



Purpose:

The purpose of this process is to confirm the facts of the occurrence, to preserve the event accurately and completely, to identify opportunities and to have a standardized process for root cause analysis, communication, and plan for correction.

Instructions:

Immediately after the event, utilize the checklist to gather all pertinent information related to the occurrence. The checklist will help guide you through the appropriate questions to evaluate the event.

Interpreting the checklist information:

1. Understanding where the resident was found allows you to evaluate if the resident was in the correct location and determine if acceptable supervision was in place
2. Evaluating the time the resident was found will gauge if identification and assessment were timely.
3. The evaluation of resident information and documentation should confirm the implementation of the process for identifying code, and that the code status was executed appropriately. Other aspects allow you to evaluate if your systems and processes were in place.
4. Evaluating the competency of staff is important when identifying opportunities. Verify that the correct skills were used, and that staff were competent with these skills during the event (e.g., assessment of choking, Heimlich and or CPR.)
5. The questions in the checklist will cue you to gather the facts of the event and all post-occurrence actions.
6. Communication with other health care providers and the resident's family or representative if a critical aspect of event management. Documentation of the time, content of the communication and names of individuals involved in each communication should be included in the incident documentation. Also, the checklist should provide you with key facts that may be needed when engaging in such communications.
7. Factual, accurate, complete, and contemporaneous documentation of events, observations and communications provides a clear picture of the event and supports the identification of additional or alternative interventions, care and/or support to minimize the potential for a subsequent event or to minimize the potential for an injury.
8. Once you have completed the checklist and assessment of the event, use the QAPI Plan of correction to help address the identified opportunities.

Post-Incident CPR Investigation Checklist

Resident Name: _____

Date: _____

What time was the resident found unresponsive?	
Was an assessment conducted and documented including vital signs or lack thereof?	
Was the assessment completed accurately along with timeline?	
When was the last time the resident observed/assessed?	
Was the code status checked?	
By whom was the code status checked?	
How long did it take to check code status?	
Was the DNR or full code status complied with?	
Was CPR started timely?	
Was the staff performing CPR have an up-to-date CPR card on file?	
Was the resident sent to the hospital? If so, what tests were performed and what were the results?	
Was MD notified of the occurrence?	
If CPR was not started why? <input type="checkbox"/> Does documentation accurately reflect irreversible signs of death? <input type="checkbox"/> What is your state regulation on presumed death? <input type="checkbox"/> Does the investigation and documentation support that?	
Was the family/guardian notified of the occurrence?	
Identify the facility staff who made the notification and who was notified?	
What was the family/guardian's response?	
Did the family/guardian request a meeting, incident report or records of the occurrence?	
Witness statements are often helpful.	
Review care plan and progress notes to ensure no unidentified change in condition in past 72 hours.	