

NEWBORN CRISIS ASSESSMENT TOOL (NCAT) INSTRUCTIONS

PURPOSE:

Newborn Crisis Assessment referrals result from a physician or health care provider having serious concerns about the infant being sent home to a potentially dangerous situation. Many times a drug-involved mother may continue using drugs, so an assessment of the home situation is needed prior to, or at the time the infant is released from the hospital. There may also be other non-drug related situations in which a physician/health care provider is concerned about releasing a newborn infant from the hospital. These generally involve an infant with medical problems when hospital personnel have serious concerns about risk to the child upon release from the hospital.

The Newborn Crisis Assessment Tool (NCAT) is to be used to assess the circumstances surrounding the newborn in crisis. The NCAT is to be used to document the response to the newborn crisis assessment referral.

NUMBER OF COPIES AND DISTRIBUTION:

One NCAT is completed when responding to the Newborn Crisis Assessment Referral (drug and non-drug involved), which includes the Safety Assessment (CD-17).

INSTRUCTIONS FOR COMPLETION:

Case Data:

Referral Number: Enter the referral number assigned by CANHU on the CA/N 1.

County: Enter the County of the worker completing the Infant Crisis Assessment.

Drug-exposed: Mark an "x" if the infant born exposed to drugs/alcohol.

Non-Drug-Exposed: Mark an "x" if the infant was not born exposed to drug/alcohol.

Case Name: Enter the case name.

Children's Service Worker: Enter the worker completing the assessment.

Child's Data:

Infant's Name: Enter the name of the infant for whom the Assessment tool is completed.

DOB: Enter the infant's date of birth.

Birth Weight: Enter the infant's weight at birth, in pounds and ounces.

Gestational Age: Enter the neonatal developmental stage (the total number of months old the infant is) as determined by the Infant's Pediatrician.

Discharge Date: Enter the infant's date of expected/actual discharge from the hospital.

Parents:

Parent 1's Name: Enter Parent 1's; Name/Date of Birth/Address/DCN/Phone number.

Parent 2's Name: Enter parent 2's; Name/Date of Birth/Address/DCN/Phone number.

Siblings:

Child's Name: Enter the name of each of the siblings of the child who the assessment is being completed on. Also enter the child's DCN and birth date.

Other Household Members/Significant Others:

Name: Enter the name of a household member or significant other to the child being assessed or to the family. Also include the person's birth date and relationship to the child.

Medical Documentation:

Hospital: Enter the name of the hospital where the infant was born.

Name of Physician: Enter the name of the mother's doctor.

Phone: Enter the phone number of the mother's physician.

Contact Person: Enter the name of the hospital staff designated contact person for Newborn Crisis Assessment Referrals.

Phone/Fax #: Enter the contact person's phone and facsimile number.

Toxicology at Birth: Enter drug/alcohol results on infant and mother. Attach copy of toxicology results to the assessment packet. In cases where toxicology is not conducted, provide a copy of medical documentation of signs/symptoms of drug/alcohol use/withdrawal as observed at birth by hospital staff.

CD-17 SAFETY ASSESSMENT

The purpose of the safety assessment is to help assess whether any children are in ***immediate danger of serious physical harm*** by assessing the presence or absence of safety factors that are a threats to the child(ren) immediate safety. When the finding of the CD-17 is "safe" and CD-18 Safety plan is not required. If the finding is "unsafe", the worker shall develop a CD-18 Safety Plan with the family to control the identified threat of danger and lack of caregiver protective Capacity.

(See forms instructions for the CD-17 and CD-18)

FACTORS:

Check all indicators that apply under each factor. Enter “N/A” for indicators that do not apply. Place a “?” by all indicators you are unable to assess.

Signs of Withdrawal Infant or Other Medical Complications: Is there medical documentation on withdrawal or medical complications associated with the exposure of drugs? Attach a copy of the medical records pertaining to documented complications.

Prenatal Care: Consider the following when addressing prenatal care: 1) Did the mother obtain prenatal care? 2) What was her drug usage during the pregnancy? Physician’s name, if different from above and additional prenatal care information.

Prenatal Appointments: Enter prenatal drug use testing results (if available) in the spaces provided. Include the following in the space provided: specific dates or frequency of prenatal appointments, if information is provided.

Pregnancy Complications: Were there any complications during this pregnancy (including self-reported and medically documented)? Include any additional information pertaining to pregnancy complications in space provided.

Physical, Emotional and Intellectual Functioning: Are there concerns related to the caregiver(s)’ physical, emotional and intellectual functioning (includes self-reported, observed behaviors, and medically documented)? Include any additional information pertaining to physical and mental functioning in space provided.

Attachment and Bonding: Are there any concerns about the caregiver(s)’ attachment or bonding with the infant (including self-report and observed behaviors)? Include any additional information pertaining to attachment and bonding in space provided.

Prior History of Abuse or Neglect: Consider the following when addressing prior history: Has the Children’s Division been involved with caregiver(s)’ before? Has there been any other drug-exposed children? Is there a current case open? Is there a history of child abuse/neglect on other members in the household? Attach a copy of ANUM screen, if applicable.

Parenting Skills/Sibling Assessment: Identify the caregiver(s)’ knowledge and ability to care for the infant and other children (if applicable).

Planning/Preparation for Infant’s Birth/Hospital Discharge: Document caregiver(s)’ readiness for the infant’s arrival.

Behavior Associated with Drug and Alcohol Use: Provide information on documented behaviors associated with drug/alcohol use as observed in the hospital as well as additional information obtained from mother/family/friends.

Special Health Care Needs: Have there been special health care needs identified and recommended by the medical staff? Have discharge plans been made and referrals to home health care providers arranged?

Strength of Family Supports: Identify key family members that may serve as positive support.

Environmental Condition of Home: Document conditions of the home where the child would be residing.

Domestic Violence: Address domestic violence issues.

Other Strengths or Concerns: Enter any additional strengths, issues or concerns not noted elsewhere.

Summation of Service Plans, Concerns, and Recommendations:

Summarize the general recommendations for the family, given the assessed strengths and needs identified. Recommendations may include closing the case or opening a case for Family-Centered Services. In some cases children are removed from the family in origin and placed in out-of-home care.

A case should not be closed if there was an “unsafe” finding on the safety assessment until the safety assessment is conducted and the finding is no longer “unsafe”.

INSTRUCTIONS FOR RETENTION:

The NCAT is filed in the family assessment file.

MEMORANDA HISTORY:

CD06-34; CD11-86; CD12-68; CD13-01