STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

Procedure No.: I.D.PR.012
Subject: Root Cause Analysis
Section: Quality Enhancement

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Approved: /s/Terrence W. Macy/KdP

A. Purpose

The Department of Developmental Services (DDS) has established a variety of policies and procedures designed to reduce risk and prevent the occurrence of adverse events that can jeopardize the health and safety of individuals who receive services from the department or any of its contracted or licensed providers. Department policy establishes the structured and formal process of root cause analysis as systematic method to review selected sentinel events in order to analyze potential factors that increase risk and to facilitate the design and implementation of effective risk prevention strategies.

B. Applicability

Root cause analysis (RCA) may be conducted for any sentinel event that occurs with any consumer of the department, regardless of the type or location of services they receive. These procedures shall apply to all formal root cause analyses conducted in response to a request by the DDS Commissioner, Deputy Commissioner, or the Chairperson of the Independent Mortality Review Board (IMRB).

Root cause analyses conducted by private providers are not subject to these procedures.

C. Definitions

See DDS Policy No. I.D.PO. 002 Root Cause Analysis

D. Implementation

1. The Commissioner, Deputy Commissioner, or the Chairperson of the Independent Mortality Review Board may request that a formal root cause analysis be performed on any sentinel event that affects a client of the department.

2. Each root cause analysis shall include, at a minimum, a review and analysis of:
   a. the sentinel event
   b. background, context, and potential contributory factors
   c. risk reduction actions already taken
   d. recommended prevention strategies
   e. incidental findings, when present

3. The department's Quality Improvement Director is responsible for overseeing the application of the root cause analysis process for cases which do not involve the death of a consumer.

4. The Chair of the Independent Mortality Review Board is responsible for overseeing the application of the root cause analysis process for cases which involve the death of a consumer.

5. Upon notification that an RCA is requested for a non-death related case the Quality Improvement Director shall appoint an RCA team and assign a team leader.

6. Upon notification that an RCA is requested for a death related case the Chair of the IMRB shall appoint an RCA team and assign a team leader.

7. Based upon the type of incident under review the department's Director of the Quality Improvement or Chair of the IMRB may appoint any or all of the following DDS staff to the RCA team:

    a. member of the QM staff and/or Investigations Unit
    b. manager or supervisor responsible for the program or service in which the event occurred
    c. investigator or lead investigator who conducted or approved any investigation that has been completed or is in process.
    d. content expert with knowledge of practice standards associated with the type of event under review
    e. one or two personnel who were directly involved in or are knowledgeable about the specific incident
    f. a DDS manager who is familiar with the RCA process

8. The team leader is responsible for scheduling and convening the team no later than ten (10) working days from the date of notice.

9. The team leader is responsible for facilitating the identification and collection of all necessary documentation that will be required by the team.

10. At the conclusion of the root cause analysis, the team leader is responsible for preparing a draft report, using an approved documentation format that summarizes the facts, findings, and any recommendations for systems improvement. The draft report is to be reviewed for comment by team members. Following receipt of team member comments, the team leader shall issue a final report to the Commissioner, Deputy Commissioner, appropriate Regional Director and either the Chairperson of the IMRB or the department's Director of Quality Improvement depending on the circumstances of the sentinel event.

11. The Executive Management Team (EMT) shall review all findings and recommendations. Following such a review, the Commissioner shall distribute the findings and recommendations to the department's managers and direct the appropriate division or regional directors to implement those recommendations accepted by the EMT. Directors shall establish an action plan with projected timelines and report progress on a periodic basis, until such time as full implementation is completed.

12. A written summary of generalized recommendations of each root cause analysis shall be posted for a minimum of 90 days on the DDS website in order to increase awareness of potential risk factors to consumers of the department. The written summary will be constructed in such a fashion as to assure protection of individual privacy rights and shall not

include the use of client, staff or other individual names or other information that could identify any person or specific non-governmental agency.

13. The department's Director of Quality Improvement shall be responsible for maintaining documentation on all root cause analyses, including implementation of any required systems improvement recommendations for cases in which the sentinel event did not result in the death of a client.

14. The Chair of the IMRB shall be responsible for maintaining documentation on all root cause analyses, including implementation of any required systems improvement recommendations for cases in which the sentinel event resulted in the death of a client.

E. References

I.D.PO.002 Root Cause Analysis

F. Attachments

Root Cause Analysis Report Form