Improving lives through supports and services that foster self-determination.

Reactive Strategy Review Process:
What does it mean for the team?

Revision based on Directive 4.300 Update

Operationalizing DD 4.300 Series
Objectives

Today you will learn

- A Quick Review of DD4.300
- Definitions of “Reactive Strategies” and “Safety Crisis Plan”
- Define basic review process of reactive strategies
- Provide an overview of 3 Tools that could be used by teams in developing a review process
- Define what follow-on workshops will address/how they will function
Quick Review of DD 4.300

- HCBS Compliance for the use of reactive strategies and restrictive interventions
- Responsibilities across the system
Quick Review of DD 4.300

- 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
DD 4.300 Requirements

Used 1 Reactive strategy that is restrictive OR history of need

Safety Crisis Plan

Reactive Strategy Threshold Reached for 3 Consecutive Quarters

Consider Referral to RBSRC

Planning Team Review

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
Reactive strategies, restrictive interventions and rights restrictions

- Are related, sometimes one strategy is all three, sometimes not
- Context is important and must be considered
- Restrictive Interventions is a CMS term and definition
Classifying Strategies: Reactive Strategies

- Is it used in response to an undesirable behavior?
- Is the aim of the strategy to bring about an immediate change in the environment, situation or behavior?
- (To reduce risk associated with the behavior?)
Classifying Strategies: Restrictive Interventions

- Is it an intervention that restricts movement, access to other individuals, locations, activities, or personal objects?
- Is it an intervention that restricts rights?
- Does it employ aversive methods?
Classifying Strategies: Rights Restrictions

- Does it place a limitation of any general liberties that are available to all citizens?
- Does it limit freedom of movement?
- Does it limit choice?
- Does it limit communication with others?
- Does it limit leisure activities, personal property or $, access to parts of the home or community?
- Does it limit any of the rights assured to clients of the Department of Mental Health?
- Does it promote treating the person with respect, dignity and least restrictive environment?
DD 4.300 Requirements

Used 1 Reactive strategy that is restrictive OR history of need
Reactive Strategy

- 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

Safety
Crisis Plan
Safety Crisis Plan

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”
REACTIVE STRATEGY
REVIEW PROCESS

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

- 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?

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.

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When should the review be done?

- After every use of a reactive strategy
- As soon after the event occurs and the team can be convened
Where should the review occur?

- Away from where the event occurred
- Neutral territory
- Safe environment
Suggested Steps to Review Reactive Strategy Use

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
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.
3. Describe what happened
   - Collect and organize the facts surrounding the event to understand what happened.
4. Identify the contributing factors

The situations, circumstances or conditions that increased the likelihood of the event are identified.
5. Identify the causes

A thorough analysis of contributing factors leads to identification of the underlying process and system issues of the event.
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
7. Measure the success of changes

Like all improvement projects, the success of improvement actions is evaluated.
Tools to Review

- The 5 Whys
- Management Oversight and Risk Tree
- Barrier Analysis
- Fault - Tree Analysis
- Change Analysis
- Failure Mode Effect Analysis
- Casual Factor Tree Analysis
- Parent Analysis
- Fishbone Diagram or Ishikawa Diagram
Tools to Review

5 Why’s

DEFINE THE PROBLEM:

WHY did it happen/WHAT happened?

WHY is that?

WHY is that?

WHY is that?

WHY is that?

WHY is that?
This questioning process is continued until all causes are found.

It is common to find the same cause for two or more contributing factors.
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.
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?
Areas to focus questions

- Communication
- Training
- Fatigue/Scheduling
- Environment/Equipment
- Rules/Policies/Procedures
- Barriers
Tools to Review CONTINUED

**Tools**

- Management Oversight and Risk Tree
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- Fishbone Diagram or Ishikawa Diagram
Barrier Analysis

WHAT HAPPENED?
(CAUSE FACTORS)
--HUMAN MISTAKE/ERROR
--MATERIEL FAILURE
--ENVIRONMENTAL FACTOR

WHY DID IT HAPPEN?
(SYSTEM INADEQUACIES/ROOT CAUSES)
- LEADER
- TRAINING
- STDS/PROCEDURES
- SUPPORT
- INDIVIDUAL

WHAT TO DO ABOUT IT?
(RECOMMENDATIONS)
- FIXES
- REMEDIAL MEASURES
- COUNTERMEASURES
Tools to Review CONTINUED

Steps in Barrier Analysis

1. Define the Goal, Behavior and Target Group
2. Develop the Behavior Questions
3. Develop Questions about Determinant
4. Develop Sessions
5. Organize the Analysis Sessions
6. Collect Field Data Results
7. Organize and Analyze the Results

Use the Results
Change Analysis Worksheet

ENABLING FORCES

RESTRAINING FORCES

ACTION

BY WHO

BY WHEN

SUCCESSFUL

UNSUCCESSFUL

NO CHANGE

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Practical Application

Follow – On Workshops
- To be scheduled by region
- To be scheduled for organizations

How might they operate
- Can be a review of systems already in place
- Can be a review to assist in establishing a system
- Can be partnering with organizations/teams to develop or review systems
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