



DEPARTMENT
OF HEALTH

Health Regulation Division Licensed Home Care Provider Advisory Council Meeting

Lindsey Krueger, Susan Winkelmann and Catherine Lloyd

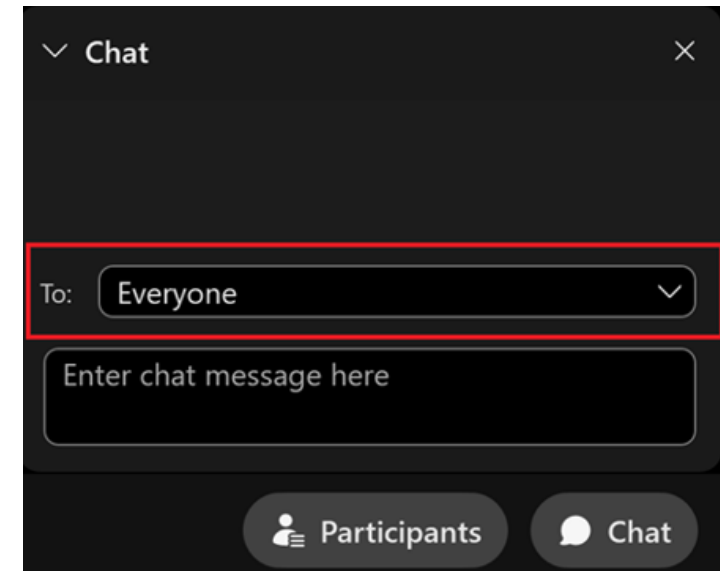
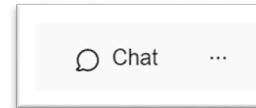
April 4, 2022

Agenda

- Welcome
- Planning and Partnership Update
 - Collaborative Safety Science Project Overview
- Home Care and Assisted Living Survey Data
- Council Member Feedback – Safety Science Project
- General Updates, Information, and Discussion
- Closing

How to Ask a Question/Provide a Comment

- Participants are muted.
- **To ask a question** Click on the chat bubble to open the chat, select Everyone, and ask a question or provide a comment.
- **We will answer** as many questions/comments as we can at the end of the time together.



ALL Together Newsletter

- Subscribe to HRD’s ALL Together Newsletter for up-to-date information regarding Assisted Living Licensure

- [MDH Email Updates \(https://public.govdelivery.com/accounts/MNMDH/subscriber/new?topic_id=MNMDH_660\)](https://public.govdelivery.com/accounts/MNMDH/subscriber/new?topic_id=MNMDH_660)



Collaborative Safety Project Update

- **2021** - Orientation for HRD staff, providers and stakeholders
- **2022 – 2024** - Contract with Collaborative Safety LLC
- **March 14 & 16** - Information session for HCPAC / RQCOI
- **Systemic Critical Incident Review Institute**
 - 14 HRD staff finished training April 1
- **CS Steering Team** meeting April & May to customize model
 - Outreach for ideas
 - Orientation session will be scheduled for providers & stakeholders

Recap - Safety Science in HRD

- **Establish a method and atmosphere** where regulators, providers, stakeholders, consumer and provider organizations study critical incidents
 - **Discuss challenges and vulnerabilities** within the system without fear of retaliation
 - **Develop a process** for learning and improving system
 - **Increase staff engagement**, morale, and retention
 - **Improve outcomes** for clients



Recap - What is the Process?

- **Develop the case study** on incidents we want to study
- **Conduct human factors debriefing**
- **Map the incident** with regulators, providers, stakeholder groups
- **Understand why** decisions were made
- **Collect data, analyze** data, learn, and recommend improvements



Revealing the “Second Story”

Old View of Identifying Cause of Critical Incident

- Asks *who* is responsible for the outcome
- Sees human error as the cause of trouble
- Human error seen as random, unreliable behavior
- Human error is an acceptable conclusion of an investigation

New View using the CS System Safety Model

- Asks *what* is responsible for the outcome
- Sees human error as a symptom of deeper issues
- Human error is systemically connected to features of people’s tools, tasks, and operation environment
- Human error is only the starting point for further investigation

Adapted from *The Field Guide to Understanding Human Error* (Dekker, 2014). Pages 6-7

Revealing Influences and Decisions-Making

Old View of Evaluating Critical Incidents

- Determines *what* people failed to do
- Determines *what* people should have done to prevent the critical incident or outcomes

New Method of Evaluating Influences & Decisions

- Tries to understand *why* people did what they did
- Asks *why* it made sense for people to do what they did

Adapted from *The Field Guide to Understanding Human Error* (Dekker, 2014). Pages 6-7

What are the Key Take-Aways

- **Facilitated process** to analyze systems and trends
- **Includes “voices”** across the system
- **Captures complexities** of the system
- **Informs change**
- **Tracks and communicates** review outcomes over time
- **Supports improvements** to systems and culture
- **Note: Our Accountability remains:** Process does not replace our existing regulatory responsibilities or reduce accountability

Systemic Critical Incident Institute

- **HRD staff** attending SCIR institute representation
- **Systemic Critical Incident Institute** staff feedback
 - I can't wait to dive more into this and really make a difference of the lives of residents, healthcare workers and all others involved!
 - A great new beginning!
 - Really eye-opening way of looking at safety and regulation.
 - The most important training ever!
- Recognize the complexities of systems leading to incidents
- Staff are engaged, energized and ready to apply the principles to improve systems, structures and outcomes

SFY 2022 Home Care/Assisted Living Top Deficiencies

Assisted Living State FY 2022 8/1/2021 to 2/1/2022

1. Infection Control Program (144G.41 Subd. 3)
2. Food Code (144G.41 Subd. 1 (13)(i)(B))
3. Fire Protection and Physical Environment (144G.45 Subd. 2 & 144G.81 Subd. 1)
4. Resident Grievances/Reporting Maltreatment (144G.41 Subd. 7)
5. Disaster Planning and Emergency Preparedness (144G.42 Subd. 10)

Home Care State FY 2022 8/1/2021 to 2/1/2022

1. Content of Service Plan (144A.4791, Subd. 9(f))
2. TB Infection Control (144A.4798 Subd. 1)
3. Individual Abuse Prevention Plan (144A.479 Subd. 6(b))
4. Required Annual Training (144A.4796 Subd. 6)
5. Employee Records (144A.479 Subd. 7)

Questions and Feedback

- What questions do you have for us?
- What feedback do you have for us on this process?
- What ideas do you have for critical incidents to study?
- How can we encourage providers to participate?

What's Next

- HRD steering team will meet with consultant from CS to build a customized model
 - Types of incidents to track
- Hold information sessions with stakeholders
- Hold orientation sessions for providers and stakeholders
- Schedule review and mapping sessions
- Collect data and report findings



Thank you and stay safe!