The Art of Investigation

Cynthia McDaniel MSN RN
Elderwise & NurseLearn

Learning Objectives

- **Differentiate between facts, observations, assumptions, and opinions when investigating**
- **Apply the STOP-LOOK-ASK-CONNECT framework to develop structured investigative thinking and systematic incident analysis in daily practice**
- **Define root cause analysis and describe its purpose**
- **Analyze incident information to determine root causes and contributing factors**
- **Document investigation findings clearly to support compliance and prevention**

How confident do you feel about your current investigation skills?

- Very Confident
- Somewhat Confident
- Not Very Confident
- Need Significant Improvement

Choose the option that best reflects where you are today

Investigation as an Art Form

- **A casual museum visitor glances at a painting and sees only the surface subject matter**
- **A trained art investigator examines texture, paint layers, cracks, and historical context to understand the complete story**
- **Similarly, anyone can document that a resident fell, but skilled investigators explore circumstances and contributing factors**
- **This deeper observation identifies risks not immediately obvious and enables intervention before harm escalates**

Why Investigation Matters

Every investigation is an opportunity to protect, learn, improve, and lead

Resident Protection

Safeguards vulnerable individuals and promotes resident safety

Staff Support

Creates fairness, consistency, and clear expectations

Regulatory Protection

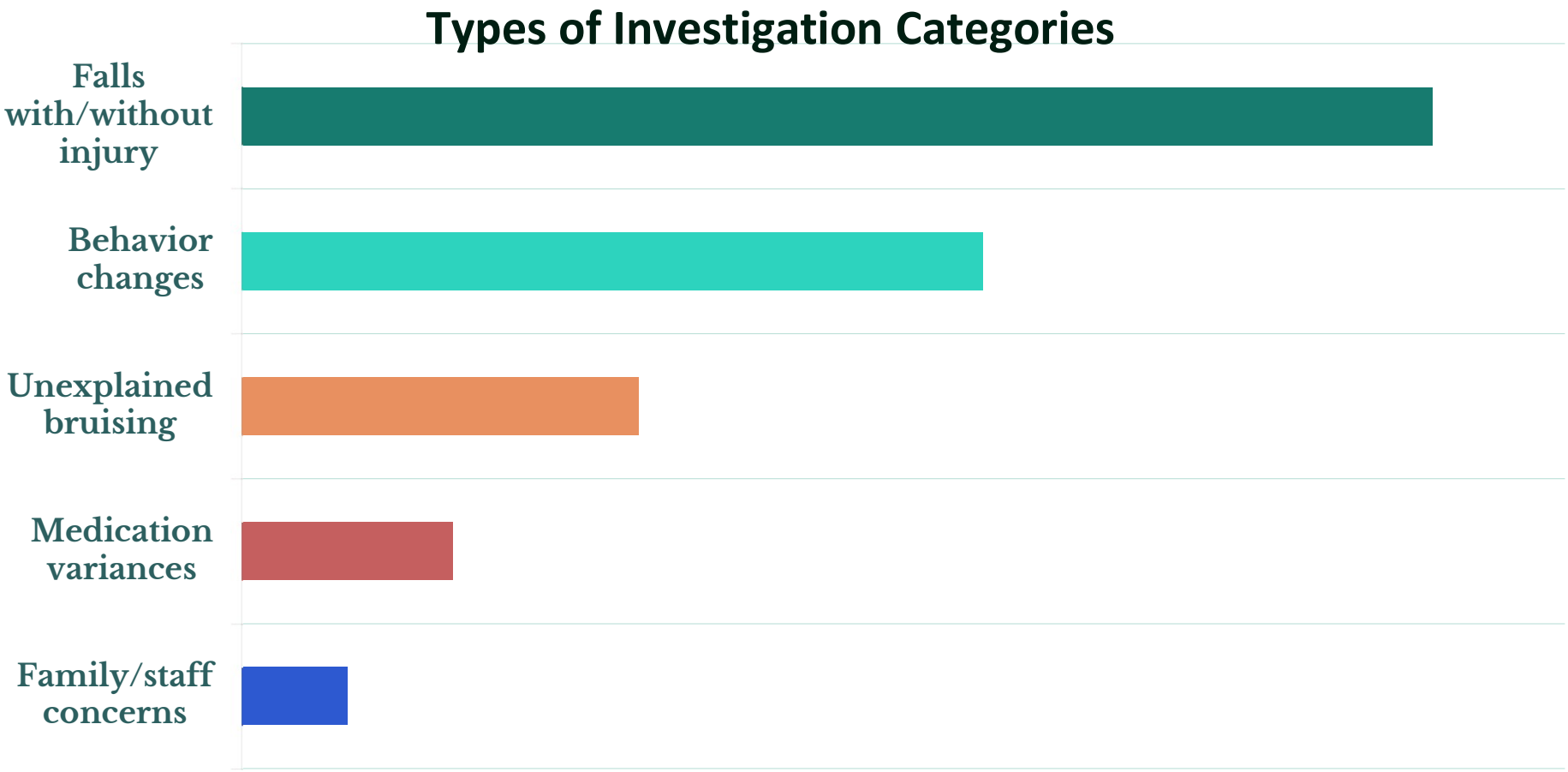
Demonstrates professional judgment and accountability

Organizational Strength

Identifies systemic risks and prevents repeat incidents

Great investigations accomplish four goals simultaneously

🔍 Reveal hidden risks ⚖️ Ensure compliance 🎯 Improve care quality 🧠 Strengthen critical thinking


Types of Investigation Categories
Falls with/without injury
Behavior changes
Unexplained bruising
Medication variances
Family/staff concerns

Red Flags to Notice

Repeat Incidents

Same resident experiencing multiple similar events within short timeframe, suggesting unaddressed underlying cause or inadequate intervention effectiveness

Vague Documentation

Incident reports consistently lack specific details, times, witnesses, or circumstances, indicating documentation quality issues or investigation avoidance

Pattern Across Residents

Multiple residents experiencing similar incidents, pointing to environmental hazards, staffing issues, or systemic care delivery problems requiring immediate attention

The Investigative Mindset

Think Like an Investigator, Not a Reporter

STOP

Pause before reaching conclusions

LOOK

Observe evidence, context, and details

ASK

Gather perspectives through neutral questions

CONNECT

Identify patterns, causes, and contributing factors

Great investigators slow down, stay curious, and follow the evidence before drawing conclusions.

SLAC: Think Slack Tide

When the water becomes still,
you can see beneath the surface.

WHAT IS SLACK TIDE?

Slack tide is the brief period between high and low tide when the water is calm and the currents pause—allowing us to see what's below.

THE SLAC METHOD

STOP

Pause before drawing conclusions.

LOOK

Observe what is actually there.

ASK

Gather perspectives and evidence.

CONNECT

Identify patterns and contributing factors.

When you slow the current of assumptions, you can see what lies beneath the surface.

STOP Pause Interpretation

Ask these four questions

What do I know for certain?	What am I assuming?	What information is missing?	What evidence do I still need?

Avoid Common Conclusions

- ❌ The resident was confused.
- ❌ It was just an accident.
- ❌ Staff did everything correctly.

The quickest conclusion is rarely the most accurate conclusion.

Pause. Investigate. Follow the evidence.

LOOK Observe the Details

Environment
Lighting
Floor conditions
Hazards
Equipment placement

Resident
Position
Injuries
Footwear
Physical condition

Situation
Time of day
Staffing
Activities
Witnesses

Documentation
Facts only
Measurements
Time stamps
Exact observations

The quality of your observations determines the quality of your investigation.

ASK - Gather Perspectives

1

ASK the resident directly about what happened using their own words, even if cognitive impairment is present—they may provide valuable details

2

INTERVIEW staff members separately using open questions like "What did you observe?" rather than "Why didn't you prevent this?"

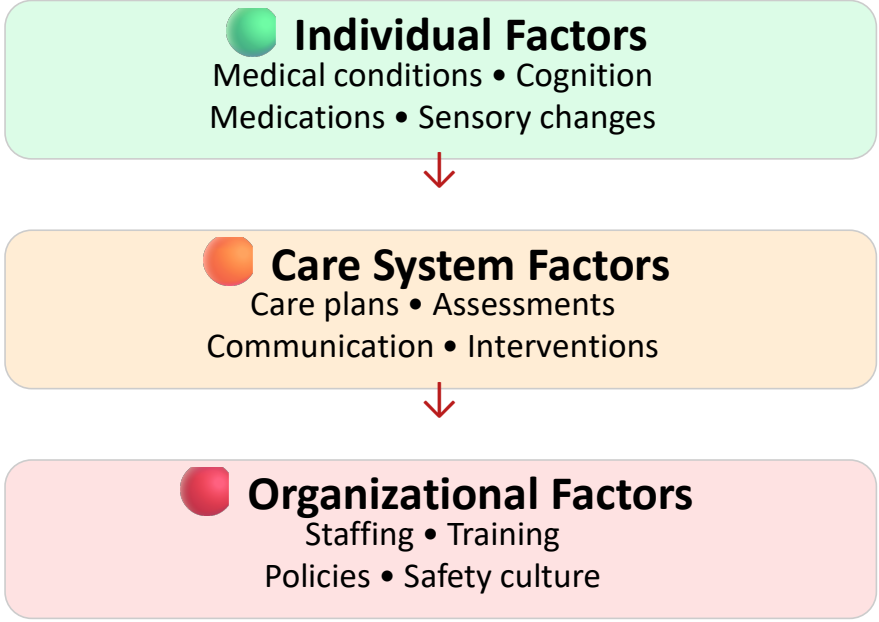
3

GATHER family insights about recent changes in behavior, function, mood, or routines that staff may not have noticed yet

4

REVIEW medical records for recent medication changes, new diagnoses, lab results, or care plan modifications that could contribute to incident

CONNECT Identify the Layers



- **Every incident involves multiple contributing layers**
- **Patterns reveal individual versus systemic issues**
- **Root-cause analysis helps prevent recurrence**
- **Document findings across all layers**

Strong investigations look beyond the event to uncover contributing factors and prevent recurrence.

Document What You See vs. What You Think

✅ FACTS: Observable Evidence

WHAT YOU SEE

Resident found on floor at 2:15 PM near Room 204. Bruising observed on left hip.

Specific • Measurable • Objective

⚠️ OPINIONS: Interpretations

WHAT YOU THINK

Resident fell because they were confused and wandering unsupervised.

Assumptions • Conclusions • Inference

Document observations first
Draw conclusions only after the investigation is complete

📋 Document Four Things Clearly

Every investigation record should answer four questions.

What Happened?

Time • Location
People Involved
Sequence of Events

What You Found?

Objective Findings
Environment
Witness Statements

What You Did?

Assessments
Notifications
Interventions

What's Next?

Monitoring Plan
Care Plan Updates
Reassessment

Clear documentation creates a complete, defensible investigation record.

Key Understandings

🛑 STOP

Pause before drawing conclusions.

👀 LOOK

Gather objective evidence and context.

❓ ASK

Seek multiple perspectives.

🔗 CONNECT

Identify patterns and root causes.

Remember

- Investigation is a quality and safety tool, not a blame process
- Document what you observe, not what you assume
- Every incident deserves review
- Strong investigations improve safety, quality, and compliance

It’s a Puzzle

- Imagine dumping a puzzle out on the table.
- You don’t see the whole picture yet
- Some pieces are flipped over
- Others don’t seem to fit at first
- If you rush, you might try to force pieces together or assume you know what the picture looks like.

Incident = The Finished Puzzle (But Broken Apart)

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- Fall
- Altercation
- Medication error
- You are handed pieces of what happened—but not the full picture.

Facts = Individual Puzzle Pieces

- Staff statements
- Resident condition
- Timeline
- Environment

👉 Each piece matters, but **none tell the full story alone**

Root Cause Analysis

Analysis = Assembling the Pieces

A skilled investigator

- Looks for patterns
- Groups related pieces together
- Doesn't force conclusions
- Keeps working until the picture makes sense

Cause = Seeing the Full Picture

At some point, the image becomes clear:

👉 *That's the moment you identify the root cause*

Not because someone guessed—but because

- The pieces fit logically
- The story makes sense
- The conclusion is supported by evidence

Common Investigation Mistakes

- Stopping at first explanation
- Writing opinions instead of facts
- No follow-up actions
- “Staff retrained” as the only solution
- Failure to connect findings to prevention

Documentation Expectations

A strong investigation includes

- ✅ Objective facts
- ✅ Timeline of events
- ✅ Who was involved
- ✅ What staff did at the time
- ✅ Analysis (why it happened)
- ✅ Conclusion
- ✅ Corrective actions

Key message:

👉 If it’s not documented, it didn’t happen

Resident to Resident Altercation with Injury

Situation

Two residents in a **memory care unit** are involved in a physical altercation in the late afternoon.

- Resident A has a **known history of agitation and territorial behavior**
- Resident B is **newly admitted** and has moderate cognitive impairment
- Incident occurs in a **shared hallway space near their rooms**
- Staff were assisting another resident at the time
- Resident B sustains a **skin tear and bruising to the forearm**

Incident report and progress note states

- “Residents had an altercation. Staff separated them. Family notified.”

Objective Facts (What Should Have Been Documented)

Exact time and location of incident

Sequence of events (who approached whom, what occurred)

Staff response and timing

Description of injury (size, location, treatment)

Names of involved residents and witnesses

Notifications made (family, RN, administrator, etc.)

👉 **Teaching point:** The original documentation is insufficient—no detail, no analysis

Contributing Factors (What Led to the Event)

- Known behavioral history of Resident A
- New admission (Resident B) without adjustment period
- Lack of supervision in high-risk time (late afternoon = common escalation period)
- Environmental setup (shared space, possible territorial reaction)
- No documented behavior plan or interventions

Root Cause

❌ **Weak Conclusion**

- “Residents got into a fight”

✅ **Strong Root Cause**

- Failure to assess and proactively manage known aggressive behaviors and environmental causes during a high-risk time of day

👉 **Key Learning Point**

This is a **system failure**, not just a resident behavior problem

Corrective Actions

Common Weak Actions
"Staff reminded to monitor residents"
"Incident reviewed with staff"

✅ Strong, Defensible Actions

- **Care Planning**
  - Develop individualized behavior support plan for Resident A
  - Add transition support plan for new admissions
- **Environment**
  - Adjust room assignments or shared space use
  - Modify high-traffic area supervision
- **Staffing / Monitoring**
  - Increase staff presence during late afternoon (high-risk period)
  - Assign consistent staff for residents with behavioral needs
- **Process Improvement**
  - Implement admission risk assessment for behavioral compatibility
  - Add daily behavior tracking for high-risk residents

Questions

- Did you **identify known risks**?
- Did you **implement preventive interventions**?
- Did the investigation show **clear reasoning and analysis**?
- Did corrective actions **address the root cause—not just the event**?

Example - Strong Documentation

Situation

At approximately 1630, Resident A approached Resident B in the hallway outside their rooms. Resident A initiated physical contact, resulting in Resident B sustaining a 2 cm skin tear to the right forearm. Staff responded within 1 minute and separated both residents. First aid was provided and RN notified.

Analysis

Resident A has documented history of agitation and territorial behavior. Incident occurred during late afternoon, a known escalation period. Resident B is newly admitted with no transition support plan. No behavior plan or environmental interventions were in place.

Root Cause

Failure to proactively identify and manage behavioral risks and environmental triggers for a resident with known aggression

Corrective Actions

Behavior support plan initiated; staffing adjusted during high-risk periods; admission assessment process updated to include behavioral compatibility review; weekly monitoring implemented

Key Learning

“Resident behavior is predictable. When it leads to injury, the investigation must ask—not just what happened—but what was and was not done to prevent it.”

Before closing an investigation, ask…

✅ **Does this tell the full story?**
✅ **Can an investigator or surveyor follow my thinking?**
✅ **Did I clearly identify the root cause?**
✅ **Will my corrective action prevent recurrence?**
✅ **Did I show evidence of follow-through?**

“Surveyors and investigators don’t just read your investigation—they follow your logic. If they cannot see how you got from the incident to root cause to interventions and prevention, the investigation is incomplete.”

Common Mistake (What leads to poor investigations)

Trying to solve the puzzle too quickly

- Picking one piece and assuming it is the answer
- Ignoring pieces that do not fit
- Stopping before the full picture emerges

👉 This is how you get incomplete or incorrect conclusions

Correct Approach (What surveyors and investigators expect)

- Gather all the pieces
- Stay objective
- Let the evidence guide the conclusion
- Ensure the final picture is clear and complete

Corrective Actions – Fixing the Puzzle Setup

Once you see the full picture, you don't just admire it—you ask…

👉 ***Why did the pieces come apart in the first place?***

Then you

- **Fix the process**
- **Adjust the environment**
- **Improve the system**

So, the puzzle doesn't break apart again

“A good investigation doesn’t guess the picture—it carefully puts the pieces together until the whole story makes sense.”

STOP – LOOK – ASK - CONNECT

THANK YOU!

Cynthia McDaniel MSN RN

cmcdaniel@elderwiseinc.com

541.419.4036