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Serious Incident Review and Root Cause Analysis TEMPLATE

This is an example and not a real person.

Individual's Name and I.D. Number: Victor XXXX ID Number *******	Date of Incident: 4/10/2023 Date of Discovery of Incident: 4/10/2023 **Incident Report #:** GHIJK1002 Review Completed Date: 4/18/2023 **Review Completed By:** Bertha Zee, LPN
Individual's DOB: 2/4/2002	**Program:** West Side Day Support Services
Location of Incident Health Office / Activity Room	**Type of Incident:** Level II serious incident
Service Received at Time of Incident: Day Support Services	**Sources of Information:** ☒Record Review ☐Policy Review ☒Interview with Individual ☒Interview with Staff ☐ Human Rights Investigation ☐Other: Click or tap here to enter text.
Is this the first incident of this kind? ☒Yes ☐ No, when did this occur before?	**Is this addressed in the ISP?** ☒Yes ☐No ☐Not applicable

Detailed description of what happened *(Provider may copy information included within the Injury/Incident Description/Circumstances field of CHRIS or include a step-by-step detailed account of the incident)*:

At 11:30am Victor's Blood Sugar was 78. Aspart Insulin 5 Units was administered. Victor went to the dining room, said he was not hungry and went to the activity room. 11:45 DSP approached Victor to offer a craft project. Victor began sweating, had slurred speech, muscle twitching and the onset of a seizure. DSP directed 2nd staff to call 911 and get the nurse. Seizure lasted 3 minutes. 12:15 pm EMS checked Victor's BS (18); glucose was administered and Victor had a repeat seizure. EMS transferred Victor to the Emergency Room. **Protocol: Blood Sugar Check prior to each meal and at bedtime.**

NEW Order unavailable to Day Support Staff:
Short Acting Insulin Aspart (NOVOLOG Flex Pen) 100 Units /ml pen **Inject 3 Units sc before each meal**
Hold if BS less than 70

PREVIOUS (OLD) Order which the day support had in Victor's record record:
Long Acting Insulin Glorgina (Lantus Solostar) 100 units/ml pen Inject 10 Units daily at 0700
Short Acting Insulin Aspart (NOVOLOG Flex Pen) 100 Units /ml pen **Inject 5 Units sc before each meal**
Hold if BS less than 70

***Disclaimer**: This template was completed in accordance with 12VAC35-105-160. In order to ensure completion within the 30-day regulatory timeframe, the most available information/resources were utilized to complete this review.*

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Victor is semi-independent with oral medication and requires total assistance with his insulin injections.

Analysis of Incident *(Analysis of trends and potential systemic issues or causes; analysis of why incident happened; identification of all underlying causes of the incident that were in the control of the provider)*:

Quality Improvement Tool used during review: ☒5 Whys ☐Fishbone ☐ FMEA ☐Other: Click or tap here to enter text.
(While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis)

Why did Victor have a seizure?

- He had a seizure because he had low blood sugar.

Why did Victor have low blood sugar?

- He was given too much insulin.

Why was he given too much insulin?

- His insulin order was recently changed, and Residential Provider did not provide the current order to Day Support.

Why didn't the Residential Provider provide the current order?

- The order was changed late on Friday and Residential Provider stated that they intended to fax it and had not gotten to it on Monday morning**.**

Why didn't the Residential provider fax the order Monday morning?

- There was a DSP who called in sick Monday morning, so the supervisor had to fill in and in all the shuffle, the supervisor forgot about the need to fax the order.

Why did the supervisor have to fill in for the DSP?

- Because there were no other staff members who could fill in; the residential provider is short staffed.

Statement of Cause(s)

His protocol for management of diabetes was not followed by the Day Support because the Residential Provider had not faxed the new order, due to a change in the Residential supervisor's duties and staffing shortages.

Recommendations/Action Plan *(Solutions to mitigate the potential for future incidents)***:**

☐There are no recommendations at this time. There were no underlying causes under the provider's control.

☐Recommendation(s)/Technical Assistance: Click or tap here to enter text.

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☒Action Plan:

1. Establish a procedure for timely updates for physicians'
2. Orders between Residential and Day Support Program.
3. Train all support staff regarding diabetes and Victor's protocol for diabetes management**.**

Due Date: 5/15/2023

Enhanced Root Cause Analysis Determination:

Based on this incident, was a threshold met as outlined in the Root Cause Analysis policy?

☐ Yes
☒ No

If "yes," the threshold criteria met is:

☐ Click or tap here to enter text. similar Level II serious incidents occur to the same individual or at the same location within a six-month period.
☐ 2 or more of the same Level III incidents occur to the same individual or at the same location within a six-month period.
☐ Click or tap here to enter text. similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period.
☐ A death that occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.

Analysis included:

☐Convening a team
☐Collecting and analyzing data
☐Mapping processes
☐Charting causal factor
☐Other: Click or tap here to enter text.

Sacia Peters	Quality Manager	4/18/2023
Completed by:	Title/Position:	**Date:**

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