask, begin with the incident report itself. The person who initiated the report and the individuals directly involved should be interviewed; it may also be a good idea to talk with others who may have been in the area or who have knowledge of the incident. The interviewer should make a list of key individuals and witnesses and prepare an interview schedule. (ECRI “Event Report”)

Interviews should take place as soon as possible after the incident, while memories of the details are still fresh. It may be useful to conduct a second round of interviews one or two weeks later to identify any new information or to answer questions that may have arisen during the investigation. As with witness statements, only factual information should be recorded, not judgments or speculation. (ECRI “Event Report”)

Planning for Interviews

While preparing for an interview, develop a list of broad, open-ended questions to ask all interviewees. Questions should be phrased to solicit descriptions and details about the incident and may follow the chronological order of the events to clarify their sequence. The list can be based on the classic fact-finding questions: who, what, when, where, why, and how. Experienced

RISK TIP



Manage evidence with great care.

If litigation arises, mishandling of or the inability to produce evidence when necessary can lead to claims of spoliation of evidence. In some jurisdictions, the court may instruct the jury that it can draw a negative inference about the missing evidence or impose other consequences.

interviewers and investigators often use a “tell me about this shift” technique in which they prompt the interviewee to narrate the sequence of events leading up to and throughout the incident. The interviewer listens quietly and saves questions until the end. (ECRI “Event Report”)

Conducting the Interview

When conducting the interview, be cognizant of body language. Avoid sitting across a desk or table from the interviewee; sitting to one side, without any physical barriers, is more likely to put the interviewee at ease. Begin the interview with assurances that all those present during or involved in the incident are being interviewed in order to gather facts, not to place blame. (ECRI “Event Report”)

Many factors can influence the reliability and credibility of interviews. Because interviewees are likely to act in what they perceive to be their own interests, be mindful of a witness’s perspective. Does he or she have a reason for hiding or not

Witness statements and interviews warrant discussion **because of both their potential benefits and special risks** they can pose regarding discovery and admissibility.

emphasizing certain information? Does he or she seem to note and remember events accurately? Does the potential for disciplinary action, criminal or civil liability, or discharge from employment exist for either the witness or his or her coworkers? Have others spoken to the witness and influenced his or her recollection of events? There are no easy ways to detect this information, but experience in interviewing will increase the ability to pick up subtle clues to discern the witness's motivations behind the information provided. Effective interviewing technique requires listening for both what is said and what is not said. (ECRI "Event Report")

Should Interviews Be Recorded?

There are several issues to consider concerning whether to take notes or record interviews with those who were involved in or have witnessed an incident. One consideration is how such recordings are treated under state or federal court rules and rules of evidence. Recorded responses from witnesses may, in some circumstances, constitute "statements," which are discoverable in litigation. Statements taken from an individual who is later named as a defendant in a lawsuit may, under some circumstances, be considered an "admission," which, under rules of evidence, may be admissible as evidence in a trial. (ECRI "Event Report")

In addition, if interviews are to be recorded, it is best to take notes rather than to use an audio- or video-recorder during the interview. Although use of an audio- or video-recorder eliminates note-taking, at the very least, using an audio- or video-recorder requires that the recording be transcribed, which can be time-consuming. (ECRI "Event Report")

Investigators should remember that interviews are not interrogations. Investigation interviews are meant to gather and vet facts about what was witnessed and not witnessed. Interrogations often take on an atmosphere of establishing culpability or blame, which can be a strong barrier to openness and fact gathering.

The factual information provided through an accurate witness statement can be useful in supporting or corroborating other facts and evidence and for developing an incident timeline. Postincident interviews can also yield updated information for apprising the resident or family members of the ongoing investigation.

RISK TIP



Work with legal counsel to develop practices for taking written statements and conducting interviews. Do not enter results of the interview in the resident's medical record or an employee's personnel file.

Investigation Findings Report: A Collection of Facts

Finally, the investigator concludes the process with a findings report for the initial investigation. The report is meant to provide facts in a clear and concise manner. Organizations may want to adopt an investigation findings report form as part of their postincident practices. This helps guide the investigator in developing the report and not going beyond the scope of purpose of the initial investigation.

In the past, many investigation methods taught investigators to hypothesize about causation. Today, to maximize the possibility of protecting analytical work and conclusions from discovery, many initial investigations stop with the purpose of fact finding. This leaves analysis, identification of root causes and contributing factors, and performance improvement recommendations to fall under the organization's QAPI program.

Conclusion

In conclusion, internal incident investigations can serve as care- and service-critical elements of a provider organization's postincident response, facilitating harm prevention, risk reduction, quality improvement, and enhanced safety for all—from the person served to the organization itself.

The facts gained from an investigation are used in several other processes in all three phases of the postincident response process. A systems thinking approach teaches thinking in terms of how systems behave, act, and relate in a continuous and ongoing fashion. When done well, information gained from an internal investigation promotes postincident communication, effective learning, performance improvement, and ultimately, builds trust. Conversely, when internal incident investigations are found lacking in quality, or are not performed at all, subsequent substandard procedures and protocols may be introduced. Information could be used but is not available, or perhaps worse yet, inaccurate information is used in communication, decision-making, and problem solving. Ultimately, effective internal investigations contribute to safe care environments for all who are served—patients, staff, and the provider organization.

For more information about ECRI's Aging Services resources and consulting services, contact Victor Rose, vrose@ecri.org

ECRI Resources*

Continuing Care Risk Management

- Event Reporting and Response.
<https://www.ecri.org/components/CCRM/Pages/QualRisk7.aspx>
- Event Report Interviews.
https://www.ecri.org/components/CCRM/Pages/QualRisk7_1.aspx
- Internal Incident Report Form for Aging Services.
<https://www.ecri.org/components/CCRM/Documents/SPT/QualRisk/QualRiskPol3.pdf>
- Healthcare Device Adverse Event Recognition and Investigation.
<https://www.ecri.org/components/CCRM/Pages/QualRisk14.aspx>
- Risk Management Tips for Device-Related Events.
https://www.ecri.org/components/CCRM/Pages/QualRisk14_1.aspx
- Medical Device Reporting.
<https://www.ecri.org/components/CCRM/Pages/LegReg5.aspx>
- Getting the Most Out of Root-Cause Analyses.
<https://www.ecri.org/components/CCRM/Pages/QualRisk25.aspx>
- Discovery: Paper Records and Electronic Information.
<https://www.ecri.org/components/CCRM/Pages/RecKeep2.aspx>
- Legal Discovery and QAPI: A Tale of Two Risks.
https://www.ecri.org/components/CCRM/Pages/RecKeep2_1.aspx

Healthcare Risk Control


- Event Reporting and Response.
<https://www.ecri.org/components/HRC/Pages/IncRep1.aspx>
- Event Report Interviews.
https://www.ecri.org/components/HRC/Pages/IncRep1_1.aspx
- Internal Incident Report Form for Aging Services.
<https://www.ecri.org/components/HRC/Documents/SPT/IncRep/IncRepPol5.pdf>
- Medical Device Adverse Event Recognition and Investigation.
<https://www.ecri.org/components/HRC/Pages/IncRep2.aspx>
- Risk Management Tips for Device-Related Events.
https://www.ecri.org/components/HRC/Pages/IncRep2_1.aspx
- Strategies for Successful Device Investigations Involving Vendors.
https://www.ecri.org/components/HRC/Pages/RMRep1013_Accident.aspx
- Investigating Device-Related Skin “Burns.”
<https://www.ecri.org/components/HRC/Pages/IncRep3.aspx>
- Medical Device Reporting.
<https://www.ecri.org/components/HRC/Pages/LawReg15.aspx>
- Hospital Relations with Police.
<https://www.ecri.org/components/HRC/Pages/AdSup3.aspx>
- Preparing Staff for Interactions with Law Enforcement.
<https://www.ecri.org/components/HRC/Pages/AskHRC041618.aspx>
- Getting the Most Out of Root-Cause Analyses.
<https://www.ecri.org/components/HRC/Pages/RiskQual23.aspx>
- Discovery: Paper Records and Electronic Information.
<https://www.ecri.org/components/HRC/Pages/MedRec3.aspx>
- Legal Discovery and QAPI: A Tale of Two Risks.
<https://www.ecri.org/components/HRC/Pages/LongTm11.aspx>

*Contact clientservices@ecri.org for information on purchasing resources that are not part of your membership.

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www.ecri.org/solutions/aging-risk-management

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ECRI is an independent, nonprofit organization improving the safety, quality, and cost-effectiveness of care across all healthcare settings. With a focus on patient safety, evidence-based medicine, and health technology decision solutions, ECRI is the trusted expert for healthcare leaders and agencies worldwide. The Institute for Safe Medication Practices (ISMP) is an ECRI affiliate. Visit ecri.org and follow @ECRI_Org.



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