

Systems Change Review 2017 Results



Prepared by the Division of Safety and Permanence, Bureau of Safety and Well-Being

Table of Contents

Acknowledgements.....	3
Wisconsin Act 78 Background.....	4
Summary Review	4
Practice Review.....	4
Systems Change Review Overview	5
Systems Change Review Process	6
Wisconsin Reviewers.....	6
Record Review	6
Human Factors Debriefing	6
Mapping	6
Second Story	8
Experience Feedback.....	8
Scoring.....	8
Exemplar.....	10
Safety Leadership Institute.....	11
Summary and Next Steps	12
Appendices	13
Appendix A: Systems Change Review Flowchart.....	13
Appendix B: WI Child Welfare Model for Practice.....	14
Appendix C: Systems Change Review Mapping Timeline.....	16
Appendix D: Criteria for a Practice Review	17
Appendix E: 2017 Example of Systems Change Review Map*	18
Appendix F: Second Story Example*	19
Appendix G: Systems Analysis Tool	20
Appendix H: Debriefing Feedback	27
Appendix I: Mapping Feedback.....	28
Appendix J: Description of the Safety Leadership Institute.....	29
Appendix K: Safety Leadership Institute Agenda	30
Appendix L: Map of Safety Leadership Institute Agency Participation	31

Acknowledgements

The Wisconsin Department of Children and Families would like to offer compassion and respect to the children and families represented within these pages, and to the CPS professionals who work tirelessly in their communities.

The Wisconsin Department of Children and Families expresses its gratitude to the counties and child welfare professionals who have participated in and collaborated with the Systems Change Review process, specifically the Wisconsin Reviewers responsible for stewarding critical components of the Systems Change Review, as well as those child welfare professionals that participated in the debriefing and mapping components of the Systems Change Review process.

The Wisconsin Department of Children and Families would like to thank Dr. Scott Modell and Noel Hengelbrok of Collaborative Safety, LLC for their expertise and training in this trauma-informed approach.

Wisconsin Act 78 Background

The 2009 Wisconsin Act 78 became effective on February 1, 2010, requiring the Department of Children and Families (DCF) to share information with the public in instances of child death, serious injury and egregious incidents due to suspected or confirmed child maltreatment and in cases where a child in out-of-home care placement is suspected to have committed suicide.

Wisconsin is a county administered, state supervised system, with the exception of Milwaukee County, which is state administered through the Division of Milwaukee Child Protective Services. As such, Act 78 extends authority to the local child welfare to notify DCF when there is suspicion that one of the following incidents have occurred:

Child death or serious injury is defined in Act 78 as “an incident in which a child has died or been placed in serious or critical condition, as determined by a physician, as a result of any suspected abuse or neglect that has been reported under this section or in which a child who has been placed outside the home by a court order under this chapter or ch. 938 is suspected to have committed suicide.”

Egregious incident is defined as “an incident of suspected abuse or neglect...involving significant violence, torture, multiple victims, the use of inappropriate or cruel restraints, exposure of a child to a dangerous situation, or other similar, aggravated circumstances.”

Once the local child welfare agency determines an incident likely meets the above definitions, Act 78 requires the local child welfare agency to submit specific case information to the DCF within 2 working days. The specific information required is outlined in 48.987 (7) (cr) (a), (b), (c), (d), (e), (f). The information the local child welfare agency submits to the DCF is transmitted via the statewide-automated system, referred to as eWiSACWIS.

The DCF has assigned primary responsibility for the review and analysis of these submissions to the Division of Safety and Permanence (DSP). Specifically, the DSP is responsible for the qualification and public notification of incidents, and determination and facilitation of review. In Wisconsin, there are two levels of review that can be assigned to an incident – a Summary Review or a Practice Review.

Summary Review

All cases that qualify for public notification receive a Summary Review that consists of reviewing the electronic case record. Results of this review are communicated to the public through the 90-Day Summary document posted on the public notice website.

Practice Review

Incidents that involve significant or current child protective services (CPS) intervention receive a further level of review in addition to the Summary Review, referred to as a Practice Review. When cases qualify for a Practice Review, the DSP is responsible to determine a method for review. In 2016, the DCF implemented a new approach to the analysis of those cases qualified for a Practice Review.

This progress report provides information and data regarding the new method adopted by the DCF. This method is formally referred to as the Systems Change Review process. This document explains how the various components of this process provide a methodical approach to the analysis of those cases assigned to a Practice Review. The study of these cases through the application of a Systems Change Review include:

- Review of the case record and development of key observations
- Interview of relevant staff (i.e., *human factors debriefing*)
- Discussion and analysis of systemic influences on key observations (i.e., *mapping*)
- Documentation of contextual information and analysis to inform and understand key observations (i.e., *second story*)
- Scoring of documentation and conversion to data points (i.e., *scoring*)

- Sharing of the scores with local agency management
- Recommended program and practice improvements for the Wisconsin child welfare system

At the completion of the Systems Change Review, the public is notified in the form of a document referred to as the 6 Month Summary that is posted on the public notice website.

The Systems Change Review began in November 2016 in the balance of the state (i.e., non-Milwaukee counties) and in June 2018 in the Division of Milwaukee Child Protective Services (DMCPS). The DCF provides additional and detailed information and training to county agencies and DMCPS regarding the Systems Change Review upon case qualification.

Because this report is applicable to CY 2017, which is prior to the initiation of System Change Review in DMCPS, all results described in this report are related to balance of state (BOS) cases.

See [Appendix A](#) for a Flow Chart of the Systems Change Review.

Systems Change Review Overview

A Systems Change Review is applied to cases that are identified for a Practice Review under Act 78. These eligible cases involve a recent incident of alleged child maltreatment resulting in a child's death or near death where there is prior agency contact that is recent and/or extensive. The review includes collaboration between the local child welfare agency, tribes, community stakeholders, the DCF and other relevant parties. The collaboration is facilitated by the DCF and includes a structured analysis of the system. Participants leave with a better understanding of how the various levels of our system influence case decision-making ("key observations") in the reviewed case. Further, the particular influences of each case are in a broader context of all cases reviewed and subsequent recommendations are made based on patterns and trends, instead of one unique case.

The Systems Change Review process utilizes principles from the field of Human Factors and System Safety Science to support the DCF to learn from critical incidents and promote system-wide improvement efforts. The Systems Change Review process improves efficiency, emphasizes increased partnership and accountability, and focuses on analysis of systemic issues. For these reasons, the Systems Change Review framework reflects Wisconsin's Child Welfare Model for Practice. As stated in the Model for Practice, "the work of the child welfare system is complex" and "how we do our work is as important as what we do." The work of child protective services is subject to acute and critical examination when a child or youth known to the system later experiences a death or near death. In these instances, more than ever, it is critical that our review process aligns with our values. The DCF has selected and developed a System Change Review framework that is trauma-informed and supports the workforce in the complex and important work that they do, while not overlooking individual and systemic accountability to the families served by the child welfare system.

An important element of the Systems Change Review includes the Wisconsin (WI) Reviewer. WI Reviewers are commonly employed full-time by the local child welfare system and trained and contracted by the DCF to complete components of the process. It is the firm belief of the DCF that alignment with the WI Model for Practice is actualized in partnership with the DCF and local child welfare agency and its staff.

See [Appendix B](#) for Wisconsin's Child Welfare Model for Practice, [Appendix C](#) for a Systems Change Review Mapping Timeline and [Appendix D](#) for Criteria for a Practice Review.

Systems Change Review Process

Wisconsin Reviewers

Wisconsin Reviewers (WI Reviewers) play an integral role in the completion of cases assigned to the Systems Change Review. Specially, the Wisconsin Reviewer:

- Reviews the case record and develops key observations
- Interviews relevant staff (i.e., *human factors debriefing*)
- Facilitates discussion and analysis of systemic influences on findings (i.e., *mapping*)
- Documents contextual information and analysis to inform and understand key observations (i.e., *second story*)

Wisconsin Reviewers are selected by the DSP for their leadership, depth and breadth of knowledge and expertise regarding child welfare policy and practice. Selection is further based on the WI Reviewers' recognized excellence in engagement and facilitation as well as critical thinking in regards to systems of influence on case practice (i.e., local, state and federal government).

Record Review

The primary objective of the record review is the identification of one or more key observations. A key observation is any area of practice that deviates from Wisconsin policy, standards or expected practice.

The key observation(s) are the focus in debriefing and mapping. It is through debriefing and the mapping that the Wisconsin Reviewer gains additional information for the second story.

Human Factors Debriefing

When identifying the key observations the Wisconsin Reviewer determines which agency staff can provide additional information regarding the key observations. Following the record review and identification of key observations, a debriefing is scheduled with the identified staff at the local agency. The identified county staff invited to participate in the debriefing are typically direct line staff and/or supervisors. The debriefing session is one-on-one and includes a conversation between a Wisconsin Reviewer and the CPS professionals. Participation is voluntary and staff can decline for any reason. An indirect result of the session includes some therapeutic benefit, likely because the CPS professionals are able to be heard and better understood through this process. The conversation is approached with sensitivity to the trauma experience.

Mapping

A mapping session occurs after the debriefing of the workers and supervisors, and is facilitated by a WI Reviewer. An established team of child welfare professionals and child welfare partners analyze systemic factors and their influences. Mapping teams are comprised of dynamic individuals who can provide insight into components of the key findings and systems being reviewed. The mapping session will end with a visual representation of the systems and their influences, and results in the construction of the "second story."

See [Appendix E](#) for an example of a Systems Change Review Map.

There is a standard team of mapping participants for each regional mapping session. Ad hoc members may be identified to join depending on case factors. Other mapping team members may include child welfare frontline staff, supervisors and administrators, health care representatives, law enforcement and community members. The mapping team will never include the direct line staff or supervisor of the case.

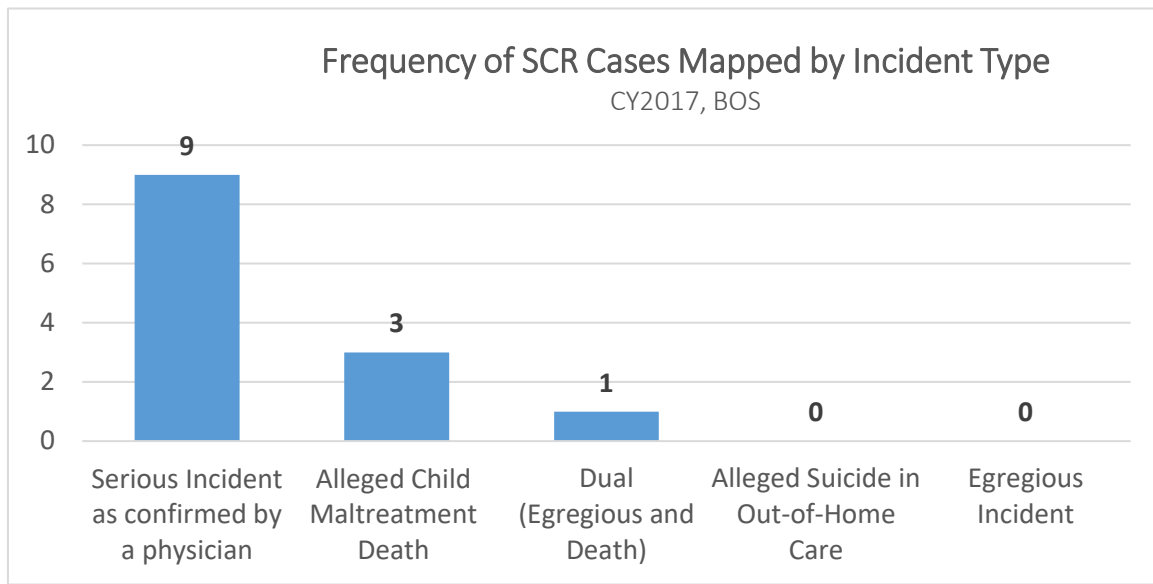
Mapping sessions are scheduled in advance to occur on two consecutive days at the end of each quarter and up to two mapping sessions can occur per day in each region, one in the morning and one in the afternoon. In total, four mapping session can occur in each region in each quarter. The standing mapping team participants are required to be available to participate in their respective regional mapping sessions two days a quarter, equaling

a commitment of up to eight full days a year. A brief orientation occurs prior to the first mapping session in order to familiarize the mapping team members to the process.

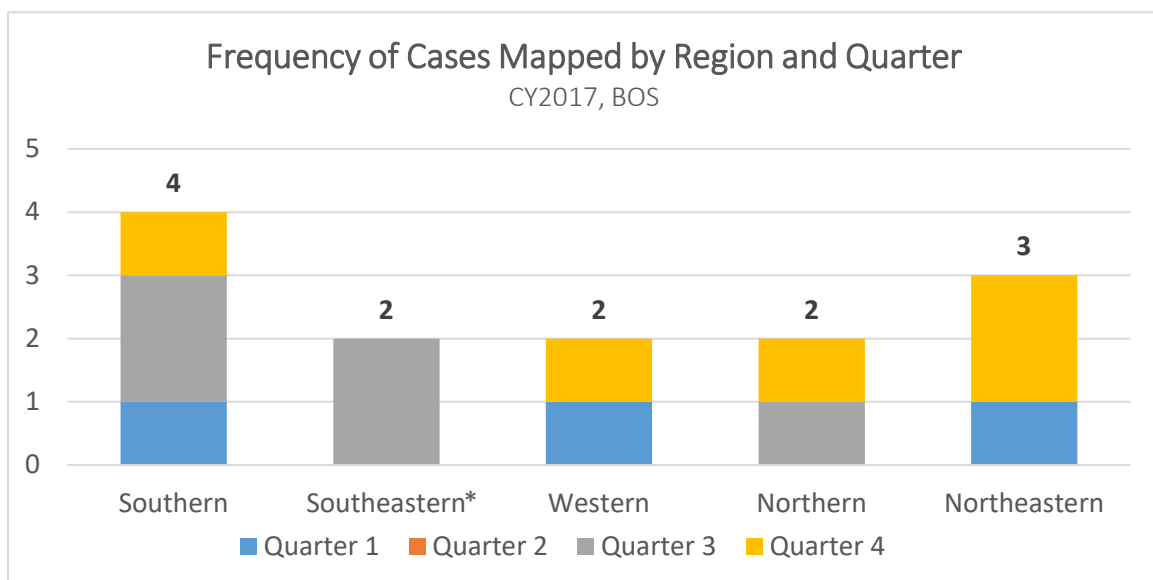
Mapping Data

A case that qualifies for a Systems Change Review is mapped two quarters after the case was qualified. For example, a case that qualifies for a Systems Change Review in Q1 2017 is mapped in Q3 2017. Therefore, some cases that *qualify* in one calendar year may be subsequently *mapped* in the following calendar year (i.e. cases that qualify in Q3 and Q4 are mapped in Q1 and Q2 of the subsequent year). The mapping results presented here includes data from all cases mapped in CY2017 in BOS.

In CY2017, 13 were mapped in the BOS. The graph below shows the frequency of cases mapped by incident type.



In CY2017, three cases were mapped in Q1 and five cases were mapped in Q3 and Q4, respectively; no cases were mapped in Q2. The below graph shows the frequency of cases mapped by region and quarter in the BOS in CY2017.



*The Southeastern region does not include Milwaukee County

Second Story

After mapping, the Wisconsin Reviewer utilizes the systemic influences identified at mapping to create a narrative called the second story. The second story moves beyond the incident, incorporating influences and details not typically revealed in the case file. The second story reflects systemic influences and constraints pertinent to work of child welfare professionals.

See [Appendix F](#) for an example of a second story used in Wisconsin Reviewer training.

Experience Feedback

The DSP maintains a commitment and interest in being trauma-informed and creating a fair and comfortable experience for all participants in this process. As part of this effort, all individuals who participate in Human Factors Debriefing receive a SurveyMonkey, seeking their anonymous feedback. Additionally, all agency staff who participate in mapping as ad hoc members, or standing members of a mapping team, are solicited for feedback on a regular basis. Lastly, agency directors are asked for feedback during quarterly phone calls that occur after their agency experienced a case reviewed via the Systems Change Review process. The Bureau of Safety and Well Being (BSWB) in DSP remains vigilant in collecting and reviewing this feedback to further improve our approach, ensure that the right participants are part of the process, and to seek partnership in changing the overall review experience to be one of learning, evolution, and positive change rather than punishment.

See [Appendix H](#) for an overview of SurveyMonkey feedback received from child welfare professionals on their experience of the debriefing process. See [Appendix I](#) for an overview of SurveyMonkey feedback received from the regional mapping teams on their experience of the mapping process.

Scoring

In CY2017, the BSWB scored the second story using a Systems Analysis Tool developed by our partners, Collaborative Safety, LLC. The scores reflect whether an influence was present in a case and supported by evidence.

Systemic findings have specific definitions developed from relevant safety science literature. Using these definitions, systemic findings are identified within and across cases. The frequency of the systemic finding is determined by the amount of times it is identified across cases, and informs opportunities for improvement and learning.

The tool scores the below influences on a 0-3 Likert Scale. The below categories represent areas that may influence all areas of the system. Narrative is used to explain scores of 2 or 3 to maintain integrity and provide detail of how the category manifested in a particular case. The numbers associated with the items reflect levels of influence.

- a. '0' indicates no evidence of influence
- b. '1' indicates some evidence of influence but not significant or relevant
- c. '2' indicates evidence of influence that is significant and relevant
- d. '3' indicates evidence of strong influence and is highly significant and relevant

Please see [Appendix G](#) for the Systems Analysis Scoring Tool, including definitions and instructions on completing the scoring tool.

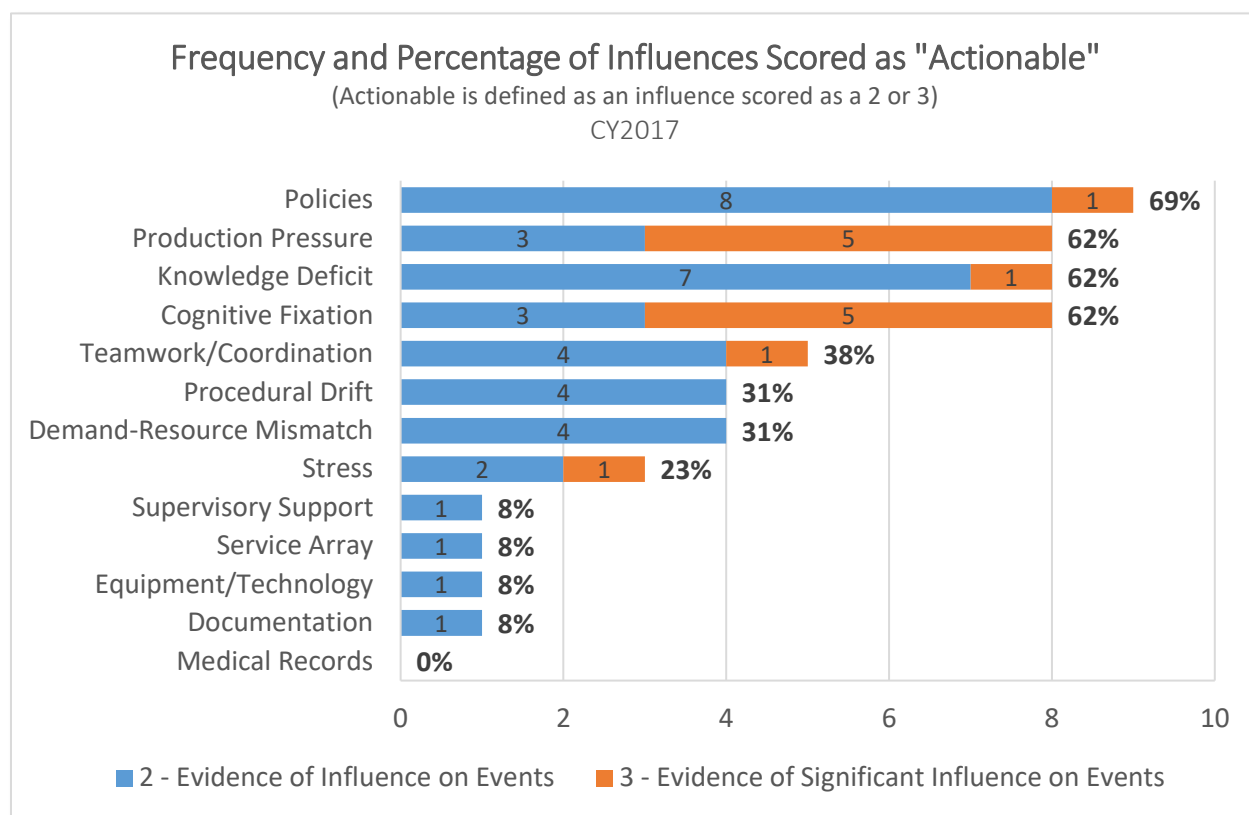
Scoring Results

The results for the 13 cases scored using the Systems Analysis Tool are outlined below:

INFLUENCE THEME & RATING	0 NO EVIDENCE OF INFLUENCE ON EVENTS	1 MINIMAL INFLUENCE ON EVENTS	2 EVIDENCE OF INFLUENCE ON EVENTS	3 SIGNIFICANT INFLUENCE ON EVENTS	TOTAL ACTIONABLE ITEMS
COGNITIVE FIXATION	1	4	3	5	8
DEMAND-RESOURCE MISMATCH	8	1	4	0	4
DOCUMENTATION	6	6	1	0	1
EQUIPMENT/TECHNOLOGY	11	1	1	0	1
TEAMWORK/COORDINATION	3	5	4	1	5
KNOWLEDGE DEFICIT	2	3	7	1	8
MEDICAL RECORDS	12	1	0	0	0
POLICIES	1	3	8	1	9
PRODUCTION PRESSURE	3	2	3	5	8
SERVICE ARRAY	10	2	1	0	1
STRESS	8	2	2	1	3
SUPERVISORY SUPPORT	8	4	1	0	1
PROCEDURAL DRIFT	5	4	4	0	4

53

The following graph depicts the frequency and percentages of influences scored as actionable (scores of 2 or 3).



Of the influences scored as actionable, four influences occurred in over 50% of the cases mapped: policies (69%), production pressure (62%), knowledge deficit (62%) and cognitive fixation (62%). These influences will be presented to Wisconsin's Child Welfare CQI Advisory Group for consideration and next steps.

Exemplar

Below are examples providing more specific information gathered during human factors debriefing and mapping that contributed to the score of 2 or 3 in the following areas.

Cognitive Fixation- A faulty understanding of a situation due to biases.

A recurring theme in 2017 cases identified workers' reliance on historical knowledge of a family and/or reliance on stakeholders' (internal and external) assessment and monitoring of safety. Cases reviewed revealed a narrow focus on safety assessment – for example, parents who appear protective and cooperative to the agency are not always fully assessed. Additionally, when service providers, such as Public Health, Law Enforcement, Probation and Parole, are involved, there is an over-reliance on these professionals' assessment of child safety.

Knowledge Deficit- An absence of knowledge or difficulties activating knowledge.

Safety planning when substance use is suspected is difficult given the complexity of understanding its effect on caregiver functioning. As evidenced in multiple cases reviewed, the concept of “in process of occurring” in safety assessment is challenging. It is relatively new and is a different way of thinking; the child welfare training course, Supervising Safety, addresses this concept but is not yet incorporated into training for all workers.

Policies- The absence or ineffectiveness of a policy.

Access and Initial Assessment Standards do not clearly direct who should be considered a household member when taking an Access report and conducting an Initial Assessment. Additionally, Safety Standards identify certain points in time where a Safety Analysis and Plan is required. However, cases reviewed revealed inconsistency in continued documentation of Safety Analysis and Plans.

Production Pressure- Demands to increase efficiency, which are incompatible with safety assurance.

High worker turnover leads to increased tasks and demands on remaining staff and supervisors. For example, in several cases reviewed supervisors often provided coverage for worker turnover that compromised their ability to provide training, support, and oversight to assigned social caseworkers. In addition, there is an efficiency/thoroughness trade-off experienced by child welfare professionals to meet the many policy and practice requirements when a child is placed in out-of-home care.

Safety Leadership Institute

The Division of Safety and Permanence oriented Wisconsin counties to the Systems Change Review process in September and October 2016 via regional orientation meetings and at the 2016 Public Child Welfare Conference. During these orientations, participating leaders from local agencies asked for additional training to leverage this approach at a local level. As a result, DSP invited our partners from Collaborative Safety, Dr. Scott Modell and Noel Hengelbrok, to facilitate a one-day training for all interested local agencies, and their respective complement of staff to learn skills needed to effectively advocate for systemic change in their community.

The DSP encouraged counties to send a team of staff from various levels and components of their organization. Safety Leadership Institutes in 2017 have included staff participation from:

- Executive Management
- Child Protective Services supervisor and staff
- Agency legal representation
- Communication liaison/Ombudsman staff
- Program improvement quality improvement staff
- Finance/budget personnel
- Human resources personnel

In CY2017, representatives from 36 of the 72 counties in Wisconsin attended a Safety Leadership Institute.

See [Appendix J](#) for a description of the Safety Leadership Institute, [Appendix K](#) for a Safety Leadership Institute agenda and [Appendix L](#) for a map of agencies who have participated in a Safety Leadership Institute.

Summary and Next Steps

As we conclude the inaugural year of Systems Change Review implementation, the Department of Children and Families moves forward with continued commitment to this process. Wisconsin child welfare professionals have participated in a variety of roles to support the development and evolution of this process. Participant feedback has been overwhelmingly positive, reporting that Systems Change Review has felt trauma-informed and supportive. The Department of Children and Families will continue to develop and monitor this process incorporating agency and individual feedback. The state and county partnership is imperative as we work toward a better understanding of influences affecting the child welfare system in Wisconsin.

In CY2018, the Systems Change Review process will complete statewide implementation, which includes the Division of Milwaukee Child Protective Services and its contracted Ongoing Services agencies.

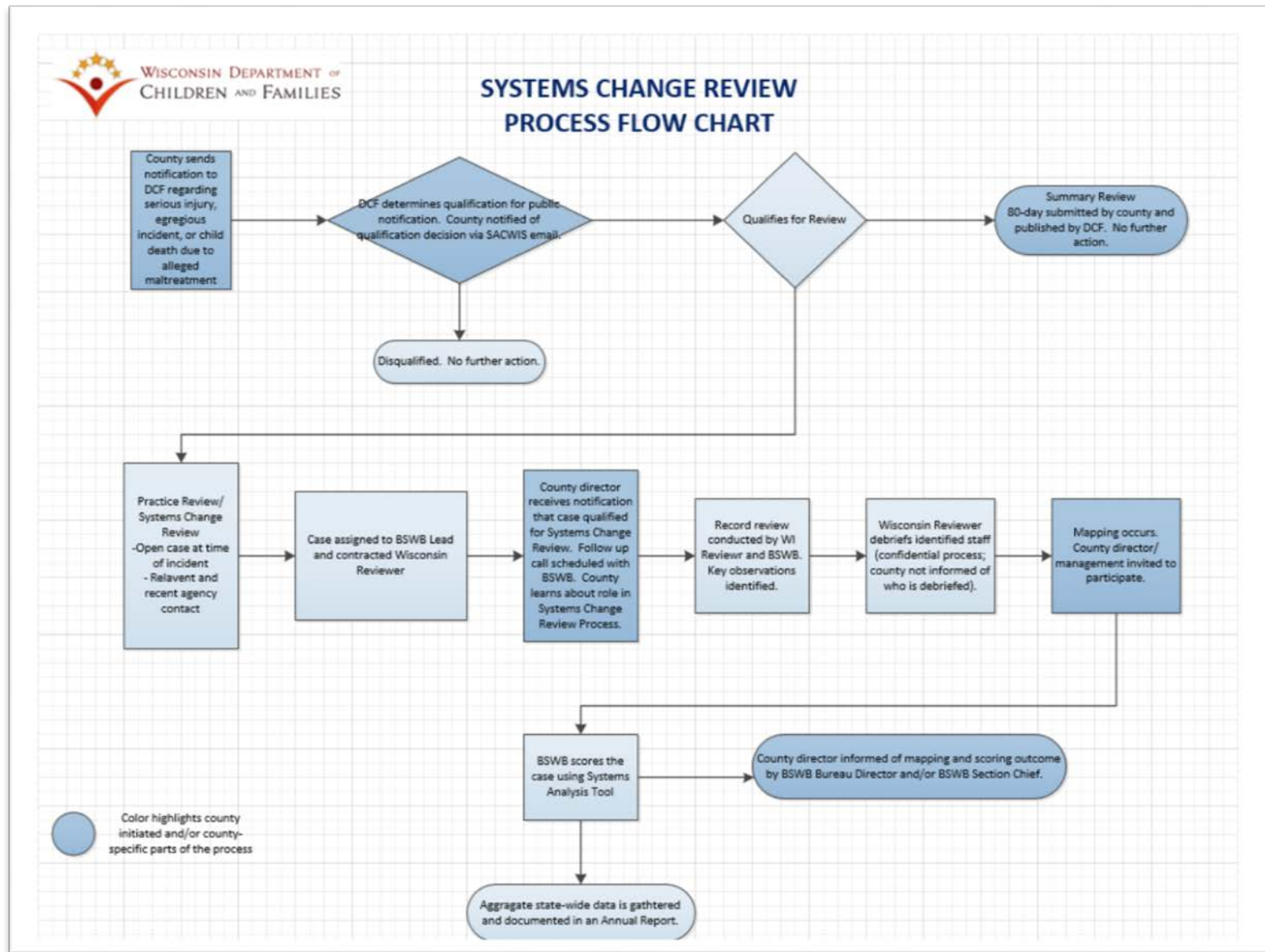
The DCF is committed to using the information learned from the Systems Analysis Scoring Tool in our continuous quality improvement (CQI) process. The DCF CQI system is supported by a CQI Advisory Group composed of stakeholders from the Department, counties, courts, tribes, and the professional development training system. The purpose of the CQI Advisory Group, which meets quarterly, is to identify and advance system-level improvement projects grounded in qualitative and quantitative data. Considerations for systems or policy-level improvements in response to the Systems Change Review results will be advanced to the Child Welfare CQI Advisory Committee. For example, the CQI Advisory Committee may recommend changes to policy related to safety analysis that will also drive enhancement efforts in the state's automated child welfare information system redesign. As another example, based on Systems Change findings related to safety analysis, the Child Welfare CQI Advisory Committee may advance a recommendation to consider specific changes to the child welfare information system that ensures accurate and streamlined safety documentation in non-traditional family structures, or for children with multiple caregivers in different households.

As another CQI tool, the DCF is establishing Applied Learning Communities administered by the Child Welfare Professional Development System. Supports for the local CPS professional level improvement in response to Systems Change Review findings will be addressed using the Applied Learning Communities. As an example, a topic for an Applied Learning Community conversation may focus on supports for CPS workers and supervisors specific to critical thinking related to household member identification during Access and Initial Assessment. The integration of key information learned through the Systems Change Review process will continue to inform our understanding of and ability to act upon areas that afford the greatest opportunity for systems-level and local-level improvements. The leveraging of identified influences to drive meaningful change and CQI projects will be the focus of 2018, along with implementation of the process in DMCPs.

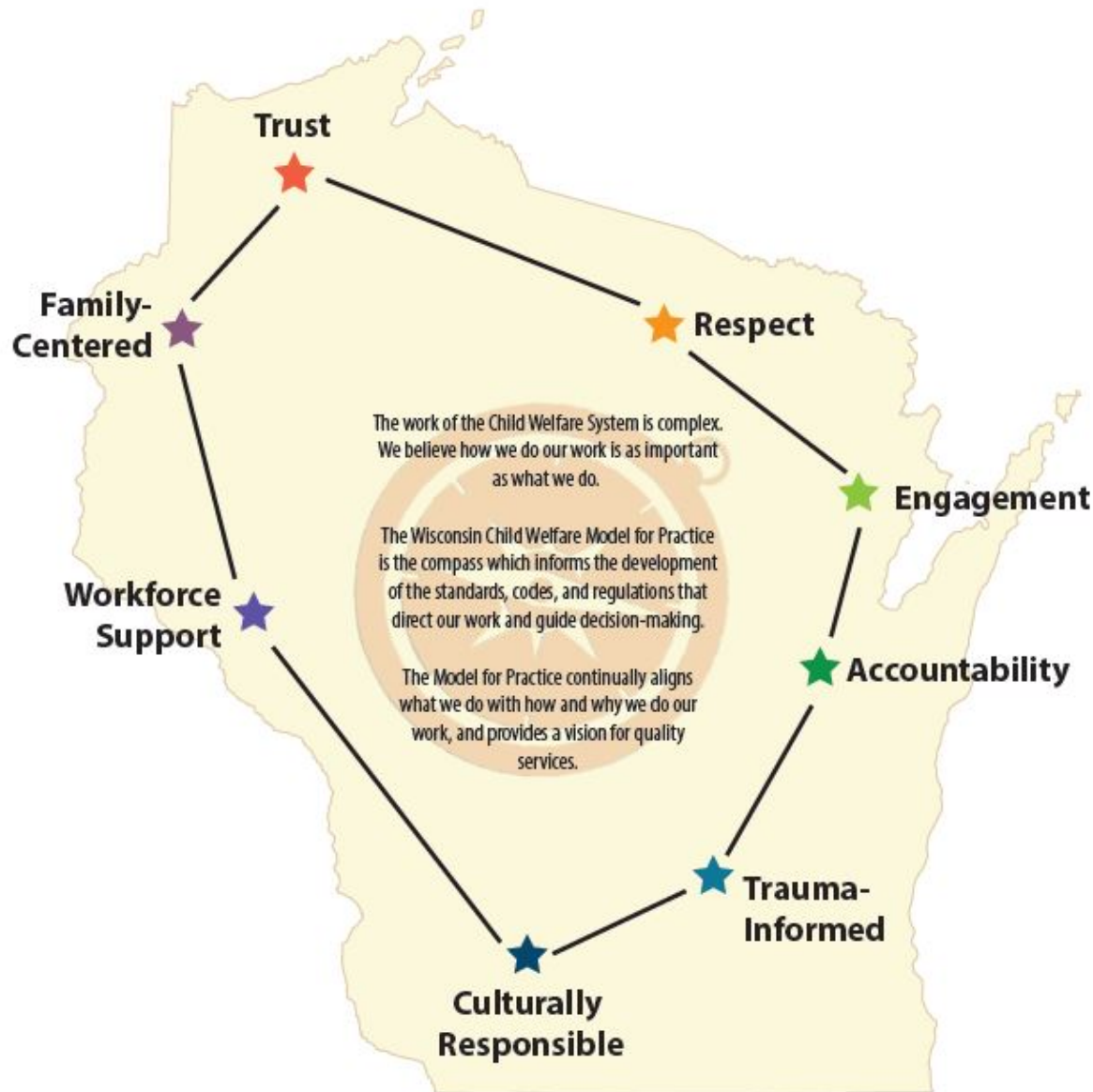
The Department of Children and Families would like to thank all child welfare professionals for their hard work and dedication to the children and families of Wisconsin.

Appendices

Appendix A: Systems Change Review Flowchart



Wisconsin Child Welfare Model for Practice

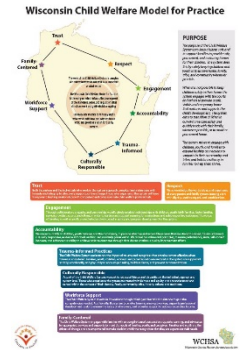


PURPOSE

The purpose of the Child Welfare System is to keep children safe and to support families to provide safe, permanent, and nurturing homes for their children. The system does this by safely keeping children and youth in their own home, family, tribe, and community whenever possible.

When it is not possible to keep children safely in their home, the system engages with the courts and others to provide a safe, stable, and temporary home that nurtures and supports the child's development. The system aims to transition children in out-of-home care safely and quickly back with their family, whenever possible, or to another permanent home.

The system strives to engage with children, youth, and families to expand healthy connections to supports in their community and tribes and bolster resiliency in families to help them thrive.



Trust

Both the system and the individuals who work in the system approach complex family situations with honesty and integrity to effectively support positive change. Those who experience the system will have transparent, trusting relationships with competent and compassionate child welfare professionals.

Respect

We acknowledge the worth, ideas, and experience of every person and family system, treating each with dignity, positive regard, and consideration.

Engagement

Through collaboration, empathy, and partnership, we effectively establish relationships with children, youth, birth families, foster families, service providers, courts, and others, in order to nurture and support meaningful connections and achieve positive outcomes. The voices of families, as well as youth, are included and welcomed in policy and program development for the system.

Accountability

We are accountable to children, youth, families and the community, to provide effective and accessible services that are strengths-based, trauma-informed, culturally responsive, evidence-informed, and focused on family preservation. We model our values and principles, measure performance, learn, self-correct, innovate, and enhance our ability to achieve positive outcomes through data-driven continuous quality improvement efforts.

Trauma-Informed Practices

The Child Welfare System understands the impact of trauma and recognizes that practice is most effective when trauma is considered. Families, youth, children, workers, and providers who are involved in the system are supported socially, emotionally, and physically to encourage healing, build resilience, and prevent re-traumatization.

Culturally Responsible

As part of the Child Welfare System, we seek to reduce all biases and disparities at the individual, agency, and system level. Those who experience the system are treated with fairness and equity, and are understood and served within the context of their identity, family, community, tribe, history, culture, and traditions.

Workforce Support

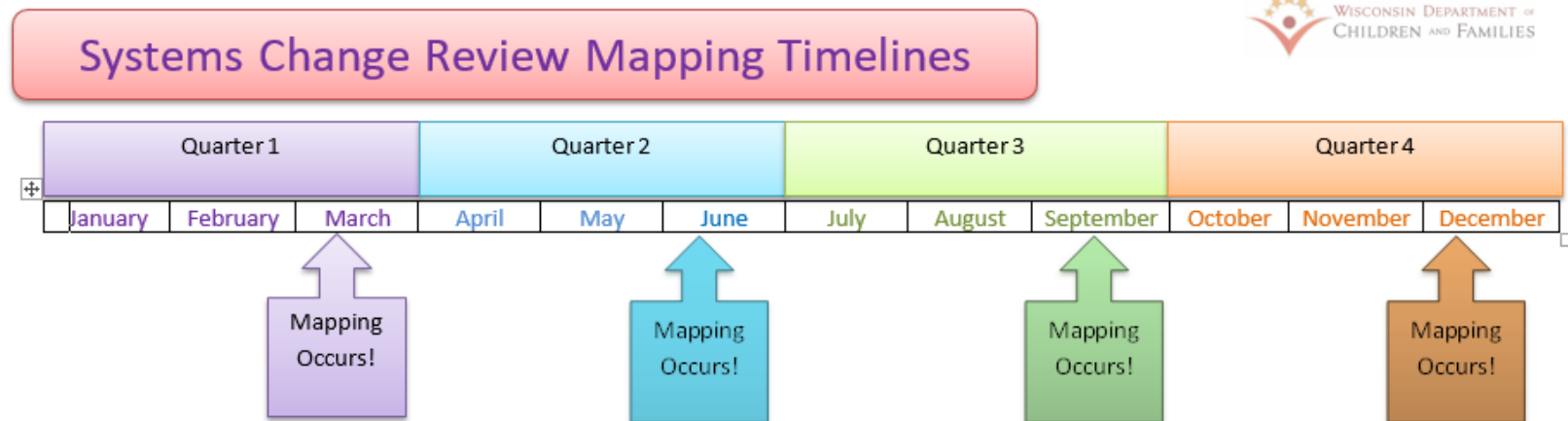
The Child Welfare System invests in its workers through training and technical assistance to gain the competencies needed. Additionally, the system promotes teaming amongst workers, supports professional development, seeks to ensure the safety of all workers, and provides support to address secondary trauma.

Family-Centered

The Child Welfare System engages with families with a strengths-based perspective, supports teaming, and advocates for appropriate services and supports to meet the needs of families, youth, and caregivers. Families and youth are the drivers of change and are empowered to make decisions with the recognition that they are experts on their needs.



Appendix C: Systems Change Review Mapping Timeline



Quarter 1 Mapping – Cases that qualified during Quarter 3 of the previous calendar year

Quarter 2 Mapping – Cases that qualified during Quarter 4 of the previous calendar year

Quarter 3 Mapping – Cases that qualified during Quarter 1 of the same calendar year

Quarter 4 Mapping – Cases that qualified during Quarter 2 of the same calendar year

Where do Mappings Occur?

Southern Regional Office, 2135 Rimrock Road, Madison, WI

Southeastern Regional Office, 141 NW Barstow, Waukesha, WI

Northeast Regional Office, 200 N Jefferson Street, Green Bay, WI

Northern Regional Office, 2187 N. Stevens Street, Rhinelander, WI

Western Regional Office, 610 Gibson Street, Eau Claire, WI

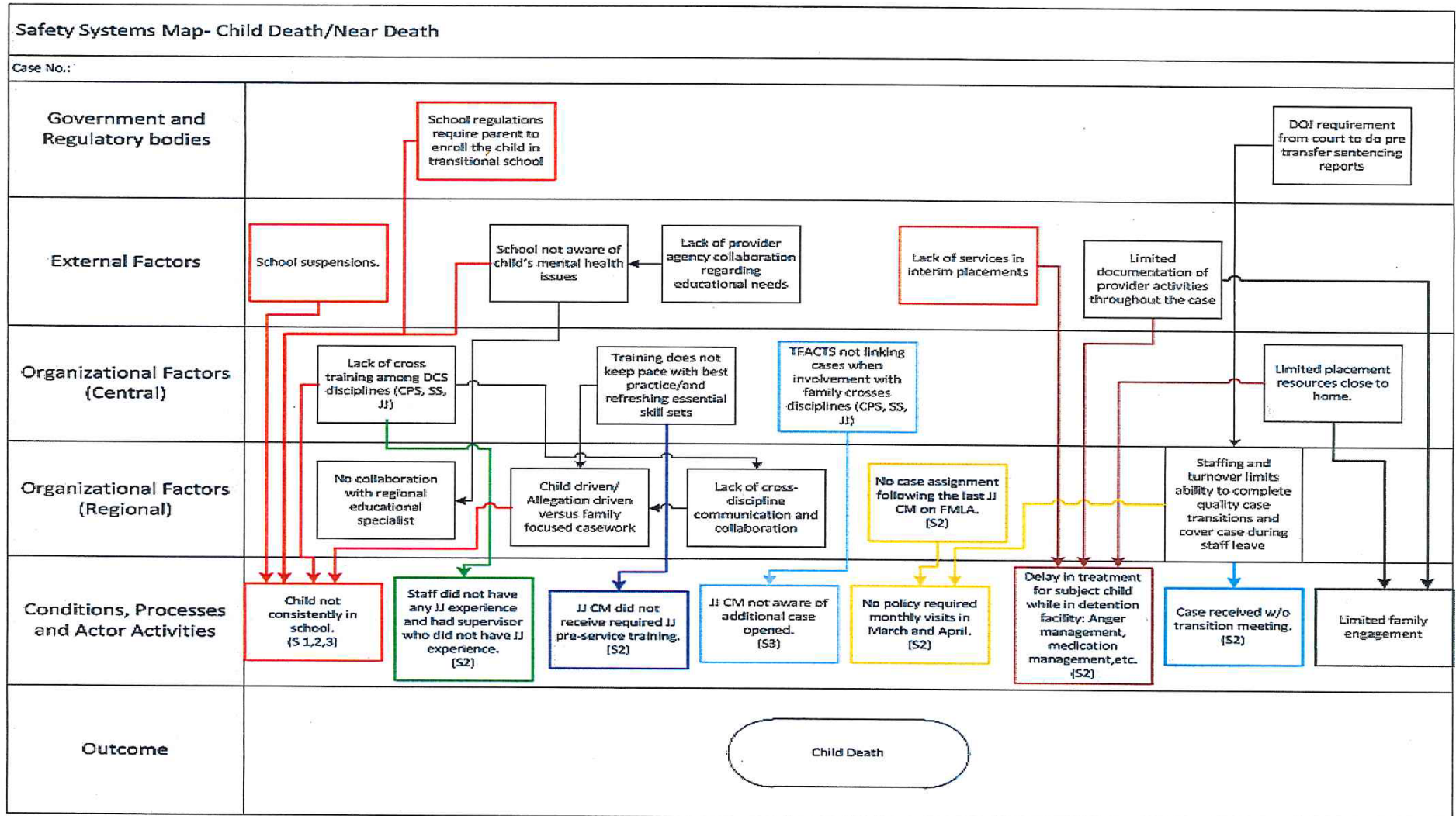
Milwaukee locations TBD

Appendix D: Criteria for a Practice Review

The Division of Safety and Permanence (DSP) reviews each critical incident submitted by counties under Act 78 to determine if it qualifies for the Systems Change Review based on one or more of the following criteria:

- a. Case open, either to Initial Assessment (IA) or Ongoing, at time of incident
- b. Case with 6 or more contacts with Access in 12 months prior to the date of the incident
- c. Case with 2 or more contacts with Access in 3 months prior to the date of the incident
- d. Case with 2 or more IAs in 12 months prior to the date of the incident

Appendix E: 2017 Example of Systems Change Review Map*



*This is an example used in our training for Wisconsin Reviewers. This case is not a result of a Systems Change Review in Wisconsin.

Appendix F: Second Story Example*

The finding that the counselor's crisis plan was not accessible to officers in the Juvenile Detention Center appears to be influenced by an apparent lack of communication with officers regarding their access to these plans. There is a misconception that the crisis plans are kept in a locked file in the contracted counselor's office. The noted lack of communication is further influenced by the absence of teaming on cases with the contracted counselor, due to her limited availability and strained relationship history with the contracted workers. The above noted finding was also influenced by frequent unit moves by both officers and students. Due to the limited capacity of the detention center, students are moved more frequently to make room for those entering the system and officers are moved to cover higher populated units. These frequent unit moves influence the officer's ability to develop areas of possession knowledge and understand the crisis needs of the students in their care.

*This is an example used in our training for Wisconsin Reviewers. This case is not a result of a Systems Change Review in Wisconsin.

Appendix G: Systems Analysis Tool

Overview

Systemic findings are identified within and across reviewed cases with the use of the Systems Analysis Tool. Upon completion of the instrument, influencing factors are identified at all levels of the system and can be communicated in quantifiable terms. Systemic findings found within cases are scored. These scores reflect whether a finding was present in a case and supported by evidence, which is captured by the label “actionable.”

Systemic findings have specific definitions developed from relevant safety science literature. Using these definitions, systemic findings are identified within and across cases. The frequency of the systemic finding is determined by the amount of times it is identified across cases. The frequency of systemic findings informs opportunities for improvement and learning.

Instructions

To administer the instrument found at the end of this manual, Bureau of Safety and Well-Being (BSWB) staff should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

1. The numbers associated with the items reflect levels of influence.
 - a. ‘0’ indicates no evidence of influence
 - b. ‘1’ indicates some evidence of influence but not significant or relevant
 - c. ‘2’ indicates evidence of influence that is significant and relevant
 - d. ‘3’ indicates evidence of strong influence and is highly significant and relevant
2. The Systems Analysis Tool exists to explain the inherently complex nature of the work and the many factors that influence trajectory of care. These influences should not be viewed as direct causal factors in a case outcome. However, the systemic themes may affect the overall trajectory of care and be an influence, among many influences, to adverse outcomes.

Item Anchors**Cognitive Fixation**

Definition: A faulty understanding of a situation due to biases (e.g., confirmation bias, focusing effect, transference).

Influence

0	No evidence of biases that impacted on objectivity.
1	Evidence of minor biases that had minimal impact on objective actions/decisions. Problems have or can be addressed with existing policy and/or practice change.
2	Biases impacted on objectivity/actions/decisions, which resulted in an increase in risk for clients and/or staff. Existing policy or practice protocols are insufficient to address these deficits or biases.
3	Biases led to actions/decisions that created immediate/significant risk for clients and/or staff. No policy or practice protocols exist to address these biases.

Demand-Resource Mismatch

Definition: A lack of resources (e.g., human, capital) to carry out safe work practices.

Influence

0	No evidence of problems with demand-resource mismatch. Worker appeared to have needed resources to carry out safe work practices.
1	Lack of resources to carry out safe work practices had a minimal influence on casework.
2	Evidence exists that a lack of or insufficient resources had an impact on case events which resulted in an increase in risk for clients and/or staff and/or an inability to effectively address client needs.
3	Lack of or insufficient resources created an immediate risk for clients and/or staff, preventing progress towards goals.

Documentation

Definition: Absent or ineffective documentation in connection with a particular case.

Influence

0	No evidence of documentation concerns. Documentation was completed within protocol timeframes and clearly communicates needed details of case activity, worker impressions, etc.
1	Absent or ineffective documentation had a minimal influence in the case. Minimal needed documentation may be absent or have been completed outside of protocol timeframes and/or documentation may not clearly communicate essential details of case activity, worker impressions, plans of action, etc.
2	Evidence of absent or ineffective documentation of case activity, worker impressions, plans of action, etc. Essential documentation (case notes, safety plans, NCPPs, etc.) not completed in SACWIS or available in the hard case file or contains minimal detail. Lack of or inefficiency of documentation result in supervisors/reviewers not having a clear sense of the details or trajectory of the case by review of SACWIS, case file documentation.
3	Evidence of absent or ineffective documentation of case activity, worker impressions, plans of action, etc. Essential documentation (case notes, safety plans, NCPPs, etc.) is not completed in SACWIS or available in the hard case file or contains minimal detail. Lack of or inefficiency of documentation result in supervisors/reviewers not having a clear sense of the details or trajectory of the case by review of SACWIS, case file documentation. The extent of documentation issues creates immediate risk for clients and/or staff, preventing progress towards goals.

Equipment/Technology

Definition: An absence or deficiency in the equipment and technology utilized to carry out work practices.

Influence

0	No evidence of problems with equipment or technology.
1	Equipment/technology had a minimal influence on work practices. Or, there have been a history of problems with equipment/technology that have been addressed through policy/practice change, SACWIS upgrades, etc.
2	Evidence that the absence of or deficiency in the equipment and technology needed to carry out work practices influenced case events.
3	The absence of or deficiencies in the equipment and technology needed to carry out work practices had a significant influence on case events, causing immediate risk for clients and/or staff and preventing progress towards goals.

Teamwork/Coordination

Definition: Ineffective collaboration between two or more entities (e.g., agencies, people and teams).

Influence

0	No evidence of problems with interfacing or collaborating with other entities involved in the case.
1	Difficulties with interfacing and collaborating with other entities involved in the case had a minimal influence on case practice. Or, historic problems have existed but have been addressed through policy and/or practice change.
2	Evidence exists that difficulties interfacing and collaborating with other entities involved in the case had an impact on case events, which resulted in an increase in risk for clients and/or staff and/or an inability to effectively address client needs.
3	Difficulties interfacing and collaborating with other entities involved in the case had a significant influence on case events, creating an immediate risk for clients and/or staff and preventing progress towards goals.

Knowledge Deficit

Definition: An absence of knowledge or difficulties activating knowledge (putting it into practice).

Influence

0	No evidence of knowledge deficits.
1	Evidence of minor knowledge deficits that had minimal impact on actions/decisions. Or, a history of knowledge deficits that have been addressed through supervision or training.
2	Knowledge deficits impacted actions/decisions made which resulted in an increase in risk for clients and/or staff. Existing policy, supervision practices/protocols, and trainings are insufficient to address these deficits.
3	Knowledge deficits led to actions/decisions that created immediate/significant risk for clients and/or staff. No policy, supervision practices or trainings exist to address these deficits.

Medical Records

Definition: Difficulties in obtaining, understanding and utilizing medical record or autopsy information.

Influence

0	No evidence of difficulties in obtaining, understanding or utilizing medical records or autopsy information.
1	Difficulties in obtaining, understanding and/or utilizing medical record or autopsy information had a minimal influence on case practice. Or, historic problems have been sufficiently addressed with policy and/or practice change.
2	Difficulties obtaining, understanding and/or utilizing medical records or autopsy information had an influence on case understanding, decisions and actions, which resulted in increased risk for clients and/or staff.
3	Difficulties obtaining, understanding and/or utilizing medical records or autopsy information had an influence on case understanding, decisions and actions, which created an immediate risk for clients and/or staff and prevented progress towards goals.

Policies

Definition: The absence or ineffectiveness of a policy.

Influence

0	No evidence to suggest that absent or ineffective policies influenced case practice.
1	The absence or ineffectiveness of policies had a minimal influence on case practice. Or, historical inefficiencies in policy have been addressed through addition of new policies or revisions of existing ones.
2	Current policies related to case practice are inefficient and resulted in an increase in risk to the client and/or staff.
3	Absent or inefficient policies had a significant influence on case practice, which created an immediate risk for clients and/or staff and prevented progress towards goals.

Production Pressure

Definition: Demands to increase efficiency (workload, economic), which are incompatible with safety assurance.

Influence

0	No evidence of problems with production pressure impacting on safety assurance.
1	Production pressure had a minimal influence on case practice. Demands for work efficiency did not appear to increase risk of safety for client or staff. Or, there have been historic problems with production pressures impacting on client/staff safety, which have been addressed with policy and/or practice changes.
2	Evidence exists that production pressures had an impact on case events, which resulted in an increase in risk for clients and/or staff and an inability to effectively address client needs.
3	Production pressures created an immediate risk for clients and/or staff, preventing progress towards goals.

Service Array

Definition: The availability of a particular service, which could support safe environments for children and families.

Influence

0	No evidence of problems with service array.
1	Minimal problems exist with service array. Needed services that would support safe environment for children and families do exist but may not be as geographically convenient as would be desired. Or, there have been historic problems with service array in the family's home community that have been addressed/mitigated.
2	Problems with service array exist. Needed services that would support safe environment for children and families do not exist within the family's home community/county. Accessing available services farther away presents a burden to the family, decreasing compliance with service plans.
3	Significant problems with service array exist. Services that would support safe environment for children and families do not exist anywhere close to the family's home community or are inaccessible, given the family's financial resources or insurance providers. These problems create an immediate risk for clients and prevent compliance with service plans and progress towards goals.

Stress

Definition: Unsafe work practices influenced by stress.

Influence

0	No evidence of stress influencing work practices.
1	Stress had a minimal influence on case practice. While worker appeared to experience some stress related to his/her work on the case, he/she felt equipped to manage that stress. Or, historical problems with stress influencing work practices have been addressed with policy and/or practice changes.
2	Evidence exists that stress had an impact on case events, which resulted in an increase in risk for clients and/or staff and an inability to effectively address client needs. Worker expressed difficulties managing the level of stress that existed during his/her work on the case or that work expectations did not allow for basic needs to be met (adequate sleep and food, reasonable work hours, etc.), thus increasing stress.
3	Stress created an immediate risk for clients and/or staff, preventing progress towards goals. Worker expressed feeling ill-equipped to manage the level of stress involved in working the case or that work expectations created unsafe working conditions.

Supervisory Support

Definition: Ineffective support or knowledge transfer from a supervisor to those supervised.

Influence

0	No evidence of problems with supervisory support. Workers expressed feeling well supported by supervisors and that supervisors are easily accessed, when needed.
1	Supervisory support had a minimal influence on case practice. Communication with or support from supervisors was generally positive but a few concerns were expressed by workers. Or, historic problems with supervisory support have been addressed with policy and/or practice changes.
2	Evidence exists that supervisory support had an impact on case events, which resulted in an increase in risk for clients and/or staff. Supervisors were not easily accessible by workers in the field to assist with decision making or were experienced as not supporting/empowering field staff.
3	Supervisory support issues created an immediate risk for clients and/or staff. Supervisors were not available or supportive, leaving field staff to have to make case decisions on their own, without supervisory approval.

Procedural Drift

Definition: An accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance and experienced success.

Influence

0	No evidence of procedural drift. Workers actions adhered closely to written protocol.
1	Procedural drift had a minimal influence on case practice. Work conducted was generally within written procedures and expectations. Or, historic problems with procedural drift have been addressed with policy and/or practice changes.
2	Evidence exists that procedural drift had an impact on case events, which resulted in an increase in risk for clients and/or staff. Case practice clearly departed from written procedure due to efforts to manage system constraints and influences or workforce/local team acceptance while in pursuit of successful outcomes.
3	Procedural drift created an immediate risk for clients and/or staff. Case practice clearly departed from written procedure due to efforts to manage system constraints and influences or workforce/local team acceptance while in pursuit of successful outcomes.

Case ID:					
Influence					
0 - No evidence of influence 1 - Minimal influence 2 - Evidence of influence on events 3 - Significant influence					
Themes	Influence				Narrative (required if rating 2 or 3)
Cognitive Fixation	0	1	2	3	
Demand-Resource Mismatch	0	1	2	3	
Documentation	0	1	2	3	
Equipment/Technology	0	1	2	3	
Teamwork/Coordination	0	1	2	3	
Knowledge Deficit	0	1	2	3	
Medical Records	0	1	2	3	
Policies	0	1	2	3	
Production Pressure	0	1	2	3	
Service Array	0	1	2	3	
Stress	0	1	2	3	
Supervisory Support	0	1	2	3	
Procedural Drift	0	1	2	3	

Appendix H: Debriefing Feedback

The Systems Change Review process receives feedback from Wisconsin County staff at two points in time through SurveyMonkey. The survey is distributed to county staff who has participated in debriefing and mapping sessions. Completion of the survey is voluntary and anonymous.

There have been 10 surveys completed for debriefing.

When asked if participants found the debriefing helpful, all 10 respondents said yes.

One respondent stated, "Yes. It was helpful to have a voice, share my knowledge/experience with the family/situation as well as allow for continued healing as the more I talk about it the less triggering it is."

When asked what did the Wisconsin Reviewer do before and after the session that was helpful?

Nearly all responded that the assigned WI Reviewer helped them understand the process, which assisted in feeling more comfortable discussing a traumatic event.

How confident are you that your contributions will support change in the agency?

Many respondents stated they were hopeful for change, but expressed doubt that change would occur due to historic experiences. Respondents conveyed desire to trust in the process, but stated that will take time.

What did you like most about the experience?

All 10 respondents stated the experience felt comfortable, non-judgmental and/or supportive.

If you were asked to voluntarily participate in a future debriefing, how likely are you to participate?

All 10 respondents stated they would be likely to participate in the future.

When asked for improvements or additional feedback:

Many responded that they would like to receive updates on the outcome on that specific case.

Appendix I: Mapping Feedback

The Systems Change Review process receives feedback from Wisconsin County staff at two points in time through SurveyMonkey. The survey is distributed to staff that have participated in debriefing and mapping sessions. Completion of the survey is voluntary and anonymous.

There have been 25 surveys completed for mapping.

When asked if participants found the mapping helpful, all 25 respondents said yes.

One respondent replied, "I did find this helpful in expanding my thought process as to the contributing factors to serious incidences. It helped me reflect on how further I can advocate for workers and support my unit along with direct staff on an ongoing basis." Another respondent replied, "It was great to look at the entire system and to also review my own role, decision making and actions on my own cases. Best meeting I have been to in over 17 years. Thank you!"

How confident are you that your contributions will support change in the agency?

The majority of respondents stated they were very hopeful that issues identified will be addressed, although they acknowledged that the complexity and systemic nature of the identified issues or concerns may take time for the county or DCF to address. Some respondents expressed concern change may not occur, because concerns similar to those addressed in mapping had not been addressed in the past.

What did you like most about the experience?

Many stated they enjoyed the open discussion, shared learning and networking. One respondent stated, "The wide array of participants that felt comfortable having a strength-based conversation, which gave a lot of different perspectives and areas that influenced and impacted decisions." Another respondent stated, "I believe this Systems Change Review when done properly is exactly what our CW system needs. (The concept is cool)"

If you were asked to voluntarily participate in a future mapping process, how likely are you to participate?

All 25 respondents stated they would like to participate in the future.

When asked for improvements or additional feedback:

The majority of feedback was around process. Several respondents stated that all mapping participants should be aware of their roles and responsibilities (specifically Ad Hoc members). There was also concern regarding the infrequency of mapping session and potential for having to "relearn" the process for each session. Several respondents requested that we hold practice mapping sessions each quarter, if a case does not qualify for mapping, to increase capacity. Some respondents differed over whether BSWB representation at mapping enhanced or diminished the experience.

Appendix J: Description of the Safety Leadership Institute

The Systems Change Leadership Institute (SCLI) is a one day training specifically designed for Wisconsin to provide agency management with a high-level understanding of safety science. The SCLI engages managers on how to support safety advancement and system change as well as how to ethically respond to failure in a way that promotes organizational learning and improvement.

The Systems Change Leadership Institute is comprised of three sections:

1. Human Factors and Systems Safety Management
2. Supporting Culture Transformation
3. Communication

Human Factors and System Safety Management

This section lays the groundwork for the participants' knowledge about safety. The section provides a framework of system safety and is designed to engage participants with a comprehensive and holistic introduction to Human Factors and System Safety from an organizational leadership perspective. It also provides current models of accountability and ethics. Concepts and learning objectives are presented in a way that enables participants to make information meaningful. Throughout the session, information is strategically and thoughtfully connected to scope of position.

Learning Objectives:

1. Learners will explore the progression of safety within complex systems and develop a comprehensive understanding of advanced safety practices
2. Learners will be able to recall advanced safety methods in child welfare and identify how those principles are practically established within their organization.

Supporting Culture Transformation

This section lays the foundation for the importance of management in supporting the advancement of safety within an agency. It also focuses on the role of management to successfully advance their agency into the 21st century of safety and system improvement. The section additionally highlights the importance of sharing advancements within their respective agency. The section is connected to the principles in the Systems Change Review Institute along with the Systems Change Review process learned by Wisconsin Reviewers. This provides management with a shared understanding of how their agency may advance these principles and how their Reviewers will approach change.

Learning Objectives:

1. Learners will be able to describe the role of management in establishing a safety culture.
2. Learners will be able to describe the unique contribution of management in establishing a safety culture and how current management can begin making a difference in their agency.
3. Learners will be able to recall with a high level of understanding, the Wisconsin Systems Change Review process learned by the Wisconsin Reviewers and how to support its successful integration.

Communication

This section provides skills and tools to respond to failure from a management perspective. It will focus on how management can communicate to the media, their staff, and others following failure in a way that promotes trust and aligns their employees towards learning and improvement.

Learning Objectives:

1. Learners will be able to discuss the role accountability plays in learning and improving as an organization after failure occurs.
2. Learners will be able to recall practical approaches to communicating with the media, their staff and others following adverse events and how to support effective system change.

Appendix K: Safety Leadership Institute Agenda

AGENDA: Systems Change Leadership Institute

9:00am - 3:00pm

9:00am-10:30am

- The Two Views of Safety
- Safety as Bureaucracy

10:30am-10:45am

- Break

10:45pm-12:00pm

- Key Concepts
- Importance of Language

12:00pm-1:00pm

- LUNCH

1:00pm-3:00pm

- Critical Incident Review
- Managing the Critical Incident
- Tracking Success

Appendix L: Map of Safety Leadership Institute Agency Participation

