

STANDARD FOR DOCUMENTATION

PURPOSE

The purpose of this standard is to provide direction and guidance to the Child and Family Services (CFS) program regarding documentation. This standard is intended to achieve statewide consistency in the development and application of CFS core services and shall be implemented in the context of all applicable laws, rules and policies. The standard will also provide a measurement for program accountability.

INTRODUCTION

Documentation is central to the services provided by the CFS program. It is the responsibility of every CFS staff to complete timely and accurate documentation in accordance with this Standard. CFS acknowledges six (6) basic functions of documentation:

Assessment and Planning

The CFS social worker's primary function is to conduct assessments and implement service plans to achieve safety, well-being, and permanency for a child. It is essential, that documentation of all case-related facts and circumstances be as clear and concise as possible. Robust information collection ensures social workers have an adequate foundation for their decision-making and service plans. Lack of quality documentation may lead to inadequate planning and intervention, critical errors in judgment, and poor outcomes for families.

Service Delivery

Thorough documentation provides a solid foundation for social workers' efforts to develop and implement high quality services whether they are direct services to families, supervision of workers, or agency administrators' management and evaluation of personnel and programs.

Continuity and Coordination of Services

CFS social workers must interact with numerous agencies, professional and lay individuals on a daily basis. Comprehensive documentation facilitates professional and interdisciplinary collaboration and coordination of services. Additionally, comprehensive documentation ensures that all CFS staff has up-to-date details concerning the child and family's needs.

Supervision

Supervision is essential to the work conducted by CFS social workers. It should be noted that supervisors, as well as administrators and agencies, can be held liable for the errors

and omissions of their staff if there is evidence of inadequate supervision. CFS social worker supervisors should routinely document the supervision they provide.

Service Evaluation

Measured outcomes and program effectiveness are central to CFS social work. Data information and collection are critical to this end. CFS social workers must strive to continually strengthen their record-keeping practices to maintain the integrity of the CFS program.

Accountability

From the first moment of contact, a CFS social worker becomes responsible and accountable to their profession, their employer, the community, the individual they serve, funding sources, co-workers, and a legal system which protects the rights of each individual. The case record serves as the source for legal, clinical, and fiscal accountability.

“If it isn’t documented, it didn’t happen.”

TERMS

Contact

Contact is communication between the assigned worker and the child, the child’s parents or caregivers, resource family members or other alternate care providers. Contact serves as a basis for assessing the child’s safety, permanency, and well-being, as well as promoting the achievement of the family’s case goals. Methods of contact include face-to-face visits, phone calls, letters, and reports.

Visitation

Visitation is planned and is separate from routine appointments such as family counseling, doctor appointments, and school meetings. Visitation is the primary mechanism through which family relationships are maintained while a child is in out-of-home care. It provides the context for learning, if and when a parent is willing and capable of providing a safe environment for their child or if a permanent plan other than reunification is to be considered. Visitation may include parents, grandparents, relatives, siblings, and other individuals with whom the child has previously established a significant relationship.

Monthly Summary Narrative

A monthly summary narrative is a summary of the worker’s on-going management of a case during a single month. The summary includes contacts with relevant collaterals such as law enforcement and service providers, case relevant decisions such as staffing dates or court decisions, and concurrent planning progress such as the search

for relatives. The summary should be brief, and not a word for word account of worker interactions.

Contact Note

A contact note is a written summary used to record a contact between a worker and a child, parent(s), foster parent(s) or other alternative care provider. The contact note should document the child's safety, well-being, permanency, and family service plan progress as assessed during the contact.

Visit Note

A visit note is a written summary used to record visitation between a child who is placed out of home, and the child's parent(s), siblings, and/or other relatives. The visit note should be made when visitation is supervised or monitored by a CFS staff or contractor.

Responsible Party

According to IDAPA 16.06.01.012.17, a Department social worker, clinician, or contracted service provider who maintains responsibility and authority for case planning and case management

IMPLEMENTING THE STANDARD

I. Principles for Documentation

All forms of documentation including electronic and hard copy case files, emails, text messages, audio/video recordings, digital pictures and photographs are subject to the Department's Rules Governing Use and Disclosure of Departmental Records. This means all forms of documentation are potentially accessible by clients, attorneys, and/or others who may gain access.

A. Critical Thinking

Critical thinking is the ability to think about one's thinking in such a way as to recognize its strengths and weaknesses and, as a result, recast the thinking in improved form. The following are the most significant standards to use in Critical Thinking when documenting one's work:

1.) Clarity

Documentation must be clear and free from ambiguity. Clarity is an essential standard. If a statement is unclear, we cannot determine if it is accurate or relevant.

2.) Accuracy

Documentation must be accurate. When documenting, a worker should

consider, “Is this really true? How can we find out if it is correct?” A statement can be clear, however inaccurate.

3.) Precision

Precision in documentation requires workers to provide specific details. A statement can be clear and accurate, but not precise. Documentation should be as detailed as possible however; precision must be balanced with being concise.

4.) Relevance

Is the statement connected to the question or issue at hand? A statement may be clear, accurate and precise, but not relevant. Documentation must be relevant to the context of the work.

5.) Depth

How does the answer or statement address the complexities of the question or issue? A statement can be clear, accurate, precise, and relevant, but lack depth. Documentation must not be superficial or lack seriousness.

6.) Breadth

Do the statements cover the extent of the issue or question to the degree needed? Should we consider another point of view?

7.) Logic

Does the statement make sense? Documentation should be logical and express sound judgment.

B. Electronic/Physical Files

According to IDAPA16.06.060.01, CFS is required to maintain an electronic file and physical file containing information on each family receiving services. The physical file will contain non-electronic documentation such as original copies of all court orders, birth certificates, social security cards, and assessment information which is original outside the Department.

iCARE is the electronic file maintained by CFS to document the case records of individuals involved with the agency. All case documentation, including audio/video recordings and photographs, which is not collected or generated in iCARE should be scanned or downloaded into iCARE with the exception of the following:

- Referral forms for services;
- Drug testing results;
- Court hearing notices;
- Petitions for hearings (**except** petitions related to initial removal/custody, TPR, and Adoption); and

- Email communication.

NOTE: In general, **email communication** should not be cut and pasted into iCARE or maintained in the hard file. Exceptions to this may include: Central Intake when receiving a report of maltreatment via email or when a Program Manager or Chief has instructed a worker to keep specific external emails which may, in their entirety, be needed for documentation purposes. If a worker exchanges electronic information with another individual that they believe is important to document, the worker can summarize the information in the monthly narrative or contact note.

C. Accessibility

According to IDAPA 16.06.60.02(a) (b), all physical family case records must be stored in a secure file storage area, away from public access and retained not less than five (5) years after the case is closed, after which they may be destroyed. Two exceptions to this include: (1) adoption records, including related child protection records, which must be forwarded to the Department’s central adoption unit for permanent storage; and (2) legal case records where ICWA was determined to apply, which must be available at any time at the request of an Indian child’s tribe or the Secretary of the Interior.

NOTE: Do not keep "private" files with information separate from the official case record. All documentation including emails and text messages is able to be subpoenaed by the court.

II. Social Worker Contact with Children, Parents, and Resource Parents or Other Alternative Care Providers

Social worker contacts with a child(ren), parents, and resource parent(s) or other alternate care providers must be documented in iCARE. Documentation of these contacts must be recorded on the “Contact Note” screen in iCARE. Documentation of these contacts must be in complete sentences. A complete contact record includes:

- Date of contact;
- Name of individual contacted;
- Participant role – child of concern or relationship to the child;
- Location of contact – family home, resource family home, office, other;
- Method of contact – face-to-face, telephone, written;
- Duration of contact;
- Result of the contact- cancelled, completed, interrupted; and
- Name and title of responsible party making the contact.

Content Requirements

Each social worker contact with the child, parent(s), or resource parent has a defined purpose related to monitoring the child’s safety, well-being, and permanency (if applicable), as well as assessing the family’s service plan progress.

1) Safety

During contact with the child, parents, or resource parent the worker must assess the safety of the child. The worker must document their observations of the child's safety and their conclusion as part of their on-going assessment of safety.

2) Well-Being

During contact with the child, parents, or resource parent the worker must assess the child's well-being. The worker must document a summary of the service needs or services received for the child's mental, physical, educational, or child's general health.

3) Permanency

During contact with a child, parents or resource parent the worker must assess the child's permanency if the child is in an out of home placement. The worker must document a summary of their discussions regarding the concurrent plan goals with the child (if appropriate), parents, or resource parent and their assessment of the progress being made towards both permanency goals.

4) Service/Case Plan Progress

During contact with a child, parents, or resource parent the worker must assess the family's progress on the service/case plan. Workers must document a summary of where the family is in completing service/case plan goals, changes made to the service/case plan, and their assessment of the progress being made towards achieving service/case plan goals.

NOTE: Please see the Standard for Contact between the Social Worker, the Child, the Family and the Resource Parents or Other Alternative Care Providers, for information regarding who requires monthly contact by a social worker.

III. Social Worker Contact with Collaterals and Other Case Relevant Individuals

On-going social worker contact with collaterals and other case relevant individuals or groups (law enforcement, relatives, attorneys, and internal or external case staffings) are documented in the monthly summary narrative. These contacts are not entered on the "Contact Note" screen in iCARE. Relative contact documentation should include the relative relationship between the individual and the child (i.e. maternal grandmother, paternal uncle) and their phone number or other contact information. This creates a record of our required "relative search." See the Concurrent Planning Standard for additional information regarding relative searches. Collateral contacts completed during information collection for the initial safety assessment are documented within the Comprehensive Safety Assessment.

IV. Visitation Between the Child and Family Members

When a child is in an out of home placement visitation between the child and the

parents, sibling(s), or other relatives must be documented. Documentation of visitation must be written in complete sentences.

A. Supervised and Monitored Visitation by a CFS Worker/Staff or Contractor

Supervised and monitored visitation between the child, the parents, sibling(s), or other relatives must be documented in the “Visit Note” screen in iCARE.

Documentation for visitation between child(ren) and their family members will include the following:

- Date of the visit;
- Type of visit (supervised or monitored);
- Staff providing supervision or staff monitoring the visit;
- Children and adults present during the visit and their relationship to the child(ren) of concern;
- Location of the visit;
- Duration of the visit; and
- Result of visitation (completed, cancelled).

Content Requirements

Each supervised or monitored visit between a child and their family member(s) has a defined purpose which is outlined in the family visitation plan. Documentation of the visit should include a summary of the activities of the visit and comment on the family’s progress on the visitation plan goal.

B. Visitation Supervised and Monitored by a Family Member or Other Non-CFS Staff Individual and Unsupervised Visitation

When visitation is supervised or monitored by a family member or other individual who is not a CFS worker/staff or contractor or when visitation is unsupervised it must be documented in the monthly summary narrative.

Content Requirements

A summary statement for the family’s visitation during the month which includes the frequency, duration, location, participant names, who is supervising the visit (if applicable) and visitation plan goal progress.

NOTE: Please see the Standard for Visitation between Parents, Siblings, Relatives and Children in Out-of-Home Care, for information regarding visitation requirements.

V. Monthly Summary Narratives

Monthly summary narratives are a summary of the collateral contacts, important case decisions, or other relevant case information a worker documents as part of their on-going management of a case. Monthly summary narratives are to be documented in complete sentences. They are not a word for word account of the social worker’s interactions with case relevant individuals. The documentation in the monthly summary

narrative should be concise and relevant.

VI. Critical Incidents

Critical incidents must be documented on the Critical Incident Report Form.

NOTE: Please see the Procedural Reporting Requirements for a Critical Incident guide on the SharePoint for specific requirements for documenting critical incidents.

http://hwteamsites/facs/cw/Lists/Critical_Incident_Input/AllItems.aspx

VII. Timeframes for Documentation

To accurately reflect the details of a referral or activities of a case, documentation should be completed as soon as possible. The timeframes established in this section reflect the maximum time permitted for the completion of documentation.

A. Adoption Assistance Agreement

Must be negotiated and signed prior to adoption finalization.

B. Adoptive Placement Agreement

The Adoptive or Legal Risk Adoptive Placement Agreement must be developed and signed at the time of the adoptive placement.

C. Alternate Care Plan/Visitation Plan/Resource Family Plan

The Alternate Care Plan will be developed no later than thirty (30) days after a child has been placed in out-of-home care. The Alternate Care Plan includes the family's Visitation Plan and Resource Family Plan. A revised Alternate Care Plan must be developed every six months thereafter.

D. Audio/Video Recordings

Audio and video recordings taken as part of a safety assessment should be uploaded into iCARE as soon as possible but no later than fifteen (15) calendar days from the date they were recorded. Digital recordings should be deleted from the recording device immediately after they are uploaded into iCARE.

E. Casey Life Skills Assessment

A Casey Life Skills Assessment must be completed no later than ninety (90) days after a youth becomes IL eligible. It should be completed with the Independent Living Plan.

F. Comprehensive Safety Assessment

Documentation of the comprehensive safety assessment must be completed no later than thirty (30) calendar days after first seeing the child(ren) of concern.

G. Contact Note

Contacts with the child, parent(s), resource parents or other alternate care provider

must be documented no later than fifteen (15) calendar days after the end of the previous month.

H. Family Development Plan

The Family Development Plan will be completed with the resource family one (1) month from approval of the licensure and will be evaluated at least annually.

I. ICPC 100 B Form

A 100 B form must be sent to the ICPC Administrator in three circumstances: 1) to reflect the decision to place a child in an approved resource at the time of placement 2) to close an ICPC upon finalization of permanency; and 3) to withdraw a pending ICPC request if placement with the approved resource will not be used as soon as a determination has been made not to place the child. (Please see the Standard on the Interstate Compact on Placement of Children for additional information).

J. ICPC Home study

The ICPC home study must be completed within sixty (60) calendar days after the ICPC Administrator receives the request. In Idaho, the sixty (60) calendar days to conduct and complete a home study will begin upon the start date on the presenting issue and service request screens in iCARE.

K. ICPC Quarterly Reports

ICPC quarterly reports must be completed no later than ninety (90) days from the date of out of state placement and every ninety (90) days thereafter. (Please see the Standard on the Interstate Compact on Placement of Children for additional information).

L. Independent Living Plan

The documentation of an Independent Living Plan must be completed no later than ninety (90) days after a youth becomes IL eligible and updated annually. It should be completed with the Casey Life Skills Assessment.

M. Independent Living Transition Plan

The documentation of an Independent Living Transition Plan must be completed at two points. The first must be completed no later than sixty (60) days before or after the youth's 17th birthday. The second must be completed no later than ninety (90) days before the youth's 18th birthday or prior to existing foster care.

N. Monthly Summary Narratives

Monthly summary narratives must be documented no later than thirty (30) calendar days from the end of the previous month.

O. Photographs/Digital Pictures

Photographs and digital pictures taken as part of a safety assessment should be

scanned or uploaded into iCARE as soon as possible but no later than fifteen (15) calendar days from the date they were taken or the date they were received from film processing. Digital pictures must be deleted from the camera or other device immediately after the pictures are uploaded into iCARE.

P. Placement Selection Committee

Placement Selection Committee documentation must be completed and uploaded into iCARE within 30 days of the meeting unless an Extended Placement Selection Committee (EPSC) is requested in which case the documentation must be uploaded no later than 2 business days prior to the EPSC.

Q. Presenting Issues

Presenting issues must be documented the same day they are received so they can be prioritized and assigned for assessment.

R. Reassessment of Safety

The Reassessment of Safety is to be completed by the social worker at key decision points in a case to guide and document case decisions. The reassessment tool must be completed prior to service planning, reunification, termination of parental rights, and case closure. Social workers may also use the reassessment tool to assess a family's progress when there have been significant changes in the family's circumstances or dynamics.

S. Resource Family Home Study

The documentation of a resource family home study must be completed no later than 60 days after placement (Expedited) or no later than 60 days after the completion of PRIDE. (See Standards for Recruitment and Licensing of Resource Parents and for Expedited Relative and Fictive Kin Placement.)

T. Resource Family Licenses

The documentation of the resource family licenses must be entered with or after the resource family home study. The license must not be entered prior to the completion of the resource family home study. (See Recruitment and Licensing of Resource Parents Standard and Expedited Relative and Fictive Kin Placement Standard.)

U. Service Plan

(1) In-home Cases

A service plan must be documented no later than thirty (30) days after the date the Comprehensive Safety Assessment was completed.

(2) Out-of-home Cases

Federal standards and the Child Protective Act require a written service plan to be developed no later than thirty (30) days after the adjudicatory hearing or sixty (60)

days from the date of initial placement, whichever is sooner.

V. Social History

Information for the child's social history is one of the early steps of the family's Concurrent Plan and must be completed prior to authorization for a TPR (Please see the Standard on Concurrent Planning for additional time frames).

W. Social Medical Forms

The initial section of the Child and Family Social and Medical Information Form (pages 1-7) should be completed prior to the shelter care hearing – or by 48 hours from placement whichever is sooner. The remainder should be completed no later than thirty (30) days from placement.

X. Supervision

Documentation of case specific supervision can be documented during supervision time; however it should be documented as soon as possible after supervision and no later than fifteen (15) calendar days after the end of the previous month. Performance based supervision should be documented in accordance with Department of Health and Welfare Human Resources policies and procedures.

NOTE: Please see the Standard for Supervision for specific supervision requirements including formats for documentation.

Y. Visitation Note

Supervised or monitored visitation between the child and their family members must be documented no later than fifteen (15) calendar days after the end of the previous month.

References

Reamer, Frederic G., "Documentation in Social Work: Evolving Ethical and Risk-Management Standards" (2005). *Faculty Publications* Paper 163.

Linda Elder, Richard Paul; www.criticalthinking.org

Any action taken not consistent with this standard must be pre-approved by the FACS Division Administrator or designee. The action, rationale and approval must be documented in the file.