Welcome to this session on Quality and Risk Management in Intellectual and Developmental Disabilities Services. We will begin with the discussion of Root Cause Analysis. We first begin with why, the question, "Why?" Why are we talking about Root Cause Analysis? Well, the unfortunate truth and this really is the founding reason for why Root Cause Analysis is needed. Is that bad things happen. It's important to keep this in mind that despite efforts to screen, protect, and monitor there are continued incidents of bad things that can result in harm to people with Intellectual and Developmental Disabilities. In many cases, this is referred to as incidents or incident reports. There are any number of incidents that could come to mind of people who are viewing this video. The important thing is to remember that Root Cause Analysis aims at getting at some of these questions. Is it inevitable? And are there some basic and underlying factors that could be recognized and aggressively addressed to make a difference? The point of Root Cause Analysis is to make a difference and avoid this happening again. So what is Root Cause Analysis? Root Cause Analysis is a structured approach to investigate, review, and analyze significant adverse events or incidents. It requires an analytic process to spend time and help underlie identifying factors that could have contributed or directly caused a serious event. The results of Root Cause Analysis are then used to guide and direct corrective changes to prevent or reduce the probability of a similar future adverse event. So really Root Cause Analysis is a tool, a tool in the toolbox for quality monitoring and quality management and risk management to use following an adverse event. And the tool is used to find out what happened, why it happened, and, very importantly, how it can be prevented from happening again? The primary goal of Root Cause Analysis is prevention. This quote by Donald Norman sums it up quite well. People make errors which lead to accidents. Accidents lead to death. The standard solution is to blame the people involved. And if we find out who made the errors and punish them, we will solve the problem, right? Wrong. The problem is seldom the fault of one individual. It is the fault of the system. Change the people without changing the system and the problems will continue. And this is where Root Cause Analysis has great strength. It really has focus on the system. So here are some of the components to keep in mind when thinking about, what underlies Root Cause Analysis and what all come together. So when we think about "adverse events", we know that when events or incidents happen, they are rarely the results of a single or isolated mistake. Usually there's a chain of events that lead up to a bad event. The important thing with Root Cause Analysis is to focus not just on the proximate event. Another way of saying what happened right before the bad event happened. But also think, think back about the entire system that comes together. There are a number of things that get focused in on a Root Cause Analysis. For example, Error Prone Situations. Usually what we consider our error prone situations that can lead to accidents. For example, in settings where there's a lot going on, a whole lot of distraction for staff supporters. There can be more accidents that happen. There's often faulty systems design that can actually begin an error chain. And this is what root cause analysis is trying at, is thinking about the systems that could actually lead to problems happening. There are indeed people factors to consider when looking at the root causes of an event. For example, momentary distraction, misjudgment. These are often the last factor in a chain of events. For people is just not possible to monitor every action in all cases. What's important is that an effective system should facilitate safe and correct behavior and minimize scope for error. Systems Design, therefore, is really essential. The role of quality monitoring is to understand and improve quality and reduce risk. And as I

mentioned earlier, a Root Cause Analysis is a tool to support that. An emphasis on systems design, is more effective than relying on individual employee discipline or particular employee action, in many cases. What we've learned through many years of analysis of events and risk analysis activities, is that errorless performance for individuals is a myth. Services and supports provided for individuals are often complex and challenging. And the best staff people are under a great amount of pressure to perform a broad range of activities without any error. It's nearly impossible to eliminate all mistakes. However, one can reduce the probability of significant events and certainly reduce the impact of events occurring with good systems planning, Quality systems can strive to understand when mistakes happen and make changes to then reduce the likelihood they can occur again. So in this brief overview, we've gotten to the point of talking about Root Cause Analysis, and there are a few criteria that really call for root cause analysis in a time when it was most effective. Root cause analysis should be employed, for example, when the cause of an event is not clear or there are different factors that seem to be contributing. Root cause analysis is typically used also in the pieces when an incident is a true sentinel event. Sentinel events are defined by different agencies, but typically include things that involve significant harm, perhaps mortality, or perhaps significant injury to a person or others. Another criterion is when human error is identified and involved. For example, when staff acted contrary to their established protocols or simply a mistake was identified. There's an opportunity there to do a root cause analysis and understand the systems underlying human error. Another criterion is when similar other incidents seem to be happening. If there's a pattern that is an opportunity for root cause analysis. There are some criteria that are really important for it to be successful. And, and the next one is, is really important. To do a root cause analysis, it's really important to have sufficient information and valid documentation. And what I mean by that is that there needs to be enough information collected in, for example, incident reports, there needs to be access to particular individuals who know about the incident and can provide any additional information if needed. Finally, an important criterion is that the results of the root cause analysis can and will be used to identify risks or a risk reduction initiative or actions. This is the role of a robust and functioning risk management and quality improvement system. And this is why Root Cause Analysis sits well within this kind of system. So to recap, Root Cause Analysis is used to learn after an adverse event and to make changes so they won't happen again. There are many factors that contribute to adverse events and these all need to be considered. Root Cause Analysis helps to understand which were the most important factors. And it is a comprehensive process that takes time. Groups really do need to consider criteria for doing a root cause analysis and determine which events should be the target of a robust process such as Root Cause Analysis. There are credits and resources on this final slide. And thank you for your attention.