



IIS PEER RECORD REVIEW INSTRUCTIONS

The IIS Peer Record Review Instructions are to be used during IIS Peer Record Reviews. These instructions will serve as a guide in making decisions regarding the rating of case record contents and quality.

Each rating has been defined so the reviewer may select the rating which most closely matches what s/he has found in the case record.

The nature of the process allows for some reviewer subjectivity, therefore each reviewer should carefully follow the instructions and rating indicators provided to maintain as much consistency as possible.

Note: It is very important for each section to be completed carefully and thoroughly to ensure the generated report is based upon the accurate findings of the reviewer.

A rating MUST be entered for each item. Some items allow the reviewer to select a rate of 1, 2, 3, or 4 with 1 being a successful rating and 4 being an area which needs improvement. Other items only allow the reviewer to select certain ratings. Review the instructions prior to making a rating selection to determine which ratings are allowed for each item.

When reviewing closed cases, consider the case materials as if the family was open and currently receiving services. For example, when asked to determine the correlation between services being provided and the family needs, examine the services which were provided when the case was open. It is incorrect to select the answer that states no services are being provided unless none were provided during the service delivery process.

At the end of each section there is space to document comments. For this review to be beneficial to the staff, all pertinent information should be provided in the comment section explaining significant findings that led to any *negative* rating. These comments are important to promote quality improvement efforts.

Reviewer Information:

This section is used to document the reviewer's name and the date the review took place.

Case Information:

In this section, the family's name and the IIS Specialist's name and agency should be documented.

Section I: Checklist of Required Documents in Case Record

This section is designed to rate whether the required documents are complete and filed in the record.

Note: For Section I, “complete” means all relevant sections of the documents have entries. The quality of the contents of the entries is addressed under Sections II – V.

- 1) Initial IIS Referral
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.
- 2) Initial Screening (written notification that family was accepted or not accepted)
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.
- 3) Statement of Understanding and Agreement
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

Note: The Statement of Understanding and Agreement is sometimes titled Participation Agreement. The Statement/Agreement must be signed and dated by the Client and the Agency.
- 4) Emergency Assistance Services (EAS) Request
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.
- 5) Initial Safety Plan
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.
- 6) Initial Family Assessment
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.
- 7) NCFAS Assessment
 1. The document is complete, and is filed in the record.
 2. The document is mostly complete, and is filed in the record.
 3. The document is not complete, but is filed in the record.
 4. The document is not filed in the record.
- 8) Service Plan
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.
- 9) Weekly Progress Notes
 1. The documents are complete, and are filed in the record.
 4. The documents are not filed in the record.

Note: Weekly Progress Notes may be prepared as daily document, or combined into a weekly format.

- 10) Client Contact Log
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

Note: The Contact Log can be a separate document, or can be the collective sections of multiple documents (e. g. Contact Log Section of Weekly Progress Notes), but Contact Log entries should be clearly labeled and itemized.

- 11) Weekly Supervision Logs
 1. The documents are complete, and are filed in the record.
 4. The documents are not filed in the record.

Note: Weekly Supervision Logs may be a separate document, or can be the collective sections of multiple documents (e. g. Weekly Supervision Log Section of Weekly Progress Notes), but Weekly Supervision Log entries should be clearly labeled and itemized.

- 12) Family Support Team Plan
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

N/A. The family refused to participate; therefore a Family Support Team Plan may not be prepared and would not appear in the record.

- 13) Termination Letter to Family
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

- 14) Termination Summary
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

- 15) Follow-up Plan
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

N/A. A follow-up plan was not required.

- 16) Crisis Funds Requests, Approvals, and Expenditure Record
 1. The document is complete, and is filed in the record.
 4. The document is not filed in the record.

N/A. No crisis funds expended.

- 17) Rating of overall inclusion of **REQUIRED DOCUMENTS IN CASE RECORD**.
 1. Overall quality of required documents met all of the above expectations.
 2. Overall quality of required documents met most of the above expectations.
 3. Overall quality of required documents met some of the above expectations.
 4. Overall quality of required documents met little or none of the above expectations.

Special Note: If more than one of these **CRITICAL DOCUMENTS** are not present: the "Initial IIS Referral," the "Initial Safety Plan," the "Initial Family Assessment," the "Service Plan," the "Weekly Progress Notes," the "Termination Summary," and the "Follow-up Services Plan," then rate overall quality of **REQUIRED DOCUMENTS IN CASE RECORD** as "4".

Section II: Quality of Service Delivery

This section is designed to rate the overall quality of IIS Service Delivery.

- 1) Was sufficient information documented in the initial family assessment to determine IIS was the appropriate service for the family?
 1. There is sufficient information documented to determine IIS was the appropriate service.
 2. There is documented information to determine IIS was appropriate, but it could be clearer.
 3. The information documented to determine IIS was the appropriate service is unclear.
 4. There is no information documented to determine IIS was the appropriate service.
- 2) Did face to face contact with the family occur within 24 hours of receipt of the initial referral by the contractor?
 1. The record clearly documents contact with the family occurred within 24 hours.
 2. An exception to the requirement is clearly documented.
 4. There is no documentation to show the worker made contact with the family within 24 hours.

Note: An example of a clear exception to the requirement could be that the family was not available during the first 24 hours; or that the CD worker requested the initial family contact be postponed beyond the first 24 hours, etc.
- 3) Was immediate safety of the family assured through a safety plan?
 1. The record clearly documents immediate safety was assured through a safety plan.
 2. Safety was assured, but the safety plan was not appropriate.
 4. There is no documentation to suggest immediate safety was assured.

Note: This documentation may be found in the initial Safety Plan.
- 4) Was the referral source notified verbally or in writing within 24 hours of the initial screening whether the family was accepted or not accepted?
 1. There is clear evidence in the record the referral source was notified verbally or in writing within 24 hours of the initial screening.
 4. There is no evidence in the record the referral source was notified verbally or in writing within 24 hours of the initial screening.
- 5) Does the initial family assessment clearly document:
 - a) Safety of the child and all family members?
 1. The initial family assessment clearly documents the safety of the child and all family members.
 4. The initial family assessment does not clearly document the safety of the child and all family members.

Note: If the initial assessment is not in the file, rate this as "4".
 - b) Areas of need?
 1. The initial family assessment clearly documents areas of need.
 4. The initial family assessment does not clearly document areas of need.

Note: If the initial assessment is not in the file, rate this as "4".
 - c) Frequency, intensity, and or/duration of behaviors?

1. The initial family assessment clearly documents the frequency, intensity, and or/duration of behaviors.
 4. The initial family assessment does not clearly document the frequency, intensity, and or/duration of behaviors.
- Note: If the initial assessment is not in the file, rate this as “4”.
- d) Examination of environmental conditions and their influence upon the family?
1. The initial family assessment clearly documents examination of environmental conditions and their influence upon the family.
 4. The initial family assessment does not clearly document examination of environmental conditions and their influence upon the family.
- Note: If the initial assessment is not in the file, rate this as “4”.
- e) Consideration of the interactions of all family members?
1. The initial family assessment clearly documents consideration of the interactions of all family members.
 4. The initial family assessment does not clearly document consideration of the interactions of all family members.
- Note: If the initial assessment is not in the file, rate this as “4”.
- f) The contingencies impacting family needs?
1. The initial family assessment clearly documents the contingencies impacting family needs.
 4. The initial family assessment does not clearly document the contingencies impacting family needs.
- Note: If the initial assessment is not in the file, rate this as “4”.
- g) Strengths and behavioral assets?
1. The initial family assessment clearly documents strengths and behavioral assets.
 4. The initial family assessment does not clearly document strengths and behavioral assets.
- Note: If the initial assessment is not in the file, rate this as “4”.
- 6) Does the record reflect that the initial family assessment was submitted to the Children’s Division within 5 calendar days after the initial screening with the family?
1. There is clear evidence in the record the initial family assessment was submitted to the Children’s Division within 5 calendar days after the initial screening with the family.
 4. There is no evidence in the record the initial family assessment was submitted to the Children’s Division within 5 calendar days after the initial screening with the family.
- 7) Does the Service Plan clearly document:
- a) Services to protect child(ren) from harm and to prevent further abuse/neglect?
1. The Service Plan clearly documents services to protect child(ren) from harm and to prevent further abuse/neglect.
 4. The Service Plan does not clearly document Services to protect child(ren) from harm and to prevent further abuse/neglect.
- Note: If the Service Plan is not in the file, rate this as “4”.

- b) Services to reduce the risks to the children's safety or well-being?
1. The Service Plan clearly documents services to reduce the risks to the children's safety or well-being.
 4. The Service Plan does not clearly document services to reduce the risks to the children's safety or well-being.
Note: If the Service Plan is not in the file, rate this as "4".
- c) Areas of focus?
1. The Service Plan clearly documents the areas of focus.
 4. The Service Plan does not clearly document the areas of focus.
Note: If the Service Plan is not in the file, rate this as "4".
- d) The idea that children have essential needs for care beyond child safety?
1. The Service Plan clearly documents the idea that children have essential needs for care beyond child safety.
 4. The Service Plan does not clearly document the idea that children have essential needs for care beyond child safety.
Note: If the Service Plan is not in the file, rate this as "4".
- e) Services which support and enhance parents' capacity to safely care for their children?
1. The Service Plan clearly documents services that support and enhance parents' capacity to safely care for their children.
 4. The Service Plan does not clearly document services that support and enhance parents' capacity to safely care for their children.
Note: If the Service Plan is not in the file, rate this as "4".
- f) The value and importance of maintaining children's connections with their families when it is believed the family unit is the best place for the children?
1. The Service Plan clearly documents the value and importance of maintaining children's connections with their families when it is believed the family unit is the best place for the children.
 4. The Service Plan does not clearly document the value and importance of maintaining children's connections with their families when it is believed the family unit is the best place for the children.
Note: If the Service Plan is not in the file, rate this as "4".
- g) Achievable, measurable, behaviorally oriented goals and tasks?
1. The Service Plan clearly documents achievable, measurable, behaviorally oriented goals and tasks.
 4. The Service Plan does not clearly document achievable, measurable, behaviorally oriented goals and tasks.
Note: If the Service Plan is not in the file, rate this as "4".
- h) Did the family participate in the development of the service plan?
1. There is clear evidence in the record the family participated in the development of the service plan.
 4. There is no clear evidence in the record the family participated in the development of the service plan.
Note: If the Service Plan is not in the file, rate this as "4".

- 8) Was the Service Plan completed within 5 calendar days after the initial family assessment?
1. There is clear evidence the Service Plan was completed within 5 calendar days after the initial family assessment.
 4. There is no clear evidence in the record the Service Plan was completed within 5 calendar days after the initial family assessment.
- 9) Did the worker coordinate activities of all internal/external resources?
1. There is clear evidence coordination of activities of all internal/external resources occurred.
 4. There is no clear evidence of coordination of activities of all internal/external resources.
- N/A. No external resources needed.
- 10) Did the services provided meet the family needs?
1. There is clear evidence the services provided met the family needs.
 2. The services met some of the family's needs.
 4. There is no clear evidence the services provided met the family needs.
- 11) Were worker interventions/activities/progress/obstacles clearly documented in the service delivery notes?
1. There is clear evidence in the service delivery notes of the worker interventions/activities.
 2. There is some evidence in the service delivery notes of the worker interventions/activities, but the document could be clearer.
 4. There is no clear evidence in the service delivery notes of the worker interventions/activities.
- 12) Does the record document ongoing safety assessment of the child, family, and community?
1. There is clear evidence of ongoing safety assessment of the child, family, and community.
 4. There is no clear evidence of ongoing safety assessment of the child, family, and community.
- Note: The word community in this context refers to whether the child and family are safe within the community and whether the community is safe from the child and family
- 13) Is there evidence the family's level of functioning was continually assessed during the intervention?
1. There is clear evidence the level of functioning was continually assessed during the intervention.
 4. There is no clear evidence the level of functioning was continually assessed during the intervention.
- 14) Did the skill-building activities respond to the individualized and specific needs of the family (e.g., child management skills, emotional management skills, interpersonal skills, assertiveness skills, advocacy skills, life skills, self-sufficiency skills, behavioral modification skills, etc.)?
1. Skill-building activities were individualized to the specific needs of the family.
 2. Skill-building activities could have been more individualized to the specific needs of the family.
 3. Skill-building activities appear to be selected from a prescribed narrow range of options, and were not individualized to the specific needs of the family.

- 4. There were no skill-building activities individualized to the specific needs of the family.
- 15) Does the record document contacts with family members to accomplish goals?
- 1. The record clearly documents contacts to accomplish goals.
 - 4. The record does not clearly document contacts to accomplish goals.
- 16) Were joint staffings conducted with other agencies/individuals pertinent to the family?
- 1. The record clearly documents joint staffings were conducted with other agencies/individuals pertinent to the family.
 - 4. The record does not clearly document joint staffings were conducted with other agencies/individuals pertinent to the family.
- 17) Is there evidence the family participated in the termination of services?
- 1. The record clearly documents joint planning with the family with the family for the termination of services.
 - 4. There is no clear documentation of joint planning with the family for the termination of services.
- 18) Were follow-up services recommended?
- 1. The record clearly documents follow-up services were recommended.
 - 4. The record does not clearly document whether follow-up services were recommended.
- N/A. No follow up services were recommended by the specialist.
- a) Were referrals and linkages made for follow-up services?
- 1. The record clearly documents referrals and linkages were made for follow-up services.
 - 4. The record does not clearly document referrals and linkages were made for follow-up services.
- N/A. No follow up services were recommended by the specialist.
- b) Was the family involved in the formulation of the follow-up plan?
- 1. The record clearly documents the family's involvement in the formulation of the follow-up plan.
 - 4. The record does not clearly document the family's involvement in the formulation of the follow-up plan.
- 19) Termination:
- a) Was the Children's Division and/or referring agency notified within 24 hours of the termination?
- 1. The record clearly documents the **Children's Division and/or referring agency were notified within 24 hours of the termination.**
 - 4. The record does not clearly document whether the **Children's Division and/or referring agency were notified within 24 hours of the termination.**
- b) Was the Termination Summary submitted to the Children's Division within 10 days after termination or 5 days for an early termination?
- 1. The record clearly documents the termination summary was submitted to the **Children's Division within the required timeframe.**
 - 4. The record does not clearly document whether the termination summary was submitted to the **Children's Division within the required timeframe.**

- 20) Rating of overall quality of SERVICE DELIVERY.
1. Overall quality of service delivery met all of the above expectations.
 2. Overall quality of service delivery met most of the above expectations.
 3. Overall quality of service delivery met some of the above expectations.
 4. Overall quality of service delivery met little or none of the above expectations.

Section III: Record Content

This section is designed to rate the record.

- 1) Are items filed in the case record in an organized and chronological manner?
 1. Items are filed in an organized and chronological manner.
 2. Items are filed in an organized manner, but are not in chronological order.
 3. Some Items are filed in chronological order, but items are not filed in an organized manner.
 4. Items are not filed in an organized and chronological manner.
- 2) Are contact entries detailed and thoroughly documented?
 1. The record clearly documents all contact entries are detailed and thoroughly documented.
 2. The record documents some contact entries are detailed and thoroughly documented, but the documentation could be clearer.
 3. The record documentation as to whether all contact entries are detailed and thoroughly documented is unclear.
 4. The record does not provide detailed or thoroughly documented contact entries.
- 3) Initial Assessment and Termination Summary are signed and dated by supervisor?
 1. The Initial Assessment and Termination Summary are signed and dated by the supervisor.
 2. The Initial Assessment and Termination Summary are partially signed and dated by the supervisor.
 4. The Initial Assessment and Termination Summary are not signed and dated by the supervisor.
- 4) Rating of overall quality of DOCUMENTATION:
 1. The documentation is thorough, neat, comprehensive, and timely.
 2. The documentation is predominately thorough, neat, comprehensive, and timely, but overall quality could be improved.
 3. The documentation is partially thorough, neat, comprehensive, and timely, but overall quality could be greatly improved.
 4. The documentation is not thorough, neat, comprehensive, or timely.

SECTION IV: SERVICE AVAILABILITY

This section is designed to rate service availability of Specialists.

- 1) Did the record document specialist availability (24/7)?
 1. The record clearly documents specialist availability (24/7).
 4. The record does not clearly document specialist availability (24/7).

- 2) Was the location of direct client services at the family home, or a location convenient to the client?
 1. The record clearly indicates the location of direct client services was at the family home, or a location convenient to the client.
 4. The location of services was not documented.

- 3) Were coverage arrangements made during the Specialist/therapist's vacation/illness?
 1. There is clear evidence coverage arrangements were made during the specialist's vacation/illness.
 4. There is no evidence coverage arrangements were made during other specialist's vacation/illness.

Note: If there was no Specialist/Therapist vacation/illness requiring coverage arrangements, rate this as "1".

- 4) List the number of weeks and hours of direct Specialist contact.
 - a) Count the total number of weeks the intervention lasted, and enter this value.
 - b) Count the number of hours of direct Specialist contact (face-to-face and telephone), and enter this value.

- 5) Overall rating of program SERVICE AVAILABILITY:
 1. All of the above elements of Service Availability are clearly met.
 2. Most of the above elements of Service Availability are clearly met.
 3. Some of the above elements of Service Availability are clearly met.
 4. Few of the above elements of Service Availability are clearly met.

SECTION V: SUPERVISION/CONSULTATION

This section is designed to rate the program activities of Supervisors.

- 1) Was there at least weekly consultation with the supervisor?
 1. There was at least weekly consultation by the specialist with supervisor.
 4. There was not at least a weekly consultation by the specialist with supervisor.

- 2) Were weekly consultation recommendations and concerns documented?
 1. Recommendations and concerns were clearly documented.
 4. Recommendations and concerns were not documented, or weekly consultations did not occur.

- 3) Did the supervisor attend the initial family screening, or did the supervisor visit the family within the first 14 calendar days of service?
 1. Supervisor attended the initial family screening, or visited the family within the first 14 calendar days.
 4. Supervisor did not attend the initial family screening, or visit the family within the first 14 calendar days.

- 4) Is there evidence the supervisor reviewed the written progress notes of the specialist?
 1. There is clear evidence in the record that the supervisor reviewed the written progress notes of the specialist.
 4. There is no evidence in the record the supervisor reviewed the written progress notes of the specialist.

- 5) Rating of overall quality of SUPERVISION/CONSULTATION:
1. All of the above elements of supervision/consultation are clearly met.
 2. Most of the above elements of supervision/consultation are clearly met.
 3. Some of the above elements of supervision/consultation are clearly met.
 4. Few of the above elements of supervision/consultation are clearly met.

Memoranda History

CD13-10