Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Quality Authority (HIQA) Regulation Directorate monitoring inspection report of Tusla social work role under the Child Care (placement of Children in Residential Care) Regulations, 1995 (22 – 25)

Name of provider:	The Child and Family Agency
Tusla Region:	South East
Tusla Service Area:	Waterford/Wexford
Type of inspection:	Announced
Date of inspection:	9 - 10 November 2022
Fieldwork ID:	Mon-0037728

About this inspection

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect children's residential centres provided by the Child and Family Agency (Tusla)[1] and to report on its findings to the Minister for Children, Equality, Disability, Integration and Youth.

This inspection relates specifically to the statutory duties of Tusla social workers in the monitoring of placements for children in residential care, to which the Child Care (Placement of Children in Residential Care) Regulations 1995 (22, 23, 24 and 25), apply.

[1] Tusla was established 1 January 2014 under the *Child and Family Agency Act 2013.*

How we inspect

As part of this inspection, inspectors met with the relevant social work managers with responsibility for children in care and evaluated the respective regulations as listed above.

The key activities of this inspection involved:

- the analysis of data submitted by the area
- interviews with:
    - the area manager

- focus groups conducted in person with:
    - principal social workers
    - social work team leaders

- the review of:
    - local policies and procedures, minutes of various meetings and case management records
    - a sample of 13 children's case records

- observation of a child-in-care review meeting.

Four children and young people spoke with inspectors about their experience. Additionally, inspectors spoke with five parents who had children placed in residential care.

Acknowledgements
The Authority wishes to thank the staff and managers of the service for their cooperation with this inspection.

Profile of Tusla social work services to children in residential care

The Child and Family Agency

Child and Family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children, Equality, Disability, Integration and Youth. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from January 2014.

The Child and Family Agency (Tusla) has responsibility for a range of services, including:

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Education and Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

The Child and Family Agency (Tusla) has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm.

The Child and Family Agency (Tusla) services are organised into 17 service areas which are managed by area managers. These areas are grouped into six regions, each with a regional manager known as a chief officer.

Service Area

Waterford and Wexford is one of the 17 areas within Tusla's Child and Family Agency. Situated in the south east of Ireland, Waterford and Wexford area comprises of Waterford, Wexford and South Kilkenny and has a population of 280,260 (Census 2016). According to data published by Tusla in 2018, the service area had a population of 73,130 children aged between of 0-17 years. In Wexford, the area saw a significant increase in population in recent years especially in the Gorey area in the north which had seen large migration from the greater Dublin area. In Waterford, 21% of the population live in disadvantaged areas (national rate 14%).

In Waterford, 58% of the population lives within 15km of the city and there is only one other large urban centre in the Dungarvan area. The rural county area has a deficit of services to meet the needs of the population. In Wexford, the population is more evenly spread across the county and services are delivered from four urban centres, Wexford Town, New Ross, Enniscorthy and Gorey. Wexford and Waterford are the 4th and 5th most deprived local authority areas in the country.

The area is under the direction of the regional chief officer for Tusla, South East, and is managed by an area manager. Children in care are managed by both the child protection and welfare teams and the children in care teams. The area had four principal social workers (PSWs). This comprised of two PSW's for the child protection and welfare teams and two PSW's for the children in care teams. At the time of inspection, there were seven social work team leaders on the child protection and welfare teams and four social work team leaders on the children in care teams across the area.

Data provided to HIQA showed that as of the 24th October 2022, the service area had placed 33 children in residential care. This consisted of five children placed in statutory residential centres and 28 children placed in non-statutory residential centres. Of the 33 children placed in residential care, 14 children were placed outside of the Waterford/Wexford service area. In addition, seven out of the 33 children were aged below 12 years. The data further indicated that eight children placed in residential care were not allocated to a social worker. At the time of the inspection, it was identified that a further child was not allocated to a social worker but was assigned to a social work team leader. Therefore, the total number of children without a social worker increased to nine'.

The area had 17.5 vacant positions across both the child protection and welfare team and the foster care team at the time of the inspection. This amounted to two social work team leader positions and 15.5 social work positions.

Compliance classifications

Inspectors will judge whether the service has been found to be **compliant, substantially compliant** or **not compliant** with the standards and regulations associated with them.

The compliance descriptors are defined as follows:

- **Compliant**: A judgment of compliant means the service is in full compliance with the relevant regulation and is delivering a high-quality service which is responsive to the needs of children.

- **Substantially compliant**: A judgment of substantially compliant means the service is mostly compliant with the regulation but some additional action is required to be fully compliant. However, the service is one that protects children.

- **Not compliant:** a judgment of not compliant means the service has not complied with a regulation and that considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk-rated red (high risk) and the inspector will identify the date by which the provider must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of children using the service, it is risk-rated orange (moderate risk) and the provider must take action within a reasonable time frame to come into compliance.

Once a judgment on compliance is made, inspectors will review the risk to children of the non-compliance.

In order to summarise inspection findings and to describe how well a service is doing, the regulations are grouped and reported under the dimension of quality and safety of the service.

Quality and safety of the service:

The quality and safety dimension relates to regulations that govern how services should interact with children and ensure their needs are planned for and met. The regulations include consideration of planning, review, visiting children and recording. They look to ensure that children are safe and supported throughout their engagement with the service.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
09 November 2022	9.00hrs to 17:00hrs	Hazel Hanrahan	Lead Inspector
09 November 2022	09.00hrs to 17.00hrs	Lorraine O'Reilly	Support Inspector
10 November 2022	09.00hrs to 17.20hrs	Hazel Hanrahan	Lead Inspector
10 November 2022	09.00hrs to 16.00hrs	Lorraine O'Reilly	Support Inspector
10 November 2022	10.00hrs to 16.40hrs	Rachel Kane	Support Inspector

Views of people who use the service

As part of the inspection, inspectors spoke with five parents and listened to their experiences of the service. The parents had experience of children placed in residential care by the area.

Hearing the voice of children is very important in understanding how the service worked to meet their needs and improve outcomes in their lives. For this inspection, children were consulted with to ask whether they wished to speak with inspectors about their experiences. Children were provided with the freedom to choose to participate or not. The majority of children selected choose not to speak with inspectors however, the inspectors spoke with four children.

Children told inspectors of their experience of contact with their social worker when in residential care with one child saying that they did not know if their social worker had visited them or if they had made contact to speak with them. Other children said the following about social worker contact;

- 'more involved with aftercare worker now'
- 'not that often, every few months, would rather more often'
- decisions are 'not always' put into action and 'I don't care anymore'

and those that did have meetings with their social worker said they were not confined to the residential centre but that;

- 'she comes to visit and brings me off, we go for a walk and talk or for a coffee'
- 'brings me out to get food'
- 'go to the cinema'.

Not all children received a copy of their care plan with one child saying that *'I'm just told about the decisions from it'.*

Children also described to inspectors their experience of participating in making decisions about their lives, talked about decisions that affected them and said that;

- 'ya I do (attend) some decisions are out of my hands, some decisions lie with people higher up'
- 'sometimes'
- 'sometimes I do, sometimes I don't, they tell me about care plans and stuff'
- if not happy about decisions 'ya I can go to the staff, or manager or social worker'.

Two children said to inspectors that they were supported by social workers to maintain family contact with one stating *'ya I go home every weekend'*.

Inspectors spoke with five parents who provided mixed feedback on their experience of the service. The parents said to inspectors that they felt that their children were safe in residential care and made the following statements;

- 'she is being looked after'
- 'nice place where she is. Staff are friendly'
- 'can ring anytime. Staff are wonderful'.

Parents spoke about the changes in social workers, and said

- the 'change of social workers was hard' and that one parent 'got worried about why was it happening'
- 'felt I had no voice before with changes in social workers
- and the impact it had on their children, 'she was upset over it'
- 'pretty annoyed about social worker changes and telling story' to someone new
- and that 'change in social workers, changed plans for contact' with child.

Parents described the social workers communication and interaction with them as:

- 'works with you'
- 'been good'
- 'contact fairly regularly'
- 'ring straight back after a missed call'
- 'do feel enough support for child'
- 'social worker includes me in support at meetings, by phone calls and updates'
- 'get updates from social worker'
- 'supported and that the social worker is always there for you'
- 'doing a good job'
- 'always know what's going on'.

All parents said that they had received a copy of the Care Plan about their child. When speaking about child-in-care reviews, parents spoke positively about the support provided to them and their child to participate at these meetings. One parent talked of how their child attended the end of the meeting and that simple language was used by professionals. Another parent said that they were given time to talk at meetings but that *'I have little to say, all the hard work is being done by the social worker*'. Other parents made the following statements;

- 'social worker and professionals definitely listen to child, read out his form and listen to (child)'
- child 'asked questions about reunification and social worker planned a visit to see (child) and talk about it'
- 'outline actions and next meeting look at them and see if done'
- 'actions from meetings get done'

- ‘plan in place is clear’
- sometimes given time to talk and other times hard to talk because professionals keep talking’.

Parents told inspectors of areas that could be improved upon in the service;

- ‘give parents more of a voice’
- ‘tell the parents more’
- ‘guide parents that its ok to talk’
- ‘not listened to when placements breaking down’
- ‘love to have more time on my own with (child)’. ‘
- ‘could ask about how [children] feel, if [they are] having a hard time, actually sit down with [children] and ask [children] how [they] feel, check in a bit more.’

Quality and safety

The data submitted by the area showed there were 33 children placed in residential care at the time of inspection. This accounted for 8.3% of the total number of children in care in the area. Inspectors reviewed 13 children's case records for care planning, reviews, supervision and visiting children and the quality of case records, to inspect the service area's level of compliance with the Child Care (Placement of Children in Residential Care) Regulations, 1995.

Care planning and review

A care plan is a written document which outlines the plan for the child’s care based on an assessment of the child’s needs. The regulations require that each child placed in residential care has a written and up-to-date care plan, which clearly outlines the aims and objectives of their placement and the supports to be provided by Tusla to the child, their parents (where appropriate) and the residential centre. This plan should include contact arrangements between the child and their family and the arrangements in place to review the plan at different intervals throughout the child’s time in care.

Data provided to HIQA by the area indicated that 32 (of 33) children in residential care had an up-to-date written care plan. This was consistent with the findings of this inspection which found that 12 of the 13 case files sampled had up-to-date care plans in place. One child's care plan was not up to date and outside of the statutory timeframes however, a child-in-care review was scheduled to take place.

Inspectors found that the care plans reviewed were child centred, of good quality and tailored to meet the needs of the individual child. Care plans were developed by a number of key professionals involved in the childs life and also included the involvement of the child's parents, where appropriate, and incorporated the child's

perspective. Inspectors found that care plans reflected the child's wishes, feelings and views and, where possible these were acted upon. Contact with family and siblings was consistent with the child's care plan, and focused on and was shaped around the child's needs. For example, a child who requested increased family contact had their views considered by professionals that resulted in their request being approved and was reflected in their care plan. Inspectors found that social workers used a variety of tools to seek the views of children to participate in their care plans and this was recorded. This included the use of child friendly booklets tailored for children, visiting children in person to gather their views and providing children with the option to attend their care plan meetings in person.

Inspectors found where possible, care plans were prepared as soon as it was identified that there was a need for a child to be placed in residential care. Inspectors found that meetings were scheduled to develop the child's care plan within the following two months of the child being placed in residential care, in line with regulations. For example, in one case a child was admitted into residential care and their care plan meeting was scheduled a week later. Another case a placement plan was developed for the child within days of their placement into residential care, with their child-in-care review scheduled within the legislative timeframe.

Inspectors found that the majority of care plans clearly documented the reason why the child was placed in residential care and the goal of meeting the child's needs. This was important as the child, their family, and the residential care team must be clear about the purpose of the child's placement. However, inspectors found one child's care plan did not identify the reason why the child was placed in residential care and the overall aim of the placement plan. Without this information it would be difficult to establish whether the placement was achieving its aim.

Care plans were comprehensive and included arrangements made to meet the child's needs in relation to a number of areas in their life that included emotional and behavioural development, education, health, the childs identity, arrangements for parental and sibling contact and aftercare. It also identified what services and actions were needed to help respond to the child's identified developmental needs. This was reviewed and updated by a multi-disciplinary team that included schools, aftercare workers and guardians-ad-litem The decision-making was clear and it was recorded who was responsible for actions and the timescales agreed for completion. However, in one case inspectors found that safety concerns for a child's behaviour was not discussed or assessed in the care plan and did not identify how this would be monitored and responded to.

Inspectors found evidence of multi-agency working from care plans and other documentation reviewed. This showed agencies worked well together to get a full overview of a child's situation and developed a co-ordinated approach of support for the child. There was evidence of good information sharing and collaboration between agencies so that professionals fully understood any risks a child may be exposed to

and action to take to keep them safe. Inspectors found that the language used in care plans was clear.

Inspectors found that for children nearing the age of 18 years, preparation for leaving care occurred within the care planning process. This was reflected in the actions outlined in the care plan to support the young person's transition into adulthood for example; a referral for aftercare, development of independent living skills and health needs. However, inspectors found that at the time of the inspection, actions from one young person's care plan had not been completed in a timley manner. This lead to uncertainty in the young persons preparation for leaving care. For example, the aftercare plan that should identify needs for aftercare supports such as accommodation, education was not completed within the six month timeframe prior to the young person leaving care.

Inspectors found that strategy meetings and professionals meetings were used where placements were at risk of breakdown or there were changes in circumstances in the child's life. From document review inspectors found that these meetings enhanced the quality and safety of the service provided to children. Risk escalation processes were used effectively to alert senior managers to increased risks to children in residential care. There was evidence of appropriate management oversight and response to mitigate these risks and promote children’s welfare and protection.

Each child placed in residential care should have their case reviewed in line with the regulations. The main process in place in Tusla to do this is called a child-in-care review. Through this process, the child’s allocated social worker assesses outcomes for the child and identifies whether their needs are being met in their current placement. The social worker ensures that the child’s care plan is being adhered to and any changes required to this plan are made during this review. The regulations place a statutory duty on the social worker to ensure these reviews take place within specific timeframes and that all relevant people are prepared and participate in the review process. It is particularly important for the child to participate and be consulted so their views and experiences can be considered when updating their care plan.

Inspectors found after reviewing 13 children’s files around their care planning and review that nine children's reviews were in line with statutory requirements. Inspectors found that for four children’s cases, they experienced delays in their child-in-care reviews. Two child-in-care reviews were delayed by two months. Children aged 12 years and under are required to have monthly reviews, for two children, under the age of 12 years, these were not consistently taking place. In exceptional circumstances, where children, aged 12 years and under are placed in residential care settings, the national policy states that statutory child-in-care reviews should be held monthly, to ensure residential care remains the most appropriate placement for them. Data submitted by the area indicated there was

seven children aged 12 or under in residential care. Inspectors found that for the majority of children who had recently moved to a residential care setting, their first child-in-care review was scheduled to be held within two months of their placement starting.

Upon reviewing case files inspectors found that child-in-care reviews provided opportunities for parents, residential care staff, other professionals and children to contribute and express their views at the meeting and that this was well documented. Inspectors found that not all children choose to attend their reviews and the reason was documented. Where children did not attend child-in-care reviews, inspectors found that child centred tools were used with the child, their views documented and captured as part of the review process. Inspectors found that these meetings monitored the progress of the plans and ensured that they were being progressed effectively.

Inspectors found that children's written views were documented exactly as the child had written them and it was given due weight throughout the review. The discussion focused on a number of areas of the child's life that included health, education, family access and emotional wellbeing. The review also looked at the suitability of the placement and the long-term stability for the child, and the parents were included in this discussion. Inspectors found in some cases there was good discussion and focus on permanency planning that looked at which option was most likely to meet the needs of the individual child, taking account of his or her wishes and feelings.

Inspectors observed a child-in-care review meeting, by virtual means that was attended by the child, residential care staff, aftercare worker and the social worker team leader. Inspectors found that the child-in-care review was not well structured and that discussions were not focused and clear about the child's life when leaving care. There were elements of drift and delay in actions being progressed from the last review. Evidence of forward planning and discussion around the child's pathway plan on leaving care was unclear, creating uncertainty for the child to make a successful transition from care. Additionally, where the child's aftercare plan was not completed in a timely manner, consideration of convening a child-in-care review earlier than the scheduled date was not taken into account. The child particpated in the review and was provided with a space to have their views heard. Following the review, assurances were sought by the inspector on the overall plans for the child in transitioning from care that promoted the welfare of the child. Evidence was provided that clearly outlined a number of steps taken and actions identified to be completed by the service to secure a stable transition from care for the child in line with their care plan. This included, development of independent living skills, and or education and work opportunities and completion of their aftercare plan. Additionally, managers had secured an interim placement for the child while working to secure permanent accommodation tailored to the child's needs.

The management and oversight of care planning and reviews for children in residential care required further improvement. Inspectors found a lack of consistent approach in the chairing of child-in-care reviews. For example; one area had oversight from an independent reviewing officer while the other area had social work team leaders take on additional responsibilities. Inspectors found from interviews and observation of a child-in-care review that social work team leader's professional capacity was stretched at a time when the area was carrying vacant social worker positions. This had placed added pressure on competing work demands that impacted, on occasion, on the monitoring and oversight of changes in a child's circumstances or placement provision or whether child-in-care reviews should be held earlier than the scheduled date.

Supervision and visiting children

When a child has been placed in a residential centre, a Child and Family Agency (Tusla) social worker is responsible for the care of the child. Their primary aim is to ensure the child is safe and supported in their placement. The regulations state that the supervising social worker should visit the child at different intervals, according to the length of time they are in their placement, and ensure that their care plan is being followed through and reviewed as necessary, and that the child's needs are being met.

Inspectors reviewed 12 children's case files for the purpose of reviewing the timeframes of statutory visits over twelve months prior to the inspection. The data submitted prior to the inspection, indicated that 25 of the 33 children in residential care had an allocated social worker, with eight children not assigned to a social worker. However, the inspectors found an additional child who was unallocated to a social worker during the inspection but was assigned to a social work team leader. The total number of unallocated children in residential care was nine.

Inspectors spoke with the area manager on the topic of children who were not allocated to a social worker. The area manager said that the majority of the unallocated cases were recent and had amounted to two caseloads. Additonally, one case was unallocated since June 2022. The cases were previously assigned to two named social workers but due to the lack of capacity as a result of staff vacancies, the cases were not reassigned by the time of inspection. For children who were not allocated to a social worker, the area had a standard operating procedure in place to ensure that all children in residential care received a level of service that ensured their safety. Part of the operating procedure was for the area to send a letter to the parents when a child became unallocated. This letter included confirmation that the child was unallocated and details regarding how to contact the team in the event of any issues arising. Inspectors did not find evidence on case files that this process was being implemented.

The principal social workers and team leaders had oversight of the unallocated cases through monthly meetings where they assessed and considered interventions in place, factors that may have increased risk, and case prioritisation and need. Documentation showed that these meetings happened and were in line with their standard operating procedure. Inspectors found examples where it was recognised that the risk was higher than originally assessed and required a higher priority for allocation.

Further assurances were sought from the area manager following the inspection on the high number of children in residential care not allocated to a social worker. The negative consequence of children in residential care not being allocated to a named social worker was that the work was limited to a monitoring function as the team leaders assigned to these children had competing case priorities. Given the level of need children in residential care require due to their vulnerability and separation from their family, these children should be allocated to a social worker as a priority. These assurances were sought through a provider assurance report and the information received provided an assurance and timeframe that all nine children would be allocated to a social worker by December 2022.

Of the 13 children's case files sampled by inspectors, it was found that 10 of these children in residential care were being visited in line with regulations. However, for three children the frequency of statutory visits was not in line with regulations. Out of these three children, two children were not allocated to a social worker. For one child there was a three week delay, another child there was a significant gap of eight months. Assurances were sought from the area manager about this child however, documentation could not be produced to evidence that the statutory visit had taken place. For a third child, their admission into the residential centre was documented as a statutory visit, which was poor practice, since the child cannot give feedback to their social worker on the first day they have been admitted to a centre. Statutory visits were incorrectly recorded where children were not seen alone.

Inspectors found that statutory visits to see children in residential care were carried out by a social worker and that while there were gaps as noted above, good practice was noted where the child, where possible, was seen alone. Social workers did not always confine their statutory visits with the child to the residential care setting but met the child at other locations and undertook activities. For example, nature walks, brought for lunch or dinner. An example of good practice seen by inspectors was where a social worker undertook child friendly work with the child around internet safety and how this was impacting on them. The social worker provided a space for the child to speak about how they were feeling about significant issues in their life.

Case notes of statutory visits documented child friendly conversations with children. However, there were several cases whereby there were no case records to evidence that statutory visits had occurred. Inspectors found that there was inconsistency in

the quality of recording of statutory visits across the different teams of social workers. There were examples found where the date of the statutory visit was only recorded, the voice of the child was not captured, or identified actions and what had happened to and for the child. Inspectors also came across statutory visit records that were missing from the case management system, NCCIS. Other weaknesses identified by inspectors were that statutory visit records were not always up to date and did not always influence the next steps in the child's care planning. Without accurate and timely information to inform risk assessments and decision-making from statutory visits, social workers may not always be able to make the right decisions, at the right time.

Case records

Case records document the child's time in care, support effective planning for the child and record how the views of the child are sought and considered, when decisions about their care are being made. The regulations require that each child placed in residential care has an individual case record which is compiled by Tusla and is kept up to date. These records should be private, permanent and secure, hold all relevant and available information about the child and be held in perpetuity. In order to meet these regulatory requirements, safe and secure information systems are needed. Systems of monitoring and managing information are also needed to promote continuous improvement in the quality of case records.

Inspectors reviewed 13 children's case files to ensure all documents required by the regulation were placed on children's records. Inspectors found that not all records required, such as care plans, medical and school reports amongst others, were always on the case management system NCCIS. Out of the 13 children's case file, five did not have all documentation on file. Assurances were sought for one child from the principal social worker to determine the location of the documents for the child's case file.

Inspectors found that there was an absence of case records of statutory visits and there was inconsistency in the quality of recording statutory visits across the different teams of social workers. Inspectors saw limited evidence of case audits of children in residential care being undertaken that focused on analysing quality. Case audits of children in residential care were not fully used or embedded into the service as part of driving and improving the quality of practice. There was poor management oversight to ensure that the necessary documents were on each child's case file, that timescales were met and that the quality and content of case recording was of a good standard.

Inspectors found through interviews with staff and the area manager that not all teams were provided with dedicated administration time per week to complete administration tasks.

Regulation 22 Case records	**Judgment: Substantially Compliant**
Not all documents required by the regulation were placed on children's records and some statutory visits were absent from case records.	
Regulation 23 Care plan	**Judgment: Compliant**
Care plans were up to date and set out all the required information in relation to the child, in line with the regulations.	
Regulation 24 Supervision and visiting of children	**Judgment: Not compliant**
Not all children in residential care had an allocated social worker. It was also found that not all children were being visited in line with regulations.	
Regulation 25 Review of cases	**Judgment: Substantially Compliant**
Not all child-in-care reviews were held in a timely manner and monthly child-in-care-reviews for children under the age of 12 years were not held consistently. Consideration of convening a child-in-care review earlier than the scheduled date was not taken in account where there was drift and delay in aftercare planning for a child.	

Compliance plan

This action plan has been completed by the Provider and HIQA has not made any amendments to the returned Compliance Plan.

Provider's response to Inspection Report No:	MON-0037728
Name of Child and Family Agency (Tusla) region:	South East
Name of Child and Family Agency (Tusla) service area:	Waterford/Wexford
Date of inspection:	9th-10th November 2022
Date of response:	6th January 2023

These requirements set out the actions that should be taken to meet the identified child care regulations.

Regulation 22: Case Record

Judgment: Substantially Compliant

The provider is failing to meet the regulations in the following respect:

Case records of children placed in residential care were not always up to date in line with requirements of the regulations. Not all documents required by the regulation were placed on children's records and some statutory visits were absent from case records.

Action required:

Under **Regulation 22** the service area is required to ensure that:

A health board shall compile a case record of every child placed in residential care by it and the said record shall be kept up to date. A case record of a child kept by a health board in accordance with this article shall include such of the following documents as are available to the board

- medical and social reports on the child including background information on the child's family.
- a copy of any court order relating to the child or of parental consent to the child's admission to the care of the board, as appropriate.
- the birth certificate of the child.
- reports on the child's progress at school, where applicable.
- a copy of the plan for the care of the child prepared by the health board under article 23 of these regulations.
- a note of every visit to the child in accordance with article 24 of these Regulations.
- a note of every review of the child's case pursuant to article 25, 26 or 27 of these Regulations, together with particulars of any action taken as a result of such review.
- a note of every significant event affecting the child.

Every case record compiled by a health board under this article shall be preserved in perpetuity.

Please state the actions you have taken or are planning to take:

Actions Taken/Planned	Person Responsible	Completion Date
Audit to be carried out by Principal Social Worker (PSW) Quality Assurance Service Improvement (QASI) of all children in residential care to review the quality of record keeping for the past 12 months. For quality assurance purposes, learnings and recommendations from this audit will be disseminated to the social work teams. Audit findings will also be reviewed by the Senior Management Teamn (SMT) as part of the area Service Improvement Plan (SIP).	PSW Children in Care (CIC) teams Social Work Team Leader (SWTL) CIC teams	January 2023
Learning morning for managers and staff on using naming conventions/ Statutory template for visit to child in care to ensure a standardised approach to recording, naming, and location of key children in care records is in place on NCCIS.	QA team PSWS/SWTLs CIC Child Protection and Welfare (CPW) teams	February 2023
Area Manager (AM) has requested that additional Business support hours are allocated to teams to support social work staff in keeping case files up to date. To monitor the impact of this additional support three monthly review meetings will take place between the children in care PSWs and business support managers across the area to review the support being offered and to measure the level of additional support required. This will ensure better oversight in terms of the management and inputting of case records to the NCCIS system and also inform future need for business support within teams that can be considered under the change project.	AM Business support manager	Request completed in December 2023 Review meetings Jan/Jun/Nov 2023
Protected time with built in targets to be incorporated into Social Worker (SW) working month to provide opportunity to ensure recording is up to date and accurate. Agreed targets to be reviewed at monthly supervision	PSWs/SWTL CIC teams	In place in Waterford. Developed in Wexford January 2023

Regulation 24: Supervision and visiting of children

Judgment: Not Compliant

The provider is failing to meet the regulations in the following respect:

Not all children had an allocated social worker, and not all children were being visited in line with regulations.

Action required:

Under **Regulation 24** the service area is required to ensure that:

A child who has been placed in a residential centre by a health board shall be visited by an authorised person as often as the board considers necessary, having regard to the plan for the care of the child prepared under article 23 of these Regulations and any review of such plan carried out in accordance with article 25, 26 or 27 of these Regulations, but in any event

i. at intervals not exceeding three months during the period of two years commencing on the date on which the child was placed in the residential centre, the first visit being within one month of that date, and
ii. thereafter at intervals not exceeding six months

A note of every visit to a child in accordance with this article shall be entered in the case record relating to the child, together with particulars of any action taken as a result of such visit.

Please state the actions you have taken or are planning to take:

Actions Taken/Planned	Person Responsible	Completion Date
All children in residential care have been allocated to a social worker.	PSWs CIC teams	Completed December 2022
Full implementation of statutory visit recording template system & associated guidance across the area which will include: - Learning morning with staff to review the Standard Operating Procedures (SOPS) in place re: statutory visits and highlighting the importance of using the area template to record same.	Quality Assurance (QA) team PSWs / SWTL CIC teams	March 2023

- Review of Statutory visit tracker to ensure that it is monitoring the Statutory visits and flagging with SW when Statutory visits are due. This will be sent to PSW for CIC in each area on a monthly basis. - Review of Statutory visit template to ensure it is capturing the required information and is user friendly for staff.		
Supervision training to be completed by managers across the area to ensure that quality supervision is taking place on a regular basis. This will provide ongoing support to staff and also ensure compliance with National Standards.	SWTLs Workforce Learning & Development	Dates set for Jan/ March 2023
Supervision template is in place. Recording will be added as agenda item for discussion at management meetings and team meetings. Audits carried out by CIC SWTLs and PSWs will inform this discussion and areas for improvement can be identified and addressed at an earlier stage	PSWs CIC SWTLS CIC	Audit to be completed in March 2023 to ensure supervision template is being used

Regulation 25: Review of cases

Judgment: Substantially Compliant

The provider is failing to meet the regulations in the following respect:

Not all child-in-care reviews were held in a timely manner and monthly child-in-care-reviews for children under the age of 12 years were not held consistently. Consideration of convening a child-in-care review earlier than the scheduled date was not taken in account where there was drift and delay in aftercare planning for a child.

Action required:

Under **Regulation 25** the service area is required to ensure that:

A health board shall arrange for the case of each child who has been placed in a residential centre by the board and, in particular, the plan for the care of the child prepared under article 23 of these Regulations to be reviewed by an authorised person as often as may be necessary in the particular circumstances of the case, but in any event—

i. at intervals not exceeding six months during the period of two years commencing on the date on which the child was placed in the residential centre, the first review to be carried out within two months of that date, and
ii. thereafter not less than once in each calendar year

Please state the actions you have taken or are planning to take:

Actions Taken/Planned	Person Responsible	Completion Date
Care plan tracker to be reviewed on a monthly basis and list of reviews due to be sent to PSW to ensure these take place.	Professional support manager QA team	Starting Jan 2023 ongoing on Monthly basis
Quarterly meetings to take place with Care Plan chairs and PSW/SWTL to plan for Child in Care Reviews (CICR) within the following 3 months to ensure these reviews are in line with regulations.	PSWs/SWTLs CIC teams	Jan/Apr/Aug/Dec 2023

Signed:

PSW QASI

Date: 6th January 2023