DEPARTMENT OF HUMAN SERVICES **DHS Report**

Culture of Safety, Systemic Critical Incident Review: Annual public report

Disability Services Division

October 2023

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Contents

I. Introduction

Purpose of report

The purpose of this report is to share updates on the Minnesota Department of Human Services Disability Services Division's culture of safety systemic critical incident review model. This report includes information on the incidents we reviewed, including considerations from regional quality councils.

Legislation passed in 2023, Minn. Stat. §256.01, subd. 12b, requires an annual public report that contains information on the number of incidents reviewed, aggregate summary of the systemic themes from incident reviews, a synopsis of conclusions and considerations for recommendations for systemic changes.

Culture of safety background

The culture of safety systemic critical incident review model seeks to improve outcomes within disability services. The model focuses on improving the reliability and safety of services through a robust and proactive response to critical incidents that emphasizes learning. Years of research have shown that assigning blame might decrease accountability because it inhibits the ability of an organization to understand and improve.

Culture of safety is a model built on safety science, commonly used in aviation, health care and nuclear power industries to improve systems and develop a culture of safety. This allows a better understanding of organizational decisions and how leaders can guide staff to achieve desired outcomes. It is a model of systemic review of adverse events and process decisions that moves organizations from superficial reactionary responses to a more complex understanding of systemic factors.

II. Incident review overview

In June 2019, DHS' Disability Services Division began to review critical incidents that occurred in 245D-licensed facilities using the culture of safety systemic critical incident review model. DHS collected and analyzed the data and information for this report between June 1, 2019, and June 30, 2023.

DSD trained 26 people to conduct critical incident reviews using the culture of safety model. About half of the reviewers are from waiver lead agencies; the remainder are DHS staff.

The reviewers encouraged 245D-licensed providers and facility staff to learn more about their experiences within the critical incident. Following the incident review, the reviewers engaged a "mapping team" made up of providers and/or facility staff, lead agency staff and DHS staff. The mapping activity helped identify systemic issues and their influences at different levels of the disability service system, refrained from blaming others and incorporated multiple viewpoints from across service systems.

DHS reviewed 71 critical incidents using the culture of safety systemic critical incident review model. We reviewed critical incidents that were obtained via Behavior Intervention Report Forms, 245D residential service terminations/suspensions and/or referred to DHS as the lead investigative agency responsible for response to vulnerable adult maltreatment reports in accordance with Minn. Stat. §626.5572, Minn. Stat. §245D.02, Minn. Stat. §245D.10 and Minn. R. 9544.0100. DHS selected the incidents under the jurisdiction of the commissioner, reported them for suspected maltreatment and closed following initial disposition.

Below is a list of the incident types and definitions.

Critical incident types and definitions

Medication error

Person received the wrong medication/dosage; person gained access to medications; medication administration policy not followed.

Supervision not maintained

Person left home and staff did not know; staff unable to follow person who left the home.

Service termination/suspension

Person received a 245D service termination and/or suspension.

Staff sleeping

Staff sleeping during shift.

Wheelchair safety

Foot pedals not on; seatbelt not secured.

Other

Not following COVID protocol.

Below is a table displaying the 71 incidents DHS reviewed, by incident type and lead agency regions. The four regions include:

1. Blue Earth, Olmsted
2. Clay, Otter Tail, Polk
3. Dakota, Hennepin
4. St. Louis.

Table 1: Number of critical incidents reviewed by lead agency and incident type

Incident type	Region 1	Region 2	Region 3	Region 4
Medication error	6	<5	10	7
Elopement	<5	<5	8	8
Service termination / suspension	<5	<5	<5	9
Staff sleeping	<5	0	<5	<5
Wheelchair safety	<5	0	<5	<5
Other	0	0	0	<5

Note: when the number of incident reviews was five or fewer in a particular region, "<5 (i.e. fewer than 5)" is used to reduce the chance of identifying individuals.

Each critical incident review collects information on the 245D-licensed provider and the facility staff's decision-making and builds a greater understanding of how the service system (e.g. policies, rules, statutes) influences those incidents. At the end of incident reviews, reviewers score the data using an analysis tool. Below are the number of systemic themes scored for the 71 critical incidents reviewed and the definitions of the systemic themes. Note: Each incident review may be scored with more than one systemic theme.

Figure 1: Number of systemic themes scored across 71 critical incident reviews

Below are the definitions of the systemic themes in the chart above. The systemic themes allow DHS to group the data to narrow the focus and better understand the barriers and challenges.

Prescribed practice

When policy or work expectations are absent, conflicting, not clear or do not support the work.

Demand-resource mismatch

The agency does not have resources available to help staff do their work (e.g., no or limited training for onboarding staff, staff shortages) or the resources available are not enough or do not support the work.

Cognition

Not fully understanding a situation because providers focused on beliefs and past experiences or focused on only one way to do things when there were other options.

Procedural drift

Staff take shortcuts or use workarounds because of challenges (e.g. staff shortages, what worked before doesn't now), co-workers' suggestions or because they deviated from the expected practice/procedure to do something else and, when it worked, they kept using that workaround because of previous success.

Production/efficiency pressure

Pressure is placed on staff to meet goals, do more work and/or work more quickly, which negatively affects the work.

Service availability

External services or supports are not available or they are difficult to find/access.

Teamwork/coordinating activities

When two or more partners (internal and/or external) are not able to work together to complete the goals (e.g., direct support professionals and clinical staff, day staff and overnight staff)

Knowledge gap

Staff do not have experience and/or knowledge and/or have difficulty using their knowledge in their work.

Fatigue

Staff being tired affects their work.

Medical

Difficulties receiving or understanding medical records or adding medical information into plans of care.

Documentation

Electronic or paper documentation is missing, not complete or inconsistent.

Supervisory support

Supervisors have difficulty providing support, supervision, sharing knowledge or being available.

Equipment/tools/technology

The equipment, tools and/or technology is not available or does not support work.

III. Incident review analysis and considerations

In 2022, DHS partnered with workgroups from three regional quality councils to help analyze our incident review data and consider recommendations for change to our disability service system. Overall, the regional quality councils collaborate with regional partners to help drive systems and social change to promote inclusion of disabled people in the state of Minnesota, as well as monitor and improve the quality of services, person-centered outcomes and overall quality of life for people with disabilities.

In 2022, the regional quality council workgroups reviewed data from 20 criticial incident reviews. All 20 reviews were related to facility staff not maintaining supervision of people who receive services. This included situations where a person left the home and staff either didn't know or were unable to follow the person. A person who leaves their home might not be able to communicate verbally that they are unhappy with their situation or want or need a change in their life. As indicated below, these considerations could support lead agencies and providers to ensure that people are getting their needs and wants met, and are ultimately happy in their homes and environments.

Some of the issues or challenges that surfaced from the incident reviews included:

- 245D-licensed providers and facility staff had challenges providing person-centered supports, as required by Minn. Stat. §245D.07, e.g. informed choice (see Minn. Stat. §256B.4905, subd. 1a), autonomy or rights (as spelled out in Minn. Stat. §245D.04), to multiple people living and working in the same settings. This was even more challenging when a provider was experiencing staffing shortages.
    - It is common for one staff member to support multiple people who have different wants and needs. Such staff members often feel stuck trying to figure out what is the "right" decision in supporting these people with different needs.
- Providers are often stuck in challenging situations where they need support and may not always have the internal expertise or capacity.
- Providers are not compensated to develop knowledge and skills to be person-centered; it feels like supporting people using person-centered practices is an unfunded mandate.
- Annual meetings are overwhelmed with the review/signing of required paperwork. This reduces the time for a person to think and have a meaningful conversation about their life.
- Most people (providers, lead agencies, people who receive services, families) are not aware of what assistive technology is and how it can help a person.

IV. Considerations for recommendations

In 2022, this was the regional quality councils' first review cycle in collaboration with DHS. The regional quality council workgroups reviewed data and developed the following considerations for recommendations. The workgroups suggested that before acting on any of the considerations, DHS undertake further engagement and information gathering to ensure these considerations apply statewide and the people who are affected (providers, lead agencies, people who receive services) have the opportunity to give their input. The science that informs this review model emphasizes the importance of understanding issues to inform system change. It encourages entities to avoid making quick, reactionary solutions. Below are the four considerations from the 2022 review cycle. Under each consideration is a description of why this change is needed and the status of the consideration.

Consideration 1

Consider creating and distributing guidance to support case managers (Minn. Stat. §256B.4905, subd. 11) and providers (Minn. Stat. §245D.071) so they can discuss the use of technology to meet people's desired outcomes.

- Better defining "technology" will address subjectivity and help case managers and providers in supporting the person to consider their interest and/or need for assistive technology.
- Most people are not aware of what assistive technology is and how it can help a person. Many people think of phones and tablets, but it can be much more.

Consideration 1 status*:* DSD is creating a supplemental guidance page on support technology and service planning. The regional quality council workgroup reviewed an initial draft.

Consideration 2

Consider reducing or consolidating required paperwork in support planning meetings. Include options to sign electronically and/or outside of the support planning meetings.

- Reducing and consolidating paperwork will give people who receive services more time to discuss their life and require less time spent on paperwork.
- Forms and paperwork seem redundant and duplicative. This greatly reduces the time people have to think and talk about what and how they want to live their lives.

Consideration 2 status*:* No state or federal policy/statute prohibits electronic signatures. We are unaware of current efforts to reduce or consolidate support planning paperwork; however, there have been discussions across DHS about this topic during the unwinding of the public health emergency.

Consideration 3

Consider building a line item into the Disability Waiver Rate System (DWRS) and individualized budgets to give providers the resources they need to provide person-centered, positive supports to support self-determination.

Adding a line item to the DWRS and individualized budgets would give providers access to resources that could be dedicated to implementing and using person-centered, positive supports with people who receive services.

Consideration 3 status*:* DSD hopes to measure this through DWRS cost reporting.

Consideration 4

Consider developing and piloting a regional support model for 245D-licensed providers. This model would provide a list of support experts to contact when a provider experiences a challenging situation and needs help.

- Such a model could reduce incidents, avoid crisis situations and support people and staff more effectively and efficiently.
- Consider using a model similar to the DSD regional resource specialists who support lead agencies.

Consideration 4 status: DSD is exploring how to increase support for home and community-based services providers.