Incident investigations in health care:

Focusing on change instead of blame

When an incident occurs in the workplace, a common reaction is to look for somewhere to place blame. It's more important and productive to look for reasons why the incident happened and what can be done to prevent it from recurring. In other words, focus on changes that will make the workplace safer rather than blaming those involved in the incident.

What is an incident investigation?

An *incident investigation* is a process that is used to determine the causes of an incident so you can take steps to prevent a similar event. Incident investigations are required by the *Workers Compensation Act* and must be done in a timely manner by people who understand the work. The investigation should include an employer and worker representative.

Traditionally, recommendations from incident investigations have focused on changing workers' behaviour. Typical suggestions include additional training or asking workers to be more attentive to workplace risks. This approach often fails to identify the underlying causes of the incident and may not improve safety in the workplace.

Incident investigations that make a difference

It's easy to find fault with individuals, but workers' decisions make sense to them at the time of an incident; no one consciously decides to become injured. Asking workers to "be safer" will not likely lead them to work more safely. A more effective approach to investigating incidents is to assume that errors are a natural part of work and everyone is susceptible to them. It is important to recognize that workers' perceptions and actions are shaped by their interaction with the work environment.

According to the Occupational Health and Safety Regulation, an incident is "an accident or other occurrence which resulted in or had the potential for causing an injury or occupational disease." In health care, incidents are often related to:

- Patient handling
- Violent or aggressive behaviour
- Exposure to infectious disease
- Slips, trips, and falls

Health care workplaces have measures in place to protect workers from injury. These measures include equipment, assessments and care plans, policies and procedures, training, and supervision. Measures that eliminate the risk are the most effective and those that simply protect a particular worker are less effective. Health care settings and patients are constantly changing, and gaps can develop between how work should be done and how it is actually being done. An investigation is an opportunity to learn from an incident to uncover gaps, ask why these gaps exist, and to correct them.

What to consider during incident investigations

Work can be divided into three components: the job, the organization, and the individual. Since worker performance is affected by all three of these components, an effective incident investigation should consider the effectiveness and interaction of all three. The following are examples of work components that should be considered.

Job

- Level of physical effort
- Workload
- Appropriateness of services for patient population
- Adequacy of safe work procedures
- Equipment or workspace design
- Relevancy of patient assessment

Organizational

- Level of certainty in roles and responsibilities
- Planning
- Effectiveness of changes from previous incidents
- Communication
- Adequacy of resources (for example, equipment, staff, or supervision)

Individual

- Adequacy of training, including new worker and refresher training
- Experience or knowledge to do the task safely
- Awareness of hazards associated with the work

An effective incident investigation not only determines whether certain conditions exist but also questions if there is a better way to do things.

See the case examples for possible questions to ask when doing an incident investigation.

Make effective changes

Once you've identified what contributed to the incident, take corrective action. Consider targeting these actions at various levels of the organization, such as the care team, department management, and senior management. If permanent corrective actions will take time to implement, use temporary measures to protect workers until you can make permanent changes.

For more information on the requirements for conducting incident investigations, see sections 172–177 of the *Workers Compensation Act* and Section 3.4 of the Occupational Health and Safety Regulation at WorkSafeBC.com.

Case example: Patient handling

A care worker was assisting a resident to her wheelchair in the bathroom. The resident was following instructions to stand but her knees buckled. The worker tried to keep the resident from falling while also ringing the call bell for help. The worker sustained a low back injury.

An investigation seeks to find the cause of an incident by asking a series of questions. Here are some examples of questions that can be asked when investigating a patient handling related incident resulting from transferring a resident. If the answer to any of the questions below is "No," the next question should be "Why." The question of "Why" may have to be asked a few times to find the true cause of the issue.

Job

- Was this resident assessed for a manual transfer? If not, was a mechanical lift available?
- Do policies and procedures exist for toileting? Are they appropriate?
- Did the room layout impede the worker's reach to the call bell?
- Did assistance come quickly?
- Were the workers who responded to the call bell at risk of injury?
- Were grab bars accessible for the resident to hold?

Organization

- How do workers know which method should be used to transfer this resident?
- How was information about transfer methods communicated to the worker? Was it verbal or written? Was it fully understood by the worker?
- Was documentation (e.g., ADL, care plan, or chart) clear about how to transfer this resident?
- Are workers supervised to ensure that they are following policies and procedures on how to transfer this resident?

Individual

- Does the worker know how to assess a resident's mobility to determine whether following the transfer plan is appropriate in each specific situation?
- Did the worker refer to the appropriate documentation before the transfer (e.g., ADL, care plan, or chart)?
- Was the necessary information included in the documentation?
- Was the information recent, relevant, and understandable?

- Was the worker's practice consistent with policies and procedures?
- Is worker training sufficient to ensure safe transferring of residents?
- Did the worker feel rushed?
- Does the worker know what to do when a resident starts to fall or lose balance?
- Did the worker feel that he or she could ask for assistance?

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Conclusions

The following provides two possible outcomes from an incident investigation. The incomplete investigation focuses on the worker's actions and therefore the corrective action centres on the worker. The more thorough investigation delved deeper into what conditions were present that led the worker to make the decisions they did and therefore the subsequent corrective actions address these conditions.

Cause(s)	Corrective action(s)
Incomplete investigation	
The worker reached for the call bell rather than assisting the resident to the floor slowly.	Review the controlled-fall procedure with staff.
Thorough investigation	
On a previous shift, another care worker who was helping this resident get dressed noticed that she was unable to lift her leg. However, the resident had not been reassessed, the care plan and ADL were not updated to reflect an inconsistent ability to weight bear, and the information was not communicated verbally to the worker. The worker was unaware that a manual transfer might no longer be appropriate for this resident.	Nurse supervisors should perform regular spot checks of all care workers to ensure they are performing bedside assessments for weight-bearing ability. These spot checks should be recorded and reviewed by the director of care and the joint health and safety committee.
	Direct care workers who are less confident, including new and casual workers, should be buddied up with a direct care worker who is experienced in performing bedside assessments.
	All workers, including nurse supervisors and care workers, should receive in-service training on performing bedside assessments.
Although instructed by nurse supervisors, many care workers are not comfortable assessing a resident's weight-bearing ability, so they tend to just follow the ADL provided in the resident's room.	Care workers should immediately flag changes about a resident's weight-bearing ability directly on the ADL. (Currently only nurse supervisors change the ADL.) Care workers should also report changes to their nurse supervisors. Any change recorded on an ADL or reported to a nurse supervisor will indicate that a reassessment is required. In the interim, care workers should consider the resident fully dependent and use a ceiling lift for transferring and repositioning.

Case example: Violence

A care worker was helping a male resident take a bath. It was mid morning. After getting the resident from his room and helping him to the tub room, the worker moved to help him to disrobe. Suddenly, the resident shoved the worker, causing her to fall backward and hit her head.

An investigation seeks to find the cause of an incident by asking a series of questions. Here are some examples of questions that can be asked when investigating a violence-related incident resulting from bathing a resident. If the answer to any of the questions below is "No," the next question should be "Why." The question of "Why" may have to be asked a few times to find the true cause of the issue.

Job

- Is the bathing assessment current, based on the resident's violent behaviour assessment, and available to workers?
- Did the bathing assessment reflect the resident's preferences (e.g., bathing method, time of day, sex of worker)?
- Was the resident checked for stressors (e.g., pain, hunger, thirst, sleep deprivation) before being taken for his bath?
- Was there too much environmental stimulation (e.g., noise, light, cold) during the bathing process?
- Did the bathroom layout restrict the way the worker approached the resident?
- Did the resident have privacy when disrobing?
- Was the worker able to call for assistance? Was the response to the worker appropriate?

Organization

- Do the bathing instructions consider the safety of the worker?
- Was documentation (e.g., ADL, care plan, or chart) clear about how to bathe this resident?
- Does the documentation reflect this resident's past behaviours during bathing?
- Have workers been educated about how to safely bathe residents?
- Does anyone observe workers while they bathe residents, and provide feedback on their performance?
- Do workers have the ability to vary the bathing routine (e.g., lengthening or changing the time of the bath, delaying it to another day, or changing the method altogether)?
- Is pressure placed on workers to follow the bathing routine even when it may not be in everyone's best interests?

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Individual

- Was the worker's practice consistent with policies and procedures?
- Did the worker refer to the appropriate documentation (e.g., ADL, care plan, or chart) before the bath?

- Does the worker know how to determine if a resident would be receptive to being bathed before starting the process?
- Was the worker aware of the resident's possible responses to being bathed?
- Does the worker report and document the results of bathing experiences with residents?
- Is the worker involved with reviews of the care plan?

Conclusions

The following provides two possible outcomes from an incident investigation. The incomplete investigation focuses on the worker's actions and therefore the corrective action centres on the worker. The more thorough investigation delved deeper into what conditions were present that led the worker to make the decisions she did and therefore the subsequent corrective actions address these conditions.

Cause(s)	Corrective action(s)
Incomplete investigation	
The worker approached the resident too quickly to help him disrobe for the bath.	Provide more training on identifying reactive behaviours.
Thorough investigation	
This resident was admitted to the facility three weeks previously. During previous bathing, the resident was agitated but could be calmed when staff covered him with a towel in the bath. Although the care workers who had previously bathed the resident wrote in the log book that the resident was agitated during the bath, they did not note that covering him with a towel reduced his anxiety. In subsequent discussions with the family it was learned that the resident was a very modest man, who used to shower in the evening, after everyone else had gone to bed.	The resident's care plan was updated with changes to his bathing plan. He will be showered after dinner. Staff will assist him to the shower and will support him to bathe himself as much as possible.
	Provide a male care worker for bathing routines with this resident whenever possible.
	Re-evaluate these changes in the bathing plan in one week's time to verify that the changes are working.
	All workers will receive further instruction on documenting changes in the abilities and behaviours of residents. Care workers should also report changes to their nurse supervisors. Any change recorded on an ADL or reported to a nurse supervisor will indicate that a reassessment is required.
Although workers are instructed to report behaviour changes, many workers feel that the bathing schedule is so rigid that there is no room to alter the schedule, and that resistive behaviour is a normal part of the bathing process.	Evaluate educational needs of workers on violence prevention.
	Assess how communication is gathered and shared on the unit.
	Assess bathing routines for other residents.

Case example: Slip and fall

A food services worker was walking past the entrance to the bathing/tub room. The worker slipped and fell, suffering a contusion to the elbow.

An investigation seeks to find the cause of an incident by asking a series of questions. Here are some examples of questions that can be asked when investigating a slip and fall incident. If the answer to any of the questions below is "No," the next question should be "Why." The question of "Why" may have to be asked a few times to find the true cause of the issue.

Job

- Is water outside the bathing/tub room a new issue? If so, what has changed?
- Did the water originate from the tub room, or did it come from somewhere else?
- Is the water a result of a leak?
- Is the bathing process designed to minimize the amount of water tracked out of the room?
- How quickly are reported spills cleaned up?
- Is there a mop or squeegee in the tub room that allows water to be cleaned up immediately?
- Is signage or barriers available to block off the spill until it is cleaned up?

Organization

- Have similar incidents resulted in corrective action?
- Do workplace inspections include slip and fall hazards?
- Does facility maintenance focus on spills?
- Were procedures for reporting spills followed?
- Had the water been reported before the worker slipped? If so, were people warned about it (e.g., was signage or barriers put in place?)
- Are temporary steps taken to make areas safer until more permanent solutions can be implemented?

Individual

- Was the worker aware that there is a higher risk of slipping by the tub room?
- Was the worker rushed or distracted while moving through this area?
- Was the worker wearing appropriate footwear with non-slip soles?

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Conclusions

The following provides two possible outcomes from an incident investigation. The incomplete investigation focuses on the worker's actions and therefore the corrective action centres on the worker. The more thorough investigation delved deeper into what conditions were present when the worker slipped and therefore the subsequent corrective actions address these conditions.

Cause(s)	Corrective action(s)
Incomplete investigation	
The worker wasn't paying attention while walking in the corridor.	Ask the worker to pay more attention while walking. Ask other workers to be more careful as well.
Thorough investigation	
Some of the water that accumulated outside the tub room came from a slow leak from a pipe connection at the back of the tub.	Ask maintenance to fix the leaking pipe.
	Change the bathing procedure to minimize the amount of water that is tracked out into the halls.
	At the end of the bathing procedure, add a visual inspection and mop-up where water leaves the room.
Some water was tracked out while moving residents from the tub room.	Warn staff to watch for slip hazards near the tub room, and to mark and report slip hazards as soon as possible (or fix them, where possible).
	Update inspection checklists to include assessment of slip hazards.
	Assess how communication is gathered and shared on the unit.
	Assess bathing routines for other residents.

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WorkSafeBC Prevention Line

If you wish to discuss an issue with a WorkSafeBC officer, call the Prevention Information Line at 1 888 621-SAFE (7233).

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