Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Overview of findings of 2012 children's inspection activity: foster care and children's residential services

July 2013

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.

- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Table of Contents

1. Introduction

The Health Information and Quality Authority (the Authority or HIQA) derives its mandate from, and undertakes its functions in accordance with, the Health Act 2007 and other relevant legislation (the Child Care Act, 1991 and the Children Act, 2001).

The Health Act 2007 places the social services inspectorate function within the Authority on a statutory basis as the Office of the Chief Inspector of Social Services with specific statutory functions. The work of the Authority has been focused on children in care, primarily on inspection of residential care. The Health Act 2007 makes provision for the inspection and registration of designated centres for older people and children, and people with disabilities including children, and also the inspection of child protection and welfare services.

Inspectors conduct inspections of children's residential centres provided by the Health Service Executive (HSE) under section 69(2) of the Child Care Act, 1991 as amended by the Child Care (Amendment) Act 2011. Special care units are inspected annually against the Child Care (Special Care) Regulations 2004 and the *National Standards for Special Care* (2001). The Authority is authorised by the Minister for Children and Youth Affairs under section 69 of the Child Care Act, 1991 as amended by section 26 to inspect residential centres and report to the Minister on its findings.

2. Methodology used in compiling this report

This report summarises the findings of two types of inspection: the inspection of children's residential services and the inspection of foster care services. All of the inspections reviewed in this overview report were undertaken in 2012.

The first section of this report examines 33 full HIQA inspection reports of 33 children's residential care settings. It looks at all 10 Standards contained in the *National Standards for Special Care* (2001), and it considers some of the specific criteria under these Standards.

The Authority's inspection reports of children's residential services outline under each standard the practices that:

- met the required standard
- partly met the required standard
- did not meet the required standard.

This report sets out data on compliance with the Standards in the 33 residential care settings inspected, while a sample of 25% of the 33 inspection reports were examined in detail to identify areas where improvements were required.

The second section of this report reviews the findings of the eight foster care service inspections undertaken in HSE local health areas (LHAs) in 2012. The Authority's inspection reports outline for each standard whether or not the relevant standard was:

- met
- met in part
- not met.

Data is provided on compliance with the *National Standards for Foster Care* (2003) across the eight foster care services inspected. This section also focuses on a number of inspection reports to identify where service improvements are required and to highlight areas of good practice found by inspectors.

Because the grading systems used in inspections of fostering services and children's residential services differ, for the purpose of this report, all standards for both children's residential centre and fostering services have been grouped into:

- standard met
- standard met in part and
- standard not met.

3. Findings from inspections of the residential centres

3.1 Overall summary of findings for children's residential services

This report examines the inspection reports for 33 residential centres for vulnerable children, mostly aged between 12 and 18 years. Children using these services have, in the main, varied and complex needs. Many of the children have often experienced a number of placements before their admission to residential care. Their behaviour may present a significant challenge to services if they put themselves and others at risk of significant harm.

During 2012, services demonstrated that they had met many of the *National Standards for Special Care* with few Standards not being met. Overall, HIQA found evidence of dedicated and committed staff, who were appropriately qualified. Their intervention led to many positive outcomes for children and young people who use the services. However, HIQA inspectors noted considerable challenges for services, and that improvements were still required. The system was found to be under significant pressure in certain aspects, and in some instances, these pressures were placing children at risk.

3.2 Emerging themes

National Standard 1: Purpose and Function

The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

HIQA findings during 2012

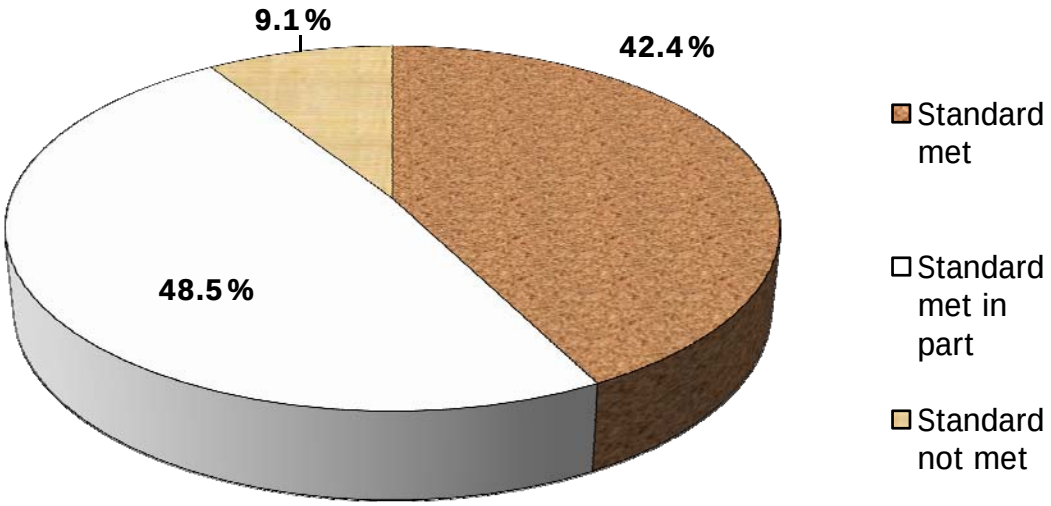
Not all centres had an up-to-date statement of purpose that accurately reflected the population of the centre at the time of inspection. The statement of purpose should be considered as the foundation document which defines the centre and the nature of services provided. Operating a centre in line with a clear, consistent statement of purpose means that well trained, well managed staff will be in place with the skills, experience and competence to provide safe, good quality care for the type of child or young person admitted to the centre.

The statement of purpose informs all children and parents about what the service is

supposed to do and what they can expect from it. Their experience of processes such as admission and discharge, for example, may be measured against the policies identified in the statement of purpose.

This Standard was deemed to be fully met in over 42% of the 33 inspection reports considered and met in part in 48.5%. It was not met in 9% of cases (see Figure 1). In some of the reports sampled, the statement of purpose was changed frequently in order to respond to the needs of children who required a placement. This meant that, over time, the purpose of the service became confused, affecting its stability and compounding the risk that children whose needs could not be met by a service might be admitted to it. This could contribute to placement breakdowns and cause considerable disruption in children and young people's lives as well as affecting their rights to safe, continuous care.

Figure 1. Compliance with Standard 1: Purpose and Function



National Standard 2: Management and Staffing

The centre is effectively managed and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

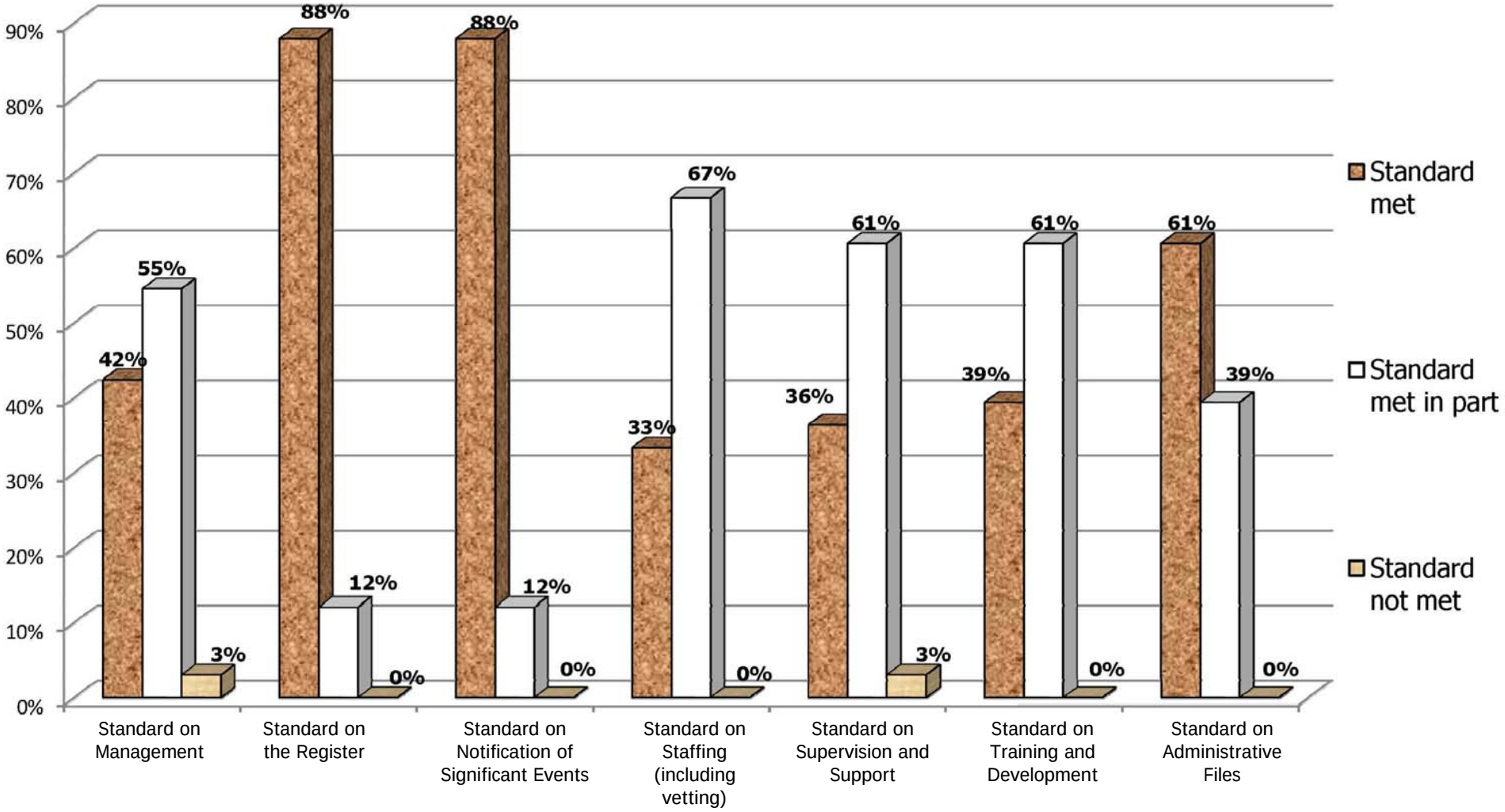
HIQA findings during 2012

There was a mixed profile of findings in relation to this Standard (see Figure 2 on the next page). Suitably qualified managers were in place (with a small number of exceptions) and sufficient staff were employed in the main. The administrative requirements of management were easier for managers to meet than those which were operational. For example, there was evidence of good practice in maintaining the register of children who were living in the centre. However, deficits were identified in the frequency of staff supervision, and there was a lack of management oversight in terms of complaints and analyses of placement breakdowns.

There was evidence that managers did not identify and manage all risks and some essential training had not been provided or undertaken. For example, children and young people in this sector presented with behaviour that challenged and took part in risk-taking behaviour such as going missing from the service. Staff undertook training in crisis management but did not receive any other training from the HSE on managing behaviour that challenges.

There were also issues in relation to safety and safeguarding training, and fire safety training, while there had been little training in *Children First: National Guidance for the Protection and Welfare of Children* (2011). Not all staff had up-to-date fire training, and inspectors found that staff and young people did not participate in fire drills to a satisfactory level. Not all staff had up-to-date Garda Síochána vetting at the time of inspection.

Figure 2. Findings under Standard 2: Management and Staffing



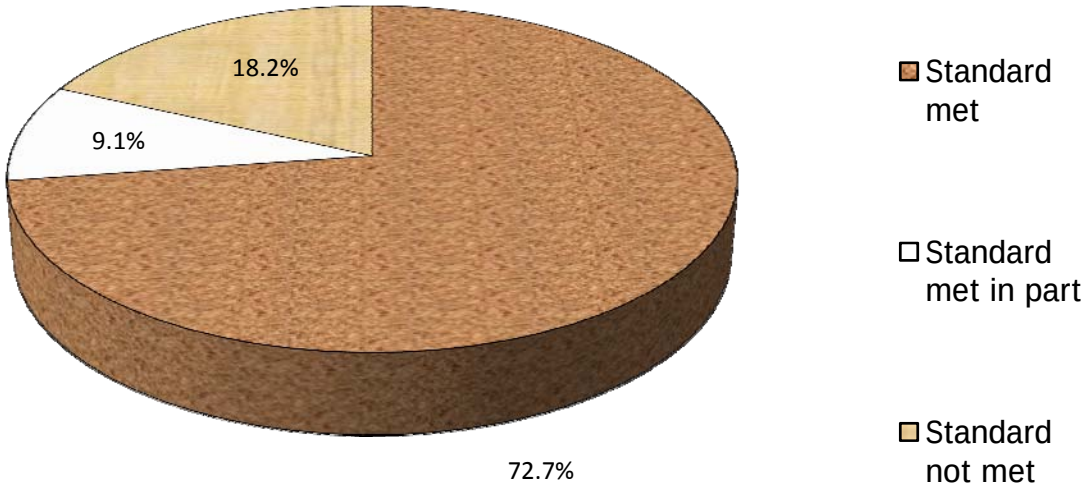
National Standard 3: Monitoring

The Health Service Executive, for the purpose of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the Health Service Executive, to monitor statutory and non-statutory children's residential centres.

HIQA findings during 2012

This standard was met in 72.7% of centres and was partly met in 9.1% of centres inspected. However, the HSE failed to meet this Standard for over 18% of the centres inspected by HIQA (see Figure 3). Inspectors found that this was because the HSE did not have sufficient monitoring officers in place in all areas, due to staff vacancies and the concurrent moratorium on public sector recruitment. As a result, monitoring officers were not providing external scrutiny of significant events, notifications and use of restraint as well as reviewing general compliance with regulations in these centres.

Figure 3. Compliance with Standard 3: Monitoring



National Standard 4: Children's rights

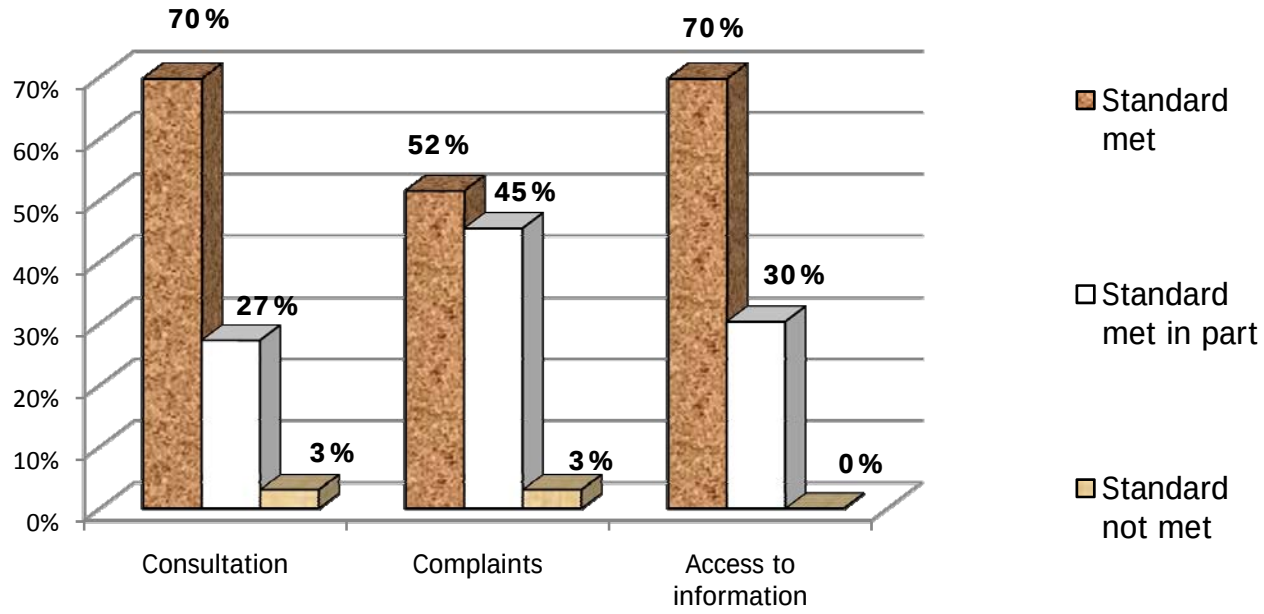
The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.

HIQA findings during 2012

Inspectors found that a culture of consultation and an open attitude to accessing information had been established in the centres. In the majority of cases, there was evidence that children were consulted about the day-to-day running of the centres (see Figure 4 below) and they had access to information about themselves.

Overall, complaints were well managed, but in some instances staff were not always clear about the difference between formal and informal complaints, and not all complaints were recorded. There was little analysis of formal and informal complaints and this was a missed opportunity to improve services. Complaints management provides an additional layer of safeguarding and a rigorous system of managing complaints is required in order to protect children's rights. There was a risk that such complaints might not be taken seriously or dealt with effectively.

Figure 4. Findings under Standard 4: Children's Rights



National Standard 5: Planning for Children and Young People

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

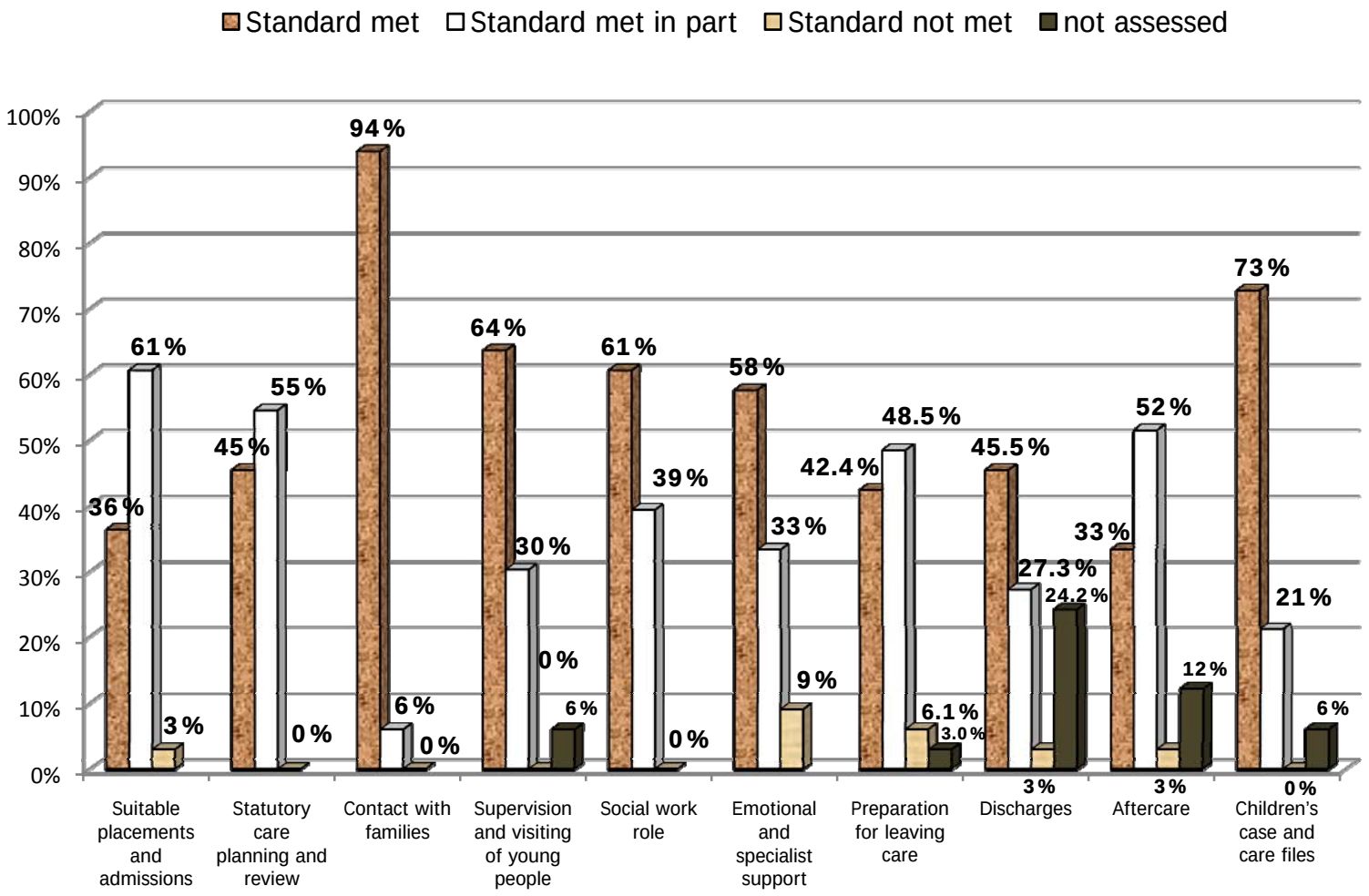
HIQA findings during 2012

There was a mixed picture in terms of compliance with this Standard (see Figure 5 on the following page). Care planning had resulted in children maintaining good quality contact with their families in 94% of inspections. In general, case files were well maintained and children were supervised and visited by social workers. More worryingly, there were was a lower rate of full compliance in relation to the suitability of placements and admissions. This may correlate with the deficits identified in the Standard on statement of purpose.

Young people leaving care require considerable support in order to achieve their full potential in adult life. Not all young people have the support of family members and many have experienced difficult events in their lives. Many of these young people had already experienced more than one placement in their care history and were likely to experience challenges in the transition to adult life. The Standard on aftercare was only met in 33% of inspections and there were also deficits in preparation for leaving care. Most children had a care plan, but there was insufficient evidence of aftercare planning in the plans. Considering the vulnerability of young people who are leaving the residential care system, this is an area of concern.

During 2012, there were some difficulties identified in accessing specialist psychological and mental health supports for children, with this Standard collectively not met or met in part in nearly half (42%) of the inspections. Again, this is of concern to the Authority and such deficits in specialist service could undermine the resilience of placements.

Figure 5. Standard 5: Planning for Children and Young People



National Standard 6: Care of Young People

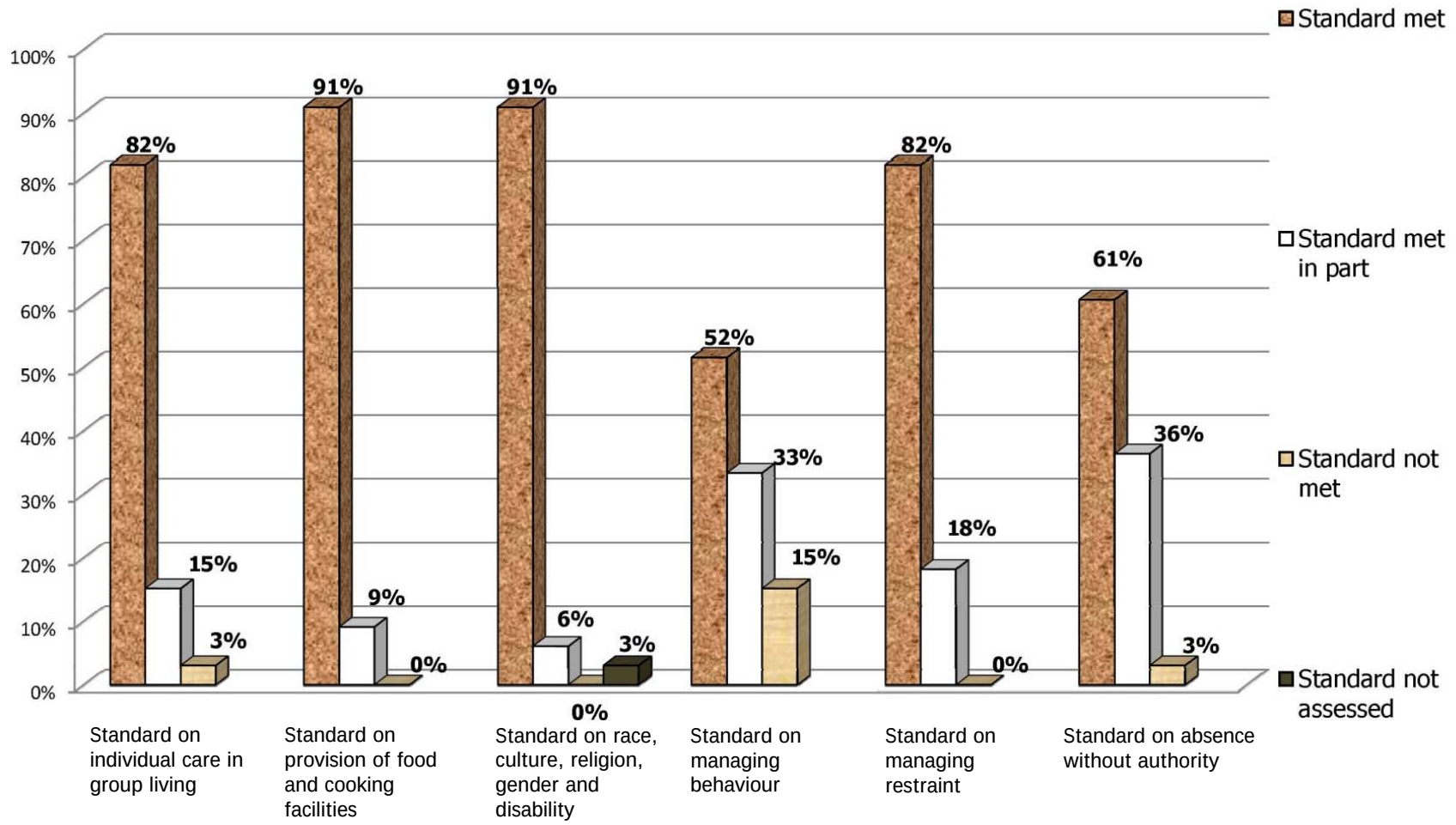
Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

HIQA findings during 2012

It was reassuring to find that of the services inspected, the highest percentage of the Standards that were met in 2012 were met in this area (see Figure 6 on the next page). The quality of care provided to children individually was good and their needs in terms of food and nutrition were met. There was evidence that children's race, culture, religion and gender were respected and that consideration was given to the needs of children with disabilities. Children's individual needs were reflected in their placement plans and the care plans. The Standard in relation to the use of restraint was met in 82% of cases. This was particularly encouraging as the inappropriate use of physical restraint can pose a threat to children's rights and safety.

Inspectors also found room for improvement. Staff were challenged in terms of responding to and managing some children's behaviour and this was an area in which there were most incidences of the Standard not being met (15%). In some centres, children and young people engaged in significant risk-taking behaviour but not all had risk assessments or crisis intervention plans in place. This may be associated with gaps in specialist supports for the children and compounded by the deficits identified in the training, support and supervision of staff. In addition, the Standard in relation to children being absent without authority was met in only 61% of inspection reports. Often, staff took an approach whereby positive behaviours were rewarded and more negative behaviour received sanctions. However, this required that all staff would be consistent when using rewards and sanctions and this was not always the case.

Figure 6. Findings under Standard 6: Care of Young People



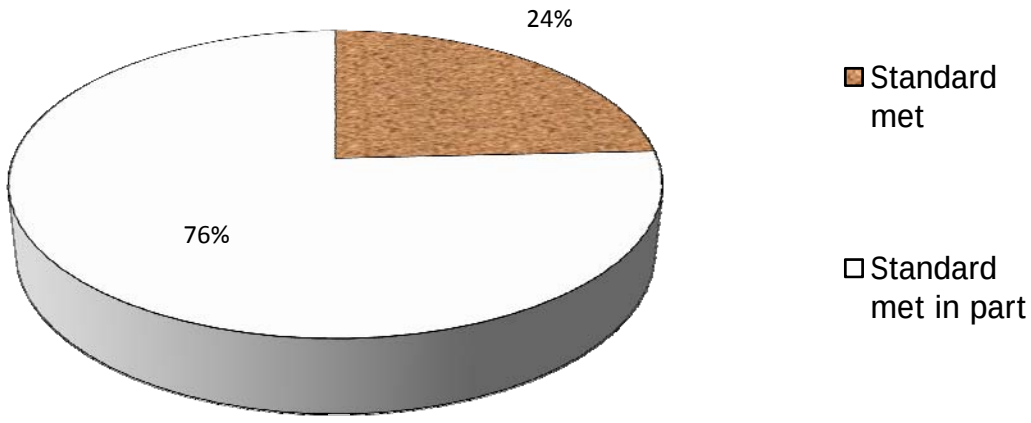
National Standard 7: Safeguarding and Child Protection

Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

HIQA findings during 2012

It is of concern that this Standard was met in only 24% of inspections during 2012, and that otherwise it was met in part (see Figure 7). The deficits in this area related to the incorrect classification of incidents as 'significant events' rather than as child protection concerns. There was a risk that allegations or concerns about possible abuse might not receive the appropriate response. For example, one report noted that a child protection concern had not been reported by staff members to the relevant social worker. There were also deficits in staff members' familiarity with the child protection and safeguarding policies and with the requirements for inter-agency communication. On a more positive note, children told inspectors that they felt safe and knew who to talk to if they had a concern.

Figure 7. Compliance with Standard 7: Safeguarding and child protection



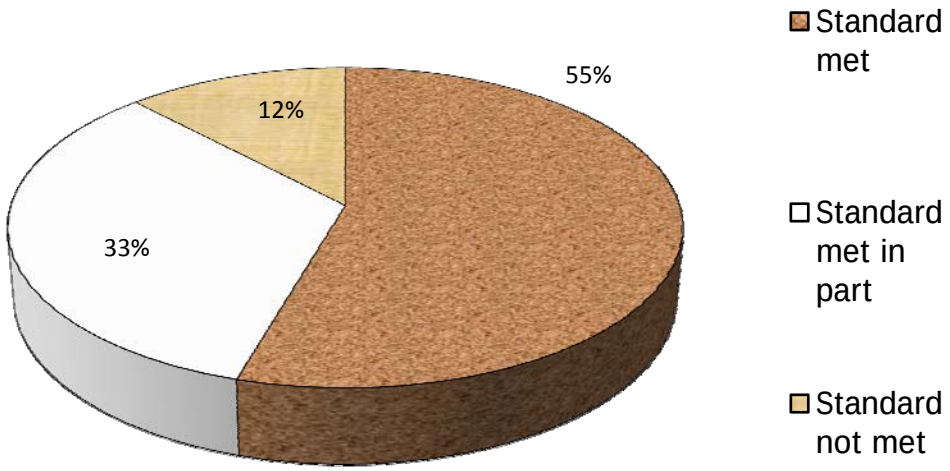
National Standard 8: Education

All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate educational facilities.

HIQA findings during 2012

Although this Standard was noted as being met in full in only 55% of inspections, this reflected an upward trajectory in terms of children's attendance and achievements in school due to the support and encouragement of staff (see Figure 8). During 2012, improvements had been made, although there were four centres in which the Standard was not met, as children were not attending school and had not been doing so for significant periods of time. In mitigation, there was evidence that staff were working hard either to engage children with school or to access places for them in the education system. While not all children were regularly attending school, there was plenty of evidence to show that many children were achieving good educational outcomes.

Figure 8. Compliance with Standard 8: Education



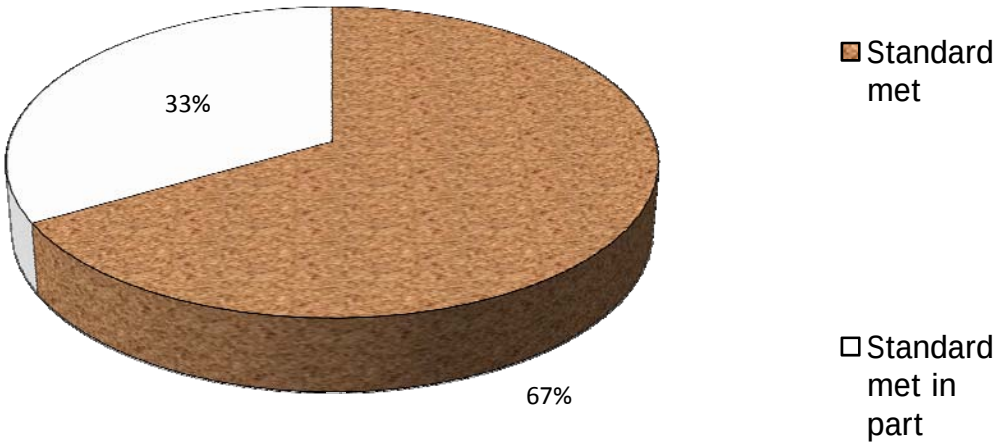
National Standard 9: Health

The health needs of the young person are assessed and met. They are given information and support to make age-appropriate choices in relation to their health.

HIQA findings during 2012

In 67% of inspections during 2012, it was noted that children's health needs were being met in line with the standard (Figure 9) and they all had access to general practitioners (GPs). There were no inspections that noted that practice did not meet the required Standard. The main issue related to the lack of continuity in the historical healthcare records for the children, particularly immunisation records. This may be a result of the children's care histories during their early childhood.

Figure 9. Compliance with Standard 9: Health



Standard 10. Premises and Safety

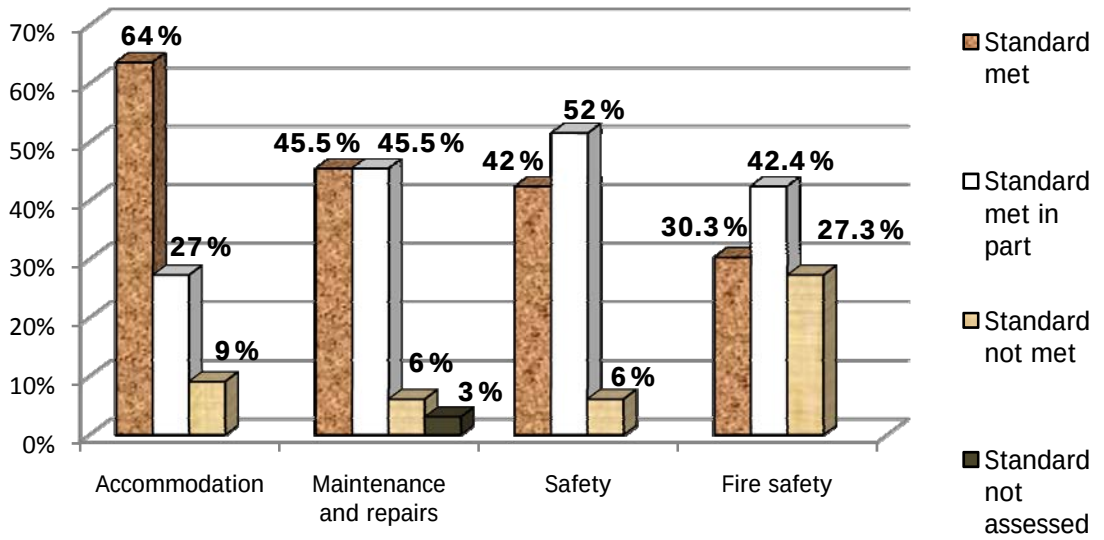
The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care Regulations, 1995.

HIQA findings during 2012

Over 27% of centres did not meet the fire safety Standard while over 42% met the Standard in part (Figure 10). This was of concern to inspectors. Staff training, fire drills and compliance with fire safety and building regulations were the main areas of non-compliance found by inspectors. A high number of centres were not able to provide satisfactory evidence of compliance from an architect or certified engineer that all requirements in relation to fire safety and building control regulations had been met. Considering the population of the centres and the fact that some children set fires, the lack of training and poor practice in terms of fire drills presented a serious risk.

Other deficits which required action were identified. Some premises were identified as being unsuitable for use as a residential centre and not all were in a good state of repair. There was a lack communal space for visitors and not all services had created a homely atmosphere. There were also gaps in safety statements. A robust process of risk assessments was required in order to provide a safe and suitable environment.

Figure 10. Findings under Standard 10: Premises and Safety



4. Discussion on children residential services inspection findings

The findings of the Authority's inspections of residential services in 2012 demonstrate that the provision of residential care services to children and young people in Ireland continues to be challenging. It is not surprising that both the Health Service Executive (HSE) nationally and staff members in local services find that meeting the needs of sometimes highly vulnerable children – often displaying extremely challenging behaviour – to be a complex and demanding undertaking. During 2012, the Authority found areas of good practice and areas where services needed to improve. Residential services for children inspected by the Authority in 2012 delivered safe care for children in the majority of cases. There was evidence that the health and educational needs of the children were met and, in the main, that their rights were upheld. Notwithstanding the good practice in evidence, the Authority remains concerned about children's journey through the residential care system, how they come to be admitted to centres, and what will happen to them when they leave.

Each residential service should have a clear statement of purpose which is up to date, regularly reviewed and not subject to constant change. Only children whose needs may be met by a service as described in its statement of purpose should then be admitted to the centre. The needs of individual children become acute in moments of crisis and there is pressure to place them in residential care, as close as possible to their communities. This can mean that if any service has a vacancy, the appropriateness of the placement and the abilities of a staff team to meet their needs may become a secondary consideration. As a result, children may be admitted to centres which cannot meet their needs.

In order to meet the needs of children and young people requiring residential care, a proactive strategy is required by the HSE National Office for Children and Family Services. A national strategy, based on a geographical needs analysis and with a child-centred focus, should support a responsive, flexible, localised service informed by the assessed needs of children and young people. This strategy should support a value for money approach, target the use of what is a costly resource, and reduce the number of placements by the HSE of children and young people in other jurisdictions, or in services which move them away from their own localities.

Inevitably, preventing and managing risk-taking and other challenging behaviour remains an issue. In a small number of centres inspected by the Authority in 2012, some young people were not safe and staff teams could not meet their needs. Some services would benefit from a review to ensure that they are fit for purpose. Inspectors found other safety issues, some of which were unexpected as they related to straightforward gaps in training and knowledge which could easily be addressed without significant expenditure. Considering the nature of the care population, training in child protection and fire prevention should be a priority for all providers of residential services for children.

The quality of children's residential services is almost entirely dependent on the commitment and quality of the staff team and its leadership. Each staff team needs to be experienced, qualified, well trained and supported to provide care for children. Strong leadership and robust governance is essential and where HIQA found that this was in place, there were much better outcomes for children. The limitations of the current set of Standards mean that the critical leadership role of the person in charge is not always easy to express in reports. The development of revised national standards for children's residential centres would bring about a more probing inspection process which would better reflect current thinking and best practice.

Next steps

The Authority continues to carry out inspections of HSE residential centres for children to monitor their compliance with Standards and regulations. The HSE has submitted action plans in response to the Authority's reports issued following inspections, including plans relating to any identified risks. When required, further inspections have been carried out to monitor progress made by the HSE in addressing non-compliances. The aggregated findings and analysis contained in this report will allow the HSE/Child and Family Agency to address deficits, make changes at a corporate level and address common themes which emerged during 2012, in order to improve the quality and safety of residential services provided to children.

5. Findings from the inspection of foster care services

5.1 Overall summary of findings of foster care service

Children achieve best outcomes when living in a family context. In the rare instances when children cannot live with their own families, the next best option is that they live in foster care. In addition, wherever possible, children should be able to live in foster care placements provided by their relatives. In this way, children remain in touch with their families, friends and communities.

Overall, inspectors found that foster carers provided good quality care to children and young people in a safe environment. However, inspectors also found that some children lived with unapproved foster carers, sometimes for long periods of time, and that the investigation by the HSE of allegations made against foster carers was not always timely.

In many areas there were insufficient numbers of foster carers. Although there were not many children awaiting foster care placements, there was little capacity in the system to respond to emergencies or especially complex needs. The system of matching children's needs with the skills of foster parents was often dependent solely on the availability of placements. There was a risk that children would be placed with foster carers who could not meet their particular needs.

Staff shortages had impacted on the HSE's capacity to deliver a safe high quality fostering service. As a consequence:

- not all children in foster care had a social worker
- not all foster carers had a link social worker (link social workers support carers in caring for children)
- assessments were not carried out in a timely manner.

HSE local health areas (LHAs) found it difficult to prioritise the assessments of the relative foster carers and such assessment could take up to a year to complete. There is therefore a possibility that children might be at risk of receiving less than optimal care during this period of time with carers whose assessments were not completed. Nonetheless, inspectors found examples of high quality social work practice which supported the safety of children and promoted good outcomes for them. Foster care assessments were found to be comprehensive once complete. This was likely to be a contributing factor in the resilience of placements and the quality of care provided by foster carers which mitigated any gaps in the supports provided by the LHAs. Inspectors found that there were many good outcomes for children in terms of their health and their attendance at school. In their daily lives, children's choices were considered and their dignity and privacy were respected. However,

these outcomes were dependent upon the quality of foster carers who were not always adequately supported or monitored. In addition, some children did not have social workers allocated to them which compounded possible gaps in supervision.

5.2 Emerging themes

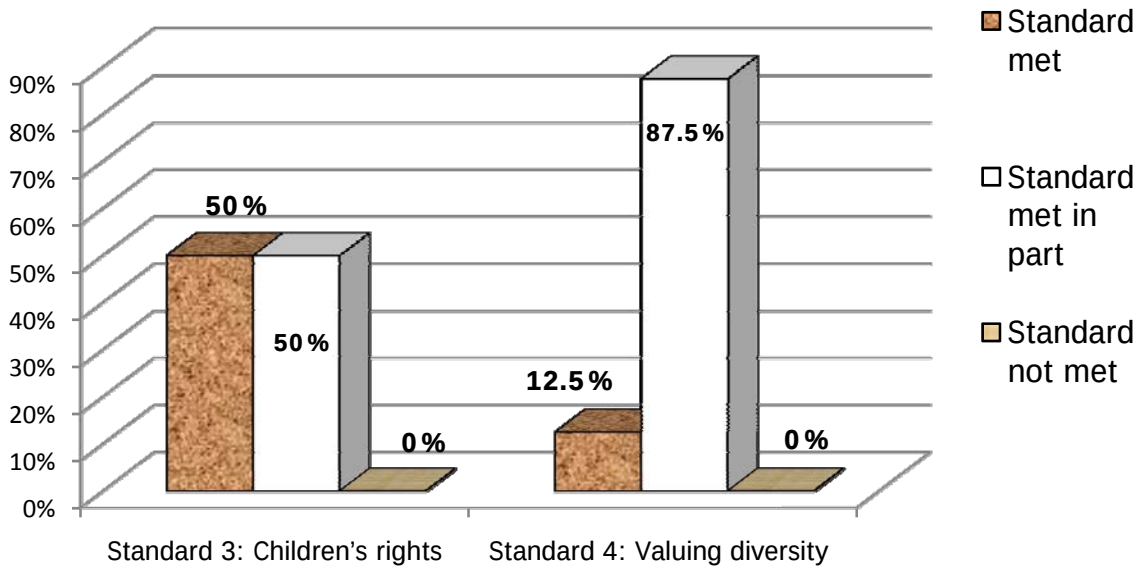
Outcome 1 – Each child receives a child-centred service that respects their rights and responsibilities.

Under this outcome measure, children in foster care receive a service that recognises their rights including their right to be listened to. They participate in making decisions and are encouraged to voice their opinion. They are communicated with in an open and honest manner. Diversity is recognised and children feel valued as individuals.

HIQA findings during 2012

The findings against Outcome 1 are outlined in Figure 11.

Figure 11. Findings against Outcome 1 during 2012



Children and young people were able to exercise choice in their lives and their rights were respected. However, they did not always have written information on their rights or on the complaints process, and were dependent on individual social workers in this regard.

The HSE had not always been successful in recruiting foster carers from a range of backgrounds to meet the needs of children from different nationalities, ethnicities and religions. Social workers made efforts to mitigate this gap by carrying out good quality individual work with children. Foster carers were respectful and sensitive to children's needs in this regard. However, international best practice* would indicate that children should be placed with foster carers from their own cultural backgrounds and community wherever possible.

Individual social workers and foster parents carried out excellent work with young people and made efforts to help them become more independent and develop the necessary skills to make the transition to independent adult life. Young people who were going to remain in households with their foster carers were obviously less at risk, and the HSE provided funding and support for young people who were remaining in education and training.

However, there were gaps identified in planning for young people who were leaving care and having access to an aftercare service. Plans were not always developed for young people once they were aged 16 and there were a limited number of available aftercare workers. This posed a risk to young people who might not receive the supports they required at a particularly vulnerable time in their lives.

* Sinclair, Ian, (2005) Fostering Now: Messages from Research. London, Jessica Kingsley.

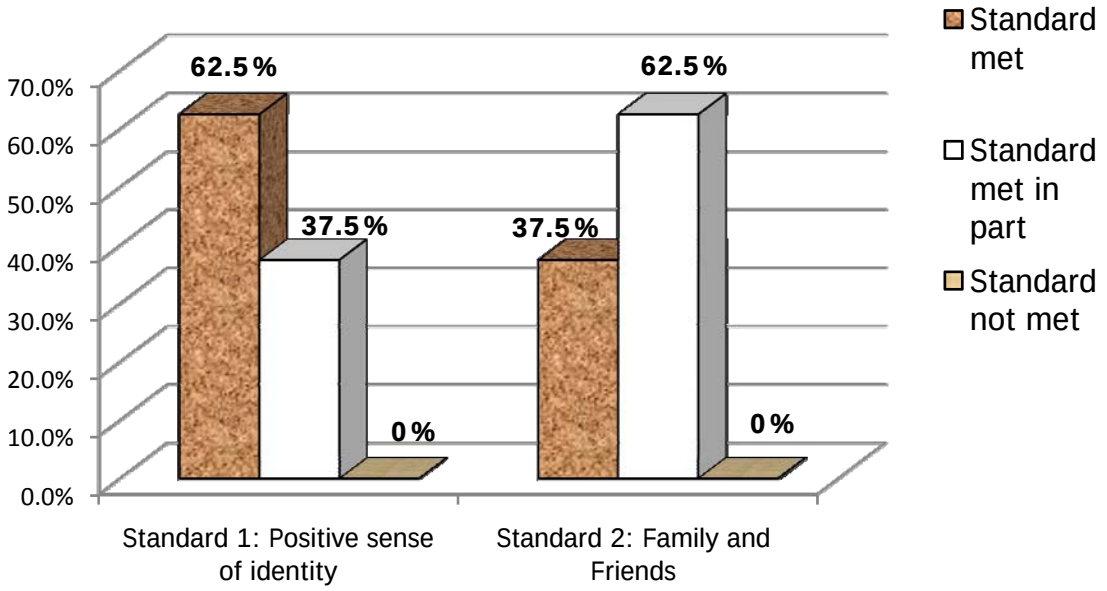
Outcome 2 – Children are able to maintain positive relationships with their parents, siblings and other significant family and friends.

Under this outcome measure, children's relationships with their families are actively promoted through regular, quality contact as appropriate to their safety. Siblings are placed together wherever possible. Services recognise the intrinsic value of kinship through placing children as much as possible with relatives and in their community. Children are supported in making, and maintaining contact with, their friends.

HIQA findings during 2012

The findings against Outcome 2 are shown in Figure 12.

Figure 12. Findings against Outcome 2 during 2012



In general, the HSE worked hard to maintain relationships between children and their families and to support a positive sense of identity for children. Social workers prioritised the placement of children within their families, and looked for relative foster care placements as a priority. Life-story work was provided by social workers to many children to help them understand past events. Children were encouraged to keep mementos of their families of origin and family members were involved in significant events such as birthdays. The HSE was not always able to keep sibling groups living together in one household, but this was often due to the size of the group and efforts were in place for children to meet up and maintain contact with each other.

It was more difficult for the HSE to provide access visits by birth family members in

suitable surroundings, and specific facilities which were in place were working at full capacity. Contrary to best practice, it was rare for such access visits to take place in foster carers' homes. Some children were placed in foster care outside of their local communities, sometimes with relatives but also with private foster care providers. If the inter-area transfer policy (where cases are transferred from one HSE area to another once a child has moved to the foster care placement in the new HSE area) was not being followed, social workers in the original HSE placement area spent long periods of time travelling to visit children in foster care or facilitate access in the new placement area, and this was not a good use of resources.

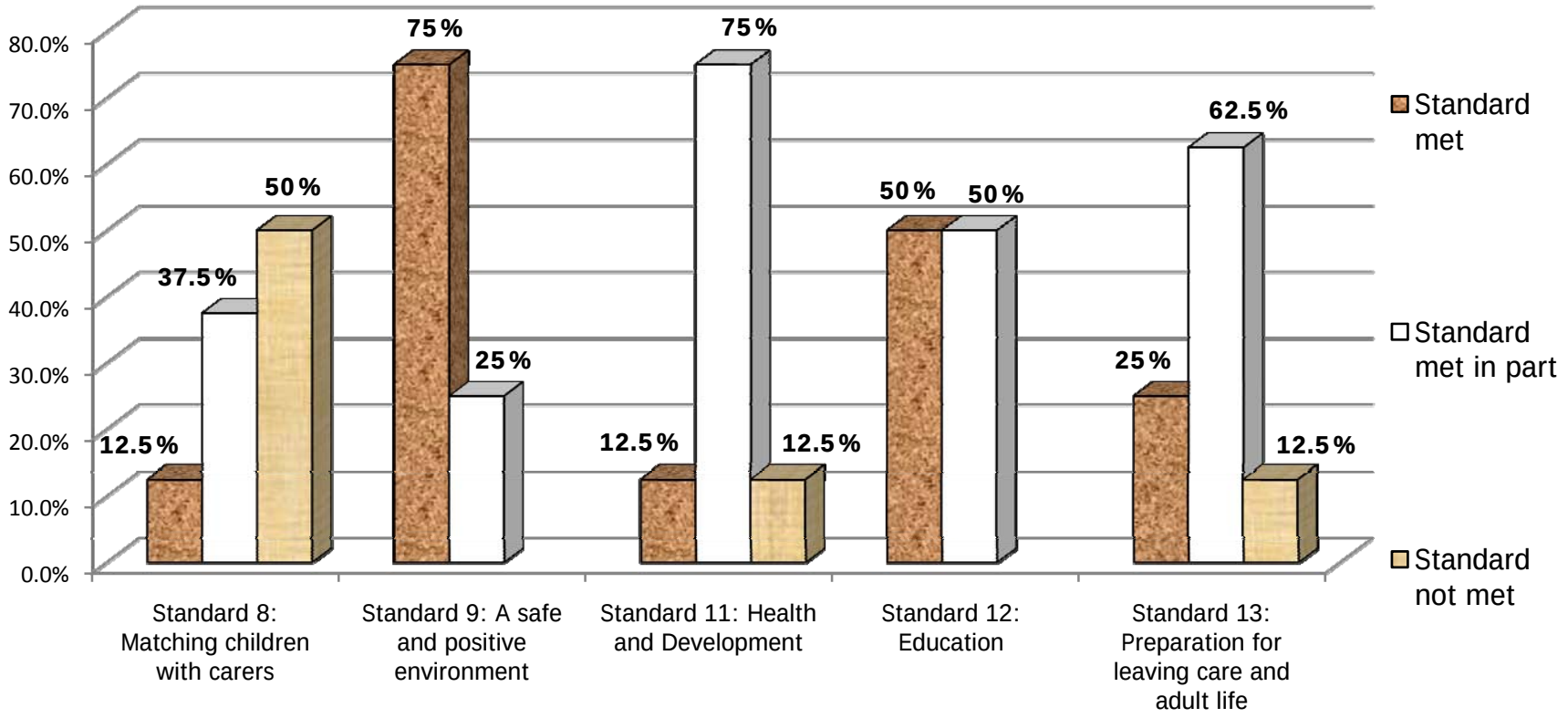
Outcome 3 – Each child achieves positive outcomes in relation to their health and development, education and transition to adulthood.

Children achieve their potential through having stable placements where they receive high quality care that promotes their self-confidence and self-esteem. Children are healthy and understand the importance of looking after their health. Their educational needs are given high priority and they attain their full potential. They experience support and security as they grow towards adulthood and independence.

HIQA findings during 2012

In general, there was evidence that children were well cared for and lived in safe and homely environments (Figure 13 on the next page). They had personal items in their rooms and were integrated into the families with whom they lived. Foster carers prioritised education, and there was evidence that children's health and educational needs were met. There was some potential risk in relation to gaps in children's medical histories, but these may not have been in the social workers' control, particularly in regard to immunisation information. LHAs did not measure educational outcomes for children but focused on their attendance at school and this was an area that required improvement. Foster carers experienced difficulty in obtaining specialist resources for children, particularly those with mild learning difficulties. They were supported by social workers but were frustrated that the needs of children in their care were not prioritised.

Figure 13. Findings against Outcome 3 during 2012



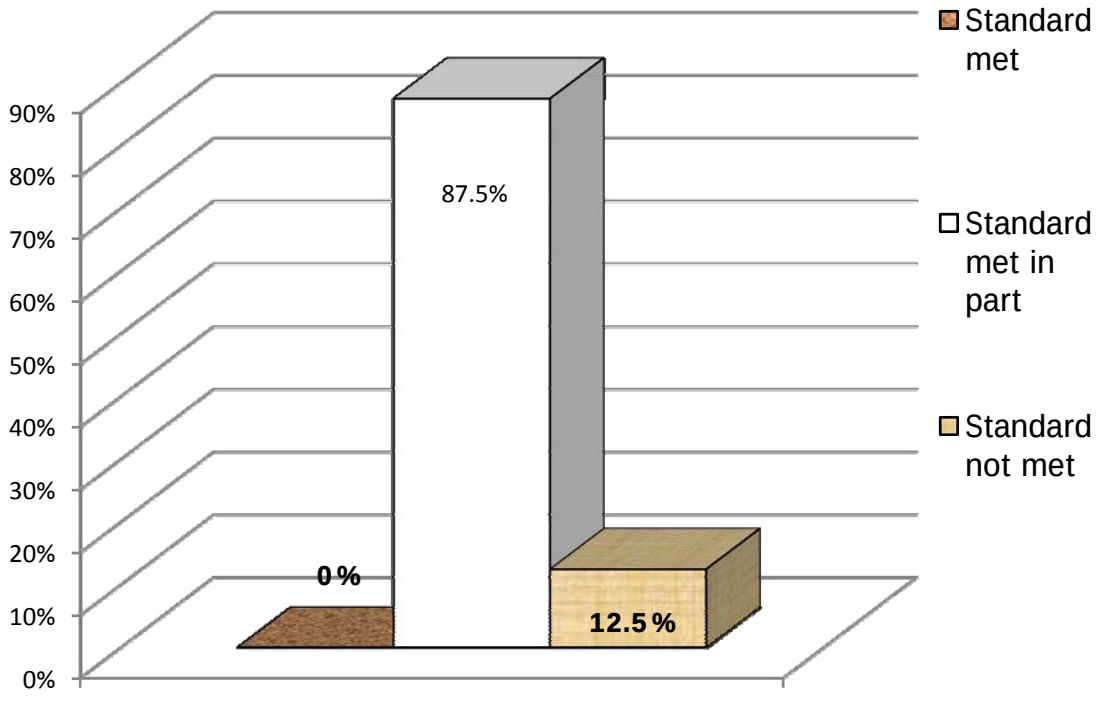
Outcome 4 – Children are safe and services comply with *Children First: National Guidance for the Protection and Welfare of Children.*

Under this outcome, children are safe and protected from abuse. They experience safety and security in their placements. Children that disclose abuse are supported and their concerns acted upon. *Children First: National Guidance for the Protection and Welfare of Children* (2011) is effectively implemented in a manner that protects and safeguards children.

HIQA findings during 2012

The inspection reports show that there were gaps in safeguarding arrangements. During the inspections under review, no foster care service met in full the Standard on safeguarding and child protection. However, this Standard was met in part in over 87% of inspections (Figure 14).

Figure 14. Findings against Outcome 4 during 2012



Standard 10: Safeguarding and child protection

Foster carers had received training on safe care as part of their initial training but had not had any update, particularly in relation to *Children First: National Guidance for the Protection and Welfare of Children* (2011). This was particularly worrying as some foster carers were caring for children with complex needs. Some Garda

Síochána vetting for foster carers was out of date. Some children continued to live in households where the carers had not been approved as foster carers, even where allegations had been upheld against adults in the home. In general, the investigation of allegations was slow.

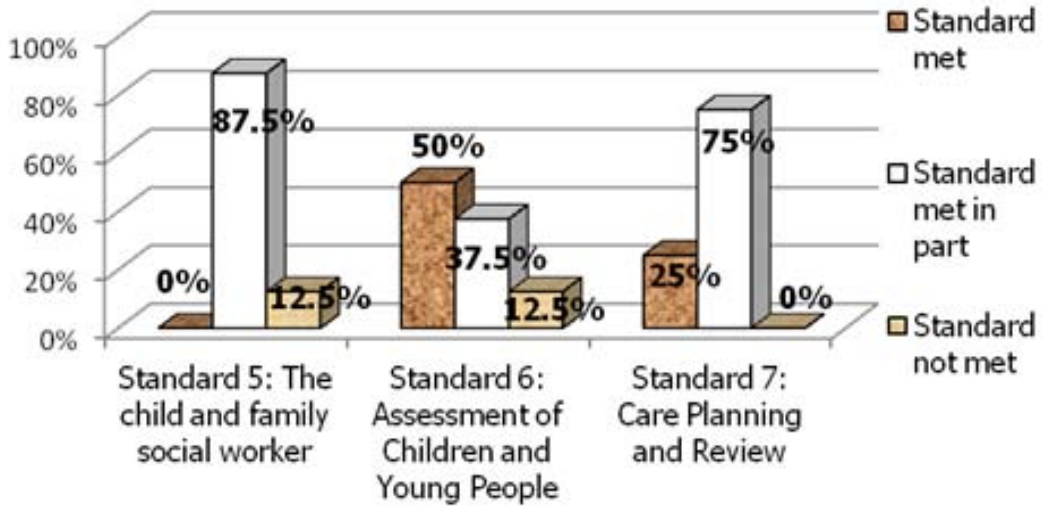
Outcome 5 – Each child receives high quality care that is effectively planned and managed by a designated social worker.

Each child has a designated social worker that plans and supports their lives while they are in care. They are involved in making decisions about their lives. Birth families and carers are consulted in making and implementing care plans. Everyone works together to support and guide children in their lives.

HIQA findings during 2012

The findings against Outcome 5 are shown in Figure 15.

Figure 15. Findings against Outcome 5 during 2012



Foster care services were experiencing the impact of staff vacancies and the HSE was struggling to meet its statutory obligations as a result. This meant that not all children in foster care had a social worker. Some children did not have an up-to-date care plan and some children were living with foster carers whose assessments were not complete. A number of children had experienced several changes in social worker and thus found it hard to build meaningful relationships with them. There was a risk that some children might not approach a social worker if there had been a number of changes in personnel.

If a child had an allocated social worker, the quality of the social work service that they received was generally good. The majority of children had assessments on

which plans to meet their needs were based, and care plans were comprehensive. Children attended their reviews, had confidence in their social workers and would tell him/her if they had a problem. The frequency and quality of monitoring was found to be good.

Children who did not have a social worker were not as well monitored compared to those who did. Although children had child in care reviews, they were carried out by duty social workers (social workers who receive and respond to referrals made to the child and family services) who did not have responsibility for the implementation of the resultant care plan. Some children had not been visited for a long period of time, up to nine years in one case. Most LHAs did not have a strategy in relation to retaining foster carers and there was a risk that some foster carers could be overburdened.

Outcome 6 – Each child receives high quality care from carers that have been appropriately assessed and approved.

Under this outcome measure, children live with carers that value, accept and support them. The HSE ensures that carers are suitable to provide this type of high quality care through its assessment and approval process. Assessments are comprehensive and all carers are approved by the foster care committee.

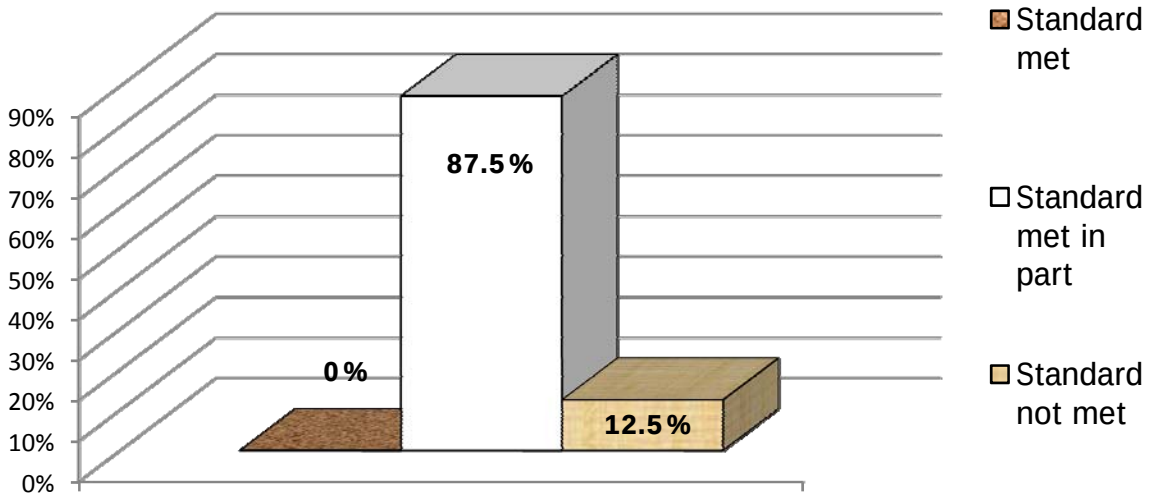
HIQA findings during 2012

There were gaps in the strategic planning of foster care, and needs analyses had seldom been undertaken within HSE local health areas (LHAs). The recruitment of foster carers had not been based on identified needs, although there had been some recruitment in relation to individual children.

There was a shortage of foster carers identified during 2012. In most areas inspected, there was no extra capacity in the fostering services with very few or no foster placement vacancies. Due to staff vacancies, LHAs were finding it difficult to carry out recruitment campaigns or assess potential carers in a timely manner. This shortage meant that the matching of children and foster carers was often solely dependent on the availability of a placement and therefore there was a risk that children would be placed with foster carers who could not meet their particular needs.

The findings against Outcome 6 are shown in Figure 16 on the next page.

Figure 16. Findings against Outcome 6 during 2012



Standard 14: Assessment and Approval of Foster Carers

Foster carers were not assessed in a timely manner. None of the LHAs inspected met in full the Standard for assessing foster carers. While there were robust policies in place in this regard and the quality of assessments was good, assessments were delayed or prolonged for up to a year in some cases. This exacerbated the shortage of foster carers and meant that some children were living with relative foster carers who were not approved for significant periods of time. In mitigation, relative foster carers had undergone the emergency element of the assessment.

The data made available to the Authority by the HSE indicated that general foster carers were prioritised for the allocation of link social workers. This strategy is understandable in the context of overall staff vacancies, but does not necessarily reflect the challenges experienced by relative foster carers and any risk to children. Furthermore, it does not recognise the pressures which relative foster carers may experience – in relation to decisions about the children – from the other family members.

Some LHAs used private foster care services and on occasion this meant that children were moved out of their local schools and communities and further away from their families. The use of private foster care placements varied hugely from one LHA to another, as did the number of children placed outside of the LHA.

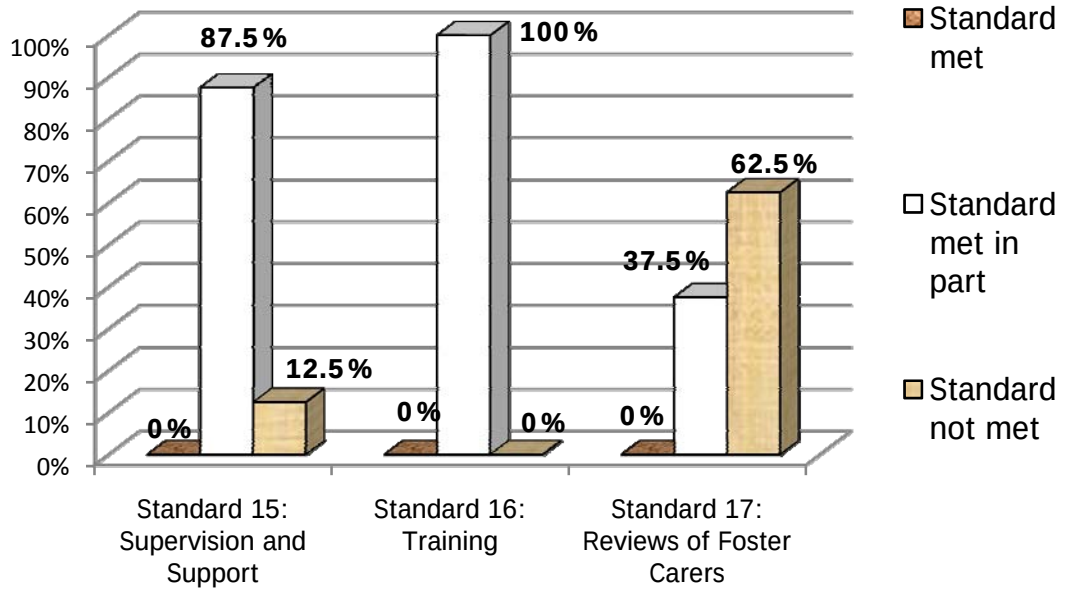
Outcome 7 – Carers are supported to provide high quality care through ongoing participation in relevant training, supervision and reviews

Carers regularly participate in training that provides them with the skills and knowledge to provide high quality care to children. Each foster care household has an allocated link worker. Link workers support carers in caring for children through regular supervision and advice. Foster carers participate in regular reviews of their continuing capacity to provide high quality care.

HIQA findings during 2012

The findings against Outcome 7 are shown in Figure 17.

Figure 17. Findings against Outcome 7 during 2012



Foster carers provided good quality care to children in the main. However, there were some issues which required improvement. Due to staff vacancies, it was difficult for social workers to provide consistent support to foster carers and supervise placements. As a result, a lot of support took place over the telephone and inevitably this kind of telephone supervision is less robust than a face-to-face meeting. Social workers did not always record supervision consistently and it was not possible to verify the level of support which had been provided.

Foster carers did not undergo reviews by the social work departments (see Figure 17), although some LHAs were beginning to start this process at the time of the inspection. Both the Standards and the HSE guidance for foster care committees require that such reviews be held at prescribed intervals. These reviews assess the

capacity of foster carers to provide safe, high quality placements on an ongoing basis. The HSE guidance on foster care committees notes that scrutiny by such committees of foster carers' review documentation adds another dimension to the necessary rigor that must be deployed to inform decisions concerning carers' continuing approval and the terms of such approval.[‡] The failure to hold the reviews in the LHAs inspected by HIQA during 2012 meant that the capacity and capability of foster carers was not formally evaluated on an ongoing basis. Recommendations could not be made and required actions taken to support foster carers to provide good quality placements and to ensure that children were not placed with carers who could not meet their needs.

Foster carers experienced difficulties in managing behaviour that challenged and this was a common cause of placement breakdowns. There was very little training provided to foster carers in this or any other regard and this meant that foster carers may not have the skills and knowledge to meet the needs of children for whom they cared. Moreover, there was a low take up from foster carers when training was provided and this was tolerated by the LHAs. However, as some placements foundered as children became adolescents or developed behaviours that challenged, specialist supports were not always in place. Following breakdowns, foster carers did not always receive a review, although some carers were given specific training. Nonetheless, retention of foster carers in most LHAs was good.

Outcome 8 – Effective governance, leadership and management arrangements enable the full range of children's needs to be met

Under this outcome measure, services are effectively managed with clear lines of accountability for the management of services to children in foster care. Services have effective systems in place to continuously assess the quality of care to children in foster care. Management demonstrate leadership and a commitment to continuous improvements in the outcomes for children in foster care.

HIQA findings during 2012

Most LHA management systems were in a transition as the HSE's child and family service prepares to move from the HSE to the new Child and Family Agency. In some LHAs, the foster care service operated in the new area structure whereas on the ground, other services operated as LHAs in reality. There were some new governance structures in place, although many of those in leadership positions were in acting roles. New business processes were being embedded and new policies were coming into use. However, LHAs were struggling to achieve the timeframes for assessments required by the Standards and regulations. Staff were not aware of other policies such as the policy on protected disclosure which acts as a mechanism to protect the quality and safety of services.

[‡] HSE Foster Care Committees, Policy, Procedures and Best Practice Guidance (January, 2013:47).

Most LHAs did not have a strategic plan in relation to foster care. They did not carry out a needs assessment, nor collate and analyse information to inform the delivery of the service. Some LHAs did not have access to a HSE special foster care service and the HSE strategy to meet the complex needs of some children was not clear. LHAs struggled with the data requirements of the Authority's inspection process and were not able to supply reliable data for the inspectors to use prior to and during the inspection. Area managers were open about the difficulties they experienced in this regard, which were exacerbated by poor information technology (IT) systems, or ones such as the Social Work Information System which did not provide the data required. A limited number of audits had taken place to support quality improvement, such as an audit of the quality of case files.

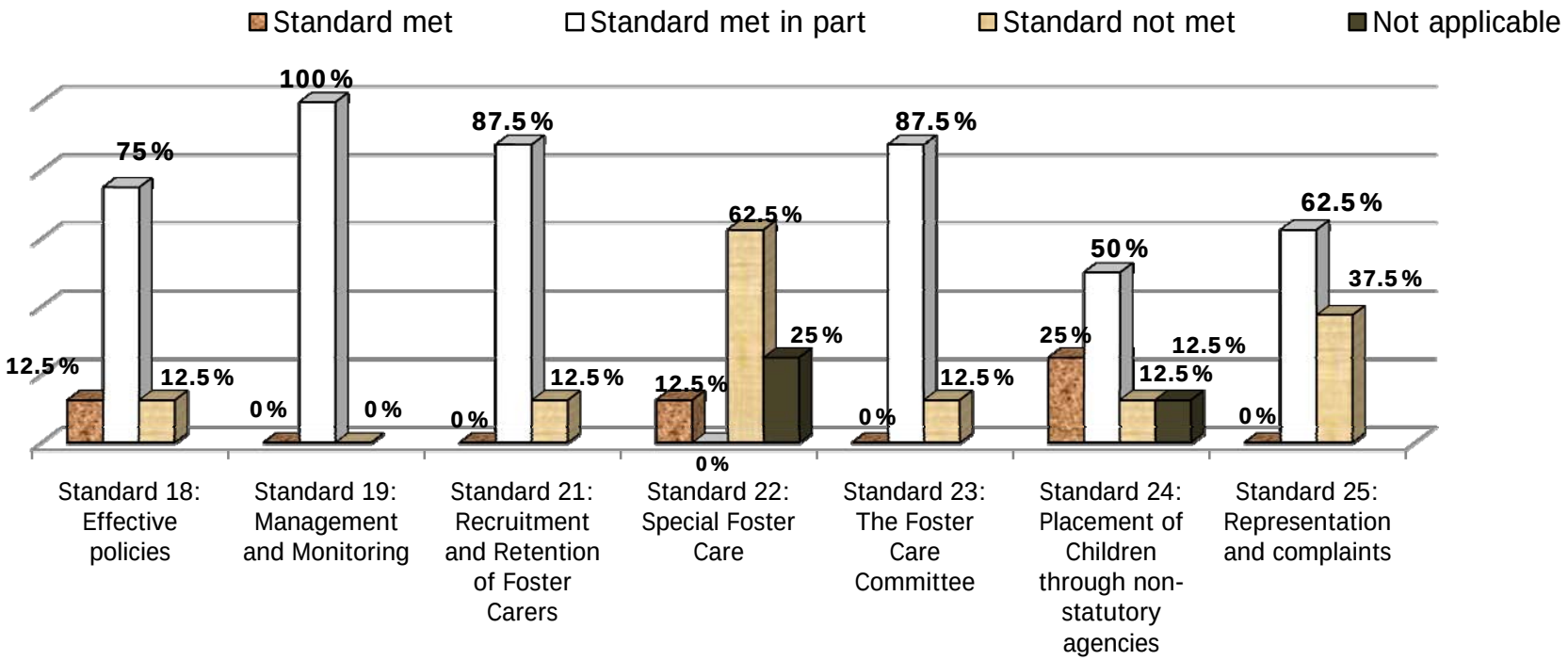
Systems to manage complaints were not robust and in over 37% of inspections this Standard was not met (see Figure 18 on the following page). Information gleaned from complaints was not analysed to drive improvements in the service. User friendly and clear information was not always available for parents and children to make complaints and those who spoke to inspectors were not always sure about how to make a complaint.

The majority of social workers felt supported by their managers and spoke about an open and positive culture. They had received briefings on Children First (2011) although little other training was provided.

Certain administrative processes were not robust. Most foster care committees did not function in accordance with the HSE policy, and complaints and concerns about foster carers were not reported to them. This created a risk to safeguarding, and children could be placed with foster carers about whom there were unresolved concerns. Other information, such as the outcome of foster carer reviews, was not always fed back to the foster care committees.

The foster care committees did not always determine what service the foster carers were to provide (such as long-term, short-term or respite care). In addition, the shortage of foster carers meant that children who were initially placed in short-term placements remained there. Foster carers were then providing a placement type for which they were not approved and to which they had not necessary agreed. While this did not necessarily present a problem, it could contribute to a lack of resilience in placements.

Figure 18. Findings against Outcome 8 during 2012



Outcome 9 – Children are supported by staff members that have appropriate qualifications, supervision and training

This outcome measure means staff members have the skills, knowledge, qualifications and experience to support children and deliver a high quality foster care service. Staff members participate in regular supervision and ongoing training.

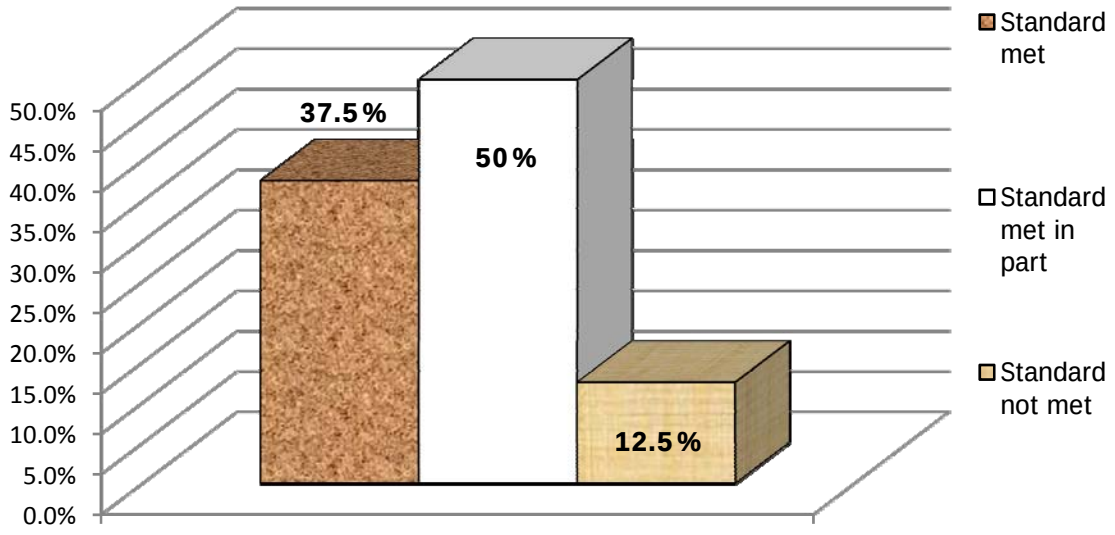
HIQA findings during 2012

Figure 19 shows the findings against Outcome 9. Inspectors found that foster care services, including assessments, were carried out by suitably qualified staff. Newly recruited staff received induction programmes and often had protected caseloads for a period of time.

Many staff received good quality supervision but this was not always provided on a regular basis. Where it took place, it was usually of good quality and staff said that they felt supported. However, pressures of work and staff vacancies impacted on the frequency of supervision. This could result in staff feeling unsupported and a lack of managerial oversight of casework.

Many qualified staff did not have opportunities to participate in training, and there was little formal training provided. There were very few examples of robust training programmes based on training needs analyses to support social workers in carrying out work in line with best practice.

Figure 19. Findings against Outcome 9 during 2012



Standard 20: Training and qualifications

6. Discussion on fostering service inspection findings

A number of important issues emerge from this review of the 2012 HIQA inspections on foster care services. There was insufficient foster care placement capacity in the LHAs inspected in this round of inspections. Although very few children were waiting for a placement, the system was operating at full occupancy. As with the residential population, some children presented with behaviour that challenged but foster carers were offered very little training in this or any other area. When offered, foster carers did not partake in regular training, even when it was a requirement in their contract. In addition, social work department staff shortages impacted on the safety and quality of services available to children and families. There were some systems deficits, such as how the foster care committees operated, while data collection and analysis was poor.

These deficits pose potential threats to the stability of foster care placements, particularly as the children became teenagers and issues around their identity come to the fore. Although recruiting more foster carers will mitigate this situation to some extent (and there is a HSE recruitment campaign under way at the time of writing this report) a needs analysis of children and young people who are at risk of coming into care should inform any recruitment process. A number of non-Irish national and immigrant communities are now well settled in Ireland and it should be possible to recruit suitable carers in these communities to support appropriate matching.

There is a lack of special foster carers. While this may be a deliberate decision in some LHAs, there should be capacity to meet children's particular needs and minimise the possibility of children and young people experiencing placement breakdowns or having to move outside their own communities. This could be delivered in a number of different ways, including through improved training and support for foster carers. At this point in time, it is not possible for the Authority to review the national average rate of placement breakdown per calendar year in the foster care population in Ireland. This analysis will be prioritised in the future by the Authority. However, this will be dependent on the quality of the available data.

Some LHAs were not able to prioritise the allocation of a link social worker for relative foster carers to support the stated policy of the HSE, which is to place children with carers from their own family network. Many of the families had not intended to become foster carers and had stepped forward to support the children. Some children have a close relationship with their families of origin and this can give rise to complications for relative foster carers. In addition, the LHAs found it difficult to prioritise the assessments of the relative foster carers and assessment can take up to a year to complete. There is therefore a possibility that children might be at risk of receiving less than optimal care during this period of time.

There is also a gap between the foster care committee and the day-to-day service

offered to the children, particularly in terms of communication and safeguarding systems. In combination with gaps in vetting and the absence of up-to-date training for foster carers on *Children First: National Guidance for the Protection and Welfare of Children* (2011), it was clear that there are deficits in this area. It is important that the foster care committees operate in accordance with the HSE's own guidelines in this regard.

Not all children in foster care in the areas inspected had an allocated social worker. The practice of a duty social worker carrying out a child in care review in order to draw up a care plan when there is no social worker to implement it does not meet the requirements of the regulations in any true sense.

The LHAs experienced considerable difficulty in collecting and learning from reliable, valid data. This meant that senior managers did not always have key information required to plan services and allocate resources. As a consequence, they have not been able to put an effective quality assurance programme in place or take actions to improve services. Inspectors found that collecting and analysing data was an ongoing problem throughout the child and family services inspected by the Authority. While this may not seem to be a priority for LHAs in the face of the significant operational pressures, without rigorous data analysis there could be no assurance that senior managers were using scarce resources to produce the best possible outcomes. At worst, the LHAs might not be fully aware of the challenges with which they were facing. Social workers and foster carers worked hard to deliver a safe and good quality service to children and young people. In an era of severe staff shortages, managing resources becomes a critical requirement.

The HSE requires a cohesive strategy based on robust data which will allow it to design a foster care service which will meet the wide ranging needs of children throughout the country.

Next steps

The Authority continues to carry out inspections of HSE foster care services for children in order to monitor compliance with Standards and regulations. The HSE has submitted action plans in response to the reports issued following inspections, including plans relating to any identified risks. The Authority has received written assurances that actions are being taken by the HSE to address risks. HIQA continues to monitor progress made by the HSE in addressing non-compliances. The aggregated findings and analysis contained in this report will allow the HSE, and the Child and Family Agency once established, to address deficits and make changes at a corporate level to address common themes which emerged during 2012 in order to improve the quality and safety of foster care services provided to children.

7. Glossary of terms

Care orders: under the Child Care Act, 1991 there are a number of procedures which the Health Service Executive (HSE) can use when dealing with children who are at risk or who are in need of care. The HSE may apply to the courts for a number of different orders, which give the courts a range of powers including decisions about the kind of care, and the access to the children for parents and other relatives. The HSE must apply for a care order if a child needs care and protection which he/she is unlikely to receive without an order. The district court judge may make an interim care order while the decision on a care order is pending. This means that the child is placed in the care of the HSE for eight days. It may be extended if the HSE and the parents agree. Generally the parents/guardians must be given notice of an interim care order application. A care order may be made when the court is satisfied that:

- the child has been or is being assaulted, ill-treated, neglected or sexually abused
- or that the child's health, development or welfare has been or is likely to be impaired or neglected
- the child needs care and protection which he/she is unlikely to receive without a care order.

When a care order is made the child remains in the care of the HSE for the length of time specified by the order or until the age of 18 when he/she is no longer a child. The HSE has the rights and duties of a parent during this time.

***Children First: National Guidance for the Protection and Welfare of Children* (2011):** promotes the protection of children from abuse and neglect. It states what organisations need to do to keep children safe, and what different bodies, and the general public should do if they are concerned about a child's safety and welfare. It sets out specific protocols for HSE social workers, Garda Síochána and other front-line staff in dealing with suspected abuse and neglect.

Emergency approval: under the child care regulations foster carers are approved for placements by a foster care committee. However, emergency placements are sometimes made prior to this approval when there are limited options for the care of the child.

Foster care: where possible the HSE places children with foster parents. The Child Care (Placement of Children in Foster Care) Regulations 1995 require that a care plan for the child be drawn up which sets out, among other things, the support to be provided to the child and the foster parents and the arrangements for access to the child in foster care by parents or relatives. If there is a shortage of foster parents, and/or it is assessed as meeting a child's needs, children may be placed in residential care instead.

Link social worker: the social worker assigned by the HSE to be primarily responsible for the supervision and support of foster carers.

Placing children with relatives: the Child Care (Placement of Children with Relatives) Regulations 1995 make provision for relatives to receive an allowance for caring for a child placed with them by the HSE. The child care regulations set out the arrangements for the placement and are broadly similar to the foster care regulations.

Preparation for leaving care and adult life: leaving care and aftercare centres prepare young people for leaving care. The young people in these centres are generally 16 or over. Leaving care and aftercare centres that accommodate young people under 18 require registration as children's residential centres.

Residential care: residential care can be in a home run by the HSE, a children's residential centre registered under the Child Care Act, 1991, a school or other suitable place of residence. The Child Care (Placement of Children in Residential Care) Regulations 1995 state the requirements for the placing of children in residential care and the National Standards for residential centres, which are registered with the HSE. The centres are subject to inspection by the Health Information and Quality Authority.

Supported lodgings: according to HSE policy, supported lodgings is the provision of support and accommodation to children in care aged 15 and over who require less supportive environments than younger or more vulnerable children. Providers of supported lodgings are vetted in accordance with HSE policy but are not assessed to the same criteria as foster carers.

Voluntary care: if a child is in need of care and protection and is unlikely to receive it at home, then the HSE must take them into care. In other cases, where parents are unable to adequately care for their children, for reasons such as serious illness or other difficulties, they may agree to their children being taken into the care of the HSE. This is known as voluntary care. In such cases, the wishes of the parents as to how care is provided to the children must be considered. The HSE is under obligation to maintain the children for as long as their welfare requires it.

Published by the Health Information and Quality Authority.

For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7

Phone: +353 (0) 1 814 7400
Email: info@hiqa.ie
URL: www.hiqa.ie