Office of Licensing

Serious Incident Review and Root Cause Analysis TEMPLATE

This is an example and not a real person.

Individual's Name and I.D. Number: Billy XXXXX. ID ########	Date of Incident: 11/4/2022
	Date of Discovery of Incident: 11/4/2022
	Incident Report #: 999999999
	Review Completed Date: 11/11/2022
	Review Completed By: Ama Zing, Quality Manager
Individual's DOB: 1/1/1980	Program: Group Home
Location of Incident: Riding in the van to work.	Type of Incident: Level II serious incident
Service Received at Time of Incident: Transportation to employment.	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? Click or tap to enter a date.	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)*:

Billy was riding in the van to work with three other individuals, including Individual #1. Billy was sitting in the back seat with Individual #1. Individual #1 used their inhaler and set it on the seat next to them. Billy picked up the inhaler and took 2 puffs. The driver stopped, called 911 and Billy was sent for a medical evaluation.

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 Billy have access to Individual #1's inhaler?

- **Individual #1 was not aware of the safety issue and need to protect their medication and Billy was sitting next to them in the van when Individual #1 sat the inhaler down on the seat. He picked up the inhaler.**

Why did Billy pick up the inhaler?

- **Billy was sitting next to Individual #1, and he has been known to take food and other objects from others.**

Why was Billy sitting next to Individual #1?

- **This was a mistake in the seating arrangement. Billy's support plan states that he is to sit in the front seat next to the driver.**

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Office of Licensing

Why didn't the driver ensure that Billy sit in the front seat?

- **A substitute driver was providing transportation and was not aware of the seating assignments.**

Statement of Cause

- **Van drivers do not have relative written instructions nor training according to Individual Support Plans.**

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.

☒Action Plan: The action plan is to:

1. **Develop an At-A-Glance tool to provide safety instructions for van drivers as it relates to those that ride the van to work.**
2. **Collaborate with the transportation company to ensure all drivers are trained on the At-A-Glance tool and obtain an orientation to the individuals' needs.**
3. **Monitor the At-a-Glance tool to ensure it is kept current.**

Due Date: 12/31/2022

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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.

Ama Zing	Quality Manager	11/11/2022
Completed by:	**Title/Position:**	**Date:**

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