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DEVELOPMENTAL
DISABILITIES

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supports and services
THAT FOSTER self-determination.

Reactive Strategy Review Process:

What does it mean for the team?

Operationalizing DD 4.300 Series

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Quick Review of DD 4.300

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- HCBS Compliance to ensure continuation of CMS funding
- Ensure limitations and restrictions are justified and necessary and appropriately implemented
- Ensure that there is clinical oversight and review on a consistent basis
- Define Physical intervention requirements
- Define Chemical intervention requirements
- Define Prohibitive practices
- Responsibilities for regional offices, providers, support coordinators and regional behavior support review committees for creating systems and processes

The Requirements

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1 Reactive strategy used OR history of need

Safety Crisis Plan

Reactive Strategy Threshold Reached

RST - Use of 3 or more reactive strategies in 6 months or 2 in 2 months

Planning Team Review

Reactive Strategy Threshold Reached for 2 Consecutive Quarters

Referred to RBSRC for Consultation

Reactive Strategy Threshold Reached for 3 or more Quarters in a 2 year period

Team required to consider Behavioral Services

NOTE 1 – Behavior Services can be considered any time in the process and it is recommended that consideration be given as early as possible

The Requirements

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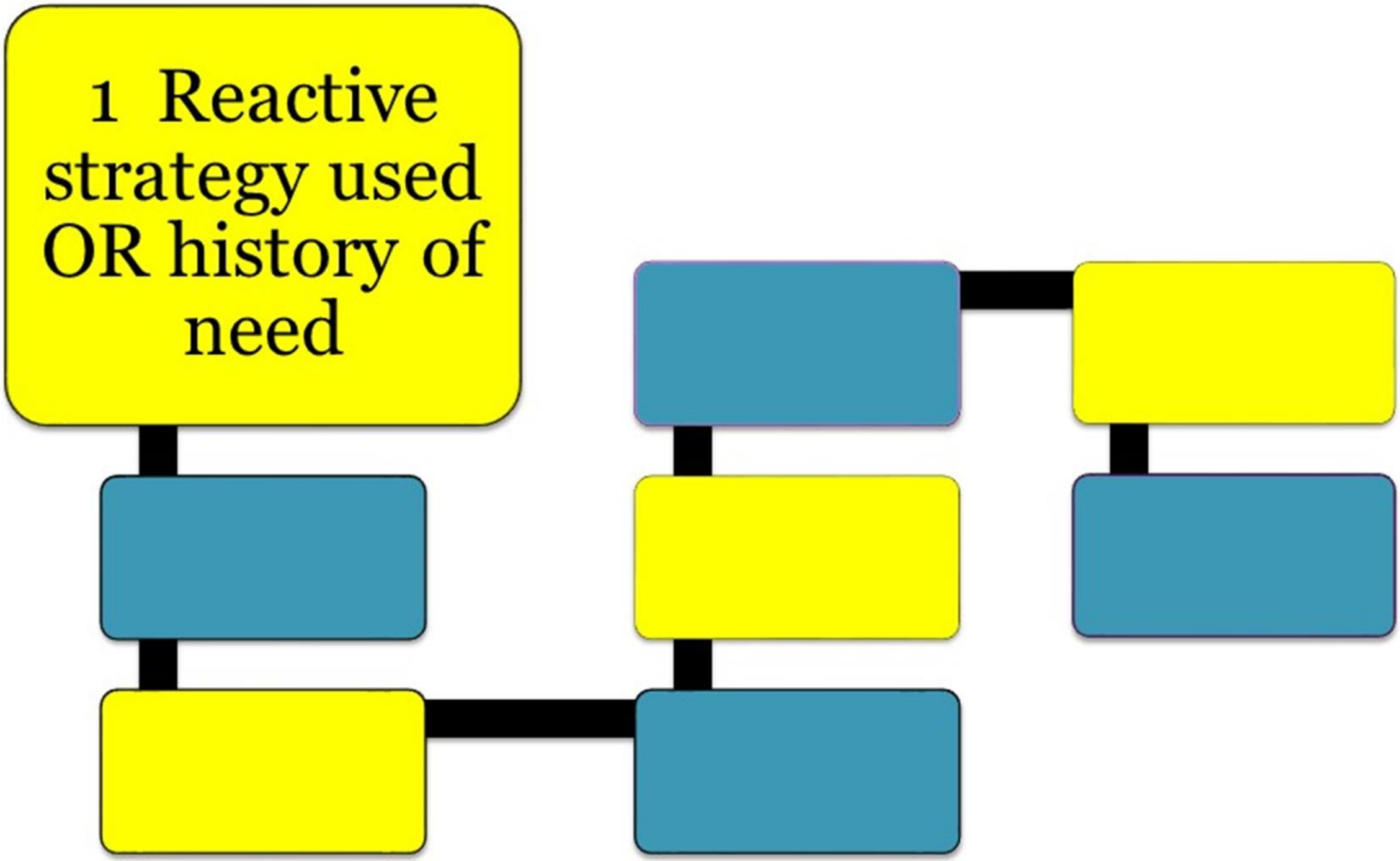
1 Reactive strategy used OR history of need



Reactive Strategy

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- Use of immediate and short term procedures
- Necessary to address dangerous situations
  - Person in harm
  - Others in harm
- Used as a first time response to an emergency situation
- Procedures include
  - Blocking
  - Physical restraints
  - Delayed responses
    - Restricting access to the community
    - Increased levels of supervision

The Requirements

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Safety Crisis Plan

Safety Crisis Plan

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- An individualized plan outlining the reactive strategies designed to most safely address dangerous behaviors at the time of their occurrence or to prevent their imminent occurrences.

"A plan so we can prevent crisis and respond appropriately if it does happen again"

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REACTIVE STRATEGY REVIEW PROCESS

Developing a System for Successful Change based on Critical Analysis of Events

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Reactive Strategy Review

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- The review is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions.
- The process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events.
- The purpose is to find out what happened, why it happened, and determine what changes need to be made.
- It can be an early step in a Performance Improvement Plan, helping to identify what needs to be changed to improve performance.
- There are a number of tools to use to perform a review

Who should be involved in the review?

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- All of the personnel involved in the event should be involved in the analysis.
  - Without all parties present, the discussion may lead to fictionalization or speculation that will dilute the facts.
  - Be aware that asking for this level of involvement may cause staff to feel hostile, defensive, or apprehensive.
  - Managers should explain that the purpose of the analysis process is to focus on the setting of the error and the systems involved.
  - Managers should also stress that the purpose of the analysis is not to assign blame.
  - The comfort level with the technique increases with use, but the analysis will always be somewhat subjective.

When should the review be done?

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- After every use of a reactive strategy
- As soon after the event occurs and the team can be convened

Where should the review occur?

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- Away from where the event occurred
- Neutral territory
- Safe environment

Suggested Steps to Review Reactive Strategy Use

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- 1. Identify the event to be investigated and gather preliminary information
  - Events and issues can come from many sources (e.g., incident report, risk management referral, resident or family complaint, health department citation).
  - The organization should have a process for selecting events that will undergo analysis – It is recommended that every event be reviewed

Suggested Steps CONTINUED

2. Develop a Team

- Select a team facilitator and team members
  - The facilitator may be appointed by leadership.
  - Team members are people with personal knowledge of the processes and systems involved in the event to be investigated.

Suggested Steps CONTINUED

- 3. Describe what happened
  - Collect and organize the facts surrounding the event to understand what happened.

Suggested Steps CONTINUED

4. Identify the contributing factors

- The situations, circumstances or conditions that increased the likelihood of the event are identified.

Suggested Steps CONTINUED

- 5. Identify the causes
  - A thorough analysis of contributing factors leads to identification of the underlying process and system issues of the event.

Suggested Steps CONTINUED

6. Design and implement changes to eliminate the root causes

- The team determines how best to change processes and systems to reduce the likelihood of another similar event

Suggested Steps CONTINUED

- 7. Measure the success of changes
  - Like all improvement projects, the success of improvement actions is evaluated.

Tools to Review

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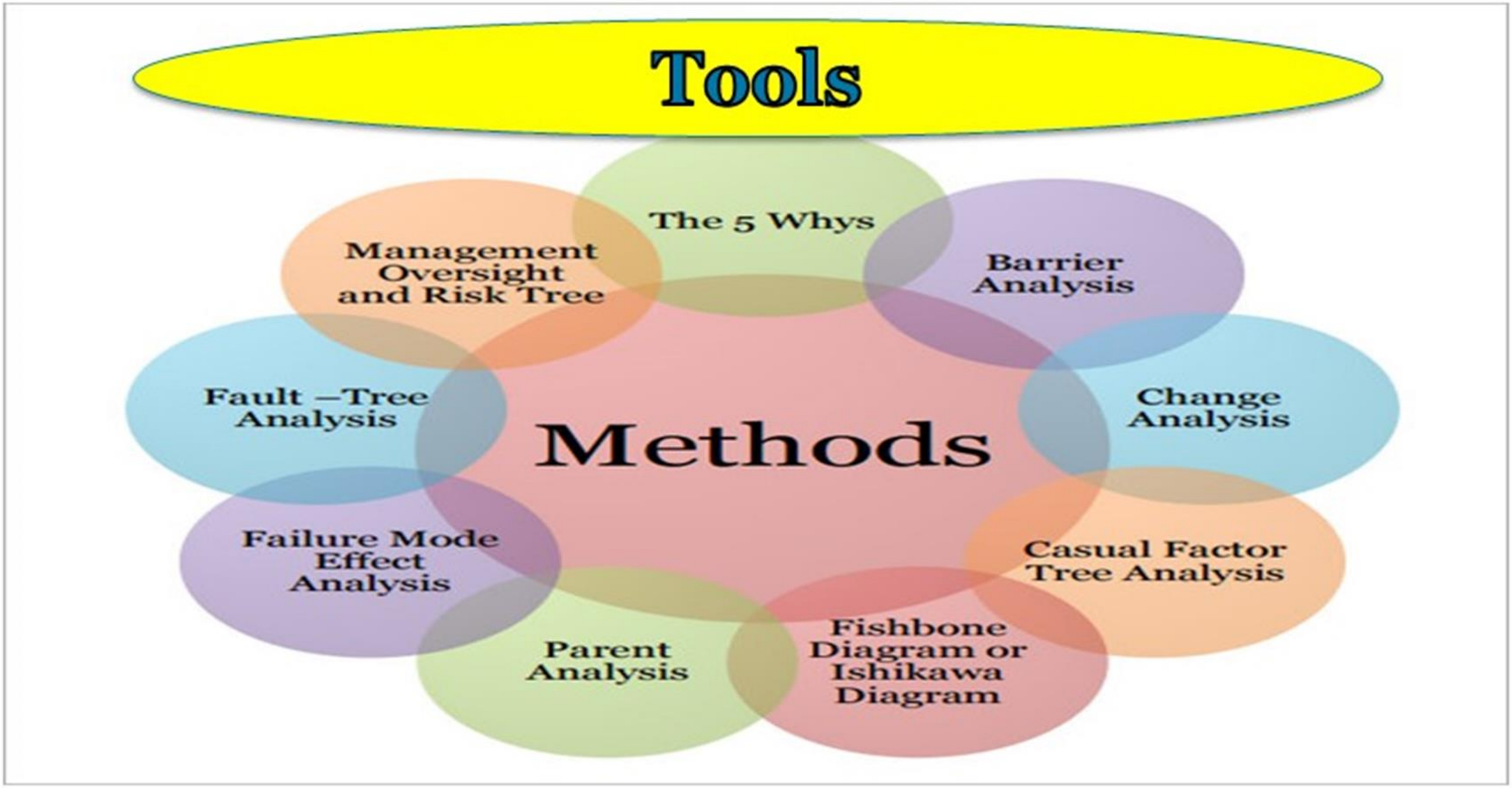

Tools to Review

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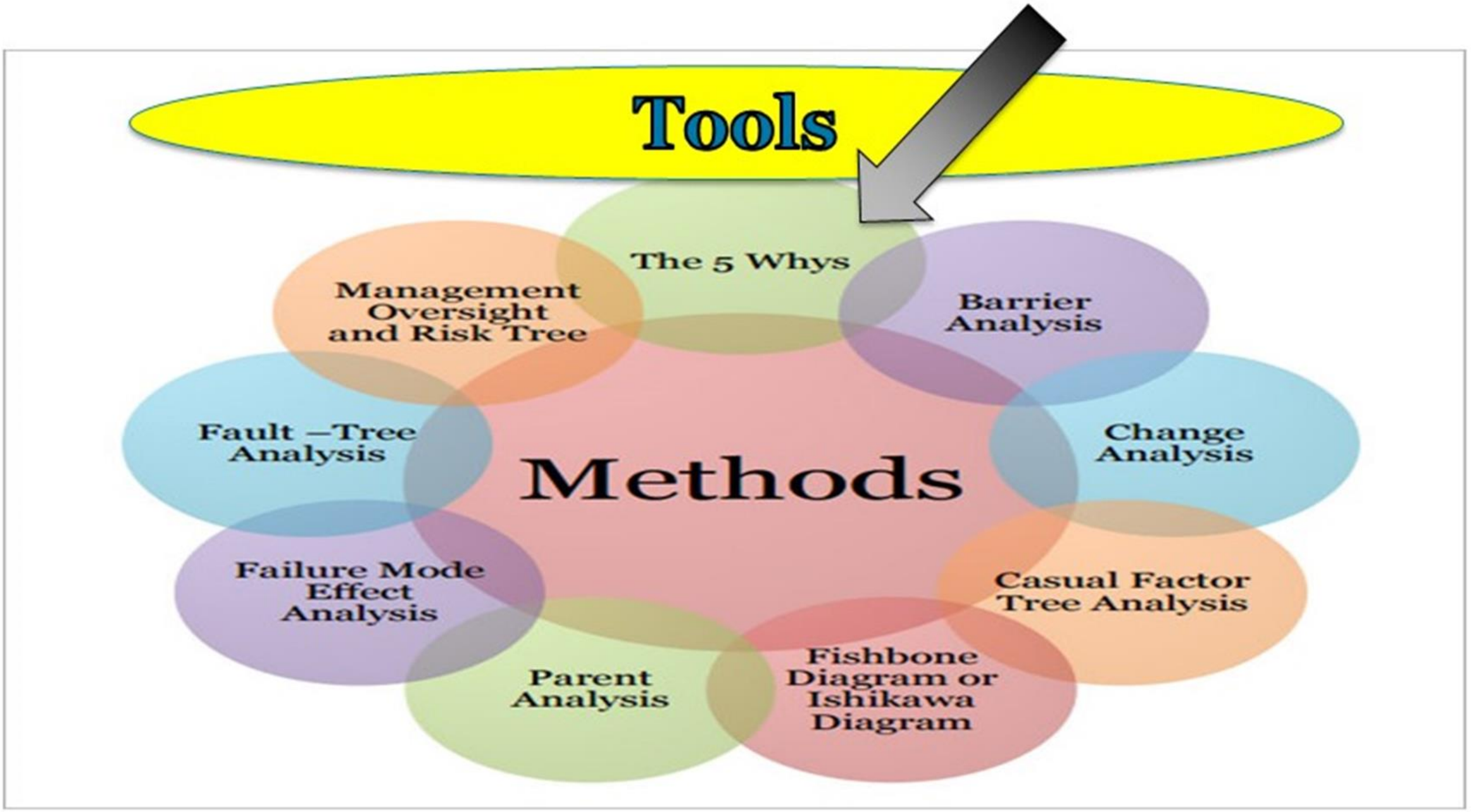

Tools to Review

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5 Why's

DEFINE THE PROBLEM:

WHY did it happen/WHAT happened?

WHY is that?

WHY is that?

WHY is that?

WHY is that?

Tools to Review CONTINUED

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- This questioning process is continued until all causes are found
- It is common to find the same cause for two or more contributing factors.

Tools to Review CONTINUED

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- Helpful Tips:
  - The team must determine if they've truly identified a cause, versus a contributing factor which requires the team to do more digging.
    - Ask the questions about each potential cause identified by the team.
      - If the answers are NO, then the team has identified the causes and they can stop the questioning process.

Tools to Review CONTINUED

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- If the answer to any question is YES, then the team may not have identified true root causes and needs to ask more "why" questions to get to the root causes. Keep asking these until you get to root causes.
- Would the event have occurred if this cause had not been present?
- Will the problem recur if this cause is corrected or eliminated?

Tools to Review CONTINUED

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- **Areas to focus questions**
  - **Communication**
  - **Training**
  - **Fatigue/Scheduling**
  - **Environment/Equipment**
  - **Rules/Policies/Procedures**
  - **Barriers**

Tools to Review CONTINUED

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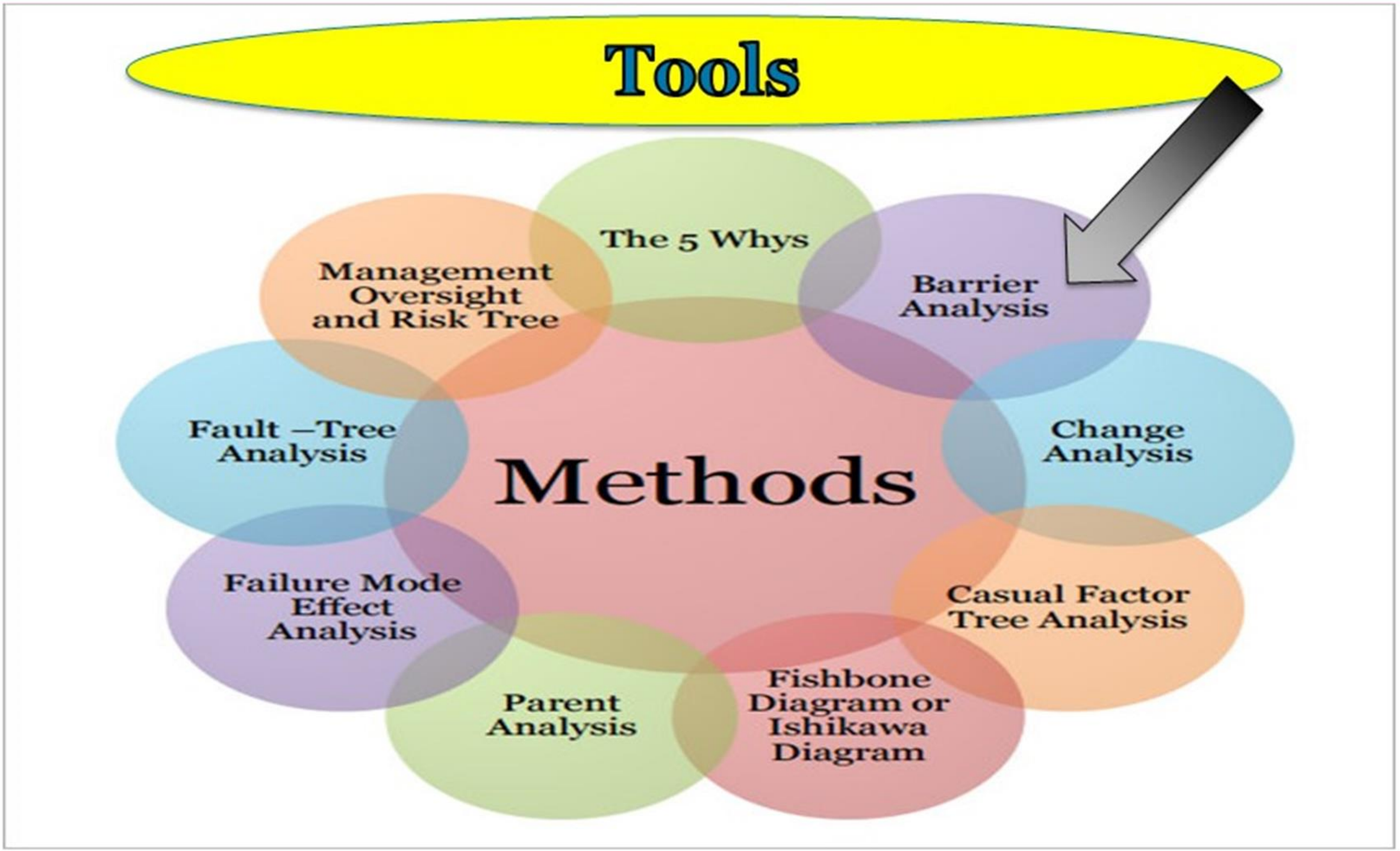
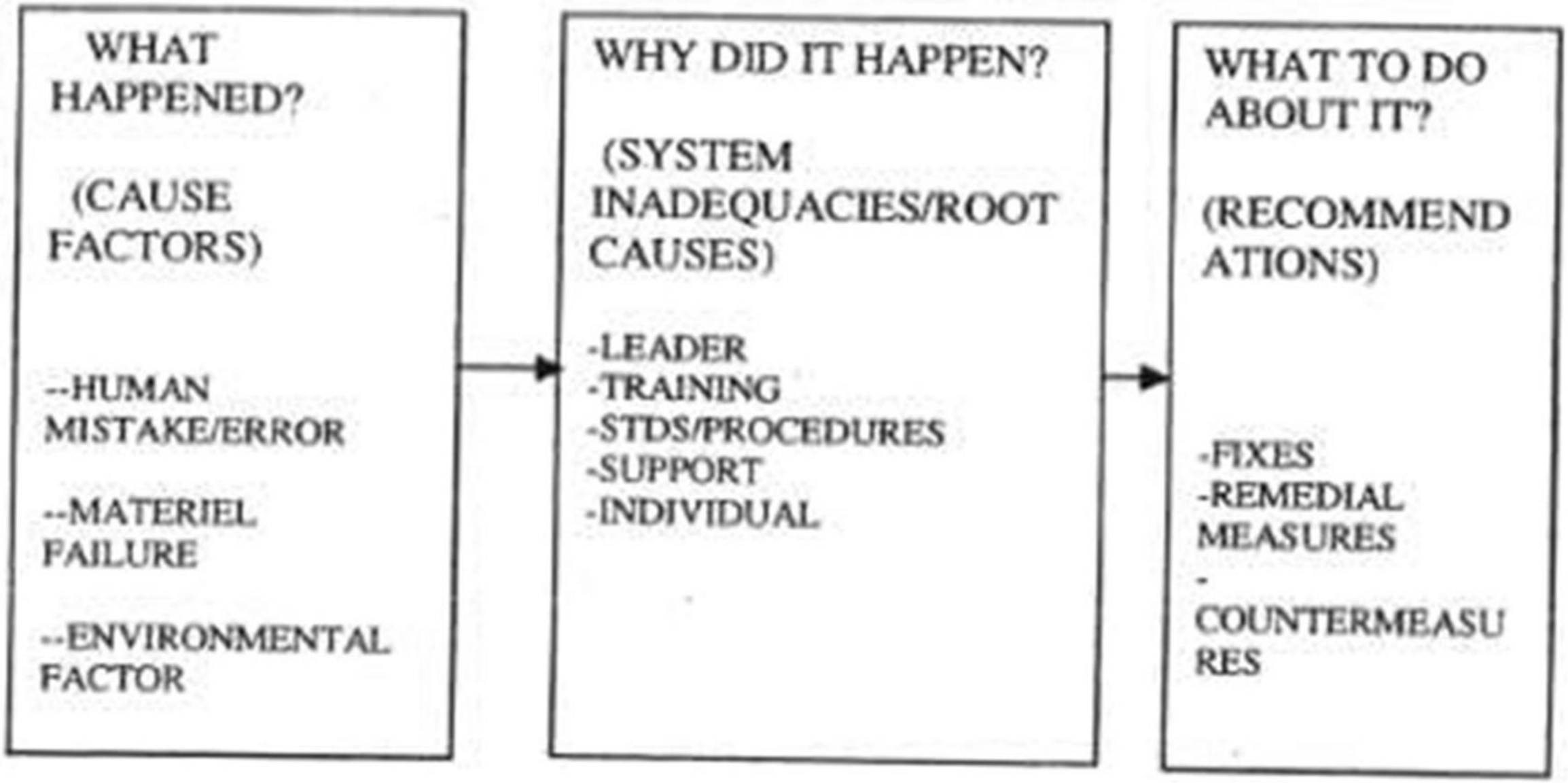
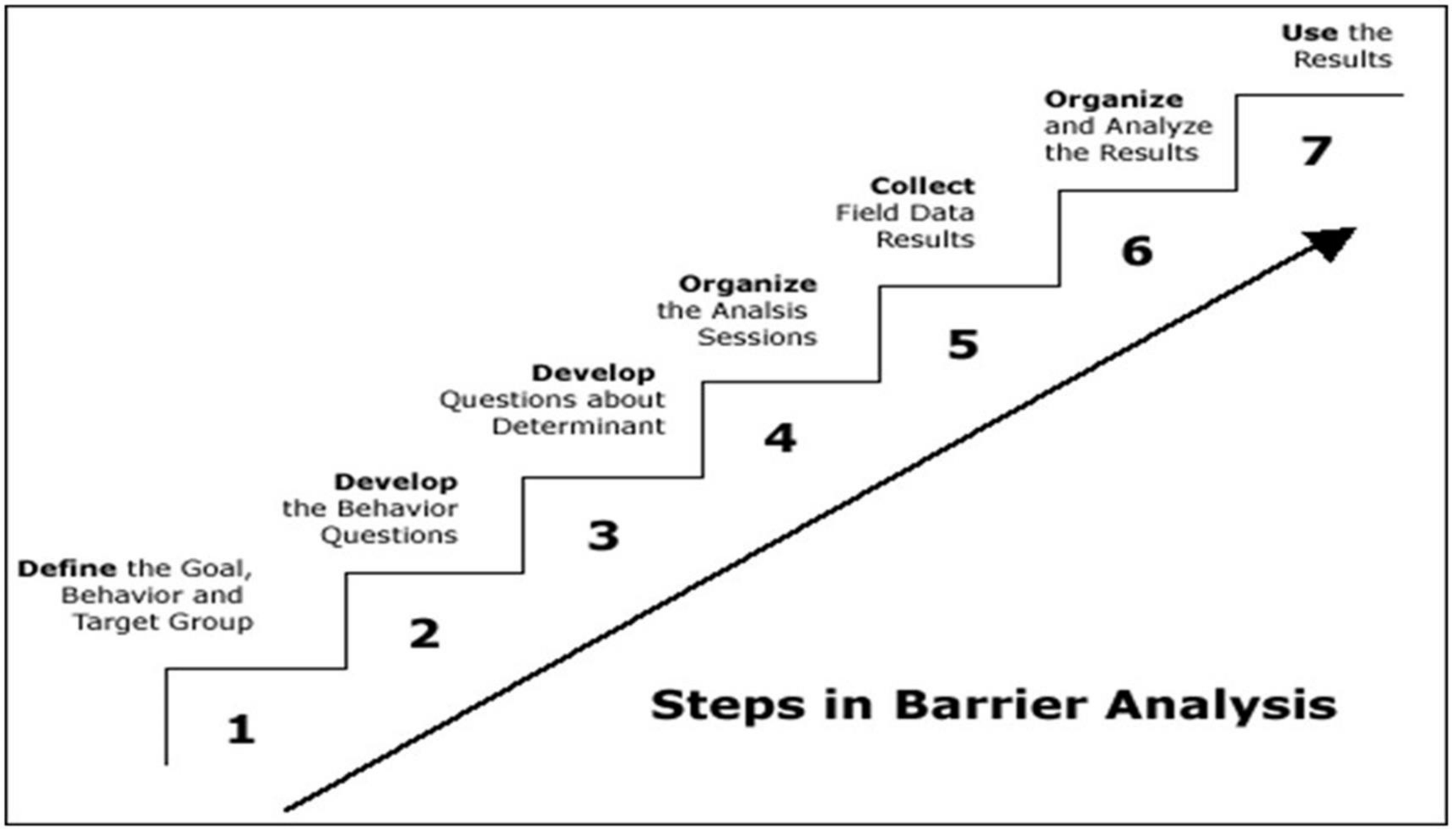


Tools to Review CONTINUED

Barrier Analysis



Tools to Review CONTINUED



Tools to Review CONTINUED

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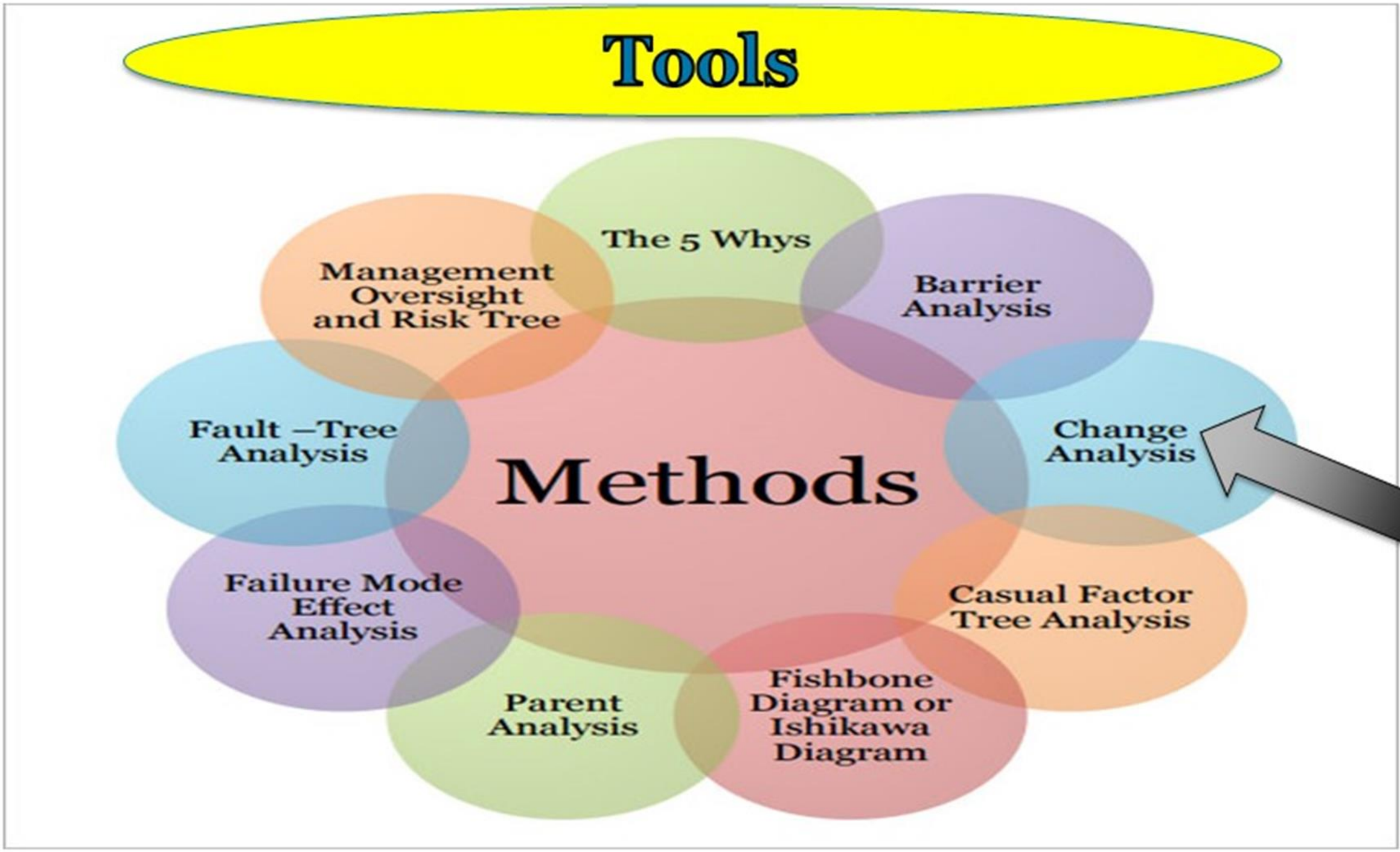

Tools to Review CONTINUED

Change Analysis Worksheet

ENABLING FORCES	RESTRAINING FORCES

www.change-management-consultant.com

	ACTION	BY WHO	BY WHEN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

	SUCCESSFUL	UNSUCCESSFUL	NO CHANGE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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Practical Application

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- Case Event Report
- Bring your own Event Report

Practical Application

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Diana was sitting on couch listening to music on you tube Diana got up and went outside with her blanket. Diana was standing next to the wall banging her head and a pillow was brought to block Diana's attempts to head bang. Diana was then placed in two man restraint. Dan was on her right arm and Penny was on her left arm. Manny Ross had Diana's right leg and Tina had left leg. Diana indicated that she was upset about hurting a staff on another shift previous day. Staff de escalation situation. Came back inside watched you tube video's at 10:20am Diana began targeting Tina, staff (Sue Ann) blocked attempt. Pillow was grabbed. Diana went in to bedroom struck Pamela in chest then began to grab bra attempted to choke herself. Diana was put in a 4 point restraint Staff (SueAnn) called team, SueAnn on right arm, Tina was on left arm Amber was on left leg, Pamela was on right leg, Dana was in back with pillow Diana was scratching Tina and SueAnn arms. Diana then stop struggling was released at 10:25am.

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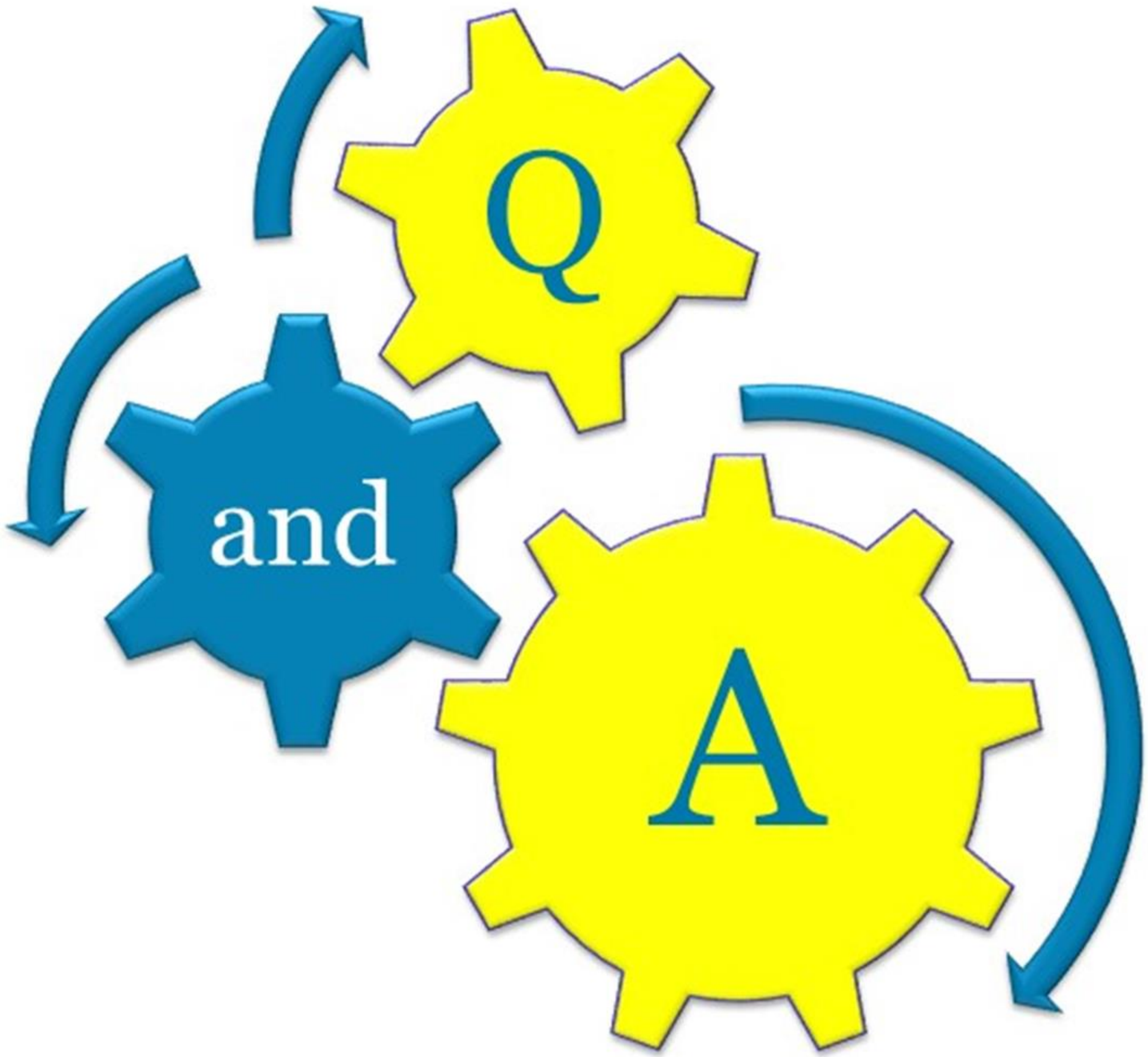

Contacts

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