

Systems Change Review 2018-2019 Results



Wisconsin Department of
Children and Families

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

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DCF would also like to thank Collaborative Safety, LLC for their continued support, expertise, training and technical assistance in implementing this trauma-informed approach to understanding and learning from these tragic events.

Systems Change Review Overview

The Systems Change Review (SCR) process is applied to cases that are identified for a Practice Review under Act 78. This subset of Act 78 qualifying 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, DCF and other relevant parties. The collaborative review process is facilitated by DCF and includes a structured analysis of the system. Participants involved in this review process leave with a better understanding of how the various levels of our system influence case decision-making 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 SCR process utilizes principles from the field of Human Factors and System Safety Science to support DCF to learn from critical incidents and promote system-wide improvement efforts. The SCR process improves efficiency, emphasizes increased partnership and accountability, and focuses on analysis of systemic issues. For these reasons, the SCR 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 System Change Review framework used by DCF 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.

The Division of Safety and Permanence (DSP) reviews each critical incident submitted by counties under Act 78 to determine if it qualifies for the SCR process 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

Once a case is qualified for a SCR, a record review is completed in order to identify key observations. A key observation is any area of practice that deviates from Wisconsin policy or expected practice. Following the record review and identification of key observations, a human factors debriefing is scheduled with the identified staff at the local agency. Participation in the human factors debriefing is voluntary and confidential and staff can decline for any reason. The information learned from the human factors debriefing is presented at a mapping session in which a team of child welfare professionals and

child welfare partners use the information to analyze systemic factors and their influences. Mapping teams are comprised of dynamic individuals who can provide insight into components of the key observations and systems being reviewed. The mapping session ends with a visual representation of the systems and influences. The mapping information is transcribed into the Second Story, which incorporates human factors and complexity science to give meaningful explanation to the key observations. The DSP scores the Second Story using the Systems Analysis Tool developed by our partners, Collaborative Safety. At the completion of the SCR, 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 SCR process 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). DCF provides additional and detailed information and training to county agencies and DMCPS regarding the SCR process upon case qualification.

See [Appendix A](#) for the Wisconsin's Child Welfare Model for Practice, [Appendix B](#) for information about Wisconsin Act 78 requirements, [Appendix C](#) for information about the SCR process, [Appendix D](#) for a Flow Chart of the SCR process, [Appendix E](#) for a SCR mapping timeline, [Appendix F](#) for an example of a SCR map, [Appendix G](#) for an example of a Second Story, and [Appendix H](#) for the Systems Analysis Tool.

Accomplishments

Implementation in the Division of Milwaukee Child Protective Services (DMCPS)

At the time of implementation in the balance of the state in November 2016, it was determined to delay implementation in the Division of Milwaukee Child Protective Services (DMCPS) in Milwaukee County until quarter two of 2018. Delaying implementation allowed for opportunity to assess the process and identify needed adaptation and dependencies before engaging larger, more complex system elements associated with the Department's administration of DMCPS. Additionally, it allowed for opportunities for DMCPS and its contract agencies to observe the SCR process in the BOS and participate in targeted training and orientation opportunities. As part of the implementation process, DSP collaborated with DMCPS and the Division of Management Services' Bureau of Performance Management (BPM) to establish a new communication process. The new process outlined what and how information will be shared, including establishing clear roles and responsibilities.

Statewide Training Opportunities

Continued training and orientation to the principles of safety science and human factors, as well as to the SCR process, is important for the ongoing implementation of the SCR process in Wisconsin. In 2018 and 2019, several training opportunities targeting child welfare professionals, local child welfare agency leaders, and local tribal child welfare professionals and agencies were offered across the state.

Systems Change Review Worker & Tribal Orientations

The Systems Change Review Worker Orientation is a two-hour orientation to the SCR process which includes an overview of the process and case managers' roles and responsibilities if a case qualifies for a SCR under Wisconsin Act 78. The goal for the worker orientation is to share the DCF vision for shifting paradigms and approaches to the review of qualified cases with direct line staff. Given the high stakes decision making that CPS social workers face on an hourly basis, it is important to DCF to educate direct line staff on how their work will be evaluated if a tragedy occurs on a current or previous case.

Systems Change Leadership Institutes

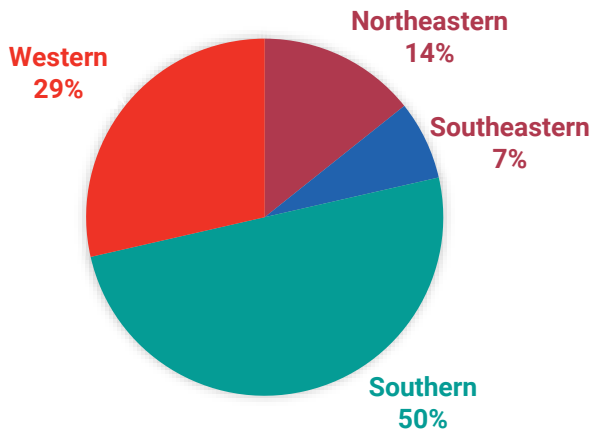
The Systems Change Leadership Institute (SCLI) is a one-day training specifically designed for Wisconsin to provide agency management with a high-level understanding of safety science. The SCLI engages managers on how to support safety advancement and system change as well as how to ethically respond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

Wisconsin Reviewers

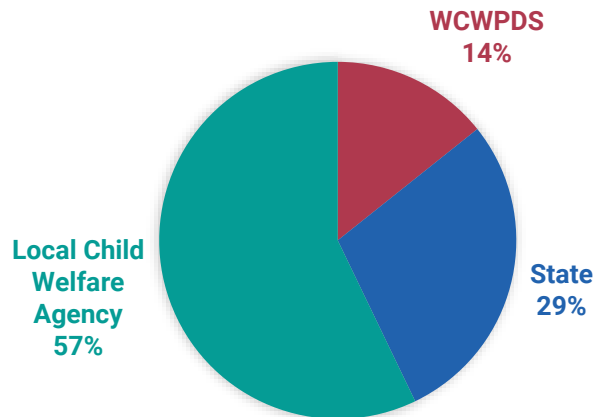
Recruitment

In calendar years (CY) 2018 and 2019, 14 new Wisconsin Reviewers were recruited to be a part of the SCR process and six people voluntarily ended their role as a Wisconsin Reviewer. Over the course of CY2018 and CY2019, the number of Wisconsin Reviewers increased by 233% and includes representatives from across the state and from core components of the state’s local child welfare agencies, the Wisconsin Child Welfare Professional Development System (PDS) and the department. The charts below show the percentage of Wisconsin Reviewers based on their primary job function and their location in the state.

Percentage of Wisconsin Reviewers by Region



Percentages of Wisconsin Reviewers by Primary Job Function



Wisconsin Reviewer Mentoring

In CY2019, DCF implemented a new way of onboarding and training new Wisconsin Reviewers. New Wisconsin Reviewers are required to complete a formal training that focuses on understanding the theory and principles of safety science and human factors, as well as teaching how to complete each component of the SCR review process. In addition, DCF created a new scope of services for a Wisconsin Reviewer mentor. A Wisconsin Reviewer mentor is responsible for mentoring a new Wisconsin Reviewer through the SCR process by providing targeted transfer of learning opportunities. In CY2019, two new Wisconsin Reviewers were onboarded to the SCR process by a Wisconsin Reviewer mentor. These one-on-one mentoring opportunities provide individualized attention to the new Wisconsin Reviewers, helping to increase knowledge activation and application. In addition, the mentor format also provides a professional development opportunity for the mentor. DCF plans to continue using a mentoring model for onboarding new Wisconsin Reviewers in the future.

Training and Technical Assistance

Wisconsin Reviewers are an integral part of the SCR process. In 2018 and 2019, DCF developed and implemented a new SCR training and technical assistance model. The Technical Assistance (TA) model consists of four 8-hour in-person TA days; one TA day is offered each quarter. The TA model targets each discrete part of the SCR process and provides additional technical knowledge, as well as opportunities for new skill development and application. The TA model is cumulative, as the information and skills learned and practiced in previous TA days builds to inform and support subsequent TA day. In 2018 and 2019, DCF offered 7 in-person TA days for Wisconsin Reviewers.

Systems Change Review Results

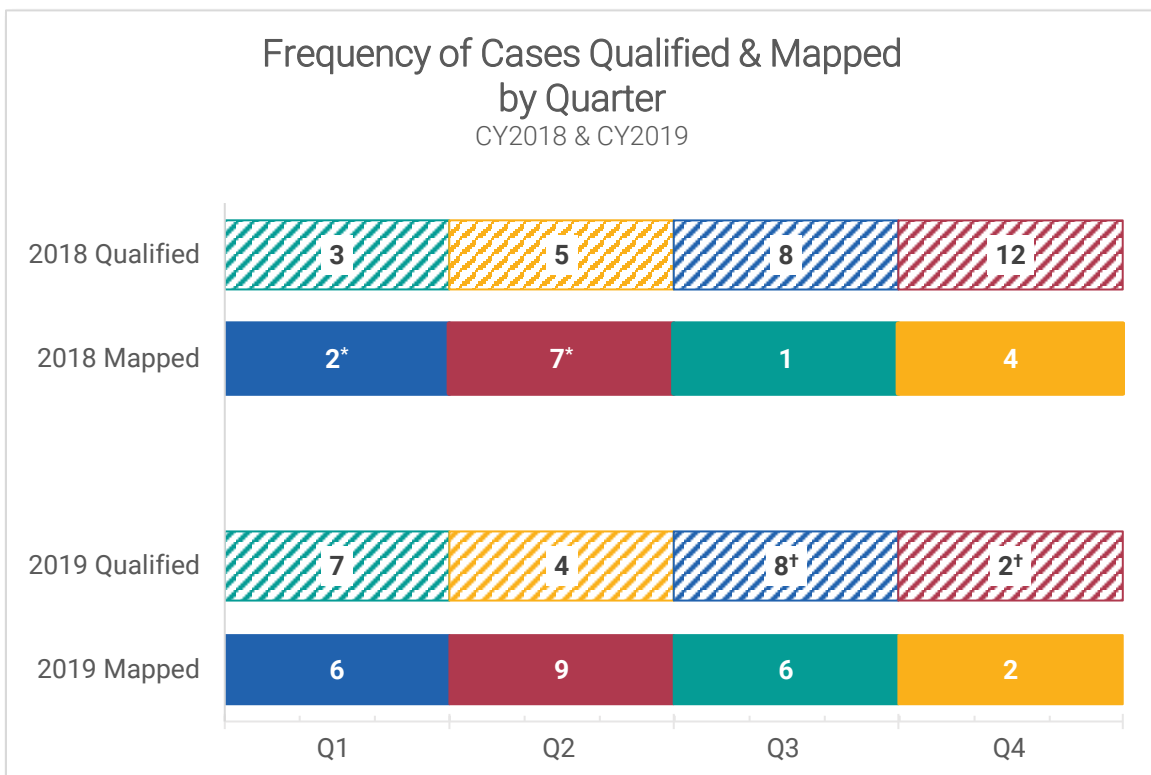
In support of the Department’s commitment to evaluate aggregate data to inform and promote systems change, rather than county or case specific findings, this report includes data and highlights recurrent themes inclusive of all cases mapped in CY2018 and CY2019. The data presented in this summary is related to cases in the balance of state (BOS) and the Division of Milwaukee Child Protective Services (DMCPS) and its contract agencies. The implementation of the Systems Change Process in DMCPS began in Q2 of 2018; no Milwaukee cases were mapped in CY2018. All of the data and exemplars are de-identified and individual county data is not presented.

Mapping Data

A case that is identified for a SCR is mapped two quarters after the case is qualified. For example, a case that qualifies for a SCR in Q1 of 2018 is mapped in Q3 of 2018. 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).

Cases are presented to mapping teams only if key observation(s) are identified through the case record review process. For this reason, there are more cases that qualify for the SCR process than that are brought to mapping teams. The mapping results presented here includes data from all cases mapped in CY2018 and CY2019 in BOS and DMCPS.

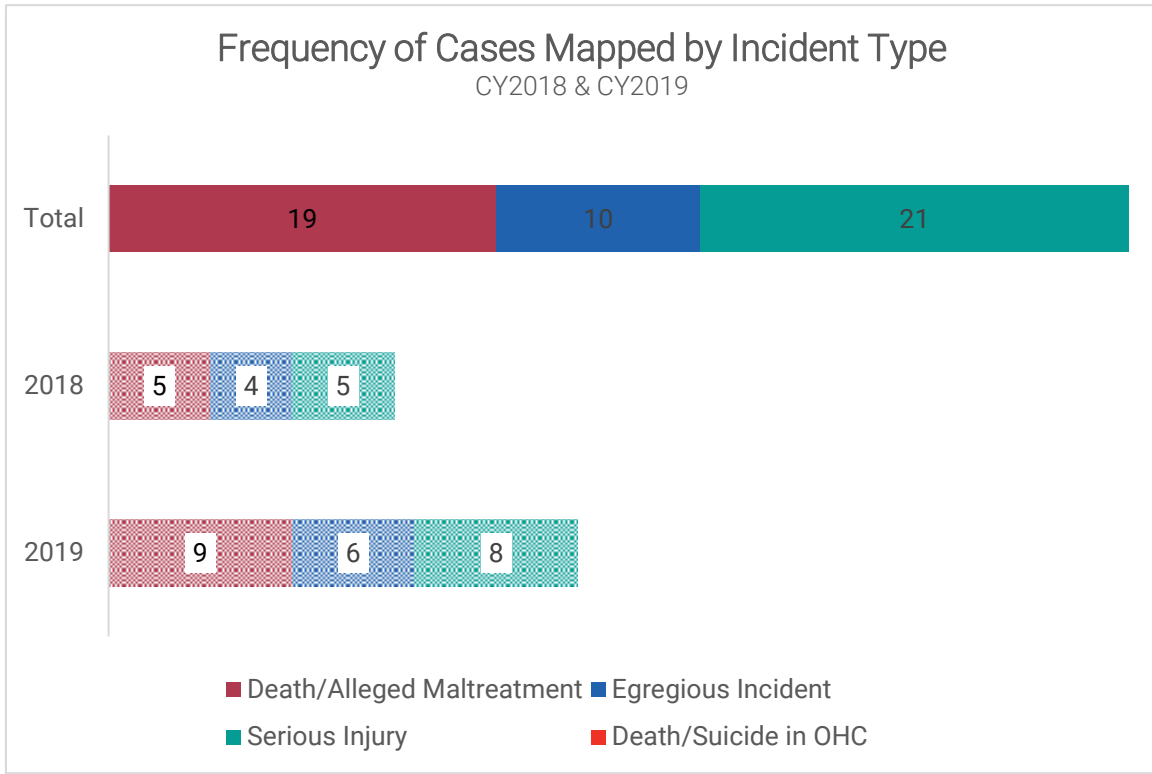
In CY2018 and CY2019, 49 cases qualified and were reviewed as part of the SCR process. Of the 49 cases that qualified, 37 cases had Key Observations identified and were presented to regional mapping teams; 12 cases were not mapped. The chart below shows the number of cases that qualified for the SCR process and the number of cases that were mapped in CY2018 and CY2019. **



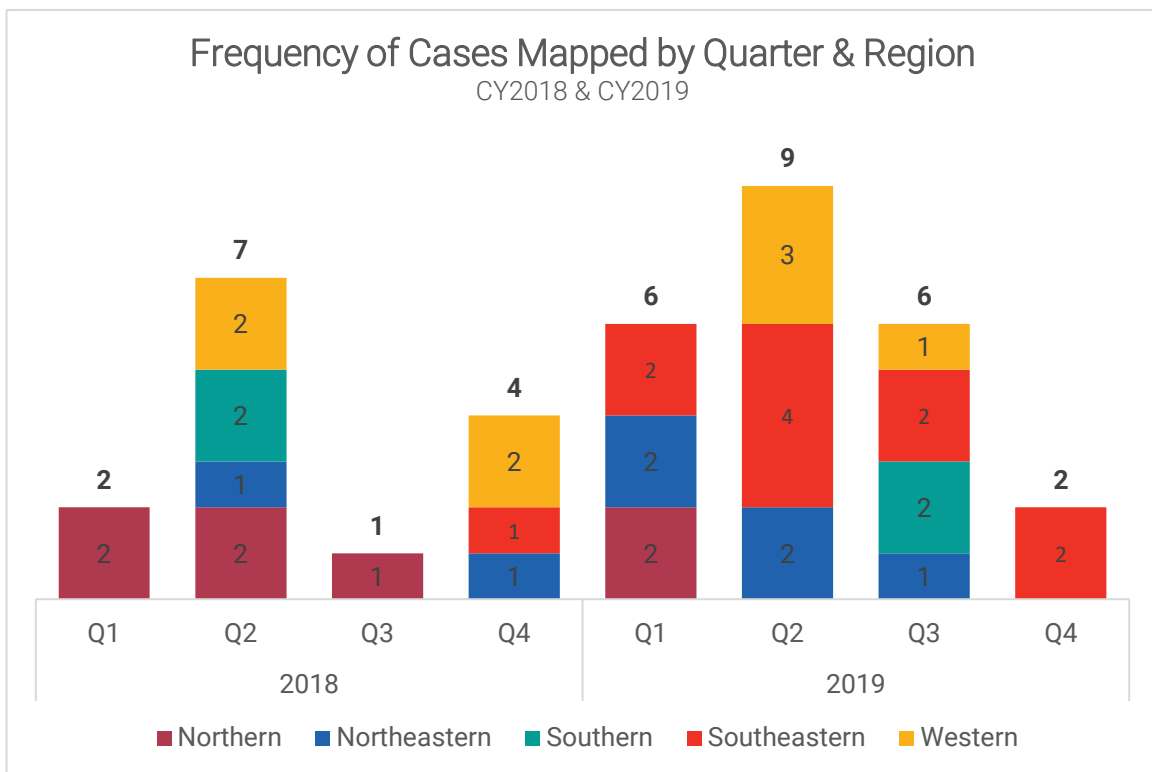
* Cases that were mapped in 2018 Q1 and Q2 were qualified in 2017 Q3 and Q4, respectively.

† Cases that were qualified in 2019 Q3 and Q4 will be mapped in 2020 Q1 and Q2, respectively.

The chart below shows the number of cases mapped by incident type.



The chart below shows the frequency of cases mapped by quarter and region. Note that the implementation of SCR in Milwaukee began in Q2 of 2018 and the first Milwaukee cases were mapped in Q1 of 2019. The increase in number of cases mapped in CY2019 is related to the implementation of SCR in Milwaukee, and not to an increase in the overall number of critical incidents occurring and

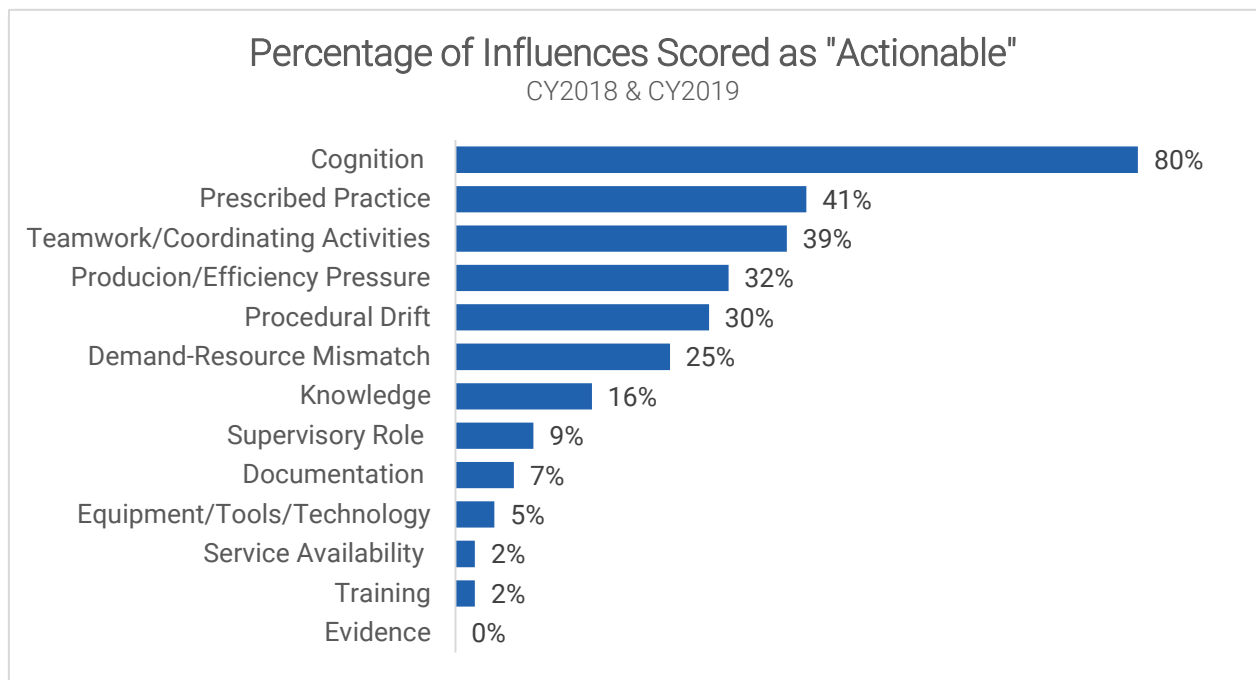


qualifying for the SCR process.

Scoring Data

The Systems Analysis Tool (SAT) is a multi-purpose information integration tool designed to be the output of the information learned through the SCR process. The purpose of the tool is to support a culture of safety, improvement, and resilience. After each case is presented to a mapping team, the Wisconsin Reviewer drafts a narrative that explains the second story for each Key Observation. The narrative includes information learned from the Human Factors Debriefing and mapping session and succinctly captures how decisions and actions are influenced within and across multiple levels of the child welfare system. Scores from completed cases reflect whether an influence was present in a case and supported by evidence, which is captured by the label “actionable.”

In CY2018 and CY2019, 37 cases were scored using the SAT scoring tool as part of the SCR process. The chart below shows the frequency of influences scored as actionable (scores of 2 or 3).



Discussion and Examples of Influences Scored as “Actionable”

The information below is an aggregate summary of influences that occurred in more than 30% of the cases mapped in CY2018 and CY2019. These influences should not be viewed as direct, causal factors in case outcomes, rather, they help to explain the inherently complex nature of the work and the many factors that influence the trajectory of care.

Cognition

Cognition is defined in the SAT as a faulty understanding of a situation due to cognitive fixation or cognitive biases (e.g. confirmation bias, focusing effect, tunneling). Cognition continued to be a frequently reoccurring influence in 80% of the cases that were mapped in CY2018 and CY2019. In general, cognition as an influence presents in a multitude of ways in cases. The most common case features that impact a child welfare professional are historical family knowledge and family engagement with CPS. Below are a few selected exemplars.

“Prior knowledge of the mother contributed to a quick decision to take custody of the older children and place them in out of home care.”

"The father was perceived by the county as being uncooperative because he did not follow through with Child Support in order to become adjudicated, he missed appointments with his Probation Agent, was in and out of jail, and did not follow through with substance abuse treatment."

"Another factor that affected the decision not to work in conjunction with another local child welfare agency was the worker's knowledge of the family's past CPS history, including that the parents often made CPS reports on one another."

"The covering worker believed that the case coverage would be short term which influenced their focus on basic needs of the family rather than the identified safety threats."

"When the worker was able to view the child that had the alleged injuries there were no visible injuries. Consequently, the perceived threat was diminished; and the other allegations were not addressed at that time."

Prescribed Practice

The definition of prescribed practice is when practice prescribed by policy or practice standards is absent, conflicting, vague or does not adequately support work. Prescribed practice was the second most frequent influence scored in cases in CY2018 and CY2019. Prescribed practice presents most often as confusion regarding practice standards issued by DCF. Specifically, narratives emphasized 'unclear standards' again and again. Below are a few selected exemplars:

"Ongoing Standards do not clearly direct who is considered a new household member when assessing the safety of a new child in the home (household composition changes positively or negatively)."

"The worker was confused, in part because each of the three sets of standards contains multiple requirements pertaining to timeframes, including the once monthly face-to-face contact requirement for children in out-of-home care, and the worker misremembered which requirement was applicable to the facts of this case."

"There is a shared understanding by staff in the County that the Ongoing Standards do not clearly define requirements around including known alleged fathers in family interaction plans."

"Wisconsin's child welfare standards discuss that household members are in the home regularly or intermittently, however, these terms are not defined, which can foster different interpretations of household composition."

"The information in the Safety Intervention Standards regarding this Present Danger Threat makes it seem as though the child has to be in the middle of the DV incident and harmed in order for the threat to be applicable."

"There is an absence of guidance regarding inter-state jurisdictional issues which resulted in this agency relying on policy related to inter-county jurisdictional issues."

Teamwork/Coordinating Activities

The teamwork and coordinating activities item is defined as ineffective joint coordination of activities between two or more entities including internal staff and external partners (e.g. CPS and Licensing, CPS and Law Enforcement, Foster Care and other External Entities). This influence was scored as actionable in 39% of cases and focuses how child welfare professionals interact with and use information from other professionals. Below are a few selected exemplars:

"In this county, the relatives' application for Kinship Care was processed by a separate

set of staff in the agency and their process does not require review of the content of Police Reports."

"During the time the case moved from child welfare to initial assessment, the child welfare worker was transitioning to another unit. This move led to a change for the child welfare worker in physical space as well relationships. These changes in roles and location led to a lack of communication between staff to ensure the services report was addressed during the IA."

"In this county, medical opinions regarding child maltreatment are often heavily relied upon and used to inform CPS decision-making related to safety and maltreatment substantiation."

"The focus of partner agencies such as law enforcement is on determining if a crime has been committed and often leads to not including children who were not directly victimized by the crime."

Production/Efficiency Pressure

The SAT defines production and efficiency pressure as demands to increase production and/or efficiency (workload, economic) which impacts safe work practices. In CY2018 and CY2019, SCR narratives documented how pressures on child welfare professionals impact their decisions and actions throughout the case and how the inability to recruit new child welfare professionals impacts caseload and workloads for the child welfare professional and can lead to turnover. Below are additional selected exemplars:

"The worker had a high caseload and when it was determined at face to face that there were no immediate safety concerns, the worker's attention could then be focused on the continued influx of cases and those cases in which safety concerns are more immediately present."

"Due to the high call volume, on-call workers operate in a crisis driven mode, jumping from one crisis to the next, leaving very little time for critical analysis of impending danger threats."

"CPS' deference to CCS is reinforced further as a means to manage the increased volume of CPS reports, and related constraints on the CPS professional's time."

"The worker had to make a tradeoff decision regarding how to spend her time during the weekend: seeing clients or entering case notes. Because the worker prioritized seeing clients during the week, this resulted in having to enter case notes on the weekends."

"The state adds new work requirements (via new policy), but rarely removes work requirements and, thus, increases the total number of tasks to be completed on a case."

"High worker turnover leads to increased demands on the limited time staff have [to conduct an assessment]. Workers face the challenge of managing their increasing workload which causes them to prioritize [who to include in the assessment]."

"Worker turnover at the agency placed an increased pressure on existing ("seasoned staff") to both respond to same day CPS cases and train new staff. "

Survey Data

The SCR process receives feedback from child welfare professionals who participate in either a Human Factors Debriefing or mapping session. Completion of the survey is voluntary and anonymous. Results of the survey help DCF understand how child welfare professionals are experiencing the SCR process and provides opportunities for change.

Human Factors Debriefing Surveys

In CY2018 and CY2019, 33 Human Factors Debriefing participants completed the survey, the aggregate, deidentified results are presented below.

Question 1: Did you find the Human Factors Debriefing experience to be helpful?

Of all survey respondents, 79% found the Human Factors Debriefing experience to be helpful or somewhat helpful. Below are a few selected quotes:

"I found it very helpful to discuss the case as well as social work practice. I found it to be focused on positives rather than negatives."

"I found my participation very helpful. I felt that it was a good way to reflect on what was going on during the time that I got assigned the case and to talk about the decisions I made without it feeling punitive or like I made a lot of mistakes."

"I found the debriefing very helpful. It was therapeutic to discuss the case and answer questions."

"I had a lot to say about the case and felt like my voice hadn't been heard yet. It was nice to finally tell someone my experience with the case."

"It was nice to talk through the process and see what could have been done differently to benefit the clients a little better."

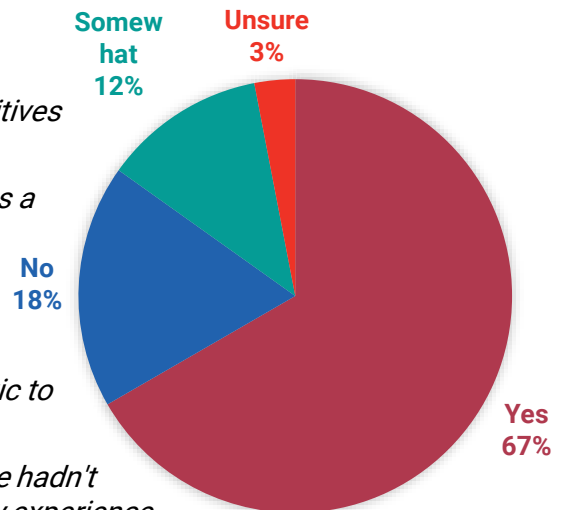
"It allowed for someone else outside of the agency to review and give a different take on things if warranted."

"It gave an opportunity to provide information that will hopefully be helpful in identifying needed changes that will support workers and agencies in their work with children and families."

"I feel neutral about it. I don't necessarily feel it was helpful, but it wasn't negative either."

"I did not feel like I was prepared to discuss the topics addressed in the meeting. I would have liked to have a better understanding of what would be discussed to better prepare to answer the questions."

"I didn't necessarily find my individual experience as helpful, but I know the whole process is helpful to learn if there are areas we need to change within the system."



Question 2: What did the Wisconsin Reviewer do before and after the session that was helpful?

The majority of respondents found the Wisconsin Reviewer to be helpful by explaining the process, asking non-judgmental and open-ended questions, and allowing the person to tell their story. Below are a few selected quotes:

"[The Wisconsin Reviewer] explained the process and what we would be talking about before the conversation, and then explained to me what the next steps would be."

"Before the session she was able to answer all of my questions and put my mind at ease about what this interview/process looks like. I did not receive anything after my session."

"[The Wisconsin Reviewer] was prepared and interested in learning more about the work that was done on the case. It did not feel like our agency's work was being judged or criticized."

"Provided info and context to the discussion and was very patient, generous with her time and open to my questions."

"Put [my] frustrated thoughts into a clearer framework and validated my feelings."

"Reviewer was supportive and approachable. The reviewer did a great job of explaining the process and purpose."

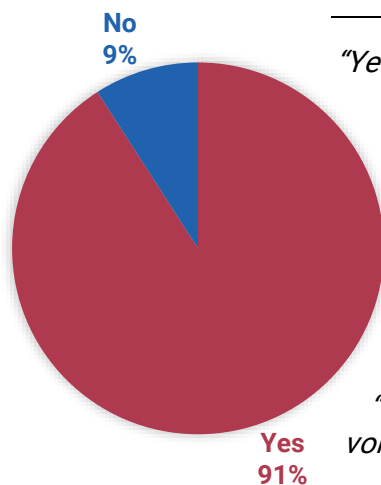
"[The Wisconsin Reviewer] explained the process very well and informed me that what I reported would be confidential. They also didn't ask why certain things were going on with this case but explored barriers to assessing the family."

"[The Wisconsin Reviewer] was very deliberate in the questions asked. They did a nice job of re-capping what was being discussed throughout the conversation to make sure they were capturing the info correctly."

"The reviewer contacted me to set up the meeting time in advance that worked for both of our schedules and kept in contact when there were any questions prior to the set date to meet. Afterwards there was an email follow up."

Question 3: Did you feel your participation was voluntary?

91% of respondents felt their participation in the Human Factors Debriefing was voluntary. Below are a few selected quotes:



"Yes, but I don't think it should be. This is important and even the way I was able to process it was important."

"Yes, I did. It was made very clear to me that this was a voluntary interview."

"Yes, I chose to participate in this review process."

"Yes, I requested to still be interviewed even though there were no key observations that were found for the county that I work in."

"Yes, [the Wisconsin Reviewer] explained many times that it was voluntary."

"I felt like I had the option to participate."

"I didn't necessarily find my individual experience as helpful, but I know the whole process is helpful to learn if there are areas we need to change within the system."

"I did not feel that my participation was voluntary but rather needed. I cannot recall if I was told my participation was voluntary. Either way, I wanted to participate."

"It was not relayed that it was voluntary but I didn't feel pressured about it."

Question 4: How confident are you that your contributions will support change in the agency?

The majority of survey respondents (52%) were either very confident, confident, or somewhat confident that their contributions would support change in the agency. Below are a few selected quotes:

"[The Wisconsin Reviewer] seemed passionate about this process, so after speaking to them, I feel that this will help support change in the agency."

"[The Wisconsin Reviewer] was great in their explanations and discussions and I felt that I was heard. I am confident that [the Wisconsin Reviewer] took the information that I provided and will bring it back to the team to influence change, as needed."

"I believe at a larger level it will help address concerns and strengths in the state. I'm not sure how much our specific county will change."

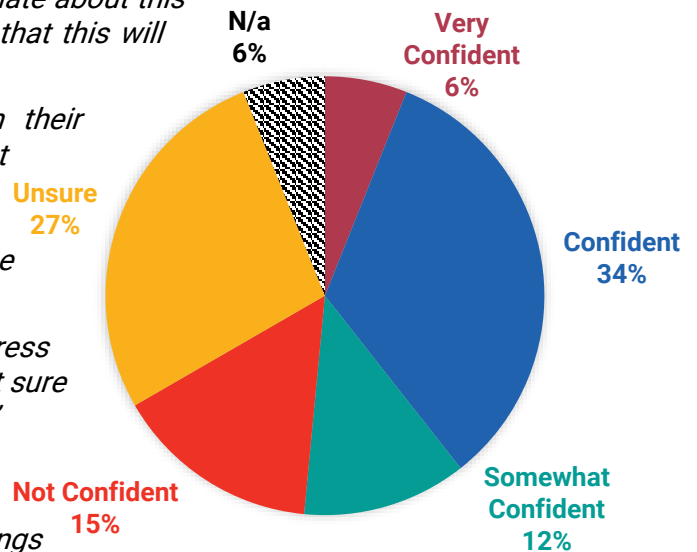
"I feel very confident that the conversation I had will help create change. The conversation helped bring to light some things that occur in my county that don't necessarily happen in other counties, and to reflect on how practice could be improved in the county."

"The reviewer appeared very genuine when they explained they would be sharing this information with the team to help our agency grow and change for the better."

"I am unsure at this time and would need to see what the results produce."

"I'm not sure. I'm confident the info will be brought back to the greater group, but what happens from there I can't be certain."

"Not very confident. I believe there are a lot of changes that need to be made to the system as a whole and this is difficult."



Question 5: What did you like most about the experience?

The majority of respondents could recall detailed things about the Human Factors Debriefing that they enjoyed. Specifically, respondents appreciated that the conversation was non-judgmental, questions were open-ended and there were no right or wrong answers. Additionally, respondents enjoyed being able to talk about the case and share their story, while also considering how systemic influences impact their work. Below are a few selected quotes:

"Being able to discuss the concerns I had during that time period, being heard, and

being validated."

"I appreciated the way [the Wisconsin Reviewer] phrased the questions. Their interview style was relaxed and non-judgmental."

"I like that no managers were present for the interview, as this made me more comfortable to provide information."

"I liked that I wasn't expected to have all the answers and that it was okay for me to not know everything. I also liked that that felt very trauma informed."

"I really enjoyed getting to speak about areas of social work practice that could be improved and my opinion on how to do these."

"It is so different from the previous reviews. It is significantly less blaming and provides for much more of a dialogue."

"It made me think of potential systematic barriers."

"It was helpful to discuss some of the unique challenges of my work with a peer that does the very same work."

"Kind and supportive reviewer. I never felt judged by them."

"That it felt like a conversation rather than an interrogation."

"That the reviewer was someone who has walked in my shoes and understands the day to day struggles of doing this job."

"What I liked most about the experience was having been asked open ended questions. I enjoyed having professional discussion about the situation and having someone see from the outside."

Question 6: If you were asked to voluntarily participate in a future debriefing, how likely are you to participate?

Over 90% of respondents stated that they were likely or very likely to participate in another Human Factors Debriefing in the future. Below are a few selected quotes:



Question 7: What suggestions or additional feedback do you have to improve the experience?

Of respondents who provided answers, the majority of the feedback centered around a feedback loop to the participant, in order to know what was learned from the mapping session, having the debriefing session sooner after the critical incident occurred, and providing more trainings and orientations to child welfare professionals about the process. Below are a few selected quotes:

"Communication afterwards about what happened with the information we provided. Discussion about what thoughts may have been brought up about possible changes."

"Would have liked to be part of the mapping and know what changes or next steps are."

"I think it would be more helpful and more beneficial to have the debriefing sessions not so long after the incident. It makes it difficult to remember details and sometimes can be re-traumatizing."

"I understand it is necessary to debrief about the Department's involvement leading up to the egregious incident, however I personally, would've liked a debrief of my work following the incident. I feel the aftermath of the incident can sometimes be more traumatizing than the incident happening itself."

"I think it would be helpful to not only look at child death cases, but maybe other cases too."

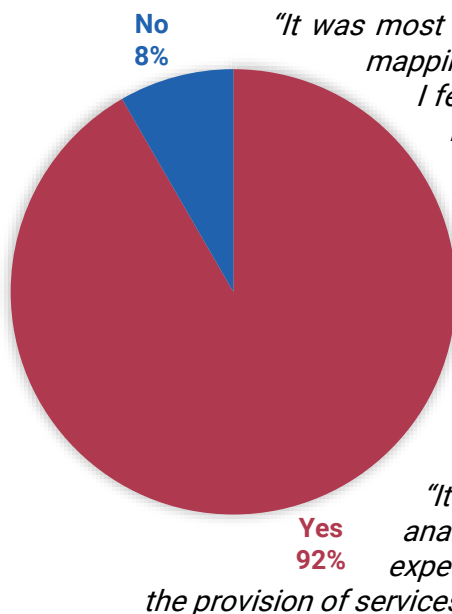
"I think it would be beneficial to have a refresher to staff about what this process looks like. I remember that we spoke about it at an all agency meeting, but that was a while ago and I don't think people realize how beneficial these meetings are."

Mapping Team Participant Survey

In CY2018 and CY2019, 96 mapping team participants completed the survey, the aggregate, deidentified results are presented below.

Question 1: Did you find the mapping experience to be helpful?

Of all survey respondents, 92% found the mapping experience to be helpful. Below are a few selected quotes:



"It was most helpful to have a shared learning experience with the other mapping team members and learn about practices around the state. I felt I could bring some of the knowledge back to my agency to inform best practices."

"It was helpful in that it allowed for a review process that was not looking for someone to blame. Instead it took a look at what happened and why with the intention of making changes to possible systemic issues."

"It is good to hear perspectives from other counties and how they may have or may have not handled things. Also helps you to feel not alone out there handling these types of cases and the struggles that come along with that."

"It allows for the open dialogue of barriers to best practice. To analyze the interplay of the multiple levels of systems and expectations that impact our ability to be as effective as possible in the provision of services."

"I found the description of key observations (i.e. what they are and how they have no causal effects on the case outcome) to be the most helpful. The overall review of the process and intent was helpful."

"I felt the mapping was very helpful to uncovering system concerns that potentially can impact child welfare work. Having the conversations and visually mapping gave way to good ideas and feedback."

"[The Wisconsin Reviewer] was able to get some good discussion going. It made me think about how we practice in our county and where some of our shortfalls may be."

"I believe that this is helpful process. It moves the blame from the worker and the county and looks at local and state issues that may need to be addressed."

Question 2: What did the Wisconsin Reviewer do before and after the [mapping] session that was helpful?

The majority of respondents found the Wisconsin Reviewer to be helpful by explaining the process, facilitating a conversation that was free of blame and focusing the conversation in order to allow all mapping participants to express their thoughts. Below are a few selected quotes:

"[The Wisconsin Reviewer] explained the process in detail and what to expect helped alleviate some nervousness going into it."

"[The Wisconsin Reviewer] kept the group on track and was able to focus on the voice of the group instead of instantly drawing connections."

"[The Wisconsin Reviewer] made it clear that this was a confidential, judgement free zone and to be mindful of that. We are not looking to place "blame" but to learn and grow from this experience."

"[The Wisconsin Reviewer] took her time to explain everything and also provided me with handouts. They were even willing to elaborate on things they had explained and provide their card if I had questions after they left."

"The reviewer was prepared before the session began and was knowledgeable about the case throughout the presentation. Appeared to be comfortable and confident in their role."

"They were able to help all participants identify and express their views. Emphasized that this was a blame free environment."

Question 3: Did you feel your participation was voluntary?

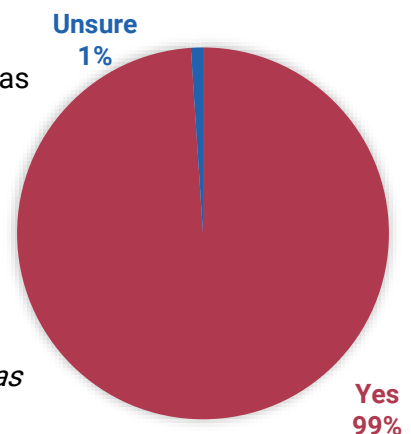
99% of respondents felt their participation in the mapping session was voluntary. Below are a few selected quotes:

"I felt that participation was voluntary, and all ideas were accepted."

"I felt it was voluntary. I offered to be on the mapping review team."

"Everything was very welcoming and inviting to everybody's ideas and thoughts. I did not feel that anybody was put on the spot."

"I felt that it was voluntary and felt that my input was appreciated."



"I felt that my voice was important and voluntary."

"I signed up for this because I believe in the process"

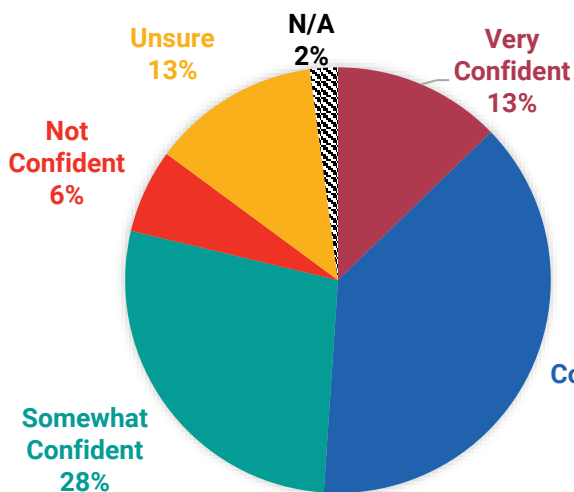
"The state always asks [for participants] and did not demand attending."

"There was active participation, but I did not feel required to participate unless I had something meaningful, I wished to add to the discussion."

"I think all CPS sups should be a part of [the mapping session]."

Question 4: How confident are you that your contributions will support change in the agency?

The majority of survey respondents (79%) were either very confident, confident, or somewhat confident that their contributions would support change in the agency. Below are a few selected quotes:



"At the end of the session I feel that there was a lot of information that would contribute to change."

"Even if they don't change anything statewide, the information that I gather from the sessions is brought back and implemented at my agency when necessary."

"I am confident that information gathered from these reviews will guide future practices in the field."

Confident 38% *"I am pretty confident that I am being heard during the process and my thoughts are being captured in the process."*

"I feel good about this experience and believe that DCF wants to use this process to positively effect change."

"I know the intent is good and hope to see actual change in the future."

"I like this process and feel that it the most supportive of positive changes than I have seen over the past 18 years."

"I LOVE this process! I can see how the recurring themes can be used to make change. I also bring back my observations and staff with my supervisor regarding things we may be able to do differently immediately."

"More confident than individual county review and training offered in the past."

"As the agency manager, I believe I am in a position to affect any needed system change. However, some of that change is difficult if the outside constraints (mainly funded) is not addressed."

"I have low-moderate confidence my contributions will lead to meaningful change during my career- But that doesn't mean we don't keep trying! Despite the efforts of a lot of well-intentioned people, there is far too much red tape in the child welfare system and not enough good PR. We can articulate the problems a million different ways. Hopefully the New View of Safety is something that will resonate and the "people in power" hear and change the system."

"I have medium to high confidence that information coming out of statewide Mapping Sessions with support changes."

Question 5: What did you like most about the [mapping] experience?

The majority of respondents recalled specific things about the mapping session that they enjoyed. Respondents appreciated that mapping sessions included collaboration with other counties in order to explore issues that are impacting child welfare professionals from multiple perspectives. The mapping sessions were often described as robust, trauma informed and focused on learning rather than on assigning blame. Below are a few selected quotes:

"Atmosphere of mutual respect, "no blame", comfortable setting to share thoughts and also being reminded that the experiences in my county really do mirror what my colleagues across the state are dealing with."

"Bigger picture - hearing about experiences across counties and how they are similar to those we experience in our county."

"Collaboration with others from different county agencies that provided another perspective."

"Feeling like I was a part of something bigger to address system issues to make changes in a non-threatening, strength-based approach."

"Having the opportunity to interact with colleagues and DCF about practice and the ways that standards interact with the daily decision making."

"Hearing all the different perspectives regarding the case (front-line, supervisors, directors)."

"I enjoy that I can express my concerns about processes, policies, etc. without judgement."

"It is both interesting and instructive to engage in open dialogue with other agencies that provide the same services. It helps to gain a better understanding of where the "pressure points" are that affect practice."

"The ability to share ideas and the belief that DCF is listening and take the information gained to improve the system."

Question 6: If you were asked to voluntarily participate in a future mapping session, how likely are you to participate?

97% of respondents stated that they were likely or very likely to participate in another mapping session in the future. Below are a few selected quotes:

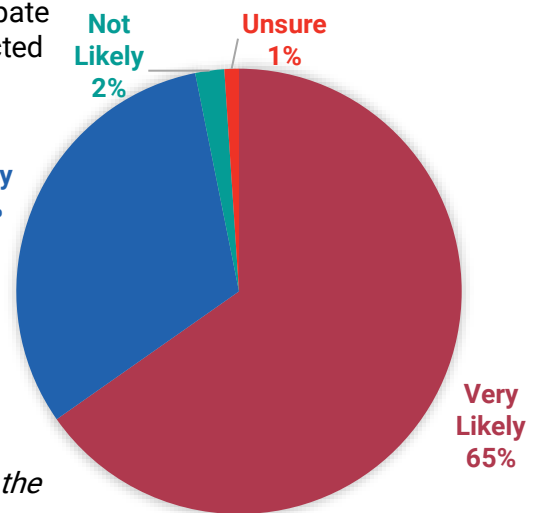
"I am very likely and look forward to it."

"I will continue to participate as a [mapping team participant]. I would recommend that all County Directors rotate in to participate and understand in the process."

"I would love to participate in a mapping session again."

"I would. In fact, I think I ended up as a backup team member after the last mapping session."

"I've already requested to be a more permanent member of the process vs a substitute. So, I am in!!"



Question 7: What suggestions or additional feedback do you have to improve the [mapping] experience?

Of respondents who provided answers, the majority of the feedback centered around a feedback loop to the mapping team participants in order to know what was learned from the mapping session and how the information will be used for change considerations at a systemic level, having more trainings or refreshers prior to mapping sessions, and meeting more frequently to review cases. Below are a few selected quotes:

"I'm anxiously awaiting to see the changes above the local level that have been influenced by these reviews. I think that will be a "big win" for the new process."

"Information as to what changes have been made at the state and local levels as a result of the mapping sessions to mapping participants would be appreciated"

"I think it would helpful for mapping participants to be made aware of policy/practice changes that are made related directly to the mapping process."

"Have more workers with direct contact with clients participate."

"Make sure to have a county representative of the case being reviewed at the table."

"I would suggest having group norms or agreements, so everyone isn't talking over everyone else."

"Still need to be careful not to blame. System needs to be aware that our staff make high stakes decisions and judgements every day."

"Everyone involved should be given a brief refresher prior to the session that this is not to point blame and we are focusing on the case."

"I would meet quarterly even if there are no cases to review to keep our skills fresh. If there were no cases to review, I would suggest meeting and doing a case example."

Conclusions and Next Steps

Over the past two years, we have continued to align the SCR process with the tenants of our Wisconsin Child Welfare Model for Practice. The SCR process exemplifies how a critical incident review process can occur in a respectful and trauma-informed manner, while also prioritizing system accountability and workforce support. DCF continues to move forward with a continued commitment to the SCR process and to prioritizing the information learned to continue to support ongoing professional development and quality improvement and to inform future statewide initiatives and systemic change.

Continual feedback and flexibility to make changes has also contributed to our successful implementation. Over the course of CY2018 and CY2019, as we continued implementation in the balance of the state and began implementation with DMCPs, participant feedback has been overwhelmingly positive, reporting that the SCR process has felt trauma-informed and supportive. We continue to elicit feedback from review and mapping session participants, as well as from Wisconsin Reviewers, which has been and continues to be used to make swift adaptations to the SCR review process. Critical refinements to the SCR based on the feedback gathered over the last two year includes, but is not limited to the following:

- Refining technical assistance provided to and increasing the number of WI Reviewers trained to carry out the SCR process, and;
- Improving with ongoing communication and coordination with local child welfare agencies.
- Enhancing ways in which the state and local child welfare agency partnership throughout the SCR process can leverage a better understanding of influences affecting Wisconsin's child welfare system and leveraging this understanding to better support system performance and accountability.

The inclusion of the critical incidents arising from DMCPs in the SCR process has afforded a more global view of child welfare practice in Wisconsin. The information learned from these reviews will be important as we continue to evaluate systemic challenges and needs and promote positive change across our state's child protective service system. We value and appreciate our Division's continued partnership with DMCPs, as well as from local CPS agencies across the state, in the SCR process as this is an integral part of understanding our child protective service system and better supporting the needs of our workforce which, ultimately, results in better service delivery and outcomes for the children and families we serve.

As we look ahead to continue to advance the learnings from this review process, DCF is committed to using the information learned from this process in our continuous quality improvement (CQI) process. DCF's CQI system is supported by a Child Welfare (CW) CQI Advisory Group composed of stakeholders from DCF, counties, courts, tribes, and the professional development training system. The purpose of the CW 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 SCR results will be advanced to the Child Welfare CQI Advisory Committee.

In closing, 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.

Appendix A: WI Child Welfare Model for Practice

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 B: 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 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 DCF is transmitted via the statewide-automated system, referred to as eWiSACWIS.

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, DCF implemented a new approach to the analysis of those cases qualified for a Practice Review, called a Systems Change Review. At the completion of the SCR process, 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.

Appendix C: Systems Change Review Process

This section explains how the various components of Systems Change Review process provide a methodical approach to the analysis of those cases assigned to a Practice Review.

Wisconsin Reviewers

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

Wisconsin Reviewers play an integral role in completing reviews 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 Wisconsin 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 child welfare professional. Participation is voluntary and staff can decline for any reason. An indirect result of the session includes some therapeutic benefit, likely because the child welfare professionals are able to be heard and better understood through this process, as a result, the conversation is approached with sensitivity to the trauma experience.

Mapping

A mapping session occurs after the Human Factors Debriefing of child welfare direct service professionals and supervisors and is facilitated by a Wisconsin 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 F](#) 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. Mapping team participants are expected to view a brief orientation prior to the first mapping session in order to familiarize the mapping team members to the process.

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 G](#) for an example of a second story used in Wisconsin Reviewer training.

Scoring

Second Stories are scored using a Systems Analysis Tool developed by 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

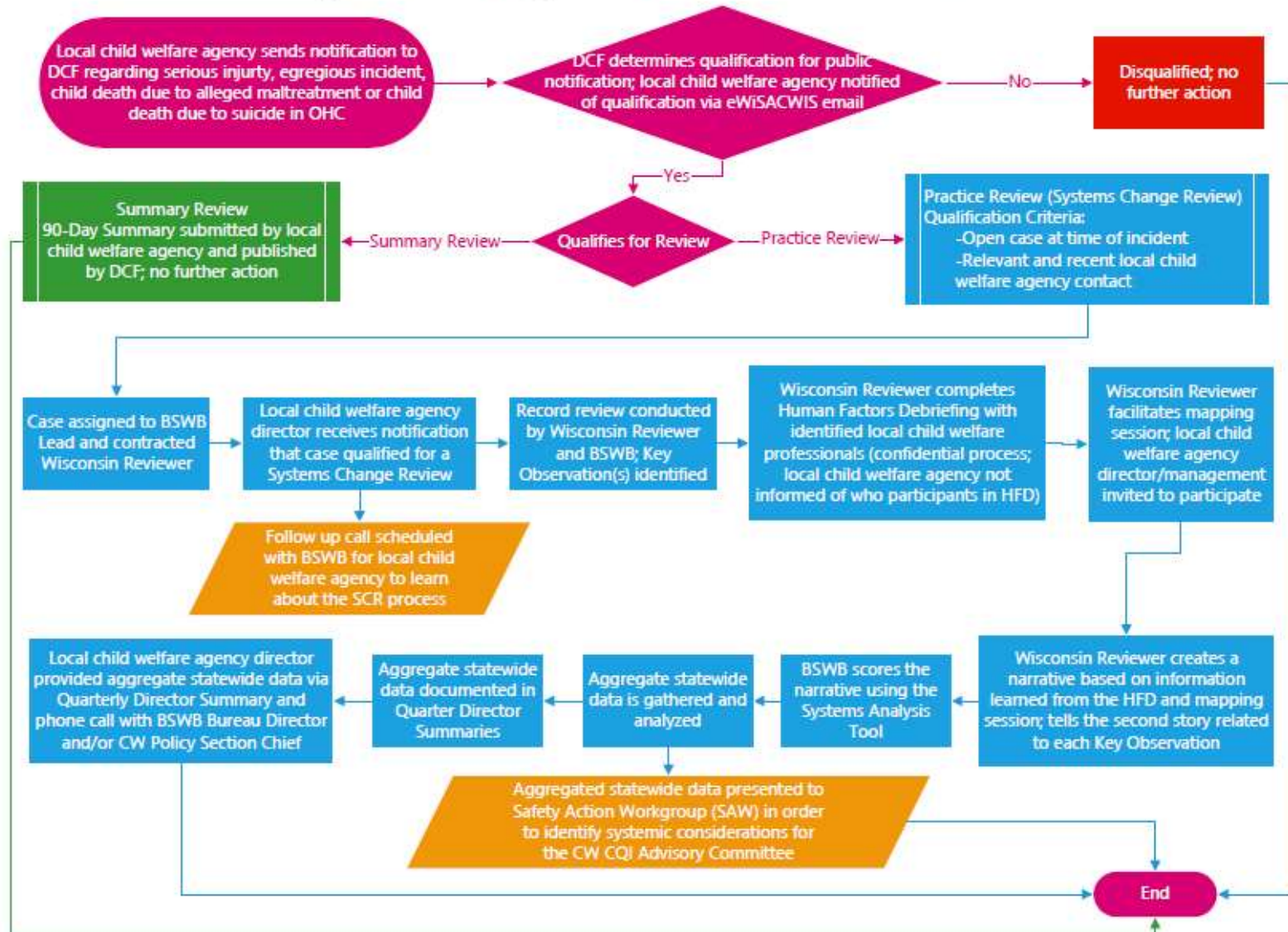
Please see [Appendix H](#) for the Systems Analysis Scoring Tool, including definitions and instructions on completing the scoring tool.

Human Factors Debriefing & Mapping Session 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 a mapping session 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.

Appendix D: Systems Change Review Flowchart

Systems Change Review Process Flowchart



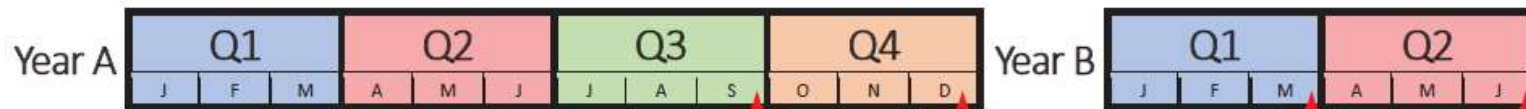
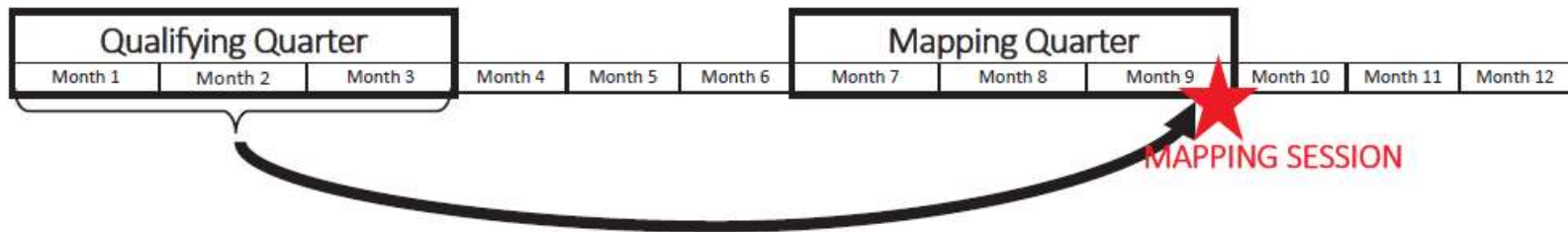
Appendix E: Systems Change Review Mapping Timeline

SCR Qualifying Quarters

Q1			Q2			Q3			Q4		
January	February	March	April	May	June	July	August	September	October	November	December

SCR Mapping Quarters

The quarter in which a case qualifies for a SCR informs which subsequent quarter the case is brought to mapping. Mapping sessions are scheduled at the end of each quarter.



Cases are mapped according to the following qualifying schedule:

- Cases that are qualified during Year A, Q1 are mapped in Year A, Q3
- Cases that are qualified during Year A, Q2 are mapped in Year A, Q4
- Cases that are qualified during Year A, Q3 are mapped in Year B, Q1
- Cases that are qualified during Year A, Q4 are mapped in Year B, Q2

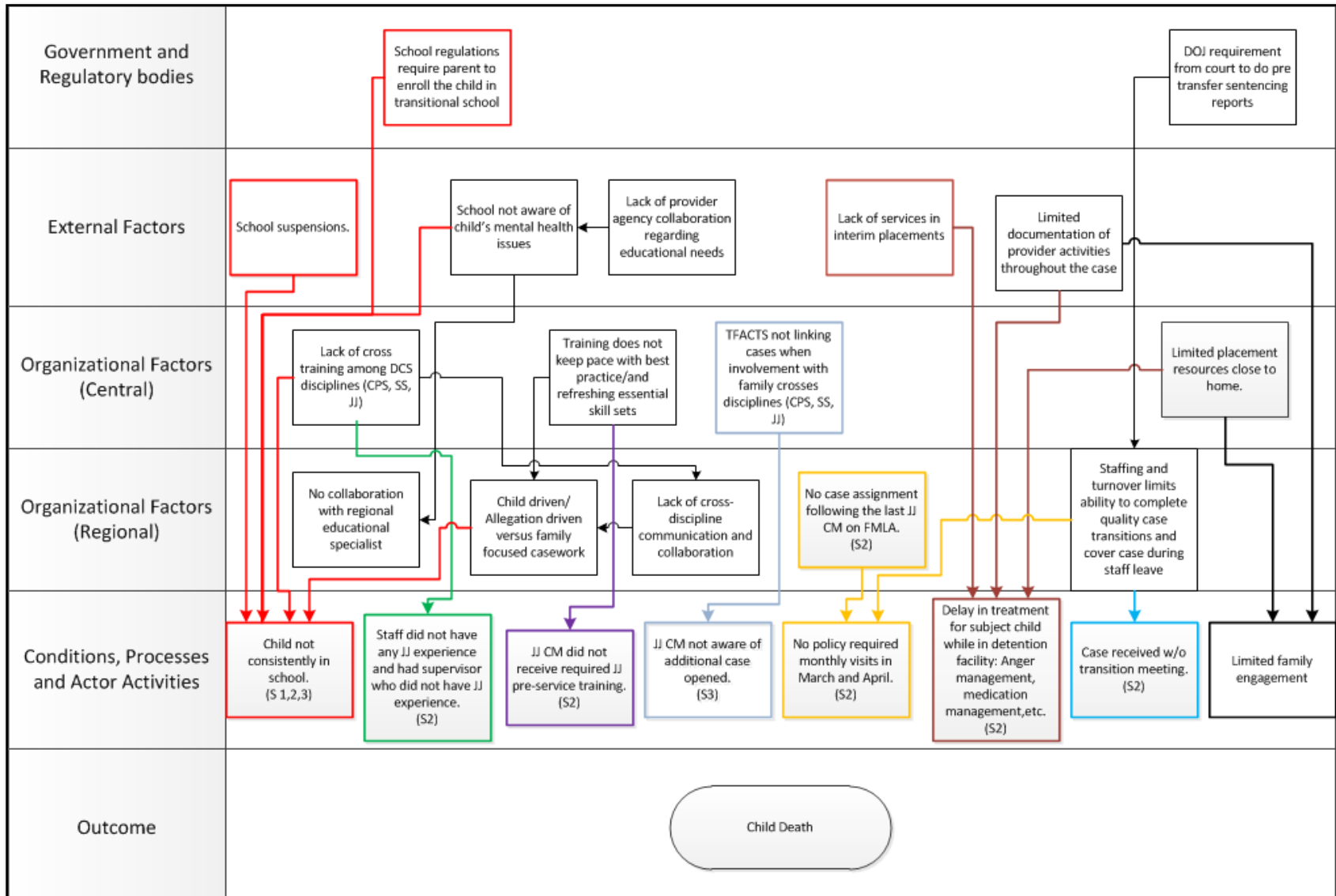
Mapping Cases
Qualified in
Year A, Q1

Mapping Cases
Qualified in
Year A, Q2

Mapping Cases
Qualified in
Year A, Q3

Mapping Cases
Qualified in
Year A, Q4

Appendix F: 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 G: Second Story Example

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

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.

Appendix H: Systems Analysis Tool

Systems Analysis Tool



Collaborative Safety, LLC www.collaborative-safety.com

Overview

Systemic findings are identified within and across reviewed cases with the use of the Systems Analysis Tool. The Systems Analysis Tool is a multi-purpose information integration tool whose purpose is to support a culture of safety, improvement and resilience. Completion of the instrument is accomplished to allow for the effective quantifiable communication of influencing factors on a case at all levels of the system. 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, the analyst or other quality improvement personnel 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
 - b. '1' indicates minimal
 - c. '2' indicates evidence and influence in casework
 - d. '3' indicates substantial evidence and significant influence in casework

2. The Systems Analysis Tool exists to explain the inherently complex nature of the work and the many factors which 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

Cognition

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

Operational Definition

0	No evidence of a faulty understanding of a situation due to cognitive fixation or cognitive biases.
1	Minimal evidence of a faulty understanding of a situation due to cognitive fixation or cognitive biases.
2	Evidence of a faulty understanding of a situation due to cognitive fixation or cognitive biases that influences case practice.
3	Substantial evidence of a faulty understanding of a situation due to cognitive fixation or cognitive biases that significantly influences case practice.

Demand-Resource Mismatch

Definition: When resources within the agency are not compatible with the needs of staff (e.g., training for onboarding staff, staff shortages).

Operational Definition

0	No evidence of resources within the agency being incompatible with the needs of staff.
1	Minimal evidence of resources within the agency being incompatible with the needs of staff.
2	Evidence of resources within the agency being incompatible with the needs of staff that influences case practice.
3	Substantial evidence of resources within the agency being incompatible with the needs of staff and significantly influencing case practice.

Documentation

Definition: Absent, incomplete or inconsistent documentation within electronic or hard copy case file.

Operational Definition

0	No evidence of absent, incomplete or inconsistent documentation within electronic or hard copy case file.
1	Minimal evidence of absent, incomplete or inconsistent documentation within electronic or hard copy case file.
2	Evidence of absent, incomplete or inconsistent documentation within electronic or hard copy case file and that influences case practice.
3	Substantial absent, incomplete or inconsistent documentation within electronic or hard copy case file and significantly influences case practice.

Equipment/Tools/Technology

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

Operational Definition

0	No evidence of difficulties with equipment, tools and or technology to carry out safe work practices.
1	Minimal evidence of difficulties with equipment, tools and or technology to carry out safe work practices.
2	Evidence of difficulties with equipment, tools and or technology to carry out safe work practices that influences casework.
3	Substantial evidence of difficulties with equipment, tools and or technology to carry out safe work practices that significantly influences casework.

Teamwork/Coordinating Activities

Definition: Ineffective joint coordination of activities between two or more entities including internal staff and external partners (e.g., CPS and Licensing, CPS and Law Enforcement, Foster Care and other External Entities, etc.).

Operational Definition

0	No evidence of ineffective joint coordination of activities between teams.
1	Minimal evidence of ineffective joint coordination of activities between teams.
2	Evidence of ineffective joint coordination of activities between teams that influenced case practice.
3	Substantial evidence of ineffective joint coordination of activities between teams that significantly influenced case practice.

Knowledge Gap

Definition: An absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice (e.g., absence of knowledge regarding policy or practice).

Operational Definition

0	No evidence of an absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice.
1	Minimal evidence of an absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice.
2	Evidence of an absence of requisite experience and/or knowledge and/or difficulties applying knowledge and integrating it into practice.
3	Substantial evidence of an absence of requisite experience and/or knowledge and/or significant difficulties applying knowledge and integrating it into practice.

Medical

Definition: Difficulties in obtaining or understanding medical records and/or integrating medical information into plans of care.

Operational Definition

0	No evidence of difficulties in obtaining or understanding medical records and/or integrating medical information into plans of care.
1	Minimal evidence of difficulties in obtaining or understanding medical records and/or integrating medical information into plans of care.

2	Evidence of difficulties in obtaining or understanding medical records and integrating medical information into plans of care.
3	Substantial evidence of difficulties in obtaining or understanding medical records and significant difficulties integrating medical information into plans of care.

Prescribed Practice

Definition: When practice prescribed by policy or practice standards is absent, conflicting, vague or does not adequately support work.

Operational Definition

0	No evidence of practice prescribed by policy or practice standards being absent, conflicting, vague or not adequately supporting work.
1	Minimal evidence of practice prescribed by policy or practice standards being absent, conflicting, vague or not adequately supporting work.
2	Evidence of practice prescribed by policy or practice standards being absent, conflicting, vague or not adequately supporting work and influencing case practice.
3	Substantial evidence of practice prescribed by policy or practice standards being absent, conflicting, vague or not adequately supporting work and significantly influencing case practice.

Production/Efficiency Pressure

Definition: Demands to increase production and/or efficiency (workload, economic), which impacts safe work practices.

Operational Definition

0	No evidence of demands to increase production and/or efficiency impacting safe work practices.
1	Minimal evidence of demands to increase production and/or efficiency impacting safe work practices.
2	Evidence of demands to increase production and/or efficiency impacting safe work practices.
3	Substantial evidence of demands to increase production and/or efficiency significantly impacting safe work practices.

Service Availability

Definition: The absence of or difficulty accessing a particular external service or support.

Operational Definition

0	No evidence of the absence of or difficulty in accessing a particular external service or support.
1	Minimal evidence of the absence of or difficulty in accessing a particular external service or support.
2	Evidence of the absence of or difficulty in accessing a particular external service or support that influences case practice.
3	Substantial evidence of the absence of or difficulty in accessing a particular external service or support that significantly influences case practice.

Supervisory Support

Definition: Difficulties in carrying out supervisory functions (e.g., decision support, clinical supervision, knowledge transfer, availability).

Operational Definition

0	No evidence of difficulties in carrying out supervisory functions.
1	Minimal evidence of difficulties in carrying out supervisory functions.
2	Evidence of difficulties in carrying out supervisory functions that influences case practice.
3	Substantial evidence of difficulties in carrying out supervisory functions that significantly influences case practice.

Procedural Drift

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

Operational Definition

0	No evidence of an accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance and experienced success.
1	Minimal evidence of an accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance and experienced success.
2	Evidence of an accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance and experienced success that influences case practice.
3	Substantial evidence of an accepted gradual departure away from written procedure due to system constraints and influences, workforce/local team acceptance and experienced success that significantly influences case practice.

Case ID:

Influence

0 - No evidence 1 – Minimal Evidence 2 – Evidence 3 - Substantial

Themes	Influence				Narrative (required if rating 2 or 3)
	0	1	2	3	
Cognition	0	1	2	3	
Demand-Resource Mismatch	0	1	2	3	
Documentation	0	1	2	3	
Equipment/Tools/Technology	0	1	2	3	
Teamwork/Coordinating Activities	0	1	2	3	
Knowledge Gap	0	1	2	3	
Medical	0	1	2	3	
Prescribed Practice	0	1	2	3	
Production/Efficiency Pressure	0	1	2	3	
Service Availability	0	1	2	3	
Supervisory Support	0	1	2	3	
Procedural Drift	0	1	2	3	