

# 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
	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: <input checked="" type="checkbox"/> Record Review <input type="checkbox"/> Policy Review <input checked="" type="checkbox"/> Interview with Individual <input checked="" type="checkbox"/> Interview with Staff <input type="checkbox"/> Human Rights Investigation <input type="checkbox"/> Other: Click or tap here to enter text.
Is this the first incident of this kind? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, when did this occur before? Click or tap to enter a date.	Is this addressed in the ISP? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Detailed description of what happened ( <i>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</i> ):  <b>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.</b>  <b>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 <u>7:00 pm</u> and Depakote 500mg 1 tab scheduled for 11/5/2022 <u>7:00 am</u>.</b>  <b>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.</b>	
Analysis of Incident ( <i>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</i> ):  Quality Improvement Tool used during review: <input checked="" type="checkbox"/> 5 Whys <input type="checkbox"/> Fishbone <input type="checkbox"/> FMEA <input type="checkbox"/> Other: Click or tap here to enter text. ( <i>While our regulations do not require use of another tool to analyze trends, providers are required to include their analysis</i> )	

**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.

## 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.

## 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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