Ministry of Children and Family Development

Northwest Inter-Nation Family and Community Services Society

(IQM, IQT)

Practice Audit Report

Report Completed: May 2023

Office of the Provincial Director and Aboriginal Services Division
Quality Assurance Branch
Field Work Completed November 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 and 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. This is the fifth audit for Northwest Inter-Nation Family and Community Services Society (NIFCSS). The last audit of the agency was completed in December 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, Family Support & Children in Care Services Policies, and the Aboriginal Operational and Practice Standards and Indicators (AOPSI) as it relates to resource and guardianship services.
- 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 four quality assurance practice analysts from the Ministry of Children & Family Development (MCFD) Office of the Provincial Director and Aboriginal Services Division who conducted the practice audit. The MCFD quality assurance practice analysts used a Share Point site to store collected data for the child and youth service, resource, and child safety and family service practice, as well as 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 or a virtual meeting 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 nine record types:

Record Types	Population Sizes	Sample Sizes
Open Child Service	35	24
Closed Child Service	14	12
Open and Closed Resource	17	14
Open Family Service	36	24
Closed Family Service	8	8
Closed Service Requests	22	17
Closed Memos	5	5
Closed Incidents	11	11

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

1. Open Child Service (CS): CS records open in the agency's offices on May 31, 2022, and had been open (continuously) at the agency for at least six months with legal category Voluntary Care Agreement, Special Needs Agreement, Removed Child, Interim Care Order, Temporary Care Order, Continuing Custody Order (CCO), or Out of Province.
2. Closed Child Service: CS records that were closed in ICM between December 1, 2019, and May 31, 2022, and managed by the office for at least six months (continuously) with the following legal categories Voluntary Care Agreement, Special Needs Agreement, Removal of Child, Interim Care Order, Temporary Care Order, CCO, or Out of Province.
3. Open and Closed Resource: Resource records in ICM that were managed by the agency that had children or youth in their care for at least three months (continuously) between June 1, 2019, and May 31, 2022. Children or youth in care records 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: Family service records open in ICM on May 31, 2022, and managed by this office for at least six months (continuously) with a service basis listed as protection.
5. Closed Family Service: Family service records closed in ICM between June 1, 2021, and May 31, 2022, and managed by this office for at least six months (continuously) with a service basis listed as protection.
6. Closed Service Requests: Service Requests closed in ICM by the agency between March 1, 2021, and February 28, 2022, where the type was request service CFS, request service Child and Family Support Assessment Planning and Practice Framework, request for family support, or youth services.

7. Closed Memos: Memos closed in ICM by the agency between March 1, 2021, and February 28, 2022, where the type was “screening” and with the resolution of "no further action".
8. Closed Incidents: Incidents that were created after November 4, 2014, and were closed by the agency between March 1, 2021, and February 28, 2022, where the type was FDR or investigation.

3. AGENCY OVERVIEW

a) Delegation

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

- Child Protection
- Out of Care Options
- Temporary Custody of Children
- Guardianship of Children and Youth in Continuing Custody
- Support Services to Families
- Voluntary Care Agreements
- Special Needs Agreements
- Establishing Resources
- Youth Agreements
- Respite Services
- Extended Family Program
- Agreements with Young Adults
- Alternatives to Care/Transfer of Custody

NIFCSS was established on February 8, 1999, and assumed C6 child protection delegation in 2017. The agency currently operates under a delegated services agreement from April 1, 2022 – March 31, 2024.

In addition to the delegated programs, NIFCSS provides the following programs/services to the children and families of their Member Nations:

- Community Lighthouses (Lighthouse(s)): serve a dual purpose; providing office space for the NIFCSS workers, and delivering prevention services, by the youth empowerment workers. The Lighthouse symbolizes strength, resilience, and reliability. The youth empowerment worker acts as the custodian of the Lighthouse and is responsible for the safe access and use of the space.

- Mental Wellness: there are six mental health clinicians delivering services. The clinicians receive referrals from the NIFCSS social workers and to expand and reach out to their community professionals, the clinical team also accepts referrals for community professionals and/or self referrals. The clinical team utilizes the Lighthouses to meet the community and membership needs.
- Prevention and Cultural programs: prevention funding is provided on an ongoing basis and as needed, to each community to plan and deliver cultural, sport and recreational events; some events are: Haisla for the Diversity Talent, a Christmas card contest, "Attitude with Gratitude" art contest as well as the purchase of sewing machines and starter sewing kits for each Lighthouse for community members who need help with regalia or for teaching regalia making. As well, there are cultural bins in each of the NIFCSS offices and Lighthouses.
- Youth Empowerment (YEP) program: the primary purpose is to provide sustainable resources, accompaniment, and spaces to Indigenous youth on their journey towards empowerment. The two foundational activities in YEP are Virtues based and S.T.A.R.T. (Science, Tradition, Arts, Recreation & Health, Technology).
- Family Support: the family support workers work directly in the member communities and provide support to children, youth, and families.
- Youth workers: In Terrace, they are used to support youth in care living in apartments and in Prince Rupert, they work 1:1 with children and youth in care and supervise visits between children and youth in care and their parents.
- Family Preservation program: the role of the family preservation worker is to meet with families, share information about how they can work together so families feel supported and to assist the family through any goals they have with the child safety team to help minimize any child safety worries for the children/youth in the family.
- Parenting program
- Virtues program

b) Demographics

NIFCSS has 2 main office locations in the urban settings of Terrace (IQT) and Prince Rupert (IQM) on the traditional territories of the Ts'msyen, Haisla and Tahltan nations. The communities in the Terrace/Kitimat area are Kitimaat, Kitselas and Kitsumkalum. The communities in Prince Rupert are Hartley Bay, Kitkatla, Lax Kw'alaams (Port Simpson), and Metlakatla. NIFCSS services seven First Nations:

- Kitselas
- Kitsumkalum
- Gitga'at (Hartley Bay)

- Lax Kw'alaams (Port Simpson)
- Metlakatla
- Gitxaala (Kitkatla)
- Haisla (Kitimaat Village)

NIFCSS also provides guardianship services to children from Member Nations that are placed and living in the Ministry Local Service Areas immediately around the Member Nations.

The Terrace office serves three communities accessible by land: Haisla (Kitimaat Village), Kitselas and Kitsumkalum. The Prince Rupert office serves four remote communities accessible only by plane or boat: Gitxaala (Kitkatla), Metlakatla, Lax Kw'alaams (Port Simpson) and Gitga'at (Hartley Bay). Additional sub-offices are in six of the seven Member Nations, these sub-offices are referred to as Community Lighthouses, where several prevention and other services are delivered.

c) Professional Staff Complement and Training

Since the last audit in 2017, the agency has experienced tremendous growth. Current delegated staffing at NIFCSS is comprised of the executive director, the practice manager, three team leaders, eight child safety social workers, two generalist social workers, two guardianship social workers, and a Roots co-ordinator. Additionally, there are 42 staff in various non-delegated services positions: 10 youth workers, four family support workers, one family preservation worker, a manager of prevention and cultural programs, five mental health clinicians, seven youth empowerment workers, two youth empowerment team leaders, an administrative supervisor, an executive assistant, four administrative personnel, a finance supervisor, a finance consultant, a finance clerk, a water taxi captain and two custodians.

The executive director and the practice manager are 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 through MCFD. The agency supports additional training/professional development opportunities, whenever possible. Staff reported that, at times, it is difficult to participate in training due to workload demands. The agency has focused on providing training on Trauma Informed Practice as well as ongoing training through MCFD. During the COVID-19 pandemic the agency offered additional online training via Knowledge City and currently staff have access to additional online training through GoSkillBoost.com. While the COVID-19 pandemic has impacted the availability of training over the past few years, the management is focused on supporting the staff's training needs and interests.

Through 2022-2023, NIFCSS is providing a Leadership Development program which is designed for staff currently in a leadership and/or supervisory position. The Leadership Development program uses The Five Practices of Exemplary Leadership by researchers and authors/mentors James Kouzes and Barry Posner.

d) Supervision and Consultation

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

- practice manager
- mental health clinicians
- Aboriginal child and youth mental health clinician
- executive assistant
- manager of prevention and cultural programs
- finance consultant
- community and organizational development

The following positions report to the practice manager:

- administrative supervisor
- three social work team leaders

The finance supervisor reports to the finance consultant. The youth empowerment team leaders report to the community and organizational development person.

Scheduled supervision was reported to be inconsistent across the teams and most staff interviewed stated a desire for more frequent scheduled supervision, without cancellations, and assistance with tracking their work. Staff described a range of satisfaction levels in the quality of their supervision. Most staff described receiving individual supervision through an open-door policy or via text, phone call or email which is working for some, but not all staff.

Each team has their own internal process for meetings, some occurring weekly as check ins and others monthly. The practice manager participates in the monthly resource, child safety and guardianship team meetings, bi-weekly management meetings, monthly all staff meetings, monthly prevention planning meetings and Terrace and Prince Rupert MCFD collaborative practice meetings.

During the COVID-19 pandemic, supervision and consultations also occurred through 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:

a) Focus on staff engagement: Staff described their colleagues as having their back and there is a good teamwork environment in each office. Staff reported having a sense of belonging and purpose in the work they are doing.

b) High staff representation: 85% of the employees are Indigenous and 80% of the leadership is Indigenous which is building the internal capacity at the agency, leading to self-governance.

c) Focus on relationship: Developing and building the Lighthouses in each community has improved the relationships between the agency and the communities. Sharing these spaces with community members enhances the collaborative work in each community.

d) Greater accessibility: In 2022, the agency purchased and received delivery of a 12-passenger boat. The boat is staffed with qualified personnel and provides more accessibility for the staff to safely travel to the communities on a more regular basis.

5. CHALLENGES OF THE AGENCY

Through the review of documentation and staff interviews, the MCFD practice analysts identified the following challenges within the agency during the reporting period:

a) Recruitment and retention of staff: This has been significantly impacted by the COVID – 19 pandemic. Despite consistent and vigorous postings, interviews, and making offers; most applicants took other offers for various reasons, including difficulty finding housing in Prince Rupert and most applicants chose positions in Terrace over Prince Rupert.

b) The COVID-19 pandemic: Brought challenges to each community, and each community had their own way of dealing with it, some with lengthy lockdowns or families and foster parents not allowing the social workers into their homes. At times, the social workers were unable to complete their work as expected because they were unable to visit a community or foster home based on personal preferences or health and safety recommendations.

c) Geographical: Prince Rupert was described as having less support services and resources than Terrace. At times, children and youth in care were moved out of their home regions and cultural territory to access services in Terrace. Travel to remote communities is impacted by poor weather.

d) Critical Incidents: Staff expressed an interest in receiving training on critical incident debriefing so that is available for staff when needed.

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 AOPSI and Chapter 3 of the Child Safety, Family Support & Children in Care Services Policies. 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 was **53%.** The audit reflects the work done by the staff in the guardianship and family service programs over a three-year period (see Methodology section for details). There was a total of 35 records identified within the sample; however, not all 23 measures in the audit tool were applicable to all 35 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	35	31	4	89%
Standard 2 Development of a Comprehensive Plan of Care	8*	2	6	25%
Standard 3 Monitoring and Reviewing the Child's Comprehensive Plan of Care	32*	6	26	19%
Standard 4 Supervisory Approval Required for Guardianship Services	35	21	14	60%
Standard 5 Rights of Children in Care	35	9	26	26%
Standard 6 Deciding Where to Place the Child	35	34	1	97%
Standard 7 Meeting the Child's Need for Stability and continuity of Relationships	35	32	3	91%
Standard 8 Social Worker's Relationship & contact with a Child in Care	35	1	34	3%
Standard 9 Providing the Caregiver with Information and Reviewing Appropriate Discipline Standards	35	4	31	11%
Standard 10 Providing Initial and ongoing Medical and Dental Care for a Child in Care	35	32	3	91%
Standard 11 Planning a Move for a Child in Care (VS 20)	15*	9	6	60%
Standard 12 Reportable Circumstances	20*	9	11	45%

Standard 13 When a Child or Youth is Missing, Lost or Runaway	3*	2	1	67%
Standard 14 Case Documentation	35	5	30	14%
Standard 15 Transferring Continuing Care Files	21*	7	14	33%
Standard 16 Closing Continuing Care Files	11*	5	6	45%
Standard 17 Rescinding a Continuing Custody Order	1*	0	1	0%
Standard 18 Permanency Planning	N/A *			
Standard 19 Interviewing the Child about the Care Experience	17*	0	17	0%
Standard 20 Preparation for Independence	17*	14	3	82%
Standard 21 Responsibilities of the Public Guardian and Trustee	26*	21	5	81%
Standard 22 Investigation of alleged Abuse or Neglect in a Family Care Home	3*	0	3	0%
Standard 23 Quality of Care Review	0*	0	0	N/A
Standard 24 Guardianship Agency Protocols	35	35	0	100%

Standard 2: 27 records did not involve initial care plans completed within the audit timeframe.
Standard 3: 3 records did not have annual care plans due.
Standard 11: 20 records did not involve children or youth moving from their care homes.
Standard 12: 15 records did not involve reportable circumstances.
Standard 13: 32 records did not involve children missing, lost, or run away.
Standard 15: 14 records did not involve file transfers.
Standard 16: 24 records did not involve file closures.
Standard 17: 34 records did not involve rescinding continuing custody orders.
Standard 18: Interim standard related to legal permanency not audited at this time.
Standard 19: 18 records did not involve changing placements.
Standard 20: 18 records did not involve youth planning for independence.
Standard 21: 9 records did not involve notifying the Public Guardian and Trustee.
Standard 22: 32 records did not involve investigations of abuse or neglect in family care homes.
Standard 23: None of the records involved Quality of Care Reviews.

Standard (St). 1: Preserving the identity of the Child or Youth in Care: The compliance rate for this measure was **89**%. The measure was applied to all 35 records in the samples; 31 were rated achieved and four were rated not achieved. To receive a rating of achieved, the record, if it was opened during the three-year audit timeframe, confirmed that:

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

Of the four records rated not achieved, all did not contain documentation that the child had access to culturally appropriate resources.

St. 2: Development of a Comprehensive Plan of Care: The compliance rate for this standard was **19**%. The measure was applied to eight of the 35 records in the samples; two were rated achieved and six 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 plan of care completed within 30 days of admission, and
- an annual plan of care completed within six months of admission.

Of the six records rated not achieved, four did not contain initial care plans completed within 30 days of the admissions and four did not contain annual care plans within six months of the admissions. The total adds to more than the number of records rated not achieved because two records had combinations of the above noted reasons.

St. 3 Monitoring and Reviewing the Child or Youth's Plan of Care: The compliance rate for this measure was **19**%. The measure was applied to 32 of the 35 records in the samples; six were rated achieved and 26 were rated not achieved. To receive a rating of achieved:

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

Of the 26 records rated not achieved, 22 contained care plans but they were not completed annually throughout the audit timeframe, four did not contain any annual care plans throughout the audit timeframe, one contained annual care plans throughout the audit timeframe but they were not developed with youth over 12, with no efforts documented, one contained annual care plans throughout the audit timeframe but they were not developed with the community, no efforts documented and one contained annual care plans throughout the audit timeframe but they were not developed with family, no efforts documented. The total adds to more than the number of records rated not achieved because three records had combinations of the above noted reasons.

St. 4 Supervisory Approval Required for Guardianship Services: The compliance rate for this measure was **60**%. The measure was applied to all 35 records in the samples; 21 were rated achieved and 14 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.
- Record transfer.
- Record closure.

Of the 14 records rated not achieved, 13 had at least one care plan that was not signed by a team leader, five did not have any documentation of a team leader approval for transfers and one did not have any documentation to indicate consultation with a team leader occurred at the appropriate decision-making points. The total adds to more than the number of records rated not achieved because five records had combinations of the above noted reasons.

St. 5 Rights of Children and Youth in Care: The compliance rate for this measure was **26**%. The measure was applied to all 35 records in the samples; nine were rated achieved and 26 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 or youth or with a significant person if there were capacity concerns or the child was of a young age throughout the audit timeframe, and
- in instances when the child's rights were not respected, the social worker took appropriate steps to resolve the issue.

Of the 26 records rated not achieved, twelve did not confirm that the rights of children in care, including the advocacy process, were reviewed within the audit timeframe, and 14 confirmed 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 26 records rated not achieved, 15 were open and required the annual review of rights for 2021/2022.

St. 6 Deciding Where to Place the Child or Youth: The compliance rate for this measure was **97**%. The measure was applied to all 35 records in the samples; 34 were rated achieved and one was 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 Service Act* (CFCSA).

In the one record rated not achieved, the involved child or youth was placed in an out of home living arrangement that was not in accordance with section 71 of the CFCSA. Specifically, the child

or youth was not placed with extended family members or within their community and there was 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 **91**%. The measure was applied to all 35 records in the samples; 32 were rated achieved and three were rated not achieved. To receive a rating of achieved, a plan was in place to support and maintain contacts between the child or youth in care and their siblings, parents, extended families, and significant others.

In the three records rated not achieved, there was no documented plan in place to support and maintain contacts between the child or youth in care and their siblings, parents, extended families, or significant others.

St. 8 Social Worker's Relationship and Contact with the Child or Youth: The compliance rate for this measure was **3**%. The measure was applied to all 35 records in the samples; one was rated achieved and 34 were rated not achieved. To receive a rating of achieved, the social worker conducted a private visit with the child or 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 35 records that documented private visits, the standard required the children or youth be seen 958 times based on the criteria above. NIFCSS documented that social workers saw the children or youth privately 173 times in this audit timeframe. This demonstrates that 18% of the required in person private visits occurred.

Of the 34 records rated not achieved, 28 documented private visits but not every 30 days throughout the audit timeframe, 13 documented visits but some or all were not conducted in private (often with sibling groups), three did not document visits of any kind between the children or youth and their social workers throughout the three-year audit timeframe, seven did not document a private visit within seven days after placement, five did not document a private visit after a change in social worker, seven did not document a private visit at time of placement and one 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 16 records had combinations of the above noted reasons.

St. 9 Providing the Caregiver with Information and Reviewing the Appropriate Discipline Standards: The compliance rate for this measure was **11**%. The measure was applied to all 35

records in the samples; four were rated achieved and 31 were rated not achieved. To receive a rating of achieved:

- Information about the child or youth was provided to the caregiver(s) at time of placement.
- Information about the child or youth was provided to the caregiver(s) as it became available.
- Information about the child or 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 31 records rated not achieved, 28 did not contain documentation confirming that the discipline standards were reviewed with the caregivers at any time throughout the audit timeframe, five did not contain documentation that the information on the child or youth was provided to the caregivers at the time of placement, seven did not contain documentation that the discipline standards were reviewed with caregivers at the time of placement and two contained documentation confirming that the discipline standards were reviewed with caregivers within the audit timeframe, but these reviews were not documented annually. The total adds to more than the number of records rated not achieved because eight records had combinations of the above noted reasons.

Of the 31 records rated not achieved, 23 are open and require documentation confirming that the discipline standards were reviewed with the caregivers in 2022.

St. 10 Providing Initial and Ongoing Medical and Dental Care: The compliance rate for this measure was **91**%. The measure was applied to all 35 records in the samples; 32 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, one did not contain documentation that a medical exam was completed upon entering care and two did not contain documentation that medical follow up was conducted as recommended.

St. 11 Planning a Move for a Child or Youth in Care: The compliance rate for this measure was **60**%. The measure was applied to 15 of the 35 records in the samples; nine were rated achieved

and six were rated not achieved. To receive a rating of achieved, the record if it involved a placement move, confirmed that:

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

Of the six records rated not achieved, six did not contain documentation confirming that orientations and pre-placement visits were arranged prior to the moves and no efforts were documented, and four did not contain documentation that the child was provided an explanation prior to the move. The total adds to more than the number of records rated not achieved because four records had a combination of the above noted reasons.

St. 12 Reportable Circumstances: The compliance rate for this measure was **45**%. The measure was applied to 20 of the 35 records in the samples; nine were rated achieved and 11 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 11 records rated not achieved, 11 contained reportable circumstance reports but they were not submitted within 24 hours (the range of time it took to submit was between two and 22 days), and one contained documentation describing incidents where a reportable circumstance would be required but submitted reports were not found in the records. The total adds to more than the number of records rated not achieved because one record had a combination of the above noted reasons.

For the one record where reportable circumstance reports were required but not found, the practice analyst notified the executive director for follow up.

St. 13 When a Child or Youth is Missing, Lost or Runaway: The compliance rate for this measure was **67**%. The measure was applied to three of the 35 records in the samples; two were rated achieved and one was rated no achieved. To receive a rating of achieved, the record, if it involved a child or youth who was missing, lost, or runaway 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.

In the one record rated not achieved, there was no documentation that a safety plan was developed once the child/youth was found.

St. 14 Case Documentation: The compliance rate for this measure was **14**%. The measure was applied to all 35 records in the sample; five were rated achieved and 30 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 30 records rated not achieved, 27 did not contain review recordings nor care plan reviews, six did not contain opening recordings, three contained review recordings or care plan reviews but they were not completed every six months, one did not contain an opening recording and one did not contain a review recording nor a care plan review when there was a change in circumstances. 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 **33**%. The measure was applied to 21 of the 35 records in the samples; seven were rated achieved and 14 were rated not achieved. To receive a rating of achieved, the record if it involved a transfer of responsibility from one worker to another, confirmed that:

- A transfer recording was completed.
- The social worker met with the child or 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 or 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 or youth's family within five days after the transfer.

Of the 14 records rated not achieved, nine did not contain transfer recordings, 10 did not contain documentation that the social worker met with the child or youth prior to the transfer of guardianship responsibility, 11 did not contain documentation that the social worker met with the caregiver prior to the transfer, seven did not contain documentation that the social worker met with the service provider(s) prior to the transfer, 12 did not contain documentation that the social worker met with the child or youth five days after the transfer, and 10 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 14 records had combinations of the above noted reasons.

St. 16 Closing Continuing Care Files: The compliance rate for this measure was **45**%. The measure was applied to 11 of the 35 records in the samples; five were rated achieved and six were rated not achieved. To receive a rating of achieved, the record if it involved closing the record when services ended, confirmed that:

- A closing recording was completed.
- The social worker met with the child or youth prior to ending services and closing the record, 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 was notified, if applicable.
- Support services for the child or youth were put in place, if applicable.

Of the six records rated not achieved, three did not contain a closing recording, five did not contain documentation that the social worker met with the child or youth prior to the closure, one did not contain documentation that efforts were made to meet with the caregiver(s) prior to the closure, two did not contain documentation that support services were put into place, and one did not contain documentation that service providers were notified of the record closing. The total adds to more than the number of records rated not achieved because three 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 **0%.** This measure was applied to one of the 35 records in the samples; it was rated not achieved. To receive a rating of achieved, the record, if it involved a rescindment of a CCO, confirmed that:

- The risk of returning a child or youth to their family home was assessed by delegated worker.
- A safety plan, if applicable, was put in place prior to returning the child or youth to their 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.

The one record rated not achieved did not contain documentation that a safety plan was completed.

St. 18 Permanency Planning: A permanent plan is considered for a child with a CCO 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 (ICFSA), 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 **0**%. The measure was applied to 17 of the 35 records in the samples; all were rated not achieved. To receive a rating of achieved, the record, if it involved a move from a placement, confirmed the child or youth was interviewed about their care experience.

Of the 17 records rated not achieved, all did not confirm that interviews were conducted with the children and youth after placement changes.

St. 20 Preparation for Independence: The compliance rate for this measure was **82**%. The measure was applied to 17 of the 35 records in the samples; 14 were rated achieved and three were rated not achieved. To receive a rating of achieved, the record, if it involved a youth about to transition from care to 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 three records rated not achieved, one did not contain documentation confirming that the youth's independent skills were assessed nor was there a plan for independence and three did not contain documentation that efforts were made to develop a plan for independence. The total adds to more than the number of records rated not achieved because three records had combinations of the above noted reasons.

St. 21 Responsibilities of the Public Guardian and Trustee (PGT): The compliance rate for this measure was **81**%. The measure was applied to 26 of the 35 records in the samples; 21 were rated achieved and five were rated not achieved. To receive a rating of achieved:

- The PGT was provided a copy of the CCO.
- The PGT was notified of events affecting the child or youth's financial or legal interests.

All five of the records rated not achieved did not contain documentation confirming the PGT was notified when the CCOs were ordered.

St. 22 Investigation of Alleged Abuse or Neglect in a Family Care Home: The compliance rate for this measure was **0**%. The measure was applied to three of the 35 records in the samples, and all 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 or youth in a family care home, confirmed that:

- A Family Care Home Investigation was conducted with the summary report on file.
- Efforts were made to support the child or youth.

All the records rated not achieved had documentation that a Family Care Home Investigation occurred, but no summary report was located on file.

St. 23 Quality of Care Review: There were no applicable records for this measure. To receive a rating of achieved, the record, if it involved a concern about the quality of care received by a child or youth in a family care home, confirmed that a Quality-of-Care Review was conducted.

St. 24 Guardianship Agency Protocols: The compliance rate for this measure was **100**%. The measure was applied to all 35 records in the samples; all 35 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 **58%.** 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 14 records in the one sample selected for this audit; however, not all nine measures in the audit tool were applicable to all 14 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	14	14	0	100%
Standard 29 Family Care Homes – Application and Orientation	14	5	9	36%
Standard 30 Home Study	4*	2	2	50%
Standard 31 Training of Caregivers	14	12	2	86%
Standard 32 Signed Agreement with Caregivers	14	12	2	86%
Standard 33 Monitoring and Reviewing the Family Care Home	14	0	14	0%
Standard 34 Investigation of Alleged Abuse or Neglect in a Family Care Home	3*	1	2	33%
Standard 35 Quality of Care Review	1*	0	1	0%
Standard 36 Closure of the Family Care Home	1*	0	1	0%

Standard 30: 10 records did not involve home studies during the audit timeframe.
Standard 34: 11 records did not involve investigations of alleged abuse or neglect in family care homes.
Standard 35: 13 records did not involve Quality of Care Reviews.
Standard 36: 13 records were not closed.

St. 28 Supervisory Approval for Family Care Home Services: The compliance rate for this measure was **100**%. The measure was applied to all 14 records in the sample; all were rated 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 or youth in a family care home prior to completing a home study.
- Receiving a report about abuse or neglect of a child or youth in a family care home.
- Receiving a concern about the quality of care received by a child or youth living in a family care home.

St. 29 Family Care Homes – Application and Orientation: The compliance rate for this measure was **36**%. The measure was applied to all 14 records in the sample; five were rated achieved and nine 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 nine records rated not achieved, five (open) did not contain completed criminal record check(s), four did not contain the required prior contact checks, three did not contain completed medical exam forms, one did not contain the three reference checks, two did not contain orientations and three did not contain a completed application form. The total adds to more than the number of records rated not achieved because three of the records had combinations of the above noted reasons. Of the five open records that did not contain completed criminal records check(s), the practice analyst notified the executive director for follow up.

St. 30 Home Study: The compliance rate for this measure was **50**%. The measure was applied to four of the 14 records in the sample; two were rated achieved and two were 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 two records rated not achieved, both did not contain home studies and continue to be open, so the practice analyst notified the executive director for follow-up.

St. 31 Training of Caregivers: The compliance rate for this measure was **86**%. The measure was applied to all 14 records in the sample; 12 were rated achieved and two were rated not achieved. To receive a rating of achieved, the training needs of the caregiver were assessed or identified, and training opportunities were offered to, or taken by, the caregiver.

The two records rated not achieved did not confirm that offers of training were provided to the caregiver or that the training needs of the caregivers were assessed or identified.

St. 32 Signed Agreement with Caregiver: The compliance rate for this measure was **86**%. The measure was applied to all 14 records in the sample; 12 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, one did not contain Family Care Home Agreements throughout the three-year audit timeframe (open record) and one contained Family Care Home Agreements, but they were not consecutive throughout the three-year audit timeframe (open record). Of the one open record without an agreement, the practice analyst notified the executive director for follow up.

St. 33 Monitoring and Reviewing the Family Care Home: The compliance rate for this measure was **0**%. The measure was applied to all 14 records in the sample; all 14 were rated not achieved. To receive a rating of achieved:

- Annual reviews of the family care home were completed throughout the audit timeframe, when required.
- 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, when required.

Of the 14 records rated not achieved, 13 documented home visits but they were not completed every 90 days as required, one did not document any home visits, two contained annual reviews but they were not completed for each year in the three-year audit timeframe and two did not contain any annual reviews completed in the three-year audit timeframe. The total adds to more than the number of records rated not achieved because three records had combinations of the above noted reasons. Of the four records that did not contain all the required annual reviews, three were open. Of these three open records, all required current annual reviews. The practice analyst notified the executive director of the open family care homes that required 2021/2022 annual reviews.

St. 34: Investigation of Alleged Abuse or Neglect in a Family Care Home: The compliance rate for this measure was **33%.** This measure was applied to three of the 14 records in the sample; one was 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 or youth in a family care home, confirmed that:

- A Family Care Home Investigation was conducted with a summary report on file.
- Efforts were made to support the caregiver.

The two records rated not achieved, one contained documentation of a Family Care Home Investigation but there was no summary report on file and one (open) contained documentation that a Family Care Home Investigation was required but did not occur. The practice analyst notified the executive director of the open family care home that required a Family Care Home Investigation be completed.

St. 35: Quality of Care Review: The compliance rate for this measure was **0%.** The measure was applied to one of the 14 records in the sample, and the record was 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 or youth in a family care home, confirmed that:

- A Quality-of-Care Review was conducted.
- Efforts were made to support the caregiver.

The one record rated not achieved contained documentation that a Quality-of-Care Review was conducted but there was no summary report on file.

St. 36: Closure of the Family Care Home: The compliance rate for this measure was **0**%. The measure was applied to one of the 14 records in the sample, and it was rated not achieved. To receive a rating of achieved, the record, if it involved closure of a family care home, contained a written notice to the caregiver indicating the intent of the agency to close the family care home.

The one record rated not achieved did not contain written notice to the caregiver.

c) Family Service

The overall compliance rate for the Child Protection Response Model set out in Chapter 3 of the Child Safety, Family Support & Children in Care Services Policies was **47%.** The audit reflects the work done by the staff in the agency's family service program over various time periods (see Methodology section for details). All electronic documentation associated with Service Requests, Memos and Incidents was reviewed. All electronic and physical documentation associated with family service records was reviewed. There was a total of 44 records in the closed Memo, closed Service Request, and closed Incident samples and a total of 30 records in the open Family Service records and closed family service record samples selected for this audit. Not all 23 measures in the audit tool were applicable to all the records. The notes below the table describe the records that were not applicable.

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 CFCSA. During this audit, no records were identified for action.

c.1 Report and Screening Assessment

Family service measure (FS) 1 to FS 4 relate to obtaining and assessing a child protection report. The records included the selected samples of 27 closed Service Requests, 12 closed Memos and 36 closed Incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 1: Gathering Full and Detailed Information	33	31	2	94%
FS 2: Conducting an Initial Record Review (IRR)	33	17	16	52%
FS 3: Assessing the Report about a Child or Youth's Need for Protection (Completing the Screening Assessment)	33	26	7	79%
FS 4: Determining Whether the Report Requires a Protection or Non-protection Response	33	33	0	100%

FS 1: Gathering Full and Detailed Information: The compliance rate for this measure was **94%**. The measure was applied to all 33 records in the sample, 31 were rated achieved and two 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 two records not achieved, the records did not contain sufficient information to determine an appropriate pathway.

FS 2: Conducting an Initial Record Review (IRR): The compliance rate for this measure was **52%**. The measure was applied to all 33 records in the samples; 17 were rated achieved and 16 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 16 records rated not achieved, eight IRRs did not indicate that Best Practices was checked, five IRRs were not documented within 24 hours (one created at NIFCSS), four did not have IRRs documented (all created at NIFCSS), and four IRRs did not contain sufficient information about previous issues or concerns (three created at NIFCSS). The total adds to more than the number of records rated not achieved because three records were rated not achieved for more than one of the above noted reasons.

Of the five IRRs that were not documented within 24 hours, the range of time it took to complete the IRRs was between five and 525 days.

The audit also identified where the IRR was created: Provincial Centralized Screening (PCS), SCFS, or Service Delivery Area (SDA). Of the 17 records rated achieved, 13 were created by PCS, three were created by NIFCSS and one was created by an SDA.

FS 3: Completing the Screening Assessment: The compliance rate for this measure was **79**%. The measure was applied to all 33 records in the samples; 26 were rated achieved and seven were rated not achieved. To receive a rating of achieved, a Screening Assessment was completed immediately if the child or youth appeared to be in a life-threatening or dangerous situation or within 24 hours in all other situations.

Of the seven records rated not achieved, all Screening Assessments were not completed within the required 24-hour timeframe (five created at SCFS). Of the seven Screening Assessments that were not completed within the 24-hour timeframe, the range of time it took to complete was between three and 133 days.

The audit also identified where the Screening Assessment was created: PCS, SCFS, or SDA. Of the 26 records rated achieved, 18 were created by PCS, seven were created by NIFCSS and one was completed by an SDA.

FS 4: **Determining Whether the Report Requires a Protection or Non-Protection Response**: The compliance rate for this measure was **100%.** The measure was applied to all 33 records in the

sample; all records were rated 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.

c.2 Response Priority, Detailed Record 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 55 closed incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 5: Assigning an Appropriate Response Priority	11	11	0	100%
FS 6: Conducting a Detailed Record Review (DRR)	11	6	5	55%
FS 7: Assessing the Safety of the Child or Youth	11	10	1	91%
FS 8: Documenting the Safety Assessment	11	2	9	18%
FS 9: Making a Safety Decision Consistent with the Safety Assessment	11	10	1	91%

FS 5: **Determining the Response Priority**: The compliance rate for this measure was **100%**. The measure was applied to all 11 records in the sample; all records were rated achieved. To receive a rating of achieved, the response priority was appropriate and if there was an override it was approved by the supervisor.

The audit also assessed whether the families were contacted within the timeframes of the assigned response priorities. Of the 11 records related to incidents with appropriate protection responses, seven documented face-to-face contact with the families within the assigned response priorities and four did not. Of the four records that did not document face-to-face contact with the families within the assigned response priorities, all were assigned the response priority of within five days. In one of the four records, there was no documentation that the social worker made face-to-face contact with the family. The range of time it took to have face-to-face contact with the remaining three families was between six and 134 days with the average time being 81 days.

FS 6: **Conducting a Detailed Record Review (DRR)**: The compliance rate for this measure was **55%**. The measure was applied to 11 records in the sample; six were rated achieved and five were rated not achieved. 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 was no previous MCFD or ICFSA involvement.
- 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 five records rated not achieved, four did not contain a DRR, and one did not contain information missing in the IRR.

FS 7: **Assessing the Safety of the Child or Youth**: The compliance rate for this measure was **91%**. The measure was applied to 11 records in the sample; 10 were rated achieved, and one was rated not achieved. To receive a rating of achieved:

- The safety assessment process was completed during the first significant contact with the child or youth's family.
- If concerns about the child or youth's immediate safety were identified and the child or youth was not removed under the CFCSA, a safety plan was developed, and the safety plan was signed by the parent(s) 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.

The one record rated not achieved had no documentation that the safety assessment process was completed during the first significant contact with the family.

FS 8: **Documenting the Safety Assessment**: The compliance rate for this measure was **18%.** The measure was applied to 11 records in the sample; two were rated achieved and nine were rated not achieved. 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 nine records rated not achieved, one did not contain a Safety Assessment form and eight contained Safety Assessment forms that were not completed within 24 hours of completing the safety assessment processes. The range of time it took to complete the forms was between three and 1194 days.

FS 9: **Making a Safety Decision Consistent with the Safety Assessment**: The compliance rate for this measure was **91%**. The measure was applied to 11 records in the sample; 10 were rated achieved and one was rated not achieved. 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.

The one record rated not achieved did not contain a safety decision as a Safety Assessment was not completed.

c.3 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 55 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	11	9	2	82%
FS 11: Meeting with Every Child or Youth Who Lives in the Family Home	11	10	1	91%
FS 12: Visiting the Family Home	11	9	2	82%
FS 13: Working with Collateral Contacts	11	8	3	73%

FS 10: **Meeting or Interviewing the Parents and Other Adults in the Family Home**: The compliance rate for this measure was **82%**. The measure was applied to 11 records in the sample; nine were rated achieved and two were rated not achieved. 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 or 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 parent(s) and other adults in the home and the rationale was documented and appropriate.

Of the two records rated not achieved, one record did not confirm that the social worker met with or interviewed other adults in the home, and one record documented that only one of two parents was interviewed.

FS 11: **Meeting with Every Child or Youth Who Lives in the Family Home**: The compliance rate for this measure was **91%**. The measure was applied to 11 records in the sample; 10 were rated achieved and one was rated not achieved. To receive a rating of achieved, the social worker had a private, face-to-face conversation with every child or 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 or youth living in the family home, and the rationale was documented and appropriate.

Of the one record rated not achieved, it did not confirm that the social worker had conversations with any children or youth living in the home.

FS 12: **Visiting the Family Home**: The compliance rate for this measure was **82%**. The measure was applied to 11 records in the sample; nine were rated achieved and two were rated not achieved. 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.

Both records rated not achieved did not confirm that the social worker visited the family home.

FS 13: **Working with Collaterals**: The compliance rate for this measure was **73%**. The measure was applied to 11 records in the sample; eight were rated achieved and three were rated not achieved. 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 or 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 or youth and the rationale was documented and appropriate.

All three records rated not achieved 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 parent(s) prior to initiating the FDR responses and whether the social worker had discussions about which collateral contacts could provide the necessary information and reached agreements about the plans to gather information from specific collaterals. Of the 11 records in the sample, all required FDR responses. Of these 11 FDR responses, eight documented that the social worker contacted the parent(s) prior to initiating the FDR response and three did not. Furthermore, of these 11 FDR responses, four had documented discussions with the parent(s) about which collateral contacts could provide the necessary information and reached agreements about the plans to gather information from specific collaterals.

c.4 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 55 closed incidents.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS14: Assessing the Risk of Future Harm	11	4	7	36%
FS 15: Determining the Need for Protection Services	11	10	1	91%
FS 16: Timeframe for Completing the FDR Assessment or Investigation	11	1	10	9%

FS 14: **Assessing the Risk of Future Harm**: The compliance rate for this measure was **36%.** The measure was applied to 11 records in the sample; four were rated achieved and seven were rated not achieved. 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 seven records rated not achieved, six Vulnerability Assessments were not approved by a supervisor, two had incomplete Vulnerability Assessments and one did not contain a Vulnerability Assessment. The total adds to more than the number of records rated not achieved because two of the records had combinations of the above noted reasons.

The audit also assessed the length of time it took to complete the Vulnerability Assessments. Of the four records rated achieved, the range of time it took to complete the Vulnerability Assessments was between six days and 151 days.

FS 15: **Determining the Need for Protection Services**: The compliance rate for this measure was **91%**. The measure was applied to 11 records in the sample; 10 records were rated achieved and one was rated not achieved. 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.

In the one record rated not achieved the decision regarding the need for FDR protection services or ongoing protection services was not consistent with the information documented.

FS 16: **Timeframe for Completing the FDR Assessment or Investigation:** The compliance rate for this measure was **9%**. The measure was applied to 11 records in the sample; one was rated achieved, and 10 were rated not achieved. 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.

In all 10 records rated not achieved, FDR assessments or investigations were not completed within 30 days. The range of time it took to complete was between 188 and 1296 days.

c.5 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 30 open family service records and six closed family service records.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 17: Completing a Family and Child Strengths and Needs Assessment	30	4	26	13%
FS 18: Supervisor Approval of the Strengths and Needs Assessment	30	4	26	13%
FS 19: Developing the Family Plan with the Family	30	2	28	7%
FS 20: Timeframe for Completing the Family Plan	30	0	30	0%
FS 21: Supervisor Approval of the Family Plan	30	3	27	10%

FS 17: **Completing a Family and Child Strengths and Needs Assessment:** The compliance rate for this measure was **13%**. The measure was applied to all 30 records in the samples; four were rated achieved and 26 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 26 records rated not achieved, 24 did not contain a Family and Child Strengths and Needs Assessment, and two contained incomplete Family and Child Strengths and Needs Assessments.

The audit also assessed whether the Family and Child Strengths and Needs Assessment was completed within the most recent six-month practice cycle. Of the four records rated achieved, no Family and Child Strengths and Needs Assessments were completed within the most recent six-month practice cycle.

FS 18: **Supervisor Approval of the Strengths and Needs Assessment**: The compliance rate for this measure was **13%**. The measure was applied to all 30 records in the samples; two were rated achieved and 26 were rated not achieved. To receive a rating of achieved, the supervisor approved the Family and Child Strength and Needs Assessment.

Of the 26 records rated not achieved, 24 records did not contain Family and Child Strengths and Needs Assessments and two did not contain documentation of supervisory approval.

FS 19: **Developing the Family Plan with the Family:** The compliance rate for this measure was **7%**. The measure was applied to all 30 records in the samples; two were rated achieved and 28 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 28 records rated not achieved, 27 did not contain Family Plans or equivalents and one had a Family Plan or equivalent with no documented collaboration with family.

The audit also assessed whether the Family Plans or equivalents were completed after the Family and Child Strengths and Needs Assessments. Of the two records rated achieved, both contained Family Plans or equivalents that were completed after the Family and Child Strengths and Needs Assessments.

FS 20: **Timeframe for Completing the Family Plan:** The compliance rate for this measure was **0%**. The measure was applied to all 30 records in the samples; all 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 30 records rated not achieved, 27 did not contain Family Plans or equivalents and three contained Family Plans or equivalents within the 12-month timeframe of the audit but they were not revised within the most recent six-month practice cycle.

FS 21: **Supervisors Approval of the Family Plan:** The compliance rate for this measure was **10%.** The measure was applied to all 30 records in the samples; three were rated achieved and 27 were rated not achieved. To receive a rating of achieved, the Family Plan or its equivalent was approved by the supervisor.

Of the 27 records rated not achieved, all did not contain Family Plans or equivalents and eight Family Plans or equivalents were not approved by supervisors.

c.6 Reassessment

FS 22 relates to the completion of the Vulnerability Reassessment or Reunification Assessment. The records included the selected samples of 24 open family service records and 12 closed family service records.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 22: Completing a Vulnerability Reassessment or a Reunification Assessment	30	1	29	3%

FS 22: Completing a Vulnerability Reassessment OR a Reunification Assessment: The compliance rate for this measure was 3%. The measure was applied to all 30 records in the samples; one was rated achieved and 29 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 29 records rated not achieved, six did not contain Reunification Assessments, 16 did not contain any Vulnerability Reassessments, six did not contain Vulnerability Reassessments or Reunification Assessments completed within the most recent 6-month protection cycle, and one contained a Reunification Assessment, but it was incomplete.

c.7 Decision to End Protection Services

FS 23 relates to making the decision to end ongoing protection services. The records included the selected sample of 12 closed family service records.

Measures	Total Applicable	Total Achieved	Total Not Achieved	% Achieved
FS 23: Making the Decision to End Ongoing Protection Services	6	1	5	17%

FS 23: Making the Decision to End Ongoing Protection Services: The compliance rate for this measure was **17%**. The measure was applied to six records in the samples; one was rated achieved and five were rated not 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.

Of the five records rated not achieved, four did not have Vulnerability Reassessments or Reunification Assessments completed within most recent six-month practice cycle and one did not document that the family had the ability to access and use formal and informal resources.

7. ACTIONS COMPLETED TO DATE

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

1. In March 2023, the Terrace Guardianship team leader scheduled tracking meetings every two weeks to encourage documentation and review standards with the guardianship social workers.
2. The new social worker hired for the Terrace office will be focusing on assisting with completing care plans for children and youth who are in care under a temporary care order.

8. ACTION PLAN

On April 17th and 20th, 2023 the following Action Plan was developed in collaboration between Northwest Inter-Nation Family and Community Services Society and MCFD Office of the Provincial Director and Aboriginal Services Division – Quality Assurance Branch.

Actions	Persons Responsible	Expected Completion Date
<u>Child Service</u> St 2 Development of a Comprehensive Plan of Care & St 3 Monitoring and Reviewing the Child or Youth's Comprehensive Plan of Care: 1. The agency will provide care plan training for all relevant delegated staff. Confirmation of the training provided, and training date(s) will be provided, via email, to the manager of Quality Assurance. St 14 Case Documentation 2. The agency will provide training on the documentation requirements for a child service record to all relevant staff. Confirmation of the training provided, and training date(s) will be provided, via email, to the manager of Quality Assurance.	Practice Manager and MCFD Aboriginal Services Branch Practice Analyst	October 31, 2023
<u>Resources</u> St 30 Home Study & St 33 Monitoring and Reviewing the Family Care Home 3. The agency will complete all outstanding home studies and current annual reviews for all open family care homes. Confirmation of the completed home studies and annual reviews will be provided, via email, to the manager of Quality Assurance.	Practice Manager	October 31, 2023
<u>Family Service</u> 4. The agency will provide a review of the Core Accountabilities to all delegated staff. The agency plans to also engage their community to determine their own internal methods of assessing child and family strengths and vulnerabilities as outlined within core accountabilities. Confirmation of the training provided, and the training date(s) will be provided, via email, to the manager of Quality Assurance.	Practice Manager and MCFD Aboriginal Services Branch Practice Analyst	October 31, 2023

Confirmation of the dates of the engagement sessions and upon completion, provide the agreed upon documentation process, via email, to the manager of Quality Assurance.		
<u>Other</u> 5. The agency will provide ICM training for all relevant staff. Confirmation of the training provided, and the training date(s) will be provided, via email, to the manager of Quality Assurance. 6. The agency team leaders will review the AOPSI and Chapter 3 standards with all delegated staff. Confirmation of the date(s) of the standards and policy review will be provided, via email, to the manager of Quality Assurance.	Practice Manager, ICM Training Consultant and MCFD Aboriginal Services Branch Practice Analyst Practice Manager	October 31, 2023 October 31, 2023