



DHS Report

Culture of Safety, Critical Incident Review: Annual public report

Disability Services Division

October 2025

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is \$2,634.

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I. Introduction

Purpose of report

The Minnesota Department of Human Services (DHS) Disability Services Division (DSD) is required to provide an annual public report on the [Culture of Safety Critical Incident Review](#), which documents and informs the commissioner of systemic changes that might decrease the amount or severity of critical incidents in the future, improve outcomes and/or enhance services provided in home and community-based settings.

This annual report provides updates for the reporting period of Oct. 1, 2024, to June 30, 2025. It contains information including the number and types of incidents reviewed, an aggregate summary of the systemic themes within the incidents, a synopsis of the data examined and suggestions for system changes. DSD developed considerations in partnership with four [Regional Quality Council workgroups](#), who acted as data action groups and represented metropolitan and rural counties in Minnesota.

Culture of Safety background

The Culture of Safety initiative, which follows the [Collaborative Safety framework](#), takes a collaborative approach to systems safety science in disability services by using a systemic critical incident review (SCIR) model to assess the systemic influences on incidents. Rather than determining the culpability of any actors involved in the incident, the model focuses on learning and engaging direct care workers, identifying systemic barriers and challenges and their influences at different levels of the disability service system, and making suggestions that would improve outcomes within disability services.

In June 2019, DSD began to review critical incidents that occurred in 245D-licensed services using the Culture of Safety SCIR model, which uses a five-axis mapping tool. DSD trained safety analysts, consisting of DHS and lead agency staff, to select critical incidents and conduct these systemic critical incident reviews.

We received the incidents via behavior intervention reporting forms, 245D residential service terminations and/or suspensions, and/or reports submitted to DHS as the lead investigative agency. These were reported for suspected maltreatment and closed following the initial disposition in accordance with [Minn. Stat. §256.01, subd. 12b \(b\)](#). A selection committee, consisting of DSD staff and trained safety analysts, selected the critical incidents that would be assigned for further review. DSD then assigned the selected incidents to a designated safety analyst to conduct the systemic critical incident review.

The designated safety analyst engaged 245D-licensed providers and direct support professionals to learn more about their experiences within the critical incident. Following this engagement, the safety analyst facilitated a critical incident review, using the SCIR mapping tool, with a systems learning team made up of lead agencies, providers and state agency staff. The critical incident review identified systemic barriers and challenges at different levels of the disability service system, refrained from blaming others and incorporated multiple viewpoints from across service systems. Following the critical incident review, we identified systemic themes within the incident. Data action groups further examined these themes to develop suggestions for systems change.

Culture of Safety present and future

From June 2019 through late 2023, the Culture of Safety initiative continued to use the SCIR model to assess the response to incidents proactively by:

- Learning and engaging those people involved in a critical incident.
- Conducting a critical incident review with the SCIR mapping tool to identify systemic barriers and challenges at different levels of the disability service system.
- Making suggestions that would improve outcomes within disability services.

However, throughout 2023, DSD identified challenges that arose while using the SCIR model. While the model focused on learning and engaging direct care workers, it was difficult to secure participation from the people directly involved, which subsequently made it difficult to understand and learn about their experience during the critical incident. In addition, the SCIR mapping tool for the critical incidents was an intensive systems learning tool that had limitations such as limited participation or dialogue among participants or a narrowed focus on a specific incident instead of a system(s) process as a whole. The critical incident reviews began yielding similar discussions, as well as similar suggestions from the data action groups.

In 2024, the Culture of Safety initiative added the Systems Learning Review (SLR) model, which also follows the [Collaborative Safety framework](#), to look at critical incidents beyond a single episode or to assess an outcome that did not go as expected within the larger disability services system. The SLR model uses an SLR tool, which allows providers, lead agencies and state agency staff, as well as external partners, to participate in a systems learning review. This review allows participants to broaden their learning of critical incidents or processes by identifying systemic barriers and/or challenges shaped by systemic themes. They can then develop considerations for systems change that can be further reviewed by the data action groups, and/or the safety action group. This model can be used to look at more than one specific incident at a time or to learn more about aspects of the service system that would not be considered incidents.

Throughout this reporting period, some DSD staff were trained on the SLR model and conducted three systems learning reviews. The critical incidents we reviewed occurred in 245D-licensed services. This trial confirmed that this newer mode of reviewing incidents would work to continue advancing system change within disability services. DSD is working to develop a procedure, similar to the SCIR model, to select incidents or learnings, assign a designated safety analyst to facilitate the systems learning review and determine how DSD, the data action groups and/or the safety action group will evaluate the suggestions that come out of each systems learning review to further develop considerations for systemic change.

In 2025, DSD continued to offer trainings about the Culture of Safety initiative to state agency staff, providers, lead agencies and regional workgroups across the state, with the intent to increase the number of trainers by 2026. DSD is also working with leadership staff to incorporate safety science principles in daily work, interpersonal relationships and as part of a comprehensive response to incidents or unexpected outcomes that present in multiple areas of disability services.

As DSD continues to develop the SLR model, there may be opportunities for the Culture of Safety initiative to conduct systems learning reviews with other business areas at DHS to further expand their learning and response to internal systems issues that did not go as expected. In addition, in June 2025, the Culture of Safety initiative created a safety action group composed of leadership staff that will meet quarterly to:

- Review systemic themes that come out of the system learning reviews.
- Provide updates on activity presented by the data action groups.
- Review the considerations outlined in this annual report that promote change within the disability services system.

In addition, the safety action group might recommend additional areas of study. As DHS begins to use new modes of systems learning and new areas of study, we will need to make changes to processes and procedures as well as the annual report.

II. Incident review overview

Since June 2019, DSD has trained 31 safety analysts to conduct critical incident reviews using the Culture of Safety SCIR model. Between June 1, 2019, and June 30, 2025, DSD selected 76 critical incidents by incident type that were reviewed by assigned safety analysts. During this annual reporting period, we completed no new systemic critical incident reviews. However, given that there was aggregate data available, the data action groups were still able to review data and provide considerations.

Below are the incident types reviewed and their corresponding 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 and/or 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 76 incidents DHS reviewed, by incident type and lead agency regions. The four regions include:

- Blue Earth, Olmsted
- Clay, Otter Tail, Polk
- Dakota, Hennepin
- St. Louis.

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

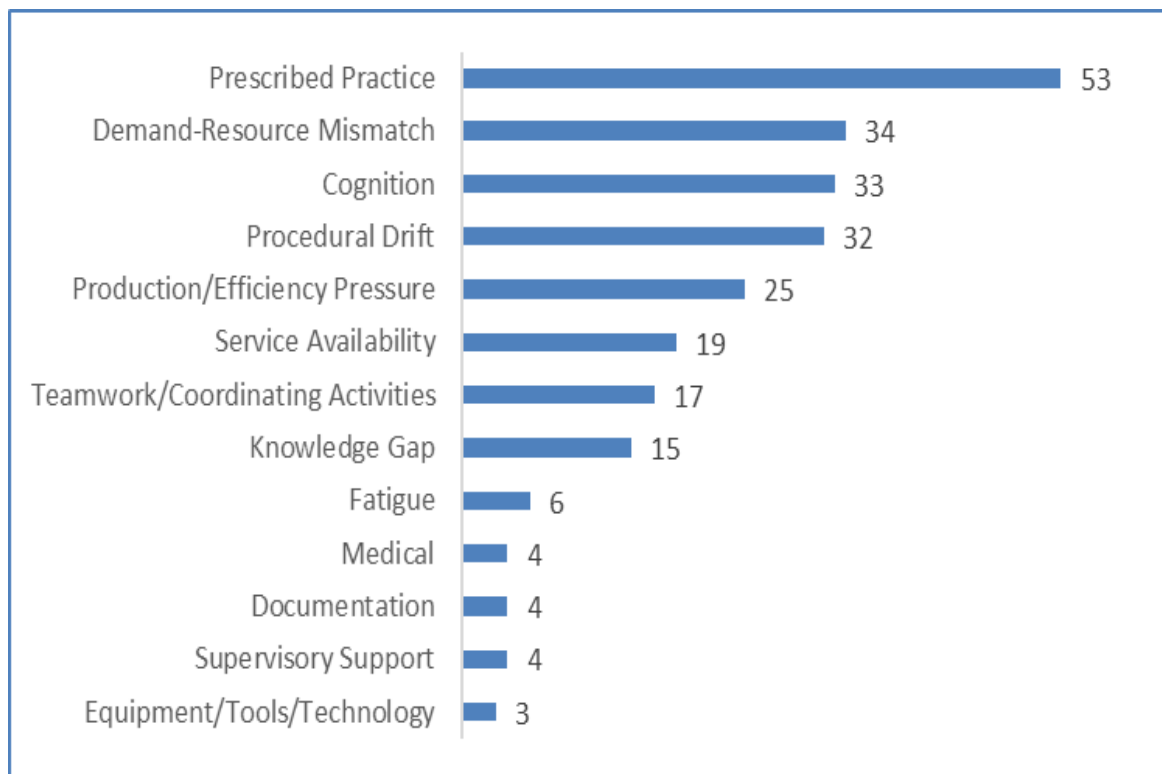
Incident type	Region 1	Region 2	Region 3	Region 4	Total
Medication error	<10	<10	12	<10	29
Supervision not maintained	<10	<10	<10	<10	21
Service termination and/or suspension	<10	<10	<10	<10	17
Staff sleeping	<10	0	<10	<10	<10
Wheelchair safety	<10	0	<10	<10	<10
Other	0	0	0	<10	<10

Note: when the number of incident reviews was 10 or fewer in a particular region, "<10 (i.e. fewer than 10)" is used to reduce the chance of identifying individuals.

Each critical incident review collects information pertaining to the 245D-licensed provider and the facility staff's decision-making during the critical incident to build a greater understanding of how the service system (e.g. policies, rules, statutes) influenced the incident. At the end of each incident review, reviewers score the data using an analysis tool to assess systemic themes. The systemic themes allow DHS to group the data to narrow the focus and better understand identified systemic barriers and challenges within incident types.

Below are the number of systemic themes scored for the 76 critical incidents reviewed and the definitions of the systemic themes. Note: Each incident review might be scored with more than one systemic theme.

Figure 1: Number of systemic themes scored across 76 critical incident reviews



Below are the definitions of the systemic themes in the chart above:

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 members take shortcuts or use workarounds because of challenges (e.g. staff shortages, what worked before doesn't now), co-workers' suggestions or the new way worked.

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

Initially, DHS partnered with three Regional Quality Council workgroups to act as data action groups to help analyze the critical incident review data and consider suggestions for change within disability services. The Regional Quality Council workgroups collaborate with regional partners to help drive systems change and social change to promote inclusion of disabled people in the state, as well as monitor and improve the quality of services, person-centered outcomes and overall quality of life for people with disabilities. At the time of this report, DHS partnered with four Regional Quality Council workgroups that represented 19 Minnesota counties.

During this annual report, four data action groups reviewed data from 23 systemic critical incident reviews related to service terminations and/or suspensions, medication errors, staff sleeping, wheelchair safety and supervision not maintained, and proposed considerations for systemic change to better support lead agencies, providers and/or people who receive services.

Three groups reviewed data from eight service termination and/or suspension incident reviews. These incidents included notices that were issued when a provider was not able to meet the needs of the person who receives services or challenging behaviors, or substance use disorders, affected the provider's ability to maintain the health and safety of the person, others in the program and/or staff.

Systemic barriers or challenges that surfaced from the 2024 data review of critical incidents related to service terminations and/or suspensions included:

- Providers might feel pressured to accept and provide services to a person with complex needs who has urgent placement needs.
- A service termination and/or suspension might be necessary for the person's welfare as the provider cannot meet the person's needs or maintain safety of the person or others.
- Providers might not be able to support a person who receives services when a person with complex needs engages in behaviors that might be detrimental to the health and safety of themselves or others, such as physical aggression, property destruction, substance use or noncompliance with medical treatment.
- Sometimes a person who receives services might be denied services or services might not be available in the least restrictive environment.

Two groups reviewed data from nine medication error incident reviews. These reviews included medication storage/security policies not being followed such as:

- Medication storage doors were unlocked
- Medications were not ordered
- Transcription or documentation steps were not completed
- Staff did not complete required medication administration training
- The person received the wrong medication/dosage.

Systemic barriers or challenges that surfaced from the 2024 data review of critical incidents related to medication errors included:

- When staff are busy with numerous tasks, their focus or attention might be distracted or they prioritize tasks, all while balancing the health and safety of multiple people while administering medications.
- Staff might feel pressure to administer medications quickly or go outside of standard practice when preparing medications for multiple people.
- Sometimes providers might feel pressure to accept people who receive services who have been in hospital settings, the transition might be rushed and medication orders might be transcribed incorrectly.
- Staff might not have time to connect with oncoming staff and may complete medication reconciliations quickly or outside of expected practice.
- Staff shortages influence the amount of time to hire and train staff and which required trainings are prioritized.

Two groups reviewed data from three staff sleeping incident reviews. These reviews included a staff member who did not hear a person call for assistance and a staff member who was asleep during an awake shift.

Systemic barriers or challenges that surfaced from the 2024 data review of critical incidents related to staff sleeping included:

- Staff who frequently work with a person who receives services might perceive that a person is safe and does not need support at that time.
- Staffing shortages influence staff to work additional hours and they might experience fatigue or burnout.
- Pressure to hire and train staff quickly has been influenced by the statewide workforce shortage.

Two groups reviewed data from two wheelchair safety incident reviews. These reviews included that a staff did not have foot pedals on a person's wheelchair during transport and a person who receives services was unable to reach staff when a wheelchair safety incident occurred.

Systemic barriers or challenges that surfaced from the 2024 data review of critical incidents related to wheelchair safety included:

- Staff might prioritize tasks when they perceive that people who receive services were safe and did not require support.
- To promote person-centeredness, staff might go outside of standard practice or adhere to policies and procedures that conflict with what the person who receives services wants.

One group reviewed data from one supervision not maintained incident review. This review included that a person's 24-hour supervision was not maintained when a staff member engaged in self-care.

Systemic barriers or challenges that surfaced from the 2024 data review of critical incidents related to supervision not maintained included:

- Staff might prioritize personal tasks when they perceived that people who receive services were safe and did not require support.
- During longer shifts, staff who work alone might not have scheduled breaks when a person requires constant audio or visual supervision.

IV. Data action groups' considerations

2024 considerations

In preparation for this annual report, we decided that changes had to be made in how considerations were presented so they could be proposed in an actionable way to the newly developed safety action group. The goal was to allow the safety action group to review the systemic barriers, challenges, suggestions and key learnings identified by the data action groups, along with a summary statement of what the data action groups believed was needed within the service system. In addition, the data action groups provided specific suggestions to illustrate potential options for implementing the broader consideration. The safety action group can use this data to deepen their understanding and improve their responses to the suggestions outlined within this report, as well as internal systems that did not go as expected. The safety action group can:

- Identify what resources are in demand
- How DHS can expand partnerships and collaboration among providers, lead agencies and people who receive services and/or their parents/guardians
- Recommend additional areas of study.

During the 2024 review period, four data action groups reviewed data from 23 critical incident reviews related to service terminations and/or suspensions, medication errors, staff sleeping, wheelchair safety and supervision not maintained. The groups identified systemic barriers or challenges, and proposed considerations for systemic change to better support lead agencies, providers and/or people who receive services.

Below, are the eight considerations developed from the data action groups that might improve outcomes of critical incidents within different levels of disability services. Under each consideration, there are explanations supporting the need for change and examples for systems change.

Additionally, the groups identified key learnings, or points of interest, that might inform future outcomes and improvements within other areas of disability services. The safety action group will review this annual report in late 2025 and provide updates on activities with the data action groups. This information will be shared in future reports.

Considerations related to service terminations and/or suspensions

Consideration 1

Develop strategies for ensuring that pertinent information about a person who receives services (including what is important to and for the person) is obtained and shared with necessary partners before intake or admission for services.

Explanations supporting the need for change

- During intake or admissions processes, participants might be reluctant to share information about a person for a variety of reasons, such as urgent placement needs or guardians/parents not recognizing a need or ashamed to admit a need that might influence a potential provider.
- Admissions or intake staff might not know whether some service needs assessments could include information from other sources beyond the person who receives services and/or their guardian.
- Coordination between the person who receives services and their support team members during an intake/admission process or service needs assessment might have a positive influence on the reduction of service terminations and/or suspensions and potentially reduce a person returning to a hospital or crisis placement.
- In some areas, specialty services might not be available or feasible, which might influence the success of the service delivery and/or placement option.

Examples of potential systems change

- During a MnCHOICES service needs assessment, consider including information about a person who receives services from multiple perspectives beyond the person and/or guardian, such as residential and day services providers, previous placements or hospital settings, lead or consistent direct care professionals, case managers, probation officers, etc.
- Provide education or resources to the person who receives services and/or guardian about a service needs assessment process and who can attend or provide additional information to determine how to best support the person and improve the overall quality of life.
- Provide education related to ways providers and/or case managers can conduct ongoing assessments of service needs, housing goals, assistive technology and dignity of risk to evaluate potential changes in services needs or desire for more independent living.
- Establish voice reviews as part of the assessment process.

- Create a way to assess the fidelity of service needs assessments by reviewing whether the assessment was successful in matching for placement options or service needs.
- Gather more data about how the intake/admission process (245D.11 subd 4) is working for people who receive services and providers.

Consideration 2

Reduce the amount and complexity of paperwork required for people who receive services, providers and lead agencies.

Explanations supporting the need for change

- During intake assessments or support planning meetings, reducing the amount of time spent on paperwork allows more time with a person who receives services to learn about what worked or did not work in previous placements and to establish goals that might influence their success and quality of life at their current or future placement. Implementing a person-centered approach might identify if placement options can meet the person's needs and influence a possible reduction of service terminations.
- Completion of annual paperwork, applications for housing or support planning documents can be redundant and time-consuming.

Examples of potential systems change

- Ensure that all forms are written in non-threatening plain language and clearly marked or color-coded to indicate who is responsible for completing each section.
- Add definitions of words that might not be well known to non-service providers or those outside of disability services.
- Create a community of practice for people who receive services and/or parents/guardians to offer support in areas such as paperwork, policies, support planning and understanding the roles of providers and lead agencies.
- Develop an online portal where a person who receives services and other authorized people have access to medical information, service history and fillable forms for electronic filing.
- Develop and conduct abbreviated versions of service needs assessments or other assessments for people whose disability service needs have not or will not change.

Consideration 3

Explore partnerships or ways to support existing efforts or legislative proposals related to service delivery and support planning

Explanations supporting the need for change

- Providers, lead agencies and case managers throughout the state expressed interest in more education and/or support from DHS.
- Working collaboratively with DHS will allow people who receive services and/or their parents/guardians, providers, lead agencies and other members of the disability services system to understand policies related to support planning, identify any issues or barriers and how to use the assessments for support planning that's individualized and person-centered.

Examples of potential systems change

- Develop a community of practice for service providers and/or lead agencies, including case managers, throughout the state to:
 - Discuss what worked/did not work in their experiences.
 - Share advice or resources to provide high-quality services.
 - Adhere to person-centered practices.
 - Equip direct care professionals with available trainings and safeguards to ensure the health and safety of staff and people served.
 - Establish continuity of care throughout transitions from hospital or crisis settings or other service providers.
- Create an affordable and accessible how-to guide or training module for new providers related to person-centered planning and service delivery, such as the assessment/intake process, creating individualized support plans, etc.
- Clearly identify who would benefit from DHS training opportunities and announcements related to support planning among different service types.
- Offer specialized training opportunities to lead agencies and case managers such as housing, waiver type, mental health resources, etc.

Consideration 4

Expand resources for youth in the disability services system.

Explanations supporting the need for change

- There are not enough service or placement options for youth that can provide the level of support needed, including treatment related to trauma-informed care, substance use disorder and other cognitive or mental health diagnoses.
- Providers might experience barriers and challenges, or even fear, when providing services to youth, such as difficulties or delays obtaining licensure, high level support needs, family dynamics and/or interactions between family and the support team members, which might influence the success of the services outcome.
- When services, including availability of intervention services, high-level treatment options or other specialized services are not available within their communities or throughout Minnesota, some youth must receive out-of-town or out-of-state services, potentially removing them from their community, which creates difficulties for families to engage in the therapeutic treatment processes.
- While Minnesota prioritizes having a youth live in or transition back to their home with services in place, there is lack of available professionals to work with the families.

Examples of potential systems change

- Increase the number of foster residence settings that are designed for youth in the metro and rural areas of state to allow youth to stay within their communities.
- Develop positive support services that specialize in working with youth and families in and out of the home.
- Gather information to conduct a study on why some services are denied for youth that are designed to meet higher levels of care or provide treatment for youth with dual diagnoses.

Key learnings related to service terminations and/or suspensions:

- Collaboration among lead agencies, providers, law enforcement and emergency services are necessary to support people with varied needs related to disability, mental health, substance use and/or crisis.
- Without multiple perspectives in person-centered planning and service delivery, there may be a disconnect between what the person who receives services wants, what the support team wants and what the assessment identifies as strengths and needs to improve the person's independence and quality of life.

- Matching a person's services needs might be influenced by an agency's intake process, long waitlists for preferred providers, a moratorium on residential settings and service access and availability.
- Challenges exist when aligning staffing ratios with the needs of the person and the capacity of the providers.

Considerations related to medication errors

Consideration 5

Consider options to attract and retain high-quality supervisors within disability service programs.

Explanations supporting the need for change

- While supervisors are expected to provide oversight and development to direct support professionals, ensure program integrity and compliance and provide person-centered services to everyone in the program, they might not be able to prioritize those duties with high turnover, administrative tasks or providing direct care in lieu of supervisory duties.
- Qualified supervisors allow for consistent training among direct support professionals, a supportive work environment, a shared understanding of roles and responsibilities and a reduction in critical incidents such as medication errors.
- Rate adjustments for supervisory staff might influence retention of not only supervisory staff, but also direct care professionals, as the increased support might influence their retention and interest in career advancement.

Examples for potential systems change

- Increase the factor for supervisory staff in the Disability Waiver Rate System to allow a higher framework percentage or wage for staff supervision and staff development.
- Gather information about how supervisory staff turnover influences the development of direct care professionals and/or the prevalence of critical incidents.

Consideration 6

Develop ways to connect various agencies to use safety science principles and practices in Minnesota.

Explanations supporting the need for change

- Service providers can use approaches learned from Culture of Safety trainings and develop a practical implementation of the initiative within their organization or among a group of organizations to collect data on areas of interest that are directly related to or affect services, providers, people served and direct care workers.
- Increased awareness and knowledge of safety science principles allow for organizations to take a proactive approach in assessing critical incidents or internal processes that shift the focus from blame and consequence to one of accountability and change.
- The use of Culture of Safety strategies within organizations might influence the reduction of critical incidents and disciplinary action, subsequently improving staff retention and quality of services and collaboration among disability service providers.

Examples of potential systems change

- Further expand the Culture of Safety initiative to develop a statewide or regional community of practice or workshop with disability service providers to collect data about various incident types or processes within their organizations. These may include internal processes when addressing undesired outcomes such as medication management or errors.
- Incentivize the Culture of Safety initiative to promote participation from providers, direct care workers and lead agencies in systemic critical incident or learning reviews.

Consideration 7

Increase equitable access and affordability of technology-related resources to service providers throughout the state.

Explanations supporting the need for change

- Access and affordability of technology, specifically in rural areas or among smaller providers, might reduce the prevalence of some critical incident types, including documentation or medication errors.
- For technology efforts to be successful, reliable internet service is imperative; however, in some regions, high speed internet is not readily available.

- Access and affordability of education and training on technology resources will allow for service providers throughout state be knowledgeable about available resources, to collect data about critical incidents and assess internal processes.
- While some technology resources are covered waived services for people who receive services, they often are not covered if the service provider chooses to use a resource such as a medication dispenser. Providers can use these resources to set up medications in advance, reduce access to medications, involve the person in the process to increase their independence with medication administration and aid in the reduction of medication errors.

Examples of potential systems change

- Increase access to affordable technology for disability service providers, such as high-speed internet, electronic documentation software, assistive technology and required trainings related to the technology.
- Increase awareness and access to assistive technology for medication management and administration to create a more efficient system with fewer medication errors and possible reduced reliance on staff.
- Develop a standardized medication administration training for direct support professionals to reduce financial and accessible discrepancies and disparities among services providers throughout the state and aid in the reduction of medication errors and subsequent consequences or disciplinary action, such as terminations.

Key learnings related to medication errors

- Staffing shortages have increased responsibilities among DSPs and supervisory staff, which influences which tasks, such as medication administration, to prioritize.
- While increased wages might not allow more time for supervisory tasks, it might influence the prioritization of supervisory tasks that might affect workplace culture, staff development, staff retention and possible reduction in critical incidents.
- Qualified and available supervisors contribute to consistency in training, positive outcomes and a supportive work environment.
- Service providers can use technology to streamline their internal processes, monitor incidents and collect data on the occurrence of incidents, such as medication errors, and prioritize the needs of the person while promoting education, independence and maintaining health and safety.
- Electronic documentation software allows for service providers to access data, monitor incidents in a timely manner and accurately and efficiently transcribe and share information; however, it is expensive to purchase and to train service providers, making it inequitable for smaller service providers.

- The creation of a standardized medication administration training offered by DHS might reduce medication errors as providers would adhere to best practices rather than deferring to their own policies and procedures.
- Communication challenges exist between providers and medical professionals.
- Because of staffing shortages or increased responsibilities, there might be limited time to share imperative health or medication changes with other staff; or staff might not be aware of what tasks to prioritize, such as medication administration.

Considerations related to staff sleeping

Consideration 8

Consider options to attract and retain high-quality direct support professionals within the disability service programs.

Explanations supporting the need for change

- Direct support professionals might experience burnout and fatigue when they are scheduled to work long hours, work multiple jobs and/or work in challenging environments.
- There are inconsistencies with training, competency and/or staff development among agencies, which might be further influenced by the workforce shortage.
- It might be challenging for direct support professionals to take a break when they are single-staffed and responsible to provide constant supervision.

Examples of potential systems change

- Increase access to mental health services for direct support professionals.
- Develop a help desk or community of practice for direct support professionals to increase support and opportunities to share experiences or best practices.
- Create standardized trainings for direct support professionals to allow for transferable training among multiple agencies.
- Assess supervision requirements and processes and options for assistive technology or remote monitoring.
- Consider reviewing unsupervised or “alone time” processes.

Key learnings related to staff sleeping

- It is imperative to re-evaluate a person's level of support and supervision needs as they might change over time.
- Emotional fatigue can influence a staff member's productivity. Access to outside mental health or support services might reduce fear/shame in the workplace and improve overall work and job satisfaction.

Considerations related to supervision not maintained and wheelchair safety

The data action groups reviewed one supervision not maintained and two wheelchair safety incidents. While formal considerations were not established, the data action groups identified key learnings related to each of the incident types.

Key learnings related to supervision not maintained

- When staff did not maintain a person's 24-hour supervision, it often was influenced by staff's focus on prioritizing another situation or their own self-care.
- To allow a direct support professional to take a break during a shift, it might be reasonable to assess a person's supervision needs, such as unsupervised time in or out of the facility, remote monitoring or other type of assistive technology.
- It is important to learn and understand what needs are being met when the person leaves without staff supervision. Using a person-centered approach might identify that the person is interested in unsupervised time without staff, which can be an opportunity to develop goals on safety, independence and possible use of assistive technology or remote monitoring to reduce the reliance on staff.

Key learnings related to wheelchair safety

- Wheelchair safety incidents often occurred when staff deviated from expected practices outlined in a person's program plans or the facility's policies and procedures.
- Discrepancies between what is documented vs. what is being done might be influenced by the person's desire not to deviate from what is in their program plans or the drift of standard practice among staff away from expected practices.

V. Summary of consideration status updates

Throughout the course of the 2024 review period, DHS shared the identified considerations and key learnings from [2024 Annual Report](#) with internal and external partners within disability services. DHS did so to explore existing efforts that promote internal systems and/or legislative change to influence the prevalence or intensity of critical incidents when supporting people who receive services. This approach acknowledges how systemic themes are influenced by barriers and challenges that exist across different levels of disability services and what considerations might promote a proactive response to critical incident outcomes.

In 2025, DSD identified ways to ensure that each consideration will be communicated to the designated internal departments. In addition, we created partnerships to ensure that considerations from the Culture of Safety were aligned with other business areas that were engaged with the community on challenges and barriers within the disability service system. In June 2025, DSD created a safety action group to:

- Review considerations and suggestions
- Provide information or education on individual policies
- Consult on equity issues that arise
- Review annual reports
- Provide feedback on previous considerations proposed by the data action groups.

The safety action group can use information received from the data action groups to create actionable outcomes that might be used to inform proposed legislative changes or make recommendations for additional areas of study with internal systems that did not go as expected.

Since the last annual report, DSD evaluated the current standard operating procedures and proposed goals to enhance the Culture of Safety initiative within the division. As the Culture of Safety initiative continues to expand into 2026, DSD is working to establish goals that promote collaboration and systems change throughout the disability services system, including:

- Using the SLR model to look at critical incidents beyond a single episode or to assess an outcome that did not go as expected within the larger disability services system.
- Establishing quarterly reviews with the data action groups and the safety action group to review key learnings and systemic themes from each systems learning review to collaborate on actionable considerations or suggestions, or recommendations for further studies within internal and external systems issues.

- Considering potential changes to the outline of the annual report and include the status updates provided by the safety action group.
- Evaluating how to address diversity, access and attrition within the roles and groups participating in the systems learnings incident review models.
- Using equity analysis tools to assess the current Culture of Safety Initiative and considerations that might be selected for implementation by the safety action group.
- Developing a plan outlining strategies for community engagement and strategic partnerships designed to foster ongoing knowledge building and the effective application of safety science principles and practices.

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ማሳሰቢያ፦ አማርኛ ተናጋሪ ከሆኑ ፤ ነጻ የቋንቋ ድጋፍ አገልግሎቶች ካለምንም ክፍያ እና ካለአላስፈላጊ መዘግየት ማግኘት ይቻላሉ። በተጨማሪም መረጃን በቀላሉ ለማግኘት በሚያስችል ቅርጽት ለማቅረብ ተገቢ የሆኑ የመስማት ድጋፍ እና አገልግሎቶች ከክፍያ ነጻ በሆነ እና ግዜውን በጠበቀ መልኩ ማግኘት ይቻላሉ። እባክዎ ከላይ ባለው ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። Amharic

تنبيه: نقدم لمتحدثي اللغة العربية خدمات مساعدة لغوية مجانية وفورية، بالإضافة إلى وسائل وخدمات مساعدة مناسبة، وبصيغة معلومات سهلة بدون تكلفة وبشكل سريع. يرجى التواصل على الرقم الموضح أعلاه أو مراجعة مقدم الخدمة المباشرة. Arabic

মনোযোগ: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জনসভা সহায়তা পরিষেবা বিনামূল্যে এবং অ-স্বল্পমূল্যে বিল ছাড়াই পাওয়া যায়। এছাড়াও, একটি সহজলভ্য ফর্মটিতে তথ্য দানের জনসভায় উপস্থিতি সহায়ক সরঞ্জাম এবং পরিষেবা বিনামূল্যে এবং সমন্বিতভাবে পাওয়া যায়। উপরের নথিতে কলকাতা অথবা আপনার মতো ভাইডারের সাথে কথা বলুন। Bengali

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာဘာသာစကား ပြောဆိုသူဖြစ်လျှင် အခမဲ့ ဘာသာစကားဆိုင်ရာ ပံ့ပိုးထောက်ပံ့ပေးမှု ဝန်ဆောင်မှုများအား မလိုအပ်သည့် နှောင့်နှေးကြန့်ကြာမှုများ မရှိစေဘဲ သင် အခမဲ့ ရရှိနိုင်မည် ဖြစ်သည်။ ထို့ပြင် အချက်အလက်များအား အလွယ်တကူ ဝင်ရောက်ရယူနိုင်စေသော ဖောမတ်ပုံစံများဖြင့် ထောက်ပံ့ပေးထားသည့် သက်ဆိုင်ရာ ဖြည့်စွက် ထောက်ပံ့မှုများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့၊ အချိန်မီ ရရှိနိုင်စေရန် စီမံပေးထားပါသည်။ ကျေးဇူးပြုပြီး အထက်ဖော်ပြပါ ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ သို့မဟုတ် သင်၏ ထောက်ပံ့သူဖြင့် ပြောဆိုဆွေးနွေးပါ။ မြန်မာဘာသာစကား၊ Burmese

យកចិត្តទុក កុំបរិសុទ្ធបេ2ងៗនិ5 យ6 7 ខែ(ខែ)
 សេ>កម្មជន្មយ6 7 ឥតគិតថៃ្ល8 នង្គជន្មនា4) យមិនគិតថៃ្ល(និង) យN:SO រាងQពេលមិនR'S ចំឡើ2ង
 លេ2ងនេះ ជំនួយ និងសេ>កម្មដែលសមសប្ប4O រាង8ៗក៏H នា4ទម្ងង់ដែល ចូលបេ2
 S នគី ចាកS ន) យឥតគិតថៃ្ល(និង នំពោលa ។ សូមb ទូរសព៌d លេខe ងលេ2
 ឬនិ5 យg មយរាង8ៗសេ>របស់4។ 67 ខែ(ខែ) Cambodian (Khmer)

注意：如果您說簡體中文，您可以免費獲得語言協助服務，且不會有不必要的延誤。此外，還能免費及時獲取以無障礙格式提供資訊的適當輔助工具和服務。請撥打上面的電話號碼，或與您的服務提供商溝通。

Cantonese (Traditional Chinese)

Á, DÉ YAWÁ PO! Dakhód'iyaye héčinghan, iyápi-wóokiye išíčhona yanke. Ka nakún wanáñ'unpi-wóokiye išíčhona yanke. Héched wónáñ'un kin iyóhiphiča dó. Wóokiye kin dená išíčhona ičúphiča nahán yuthéhanšniyan ičúphiča dó. Wičhóiyé kin dená iwánkab, wóiyawa wan yanke kin mas'ákiphapi na wóokiye-wicháša kičhí wóhdaka po. Dakota

TRS: 711

PAUNAWA: Kung nagsasalita ka ng Filipino, ang mga libreng serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad at walang hindi kinakailangang pagkaantala. may mga angkop na pantulong na kagamitan at serbisyo upang maibigay ang impormasyon sa naaangkop na anyo, nang libre at sa tamang oras. Mangyaring tawagan ang numero sa itaas o makipag-usap sa iyong provider. Filipino

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, sans frais et sans délai. En outre, des aides et services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont disponibles gratuitement et rapidement. Veuillez appeler le numéro ci-dessus ou contacter votre fournisseur. French

સાવધાન: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાયની મફત સેવાઓ તમારા માટે નિ:શુલ્ક અને બિનજરૂરી વિલંબ વગર ઉપલબ્ધ છે. વધુમાં, સુલભ પ્રારૂપમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક મદદ અને સેવાઓ નિ:શુલ્ક અને સમયસર ઉપલબ્ધ છે. કૃપા કરીને ઉપરના નંબર પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. Gujarati

!। न दशमदि आप हिंदी बोलते ह2तो आपके लिए नि:शु8 भाषा सहायता सेवाएँ नि:शु8 और बिना किसी अनावA क देरी के उपलC ह2 इसके अतिरG , सुलभ H।। पों मञ्जानकारी Hदान करने के लिए उपयुG सहायक साधन और सेवाएँ नि:शु8 और समय पर उपलC ह2 कृपया ऊपर दिए गए नंबर पर कॉल करञ्ज् अपने Hदाता से बात कर%।Hindi

CEEB TOOM: Yog koj hais lus Hmoob, muaj kev pab txhais lus dawb rau koj siv. Koj tsis tas them nqi thiab yuav tsis qeeb. Kuj muaj cuab yeej thiab kev pab los pab koj nyeem cov ntaub ntawv kom yooj yim nkag siab. Koj hu tau rau tus xov tooj saum toj no lossis nrog koj tus kws kho mob tham. Hmong

ဟံသာဝတီသား- နမ့်ကတိကညီကိုင်အယိ, နမ့်န့် ကိုင်တံဆိပ်ထွဲမၤစၢၤ လၢတလက်ဘျီလက်စ့ၤ ဒီးတအိုင်ဒီး တံမၤယံမၤနီၤသးဘဉ်န့ၣ်လီၤ. အိၣ်အန့ၣ်, တံအိုင်စ့ၢ်ကီးဒီး တံမၤစၢၤတံနီၤဟူၣ်ဒီး တံမၤစၢၤတံမၤတဖၣ် လၢကဟ့ၣ်တံဂံၢ်တံဂျီၤ လၢပုၤအါဂၢၢ်ပၢ်အီၤသ့ လၢတအိုင်ဒီးအဘူးအလဲ ဒီးချူးဆၢချူးကတိၢ်န့ၣ်လီၤ. ဝံသးစ့ၤ ကိးနီၣ်ဂံၢ်လၢထး မ့တမ့ၢ် တဲသကိးတံဒီး ပုၤလၢအဟ့ၣ်န့ၣ်တံမၤစၢၤ တက့ၢ်. ကညီကိုင် Karen

안내: 한국어를 사용하시는 분께는 언어 지원 서비스를 무료로, 지체 없이 제공해 드립니다. 또한, 정보 접근성을 위한 적절한 보조 기구 및 서비스가 무료로, 시의적절하게 제공됩니다. 위에 있는 번호로 전화하시거나 담당자에게 말씀해 주십시오. Korean

ئاگاداری: ئه‌گه‌ر تۆ به‌ زمانی کو وێ عێزانی قسه‌ ده‌که‌یت، ئه‌وا خزمه‌تگوزاری هاوکاریی زمان به‌ بێهه‌رامبه‌ر و به‌ی دواکه‌وتنی ناپیویست له‌به‌رده‌ستتدایه‌. جگه‌ له‌وه‌ش، هاوکاری و خزمه‌تگوزاری به‌ یارمه‌تیده‌ره‌ گونجاو هه‌کان بۆ دابینه‌کردنی زانیاری به‌ شیوه‌ی گونجاو به‌ی به‌رامبه‌ر و هاوکات به‌رده‌ستن. تکایه‌ پهیوه‌ندی به‌ ژماره‌یه‌ عێسه‌ره‌وه‌ بکه‌ یان له‌گه‌ڵ دابینه‌که‌ره‌ مه‌کتدا قسه‌ بکه‌ن. کوردی سۆرانی Kurdish Sorani



TRS: 711

BALDARÎ: Heke hûn bi Kurdîya Kurmancî diaxivîn, xizmetên alîkarîya ziman bêpere û bêyî derengmayîneke nehewce ji we re peyda dibin. Her wiha, hevkarîyên guncaw û karûbarên alîkar bêpere û di heman demê de ji bo dabînkirina agahdariya guncaw hene. Ji kerema xwe bi jimareya jorîn re telefon bikin an jî bi dabînkerekê xwe re biaxivîn. Kurdish Kurmanji

Á, LÉ YAWÁ PO! Lakhól'iyaye héçi, iyápi-wóokiye isííchola yanké. Nahán nakún waná'h'unpi-wóokiye isííchola yanké. Héçhel wóna'h'un kin iyóhiphiça yeló. Wóokiye kin lená isííchola ičúphiça nahán yuthéhanšniyan ičúphiça yeló. Wičhóiyé kin lená iwánkab, wóiyawa wan yanké kin mas'ákipħapi na wóokiye-wiçháša kičí wóglaka po. Lakota

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານຈະໄດ້ຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ແລະ ບໍ່ມີການຊັກຊ້າທີ່ບໍ່ຈຳເປັນ. ນອກຈາກນັ້ນ, ເຄື່ອງມືຊ່ວຍເຫຼືອແລະ ບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ກະລຸນາໃຫ້ທາເບີໂທລະສັບຂ້າງເທິງ ຫຼື ສົນທະນາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. Lao

注意：如果您说简体中文，您可以免费获得语言协助服务，且不会有不必要的延误。此外，还能免费及时获取以无障碍格式提供信息的适当辅助工具和服务。请拨打上面的电话号码，或与您的服务提供商沟通。
Mandarin (Simplified Chinese)

PALE RO PINY: Mi ruaci ke thok Nuärä, luäk mi lor ke kuic thuok kene lät tin jiëke tõe thin baan a thiel mi yuor ke piny kä thiele mi gaal je. Min dëe nyok ke mat thin, e luäk mi dodien kene lät tin koken tin nöön ke läri ke duop min jiëke ke tõe ke thin baan thile mi yuorke piny ke kuicdien ke guath mi goa. Mi nhok i je yotni nambär emo tõe nhial o ikä kie ruacni ke ram min luäkdü. Nuer

MAH BIZ'SIN'DAN: Keesh'pin, keen Ojibwe'mo, kaa'ween ina'gin'de wiiji'kaa'kii'ki'do miina'waa ke'nebe-naa'ta'maw chi'nis'too'ta'man noon'goom. Da'kon'an, wee'chi'ma'zinaa'beke'webene'kan'an ozhe'che'kan miina'waa kinah ozhee'bee'geh ma'zenah'egan'an kaa'ween ina'gin'de miina'waa da'daa'ta'be'bee'an. Da'gah'na'sa ka'noozh aseh'ge'beh'egan ish'peh'meng ge'maa kee'kidoon wii'doo'kaa'geh. Ojibwe

HUBADHAA: Yoo Afaan Oromoo dubbattu ta'e, tajaajila gargaarsa turjumaana afaanii biliisaan akkasumas turtii barbaachisaa hin taane hambisu danda'u isiniif dhihaatee jira. Dabalataanis, odeeffannoo haala salphaan argamuu danda'an dhiyeessuuf gargaarsa fi tajaajiloota deeggarsaa qama midhamtootaaf mijatoo ta'an, kaffaltii tokko malee fi yeroo isaa eeggatee kennamu dhihaatee jira. Odeeffanno dabalataaf lakkoofsa armaan oliitti fayyadamuun namoota gargaarsa kana isiniif kennan qunnamaa. Oromo

ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos e sem demoras desnecessárias. Além disso, estão disponíveis, gratuitamente e numa forma atempada, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Por favor, contacte o número acima ou fale com o seu prestador de serviços. Portuguese

TRS: 711

ВНИМАНИЕ: Если вы разговариваете на русском языке, воспользуйтесь услугами языковой поддержки бесплатно и без лишних проволочек. Также бесплатно и незамедлительно предоставляются соответствующие вспомогательные средства и услуги по обеспечению информацией в доступных форматах. Позвоните по указанному выше номеру или обратитесь к своему поставщику услуг. Russian

PAŽNJA: Ako govorite srpski, besplatne usluge jezičke pomoći su vam dostupne besplatno i bez nepotrebnog odlaganja. Pored toga, odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima dostupne su besplatno i blagovremeno. Molimo vas da pozovete gore navedeni broj ili razgovarate sa vašim pružateljem usluga. Serbian

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, waxaa si bilaash ah kuugu diyaar ah adeegyada caawinada luuqadeed oo aan lahayn daahitaan aan munaasib ahayn. Intaas waxaa dheer, waxaa la heli karaa adeegyada iyo kaabitaanka naafada ee haboon si macluumaadka loogu bixiyo qaabab la adeegsan karo oo bilaash ah laguna bixinayo waqqigeeda. Fadlan wac lambarka kore ama la hadal adeegbixiyahaaga. Somali

ATENCIÓN: si habla español, tiene a su disposición los servicios gratuitos de traducción sin costo alguno y sin demoras innecesarias. Además, se encuentran disponibles de forma gratuita y oportuna ayuda y servicios auxiliares adecuados con el fin de brindarle información en formatos accesibles. Llame al número indicado anteriormente o hable con su proveedor. Spanish

ZINGATIO: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha zinapatikana kwa ajili yako bila malipo na bila ucheleweshaji usio wa lazima. Aidha, vifaa saidizi vya mawasiliano na huduma kwa walemavu ili kutoa habari katika miundo inayofikika zinapatikana bila malipo na kwa wakati. Tafadhali piga simu kwa namba ya hapo juu au zungumza na mtoa huduma wako. Swahili

መተሓሰቢ:- ትግርኛ ተዛራቢ እንተኾይኖም ፤ ናጻ ናይ ቋንቋ ሓገዝ ግልጋሎታት ብዘይምድንጓይ ምርካብ ይኸእሉ እዮም። ብተወሳኺ ሓበሬታ ብቐሊሉ ምርካብ ብዝከእል ቅርጽታት ንምቕራብ ፤ ግቡእ ናይ ምስማዕ ሓገዝን ግልጋሎታትን ካብ ክፍሊት ናጻ ብዝኾነን ግዚኡ ብዝሓለወን መልኰ ይርከቡ። ቢይዝኡም ኣብ ላዕሊ ናብ ዘሎ ቐጽሪ ይደውሉ ወይድማ መቐረቢኡም የዘራርቡ። Tigrinya

УВАГА: Якщо ви розмовляєте українською мовою, ви можете скористатися послугами мовної підтримки безкоштовно та без зайвих зволікань. Ви також можете безкоштовно та оперативно отримати відповідні допоміжні засоби та послуги з надання інформації у доступному форматі. Зателефонуйте за вказаним вище номером або поговоріть зі своїм постачальником послуг. Ukrainian

LƯU Ý: Nếu bạn nói tiếng Việt, bạn có thể được hỗ trợ ngôn ngữ miễn phí mà không phải chờ đợi lâu. Ngoài ra, các thiết bị hỗ trợ và dịch vụ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng có sẵn miễn phí và kịp thời. Vui lòng gọi số điện thoại phía trên hoặc trao đổi với nhân viên y tế của bạn. Vietnamese

ÌKÉDE PÀTÀKÌ: Tí o bá leè sọ èdè Yorùbá, àwọn ètò ìrànlówọ èdè wà fún ọ ní ọfẹ tí kò sì ní ìdènà nínú. Ní àfikún, àwọn ìlànà isẹ àti ohun èlò ìrànlówọ tó pé ye wá ní ẹkúnrẹfẹ látí pèsè àlàyé èyíkéyíí tí o bá nílò ní ọfẹ àti ní òrèkòòrè. Lọwọ, pe ẹrò Ìbáńsọrọ tó wà lókè tàbí kí o bá aṣojú rẹ sọrọ. Yoruba

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