A Nursing Brief: Emerging Best Practice In Department of Children and Families Nursing
Anne Kiwanuka, Valerie Boyar, Monica Jensen

In 2012, more than 400,000 children in the United States were in the child welfare system because of abuse or neglect. These children are uniquely vulnerable and present multiple health challenges to child welfare and health professionals. According to the most recent Child and Family Services Reviews (CFSR) from the U.S. Department of Health and Human Services Administration for Children and Families’ Children’s Bureau (2010), none of the 50 states, Puerto Rico, and the District of Columbia were “in substantial conformity” in meeting the well-being outcome for the physical and mental health needs of the children in their care. To address this deficiency, Connecticut nurses caring for children involved with Department of Children and Families (DCF) collaborated to establish nursing standards of practice leading to improved health services for children in care and a mechanism to readily transfer health information. Post-implementation evaluation revealed improved quality of care and the availability of enhanced health information. These endeavors have led to the recognition that nurses working in DCF venues are members of an emerging professional nursing specialty: “nursing in child welfare.”

Child and Family Services Reviews

In fulfillment of a 1994 Congressional mandate, the Administration for Children and Families (ACF) administers Federal Child and Family Service Reviews (CFSR) to identify strengths and weakness in state child welfare programs and to determine how states meet the federal mandates (Huber & Grimm, 2004). The reviews assess the state’s performance during a specified time with regard to seven child welfare outcomes in the areas of safety, permanency, well-being, and several systemic factors; and make a determination of strength, areas needing improvement, or not applicable. Based on the finding relating to these practices, the state is determined to be in substantial conformity, partial conformity, or not in conformity. The 2003 and 2004 CFSR reviews concluded that most states failed to meet the psychological and behavioral treatment needs of child abuse and neglect victims (Children’s Bureau, 2004). When children’s psychological and behavioral needs go untreated, it is difficult for children to have a safe, stable, and permanent goal (Huber & Grimm, 2004).

In 2012, 400,450 children were in the protective services of the child welfare system in the United States due to abuse or neglect (Administration for Children and Families [ACF], 2012). The Child Welfare League of America (CWLA) (2007) defines child welfare as the “collective and necessary social and familial protections and provisions that should be provided to all children and adolescents to ensure their health, education, socialization, social membership, opportunities and fair life chances” (p. 115). Additionally, child welfare is the “continuum of services...for the purpose of protecting children...providing permanency...and promoting children’s wellbeing” (CWLA, 2007, p. 115). Schor (1988) described child welfare agencies as governmental agencies that take responsibility for the health, education, and well-being of foster children while providing counseling and with a final goal of reunification with the biological family. If after an investigation it is determined that parents cannot meet the needs of the child, parental rights might be terminated, and adoption is considered. When reunion or adoption is not possible, some children remain in permanent foster care until they reach adulthood (Schor, 1988).

The term “best practice” has appeared in professional literature over the past decade as an indicator of efforts toward excellence. Research on practice outcomes has been one mechanism through which decisions regarding the achievement of excellence can be made. Another mechanism has been to gather the collective experience and wisdom of accomplished practitioners into guidelines to be used by those striving for excellence. Since 2009, a group of Connecticut nurses who provide services to Department of Children and Families (DCF) clients have pooled their experience and knowledge. This collaboration has resulted in initiatives that have assisted the emergence of heightened professional nursing consistent with “best practice” principles. This article will outline those initiatives, describe the processes used to institute the initiatives, and discuss the responses within the child welfare system, as well as identify areas for further development. Through careful analysis of the role of the nurse within this unique, non-health care setting, a new nursing specialty may be emerging: the child welfare nurse.

Child Welfare

In 2012, 400,450 children were in the protective services of the child welfare system in the United States due to abuse or neglect. These children are uniquely vulnerable and present multiple health challenges to child welfare and health professionals. According to the most recent Child and Family Services Reviews (CFSR) from the U.S. Department of Health and Human Services Administration for Children and Families’ Children’s Bureau (2010), none of the 50 states, Puerto Rico, and the District of Columbia were “in substantial conformity” in meeting the well-being outcome for the physical and mental health needs of the children in their care. To address this deficiency, Connecticut nurses caring for children involved with Department of Children and Families (DCF) collaborated to establish nursing standards of practice leading to improved health services for children in care and a mechanism to readily transfer health information. Post-implementation evaluation revealed improved quality of care and the availability of enhanced health information. These endeavors have led to the recognition that nurses working in DCF venues are members of an emerging professional nursing specialty: “nursing in child welfare.”

Anne Kiwanuka, APRN, BC, is a Clinical Nurse Director, Adolescent and Juvenile Division, State of Connecticut, Department of Children and Families, Hartford, CT.

Valerie Boyar, MA, MS, RN, is a Health Educator, Adolescent and Juvenile Division, State of Connecticut, Department of Children and Families, Hartford, CT.

Monica Jensen, MSN, RN, is a Nurse Clinical Instructor, Adolescent and Juvenile Division, State of Connecticut, Department of Children and Families, Hartford, CT.
The outcome of relevance to nursing is Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs. The CSFR reviews Outcome Well-Being 3 by examining and reviewing data from a state regarding the provisions of health care, including Early Periodic Screening Diagnosis and Treatment (EPSDT) to children in state care and placement. For the mental health of children, the CSFR reviews data available regarding the mental health needs of children in state custody or care. Reviewers assess how the state ensures that the mental health needs of the children are identified in assessments and case planning activities, and if the mental health needs of the children are being addressed through services.

In September 2010, the ACF completed the second round of CSFR reviews. Although the review showed some states met “strength” in one area, such as physical health or mental health, all 50 states, Puerto Rico, and the District of Columbia were found “not in substantial conformity” with Well Being Outcome 3 (Children’s Bureau, 2011).

Health Needs in Child Welfare

Children in the child welfare system are uniquely vulnerable and present both complex and multiple health challenges to child welfare workers and health professionals alike. Research on the health status of children in foster care consistently shows that these children are at higher risk for both chronic health problems and special health needs. The prevalence is striking:

- 30% to 60% of children in foster care have chronic health conditions (Ringstein, Casnueva, Unate, & Cross, 2008).
- 25% of those children have three or more such conditions (Ringstein et al., 2008).
- 40% and 60% of children in foster care suffer from at least one psychiatric disorder (dosReis, Zito, Safer, & Soeken, 2001).
- The prevalence of mental conditions requiring attention upon entry in foster care system ranges from 50% to 95% (Halton, Kaufman, Perez, Inkelas, & Flint, 2001).
- Children in foster care also have a high prevalence of dental problems (Szlagni, 1998).
- Both under-immunization and over-immunization due to lack of medical records are prevalent (Schor, 1988).

When behavioral, emotional, or developmental concerns are included, up to 80% have at least one chronic need that has an impact on their health (Ringstein et al., 2008). Typical chronic health problems of children in foster care include asthma, severe allergies, and neurologic problems that require ongoing evaluation and treatment (Ringstein et al. 2008). In addition, the American Academy of Pediatrics (AAP) identified that older children in foster care have higher rates of vision problems (AAP, 2005).

The higher health risk of these children stems from the same factors that bring them into the child welfare system. Injuries sustained from abuse and/or neglect is only one cause for health problems. Inadequate care for chronic illnesses, poor prenatal care, prenatal substance exposure, poverty, poor nutrition, and inconsistent health care all contribute to the development of complex and chronic health challenges that pre-date the child’s entry into foster care. (The term “foster care” is used in the literature to refer to any out-of-home care for children who cannot live with their biological parents and includes living arrangements in kinship care, non-kin foster families, and congregate care settings, such as group homes and residential programs.) Chronic health problems persist as a consequence of inadequate resources of the child’s family, limited access to health and medical services, and patterns of continuing chaos within the family (AAP, 2005).

The challenge for child welfare agencies responsible for the safety and well-being of children is to recognize the high risk for health problems and create systems of care with qualified personnel sufficient to meet these needs. The issues in child welfare that place children at risk are particularly important to pediatric nurses, who will work with children at risk due to poverty, instability, and at-risk community (Herrmann, 2008).

Nursing and Child Welfare

Nurses have long been actively involved in child welfare. In the early 20th century, public health nurses were central players in efforts to remedy the threats of infection, inadequate nutrition, and maltreatment of children living in poor, tenement neighborhoods (Ivanov & Blue, 2008). Today, nurses in almost every state continue to work with child welfare agencies to address children’s many and often complex health issues. In some states, public health nurses are “loaned” to child welfare agencies to provide nursing consultation in a case management role. Other state child welfare agencies employ nurses directly for similar case management activity. In either capacity, nurses working within child welfare systems use professional nursing skill and expertise to advance the health and well-being of the children in care.

CWLA (2007) has asserted that effective partnerships that develop, coordinate, and evaluate interventions are “necessary to ensure best outcomes for the child” (p. 22). Systems of multi-disciplinary interventions have evolved to meet the special health needs of children in foster care. These systems, however, often do not access the skills of nurses to navigate the confusing networks of child welfare, multiple caregivers, health care providers, and insurance. Halton et al. (2001), McCarthy (2002), the AAP (2005), and CWLA (2007) have identified that this fragmentation of information and care contributes greatly to the reduced health status of children in foster care.

Professional nursing best practice protocol offers an approach to collate fragmented information and create a comprehensive plan of care. The American Nurses Association (ANA) Scope and Standards of Practice defines nursing practice as “the protection, promotion, and optimization of health and abilities; the prevention of illness and injury; alleviation of suffering through the (nursing) diagnosis and treatment of human response; and advocacy in the care of individuals, families, communities, and populations” (ANA, 2004, p. 7). This holistic approach makes nursing a natural partner to child welfare in integrating children’s health needs into the overall child welfare goals of safety, permanence, and well-being. Nursing best practice, or nursing process, guides the nurse’s actions. For child welfare, the nursing process offers a framework with which to organize and collate fragmented information, formulate, and implement coordinated plans, and evaluate all in collaboration with other child welfare professionals. The nurse’s perspective, education, and best practice complement the mission of child welfare. (Please see Appendix A for a comparison of DCF Standards to ANA Scope and Standards of Practice).
Challenges

Child welfare systems present particular challenges to the process of assessing health needs and the development and implementation of plans of care. Accessing essential health information is often hampered by the children’s fragmented health care experiences, incomplete histories, and transient family life (Halfon et al., 2001; McCarthy, 2002). A lack of coordination between the health care and the child welfare system also interferes with the development of comprehensive health services for the children (Schneiderman, 2006). The American Academy of Pediatrics Task Force on Health Care for Children in Foster Care indicated that addressing children’s health needs is a struggle for social workers who are simultaneously trying to meet child welfare mandates for permanency (AAP, 2005). Research about nursing practice in child welfare has confirmed this inherent struggle. Schneiderman (2006) noted that “working within the organizational context of the child welfare agencies has proven difficult for nurses because the organizational goal of safety does not always include health” (p. 317). These potentially conflicting priorities present challenges to care planning.

Another challenge identified for nurses in a child welfare agency is that state administration often determines nurse practice boundaries within “narrowly defined case management functions” (Schneiderman, 2006, p. 319). Such practice boundaries potentially limit the scope and effectiveness of nursing intervention. Without political influence to change the structure, especially for those who are not direct employees of an agency, nurses may be unable to use their full range of professional skills because of administration policy and procedure barriers. Schneiderman (2006) promoted the nurse’s role in improving foster children’s health by explaining that nurses in child welfare understand the system’s challenges to the development and coordination of care, and that nurses are “integral to optimum coordination” (p. 321).

Recent research by the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) recommended that nurses’ skill and expertise be maximized in all practice settings. The Future of Nursing, a seminal research brief issued by the RWJF and IOM in 2010, strongly recommended that nurses be allowed to “practice to the full extent of their education and training” (IOM, 2010, p. 2). If nurses within child welfare could actively practice to their fullest capacity, the health and wellbeing of the children in care would benefit from the unique expertise and approach that nurses bring to their work.

The Connecticut Department of Children And Families (DCF) Story

In January 2011, approximately 4,792 children were in placement with the Connecticut Department of Children and Families (DCF) (excluding children involved in DCF who are not in DCF placements). Approximately half of the children were between the ages of 12 and 18 years. The next largest group (29%) were children 0 to 5 years of age. Children 6 to 11 years of age made up 17% of the group; the remaining 4% were over 18 years of age. Half of the children lived in DCF foster homes, 15% in relative care, and the remainder in DCF facilities, group homes, independent living arrangements, medical facilities, residential facilities, or short-term shelters (State of Connecticut, Department of Children’s Health, n.d.).

The majority of children moved by DCF to living quarters other than their birth home are removed through a “96-hour hold.” This is a legal action taken to place the child in protective custody for up to 96 hours. As many as 43% of children removed to protective custody in the “96-hour hold” are ordered by the court. A small percentage, about 3%, are the result of voluntary actions by the child’s legal caretakers who request services for the child and the family from DCF.

Disrupted communication among various care providers during the removal and placement process can easily lead to a health need for any child being unattended. Establishing protocols and development of collegial rapport with care providers is essential for successful management of the health needs of these children. Being able to meet children’s health needs immediately after placement becomes complicated by multiple actors and modes of communication. Failure to meet a child’s health needs stems from the failure to develop necessary rapport and effective communication among care providers.

Contributions of DCF and Private Provider Nurses

Over 130 registered nurses, licensed practical nurses, and advanced practice registered nurses practice within various divisions of DCF. Nurses in DCF partner with their non-medical colleagues to provide the guidance and support necessary to meet children’s health needs through education, interpretation, and care coordination. DCF nurses actively participate in individual case management and in agency systems development. They offer a link to community health providers to ensure comprehensive care and continuity. Nurses who work in over 120 DCF licensed, private provider group homes, shelters, and residential programs (private provider nurses) are also vital players in meeting the health care needs of the vulnerable children in their programs. These nurses are actively engaged in assessing children’s needs, accessing care in collaboration with DCF and community providers, and collecting important health information that becomes part of a child’s comprehensive health record. Private provider nurses, DCF-area office nurses, Central Office nurses, and DCF-operated facility nurses practice within a unique, non-medical environment. The collaborative spirit that exists among these nurses caring for the children in DCF has resulted in better outcomes for children. Connecticut child welfare nurses’ roles are similar to their counterpart public health nurses in California whose “role activities are directed to the needs of an individual child as well as to the system as a whole through assessing strengths, needs, and identifying problems, developing and implementing a plan of action, and evaluating the effects of those actions” (California Department of Health Services, Children’s Medical Services Branch, 1999, p. 47).

Positive Outcomes Of Connecticut Nurse Collaboration

Multi-level communications, multi-discipline decision-making, and the establishment of professional scope and standards of practice have all contributed to emerging nursing best practice in child welfare in Connecticut. The collaboration of Connecticut nurses caring for children involved with DCF has lead to improved health services for children in care.

DCF nursing standards and exit outcome #15. In recent years, Federal oversight has prompted DCF to iden-
tify specific outcome goals for children and families receiving services. Outcome #15 specifically requires the agency to measure and document efforts in meeting children’s health care needs and in improving their health and well-being while in care (see Figure 1). As part of DCF’s response, a group of nurses and physicians employed by DCF convened to design a uniform framework by which professional nursing practice throughout all DCF-licensed, congregate-care facilities could be measured and enhanced. The 2008 DCF nursing standards defined a standardized model for performance consistent with the American Nurses Association’s (ANA) standards of nursing practice. Presented as a guide for DCF provider nurses in safe and effective use of current nursing best practice protocols, the DCF nursing standards were intended to facilitate meeting health needs of DCF children and youth in congregate-care facilities. Central to those protocols was the nursing process: assessment, planning, implementation, and evaluation.

Prior to the implementation of the DCF nursing standards, all DCF provider nurses were trained regarding the new DCF nursing standards; additionally, senior leadership at DCF agreed to make the implementation of the nursing standards part of the provider-licensing requirement in the state. In October 2008, the DCF nursing standards were implemented, and in November 2008, DCF began an analysis of responses within the provider-nurse community. General nursing practices as well as management of medication administration systems were examined. At that time, approximately 2,700 DCF children and youth were residents in 120 congregate-care facilities licensed by DCF. An APRN in the Central Office collaborated and consulted with the DCF Licensing Unit for onsite visits to residential treatment facilities, group homes, shelters, and safe homes. The APRN designed a monitoring tool to gather data reviewing nursing, medical, and medication administration practices.

Subsequent to dissemination of the DCF nursing standards to over 100 provider nurses, a mechanism to measure the responses was designed and implemented. A tool was created to be consistent with the Statistical Package for Social Sciences (SPSS) (IBM, 2007) data analysis system available to DCF, which would capture data for further analysis. The tool referenced “DCF Regulations for Operations of Child-Caring Agencies and Facilities, Reg.17a-145-93, Medical, Dental and Nursing Care, DCF Standards and Resolution.” Individual residents’ records, facility operations, and review of each facility’s medical policies were examined and rated. Three categories of information were assessed: 1) need for service, 2) medical services offered, and 3) ratings for each provider facility regarding the records reviewed.

Each visit was time-consuming and thorough. From December 2008 through October 2009, approximately 57 facilities were fully reviewed. See Tables 1 and 2 for data recovered by these onsite reviews. Analysis of data revealed that 1) the quality of nursing care for DCF children in facilities improved with implementation of the nursing standards, and 2) nurses working in the private provider facilities were developing and using enhanced information regarding a child’s health (such as data collection, nursing care plans, quarterly nursing reports, and compiling of immunization records). Interviews with the participating nurses revealed another positive outcome since the introduction of the 2008 DCF nursing standards; nurses reported increased job satisfaction because they were now better able to meet the standards of their own profession.

Enhanced communication. Although data were encouraging, more information was needed to truly affect change in how the health needs of children in DCF were managed. A group of private provider nurses approached DCF with the goal of increasing communication with other DCF nurses and DCF stakeholders. These nurses believed it was important to communicate more collaboratively with a multidisciplinary approach. A decision was made to further the process throughout the entire nursing community serving DCF children and youth. In an effort to create a keen awareness that all nurses serving DCF youth were members of the same community (for example, to remove the effect of separate “silos”), a Nursing Steering Committee was formed. Membership on the committee represented nurses working in every venue: in the private provider facilities, in the DCF Area Offices, in DCF-operated facilities, and with the nurses in the Central Office.

The first task for the new Steering Committee was to design and test a mechanism by which the barriers to nurse-to-nurse communication within the child welfare system could be overcome. Because DCF was already using an electronic system for communication (called LINK), and because provider nurses contribute to a rich depository of health information on children in placement, the Committee decided to create a form that could easily become part of the LINK health record for every child in placement. Collaboration with the DCF Information Systems Unit was necessary regarding the layout of the form. Once the myriad glitches had been resolved, members of the Steering Committee took the form back to their worksites for testing. Four private provider facilities agreed to conduct a pilot study with the form, now called the Congregate Care Quarterly Nursing Report, DCF Immunization Record, and Congregate Care Nursing Discharge Report. The Congregate Care Quarterly Nursing Report and Immunization Records are an important beginning step for DCF private provider nursing in meeting CWLA/AAP Standards for Health Services to Children in Out-of-Home Placement. These forms, along with DCF nursing standards, allow nurses to assess health needs, health services, data collection, retrieval of data through DCF LINK system, quality assurance activities, organization and administration of health services, coordination of state and local agencies, and training of caretaker and case workers.

Simultaneously, the APRN conducted continuous monitoring of the Congregate Care Quarterly Nursing Report because the report appeared in a child’s LINK record. Some nurses working in the Area Offices began to use the form in their own work as well. In addition, other members of the health care team within the department began to request copies of the Congregate Care Quarterly Nursing Report because they discovered the relevance of the nurses’ information to their interventions. Several child psychiatrists asked that they receive the reports.

The second task addressed by the Steering Committee was to establish a way to inform all nurses caring for children in DCF about the value of their contributions and about the Committee’s initiatives. The Committee decided to offer quarterly events focusing on best practice in nursing. Collaboration with DCF units (such as licensing, risk management, program evaluation, special investigation) and those serving as leaders for specified DCF programs provided
# Figure 1. Positive Outcomes for Children

| 1. Commencement of Investigation | At least 90% of all reports must be commenced in the same calendar day, 24 hours or 72 hours depending on response time designation. |
| 2. Completion of Investigation | At least 85% of reports shall have their investigation completed within 45 calendar days of acceptance by Hotline. |
| 3. Treatment Plans | At least 90% of cases shall have treatment plans that are clinically appropriate, individualized, developed with family and community members, and approved within 60 days of opening in treatment or a child's placement out of home. |
| 4. Search for Relatives | For at least 85% of children in placement, DCF shall conduct searches for relatives, extended or informal networks, friends, family, former foster parents, or other significant persons known to the child. Excludes voluntary cases. |
| 5. Repeat Maltreatment | No more than 7% of children who are victims of substantiated maltreatment during a 6-month period shall be the substantiated victims of additional maltreatment within 6 months. |
| 6. Maltreatment of Children in Out of Home Care | No more than 2% of children in out-of-home care shall be the victims of substantiated maltreatment by a substitute caregiver while in out-of-home care. |
| 7. Reunification | At least 60% of children who are reunified with parents/guardians shall be reunified within 12 months of their most recent removal from home. Excludes voluntary cases. |
| 8. Adoption | At least 32% of children who are adopted shall have their adoptions finalized within 24 months of their most recent removal from home. Excludes voluntary cases. |
| 9. Transfer of Guardianship | At least 70% of all children whose custody is legally transferred shall have their guardianship transferred within 24 months of their most recent removal from home. Excludes voluntary cases. |
| 10. Sibling Placement | At least 95% of siblings currently in or entering out-of-home placement shall be placed together unless there are documented clinical reasons for separate placements. Excludes voluntary cases and children for whom termination of parental rights (TPR) has been granted. |
| 11. Re-Entry into DCF Custody | No more than 7% of all children entering DCF custody shall re-enter care within 12 months of a prior out-of-home placement. Excludes voluntary cases. |
| 12. Multiple Placements | At least 85% of children in DCF custody shall experience no more than 3 placements during any 12 month period, excluding respite, hospitalizations lasting less than 7 days, run-aways, home visits, and Connecticut Juvenile Training School (CJTS). Excludes voluntary cases. |
| 13. Foster Parent Training | Foster parents shall be offered 45 hours of post-licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. However, relative, special study and independently licensed foster parents require 9 hours pre-service. |
| 14. Placement Within Licensed Capacity | At least 96% of all children placed in foster homes shall be in foster homes operating within their licensed capacity, except when necessary to accommodate siblings. |
| 15. Needs Met | At least 80% of all families and children shall have their medical, dental, mental health, and other services needs provided as specified in the most recent treatment plan. |
| 16. Worker-Child Visitation Out-of-Home | All children must be seen quarterly by a DCF social worker. At least 85% of children in out-of-home care shall be visited at least once a monthly. Private agency social worker visits may count for monthly visits if the content of the visit is documented in LINK. |
| 17. Worker-Child Visitation, In Home | At least 85% of all in-home cases shall have a social worker visit at least twice a month. All visits must be documented in LINK. |
| 18. Case Load Standards | No DCF social worker’s caseload shall exceed the standard for more than 30 days. |
| 19. Residential Reduction | No more than 11% of the total number of children in out-of-home care shall be in residential placements. Excludes voluntary cases. |
| 20. Discharge Measure | At least 85% of children age 18 or older shall achieve specified educational/vocational goals prior to discharge (such as high school diploma, full-time employment). |
| 21. Discharge Children with Mental Deficiencies | DCF shall submit a written discharge plan to the Department of Mental Health and Additional Services (DMHAS) or the Department of Developmental Disabilities (DDS) for all committed or dually committed children who are mentally ill or mentally challenged and require adult services within 180 days prior to anticipated discharge date. |
| 22. Multi-Disciplinary Exams (MDE) | All children entering DCF custody must have a multidisciplinary exam (MDE). At least 85% of these must have had their MDE completed within 30 days of placement. |

Source: State of Connecticut, Department of Children's Health, n.d.
### Table 1.
**Need for Services ($N = 47$)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>Percentage</th>
<th>No</th>
<th>Percentage</th>
<th>Partial</th>
<th>Percentage</th>
<th>Not Applicable</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td></td>
<td>n</td>
<td></td>
<td>n</td>
<td></td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>Reason for placement stated</td>
<td>38</td>
<td>80.9%</td>
<td>8</td>
<td>17.0%</td>
<td>1</td>
<td>2.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial history</td>
<td>23</td>
<td>48.9%</td>
<td>13</td>
<td>27.7%</td>
<td>5</td>
<td>10.6%</td>
<td>6</td>
<td>12.8%</td>
</tr>
<tr>
<td>Comprehensive psychiatric evaluation</td>
<td>12</td>
<td>25.5%</td>
<td>17</td>
<td>36.2%</td>
<td>16</td>
<td>34.0%</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Evaluation completed in 30 days</td>
<td>27</td>
<td>57.4%</td>
<td>11</td>
<td>23.4%</td>
<td>5</td>
<td>10.6%</td>
<td>4</td>
<td>8.5%</td>
</tr>
<tr>
<td>Justification medication risks/benefits</td>
<td>25</td>
<td>53.2%</td>
<td>11</td>
<td>23.4%</td>
<td>9</td>
<td>19.1%</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Treatment recommendation complete</td>
<td>26</td>
<td>55.3%</td>
<td>9</td>
<td>19.1%</td>
<td>8</td>
<td>17.0%</td>
<td>4</td>
<td>8.5%</td>
</tr>
<tr>
<td>Mental status examination</td>
<td>31</td>
<td>66.0%</td>
<td>11</td>
<td>23.4%</td>
<td>3</td>
<td>6.4%</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>DSM IV admission</td>
<td>38</td>
<td>80.9%</td>
<td>5</td>
<td>10.6%</td>
<td>2</td>
<td>4.3%</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Current DSM IV</td>
<td>38</td>
<td>80.9%</td>
<td>7</td>
<td>14.9%</td>
<td>2</td>
<td>4.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological examination complete</td>
<td>26</td>
<td>55.3%</td>
<td>2</td>
<td>4.3%</td>
<td>19</td>
<td>40.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional assessment – IQ less than 68</td>
<td>2</td>
<td>4.3%</td>
<td></td>
<td></td>
<td>45</td>
<td>95.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Researcher’s comment – The “partial” response represented another important variable. For example, sometimes the partial response meant that the provider(s) did not clearly state conditions that necessitated a placement for a child, a psychosocial history was not completed within the 30 days from admission, a psychiatric evaluation was not comprehensive, or a mental status exam did not document a systematic observation. “Partial” could also mean that of four records reviewed, only two had evidence of mental exam, or DSM-IV diagnosis.

### Table 2.
**Medical Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Valid Cases = 47</th>
<th>Percentage of Valid Cases</th>
<th>Valid Cases = 42</th>
<th>Percentage of Valid Cases</th>
<th>Partial</th>
<th>Percentage of Valid Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assessment within 72 hours</td>
<td>29</td>
<td>61.7%</td>
<td>13</td>
<td>31.0%</td>
<td>3</td>
<td>7.9%</td>
</tr>
<tr>
<td>Nursing care plan within 30 days</td>
<td>17</td>
<td>36.2%</td>
<td>17</td>
<td>40.5%</td>
<td>12</td>
<td>31.6%</td>
</tr>
<tr>
<td>Nursing participates in discharge</td>
<td>24</td>
<td>51.1%</td>
<td>20</td>
<td>47.6%</td>
<td>3</td>
<td>7.9%</td>
</tr>
<tr>
<td>DCF medication monitoring</td>
<td>25</td>
<td>53.2%</td>
<td>9</td>
<td>21.4%</td>
<td>11</td>
<td>28.9%</td>
</tr>
<tr>
<td>Physical examination within the year</td>
<td>38</td>
<td>80.9%</td>
<td>5</td>
<td>11.9%</td>
<td>4</td>
<td>10.5%</td>
</tr>
<tr>
<td>Physical examination meets early periodic screening diagnosis and treatment</td>
<td>29</td>
<td>61.7%</td>
<td>12</td>
<td>28.6%</td>
<td>6</td>
<td>15.8%</td>
</tr>
<tr>
<td>Ongoing medical monitoring</td>
<td>35</td>
<td>74.5%</td>
<td>2</td>
<td>4.8%</td>
<td>10</td>
<td>26.3%</td>
</tr>
<tr>
<td>Routine eye care within 1 year</td>
<td>31</td>
<td>66.0%</td>
<td>10</td>
<td>23.8%</td>
<td>6</td>
<td>15.8%</td>
</tr>
<tr>
<td>Dental care within 6 months</td>
<td>35</td>
<td>74.5%</td>
<td>7</td>
<td>16.7%</td>
<td>5</td>
<td>13.2%</td>
</tr>
<tr>
<td>Immunization records on file</td>
<td>26</td>
<td>55.3%</td>
<td>7</td>
<td>16.7%</td>
<td>14</td>
<td>36.8%</td>
</tr>
<tr>
<td>Nursing progress notes on file</td>
<td>35</td>
<td>74.5%</td>
<td>9</td>
<td>21.4%</td>
<td>3</td>
<td>7.9%</td>
</tr>
<tr>
<td>Nursing care plan included in treatment plan</td>
<td>7</td>
<td>14.9%</td>
<td>33</td>
<td>78.6%</td>
<td>4</td>
<td>10.5%</td>
</tr>
<tr>
<td>MD and psychiatric notes complete</td>
<td>25</td>
<td>53.2%</td>
<td>10</td>
<td>23.8%</td>
<td>12</td>
<td>31.6%</td>
</tr>
<tr>
<td>Standing orders signed by nurse/MD</td>
<td>43</td>
<td>91.5%</td>
<td>4</td>
<td>9.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication administration record</td>
<td>40</td>
<td>85.1%</td>
<td>3</td>
<td>7.1%</td>
<td>4</td>
<td>10.5%</td>
</tr>
<tr>
<td>Permission to treat signed by guardian</td>
<td>38</td>
<td>80.9%</td>
<td>5</td>
<td>11.9%</td>
<td>4</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

**Note:** Researcher’s Comment – It is important to remember the implications for the child when a response in the tables above was either “no” or “partial.” In both cases, the response means the child did not receive needed services.
insight into barriers that nurses face. Those insights became learning points developed for presentation during the Nursing Best Practice Seminars.

Four Nurse Best Practice Seminars were held during the first year (2010). Attendance ranged from 50 to 70 nurses. Of that number, 60% were nurses from the DCF-licensed private provider facilities. The remaining 40% were nurses representing each DCF nursing venue. Topics included introduction to the Congregate Care Quarterly Nursing Report, along with testimony from those nurses participating in the pilot study. Attendees were encouraged to use the form in their own facilities and to bring feedback to subsequent seminars. Speakers from the Connecticut Department of Public Health presented information about accessing immunization information for children in placement. A presentation from the DCF Risk Management Unit reviewed the frequency of medication errors in congregate-care settings. Updates on the DCF Medication Administration Program were offered with the release of a newly revised Medication Administration Handbook, and information was presented about accessing the DCF Health Advocate for assistance with obtaining health insurance for each child. Clinical topics included a focus on the high vulnerability of children in the child welfare system to sex trafficking.

Responses to these four Nursing Best Practice Seminars have been strongly enthusiastic. Participants appreciated the opportunity to network with colleagues facing similar barriers to health services for the children in their care. They have identified topics for future seminars and have urged the organizers to create novel strategies for ongoing networking opportunities. This coalition of nurses experienced encouragement and stimulation derived from sharing the challenges they face and the strategies their colleagues have found useful. The nurses as a group have a new sense of commonality and identity as “the community of nurses in child welfare.”

An additional initiative emerging from the nursing group at the DCF Central Office was the preparation of a manual to orient nurses working in the DCF-licensed, private-provider, congregate-care facilities to the complexities of working with the Department of Children and Families. The orientation manual committee was composed of nurses from the private facilities and from the DCF Central Office. Once again, collaboration allowed a synthesis of ideas to formulate content relevant to both groups. The role of private facilities’ nurses was identified in the context of membership in a community of nurses serving DCF children and reflective of the 2008 DCF nursing standards. This document, “Orientation Manual: Pathways to Collaboration,” has been made available electronically on the DCF nursing Web site.

Future Directions

Although the group of Central Office nurses and the Nursing Steering Committee are gratified with their initial efforts to enhance nurse-to-nurse communication on behalf of DCF children and their continuing health needs, the group recognizes they have only begun. There are many tasks yet to address. Among them are the following:

- Develop research methodologies to measure the impact of nursing interventions of the health status of DCF clients.
- Expand collaboration between private provider nurses and DCF nurses.
- Develop curriculum and present training for DCF social workers on health needs.
- Provide ongoing continuous quality improvement activities to evaluate how well the system is working.
- Expand nursing initiatives for new forms of collaboration with other health professionals.
- Collaborate with the DCF Information Systems Unit to update electronic routes for communication that meet the Health Insurance Portability and Accountability Act (HIPAA) requirements between various health providers.
- Continue the Nursing Best Practice Seminars with particular attention to novel opportunities for inter-nurse networking.
- Continue to develop and implement a nursing best practice model.
- Adopt evidence-based assessment tools.
- Encourage widespread use of the Congregate Care Quarterly Nursing Report and Immunization record with ongoing adjustments to improve functionality and accessibility.
- Provide feedback sessions after each Nursing Best Practice Seminar regarding implementation of the orientation manual.
- Establish a quarterly session for all newly hired nurses to acquaint them with the Nursing Orientation Manual.

Reflection

Nurses caring for children involved with DCF share a common concern that these vulnerable children be served well. Similarly, these nurses also experience shared frustrations about the challenges in child welfare to meeting children’s health care needs. Although there is sufficient motivation to tackle these barriers from the vantage of professional nursing, that motivation has never been all that was necessary. In retrospect, the dynamics of organizations, the phenomenon of change within a system, and rules from the field of organizational change have helped channel the strong desire for change experienced by this community of nurses. The basics included identifying a person who could serve as a “champion” for the cause who could meet with administrative leaders and speak from sound statistical foundations about the benefits of nursing interventions for the system. Key stakeholders had to be personally involved in seeking solutions and creating new initiatives. The best practice initiatives were supported by the framework of nursing process as endorsed by the national professional organization, ANA. The new tools had to ensure collaboration and improved health-related decision making among its users while integrating the dynamics of a child welfare system.

In the past 15 to 20 years, nursing practice specialties have evolved that reflect unique patient populations or settings for nursing practice and entire new cultures for professional nursing. Board certification is available to nurses in a host of specialties, including case management, school nursing, and community health. APRNs and pediatric nurse practitioners (PNPs) are primary care practitioners. The certificed holistic nurse integrates holistic healing practice with traditional health care. As these new specialties and roles evolve, efforts to identify how to achieve excellence must also evolve. Through the Connecticut nurses’ endeavors, a recognition has emerged that nurses working in the various DCF venues are in reality members of a newly evolving specialty in professional nursing: “nursing in child welfare.”
Appendix A.

The Connecticut Department of Children and Families Nursing (DCF) Standards are consistent with ANA Nursing Scope and Standards of Practice.

ANA Standard I: Assessment – The registered nurse collects comprehensive data pertinent to the patient’s health or the situation.

In a Connecticut DCF-licensed facility, the registered nurse will assess the individual’s health status. This includes both the deliberate and systematic collection of data to determine an individual’s current health status and to evaluate his or her present and past coping pattern, data analysis, and problem identification. A nursing admission assessment needs to be completed within 72 hours. Connecticut DCF has developed a nursing admission form for provider nurses to use. A registered nurse completes an assessment whenever there is a change in an individual’s health status. The registered nurse completes an assessment on a quarterly basis or frequently as determined by the registered nurse.

ANA Standard II: Nursing Diagnosis – The registered nurse analyzes the assessment data to determine diagnosis or issues.

The nurse analyzes data using a scientific approach, principles, and professional judgment. The nurse collaborates with other disciplines to determine the appropriate nursing diagnosis for the individual and population aggregate. The rationale for this approach rests in the nurse’s responsibility for recognition and identification of human response to actual or potential health problems that are prevalent in abused, neglected children and their families.

In a DCF-licensed facility, the nurse develops a nursing diagnosis and begins developing a nursing care plan based on the data collected. The nursing diagnosis will include a Diagnostic Statement (NANDA).

ANA Standard III: Outcomes Identification – The registered nurse identifies expected outcomes for a plan individualized to the patient or situation.

In Connecticut DCF, the registered nurse is responsible to identify those expected outcomes that support the health and development of the child and assist in the development of an appropriate health plan.

The registered nurse working in child protective agency accomplishes this by working with social worker(s), therapist(s), psychiatrist(s), pediatrician(s), and other team members to develop specific goals and interventions unique to the infant/child, caregiver, or families to meet the needs. The nurse must work with other team players to ensure the child’s health plan is used to guide/monitor risk factors, therapeutic interventions, and progress toward the desired health outcome. In a DCF-licensed facility, the nurse develops expected outcome, such as Nursing Outcome Classification (NOC).

ANA Standard IV: Planning – The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

In Connecticut DCF, the registered nurse working in a child protective agency develops a plan considering patient characteristics. The nurse identifies strategies within the plan that address each of the identified nursing diagnoses, including strategies for promotion or restoration of health. In a DCF-licensed facility, a nursing care plan needs to be completed within 30 days of the child being admitted.

ANA Standard V: Implementation – The registered nurse implements an identified plan.

In partnership with the team, the nurse working in a child protective agency implements interventions identified in the health plan that promote, maintain, or restore health and development. In a DCF-licensed facility, the licensed nurse (LPN/RN) intervenes as guided by the nursing care plan to implement nursing actions that promote, maintain or restore, prevent illness, and affect rehabilitation.

ANA Standard VI: Evaluation – The registered nurse evaluates progress toward attainment of outcomes.

The registered nurse working in a child protective agency evaluates the progress of the system, child, and caregivers toward attainment of the identified health goals.

The need to continually consult the dynamic of the data, nursing diagnosis, and care plans into identified individual and aggregate health care goals.

In a DCF-licensed facility, the registered nurse evaluates the individual response to the nursing care plan and interventions to revise the database, nursing assessment, and nursing care plan. On a quarterly basis, the registered nurse will prepare and provide a summary of the individual’s interventions and outcomes with the team; this is done by the Congregate Care Quarterly Nursing Report.

Standards of Professional Performance Practice

ANA Standard VII: Quality of Practice – The registered nurse systematically enhances the quality and effectiveness of nursing practice.

In Connecticut DCF, there is accountability of ensuring that children in child protective care are receiving quality nursing care.

ANA Standard VIII: Education – The registered nurse attains knowledge and competency that reflects current nursing practice.

Nurses working in Connecticut DCF need to continually maintain appropriate knowledge and skills to effectively implement the nursing standard of practice and specialty guidelines. This has been accomplished through ongoing quarterly DCF Nursing Best Practice Seminars; nursing contact hours are offered at some of the seminars.

ANA Standard IX: Professional Practice Evaluation – The registered nurse evaluates one’s own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.

Nurses working in a child protective agency need to participate in self and program evaluation.

continues on next page
Appendix A. (continued)


ANA Standard X: Collegiality – The registered nurse interacts with and contributes to the professional development of peers and colleagues.

Nurses contribute to professional development of peers, colleagues, team members and community providers. Connecticut DCF nurses have accomplished this through Best Practice Seminars, monthly Nursing Steering Committee meetings, development of the Nursing Orientation Manual, training, and development of the Connecticut DCF Nursing Quarterly Report, Immunization Record, and DCF Nursing Discharge Summary.

ANA Section XI: Collaboration – The registered nurse collaborates with patient, family, and others in the conduct of nursing practice.

Collaboration with the team facilitates the provision of health care services for children receiving protective services. Connecticut DCF nurses collaborate by meeting monthly with other nurses taking care of children in protective care.

ANA Standard XII: Ethics – The registered nurse integrates ethical provisions in all areas of practice.

Ensure that health decisions and actions on behalf of children in child protective services are determined in an ethical manner. Connecticut DCF has a Medical Review Board and Central Medication Consent Unit that assures that ethical decisions are being made.

References


Additional Reading