WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR SOCIAL SERVICES

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STANDARD OPERATING PROCEDURE

CRITICAL INCIDENT REVIEW
Field Practice Procedures
and
Critical Incident Review Process
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1. PURPOSE:

A. An initial assessment must occur whenever there is a deceased or severely injured child, whose death or injury is suspected to have been caused by abuse and/or neglect. Information obtained during the assessment process, in applicable cases, is crucial to the Critical Incident Review Team being able to make appropriate decisions and recommendations for necessary changes in regard to practice, policy, and training. This document will define standard operating procedures to be followed when completing a critical incident initial assessment. Steps, as dictated by policy, will be clearly outlined in an effort to maintain efficiency and provide consistency statewide.

B. The Critical Incident Review Process is a quality assurance process to examine practice, policy and training and to make needed program improvements. The review process will focus on children that have had prior contact with either Child Protective Services (CPS) or Youth Services (YS) assessment and/or open case, in the 12 months preceding the incident. Recommendations will be made by the review team for a *Plan for Action*.

2.0 DEFINITIONS:

Critical Incident: A fatality or near fatality alleged to have been caused by abuse or neglect or when abuse or neglect has been determined to have led to a child's death or near death.

Fatality: An occurrence of death.
Near Fatality: An act that, as certified by a physician, places the child in serious or critical condition.

Initial Assessment: This term refers to the function that is commonly referred to as investigation. It determines who CPS will serve by assessing and reaching conclusions about caregivers who are unable or unwilling to protect their children from impending safety threats.

Known to the Agency: This is defined as a family with a CPS or YS assessment and/or open case within the 12 months preceding the critical incident.

Plan for Action: A plan developed as a result of the critical incident review process to improve practice, policy, and/or training.

Safe Systems Improvement Tool (SSIT): An information tool used to gather details about the needs of the family and child at the time of the critical incident and assess staff experiences and systemic contributors to casework practice. The tool includes four domains (Family, Professional, Team, and Environment). Items within the domains are rated based on closeness or connection to the critical incident, with the intent to create solutions for barriers identified in the system.

3.0 PROCEDURES:

3.1 CRITICAL INCIDENT INITIAL ASSESSMENT AND REVIEW PROCESS

1. Centralized Intake (CI) receives a critical incident referral and documents the necessary fields and screens in West Virginia People's Access to Help (PATH) social service system to initiate an email alert to the appropriate personnel when the screening decision is rendered.
2. If the intake involves an Institutional Investigative Unit (IIU) setting, it will be forwarded to the IIU Supervisor for a screening decision.
3. If the referral meets the definition for child abuse and/or neglect, it is screened in and assigned to the district for assessment.
4. If the referral does not meet the definition for child abuse and/or neglect, it is screened out. Screened out referrals will be reviewed by the policy unit to ensure the decision to screen out is accurate. If the policy unit determines the referral needs screened in and assigned for assessment, the director of CI will be notified to override the original screening decision.
5. If a district receives a referral that has not been identified as a critical incident and believes the information meets the definition of a fatality or near fatality, the supervisor shall contact their program manager (PM) who will review the information with the Division of Children and Adult Services, Office of Policy and Programs (policy unit). If a correction is necessary, CI and Division of Planning and Quality Improvement (DPQI) will be notified.

6. Upon supervisor review, the referral will be assigned to two workers. If assigning two workers is not feasible, it is acceptable to assign a worker and a supervisor. Tenured staff should complete critical incident initial assessments; two new workers should not be assigned. Management staff are encouraged to remain mindful of trauma that can be associated with completing a critical incident initial assessment and consider the most appropriate staff to assign based on their experience and individual needs. It should be noted that a worker with significant experience with critical incidents may be knowledgeable and skilled in completing assessments but may also be experiencing effects of trauma and intense or overwhelming workload demands.
7. Districts are urged to have a critical incident plan for on-call. If a critical incident is received during on-call hours, the district should still assure that two workers respond. Each district should establish a back-up plan, so that the on-call worker does not have to continue to respond to other after-hours calls, in the event of a critical incident referral. Districts need to ensure all staff on the call roster are aware of and understand this directive.
8. The SSM or supervisor will immediately verify that the PM and/or child welfare consultant (CWC) assigned to the district have been notified of the critical incident referral.
9. The worker or supervisor will notify law enforcement, if they are not already involved, and the prosecuting attorney's office.
10. Assigned workers will follow CPS interview protocol.
11. Assigned workers will complete a review of the family's involvement with the agency.
12. Assigned workers will immediately begin the initial assessment regarding any other children in the home or custody of the alleged maltreater and ensure they are safe. Workers will complete full documentation of the initial assessment if there are other children remaining in the home. If no other children are in the home, the worker will complete the initial assessment including any critical information about the child's death due to maltreatment, if applicable, and the alleged maltreater's information. The maltreatment and nature of maltreatment sections must be fully completed, and all other functioning areas must be completed with all known information gathered during the assessment process. Refer to CPS Policy 4.29 for further guidance.
13. If, after initial contact with the family, the district does not believe the referral is a critical incident, the SSM will notify the PM, who will consult the policy unit. The policy unit will determine if the case meets the definition of a critical incident. If it is determined that the case should not be a critical incident, the policy unit will notify the director of DPQI, or their designee.
14. For assigned critical incident referrals, the PM or CWC will submit the *Report of Critical Incident by PM or CWC Part I: Preliminary Report of Critical*

Incident to SSM, CWC, PM, director of Program Support, DPQI Director and designee PM, deputy commissioner of Quality Assurance, deputy commissioner of Policy and Programs, deputy commissioner of Field Operations, and the commissioner within one business day. **See Attachment A**

15. If the *Report of Critical Incident by PM or CWC* form indicates the family has a history of involvement with the agency within the 12 months preceding the incident, the child's case will meet the criteria for a Critical Incident Review.
16. The director of DPQI, or designee, will appoint a DPQI staff to act as team lead for the field review team. Program managers from the region and the policy unit will be asked to appoint representatives from the field and policy to participate on the field review team.
17. Immediate consultation between the district and PM or CWC will occur, during which actions that need to occur will be discussed. The involvement of the PM or CWC in consultation of the assessment and approval process is not optional. Consultation should include the workers and supervisors involved with the assessment and the SSM. The PM or CWC will offer support and guidance to the district through completion of the assessment. Consultation will include discussion of staff well-being and the safety of any children remaining in the home. Consultation will further include review of information gathered and/or needed to support decisions related to findings and safety threats/planning. The PM or CWC will be tasked with relaying necessary information pertaining to the critical incident as outlined below.
18. The worker will obtain information from relevant collateral sources. This includes obtaining and thoroughly reviewing any medical records of the child(ren), and any records of a parent participating in a Medication Assisted Treatment program (MAT).
19. Within three business days of the initial consultation, the PM or CWC will submit the *Report of Critical Incident by PM or CWC Part II: Addendum to Preliminary Report of Critical Incident* to the supervisor, SSM, CWC, PM, director of Program Support, DPQI Director and designee PM, deputy commissioner of Quality Assurance, deputy commissioner of Policy and Programs, deputy commissioner of Field Operations, and the commissioner. **See Attachment A**
20. In the event of a child death, the District may be contacted by the Office of the Chief Medical Examiner (OCME) for information regarding the child/family. The OCME should be provided with a detailed summary of agency involvement with the family, including psychosocial information, which will be used to assist in completing their immediate case review/findings and during their Child Fatality Review Team meetings.
21. Timely completion of a critical incident assessment is essential to meeting the needs of the family and aiding in the facilitation of an agency Critical Incident Field Review, if applicable.

22. The district will be contacted by DPQI staff to arrange a Critical Incident Field Review if the family has been involved with the agency in the 12 months preceding the incident. The Field Review Team will coordinate with the district to complete interviews with agency staff and external providers that have been involved with the family within the 12 months preceding the date of the critical incident. These interviews will include, but are not limited to, all child welfare workers completing assessments or casework, and their supervisor(s); any service providers working with the family; and law enforcement.
23. The Field Review Team will do a complete and thorough review of the family's history as documented in FACTS and/or PATH, and circumstances related to the critical incident. A review of the paper file will be completed.
24. The Field Review Team will complete the critical incident review following information gathering and documentation by the district, but prior to approval of the assessment. This review should occur within 30 days of the intake.
25. The Field Review Team will evaluate information that has been gathered and documented to ensure it supports the finding the district intends to make. If the field review team agrees the finding is supported in documentation, the PM or CWC will advise the district that the initial assessment can be approved in PATH. If the field team is unable to reach a consensus, the policy unit will be asked to provide a decision.
26. The Field Review Team may offer feedback or suggestions to the district regarding information gathering and documentation. If this occurs, the Field Review Team may need to reconvene after revisions are complete.
27. Once the initial assessment is approved, the PM or CWC will send *Report of Critical Incident by PM or CWC Part III: Summary of Critical Incident* Assessment to the SSM, CWC, PM, director of Program Support, DPQI Director and designee PM, deputy commissioner of Quality Assurance, deputy commissioner of Policy and Programs, deputy commissioner of Field Operations, and the commissioner within three business days. **See Attachment A**
28. Following completion of record review and interviews, the Field Review Team will document family history and case circumstances for record keeping, and thoroughly complete the Safe Systems Improvement Tool (SSIT) in which items are rated to describe the needs of the family/youth at the time of incident and assess systemic contributors to casework problems, if applicable. (**See Attachment B)** The results will be shared with the Critical Incident Review Team and will aid in identifying and prioritizing systems improvement opportunities.
29. The Field Review Team will schedule a separate meeting with the district to debrief the review process and offer information about SSIT outcomes.
30. If there are apparent unmanaged safety threats, or the assessment is not completed following the requirements, DPQI staff will notify appropriate staff using the communication protocol outlined in section 3.3.

3.2 Critical Incidents Involving the Institutional Investigative Unit (IIU)

Effective October 1, 2019, the critical incident review process will include the review of all child fatalities involving any child in the custody of the department. This will include children in an out of home placement setting, school setting, child-care setting, and children who are on a home visit while in department custody. These reviews will be handled by the Division of Regulatory Management, Senior Program Manager or designee, along with DPQI, policy, and field staff. The information gathered during these reviews will be presented at the critical incident review team meetings.

Reports of suspected child abuse or neglect in an out of home setting are assessed in a different manner than those in an intra-familial setting. The process used for IIU investigations is one that focuses on ensuring safety of the child(ren), determination of whether the incident occurred, whether maltreatment occurred, the culpability of the agency/provider and areas of concern identified during the investigation that may indicate non-compliance.

The step-by-step process of the IIU is as follows:

1. An allegation of child abuse and/or neglect is received on an out of home setting, school setting, or childcare setting.
2. The IIU supervisor is notified of the allegation(s), and the intake is entered in PATH.
3. The IIU supervisor reviews the intake and determines if the information collected meets the statutory or operational definition of child abuse or neglect.
4. If information indicates a reasonable cause to suspect child abuse or neglect may have occurred and/or the victim is in State's custody, the IIU supervisor accepts the intake, identifies a response time (14 days) and assigns it to an IIU worker.
5. After consultation with the Policy Unit, if there is no abuse and/or neglect alleged and the victim is in State's custody, the IIU intake will be accepted and assigned for investigation without the designation of Critical Incident. These cases will not be assigned for a critical incident review. If upon assessment, IIU determines there is evidence of abuse and/or neglect, parties will be notified, and a critical incident review team will be assigned.
6. The IIU Supervisor notifies the management of the Division of Regulatory Management.
7. The Senior Program Manager or designee notifies Administration of the child fatality involving a child in State's custody.
8. The IIU worker will complete the investigation within 60 days, unless otherwise approved by supervisor.

9. During the course of the investigation, the IIU worker and supervisor will consult with the Program Manager and/or Senior Program Manager as well as Policy as needed.
10. Following the Critical Incident IIU investigation, or IIU Child Fatality Investigation where abuse and neglect has been substantiated, a field review team will conduct a critical incident review as outlined in the Critical Incident SOP, using the Safe Systems Improvement Tool (SSIT) to assess systemic contributors to casework problems.
11. Review findings will be presented at the critical incident review team meetings, to aid in identifying and prioritizing systems improvement opportunities.

3.2.A IIU Procedural Process

A. The critical incident review will take place in the county of case origin, as opposed to the county of placement.
B. The review will include a 12-month history of residential facilities and all history on foster home providers, including all corrective action plans.
C. The CWC involved in the review will be from the child's home district, as opposed to the county in which the critical incident occurred.
D. The Senior Program Manager, or designee, overseeing IIU will participate in the field review team.
E. Interviews will minimally include district supervisor, IIU staff assigned to the case, county of origin worker(s) involved in the case, and the licensing specialist.
F. The field review team will review all records, including the hard copy of the child's original record, FACTS and/or PATH records, medical records, and any other records pertaining to the child fatality.

3.3 COMMUNICATION PROTOCOL FOR SITUATIONS REQUIRING IMMEDIATE ACTION

If information gathered during the critical incident field review process indicates there is a situation that requires immediate action and/or an unsafe situation exists for a child, the following protocol will be used to communicate the concerns. The concerns will be documented in an email and forwarded, as outlined below.

If the critical incident assessment is not completed following policy requirements, the same communication protocol will be applied.

DPQI lead to DPQI director and/or their designee program manager for Critical Incident Review

DPQI director and/or their designee program manager to regional program manager and/or director of Program Support

If neither the DPQI director or their designee are available, the DPQI lead will contact one of the other DPQI program managers, who will appropriately forward the necessary information. If circumstances are such that the information cannot be immediately put into email form, the DPQI lead will make contact by phone and document in email form as soon as possible.

4.0 CONFLICT OF INTEREST

At all points during review, conflicts of interest will be avoided. It shall be the intent of the review process to involve personnel who have no vested interest in the case being reviewed. All participants in the review are required to keep the information confidential and to divulge information only in the interest of completing the review. If a worker or supervisor identifies a conflict with completing a critical incident initial assessment, they will immediately notify the appropriate individuals so that the case may be reassigned. If a member assigned to the Field Review Team tasked with completing a Critical Incident Review identifies a conflict, they will immediately notify their supervisor so that a new member may be appointed to the team in their place.

5.0 CRITICAL INCIDENT REVIEW TEAM MEMBERSHIP

The Critical Incident Review Team will be chaired by the director of DPQI, or their designee. Membership will consist of the commissioner of the Bureau for Social Services, the deputy commissioner of Quality Assurance, the deputy commissioner of Policy and Programs, the deputy commissioner of Field Operations, and the deputy commissioner of Field Support. Membership will further consist of the director of Program Support, the director of Professional Development, the director of Centralized Intake, a Policy program manager, Program Manager from Division of Regulatory Management, and program managers from each region. Additional staff may include child welfare consultants, policy specialists, and members of the Division of Professional Development.

6.0 CRITICAL INCIDENT REVIEW TEAM MEETING PROCEDURE

The Critical Incident Review Team will meet on a biannual basis, in May and November of each year. The first Wednesday and Thursday of the biannual months will be set aside for meetings, unless otherwise indicated.

DPQI staff will present a case summary of factual information, to include a brief summary of the family's involvement with the agency and the findings/outcome of the critical incident assessment and field review.

The item rating outcomes from the SSIT will be used to identify trends and improvement opportunities. Rating outcomes from each case will be captured in aggregate and presented to the Critical Incident Review Team. Improvement opportunities and change will be based on what is valuable to high quality casework practice and identified needs of youth and families. A *Plan for Action* will be developed in order to address concerns from the reviews and will be reviewed by the Critical Incident Review Team at the biannual meetings.

6.1 CASE REVIEW SCHEDULE

The case review schedule and legislative report are based on the Federal Fiscal Year, which begins October 1st and concludes September 30th.

Cases received during the months of October, November, December, January, February, and March will be reviewed at the biannual meeting held in May.
Cases received during the months of April, May, June, July, August, and September will be reviewed at the biannual meeting held in November.

7.0 CRITICAL INCIDENT ANNUAL REPORT

On the first day of December, the review team will submit the *Critical Incident Annual Report* to the commissioner of the Bureau for Social Services to present to the West Virginia Legislature, Health and Human Resources Committee. The annual report is required as a result of the Performance Evaluation Research Division (PERD) audit.

The annual report contains information on child fatalities and near fatalities confirmed to be the result of abuse and/or neglect during the federal fiscal reporting year. Child and maltreater demographic information, including age, race, and gender are included, along with a map of occurrences and summary of data and trends from the year. The report additionally includes the agency's *Plan for Action*.

In order for this report to be completed, it is necessary to adhere to agency timeframes for completing assessments, as well as the timeframes outlined in this SOP for completing a critical incident review and presenting the information to the Critical Incident Review Team.

8.0 NCANDS

The Bureau for Social Services is required to report all child fatalities to the Children's Bureau on an annual basis, as part of our NCANDS report. To ensure accuracy of this report, the DPQI director or designee will work with PATH staff and program managers from each region to ensure that all cases are accurate.

PATH staff will provide a list to the DPQI director or designee of cases being reported, who will review the case list and document discrepancies. Program managers will ensure that all cases that have been reviewed as part of a child fatality have accurate findings. Any child missing from the list that should be included will be reviewed to ensure the findings have been made and are accurate. For cases not meeting review criteria, the program managers will review findings to ensure accuracy. The program managers will report their results to the DPQI director or designee, who will verify the names with PATH staff.

Since all fatalities are reported in NCANDS, including those involving families not known to the agency, the NCANDS numbers could be higher than those reported in the annual *Critical Incident Report*.

9.0 CRISIS EVENT RESPONSE

Child welfare staff have the mission of promoting child safety, well-being, and permanence through the provision of child-focused, family-based practice. On a daily basis staff interact with people who have experienced multiple traumas. Secondary traumatic stress (STS) is the emotional duress that results when an individual hears about the firsthand trauma experiences of another person. Given the nature of their work, child welfare staff are at very high risk of developing STS, and they can be at risk of experiencing trauma first-hand. In addition, the trauma and secondary trauma experienced by clients and staff can affect organizations and the organizational culture. If left unaddressed, STS can have a negative impact on the ability of individuals and organizations to help children and families. Supervisors and administrators have the challenging task of developing and maintaining high-quality practice in a traumatogenic environment. BSS is committed to ensuring support is available to strengthen and protect the workforce from secondary traumatic stress. BSS has contracted with Marshall University Center of Excellence for Recovery to maintain a Trauma Sensitive Workplace (TSW) team. Multiple services and supports are available, including responding to critical and crisis events that may contribute to workplace trauma to offer individual and group setting support services; peer support groups; and trauma training.

9.1 CRISIS EVENT RESPONSE PROCEDURE

1. Upon receipt of a critical incident assessment, the Social Services Manager, or designee, will notify the Trauma Sensitive Workplace (TSW) team their district is involved in a crisis event, to ensure staff are offered the option to participate in individual and/or group support services.
2. Notification will be sent by email to tsw@marshall.edu.
3. TSW team members will reach out to the district to offer services/support. Staff are not required to participate; individuals shall be permitted to opt in or out on their own behalf.
4. TSW team members will coordinate service and/or support delivery with interested parties.
5. During the critical incident assessment consultation process, Program Managers and/or Child Welfare Consultants can initiate a referral to TSW, if notification has not previously been issued and/or a change in circumstances exists to warrant additional notification on behalf of an individual or group of staff.
6. If the critical incident meets criteria for a field review, a member of the field review team can initiate a referral to TSW, if notification has not previously been issued and/or a change in circumstances exists to warrant additional notification on behalf of an individual or group of staff.
7. Notification of crisis events is not limited to critical incident assessments and can be issued by any interested or concerned party.
8. Staff interested in more information about TSW may visit their website at: https://mucenterofexcellence.org/projects/trauma-sensitive-workplace-tsw/

ATTACHMENT A

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Bureau for Social Services
Report of Critical Incident by PM or CWC

Part I – Preliminary Report of Critical Incident

This report is required to be submitted within 1 business day of receiving a critical incident referral. It is to be submitted via email to the following individuals: Social Services Manager, Child Welfare Consultant, Program Manager, Director of Program Support, DPQI Director and designee Program Manager, Deputy Commissioner of Quality Assurance, Deputy Commissioner of Policy and Programs, Deputy Commissioner of Field Operations, and Commissioner.

Referral Name/ID: Click or tap here to enter text.

Date / Time of Referral: Click or tap here to enter text.

CWC/PM: Click or tap here to enter text.

Type of Critical Incident: ☐ Fatality ☐ Near Fatality

Assigned Worker: Click or tap here to enter text.

Direct Supervisor: Click or tap here to enter text.

County: Click or tap here to enter text.

Child Victim(s)

Name	Date of Birth / Age	Date of Death
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Siblings/Non-Victims/Other children living in the home:

Name	Date of Birth / Age	Relationship to Deceased Child
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Caregivers(s):

Name	Date of Birth / Age	Relationship to Deceased Child
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Summary / Narrative of Known Events: (Attached additional page if needed.)
Click or tap here to enter text.

List all CPS involvement within the preceding 12 months. Must include Referral ID, Referral Date, Disposition of the Referral, Type of Maltreatment Substantiated (if applicable), Ongoing Case ID (if applicable), and indicate if any of the children has ever been removed from the caregivers via court action, law enforcement custody agreement, and/or protection plan. (Attached additional page if needed.)
Click or tap here to enter text.

Scheduled Date/Time of Consultation with District:
Click or tap here to enter text.

Part II – Addendum to Preliminary Report of Critical Incident

Immediate consultation by CWC or PM with the district must occur. This addendum must be completed and submitted within 3 business days of the consultation to the Supervisor, Social Services Manager, Child Welfare Consultant, Program Manager, Director of Program Support, DPQI Director and designee Program Manager, Deputy Commissioner of Quality Assurance, Deputy Commissioner of Policy and Programs, Deputy Commissioner of Field Operations, and Commissioner.

Detailed Summary of Initial Action Taken by District
Click or tap here to enter text.

CWC/PM Recommendations for Child(ren)
Click or tap here to enter text.

CWC/PM Recommendations for Assessment (ex: safety plan, petition, evaluations, etc.)
Click or tap here to enter text.

Part III – Summary of Critical Incident Assessment

This section is to be completed at the conclusion of the Initial Assessment. This addendum must be completed and submitted within 3 business days of the initial assessment approval. This is to be submitted via email to the following individuals: Social Services Manager, Child Welfare Consultant, Program Manager, Director of Program Support, DPQI Director and designee Program Manager, Deputy Commissioner of Quality Assurance, Deputy Commissioner of Policy and Programs, Deputy Commissioner of Field Operations, and Commissioner.

Additional Actions Taken by District
Click or tap here to enter text.

Findings
Click or tap here to enter text.

Safe Systems Improvement Tool:
National Partnership for Child Safety Version (SSIT-NPCS)

2022
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the Safe Systems Improvement Tool (SSIT). This information integration tool is designed to support system improvement activities. The SSIT is an open domain tool. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and certification is expected for appropriate use.

For specific permission to use please contact the Praed Foundation. For more information on the SSIT contact:

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I. INTRODUCTION

SAFE SYSTEMS IMPROVEMENT TOOL

The pursuit of learning is the characteristic that distinguishes high-quality service delivery systems. Organizations with a well-developed culture of excellence find ways to successfully identify improvement opportunities, implement strategies for change, evaluate change over time, and hardwire what they learn.

The following is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of this instrument is to support a culture of safety, improvement, and resilience. As such, completion of this instrument is accomplished in order to allow for effective communication at all levels of the system. Since its primary purpose is communication, this instrument is based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding this instrument.

SIX KEY PRINCIPLES

1. Items are included because they are relevant and inform system change opportunities.
2. Each item uses a 4-level rating (0-3) system. Ratings translate into action levels designed to support quality improvement (QI) activities. For a description of these action levels please see below.
3. Ratings are made to identify an opportunity for improvement independent of a current intervention. If interventions are in place that are masking a need/opportunity, the underlying need/opportunity is described, not its status as a result of the intervention. For example, if a work-around has been created to overcome an equipment failure, the underlying equipment failure should be rated.
4. Item-level ratings are designed to promote objectivity and avoid bias. The potential for implicit and explicit biases should always be considered when rating an item.
5. Ratings use the influences' proximity to the incident as an organizing principle to support communication. If there was closeness in time or distance, and with relationship to the incident, a rating of "proximal" (i.e., 3) is appropriate.
6. It is about the "what and how," not the "who and why." Items are organized into domains to engage rich discussion on the complexity of factors affecting casework practice. Items are about *relationship and influence* and avoid the controversy of causal assumptions.

This is an effective assessment tool for use in critical incident review (e.g., child fatalities, child near fatalities) but may be used more broadly to understand systemic influences to other outcomes (e.g., youth in foster care being trafficked, children experiencing a long-length of stay in care, maltreatment recurrence). In short, the SSIT provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework. To administer the instrument found at the end of this manual, the reviewer should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

REFERENCE GUIDE STRUCTURE

This reference guide is divided into the following four parts:

Section One: origins, overarching purpose, and the general structure of how items are rated

Section Two: domains and items, item definitions, descriptive rating anchors, and guidance (i.e., "Questions to Consider") in assessing the items.

Section Three: scoresheet as a template for case reviews

Section Four: sharing the "system's story" of a critical incident and advocating for strategic quality improvement work to support safe, effective, and reliable care of children and families.

HISTORY AND BACKGROUND

The SSIT was first developed for use in Tennessee's Department of Children's Services' (TN DCS) critical incident reviews (i.e., Child Death and Near-Death reviews). During critical incident reviews, professionals assigned to work with the family, both past and present, are requested to participate in debriefing. These debriefings are voluntary, supportive, facilitated opportunities for professionals to process their casework, identify barriers and improvement opportunities, and highlight learning. SSIT provides both a guide in facilitating these debriefings (e.g., questions to consider) and an efficient means to capture the complex information provided as a result of debriefings. After debriefings, critical incident reviews are presented to a multi-disciplinary team who dissects the case and relevant findings from a systemic perspective. SSIT is used to facilitate these conversations and to capture rich discussion. SSIT is only completed once, at the closing of every case review. SSIT's scores are aggregated and analyzed on at least a quarterly basis to review findings and discuss trends. In a similar way to how a barometer measures pressures in the atmosphere, SSIT measures pressure existing within organizations and provides a frame for targeted quality improvement work.

Since 2015, the SSIT has been successfully used to support the analysis of deaths and near deaths, reports made to TN DCS' Confidential Safety Reporting System, and critical incident reviews that do not involve death or near death (e.g., staff injuries, incidents where custodial children absconded and were subsequently exploited).

In 2019, Casey Family Programs led a pioneering team of twelve child-welfare jurisdictions to form the National Partnership for Child Safety. Their aim to reduce maltreatment-related fatalities, enhance system safety through the lens of safety science, and advance the child welfare system into the 21st century—a place where technology, community-based family supports, and partnership with public health would effectively reduce the presence of social determinants to poor outcomes and promote holistic health. The SSIT-NPCS was designed with the input of all NPCS jurisdictions as a way to communicate the learnings from their respective critical incident reviews and provide a foundation for informed data-sharing. In 2021, the National Partnership for Child Safety had grown to 26 public child welfare jurisdictions and tribes.

WHAT IS THE SSIT?

IT IS AN IMPROVEMENT STRATEGY

When items are rated with a 2 or 3, they indicate a need for improvement. The SSIT helps a system identify and prioritize systems improvement opportunities. The structure of the SSIT allows a system to uncover those threats/opportunities that are most proximal to adverse events. Quality improvement resources can then be directed efficiently to mitigate risk and support safe, reliable, and effective care.

IT FACILITATES OUTCOMES MEASUREMENT

Ratings on items can be aggregated across cases. The SSIT standardizes critical incident review data for use in quality improvement. SSIT data contributes to professional learning at the individual case level and can be aggregated at any level of the system to support improvement and evaluate change over time.

IT IS A COMMUNICATION TOOL

Classifying complex systems findings into a common language supports improvement discussions at all levels of the organization. SSIT domains, items, and anchors derive from research in human factors and safety science. The SSIT supports organizational learning and an improvement approach focused on human interaction in complex systems.

IT IS A CULTURE CARRIER

The SSIT becomes an important organizational artifact. Use of the SSIT in critical incident reviews reinforces important organizational values and shifts focus away from discussions of blame-worthy acts and simple cause and

effect relationships. It supports efforts to create a culture of safety by increasing understanding of complex interactions in tightly-coupled systems.

SSIT BASIC STRUCTURE

The SSIT is organized into four domains to facilitate learning and improvement. While each item is unique and not replicated in other items, the domains are nested. In other words, a family working with a professional, who works within a team, who all work within an environment. For example, a professional may have experienced trouble interpreting external assessments (e.g., medical records) about a child with complex needs, which may have been exacerbated by the availability and case direction given by the supervisor. These factors may be further affected by the absence of helpful policy, training, and internal professionals to support the interpretation of medical records. In summary, while the domains provide structure to learning, they are not intended to suggest exclusivity. The intention is of the domains is to guide the reviewer into assessing all system levels.

Child/Family Domain		
Family Conflict	Substance Use	Child Medical/Physical
Developmental	Economic Stability	Child Developmental/Intellectual
Mental Health	Parenting Behavior	Child Mental Heath
Professional Domain	**Team Domain**	**Environment Domain**
Cognitive Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology/Tools
Fatigue	Supervisory Knowledge Transfer	Policies/Rules/Statutes
Knowledge Base	Production Pressure	Training
Documentation		Service Array
Information Integration		Practice Drift

RATING ITEMS

The SSIT is easy to learn and use in critical incident reviews. It provides structure to organizational learning. The SSIT assesses the underlying factors that influence casework problems. For example, if a critical incident review about a child's unsafe sleep-related death discovers the child welfare professional assigned to the family did not educate on safe sleep practices, the SSIT is designed to support an understanding of the factors that influenced that problem. To use the same example, it is possible the professional co-bedded with his/her own children and therefore undervalued safe sleep practices (SSIT item: Cognitive Bias), had no policy, training or supervision to support the provision of safe sleep information (SSIT items: Policy/Rules/Statutes, Training, Supervisory Support), and/or did not have external or internal resources to provide the family with a safe sleeping environment (SSIT items: Service Array, Demand-Resource Mismatch).

Improvement Opportunities

It is important to note the SSIT does not identify the problems in the case under review. In this Reference Guide, problems identified in the case under review are called Improvement Opportunities (IOs). These are defined as actions or inactions in the case under review that are either relevant to the outcome (e.g., a child dies abusively at the hands of a caregiver unassessed by the child welfare agency prior to the death) or an important industry standard (e.g., meeting response timeframes for assessing an alleged victim, speaking to collaterals). The most important Improvement Opportunities are family-centered and describe what the family needed vs. received from the helping system. Since the goal is system transformation to advance family well-being and meaningful

transformational help is what professionals intend and want for those they serve, families' needs are at the center of any critical incident review. For this reason, the Family Domain exists to point reviewers to consider potential IOs for further exploration. The SSIT's System Domain ratings are organized around IOs. In order to rate a SSIT as a 2 or 3, the item must be affecting an identified IO.

The SSIT should be used by someone who is well-versed in their system and current industry standards, acknowledging of the high-risk and complex sociotechnical nature of human service work, appreciative of the professional's goal to achieve the best outcomes, and with personal experience serving families. Someone with lived experience in the child welfare system is a highly valued contributor for these reviews.

Like all Transformational Collaborative Outcomes Management (TCOM) tools, the ratings translate into action levels. The SSIT has one retrospective set of action levels for the Family domain, and a prospective set of action levels for the remaining domains.

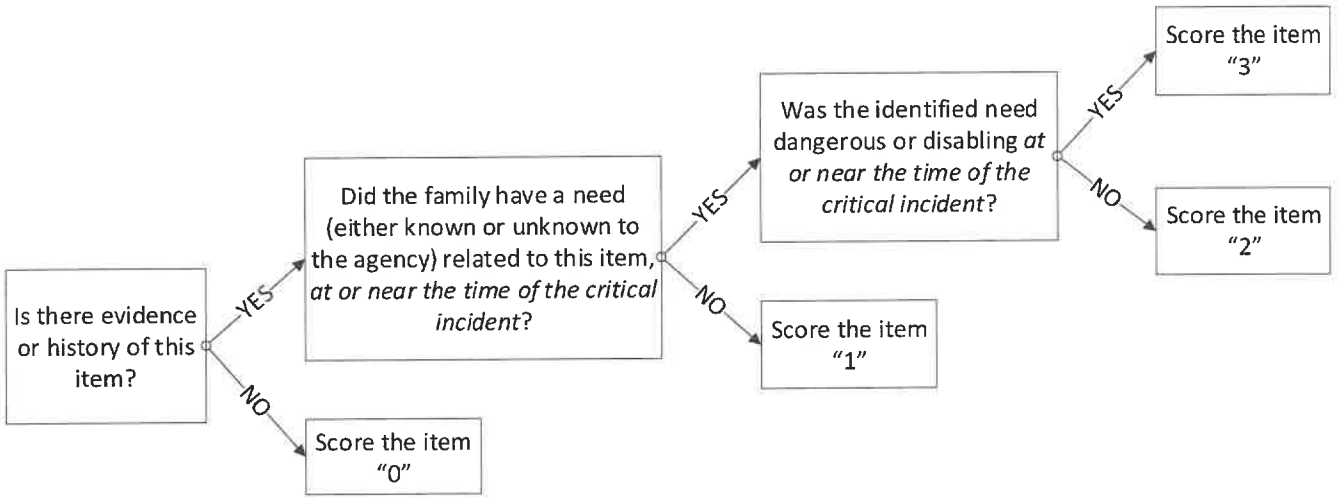
Scoring the Child and Family Domain

For the Family Domain, the items are rated based on the family's status at the time of the critical incident (Table 1). Consistent with the National Partnership for Child Safety's Data Dictionary, caregiver is defined as the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child, and a household is a group of people who have frequent contact with the child leading up to the time of the critical incident. It is recommended the Family Domain be tentatively scored prior to debriefing professionals who worked with the family, in the interests of identifying unmet family needs as potential IOs.

Table 1: Child Family Domain Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action was needed
1	History	Watchful waiting/prevention was indicated
2	Need interfered with functioning	Action/intervention was needed
3	Need was dangerous or disabling	Immediate action/intensive action was needed

Figure 1: Decision Scoring Tree for Family Domain



A scoring of '2' or '3' denotes an item as retrospectively actionable. Whether known or unknown to helping professionals at the time of the critical incident, scoring these items actionably means the family had a need for

support (e.g., intervention, formal/informal help, services) at or near the time of the critical incident, actionable items are accompanied by a narrative description to support the rating.

Scoring the System Domains: Proximity

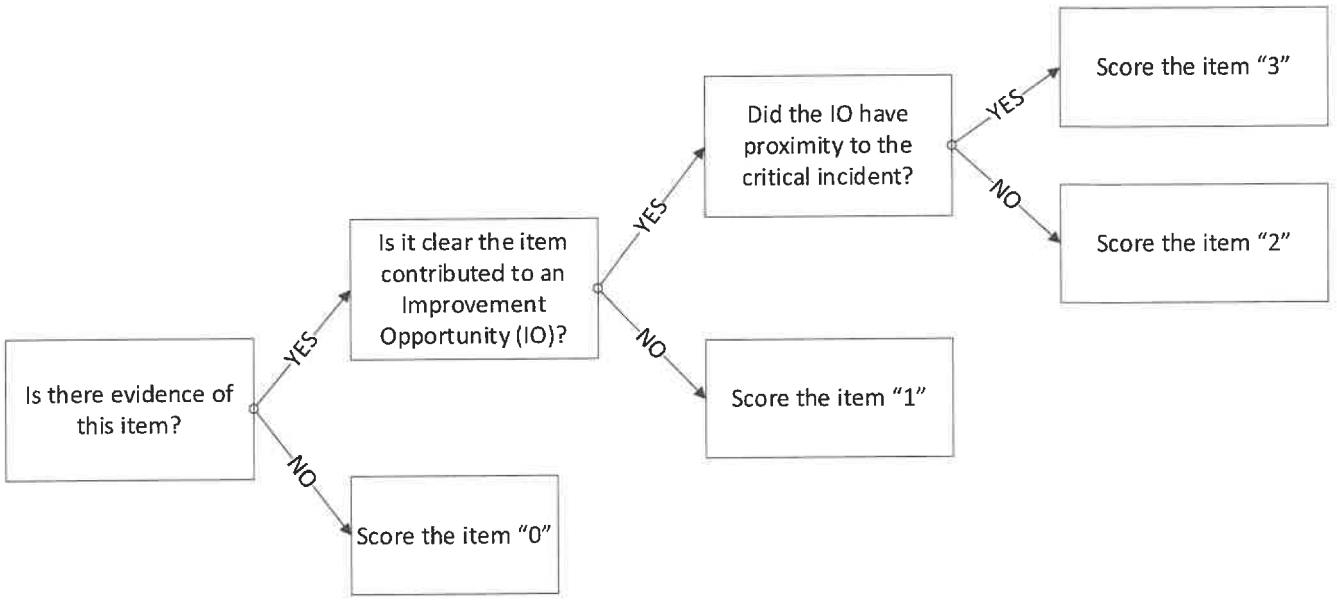
Proximity is used to differentiate between ratings of 2 and 3 (Figure 2) in the 3 system domains – Professional Team, and Environment. Proximity is a Gestalt Principle about how the human mind naturally organizes items. If an IO identified in a case was close in time or distance and with relationship to the critical incident, then a rating of proximal (3) is appropriate. For example, if an infant dies in an unsafe sleep environment, and the child welfare agency did not provide safe sleep education and/or timely access to needed safe sleep resources, then SSIT items related to that IO are all scored as proximal (3). Conversely, if an infant dies from a congenital heart condition, yet historical engagement with the household did not include a private interview with all children in the home, all SSIT items related to the IO are scored as non-proximal (2).

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity **without** proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to Improvement Opportunity **with** proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education, forming a local ad hoc QI team, developing system-level improvement projects.

Scoring in this way promotes rating reliability and secures an understanding of the system-level needs most proximal to critical incidents (Figure 1). While human service agencies are not solely responsible for prevention of critical incident, such organizations are still invested in reducing any and all adverse outcomes as much as possible, in pursuit of the best outcomes for every family.

Figure 2: Decision Scoring Tree for System Domains



A scoring of '2' or '3' denotes an item as actionable; it means the item affected an IO. Actionable items should be accompanied by a narrative description to support the rating. This combination of quantitative and qualitative data facilitates simple and structured communication on every case but also creates a rich database of information over time—allowing for dissection of themes.

2. SSIT DOMAINS AND ITEMS

FAMILY DOMAIN

This section focuses on factors present in the family at the time of the critical incident. It provides an opportunity to document the family, caregiver and child/youth's needs during the time the critical incident occurred, even if they were unknown to the agency prior to the incident occurring. This domain can be useful in drawing correlations between systems-level items and certain family items (e.g., if service array challenges are often scored actionably when families identify with developmental/intellectual diagnoses). Unmet family needs identified in this domain are potential Improvement Opportunities to explore during the review. Consistent with the National Partnership for Child Safety's Data Dictionary, caregiver is defined as the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child, and a household is a group of people who have frequent contact with the child leading up to the time of the critical incident.

For the **FAMILY DOMAIN,** the item ratings translate into the following categories and action levels, *as they existed at the time of the critical incident* (e.g., death or near death):

0 No evidence; there was no need for action at the time of the critical incident

1 History; there was a need for "watchful waiting" at the time of the critical incident

2 Action was needed at the time of the critical incident

3 Dangerous or disabling problem required immediate and/or intensive action at the time of the critical incident

FAMILY/CAREGIVER ITEMS

FAMILY CONFLICT

This item refers to how much fighting and arguing occurred between family members. Domestic violence refers to physical fighting in which family members might get hurt.

	Ratings & Descriptions	
Questions to Consider • Did members of the family get along well? • Did arguments escalate to physical altercations?	0	Family had minimal conflict, got along well and negotiated disagreements appropriately.
	1	Family generally got along fairly well, but when conflicts arose, resolution was difficult or there was a history of significant conflict or domestic violence.
	2	Family was generally argumentative and significant conflict was a fairly constant theme in family communications.
	3	Family experienced domestic violence. There was threat or occurrence of physical, verbal, or emotional altercations. If the family had a current restraining order against one member, then they would be rated here.

CAREGIVER DEVELOPMENTAL

This item refers to developmental disabilities including autism and intellectual disabilities. A formal diagnosis is not required to rate this item.

Questions to Consider

- Had the caregiver been identified with any developmental or intellectual disabilities?

Ratings & Descriptions

0	There was no evidence that the caregiver had developmental needs.
1	The caregiver had developmental challenges, but they did not currently interfere with parenting or there was a history of those challenges interfering with parenting.
2	The caregiver had developmental challenges that interfered with their capacity to parent.
3	The caregiver had developmental challenges that made it very difficult or impossible for them to parent.

CAREGIVER MENTAL HEALTH

This item refers to mental health needs only (not substance abuse). A formal mental health diagnosis is not required to rate this item.
Note: Mental Health Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider

- Did the caregiver have any mental health needs?
- Were the caregiver's mental health needs interfering with their functioning?

Ratings & Descriptions

0	There was no evidence that the caregiver had mental health needs.
1	The caregiver was in recovery from mental health difficulties or there was a history of mental health problems.
2	The caregiver had mental health difficulties that interfered with their capacity to parent.
3	Caregiver had mental health difficulties that made it very difficult or impossible for them to parent.

CAREGIVER SUBSTANCE USE

This item includes problems with alcohol, marijuana, illegal drugs and/or prescription drugs. A formal diagnosis is not required to rate this item.
Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider

- Did caregivers have any substance use needs that made parenting difficult?
-

Ratings & Descriptions

0	There was no evidence that the caregiver used alcohol or drugs.
1	The caregiver may have had mild problems with work or home life that result from occasional alcohol or drug use or there was a past history of substance use problems.
2	The caregiver had substance use that interfered with their life; caregiver had a diagnosable substance-related disorder near the time of the critical incident.
3	Caregiver had substance use that made it very difficult or impossible for them to parent.

CAREGIVER ECONOMIC STABILITY

This item rates the caregivers' ability to consistently have met daily needs, such as affordable and safe housing, childcare, adequate income, healthy food, and reliable transportation. A family may have had adequate living stability via government and non-governmental assistance. If the government or non-governmental assistance was temporary or at-risk of being lost, this is a reason to rate the item a 2 or 3.

Questions to Consider:

Ratings & Descriptions

0	No current need; no need for action or intervention. This may have been a resource for the child. Caregivers had sufficient resources to raise the child.

• Did the caregiver ever struggle financially? • Did the caregiver ever worry they won't enough money to meet needs? • How stable was the family's life at the time of the critical incident?	1 Caregivers had limited resources but usually had daily living needs met for the child. History of struggles with sufficient resources would be rated here as would the presence of ongoing governmental (e.g., subsidized housing) or non-governmental (e.g., food pantries, low-income medical clinics) supports that create economic sufficiency and are not at known risk of being lost (e.g., closing program, family at risk of not meeting eligibility criteria) 2 Caregiver needed help stabilizing their economic situation. The caregiver may have been at risk of losing economic supports, such as losing reliable transportation or housing or childcare. Daily living needs were sometimes unmet for the child. 3 Caregiver needed urgent help, perhaps due to homelessness, inadequate food, income, or no transportation. Child's daily living needs were often unmet.

CAREGIVER PARENTING BEHAVIORS

This item rates the caregiving behaviors of the primary caregivers. The item rates if the caregiver gave developmentally-appropriate care and followed the care-based recommendations of professionals (e.g., physicians)

Questions to Consider	Ratings & Descriptions
• Did caregivers provide developmentally appropriate supervision? • Did caregivers meet the basic caregiving needs of the child, following through on the recommendations of professionals (e.g., physicians, counselors)?	0 Caregiver(s) were involved with the child and provided appropriate levels of expectations and supervision for the child. 1 Caregiver(s) were involved and generally provided appropriate levels of expectations and supervision for child. There were some concerns about caregiving behavior, but they were mild or historical and unrelated to child safety. 2 Caregiver(s) did not follow through with professional recommendations or provide developmentally-appropriate care. Caregivers often did not provide appropriate levels of expectations and supervision. 3 Caregiver(s) did not provide adequate developmentally-appropriate care and deficits in caregiving resulted in serious safety concerns.

CHILD/YOUTH ITEMS

CHILD/YOUTH MEDICAL/PHYSICAL

This item is used to describe the child/youth's medical/physical health.
Note: Most transient, treatable conditions would be rates as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a '2'. The rating '3' is reserved for life threatening medical conditions. A formal diagnosis is not required to rate this item.

Questions to Consider	Ratings & Descriptions
• How was the child/youth's health? • Did the child/youth have any chronic conditions or physical limitations?	0 No evidence that the child/youth had any medical or physical challenges, and/or they were healthy. 1 Child/youth had transient or well-managed physical or medical challenges. These include well-managed chronic conditions like juvenile diabetes or asthma. 2 Child/youth had serious medical or physical challenges that required medical treatment or intervention or child/youth had a chronic illness or a physical condition that requires ongoing medical intervention. 3 Child/youth had life-threatening illness or medical/physical challenges. Immediate and/or intense action was needed due to imminent danger to child/youth's safety, health, and/or development.

CHILD/YOUTH DEVELOPMENTAL/INTELLECTUAL

This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning. A formal diagnosis is not required to rate this item.

Questions to Consider

- Did the child/youth's growth and development seem age appropriate?
- Had the child/youth been screened for any developmental problems?

Ratings & Descriptions

0	No evidence of developmental delay and/or child/youth had no developmental delay or intellectual disability.
1	There were concerns about possible developmental delay. Child/youth may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning were indicated.
2	Child/youth had developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD affected communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
3	Youth had severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

CHILD/YOUTH MENTAL HEALTH

This item is used to describe the child/youth's mental health (not substance use or dependence). A formal mental health diagnosis is not required to score this item.

Questions to Consider

- Did the child/youth have any mental health needs?
- Were the child/youth's mental health needs interfering with their functioning?

Ratings & Descriptions

0	There was no evidence or signs the child/youth was experiencing mental health challenges.
1	The child/youth had mild challenges with adjustment, may have been somewhat depressed, withdrawn, irritable, or agitated. A history of mental health challenges would be scored here.
2	The child/youth had moderate mental health challenges that interfered with their functioning in at least one life domain (e.g., school).
3	The child/youth had significant challenges with their mental health, affecting two or more life domains (e.g., school, neighborhood community). The child/youth may have had a serious psychiatric disorder.

PROFESSIONAL DOMAIN

This section focuses on factors primarily present within professionals. Largely intrapersonal in focus, this domain centers on the experience, knowledge, perceptions, and skills of professionals assigned to the family's care or experiencing the problem under review. This domain focuses on behaviors as well as the presence of psychological factors within professionals, like fatigue and stress. Neither this domain nor any domain is created to assign individual blame for a problem's existence; rather this domain offers an organized way to deconstruct perspectives before, during, and after decision-making.

For the **PROFESSIONAL DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

COGNITIVE BIAS

A faulty understanding of a situation or person(s) due to basic human limitations (e.g., confirmation bias, cognitive fixation, focusing effect, transference) as well as unconscious or conscious bias, including microaggressions. Identity-based biases are rated here, such as racism, sexism, genderism, and ableism. Undervaluing culturally-normative traditions or caregiving behaviors is also rated here.

Questions to Consider	Ratings & Descriptions	
• What were your thoughts when you received the referral/case? About the family? Perpetrators? Children?	0	No evidence of bias(es).
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but bias was present).
	2	Bias(es) contributed to an Improvement Opportunity without proximity to the outcome.
	3	Bias(es) contributed to an Improvement Opportunity with proximity to the outcome.

STRESS

Psychological strain or tension resulting from adverse or demanding circumstances. Professionals express or exhibit difficulty managing the strains of casework and/or other life circumstances (e.g., divorce).

Questions to Consider	Ratings & Descriptions	
• What were the pressures you faced, professionally and personally? How did that impact casework? How do you know when you are stressed?	0	No evidence of stress.
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but stress was present).
	2	Stress contributed to an Improvement Opportunity without proximity to the outcome.
	3	Stress contributed to an Improvement Opportunity with proximity to the outcome.

FATIGUE

Extreme tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).

Questions to Consider	Ratings & Descriptions	
• What were the pressures you faced, professionally and personally, that contributed to fatigue? How did that impact casework? How much sleep had you received in the days preceding this incident?	0	No evidence of fatigue.
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but fatigue was present).
	2	Fatigue contributed to an Improvement Opportunity without proximity to the outcome.
	3	Fatigue contributed to an Improvement Opportunity with proximity to the outcome.

KNOWLEDGE BASE

An absence of knowledge or difficulty activating knowledge (i.e., putting knowledge into practice).

Questions to Consider	Ratings & Descriptions	
• Was there anything you learned from this case that you previously had not known? Were there items you felt unequipped to assess or address? Were any records (i.e., medical records) difficult to interpret?	0	No evidence of knowledge gaps.
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but knowledge gaps were present).
	2	Knowledge gaps contributed to an Improvement Opportunity without proximity to the outcome.
	3	Knowledge gaps contributed to an Improvement Opportunity with proximity to the outcome.

DOCUMENTATION

Absent or ineffective official, internal records. *Note: Sometimes an Improvement Opportunity is about Documentation but only score this item if Documentation contributed to an Improvement Opportunity – not if Documentation was the Improvement Opportunity.*

Questions to Consider	Ratings & Descriptions	
• If someone only read the notes, would they know what was going on?	0	No evidence of documentation concerns.
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but documentation concerns were present)
	2	Documentation contributed to an Improvement Opportunity without proximity to the outcome.
	3	Documentation contributed to an Improvement Opportunity with proximity to the outcome.

INFORMATION INTEGRATION

Challenges with externally-sourced information (e.g., obtaining or using medical records, school records/assessments, criminal records, formal assessments). *Note: Sometimes an Improvement Opportunity is about Information Integration but only score this item if Information Integration contributed to an Improvement Opportunity – not if Information Integration was the Improvement Opportunity. Also, if knowledge gaps contributed to misunderstanding external records, this would be scored under Knowledge Base.*

Questions to Consider	Ratings & Descriptions	
• How did you decide what records to request in this case? Were historical records on previous services requested? How were assessments used to plan services?	0	No evidence of difficulties in obtaining or synthesizing external records.
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but difficulties were present).
	2	Difficulties obtaining or synthesizing external records contributed to an Improvement Opportunity without proximity to the outcome.
	3	Difficulties obtaining, or synthesizing external records contributed to an Improvement Opportunity with proximity to the outcome.

TEAM DOMAIN

This section focuses on factors primarily present within teams. The pressures, communication, and climate of the team are considered in this domain, with specific attention given to the supervisor's unique role in supporting the professional. This domain is not exclusive to factors only present among internal teams; collaboration with relevant community partners is assessed as well.

For the **TEAM DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

TEAMWORK/COORDINATION

Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people and teams). Notably, this item does not encompass the family's willingness or cooperation but rather the team of family-serving professionals.

Note: Ineffective teamwork between a supervisor and supervisee is captured under "Supervisory Support."

Questions to Consider	Ratings & Descriptions	
• What barriers existed in communicating with outside partners during this case? How often did you communicate? What barriers existed in internal communication while working this case?	0	No evidence of issue with teamwork/coordination.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but teamwork/coordination concerns were present).
	2	Teamwork/coordination problems contributed to an Improvement Opportunity without proximity to the outcome.
	3	Teamwork/coordination problems contributed to an Improvement Opportunity with proximity to the outcome.

SUPERVISORY SUPPORT

Supervisor provides ineffective support, communication, teamwork, and/or is unavailable.

Questions to Consider	Ratings & Descriptions	
• What support was received from supervisors during this case? What is supervision generally like on this team? What was the supervisor's leadership style?	0	No evidence of problems with supervisory support.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but supervisory support concerns were present).
	2	Supervisory support problems contributed to an Improvement Opportunity without proximity to the outcome.
	3	Supervisory support problems contributed to an Improvement Opportunity with proximity to the outcome.

SUPERVISORY KNOWLEDGE TRANSFER

Case direction from supervisor was inconsistent with best practice.

Questions to Consider	Ratings & Descriptions	
• What case direction was received from supervisors during this case? Was case direction aligned with best practice?	0	No evidence of problems with supervisory case direction.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but supervisory case direction concerns were present).
	2	Supervisory case direction contributed to an Improvement Opportunity without proximity to the outcome.
	3	Supervisory case direction contributed to an Improvement Opportunity with proximity to the outcome.

PRODUCTION PRESSURE

Demands on professionals to increase efficiency.

Note: This is distinctive from Demand Resource Mismatch (DRM) as Production Pressure describes pressures within casework (e.g., overdues, extensive court involvement, child removals in other assigned cases). Though not exclusively, the presence of DRM may impact the presence of Production Pressures.

Questions to Consider	Ratings & Descriptions	
• How pushed were you by deadlines in this case? How many other cases did you have? What was happening in other cases during the time of this incident?	0	No evidence of problems with production pressures.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but production pressures were present).
	2	Production pressures contributed to an Improvement Opportunity without proximity to the outcome.
	3	Production pressures contributed to an Improvement Opportunity with proximity to the outcome.

ENVIRONMENT DOMAIN

This section focuses on factors present in the team's environment. This domain fosters an appreciative inquiry of the team's internal and external access to resources, policies, services, training, and technologies needed to support safe and reliable care delivery. Items in this domain refer to the child/family-serving macrosystem. These items can have positive, negative, or mixed impact to vulnerable populations, such as Black Indigenous People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Two Spirit (LGBTQ2S).

For the **ENVIRONMENT DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

DEMAND-RESOURCE MISMATCH

A lack of internal resources or programs (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices. *Note: The absence of equipment/technology and external resources/programs are scored in separate items.*

Questions to Consider	Ratings & Descriptions	
• What was the staffing pattern at the time of this case? How long has it been that way? What problems did it cause in this case? What is the barrier to having adequate staffing?	0	No evidence of problems with demand-resource mismatch. Assigned case professionals appeared to have needed resources to carry out work practices.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but demand-resource mismatch was present).
	2	Lack of resources to carry out safe work practices contributed to an Improvement Opportunity without proximity to the outcome.
	3	Lack of resources to carry out safe work practices contributed to an Improvement Opportunity with proximity to the outcome.

PRACTICE DRIFT

A widely-accepted, often gradient, departure from work-as-prescribed. Practice Drift usually occurs as a result of experienced success and as a means of managing production pressures and/or complex interpersonal decisions. Practice Drift uniquely describes an environmental (e.g., system-wide, county-wide, office-wide) departure from work-as-prescribed and may involve a single or multiple child serving agencies.

Questions to Consider	Ratings & Descriptions	
• Were workarounds present at the time of the case? Did these workarounds potentially affect the family in a positive or negative way? Was the workaround widely-used in the county or across the state?	0	No evidence of Practice Drift.
	1	Evidence of latency (i.e., no known impact an Improvement Opportunity, but Practice Drift was present).
	2	Practice Drift contributed to an Improvement Opportunity without proximity to the outcome.
	3	Practice Drift contributed to an Improvement Opportunity with proximity to the outcome.

EQUIPMENT/TECHNOLOGY/TOOLS

An absence or deficiency in the equipment and technology (e.g., electronic records management system like SACWIS, communication devices, electronics) used to carry out work practices. Tools refers to the structured assessments (e.g., CANS, FAST, SDM), predictive analytics, and related algorithms (e.g., algorithms may perpetuate systemic bias toward underrepresented populations).

Questions to Consider

- What equipment would have been helpful in this case? Were there any difficulties in acquiring or using certain equipment or technology?

Ratings & Descriptions	
0	No evidence of problems with equipment, tools or technology.
1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but issues with equipment/technology/tools were present).
2	The absence or deficiency of equipment, tools or technology contributed to an Improvement Opportunity without proximity to the outcome.
3	The absence or deficiency of equipment, tools or technology contributed to an Improvement Opportunity with proximity to the outcome.

POLICIES/RULES/STATUTES

The absence, poor clarity, or ineffectiveness of an internal written practice or procedure. Conflicting policies would also be rated here, as well as other written rules, statutes, and procedures detailing work-as-prescribed.

Questions to Consider

- What policies, protocols, or forms affected this case? How did it impact decisions? What would have been more helpful?

Ratings & Descriptions	
0	No evidence of absent or ineffective policies.
1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but the absence of ineffectiveness of a policy was present).
2	The absence or ineffectiveness of one or more policies contributed to an Improvement Opportunity without proximity to the outcome.
3	The absence or ineffectiveness of one or more policies contributed to an Improvement Opportunity with proximity to the outcome.

TRAINING

The absence, poor clarity, or ineffectiveness of an internal formal instruction. This may include a variety of learning modalities, such as: web-based, classroom, independent study, formal mentoring or coaching, etc.)

Questions to Consider

- What trainings affected decision-making in this case? Were needed trainings helpful and available? What trainings would have been useful?

Ratings & Descriptions	
0	No evidence of absent or ineffective trainings.
1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but the absence of ineffectiveness of a training was present).
2	The absence or ineffectiveness of one or more trainings contributed to an Improvement Opportunity without proximity to the outcome.
3	The absence or ineffectiveness of one or more trainings was contributed to an Improvement Opportunity with proximity to the outcome.

SERVICE ARRAY

The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).

Questions to Consider

- What services are available in the area? How accessible are those services? How effective do services appear to be?

Ratings & Descriptions	
0	No evidence of problems with service array.
1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but service array concerns were present).

SERVICE ARRAY The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).		
	2	Problems with service array contributed to an Improvement Opportunity without proximity to the outcome.
	3	Problems with service array contributed to an Improvement Opportunity with proximity to the outcome.

3. SSIT SCORESHEET

CASE ID:	

Improvement Opportunities (IOs)
1
2
3
4
5

Abbreviated Rating Summary for Family Domain

0=No Evidence | 1=Minimal Problem or History | 2=Problem affected Functioning | 3=Severely Disabling or Dangerous Problem

Abbreviated Rating Summary for Professional, Team, and Environment Domains

0=No Evidence of Influence | 1=Latent Factor | 2=Evidence of Influence | 3=Evidence of Proximity to Poor Outcomes

Family Domain	Influence 0	1	2	3	Narrative *Required if rating is 2 or 3*
1. Family Conflict (Caregiver)	○	○	○	○	
2. Developmental (Caregiver)	○	○	○	○	
3. Mental Health (Caregiver)	○	○	○	○	
4. Substance Use (Caregiver)	○	○	○	○	
5. Economic Stability (Caregiver)	○	○	○	○	
6. Parenting Behaviors (Caregiver)	○	○	○	○	
7. Medical/Physical (Child)	○	○	○	○	
8. Developmental/Intellectual (Child)	○	○	○	○	
9. Mental Health of (Child)	○	○	○	○	
Professional Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
10. Cognitive Bias	○	○	○	○	
11. Stress	○	○	○	○	
12. Fatigue	○	○	○	○	
13. Knowledge Base	○	○	○	○	
14. Documentation	○	○	○	○	
15. Information Integration	○	○	○	○	
Team Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
16. Teamwork/Coordination	○	○	○	○	
17. Supervisory Support	○	○	○	○	
18. Supervisory Knowledge Transfer	○	○	○	○	

19. Production Pressure	○	○	○	○	
Environment Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
20. Demand-Resource Mismatch	○	○	○	○	
21. Practice Drift	○	○	○		
22. Equipment/Technology/Tools	○	○	○	○	
23. Policies/Rules/Statutes	○	○	○	○	
24. Training	○	○	○	○	
25. Service Array	○	○	○	○	

4. QUALITY IMPROVEMENT ADVOCACY

In this final section we provide strategies for using SSIT data to share the "system's story" of a critical incident and support advocacy for system improvement actions. A primary purpose of measurement is to cultivate shared language and inform decision-making. For this reason, item ratings within the Professional, Team, and Environment domains translate into the following action levels:

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity **without** proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to Improvement Opportunity **with** proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education or forming an ad hoc QI team.

SSIT action levels are not intended to be prescriptive. They are a steady and reliable guide for targeting system reform in the areas most likely to prevent a future critical incident. Items scoring "3" translate into a priority for action because the item influenced an IO proximal to a critical incident. Nesting the domains serves as a prompt to direct QI resources as deep into the system as possible, so—if a review yields proximal scores in the Professional, Team, and Environment domains—resources can be directed to improve the Environment, rather than merely providing professionals with directives.

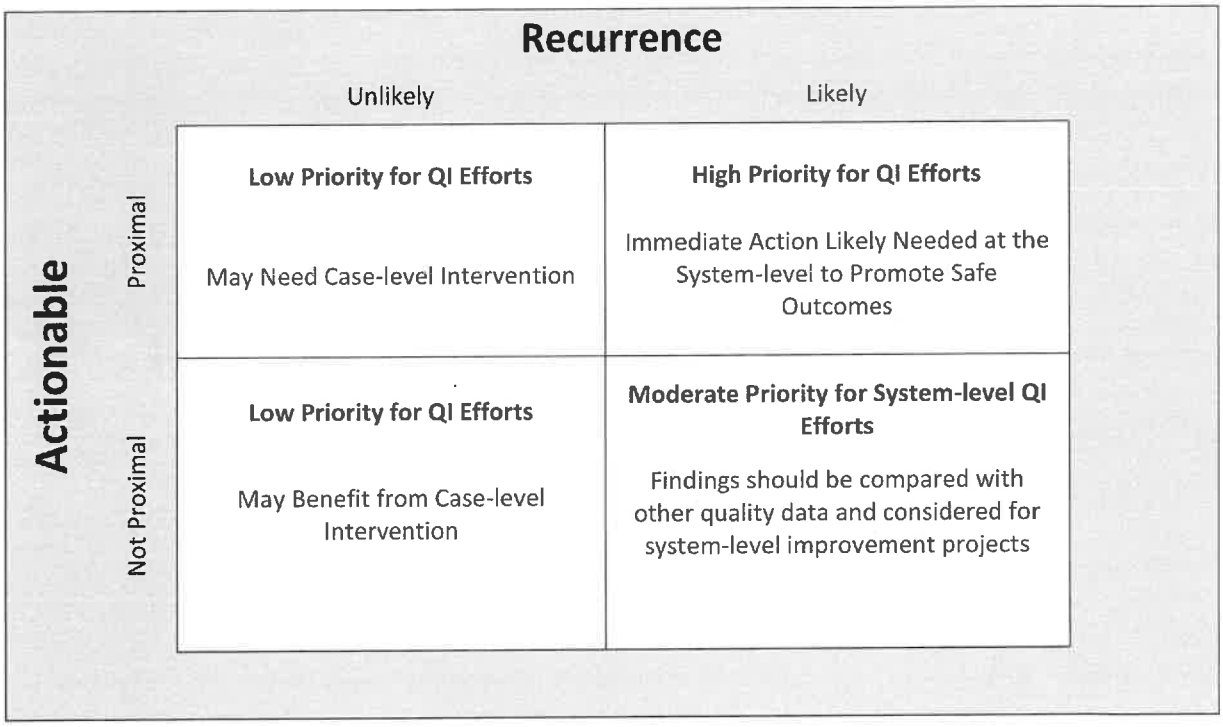
SSIT data can be aggregated and reviewed to inform system-focused quality improvement opportunities. SSIT data should be viewed alongside the IOs from reviewed cases. For example, IOs may reveal inconsistent engagement of all caregivers in a home, allegation/incident-focused casework practice, or barriers in reviewing all applicable case history. Prior to review of SSIT data, it is useful to consider how likely these IOs are to recur in the system. While this can be done through content analysis of IOs as well as a review of other QI data (e.g., Child and Family Service Review findings), the following anchors (table 3) may be helpful in thinking through the likelihood for IOs to recur within a system:

Table 3: Recurrence Rating Structure

ORGANIZATIONAL RECURRENCE	
Questions to Consider • Is this finding already known to be part of a systems issue? • Are effective procedures in place to address? • Have system changes already been in effect since the problem last occurred?	Ratings & Descriptions 0 Minimal or no likelihood of recurrence; problem appears a rare outlier. 1 There is a history of recurrence that appears to have been successfully addressed through organizational improvement(s). 2 There is a likelihood of future recurrence. Though some organizational constructs (e.g., policy, supervision practices, trainings, technology, resource allocation) exist to address the problem, it is unproven or disproven if these will successfully reduce recurrence. 3 Minimal or no organizational constructs currently exist to address the problem.

When considering where to focus finite QI resources, the QI Advocacy Matrix (figure 2) may support decision-making. After establishing recurrence likelihood - and with proximity established by the SSIT - QI professionals can use the matrix to identify and advocate for those IOs that should be prioritized. IOs that are both proximal and likely to recur may require more immediate action form the system (see top right quadrant in table below). IOs likely to recur but not proximal to critical incidents may benefit from system-level QI resources, but it is prudent to compare such findings with other system data so as to make the most informed decision (see bottom right quadrant). IOs unlikely to recur may be suitable for case-level intervention (see left side). For example, a region may have experienced an isolated and/or unusual problem that can be improved by collaborating directly with local region's personnel. The following table is a graphic depiction of this concept:

Figure 2: QI Advocacy Matrix



Advocating for System Change

Those tasked with reviewing critical incidents rarely have formal authority to move systems to change. More often, their success lies in their ability to effectively use data to tell a story and influence communities with such formal authority to move to action. These traits—accurate story-sharing and influence-- are the hallmarks of an effective advocate. QI advocacy, like all forms of advocacy, requires dedicated, experienced individuals armed with information. The SSIT allows a system to standardize important information about its system and to support QI advocacy.