



Preparation for New Risk Managers and Peer Reviewers

Incident Investigation Documentation

Part 3 of a 5-Part Series

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Preparation for New Risk Managers and Peer Reviewers

Part 1: Introduction to Incident Investigations

Part 2: Initiating an Incident Investigation

Part 3: Incident Investigation Documentation

Part 4: Determining the SOC within the KS State Risk Management Regulations

Part 5: Creating a Plan of Corrective Action for the Incident

Incident Documentation

KAR 28-52-1(c)

- ☐ Investigation Findings
- ☐ Conclusions and Rationale
- ☐ Level of the Standard of Care
 - Initial
- ☐ Recommendations
- ☐ Actions Taken and Follow Up
- ☐ Primary Reviewer Signature and Date



Investigation Documentation



Investigation Documentation

The Process

Identify all involved

- **KAR 28-52-4(b)** Separate standard-of-care determinations shall be made for each involved staff member or provider and each clinical issue reasonably presented by the facts.

Individuals, not peers or outside your department

- Notify Risk Manager
- Stay within your credential and/or department

Pitch it back to Risk Management - ASAP

- Sentinel Event (SE)/Serious Reportable Event (SRE)
- Root Cause Analysis (RCA)



Investigation Documentation

The Process – Formulating the Summary

Why Did the Incident Occur?

- Was there a deviation from the norm?

Were Policies and Procedures Followed?

- Which policies?
- Who did and didn't follow them?
- Why weren't they followed, and what were the contributing factors?
- What was the impact on the patient?

Were Those Involved Within Their Professional Scope of Practice?

- Which one
- Who was/wasn't
- Why not/contributing factor
- Patient impact



Investigation Documentation

The Process – Formulating the Summary

Best Practices and Evidence-Based Practices

- Which one?
- Who did or didn't follow best practices?
- Why weren't they followed, and what were the contributing factors?
- What was the impact on the patient?

Comparison to Current Practice Patterns

Reasonable Person Comparison

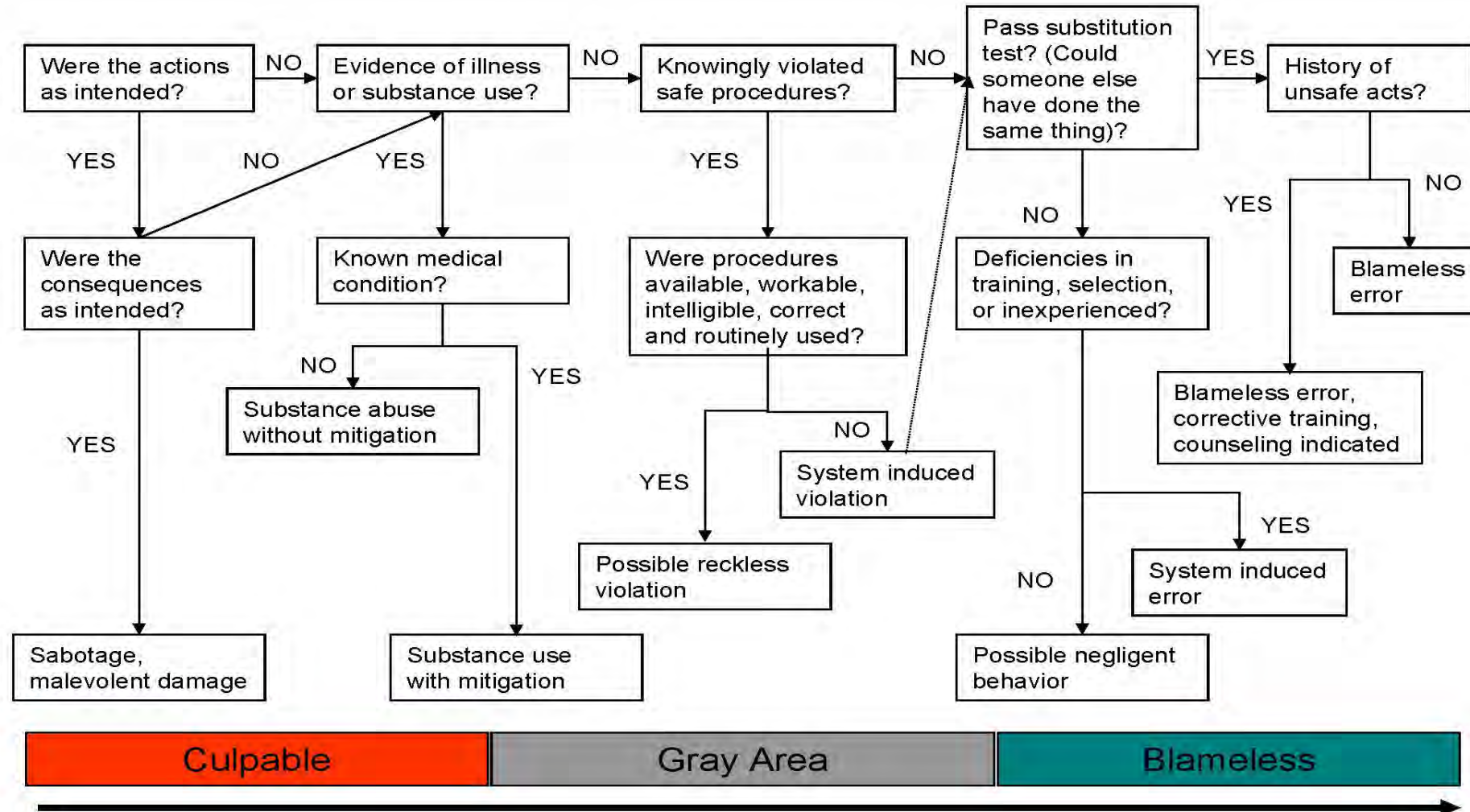
Disruptive Forces

- Technology
- Other providers and staff



Investigation Documentation

Unsafe Acts Algorithm



Adapted from James Reason. (1997). Managing the Risks of Organizational Accidents.

Investigation Documentation

Conclusion and Rationale Documentation

Document What You Identified to be Your Peer's Issues

Avoid Using Staff Names

- *After investigation, it was found the lab tech...*

Review Only Your Peer or Your Department

- *Upon review, the cardiac rehab staff were unaware of scheduled generator testing...*
- *Maintenance staff rescheduled generator testing due to...*

Include Specific Circumstances of the Staff's Actions or the Reason for the Event.

- *A power outage due to lightening strike... Per policy, only emergency surgery is initiated on generator/alternative power. The patient's anesthesia was reversed prior to intubation by the CRNA and patient was monitored by the RN and CRNA until power was restored.*



Investigation Documentation

Conclusion and Rationale Documentation

Document the Patient's Outcome

- *No further issues were noted due to initial low glucose level. The newborn was discharged home with mother per routine post partum plan.*
- *The patient stay was longer than expected due to continuing monitoring and serial lab testing for cardiac enzymes.*

Additional Requirements

- Additional diagnostic exams that were ordered
- Additional exams or monitoring that were performed
- Extended length of stay
- Additional specialty consults
 - Orthopedic
 - Neurology



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Documentation to Avoid

Avoid Not Documenting a Conclusion or Rationale

Avoid Harsh or Mean Comments or Finger Pointing

Avoid Humor

- *...due to the medication error the patient found a new love of the padded seat on the commode, however no harm occurred.*

Avoid Vague Documentation

- *No error*
- *All policies and procedures met*
- *Consent implied*
- *Error did not reach patient*
- *Non-compliant patient*
- *Staff no longer works here*



Investigation Documentation

Promote a Culture of Reporting

Employer Retribution is destructive and a violation of the Kansas Statutes.

- **KSA 65-4928(a)(b)**
 - › **(a)** No employer shall discharge or otherwise discriminate against any employee for making any report pursuant to K.S.A 1986 Supp. 65-4923 or 65-4924.
 - › **(b)** Any employer who violates the provisions of subsection (a) shall be liable to the aggrieved employee for damages for any wages or other benefits lost due to the discharge or discrimination plus a civil penalty in an amount not exceeding the amount of such damages.

When in Doubt, Fill One Out

- Risk Management is here to help each staff member be best they can be, while providing best possible care for our patients.
- **We can't fix it, if we don't know about it.**



Incident Investigation Documentation

Key Takeaways

- You went through the investigation – document what you found out
 - Do not leave sections blank
- Only review issues or people in your department or credential
- Be concise and thorough without personal feelings

Questions?

Feel Free to Reach Out

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Up Next

Part 4: Determining the SOC within the KS State
Risk Management Regulations