



Connecticut Department of Mental Retardation

Peter H. O'Meara, Commissioner
Kathryn duPree, Deputy Commissioner



M. Jodi Rell, Governor

Safety Summit Action Plan

September 2006

On July 12, 2006, the Department of Mental Retardation held a Safety Summit for key department and provider staff, provider trade organizations, DMR Advisory Council members, OPA, Labor Unions, families and consumers. Topics explored at the Summit included DMR staff training information on dysphagia, a statistical analysis of recent deaths in DMR and information on two risk management/mitigation tools—Failure Mode and Effect Analysis (FMEA) and Root Cause Analysis (RCA). Part of the agenda included small group discussion and generation of proposed recommendations for a DMR Safety Action Plan that would enable the department to keep its focus on safety at the forefront of service delivery and address systemic changes that will promote the safety and welfare of individuals supported by DMR.

The following are broad recommendations for the department's Safety Action Plan:

Organizational Structure for Safety and Risk Management

In order to sustain the focus on its safety campaign and oversee a coherent and integrated approach to safety, the department must consider the establishment of a clear organizational structure with responsibility for safety and risk management/mitigation at the central office and regional administrative levels. Safety and risk management is a critical operation for the department and resources must be assigned accordingly to effectively carry out and oversee the implementation of a variety of ongoing safety initiatives and to analyze the effectiveness of the campaign and its strategies.

Failure Mode and Effect Analysis—FMEA

Steven Staugaitis, Ph.D. presented an overview of FMEA at the Safety Summit. Dr. Staugaitis states that, "Failure Modes and Effects Analysis is a structured approach for evaluating processes and activities that can fail, resulting in injury or harm to consumers and/or the staff who support them. FMEA is a proactive approach designed to anticipate and correct problems before they become a major safety concern. FMEA focuses on a specific process or activity and includes a careful review of:

- **Discreet steps** in the process (task analysis)
- **Failure modes** for each step (what could go wrong)
- **Causes** of failures (why those failures are likely to take place)
- **Effects** of failures (potential consequences if they do occur)
- **Relative risk** for each potential failure (impact, probability and likelihood of being discovered before harm occurs).

Following identification of the highest risk components of a process, change plans are developed that are designed to reduce the probability of failure in those steps."

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Representatives from DMR and Private Providers received introductory training on Failure Mode and Effects Analysis (FMEA) in June prior to the Summit. Staff who participated in the training have begun to use the FMEA process on a procedure used in their agency that is typically associated with risk. These staff will meet in the Fall to review and share the procedures they have analyzed. These analyzed procedures when completed, plus others available on the website www.ihf.org, will be shared with public and private provider staff as system improvement resources available for use to address safety issues. As common risk themes emerge from the use of FMEA, the department will issue safety alerts or new procedures to address these safety concerns and provide related training.

Root Cause Analysis—RCA

The department will continue the use of RCA as a risk management and organizational learning tool. Currently, department staff at the Commissioner's direction have used the RCA process to review a number of events, which have negatively affected individuals receiving DMR services. Findings of these reviews were shared with stakeholders empowered to design quality improvement activities to reduce the probability of future similar incidents.

RCA is a structured, analytic process designed to help identify the underlying factors that have contributed to or have directly caused a major adverse event or systems failure. The results of a RCA are typically utilized to guide and direct changes to processes, the environment, and human behavior in order to prevent or reduce the probability that the adverse event will occur in the future. RCA can be incorporated into existing or planned risk management and quality improvement procedures in order to:

1. PREVENT the future occurrence of adverse events that do or can cause harm to individuals; and,
2. CORRECT practices that have led to regulatory noncompliance, including identified deficiencies noted by regulatory agencies such as CMS.

As common risk themes emerge from the use of RCA, the department will issue safety alerts or new procedures to address these safety concerns and provide related training.

Level of Need (LON) / Individual Plan (IP) “audits and accolades”

The department has implemented a new Level of Need assessment tool that electronically generates an individualized risk summary for each individual served by DMR, based on responses to questions in the LON. These data are entered into a database that, over time, will allow DMR to identify individuals who have certain high-risk profiles (individuals with dysphagia, chewing and swallowing difficulties, special bathing or eating procedures, PICA and some of the low frequency/high-risk behaviors presented and discussed at the Summit). As information in the LON database is accumulated, the department will be able to conduct reviews or audits of the Individual Plans for these consumers to determine if their plans and actual services address the risks identified in their LON assessments. The findings of these audits should result in “accolades” for exemplary service providers, sharing of best practices and development and implementation of system improvements. These activities are expected to begin in January 2007.

Communication and Training

As a part of the department's ongoing safety campaign, safety tips and information will be included in posters, paycheck inserts, employee newsletters, and fact sheets on the DMR website for access by department and private agency employees, individuals and their families. The Commissioner's video safety message will be viewed by all new employees at the time of hire, and the message reinforced in worksite specific orientations conducted by supervisors. A series of common safety scenarios that put people at risk will be developed and used for instructional purposes at agency staff meetings and forums. Scenarios will highlight practical strategies that will prevent future incidents. To increase safety awareness on-the-job, supervisors will be encouraged to observe staff behavior and provide supportive, corrective feedback to employees as they carry out their daily responsibilities. Individuals receiving services from the department, supervisors and direct support staff will be provided with opportunities to participate in the development and implementation of safety related initiatives.

Independent Mortality Review Board (IMRB) and Fatality Review Board (FRB) Findings

The department's IMRB and the FRB, convened by the Office of Protection and Advocacy, produce findings and recommendations for improvement of services for people who receive supports from DMR. The department needs to develop an ongoing mechanism to share these findings with service providers and develop system improvements in response to these findings. There is critical information gleaned from these reviews that could have a significant effect on the safety and welfare of people supported by DMR. The department must systematically translate this information into system improvements that are implemented and reviewed system-wide for their effectiveness in addressing health and safety issues.
