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: Sam XXXX ID Number *******	Date of Incident: 11/5/2022 Date of Discovery of Incident: 11/5/2022 Incident Report #: 12345678 Review Completed Date: 11/15/2022 Review Completed By: Mini Talents, Supervisor
Individual's DOB: 3/4/1995	Program: Acme Residential Services
Location of Incident: Group home.	Type of Incident: Level II serious incident
Service Received at Time of Incident: Residential 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? 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)*:

On 11/5/2022 at 1pm-1:20 pm, Sam had 3 back-to-back seizures. Per his seizure protocol, he required a medical evaluation. At 1:30pm he was transported to the hospital by the group home supervisor.

As staff was gathering additional paperwork for the hospital, DSP #2 observed on the MAR that some medications were not signed off. Upon review of the medication bubble packs the DSP determined that the following medications had not been administered: Depakote 500mg 1 tab scheduled for 11/4/2022 7:00 pm and Depakote 500mg 1 tab scheduled for 11/5/2022 7:00 am.

At the emergency room, blood level was low for Depakote secondary to the missed doses of Depakote and the probable cause of the seizure breakthrough.

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)

***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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Part 1.
Why was the 7:00 pm dose of Depakote missed?
On Friday 11/4/2022 @ 7:00 pm Sam was watching TV and stated that he would take it later.

Why didn't Sam take his medication later?
At shift change, the DSP did not report Sam needing assistance to take his medication within the 1-hour window (by 8:00 pm).

Why wasn't the missed dose detected earlier?
There is no procedure for medication reconciliation at the end of each shift.

PART 1 Statement of Cause(s)
• Lack of team communication.
• Medication scheduled at time of shift change.

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Part 2.
Why was the 7:00 am dose of medication missed?
On Saturday 11/5/2022 @7:00 am DSP #1 was distracted while preparing Sam's morning medication.

Why was DSP #1 distracted during 7:00am medication assistance?
A housemate requested assistance with breakfast.

Why didn't a second staff assist with breakfast?
There was 1 staff for 5 individuals.

Why was there only one staff at the time?
Two staff were scheduled. At 6:00 am, DSP #2 called to state that he was having car trouble and would be in at noon.

Why wasn't additional staff identified?
The overnight staff that took the call did not notify the supervisor, nor did day staff.

Why weren't the missed doses detected earlier?
Med Pass procedure was not followed.
Procedure for medication reconciliation at the end of each shift was not followed.

PART 2 Statement of Cause(s)
• DSP working a 1:5 ratio was overwhelmed and had difficulty with prioritizing the tasks.
• Med Pass procedure was not followed.
• Procedure for medication reconciliation at the end of each shift was not followed.

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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:

1. **All staff will review the Shift Report process.**
2. **Consult with Neurologist for changing medication schedule. (8:00 am and 8:00pm?)**

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3. **Establish a morning routine process change so that all medication be given, and then staff can assist with breakfast.**
4. **All staff will receive refresher training of Med Pass Procedure to include #1- verification of last dose given.**
5. **Develop a procedure for medication reconciliation per shift.**
6. **All staff will receive training of medication reconciliation procedure.**
7. **Quality Improvement team members will monitor implementation of procedures.**

Due Date: 12/15/2022

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.

Mini Talents	Supervisor	11/15/2022
Completed by:	**Title/Position:**	**Date:**

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