Ministry of Children and Family Development

Kw'umut Lelum Child and Family Services

(IKB, IKI, IKJ, IKK, IKL, IKQ, IKU)

PRACTICE AUDIT REPORT

Report Completed: August 2022

Office of the Provincial Director of Child Welfare and Aboriginal Services
Quality Assurance Branch
Field Work Completed January 2022

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1. PURPOSE

The purpose of the audit is to improve and support child and youth service, resource, and child safety/family service practice. Through the review of samples of records, the audit provides a measure of the quality of documentation during the audit timeframes (see below for dates), confirms good practice, and identifies areas where practice requires strengthening. Practice is confirmed through documentation in the physical and electronic records and from information gathered in interviews with the delegated staff. This is the fifth audit for Kw'umut Lelum Child and Family Services (KLCFS). The last audit was completed in April 2017.

The specific purposes of the audit are to:

- further the development of practice
- assess achievement of key components of the Child Protection Response Model set out in Chapter 3 of the Child Safety and Family Support Policies and the Aboriginal Operational and Practice Standards and Indicators (AOPSI) as it relates to resource and guardianship
- determine the current level of practice across a sample of records
- identify barriers to providing an adequate level of service
- assist in identifying training needs
- provide information for use in updating and/or amending practice standards or policy

2. METHODOLOGY

There were three quality assurance practice analysts from MCFD's Office of the Provincial Director of Child Welfare and Aboriginal Services Division who conducted the practice audit. The MCFD Share Point site was used to collect the data for the child and youth service, resource, and child safety/family service practice, to generate program compliance tables (see Findings and Analysis section) and a compliance report for each record audited. Interviews with the delegated staff were conducted by phone after the data collection was completed.

The population and sample sizes for all the record types used in the audit were extracted from the Integrated Case Management (ICM) database. The sample sizes provide a confidence level of 90% with a +/- 10% margin of error. However, some of the standards used for the audit are only applicable to a reduced number of the records that were selected and so the results obtained for these standards have a decreased confidence level and an increased margin of error. The following are the sample sizes for the eight record types:

Record Types	Population Sizes	Sample Sizes
Open child service cases	90	39
Closed child service cases	46	28
Open and closed resource cases	38	25
Open family service cases	49	29
Closed family service cases	26	19
Closed Service requests	50	29
Closed Memos	30	21
Closed Incidents	136	46

The above samples were randomly drawn from populations with the following parameters:

1. Open child service: CS records open in ICM on July 31, 2021 and managed by the agency for at least six months (continuously) with the following legal categories: VCA, SNA, removal, interim order, TCO and CCO.
2. Closed child service: CS records closed in ICM between January 31, 2019 and July 31, 2021 and managed by the agency for at least six months (continuously) with the legal categories: VCA, SNA, removal, interim order, TCO and CCO.
3. Open and closed resource: RE records relating to foster homes that had children or youth in their care for at least three months between August 1, 2018 and July 31, 2021. Children or youth in care had to have one of the following placement or service types: Regular Family Care, Restricted Family Care, Level 1 Care, Level 2 Care, Level 3 Care, and First Nations Foster Home.
4. Open family service cases: FS records open in ICM on July 31, 2021 and managed by the agency for at least six months (continuously) with a service basis listed as protection.
5. Closed family service cases: FS records closed in ICM between August 1, 2020 and July 31, 2021 and managed by the agency for at least six months (continuously) with a service basis listed as protection.
6. Closed service requests: Service requests that were closed in ICM between June 1, 2020 and May 31, 2021, where the type was request service – CFS, request service – CAPP, request for family support, or youth services.
7. Closed memos: Memos that were closed in ICM between June 1, 2020 and May 31, 2021, where the type was screening and with the resolution of "No Further Action". Exclude Memos that were created in error.

8. Closed incidents: Incidents that were created after November 4, 2014, and were closed in ICM between June 1, 2020, and May 31, 2021, where the type was family development response or investigation.

The audit also determined whether Provincial Centralized Screening (PCS); Indigenous Child and Family Service Agency (ICFSA); or Service Delivery Area (SDA) completed the requirements at FS 1: Gathering Full and Detailed Information, FS 2: Conducting an Initial Record Review (IRR) and FS 3: Completing the Screening Assessment.

3. AGENCY OVERVIEW

a. Delegation

KLCFS operates under C6 delegation. This level of delegation enables the agency to provide the following services:

- Child Protection
- Out of Care Options
- Alternatives to Care/Transfer of Custody
- Temporary Custody of Children
- Guardianship of Children and Youth in Continuing Custody
- Support Services to Families including respite services to families
- Voluntary Care Agreements
- Special Needs Agreements
- Establishing Residential Resources
- Respite Services
- Extended Family Program
- Independent Living Agreements/Aging into Community Agreements

KLCFS assumed C6 child protection delegation in April 2014. The agency currently operates under a delegated services agreement from April 1, 2020 – March 31, 2023.

KLCFS also provides supports and programs to the children, youth, and families of their member Nations. While respecting Coast Salish practices and traditions, the agency offers services and programs that keep their children safe, strengthen and preserve their families, connect to their culture, and enhance their community well-being through the following services:

- Wellness and Prevention: works within the communities offering a range of opportunities such as individual counselling, group recreation activities and family education events
- 4 Seasons Cultural Program: supports children and youth across the nine communities to connect with their culture through weekly cultural programming. This program

facilitates opportunities for Kw'umut Lelum youth aged 12-18 to immerse themselves in a challenging, educational, and cultural journey integrating the "two worlds"

- 4 Seasons Early Years: enhances early childhood development and overall family health and wellness for First Nations preschool children (birth to six years old) on reserve
- Step Up: helps the youth in or from care to develop independence across 5 domains of personal effectiveness, education, housing, culture and community, and employment Step Up is a youth-driven program that is supported by the Youth Advisory Council
- Wellness and Child and Youth Care workers: works closely with the Guardianship team to ensure a strong collaborative process that promotes cohesive care planning for our children and youth in care
- Family Support workers: provide a range of services and supports like housing, alcohol and drug and mental health
- Youth Advisory Council: comprised of seven former youth in care who meet monthly with two Step Up Transition Workers. The identified values for the 2020/2021 fiscal year were family, caring, continuous improvement and communication
- Recreation Therapy: aims to support improved holistic health, quality of life and well-being through recreation and leisure-like participation

b. Demographics

KLCFS provides services to children and families in the communities of Halalt First Nation, Malexel Nation (Malahat), Lyackson First Nation, Penelakut Tribe, Ta'uubaa'asatx (Lake Cowichan), Qualicum First Nation, Snaw-Naw-As First Nation (Nanoose), Snuneymuxw First Nation, Stz'uminus First Nation (Chemainus) and to Member Nation children and families living in the urban areas of Nanaimo, Parksville/Qualicum, and Duncan.

The agency has three locations: in December 2017, the agency returned to their location in Snuneymuxw after a fire in 2016. In 2016 the agency had to move all their staff and services temporarily to Stz'uminus. In January 2019, the agency opened their Urban Services Hub to provide support to Member Nation families in Nanaimo and in August 2020, the agency opened an office in Duncan which acts as a service hub for Member Nation families living in Duncan, as well as those living in the communities of Malahat, Halalt, Penelakut, Ta'uubaa'asatx (Lake Cowichan), and Stz'uminus.

Professional Staff Complement and Training

Since the last audit in 2017, the agency has experienced tremendous growth. Current delegated staffing at KLCFS is comprised of the executive director, the associate executive director, five

team leaders, five Le'lumilh (resource) social workers, one Le'lumilh Kinship Care social worker, five guardianship social workers, two kinship care social workers and five child safety social workers. Additionally, there are 37 staff in various non-delegated services positions, 15 staff in operations/administrative positions, two staff in corporate lead positions and two staff in corporate support positions.

The executive director is delegated at the C4 level, the associate executive director is delegated at the C6 level, and all the remaining delegated staff are delegated at their program level or above. Several staff have changed positions or have pursued C6 delegation to ensure they are able to assist with additional work as needed. All the delegated staff interviewed completed their delegation training through Indigenous Perspectives Society or through the Justice Institute of British Columbia. Additional training/professional development opportunities are supported, whenever possible, by the agency. Staff reported that the agency has focused on providing training on Trauma Informed Practice, permanency, adoption, cultural teachings, Dr. Martin Brokenleg's Cultural Healing and Resilience, ASSIST, problematic substance use and SAFE. The agency offers "learning Tuesdays" and the Le'Lumilh social workers have completed the foster caregiver pre-service and kinship caregiver training and are included in all other training offered to their caregivers. While the COVID-19 pandemic has impacted the availability of training over the past two years, the management is focused on supporting the staff's training needs and interests.

The agency also offers individual staff career coaching by psychologist Catherine Carr and team leader leadership coaching by DECK Leadership.

c. Supervision and Consultation

The executive director reports to the Board of Directors and the following positions report to the executive director:

- associate executive director
- finance manager
- office manager/executive assistant
- human resources manager

The following positions report to the associate executive director:

- prevention services manager
- information and communications officer
- community wellness manager
- guardianship team lead
- kinship care team lead

- child safety team lead
- Le'lumilh (resource)team lead
- south office team lead
- supervisor administrative services

Delegated staff report having satisfactory, accessible, and supportive supervision and consultation opportunities. The child safety teams have a team meeting every month to two months, scheduled one to one clinical supervision bi-weekly as well as an open-door policy for consultation as needed. At times, during the child safety team meetings, the Su'ye'yu (kinship) team participates. The Le'lumilh (resource) team meets bi-weekly, has scheduled one to one clinical supervision bi-weekly and an open-door policy for consultation as needed. The guardianship team meets bi- weekly, has scheduled one to one clinical supervision bi-weekly and an open-door policy for consultation as needed. It was reported that the social workers and team leaders are very collaborative and work well across the programs and teams.

The social workers and team leaders utilize a dashboard tracking system during their one-to-one clinical supervision, which staff reported as helping them manage due dates and timelines.

The team leaders have open door consultation with the associate executive director; currently there is no scheduled one to one clinical supervision. There are monthly team lead meetings with child safety, guardianship and Le'lumilh (resource) with a recent addition of the non-delegated program team leads joining the monthly meetings. Finally, there are quarterly agency wide staff meetings with the executive director and the associate executive director that are focused on agency/operational updates.

During the COVID-19 pandemic, supervision and consultations have been provided through a combination of face to face, emails, texts, phone calls, and video conferencing.

4. STRENGTHS OF THE AGENCY

Through the review of documentation and staff interviews, the practice analysts identified the following strengths at the agency:

- Emphasis is placed on maintaining contacts between the children/youth in care and their family members. Family visits, placements with relatives and in community homes are the methods used to support and preserve these relationships
- Permanency planning for all children and youth in care to avoid youth aging out of foster care
- Strong culturally aware practice that includes the use of ceremony, Elders, Big House, language, blanketing, gifting, and drumming was found throughout the practice in all programs

- In addition to the COVID-19 Provincial Health Orders, the agency continued to deliver services utilizing PPE and COVID-19 safety procedures, Zoom, Facetime, text, email, and phone calls when several of their Member Nations had shelter-in-place orders
- Strong emphasis on collaboration and inter-agency teamwork with the agency's support programs. Staff acknowledged the benefits of all the internal support programs. There are cultural permanency workers on each of the delegated teams, there is an ease of access to all the other support programs, and they are considered true wrap around services for the children, youth, and families they serve
- Focus on cultural training and support for staff
- The development of the Se'ye'yu (Kinship) team in 2021 is a dedicated out of care options team which is managing the work involved with children/youth and caregivers under an EFP or temporary care of other 35 2 (d) or 41 1 (b)
- In July 2020, KLCFS implemented an innovative approach to enhance employee wellness, boost productivity and creativity and reduce time commuting to and from work. All KLCFS employees were offered the opportunity to participate in a 4-day work week, allowing them to work the same number of hours week, condensed into 4 days instead of 5
- The agency has developed a Care Plan Circle process which is very collaborative, culturally and child/youth in care driven and is currently being used to inform the standardized Care Plan
- Management has been supportive and flexible with staff throughout the COVID-19 pandemic

5. CHALLENGES OF THE AGENCY

Through the review of documentation and staff interviews, the MCFD Quality Assurance practice analysts identified the following challenges at the agency:

- Shortage of housing and homelessness is impacting the families the agency is working with
- Staff turnover and transfers within the delegated or non-delegated programs resulting in vacancies in positions and at times, requiring additional caseload coverage

6. FINDINGS AND ANALYSIS

The findings are presented in tables that contain counts and percentages of ratings of achieved and not achieved for all the measures in the audit tools.

The tables present findings for measures that correspond with specific components of the policies within the Aboriginal Operational and Practice Standards and Indicators (AOPSI) and the Child Safety and Family Support Policies, Chapter 3. Each table is followed by an analysis of the findings for each of the measures presented in the table. Please note that some records received ratings of not achieved for more than one reason.

a) Child Service

The overall compliance rate for the AOPSI Guardianship Practice Standards for open and closed children/youth in care was **70%.** The audit reflects the work done by the staff in the guardianship program over a three-year period (see Methodology section for details). There was a combined total of 67 records in the sample for this audit. However, not all 23 measures in the audit tool were applicable to all 67 records. The notes below the table describe the records that were not applicable.

Standards	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
Standard 1 Preserving the Identity of the Child in Care and Providing Culturally Appropriate Services	67	67	0	100%
Standard 2 Development of a Comprehensive Plan of Care	7*	4	3	57%
Standard 3 Monitoring and Reviewing the Child's Comprehensive Plan of Care	62*	49	13	79%
Standard 4 Supervisory Approval Required for Guardianship Services	67	44	23	66%
Standard 5 Rights of Children in Care	67	42	25	63%
Standard 6 Deciding Where to Place the Child	67	65	2	97%
Standard 7 Meeting the Child's Need for Stability and continuity of Relationships	67	67	0	100%
Standard 8 Social Worker's Relationship & contact with a Child in Care	67	5	62	7%
Standard 9 Providing the Caregiver with Information and Reviewing Appropriate Discipline Standards	67	8	59	12%
Standard 10 Providing Initial and ongoing Medical and Dental Care for a Child in Care	67	64	3	96%
Standard 11 Planning a Move for a Child in Care (VS 20)	34*	32	2	94%
Standard 12 Reportable Circumstances	19*	3	16	16%
Standard 13 When a Child or Youth is Missing, Lost or Runaway	4*	4	0	100%

Standard 14 Case Documentation	67	41	26	61%
Standard 15 Transferring Continuing Care Files	28*	11	17	39%
Standard 16 Closing Continuing Care Files	22*	13	9	59%
Standard 17 Rescinding a Continuing Custody Order	11*	11	0	100%
Standard 18 Permanency Planning	N/A*			
Standard 19 Interviewing the Child about the Care Experience	38*	12	26	32%
Standard 20 Preparation for Independence	21*	20	1	95%
Standard 21 Responsibilities of the Public Guardian and Trustee	54*	51	3	94%
Standard 22 Investigation of alleged Abuse or Neglect in a Family Care Home	7*	5	2	71%
Standard 23 Quality of Care Review	3*	1	2	33%
Standard 24 Guardianship Agency Protocols	67	67	0	100%

Standard 2: 60 records did not involve a 30 day or 6-month care plan within 30 days of admission within the audit timeframe
Standard 3: 5 records did not involve an annual care plan completed within the audit timeframe
Standard 11: 33 records did not involve children/youth moving from their care homes
Standard 12: 48 records did not involve reportable circumstances
Standard 13: 63 records did not involve children missing, lost, or run away
Standard 15: 39 records did not involve file transfers
Standard 16: 45 records did not involve file closures
Standard 17: 56 records did not involve rescinding continuing custody orders
Standard 18: interim standard related to legal permanency not audited at this time
Standard 19: 29 records did not involve changing placements
Standard 20: 46 records did not involve youth planning for independence
Standard 21: 13 records did not involve the Public Guardian and Trustee
Standard 22: 60 records did not involve investigations of abuse or neglect in family care homes
Standard 23: 64 records did not involve quality of care reviews

St. 1: Preserving the identity of the Child or Youth in Care: The compliance rate for this measure was **100**%. The measure was applied to all 67 records in the samples; all records were rated achieved. To receive a rating of achieved:

- efforts were made to identify and involve the child/youth's Indigenous community
- efforts were made to register the child when entitled to a Band or Aboriginal community or with Nisga'a Lisims Government
- a cultural plan was completed if the child/youth was not placed within their extended family or community
- the child/youth was involved in culturally appropriate resources
- if the child/youth was harmed by racism, the social worker developed a response
- if the child/youth was a victim of a racial crime, the police were notified

St. 2 Development of a Comprehensive Plan of Care: The compliance rate for this measure was **57%**. The measure was applied to seven of the 67 records; four were rated achieved and three were rated not achieved. To receive a rating of achieved, the record, if it was opened during the three-year audit timeframe, contained:

- an initial care plan completed within 30 days of admission
- an annual care plan completed within six months of admission

Of the three records rated not achieved, all did not contain an initial care plan completed within 30 days of admission.

St. 3 Monitoring and Reviewing the Child or Youth's Comprehensive Plan of Care: The compliance rate for this measure was **79**%. The measure was applied to 62 of the 67 records in the samples; 49 were rated achieved, 13 were rated not achieved and five were not applicable. To receive a rating of achieved:

- care plans were completed annually throughout the audit timeframe
- efforts were made to develop the care plan(s) with youth over the age of 12
- efforts were made to develop the care plan(s) with the family
- efforts were made to develop the care plan(s) with the service providers
- efforts were made to develop the care plan(s) with the caregiver(s)
- efforts were made to develop the care plan(s) with the Indigenous community

Of the 13 records rated not achieved, two did not contain any care plans throughout the audit timeframe and 11 contained care plans but they were not completed annually throughout the audit timeframe. Of the 13 records rated not achieved, two were open and required annual care plans in 2020/2021.

St. 4 Supervisory Approval Required for Guardianship Services: The compliance rate for this measure was **66**%. The measure was applied to all 67 records in the samples; 44 were rated achieved and 23 were rated not achieved. To receive a rating of achieved, the following key decisions and documents were approved by a supervisor:

- care plan
- placement change
- placement in a non-Indigenous home
- restricted access to significant others
- return to the parent(s) prior to CCO rescindment
- transfer of guardianship
- plan for independence

- case transfer
- case closure

Of the 23 records rated not achieved, 22 had one or more care plans that were not signed by supervisors and one case transfer was not approved by the supervisor.

St. 5 Rights of Children and Youth in Care: The compliance rate for this measure was **63**%. The measure was applied to all 67 records in the samples; 42 were rated achieved and 25 were rated not achieved. To receive a rating of achieved:

- the rights of children in care, including the advocacy process, was reviewed annually with the child/youth or with a significant person if there were capacity concerns or the child was of a young age throughout the audit timeframe
- in instances when the child's rights were not respected, the social worker took appropriate steps to resolve the issue

Of the 25 records rated not achieved, five did not contain documentation confirming that the rights of children in care, including the advocacy process, were reviewed within the audit timeframe and 20 contained documentation confirming that the rights of children in care, including the advocacy process, were reviewed within the audit timeframe, but these reviews were not conducted annually. Of these 25 records rated not achieved, five were open and require the annual review of rights for 2020/2021.

St. 6 Deciding Where to Place the Child or Youth: The compliance rate for this measure was **97**%. The measure was applied to all 67 records in the samples; 65 were rated achieved and two were rated not achieved. To receive a rating of achieved, efforts were made to place the child in an out of home living arrangement that was in accordance with section 71 of the Child, Family and Community Services Act.

In the two records rated not achieved, the involved child/youth was placed in an out of home living arrangement that was not in accordance with section 71 of the Child, Family and Community Services Act. Specifically, the child/youth was not placed with extended family members or within their community and there were no documentation confirming the efforts to resolve this issue.

St. 7 Meeting the Child or Youth's Needs for Stability and Continuity of Relationships: The compliance rate for this measure was **100**%. The measure was applied to all 67 records in the samples; all were rated achieved. To receive a rating of achieved, a plan was in place to support and maintain contacts between the child/youth in care and their siblings, parents, extended families, and significant others.

St. 8 Social Worker's Relationship and Contact with the Child or Youth: The compliance rate for this measure was **7**%.

The measure was applied to all 67 records in the samples; five were rated achieved and 62 were rated not achieved. To receive a rating of achieved, the social worker conducted a private visit with the child/youth:

- every 30 days
- at time of placement
- within seven days after placement
- when there was a change in circumstance
- when there was a change in social worker

Of the 62 records rated not achieved, 62 documented private visits but not every 30 days throughout the audit timeframe, 32 documented private visits but not every 30 days and some or all were not conducted in private (often with sibling groups), four did not document a private visit at the time of placement, six did not document a private visit within seven days after placement, six did not document a private visit after a change in social worker and three did not document a private visit when there was a change in circumstance. The total adds to more than the number of records rated not achieved because 45 records had combinations of the above noted reasons.

Of the 67 records that documented private visits, the standard required the child/youth to be seen 1752 times based on the criteria above. KLCFS documented that the social workers saw the child/youth privately 1117 times in this audit timeframe. This demonstrates that 64 % of the required in person private visits occurred.

St. 9 Providing the Caregiver with Information and Reviewing the Appropriate Discipline Standards: The compliance rate for this measure was **12**%. The measure was applied to all 67 records in the samples; eight were rated achieved and 59 were rated not achieved. To receive a rating of achieved:

- information about the child/youth was provided to the caregiver(s) at time of placement
- information about the child/youth was provided to the caregiver(s) as it became available
- information about the child/youth was provided to the caregiver(s) within seven days of an emergency placement
- discipline standards were reviewed with the caregiver(s) at the time of placement
- discipline standards were reviewed annually with the caregiver(s)

Of the 59 records rated not achieved, 31 did not contain documentation confirming that the discipline standards were reviewed with the caregivers at any time throughout the audit

timeframe, 22 contained documentation confirming that the discipline standards were reviewed with caregivers within the audit timeframe, but these reviews were not documented annually, 12 did not contain documentation that the discipline standards were reviewed with caregivers at the time of placement and 14 did not contain documentation that the information on the child/youth was provided to the caregivers at the time of placement. The total adds to more than the number of records rated not achieved because 16 records had combinations of the above noted reasons. Of the 59 records rated not achieved, 18 were open and require documentation confirming that the disciplinary standards were reviewed with the caregivers in 2020/2021.

St. 10 Providing Initial and Ongoing Medical and Dental Care: The compliance rate for this measure was **96**%. The measure was applied to all 67 records in the samples; 64 were rated achieved and three were rated not achieved. To receive a rating of achieved:

- a medical exam was conducted upon entering care
- dental, vision and hearing exams were conducted as recommended
- medical follow up was conducted as recommended
- in instances when the youth had chosen not to attend recommended appointments, the social worker made efforts to resolve the issue

Of the three records rated not achieved, two did not contain documentation that a medical exam was completed upon entering care and one did not contain documentation of medical follow up.

St. 11 Planning a Move for a Child or Youth in Care: The compliance rate for this measure was **94**%. The measure was applied to 34 of the 67 records in the samples; 32 were rated achieved and two were rated not achieved. To receive a rating of achieved, the record if it involved a placement move, confirmed that:

- the child/youth was provided with an explanation prior to the move
- the social worker arranged at least one pre-placement visit
- if the child/youth requested the move, the social worker reviewed the request with the caregiver, resource worker and the child to resolve the issue

Of the two records rated not achieved, both did not contain documentation confirming that orientations and pre-placement visits were arranged prior to the moves and no efforts were documented.

St. 12 Reportable Circumstances: The compliance rate for this measure was **16**%. The measure was applied to 19 of the 67 records in the samples; three were rated achieved and 16 were rated not achieved. To receive a rating of achieved, a report about a reportable circumstance was submitted to the Director within 24 hours from the time the information about the incident became known to the social worker.

Of the 16 records rated not achieved, four contained documentation describing reportable circumstances but submitted reports were not found in the records, 13 contained reportable circumstance reports but they were not submitted within 24 hours (the range of time it took to submit was between eight and 1024 days, with the average being 127 days).

Of the four records that described reportable circumstances but submitted reports were not found in the records, one was open in January 2022. This record was brought to the attention of the agency for possible follow up.

St. 13 When a Child or Youth is Missing, Lost or Runaway: The compliance rate for this measure was **100**%. The measure was applied to four of the 67 records in the samples; all were rated achieved. To receive a rating of achieved, the record, if it involved a missing, lost, or runaway child/youth who may have been at high risk of harm, confirmed that:

- the police were notified
- the family was notified
- once found, the social worker made efforts to develop a safety plan to resolve the issue

St. 14 Case Documentation: The compliance rate for this measure was **61**%. The measure was applied to all 67 records in the samples; 41 were rated achieved and 26 were rated not achieved. To receive a rating of achieved, the record contained:

- an opening recording
- review recordings or care plan reviews every six months throughout the audit timeframe
- a review recording or care plan review when there was a change in circumstance

Of the 26 records rated not achieved, one did not contain an opening recording, 14 did not contain review recordings nor care plan reviews during the audit timeframe, nine contained review recordings/care plan reviews but not every six months and four did not contain review recordings nor care plan reviews when there was a change in circumstance. The total adds to more than the number of records rated not achieved because two records had combinations of the above noted reasons.

St. 15 Transferring Continuing Care Files: The compliance rate for this measure was **39**%. The measure was applied to 28 of the 67 records in the samples; 11 were rated achieved and 17 were rated not achieved. To receive a rating of achieved, the record if it involved a case transfer, confirmed that:

- a transfer recording was completed
- the social worker met with the child/youth prior to the transfer or, in instances when the youth had chosen not to meet, the social worker made efforts to resolve the issue

- efforts were made to meet with the caregiver(s) prior to the transfer
- efforts were made to meet with the service providers prior to the transfer
- the social worker met with the child/youth within five days after the transfer or, in instances when the youth had chosen not to meet, the social worker made efforts to resolve the issue
- efforts were made to meet with the child/youth's family within five days after the transfer

Of the 17 records rated not achieved, 11 did not contain transfer recordings, nine did not contain documentation that the social worker met with the child or youth prior to the transfer, eight did not contain documentation that the social worker met with the caregiver prior to the transfer, six did not contain documentation that the social worker met with the service provider(s) prior to the transfer, 11 did not contain documentation that the social worker met with the child/youth five days after the transfer and five did not contain documentation that the social worker met with the family five days after the transfer. The total adds to more than the number of records rated not achieved because 12 records had combinations of the above noted reasons.

St. 16 Closing Continuing Care Files: The compliance rate for this measure was **59**%. The measure was applied to 22 of the 67 records in the samples; 13 were rated achieved and nine were rated not achieved. To receive a rating of achieved, the record if it involved a case closure, confirmed that:

- a closing recording was completed
- the social worker met with the child/youth prior to the closure or, in instances when the youth had chosen not to meet, the social worker made efforts to resolve the issue
- efforts were made to meet with the caregiver(s) prior to the closure
- service providers were notified of the closure
- the Indigenous community members were notified, if appropriate
- support services for the child/youth were put in place, if applicable

Of the nine records rated not achieved, eight did not document the social worker's efforts to meet the youth nor the caregiver prior to the closure, two did not contain confirmation that the child/youth's band had been notified of the closure and one did not contain documentation that support services were put into place. The total adds to more than the number of records rated not achieved because two records had combinations of the above noted reasons.

St. 17 Rescinding a CCO and Returning the Child or Youth to the Family Home: The compliance rate for this measure was **100**%. The measure was applied to 11 of the 67 records in the samples; all were rated achieved. To receive a rating of achieved, the record, if it involved a rescindment of a continuing custody order, confirmed that:

- the risk of return was assessed by delegated worker
- a safety plan, if applicable, was put in place prior to placing the child/youth in the family home
- the safety plan, if applicable, was developed with required parties
- the safety plan, if applicable, addressed the identified risks
- the safety plan, if applicable, was reviewed every six months until the rescindment

St. 18 Permanency Planning: A permanent plan is considered for a child with a Continuing Care Order when the plan's priorities are in the best interests of the child and the preservation of the child's cultural identity are priorities of the plan.

This is an interim standard for use until Indigenous Child and Family Service Agencies, cultural groups and Indigenous communities have researched and reviewed the ministry permanency planning policy. As this is still an interim standard, it has not yet been audited by Quality Assurance.

St. 19 Interviewing the Child or Youth about the Care Experience: The compliance rate for this measure was **32**%. The measure was applied to 38 of the 67 records in the samples; 12 were rated achieved and 26 were rated not achieved. To receive a rating of achieved, the record, if it involved a move from a placement, confirmed the child/youth was interviewed about their care experience.

Of the 26 records rated not achieved, all did not contain documentation confirming that interviews were conducted with the children and youth after placement changes.

St. 20 Preparation for Independence: The compliance rate for this measure was **95**%. The measure was applied to 21 of the 67 records in the samples; 20 were rated achieved and one was rated not achieved. To receive a rating of achieved, the record, if it involved a youth about to leave care and enter an independent living situation, confirmed that:

- efforts were made to assess the youth's independent living skills
- efforts were made to develop a plan for independence

Of the one record rated not achieved, it did not contain documentation confirming that the youth's independent skills were assessed nor was there a plan for independence.

St. 21 Responsibilities of the Public Guardian and Trustee (PGT): The compliance rate for this measure was **94**%. The measure was applied to 54 of the 67 records in the samples; 51 were rated achieved and three were rated not achieved. To receive a rating of achieved:

- the PGT was provided a copy of the continuing custody order

- the PGT was notified of events affecting the child/youth's financial or legal interests

Of the three records rated not achieved, all did not contain documentation confirming that the PGT was notified when the continuing custody orders were granted.

St. 22 Investigation of Alleged Abuse or Neglect in a Family Care Home: The compliance rate for this measure was **71**%. The measure was applied to seven of the 67 records in the samples; five were rated achieved and two were rated not achieved. To receive a rating of achieved, the record, if it involved a report of abuse and/or neglect of a child/youth in a family care home, confirmed that:

- a protocol investigation response was conducted
- efforts were made to support the child/youth

Of the two records rated not achieved, all described sec 13 concerns in the foster home but submitted reports were not found in the records, both were open in January 2022. These records were brought to the attention of the agency for possible follow up.

St. 23 Quality of Care Review: The compliance rate for this measure was **33**%. The measure was applied to three of the 67 records in the samples; one was rated achieved and two were rated not achieved. To receive a rating of achieved, the record, if it involved a concern about the quality of care received by a child/youth in a family care home, confirmed that a quality-of-care response was conducted.

Of the two records rated not achieved, both did not contain summary reports.

St. 24 Guardianship Agency Protocols: The compliance rate for this measure was **100**%. The measure was applied to all 67 records in the samples; all were rated achieved. To receive a rating of achieved, all protocols related to the delivery of child services that the agency has established with local and regional agencies have been followed.

b) Resources

The overall compliance rate for the AOPSI Resource Practice Standards was **84%.** The audit reflects the work done by the staff in the agency's resource program over a three-year period (see Methodology section for details). There was a total of 25 records in the one sample selected for this audit. However, not all nine measures in the audit tool were applicable to all 25 records. The notes below the table describe the records that were not applicable.

Standards	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
Standard 28 Supervisory Approval Required for Family Care Home Services	25	19	6	76%
Standard 29 Family Care Homes – Application and Orientation	25	21	4	84%
Standard 30 Home Study	14*	13	1	93%
Standard 31 Training of Caregivers	25	24	1	96%
Standard 32 Signed Agreement with Caregivers	25	23	2	92%
Standard 33 Monitoring and Reviewing the Family Care Home	25	15	10	60%
Standard 34 Investigation of Alleged Abuse or Neglect in a Family Care Home	2*	2	0	100%
Standard 35 Quality of Care Review	1*	1	0	100%
Standard 36 Closure of the Family Care Home	10*	10	0	100%

Standard 30: 11 records did not involve home studies during the audit timeframe
Standard 34: 23 records did not involve investigations of alleged abuse or neglect in family care homes
Standard 35: 24 records did not involve quality of care reviews
Standard 36: 15 records were not closed

St. 28 Supervisory Approval for Family Care Home Services: The compliance rate for this measure was **76**%. The measure was applied to all 25 records in the sample; 19 records were rated achieved and six were rated not achieved. To receive a rating of achieved, the record confirmed that the social worker consulted a supervisor at the following key decision points:

- a criminal record was identified for a family home applicant or any adult person residing in the home
- approving a family home application and home study
- signing a Family Home Care Agreement
- approving an annual review
- determining the level of a family care home
- placing a child/youth in a family care home prior to completing a home study
- receiving a report about abuse or neglect of a child/youth in a family care home
- receiving a concern about the quality of care received by a child/youth living in a family care home

Of the six records rated not achieved, all the records did not document supervisory approval when a criminal record history was found.

St. 29 Family Care Homes – Application and Orientation: The compliance rate for this measure was **84**%. The measure was applied to all 25 records in the sample; 21 were rated achieved and

four were rated not achieved. To receive a rating of achieved, the record confirmed the completion of the following:

- application form
- prior contact check(s) on the family home applicant(s) and any adult person residing in the home
- criminal record check(s)
- Consent for Release of Information form(s)
- medical exam(s)
- three reference checks
- an orientation to the applicant(s)

Of the four records rated not achieved, three did not contain one or both required criminal record checks (one was open), two did not contain documentation of completed medical exam forms, and one did not document some or all the required reference checks. The total adds to more than the number of records rated not achieved because two records had combinations of the above noted reasons.

St. 30 Home Study: The compliance rate for this measure was **93**%. The measure was applied to 14 of the 25 records in the sample; 13 records were rated achieved and one was rated not achieved. To receive a rating of achieved:

- the social worker met the applicant in the family care home
- a physical check of the home was conducted to ensure the home meets the safety requirements
- a home study, including an assessment of safety, was completed in its entirety

Of the one record rated not achieved, it did not contain documentation that an inspection of the home was completed.

St. 31 Training of Caregivers: The compliance rate for this measure was **96**%. The measure was applied to all 25 records in the sample; 24 records were rated achieved and one was rated not achieved. To receive a rating of achieved, the training needs of the caregiver was assessed or identified, and training opportunities were offered to, or taken by, the caregiver.

Of the one record rated not achieved, it did not contain documentation of any training offered or taken.

St. 32 Signed Agreement with Caregiver: The compliance rate for this measure was **92**%. The measure was applied to all 25 records in the sample; 23 records were rated achieved and two were rated not achieved. To receive a rating of achieved, there were consecutive Family Care Home Agreements throughout the audit timeframe, and they were signed by all the participants.

Of the two records rated not achieved, both did not contain consecutive agreements during the audit time frame (both were closed).

St. 33 Monitoring and Reviewing the Family Care Home: The compliance rate for this measure was **60**%. The measure was applied to all 25 records in the sample; 15 were rated achieved and 10 were rated not achieved. To receive a rating of achieved:

- annual reviews of the family care home were completed throughout the audit timeframe
- the annual review reports were signed by the caregiver(s)
- the social worker visited the family care home at least every 90 days throughout the audit timeframe

Of the 10 records rated not achieved, five documented home visits but they were not completed every 90 days as required, four contained annual reviews but they were not completed for each year in the three-year audit timeframe, two did not contain any annual reviews completed in the three-year audit timeframe and one did not document any home visits. The total adds to more than the number of records rated not achieved because two records had combinations of the above noted reasons. Of the six records that did not contain all the required annual reviews, three were open. Of these three open records, none required current annual reviews.

St. 34: Investigation of Alleged Abuse or Neglect in a Family Care Home: The compliance rate for this measure was **100**%. The measure was applied to two of the 25 records in the sample; all records were rated achieved. To receive a rating of achieved, the record, if it involved a report of abuse and/or neglect of a child/youth in a family care home, confirmed that:

- a protocol investigation response was conducted
- efforts were made to support the caregiver

St. 35: Quality of Care Review: The compliance rate for this measure was **100**%. The measure was applied to one of the 25 records in the sample; this record was rated achieved. To receive a rating of achieved, the record, if it involved a concern about the quality of care received by a child/youth in a family care home, confirmed that:

- a response was conducted
- efforts were made to support the caregiver.

St. 36: Closure of the Family Care Home: The compliance rate for this measure was **100**%. The measure was applied to 10 of the 25 records in the sample; all were rated achieved. To receive a rating of achieved, the record, if it involved a case closure, contained a written notice to the caregiver indicating the intent of the agency to close the family care home.

c) Family Service

The overall compliance rate for the Child Protection Response Model set out in Chapter 3 of the Child Safety and Family Support Policies was **82%.** The audit reflects the work done by the staff in the agency's intake and family service programs over various time periods (see Methodology section for details). There was a total of 96 records in the closed memo, closed service request, and closed incident samples and 48 records in the open and closed FS case samples selected for this audit.

Records Identified for Action
Quality assurance policy and procedures require practice analysts to identify for action any record that suggests a child may need protection under section 13 of the Child, Family and Community Service Act. During this audit, no records were identified for action.

c.1 Report and Screening Assessment

FS 1 to FS 4 relate to obtaining and assessing a child protection report. The records included the selected samples of 29 closed service requests, 21 closed memos and 46 closed incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 1: Gathering Full and Detailed Information	96	88	8	92%
FS 2: Conducting an Initial Record Review (IRR)	96	39	57	41%
FS 3: Assessing the Report about a Child or Youth's Need for Protection (Completing the Screening Assessment)	96	71	25	74%
FS 4: Determining Whether the Report Requires a Protection or Non-protection Response	96	94	2	98%

FS 1: Gathering Full and Detailed Information: The compliance rate for this critical measure was **92**%. The measure was applied to all 96 records in the samples; 88 were rated achieved and eight were rated not achieved. To receive a rating of achieved, the information gathered from the caller was full, detailed, and sufficient to determine an appropriate pathway.

Of the eight records rated not achieved, all lacked detailed and sufficient information from the callers to determine the appropriate pathways.

The audit identified where the report was created. Of the 96 records, 44 were created by PCS, 49 were created by the ICFSA and three were created by an SDA. Of the eight records rated not achieved, seven were created at the ICFSA.

FS 2: Conducting an Initial Record Review (IRR): The compliance rate for this critical measure was **41**%. The measure was applied to all 96 records in the samples; 39 were rated achieved and 57 were rated not achieved. To receive a rating of achieved:

- the IRR was conducted from electronic databases within 24 hours of receiving the report
- the IRR identified previous issues or concerns and the number of past service requests, incidents, or reports
- if the family had recently moved to BC, or there was reason to believe there may have been prior child protection involvement in one or more jurisdictions, the appropriate child protection authorities were contacted, and information was requested and recorded

Of the 57 records rated not achieved, 25 did not have IRRs documented (18 created at the ICFSA), 12 IRRs were not documented within 24 hours (five created at the ICFSA), 16 IRRs did not contain sufficient information about previous issues or concerns or number of past service requests, incidents or reports (11 created at the ICFSA), 16 IRRs did not indicate that BP was checked (six created at the ICFSA), and one IRR did not indicate that the Protection Order Registry was checked. Of the 12 IRRs that were not documented within 24 hours, the range of time it took to complete the IRRs was between two and 32 days, with the average time being eight days. The total adds to more than the number of records rated not achieved because 12 records were rated not achieved for more than one of the above noted reasons.

The audit identified where the IRR was created. Of the 39 records rated achieved, 23 were created by PCS, 14 were created by the ICFSA and two were created by an SDA.

FS 3: Completing the Screening Assessment: The compliance rate for this critical measure was **74**%. The measure was applied to all 96 records in the samples; 71 were rated achieved and 25 were rated not achieved. To receive a rating of achieved, a Screening Assessment was completed immediately if the child/youth appeared to be in a life-threatening or dangerous situation or within 24 hours in all other situations.

Of the 25 records rated not achieved, all Screening Assessments were not completed within the required 24-hour timeframe (all created at the ICFSA). Of the 25 Screening Assessments that were not completed within the 24-hour timeframe, the range of time it took to complete was between two and 75 days, with the average time being 12 days.

The audit identified where the Screening Assessment was created. . Of the 71 records rated achieved, 23 were created by PCS, 45 were created by the ICFSA and three were completed by an SDA.

FS 4: **Determining Whether the Report Requires a Protection or Non-Protection Response**: The compliance rate for this critical measure was **98**%. The measure was applied to all 96 records in

the samples; 94 were rated achieved and two were rated not achieved. To receive a rating of achieved, the decision to provide a protection or non-protection response was appropriate and consistent with the information gathered.

Of the two records rated not achieved, one was a memo with an inappropriate non-protection response, and one was an incident that was incorrectly documented under the mother's name when she did not have any children living with her or in her care (the incident was correctly documented under the father's name and appropriately responded to by the SDA).

c.2 Response Priority, Detailed Records Review and Safety Assessment

FS 5 to FS 9 relate to assigning a response priority, conducting a detailed record review (DRR) and completing the safety assessment process and Safety Assessment form. The records included the selected sample of 46 closed incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 5: Assigning an Appropriate Response Priority	47*	44	2	96%
FS 6: Conducting a Detailed Record Review (DRR)	47*	37	9	80%
FS 7: Assessing the Safety of the Child or Youth	47*	42	4	91%
FS 8: Documenting the Safety Assessment	47*	20	26	43%
FS 9: Making a Safety Decision Consistent with the Safety Assessment	47*	45	1	98%

* Total Applicable includes the sample of 46 incidents augmented with the addition of one memo with an inappropriate non-protection response.

FS 5: **Determining the Response Priority**: The compliance rate for this critical measure was **96**%. The measure was applied to all 47 records, 44 were rated achieved, two were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the response priority was appropriate and if there was an override it was approved by the supervisor.

Of the two records rated not achieved, one was a memo with an inappropriate non-protection response, and one had a response priority of five days when it should have been within 24 hours.

The audit also assessed whether the families were contacted within the timeframes of the assigned response priorities. Of the 46 records, 32 documented face-to-face contact with the families within the assigned response priorities and 14 did not. Of the 14 records that did not document face-to-face contact with the families within the assigned response priorities, one was a memo with an inappropriate non-protection response, 11 were assigned the response priority of within five days and two were assigned the response priority of immediate or within 24 hours. Of the 11 records assigned the response priority of within five days, the range of time it took to

establish face-to-face contact the remaining 11 families was between six and 106 days with the average time being 30 days. Of the two records assigned the response priority of immediate or within 24 hours, the times it took to establish face-to-face contact with the families was six and 15 days.

FS 6: **Conducting a Detailed Record Review (DRR)**: The compliance rate for this critical measure was **80**%. The measure was applied to all 47 records; 37 were rated achieved, nine were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the DRR:

- was conducted in electronic databases and physical files
- contained any information that was missing in the IRR
- described how previous issues or concerns had been addressed, the responsiveness of the family in addressing the issues and concerns and the effectiveness of the last intervention
- was not required because there were no previous MCFD/ICFSA histories
- was not required because the supervisor approved ending the protection response before the DRR was conducted and the rationale was documented and appropriate

Of the nine records rated not achieved, one was a memo with an inappropriate non-protection response, two did not have DRRs documented and six DRRs did not contain the information missing in the IRRs.

FS 7: **Assessing the Safety of the Child or Youth**: The compliance rate for this critical measure was **91**%. The measure was applied to all 47 records; 42 were rated achieved, four were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved:

- the safety assessment process was completed during the first significant contact with the child/youth's family
- if concerns about the child/youth's immediate safety were identified and the child/youth was not removed under the CFCSA, a Safety Plan was developed, and the Safety Plan was signed by the parents and approved by the supervisor
- the supervisor approved ending the protection response before the safety assessment process was completed and the rationale was documented and appropriate

Of the four records rated not achieved, one was a memo with an inappropriate non-protection response and three did not confirm that Safety Plans were signed by the parents.

FS 8: **Documenting the Safety Assessment**: The compliance rate for this critical measure was **43**%. The measure was applied to all 47 records; 20 were rated achieved, 26 were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the Safety Assessment form was documented within 24 hours after the completion of the safety assessment process, or the supervisor approved ending the protection response before the Safety Assessment was documented and the rationale was documented and appropriate.

Of the 26 records rated not achieved, one was a memo with an inappropriate non-protection response, and 25 Safety Assessment forms were not completed within 24 hours of completing the safety assessment processes. Of the 25 Safety Assessment forms that were not completed within 24 hours of the safety assessment processes, the range of time it took to complete the forms was between two and 127 days, with the average time being 24 days.

FS 9: **Making a Safety Decision Consistent with the Safety Assessment**: The compliance rate for this critical measure was **98**%. The measure was applied to all 47 records; 45 were rated achieved, one was rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the safety decision was consistent with the information documented in the Safety Assessment form or the supervisor approved ending the protection response before the Safety Assessment form was documented and the rationale was documented and appropriate.

Of the one record rated not achieved, it was a memo with an inappropriate non-protection response.

Steps of the FDR Assessment or Investigation

FS 10 to FS 13 relate to meeting with or interviewing the parents and other adults in the family home, meeting with every child or youth who lives in the family home, visiting the family home and working with collateral contacts. The records included the selected sample of 46 closed incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 10: Meeting with or Interviewing the Parents and Other Adults in the Family Home	47*	39	7	85%
FS 11: Meeting with Every Child or Youth Who Lives in the Family Home	47*	37	9	80%
FS 12: Visiting the Family Home	47*	41	5	89%
FS 13: Working with Collateral Contacts	47*	44	2	96%

***** Total Applicable includes the sample of 46 incidents augmented with the addition of one memo with an inappropriate non-protection response

FS 10: **Meeting or Interviewing the Parents and Other Adults in the Family Home**: The compliance rate for this critical measure was **85**%. The measure was applied to all 47 records; 39 were rated achieved, seven were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the social worker met with or interviewed the parent(s) and other adults in the home (if applicable) and gathered sufficient information about the family to assess the safety and vulnerability of all children/youth living or being cared for in the family home or the supervisor approved ending the protection response before the social worker met with or interviewed the parents and other adults in the home and the rationale was documented and appropriate.

Of the seven records rated not achieved, one was a memo with an inappropriate non-protection response, four confirmed that only one of two parents was met with or interviewed, and two did not confirm that the social workers had met with or interviewed the other adults in the homes.

FS 11: **Meeting with Every Child or Youth Who Lives in the Family Home**: The compliance rate for this critical measure was **80**%. The measure was applied to all 47 records; 37 were rated achieved, nine were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care.

To receive a rating of achieved, the social worker had a private, face-to-face conversation with every child/youth living in the family home according to their developmental level, or the supervisor granted an exception, and the rationale was documented, or the supervisor approved ending the protection response before the social worker had a private, face-to-face conversation with every child/youth living in the family home and the rationale was documented and appropriate.

Of the nine records rated not achieved, one was a memo with an inappropriate non-protection response, seven did not confirm that the social workers had conversations of any kind with any

children/youth living in the homes, and one confirmed that the social workers interviewed some, but not all, of the children living in the homes.

FS 12: **Visiting the Family Home**: The compliance rate for this critical measure was **89**%. The measure was applied to all 47 records; 41 were rated achieved, five were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the social worker visited the family home before completing the FDR assessment or the investigation or the supervisor granted an exception and the rationale was documented, or the supervisor approved ending the protection response before the social worker visited the family home and the rationale was documented and appropriate.

Of the five records rated not achieved, one was an inappropriate non-protection response, and four did not confirm that the social workers visited the family homes.

FS 13: **Working with Collaterals**: The compliance rate for this critical measure was **96**%. The measure was applied to all 47 records; 44 were rated achieved, two were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the social worker obtained information from individuals who may have relevant knowledge of the family and/or the child/youth before completing the FDR assessment or the investigation or the supervisor approved ending the protection response before the social worker obtained information from individuals who may have relevant knowledge of the family and/or the child/youth and the rationale was documented and appropriate.

Of the two records that received ratings of not achieved, one was a memo with an inappropriate non-protection response, and one did not have any collaterals documented.

The audit also assessed whether the social workers, if the records were incidents with FDR protection responses, contacted the parents prior to initiating the FDR responses. As well, the audit assessed whether the social workers had discussions with the parents about which collateral contacts could provide the necessary information and reached agreements about the plans to gather information from specific collaterals. Of the 47 records, 44 required FDR responses. Of these 44 FDR responses, 39 documented that the social workers contacted the parents prior to contacting collaterals and five did not. Furthermore, of these 44 FDR responses, 11 documented discussions with the parents about which collateral contacts could provide the necessary information and reached agreements about the plans to gather information from specific collaterals.

c.3 Assessing the Risk of Future Harm and Determining the Need for Protection Services:

FS 14 to FS 16 relate to assessing the risk of future harm, determining the need for protection services and the timeframe for completing the FDR assessment or investigation. The records included the selected sample of 46 closed incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS14: Assessing the Risk of Future Harm	47*	43	3	93%
FS 15: Determining the Need for Protection Services	47*	45	1	98%
FS 16: Timeframe for Completing the FDR Assessment or Investigation	47*	11	35	24%

***** Total Applicable includes the sample of 46 incidents augmented with the addition of one memo with an inappropriate non-protection response

FS 14: **Assessing the Risk of Future Harm**: The compliance rate for this critical measure was **93**%. The measure was applied to all 47 records; 43 were rated achieved, three were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the Vulnerability Assessment was completed in its entirety and approved by the supervisor, or the supervisor approved ending the protection response before the Vulnerability Assessment was completed in its entirety and the rationale was documented and appropriate.

Of the three records rated not achieved, one was a memo with an inappropriate non-protection response, and two Vulnerability Assessments were not approved by supervisors.

The audit also assessed the length of time it took to complete the Vulnerability Assessments. Of the 43 records rated achieved, the range of time it took to complete the Vulnerability Assessments was between three days and 477 days, with the average time being 63 days.

FS 15: **Determining the Need for Protection Services**: The compliance rate for this critical measure was **98**%. The measure was applied to all 47 records; 45 were rated achieved, one was rated as not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the decision regarding the need for FDR protection services or ongoing protection services was consistent with the information obtained during the FDR assessment or the investigation or the supervisor approved ending the protection response before the decision was made regarding the need for FDR protection services or ongoing protection services and the rationale was documented and appropriate.

Of the one record rated not achieved, it was a memo with an inappropriate non-protection response.

FS 16: **Timeframe for Completing the FDR Assessment or Investigation:** The compliance rate for this critical measure was **24**%. The measure was applied to all 47 records; 11 were rated achieved, 35 were rated not achieved and one was not applicable because it was incorrectly documented under the mother's name when she did not have any children living with her or in her care. To receive a rating of achieved, the FDR assessment or investigation was completed within 30 days of receiving the report or the FDR assessment or investigation was completed in accordance with the extended timeframe that had been approved by the supervisor.

Of the 35 records rated not achieved, one was a memo with an inappropriate non-protection response, and 34 were not completed within 30 days of receiving the report. Of the 34 FDR assessments or investigations that were not completed within 30 days, the range of time it took to complete was between 34 and 477 days, with the average time being 131 days.

c.4 Strength and Needs Assessment and Family Plan

FS 17 to FS 21 relate to the completion of the Family and Child Strengths and Needs Assessment and the Family Plan. The records included the selected samples of 29 open FS cases and 19 closed FS cases.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 17: Completing a Family and Child Strengths and Needs Assessment	48	46	2	96%
FS 18: Supervisor Approval of the Strengths and Needs Assessment	48	45	3	94%
FS 19: Developing the Family Plan with the Family	48	45	3	94%
FS 20: Timeframe for Completing the Family Plan	48	36	12	75%
FS 21: Supervisor Approval of the Family Plan	48	41	7	85%

FS 17: **Completing a Family and Child Strengths and Needs Assessment:** The compliance rate for this critical measure was **96%.** The measure was applied to all 48 records in the samples; 46 were rated achieved and two were rated not achieved. To receive a rating of achieved, the Family and Child Strength and Needs Assessment was completed in its entirety.

Of the two records rated not achieved, one did not contain a Family and Child Strengths and Needs Assessment, and one contained an incomplete Family and Child Strengths and Needs Assessment.

The audit also assessed whether the Child and Family Strengths and Needs Assessment was completed within the most recent six-month practice cycle. Of the 46 records rated achieved, 39 Family and Child Strengths and Needs Assessments were completed within the most recent six-month practice cycle and seven were not (these seven were completed within the 12-month timeframe of the audit).

FS 18: **Supervisor Approval of the Strengths and Needs Assessment**: The compliance rate for this critical measure was **94%**. The measure was applied to all 48 records in the samples; 45 were rated achieved and three were rated not achieved. To receive a rating of achieved, the Family and Child Strength and Needs Assessment was approved by the supervisor.

Of the three records rated not achieved, one did not contain a Family and Child Strengths and Needs Assessment, and two Family and Child Strengths and Needs Assessments were not approved by supervisors.

FS 19: **Developing the Family Plan with the Family:** The compliance rate for this critical measure was **94%**. The measure was applied to all 48 records in the samples; 45 were rated achieved and three were rated not achieved. To receive a rating of achieved, the Family Plan form or its equivalent was developed in collaboration with the family. An equivalent to the Family Plan form can be the plan developed during a facilitated meeting, such as at a Family Case Planning Conference, Traditional Family Planning Meeting, or Family Group Conference. The equivalent plan must have the following key components:

- the priority needs to be addressed
- the goals described in clear and simple terms regarding what the family would like to change in their lives in relation to the identified need
- indicators that described in clear and simple terms what will appear different when the need is met (from the viewpoint of the family or from the viewpoint of others)
- strategies to reach goals, where the person responsible for implementing the strategy is also noted
- a review date, when progress towards the goal will be reviewed and a determination made on whether the goal has been met

Of the three records rated not achieved, all did not contain Family Plans or equivalents.

The audit also assessed whether the Family Plans or equivalents were completed after the Family and Child Strengths and Needs Assessments. Of the 45 records that received ratings of achieved, 30 contained Family Plans or equivalents that were completed after the Family and Child Strengths and Needs Assessments, and 15 Family Plans or equivalents were completed without first completing the Family and Child Strengths and Needs Assessments.

The audit also assessed the type of Family Plan that was completed. Of the 45 records with completed Family Plans, 39 contained Family Plan templates and six contained equivalents.

FS 20: **Timeframe for Completing the Family Plan:** The compliance rate for this critical measure was **75%**. The measure was applied to all 48 records in the samples; 36 were rated achieved and 12 were rated not achieved. To receive a rating of achieved, a Family Plan or its equivalent was created within 30 days of initiating ongoing protection services and revised within the most recent six-month practice cycle.

Of the 12 records rated not achieved, one did not contain a Family Plan or equivalent and 11 did not contain Family Plans or equivalents within the most recent six-month practice cycle, but they did contain Family Plans or equivalents created within the 12-month timeframe of the audit.

FS 21: **Supervisors Approval of the Family Plan:** The compliance rate for this critical measure was **85%**. The measure was applied to all 48 records in the samples; 41 were rated achieved and seven were rated not achieved. To receive a rating of achieved, the Family Plan or its equivalent was approved by the supervisor.

Of the seven records rated not achieved, three did not contain Family Plans or equivalents and four Family Plans or equivalents were not approved by supervisors.

c.5 Reassessment

FS 22 relates to the completion of the Vulnerability Reassessment or Reunification Assessment. The records included the selected samples of 29 open FS cases and 19 closed FS case.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 22: Completing a Vulnerability Reassessment or a Reunification Assessment	48	44	4	92%

FS 22: Completing a Vulnerability Reassessment OR a Reunification Assessment: The compliance rate for this critical measure was **92%**. The measure was applied to all 48 records in the samples; 44 were rated achieved and four were rated not achieved. To receive a rating of achieved, a Vulnerability Reassessment or Reunification Assessment was completed within the most recent six-month practice cycle and a Reunification Assessment completed within three months of the child's return or a court proceeding regarding custody and the assessment(s) was approved by the supervisor.

Of the four records rated not achieved, one contained an incomplete Vulnerability Reassessment, one contained an incomplete Reunification Assessment and two contained Vulnerability

Reassessments or Reunification Assessments within the 12-month audit timeframe, but they were not revised within the most recent six-month practice cycle.

c.6 Decision to End Protection Services

FS 23 relates to making the decision to end ongoing protection services. The records included the selected sample of 19 closed FS cases.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 23: Making the Decision to End Ongoing Protection Services	19	19	0	100%

FS 23: Making the Decision to End Ongoing Protection Services: The compliance rate for this critical measure was **100%**. The measure was applied to all 19 records in the sample; all were rated achieved. To receive a rating of achieved:

- the decision to conclude ongoing protection services was made in consultation with a supervisor
- there were no unaddressed reports of abuse or neglect
- there were no indications of current or imminent safety concerns
- the family demonstrated improvements as identified in the Family Plan
- a recent Vulnerability Reassessment or Reunification Assessment confirmed that factors identified as contributing to high vulnerability no longer existed or have been sufficiently addressed
- the family demonstrated the ability to access and use formal and informal resources and the family had the ability to parent without MCFD support.

7. ACTIONS COMPLETED TO DATE

Prior to the development of the action plan, the following actions were implemented by the agency:

1. The social workers utilize the dashboard tracking system to monitor frequency of children in care (CIC) visits.
2. The social workers document all private CIC visits in the care plan.
3. The social workers use the ICM generated referral document and provide at time of placement, as it became available and within 7 days of an emergency placement.
4. The social workers utilize the dashboard tracking system to monitor the discipline standards completion.

5. The social workers review reported incidents that meet requirements for Reportable Circumstances and complete an initial report within 24 hours.
6. The social workers complete all required transfer recordings and document transfers in ICM.
7. The social workers provide interview feedback on child's experience to the resource social worker.
8. The social workers document CIC interview on the CS file when a child leaves a placement.
9. The social workers complete all required safety assessments within the 24 hrs required time frame with Team Lead consultation & finalization.
10. The social workers document exceptions to extend the 30-day timeframe for completing the FDR assessment.
11. The resource social workers document all completed 90-day Home Visits utilizing the KL Resource form.
12. The resource social workers utilize the dashboard tracking system to track the annual review dates for completion.

8. ACTION PLAN

On May 26, 2022, the following Action Plan was developed in collaboration between KLCFS and MCFD Office of the Provincial Director of Child Welfare Quality Assurance & Aboriginal Services.

Actions	Persons Responsible	Completion Dates
CHILD SERVICE: **<u>Standard 8 Social Worker's Relationship & contact with a Child in Care:</u>**	**EXECUTIVE DIRECTOR**	
1. The Agency will complete an In-Service training session on Standard 8 for all Guardianship Social Workers. Confirmation of the completion of this training will be provided, via email, to the manager of Quality Assurance.	Delegated Team Leads	June 7, 2022
2. The Agency will modify the dashboard tracking system to include all required CIC visits: • Day of placement • Seven Days after placement • Every 30 days thereafter • When a child moved • Significant change • Change in social worker	Delegated Team Leads	June 30, 2022

Confirmation of the updates to the dashboard tracking system will be provided, via email, to the manager of Quality Assurance. **<u>Standard 9 Providing the Caregiver with Information and Reviewing Appropriate Discipline Standards</u>**: 3. The Agency will review all CS files and update the CS tabs, including child + youth information tab. Confirmation of completion will be provided, via email, to the manager of Quality Assurance. 4. The Agency will review all outstanding files (CS & RE) requiring Discipline standards and complete. Confirmation of completion will be provided, via email, to the manager of Quality Assurance. **<u>Standard 12 Reportable Circumstances</u>**: 5. The Agency will schedule in-service training on reportable circumstances with Provincial Practice Analyst. Confirmation of the completion of this training will be provided, via email, to the manager of Quality Assurance. **<u>Standard 19 Interviewing the Child about the Care Experience</u>**: 6. The Agency will complete an In-Service on the requirements of this Standard. Confirmation of the completion of this training will be provided, via email, to the manager of Quality Assurance	Delegated Team Leads Delegated Team Leads Delegated Team Leads Delegated Team Leads	August 31, 2022 September 30, 2022 June 30, 2022 June 7, 2022
FAMILY SERVICE: **<u>FS 2 Conducting an Initial Record Review (IRR)</u>** 7. The Agency will complete In-house training on memo creation including IRR. Confirmation of the completion of this training will be provided, via email, to the manager of Quality Assurance **<u>FS 16 Timeframe for Completing the FDR Assessment or Investigation:</u>** 8. The Agency will review all open incidents and complete outstanding incidents for closure. Confirmation of completion will be provided, via email, to the manager of Quality Assurance	**EXECUTIVE DIRECTOR** Delegated Team Leads Delegated Team Leads	June 7, 2022 September 30, 2022

RESOURCES: **<u>Standard 33 Monitoring and Reviewing the Family Care Home</u>** 9. The Agency will review all open Resource files and complete outstanding 90 Day Visits. Confirmation that this review was completed will be sent, via email, to the manager of Quality Assurance.	**EXECUTIVE DIRECTOR** Delegated Team Leads	September 30, 2022