

Central Service Area

Initial Safety Assessment 2nd Round - Safety Model QA Review



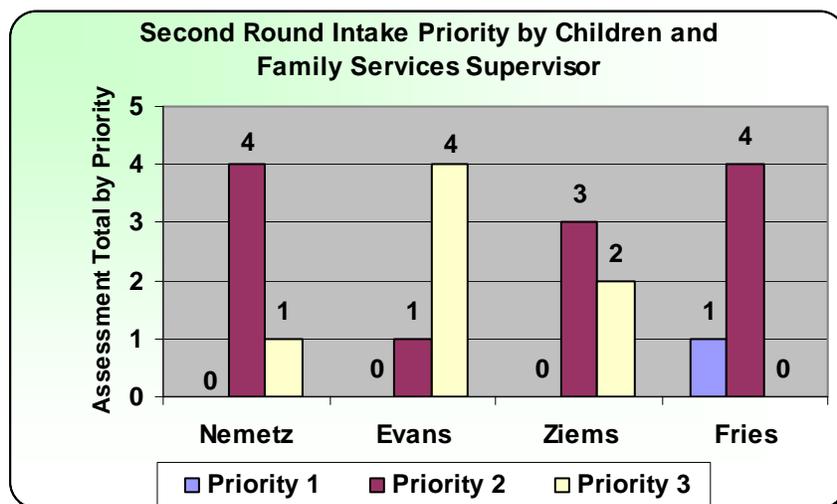
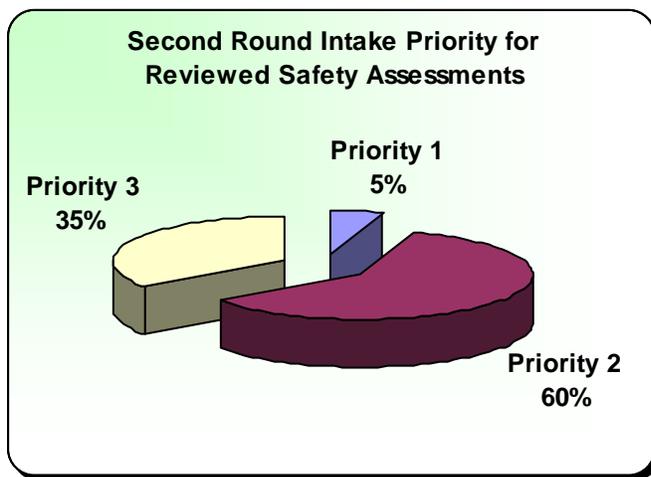
**Nebraska Department of Health and Human Services
Quality Assurance**

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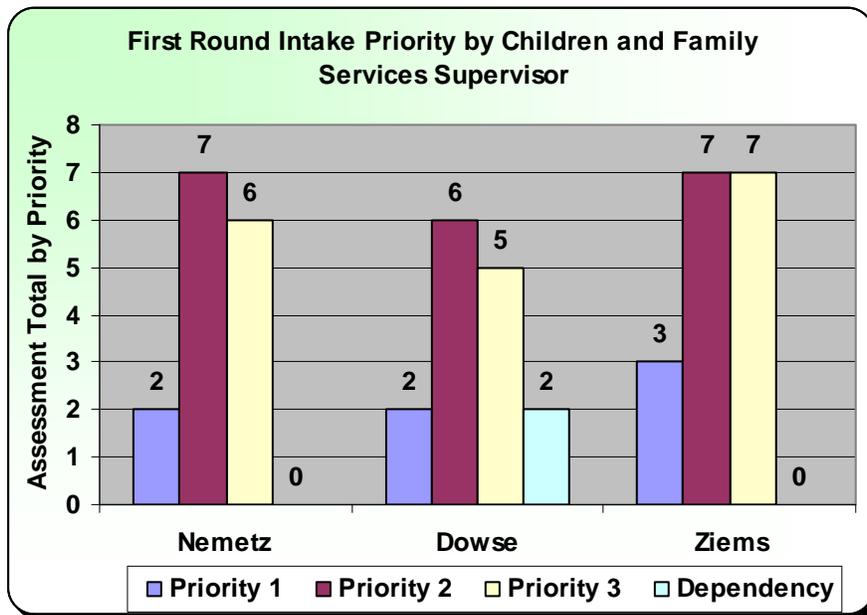
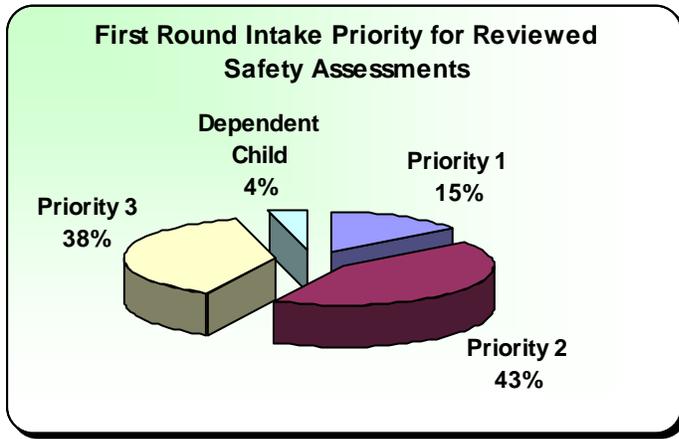
Quality Assurance Team completed second round of Initial Safety Assessment Reviews in October 2008. A total of 20 finalized Safety Assessments were randomly selected by QA staff from four Children and Family Services Supervisors (CFSS). Review consisted of five assessments from each CSA Supervisor; Laurie Ziems, Chris Nemetz, Brett Fries and Colette Evans.

First round of reviews of Initial Safety Assessment for CSA was completed in March 2008. A total of 47 finalized Safety Assessments were submitted to QA staff from three Children and Family Services Supervisors in CSA. The reviews consisted of seventeen assessments from Laurie Ziems and fifteen cases each from Chris Nemetz and Kristi Dowse.

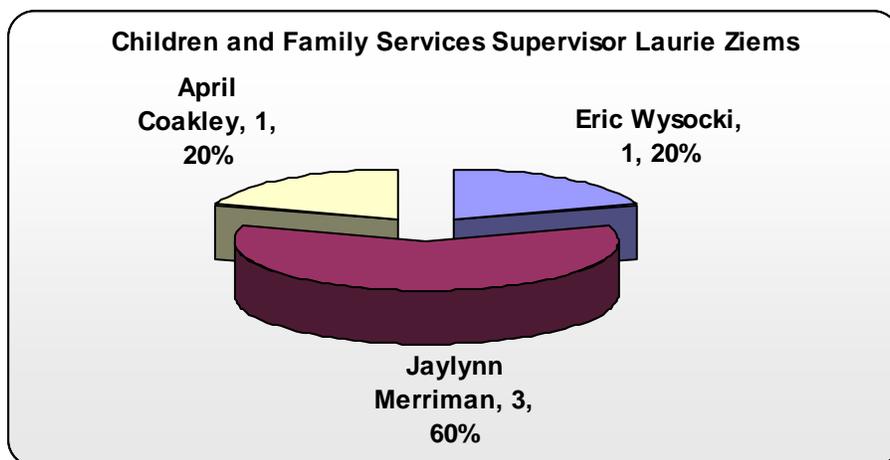
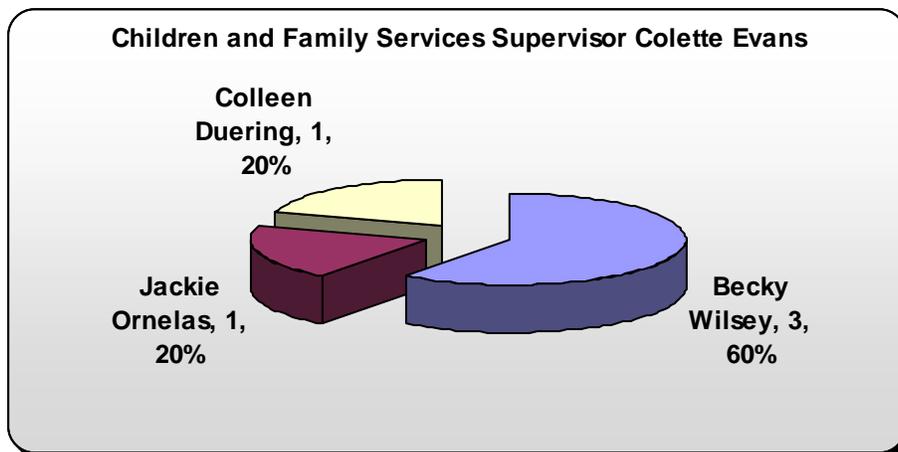
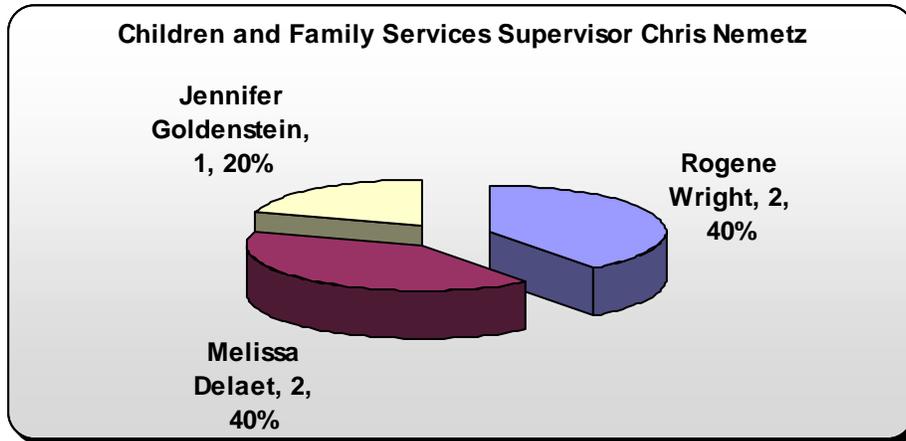
Second Round: 20 assessments reviewed; 1 was Priority 1, 12 were Priority 2 and 7 were Priority 3.



First Round: 47 assessments reviewed; 7 were Priority 1, 20 were Priority 2, 18 were Priority 3 and 2 intakes were dependency and did not have a priority listed on the intake or the assessment.



All reviewed Safety Assessments for Children and Family Services Supervisor Brett Fries were completed by Children and Family Services Specialist, April Coakley. The following charts contain a breakdown of reviewed assessments per worker for each Children and Family Services Supervisor:



The following is a summary of Second Round Data from ALL 20 Initial Safety Assessment reviews. Charts for these overall data can be found in the attached excel file: CSA Safety QA Report.CHARTS.Overall 2nd Round. Charts in these attachments, compare 1st Round and 2nd Round Initial Safety Assessment Reviews.

Initial Response/Contact Information (Chart 1):

- Initial contact with child victim was made within required time frame in 90% of the Safety Assessments (18 out of 20 instances).
- Other children in the household were present in 3 of the 20 (15%) of the reviewed assessments. Other children in the home were interviewed in 3 out of 3 instances (100%).
- 6 out of 20 reviewed assessments had a non-maltreating caregiver listed in the intake. The non-maltreating caregiver was interviewed in 100% of the instances.
- Other adults were present in 2 of the reviewed assessments. 50% or 1 out of 2 of these adults was interviewed by workers.
- Interviews with the maltreating caregiver occurred in 89.5% or 17 out of 19 assessments where a maltreating caregiver was identified. One reviewed assessment was not applicable to this item.
- Interview protocol was followed in 60% or 12 out of 20 assessments. For those assessments that did not follow protocol reviewers were unable to find documentation to indicate the reason for the deviation from protocol in 8 out of 8 assessments (0%).

Present Danger (Chart 2):

- Present danger at the initial contact with the child victim and/or family was not identified in the reviewed assessments (0%).
- Reviewers agreed with the worker's assessment of Present Danger (100%).
- No Safety Assessments had an Immediate Protective Action (IPA) taken.

Domains (Chart 4):

- **Maltreatment** – Sufficient information was collected in 70% (14 out of 20) of the assessments.
 - *Reviewer Comments: Interview or include information for everyone listed as perpetrators. Include findings/conclusions and evidence to support findings, include removal of child, address all areas of concern in the intake. Caution run on narratives, information needs to be separated into other domain areas.*
- **Nature** – Sufficient information was collected in 45% (9 out of 20) of the assessments.
 - *Reviewer Comments: Information contained in domain is evidence and goes to supporting the finding, therefore should be contained in maltreatment. Include analysis of events/factors surrounding the abuse and neglect. Include pattern of why the abuse and neglect is occurring in the home.*
- **Child Functioning** – Sufficient information was collected in 70% (14 out of 20) of the assessments.
 - *Reviewer Comments: What conclusions can be drawn from the worker's contact with all parties regarding the child's behavior and development? Discuss nature of peer interactions. Worker observation of child (ren), description of overarching statements surrounding child's development or behavioral difficulties; need to assess all children living in home.*

- **Disciplinary Practices** – Sufficient information was collected in 45% (9 out of 20) of the assessments.
 - *Reviewer Comments: Include situations and detailed information in which the parent implements discipline for the child(ren), future discipline plans in assessments involving infants, children’s statements of discipline in home, patterns of discipline with older children.*
- **General Parenting** – Sufficient information was collected in 40% (8 out of 20) of the assessments.
 - *Reviewer Comments: Routines within the home, include past parenting of children that may have been relinquished or terminated, family activities, parental roles, include parenting for all individuals living in the home if they take role in caring for the children.*
- **Adult Functioning** – Sufficient information was collected in 45% (9 out of 20) of the assessments.
 - *Reviewer Comments: Need to include all adults living in the home, community or family supports, Mental Health, Domestic Violence and Substance Abuse information. Talk about the nature of adult relationships within the home (marriage and other relationships).*

Collateral Source (Chart 4):

- 13 out of the 20 assessments indicated that information should have been collected from a collateral source. Collateral information was collected in 38.5% or 5 out the 13 assessments.
 - *Reviewer Comments: Incorporate the information gained from collaterals into the assessment. Many times a contact is recorded on the contact sheet but the information gained is not incorporated into the assessment. Suggest workers utilize the narrative portion in the contact sheet to document the family’s relationship to the contact.*

Maternal/Paternal Relatives (Chart 4): *There is a significant decrease in the identification of maternal and paternal relatives in the second round of reviews. This is attributed to the Service Area’s practice of not identifying relative in instances involving children who have been determined to be SAFE. In October 2008, clarification regarding the identification of relatives regardless of the safety determination was provided to the CFS Administrators and the SAA’s. All cases will have relatives identified.*

- Maternal relatives were identified in 30% of the assessments (6 out of 20).
- Paternal relatives were identified in 20% of the assessments (4 out of 20).
 - *Reviewer Comment: Documentation needs to contain at a minimum first name, last name, and location (city & state). Include in documentation parents’ refusal to provide extended family information during assessment.*

ICWA (Chart 4):

- Information regarding ICWA was obtained in 30% of the assessments (6 out of 20).
 - *Reviewer Comments: Workers need to utilize the kinship narrative and include a statement as to how ICWA information was obtained by CFS Specialist. For example, ICWA does not apply to family or N/A. Need to include statement of how the worker learned that it did not apply.*

- *Examples:*
 - *Per mother/name and father/name child does not meet criteria for ICWA because of the following reason.*
 - *Father was asked about enrollment or qualification he may meet in Native American Tribe in which he denied eligibility for him or his son.*
 - *According to (parents/name), no Native American Tribal heritage exists within the family.*

Impending Danger (Charts 3 & 4):

Impending Danger at the initial contact with the youth and/or family (Chart 3): The worker identified impending danger at the initial contact with the child or family in 20% or 4 out of the 20 reviewed assessments. One assessment the worker did not identify impending danger at initial contact due to the child living outside of the adoptive parents' home with another relative. This decision was made by the adoptive parents due to child's behavior in their home. The Department later assessed the child to be unsafe and voluntary services were initiated with the adoptive family in order to formalize arrangements with the current relative providing for the child. **The reviewer agreed with the worker's decision in 75% or 15 out of the 20 reviewed assessments.**

- Reviewer disagreed with the worker in 5 of the assessments, where the worker indicated that there was NO impending danger at the initial contact with the youth and family. The reviewers determined that there was not enough information in the assessment to determine if impending danger was present initial contact with the child and/or family.
- Although there was not enough information initially to determine impending danger, these Safety Assessments did not rise to the level of Service Area Administrator notification.

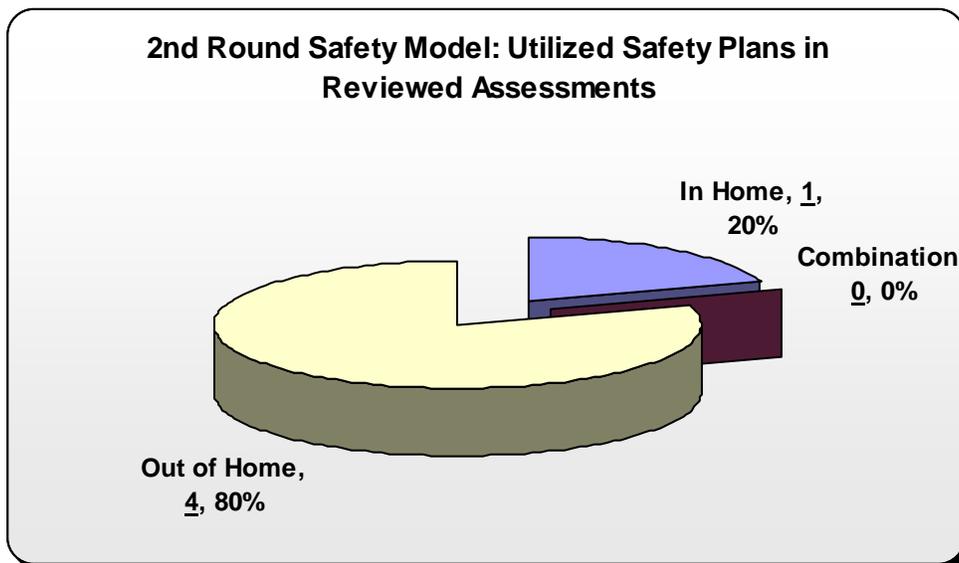
Impending Danger at the end of the Initial Assessment (Chart 4): The worker identified impending danger at the end of the initial assessment in 5 out of the 20 cases reviewed.

- 9 out of 20 (45%) of the reviewed assessments contained sufficient information to provide a reasonable understanding of family members and their functioning.
- 9 out of 20 (45%) of the reviewed assessments contained sufficient information to support and justify decision making.
- 8 out of 20 (40%) of the reviewed assessments contained sufficient information in the six domains to accurately assess the 14 factors.
- Safety threats were identified in 5 of the reviewed assessments.
 - In 80% or 4 out of 5 of the instances the reviewer agreed with the worker on all of the safety factors identified "yes".
 - Within the safety factors identified "**yes**", 4 out of 5 (80%) contained threshold documentation for identification/justification of impending danger.
- In 55% or 11 out of 20 assessments, the reviewer agreed with the worker on all of the safety factors identified "no".
- Safety Assessment Conclusion:
 - The worker determined that the child was UNSAFE at the conclusion of the safety assessment in 5 out of 20 (25%) of the reviewed assessments. The reviewer agreed with the worker's decision that the child was UNSAFE in 5 out of the 5 (100%) assessments.

- The worker determined that the child was SAFE in 15 out of 20 (75%) of the reviewed assessments. The reviewer agreed with the worker's decision that the child was SAFE in 8 out of the 15 assessments (53.3%). Reviewer determined that the child was unsafe or that the information in the assessment was not sufficient to make determination of safe or unsafe in 7 out of the 15 assessments (46.6%) in which the worker determined the child to be SAFE.

Safety Plan (Charts 5 & 6): The worker determined that the child was unsafe in 5 out of the 20 (25%) reviewed assessments. Safety plans were established at the conclusion of the safety assessment in 5 out 5 (100%) of the reviewed assessments.

- 20% or 1 out of 5 of the safety plans were in home safety plans. Reviewer agreed that the worker used the appropriate safety plan.
- No combination safety plans were utilized. Reviewer agreed that it was appropriate not to utilize a combination safety plan.
- 80% or 4 out of 5 of the safety plans were out of home safety plans. Reviewer agreed that the worker used the appropriate safety plan in all cases where an out of home safety plan was used.



- 5 out of 5 (100%) safety plans contained a contingency plan; reviewer judged the contingency plan to be appropriate in 2 out of 5 (40%) of the reviewed assessments.

Examples of sufficient contingency plan:

Note: The intent of having a sufficient contingency plan is to have staff think ahead, anticipate situations that might come up and make a plan to deal with them. A good contingency plan is an actual backup plan with names and information of individual(s) that will take over or complete safety actions if the original safety plan participant is unable to do so. A good contingency plan is one that can prevent the need for immediate caseworker notification or action.

For Out of Home Safety Plans:

1.) *If (NAME) approved relative provider is unable to care for the (child/youth), the relative care provider will contact the child's caseworker and the child will be placed with (NAME) another identified and approved relative provider.*

2.) *If (NAMES) foster parents are unable to care for the (child/youth), the foster parents will contact the child's caseworker and the child will be placed with (NAME) identified respite care provider or (NAME) identified traditional or agency foster care provider.*

For IN Home Safety Plans:

1.) *If (NAME) relative safety plan provider is unable to be at (NAME) family home as expected from 4-6pm. Then (NAME) will contact (NAME) another relative safety plan participant who will substitute for them during that time. If both are unavailable due to a family emergency then (NAME) the pastor's wife will substitute for them during that time.*

2.) *If (NAME) a contractor providing safety services for the family is unable to do what they agreed to do, they will notify the caseworker and (NAME) another safety service contractor will be utilized.*

Examples of insufficient contingency plan:

- 1) *The placement unit will need to find another placement.*
- 2) *Child will be made a state ward and placed into foster care.*
- 3) *This is an out of home safety plan and there is not a need for a backup plan.*
- 4) *The assigned caseworker should be contacted.*
- 5) *Their designee will take over*
- 6) *None*

- Suitability of the safety plan participants was completed in 4 out of 5 (80%) of the assessments.
 - Reviewer judged that there was sufficient information to support the decision made with regards to the suitability of the safety plan participants in 2 out of 5 (40%) of the safety plans.
 - *Reviewer Comments: Need to ensure suitability is completed for all participants including two-parent foster families, providers and informal supports. Include background checks on suitability.*
- 3 out of 5 (60%) safety plans addressed who was going to make sure the child was protected.
- 2 out of 5 (40%) safety plans addressed what action is needed.
- 3 out of 5 (60%) safety plans addressed where the plan and action are going to take place.
- 0 out of 5 (0%) safety plans addressed when the action will be finished.
- 1 out of 5 (20%) safety plans addressed how it is all going to work and how the actions are going to control for safety.
- 100% of safety plans did not contain caregiver promissory commitments.
- 1 out of 5 (20%) safety plans involved in home services.
- 5 out of 5 (100%) safety plans contained a plan for oversight.
 - Reviewers determined that the oversight requirements were sufficient to assure that the safety plan was implemented in accordance with expectation and was assuring child safety in 3 out of 5 (60%) of the reviewed safety plans.
- 5 out of 5 (100%) safety plans adjusted as threats increased or decreased.
- Overall, 0% (0 out of 5) Safety Plans were judged to be appropriate by Reviewers.

Reviewer's Overall Analysis and Conclusion of the Work:

For the purpose of a case review, the reviewer assessed the following information based on their review of the case. This part of the review contains the same information as those included in the Supervisory Review of Nebraska Safety Assessment.

Category	CSA 1	CSA 2	Nemetz 1	Nemetz 2	Dowse 1	Evans 2	Ziems 1	Ziems 2	Fries 2
The Nebraska Safety Assessment Instrument was completed correctly and completely	21%	10%	7%	0%	20%	0%	35%	20%	20%
Documentation is on N-FOCUS	100%	100%	100%	100%	100%	100%	100%	100%	100%
Required Time Frames were met	84%	90%	80%	100%	92%	80%	82%	80%	100%
A reasonable level of effort was expended given the identified safety concerns.	66%	55%	33%	80%	87%	20%	76%	60%	60%
Safety of the child/youth was assured during the assessment process.	85%	90%	87%	100%	87%	80%	82%	80%	100%
Sufficient information was gathered for informed decision making	40%	40%	20%	40%	47%	20%	53%	60%	40%
Available written documentation was obtained from law enforcement and others as approp.	67%	100%	50%	100%	60%	0%	80%	100%	0%
ICWA information was documented	89%	30%	93%	40%	80%	20%	94%	40%	20%
Information was obtained about non-custodial parent, relatives, and other family support.	66%	15%	67%	20%	40%	0%	88%	20%	20%
An Immediate Protective Action was appropriately implemented to assure child safety.	0%	N/A	0%	N/A	0%	N/A	N/A	N/A	N/A
A Safety Plan was appropriately completed and implemented to assure child safety.	45%	0%	25%	0%	57%	0%	N/A	0%	0%
A Safety Assessment was documented in accordance with required practice.	30%	30%	7%	40%	40%	20%	41%	40%	20%
A Protective Action was documented in accordance with required practice.	50%	N/A	0%	N/A	100%	N/A	N/A	N/A	N/A
A Safety Plan was documented in accordance with required practice.	67%	40%	33%	50%	83%	50%	N/A	0%	0%
The family network and others were appropriately involved in the gathering of information.	47%	52.6%	40%	60%	50%	25%	50%	60%	60%
The family networks and others were appropriately involved in developing Safety Plans.	56%	40%	0%	50%	83%	50%	N/A	0%	0%
Policy and procedures related to safety intervention were followed.	36%	65%	13%	80%	33%	40%	59%	80%	60%
Safety plan is sufficient to protect child from threats of severe harm.	67%	20%	33%	50%	83%	0%	N/A	0%	0%
Efforts to coordinate with law enforcement were documented.	89%	100%	80%	100%	92%	100%	93%	100%	100%
Interview protocols were followed or reason for deviation were documented.	45%	63.2%	33%	80%	53%	20%	47%	75%	80%
The appropriate definition was used in making the case status determination.	79%	95%	73%	100%	80%	100%	82%	80%	100%
The finding was correctly documented in N-FOCUS	96%	95%	93%	100%	93%	80%	100%	100%	100%
Factual information supports the selected finding.	87%	90%	67%	80%	93%	100%	100%	100%	80%
Proof of certified notice to the alleged perpetrator is located in the file.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A